Board of Directors - Open (Thursday 8 December 2022)

Thu 08 December 2022, 01:00 PM - 05:15 PM

Cornwallis Room, Spitfire Ground, Old Dover Road, Canterbury CT1 3NZ & WebEx

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:10 PM
10 min

22/162
Welcome and Apologies for Absence (1:00) 10 mins

To Note *Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

22/163
Confirmation of Quoracy

To Note *Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

22/164
Declaration of Interests

To Note *Chairman*

22-164 - REGISTER 2022-23 V55 - from November 2022.pdf (5 pages)

01:10 PM - 01:10 PM
0 min

22/165
Minutes of Previous Meeting held on 3 November 2022

Approval *Chairman*

22-165 - Unconfirmed BoD 03.11.22 Open Minutes DRAFT.pdf (19 pages)

01:10 PM - 01:10 PM
0 min

22/166
Matters Arising from the Minutes on 3 November 2022

Approval *Chairman*

22-166 - Front Sheet Public BoD Action Log.pdf (3 pages)

01:10 PM - 01:40 PM
30 min

22/167
Patient Experience Story (1:10) 30 mins

Discussion *Chief Nursing and Midwifery Officer (CNMO)*

- 22-167.1 - Patient Experience Story Board Front Sheet 8.12.22 FINAL.pdf (2 pages)
- 22-167.2 - Appendix 1 Patient Experience Story Board 8 Dec 2022 FINAL.pdf (4 pages)

01:40 PM - 01:45 PM
5 min

22/168
Chairman's Report (1:40) 5 mins

Information *Chairman*

- 22-168.1 - Chairman Report Dec 2022 Board.pdf (4 pages)
- 22-168.2 - App 1 Summary Board meeting IIEKMS report Nov 2022 (003).pdf (2 pages)
- 22-168.3 - App 2 Chairman Report NEDs commitments.pdf (1 pages)

01:45 PM - 01:55 PM
10 min

22/169
Chief Executive's (CE's) Report (1:45) 10 mins

Discussion *Chief Executive*

- **Elective Recovery Programme - Tier 1 and 2 Self-certification**

- 22-169 - CEO Report to Board December 2022.pdf (5 pages)

01:55 PM - 02:25 PM
30 min

22/170
Reading the Signals – Delivering through Pillars of Change (1:55) 30 mins

Discussion *Chief Executive*

- 22-170 - Reading the signals - delivering through pillars of change FINAL.pdf (5 pages)

02:25 PM - 02:45 PM
20 min

22/171
Maternity Services: (2:25) 20 mins

CNMO / Clinical Director for Women's Health / Interim Director of Midwifery (DoM)

- **Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme Year 4**

22/171.1
Perinatal Quality Surveillance Tool (PQST) Report

Assurance *CNMO / Interim DoM*

- 22-171.1.1 - October 22 PQST BoD.pdf (12 pages)

22/171.2
CNST Workforce

Approval *CNMO / Interim DoM*

22/171.2.1
Safety Action 5: Bi-Annual Midwifery Workforce Oversight Report covering Staffing/Safety issues

Approval *CNMO / Interim DoM*

- 22-171.2.1 - Midwifery workforce biannual report December 2022 FINAL.pdf (26 pages)

22/171.2.2

Safety Action 4: Clinical Workforce

Approval *CNMO / Interim DoM*

- 22-171.2.2 - Safety Action 4 Board Report December 2022 Final.pdf (11 pages)
- 22-171.2.2.1 - App 4 SA4.R8.2. QEQM staffing workforce Calculator tool oct 21.pdf (3 pages)
- 22-171.2.2.2 - App 5 SA4.R8.3. WHH staffing workforce calculator tool oct 21.pdf (3 pages)

22/171.3
Maternity Serious Incidents: Q2 Summary Report

Assurance *CNMO*

- 22-171.3 - SI quarterly Q2 22-23.pdf (4 pages)

22/171.4
CNST Maternity Incentive Scheme Declaration process and October 2022 Guidance changes

Decision *CNMO*

- 22-171.4 - CNST Declaration Process front sheet.pdf (7 pages)

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

02:45 PM - 03:15 PM
30 min

22/172
Integrated Performance Report (IPR) (2:45) 30 mins

Discussion *Chief Executive/Executive Team*

- 22-172.1 - IPR Header November 2022.pdf (4 pages)
- 22-172.2 - Appendix 1 IPR_v4.3_Oct 22.pdf (37 pages)

03:15 PM - 03:25 PM
10 min

TEA/COFFEE BREAK 3:15-3:25 (10 Mins)

03:25 PM - 03:35 PM
10 min

22/173
Finance Report (3:25) 10 mins

Information *Chief Finance Officer (CFO)*

- **Month 7 Finance Report**

- 22-173.1 - Front Sheet M7 Finance Report Board.pdf (2 pages)
- 22-173.2 - Appendix 1 - 202307.pdf (17 pages)

03:35 PM - 03:45 PM
10 min

22/174
Medical Revalidation Report (3:35) 10 mins

Discussion *Chief Medical Officer (CMO)*

- 22-174 - BoD Revalidation 122022.pdf (4 pages)

03:45 PM - 03:55 PM
10 min

22/175
Infection Prevention and Control (IPC) Quarterly Update (3:45) 10 mins

Discussion *Executive Director of IPC*

22-175 - IPC Quarterly update Dec 2022.pdf (4 pages)

OUR PATIENTS OUR QUALITY AND SAFETY

03:55 PM - 04:05 PM
10 min

22/176
Panorama and Learning Disabilities and or Autism Report (3:55) 10 mins

Assurance *CNMO*

22-176 - Board LD Paper November 2022.pdf (5 pages)

OUR FUTURE OUR SUSTAINABILITY

04:05 PM - 04:15 PM
10 min

22/177
Health and Safety, Estates Statutory Compliance and Backlog Maintenance update (4:05) 10 mins

Discussion *Managing Director, 2gether Support Solutions*

22-177 - HS and Estates Report December Final.pdf (9 pages)

REGULATORY AND GOVERNANCE

04:15 PM - 04:25 PM
10 min

22/178
People and Culture Committee (P&CC) – Chair Assurance Report (4:15) 10 mins

Assurance *Chair People & Culture Committee - Stewart Baird*

22-178 - PCC Chair Assurance Report BoD 29 Nov 22 final.pdf (6 pages)

04:25 PM - 04:35 PM
10 min

22/179
Finance and Performance Committee (FPC) - Chair Assurance Report (4:25) 10 mins

Approval *Chair Finance and Performance Committee - Nigel Mansley*

- Treasury Policy

22-179.1 - FPC Chair Committee Assurance Report BoD 29.11. 22 v3.pdf (5 pages)
22-179.2 - Appendix 1 Treasury Policy (FINAL).pdf (22 pages)

04:35 PM - 04:45 PM
10 min

22/180
Quality and Safety Committee (Q&SC) - Chair Assurance Report (4:35) 10 mins

Assurance *Chair Quality & Safety Committee - Andrew Catto*

22-180 - QSC Assurance Report 01.12.22 BoD Final.pdf (6 pages)

04:45 PM - 04:50 PM
5 min

22/181
Nominations & Remuneration Committee (NRC) - Chair Assurance Report (4:45) 5 mins

Assurance *Chair Nominations and Remuneration Committee - Jane Ollis*

181 - NRC Chair Board Assurance Report Dec 2022 Open V1.pdf (2 pages)

04:50 PM - 04:55 PM
5 min

22/182
Charitable Funds Committee (CFC) - Chair Assurance Report (4:50) 5 mins

Assurance *Chair Charitable Funds Committee - Jane Ollis*

182 - CFC Chair Board Assurance Report (06.12.22) DRAFT V1.pdf (2 pages)

CLOSING MATTERS

04:55 PM - 05:00 PM
5 min

22/183
Any Other Business (4:55) 5 mins

Discussion *All*

Verbal

05:00 PM - 05:15 PM
15 min

22/184
Questions from the Public (5:00)

Discussion *All*

Verbal

Date of Next Meeting: Thursday 9 February 2023

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM NOVEMBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Chief People Officer	None **Closed interest** MY Trust (started 11 November 2014/finished 20 July 2020) **(4)**	Appointed 1 September 2019
BAIRD, STEWART	Non-Executive Director	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Non-Executive Director of Spencer Private Hospitals (started 1 November 2021) **(1)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)** **Closed interests** Stone VP (No 3) Ltd (started 20 November 2017/finished 21 March 2022) **(1)** Qunifi Holdings Ltd (started 30 November 2017/ finished 21 March 2022) **(1)** Qunifi Ltd (started 13 February 2015/ finished 21 March 2022) **(1)** Unicus Travel Ventures Ltd **(1)** **Companies Non-Trading interests** Tempco 0819 Ltd **(1)** Solution Telecom Holdings Ltd **(1)** Qdos Communications Ltd **(1)** Solution Builders Ltd **(1)** Hidden Travel (Flights) Ltd **(1)** Pebble Holidays Holdings Ltd **(1)**	1 June 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM NOVEMBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
CARLTON, REBECCA	Chief Operating Officer	None	Appointed 16 July 2021
CATTO, ANDREW	Non-Executive Director	Chief Executive Officer, Integrated Care 24 (IC24) **(1)** Member of east Kent Health and Care Partnership (HCP) **(1)**	1 November 2022 (First term)
CAVE, PHILIP	Chief Finance Officer	Wife works as Head of Contracts for NHS Kent and Medway Integrated Care Board (ICB) (started 1 April 2021) **(5)** **Closed interests** Wife worked as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Groups (CCGs) (started 9 October 2017/finished 31 March 2021) Interim Managing Director for 2gether Support Solutions **(1)** (started 21 December 2021/finished 28 February 2022)	Appointed 9 October 2017
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
DICKSON, NIALL	Chair	Director, Leeds Castle Enterprises (started 31 May 2012) **(1)** Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)**	5 April 2021
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FOX, ALISON	Group Company Secretary	Company Secretary, Grabba Enterprises Limited (started 1 December 2020) **(1)** Director, MinervaPro Limited (started 28 November 2021) **(1)**	Appointed 11 November 2013

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM NOVEMBER 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019
IVANOV, TINA	Executive Director of Quality Governance	None	10 May 2021
MANSLEY, NIGEL	Non-Executive Director	None **Closed interests** Jeris Associates Ltd (started 1 July 2017/finished 26 January 2021) **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018/finished 14 July 2021) **(1)**	1 July 2017 (Second term)
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OLASODE, OLU	Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, General Purposes and Audit Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director, Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM NOVEMBER 2022

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

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM NOVEMBER 2022

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

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

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

Spencer Private Hospitals:
Stewart Baird – Non-Executive Director in common
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 & TWENTY FOURTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 3 NOVEMBER 2022 AT 1.00 PM IN THE HARRIS ROOM, THE SPITFIRE GROUND, CANTERBURY CRICKET GROUND, OLD DOVER ROAD, CANTERBURY CT1 3NZ AND AS A WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Mr R Anakwe	Non-Executive Director (NED) (WebEx)	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Mr S Baird	NED/People and Culture Committee (P&CC) Chair	SB
Ms R Carlton	Chief Operating Officer (COO)	RC
Dr A Catto	NED	AC
Mr P Cave	Chief Finance Officer (CFO)	PC
Mr S Corben	NED	SC
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Mr N Mansley	NED/Finance and Performance Committee (FPO) Chair (left at 2.15 pm)	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair	OO
Mrs J Ollis	NED/Vice Chairman/Nominations and Remuneration Committee (NRC) Chair/Charitable Funds Committee (CFC) Chair	JO
Mrs S Shingler	Chief Nursing and Midwifery Officer (CNMO)	SSh

ATTENDEES:

Dr A Brown	Improvement Director, NHS England (NHSE)	AB
Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Dr D Hargroves	Consultant in Stroke and Health Care of Older People (HCOOP)	DH
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Dr T Ivanov	Executive Director of Quality Governance (EDoQG)	TI
Dr N Wigglesworth	Executive Director of Infection Prevention & Control (EDIPC)	NW
Ms F Wise	Executive Maternity Services Strategic Programme Director	FW
Dr Z Woodward	Clinical Director, Women's Health (for minute number 22/)	ZW
Mrs N Yost	Executive Director of Communications and Engagement (EDoC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Mrs S Hayward-Browne	Business Manager to the Chairman	SH-B
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs B Armstrong	Member of the Public
Ms S Appleby	Member of the Public (WebEx)
Ms M Bonney	Governor
Ms V Brandon	Member of the Public (WebEx)
Mr J Casha	Governor (WebEx)
Mr N Daw	Staff Member
Mr J Fletcher	Governor (WebEx)
Ms C Heggie	Member of the Public (WebEx)
Mr J Melley	Member of the Public (WebEx)
Mr M Norman	Member of the Public/BBC South East News Journalist (WebEx)
Mr C Plummer	Governor (WebEx)
Mrs P Pryer	Member of the Public (WebEx)
Mr T Pugh	Member of the Public/BBC South East News Journalist (WebEx)
Mr D Richford	Member of the Public (WebEx)
Mrs M Smith	Member of the Public (WebEx)
Mrs M Turton	Member of the Public
Mrs M Warburton	Governor (WebEx)
Ms A Warman	Staff Member (WebEx)

MINUTE NO.		ACTION
22/134	**WELCOME AND APOLOGIES FOR ABSENCE** The Chairman welcomed those in attendance and noted apologies for absence received from Ms L Shutler (LS), Deputy CEO/Chief Strategy Officer (CSO). The Chairman stated a Closed BoD meeting had been held that morning, items covered included; Independent Investigation into East Kent Maternity Services (IIEKMS), and Board Committee Chair Exception Reports. The Chairman welcomed Dr Andrew Catto, NED, to his first Board meeting who had commenced with the Trust on 1 November 2022. The Chairman reported the papers presented were much too long and needed to be reduced, be much more concise whilst highlighting the key issues the Board needed to be aware of. He was working with the CE to ensure the volume of papers presented was reduced.	
22/135	**CONFIRMATION OF QUORACY** The Chairman **NOTED** and confirmed the meeting was quorate.	
22/136	**DECLARATION OF INTERESTS** There were no new interests declared.	
22/137	**MINUTES OF THE PREVIOUS MEETING HELD ON 6 OCTOBER 2022** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 6 October 2022 as an accurate record. *Post meeting note* – Mr Newington raised outside of the meeting a sentence that was not included in the question he raised at the October meeting, which is noted and the minutes amended including this. *'His experience is that within the Trust cover up and dishonesty in investigations presently accepted and positively tolerated, this would not be accepted in other industries.'*	
22/138	**MATTERS ARISING FROM THE MINUTES ON 6 OCTOBER 2022** The Board of Directors **NOTED** the action from the previous meeting and that this was for a future meeting.	
22/139	**CHAIRMAN'S REPORT** The Chairman reported the Trust and its Board recognised and apologised for the harm, inadequate care and treatment of women and families at its meeting held on 21 October to discuss the published IIEKMS Reading the Signals report. He noted progress had been made in some areas but there was still much more to be done. The Board of Directors **NOTED** the contents of the Chairman's report.	
22/140	**CHIEF EXECUTIVE'S (CE'S) REPORT** The CE reported focus on the IIEKMS report and next steps to address the recommendations and commence a restorative process throughout the Trust building a culture of excellence, delivering high quality, effective and compassionate care.	

The NEDs raised the increased demand on services, seen first hand at a recent hospital visit, commenting staff were working really hard in very busy environments and the challenges faced going into the winter period, the initiatives and plans in place and whether this was sufficient to manage patient demand at the front door. The CE stated the elements around managing patient demand and accessing Emergency Departments (EDs) was covered in the Winter Plan. The COO and operational team were looking at patient flow, effectively managing care pathways in EDs as well as addressing blockages, and working with system partners on what could be done differently to meet demand. She highlighted the regular use of escalation areas in the EDs and corridor care that was not how the Trust wanted to treat patients.

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

22/141 **INDEPENDENT INVESTIGATION INTO EAST KENT MATERNITY SERVICES (IIEKMS) REPORT – READING THE SIGNALS – NEXT STEPS**

The CE highlighted key next steps from the report:

- Bottom up, top down approach building a culture of listening, kindness, excellence, openness and team working, implementing changes needed to provide an improved and consistent good service;
- Actions to address themes need to be embedded and owned by all staff across all areas throughout the whole organisation, not just maternity;
- Enough is enough, poor behaviours are unacceptable, an East Kent way of working to be established setting out the Trust's expectation from staff, if not adhered to this would be challenged and addressed.

The MSSPD noted:

- Report presented provided a high level overview of the four areas for action supporting the recommendations, that included some that could be implemented promptly and some that needed more consideration and time to address;
- Maternity reports presented to the Board from the Maternity and Neonatal Assurance Group (MNAG) and Clinical Negligence Scheme for Trusts (CNST) on progress of the maternity improvement plan;
- Meeting would be held in November with the Chairman and Chief Executive with Dr Kirkup to discuss the report, providing a learning opportunity and insight of what had worked well in other organisations.

The CNMO reported:

- Independent experts would be appointed to review cases of families that had come forward to the Trust requesting a review of care received. Terms of Reference (ToR) would be agreed with each family, covering every aspect of their care for investigation, families would receive the full investigation outcome from the Trust;
- She had spoken to all the families that had come forward, and had met with the CE one family to date;
- Trust was working closely with Shrewsbury and Telford NHS Trust around learning from the actions they implemented following their investigation report.

Board members presented ideas, thoughts and reflection on areas to be taken forward in addition to that included in the report presented:

- Apologised to all the families for the unnecessary harm caused;
- Profound impact from the contents of the report, distressing and sorrowful, valuable feedback;
- Ensure this was not repeated. Explore why actions and changes had not happened previously;
- Loss of confidence in the Trust of its patients, local community and staff, would be a challenge to improve and was committed to make changes and improvements;
- Acknowledged mistakes do happen in healthcare, important to be open, compassionate and explain what went wrong;
- Recognise women know their own bodies and know if something does not feel right, need to listen to women, giving them a voice, this had already been put in train with Patient Voice and contacting women and families following the birth of their child;
- Acknowledged more staff and better facilities would not have had an impact or difference in the outcome of care;
- Reflect on the title of report 'Reading the Signs', the need to identify the reasons the small number of families that did not wish to return to the Trust for care;
- Acknowledged poor behaviours and attitudes was not just limited to maternity and was in other areas in the organisation, this was not welcome and commitment from the Board this would not be tolerated, neither would bullying, taking disciplinary action as appropriate. Recognition that some staff referred to in the report remained in the organisation;
- Professional accountability, responsibility, standards and values, obligation of every member of staff to behave and interact professionally, consistently providing treatment with compassion and kindness to patients, families and colleagues. Provide staff with the tools to address non-compliance. Holding individuals to account if were not abiding by the required standards, treating everyone fairly. This covered all areas across the whole of the organisation;
- Recognition culture needed to be addressed and promptly, change programme was complex and difficult, long term commitment to address and make changes. Importance of assuring workforce and service users of a clear strategy, statement and ambition for change, leadership providing role model of positive culture and behaviour providing the best care possible to the Trust's standard. There had been poor standards of care, working towards high standard, all staff required to support the programme and support colleagues to implement. Staff having the confidence to speak up and raise if care was not at the required standard. Multi-disciplinary team service and the importance of collaborative working together as a team to make changes;
- Ensure promotion and utilisation of staff being able to speak up, raise and report concerns with the Freedom to Speak Up Guardian (FTSUG) service;
- Acknowledgement of the crisis, seriousness and impact of the report by everyone in the Trust;
- Importance of human factors training for all staff;
- Learning was a key element, having a positive learning culture and a no blame/victim culture. The impact for current and future students, importance of supporting these individuals, assurance of commitment to make changes, positive team work environment, with good experience of those on placements;
- Consider reviewing the Cleveland Clinic leadership model that was around a major culture programme, top down, bottom up, proven evidence based outcome providing effective patient care;
- Need to improve the infrastructure to support the fundamental changes required;

- Importance of patient feedback, the patient voice, listening and engaging with all service users of all services across the Trust, as well as listening to staff, respond to issues raised and take action. Intervention and feedback on changes made, empowering those raised issues that action and changes had been made as a result, being open and transparent with patients, families, staff and regulators. Measure Trust's performance by listening;
- Working with system partners to discuss funding needs, and what support could be provided (e.g. training), holding them to account;
- Recognition of the evidence that women from minority groups, and vulnerable women, more likely to have poor outcomes, listening and engaging with these women, hear their voice and input to co-produce care pathways and what was being done to support these women;
- Central digital strategy for maternity care records for women, providing a complete and visible record of all aspects of their care accessible across all digital systems;
- Consider setting up a Taskforce Finish or Learning Lessons Group (for a limited set period with ToR to be agreed by the Board), sub-group of Board with representation from Board members, clinical staff, Governors, families, and patients, broad membership across the organisation, reporting into the Board and supported by a Project team. Focussing on key areas, progress of the culture change programme, review lessons learnt across the organisation, work on co-production and design with patient input communicating changes made, building trust, being open, honest and transparent, listening to voices on the group. Acknowledge positive changes made to date and feedback from staff listening events. Group to set agreed metrics for interventions over agreed periods of time, generate new ideas, oversee response and monitor progress on the lessons from the report. Support the Trust's improvement journey;
- Consider setting up a patient forum for those harmed, giving patients a restorative voice, to come together, listen to experiences and provide feedback on what could make a real change;
- Important all staff read the report, continue to communicate and talk about the report, learn from it to improve their day to day activities;
- Design a fit for purpose report providing robust and meaningful data and quality measures 'noise by numbers', to ensure prompt alerting where things were not working and needed to be addressed. Ensuring the Board and Governors were made aware of the reality of what was happening on the ground and at the front door. Meaningful measures identifying where changes had been made and if these had resulted in positive improvements, e.g. patient experience feedback and FTSUG data feedback;
- Importance of effective ward to Board assurance arrangements in place;
- Action plans previously implemented that had not had an impact and the need to do things fundamentally different;
- Importance of having in place robust and appropriate governance structures and risk management processes to effectively take forward and embed the required actions with a clear pathway of how this would be taken forward, as well as the culture change, to be presented to the Board, along with implications if actions were not implemented.

The Chairman thanked the Executive team, CMO, CNMO, Interim DoM, Clinical Director for Women's Health and all staff working with families to make changes and improvements, acknowledging changes had already been made.

The CNMO would be working with the Governors supporting them with engaging with the community and families to gather feedback. The Trust was producing a video for staff around treating everyone with respect, providing high quality standard of care, with compassion and dignity, supporting our patients during

difficult situations.

The Chairman opened the meeting for questions from the public.

Mrs Armstrong highlighted the report in 2015 from The King's Fund that looked at trusts that had issues across three different hospitals, reviewing in detail each step and where things went wrong with each step, noting significant progress and improvements had been made. The Interim DoM commented on the work of the Trust to review care pathways for the women's journey from perinatal to delivery, those that interfaced with them, and building into the digital processes ensuring a record of all information as well as conversations with women about their care (so these did not have to be repeated).

Mrs Warburton enquired whether a time had been set for completion of the action plan. The Chairman noted the improvement work that had already been done, the actions would be discussed, learning from the report as well as learning from discussions with Shrewsbury and Telford about what they did. A document would be produced outlining the Trust's plan, what actions needed to be taken, and what was to be achieved with clear timeframes over a period of time (likely to be around 12 months).

Mrs Heggie highlighted the Trust had been put into quality safety measures in 2014, staff bullying and behaviours had been raised at that time and poor behaviours needed to be tackled and taken seriously. She commented the need to look at why action was not taken in addressing these issues. She raised the poor culture in 2gether Support Solutions (2gether) that also needed addressing. The Chairman acknowledged the need to understand what work was done and why this did not result in changes, that changes needed to happen and be effective, working with and involving staff to support the culture change. The CE commented on the need to look at any barriers preventing improvements and removing these as the organisation needed to improve.

Ms Bonney highlighted the impact of the investigation report, that was beyond the families involved with the investigation and issues had been raised with her, the importance that the wider community understood the changes that needed to be from the top down. She enquired when poor staff behaviours would be addressed and appropriate action taken, enabling the culture change programme to begin. She raised the significant investment costs required to achieve what was needed across all levels to raise clinical care standards and the need for a plan to be put in place at pace. The Chief Executive stated families not part of the investigation had come forward to the Trust about their individual cases, and encouraged others to share their experience, highlighting the commitment of the Trust to work with families to do what was needed to make improvements. She reported the Maternity team were actively working to address poor behaviours through the appropriate HR procedures. She accepted the need for significant investment that would be reviewed and discussed.

Mrs Turton raised a complaint submitted about her daughter's treatment on 6 and 7 August 2022. The Patient Advice and Liaison Service (PALS) had been ineffective and closed the case. She asked for assurance and an apology that her case would be dealt with, investigated and be provided with a satisfactory response. She raised the nursing staff had been very good and was concerned for other patients and their experience in A&E. Her family had been deeply affected by their experience. The CE apologised to Mrs Turton for her experience, noting she had been in communication with Mrs Turton as too had the EDoQG, extended an invitation to meet with Mrs Turton and her daughter to understand their experience and what could be done better, this would be picked up outside of this Board meeting.

DECISION: The Board of Directors discussed the IIEKMS Report - Reading the Signals and **AGREED** the key next steps.

22/142 **INTEGRATED PERFORMANCE REPORT (IPR)**

Hospital Standardised Mortality Ratio (HSMR)

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

- Trust had maintained its position of 17th out of the 121 acute non-specialist trusts on the Telstra Health platform;
- Continued focus improving patient care outcomes for those on the fracture Neck of Femur pathway, current 12 month rolling HSMR at 90.6 as expected;
- New alerts for residual codes (symptoms and signs) and biliary tract disease that were being investigated to identify any potential diagnostic groups of concern.

Reduce Incidents (avoidable Harm)

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

- Above threshold in September of 33 incidents an increase from the previous month, main contributors of harm being care and treatment, and harm and delay failure incidents;
- Falls was also a contributing harm factor with five incidents moderate or above, a reduction on the last two months. Staffing remained an issue. Safe staffing levels was a direct link to these harm incidents, managing demand at the front door and moving staff from wards to EDs supporting patients receiving corridor care. Risk assessments were undertaken during these periods;
- Focussed improvement work on care and treatment, around understanding the emerging themes and actions to mitigate and reduce incidents, with work on-going. Themes included delays in diagnosis of patients on cancer pathway and delays in initiating urgent treatment pathway for ophthalmology patients;
- No reported cases of Pressure Ulcers (PUs) moderate or above for last six months.

The NEDs raised falls and whether there was sufficient focus with We Care to target behavioural change to ensure reduction of falls was sustained. The CNMO reported the Falls team was small, with continued focus on Internationally Educated Nurses (IENs) onboarding, as well as training and supporting staff across the hospital sites. It had been acknowledged the team size was insufficient and not adequate to cover across the sites, this was being reviewed with what could be done differently or to increase the team resources. She highlighted the Trust was able to identify incident areas to be addressed with targeted support.

The NEDs enquired whether the cost impact of falls had been quantified in respect of care and Length of Stay (LoS) and comparison of current falls incidents against the same period the previous year. The CNMO reported all was being done to reduce the risk of falls, sustain incidents and these not increasing, and confirmed risk assessments were undertaken. She highlighted the pressures to meet demand in the EDs and moving registered nurses from wards to support these areas in

managing patients.

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

The COO reported:

- RTT performance had remained static for the total waiting time, with continued reduction week on week of the long waiting patients;
- To improve capacity a 'sustaining access' strategic initiative with system partners around demand management, pathway design, and focusing on waiting times for first outpatient appointment;
- Continued work at pace to reduce impact of demand pressures, with progress collaborating with system partners to improve patient flow, discharging of patients not fit to reside, and improving ambulance handover.

The NEDs enquired what was being done to meet the health needs of migrants at the Manston centre, whether the Trust was involved in provision of care and what support was available on leaving the centre in the community, taking into consideration some individuals might have had illnesses that had not been addressed for some time. The COO reported provision of pharmacy support, and care and treatment support as part of their integration into the community.

The NEDs raised Serious Incidents (SIs) and never events and requested assurance there was learning from these that resulted in embedding changes. The COO stated daily ED reports looking at patient experience, waiting times, after care reviews to ensure staff had sight of learning and outcomes in managing periods of high demand and pressures. The EDoQG confirmed issues addressed at the time of incidents and events and learning disseminated following review and investigation of these.

Patient Experience: Inpatient Survey

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

- Actions in response to patient feedback to address and ensure uninterrupted sleep, included the provision of ear plugs and eye masks for those receiving corridor treatment, lights were switched off at night around patients beds, and wards working with IENs and newly qualified nurses that they were aware of night time practices.

Staff Engagement: Staff Involvement Score

The CPO highlighted key points to improve the staff engagement score to 6.8 by March 2023:

- Slight improvement of 7-point staff engagement from 6.26 to 6.33 required to consistently continue to achieve the set target;
- Focus driving forward interventions encouraging staff to complete staff survey, currently at 35.11% completion rate, importance around staff motivation and advocacy, and staff providing feedback on their experience working for the Trust and what could be improved.

The NEDs highlighted the importance of the Trust being aware of how staff felt and having a good take up of the staff survey. The CPO commented all was being done to remind and encourage staff to complete the staff survey before its closure in the next three weeks. She stated uptake was good when launched and had slowed pre and post IIEKMS publication, noting another contributing factor was staff being busy and work pressures.

Financial Position (Income and Expenditure (I&E) Margin)

The CFO reported:

- Delivery of a breakeven annual plan with a £30m efficiency savings target. Fortnightly meetings continued with clinical and corporate areas to review budgets and expenditure to identify additional areas for potential efficiencies;
- £1.6m deficit in September, year-to-date (YTD) position of a £13m deficit, £9m adverse to the plan;
- Behind plan with the reduction of premium pay, with deep dives held with Care Groups to test and review further actions to address and ensure delivery. Increased spend in September of £0.8m, of which £0.5m due to backdated pay award for bank staff;
- Risk of Trust not delivering breakeven position at Year-End (YE), and a potential deficit of approximately £20m even with the contingencies, with discussions taking place with NHSE.

The NEDs raised concern about achieving the £30m Cost Improvement Programme (CIP) and the Board needed to be aware of the extent of the challenge for the remaining period to YE and receive assurance on the actions being taken to mitigate the risks. The CFO stated a detailed CIP and forecast financial report had been presented to the Finance and Performance Committee and would ensure a briefing on the financial forecast and CIP target position, mitigating actions, and feasibility of achieving the annual breakeven plan and £30m CIP target would be included in the finance report presented to the next Board meeting.

ACTION: Include in finance report presented to the December 2022 Board meeting a briefing on the current financial forecast and CIP target position, mitigating actions, and feasibility of achievement of the annual breakeven plan and £30m CIP target. — CFO

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

22/143 **FINANCE REPORT**

- **MONTH 6 FINANCE REPORT**

The CFO noted the financial key points had been covered within the IPR discussion.

The Board of Directors **NOTED** the Month 6 Finance Report, financial performance and actions being taken to address issues of concern.

22/144 **CHIEF MEDICAL OFFICER'S (CMO'S) REPORT: MEDICAL WORKFORCE**

The CMO highlighted key points:

- The need for the UK to produce more medical graduates and remain

competitive in the international market for doctors, critical for workplaces to be more inclusive, compassionate and supportive. To support improving patient care, staff retention, and more efficient multidisciplinary working;
- Quality Assurance visit undertaken around providing assurance the duties of the Responsible Officer in driving quality and performance, as well as appraisals of the medical workforce was meeting regulatory requirements. This identified areas of good practice as well as recommendations on opportunities to strengthen supporting excellence that were being progressed;
- Summary of the key findings of the General Medical Council (GMC) medical workforce report and its impact locally;
- Importance of providing meaningful medical career pathways supporting the medical workforce to develop their careers, UK and non-UK graduates.

The NEDs enquired about the opportunities to expand the medical workforce with those working outside the Trust and engaging with those in primary care. The CMO stated discussions had already been held within the Integrated Care Board (ICB) with willingness to look differently at rotational opportunities, experiencing working in different areas of medicine, and supporting career development across secondary care, primary care and other NHS provider organisations.

The NEDs raised the issue about the Trust's estate and buildings and the plans to address this to support staff. The CMO commented work in progress to continue improving recruitment and retention of doctors with provision of support for wellbeing, inclusivity, career development, education and recognition providing an effective working environment. Working with doctors, medical education and the People and Culture team on the delivery of actions as well as recruiting through excellence, testing at interviews applicants had the right attitude and behaviours that aligned to the Trust's values and staff appointed continued to meet these requirements.

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

- CMO's report: Medical Workforce;
- implications of the changing medical workforce for East Kent Hospitals;
- actions underway to improve recruitment and retention with an immediate focus on support to international medical graduates and locally employed doctors.

22/145 **BOARD ASSURANCE FRAMEWORK (BAF) RISK REGISTER**

The CE reported:

- Two new risks added to the BAF:
  - **BAF 39**: A risk that women and their families would not have confidence in east Kent maternity services if sufficient improvement cannot be evidenced following the outcome of IIEKMS;
  - **BAF 40**: A risk of failure to address the equality, diversity and inclusion in the Trust.
- Continued focus on risks, the controls, gaps, actions to mitigate risks were appropriate and having an impact to reduce level of risks, and the identification of any further actions required;
- Importance of aligning the BAF with the IPR and the actions to provide the required level of assurance of mitigations;
- Risk appetite session would be held the following week at the Board Development Strategy Day.

The NED/IAGC Chair commented a refresh of the BAF following the Board Development Strategy Day to ensure this provided the necessary assurance on the management of risks, including recommendations from the IIEKMS report.

DECISION: The Board of Directors:

- **APPROVED** the latest update of the BAF;
- Received **ASSURANCE** that risks on the BAF were being appropriately mitigated.

22/146 **MATERNITY SERVICES:**

- **CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) – MATERNITY INCENTIVE SCHEME – MATERNITY INCENTIVE SCHEME YEAR 4**

22/146.1 **PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT**

The CNMO reported:

- Three SIs declared in September, one a gynaecological incident as an early pregnancy case;
- Achieved compliance across fetal monitoring and Newborn Life Support (NLS) for all clinically registered staff;
- PRactical Obstetric Multi-Professional Training (PROMPT) mandatory training was hampered by the unscheduled Public Holiday, impacting 24 staff members and plans in place to ensure staff received this training;
- Continued Your Voice is Heard feedback, with 62.4% of women taking up the offer of a follow-up call with a patient experience midwife 6 weeks after delivery of their baby. Themes included good care, delayed care, not getting pain relief, not listened to by staff, not feeling looked after, and insufficient staffing;
- Safety Champion walkabouts continued with feedback highlighting challenges with staffing level issues in both midwifery and neonates, aligned to increased activity and acuity;
- Student midwives continued to provide feedback, highlighting some differences between the two units, supernumerary status had been maintained;
- CNST compliance remained reduced as previously reported, due to the surveillance information not being completed within one month of the death for three cases, awaiting feedback from NHS Resolution;
- Submission date for CNST had been moved to February 2023;
- Improvement in Ockenden compliance in month to 97%.

The Board of Directors:

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

22/146.2 **PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT – Q2 2022/23**

The Interim DoM reported:

- PMRT generated Board report was blank for the reporting period as there were no cases or actions for review using the tool during the reporting period;
- During Q2 a total of nine cases reported, seven of which were stillbirths and two neonatal deaths;
- Concerns about the quality of the bereavement pathway, after care and supporting families at the time of the death had been addressed working with women and families to improve this, that was being progressed for implementation.

The Board of Directors **NOTED**:

- the Quarterly PMRT paper received for Q2 2022/23 in line with CNST requirements;
- As outlined in the paper the service had not demonstrated full compliance due to failure to complete the surveillance forms for 3 cases over Q1 and Q2.

22/146.3 **TRANSITIONAL CARE (TC) SERVICES TO MINIMISE SEPARATION OF MOTHERS AND THEIR BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING TERM ADMISSIONS INTO NEONATAL UNITS (ATAIN) PROGRAMME - QUARTER 1 REPORT**

The Interim DoM reported:

- Audit processes in place;
- Site leads supporting learning lessons;
- Management and support of TC services across multi-disciplinary staff.

The Board of Directors:

- Received **ASSURANCE** there was an effective process of ongoing assessment in place and that the evidence provided was sufficiently robust;
- **NOTED** the receipt and content of this CNST Safety Action 3 Quarterly update report and TC and ATAIN action plan; and
- **SUPPORTED** the broader considerations and the development of further improvements as defined within the action plan.

22/146.4 **MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) – QUARTERLY REPORT**

The CNMO highlighted the MNAG report and its work overseeing the improvement of maternity services and adherence to national regulatory requirements.

The NEDs raised the note in the report that progress against the culture and behavioural work had been reviewed and discussed, highlighting nothing had been presented to the Board on progress of the maternity culture improvement. The CNMO confirmed progress updates on the culture programme were presented to MNAG that reported into the Q&SC, who reported to the Board, as well as the Board receiving quarterly MNAG reports. The CPO commented it had been discussed covering the culture programme at a future Board Development Strategy session.

The Board of Directors:

- **NOTED** the content of the MNAG Quarter 2 and Quarter 3 report;
- Received **ASSURANCE** MNAG had established robust reporting

mechanisms in place ensuring line of sight on key areas within maternity to the Trust Board.

22/147 **CHIEF NURSING AND MIDWIFERY OFFICER (CNMO) QUARTERLY REPORT**

The CNMO reported:

- Progress in delivering the Improving Quality Roadmap against the four domains: Staff development, Fundamentals of Care, Patient Voice and Sustaining Improvement;
- Recruitment to the additional 370 band 5 posts in respect of right sizing the nursing workforce within the in-patient areas (43 wards) would be achieved by December 2022, with 400 IENs recruited that year and 61 newly qualified nurses due to start that month;
- Strengthening of the nursing leadership with the 6-month Matron development programme that commenced on 1 November involving all Matrons, in-house course developed with NHSE and Health Education England (HEE) built around the national Matrons Handbook;
- Nursing and Midwifery Conference would be held on 22 November 2022 that would launch the Nursing and Midwifery Strategy.

The Board of Directors:

- **NOTED** the content of the CNMO Quarterly report;
- Received **ASSURANCE** in the progress being made in the delivery of the Improving Quality Roadmap and the priorities included within the domains to improve care and patient experience.

22/148 **SAFEGUARDING ADULTS AND CHILDREN QUARTER 1 REPORT**

The CNMO reported:

- Regular safeguarding activity reports provided to the Quality and Safety and Safeguarding Assurance Committees for assurance;
- Developing a safeguarding sustainability plan based on the nine deliverables from the All Age Safeguarding Deliverables (AASD), now forming part of business as usual safeguarding activities to ensure an exit strategy from the action plan;
- Risks remained with delivery of safeguarding activities, led by an experienced Interim Head of Safeguarding, who continued to work with Care Group staff to address the issues around safeguarding adults' competencies, skills and their understanding and responsibilities around safeguarding regulations and assisting with complex safeguarding cases.

The NED/Safeguarding Assurance Committee Chair confirmed all policies and procedures had been reviewed aligning these to strengthening safeguarding activities. The provision of support, education and tools to all staff to ensure safeguarding requirements were consistently adhered to.

The Board of Directors:

- **NOTED** the Safeguarding Adults and Children Quarter 1 report and the key issues highlighted;
- Received **ASSURANCE** on the activities and completion of the AASD action plan for safeguarding adults and children.

22/149 **WINTER PLAN 2022/23**

The COO reported:

- Winter Plan modelling covered the period November 2022 to April 2023;
- Detailed modelling addressed the expected increase in demand under four key cohorts of patients:
  - Respiratory Admissions - increasing by 30% to occupy an additional 36 beds;
  - Non-High Risk Non-Respiratory Admissions - increasing by 10% to occupy an additional 29 beds;
  - High Risk Non-Respiratory Returning Admissions - increasing by 20% to occupy an additional 41 beds;
  - Adjusting the demand assumptions to provide for a 92% occupancy – an additional 104 beds.
- Key supportive schemes developed on the shared challenge with system partners working collaboratively on mitigating actions by the Health Care Partnership (HCP) included:
  - Development of Integrated SDEC to support admission avoidance and front door discharge – reduction of 46 beds;
  - Delivery of Virtual Ward reduction of 30 beds;
  - Development of bridging facilities to support discharges through supporting patients within the final stages of acute care pathway prior to accessing their package of home care or inpatient residential care - reduction of 30 beds;
  - Increased capacity of Pathway 1 packages of care – reduction of 45 beds;
  - Out of hospital Stroke rehabilitation beds – reduction of 3 beds;
  - End of Life (EOL) – reduction of 12 beds.
- Currently running with an average of 50-60 escalation beds in operation at a capacity of 104/5%, with escalation areas regularly running at 20-30 per day in the EDs and patients receiving corridor care.

The NEDs enquired whether there was sufficient funding to deliver the requirements of the Winter Plan and its schemes to meet demand, and if there was appropriate resilience in respect of essential supplies e.g. oxygen/electrical. The CFO reported on-going discussions with the HCP about the potential cost impact of approximately £2m that was currently unfunded with the likelihood of no additional funding provision, in addition to the current £4m deficit to deliver escalation beds. The COO confirmed robust Emergency Preparedness, Resilience and Response (EPRR) arrangements in place around testing and learning to ensure the Trust was able to respond to any incidents. She commented there was the Strategic Gold forum that met and frequency would be increased during escalation periods.

The NEDs raised concern if there was no provision of additional funding, how the schemes would be supported, and whether there needed to be some remodelling. The COO highlighted the collaborative system working in redesigning patient pathways, particularly with the community supporting patients outside the acute setting and in their own homes, delivering virtual ward provision that was hoped would be extended in December.

The Board of Directors:

- discussed and **NOTED** the Winter Plan 2022/23 report;
- **NOTED** the direction of winter plans;
- **ACKNOWLEDGED** the presented risks to the proposed schemes and the impact to demand if the schemes did not deliver and **NOTED** regular

updates to the Winter Plan, the financial decisions made against the schemes proposed by the HCP to be communicated through the Trust's internal Committees and the Board;
- **ACKNOWLEDGED** the work in progress nature of the report and the Governance structures in place to ensure communication and decision-making lines were established and adhered to.

22/150 **PATIENT SAFETY AND QUALITY GOVERNANCE ROADMAP - UPDATE**

The EDoQG reported:

- Progress made moving towards good quality governance and a golden thread of patient safety, although significant time, engagement and investment was required to ensure this was in place and embedded, and exploring the development of a business case to support this work;
- Launch of the Patient Safety Incident Response Framework (PSIRF) that required a specific discussion at a future Board Development session. This would include the changes in patient safety and quality governance, risks and learning, and putting patients' voice at the centre of everything the Trust did. This would support the culture improvement programme, continuing to change ways of working and long-term transformational change, that would be multi-professional working closely with Leadership and Governance teams;
- Working together with national and local systems;
- Work had already commenced with focus groups including involvement from Care Groups and Corporate teams;
- Review and changing policies and operating procedures where needed;
- Emphasis on 'Releasing' change by coaching programmes, safety meeting schedules, learning events, listening events, safety walks, case studies, safety systems reviews, safety audits, education and training programmes and safety awards.

The NEDs highlighted this work was critical in supporting the culture improvements. Concern was raised about the poor Duty of Candour (DoC) compliance that had further deteriorated that month, and the late issue of letters to patients following cancer investigation tests and confirmation no cancer detected. The EDoQG confirmed provision of additional resources to assist in addressing DoC with the expectation there resulting in improved compliance and working towards achieving the required compliance.

The NEDs enquired when it would be known the level of investment to address the recommendations and work needed. The EDoQG reported the Steering Group would evaluate and identify the costs required, whilst reviewing information provided by early adopters on their associated costs.

DECISION: The Board of Directors:

- **NOTED** the progress in patient safety and quality governance activities, the planned introduction of PSIRF and upgrade to Datix;
- **NOTED** investment would be required to meet the obligations under PSIRF and this would be explored through the business planning process;
- **APPROVED** an information session on PSIRF in a Board Strategy Development session.

22/151 **OUTCOME OF NHS ENGLAND CORE STANDARDS FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL ASSURANCE AND UPDATE ON CURRENT WORKSTREAMS**

The COO reported the Trust was fully compliant in meeting the NHSE Core Standards for EPRR in 2022, which was the first time in four years. She thanked the Head of EPRR and the EPRR team for their hard work in achieving this. The team were working on what was needed to maintain full compliance and ensure this was achieved in future years.

The Board of Directors **NOTED** and received **ASSURANCE** from the EPRR paper, the Trust was fully compliant in meeting the NHSE Core Standards for EPRR in 2022, and the update in EPRR activity in 2022.

22/152 **KENT AND MEDWAY (K&M) MECHANICAL THROMBECTOMY SERVICE BUSINESS CASE**

The CFO reported:

- Approved by the Finance and Performance Committee (FPC) in March 2022 subject to sourcing capital funding that had now been confirmed;
- Service provided at Kent and Canterbury Hospital (K&C), commissioned by NHSE Specialised Commissioning across K&M, total financial impact:
  - Capital (adjusted for inflation from £4.1m) £4.6m
  - 5-year revenue cost (including capital charges) £9.0m
  - 5-year income (including training and tariff "top-up) £9.0m.

The NEDs enquired whether funding provision would allow for expansion to a 24/7 service. The CFO confirmed the funding reflected a 08:00 – 18:00 Monday to Friday service with a full review after the first full year of implementation.

The NEDs highlighted the issue about power capacity that had been raised by 2gether Support Solutions and noted in the report across all three main sites, and what exactly this risk was for the Trust. The CFO would liaise with the CSO to provide an update on the power capacity risk.

ACTION: Liaise with the CSO about the power capacity issue raised in the report by 2gether and provide an update on this risk. CFO

The Chief Executive congratulated the Consultant in Stroke and HCOOP and the Stroke team who had recently won a national Health Service Journal award for the team's quality improvement project.

DECISION: The Board of Directors **APPROVED** the business case to develop a K&M Mechanical Thrombectomy Service at the K&C, following confirmation of capital and revenue funding.

22/153 **GOVERNANCE IMPROVEMENT PLAN AND RECOVERY SUPPORT PROGRAMME (RSP) UPDATES**

- **NATIONAL TEAM FOR INTENSIVE SUPPORT – SCOPE DOCUMENT**

The CFO reported:

- The 50 actions identified through the governance review had been completed, evidence provided, and this programme was now closed and would no longer be required to report to Board;
- 20 RSP actions required to be completed for the Trust to exit system

oversight framework four (SOF4). One action completed and evidenced, remainder had Executive owners with due dates by the end of 2022, areas covered included maternity, finance, operational, safeguarding, workforce and leadership;
- Delay in exiting SOF4 by December 2022, with expectation to progress actions for exiting at end of Quarter 3 of 2023/34 FY. Meeting being held on Monday of the following week to discuss the Trust's actions, scores and progress to exit SOF4;
- Additional funding provision from NHSE of £630,500 supporting various RSP strand work.

The Board of Directors:

- **NOTED** the Governance Improvement Plan and RSP update report, acknowledged the completion of the Governance Improvement Programme and the continuing development of the RSP;
- **NOTED** and acknowledged the current support from NHSE a nationally mandated component to support the Trust towards segment 3 and transition from RSP.

22/154 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

- **BUSINESS CASES (BC)**
  - **COMMUNITY DIAGNOSTICS CENTRE (CDC) STRATEGY BC**
  - **PUBLIC SECTOR DECARBONISATION SCHEME – ROUND 3B**

The FPC Chair highlighted:

- Assurance received on the update of the latest 2022/23 forecast position and the actions to mitigate identified risks;
- Partial assurance received from the IPR and performance against key metrics for 2022/23;
- Approval of the K&M Vascular Surgery Decision-Making BC, and two BCs recommended for Board approval as noted below (following presentation through the governance structure):
  - CDC Strategy working as part of a system, capital investment of £11.5m and revenue funding of £26.8m for the period 2023/24 to 2025/26;
  - Public Sector Decarbonisation Scheme – Round 3B, energy saving schemes (to pursue a grant award of £25.2m to fund heat decarbonisation, PV Solar and energy efficiency measures for the Trust's acute sites), following outcome of bid would be presented to FPC and Board for approval to accept funding.

DECISION: The Board of Directors:

- **NOTED** the 25 October 2022 FPC Chair Assurance Report;
- **APPROVED** the:
  - CDC Strategy Business Case; and
  - Public Sector Decarbonisation Scheme – Round 3B.

22/155 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted the pressure in the high number of inpatients no longer meeting the criteria to reside that was a significant operational pressure to the Trust, which equated currently to approximately 170 patients.

The Chairman thanked RA for undertaking the role of Q&SC Interim Chair, noting

following the appointment of the new NED, AC, who would now be taking on this role substantively.

The Board of Directors **NOTED** the 27 October 2022 Q&SC Chair Assurance Report.

22/156 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The IAGC Chair highlighted key points:

- Governance structure and its effectiveness;
- Trust Chairman to consider the Board Committee Chair Assurance Reports being discussed earlier on the Board agenda in future allowing early discussion on assurance items before operational items were taken;
- IAGC membership consisted the Board Committee Chairs to test assurance received at these meetings, and if they were unable to attend there would be a gap. It was proposed consideration that a NED Board Committee member be invited to attend if the Committee Chair was unable to attend an IAGC meeting.

The Trust Chairman supported the proposal that a NED Board Committee member be invited to substitute for their Committee Chair if unable to attend an IAGC meeting. It was agreed the IAGC Terms of Reference (ToR) would be amended reflecting the substitute member attendance and this would be circulated for virtual approval by the IAGC, once approved to be presented to the Board for approval.

ACTION: Amend the IAGC ToR reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval. — IAGC Chair /GCS

The Board of Directors **NOTED** the 18 October 2022 IAGC Chair Assurance Report.

22/157 **NOMINATIONS & REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the 11 October 2022 NRC Chair Assurance Report.

22/158 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The Board of Directors **NOTED** the 11 October 2022 CFC Chair Assurance Report.

22/159 **ANY OTHER BUSINESS**

There were no other items of business raised.

22/160 **QUESTIONS FROM THE PUBLIC**

Ms Heggie acknowledged the good news about the provision of the K&M Thrombectomy Service at K&C. She enquired about the possibility of the provision of a Hyper-acute Stroke Unit at K&C. The CE reported a K&M decision agreeing that K&M stroke services to be provided at William Harvey Hospital (WHH) with provision of capital funding, following a judicial review.

Mrs Pryer commented it was great to hear the Trust had implemented a Patient Participation Group and extended her interest in joining this group following her

recent poor experience at the WHH ED where she had waited 50 hours for treatment, and discharged herself. She raised concern with patients receiving corridor treatment, that appropriate support and training be provided to IENs and the challenges with language and interaction with patients. She raised the pressures and challenges across the whole NHS and demand for services as had also experienced a long wait to receive a response telephone call through 111. The CNMO reported she would arrange for the Head of Patient Voice & Involvement to contact Mrs Pryer about becoming involved with this group. IEN staff were assessed and challenges with communication and language had not been identified as a barrier with themes from complaints. The Chairman acknowledged the efforts and hard work of all Trust staff in managing demand for treatment and care, recognising that at times this was not at the level and experience patients expect.

Post meeting note - Question submitted in writing by Mr Harman, Trust staff member. Question about the Trust re-introducing staff parking permits, understanding it was necessary for charges to apply due to the upkeep costs of the car parks, and if the cost of permits could be considered in comparison with other trusts, as East Kent Hospitals was almost double for each banding group and the reason for this. With the current cost of living crisis any additional costs each month could be very worrying for individuals who were already struggling. To consider the current economic situation and if possible to re-examine the current pay structure for permits to support those who would potentially struggle with the re-introduction and that costs were aligned and consistent with other trusts. The CFO responded to this question, stating the Trust had aligned its pricing for staff car parking to that of Maidstone and Tunbridge Wells NHS Trust (MTW) until 31 March 2023. Planned to return to the 2019/20 values from 1 April 2023 but would evaluate the position during the next few months before increasing.

The Chairman closed the meeting at 5.15 pm.

Date of next meeting in public: Thursday 8 December 2022 in the Chiesman Pavilion, Spitfire Ground - Canterbury Cricket Ground.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 3 NOVEMBER 2022**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.				
Summary of Key Issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** the action log from the actions from the previous meeting and **APPROVE** the action recommended for closure.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	None				
Link to the Corporate Risk Register (CRR):	None				
Resource:	Y/N	N			
Legal and regulatory:	Y/N	N			
Subsidiary:	Y/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 6 OCTOBER 2022

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/14/22	Undertake a repeat analysis in March 2023 of the impact of We Care on staff engagement levels on the data provided by the National Staff Survey 2022 and National Quarterly Pulse Survey (NQPS) Quarter 4.	Apr-23	Chief People Officer (CPO)	Open	Item for future Board meeting.
B/15/22	Include in finance report presented to the December 2022 Board meeting a briefing on the current financial forecast and CIP target position, mitigating actions, and feasibility of achievement of the annual breakeven plan and £30m CIP target.	Dec-22	Chief Finance Officer (CFO)	To Close	The forecast position and CIP were covered at FPC on 29 November 2022 and outlined in the FPC assurance report attached to the 08.12.22 Board papers. The current forecast is a £30m deficit but the Trust is working with system and national colleagues to improve the position. Continue monitoring through FPC. **Action for agreement for closure at 08.12.22 Board meeting.**
B/16/22	Liaise with the CSO about the power capacity issue raised in the report by 2gether and provide an update on this risk.	Dec-22	Chief Strategy Officer (CSO)	To Close	Verbal update will be provided at 08.12.22 Board meeting.

B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	Feb-23	Integrated Audit and Governance Committee (IAGC) Chair/Group Company Secretary (GCS)	Open	Amended IAGC ToR being circulated for virtual approval, with formal ratification at its next meeting in January 2023 and presented to the February 2023 Board meeting for approval, as part of the IAGC Chair Assurance Report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**PATIENT EXPERIENCE STORY**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER (CNMO)/ EXECUTIVE BOARD MATERNITY SAFETY CHAMPION**				
PAPER AUTHOR:	**HEAD OF PATIENT VOICE AND INVOLVEMENT**				
APPENDICES:	**APPENDIX 1: PATIENT EXPERIENCE STORY**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The report provides background for the patient story that will be heard at the Board meeting. The story relates to a young man who was terminally ill with cancer of the oesophagus, who was admitted to the Queen Elizabeth the Queen Mother (QEQM) Hospital.				
Summary of Key Issues:	The suboptimal care he received, our failure to listen to his partner and family's concerns, and the failure of staff on the ward to seek additional help or to escalate their concerns, meant that at the end of his life, J was not afforded the compassionate care, kindness, pain relief and dignity he should have received. Compassionate and dignified care is within the gift and responsibility of all our staff. We need to hear J's story, the story of those who loved him, and understand the devasting impact our lack of care and compassion had, both at the end of his life, and for his family in bereavement. We only have one chance to get end of life care right, and we sadly missed that opportunity for J and his family. J's mother will attend the Board meeting to talk about J's story and the impact it had on J, his partner and his family. The Trust's Consultant Nurse Palliative Care, will attend to talk about the improvement work being undertaken related to end of life care.				
Key Recommendation(s):	The Board of Directors is invited to: 1. **LISTEN** to the mother's experience and how this made her and her family feel; 2. **ACKNOWLEDGE** the failures of the care we provided; and 3. **ENSURE** that we use the learning from this family's experience to ensure that patients who are at the end of life and patients deemed Bariatric receive care that maintains their dignity and safety and ensures their pain is managed. And that patients and their family are listened to, and their concerns addressed with kindness and compassion at the time they are raised.				

East Kent Hospitals University NHS Foundation Trust

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	Our people	Our future	Our sustainability	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.			
Link to the Corporate Risk Register (CRR):	**CRR 118**: There is a risk that the underlying organisational culture impacts on improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours.			
Resource:	Y/N	None.		
Legal and regulatory:	Y/N	Care Quality Commission regulations.		
Subsidiary:	Y/N	Not applicable.		
Assurance Route:				
Previously Considered by:	Not applicable.			

East Kent Hospitals University NHS Foundation Trust

PATIENT EXPERIENCE STORY

1. Purpose of the report

1.1 The report provides background for the patient story that will be heard at the Board meeting. The story relates to a young man who was terminally ill with cancer of the oesophagus, who was admitted to the Queen Elizabeth the Queen Mother (QEQM) Hospital. The subsequent suboptimal care he received, our failure to listen to his partner and family's concerns, and the failure of staff on the ward to seek additional help or to escalate their concerns, meant that at the end of his life, J was not afforded the compassionate care, kindness, pain relief and dignity he should have received. His family were caused unnecessary distress through witnessing this and their concerns not being acted upon. J's mother will attend the Board meeting to talk about J's story and the impact it had on J, his partner and his family.

2. Background

2.1 J was a 38-year-old, male patient who had been previously diagnosed with cancer of the oesophagus with bone and lymph node metastases. Metastases is when cancer cells break away from where they first formed and travel through the blood or lymph system and form new tumours.

2.2 In September 2021, J was seen by the community hospice team at home, presenting with new confusion. J and his partner wished for investigation of any reversible causes and active treatment. The Hospice doctor provided J with a referral letter and advised him to attend the Emergency Department (ED).

2.3 J attended the ED of the QEQM with shortness of breath, confusion, and reduced mobility. During the handover from Acute Medical Unit (AMU) A to Quex ward, staff were advised that a request had been made to the clinical site team for a bed space to be closed, to facilitate enough space for the bariatric bed that J needed. Due to the bed and patient flow pressures within the hospital, it was not possible to close a bed space, so a side room was provided. This meant that J did not get the most clinically appropriate ward placement to meet his needs, as a patient requiring additional space/equipment.

2.4 Quex ward is an acute medical 28 bed ward specialising in Gastroenterology. At the time of the J's admission, there was a significant reduction in staffing (up to 60% for Registered Nurses (RNs) and 25% for Health Care Assistants (HCAs).

2.5 J's wish and his partner and his family's wish was for him to die at home. Despite attempts to discharge J home, this was not possible as the appropriate staffing ratios to meet his moving and handling needs were not available within the care providers identified. There was also an issue about the appropriate bariatric bed and equipment not being readily available.

2.6 Three days after admission to Quex ward, J was found on the floor in the side room, having had an unwitnessed fall whilst trying to get out of bed to go to the toilet. As space in the side room was limited, J was transferred onto a sheet and slide sheets, to facilitate moving from the side room into an open space so that staff could use the HoverJack® hoist to transfer the J back to his bed. Whilst J sustained no physical injuries, this episode caused distress to both him and his family.

2.7 Several days later J's partner and his father reported to the matron that they had observed J with faeces on his hands and in his mouth. J's mother also spoke to the matron and expressed that she felt there was lack of care and support for J, and due to lack of staff the family were put in a position where they had to provide care since admission, which she felt they should not have had to do. J's siblings found this particularly distressing, and were anxious that if they visited J, they would have to undertake personal care tasks that they felt were not appropriate or dignified for J. The matron apologised and offered reassurance and support.

2.8 From staff's narrative accounts of J's care, it appears that ineffective bowel management was a contributory factor to J's unwitnessed fall. It was also likely to have been a contributory factor influencing J's discomfort and soiling of his hands, likely linked to attempts to 'self-evacuate'.

2.9 There was no nursing healthcare record documentation indicating consideration of constipation and the requirement for When Required Medications (PRN), despite risk factors such as: the use of opioids, decreased dietary intake, reduced mobility, absence of bowel movements, and J's family reporting J's faecal soiled fingers and face.

2.10 J's family contacted social services safeguarding team and the Care Quality Commission (CQC) to raise their concerns regarding the provision of care for him. J sadly died nine days after his admission to QEQM.

2.11 The subsequent investigation team found that although the palliative care team (consisting of the Clinical Nurse Specialist (CNS) and Palliative Medicine Consultant) promptly reviewed J on admission and appropriately throughout the time he was on the ward:

- There are omissions in utilising and collaboratively working with the palliative care team, to seek additional advice or review in supporting J's symptom management throughout admission.
- Despite the team providing the ward with contact details and reinforcement to use the on-call services over the weekend, it was unclear why this was not implemented.
- There are episodes following the palliative care team reviews, where ineffective medication management for symptom control and observations of poor fundamental care (hygiene) were noted. However, this concern was not escalated to either a nurse in charge or the Senor Nursing Leadership Site team for immediate actions.
- There are multiple inaccuracies within the completion of the rounding tool, indicative of concerns, yet without documented structured evidence of the observations or further actions required.
- Following the Palliative Medicine Consultant's implementation of the multidisciplinary document care on the last hours and days of life, this was poorly completed by Medical and Nursing staff.
- There was evidence of documentation that the patient had no anxiety or breathlessness, despite this being the case, and multiple gaps within the suggested comfort checks.
- The investigation has been unable to conclude if The Compassion Symbol was explained or displayed, but the family say it was not displayed, nor was his name put on the board above his bed.

2.12 These omissions in care are fundamentally missed opportunities to have provided better-quality care. This not only deviates from aligning to the Trust values and standards, it also demonstrates an absence in compassionate and quality care for J and his family. The investigation team concluded that the staffing shortages and skill mix, omissions in medication management, poor personal care observations and expected standards of documentation, meant that J was not cared for in line with the Trust's expectations.

2.13 The investigation team have acknowledged and apologised to the family for the omissions in fundamental care that J experienced. Furthermore, the investigation team acknowledged that the investigation process and delays have caused distress to a family who are grieving the death of their loved one.

2.14 Compassionate and dignified care is within the gift and responsibility of all our staff. We need to hear J's story, the story of those who loved him, and understand the devasting impact our lack of care and compassion had, both at the end of his life, and for his family in bereavement. We only have one chance to get end of life care right, and we sadly missed that opportunity for J and his family.

2.15 The Board have access to the final report into the Serious Incident (SI) related to J's care WEB 198831.

3. End of Life Care best practice

3.1 Care of the Dying adults in the last days of life - the Trust has developed a care plan for the Last Hours and Days of Life, which is a multi-professional document based on the five priorities of care for the dying patient outlined in One Chance to get it Right (June 2014). This care plan should be followed with an individualised assessment when patients are recognised as being in the last hours and days of life.

3.2 The compassion symbol, promotes dignity, respect and compassion for dying patients and their families. It is used across the Trust to encourage an atmosphere of quiet and respect at this time.

4. Fundamentals of Care

4.1 The Trust has designed and is currently implementing a Ward Accreditation programme led by the Quality Improvement Matron and overseen by the Associate Director of Nursing. This reports into the Fundamentals of Care Committee. This is a two-year improvement programme aligned to 'We Care' to improve the standards of care across the Trust. There is a Fundamentals of Care audit tool for ward managers to complete, designed around 12 key standards and when fully established will be used by the care groups to target improvements required in patient care.

4.2 In May 2022 a brief investigation of current practice in Bowel Management was undertaken to explore recording and reporting of bowel actions for inpatients. This highlighted the need for further consideration being given to the improvements surrounding the recording and management of the adult patient's bowels. Following this a new daily bowel record was designed and implemented. It is based on bowel action recordings that are entered on the VITALPAC system (IPODS). The daily Excel report is now filterable and searchable, and reports only patients who haven't had their bowels open (or recorded) for 2 or more days. The report is sent to Directors and Heads of Nursing, and in turn to the Matrons and ward managers.

5. Care for Bariatric / plus size patients

5.1 There is a task and finish group who are currently reviewing the Standard Operating Procedure for the care of Bariatric patients. This procedure will be updated and become a policy. Work is now planned on seeking the views of plus size patients specifically, to get feedback on their experience whilst patients and to identify any improvements that are needed.

6. Conclusion

6.1 The issues J's story raises around compassion and culture are wider reaching than just end of life care services. J was assessed and subsequently reviewed throughout by the Supportive and Palliative Care Team. However, the SI investigation found that the standards of fundamental care and end of life care expected were not achieved. There were opportunities missed to involve the Moving and Handling team and to escalate concerns to senior staff.

5.2 Lucie Rudd, Consultant Nurse Palliative Care will attend to provide information of improvement work underway. Whilst this will provide some assurance to the Board, our patients, their families and communities, the care provided to patients is primarily in the hands of the medical, nursing and support staff on the ward.

5.3 We need a commitment from Board to ward to:

- Demonstrate compassion to those we look after;
- Model compassionate leadership;
- Create a culture where staff speak up when something isn't right, and continue to speak up without fear or apathy.

5.4 J's mother, Allyson, wants to work with the Trust to support improvements that will mean that J's experience will not happen to others. Allyson is now one of the Trust's Participation Partners, and is co-Chair of our new Patient Participation and Action Group. Allyson will also be getting involved in the End of Life Care Committee. We can't change what J, his partner, Allyson and family experienced. But we can do our best to make sure it doesn't happen again.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHAIRMAN'S REPORT**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**CHAIRMAN**				
APPENDICES:	**APPENDIX 1: SUMMARY OF NEXT STEPS AS AGREED BY THE BOARD (INDEPENDENT INVESTIGATION INTO EAST KENT MATERNITY AND NEONATAL SERVICES)** **APPENDIX 2: NON-EXECUTIVE DIRECTORS' (NEDs') COMMITMENTS**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.				
Summary of Key Issues:	Update the Board on: • Current Updates/Introduction; • Health and Care Partnership (HCP); • Activity of the CoG; • Visits/Meetings.				
Key Recommendation(s):	The Board of Directors is requested to **NOTE** the contents of this Chairman's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	~~Y~~/N	N			
Legal and regulatory:	~~Y~~/N	N			
Subsidiary:	~~Y~~/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

Reading the Signals
Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation

We continue to reflect on the devastating report into our maternity services which must guide this organisation in the months and years to come. We are clear that the issues are deep seated and lie across the Trust not only within midwifery. The Board met last month to consider how we should take forward our response and we are producing an action plan which will seek to take the first steps to transforming our culture. I have attached a summary of the next steps as agreed by the Board at the Strategy Day. A paper will be presented today by our Chief Executive Tracey which will provide a further update

There have been many other plans and opportunities to tick boxes and point to process changes. This has to be different. It has to be about the values we live by, the way we work, the way we relate to each other, the way we behave towards patients and their friends, carers and relatives. And by 'we', I mean everyone from those of us on the Board, senior leaders throughout the organisation, clinical and managerial, and everyone supporting as well as everyone on the front line of care. We have so many wonderful staff and many wonderful teams who every day do great things but the maternity report, our poor staff survey results and too much other evidence tells us there are fundamental issues we all need to address.

Tracey, and I had a positive meeting with Dr Bill Kirkup and the investigation secretary Ken Sutton. Following that discussion, as well as addressing the many concerns raised in the report, I hope we can help to pioneer new ways of measuring performance in maternity and create new ways of reading the signals of what is going on.

Entonox withdrawal

In her report Tracey refers to the ongoing work to tackle the excessive levels of Entonox in labour rooms at the William Harvey Hospital (WHH). We will discuss this at today's meeting but I am clear we need to commission an external review to understand fully the circumstances, including why this occurred and its implications.

Urgent and Emergency Care

I had a useful visit to our acute and emergency care operation at the WHH last month. The expansion of our emergency services with the 12 bedded Rapid Assessment Unit and 9 bedded Resus are such an advance on what was there before, and along with the expanded same day emergency care ward means we now take 30-40% of medical take directly from the Emergency Department (ED) which represents real progress. The experience of too many patients as I have said before is simply not good enough but we should acknowledge the formidable work that is underway to improve patient flow and with the winter plan to manage what is certain to be even greater demand.

East Kent Hospitals University NHS Foundation Trust

East Kent Oversight Meeting

Tracey and I attended an East Kent oversight meeting chaired by the Integrated Care Board (ICB) chief executive Paul Bentley at which we discussed the progress the Trust has made towards exiting the Recovery Support Programme (RSP). Given the current financial position, the ongoing pressures in Emergency and Urgent Care, the large number of patients who are ready to discharge but remain with us and the conclusions of the maternity investigation, it was recognised that we will not be ready to leave the programme before the end of Quarter 2 in 2023. Further discussions are underway to devise the criteria for judging progress.

3. Health and Care Partnership (HCP) Board

The HCP Board which I chair met on 17 November and we were joined by colleagues from the education sector for an initial discussion about growing our health and social care workforce in East Kent. There is real enthusiasm and commitment from those working in education to partner with the NHS and social care and create innovative solutions to tackle our huge and growing workforce crisis. The East Kent colleges are signing up to a memorandum of agreement with the HCP to expand key programmes, establish a partnership to build volunteering opportunities for young people, take part in an NHS England (NHSE) system leadership opportunity, and create a Senior Responsible Officer to drive this programme to target our most significant challenges.

There were also updates on the work through our Wellbeing and Health Improvement Partnership particularly around support for the growing cost of living. Over the last few months more than 1100 people have attended our “Eat well” events which are focussed on food poverty. The HCP also organised the first of a number of events, which provide support and information on the cost of living, and combine this with key health messages and health checks, to support people to keep well over winter. More than 300 people attended the first event in Folkestone It is testament to our growing relationship with the Voluntary sector that we are able to deliver this.

4. Council of Governors (CoG)

The CoG met on 1 November and of course much of the meeting was devoted to the Report of The Independent Investigation (*Reading the Signals*). The Governors issued a statement following the report and have made clear their commitment to challenge and work with and alongside the Trust in bringing about reform. The Council also discussed the use of Urgent Treatment Centres (UTC), Paediatric Emergency facilities and received a presentation from the Freedom to Speak Up Guardians. Since the last Board, Governors have conducted joint site visits to Queen Elizabeth the Queen Mother Hospital (QEQM) to visit the new ED, Kent Canterbury Hospital (K&CH), UTC and Children’s assessment centre and WHH, UTC, Same Day Emergency Care (SDEC) and Kings ward. Governors have also been invited to the Christmas lunches to say thank you to our volunteers as part of their engagement programme.

A Governors newsletter for November has been sent to the membership. An early step to increase awareness of Governors and their role was an advertisement for new members in the next Ashford Borough Council newsletter.

We are now starting the election process for the vacant seats of Swale (1) Canterbury (1) rest of England (1). These elections will also include the Governors constituency seats for those that are coming to the end of their tenure, and these all should conclude by the beginning of February 2023.

The CoG Nominations and Remuneration Committee (NRC) Committee have held the shortlisting meeting for the replacement of Jane Ollis and Nigel Mansley whose terms end next year and we are now entering the interview stage to be held over the next few weeks.

5. Visits/Meetings/Talks

MP visit to QEQM ED with Sir Roger Gale
Site visit Acute Medicine WHH
Talk with Margate Rotary Club
Institute of Directors (IOD) Training
Together We Care Symposium

A summary of the next step as agreed by the East Kent Board following the report from the Independent Investigation into East Kent Maternity and Neonatal Services – Reading the Signals

At the Board meeting on November 10, 2022, we agreed:

1. We will produce a response document setting out what we plan to do to use the Investigation's report to help drive transformation across the organisation. This will set out the areas for action along with timeframes for completion.

2. We will publish a major statement setting out our ambition to transform the culture of the Trust which will include messages around our commitment to openness, honesty, kindness and learning, and that poor behaviour will not be tolerated. This may take the form of two separate statements – one to staff (including those in our subsidiaries) and one addressed to the East Kent the community. We will consult governors, other organisations and families before any statements are published.

3. The Trust will develop a universal, consistent face to face programme which will engage every member of staff. It will seek to explain and explore how we embed a change in culture across the Trust. We recognise different teams may also need bespoke interventions and will seek advice on the best way to devise and deliver the programme.

4. We will invite Dame Eileen Sills the chief nursing officer at the ICB to attend a future Board to present the Barbara's Story initiative she led at St Thomas's Hospital.

5. We will explore bringing in external support to help us bring about culture change, learning from others that have implemented similar programmes. We will liaise with Professor Michael West a leading figure in shaping compassionate leadership to explore using his experience and advice to shape the Trust's approach.

6. We will bring together and if necessary, refine existing programmes and initiatives and make sure that we take account fully of Equality, Diversity, and Inclusion in all strands of this work.

7. We will consult and involve patients and families including in the development and testing of new policies and procedures, where applicable. This will include taking forward our Patient Voice and Involvement Strategy the next phase of which will engage with wider community to provide support.

8. We will establish a Reading the Signals Assurance Group with a defined terms of reference which will lie within the Trust's governance structure. Its function will be to provide oversight, assurance, and validation, seeking challenge, engagement, and advice, with representation internally, including members of the Council of Governors and externally. It must listen to patients engaging with women, families, and the community.

9. Accountability and ownership of the report must remain with the Board, monitoring the agreed actions and progress. It was recognised that we will need more time to

consider how the Reading the Signals Assurance Group would work, how progress would be measured, and whether the current process of feedback from mothers and families is effective. We also acknowledged though the need for changes to be made at pace while recognising the time required to influence and alter the culture of organisations. The Assurance Group will be time limited - around 12 to 20 months, with an external review of progress at 12 months and at end of period.

1. We agreed we should seek some form of external independent review of both our progress in maternity and in our culture work. The form to be considered and agreed at a future Board meeting.

2. We will need to consider additional costs of all these measures and if necessary, develop a business case and explore whether to approach Regional and National colleagues on what support could be provided to take the necessary work forward.

3. The Board gave strong support to the Pillars of Action document produced by the senior management team and asked for it to be taken forward along with other actions agreed in the meeting.

4. We agreed to include health inequalities and vulnerable people in the Pillars of Action.

5. We approved the proposed approach to the Management of Care Review Requests and Retrospective Serious Incidents (SIs) following publication of the IIEKMS outlined by the Chief Nursing and Midwifery Officer and agreed this would be presented to NHS South East Region.

Niall Dickson
Chairman
18 November 2022

East Kent Hospitals University NHS Foundation Trust

Non-Executive Directors' (NEDs) Commitments

NEDs November 2022 commitments have included:

Chairman	Meetings with individual NEDs Meetings with Executive Directors NED recruitment shortlisting meeting Meeting with Lead Governor and Deputy Lead Governor Meetings with Governors Meeting with 2gether Support Solutions (2gether) Chairman Meeting with Spencer Private Hospitals (SPH) Chairman Meeting with Integrated Care Board (ICB) Chair Meeting with East Kent Hospitals Chief Executive and ICB's Chair and Chief Executive Meeting with NHS England (NHSE) Improvement Director Meeting with Chair of The Shrewsbury and Telford Hospital NHS Trust Meeting with East Kent Hospitals Chief Executive and Dr Bill Kirkup MP (North Thanet) Visit to Emergency Department (ED) at Queen Elizabeth the Queen Mother Hospital (QEQM) Board of Directors Development Strategy Day East Kent Hospitals Recovery Support Programme (RSP) Review meeting East Kent Health and Care Partnership (HCP) Board meeting East Kent Quarterly HCP/Place Oversight meeting Kent and Medway (K&M) Chairs meeting Ockenden Report Assurance Committee (ORAC) meeting at The Shrewsbury and Telford Hospital NHS Trust Institute of Directors Training – Role of the Director and the Board Site visit to William Harvey Hospital (WHH) (Acute Medicine)

Non-Executive Directors	Meetings with Chairman Meetings with Executive Directors Meeting with SPH Chief Executive Meetings with SPH NEDs Meeting with Lead Governor Meeting with Freedom to Speak Up Guardians Board of Directors Development Strategy Day Quality and Safety Committee (Q&SC) meeting Finance and Performance Committee (FPC) meeting People and Culture Committee (P&CC) meeting Patient Participation and Action Group meeting Strategic Capital Planning and Performance Committee meeting 2gether Audit Committee East Kent HCP Board meeting Institute of Directors Training – Role of the Director and the Board Joint NED/Governor site visit to Kent and Canterbury Hospital (K&C) Good Governance Institute (GGI) Chair's event NHS Providers Annual Conference and Exhibition

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF EXECUTIVE (CEO)**				
PAPER AUTHOR:	**CHIEF EXECUTIVE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.				
Summary of Key Issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.				
Key Recommendation(s):	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.				
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.

2. Background

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

3. Clinical Executive Management Group

There were no Business cases approved or recommended for approval at the meetings of the CEMG on 9 and 23 November 2022.

4. Operational Update

4.1 Winter Planning

The Trust's winter plans were presented to the Board of Directors and CEMG in November. As outlined in the document there have been two key focus areas for development throughout this period:

- The finalisation of staffing rotas for key three weeks over the Christmas period. The Trust's Care Groups have been tasked with providing detailed cover and contingency arrangements for staffing across all services. This work is near completion with staffing plans being submitted and reviewed via the Chief Operating Officer.

- The second area of focus relates to the unfunded position of a number of the proposed winter schemes which pose a significant risk. On Wednesday 23 November 2022, the Trust was made aware of the allocation of funding from the Adult Social Care Discharge Fund; proportioned funding amounts for Kent and Medway were provided with the Kent and Medway Integrated Care Board (ICB) allocated £9.8 million out of the total £15.7m.

Funding conditions to access the Adult Social Care Fund outlined the need to prioritise schemes that are most effective in freeing the maximum number of hospital beds, reducing bed days lost, that maximise the provision of homecare and boost the general adult social care workforce capacity.

To this end, a collective partnership of East Kent (EK) representatives from Kent Community Health NHS Foundation Trust (KCHFT), Kent County Council (KCC), EKHUFT and East Kent Primary Care Network (PCN) submitted a developed set of winter schemes that satisfy the above criteria. The EK submission totalled £4.37m and includes schemes for bridging capacity, increasing Pathway One capacity, supportive discharge schemes and the extension of multiple services offered by EKHUFT, all with the direct aim to alleviate the bed pressure within the Trust and across the HCP, to improve flow over winter and maximise available capacity.

The Trust expects to receive an update on the funding allocation within the next week.

4.2 Elective Care for Tier 1/ Tier 2 providers

On 25 October 2022, NHSE wrote to the NHS outlining further plans to boost capacity and resilience for services over the challenging winter period. This letter set out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives relating to 78 week waiters and 62 day cancer waits are met.

NHSE requested that the Trust provide detail of the current position against key areas by way of self-certification that will allow NHSE to identify the greatest challenges posed to the Trust and identify the support that may be required to reduce the waiting list. The key fundamental areas, that NHSE have collectively chosen to work on are as followed:

- Excellence in the fundamentals of waiting list management
- Validation
- Appropriate surgical and diagnostic prioritisation
- Cancer pathway re-design for Lower GI, Skin and Prostate
- Outpatient transformation
- Surgical and theatre productivity

The Trust was asked to confirm its position in relation to governance, ownership, recovery trajectories, current performance, pathways reviews and productivity. All areas have been RAG rated following a review by the Chief Operating Officer (COO) and the Interim Elective Recovery Director; all were rated green as 'in progress' or 'in place'.

Supporting evidence was also provided in response to specific areas of development related to Lower GI, Skin and Prostate cancer pathways, 'Super September' validation of non-admitted waiting lists and validation of those patients on the Trust's waiting list.

Led by the Trust's COO and Interim Elective Recovery Director, and signed off by the Chairman and the CEO the self-assurance certification was completed and issued to NHSE on Friday 11 November 2022.

5. Finance Update

5.1 Financial Plan 2022/23 forecast

The Trust is experiencing a number of financial pressures this year including increased escalation beds on our acute sites, an increase in the use of temporary staffing and a shortfall in its efficiency target and is therefore predicting a financial deficit of £30m. The Trust is continuing to work with system and regional NHS colleagues to improve this position.

5.2 Financial performance Year to Date (YTD)

At the end of month 7 (October) the Trust has a year-to-date deficit of £15.3m, which is £11.4m adverse to plan, with an in-month deficit of £2.4m. This deficit position continues to be driven by a number of escalation areas opened across the Trust (60 beds) to accommodate patient demand and flow

(£4.8m), a £1.0m gap in other income with staff parking charges not commencing in line with the previous plan and other bank/ agency spend £1.9m ahead of budget due to clinical pressures across the Trust.

The Trust achieved efficiency savings of £2.0m in October, £0.8m behind plan, moving the year-to-date position £1.3m behind the plan of £12.0m. The PMO continue to meet regularly with Care Groups and Corporate teams, with enhanced financial governance arrangements to be introduced in December, including a revamped Financial Improvement Oversight Group (FIOG) and a new Clinical Leaders Efficiency Group.

5.3 Financial Controls NHSE – Protocol for changes to in-year revenue financial forecast

The Trust has received the protocol for changes to in-year revenue financial forecast from NHSE detailing the process for an organisation to revise its financial forecast.

The protocol details a number of conditions that will be applied to Providers and/ or ICBs if the protocol is enacted and a reforecast is required. The most notable would be for the Trust to implement a double-lock sign-off process for any revenue investments above £50,000 with sign-off required by the provider and the ICB; further details of the operation of this mechanism will be issued separately, and may need to be tailored to fit with local governance arrangements.

6. Independent Investigation into East Kent Maternity & Neonatal Services

The Board discussed the Trust's response to the report, *Reading the signals*, at the Board Development session on Thursday 10 November 2022. The direction from discussion was to ensure that the work required in the Trust became a key part of the overall focus of the improvement agenda and not something that was simply associated with maternity and neonatal services alone. The specific maternity and neonatal improvement programme of work will continue to be overseen by the Maternity & Neonatal Assurance Group (MNAG).

Representatives from the Executive team and the senior clinical leaders from the Care Group attended the Kent County Health Oversight and Scrutiny Committee on Wednesday 30 November 2022 to respond to questions from committee members. This was understandably a challenging session and involved insightful, fair questioning.

7. Recovery Support Programme (RSP) Review

The Chair and representatives from the Executive team attended an RSP Oversight meeting with the national executive team as well as representatives from the regional NHSE team and the Kent & Medway ICB. It was proposed that the Trust would not meet the exit criteria to move from SOF4 to SOF3 by December 2022, particularly associated with the financial position and as a consequence of a significant change of the organisation's position following the publication of the Kirkup report, Reading the signals.

It was agreed that the exit date and criteria would be reviewed between the NHSE regional office team and the Trust, in conjunction with the ICB team. These details

will be brought back to the Board of Directors for discussion and agreement at the first meeting in 2023.

8. Staff Survey

The National NHS Staff Survey, aligned with the NHS People Promise, closed on Friday 25 November 2022 with the Trust achieving a response rate of 42.43%, which may increase to between 44 – 45% once data has been cleansed. This response rate is disappointingly below that of last year, despite increased efforts to encourage completion. This is however aligned to behaviours observed across the local system and expected to be in line with the national response rate.

All staff are encouraged to provide anonymised responses to the survey to ensure that their voice is heard by the organisation and that it is used to prioritise areas of improvement.

9. Entonox issues at William Harvey Hospital (WHH)

On Thursday 24 November 2022 the Trust made the decision to temporarily suspend the use of Entonox (gas and air) in the delivery unit at WHH due to high levels of Nitrous Oxide in the labour rooms. Nitrous Oxide is a gas present in Entonox.

Although it was assessed that mothers and babies were not at risk of harm, there was a risk to our midwifery staff and midwifery students due to the increased risk associated with long-term exposure to Entonox they would experience through their work. To keep those staff who work in the maternity department safe, it was necessary to temporarily suspend the use of gas and air until new ventilation systems are installed and regular monitoring shows levels are safe.

It was arranged by the clinical teams that women in labour would be offered alternative methods of pain relief. The midwifery team provided advice to mothers due to give birth at WHH to talk to their midwife if they have any concerns, including if they wished to transfer their care to Queen Elizabeth the Queen Mother Hospital (QEQM).

By the end of the following week, Friday 2 December, the temporary solution was in place and we were able to make Entonox available to women. A permanent solution is to be installed during the next three months.

It is important that we review how this situation materialised in terms of design choices, monitoring and overall governance. Reviews will be initiated to examine both aspects to ensure that we learn what needs to change and what we should be doing differently. Timescales for this work will be confirmed separately.

10. Conclusion

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**					
REPORT TITLE:	***READING THE SIGNALS* – DELIVERING THROUGH PILLARS OF CHANGE**					
MEETING DATE:	**8 DECEMBER 2022**					
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER (CEO)**					
PAPER AUTHOR:	**STRATEGIC PROGRAMME DIRECTOR**					
APPENDICES:	**APPENDIX 1: *READING THE SIGNALS*: DELIVERING THROUGH PILLARS OF CHANGE**					
Executive Summary:						
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**	
Purpose of the Report:	To provide an update to the Board of Directors on the approach to delivering a programme of change to respond to the findings of *Reading the signals* the report of the independent investigation into maternity and neonatal services in east Kent, published on 19 October 2022.					
Summary of Key Issues:	The Board has recognised there is a need to develop a universal programme of work with Trust wide ownership setting out the required leadership as well as reviewing programmes currently in place. The programme also needs to be assessed for its effectiveness and when necessary, to consider what needs to be done differently. This paper sets out a Trust wide approach to delivering a process of change through our Pillars of Change in response to *Reading the signals*.					
Key Recommendation(s):	The Board of Directors is asked to discuss this Report and the approach being taken and **AGREE** the immediate next steps.					
Implications:						
Links to 'We Care' Strategic Objectives:						
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**		
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.					
Link to the Corporate Risk Register (CRR):	**CRR 118:** Risk of failure to address poor organisation culture.					
Resource:	N					
Legal and regulatory:	N					
Subsidiary:	N	2gether Support Solutions				
Assurance Route:						
Previously Considered by:	N/A					

East Kent Hospitals University NHS Foundation Trust

READING THE SIGNALS – MATERNITY AND NEONATAL SERVICES IN EAST KENT - THE REPORT OF THE INDEPENDENT INVESTIGATION - DELIVERING CHANGE

1. Purpose of the report

1.1 To provide an update to the Board of Directors on the approach to delivering a programme of change to respond to the findings of *Reading the signals* published on 19 October 2022.

2. Findings of the investigation

2.1 The panel found that too often clinical care was suboptimal and led to significant harm, we failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

2.2 Individual and collective behaviours were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, and lay at the root of the pattern of recurring harm. At any time during this period, these problems should have been acknowledged and tackled effectively. There were eight clear separate opportunities when that could and should have happened.

2.3 Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases. The Panel had not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

2.4 Nor was the harm restricted to physical damage. Chapter 3 of the report sets out the equally disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

3. Areas for action

3.1 The Trust accepts the reality of the findings of the Report and agrees with the key recommendation specifically for the Trust, that it should embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

3.2 The Report also has within it four areas of action for the NHSE and partners to address:

- Monitoring Safe Performance
- Standards of Clinical Behaviour
- Flawed Team Working
- Organisational behaviour

4. Implementing the recommendations

4.1 Since the publication of the report there has been a number of discussions internally and with partners, including a Board Development Day held on 10 November. The CEO, Chief Nursing and Midwifery Officer, Chief Medical Officer and senior leaders from the women's care group, also attended Kent County Council's Health Overview and Scrutiny Committee on 30 November to discuss the report.

4.2 The Board has recognised the need to develop a universal programme of work with Trust-wide ownership, setting out the required leadership as well as reviewing programmes currently in place and being progressed, to identify their effectiveness, and gaps and what needs to be done differently.

4.3 This paper sets out a whole Trust approach to delivering a programme of work through our Pillars of Change, taking account the four key recommendations set out above as well as the recommendation set specifically for the Trust. It is recognised that NHSE is expected to set some national direction in responding to these recommendations too.

4.4 Specific improvements relating to maternity and neonatology services will continue to be overseen by the Maternity and Neonatal Assurance Group that reports to the Trust Board.

5. Delivering through Pillars of Change

5.1 The draft Pillars of Change (appendix 1) have been developed and focus on five key areas of work to be undertaken. The foundations start from now and complete within the next 6 months, 6-24 months includes measuring the effectiveness of the changes and how they are embedded and further rolled out, and then reaching the sustained change we want to see, over the next 2-3 years.

5.2 The draft pillars as developed respond to Dr Kirkup's areas for action, and focuses on:

- Reducing Harm and Service Delivery
- Care and Compassion
- Engagement, Listening and Leadership
- Organisational Governance and Development
- Patient and Family Voices

5.3 The programmes of work in some cases build on existing initiatives and subject to Board approval to this approach will then be further progressed around content and executive ownership. This will be reviewed against existing programmes of work to ensure consistency and avoidance of duplication, for example alignment and links with the We Care Quality Improvement Programme.

5.4 The importance of engaging our staff, families, partner organisations and regulators with this approach will be very important next steps.

5.5 Day to day Executive responsibly for delivery will be monitored through Clinical Executive Management Group to enable the programme to be built into the core way of managing and developing the approach.

6. Immediate Next Steps

6.1 It is proposed that following discussion at the Trust Board that the next immediate steps to be put in place before the end of January should be as follows:

6.2 Alongside delivering the actions in the pillars we will discuss the plan with our staff, families, communities and partner organisations and regulators to continue to develop the proposed Pillars of Change.

6.3 Develop five outcome measures for each of the pillars which will be included in a 'Reading the signals Outcome Framework' which will track the improvements.

6.4 Draft and agree a statement setting out the Trust's ambition to embrace openness and honesty, work with patients and families and bring about change in attitudes and behaviour so that everyone is treated with courtesy, respect and kindness.

6.5 Produce a proposal to establish a Community Assurance Committee (previously taskforce), developing terms of reference and membership, a reporting structure aligning with the current governance structures and defining how the Group would engage internally and externally with women, families and wider community as well as monitoring progress of the Change Programme. It is important that public confidence is restored through this process.

6.6 Establish the Independent Case Review Process for managing responses to maternity care concerns from families and have in place for mid December 2022.

6.7 Organisation Restructure Consultation Document to be launched

6.8 Begin Team Brief in January 2023, a standardised approach bringing managers together with the Executive and then their teams, face-to-face on a monthly basis, so that information can be delivered, questions asked and feedback collected.

6.9 Establish an approach to Listening Events based on learning from the maternity listening events. These events would be designed to engage directly with staff giving them an opportunity to share views and experiences and an opportunity to develop a culture of openness.

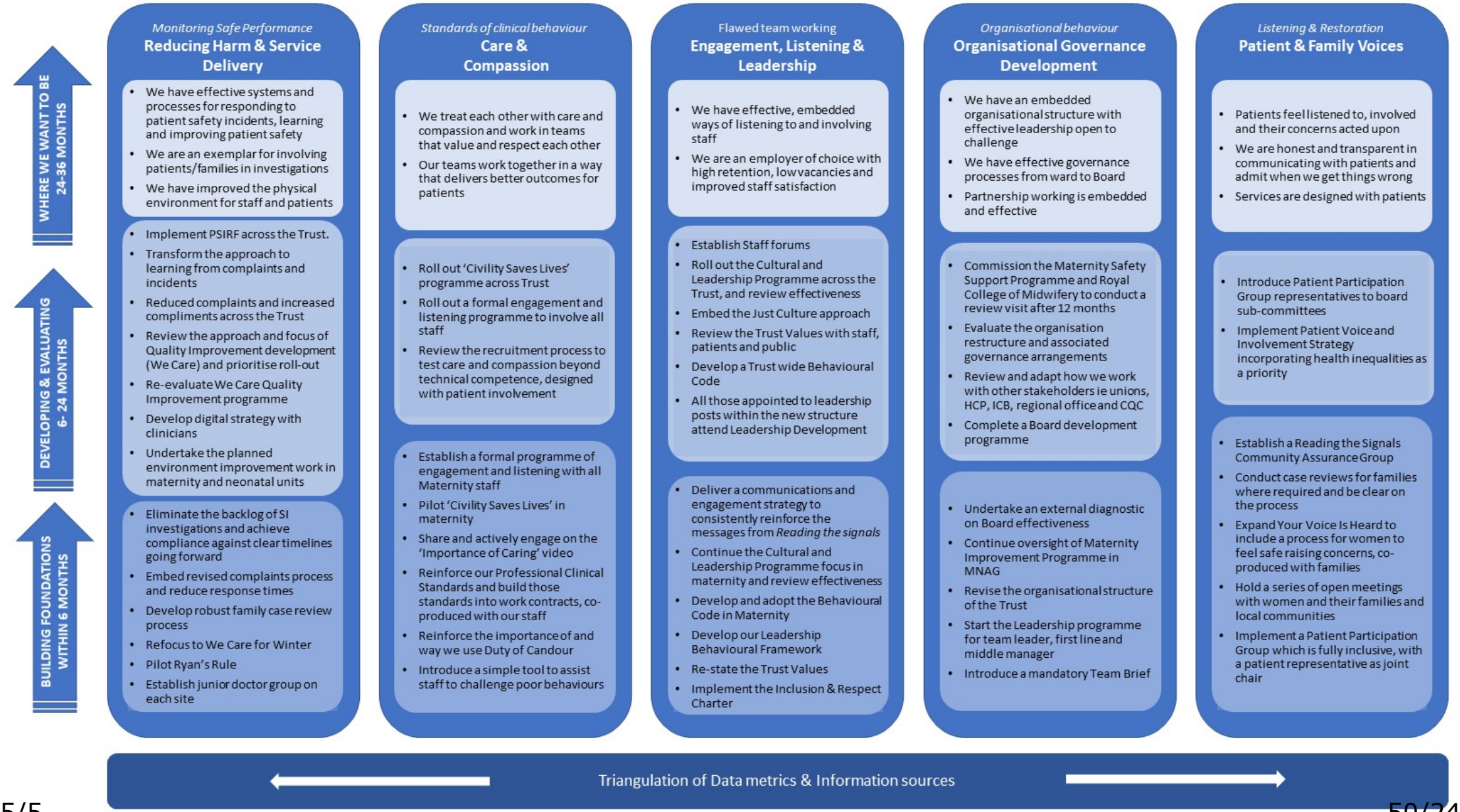
6.10 Pilot ' Civility Saves Lives ' across maternity services from January 2023 - a programme designed to create an environment where rudeness is not tolerated - increasingly studies have proven that rudeness has a negative impact on performance and outcomes.

7. Key Recommendations

7.1 The Board is asked to discuss this Report and the approach being taken and agree Immediate Next Steps

East Kent Hospitals University NHS Foundation Trust

Reading the Signals: Delivering through Pillars of Change



East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT**
MEETING DATE:	**8 DECEMBER 2022**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER (CNMO): EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY IMPROVEMENT AND TRANSFORMATION MANAGER**
APPENDICES:	**APPENDIX 1: PERINATAL QUALITY SURVEILLANCE TOOL**

Executive Summary:

Action Required:	Decision	Approval	Information	**Assurance**	Discussion

Purpose of the Report:

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

Summary of Key Issues:

- The report confirms that the service is using the tool to the required standard, as set out in the NHS Implementing a Revised Perinatal Quality Surveillance Model Report December 2020.
- The report includes the following key messages for the Board's attention:
  - There were 9 cases of moderate or above incidents reported for October. 4 have been reported as Serious Incidents (SIs) and 1 was reported as an After-Action Review (AAR) as learning was identified but the threshold for SI was not met. 1 of the 9 has been downgraded following rapid review.
  - 90% training compliance has not been maintained across all staff groups. Midwives 89.6% in fetal monitoring, all staff groups 84.8% in PRactical Obstetric Multi-Professional Training (PROMPT) and Doctors 89.7% in Neonatal Life Support. Trajectory shows compliance will be reached by end of November but dependent on all staff booked onto training attending.
  - 1:1 care in labour review shows 100% compliance Queen Elizabeth the Queen Mother Hospital (QEQM) and 99.7% William Harvey Hospital (WHH).
  - Supernumerary status is below 100%. CNST guidance update provides clarity on definition and work in progress to cleanse data to align to this.
  - Maternity Voices Partnership (MVP) feedback received covering March to November period. This will be themed and actions agreed against other Service user feedback.
  - Feedback Themes around Midwifery Led Unit (MLU) closure and turning to other trusts to birth, being transferred to General Theatre for C-Sections when maternity theatre is in use,

East Kent Hospitals University NHS Foundation Trust

	inadequate pain relief, insufficient communication, staff relationships and information, choice, exhausted staff. - Positive feedback around kind, safe, caring staff and feeling safe, empowered and supported. - Your Voice is Heard 6 week follow up call 167 Staff mentioned in a positive way and 13 complaint emails - 4 for reference only and 9 that require a response. - 1 episode of Consultant non-attendance for a Royal College of Obstetricians and Gynaecologists (RCOG) required situation which was escalated and actioned. - Staff feedback through walkabouts, student forum and Triage listening events. Concern over QEQM Entonox exposure being acted on and lessons learnt applied to WHH. - 1 letter of concern received from Healthcare Safety Investigation Branch (HSIB). - Publication of *Reading the signals*: Maternity and neonatal services in East Kent – the Report of the Independent Investigation. • CNST areas of non-compliance: o Safety Action 1: Perinatal Mortality Review Tool (PMRT) standard ai). o Safety Action 6: Saving Babies Lives Care Bundle, Fetal Monitoring 90% compliance. o Safety Action 8: Training compliance 90% and training delivery aligned to Core competency framework impacted by workspace and PROMPT. o Challenges remain around the ability of the anaesthetic team to attend PROMPT. • Ockenden Immediate and Essential Actions (IEA) compliance 97%.
Key Recommendation(s):	The Board of Directors is invited to: 1. **DISCUSS** the contents of this report; 2. Receive **ASSURANCE** and **NOTE** that a monthly perinatal quality assurance report has been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements; and 3. **APPROVAL** for the contents of this report to be shared through the Perinatal Quality Surveillance Model Framework with the Local Maternity and Neonatal System (LMNS), Region and Integrated Care Systems.

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

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

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East Kent Hospitals Perinatal Quality Surveillance Reporting October 2022

Month: October 2022	**East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting**

CQC Maternity Ratings

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

Maternity Safety Support Programme	Yes	Support Lead: Mai Buckley
Findings of review of cases eligible for referral to HSIB	0 cases referred	
The number of incidents logged graded as moderate or above and what actions are being taken.	There were 9 cases of moderate or above incidents reported for October. 4 Have been reported as SIs and 1 was reported as an AAR as learning was identified but the threshold for Serious Incident was not met. 1 of the 9 has been downgraded following rapid review, the following 3 are waiting for review at rapid review which will take place by end of this week.	
Themes from reviews of perinatal deaths	**Themes** The noted themes that have highlight through October have been – • The compliance of 4 hourly observations when the women are going through the induction process in the bereavement suite • Noted non-compliance of portograms being commenced	**Actions** As part of the mandatory bereavement update both points are being addressed. The bereavement midwife is in the process of developing a 2 minute 'take away' recorded video to be shared with staff regarding learning points.
100% of perinatal mortality reviews include an external reviewer	Compliant	

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

Fetal Monitoring All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	201	238	84.5%
Midwife - Community	77	94	81.9%
Obstetric Consultant	31	32	96.9%
Other Obstetric Doctor	28	28	100.0%
Unknown	1	2	50.0%
Maternity Support Worker	0	0	NaN
Total	**338**	**394**	**85.8%**

Fetal Monitoring Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	190	212	89.6%
Midwife - Community	68	76	89.5%
Obstetric Consultant	31	32	96.9%
Other Obstetric Doctor	28	28	100.0%
Unknown	1	2	50.0%
Maternity Support Worker	0	0	NaN
Total	**318**	**350**	**90.9%**

Challenges:
- Please see CNST Safety Action 8 below for escalations and mitigations

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Prompt All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	193	241	80.1%
Midwife - Community	78	93	83.9%
Maternity Support Worker	53	72	73.6%
Obstetric Consultant	26	29	89.7%
Other Obstetric Doctor	24	27	88.9%
Unknown	2	2	100.0%
Total	**376**	**464**	**81.0%**

PROMPT Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	181	215	84.2%
Midwife - Community	69	75	92.0%
Maternity Support Worker	50	67	74.6%
Obstetric Consultant	26	29	89.7%
Other Obstetric Doctor	24	27	88.9%
Unknown	2	2	100.0%
Total	**352**	**415**	**84.8%**

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	223	244	91.4%
Midwife - Community	84	94	89.4%
Maternity Support Worker	70	74	94.6%
Obstetric Consultant	29	32	90.6%
Other Obstetric Doctor	26	29	89.7%
Unknown	2	2	100.0%
Total	**434**	**475**	**91.4%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	212	218	97.2%
Midwife - Community	76	76	100.0%
Maternity Support Worker	67	69	97.1%
Obstetric Consultant	29	32	90.6%
Other Obstetric Doctor	26	29	89.7%
Unknown	2	2	100.0%
Total	**412**	**426**	**96.7%**

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

1 to 1 care in Labour (target 100%)		
Month	QEQM	WHH
May	100%	99.5%
June	100%	99.6%
July	100%	99.5%
August	100%	100%
September	100%	100%
October	100%	99.5%
Total Average	100%	99.7%

Supernumerary Maintained (target 100%)		
Month	QEQM	WHH
May	99.4%	98.5%
June	99.2%	92.2%
July	98.7%	92.9%
August	99.4%	96.5%
September	99.4%	95.7%

1:1 Care in Labour: Work took place this month to reinvigorate the case by case review and identify areas of incorrect recording of data. This has resulted in a much better position and the dashboard data has been update to reflect this.
Supernumerary Status: CNST Year 4 guidance updates have been provided giving clarity of Supernumerary Status.
The data is pulled from the acuity tool but this can't be retrospectively updated to align with new understanding. However, the dashboard data will be amended to reflect new position once validated with leads. See Safety Action 5 below for further detail.

Midwifery
QEQM
Sick leave: 1.7
Mat leave: 4.5
Study leave: 5.4
Vacancies: B7 0.6 WTE B6 6 WTE
Over established: for Band 5's which will equalise itself by uplifts to band 6
New midwives in the pipeline B5 1.2, WTE, B6 0.8 WTE
Leavers: known about None

1. **Ongoing recruitment efforts**: including pending roles to advertise and what the delays are Currently awaiting ESR

Obstetric
WHH
Training attendance: no concerns but safeguarding generally low and is being addressed
Consultants: No incidences of non-attendance. 3 cons vacancies - 2 posts shortlisted and interviews 9th Dec, 2 cons not doing on call due to health issues (total 2 on call slots not covered as 2 agency locums in post). Ongoing discussion still re options to cover in short and long term.
Specialist Doctor: 1 vacancy - 2 appointed and still awaiting start date. Using some agency locums until spec Drs start
SHO: level 2 gaps - at shortlisting stage, plus some on LTFT.
QEQM
Consultant: One incidence of Consultant non-attendance - telephone did not work reflection completed.
Two long term consultant vacancy. Two consultants unable to perform on call duty. Reduction in on call cover of consultant returning from retirement.
Reduced on call cover consultant to undertake clinical director role. Part time consultant to retire within next three months. Therefore, three adverts to go out for three consultant posts. Ongoing heavy Locum requirement
Middle grade: rota has two gaps. One gap appointed to awaiting visa. Other candidate and reserve withdrew -

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October	100%	96.5%
Total Average	99.3%	95.3%

numbers for Telephone Triage midwives 6 and 7 to go on TRAC
2. Band 2 equipment House keeper shortlisted interview in November

WHH
Sick leave: 7: 1 WTE (OTA), B2: 1LTS, Admin 1WTE LTS
Mat leave: 7: 1WTE, 6: 7.4 WTE, B4, B2 2.08
Vacancies: B7: 2.43 WTE, B6: 8.51 WTE, B5: 1.04, B4: 1.2,
MSW: 4.53. Admin 0.4-Out to advert-no appointments made and so back out again.
Over established: 1 WTE starting in January following Mat Leave
New midwives in the pipeline: Interest through the pool and hope vacancy will be filled.
Leavers: B5: 1 WTE Relocated
Ongoing recruitment efforts: MSW recruited 2 WTE, B7: 2.43 WTE Out to advert, B4.0.4-Out to advert-no appointments made and so back out again

shortlisting once more all no quick fix as majority if not all candidates require visa. None of our frequent Locum currently are registered with RCOG cell programme.
St3: requires out of hours support
SHO: fully staffed

FFT Feedback

FFT Main Themes October 2022 (collated on 3rd November)	Actions
292 responses which is a 16% response rate with 92.9% extremely likely or likely to recommend 194 comments in total, 159 positive comments Positive experiences and Named staff in comments- 60 members of staff named Good care/ compassionate/ friendly staff, good breastfeeding help some of the positive themes Good comments for Hearing screening	Reported back to staff via personalised email and new posters on the wards, hard to define good care Hearing screening manager is aware of the results
Delay in care: buzzers being answered, pain relief, catheters checked and clean bedding on the PN ward	Essential rounding (4hourly) started on the 10th October in line with this feedback, to speak with women and ensure they have had questions and concerns answered, as well as pain relief addressed
Lack of communication between staff	SBAR communication and sheets started to be used in September, feedback on if this is working shall have to be discussed
Too small areas on ward for families	Estates plan phase 2, to see if this is being addressed
Birth plan not respected	To feed this back to the labour ward managers
Rude staff	To feed this back to managers and look at training. Individuals where identified addressed by the matron or HOM to actions taken to improve
Conflicting advice from different hospitals and consultants leading to confusion	Feed this back to HOMs and Matrons and lead consultants – this links to the development of improved resources for informing women
Rushed appointments and felt like an inconvenience	Feedback to Community Midwife Matrons
Lack of compassion and explanations	Feedback to HOMs Matrons and Managers
Loud and Noisy Ward	Estates plans, New bins have been ordered for Folkestone Ward
Understaffed	Continuing employment plan.

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – October	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
167 Staff mentioned in a positive way	Feedback to staff and their line managers via email
13 complaints emails - 4 for reference only and 9 that need follow up	Feedback to relevant Matron/Head of Midwifery (HoM) and Professional Midwifery Advocate (PMA) lead

• Mostly positive feedback • Lack of continuity from community midwife • Lack of pain relief on the PN ward • Night staff issues with lack of care and poor attitude – predominantly at WHH on the PN ward • No provision of refreshments for partners and lack of comfortable chairs	Meetings with ward managers, Matrons and HoM's to discuss feedback
Maternity Voice Partnership-Themes shared from period March to November 2022	
8 comments about WHH MLU being closed - when will it be open (2 comments from October, 2 births date back to 2021 but women submitted feedback in Oct 2022). This included 2 women who accessed care in neighbouring trust so that they could birth in their MLU.	• As feedback April to November, Historical feedback received more recently will be themed and actions agreed • There are interviews for a MLU manager occurring in the next few weeks to then hopefully look at opening the MLU at WHH by the end of the year? • Personalised care and support plans drafted. Information portal is being updated including choice of place and type of birth. • Pain management task and finish group set up to improve. Intentional rounding initiated to ensure women being offered pain relief. Alternative ways of delivering pain relief being explored • Cultural change and leadership programmes being rolled out to target this. Feedback directly to staff and managers where individuals are named. • Business case for second theatre at QEQM submitted and plan being progressed.
Partners not present in Triage when in early labour and emotional impact	
Choice not given or supported around Induction of Labour or monitoring of baby or as above-place of birth	
Adequate pain relief not provided	
Exhausted and overwhelmed midwives dealing with stream of negativity and more paper to fill in not a solution	
Stressful environment, privacy not maintained by door open and screen	
Interprofessional relationships between Midwives and Doctors strained and impact on confidence in care provided and stressful atmosphere	
2 women fed back on experience of needing a C-Section and maternity theatre being in use for another case and impact of being taken to General Theatre for delivery.	
Communication and explanation of care and reason for outcomes-examples of PPH and placental position at scan, comments at USS without explanation causing worry. One women on the PN ward called 111 to seek advice.	
Suggestion to adopt use of 'Trauma Informed Care Sticker' on women's notes	
Lots of positive messages about kind, caring, hardworking midwives and feeling safe, supported and empowered	

Number of Complaints

Date Received	Site	Theme	Sub Theme
10/10/2022	QEQM	Clinical management	Unhappy with treatment
04/10/2022	QEQM	Clinical management	Unhappy with treatment
04/10/2022	QEQM	Surgical management	Unexpected outcome / post op complications
04/10/2022	WHH	Attitude	Problems with nurse's attitude

Within October 4 complaints were received for obstetrics; 3 in relation to QEQM and 1 for the WHH. Complaint themes were in relation to-

- A historic complaint from 2018 regarding care planning and follow up.
- Involvement in care planning, staff attitude and care on the ward.
- Investigations not being undertaken
- Care on the postnatal ward and breastfeeding support

Within the care group a 'sprit' is being agreed by the senior team to address the backlog of complaints. Job plans are currently being reviewed to look at ongoing workforce regarding complaints.

Number of PALS

Date	Site	Location	Detail
18/10/2022	WHH	PN Ward	Patient would like copy of discharge summary.
31/10/2022	WHH	PN Ward	Client concerned as they have had to be referred urgently in August by women's services to GP for GP to refer back to women's services.
18/10/2022	QEQMH	Office	Email from head of midwifery requesting actions on a HOT complaint.
01/10/2022	QEQMH	PN Ward	Feedback on breastfeeding concerns and assistance on Kingsgate ward after giving birth at QEQM.
19/10/2022	Community	Office	Unable to contact her midwife about her birthing plan client is 35/40. Asking to be seen by another midwife

Listening to women engagement activities and evidence of co-production	LMNS facilitated Perinatal Quality Equity Workshop event Ockenden Peer Review

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Staff feedback from frontline safety champions and walk-abouts

Themes and actions

Safety Discussions/Themes	Actions
Student Forum 1. Discussion around the role of Practice Supervisors and Practice Assessors. Challenges still seem to be present around people's understanding on the roles and responsibilities of both roles. Clarity provided that PA cannot sign of individual competencies and that this is the PS role. 2. Students reported that some midwives were still concerned about signing competencies off ''on their PIN'' 3. Overall most students felt supported in practice and no one reported not being supernumerary 4. Concerns raised around the response of some midwives over students being offered a job without interview. Carol clarified how she was challenging this out of date view point. 5. Discussion regarding fetal monitoring training	1. To provide written communication to staff regarding the roles and responsibilities 2. Linked to above there is some myth busting to do 3. – 4. It was Director of Midwifery (DOMs) opinion that it is down to us as a learning environment that we ensure students at the point of qualification are ready for the demands of a qualified midwife, and that we should not be using an interview to do this. 5. DOM and Fetal monitoring Training Lead MW will look at how we can provide as many opportunities for students to access workshops. Third years will now be attending the mandatory training within the trust which includes this.
Theme from walkabouts across all sites 1. Risk to staff from the reported Entonox exposure that has been happening since 2019. (QEQM) 2. Some concern was raised by staff regarding the offer of jobs to 3rd year students without an interview (WHH and QEQM)	**Actions** 1. The answer to this was not known at point of raising. Subsequently the DOM has held a meeting with Estates, pharmacy, health and safety as well as occupational health and HOM as HOM. Work has now begun on understanding the further the cause of the issue as well as how we monitor the levels to keep staff safe. Scoping work in progress with estates to understand requirements. Immediate action has included testing ventilation flow, decommissioning two rooms to allow ventilation to be installed and planning ongoing testing on both the QEQM and WHH sites. This has also been escalated to the Executive team and update is being made to risk register. 2. DOM explained that it is important that as we support students in the learning environment, which makes up 50% of their programme, as practice Supervisors and Practice Assessors, we ensure the student receives the appropriate learning. We are also incorporating students in their 3rd year in our mandatory training. It is our duty to ensure we help the students to succeed. Where concerns are flagged these should be addressed in the moment and not left for an interview process to resolve. It is vital we work with CCCU to ensure all students are supported and given the best opportunity to succeed, but where concerns are identified these are addressed appropriately at the time.
Maternity Triage WHH Listening Event 1. Medical staffing cover and lack of dedicated cover 2. Behaviour of some medical colleagues 3. Lack of admin support 4. Lack of support by Band 7 5. MOSOS triage 6. Polyhydramnios guideline 7. Scan plots and review	**Actions** 1. Working with site lead to clarify how this will work 2. Discussed with the Clinical Director, actions agreed on how this will be address 3. To go out immediately for NHSP whilst permanent recruitment is completed 4. Recognise there is not always an Ops role, but work is happening to ensure this is in place. Plan moving forward to allocate band 7 to triage as Ops and not as is now the labour ward, to follow the QEQM model and aid understanding and support Please can we make sure communication is shared with staff regarding this 5. IT walkaround top identify requirement, including cabling and power, took place in July. Estates work request submitted and waiting for this to be progressed. Additional Moxa boxes are not required and can be accommodated by existing LW unit. Will chase update 6. Lack of consistency in application of guideline between maternity and sonography -to meet with sonography to address 7. This needs urgent addressing. Need to remove plotting but also agree appropriate process for review. Meeting with sonography to address

HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust

1 letter of concern received from HSIB
Publication of: *Reading the signals*; Maternity and neonatal services in East Kent – the Report of the Independent Investigation

Coroner Reg 28 made directly to the Trust	

Progress in achievement of CNST 10 Safety Standards

Safety Action	Rational for Red/Green status	BRAG status (not due to deliver until 30 June 2022)
1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Standard ai) All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards have been notified to MBRRACE-UK within seven working days **BUT** the surveillance information has not been completed within one month of the death for 3 cases on births in our trust. Mitigations have been put in place. The PMRT Lead MW role is to be appointed to and a Maternity Warning and Control System (MWACS) PMRT Patient tracking list is being developed.	
2. Submitting data to the Maternity Services Data Set to the required standard	This Safety Action is made up of 7 standards and the Trust is currently compliant in standards 1 to 6 Standard 1-Digital Strategy has been developed and presented through September MNAG Governance and October TB. Requires LMNS approval which is to take place in October and ICB approval which is planned for December. July Scorecard shows us meeting 11/11 data quality standards and all other standard have been passed. CNST declaration is based on this evidence and so the Trust is able to declare compliance against Safety Action 2.	
3. Demonstrating transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme	Transitional Care actions from audit findings are to be agreed. ATAIN Regional Operational Delivery Network (ODN) report received for Q2 which shows WHH 3.0% (Lowest rate in the Region) and QEQM 3.6% which remains below the National target of 5% Outstanding action is joint signatory of the Transitional Care Guideline. An email evidence trail is to be provided demonstrating the joint Neonatal and Obstetric development of the guidance.	
4. Demonstrating an effective system of clinical* workforce planning to the required standard	Year 4 Action plan developed which also includes Neonatal Nursing actions from year 3, which require significant investment to increase the workforce-also will be required to meet Ockenden 2 Neonatal Actions. Audits against BAPM standards are in progress and demonstrate compliance. Audits against Anaesthetic standards are complete and show compliance. Clinical Workforce Papers were presented to MNAG for October reporting	
5. Demonstrating an effective system of midwifery workforce planning to the required standard?	The Trust can report compliance with this standard if this is a one-off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. New guidance around the definition of Supernumerary status has been provided in the October Year 4 update. Supernumerary status is recorded on the Dashboard, pulling data from the intrapartum acuity tool. It has become clear that there has not been a shared understanding of what supernumerary means but staff have reporting that the labour ward coordinator is **NEVER** required to be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a **high-risk** woman requiring constant observation. A revised coordinator sheet has been shared that included supernumerary care and detail of situations and actions if not maintained to allow more robust and standardised capture. It is not possible to alter the acuity tool retrospectively but going forward the dashboard data can be altered if inaccuracies are identified following validation by the clinical teams. Communication messages have gone out to staff advising of the definition. Supernumerary status for October is 100% QEQM and 96.5% WHH drawing from Acuity Tool submitted data. 1:1 care in labour 99.5% WHH and 100% QEQM an action plan has been incorporated into the workforce workstream.	

6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2

A quarterly report including all risks, mitigating actions and escalations is included in February Maternity and Neonatal Assurance Group (MNAG) Reporting.

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		
5 Elements of SBLCBV2	**RAG**	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring-Booking 95%, 36 weeks 77.8%. Note: The Trust board should receive data from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four-month period. The period of June to September was average 82% and the average of the last 4 months is currently 80.1% An action plan is in place to achieve over 95%.
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		20-week risk assessment is not electronically captured but the Fetal Growth Guideline has been updated to describe how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. Guideline requires ratification and audit of 40 cases to be completed. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated-included in training but attendance has been impacted on by workforce pressures Risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance awaiting guideline ratification
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 95% (requirement 80%) for women attending with reduced Fetal Movements having Computerised CTGs and 87.3% receive Reduced Fetal Movements Information Leaflet. Action plan in place to achieve over 95%
ELEMENT 4: Effective fetal monitoring during labour		Compliance: Community MW: 87.1% Acute Midwives: 87.1% Consultants: 96.7% Other Doctors: 100% An action plan is in place to achieve over 95%. A full time dedicated Fetal Monitoring Lead Midwife per site posts are in place but one has left and post out to advert and the other is currently on long term sick leave. Fetal Monitoring Lead Obstetrician (0.1 WTE) per consultant led unit are in post
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards but will not result in failure of this standard-action plan in place

	Action plan and Mat Neo Quality Improvement work in progress to support. Risk assessment and management in multiple pregnancy complies with NICE guidance-guideline not yet ratified		
7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services	Process for expenses to be reimbursed by MVP members for Trust specific coproduction work is being explored Coproduction plan to be signed off at the next LMNS Quality Assurance Board.		
8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4	**Severe Risk** CNST October guidance has been updated to bring forward the reporting period to 5 December from 5 January 2022. Also training compliance had previously been to cover an 18-month period, in recognition of workforce Covid pressures, but this has now been reduced to 12 months. **Escalations** 1. The 3-year training programme signed off by MNAG and LMNS is not being fully delivered as agreed in May 2022. The elements of it that are being delivered include PROMPT in a virtual method, fetal monitoring and life support including NLS. The other elements of the agreed training plan are not being delivered. 2. That the continuance of virtual PROMPT training risks making us an outlier as other trusts return to face to face emergency skills training. 3. The effectiveness (in terms of quality) of learning emergency practical skills in a virtual online format is limited given the practical nature of the skills being taught. 4. Virtual training means we cannot provide assurance that every member of staff can undertake the skills safely. 5. 34/80 (42.5%) Anaesthetic workforce have attended multi-professional maternity emergencies PROMPT virtual or our PROMPT trainer training day. 6. The issues limiting implementation include no space on the WHH site for PROMPT 7. DNAs for training and impact on filling spaces and fitting in later in the year **Mitigations** Signing the lease for the CCCU site will take place by 4 December 2022. This will provide location for 4 of the training days to take place face to face. Conversations are taking place to try to reclaim the MLU at the WHH to allow face to face PROMT to be delivered there. QEQM to continue F2F and WHH to be virtual until solution agreed. Discussions to take place with Care Group Directors to see if Anaesthetic staff could attend virtual PROMPT sessions over the next month. They would still need to attend F2F throughout the year but is a way of raising compliance in the interim. Further comms to advise, only HOMs or DOM can approve Midwifery staff being pulled to cover workforce pressures.		
9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	Midwifery Continuity of Carer update provided in the Biannual Workforce paper. Plan submitted to the LMNS and standardised data document submitted. Aiming for launch in Quarter 4 2022/23 if building blocks are in place. Safety Champion Walkabout, feedback sessions continue monthly on each site. Actioning of concerns are captured in a repository and themes are included in PQST report. MatNeoSip work is aligned to the Preterm Optimisation National Driver and is supported by the Safety Champions. A workshop was held 17 October supported by the Board and Maternity Safety Champions.		
10. Reporting 100% of qualifying 2019/20 incidents under NHS Resolution Early Notification scheme	New reporting process in place from 1 April requiring cases to be referred through the Trust Legal Team to NHSR. Maternity will continue to also refer all relevant cases to HSIB. Process agreed to ensure reporting with Legal and Maternity Teams. NHSR Webinar attended.		

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Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	No new reports
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	No new reports
Outstanding Ockenden recommendations	97% compliant We have 4 outstanding actions which fall into 3 themes shown below. The table shows percentage compliance and Questions these relate to. 1. 3 actions are around Personalised Care and Support Plans-these are being codeveloped with LMNS and should be in place by Q2 2. 1 action-Risk assessment of Guidelines not following NICE-Physiological Interpretation and IOL-Developed and shared for comment.

IEA No:	Phase 2 score	Current compliance following LMNS Peer review 2022	Areas now compliant since Phase 2	Outstanding Actions
1: Enhanced Safety	81%	100%	PMRT Audit and 100% compliance in external reviewer and parent notified. PQST structures are now in place	All actions closed
2: Listening to Women and Families	88%	100%	Q13.1, Q15.1 Coproduction plan developed and approved.	All actions complete and closed
3: Staff Training and Working Together	72%	100%	LMNS SOP in place TNA Approved at Trust Level Q17.2 and Q23.2 LMS reports showing regular review of training data (Q21.3 LMS reports showing regular review of training data	All actions Closed
4: Managing Complex Pregnancy	86%	100%	Q29.1 Agreed MM Pathways Q29.2 Criteria for referrals to MMC	All actions closed
5: Risk Assessment Throughout Pregnancy	73%	83%	Definition of antenatal risk assessment as per NICE guidance in place	Q30.2, Q31.3, Q33.3 Personalised Care and Support plans are not in place-LMNS Coproduction Work in progress.
6: Monitoring Fetal Wellbeing	67%	100%	Fetal monitoring leads involved in adverse outcome reviews, run regular sessions and raise the profile of fetal wellbeing monitoring now evidenced TNA Trust Level sign off	Fully implemented

	7: Informed Consent	50%	100%	Gap analysis has been completed and plan to improve in place Q43.1 Coproduction Plans-Coproduction plan in place and evidence of embedding peer reviewed and approved Q41.1 Women must be enabled to participate equally in all decision-making processes. An audit of 1% of notes demonstrating compliance. Q42.1 An audit of 5% of notes [or a total of 150 which is ever the least from January 2021] demonstrating compliance	07.09.22 Presented audit findings supported by YVIH findings and next step actions in a narrative paper to LMNS Peer Review Panel. After much discussion it was agreed that the action had been met in terms of an audit taking place but that the audit alone did not demonstrate that there was compliance against the actual recommendation. It was agreed that the action could be approved as met but as a system there would be an agreed approach to take forward this work supported by existing workstreams i.e. PCSP
	Workforce	70%	90%	Clinical workforce evidence reviewed, relabelled and most recent reports added.	Q49.2 Evidence of risk assessment where NICE guidance is not implemented.
	Total	73%	97%		

Glossary

CQC: Care Quality Commission
CNST: Clinical Negligence Scheme for Trusts. An insurance scheme whereby NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims
CNST: Maternity Incentive Scheme. Aims to support the delivery of safer maternity care through an incentive element to trusts CNST insurance contributions. The maternity pricing is inflated by 10% which trusts are incentivised to recover through the delivery of 10 safety actions.
DATIX: The trusts incident reporting system
ENS: Early Notification Scheme. FFT-Friends and Family Test. A quick anonymous survey for service users to give views after receiving care or treatment and for staff to feedback on whether they would recommend as a place to work or receive treatment.
HSIB: Healthcare Safety Investigation Branch. Independent investigation body tasked with carrying out investigations and reporting using a standardised approach without attributing blame or liability
IEA: Immediate and Essential Actions (in relation to the Ockenden Report Recommendations December 2020)
Kleihhauer test: A test performed to understand if there is any fetal blood in the maternal circulation on Rh-negative mothers. The test should be done and any subsequent Anti D immunoglobulin administered within 72 hours of delivery, sensitising event (i.e. abdominal trauma) or invasive procedure.
MIS: Maternity Information System. At East Kent we use Euroking as our MIS provider
MNAG: Maternity and Neonatal Assurance Group. Governance reporting forum.
MSDS: Maternity Services Data Sets. A patient level data set that captures information about activity carried out by Maternity Services relating to mother and baby(s), from the point of the first booking appointment until discharge from maternity services
MVP: Maternity Voices Partnership. A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.
NLS: Neonatal Life Support Training
NHSR: NHR Resolution
Partogram: A tool used to monitor labour and prevent prolonged and obstructed labour focusing on observations related to maternal, fetal condition and labour progress.
PMRT: Perinatal Mortality Review Tool. Aims to support a standardised process of perinatal mortality reviews, learning reporting and actions to improve care across NHS maternity and neonatal units.
PROMPT: Practical Obstetric Multi-Professional Training. Covers the management of a range of obstetric emergency situations
SBLCBv2: Saving Babies Lives Care Bundle Version 2. A care bundle for reducing perinatal mortality
Uterine artery Doppler screening: An ultrasound scan that uses waveform analysis in the second trimester of pregnancy as **a predictive marker for** the later development of preeclampsia and fetal growth restriction.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**SAFETY ACTION 5: BI-ANNUAL MIDWIFERY WORKFORCE OVERSIGHT REPORT COVERING STAFFING/SAFETY ISSUES**
MEETING DATE:	**8 DECEMBER 2022**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER (CNMO): EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY** **IMPROVEMENT AND TRANSFORMATION MANAGER**
APPENDICES:	**APPENDIX 1: POSITIVE CULTURE IN MATERNITY UPDATE 26 SEPTEMBER 2022** **APPENDIX 2: MIDWIFERY WORKFORCE ACTION PLAN**

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

Purpose of the Report:

Purpose

- This paper is presented in compliance with NHS Resolution (NHSR) Maternity Incentive Scheme; Clinical Negligence Scheme for Trusts (CNST) Safety Action 5 in relation to Maternity Incentive Scheme Standards for Safe Staffing in Maternity Settings.
- The requirement is that a systematic review of the midwifery establishment is submitted to the Board bi-annually.
- This paper will also include wider workforce considerations including progress against Ockenden final report actions, cultural change programme and Leadership Development.
- The last Midwifery Workforce report was received by this Committee in May 2022 and covered November 2021 to April 2022.
- This report covers the five-month reporting period of May 2022 to September 2022.

Compliance is reported against CNST Safety Action 5 Standards a-e;

1. A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
2. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
3. The midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
4. All women in active labour receive one-to-one midwifery care.
5. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.

Summary of Key Issues:	The report evidences compliance against the CNST Safety Action 5 Standard in relation to midwifery workforce including; • A recruitment trajectory as part of the workforce plan is in place.

	• Birth to Midwife to Ratio is recorded as 1:21 but this includes all Bank and NHS Staff as data is currently drawn from Finance systems. Work has recently completed so that moving forward this information will be drawn from the Electronic Staff Record (ESR). • The redeployment plan for implementation of Midwifery Continuity of Carer (MCoC), once the appropriate workforce and building blocks are in place. • The percentage of specialist midwives employed, including those in management positions has previously been reported as 22.7%. This is currently being reviewed to ensure that non-clinical and clinical components of the role are split out and recorded. • Evidence from the intrapartum acuity tool shows Queen Elizabeth the Queen Mother Hospital (QEQM) 98.9% and William Harvey Hospital (WHH) 97.8% compliance with supernumerary labour ward co-ordinator status. This remains unchanged from the previous 6 month reporting period. The workforce action plan shows mitigations to cover shortfalls and achieve 100%. • Evidence from the maternity dashboard figures demonstrating 95.6% compliance on the QEQM site and 99.3% compliance on the WHH. The midwifery workforce action plan identifies mitigations to cover shortfalls.
Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** the results of the CNST bi-annual midwifery workforce report and contents of the action plan in compliance with CNST Safety Action 5 required standard; and 2. **APPROVE & SIGN** the inclusion of the Midwifery Workforce Action Plan.

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

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.	
Resource:	Y	Additional resource will be required to implement the Final Ockenden Report Immediate and Essential Actions.
Legal and regulatory:	Y	NHSR, CNST, Ockenden 1, Ockenden 2 Final.
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	Maternity and Neonatal Assurance Group (MNAG) People and Culture Committee (P&CC)	

East Kent Hospitals University NHS Foundation Trust

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

1. Purpose of the report

1.1. This paper is presented in compliance with NHS Resolution Maternity Incentive Scheme; CNST Safety Action 5 in relation to Maternity Incentive Scheme Standards for Safe Staffing in Maternity Settings.
1.2. The requirement is that a systematic review of the midwifery establishment is submitted to the Board biannually.
1.3. The last Midwifery Workforce report was received by this board in May 2022 and covered November 2021 to April 2022.
1.4. This report covers the five -month reporting period of May 2022 to September 2022.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
a.	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b.	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
c.	The midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
d.	All women in active labour receive one-to-one midwifery care
e.	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period (from 8 August 2021 until 30 June 2022)

Standard a) A systematic, evidence-based process to calculate midwifery staffing establishment

1.5. A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
1.6. Findings from the BirthRate plus review carried out November 2020 and a further full midwifery line by line staffing review conducted in August 2021 have previously been shared with MNAG and Board of Directors. The workforce review was supported by the Regional workforce lead and the approach was validated by the Local Maternity and Neonatal System (LMNS) and has since been replicated across the other Trusts within the Kent and Medway Network.
1.7. These reviews indicated a shortfall of staff to deliver maternity care appropriate for the complexity of the case mix at EKHUFT. Safe Staffing investments of an additional £1.6m since 2021, combined with £1.8m Ockenden funding, resulted in an additional 38 midwives and 11 specialist midwifery posts being created.
1.8. Having the correct number of midwives in post is one of the key building blocks to safety and must be in place before progressing plans to roll out Midwifery Continuity of Carer at scale. This has been clearly reiterated within the publication of Donna Ockenden's Final Report and in a letter received from the National Team on 21 September 2022 we were advised that there will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them.
1.9. Continuity of Carer continues to be suspended due to the ongoing workforce challenges which aligns with decision 3 within 'The Ockenden Final Report Letter, April 2022 and is reiterated in the above-mentioned September Letter.

We expect you to continue to review your staffing in the context of Donna Ockenden's final report. Your local LMNS regional and national colleagues are here to support you with this including how to focus MCoC on those women from vulnerable groups who will benefit the most from this care.

As we have said previously:

1. *Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.*
2. *Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.*
3. *Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.*

1.10. To inform future implementation, once safe staffing and other building blocks are in place, the Trust has used the NHS England (NHSE) toolkit to plan the phased role out. This defines the recruitment and deployment plans but not timeframes at this stage as dependent on the success of recruitment. The deployment plan accounts for staffing ratios, demonstrating planned safe staffing at any given time during this process.

1.11. The table below shows the trajectory roll out plan that mirrors the deployment plan developed. This has been submitted to the Region but will be subject to Safe Staffing Levels being in place. However, due to the recent communication from NHSE this is on hold and the dates for roll out will be reviewed at the appropriate time.

Wave	Timelines	Teams rolled out in this wave		Total Teams now implemented
		QEQM	WHH	
1	Q4 22/23	1	1	2
2	Q1 23/24	1	1	4
3	Q2 23/24	2	2	8
4	Q3 23/24	2	2	12
5	Q4 23/24	3	3	18
6	Q1 24/25	0	5	23
TOTAL		**9**	**14**	**23**

1.12. Team configurations will be aligned with national recommendations of 1:36 women receiving whole pathway care with each midwife attending 2-3 births per month.

1.13. 9 teams are required across the QEQM and 14 across the WHH geographical areas. Implementation will take place over 6 phases.

1.14. The first 3 to 4 teams will focus on the geographical areas in Thanet and Ashford that have the highest population of women identified at risk of poorer outcomes based on Black, Asian and Minority Ethnic (BAME) and deprivation.

1.15. This plan has been developed and was presented to Trust Board, LMNS and Region within the required timeframes that were previously set.

1.16. Reporting into NHS Digital on provision of continuity of carer is required as part of the Maternity Services Data Set. We are unable to currently meet this element as there are no longer any Women who are on MCoC Pathways. This results in a failed element being recorded on this section of the scorecard and although it

is anticipated that this standard will be amended in light of the changed National Guidance, clarification is to be sought.

MCOC	MCOC					No
	COC_DQ04	550	555	99.1	0	Yes
	COC_DQ05	0	0	0	0	No
	COCDQCareProfIID	9710	10720	90.6	0	Yes

2. Action Plan to address findings from workforce review table-top exercise

2.1. The actions to achieve the additional staff required to address the deficits identified within the BirthRate plus and detailed workforce review have been included in the midwifery workforce action plan (Appendix 2: Midwifery Workforce Planning Actions and status). Activity levels have remained constant and the 25% uplift has remained appropriate based on the current average of absence over the last 3 years. However, there is agreement to over recruit to acknowledge the higher than normal maternity leave rate.

2.2. A project workstream has been established to deliver the workforce improvement activities including recruitment of additional staff, training, student allocations, leadership and skill mix as well as culture and behaviour.

3. Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

3.1 Plans continue to recruit to all midwifery vacancies (The vacancy rate for September 2022, overall for core and specialist roles/leadership roles is 10.9%, but the core midwifery vacancy rate is 8.9%).

3.2 21 newly qualified midwives joined us last year and 18 will be starting in post this September.

3.3 A supernumerary Band 7 neonatology nurse shift leader is now on every shift at WHH and two additional band 7 posts created at QEQM, to support decision making, escalation and safe transfers.

3.4 There is a dedicated telephone triage midwife on both sites, directly answering 99% of calls (since Nov 2021 – the remaining 1% are calls passed to a midwife).

3.5 There are two fetal monitoring midwives and two designated fetal monitoring obstetricians funded for each site in line with CNST and Ockenden requirements. At the end of September one of the fetal monitoring midwife posts was vacant, however recruitment is in progress.

3.6 Recruitment premium has been applied to band 6 posts, to attract experienced midwives to stabilise skills mix, as newly qualified midwives recruited.

3.7 International recruitment of midwives has achieved the agreed number of 8 Whole Time Equivalent (WTE), and individuals will be commencing in post over the next 3 months.

3.8 Progress on recruitment against the workforce enhancement Business case is monitored monthly and reported through Maternity and Trust Governance structures.

4. Planned versus actual midwifery staffing levels

4.1 The Unify Report on Health Roster provides access to information on planned versus actual midwifery levels which are reviewed as part of ongoing monthly monitoring, led by the Heads of Midwifery. Reports can be separated per unit but going forward reporting will move to using ESR data which will provide more accurate reporting and can be split into area as well as site.

4.2 Staff Planned versus actual staffing levels are also monitored through the dashboard capture of sickness, vacancy and turnover levels.

5. Midwifery Vacancy and Recruitment

5.1 Funded establishments for Core Midwifery as at the end of September for band 7, 6 and 5.

Band	Budget				In post				Vacancy
	QEQM	WHH	Community	Total	QEQM	WHH	Community	Total	
7	17	17	5.8	39.8	15	14.7	5.4	35.1	-4.7
6	55.3	68.5	78.4	202.2	46.3	52.7	71.5	170.5	-31.7
5	7.4	9.5	0	16.9	13.5	17.2	0	30.7	+13.8
Total	**79.7**	**95**	**84.2**	**258.9**	**74.8**	**84.6**	**76.9**	**236.3**	**-22.6**

5.2 Funded establishment for leadership, governance and specialist roles – currently under review to enhance bereavement roles.

Band	Budget	In post	Vacancy
8D	1	0	1
8C	2	2	0
8B	4	2	2
8A	8	7	1
7	17.4	11.9	5.5
6	8.3	7.61	0.69
Total	**40.7**	**30.51**	**10.19**

5.3 **The midwife to birth ratio**

5.4 The birth to midwife ratio is tracked and reported through the maternity dashboard, along with several other workforce performance metrics. The Trust applies a standard of 1:24 recognising that although there is no national standard agreed, it is generally considered that reporting 1:24 is acceptable.

5.5 The only way to get a reliable calculation on the number of staff actually on the 'shop floor' is to use ESR data rather than the currently used financial data. The senior midwifery team have been working with the HR business partner to ensure the ESR data is accurate for all areas to aid this calculation.

5.6 Birth to Midwife Ratio is recorded as 1:21 on the maternity dashboard by applying the existing methodology but moving to ESR recording shows 1:24 to be a more accurate position.

5.7 The following table shows the Workforce Performance Metrics displayed on the Maternity Dashboard.

KPI	SPC	Thres.	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
1 to 1 in Labour		100.0%	99.2%	99.4%	99.4%	99.3%	99.2%	99.5%	98.3%
Worked WTE: Birth Ratio		24.00	22.27	19.65	22.51	23.03	21.67	21.51	
Midwifery Turnover		11.5%	2.6%	3.1%	3.0%	2.9%	3.7%	4.3%	
Maternity Sickness		5.0%	9.9%	9.1%	7.3%	6.6%	9.1%		
Midwifery Vacancy Rate		10.0%	9.3%	9.6%	7.9%	8.3%	8.2%	11.9%	
Midwifery Appraisal Rate		85.0%	73.7%	77.6%	72.8%	74.2%	73.9%	72.0%	
Total On-Call Hours		Sigma	717.3	433.8	558.8	822.7	807.5	535.1	404.8
Occurance On-Call In		Sigma	140	91	101	129	133	80	65

6. The percentage of specialist midwives employed and mitigation to cover any inconsistencies

6.1 As part of the workforce review, gaps in specialist roles were identified, along with a review of potential impact to the core team of historically creating specialist roles by transferring funding from the baseline clinical establishments.

6.2 Additional roles have been recruited, to strengthen areas of specialist work.

6.3 The percentage of specialist midwives employed, including those in management positions has previously been reported as 22.7%. This is currently being reviewed in detail to ensure that non-clinical and clinical components of the role are split out and recorded.

6.4 A further review is currently being completed to improve and strengthen the workforce to support the care of bereaved families.

Band	Specialist Midwife Roles
Band 6	Clinical Skills Facilitator
Band 7	Gynaecology Clinical Governance Lead
Band 7	Practice Development Midwife
Band 7	Audit and Research Midwife
Band 7	Maternity Investigation Lead Midwife
Band 7	Patient Safety Midwife
Band 7	Perinatal Mortality Review Tool (PMRT) Lead Midwife
Band 7	Fetal Monitoring Midwife
Band 7	Guideline and Patient Information Lead Midwife
Band 7	Student Practice Lead Midwife
Band 7	Compliance and Assurance Lead Midwife
Band 7	Fetal Monitoring Midwife
Band 6	Bereavement Lead Midwife
Band 6	Antenatal and New-born Screening Midwife
Band 6	Lactation Consultant
Band 6	Midwifery Practice Educator Fellow
Band 6	Lactation Consultant Maternity
Band 6	PMA Role (Midwife)
Band 6	Preterm Lead Midwife
Band 6	Midwifery Practice Educator Fellow
Band 7	Specialist Midwife Smoking in Pregnancy
Band 7	Perinatal Mental Health Midwife
Band 7	Clinical Skills Facilitator
Band 7	Infant Feeding Coordinator
Band 7	Infant Feeding Coordinator
Band 7	Antenatal and Newborn Screening Coordinator
Band 7	Fetal Wellbeing Midwife
Band 7	Fetal Wellbeing Midwife
Band 7	Midwife Maternity Matters
Band 7	Fetal Monitoring/Surveillance Midwife
Band 7	Fetal Monitoring/Surveillance Midwife
Band 7	Perinatal Mental Health Midwife
Band 7	Midwife Maternity Matters
Band 7	Midwife Maternity Matters
Band 7	Midwife - Digital
Band 7	Patient Experience Midwife
Band 7	Better Birth Lead Midwife
Band 7	Fetal Monitoring Midwife
Band 8A	Better Births Lead Midwife
Band 8A	Lead Professional Midwifery Advocate
Band 8A	Midwifery Matron - Public Health
Band 8B	Deputy Head of Midwifery - Governance
Band 8B	Midwifery Consultant - Holistic Midwifery Consultant
Band 8B	Midwifery Consultant - Public Health
Band 8A	Clinical Governance Matron

Standard b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

7. Supernumerary Labour Ward Co-ordinator Status

7.1 Supernumerary Labour Ward Status is pulled from the intrapartum acuity tool data and recorded on the maternity dashboard. The 5-month compliance average is 98.5%. The national and CNST defined standard is 100%. The Midwifery Workforce Action Plan shows mitigations to improve.

7.2 The table below shows the Supernumerary Labour Ward Coordinator Status over the past five months. The high levels of short-term sickness and maternity leave, especially at the WHH have impacted on the ability to reach 100%

Supernumerary Status Maintained			
Month	QEQM	WHH	Target
May	99.2%	99.5%	100%
June	98.6%	98.4%	100%
July	98.1%	98.1%	100%
August	99.3%	97.7%	100%
September	99.4%	95.7%	
Total Average	98.9%	97.8%	100%

8. Workforce Red Flags incidents

8.1 Red flag events may indicate that there may not be enough midwives available. National Institute for Health and Care Excellence (NICE) Recommend that during the day or night shift, the midwife in charge should look out for 'red flag events'.

8.2 Data is collected around Red Flag events on the Birthrate Plus Intrapartum Acuity Tool which supports easier data entry and reporting on acuity and red flags including Supernumerary status for the Midwife coordinating Labour Ward.

8.3 Staff aim to input data into the acuity tool every 4-hour period this was achieved on average at QEQM 82.4% and at WHH 62.4% of the time. Depleted workforce availability has been the key contributor to this data not being recorded.

9. WHH Red Flag Events for the 6-month period November 2021 to April 2022

	Type of Red Flag	FF	KIN	QLAB	WLAB	Total
1	Delay between admission for induction and beginning	1	0	1	8	10
2	Coordinator not able to maintain supernumerary	0	0	1	4	5
3	Delay in providing pain relief	0	0	0	1	1
4	Delayed or cancelled time critical activity	0	0	1	2	3
5	Any occasion when 1 midwife is not able to provide 1:1 Care in Labour	0	0	0	3	3
6	Missed or delayed care	0	0	0	1	1
7	Delay between presentation and triage	0	0	0	0	0
8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0

9	Full clinical examination not carried out when presenting in Labour	0	0	0	0	0
10	Missed medication during an admission to hospital	0	0	0	0	0
	Total	1	0	3	19	23

Standard c) All women in active labour receive one-to-one midwifery care

9.1 1:1 care in labour is recorded on the maternity dashboard and review of each case of non-compliance takes place by the Maternity Matrons to draw out any learning themes. The 6-month compliance average is 98.7%. The national and CNST defined standard is 100% 1:1 care for all women in established labour. The Midwifery Workforce Action Plan shows mitigations to improve.

9.2 The table below shows compliance over the last five-month period One-to-One Care in Labour. There is a need to ensure the care of the women identified as not receiving 1:1 is reviewed promptly, as initial analysis has identified that the care episodes are not always recorded completely thus impacting this result. Ongoing reporting will be taken monthly through the Maternity and Neonatal Assurance Group

1 to 1 care in Labour			
Month	QEQM	WHH	Target
May	99.4%	98.5%	100%
June	99.2%	92.2%	100%
July	98.7%	92.9%	100%
August	99.4%	96.5%	100%
September	100%	97.2%	100%
Total Average	99.3%	95.6%	100%

Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period (from 8 August 2021 until 30 June 2022)

9.3 Bi annual midwifery staffing oversight reports, covering staffing and staffing safety issues, as defined by the CNST Safety Action 5 standards, have been presented to Trust Board.

9.4 The last Midwifery Workforce report was received by this board in May 2022 and covered November 2021 to April 2022.

9.5 This report covers the five-month reporting period of May 2022 to September 2022.

10. Additional key areas of Work

11. Support available/offered to staff

11.1 Trauma Risk Management Resiliency Support (TRiM) is provided through peer delivered risk assessment and ongoing support system, designed specifically to help in the management of traumatic events. The system allows peers to understand likely reactions to traumatic incidents and to conduct structured risk assessments aiming to identify people needing early referral to qualified medical support.

11.2 Monthly Safety Champion Walkabouts on each site, capturing staff safety concerns and putting actions in place to address. Themes and actions for the past year were presented to MNAG in August 2022 and shared with staff through the 'Weekly Wrap' Monthly feedback is included in the Perinatal Quality Surveillance Tool (PQST) Report.

11.3 Delivery of Culture and Leadership workshops / programme is being progressed and aligning to the' We Care' Quality Improvement methodology.

11.4 There is confidential wellbeing support available to staff regardless of role or site. available at WHH and at QEQM for wellbeing support.
11.5 Staff can also confidentially discuss any concerns at work through the maternity Freedom to Speak Up Guardian.

12. Staff communication and engagement sessions

12.1 A regular communication update is now provided to all staff within maternity services through the Director of Midwifery's weekly wrap up.
12.2 To support communication flow and provide opportunities for Q&A sessions and escalation of concerns, several additional staff forums have been set up. These are in addition to the formal Site and Trust wide and Governance meetings. These include; Women's Health Care Group Feedback session, Virtual Student Forums, Band 6 and Band 7 Forums, Community Midwife forums and Senior Midwife Forums.
12.3 The Perinatal Quality Surveillance Tool Report is shared with leads to cascade to their teams and provides a high-level summary of safety themes including Serious Incidents, HSIB and PMRT cases, Feedback from staff and service users, training compliance, workforce updates and issues and progress against Saving Babies Lives Care Bundle, Ockenden and CNST actions.

13. Following the publication of the Ockenden final report in March 2022, a gap review identified additional areas of work requiring focus. Progress is being made in the following areas.

- **Immediate and Essential Actions (IEA) IEA 2. Recruitment plans** and reassess requirements based on the Ockenden report. EKHUFT completed a robust midwifery workforce review September 2021, but further reviews should be ongoing. The biannual workforce paper includes details around reviews of workforce and ongoing recruitment plans. The LMNS are reviewing whether to commission a further BirthRate Plus Workforce Review.
- **IEA4. Improved guideline development and audit processes** will be supported through the new appointment of midwifery audit leads.
- **IEA 5. Processes are in place to learn from Serious Incident** actions and also to inform mandatory training plans. All lesson plans include learning from cases where appropriate. A Rapid Review Process has been implemented to discuss any cases of concern three times a week to ensure early escalation and action.
- **IEA7. Maternity training policy** aligns to the National Core Competency Framework and training plans are informed by Local Training Needs Assessments. Training is attended by the multidisciplinary team.
- **IEA8. The maternal medicine network** has now been established. East Kent comes under the South London Maternal Medicine and refers cases through the Medway Hospital sub-hub. Pathways and criteria for referral have been developed and Maternity Obstetric leads and criteria specific leads have all been identified. There is further work in progress to set up the Trust service including dedicated clinics (currently seen in AN Clinics) and appoint a Maternal Medicine Specialist Midwife.
- **IEA8. The Trust has a Specialist Twins Clinics** with Obstetric Consultant lead. There remains a need for a lead Specialist Midwife and Specialist Sonographer for Twins.
- **IEA10. Personalised Care and Support Plans** will be in place by January 2023 and the service is working in partnership with the LMNS and Maternity Voices Partnership (MVP) to coproduce the plans.
- **IEA10. Induction of labour, guidance** is being reviewed as part of an LMNS wide team to consider alternative approach being adopted that will not updated align with new NICE Guidance in its entirety. Risk assessments will be completed as part of this work and if it is agreed not to follow NICE then this will also be added to the Risk Register. New guidance will include a mechanism to clearly describe safe pathways for Induction of Labour (IOL) if delays occur due to high activity or short staffing.
- **IEA12. A review of how unwell and Postnatal readmissions** are systematically reviewed and have a Consultant review is required.
- **IEA13. Investment in Bereavement staff and pathway** has been agreed and recruitment will commence during October 2022.

- An improvement workstream focussed on Perinatal Optimisation, aligned to the Maternity and Neonatal Safety Improvement Programme (MatNeoSip) was established in 2020 to:
  - Develop electronic datasets to enable: (i) oversight of perinatal optimisation data (ii) accuracy of perinatal optimisation data.
  - Provide multidisciplinary advocacy on perinatal optimisation improvement work.
  - Undertake selected quality improvement activities suited to the local context.

14. Next Steps

14.1 Progress mitigation/escalation plans to cover shortfalls identified in workforce action plan including recruiting to outstanding business case posts.

14.2 Continue to implement Immediate and Essential Actions from the Ockenden Final report and review additional workforce requirements this exposes.

14.3 Scope additional workforce and Specialist roles to further mitigate against exposed safety and quality gaps.

14.4 Work has started to implement the Maternity Support Worker (MSW) Competency, Education and Career Development Framework to ensure that MSWs can achieve standardised levels of competency required to carry out this vital role. The role of the MSW will then become more defined and consistent across England, ensuring that women receive good quality care provision in line with Health Education England (HEE) requirements.

14.5 The LMNS Programme for Newly Qualified Midwife Induction has not yet been completed. Work has therefore progressed with a trust wide package that has been adapted to take on the national recommendations. This includes extended supernumerary periods when starting in new workplace areas/settings and taking on QI projects.

14.6 Further student midwife programmes have been commissioned through a 2-year model to enhance and mitigate for recent challenges from the current pre-registration programme.

14.7 A model to introduce a team of obstetric nurses is being taken forward to release midwifery time.

14.8 All 3rd year students have been written to again this year to offer jobs on qualifying.

14.9 Next Workforce paper due to this committee April 2023.

15. Appendices

Appendix 1: Positive Culture in Maternity Update 26 September 2022

Positive Culture in Maternity Update 26 September 2022
Introduction
This report outlines the culture journey for maternity services from January 2021 to date. The background outlines the starting point which was the NHSE Culture and Leadership process. This resulted in a **Positive Culture plan** which was developed for and by the Midwifery staff through the Change Team. The report then outlines actions that have under the headings of this plan, next steps to continue progress and look at sustainability and our measure, the staff survey.

Background
In order to support staff engagement and improve staff experience, it was recommended in late 2020 that Maternity utilise the NHSE Culture & Leadership process (CLP). The CLP is an evidence-based approach to reviewing culture developed by the Kings fund.

The CLP has 4 phases to develop and implement strategies to work towards a positive culture. The 4 phases are:

- **Scoping** – engagement of existing staff called the 'Change Team' to design the programme. In March 2021 Maternity recruited around 15 Change Team members who were trained to interview staff and run focus groups.
- **Discovery** – a questionnaire, Leadership interviews and focus groups took place in May and June 2021.
- **Design –** a synthesis event took place in July and Sept 2021 led by the Change team to review responses and design what should be delivered. The most important priority from the Change Team was behaviours and they outlined what needed to take to support each of these actions.
- **Deliver –** the outcomes of this work were built in a positive culture plan to develop the following:

Following an incident in November 2021 within Maternity at WHH, a Transformational Practice Development Consultant was bought in to review the incident, with particular interest into behaviours and culture. Having undertaken an after-action review (AAR) methodology interviewing approximately 40 staff it was identified six workstreams for development relating to culture and behaviours which aligned with the CLP action plan (as outlined above).

- Unprofessional behaviour, language and conduct / lack of personal respect
- Role clarity / power struggles / old grievances between staff
- Poor team working
- Student support, development and assessment
- Staff morale

- Safety and quality issues

They also interlink with the National People Promise and utilising the Concept Framework for Effective Workplace Culture (Reference: Effective workplace culture; attributes, enabling factors and consequences of a new concept, Kim Manley, Kate Saunders, Shaun Cardiff and Johnathan Webster .2011) work began collaboratively working with Senior colleagues, staff and forming the Positive Culture team in December 2021.

The Positive Culture team was set up to support midwifery management team in delivering of an effective work base culture. The team consisted of Transformation Practice Development, HR Business Partner, OD Business Partner, Early Resolution Facilitator and later Freedom to Speak up Guardian, Wellbeing Nurses and Professional Midwifery Advocate (PMA) Lead.

Outlined below are the actions taken under each element of the **Positive Culture Plan**:

Developing an effective culture - how we behave

One of the essential attributes of developing an effective work-based culture is having a shared vision and working with stakeholders' values.

- Vision and Values Workshops

In December 2021 drop in sessions were organised for staff to talk about concerns. The values leaflet was re-designed and printed using the Situation, Behaviour, Impact, Change/Continue (SBIC) feedback model.

The Change Team outlined in their plan the need for Vision and Values workshops onsite setting out expected at the Trust behaviours, what we want to see and don't want to see, a standard feedback model and asking staff to sign up to the values and behaviours.

In January 2022, the Vision and Values workshops commenced in small Multi-Disciplinary Teams (MDT) and covered Human Factors, Civility Saves Lives, what is it like to be on the receiving end of me? what can I do if I have concerned – feedback model / mediation and asking for a commitment.

A number of reconciliation/mediation meetings have taken place in Maternity to support individuals to air concerns and agree future positive working relationships.

In February 2022 all Band 7's at WHH were invited to a one to one personal development and input meeting with an OD Business Partner. Through that process the themes resonated with the CLP action plan and the effective workplace culture framework and crystallized the action plan going forward.

In establishing an effective workplace culture, it is vital that we are collaborative and inclusive and have participation from all stakeholders.

- Equality, Diversity and Inclusion (ED&I)

Following vision and values workshops ED&I events have been run on the units to celebrate diversity and build knowledge.

Outputs from the vision and values sessions have been weaved into a Respect and Inclusion Promise which has been drafted for the whole Trust and will be launched late 2022 in all Maternity units.

- Leadership behaviours

Behaviours not in line with Trust Values were identified, support for leaders was provided through the use of a simple 360 tool and by adapting the Nursing and Midwifery Council (NMC) Enabling Professionalism plan and one to one coaching.

We also introduced the Just and Learning Culture model and where behaviour concerns were raised, staff were given the opportunity to reflect, learn and be supported. We

developed an environment of high support and high challenge, giving and receiving feedback about every day performance both individual and organisational.

We are demonstrating a just and learning culture utilising the Trust Policy and enhancing it to Maternity service needs. A learning contract tool has been developed to support a consistent, documented and evidenced approach to learning from errors or mistakes.

The Positive Culture Team recognised the importance of all practitioners on being reflective and having objectives on their leadership style, culture and its application. However, management roles and responsibilities have been seen to play a significant role in the development and sustainability of an effective workplace culture and maintain positive behaviours. With this in mind the Director of Midwifery initiated a review of roles and responsibilities of the senior midwifery team and support and clarify how they may deliver their role.

Feedback from all levels of staff highlighted that there was lack of role clarity for all staff groups. The Positive culture team have started developing a Skills and Knowledge directory to identify expectations of clinical skills needed to fulfil the grade and progress to the next level.

The lack of role clarification for the on shift senior MDT team including the band 7 midwives had caused a number of issues on shift. There was an opportunity to develop and clarify the role of the Consultant and the band 7s in their leadership positions. Changes have been made for example, different coloured uniforms to clearly define roles on shift. The escalation policy outlines clear roles and responsibilities of the Consultants and Shift Leaders.

Leadership Development

- Leadership Development – all levels

The Trust made an investment with Connect Health Advisory to deliver a Connected Matron / Senior Nursing and Midwifery programme in 2019/20. The Midwifery Matrons attended this programme.

The Medical Site Leads and Consultants attended development days in February and March 2022 to seek input around change.

Band 7/8a away days have taken place during 2021/22, starting with a cross site Group Practice Leader (GPL) and B7 and Matron day in November 2021 and B7 WHH events in September 2022. These away days are designed to give updates / development and also to engage with our leaders on what is working and what needs to change.

- Band 7 Leadership Development Programme

The feedback from the Connected Matron programme was very positive and therefore it was decided that this would be utilised for the Band 7 workforce.

The programme has been arranged over three cohorts mixing Maternity with staff from Gynaecology, Neonatal Intensive Care Unit (NICU) and Paediatrics to support peer development and support. The cohorts are planned as follows:

	Dates	Number of attendees from Maternity
Cohort 1	31 May 22 to 1 December 2022	14
Cohort 2	16 November to 25 April 2023	18
Cohort 3	13 February 2023 to 28 July 2023	20

The programme starts with a workshop looking at Myers-Briggs Type Indicator (MBTI) type, then moves on to shadowing, feedback and then 6 masterclasses covering Leadership, Performance Management, Risk and Safety, Finance and Performance & Patient Experience.

In May 2022 Donna Ockenden outlined an essential action that all trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.

The Connected band 7 programme covers the majority of the action including managing Self, Cultures, Values and Beliefs and the principles which come under the human factors umbrella. Situational Leadership, Authenticity and Psychological safety, and tackling behaviour is also covered in this course. Cultural elements and Human factors are now taught to all staff on their annual update.

At the end of cohort one we will meet with delegates to encourage them to reflect on their learning and how they are going to translate that into practice. The present this at a celebration event to the Maternity Leadership team.

- Succession Planning and Talent Management

One to one coaching has been facilitated with 26 members of staff, offering reflection through critical companionship / restorative clinical supervision. This has enabled 14 people to explore career progression and have been successful in achieving interim and permanent posts in Maternity. The positive culture team working in collaboration with the maternity management team have identified and supported new roles within WHH Maternity. Deputy Ward Managers and Trust wide B7 to support students.

The Positive culture team are aware of the on-going staffing and recruitment challenges in maternity services. The team are offering support to the Midwifery Managers and Practice Development in implementing the National HEE framework to develop Maternity Support Worker roles (MSW). In addition to support Qualified Nurses and Nursery Nurse roles and responsibilities to enhance the future workforce.

The Trust is launching a leadership development programme starting in October 2022. There are three levels in this programme and the First Line is intended for those looking to move into a Leadership or new to a Leadership role. Maternity are planning to release experienced, well performing band 6's onto this in line with their appraisal and Personal Development Plans (PDP) to support future succession planning.

The way we work as Teams

- The Connected Band 7 programme has been setup mixing teams from across sites and integrating with NICU.
- The annual update weeks have been set up in MDT teams to support development, relationship and network building and mutual support.
- The Band 7 away days are designed to give teams time away from the workplace to think about them as a team and their needs as a team. The away days have been scheduled as onsite teams and cross site teams including community.
- The Trust is offering Team Engagement and Development (TED) which is a research-based tool to identify priorities against the 8 factors of an effective, high performing and engaged team. It then gives access to over 100 tools to facilitate the changes needed. The TED tool is due to be delivered to Team Leaders in the Maternity business and operational teams in October and November 2022 and in December to the GP Liaison Officers (GPLs) and Community Midwifery Teams. TED tool should be utilised within the acute units once MDT micro teams are established.

Speaking up

- A full time Freedom to Speak up (FTSU) Guardian was recruited in January 2022 and since then has held onsite FTSU clinics and also presented at Away Days on the FTSU model and why it is important.
- Maternity provide many ways for staff to speak up and this can be through the Positive Culture team, the PMA's, OD Business Partner, Wellbeing Nurse Advisors and the Leadership team at regular webinars.

Wellbeing

- Since 2016 when Supervision of Midwifery was removed from statute the Advocating for Education and Quality Improvement (AEQuIP) has been implemented. With the appointment of the Professional Midwifery Advocate (PMA) lead a strategy has been written and ratified and shared with Professional Nurse Advocates Trust wide to ensure consistency of application of the model across the Trust. PMA's have supported Midwives attending Coroners Courts, learning through incidents and in the development of an effective workplace culture.
- Secured funding for 2 part time Wellbeing Nurse Advisors to support and promote wellbeing for all staff on the Units. This started in 2021 and their hours have been increased from mid-2022. They are proactive on the units talking to staff and providing support strategies.
- From autumn 2022, a room will be available at the WHH and QEQM as Wellbeing Rooms where staff can take time out, access resources and have confidential de-brief sessions. Additional resources have been put in place to support wellbeing from September 2022 including a confidential helpline and access to fast track blocks of counselling.
- Starting in January 2023 we are supporting an external programme called "Sinking to Soaring - Foundations to Better Emotional Health for Midwives and Maternity Services" it is a five-hour workshop suitable for up to 40 midwives per workshop and counts towards participatory CPD requirements. This transformative workshop specifically designed with the needs of midwives and maternity services in mind covers 4 main topics, all which interconnect for optimal emotional health including Resilience and bounce-back ability, Healthy mind: body connection, building confidence and self-esteem, Identifying and challenging unhelpful triggers, perceptions and beliefs**.**

Engagement

- The organisational enabling factors of effective work-based culture identify a flat and transparent management and good support from human resources. There is enhanced site presence and leadership through an additional Head of Midwifery on site and an additional Community Matron. In addition, the Human Resource function has been increased with a separate HR Business Partner and OD Business Partner.
- We offer a range of opportunities for staff to have a voice through focus groups, away days and on-site workshops.
- A weekly newsletter is emailed to all staff to update on any positive feedback and to give updates relevant to the service.
- The Maternity Facebook page is used to seek input from staff.
- Regular webinars take place led by the Care Group leadership team to share information and seek feedback.
- Use of the TED survey tool will support better team engagement through smaller teams.

Recognition

- Regular EPIC awards are given out by Matrons and Head of Midwifery (HoM's) on site.
- The Director of Midwifery also presents Kindness Awards to staff who have gone over and above.
- The thank you cards are used regularly in maternity to recognise when staff have made a difference.

Next Steps and Sustainability

As a Positive Culture team, we have regularly evaluated and re-directed resources as and where required.

Our next steps are to re-evaluate our starting position of developing an effective work-based culture, working with vision and values and measure our progress and how this is demonstrated and sustained.

Working collaboratively with staff and the university to achieve reapproval of the midwifery programme from the NMC.

We need to use the data from "Their voice is heard" and support the development of the patient voice and co-creation of service improvements to support the We Care methodology. Next steps and sustainability will be through:

Area	Next steps
Vision and Values	• Annual Human Factors and culture updates including embed HALT and SBIC tool • Trust recruitment of Culture Connectors • Embed the Respect and Inclusion Charter • Re-survey Band 7 at WHH and send to QEQM and GPLs • All staff to be aware of Enabling Professionalism development document and can be used prior to appraisal or revalidation • Staff objectives around culture and ED&I • Skills directory to be finalised and then staff skills measured against it • Continue to embed Just and Learning Culture and Learning Contract
Leadership	• Continued development of effective Leadership through away days, and cohort 2 and 3 of Connected Programme and embedding practice in the workplace. • Cross team away days for staff. • Ensure that management skills and training is delivered • Continue to support the workforce plans around MCA, Nursery Nurse and Qualified Nurse Recruitment • Ensure robust succession planning and development of staff.
Teamworking	• Development of MDT micro-teams • Utilisation of TED Tool in small teams • Continued MDT learning and development
Speaking up	• Continued development of speaking up culture and embedding high support and high challenge
Wellbeing	• Continue wellbeing service and move to a more proactive offering • Support the Sinking to Soaring programme for Midwives
Engagement	• Regular staff surveys and communication of action as a result • Work to increase response rates to surveys
Recognition	• Celebration events following Connected programme

Reviewing progress against the Staff Survey

Our baseline survey is the September/October 2021 staff survey. We continue to monitor results when available through the quarterly pulse survey. Quarter 2 is the first time we were able to see the pulse survey broken down by site.

Locality	Survey invites sent	Surveys completed	Response rate	Staff Engagement Score	Motivation score	Involvement score	Advocacy score
EKHUFT	8,976	2,519	28%	6.33	6.76	6.28	5.95
Women's Health Q2 2021	599	135	23%	5.83	6.42	5.56	5.52
Women's Health Q2 2022	626	138	22%	6.01	6.59	5.96	5.49
Maternity	419	69	16%	5.74	6.4	5.84	4.99
Maternity K&C and Canterbury Coastal Community	103	16	16%	5.92	6.3	6.15	5.31
Maternity QEQM	135	17	13%	5.66	6.23	5.6	5.15

Maternity WHH	134	18	13%	5.31	6.48	5	4.44
Midwifery Management	43	18	42%	6.1	6.57	6.62	5.09

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Appendix 2: Midwifery Workforce Planning Actions and status

Action Number	Overall Action Status	Action	Lead	Target Finish	Update/progress report
MIP WFP 01	Complete	To complete a detailed analysis of the overall midwifery workforce across the whole service	Interim Director of Midwifery	10/09/2021	09.12.21 - Complete detailed workforce paper and business case approved at Board in Sept, funding in place
MIP WFP 01(i)	In progress (on schedule)	To complete a detailed analysis of the medical Women's Health (Obs & Gynae) workforce	Clinical Director	31/03/2022	04.10.22 - Reset deadline to 31/12/22 from Mr 2022. Gap analysis from CK going to MNAG in October
MIP WFP 02	Complete	To complete business case for approval to support additional workforce requirements	Interim Director of Midwifery	30/09/2021	Business approved by Trust Board September
MIP WFP 02(i)	Complete	Medical workforce requirements included in training business case i.e. Increase to clinical workforce for training delivery (through PDM team).	Clinical Director	31/03/2022	Complete
MIP WFP 02(ii)	Superseded	Monitor gynae consultant provision against current guidance to ensure sufficient establishment to manage timeliness of outpatient appointments; consider increased capacity	Clinical Director	31/03/2022	04.10.22 - Action superseded and merged with ref. 02(i) as part of medical workforce analysis
MIP WFP 03	Complete	To complete JDs for new leadership roles identified as part of workforce review	Interim Director of Midwifery	01/11/2021	21.03.22 - Final JD received
MIP WFP 04	In progress (Overdue)	To advertise new leadership roles, aligned to agree timescales within BC	Interim Director of Midwifery	01/11/2021	using a recruitment agency to recruit; due to advert by end of November. Deadline amended from Nov 21, to Nov 22
MIP WFP 04(i)	In progress (Overdue)	Recruit to clinical fellow posts (x 2)	Clinical Director	31/03/2022	05.10.22 - Followed up latest position with Ops lead
MIP WFP 05	Complete	To explore alternative approaches to recruitment including open days	Interim Director of Midwifery	16/10/2021	27.07.22 We are recruiting B5,6,7 int/ext for both sites and allocate as per preferences, also following up int'ntl. JD-G looking at use of social media. Need to agree acceptable vacancy rate (mat. dashboard, 10%) LJ asked JD-G cc: PH for a recruitment plan (to Inc. method of r'ment) then close this action and review

					as Business As Usual (BAU) via monthly progress /highlight report at w/force stocktake meeting - considering Obs midwives by completing Obstetric module, also 18mth HEE programme / increasing cohort numbers
MIP WFP 06	Complete	Revisit line by line review with Finance BP to ensure new roles mapped in, and there's a clear understanding of LTS and maternity leave	Interim Director of Midwifery	30/11/2021	09.12.21 – Set up ongoing monthly status check; finance to update their figures / spreadsheet (19.95% Mat. Leave). Process in place 02.03.22 - **MOVE TO BAU**;
MIP WFP 07	In progress (On schedule)	Work with regional team to establish international midwifery recruitment pipeline	Interim Director of Midwifery	30/04/2022	04.10.22 - 2 x Cohorts: 1 from Jamaica / 1 from the Philippines. Due bet. Nov-Jan - deadline amended from Apr 2022 to Jan 2023
MIP WFP 08	Complete	To map the new admin roles across the service to identify how best to deploy to release midwifery time	Operations Director	30/11/2021	19.01.22 - CMW Admin posts: 4 x WHH, 0 interest QEQM- back out to advert.
MIP WFP 09	Complete	To commence leadership development programme for band 7 midwives.	Interim Director of Midwifery	30/06/2021	27.07.22 - Follow up above queries and how dates link with Kirkup follow-up sessions
MIP WFP 09(i)	Superseded	Initiation and ongoing delivery of Clinical Fellowship programme	Clinical Director	01/04/2022	04.10.22 - Training business case
MIP WFP 10	In progress (Overdue)	To support development of Senior midwifery roles 8A and above Evaluate development/mentoring/coaching completed to date for each individual	Interim Director of Midwifery	31/03/2022	04.10.22 - PDPs and coaches / mentors agreed via appraisal process. Also will be working on snr midwife dev. programme. Appraisal schedule for all 8a+ requested
MIP WFP 10(i)	In progress (Overdue)	Continuing access to clinical leadership development programme and mentorship programme (Clinical Director, Site leads)	Clinical Director	01/04/2022	27.07.22 - No update; will pick up during appraisal process and present options to individuals for personalised development programmes. Formalise in a competency framework document for standardisation
MIP WFP 11	Complete	To review and revise the PMA model at EKHUFT and align to those outlined in the A-quip Model. Link to the development of the PMA Strategy being	Interim Director of Midwifery	31/03/2022	22.12.21 - Appointed 8a interim until Mar 2022, plus 2 x pt. experience MWs 27.04.22 – PMA Strategy will be presented to MNAG in June

		led by Jill Roffey (PMA Lead), due in Feb/Mar 2022			14.06.22 - Presented to MNAG - agreed and now needs formal approval via QSC
MIP WFP 12	Complete	To review and update the TNA for maternity services aligned to national and local requirements (Ciaran Crowe to provide input from Medical)	PDM team	30/09/2021	27.04.22 - CC has the working draft, which will be presented to MNAG in May.
MIP WFP 13	Complete	To review the content of training programme and redesign for 22/23. (Align to LMS Governance Framework launched w/c 10/01/22)	PDM team	30/10/2021	Training awayday held to map all requirements for across MDT. Draft Programme in place. Resourcing gaps Identified and BC developed 27.04.22 - Start date at risk of delay until June due to venue issues Monitoring compliance, and prioritising those with expired competencies. The focus areas will be NLS, PROMT, Fetal Medicine. 22.06.22 - Block training launched - ask CC for docs
MIP WFP 13(i)	In progress (Overdue)	Use themes from a joint neonatal, antenatal/ perinatal review of cases across both sites re: higher than expected rates requiring cardiac compression drugs, and consider elements to include in NLS training programme / lesson plan	Practice Development Midwife	31/03/2022	07.07.22 Sim sessions have been conducted on both sites highlighting the airway management prior to Cardiac compressions. Audit going on at QEQM to review improvement. BAM supervising it.
MIP WFP 13(ii)	In progress (overdue)	Secure anaesthetic resource to support PROMPT elements of block stat/mand training 2022/23	Practice Development Midwife	31/08/2022	27.07.22 - Interim plan in place but needs further stability due to anaesthetic capacity 04.10.22 - No change to anaesthetic capacity to support Maternity (via Michelle Walters) re: Ockenden requirements, reporting to MNAG this month previous comment, but links to wider work around
MIP WFP 14	Complete	To build plan to support implementation of new programme ref. WFP 13	PDM team	30/11/2021	09.12.21 - PDM to share the plan for the programme

					19.01.22 - See notes for action ref: 13
MIP WFP 15	Complete	To establish more effective process for ensuring all staff across the whole service are compliant with mandatory training (for Medical, specifically SG L3).	PDM team	30/11/2021	04.10.22 - Now BAU through Mat. Dashboard monitoring
MIP WFP 16	Complete	To ensure staff (Inc. permanent Medical staff) are appraised and learning needs identified	Matron (QEQM)	30/11/2021	27.04.22 - reported completion rate as 79% with CMWs/QEQM working on improving their completions. Progressed well at QEQM 31.08.22 - Close and move to BAU, as review by PRM
MIP WFP 17	In progress (On schedule)	To ensure each role has clear competency framework to support learning and development. For Medical, (Good Medical Practice Guideline) governed through annual appraisal for employees, and trainees via yearly educational supervisory meetings	PDM team	31/12/2022	Work has commenced on a competency tool for community midwives, but need to scope for whole workforce / all roles 27.04.22 – deferred completion now anticipated by Dec 2022; 04.10.22 – Ops lead completed B5/6 and working on B7
MIP WFP 18	Superseded	To ensure where staff are involved in SI cases, learning is identified and documented plans are in place and completed (Links to Incidents tab of MIP) NB: If medical trainees involved they cannot progress in their qualification until SI requirements met, consultants required to raise at appraisal, any concerns escalated to Chief Medical Officer (CMO) for advice	Head of Governance	30/11/2021	Working with Governance and senior midwives to establish a process. 02.03.22 - Action to be moved to Governance Plan
MIP WFP 19	In progress (Overdue)	To utilise eRoster to identify skills required each shift in each area	Matron (QEQM)	31/09/2022	Seeking clarification on the potential to establish this

MIP WFP 19(i)	In Progress (Overdue)	To ensure there is a robust system for ongoing assurance of necessary skill mix on each shift	Clinical Director	31/03/2022	21.02.22 - This is a manual process of rostering to identify skills required each shift in each area 09.03.22 - support with automating this process 27.04.22 - Linked to action. 19 above
MIP WFP 20	In Progress (Overdue)	To establish regular meeting with Christchurch to discuss and identify plans, as well as issues for students in placement Re: Medical, meetings with deanery to continue three times per year	Interim Director of Midwifery	31/12/2021	27.07.22 - ON HOLD pending student numbers etc and NMC decision 31.08.22 - NMC declined option so working with CCCU and HEE to implement 18mth programme from Worcester
MIP WFP 21	Complete	To develop open communication with students to understand their concerns	Interim Director of Midwifery	30/09/2021	Monthly forums established with students, hosted by DOM feedback shared with Mat. Management team
MIP WFP 22	In Progress (Overdue)	To work with CCU to review the number of student cohorts to reduce the number qualifying at one time	Interim Director of Midwifery	31/12/2021	Initial discussions held with CCU 09.12.21 - Agreed to move to 2 x cohorts per year with a view to slightly increase intake numbers-this cannot be planned until University has reapproval in April 2022." 04.10.22 - Deadline changed from Dec 2021 to Apr 2023 as new education provider added
MIP WFP 23	In progress (Overdue)	To update maternity escalation guidance to ensure it is aligned to Mutual Aid policy for the sector	Operations Director	08/10/2021	09.12.21 - TH has meeting and is coordinating with mutual aid; links to action around Escalation Policy for CQC 14.01.22 - Guidance pending contact details to be added 27.04.22 Shared for comment
MIP WFP 24	Superseded	To clearly define the roles and responsibility of the operational/Flow coordinator **ACTION SUPERSEDED**	Interim Director of Midwifery	31/01/2022	Role of the Flow Coordinator identified as essential in supporting the B7 culture workstream 27.04.22 - Decision made to retract this

					post but an alternative will need exploring as it's left resources short at WHH. CD considering.
MIP WFP 25	Superseded	To provide training to Coordinators in relation to escalation pathways and actions to factor in huddles and discussions with medical workforce / ward rounds	Interim Director of Midwifery	30/10/2021	27.04.22 - Pending launch of escalation policy. As above
MIP WFP 26	Complete	To establish a more robust service-wide daily SITREP meeting. Consultants to join SITREP, to replace cross-site call	Interim Director of Midwifery	30/11/2021	10 AM daily meeting established, including community. SOP in place for meeting - now needs to be embedded 04.10.22 - 10:00 SITREP does not include doctors, but there is a MDT on-site huddle at 08:00, 13:20 - coordinator to coordinator. Close and supported by Escalation, Handover, and Consultant SOP
MIP WFP 27	Complete	To establish open forums for staff to discuss improvement plans and raise concerns as well as suggestions RSP Exit Criteria: Feedback from staff on their current experiences regarding safety, culture and leadership	Interim Director of Midwifery	30/11/2021	Open forums in place with DOM Also the safety champion feedback goes to Improvement lead for collation Positive culture group set up Looking at an app called 'ImproveWell'. This will give us a Realtime view on Staff Feedback and improvement ideas, we just need to see whether this will work for us." 07.03.22 - FTSU Accreditation due 31/03/2022. Launch from 01 Apr 2022 27.07.22 - Still running alongside FTSUG but maybe need more presence on the units for localised discussion around concerns 31.08.22 - Regular forums are established, wrap-up, FTSUG present on site - close
MIP WFP 28	Complete	To establish a monthly award for kindness, to include medical workforce	Interim Director of Midwifery	30/11/2021	Initiative underway and awards being regularly presented and shared in Carol's weekly wrap-up / Trust News / Newsflash. In addition, Thank You cards for staff have

					been handed to managers for giving to the workforce
MIP WFP 29	Complete	To establish regular communication to update all staff within maternity services. Needs medical input to weekly wrap-up / alternative medical weekly updates alongside Director of Midwifery (DoM) message	Interim Director of Midwifery	30/08/2021	Weekly communication updates sent by DOM 29.12.21 - GOLD updates also being shared by TH via email with WH care group
MIP WFP 30	In progress (on schedule)	Delivery of Culture and Leadership workshops / programme. Medical members are on this programme. Consider a link to the Trust's development of an EDI Strategy	HR Business Partner	31/03/2022	FTSU guardian appointed and Jan 22 Interim 3 days a week in place to work alongside staff around behaviours Workshops across the Trust taking We Care, mission statements and values so all staff (630) aware. Workshops on RCOG doc re: roles & resp of Obs on call (25 Feb / 04 Mar) **Current delivery plans are:** - WHH up to Mid-May - Community May to June - QEQM June to July 04.10.22 - MNAG paper next week will close this action
MIP WFP 31	Not started/At risk	Consider use of 15 Steps to support culture change programme	Consultant (Workforce Culture)	31/01/2022	15 steps program and MVP feedback will be part of the Cultural work. We are aligning this with the We Care program so this is on the radar and we are working toward these dates. 18.08.22 - To follow up
MIP WFP 32	In progress (Overdue)	Invite MVP representative for ward visits and run feedback analysis from now to end of March, following KH culture work (MVP relevant for all services, obtain expressions of interest for medical if needed) RSP Exit Criteria: Feedback from service users and evidence of impact.	Consultant (Workforce Culture)	31/03/2022	28.02.22 - Initiative not started (KH)

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MIP WFP 33	In progress (Overdue)	Further to investigation 12-14 Nov, KH working with Folkestone Ward developing effective work based culture: quality pt. safety. Pt exp, leadership development and L&D culture	Consultant (Workforce Culture)	31/01/2022	14.01.22 Update from KH that "I have started supporting the Band 7 ward manager, as a professional midwifery advocate and mentor
MIP WFP 34	Complete	From GIRFT Neonatal visit outcomes (11/10/21): Please work with maternity colleagues to access maternal perinatal mental health services where appropriate as well as developing a business case for psychological support within the neonatal unit. This is strongly recommended	Consultant Midwife (Public Health)	31/03/2022	11.05.22 - Confirmed at GIRFT review meeting that business case is written and pending approval; Requested copy of the draft BC for our records (on leave until 16/05)
MIP WFP 35	Not started/At risk	Establish a process to ensure a Specialist Multiple Pregnancy/Twins lead midwife is in place in line with NICE Guidance and HSIB Case specific action plan	Head of Midwifery (QEQM)	31/03/2022	03.02.22 - Requested new action; requirement of NICE standards. 27.04.22 - No progress; reliant on funding, and a JD to be written 04.10.22 - Identified funding and potential to be a joint post with consultants - pending response from JD-G

No. Actions	45	Status (%)
At risk / Not started	1	2%
In progress (overdue)	11	24%
In progress (on schedule)	7	16%
Complete	20	44%
No Status	6	13%
TOTAL	**45**	**100%**

Board Sign off

Name_____ Date of Signing_____

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**SAFETY ACTION 4: CLINICAL WORKFORCE**
MEETING DATE:	**8 DECEMBER 2022**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER (CNMO): EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY** **IMPROVEMENT AND TRANSFORMATION MANAGER**
APPENDICES:	**APPENDIX 1: SAFETY ACTION NO 4 REPORT AGAINST STANDARDS (ATTACHED)** **APPENDIX 2: OBSTETRIC/MIDWIFERY ACTION PLAN/ FEEDBACK DOCUMENTATION FOLLOWING DATIX INCIDENT (ATTACHED)** **APPENDIX 3: NEONATAL NURSING ACTION PLAN (ATTACHED)** **APPENDIX 4: NEONATAL WORKFORCE CALCULATOR REPORT QEQM** **APPENDIX 5: NEONATAL WORKFORCE CALCULATOR WHH**

Executive Summary:

Action Required:	Decision	**Approval**	Information	Assurance	Discussion

Purpose of the Report:	• The purpose of this report is to assure the Board that maternity services are delivering Safety Action 4, Clinical Workforce Standards and reporting position to Trust Board. • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 4, which aims to continue to support the delivery of safer maternity care and Ockenden Report Recommendations. • Present action plans in relation to Obstetric Workforce and Neonatal Nursing, in compliance with the scheme.
Summary of Key Issues:	• The report confirms that the service is implementing the Clinical Negligence Scheme for Trusts (CNST) Safety Action 4 Standards. • Detailed papers for each discipline have been previously discussed at Maternity and Neonatal Assurance Group (MNAG). The report highlights key messages for the Board's attention: • Sign off at Trust Board level acknowledging and committing to incorporate and engage with the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) document took place with a paper to Board in June 2022. • There has been one episode of non-attendance, which occurred in October 2022. The Consultant was on site and in the Consultant office but poor mobile phone signal affected the call getting through and Midwives were not aware of office number. An action plan is attached as appendix 2. • There is a duty anaesthetist immediately available for the obstetric unit 24 hours a day and the service is compliant with individual elements. • The neonatal workforce is compliant with CNST requirements,

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	supported by action plans following required audits. Details in action plan attached. • The neonatal clinical reference group nursing workforce calculator has been completed and continues to show gaps in Nursing staff. A paper was presented to MNAG in October and an action plan is attached for Trust Board approval.
	The Board of Directors is invited to: 1. **RECORD** in Board Minutes One episode of non-attendance occurred in October 2022. The Consultant was on site and in the Consultant office but poor mobile phone signal affected the call getting through and Midwives were not aware of office number; 2. **SIGN OFF** An action plan presented to December Trust Board; 3. Trust Board is required to formally **RECORD** in Trust Board minutes that it meets the recommendations of the neonatal medical workforce training action; 4. **RECORD** the neonatal nursing workforce calculator tool has been completed to assess staffing needs against service specification standards; 5. **RECORD** that the standard for neonatal nursing has not been met in both year 3 and year 4 of the CNST scheme but an action plan has been received to improve; and 6. **NOTE** in minutes that Copy of actions related to the neonatal nursing workforce has been submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.

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

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

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CNST Maternity Incentive Scheme Year 4:

Safety action No. 4 Report Against Standards

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Rational for Status	Action for Board	Evidence presented to support against Declaration	File route on Admin Control
1	**a) Obstetric medical workforce** 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. Sign off at Trust Board level acknowledging engagement with the RCOG document https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report	Yes	Sign off at Trust Board level acknowledging and committing to incorporate and engage with the principles outlined in the RCOG document took place with a paper to board in June 2022.	Note in Board Minutes that paper was received and reporting takes place monthly with action plan for cases of non-attendance.	Sign off at Trust Board level acknowledging engagement with the RCOG document (by 16 June 2022) along with an action plan to review any non-attendance to the clinical situations listed in the document. **Trust BOARD PACK with minutes NOTING Trust Board acknowledgement with RCOG document** • SA4.R1.5. Board of Directors open meeting pack (7 July 2022).pdf 22/55.4 • SA4.R1.1. 22-55.4 - CNST SA4_ RCOG Consultant Attendance Final.docx • SA4.R1.6. SA4.R1.6. MNAG Board Pack PDF133131712324020778.pdf (pg. 112/233) **Perinatal Quality Surveillance Tool Reports August, September and October showing ongoing monthly reporting to MNAG and Trust Board** • SA4.R1.2. PQST Report August 2022.v4 docx.docx • SA4.R1.3. PQSTR September Final.docx • SA4.R1.4. October 22 PQST.BOD.CM.docx	
2	2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance must be signed off at Trust Board Level. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.	Yes	The Trusts continues to evidence their position to Trust Board, Trust Board level safety champions through Perinatal Quality Surveillance Tool reporting each month and also through tracking of the Datix reports. An additional section was added to Datix to make this possible and a new Euroking Workflow to capture and audit compliance has been developed and is waiting for implementation by the supplier. A presentation will take place at the Local Maternity and Neonatal System (LMNS) Quality Assurance Group meeting in December as required at least once from the relaunch of MIS year 4 in May 2022. One episode of non-attendance occurred in October 2022. The Consultant was on site and in the Consultant office but poor mobile phone signal affected the call getting through	One episode of non-attendance occurred in October 2022. The Consultant was on site and in the Consultant office but poor mobile phone signal affected the call getting through and Midwives were not aware of office number. An action plan is to be presented to December Trust Board. Numbers are now on the LW Board.	**Monitor compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person.** **Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022** **Trust BOARD PACK with minutes NOTING Trust Board acknowledgement with RCOG document** • SA4.R1.5. Board of Directors open meeting pack (7 July 2022).pdf 22/55.4 • SA4.R1.1. 22-55.4 - CNST SA4_ RCOG Consultant Attendance Final.docx • SA4.R1.6. SA4.R1.6. MNAG Board Pack PDF133131712324020778.pdf (pg. 112/233)	

			and Midwives were not aware of office number. An action plan is attached as appendix 2, to be presented to December Trust Board. Numbers are now on the LW Board.		• SA4.R2.1. MNAG report on obstetric workforce.doc **Perinatal Quality Surveillance Tool Reports August, September and October showing ongoing monthly reporting to MNAG and Trust Board** • SA4.R1.2. Perinatal Quality Surveillance Tool (PQST) Report August 2022.v4 .docx • SA4.R1.3. PQSTR September Final.docx • SA4.R1.4. October 22 PQST.BOD.docx **Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance must be signed off at Trust Board Level. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.** SA4.R2.1. Obstetric/Midwifery Action Plan/ Feedback documentation following Datix Incident **Euroking workflow capturing clinical situations listed in RCOG document that require Consultant attendance** • SA4.R2.2. MR 14.09.21 v4.1 Consultant Attending workflows.xlsx	
3	**b) Anaesthetic medical workforce** • Is a duty anaesthetist immediately available for the obstetric unit 24 hours a day and do they have clear lines of communication to the supervising anaesthetic consultant at all times? • Where the duty anaesthetist has other responsibilities, are they able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)? The rota should be used to evidence compliance with ACSA standard 1.7.2.1.	Yes	There is a duty anaesthetist immediately available for the obstetric unit 24 hours a day and they do have clear lines of communication to the supervising anaesthetic consultant at all times. This is documented in the EKHUFT Anaesthetic Obstetric Escalation Guideline and communicated at induction Where the duty anaesthetist has other responsibilities, they able to delegate care of their non-obstetric patients in order to be able to attend immediately to and prioritise obstetric patients. (ACSA standard 1.7.2.1) The rota evidences compliance with ACSA standard 1.7.2.1	Note in minutes that ACSA standard.7.2.1 is fully met.	**The rota should be used to evidence compliance with ACSA standard 1.7.2.1.** • SA4.R3.1. William Harvey Hospital (WHH) Anaesthetic 24hr Obs Cover Audit Aug 21 to Feb22.docx • SA4.R3.2. Queen Elizabeth the Queen Mother Hospital (QEQM) Anaesthetic 24hr Obs Cover Audit Aug 21 to Feb22.docx • SA4.R3.3. Confirmation of Anaesthetic Night Cover WHH.docx **Supportive Documents** • SA4.R3.4. EKHUFT Anaesthetic obstetric escalation guideline.doc • SA4.R3.5. Standard of Obs Anaesthesia ACSA. WHH docx.docx • SA4.R3.6. Standards of Obs Anaesthesia (ACSA) QEQM (2).docx • SA4.R3.7. October MNAG agenda.docx • SA4.R3.8. Anaesthetic workforce paper October 2022.pdf • SA4.R3.8. Trainee guide to obstetric anaesthesia at WHH.pdf	16.02.21

					• Audit against rotas for 6 months • Induction programme	
4	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	N/A	No Action plan for year 3 as compliant Compliant Year 4 so action plan not required	Standard met and action plan not required	No Action plan for year 3 as compliant Compliant Year 4 so action plan not required	
5	**c) Neonatal medical workforce** • Do the neonatal units meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing? • Has a review been undertaken for any 6-month period between August 2021 and 5 January 2023 to assess this?	Yes	Rota cover demonstrates compliance in terms of cover but there are episodes of Consultants acting down to support this. For the CNST Standard compliance is met but October workforce paper highlights challenges and staffing gaps.	Standard met and action plan not required	• 6 month audit against BAPM Standards Action plan if required between August 2021 and 5 January 2023 • SA4.R5.1. Neonatal Workforce Paper (1).docx • SA4.R5.9. October MNAG agenda.docx • SA4.R5.2. August 2021 to November 9WK SHO JUNIOR DR ROTA QEQM.xlsx • SA4.R5.3. December 2021 to April 2022 SHO Junior 9WK DR ROTA QEQM.xlsx • SA4.R5.4. March 2021 to September 2021 QEQM Middle Grade rota .xlsx • September 2021 to March 2022 QEQM Middle Grade rota latest version • SA4.R5.5. NEONATAL JUNIOR DOCTOR ROTA MARCH- SEPTEMBER 2021 WH.ver 6.docx • SA4.R5.6. NEONATAL JUNIOR DOCTOR ROTA SEPTEMBER 2021 to March 2022 WH .docx • SA4.R5.7. Neonatal Registrar Rota March - September 2021 WH ver 2.docx • SA4.R5.8. NEONATES REGISTRAR ROTA SEPTEMBER 2021-MARCH 2022 WH .docx ver 1.docx • Email confirmation of rota review and compliance met by Neonatal Safety Champion	
6	• If the requirements had not been met in both year 3 and year 4 of MIS, can Trust Board evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies • If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, has Trust Board developed an action plan in year 4 of MIS to address deficiencies? • Has the action plan and related progress details been shared with the Neonatal Operational Delivery Network (ODN)? • There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post	N/A	Audit against rota for a six month period demonstrated compliance so action plan not required. This has been reviewed and validated by the Neonatal safety champion	Standard met and action plan not required	No Action plan for year 3 as compliant Compliant Year 4 so action plan not required	

	(rota gap). There should also be a record of the rota tier affected by the gaps. • Has the Trust formally recorded in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action? • If the requirements are not met, can Trust Board evidence progress against the action plan developed in year 3 of MIS to address deficiencies.					
7	**d) Neonatal nursing workforce** Does the neonatal unit meets the service specification for neonatal nursing standards? Has a Nursing workforce review been undertaken at least once during year 4 reporting period?	No	The neonatal clinical reference group nursing workforce calculator has been completed and continues to show gaps in nursing staff. A paper was presented to MNAG in October and an action plan is attached for Trust Board approval. We have recurrent funding for a 0.6 WTE 8b clinical psychologist starting in the next financial year, an OT pilot for 6 months (0.4 WTE) and recurrent funding (seconded into and starting December 2022) and recurrent funding for an ANNP (1.0 WTE 8a). The new risk that is to be added to the risk register is 1.5WTE deficit for band 7 pharmacy support for NICU. Trust Board minutes must record nursing workforce calculator tool has been completed to assess staffing needs against service specification standards.	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. We are not meeting these standards and an action plan is attached to support improvement Action plan developed to meet the standards and signed off by the Trust board.	• SA4.R3.7. October MNAG agenda.docx • SA4.R5.1. Neonatal Workforce Paper (1).docx	
8	If the requirements had not been met in both year 3 and year 4 of MIS, can Trust Board evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies? If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, has the Trust Board developed an action plan in year 4 of MIS to address deficiencies? Has a copy of the action plan, outlining progress against each of the actions, been submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead?	Yes	The standard was not met for year 3 of the CNST scheme either and the attached action plan shows progress being made with both Year 3 and 4 findings. One this has been seen by Trust Board, a Copy of actions will be submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.	Note in minutes that Copy of actions has been submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead	• SA4.R8.1. Neonatal Workforce Action Plan February 2022.xlsx MM.xlsx • SA4.R8.2. QEQM staffing tool oct 21.xlsx • SA4.R8.3. WHH staffing tool oct 21.xlsx • SA4.R8.4. Risk Register NICUSCBU Oct 2022.pdf • Outstanding-Email confirmation that Copy of actions has been submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead	

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Appendix 2. Safety Action 4: Obstetric Attendance for the situations outlined in the GMC Document

WEB Number	Staff Member	Incident details	Discussion	Actions	Interview by
WEB228873	Removed for reporting	Did not answer phone when needed by reg overnight	Her phone has slipped onto silent. She was onsite in the consultant office and had the bleep with her. She believed the team to know where to find her.	Ensure the team overnight know where she is and that she has the bleep with her in case of no answer from the phone. Consider giving office number as well as back up	Obstetric Site Lead

Board approval ----------

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Appendix 3: Neonatal Workforce Action Plan

Safety Action 4: Neonatal nursing workforce Action Plan								
Action Number	**Safety Action Requirement**	**Actions to achieve standard**	**BRAG Status**	**Update/Progress/Rational for status**	**Care Group Lead**	**Start Date**	**Planned Completion Date**	**Date of completion**
NNWF.1	• The neonatal unit meets the service specification for neonatal nursing standards. • Nursing workforce review has been undertaken at least once during year 4 reporting period.	Workforce review completed and data reviewed and shared. Action plan amended according to findings	Complete	August 2021 CNST Year 4 Guidance and action plan shared with Neonatal Matron. Nursing workforce review is to be repeated to support action plan update and raise awareness of any change in compliance position. September 2021 Discussed with Neonatal Matron. Time being created to update tool and associated action plan. October 2021 Update on position requested and to be shared by Neonatal Matron. **31.10.22** Nursing Workforce Review tool completed on both sites.	Neonatal Matron	08.08.21	30.06.22	
NNWF.2.1	• If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address defi+B4:B20ciencies. • share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.	To continue to 'grow our own' due to national shortage of qualified in speciality (QIS) nurses; with overall aim of increasing % of QIS nurses above 70% on both sites in the next two years. We are training six nurses at WHH and one at QEQM this year.	In progress (On schedule)	**16.02.22 QEQM workforce review-**To increase total QIS to required 12.3 WTE - external recruitment of QIS staff has not been successful and therefore continuing with 'grow your own' strategy. There is one nurse currently on the QIS course, due to complete by September 2022 leaving a deficit of 2.5WTE. Plan to send 1-2 nurses on QIS training in September 2022. Anticipated trajectory for compliance with recommendation - September 2024 -this has been updated from 2023. **28/11/2022** 66.2% of the current total workforce are QIS trained. One nurse is currently on QIS training and due to complete in March 2023 **WHH Workforce Review-**to increase total QIS to required 46.7 WTE - external recruitment of QIS staff has not been successful and therefore continuing with 'grow your own' strategy. There are three nurses currently on the QIS course, due to complete by September 2022 leaving a deficit of 11.5WTE. Plan to send 4 nurses on QIS training in September 2022. Anticipated trajectory for compliance with recommendation - September 2024. **28/11/2022** WHH is currently compliant with target with 77% of total workforce qualified in specialty. However, with leavers in late 2022/early 2023 there will remain a small deficit. Two nurses have started QIS training in September 2022. Following successful recruitment to band 5 positions, there will be 4-6 nurses ready to send for training in September 2023.	Neonatal Matron	04.03.21	01.09.24	
NNWF.2.2		To reduce non QIS registered nursing workforce to align with recommendation - To support all new band 5 starters to attend the QIS training within 12-18months of start date.	In progress (On schedule)	16.02.22-We have not replaced some of our band 4 nursery nurses when leaving at WHH site. We are now at the correct level at per staffing tool. To plan to not replace at the QE site and replace with trained nurses until recommendations reached to allow more flexibility in allocation and rostering. All new registered nurses seeking employment are asked about their interest in doing their QIS training at interview. **28/11/2022** Plan as above	Neonatal Matron			
NNWF.2.3		To employ two WTE band 6 nurses at **WHH** to provide leadership, training and support in HDU nursery	Complete	**16.02.22** Appointed and Started in post January	Neonatal Matron	04.03.21	05.07.21	31.01.22

NNWF.2.4		To increase the band 6 workforce at QEQM to ensure that there is skilled and experienced in-charge cover which is not jeopardised by annual leave/sickness.	In progress (On schedule)	16.02.22 Reviewing requirements currently. Aim is to increase to ensure 2 QIS on each shift. Currently 1 per shift. **28/11/2022** At present unable to maintain two QIS on every shift. Continuing to train in-house. 1xband 7 clinical sister post advertised and filled.	Neonatal Matron	04.03.21	01.02.23	
NNWF.2.5		To make a plan not to replace nursery nurses at William Harvey Hospital over the next two years when leaving/retiring, and to instead increase registered nurse establishment to give greater versatility in workforce	Complete	**16.02.22** Following Workforce review, the plan remains to reduce non registered nursing workforce to align with recommendation to replace any further leavers with registered nursing posts. Currently at minimum level of Nursery Nurses and no plans to reduce further	Neonatal Matron	04.03.21	01.09.21	16.02.22
NNWF.2.6		To submit a business case for substantive neonatal 'hospital at home' service, to facilitate earlier discharge and to ensure robust follow-up service for high risk babies and their families leaving from our postnatal and neonatal areas	In progress (At risk/Overdue)	**16.02.22** Service set up and running at risk**.** No Business Cases are being accepted for 22/23**.** Spec Com proposal for a Kent and Medway solution. This will be submitted 15.02.22**. 28/11/2022** Service currently suspended as anticipated funding from central source is no longer available. 1.0WTE can be utilised to run neonatal outreach clinics from current nursing establishment, until further funding available. Short business case prepared for consideration at 2023/24 business planning. **Remains on local neonatal risk register.**	Neonatal Matron	04.03.21	TBC	
NNWF.2.7		To submit a business case to train six Advanced Neonatal Nurse Practitioners (ANNP) to enhance the workforce, to promote the nursing voice and to aid retention of experienced nurses on the unit. This will provide consistent ANNP presence on both sites 7days a week for 11.5hours per day	Complete	**16.02.22** 3 Trained and will be qualified by Sept 22. Putting forward 2-3 for 2022. Funding through Apprentice Levy. Need to fund backfill during training. Come out of training at 8a. Close and replaced by NNWF.2.14	Neonatal Matron		01.09.22	
NNWF.2.8		To continue to provide wellbeing support to team and to introduce weekly drop in clinical supervision sessions to optimise recruitment and retention of staff.	Complete	**16.02.22** In place every Wednesday QEQM and WHH	Neonatal Matron		Ongoing	16.02.21

NNWF.2.9		**Trust wide Neonatal Services plan: to increase specialist roles to comply with recommendations outlined by GIRFT.** **To be funded from within existing budget** - To increase education roles Trust wide. To employ a **Trust wide** band 7 infant feeding lead. To employ a Trust wide OT. To increase Trust wide physiotherapy hours. To employ a Trust wide clinical psychologist. To employ a Trust wide dietician. To provide dedicated pharmacy support to NICU WHH as a level 3 unit	In progress (On schedule)	16.02.22 Awaiting some funding establishment to be released from other roles **28/11/2022** *Education* **-** Now have one band 7 lead and one band 6 clinical skills facilitator on each site. Job description just being prepared for band 7 Clinical Nurse Educator at WHH NICU to support transition of learner's pre-intensive care course and continued development of skilled intensive care nurses post course. *Infant feeding lead* - To discuss at workforce planning meeting on 29/11/2022. *Dietician* - ad hoc support. Business case for dedicated neonatal position to be presented at 23/24 business planning rounds. *Physiotherapy* - slight increase to >1.0WTE, but requires further increase - to be presented to 23/34 business planning. *Clinical Psychology* - Additional funding (recurrent) secured from Ockenden monies (0.6WTE at 8b) To commence from March 2023. JD just being finalised. *Occupational Therapy* - 0.4WTE Band 7 OT pilot secured and employed as secondment starting Dec 2022. *Dedicated neonatal pharmacy input.* Deficit of 1.5WTE band 7 - added to risk register and to be included in business planning bid for 2023/24	Neonatal Matron		01.07.23	
NNWF.2.10		**To be funded from within existing budget -** To employ a **Trust-wide** band 6/7 research nurse.	In progress (On schedule)	**16.02.22** Additional funding available for a part time (0.2WTE) research nurse. 6 months funding currently provided from Trust research team, but will come from nursing establishment once this ceases.	Neonatal Matron		01.02.23	
NNWF.2.11		**To be funded from within existing budget** - To increase education roles Trust wide. To recruit Trust wide band 2 breastfeeding support workers.	In progress (On schedule)	**16.02.22** Scoped - to review funding options**. 28/11/2022** JD to be written and sent to banding panel	Neonatal Matron		01.02.23	
NNWF.2.12		**To be funded from within existing budget** - To increase education roles Trust wide. To employ a Quality Improvement Matron to be based at QEQM site.	Complete	**16.02.22** In post 3 January 2022	Neonatal Matron			3.01.22
NNWF.2.13		**To be funded from within existing budget** - To increase TC assistant role to 7/7.	Complete	**16.02.22** In post QEQM and going out to advert WHH **28/11/2022** Funding sourced but not yet out to advert as nursery nurses now employed for TC who can fulfill this role at weekend. Closed	Neonatal Matron		01.04.22	
NNWF.2.14		**To be funded from business case funding**: To increase to total of 9 WTE ANNP's (to allow 24/7 cover at QEQM and 12/7 cover at WHH).	In progress (On schedule)	**16.02.22** Aiming to change this action from last year to increase cover.3 Trained and will be qualified by Sept 22. Putting forward 2-3 for 2022. Funding through Advanced Skills Training budget. Need to fund backfill during training. Come out of training at 8a. **28/11/2022** 3x ANNP trainees now in clinical supervision consolidation period. Will receive final sign off by NMC in March 2023. Fourth ANNP trainee commenced training in October 2022 and will be fully signed off by March 2025. Additional recurrent funding (1.0WTE 8a) received for ANNP from central Ockenden funding.	Neonatal Matron		31.03.25	
NNWF.2.15		To be funded from business case funding: Neonatal workforce to support Transitional Care (band 5/6)	In progress (On schedule)	16.02.22 To support TC Service development-not yet scoped **28/11/2022** Planning meeting with maternity and at stage of considering JD's for neonatal nurses to support nursery nurses that have already been employed by maternity team.	Neonatal Matron		01.02.23	

NNWF.2.16		To be funded from business case funding: Band 8a Family Support Matron to take strategic leadership of outreach/bereavement and TC Trust wide.	In progress (On schedule)	16.02.22 To support strategic leadership. Idea has been scoped but funding opportunity not yet known. **28/11/2022** External funding for family support role will be made available in 2024 and therefore role adapted to cover SCBU/TC and outreach oversight. JD currently being prepared and will go out to advert in January 2023. Bereavement role being reviewed in collaboration with maternity team.	Neonatal Matron		01.03.23	
NNWF.2.17		To employ a part time Speech & Language Therapist WHH (funded from Therapies budget).	In progress (at risk/overdue)	16.02.22 - due to go out to advert shortly to fill recently vacated post. **28/11/2022** Post filled but now vacant again and recent recruitment attempts unsuccessful. JD re written and back out to advert as a training post	Neonatal Matron		01.03.23	

Workforce Calculator - ODN Input Sheet

TRUST	East Kent Hospitals University NHS Foundation Trust
UNIT	QEQM
DESIGNATION	SCU
COMPLETED BY	Melanie Mears
DATE COMPLETED	31/10/2021

COLOUR CODING

Unit to complete / update
Unit to check and correct if necessary
Summed from inputs
Calculated requirement from tool
Guidance

CURRENT UNIT STAFFING: DIRECT CARE ONLY

	WTE BUDGET	WTE IN POST	OF WHICH QIS
BAND 7	0.41	0.31	0.31
BAND 6	6.50	5.91	5.91
BAND 5	9.18	9.26	2.53
BAND 4	5.06	5.06	
BAND 3			

Numbers should be for nurses providing direct patient care on neonatal unit only.
Please **Exclude**
- transitional care staffing
- additional roles e.g. management, outreach, education, transport.
- ANNPs on tier 1 and 2 rotas

Staffing input numbers (for CRG tool)

	Budget	In post	Calculated requirement
Total QIS	9.44	8.75	12.32
Total non QIS	6.65	6.73	5.28
Total non reg	5.06	5.06	3.45
Total	**21.15**	**20.54**	**21.06**

This is calculated from the input figures above and used in the tool.
Budget for QIS nurses is calcuated as budget for band 7 and band 6 plus QIS in post for band 5.
The requirement is the output from the tool based on activity and BAPM ratios.
A supernumerary nurse in charge is included in the calculations for all shifts.

Other STAFFING: NOT DIRECT CARE

	WTE BUDGET	WTE IN POST	Comments. Please
Nurse management	1.00	1.00	1.0W
Practice educators			
Research			
Family intergrated care			
Outreach	0.40	0.40	0.4WTE Band 5 outreach
Feeding			
Bereavement			
Other (please state)			

Note: This not required by the tool but may inform workforce and funding decisions
These nurses should NOT be included in the direct care figures above.

COTS	**DECLARED COTS**	**Average occupied cots**	**Calculated requirement**
NICU	0	0.1	1
HDU	2	0.7	1
SCBU	10	6.1	7
TOTAL	12	6.9	9

ANNUAL CARE LEVEL DAYS.

HRG 2016	Total CARE DAYS (3 years)		3 year average
HRG 1	107	IC (HRG 1)	36
HRG 2	786	HD (HRG 2)	262
HRG 3	5245	SC (HRG 3-5)	2216
HRG 4	582		
HRG 5	822		
Total	7542		2514

These are ODN figures for your declared cots. If they are wrong please correct.
Average occupied is calculated from the care day info across 3 years.
Requirement is calculated by tool at 80% occupancy

These are average care days by HRG16 across 2018/19, 2019/20 and 2020/21 from badgernet where the ward location was coded as NNU.
Transitional care and care given on postnatal ward are excluded.
For purposes of this tool all days not coded as HRG16 1 or 2 are counted as special care.
If you believe figures should be significantly different please contact j.bobby@nhs.net

Neonatal Nurse Staffing Workforce Plan for 2022 for QEQM SCBU

Aim 1: to increase total QIS to required 12.3 WTE - external recruitment of QIS staff has not been successful and therefore continuing with 'grow your own' strategy. There is one nurse currently on the QIS course, due to complete by September 2022 leaving a deficit of 2.5WTE. Plan to send 1-2 nurses on QIS training in September 2022. Anticipated trajectory for compliance with recommendation - September 2024.

Aim 2: to reduce non registered nursing workforce to align with recommendation - To replace any further leavers with registered nursing posts.

Trustwide Neonatal Services plan: to increase specialist roles to comply with recommendations outlined by GIRFT.

To be funded from within existing budget - To increase education roles Trustwide. To employ a Trustwide band 7 infant feeding lead. To employ a Trust-wide band 6/7 research nurse. To recruit band 2 breasfeeding support workers. To employ a Quality Improvement Matron to be based at QEQM site. To increase TC assistant role to 7/7.

To be funded from business case funding: To increase to total of 9 WTE ANNP's (to allow 24/7 cover at QEQM and 12/7 cover at WHH).

Neonatal workforce to support Transitional Care (band 4/5). Band 8a Family Support Matron to take strategic leadership of outreach/bereavement and TC Trustwide.

To be supported by business case or by Specialist Commissioning: Neonatal outreach/hospital at home service to become substantive.

Neonatal Nursing Workforce Tool (2020): QEQM

Input unit details			
Trust	East Kent Hospitals University NHS Foundation Trust		
Unit	QEQM		
Designation	SCU		
Completed by	Melanie Mears		
Date completed	31/10/21		
Activity period	3 year average apr 2019- mar 2021	n period	365

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	36	0
HRG 2 (HD)	262	2
HRG 3 (SC)	2,216	10
Total	**2,514**	**12**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	9.44	8.75
Total Non QIS	6.65	6.73
Total Non Reg	5.06	5.06
Total	**21.15**	**20.54**

Activity (HRG 2016)

	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	36	*0.1*	*6.07*	0		1	-1
HRG 2	262	*0.9*	*3.04*	2	35.89%	1	1
HRG 3	2,216	*7.6*	*1.52*	10	60.71%	7	3
Total	**2,514**			**12**	**57.40%**	**9**	**3**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY

NB total nurse staffing required to staff declared cots = 27.32, of which 19.12 (70%) should be QIS

	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	21.15	####	21.06	0.09	-0.52
Total reg nurses	16.09	####	17.60	-1.51	-2.12
Total QIS	9.44	8.75	12.32	-2.88	-3.57
Total non-QIS	6.65	6.73	5.28	1.37	1.45
Total non-reg	5.06	5.06	3.45	1.61	1.61
Reg nurses as % nursing staff	76.1%	####	83.6%		
QIS as % reg nurses	58.7%	####	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Workforce Calculator - ODN Input Sheet

TRUST	East Kent Hospitals University NHS Foundation Trust
UNIT	William Harvey
DESIGNATION	NICU
COMPLETED BY	Melanie Mears
DATE COMPLETED	31/10/2021

COLOUR CODING

Unit to complete / update
Unit to check and correct if necessary
Summed from inputs
Calculated requirement from tool
Guidance

CURRENT UNIT STAFFING: DIRECT CARE ONLY

	WTE BUDGET	WTE IN POST	OF WHICH QIS
BAND 7	6.78	5.78	5.78
BAND 6	23.66	19.76	19.76
BAND 5	31.43	30.82	6.65
BAND 4	5.45	3.37	
BAND 3			

Numbers should be for nurses providing direct patient care on neonatal unit only.
Please **Exclude**
- transitional care staffing
- additional roles e.g. management, outreach, education, transport.
- ANNPs on tier 1 and 2 rotas

Staffing input numbers (for CRG tool)

	Budget	In post	Calculated requirement
Total QIS	37.09	32.19	46.72
Total non QIS	24.78	24.17	12.59
Total non reg	5.45	3.37	5.39
Total	**67.32**	**59.73**	**64.70**

This is calculated from the input figures above and used in the tool.
Budget for QIS nurses is calcuated as budget for band 7 and band 6 plus QIS in post for band 5.
The requirement is the output from the tool based on activity and BAPM ratios.
A supernumerary nurse in charge is included in the calculations for all shifts.

Other STAFFING: NOT DIRECT CARE

	WTE BUDGET	WTE IN POST	Comments. Please
Nurse management	2.00	2.00	1.0 WTEBand 8a N
Practice educators	1.92	1.92	1.0 WTE Band 7 PDN, 0.92 WTE Band 6 Clinical Skills Facilitator
Research	0.40	0.40	0.2WTE Band 7, 0.2WTE Band 6
Family intergrated care	0.92	0.92	0.92WTE Band 7 SCBU co-ordinator
Outreach	3.02	3.02	1.0WTE Band 7 outreach co-ordinator, 0.61WTE Band 6
Feeding			not dedicated roles
Bereavement			not dedicated roles
Other (please state)	3.68	3.68	1.0 WTE Band 7, Clinical Technologist, 2.68 WTE Band 7 ANNP

Note: This not required by the tool but may inform workforce and funding decisions
These nurses should NOT be included in the direct care figures above.

COTS	DECLARED COTS	Average occupied cots	Calculated requirement
NICU	7	3.4	5
HDU	4	3.9	5
SCBU	14	9.5	11
TOTAL	25	16.8	21

ANNUAL CARE LEVEL DAYS.

HRG 2016	Total CARE DAYS (3 years)		3 year average
HRG 1	3720	IC (HRG 1)	1240
HRG 2	4294	HD (HRG 2)	1431
HRG 3	8497	SC (HRG 3-5)	3460
HRG 4	906		
HRG 5	978		
Total	18395		6131

These are ODN figures for your declared cots. If they are wrong please correct.
Average occupied is calculated from the care day info across 3 years.
Requirement is calculated by tool at 80% occupancy

These are average care days by HRG16 across 2018/19, 2019/20 and 2020/21 from badgernet where the ward location was coded as NNU.
Transitional care and care given on postnatal ward are excluded.
For purposes of this tool all days not coded as HRG16 1 or 2 are counted as special care.
If you believe figures should be significantly different please contact j.bobby@nhs.net

Neonatal Nurse Staffing Workforce Plan for 2022 for WHH NICU

Aim 1: to increase total QIS to required 46.7 WTE - external recruitment of QIS staff has not been successful and therefore continuing with 'grow your own' strategy. There are three nurses currently on the QIS course, due to complete by September 2022 leaving a deficit of 11.5WTE. Plan to send 4 nurses on QIS training in September 2022. Anticipated trajectory for compliance with recommendation - September 2024.

Aim 2: to reduce non QIS registered nursing workforce to align with recommendation - To support all new band 5 starters to attend the QIS training within 12-18months of start date.

Trustwide Neonatal Services plan: to increase specialist roles to comply with recommendations outlined by GIRFT.

To be funded from within existing budget - To increase education roles Trustwide. To employ a Trustwide band 7 infant feeding lead. To employ a Trust-wide band 6/7 research nurse. To employ Trustwide band 2 breast feeding support workers. To increase TC assistant role to 7/7.

To employ a part time Speech & Language Therapist (funded from Therapies budget). To employ a Quality Improvement Matron to be based at QEQM site (funded from Child Health Matron budget).

To be funded from business case - expansion of ANNP workforce to total of 9 WTE (to allow 24/7 cover at QEQM and 12/7 cover at WHH).

Neonatal workforce to support Transitional Care (band 4/5). Band 8a Family Support Matron to take strategic leadership of outreach/bereavement and TC Trustwide.

To be supported by business case or by Specialist Commissioning: Neonatal outreach/hospital at home service to become substantive.

Neonatal Nursing Workforce Tool (2020): William Harvey

Input unit details			
Trust	East Kent Hospitals University NHS Foundation Trust		
Unit	William Harvey		
Designation	NICU		
Completed by	Melanie Mears		
Date completed	31/10/21		
Activity period	3 year average apr 2019- mar 2021	n period	365

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	1,240	7
HRG 2 (HD)	1,431	4
HRG 3 (SC)	3,460	14
Total	**6,131**	**25**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	37.09	32.19
Total Non QIS	24.78	24.17
Total Non Reg	5.45	3.37
Total	**67.32**	**59.73**

Activity (HRG 2016)

	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	1,240	*4.2*	*6.07*	7	48.53%	5	2
HRG 2	1,431	*4.9*	*3.04*	4	98.01%	5	-1
HRG 3	3,460	*11.8*	*1.52*	14	67.71%	11	3
Total	**6,131**			**25**	**67.19%**	**21**	**4**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY

NB total nurse staffing required to staff declared cots = 81.95, of which 57.37 (70%) should be QIS

	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	67.32	####	64.70	2.62	-4.97
Total reg nurses	61.87	####	59.31	2.56	-2.95
Total QIS	37.09	####	46.72	-9.63	-14.53
Total non-QIS	24.78	####	12.59	12.19	11.58
Total non-reg	5.45	3.37	5.39	0.06	-2.02
Reg nurses as % nursing staff	91.9%	####	91.7%		
QIS as % reg nurses	59.9%	####	78.8%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATERNITY SERIOUS INCIDENTS (SI): Q2 SUMMARY REPORT**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER (CNMO): MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**				
PAPER AUTHOR:	**INTERIM DEPUTY HEAD OF MIDWIFERY AND GYNAECOLOGY FOR GOVERNANCE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The purpose of this report is to summarise the number of Serious Incidents (SI) and initial key learning points within the maternity service.				
Summary of Key Issues:	Key issues for discussion with, and to bring to the attention of the Board of Directors: **2022/23 Quarter 2 summary** Between July and September 2022, 10 SIs were declared. 6 occurred at William Harvey Hospital (WHH) and related to maternity clinical care, 1031 babies were delivered in Q2. 4 occurred at Queen Elizabeth the Queen Mother Hospital (QEQM) where 638 babies were delivered in Q2. 2 SIs met the criteria for referring to Healthcare Safety Investigation Branch (HSIB) who are undertaking investigations. It should be noted that cases referred to HSIB are automatically declared as an SI. Some key learning themes have been highlighted relating to the use of clinical assessment tools (Maternity Emergency Obstetric Warning Score (MEOWS)), completion and documentation of Holistic Assessment, senior clinical oversight and management of care, handover and escalation of care and pain relief for women. This work flow is being prioritised with key resources allocated. A key risk for the Trust is the capacity and competency within the care group to complete root cause analysis (RCA) investigations in a timely manner to understand what went wrong and reduce the risk of recurring harm.				
Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** and **DISCUSS** the contents of the report; 2. **NOTE** the recurring themes that have been identified and the actions that are being taken; 3. **NOTE** the key risk raised in relation to capacity and competency to complete RCAs and the alternatives that are being explored to address the issue.				

East Kent Hospitals University NHS Foundation Trust

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

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.	
Resource:	*Y*	
Legal and regulatory:	*Y*	Clinical Negligence Scheme for Trusts (CNST), NHS Long Term Plan, Ockenden, Care Quality Commission (CQC)
Subsidiary:	*N*	
Assurance Route:		
Previously Considered by:	**Women's Health Governance Meeting 25/11/22**	

East Kent Hospitals University NHS Foundation Trust

MATERNITY SI REPORT FOR Q2 2022/23

1. Purpose

The purpose of this report is:

1.1 To report to the Board of Directors the progress with identifying, investigating and learning from SIs.

1.2 To highlight risks in investigating and implementing improvements within external reporting timeframes and describe the next steps to address.

1.3 To comply with the requirements of the Immediate and Essential Actions set out in the Ockenden Report, that a summary of the Trust's maternity SI and Healthcare Safety Investigation Branch (HSIB) reports will be provided to the Trust Board.

2. Overview of Serious Incidents identified in Q2

2.1 SI as defined by the NHS Serious Incident Framework can broadly be an event in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

2.2 In Q2, 10 SIs were declared and currently no investigations have been completed.

6 SIs occurred at WHH where 1031 babies were delivered. The cases related to:

- Neonatal resus (1)
- Still birth (2)
- One baby born needing therapeutic cooling in NICU (1) – being investigated through HSIB
- One baby requiring an unexpected admission to SCBU (1)
- Care of the preterm (1).

4 SI's occurred at the QEQM where 638 babies were delivered, the cases included:

- One baby born needing therapeutic cooling in NICU (1) – being investigated through HSIB
- MOH hysterectomy (1)
- Early Pregnancy care (1)
- Care of the preterm (1)

2.3 The Incidents workstream of the Maternity Improvement Plan is monitoring the actions for completed SI, HSIB and Perinatal Mortality Review Group.

2.4 The details for each of the SIs are provided in the table on page 5.

3.0 Key risks and next steps

3.1 The investigation reports for the SIs in Q2 have not been finalised making it difficult to establish key learning and embedding any changes needed, however immediate actions are highlighted through the 72-hour process. Our SIs are complex and usually involve several members of the Multi-Disciplinary Team (MDT) and external stakeholders at different stages of the woman's pathway. Gaps in the

Maternity Governance Team, and the availability of key clinicians have impacted on both the quality and timeliness of investigations. The interim support that was provided through an agency ended and the team are currently out to advert for the substantive role. The capacity and competency to complete root cause analysis (RCA) investigations in a timely manner needs to be strengthened, to prevent and reduce the risk of recurring themes resulting in unsafe care for women.

3.2 Some of the key learning themes have been highlighted through the 72-hour reviews around MEOWS, documentation of Holistic Assessment, Situation, Background, Assessment, Recommendation (SBAR) and pain relief for women. These themes have been prioritised within the key priorities thematic action plan. The oversight of this plan is reported through the maternity and neonatal assurance group.

3.3 SI MDT panels with external expertise are being supported by NHS England (NHSE) colleagues whilst a permanent solution is sought. Panels are ongoing planned until the end of the year.

3.4 The rapid review process has continued with the MDT. The process has enabled early review of key incidents and implementation of key learning. The rapid review process is now established into practice and well attended.

3.5 Within the care group the process of the submission of STEIS wording and 72-hour reports has been tightened to ensure reporting within the recognised time frame. The quality of our submitted reports has been formally recognised within the Local Maternity and Neonatal System (LMNS).

3.6 Work has been completed to further strengthen the process around HSIB and action plan development, there has been a large project to review the management of the backlog of HSIB cases received by the Service. The backlog of final DOC process is currently being managed. There has been very productive MDT engagement to develop the action plans and are currently reviewing our systems for the development of oversight of action plans going forward which will be inclusive of the positive findings of the reports.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME DECLARATION PROCESS AND OCTOBER 2022 GUIDANCE CHANGES**
MEETING DATE:	**8 DECEMBER 2022**
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER (CNMO): EXECUTIVE BOARD MATERNITY & NEONTAL SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY IMPROVEMENT & TRANSFORMATION MANAGER**
APPENDICES:	**NONE**

Executive Summary:					
Action Required:	**Decision**	Approval	Information	Assurance	Discussion
Purpose of the Report:	• To provide an update on the October CNST Year 4 Guidance changes. • To provide clarity to the Trust Board on the conditions and process for CNST Maternity Incentive Scheme Year 4 Declaration and submission to NHS Resolution (NHSR). • To seek agreement around a process of evidence review and subsequent presentation of position to the Trust Board and Chief Executive Officer (CEO) to enable decision making on declaration position against each safety action and associated standards.				
Summary of Key Issues:	• New CNST Maternity Incentive scheme guidance was received by Trusts 11 October 2022. • Timelines for the declaration submission have been delayed from 5 January to 2 February 2023. • Key changes include bringing forward timelines for collection of data, for Safety Actions 2, 4, 5, 7, 8 and 9, from 5 January 2023 to 5 December 2022. • This revised timeline puts the Trust at greater risk of achieving Safety Action 8-Maternity Training standard compliance. • Training compliance of 90% of all relevant staff groups is further put at risk by removing the 18-month compliance period and replacing with 90% compliance which needs to be demonstrated across 12 consecutive months within the reporting period of August 2021 and 5th December 2022. • Further clarification of the definition of supernumerary status (Safety Action No:5) has been provided. It includes that where these situations are breeched then a mitigating action plan will now not allow compliance to be declared. • Clarity is provided around element 2 of the Saving babies Lives Care Bundle standards and how to demonstrate risk assessments of growth restriction following the booking risk assessment and how to evidence this is in place. • Perinatal Mortality Review Tool (PMRT): ai) surveillance period breached for reporting commencement of investigation at 2 months. • Under the NHSR Maternity Incentive Scheme (MIS) guidance, in addition to demonstrating the achievement of the 10				

East Kent Hospitals University NHS Foundation Trust

	maternity safety actions, it must also declare that there are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to the Trust's declaration. All such reports should be bought to the MIS team's attention before Thursday 2 February 2023. The Board are asked to consider the following to reports in line with this: • ***Independent Inquiry into Maternity Services at East Kent*** • ***Care Quality Commission (CQC) Inspection report October 2021 Maternity services, following the July 2021 inspection*** The CQC report from the July inspection, in particular highlights staffing levels.
Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** in the minutes that Guidance change and Declaration process paper has been received; 2. **NOTE** the risks included within the report and the likelihood that the Trust will not be in a position to submit a compliant declaration; 3. **NOTE** that an action plan will be completed for areas of noncompliance, describing position and mitigations to improve; 4. **APPROVE** the request for the MIS team to be contacted before Thursday 2 February 2023 to advise that there are two reports that relate to the provision of maternity services that may provide conflicting information to our declaration; and 5. **APPROVE** the proposed evidence review process with the findings and agreed compliance position presented to the Board of Directors in the Board declaration and joint submission by the Director of Midwifery and Clinical Director in January 2022.
Implications:	
Links to 'We Care' Strategic Objectives:	

Women and Families	Our people	**Our future**	**Our sustainability**	**Our quality and safety**

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

	CRR 2742: (on neonatal RR) There is a risk that the Trust will not be able to provide responsive post bereavement care to bereaved parents in neonatal areas.	
Resource:	N	
Legal and regulatory:	Y	NHSR, CNST, Ockenden.
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	Maternity and Neonatal Assurance Group (MNAG)	

East Kent Hospitals University NHS Foundation Trust

CNST MATERNITY INCENTIVE SCHEME DECLARATION PROCESS AND OCTOBER 2022 GUIDANCE CHANGES

1. The purpose of report

1.1 To provide an update on the October CNST Year 4 Guidance changes.

1.2 To provide clarity to the Board of Directors on the conditions and process for CNST Maternity Incentive Scheme Year 4 Declaration and submission to NHS Resolution.

1.3 To seek agreement around a process of evidence review and subsequent presentation of position to the Board of Directors to enable decision making on declaration position against each safety action and associated standards.

2. CNST Year 4 Safety Action Guidance Changes

2.1. The date for Trusts to submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) has changed from 5 January to 12 noon on Thursday 2 February 2023.

2.2. Safety Action 2 changes the date for the Digital Strategy approval from 'by October' to 31 October 2022. East Kent Maternity Strategy has been through internal Governance and is now waiting for Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB) sign off.

2.3. Safety Actions 2 (Maternity Service Data Sets), Safety Action 4 (Clinical Workforce), Safety Action 5 (Midwifery Workforce), Safety Action 7 (Maternity Voices Partnership (MVP) Workplan and Coproduction), Safety Action 8 (Training) and Safety Action 9 (Assurance to the Board on maternity and neonatal safety and quality issues) have all had timelines for delivery brought forward from 5 January to 5 December. This creates the greatest risk to delivery of the training compliance standard.

2.4. Safety Action 5, midwifery workforce includes greater detail on how Supernumerary status should be defined:

> ***The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.***
>
> ***Supernumerary status will be lost if the labour ward coordinator is required to be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.***
>
> ***As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 4 of MIS.***

Work is underway to ensure there is clear understanding by relevant staff and recording of supernumerary status.

2.5. Safety Action 6, Saving Babies Lives (SBL) Care Bundle has given further guidance regarding element 2 of the SBL care bundle V2-risk assessments completed following the 20-week scan.

> ***It should be appreciated that some women will develop additional risk factors after the booking appointment such as significant bleeding or risk factors that will only be evident after the mid trimester anomaly scan, such as echogenic bowel or EFW <10th centile. When these risk factors are identified their clinical pathway will change as per SBLCBv2 Figure 6 in Appendix D. If a Trust chooses to meet this standard using an electronic audit which is unable to capture risk factors after booking then the Trust should include a brief description of how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. There will be a variety of ways Trusts choose to do this, but what is important is that women with these risk factors receive the appropriate care.***

The Trust does not have an electronic process to capture the risk assessment following booking and so the guideline is to be updated to clearly describe the escalation process for risk factors occurring after booking.

2.6. Safety Action 8, Maternity Training standard has been altered from allowing an 18-month compliance period to be included, in acknowledgement of Covid workforce pressures, to now assessing compliance based on the proportion of staff trained in 12 consecutive months within the reporting period of August 2021 and 5 December 2022. 90% compliance should be demonstrated by the end of the 12-month period.

2.7. This change has meant that we will be unable to meet training compliance across all staff groups, if further steps are not taken. There are two main area of concern, one is related to attendance of medical staff which has been highlighted and is being addressed, the other is around Anaesthetic Staff attendance which has not been resolved.

3. Maternity incentive scheme year four: conditions

3.1. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2 February 2023 and must comply with the following conditions:

3.1.1. Trusts must achieve all ten maternity safety actions.

3.1.2. The declaration form is submitted to Trust Board with an accompanying joint presentation detailing **position and progress** with maternity safety actions by the **Director of Midwifery/Head of Midwifery and Clinical Director** for Maternity Services.

3.1.3. The Board declaration form must be signed and dated by the **Trust's Chief Executive Officer** (CEO) to confirm that:

- The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
- There are no reports covering either year 2021/22 or 2022/23 that relate to the

provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 2 February 2023.

3.1.4. The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

3.1.5. In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is appraised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

*Note: Clinical Commissioning Group (CCG) functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations July 2022.

3.1.6. Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

3.1.7. The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

3.1.8. NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirms compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.

3.1.9. NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

4. Evidence for submission

4.1. The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.

4.2. Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.

4.3. The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission.

4.4. Trusts will need to report compliance with MIS by Thursday 2 February 2023 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.

4.5. The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

4.6. Only for a set amount of safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

4.7. The declaration form will be available on the MIS webpage at a later date.

4.8. Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date.

5. For Trusts who have not met all ten safety actions

5.1. **Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progres**s. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 2 February 2023 to NHS Resolution (nhsr.mis@nhs.net). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.

6. Evidence Review Panel Meetings

6.1. Following the completed process for CNST Year 3 evidence review, there is a plan to submit all evidence against the CNST Safety Action 4 Standards through an evidence review panel during November and December.

6.2. Dates are being agreed with the key stakeholders of Chief Nursing and Midwifery Officer, Interim Director of Midwifery, Clinical Director, Deputy Operations Director and Governance leads.

6.3. Evidence will be reviewed in advance of meetings to maximise focussed conversations during the meeting and identification of areas where evidence needs to be strengthened to provide greater assurance and agree compliance status.

6.4. The findings and agreed compliance position will then be presented to the Trust Board in the Board declaration and joint submission by the Director of Midwifery and Clinical Director.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INTEGRATED PERFORMANCE REVIEW (IPR)**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF FINANCE OFFICER (CFO)**				
PAPER AUTHOR:	**CHIEF FINANCE OFFICER**				
APPENDICES:	**APPENDIX 1: OCTOBER 2022 IPR**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Trust has been engaged with a quality improvement programme called "We Care". The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep). This report is updated for the key metrics that the Trust will focus on in 2022/23.				
Summary of Key Issues:	The attached IPR is now ordered into the following: **True Norths-** These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years it may be that the targets are not met immediately and it is important to look at longer term trajectories. The areas are: • our **quality and safety.** The two metrics the Trust has chosen to measure against incidents with harm and mortality rate. • our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) over 12-hour target, the Referral to Treatment (RTT) 18-week target and the Friends and Family recommended %. • our **people.** The one metric chosen is for staff engagement. • our **sustainability.** The two metrics chosen to improve are the Trust's financial position and carbon footprint. • our **future.** The two metrics chosen are the medically fit for discharge % and virtual outpatients usage. **Breakthrough objectives-** These are objectives that we are driving over the next year and are looking for rapid improvement. The four key areas are: • **Improving theatre capacity.** The lost theatre opportunities in month was 43 which is worse than the 25 target and is 2 better than last month. Cancellations on day also had a slight decrease from 167 in August to 157 in September. • Elective Orthopaedic Centre (EOC) has focused on increasing productivity by holding a multidisciplinary 6-4-2 booking meeting. This has improved both booked and actual performance. The planned booking for the EOC has increased during the month from 87.7% to 93.5%. The actual performance has improved from 81.4% to 87.8%.				

	• Implementation of 6-4-2 booking commenced from 3rd October which enable specialities to focus on booking ahead to maximise opportunity and improve patient experience. • To facilitate further improvement there are a number of measures that have been implemented, with further actions: • The Trust is optimising scheduling opportunities with the booking teams. This includes awareness of individual targets and discrepancies between planned and actual utilisation. October booking performance Trust-wide was 87.6% which was an increase of 0.5% on last month. Actual theatre occupancy was 79.4% which was an increase of 1.3% on the previous month. • Late starts were a focus for General Surgery in September where it was identified that delays were due to Intensive Therapy Unit (ITU) bed confirmation. The action was to add a small case first on the list; as a result, there has been a 1% improvement in October. • Urology and General Surgery are focusing on creating standby patients to reduce cancellations on the day by increasing pre-assessment pool. • The theatre optimisation group meets fortnightly led by the Surgery & Anaesthetic leadership team. This group is focusing on the development of Standard Operating Procedures (SOPs) regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. • **Same Day Emergency Care (SDEC) Admissions.** The SDEC activity across all services saw a decrease in the number of attendances in October 2022 (1,909 v 2007 September 22). SDEC remains an area that is not used for escalation inpatient beds. The principle of using the same day emergency care space for direct access and same day care exclusively enables patient access and flow to be maintained. 75% of patients who use the SDEC service are not admitted. • The Direct Access Pathway/SDEC workstream, is working on delivering an extended SDEC model for winter Patients with long term conditions attending Emergency Department (ED) require the support of an integrated approach with community clinicians and acute hospital specialists. This opportunity is being developed as part of the winter planning programme with Kent Community Health NHS Foundation Trust (KCHFT). • Using the Acute Emergency Care (AEC) directory and analysing further opportunities to increase numbers through the SDEC medical pathway has been completed and plans are in progress to extend the William Harvey Hospital (WHH) SDEC to 23.00 hours 7 days a week from the 1 December. • Work in place to review the changes to the hours of the Queen Elizabeth the Queen Mother Hospital (QEQM)

	service to maximise the opportunity for more patients to access the service. • Due to the Operational Pressures Escalation Level (OPEL) 4 status at WHH, the extended hours SDEC model has been delivered from the 14 November. Tracking and monitoring of activity and benefits in place as part of the wider Urgent Emergency Care (UEC) workstream • The creation of 4 'Hot Slots' for referral into SDEC the next day commenced from 14 November. The aim is to provide the ability for clinicians to discharge patients who attend out of hours to return to a booked slot the next day. Monitoring is in place. • Integrated SDEC pathways pilot commenced in October for 111 to direct South East Coast Ambulance Service (SECAmb) to ensure patients can access to the SDEC service. The aim is to increase the slots to maximise the use of the ambulatory pathways. • Work progressing on the development of the Medical Day Unit at Canterbury to realise further opportunity to manage more patients from across the sites reducing the impact on capacity. • The focus for this month is to extend SDEC at WHH until 23.00 hours 7 days a week with a key focus on developing the SDEC and Direct Access models to optimise these pathways and establish a defined clinical model for the future. This is highlighted in the winter plan. • **Staff Involvement.** The current staff involvement score has remained at 6.28 in month with an aim to reach 6.8 by the end of 2022/23. • 20 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology, with a further 16 planned before the end of November. • The We Care rollout has been extended beyond the 20 'units' surveyed in July as part of the National Quarterly Pulse Survey (NQPS) and will also include Urology and Cardiology. • Two of the priority areas identified as part of the National Staff Survey data review (those with the lowest scores for involvement) are completing KENT Fundamentals in September. • The new staff intranet has been reviewed and can provide; sentiment analysis, target pulse surveys and an online suggestion area, the effectiveness of which will be piloted. • An 'Involvement Toolkit' is being finalised to provided support at team leader, speciality and Care Group level throughout the National Staff Survey (NSS). • **Premium Pay costs.** The Trust spends £87m per annum on premium pay with an aim to reduce this by 10% over the year. In October 2022 premium pay spend has decreased by £0.4m. The drop is mainly related to the pay award back pay being paid in September. • The Executive team are continuing their focus in this area as this is a key contributor to the financial position.

	• Key Interventions include:
	  • Formalising and strengthening the weekly premium pay meeting.
	  • Detailed focus by Care Groups on drivers of premium pay. Premium pay deep dives occurring through September.
	  • Review of bank, agency and overtime rates across all staff groups.
	  • Ensure improved sign off processes and governance across the Trust.
	  • Recruitment to key clinical posts to reduce the need for temporary staffing.
	
	Watch Metrics - these are metrics we are keeping an eye on to ensure they do not deteriorate.

Key Recommendation(s):	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

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

Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered **.** **BAF 34**: There is a risk that our constitutional targets are not met. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19.	
Link to the Corporate Risk Register (CRR):	**CRR 77:** There is a risk of failure to provide adequate maternity services to women and their families. **CRR 78:** There is a risk of overcrowding in ED due to a lack of capacity in the system and increased local demand.	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	Y	Working through with the subsidiaries their involvement and impact on We Care.
Assurance Route:		
Previously Considered by:	None	

NHS
East Kent
Hospitals University
NHS Foundation Trust

Integrated Performance Report

October 2022

We care

Our vision, mission and values

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

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

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

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

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

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

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

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

What is the Integrated Performance Report (IPR)?

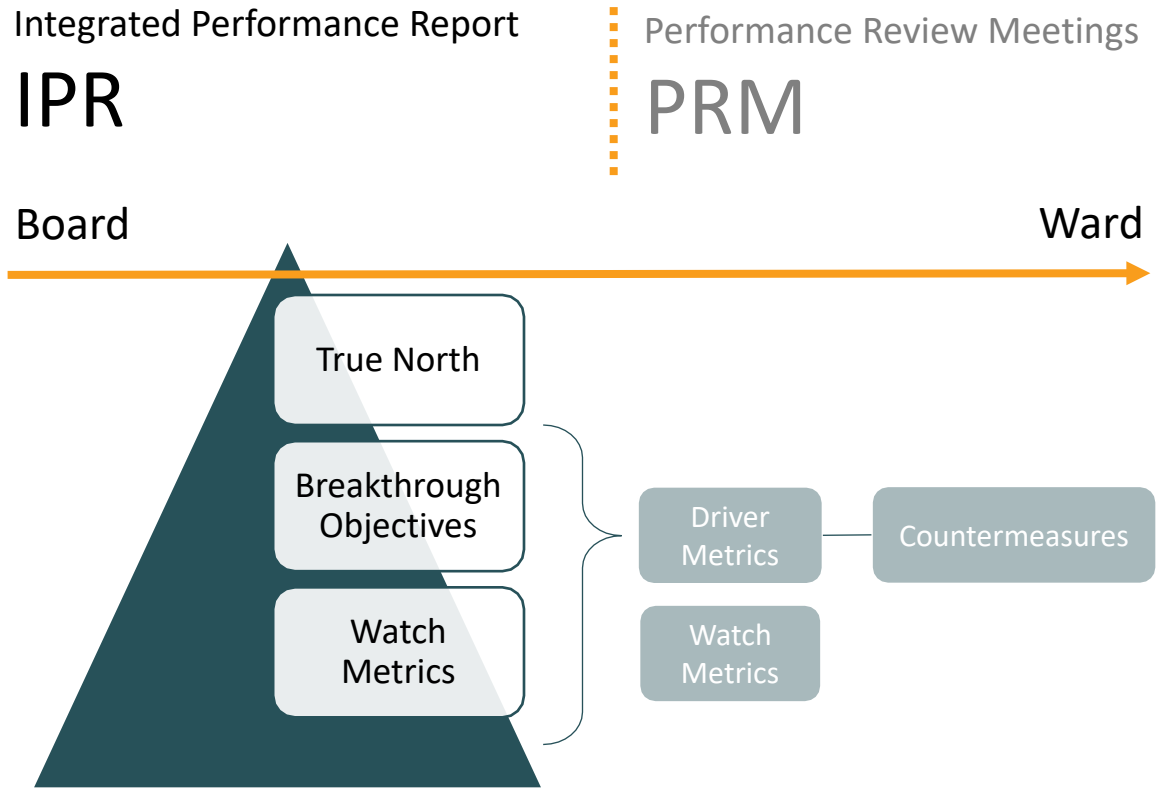
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing Patient Safety Incidents resulting in harm
- Reducing time spent in our ED Departments
- Improving theatre capacity
- Improving our Staff Involvement Score
- Reducing Premium Pay Spend

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

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

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



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2022/23. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

NHS Improvement SPC icons

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

Where to find them

What are the Business Rules?

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

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

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

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

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

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

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

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

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

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
97.4	92.3	89.3	88.1	86.9	88.2	89.1	90.4	90.8			

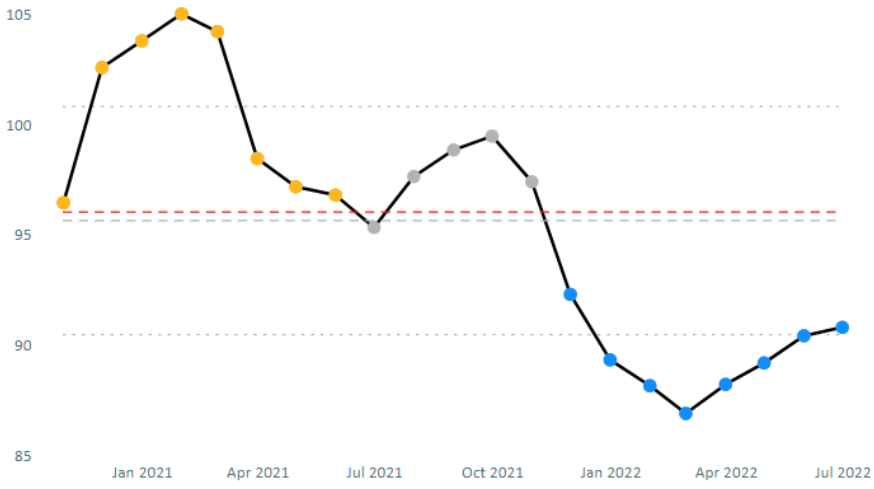
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The Trust HSMR remains below the lower control limit showing 'special cause variation of improving nature'. The metric demonstrates a 12 month rolling position to July 2022 which is the last data release. At time of reporting this remains 'lower then expected.'

From last month the Trust has maintained its position now lying 16th out of the 121 acute non-specialist Trusts on the Telstra Health platform.

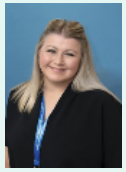
Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. A Trust Priority Improvement Project (TPIP) is underway for 2022/23 to support driving this at WHH and QEQM sites
- Current 12 month rolling HSMR for fractured neck of femur patients is 93.7 (to July 2022) and is now 'as expected'.
- Mortality metrics continue to be reported and discussed at monthly Mortality Surveillance Group and intelligence used to drive deep dives into pathways where indicated.
- There were no new alerts for this month
- Work continues to dive into the biliary tract disease alert reported last month

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk with the national baseline not stabilised.

Our quality and safety



Sarah Shingler

Incidents with Harm

The True North target is to achieve zero patient safety incidents of moderate and above avoidable harm within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. **Our target for the next 12 months is to reduce avoidable harm incidents of moderate harm and above to no more than 26 incidents per month by March 2023 (5% reduction).**

The breakthrough objective will be to reduce all patient safety harm incidents with a harm severity score of moderate and above, this will be achieved through the Fundamentals of Care and Patient Voice and Involvement workstreams.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
14	28	26	29	25	21	13	21	31	22	32	40

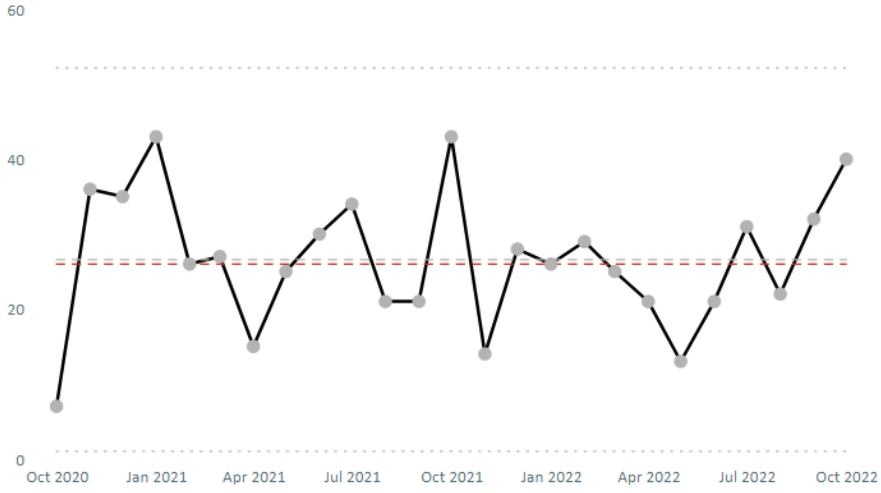
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 40 incidents in October, which continues to be above threshold. The highest contributors to harm for the second month were care/treatment with 12 harm incidents, which is an increase from the previous month, delay/failure was the second highest with 7 incidents and this is again an increase. The third highest contributor were pressure ulcers with 4 harm events but this is the first time in over 6 months that pressure related incidents have caused moderate harm to our patients, 2 of these incidents are directly linked to patients in ED with a length of stay over 24 hours. For the last 7 months care/treatment and delay/failure have both featured in the top three highest contributors. There have been no moderate harm or above incidents related to falls during October.

Intervention and Planned Impact

The Deputy CMO and corporate governance team are supporting with reviewing care/treatment and delay/failure categorisation of incidents and themes. These vary but are mostly delayed diagnosis for patients on the cancer pathway and delays in initiating the correct urgent referral and treatment pathway in ophthalmology patients. Recognition and escalation of the deteriorating patient and failure to implement Treatment Escalation Plans (TEP.) A decision was taken by the CMO in November to have an in depth review by the site triumvirates to determine the site based themes and these will be reported to the December Patient Safety Committee for action. A priority will be to review the deteriorating patient pathway and auditing sepsis screening compliance.

Safe staffing and our current capacity challenges continue to be a factor contributing to patient harm, we continue to see a direct correlation between low staffing levels and harm and this has continued throughout the previous months. Our full capacity policy has continued to be initiated and we have remained in OPEL 3/4 escalation for extended periods. Length of stay in our EDs continued to increase and we reported significant 12 hour trolley breaches. Escalation areas continued to be utilised due to high numbers of patients being cared for in corridors and other non-clinical areas. Both ED's are reporting into the Fundamentals of Care (FOC) committee on their harm events and compliance with the corridor escalation SOP and their ability to deliver basic care to our patients. The speciality tissue viability team have an increased presence in both ED's and escalation areas to support clinically and educationally and ensure all patients have had a risk assessment and are placed on a pressure relieving device. The Trust has now purchased repose trolley mattress toppers and these are now in place in both departments. A revised and quicker risk assessment is being trialled in both ED's.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where high risk patients are cared for. Ward leaders, Matrons and Therapy teams are on the floor supporting ward teams, increasing oversight that risk assessments for pressure areas, falls and nutritional requirements are completed and reduction strategies are being used. The teams actively promoted the national "stop the pressure day" on the 17th November.

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Harm Events	W4		IPC: CDiff Infections		6	13	9	18	13
	W4		VTE Assessment Compliance		95.0%	92.4%	92.4%	94.0%	
	W4		Serious Incidents Breached		0	99	52	21	16

IPC: C diff Infections

The Trust remains above trajectory to achieve the external threshold for 2002/23. This position continues to reflect a local, regional and national change that is, as yet, unexplained. Locally we are working with the ICB to investigate risk factors for 'community onset, healthcare associated (COHA) cases, as East Kent is currently and historically above the national rate for these cases. Each hospital onset case is investigated using a Root Cause Analysis to identify learning. No cases of transmission have been identified in the reporting year to date, nevertheless existing infection prevention measures are being reinforced.

VTE Assessment Compliance

While VTE compliance remains below threshold and is driven by underperformance across three out of the six Care groups impacting on this metric, the impact of recent improvement work can be seen. This continues to be monitored through performance meetings and the Care Groups have improvement plans in place that continue. There is currently no data for October 22 due to an upgrade to the data collection system.

Serious Incidents Breached

Over the last four months there has been significant improvement in the number of breaches. There are currently 16 SIs that have breached, and they are all within Maternity Services. Of the sixteen cases there are two historical cases which have been reopened and which will be removed from this list as they are undergoing an adapted process. Two of the remaining fourteen cases breached in October 22 and there have been no further breaches since. It is the expectation within the Maternity Services that there will be no further breaches. For the remaining breaches all of these reports apart from two, have been completed and all of them are will either being signed off at the MDT meetings on either the 18th, 21st, 25th November 22, or with the Care Group for Action planning and local sign off.

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

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

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

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
61.8%	61.3%	59.6%	59.6%	60.1%	60.1%	61.1%	59.2%	59.5%	58.8%	58.3%	56.4%

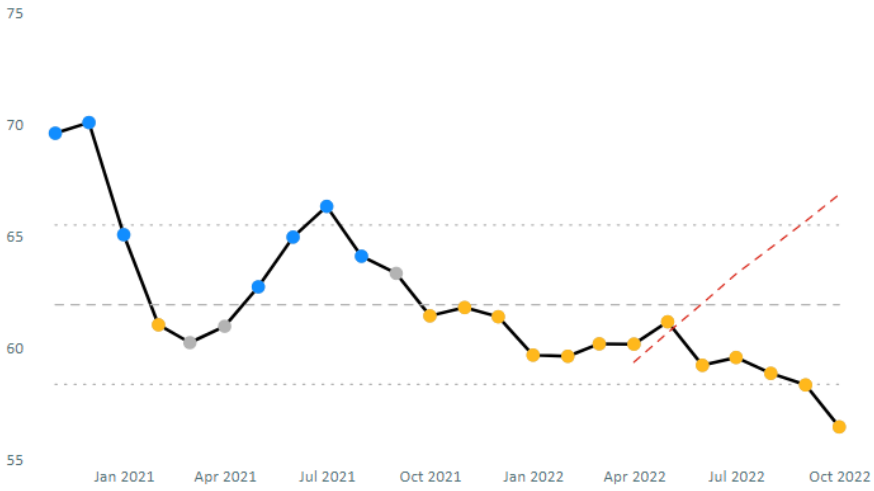
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

Over the last 6 months performance has remained static for the total waiting time however, our long waiting patients have continued to reduce. In line with other Trusts in the region EKHUFT have reduced 104w waits almost entirely with exception for patients who have contracted Covid or whom do not wish to proceed with surgery at the time. There has been good progress in addressing 78w waits which, as at the end of October, were reduced to 380. The deterioration in performance in October for the 18w standard is due to the volume of patients in month waiting in excess of 18 weeks for a first out patient appointment.

Intervention and Planned Impact

- Outpatient waiting lists continue to grow – The Trust is targeting areas of transformation to improve this element of the service. The Trust is working with the Kent and Medway System Team to develop a new approach for managing referrals in 2023/24.
- 104 week breach position has reduced from 34 in April 2022 and is now 9 as of September 2022 (due to patient choice and Covid); this risk of 104w breach is reducing rapidly as EKHUFT are treating patients earlier in their pathway to minimise the risk of the 7 week delay should a patient test positive.
- 'Super weeks' have been scheduled for orthopaedic elective surgery with a planned extension to other specialities to support the 78 week recovery plan.
- DNA rate in outpatients has reduced from 11% to 7.8% and focussed work continues to increase the volume of patients fully booked to improve the DNA rate further.
- Increasing volume of patients are accepting transfer to alternate providers across East and West Kent for elective assessment and/or treatment.
- Recruitment of Theatre Operating Department Practitioners, Administration Booking Staff and Radiology Staff remains a key priority to enable the recover of our outpatient, diagnostic and elective services.
- Improving the efficiency and productivity metrics across all diagnostic and elective services continues to be key feature in our recovery journey.

Risks/Mitigations

- Winter planning initiatives to maintain elective and diagnostic are a key priority for the Trust.
- The Trust continues to reduce waits for admitted care.
- In order to mitigate the risk of an elongated outpatient pathway, there is a focus on transformation and innovation. This includes work to improve the advice and guidance and patient initiated follow up metrics.

22/23 breakthrough objective

Theatre Session Opportunity

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

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

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
38	52	54	60	39	36	32	30	34	43	45	43

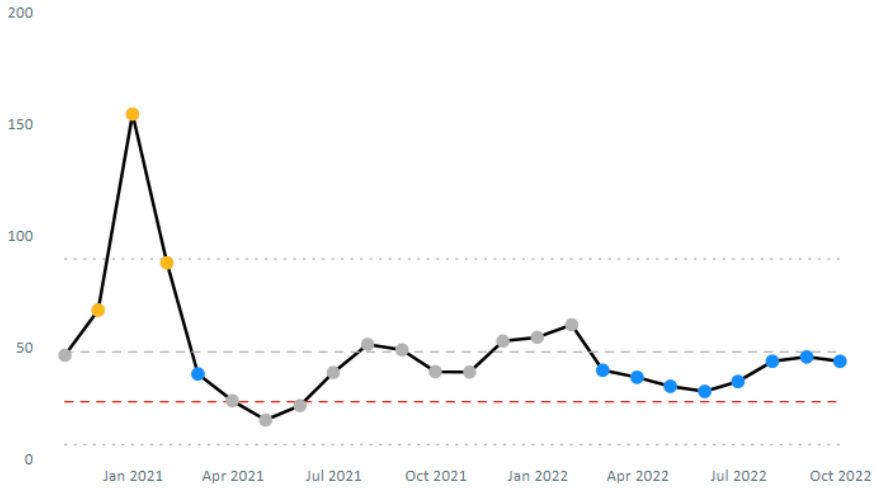
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. The chart indicates that we saw a slight improvement in our performance; this is particularly positive in light of a sustained pressure on the emergency/inpatient pathway with all services facing increased demand and changes to the bed base.

Intervention and Planned Impact

- Elective Orthopaedic Centre (EOC) has focused on increasing productivity by holding a multidisciplinary 6-4-2 booking meeting. This has improved both booked and actual performance. The planned booking for the EOC has increased during the month from 87.7% to 93.5%. The actual performance has improved from 81.4% to 87.8%.
- Implementation of 6-4-2 booking commenced from 3rd October which enable specialities to focus on booking ahead to maximise opportunity and improve patient experience.
- To facilitate further improvement there are a number of measures that have been implemented, with further actions:
- The Trust is optimising scheduling opportunities with the booking teams. This includes awareness of individual targets and discrepancies between planned and actual utilisation. October booking performance Trust-wide was 87.6% which was an increase of 0.5% on last month. Actual theatre occupancy was 79.4%.which was an increase of 1.3% on the previous month.
- Late starts were a focus for General Surgery in September where it was identified that delays were due to ITU bed confirmation. The action was to add a small case first on the list; as a result there has been a 1% improvement in October.
- Urology and General Surgery are focusing on creating standby patients to reduce cancellations on the day by increasing pre assessment pool.
- The theatre optimisation group meets fortnightly led by the Surgery & Anaesthetic leadership team. This group is focusing on the development of SOPs regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance.

Risks/Mitigations

- Theatre staff shortages continue mainly at WHH Active recruitment is on going.
- Daily review of staffing across all sites to mitigate reduction of lists.
- Theatre Business case (pending CEMG approval) would provide increased substantive staffing levels across all sites & staff the current unfunded theatre sessions.

Our patients

Rebecca Carlton

ED 12h Total Time in Department

There is a nationally proposed new set of Emergency Department Access Standards which will focus on 12 hour Total Time in Department. This measures from arrival to either discharge, transfer or admission.

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

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

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
9.8%	9.6%	9.5%	9.2%	10.5%	10.4%	8.7%	9.5%	11.2%	12.1%	11.4%	10.5%

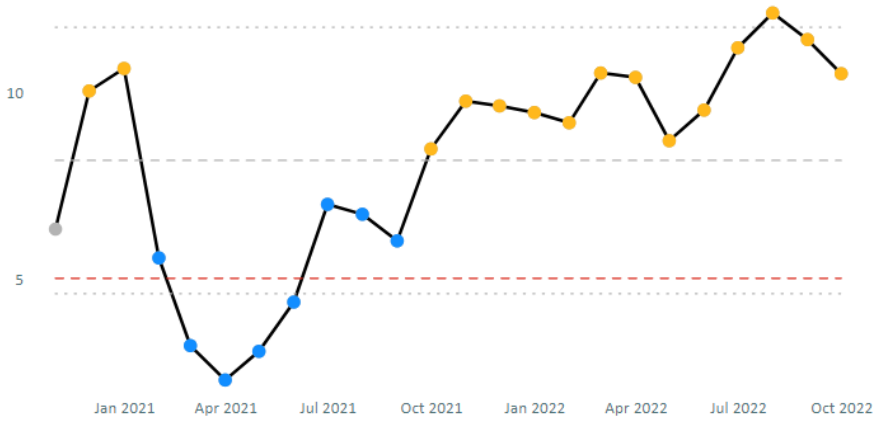
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The new national standard is for no more than 2% of patients to spend longer than 12hrs in the emergency department, from arrival to admission, transfer or discharge.

The number of patients reported as waiting more than 12 hours in the Trust's EDs saw an improvement in October (10.5% in Oct v 11.4% in September).

The 12 hour trolley wait numbers have reduced in October to 1,028 v 1,126 in September.

There were 29.7k attendances (all types) in October, the highest number recorded over the last 12 months with the number of DTAs in the departments waiting for beds was also the highest (ave. 55.4) reported in the last 12 months. The number of >21 days for October was 291 v 283 in September, again the highest number of cases recorded in the last 12 months.

Intervention and Planned Impact

The key interventions below key aim is to improve the total times in ED, through the development of direct access pathways:

- The UEC improvement delivery plan is focussed on enhancing and developing pathways to reduce patients attending the ED and includes the enhancement of the SDEC model. This work includes both the acute and the community
- SECAMB/111 pathways to support the direct access to the right service first time.
- Front Door Frailty service – implementation of a roving model to support the frailty cohort across the front door over winter whilst an established dedicated unit can be released once the ED build has completed.
- The Internal Professional Standards, launched earlier this year are being supported and monitored via the UEC workstream programme to support timely access to decision making from clinicians, reduce waits for referrals and response to impact positively on the overall total time in ED.
- Children's ED (CED) - Paediatrics will be providing an extra Night Paediatric Registrar to support the waits for children in the CED waiting to be seen/for decisions to reduce the overall total time in ED.
- Mental Health have commenced a pilot in November to provide a front door assessment nurse to support suitable patients direct to alternative services.

Risks/Mitigations.

- A review of all the areas across the EDs was completed in October with a paper to EMT to approve the use of the SAL lounge as a dedicated area for patients who are managed within a 'ward type environment'.
- Identification of space to support the mental health safe haven initiative.

22/23 breakthrough objective

Same Day Emergency Care (SDEC)

Ensuring patients are seen and treated in the right setting, at the right time and in the right way are key aspects of efficient and effective patient care. A number of patients currently accessing our Emergency Departments can be safely assessed, treated and discharged via a Same Day Emergency Care pathway, such as Emergency Ambulatory Care, Gynaecology, Surgery or Frailty). Access to an SDEC service may be following a direct referral by a GP or via the Emergency Department.

It is anticipated that an average of 2,600 patients each month can be safely seen and treated via a Same Day Emergency Care pathway, this is the ambition for 2022/23.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
2,288	2,017	2,144	1,940	2,302	1,945	2,076	1,972	2,032	1,793	2,007	1,909

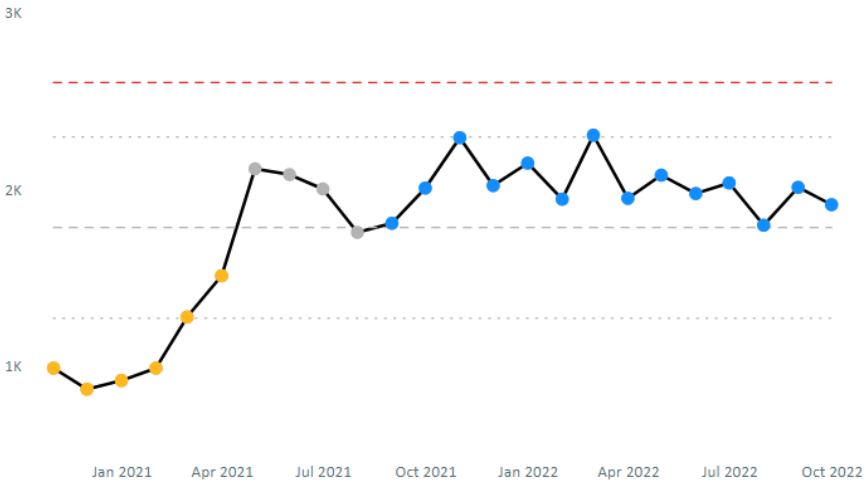
Variation indicates consistently falling short of the target

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

The SDEC activity across all services saw a decrease in the number of attendances in October 2022 (1,909 v 2007 September 22). SDEC remains an area that is not used for escalation inpatient beds . The principle of using the same day emergency care space for direct access and same day care exclusively enables patient access and flow to be maintained. 75% of patients who use the SDEC service are not admitted.

Intervention and Planned Impact

- The Direct Access Pathway/SDEC workstream, is working on delivering an extended SDEC model for winter Patients with long term conditions attending ED require the support of an integrated approach with community clinicians and acute hospital specialists. This opportunity is being developed as part of the winter planning programme with KCHFT.
- Using the Acute Emergency Care (AEC) directory and analysing further opportunities to increase numbers through the SDEC medical pathway has been completed and plans are in progress to extend the WHH SDEC to 23.00 hours 7 days a week from the 1st December.
- Work in place to review the changes to the hours of the QEQM service to maximise the opportunity for more patients to access the service.
- Due to the OPEL 4 status at WHH, the extended hours SDEC model has been delivered from the 14th Nov. Tracking and monitoring of activity and benefits in place as part of the wider UEC workstream
- The creation of 4 'Hot Slots' for referral into SDEC the next day commenced from 14th November. The aim is to provide the ability for clinicians to discharge patients who attend out of hours to return to a booked slot the next day. Monitoring is in place.
- Integrated SDEC pathways pilot commenced in October for 111 to direct SECAMB to ensure patients can access to the SDEC service. The aim is to increase the slots to maximise the use of the ambulatory pathways
- Work progressing on the development of the Medical Day Unit at Canterbury to realise further opportunity to manage more patients from across the sites reducing the impact on capacity.
- The focus for this month is to extend SDEC at WHH until 23.00 hours 7 days a week with a key focus on developing the SDEC and Direct Access models to optimise these pathways and establish a defined clinical model for the future. This is highlighted in the winter plan

Risks/Mitigations

Maintain non admitted pathway in SDEC areas and increase opportunity for access to meet demand

- Work is in progress to scope out the QEQM SDEC service to move the hours of service from 08.00-17.00 to 10.00 -20.00 to manage a wider number of patients identified for the ambulatory pathway
- Review of the streaming function at the front door – work commenced to develop processes to directly send patients to SDEC , bypassing the ED.

Our patients

Trust Access Standards: Cancer 62day

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

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

Rebecca Carlton

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
84.3%	78.0%	75.6%	71.0%	74.5%	66.1%	61.7%	73.2%	78.0%	71.7%	65.8%	65.2%

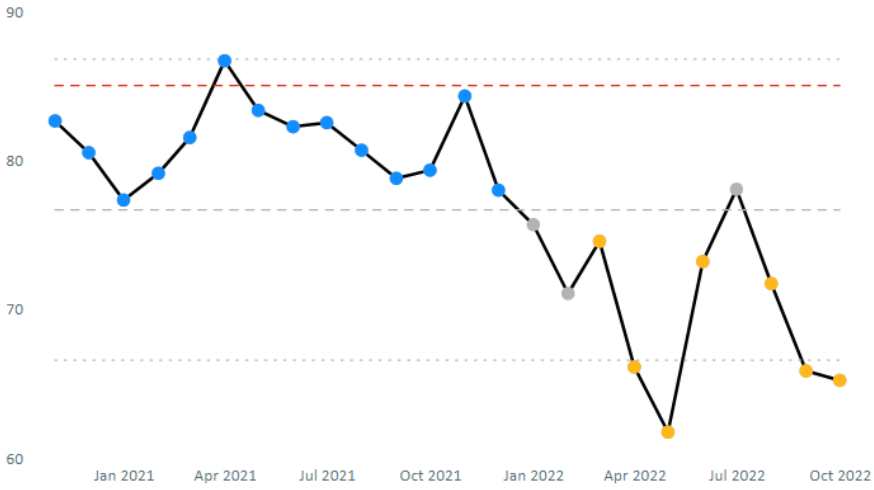
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Performance has reduced in October with a lower number of overall treatments than the previous months and higher number of breaches treated in month. An increase of 10% in the referrals for cancer services has resulted in a 5% decrease in performance at 62 days. The Trust remains in the top 3 performers nationally for 2 week wait access.

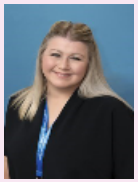
Intervention and Planned Impact

- Due to reduction in performance and competing challenges for all tumour sites, new daily/weekly early escalation implemented, with lead CNS's involved to ensure prioritisation of most vulnerable patients and greater support and guidance.
- Consistent high levels of 2ww referrals. Patients are being supported with the development of 2ww information on the Trust web page to include information on suspected cancer pathway and useful contact numbers to aid communication and support. Proactive management of long waiting patients to understand how we can best manage these groups through to treatment. Patients above day 40 on the pathways have been contacted to ensure they are fully supported and are aware of next steps. The total number of patients waiting for treatment has reduced.
- A group has been set up with MTW colleagues to improve joint understanding of their pressures, benefit working relationships, reduce delays and improve patient experience. A new pilot is due to start to secure faster chemotherapy prescribing and reduced risk/stress within teams.
- Lower GI straight to test (STT) implementation continues with PGDs for bowel cleansing approved end of September. Faster Diagnosis Manager has commenced escalation meetings with the endoscopy booking team, along with clinical support and nursing lead. qFIT project facilitator to discuss complex patients and improve booking times.
- Lower GI Pathway reduced to 1,000 waiting from 1,500.

Risks/Mitigations

- Delays to diagnostics booking remains a risk due to teams challenges and increased demand
- Theatre capacity and skill set for Urology, Head & Neck and Lower continues to be a risk
- Tertiary capacity for diagnostics and treatments remains challenging, working with the Alliance to support improvements.

Our patients



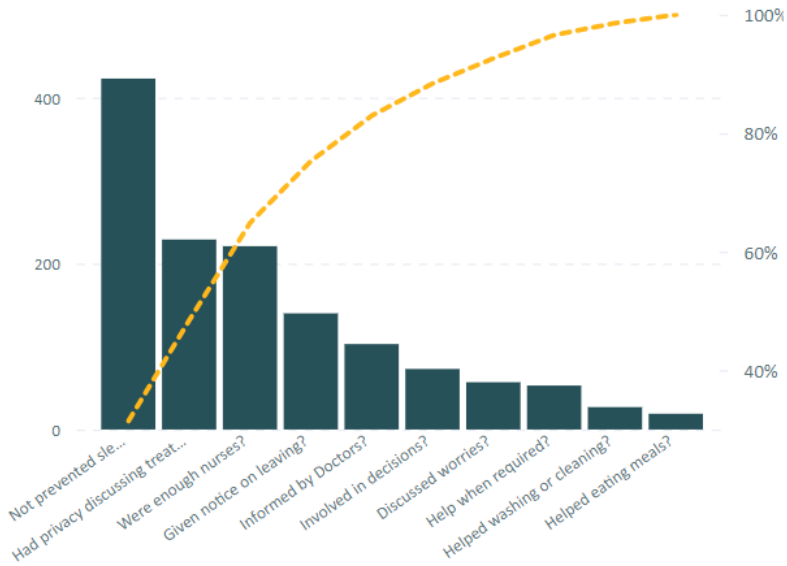
Sarah Shingler

Patient Experience: Inpatient Survey

The National In Patient Survey published in October 21 (surveyed patients discharged in November 2020), completed responses for the trust were received from 515 patients (1,250 invited) with a response rate of 43%. The survey consists of 45 questions and the trust scored below the national trust average on all questions, and in 23 out of the 45 responses the trust scored in the bottom five trusts in the region, and in the bottom five Nationally.

The Trust has chosen ten questions from the National In-Patient survey, and our average for our focused 10 questions is 7.13 compared to 7.65 as a national average.
41 adult in-patient wards will complete 50 surveys per month (2,050) using the tendable app using the 10 questions.
Our ambition is to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023.

Question # stratified by Question - Oct 22



Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
Not prevented sleeping by noise?	911	1,334	6.8	7.7	423	31.4%
Had privacy discussing treatment?	1,187	1,416	8.4	7.7	229	48.5%
Were enough nurses?	1,228	1,449	8.5	7.7	221	64.9%
Given notice on leaving?	776	916	8.5	7.7	140	75.3%
Informed by Doctors?	1,288	1,391	9.3	7.7	103	83.0%
Involved in decisions?	1,297	1,370	9.5	7.7	73	88.4%
Discussed worries?	1,332	1,389	9.6	7.7	57	92.6%
Help when required?	1,376	1,429	9.6	7.7	53	96.6%
Helped washing or cleaning?	1,088	1,115	9.8	7.7	27	98.6%
Helped eating meals?	841	860	9.8	7.7	19	100.0%

What the chart tells us

There were 1,459 patient Experience surveys completed in October via Tendable across 52 wards, this failed to meet the target of 2,050. The positive responses to 9 of the 10 questions asked were above target threshold of 7.7, with the exception of patients reporting that they had difficulty sleeping at night due to noise from other patients. For this specific question, the 'No' response is a positive, therefore the 68% (6.8) score is reflecting those patients that had a positive experience.

Intervention and Planned Impact

CNMO has set trajectory for all wards to be completing 50 surveys per month to achieve the 2050 surveys per month across the Trust inpatient wards. The accreditation team are supporting ward areas who are not currently reaching their target of 50 surveys per month and this is monitored daily for each site. HONs and DONs are held to account at the Nursing, Midwifery & AHP board on a monthly basis by the CNMO to ensure that responsibility is taken for supporting the wards to complete their surveys and develop actions to address poor responses. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FOC), measures have been implemented to counteract the noise disturbances at night with the frontline teams. The guidelines for ward night duty staff have been produced and ratified at the FOC committee and will provide support to all our newly appointed staff. All areas are being encouraged to stock ear plugs and eye masks to offer patients at night with a focus on our escalation areas and corridors where disturbances at night are hard to avoid due to the nature of the current operational challenges. Procurement have shared the order number for these items to all areas. An in-patient information booklet has been developed and ratified to help meet expectations whilst in hospital and provide information in the flow of a ward over a 24 hour period. The dementia working group have contributed to this booklet to raise awareness of patients who are living with dementia, address perceptions and explain how we support these vulnerable patients as health care professionals, this is as a result of direct patient feedback from the inpatient questions. The finalised booklet is being sent to the printers w/c 21st November.
The Head of Patient Voice and Involvement is working with the Associate Director of Nursing for Quality and FOC. An anticipated key role of the patient volunteers and champions will be to support the wards in the completion of the surveys but currently this has been placed on hold due to a challenge with information governance and access to tendable without an NHS email. A patient champion/member of the public has now joined the monthly FOC committee and it is hoped they will become a regular and active participant.

Risks/Mitigations

If culture and behaviours do not change and the patients voice continues not to be heard, there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Cancer 62d			Cancer 2ww Performance		93.0%	95.5%	94.6%	95.7%	95.7%
	W4		Cancer 28d Performance		75.0%	67.7%	68.3%	68.0%	69.9%
	W4		Radiology Diags vs Plan		Traj.	17.6K	17.7K	17.5K	18.5K
	W4		Endoscopy vs Plan		Traj.	1,419	1,439	1,309	1,396
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	480	448	396	380
	W4		DM01 Compliance		75.0%	70.1%	65.8%	64.0%	65.1%
	W4		RTT OP Booking Breaches		14,000	24.3K	26.6K	27.2K	27.0K
	W4		OPA vs Plan		Traj.	71.1K	71.9K	75.0K	71.8K
	W4		Elective Admissions vs Plan		Traj.	8,502	9,200	8,827	8,493
ED Compliance	W4		ED Compliance		90.0%	68.1%	65.0%	68.1%	68.8%
	W4		Clinician First Seen within 1h		50.0%	40.2%	42.0%	48.4%	45.3%
	W4		A&E Atts vs Plan		Traj.	23.9K	22.0K	22.1K	24.1K
	W4		Unplanned Re-attendance ED		10.0%	14.5%	14.1%	14.2%	13.7%
	W4		Super Stranded >21D		107	247	271	283	291
			Pathway 0 Patients >7 Days		Sigma	139	135	134	149
	W4		NEL Admissions vs Plan		Traj.	7,184	7,097	6,691	6,629

Regional access position

The regional position has been included below to give context on the relative performance of EK within the System.

*figures shown are one month in arrears as this is the latest national data available

Target/Trust	EKHUFT	MTW	Medway	Dartford
A&E 4 Hour	68.8%	84.0%	62.0%	73.2%
Cancer 62D	*65.8%	*73.6%	*85.7%	*71.2%
DM01	65.1%	89.9%	77.9%	84.3%
18w RTT	56.4%	66.4%	61.5%	69.7%

RTT 18 Weeks

In all three categories of wait the Trust is seeing improvement and a reducing admitted patient waiting list. The Elective Orthopaedic Centre is applying for Elective Surgical Hub accreditation and will aspire to meet the best practice standards set out by the GIRFT programme. Planning is in progress to have super surgical weeks underway that will support increased throughput of admissions.

DM01, with focus on the most challenged diagnostic services, continue to optimise capacity where workforce allows.

Focus to improve the volume of patients scheduled for first out patient appointments continue, through reducing DNA and cancellation rates with further focus required to increase the utilisation of clinics where we are seeing short notice cancellations.

ED Compliance

A gradual improvement is being seen, a focus is on driving up the UTC performance at the WHH where it has been below the 95% target since March 2022, and often below 90%. A UTC improvement plan is in place and being monitored weekly within UEC.

The system Summary Acute Provider Indicator Table (SAPIT) data shows that for both hospitals in EK the percentage ambulance arrivals against attendances is above 28% and indicated high against our system partners.

The dwell time in ED against the 4 hour standard reports a mean time of 3.5 hours for non-admitted patients (an improvement against the previous month of 3.7 hours) and 25.4 hours for admitted patients (a deteriorating position against September 22.1 hours).

Unplanned reattendance

The adjusted number when planned activity is removed is less than 10%. The BI team are automating this activity to reflect in the dashboard. For clarity, the reattender categories are:

1. Patients who arrive in ED and then are streamed to UTC who are recorded by the IT system as two episodes on the same day (about 3%)
2. Patients who return for diagnostic results but attend the ED and not a speciality pathway, impact current unknown.
3. Frequent attenders (3 or more attendances) who are managed by the frequent attender program (these few patients are a disproportional impact on our performance, again impact unknown).
4. Those who attend within 7 days but for a different reason.

Super stranded over 21 days

In response to increased pressure we have introduced patient by patient review with key decision makers and enablers from within the Trust and from our community partners.

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
FFT	W4		FFT Maternity Response Rate		18.0%	13.8%	13.4%	7.7%	16.6%
	W4		Complaint Response		90.0%	10.3%	20.3%	54.5%	18.9%
	W4		Duty of Candour - Verbal		100.0%	80.0%	75.9%	81.8%	68.8%
	W4		Duty of Candour - Written 15wd		100.0%	77.8%	64.3%	55.0%	73.7%

Duty of Candour (DoC)

With the new DoC dashboard, the Care Groups are able to monitor, on a daily basis with real time data, what elements of their DoC are outstanding prior to it breaching. There continues to be a challenge within the Care Groups in compliance with the DoC deadlines that have been set. The dashboard monitors both current DoC, Recent breaches (Since April 2022), and the Backlog. The recent breaches have significantly reduced which demonstrates that although the 10-day compliance has not improved, the breaches since April 2022 have reduced by approximately a third in October 2022. In addition, the number that are being completed within a month has also increased. It is anticipated that the November 2022 figures on compliance with be much improved due to an additional available resource. With the improved figures expected in November, confidence remains that a >90% compliance rate will be achieved in December 2022.

Complaints

During the month of October 2022, the care groups have maintained a good level of compliance, but the corporate complaints team have continued to experience a significant reduction in their staffing levels which has affected their ability to maintain high levels of managing complaints. A new starter left the role within the first week, one of the externally funded members of staff was unable to work for much of October and has now left and one member of staff has been supporting the maternity information line full time. The other factor that has impacted the compliance this month was the time Executives had to review and sign off complaints and the need to prioritise work supporting the publication of the investigation report and Maternity Services. There are currently approximately 35-40 complaints per week sent to the executive to be signed off. With the staff returning from sickness, the midwifery information line now reduced and a new externally funded support person, it is expected that compliance will improve next month.

Our people

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

Our people

Andrea Ashman

Staff Engagement (score)

Staff Engagement levels have remained below the national average throughout the last five years. The Staff Engagement Index itself has been on a downward trend for three years and, as an organisation, we are one of the most challenged in the country, sitting in the bottom 20% nationally. Given the negative implications of reduced staff engagement, it is imperative that levels are significantly and consistently improved.

The National NHS Staff Survey (NSS) is used to give an indication of staff engagement, providing an overall Staff Engagement Index to the Trust. In order to monitor this more regularly, we are also measuring this at quarterly intervals through the National Quarterly Pulse Survey (NQPS). Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
6.41	6.41	6.35	6.35	6.35	6.26	6.26	6.26	6.33	6.33	6.33	

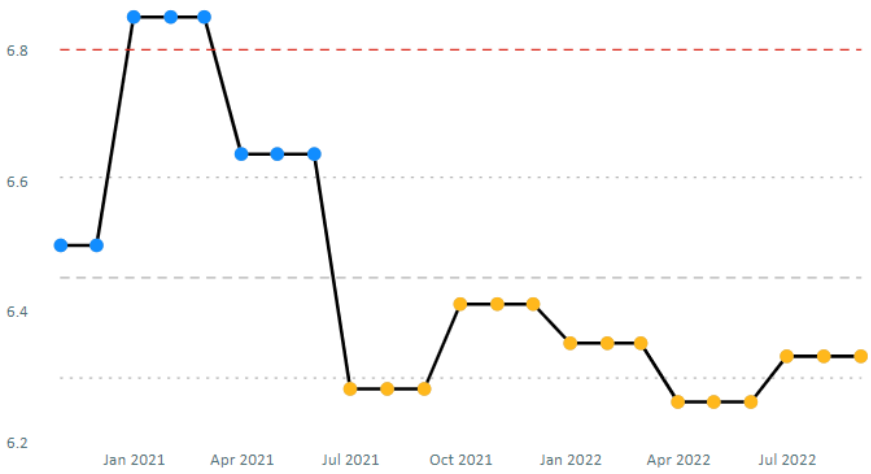
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

Fieldwork for the National Staff Survey (NSS) is almost complete, the results of which will populate a revised Staff Engagement position. Following conclusion of the NSS on 25th November, these results will not become available until January 2023.

Staff Engagement remains at 6.33. The Trust is currently benchmarked 120th out of 187 Trusts nationally, in quartile 2 – and 0.3 from the national average (6.6).

Interventions and Planned Impact

The Trust was the first to launch the National Staff Survey this year and has a wide programme of activity taking place to ensure all staff have an opportunity to share their voice. At the time of writing, the response rate was 38.2% (3,459 respondents) which is 1% ahead of the national average (37.1%).

The activity taking place includes; polling stations, a booster campaign, targeted visits, attendance at audit days, weekly webinars to myth-bust and encourage transparency, 'We Said We Did' weekly communications, the development of a Managers Toolkit, a weekly Care Group barometer to encourage healthy competition and a detailed tracker to view areas requiring the greatest input.

Response rates are currently lowest in ENT (19%), Obstetrics & Gynaecology (21%) and Acute Medicine Wards (23%). By contrast, response rates are highest in Rheumatology (81%), Audiology (80%) and Medical Physics (79%).

Risks/Mitigations

The timing of publication of the investigation into our maternity services has impacted on the overall response rate, with communications necessarily being directed toward the publication of the report. The response rate appears to be similar to MTW (37%) and Medway (32%), but is about 7% behind last year at the same time-point despite tracking ahead until this time. There is a risk that the report also has an impact on all of the NSS results, specifically advocacy and therefore engagement.

22/23 breakthrough objective

Staff Involvement Score

EKHUFT's staff involvement score is lower than the national average for acute trusts (6.7). Staff involvement is one of the 3 components that contributes to staff engagement – the We Care People True North. Of the three components, staff involvement is more heavily weighted, it can be tangibly impacted and also influences the other two components - staff motivation and advocacy. Our aim is to improve staff involvement, as a core aspect of improving the overall staff engagement score.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
6.35	6.35	6.20	6.20	6.20	6.13	6.13	6.13	6.28	6.28	6.28	

F

Variation indicates consistently falling short of the target

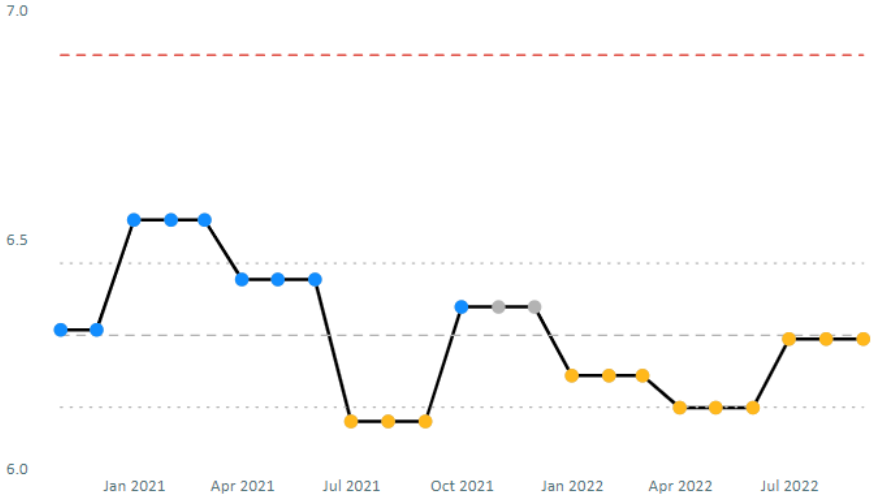
L

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

Flag Description

Below Mean Run Group

XMR Run Chart



What the chart tells us

National Staff Survey fieldwork is now complete for 2022 and a new staff involvement score will be available in January 2023. Model Health indicates that Staff Involvement is currently benchmarked 109th out of 187 Trusts nationally for staff involvement. This is in quartile 2 (25-50%) and means we are <0.1 away from both the national average (6.4) and that of our benchmarked peers (also 6.4).

There have been subtle improvements against a backdrop of national decline against staff involvement. Whilst the score is improving (by 2-4% in July), it needs to do so consistently over each of the next quarters in order to achieve the desired position.

Intervention and Planned Impact

- 20 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology, with a further 18 planned before the end of November
- The We Care rollout has been extended beyond the 20 'units' surveyed in July as part of the NQPS and will also include Urology and Cardiology
- Two of the priority areas identified as part of the National Staff Survey data review (those with the lowest scores for involvement) have completed the KENT Fundamentals programme
- The new staff intranet has been reviewed and can provide; sentiment analysis, target pulse surveys and an online suggestion area, the effectiveness of which will be piloted
- An 'Involvement Toolkit' is being finalised to provided support at team leader, speciality and Care Group level throughout the NSS

Risks/Mitigations

- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years and there has been a pronounced fall in recent quarters
- The Kirkup Report could have a significant impact on overall staff morale and may affect the way colleagues respond to the National Staff Survey questions
- Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Staff Engagement	W4		Appraisals Compliance		80.0%	67.4%	69.4%	69.9%	69.8%
	W4		Safeguarding Children Training		90.0%	89.5%	88.2%	87.0%	86.2%
			Staff Turnover Rate		11.5%	10.8%	10.8%	10.8%	10.5%
	W4		Safeguarding Adults Training		90.0%	89.0%	87.9%	86.3%	85.0%
	W4		Vacancy Rate		10.0%	12.7%	13.6%	12.3%	10.9%
	W4		Staff Turnover: HCA		13.5%	14.4%	14.9%	14.3%	13.9%
			Premature Turnover Rate		25.0%	23.1%	22.9%	23.5%	23.6%
	W4		Medical Job Planning Rate		90.0%	32.9%	34.0%	31.5%	33.3%

Appraisal

Overall appraisal compliance had been on an upward trend during the last few months. As usually happens in May and June each year, the appraisal rate fell back and dropped significantly to 66% in June. However, July to October have seen an increase, with compliance at 69.8% in October. The metric is below the reviewed alerting threshold of 80%. The compliance by Care Group ranges from 89% for Surgery HNBD to 63.5% for UEC. The Corporate areas are the lowest of the groups at 54.8%. Teams are working to book appraisals in during the next two months to improve compliance. Non-compliance is highest within the N&M and A&C staff groups. Appraisal compliance is an area of concern as it is a good indicator of staff engagement and personal development planning. In addition, Health & Wellbeing conversations (and updated COVID Risk Assessments) form part of the appraisal process. Whereas previously, Appraisal Compliance was a driver for many, this will now be supported through the Trust objective of Staff Involvement, which is a Driver for some Care Groups.

Staff Turnover

Staff Turnover currently stands at **10.50%.** This is below the desired threshold (11.5%) and has improved in October, falling below 10% for the first time in-month since June. Total turnover stands at just **8.28%** in-month. This has helped the largest net growth of WTE this year (n=181).

Healthcare Assistant turnover fell to 8.89% in-month in October - the lowest it has been in over a year. The HCSW headcount is now at a record high (n=1098).

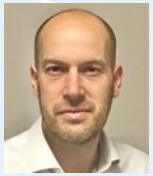
Nurse turnover remains below the alerting threshold of 10% and fell to just 9.23% in-month in October. This has now been below the alerting threshold for 10 of the last 12 months.

Vacancy Rate

The overall vacancy rate has improved, decreasing from 12.3% to 10.9% in October, largely due to an increase in nursing staff through the IEN recruitment plan and a reduction in the number of trainee doctor vacancies. There is also a rolling programme of recruitment in place for HCSW posts plus a marketing campaign supported by the East Kent Healthcare Partnership which is having a smaller positive impact on the vacancy rates.

Our sustainability

Our sustainability



Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the years up to 2019/20, in the last two financial years a breakeven position or better was delivered. This metric will measure us against our long term aim to maintain a breakeven position.

For 2021/22 the impact of Covid-19 paused the NHS business planning process nationally and had limited the ability of the Trust to hit its cost efficiency targets. In 2022/23 there is a return to a more traditional planning process and an efficiency target of £30m, in additional to Covid spending reductions of £9m and elective recovery fund (ERF) income of £18m. The current plan is for breakeven which improves from the figures quoted last month because of £6m additional inflation funding and £16m non-recurrent ICS funding.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
-0.996	-0.941	-0.090	1.307	0.076	-3.700	-6.624	-6.604	-7.795	-11.453	-13.015	-15.313

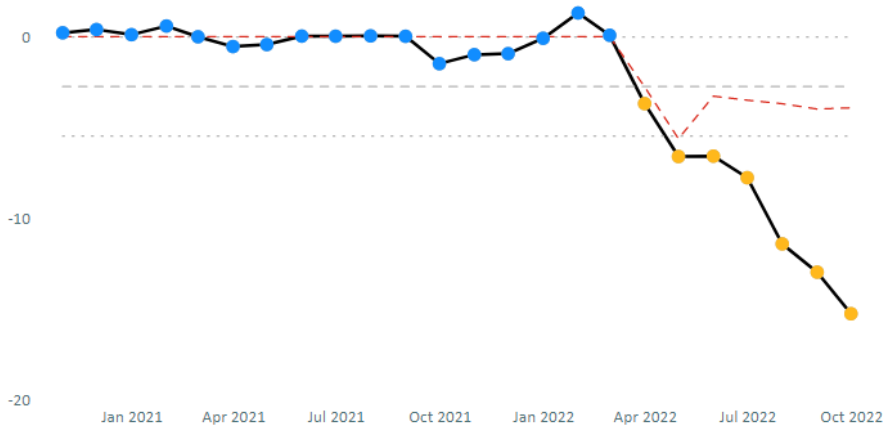
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

The first two years of the graph show the monthly financial performance of the organisation which has resulted in both years being breakeven. The final graph point shows position in October which is a £15.3m deficit against a plan of £4.0m deficit. The key drivers behind the deficit are: £1.3m behind plan on CIPs, £4.8m on escalation areas (additional 60 beds), £1.9m bank and reductions not seen, overspends on work permits £1.0m, drugs overspend £1m and not charging for parking £1m. The Trust is currently reforecasting the position to a potential £30m deficit in year.

Interventions and Planned Impact

The largest interventions for the plan are:

- Delivery of the £30m CIP programme, the largest pillar of this is the reduction of premium pay which is a breakthrough objective. Fortnightly meetings being held with clinical and corporate areas, use of national benchmarking data, plus detailed budget reviews underway.
- Premium pay deep dives are being held with care groups to test plans and review further actions to be taken.
- Away day held in September which had a focus on efficiencies, the PMO are working through the outputs to identify key areas of development.

Risks/Mitigations

For 2022/23 the key risk and mitigations are:

- Efficiency target of £30m, PMO team working with care groups and executive directors
- Covid-19 spend reductions £9m, DIPC working with finance to release costs
- ERF delivery £19m, 104% of 19/20 activity to be delivered, care groups have plans and weekly oversight by COO.
- Non-pay inflation. Procurement is working closely with NHS England procurement and supply chain to minimise impact.

22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst the most influenceable by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective is to reduce the spend by 10% or £8.7m in 2022/23 but may be refined once the full project plan is developed.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
7,255	6,441	7,168	7,403	9,148	7,890	7,497	8,894	8,702	8,809	9,618	9,178

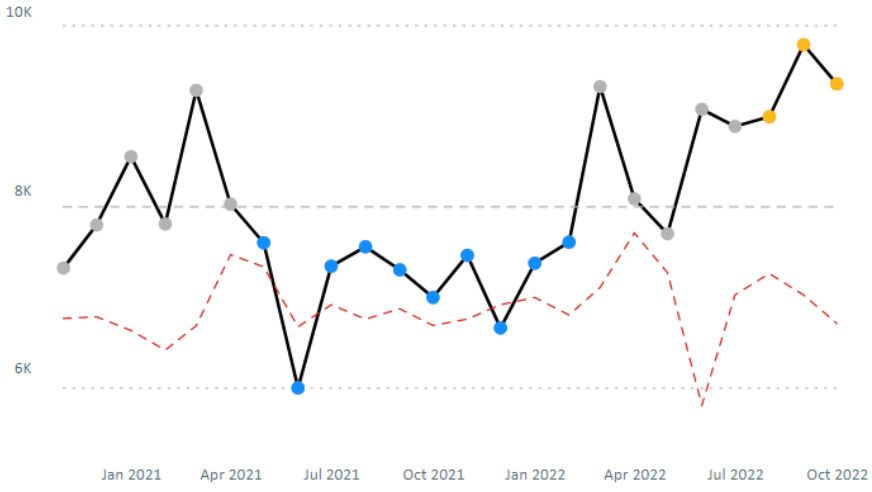
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits. This is caused by the Trust ensuring all costs in that financial year are captured and include unpaid claims due in year.

This information is the baseline for which we will measure improvement over 2022/23. In October 2022 premium pay spend has decreased by £0.4m. The drop is mainly related to the pay award back pay being paid in September.

Intervention and Planned Impact

- The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.
- The working up of an A3 project plan is complete and will be reported through EMT and PRMs and subsequently Board each month.
- Key Interventions include:
- Detailed focus by care groups on drivers of premium pay. Premium pay deep dives occurring through November.
- Review of bank, agency and overtime rates across all staff groups.
- Ensure improved sign off processes and governance across the Trust.
- Recruitment to key clinical posts to reduce the need for temporary staffing.
- Ensuring exit plans in place for high cost medical agency locums

Risks/Mitigations

- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- The remainder of spend is caused by sickness and operational demand. The former should reduce but work is required to control and reduce the latter.
- Escalation beds opened plus more specialing increases need for temporary staff

Our sustainability

Liz Shutler

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
8.06	8.60	9.55	7.65	7.97	6.12	6.63	2.44	4.22	4.63	4.11	

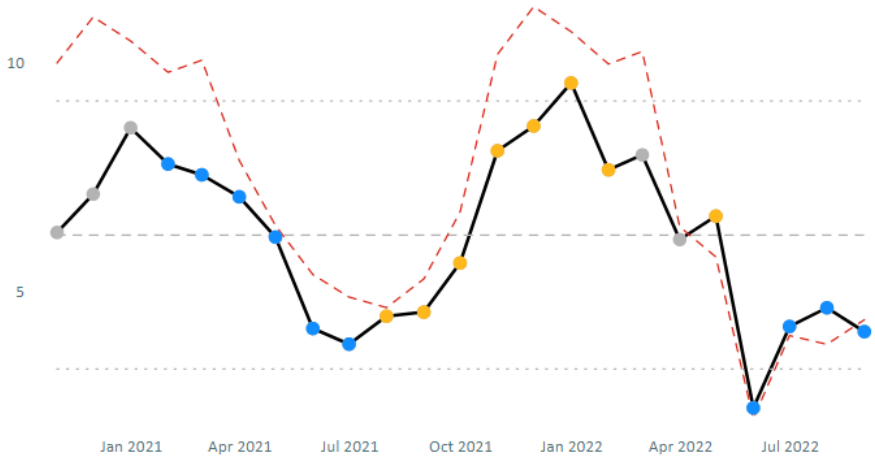
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. The position is reporting below the monthly trajectory of 4.37 at 4.11 kgC02e per m2 and is below the same period last year (which reported at 4.53). The Trust has increased its m2 during 2022 (ie, new ITU build at the William Harvey Hospital) and this, plus the installation of combined heating and power (CHP), will have an impact on the Trust's energy usage. CHP in particular will have an impact on the amount of gas used. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

Breathe Energy has been working with the Trust and 2gether to identify carbon reduction schemes that could be commissioned in the new financial year. The Trust, with 2gether, has produced a business case which identifies the installation of heat pumps on the three acute sites funded via the PSDS 4 Grant. The Trust submitted its bid on 15 October 2022 and confirmation has been received that the bid has passed through to the second stage. It is expected that the outcome of all submissions will be made public in December/January 2022/3. The Trust's bid for capital being £25.2m. The total annual carbon emissions saved by the use of heat pumps 3,370 tonnes per annum which constitutes a 22% contribution to the Trust's trajectory (80% reduction in Co2 by 2030). The scheme put forward focusses on carbon reduction, rather than financial savings, although financial reductions will be part of the programme of work.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions. This Group will drive the strategic improvements required to reduce the carbon footprint, in line with our agreed trajectory.

Risks/Mitigations

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

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Financial Position	W4		Total Pay		0.0%	-3.6%	-4.0%	-6.6%	-6.9%
	W4		Efficiencies YTD Variance (£M)		0.0	-2.7	-3.2	-1.1	-1.3
	W4		Efficiencies FOT Variance (£M)		0.0	-4.7	-6.2	-5.3	-3.4
	W4		Efficiencies Green Schemes		90.0%	32.8%	41.5%	53.6%	58.9%
	W4		I&E Monthly Variance Trust (£)		0	-315.6K	-3.1M	-1.4M	-2.4M
	W4		I&E YTD Variance (£)		0	-4.0M	-7.1M	-8.5M	-11M
			I&E FOT Variance (£)		0	0	0	0	-30M

Total Pay

This metric is mainly driven by the expected reduction in premium pay not being achieved. Premium pay reductions are still a focus of care groups as a break through or driver metric. Other key drivers are the opening of escalation beds and a shortfall in CIP.

Efficiencies YTD Variance/ Efficiencies Green Schemes

The Trust has been slower than expected in developing its CIP programme due to operational pressures in Q4 of 21/22. The total CIP plan for the year is £30m for which £27m is identified. The executive team are monitoring progress through PRMs and CEMG. In addition the CFO is meeting with care groups on a fortnightly basis.

I&E Monthly Variance Trust/ I&E YTD Variance

The key drivers behind the deficit are: £1.3m behind plan on CIPs, £4.8m on escalation areas (additional 60 beds), £1.9m bank and reductions not seen, overspends on work permits £1.0m, drugs overspend £1m and not charging for parking £1m. The Trust is currently reforecasting the position to a potential £30m deficit in year.

Our future

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

Our future

Rebecca Carlton

Not fit to reside (patients/day)

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

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

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

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
332.0	346.2	314.3	320.4	336.2	351.1	352.9	354.9	402.6	385.9	358.3	362.2

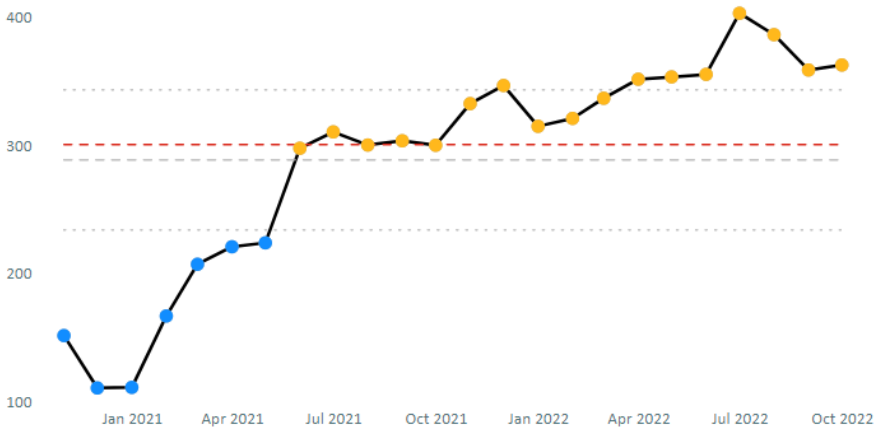
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

This chart should be seen in the context of the Total Time in Emergency Department True North and specifically the impact on the admitted pathway who are delayed in ED (12hr trolley waits). Patients who cannot leave hospital and are delayed will in turn reduce the available beds for emergency admissions from the Emergency Department. Nationally it has been recognised that systems across England are under severe operational pressures. The ability of any system to support people ready to leave hospital will be an area of renewed focus as we approach winter.

The SAPIT data shows EK growth is substantial in comparison to system partners in long stay patients in each category of 7, 14 and 21 day stay, with over 100% growth in 21 days for both QEQM and WHH compared to Medway with second highest growth in this area of 59%.

Intervention and Planned Impact

Recently EKHUFT, KCHFT and KCC have collaborated on a plan to improve patient flow for our collective residents. This involves proactive collaboration focussed on three priorities, SDEC, Virtual ward, Bridging. This work continues at pace with progress:

1. Identification of key pathways and areas where the community and specialist teams can link up.
2. Virtual Ward.
3. Bridging arrangements that help people leave an acute hospital bed prior to care at home or long term residential care being available.

The Trust is working with partners from ICB, KCC, RTS and Primary Care to run a multi-disciplinary discharge event. This builds on work at the WHH which involved a patient-by-patient review with key decision makers supporting patient on-going care. As part of a wider collaboration this event will cover all the Trust's hospital sites and is supported by the external improvement lead working with the East Kent system.

Our work continues with Pathway 0 patients who have onward care or rehabilitation needs to ensure we minimise these patients length of stay.

Themes from both of these reviews are influencing and shaping the Trust's evolving winter plan.

Risks/Mitigations

- 30% of the Trust bed base is occupied by patients who no longer need our care. >60% of patients admitted via ED have a total time in ED of over 12 hours. The % of no longer fit to reside patients occupying the trust bed base is directly affecting our ability to admit patients on a timely way.
- A higher than usual number of patients leave EKUHFT to residential care settings. The process for understanding choice and early decision making is part of our collaborative work with KCC and KCHFT

Our future

Liz Shutler

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
303	198	116	91	246	129	162	430	82	161	190	111

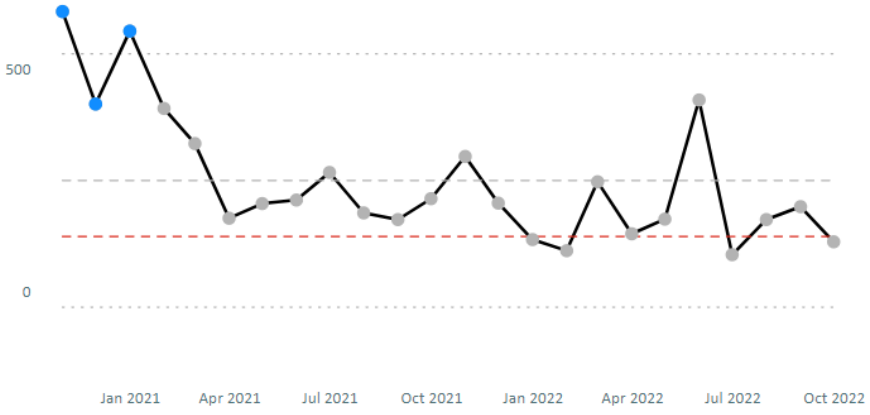
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

In 2020/21, 5,132 patients were recruited into trials. This number is significantly higher than usual as it included 3,000 Covid patients. In 2021/22, the Trust recruited 2,285 patients (including 240 Covid patients) across 22 specialities. The October position of 111 participants is slightly below the threshold of 123. However the April – October cumulative position is 1,265 patients recruited to trials, which is above the year to date trajectory of 861 (47% above plan). A total of 10 studies opened in October (4 commercial and 6 non-commercial), which will generate additional recruits and income over the coming months. Key successes include recruitment to the MIDI project which trains a deep learning algorithm to recognise abnormalities on Head MRIs and the MINDARISE study of mindfulness in response to NHS staff. These two studies account for a third of the month's recruits. In addition, the Trust is the chief investigating site for the SILVER commercial surgical study into wound treatment, which opened in October and has already recruited 3 of the 15 recruits required over an 8 month period.

Intervention and Planned Impact

- The Trust is a member of the Trinetx (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators). The Trust attended the recent annual summit, providing the scope for EKHUFT to use global data in developing homegrown studies.
- Three new expressions of interest have been made to three big commercial studies.
- An expression of interest has been submitted to host the Central Research Network and the Trust has been successful in moving to the next stage of the process. Hosting the Central Research Network would bring significant reputational benefit and status within the region as the 'go to place' for research.
- The Harmonie trial (looking at how strongly babies can be protected from serious illness due to RSV) commences in November.
- Further studies in maternity are currently in the pipeline.

Risks/Mitigations

- Space at K&C has been identified as a constraint with the key risk being the impact on the Trust's ability to continue to provide a number of cancer trials. Space requirements are being reviewed urgently.
- Lack of recurrent funding to support the additional research fellow posts.
- Lack of outpatient space for follow-ups. As trials increase, this will become more challenging
- The delay in the new research database will delay the Trust's ability to move to the original metric.
- Completion of East Kent data integration.

Appendix 1
Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Harm Events	W		Falls		Sigma	148	143	154	152
	W		IPC: EColi Infections		10	9	8	9	8
	W		IPC: Klebsiella Infections		6	8	5	4	7
	W		IPC: Pseudomonas Infections		3	1	2	2	2
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	232	222	216	183
	W		Medication Errors; Severity C+		1	1	1	1	1
	W		Nutrition Incidents		Sigma	47	60	60	63
	W		Pressure Ulcers: Cat 2		Sigma	40	35	30	40
	W		Pressure Ulcers: Cat 3 & 4		Sigma	2	0	0	1
	W		Pressure Ulcers: DTI		Sigma	8	11	11	7
	W		Pressure Ulcers: Unstageable		Sigma	8	12	10	15
	W		IPC: Audits Composite		85.0%	86.5%	85.7%	85.1%	86.8%
	W		Safeguarding Incidents		Sigma	18	19	21	21
	W		IP Spells with 3+ Ward Moves		Sigma	496	507	459	494
	W		Clinical Incidents		Sigma	2,237	1,995	1,876	2,116
	W		Serious Incidents		Sigma	25	14	21	24
	W		Overdue Incidents		Traj.		6,698	6,531	6,532
	W		Never Events		0	0	1	1	1
	W		Maternity Serious Incidents		2	6	1	3	6

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Mortality	W		Extended Perinatal Mortality		5.93	4.26	4.12	4.43	4.61
Staff Engagement	W		Sickness		5.0%	6.0%	5.0%	4.8%	5.5%
	W		Statutory Training		91.0%	91.9%	91.7%	91.1%	90.2%
	W		Staff Turnover: Nursing		10.0%	9.4%	9.4%	9.5%	9.7%
Financial Position	W		Non Pay		0.0%	1.8%	0.7%	0.9%	-0.4%

True North Domain	BR	Flag	KPI	SPC	Thres.	Jul-22	Aug-22	Sep-22	Oct-22
Cancer 62d	W		Cancer 31d Performance		96.0%	98.3%	98.3%	96.2%	98.2%
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,652	1,718	1,626	1,646
	W		RTT 52w Breaches		Traj.	3,419	3,453	3,386	3,602
ED Compliance	W		Discharges by Midday		15.0%	13.9%	13.6%	15.1%	12.8%
	W		NEL Readmissions		15.0%	9.6%	9.7%	9.2%	8.9%
	W		Stroke Ward within 4 Hours		50.0%	55.7%	59.4%	56.0%	69.2%
FFT	W		FFT IP Response Rate		15.0%	19.2%	18.1%	20.9%	19.5%
	W		FFT DC Response Rate		27.0%	30.3%	30.5%	29.5%	29.8%
	W		FFT ED Response Rate		12.0%	14.5%	14.3%	15.1%	14.4%
	W		FFT OP Response Rate		17.0%	20.0%	20.2%	20.5%	19.2%
	W		Complaints Number		Sigma	85	72	72	67
	W		Mixed Sex Breaches		Sigma	69	46	69	108
	W		Duty of Candour - Findings		100.0%	75.0%	66.7%	50.0%	100%

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Dates will be reviewed at next A3 meeting	• Operational issues have delayed the meeting with SRO and Leads to review the future direction of the project and update the A3.	• Project incorporated into the Emergency Care Delivery programme (Same Day Emergency Care SDEC, Break Through Objective.
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022 New date Sept 2022	• Clinical Guidelines Governance Policy is fully approved and published on the Policy Centre. • Details of the Policy and Clinical Guidelines Template (contained therein) are now available on Staff Zone. • Initial specialties for MicroGuide roll-out have been approached and preparations have begun. • The use of specific document stores for Clinical Guidance and SOPs has been discussed within Trust-wide steering groups with actions to take forward.	• Further analysis of current MicroGuide Content and usage to inform roll-out procedures. • MicroGuide documents highlighted for re-location to alternative storage to be discussed with relevant specialties. • Review of clinical guidelines from initial specialties selected for MicroGuide roll-out, in preparation for upload. • Clinical Guidelines Approval Group (CGAG) Terms of Reference to be finalised following presentation at the Patient Safety Committee.
Improving End of Life Care	Sarah Shingle r	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC at next meeting	• Work with ReSPECT lead to raise IT functionality issues with CCG and Trust IT around introduction of ReSPECT • Finalising script and filming locations for EoL film. • 1st pilot of an in house 'introduction to communication skills' course 14th October – well evaluated • Developing relationship with Patient Voice and Involvement Team to begin to scope EoLC involvement	• Project incorporated into the Emergency Care Delivery programme (Same Day Emergency Care SDEC, Break Through Objective.

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Fractured Neck of Femur	TBC	To agree, develop and implement a Trust wide Fractured Neck of Femur pathway that will address and improve the eight Key Performance Indicators on the National Hip Fracture database	TBC	• The new Deputy Head of Nursing is in place and will be leading this project across both sites. • Handover of this project is this week • Plan is to initially meet with the trauma coordinators from both sites and organise a multidisciplinary work shop to discuss the Hip fracture patient pathway.	• Working with therapies resolving prompt mobilisation at QE • Improving alerts to trauma co-ordinators when patients arrive in ED • Working with the site teams to ensure patients are admitted to the right ward at the right time .
Maternity Ultrasound Booking	TBC	Provide a booking service for Ultrasonography that is linked to the patients pathway Improve the link between appointments team and clinicians Ensure PACs connects to the maternity systems Develop a robust workforce with clear roles and responsibilities to ensure a sustainable service Ensure capacity is available to meet the demand of the service	TBC	• Review the clinical priority list for maternity referrals to Sonography • Pilot agreed to look at DNA rates. • Review information and explanation documentation supporting Women's needs • Contact Information department for feasibility of auto notification once pregnancy details are added to referral PTL	• Away day with Team completed • Reviewing 12 and 20 week scanning pathway • Developed and agreed action log and working through the documents. • To schedule whole antenatal pathway work shop with lead consultants, midwives and radiology looking at Multiple births, Pre-term and Twin pathways

Appendix 2
Completed Trust Priority Improvement Projects

NHS
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NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Sarah Shingler	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Complete BAU Oct 22
Trust wide Job Planning	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	Complete BAU Oct 22
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	Complete BAU Oct 22

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

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

Appendix 3: Glossary of Terms

NHS
East Kent Hospitals University
NHS Foundation Trust

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

Appendix 3: Glossary of Terms

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**MONTH 7 FINANCE REPORT**
MEETING DATE:	**8 DECEMBER 2022**
BOARD SPONSOR:	**CHIEF FINANCE OFFICER (CFO)**
PAPER AUTHOR:	**DIRECTOR OF CONTRACTING, COMMISSIONING AND COSTING**
APPENDICES:	**APPENDIX 1: M7 FINANCE REPORT**

Executive Summary:

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

Purpose of the Report: The report is to update the Board on the current financial performance and actions being taken to address issues of concern.

Summary of Key Issues:

The Trust reported a £2.4m deficit in October, which brought the year-to-date (YTD) position to an £15.3m deficit which is £11.4m adverse to the plan.

The Trust worked with Kent & Medway (K&M) NHS system partners to resubmit a financial plan for 2022/23 at the end of June following a national announcement confirming additional funding to mitigate inflationary pressures. In the resubmitted plan the Trust receives £22m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing our overall plan to a breakeven position.

Delivery of this breakeven 2022/23 financial plan looks extremely challenging as it requires that the Trust:

1) Delivers £30m of efficiency savings.
2) Receives £18m of additional Elective Recovery Funding (ERF) for treating planned patient activity above a nationally-set threshold.
3) Reduces the average spend on incremental Covid-19 costs by £9m as compared to the previous financial year.
4) Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Varian**
EKHUFT Income	70,701	74,505	3,804	493,588	503,556	
EKHUFT Employee Expenses	(42,786)	(46,633)	(3,848)	(298,630)	(319,248)	(
EKHUFT Non-Employee Expenses	(28,051)	(30,420)	(2,370)	(199,920)	(200,220)	
EKHUFT Financial Position	**(135)**	**(2,548)**	**(2,413)**	**(4,962)**	**(15,912)**	**(
Spencer Performance After Tax	56	60	4	88	228	
2gether Performance After Tax	100	110	10	698	711	
Rephasing/Sub IFRS16 Adjustment	42	(5)	(47)	197	(18)	
Consolidated I&E Position (pre Technical ad	**63**	**(2,384)**	**(2,446)**	**(3,978)**	**(14,991)**	**(
Technical Adjustments	6	87	81	45	(322)	
Consolidated I&E Position (incl adjs)	**69**	**(2,297)**	**(2,365)**	**(3,933)**	**(15,313)**	**(

East Kent Hospitals University NHS Foundation Trust

	The in-month deficit of £2.4m has resulted in an adverse position against plan of £11.4m YTD. The main drivers of this adverse position were as follows: • Escalation Areas opened of around 60 beds across the Trust due to patient demand and flow £4.8m. • Other income £1.0m under plan due to staff parking charges not commencing in line with the previous plan. • Other Bank and Agency £1.9m due to clinical pressures across the Trust. • Work permits for overseas staffing £1.0m. • Drugs £1.0m. • Cost Improvement Programme (CIP) Slippage £1.3m. All NHS systems have access to funding in 2022/23 through the ERF, subject to meeting the required threshold of 104% of 2019/20 activity levels. We have assumed to receive full ERF funding in April to October as it is expected that activity shortfalls for the full year are underwritten by national funding. The Group cash balance (including subsidiaries) at the end of October was £39m which was a £2m decrease from September but remains £4m below plan. Total capital expenditure at the end of October was £18.5m against an £16.6m plan. The capital expenditure overspend is not considered to be an issue and the Trust is working closely with system partners to maximise the available funding to support required investments. The Trust achieved efficiency savings of £2m in October which is £0.8m below plan bringing the year-to-date position to £1.3m below the plan of £12m. CIP delivery represents one of the biggest risks to achieving our financial plan in 2022/23 especially as a large proportion are non recurrent and non cash releasing.
Key Recommendation (s):	The Board of Directors is being asked to **REVIEW** and **NOTE** the financial performance and actions being taken to address issues of concern.

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

Link to the Board Assurance Framework (BAF):	BAF 38: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE) may result in the Trust not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.	
Link to the Corporate Risk Register (CRR):	None	
Resource:	N	Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	None	

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2022/23

October 2022

Chief Finance Officer
Philip Cave

Contents and Appendices

Month 07 (October) 2022/23

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Executive Summary
Month 07 (October) 2022/23

Executive Summary

The Trust achieved a £2.4m deficit in October, which brought the year-to-date (YTD) position to a £15.0m deficit which is £11m adverse to the plan.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2022/23 at the end of June following a national announcement confirming additional funding to mitigate inflationary pressures. In the resubmitted plan the Trust receives £22 m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing our overall plan to a breakeven position.

Delivery of this breakeven 2022/23 financial plan looks extremely challenging as it requires that the Trust:
Delivers £30m of efficiency savings.
Receives £18m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold.
Reduces the average spend on incremental Covid-19 costs by £9m as compared to the previous financial year.
Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.

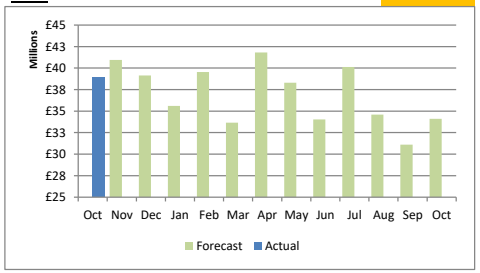
	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	70,701	74,505	3,804	493,588	503,556	9,967
EKHUFT Employee Expenses	(42,786)	(46,633)	(3,848)	(298,630)	(319,248)	(20,618)
EKHUFT Non-Employee Expenses	(28,051)	(30,420)	(2,370)	(199,920)	(200,220)	(300)
EKHUFT Financial Position	**(135)**	**(2,548)**	**(2,413)**	**(4,962)**	**(15,912)**	**(10,951)**
Spencer Performance After Tax	56	60	4	88	228	140
2gether Performance After Tax	100	110	10	698	711	13
Rephasing/Sub IFRS16 Adjustment	42	(5)	(47)	197	(18)	(215)
Consolidated I&E Position (pre Technical adjs)	**63**	**(2,384)**	**(2,446)**	**(3,978)**	**(14,991)**	**(11,013)**
Technical Adjustments	6	87	81	45	(322)	(367)
Consolidated I&E Position (incl adjs)	**69**	**(2,297)**	**(2,365)**	**(3,933)**	**(15,313)**	**(11,380)**

All NHS systems have access to funding in 2022/23 through the Elective Recovery Fund (ERF), subject to meeting the required threshold of 104% of 2019/20 activity levels. We have assumed to receive full ERF funding in April to October as it is expected that activity shortfalls for the full year are underwritten by national funding which has recently been announced.

Income and Expenditure R

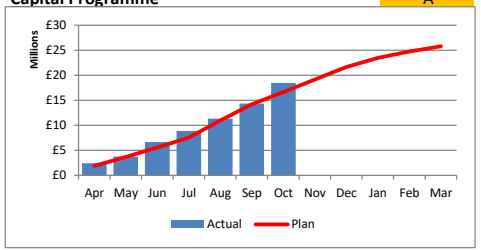
The Trust achieved a £2.4m deficit in October, YTD £15m, which is £11m YTD below the planned position.
The key drivers to the YTD deficit are:
Escalation Areas opened of around 60 beds across the Trust due to patient demand and flow £4.8m
Other income £1.0m under plan due to staff parking charges not commencing in line with the previous plan
Other Bank and Agency £1.9m due to clinical pressures across the Trust
Work permits for overseas staffing £1.0m
Drugs £1.0m
CIP Slippage £1.3m

Cash A



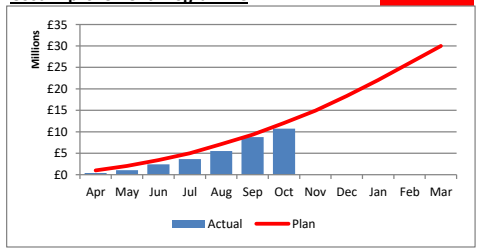
The Group cash balance (including subsidiaries) at the end of October was £39m which was a £2m increase from September but remains below plan (£4m)

Capital Programme A



Total capital expenditure at the end of October was £18.5m against an £16.6m plan. The capital expenditure overspend is not considered to be an issue and the Trust is working closely with system partners to maximise the available funding to support required investments.

Cost Improvement Programme R



The Trust achieved efficiency savings of £2m in October which is £0.8m below plan bringing the year-to-date position to £1.3m below the plan of £12m. CIP delivery represents one of the biggest risks to achieving our financial plan in 2022/23 especially as a large proportion are non recurrent and non cash releasing.

Income and Expenditure Summary
Month 07 (October) 2022/23

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	9,470	8,465	(1,004)	62,212	57,562	(4,650)	108,860
Non-Electives	20,359	17,655	(2,704)	139,829	126,232	(13,597)	238,198
Accident and Emergency	3,958	3,880	(78)	27,398	26,760	(638)	44,972
Outpatients	9,887	9,052	(835)	67,939	61,421	(6,518)	116,834
High Cost Drugs	3,869	5,011	1,143	27,081	30,041	2,960	46,424
Private Patients	23	14	(9)	163	98	(65)	279
Other NHS Clinical Income	18,031	25,254	7,223	134,557	167,365	32,808	231,593
Other Clinical Income	115	155	40	802	982	180	1,375
Total Income from Patient Care Activities	**65,711**	**69,487**	**3,776**	**459,981**	**470,462**	**10,480**	**788,536**
Other Operating Income	4,990	5,018	28	33,607	33,094	(513)	58,458
Total Income	**70,701**	**74,505**	**3,804**	**493,588**	**503,556**	**9,967**	**846,994**
Expenditure							
Substantive Staff	(38,246)	(39,244)	(998)	(262,535)	(271,310)	(8,775)	(455,299)
Bank	(2,213)	(3,529)	(1,316)	(18,101)	(23,011)	(4,910)	(28,215)
Agency	(2,326)	(3,860)	(1,534)	(17,994)	(24,927)	(6,933)	(28,384)
Total Employee Expenses	**(42,786)**	**(46,633)**	**(3,848)**	**(298,630)**	**(319,248)**	**(20,618)**	**(511,898)**
Other Operating Expenses	(27,237)	(29,573)	(2,337)	(193,751)	(194,575)	(824)	(326,549)
Total Operating Expenditure	**(70,022)**	**(76,206)**	**(6,184)**	**(492,381)**	**(513,823)**	**(21,442)**	**(838,447)**
Non Operating Expenses	(814)	(847)	(33)	(6,169)	(5,645)	524	(10,493)
Income and Expenditure Surplus/(Deficit)	**(135)**	**(2,548)**	**(2,413)**	**(4,962)**	**(15,912)**	**(10,951)**	**(1,947)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	66,999	70,898	3,899	469,802	479,038	9,236
Other Operating Income	4,541	5,318	777	30,186	32,555	2,369
Total Income	**71,540**	**76,216**	**4,676**	**499,988**	**511,593**	**11,605**
Expenditure						-
Employee Expenses	(46,033)	(50,112)	(4,079)	(321,308)	(345,108)	(23,800)
Other Operating Expenses	(24,598)	(27,624)	(3,026)	(176,269)	(175,589)	680
Total Expenditure	**(70,631)**	**(77,736)**	**(7,105)**	**(497,577)**	**(520,697)**	**(23,120)**
Non-Operating Expenses	(846)	(864)	(18)	(6,389)	(5,887)	502
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**63**	**(2,384)**	**(2,447)**	**(3,978)**	**(14,991)**	**(11,013)**

Income from Patient Care Activities

In month the Trust saw an overperformance against plan of £3.8m.

Other NHS Clinical Income over performed in month by £7.2m. This is made up of:

- £1.0m of additional funding to cover the cost of the pay award.
- £2.6m benefit from income provision release. An assessment of the income provisions was carried out in month and most of the provisions have been released as the risk has not materialised.
- £0.2m under performance due to unfunded service developments inherent in our plan
- £3.8m offset over performance to balance off activity under performance.

Rechargeable drugs over performed by £0.5m in month, with matching expenditure resulting in no impact on the overall financial bottom line. The remaining £0.6m overperformance against this pod is due to NHSE reallocating from Other NHS Clinical Income.

Out of Area patients are now directly funded and set nationally, this has resulted in the Trust receiving block amounts from ICBs which are direct payments. The majority of the annual amount of this income has been collected.

Other Operating Income and Expenditure

Other operating income is marginally favourable to plan in month and adverse to plan by £0.5m YTD. In month, favourable variances on non patient care and education and training income totalling £0.7m are offset by below plan income for car parking and other income including Covid-19 totalling £0.5m. YTD adverse variances in Other of £1.1m (the net of plan changes and VAT rebates) and car parking, property rental, staff accommodation and R&I totalling £1.6m, are offset by donated income of £0.8m and above plan income for education and training and non patient care activities totalling £1.4m.

Total operating expenditure is adverse to plan in October by £6.2m and by £21.4m YTD. Covid-19 expenditure stands at £0.5m in month and £2.3m YTD, with spend being £0.4m less than plan in month and favourable to plan £0.5m YTD.

Employee expenses is adverse to plan in October by £3.8m and by £20.6m YTD. Expenditure relating to all Covid-19 pay streams is £0.3m in month and £3.2m YTD Indicative direct costs for escalation beds are at least £0.8m and £4.8m YTD and 1:1 specialling costs are £0.6m and £3.3m YTD. Total expenditure on pay in October was £46.6m, a reduction of £4.2m when compared to September, which included backdated pay award arrears.

Other operating expenditure is adverse to plan by £2.3m in October and by £0.8m YTD. Expenditure on all Covid-19 non-pay streams is £0.2m in month and £2.3m YTD. The in-month variance is driven mainly by above plan spend on the OHF contract of £1.3m and Other expenditure (mainly UTCs and work permits) of £0.8m.

Other operating expenditure was £29.6m in October, an increase of £2.6m when compared to September. The growth relates mainly to increased OHF costs of £0.5m, increased business rates and court costs totalling £1.0m, following receipt of rebates and release of provisions in September, increased cost of contracted out services (mainly UTCs) of £0.4m and increased work permit and course fees totalling £0.3m.

Income and Expenditure Summary
Month 07 (October) 2022/23

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
General and Specialist Medicine	4,029	2,595	(1,435)	24,283	19,519	(4,765)
Urgent and Emergency Care	2,317	1,274	(1,043)	15,779	11,339	(4,440)
Surgery and Anaesthetics	369	(849)	(1,218)	(1,127)	(4,849)	(3,722)
Surgery - Head and Neck, Breast Surgery and Dermatology	2,193	2,078	(115)	12,230	12,151	(79)
Clinical Support Services	(4,827)	(5,116)	(288)	(34,389)	(35,528)	(1,139)
Cancer Services	791	922	131	7,275	6,895	(380)
Child Health	73	34	(40)	(257)	(350)	(92)
Women's Health	623	435	(188)	3,714	3,334	(380)
Strategic Development and Capital Planning	(6,423)	(6,665)	(243)	(45,321)	(44,532)	788
Corporate	(4,539)	(4,934)	(395)	(31,001)	(32,079)	(1,078)
2gether Support Solutions	100	110	10	698	711	13
Spencer Private Hospitals	56	60	4	88	228	140

General and Specialist Medicine
October pay is £1.1m adverse to plan, and £3.7m adverse YTD. Staff in post increased by a further 34 wte, growth since April is 138 wte. Premium pay has increased by £0.1m to £2.9m, the average monthly cost of £2.6m is £0.4m higher than 21/22.
Nursing and HCA staff in post has grown by 122 wte since April and premium pay monthly costs are £0.4m higher than April. Asi de from the issues described above, there are premium pay demands whilst overseas nurses are supernumerary in training, and demands on HCA staff ing have resulted in agency now being used to cover gaps.

Urgent and Emergency Care
Pay was £0.83m overspent in October and by £3.29m YTD. The position is driven by the factors outlined above with the growth in premium pay and savings shortfalls applying the most pressure.
Covid-19 expenditure increased by £0.02m on last month, but was £0.04m below the Covid-19 budget allocation. Therefore, it is not causing a budgetary pressure.

Surgery and Anaesthetics
Bank £1.9m & Agency £0.8m staffing overspends are partly from covering a high level of vacancies both in Nursing and HCA's an d additional staffing requirements for escalation beds, specialing care and theatres. Also In addition, there is no Substantive staffing underspend to offset Bank & Agency, since any vacancy underspends have been offset against the CIP target non-recurrently until the efficiency schemes start to deliver.

Surgery - Head and Neck, Breast Surgery and Dermatology
Substantive staffing is £0.5m underspent, which is partially offset with an Agency overspend of £0.3m for Medical staffing.
CIP target YTD of £0.4m has been fully met, but mostly from non-recurrent pay underspends whilst plans are worked on to progress recurrent schemes.

Clinical Support Services
Non-pay costs (Clinical Supplies and Services) were overspent in month as per the trend this year. There continues to be an overspend in pathology. The overspend in month and year to date is predominantly on the Abbott contract supplying reagents and laboratory consumables in Clinical Biochemistry (blood sciences). This overspend is £0.1m in month and £0.48m year to date. Another major driver of t he overspend in Pathology is on tests externally referred to specialist laboratories - £0.05m overspend in month and £0.22m year to date. This is driven by increased testing activity above funded levels (outturn) driven by increasing demand throughout the Trust and also primary ca re referrals. Total net non-pay overspend in Pathology is now at £0.7m year to date.

Cancer Services
There has been an improvement this month in the non-pay position with drugs costs being underspent. The year to date position is reflective of the previous overspends on non-rechargeable drugs and the unmet CIP target which is situated in the non-pay category.

Child Health
Premium pay costs (agency/bank/locum/overtime) totalled £0.42m in October, £0.04m higher than last month and £0.03m higher than the average for 2021/22 (and budgets are set at the average - i.e. 2021/22 outturn). Premium pay expenditure is driven by four main factors:
- Medical agency due to vacancies and sickness across the site teams, as well as insufficient substantive middle grade cover at the QEQMH.
- Growth in referrals into the Community Paediatrics Service requiring additional capacity.
- Nursing agency/bank, due to ward vacancies and admissions requiring one-to-one specialist care.
- Medical consultant resource being used to reduce endoscopy waiting times.

Women's Health
Non-Pay was £0.06m overspent in October, driven mainly by clinical supply/drugs costs and savings shortfalls. The rise in clinical supply expenditure requires further investigation but higher caesarean rates have been identified a factor. Policy changes to improve clinical outcomes have also been identified as the primary cause behind rising drug costs. Non-recurrent expenditure on non-clinical equipment has also added to the pressure on the budget this month.

Strategic Development and Capital Planning
Pay is favourable £0.09m in MTH and £0.73m YTD. The position in MTH is due to vacancies within IT and SD&CP management. IT is £0.48m favourable YTD, 11.09 WTE vacant. Recruitment is underway and historic vacancy rates are being looked into.

Corporate
The position is MTH and YTD is mostly attributable to a large increase in visa (including renewals)/work permit costs for doctors and overseas nurses. Investigation is ongoing to make sure activity is correct and appropriately accounted for. Recruitment should see a decrease in agency/bank staff in care groups.

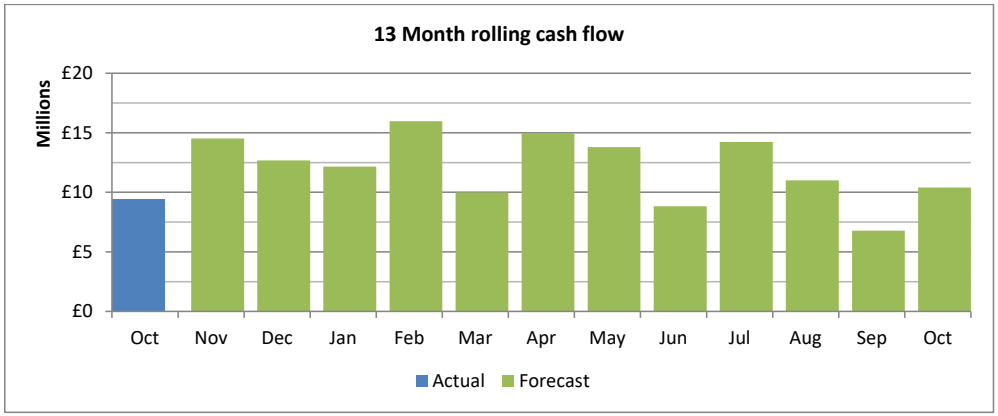
2gether Support Solutions
Income and cost variances mostly relate to the budgeting assumption of capital ; this is partly offset with consumables and ad-hoc recharges levels above budget.

The Operating Profit exceeds budget mainly due to timing of baseline role vacancies across all areas of the business with costs expected in H2, offset by above budget non-pay costs for patient feeding (volume and price), EME maintenance & IHSS sterilisation.

Spencer Private Hospitals
Theatre activity is returning to pre Covid levels with a slight increase in the proportion of private patients.

We are still seeing increased costs to due difficulties in recruiting nursing staff and the need to book agency nursing to cover vacancies.

Cash Flow
Month 07 (October) 2022/23



Unconsolidated Cash balance was £9.4m at the end of October 22, £1.5m below plan.

Cash receipts in month totalled £83.7m (£8.6m above plan)

K&M CCG paid £60.4m in September. £6.5m above plan

NHS England receipts were over plan by £0.6m.

VAT reclaim is £3.8m above plan as August and September reclaims were both received in Month 7

Other receipts were £2.3m below plan in month

Cash payments in month totalled £81.1m (£9.6m above plan)

Creditor payment runs including Capital payments were £24.8m (£4.2m above plan).

Payments to 2gether Support Solutions were £14.4m (£1.4m below plan).

Payroll was £44.1m (£6.8m above plan largely due to increased PAYE, NI and Pension costs relating to the September backdated pay award).

YTD cash receipts total £540.0m (£17.9m above plan - largely driven by block receipts from K&M ICB and additional receipts from NHS England)

YTD cash payments total £557.7m (£19.3m above the plan - mainly driven by creditor (£15.2m) and 2gether Support Solutions payments (-£7.9m) and Payroll (£13.4m))

2022/23 Plan

The revised group plan submitted to NHSE/I in June 2022 shows a breakeven position at the end of 2022/23. A breakeven position eliminates the option of borrowing cash and so all borrowing has been removed from the forecast. (The Trust had expected to require addition funds from September 2022)

Additional income from NHS Kent & Medway ICB commenced in July. The cash forecast is showing future receipts spread evenly to the end of the financial year.

Any cash shortfalls will continue to be managed by careful control of creditor payments as required.

2023/24 Forecast

2023/24 receipts and payments are based on 2022/23 levels with a 1% uplift assumed for K&M ICB and NHS England block payments.

No borrowing has been forecast in 2023/24.

Future year forecasting will be revised when further information is available.

Creditor Management

The Trust has been paying to 30-day creditor terms throughout 2022/23, however, it was necessary in September to pull back to 34 day terms in the last payment run of the month. In October, however, the Trust moved back to 30 day terms. This has only been possible by withholding payment to one key supplier. As at 31st October 2022, £7.9m is overdue for payment to them. Weekly payment runs are being reviewed and this suppliers' invoices cleared when funds are available. (£2.5m was paid to them in October)

At the end of October 2022, the Trust was recording 67 creditor days (Calculated as invoiced creditors at 31st October/ Forecast non-pay expenditure x 365).

Cash Flow

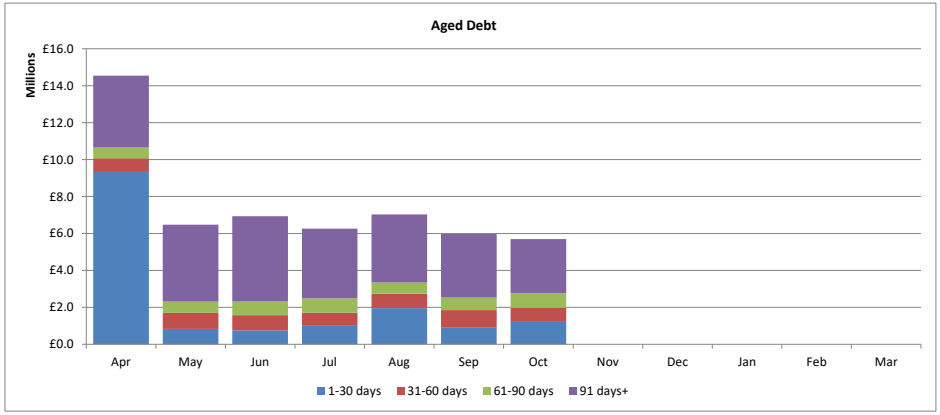
Month 07 (October) 2022/23

	This Month			Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
	Plan	Actual	Variance	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Opening Cash Balance	7,330	6,798	(531)	6,798	9,421	14,517	12,689	12,156	15,968	9,985	14,972	13,794	8,829	14,226	10,997	6,783
Prior Year Main Contract CCGs																
Kent & Medway CCG Contract	53,880	60,178	6,298	60,178	51,754	51,754	51,754	51,754	51,754	53,854	53,854	53,854	53,854	53,854	53,854	53,854
Kent & Medway CCG - Other		231	231	231	2,199	2,126	2,126	2,126	2,126	539	539	539	539	539	539	539
NHS England	11,235	11,871	636	11,871	11,235	11,235	11,235	11,235	11,235	11,341	11,341	11,341	11,341	11,341	11,341	11,341
All Other NHS Organisations	1,213	1,315	101	1,315	10,455	1,205	1,213	4,205	1,229	7,072	1,213	1,213	7,088	1,221	1,205	7,096
Capital Receipts																
All Other Receipts	8,754	10,112	1,358	10,112	4,870	5,702	5,184	4,702	7,663	4,741	4,804	4,904	4,804	4,835	4,872	4,835
Provider Sustainability Fund																
PDC Loans																
Total Receipts	**75,082**	**83,706**	**8,624**	**83,706**	**80,512**	**72,023**	**71,512**	**74,023**	**74,007**	**77,547**	**71,751**	**71,851**	**77,626**	**71,791**	**71,812**	**77,666**
Opening Cash Balance																
Monthly Payroll inc NI & Super	(37,290)	(44,069)	(6,779)	(44,069)	(37,797)	(37,790)	(37,890)	(37,890)	(37,890)	(37,890)	(37,890)	(37,890)	(38,090)	(38,090)	(38,090)	(38,390)
Creditor Payment Run	(34,231)	(36,557)	(2,326)	(36,557)	(36,314)	(33,258)	(31,356)	(30,243)	(35,768)	(33,423)	(33,793)	(37,368)	(32,893)	(35,372)	(32,689)	(34,409)
Capital Payments		(457)	(457)	(457)	(1,306)	(2,802)	(2,799)	(2,077)	(1,558)	(1,247)	(1,247)	(1,558)	(1,247)	(1,558)	(1,247)	(1,247)
PDC Dividend Payment									(4,773)						(4,000)	
Interest Payments																
Total Payments	**(71,521)**	**(81,083)**	**(9,562)**	**(81,083)**	**(75,417)**	**(73,851)**	**(72,046)**	**(70,211)**	**(79,990)**	**(72,560)**	**(72,929)**	**(76,816)**	**(72,229)**	**(75,020)**	**(76,025)**	**(74,046)**
Total Movement In Bank Balance	**3,561**	**2,623**	**(938)**	**2,623**	**5,096**	**(1,828)**	**(533)**	**3,812**	**(5,982)**	**4,987**	**(1,178)**	**(4,965)**	**5,397**	**(3,229)**	**(4,214)**	**3,620**
Closing Bank Balance	**10,891**	**9,421**	**(1,470)**	**9,421**	**14,517**	**12,689**	**12,156**	**15,968**	**9,985**	**14,972**	**13,794**	**8,829**	**14,226**	**10,997**	**6,783**	**10,403**
Plan				10,891	9,793	10,256	9,646	13,893	4,015	16,896	16,218	11,753	17,649	14,420	10,206	14,326
Variance				(1,470)	4,724	2,433	2,510	2,075	5,970	(1,924)	(2,424)	(2,924)	(3,424)	(3,424)	(3,424)	(3,924)
2gether Support Solutions Ltd				26,236	23,767	24,181	21,704	22,118	22,557	25,866	23,659	24,359	25,049	22,849	23,541	22,758
Spencer Private Hospitals Ltd				3,281	2,653	2,273	1,750	1,458	1,123	984	856	851	843	759	775	951
Group Closing Balance				**38,938**	**40,937**	**39,143**	**35,609**	**39,544**	**33,665**	**41,823**	**38,309**	**34,038**	**40,118**	**34,604**	**31,099**	**34,112**

Working Capital
Month 07 (October) 2022/23

Top ten debtor balances outstanding as at 31/10/2022

Debtor Name	Current	1+	31+	61+	91+	Total
HEALTH EDUCATION ENGLAND T1510	9,142					9,142
SPENCER PRIVATE HOSPITALS LIMITED	490	388	349	456	391	2,074
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	428	257	37	105	265	1,091
NHS KENT AND MEDWAY ICB	549	80	24	22		675
MEDWAY NHS FOUNDATION TRUST	125	105	1	1	354	587
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	246	39	61	39	83	468
2GETHER SUPPORT SOLUTIONS LTD	154		138		9	301
PHILIPS RESPIRONICS					245	245
SRCL LTD	213				0	213
DARTFORD AND GRAVESHAM NHS TRUST	102	29			19	150
Total	**11,449**	**898**	**611**	**622**	**1,365**	**14,945**



Total invoiced debtors have increased from the 22/23 opening position of £16.8m by £1.2m to £18.0m (of which £12.3m is current debt)

This increase is largely driven by a £9.1m Health Education England invoice outstanding at Month end, offset by an £8.6m decrease in Kent & Medway CCG/ICB debt. Spencer Hospitals debt increased by £0.4m and Kent Community Health FT debt increased by £0.5m.

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

- Health Education England owe £9.1m - payment of which has been received in early November
- Spencer Private Hospitals owe £2.1m - the Trust is working to bring reciprocal balances down
- Kent Community Health NHS FT owes £1.1m, of which £0.4m is current debt

Top ten creditor balances outstanding as at 31/10/2022

Supplier Name	Current	1+	31+	61+	91+	Total
NHS Professionals Ltd	3,562	5,582	2,337			11,481
Other Creditors	7,721	1,032	471	180	1,559	10,962
Spencer Private Hospitals Ltd		69	301	(664)	2,289	1,994
2gether Support Solutions Ltd		645	361	244	376	1,626
Medway NHS Foundation Trust (RPA)	9	392	22	396	221	1,041
Maidstone & Tunbridge Wells NHS Trust (RWF)	78	188	185	169	11	631
Invicta Health Community Interest Company	590				0	590
HealthNet Homecare (UK) Ltd	523	36				559
Abbott Laboratories Ltd	553					553
InHealth Ltd	500					500
Total	**13,536**	**7,944**	**3,677**	**324**	**4,456**	**29,937**

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	39,798	336,810	40,732	350,186
Total bills paid within target	37,359	311,384	35,768	308,531
Percentage of bills paid within target	**93.9%**	**92.5%**	**87.8%**	**88.1%**
NHS				
Total bills paid in the year	1,576	6,161	1,365	6,955
Total bills paid within target	1,267	4,918	979	4,654
Percentage of bills paid within target	**80.4%**	**79.8%**	**71.7%**	**66.9%**
Total				
Total bills paid in the year	41,374	342,971	42,097	357,141
Total bills paid within target	38,626	316,302	36,747	313,185
Percentage of bills paid within target	**93.4%**	**92.2%**	**87.3%**	**87.7%**

Invoiced creditors have increased by £9.1m from the opening position to £29.9m.

45% relates to current invoices with 15% or £4.5m over 90 days.

NHSP debt has grown significantly during the year from £2.74m to £11m which is due to an increased reliance on premium pay staff to fill gaps along with mounting pressures on the Trusts available cash.

Our BBPC figures have dipped below 90% in places and as such we are now required to report to NHSEI the reasons behind this.

Income from Patient Care Activities

Month 07 (October) 2022/23

Trust Income Plan	Trust Actual Income	Income Variance
£459.981m	£470.462m	£10.480m

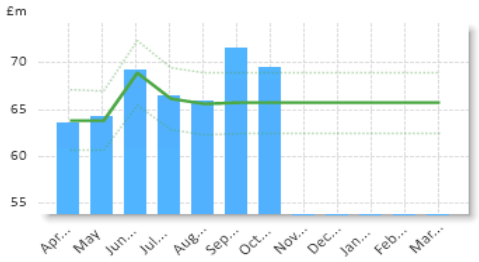
2022/23 - Month 7 Model

East Kent Hospitals University NHS
NHS Foundation Trust

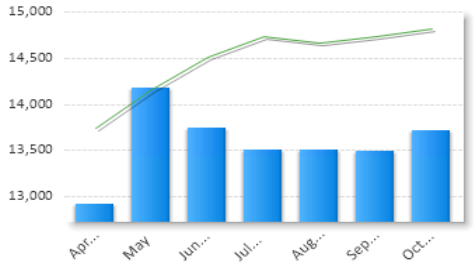
	Year to Date			This Month vs. Run Rate		
Summary	Plan	Actual	Variance	Actual	Run Rate to	Var to M6 ate
1 Total Non Elective Spells	139.8	126.2	(13.6)	17.7	18.1	(0.4)
2 Accident & Emergency	27.4	26.8	(0.6)	3.9	3.8	0.1
3 Total Elective Spells	62.2	57.6	(4.7)	8.8	8.1	0.6
4a New Outpatient Attendances	30.2	27.9	(2.3)	4.0	4.0	0.0
4b Outpatient Follow Up Attendances	37.8	33.5	(4.2)	4.8	4.8	0.0
5 Other Cost Per Case	92.3	97.9	5.6	14.6	13.9	0.7
6 Block Agreements	13.7	13.6	(0.1)	1.9	1.9	(0.0)
7 Income Additional to PbR	44.8	76.0	31.2	12.5	10.6	1.9
8 Risks and Adjustments	(0.0)	(0.9)	(0.8)	(0.5)	(0.1)	(0.4)
9a Elective Recovery Fund	11.9	11.9	(0.0)	1.7	1.7	0.0
9c Adjust Prior Month Reported Position	-	0.0	0.0	(0.0)	0.0	(0.0)
Grand Total	**460.0**	**470.5**	**10.5**	**69.5**	**66.8**	**2.7**

	This Month			Year to Date			Annual
Care Group Income £m	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cancer Services	5.1	5.1	0.0	35.2	35.2	(0.0)	60.2
Central	6.2	10.0	3.8	51.7	62.2	10.5	89.6
Child Health	3.0	3.0	(0.0)	20.2	20.2	(0.0)	34.8
Clinical Support Services	5.9	5.9	(0.0)	41.1	41.1	0.0	70.5
General and Specialist Medicine	14.9	14.9	0.0	103.9	103.9	0.0	176.5
Surgery - Head and neck, Breast Surgery...	4.7	4.7	0.0	30.2	30.2	0.0	52.7
Surgery and Anaesthetics	12.0	12.0	(0.0)	82.4	82.4	(0.0)	142.0
Urgent and Emergency Care	9.2	9.2	(0.0)	63.2	63.2	(0.0)	106.8
Womens Health	4.8	4.8	(0.0)	32.2	32.2	(0.0)	55.6
	65.7	**69.5**	**3.8**	**460.0**	**470.5**	**10.5**	**788.5**

Income by Month

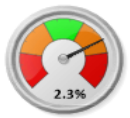


Monthly WAU - vs Plan

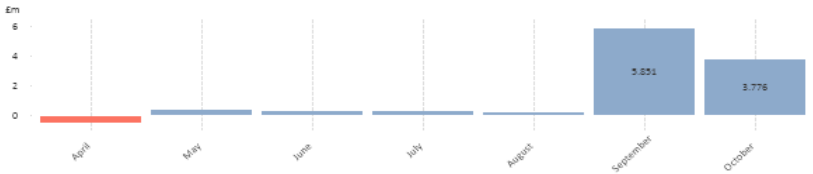


	This Month			Year to Date			Annual
Commissioner Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Kent and Medway CCG	53.5	55.0	1.5	374.6	382.5	7.9	642.1
NHS England SS	6.5	6.5	(0.0)	45.4	46.7	1.3	77.9
NHS England - Rechargeable Drugs	2.7	3.3	0.6	18.7	22.0	3.3	32.1
Public Health & Secondary Dental	1.3	0.6	(0.7)	9.3	7.0	(2.2)	15.9
Cancer Drugs Fund and Hep C	0.5	0.4	(0.2)	3.8	2.7	(1.2)	6.6
Out of Area CCGs	0.4	0.4	(0.0)	2.8	2.8	(0.0)	4.8
NHS England - Other	0.4	0.0	(0.4)	2.5	0.0	(2.5)	4.2
Other Organisations	0.3	0.4	0.0	2.3	2.4	0.1	3.9
Sussex Integrated Care Board	0.1	0.1	0.0	0.6	0.7	0.0	1.1
Prior Year Income	-	2.8	2.8	-	3.8	3.8	-
	65.7	**69.5**	**3.8**	**460.0**	**470.5**	**10.5**	**788.5**

Total Income Var



Income Variance



Due to national guidance not to accrue risk on Elective Services Recovery Fund (ESRF), the variable element of the Aligned Incentive Contracts relates to the activity-based and is currently reported as on plan. This is an annual target based on Trusts delivering 104% of the financial value of Elective activity performed in 19/20.

Elective spells activity has underperformed by 10% against plan in October, and is showing a 9% underperformance against plan YTD. Regular Attenders is showing a 7% underperformance YTD; however, these are excluded from the calculation of ESRF. Elective pathways are showing a 9% YTD underperformance and being driven by over performances in Clinical oncology (549 spells which is 10% over plan), Dermatology (193 spells which is 10% over plan) and Cardiology (129 spells which is 9% over plan). The areas under plan are Orthopaedics (812 spells which is -18% under plan), Gastroenterology/Endoscopies (-2,588 spells -16% under plan), Ophthalmology (-782 spells -28% under plan) and Urology (-937 spells which is -12% against plan).

The outpatient element is 7% under plan YTD. Speciality performance details exclude Pre-Op Assessments due to a change in recording methodology. Performance is driven by over performances in Physiotherapy (2,924 appointments which is +8% against plan). Colorectal Surgery (697 appointments which is +8% against plan) and T&O (563 appointments which is +2% against plan). The adverse specialties are Cardiology (-4,976 appointments which is -16% against plan), Ophthalmology (-3,680 appointments which is -14% against plan) and Gastroenterology (-2,395 appointments which is -13% against plan).

There has continued to be a high number of escalation beds open across the Trust and there has been a material increase in the number of patients over 24 hours and over 48 hours recorded as an A&E attendance rather than an admission. There were a total of 1,683 patients recorded as an A&E attenders for over 24 hours in October. We are working with the care group to review the recording of these patients as potentially we are under-recording our emergency admissions activity.

The variable element of NHSE High Cost drugs is £2.8m above plan, but are pass through costs and net with expenditure.

Activity

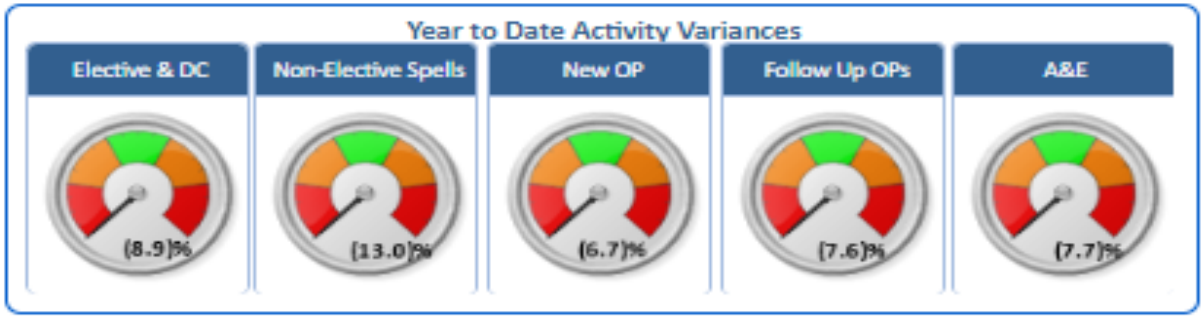
Month 07 (October) 2022/23

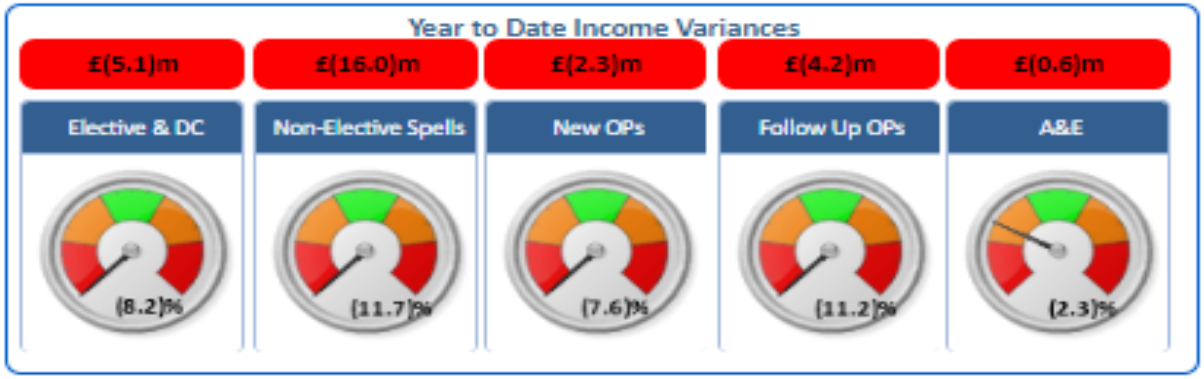
Trust Income Plan	Trust Actual Income	Income Variance
£459.981m	£470.462m	£10.480m

2022/23 - Month 7

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	51,901	45,136	(6,765)	£137.3 m	£121.3 m	£(16.0)m	£2,646	£2,687
2 Accident & Emergency	176,668	163,013	(13,655)	£27.4 m	£26.8 m	£(0.6)m	£155	£164
3a Total Elective Spells	56,809	51,778	(5,031)	£62.0 m	£56.9 m	£(5.1)m	£1,091	£1,098
4a New Outpatient Attendances	155,700	145,311	(10,389)	£30.2 m	£27.9 m	£(2.3)m	£194	£192
4b Outpatient Follow Up Attendances	342,618	316,655	(25,963)	£37.8 m	£33.5 m	£(4.2)m	£110	£106





The Trust has investigated the Non-Elective underperformance against plan of 13%, compared to the increased pressure the services are under. The Trust is experiencing difficulties with the flow of Non-Elective patients, caused by significant delays to the discharging of some medically fit patients. There were 584 patients stranded over 7 days and of these 291 Super stranded for over 21 days. The combination of this and an evolution in the use of observation bays appears to have resulted in a greater proportion of patients seen and treated in A&E with stays >12hrs, resulting in the number of Non-Elective admission being lower.

This has seen average length of stay of Non-Elective patients rise steadily from 3.2 in May 2021 to 4.1 days in March 22, up to 5.3 days in October 22.

Outpatients have operated at 10% under planned levels in October, and are showing 7% under plan YTD.

Daycase and Elective inpatient activity has underperformed by 12% against plan in October, and is showing an 9% underperformance against plan YTD. The financial element of Elective Inpatients and Daycases is under plan by £0.7m in month and £4.6m YTD. T&O is £2.7m below plan YTD and Gastro/Endoscopy are £1.4m below plan YTD, both of which are significant drivers of the ERF under-performance against baseline, which is being reviewed.

The level of A&E attendances is running an underperformance against plan of 6% in month and 8% YTD. The financial variance is lower at -1% in month and -2% YTD., which reflects a richer case mix of patients now seen and treated in A&E.

ERF Income

Month 07 (October) 2022/23

Reporting POD Reporting POD £000	In-Month Income Target (104%) (£m)	In-Month Price Actual (£m)	In-Month Financial Adjustment @ 75% (£m)	Income Target (104%) + 1.6% October Inflation	YTD Price Actual (£m)	YTD Financial Adjustment @ 75% (£m)	YTD Income Performance vs 100% Baseline	YTD Activity % vs 100% Baseline
Daycases	2,938	4,612	1,256	28,306	30,055	1,312	110%	105%
Elective Inpatients	3,849	3,842	(6)	27,434	24,139	(2,471)	92%	80%
Outpatient News	3,998	3,624	(281)	25,234	24,054	(886)	99%	99%
Outpatient Follow Ups	4,476	3,691	(589)	28,290	23,316	(3,731)	86%	99%
Outpatient Procedures	1,822	1,731	(69)	11,750	11,885	101	105%	107%
Chemotherapy	415	389	(19)	2,866	3,307	330	120%	106%
Grand Total	**17,499**	**17,889**	**292**	**123,881**	**116,755**	**(5,345)**	**98%**	**100%**

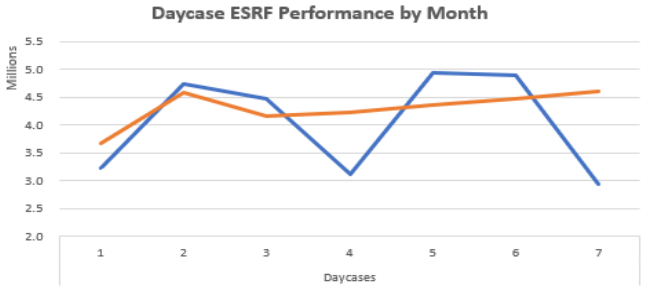
IncomeTarget (104%) + 1.6% October Inflation

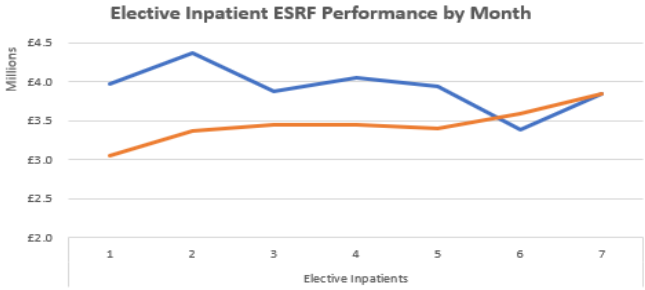
YTD Price Actual (£ '000)

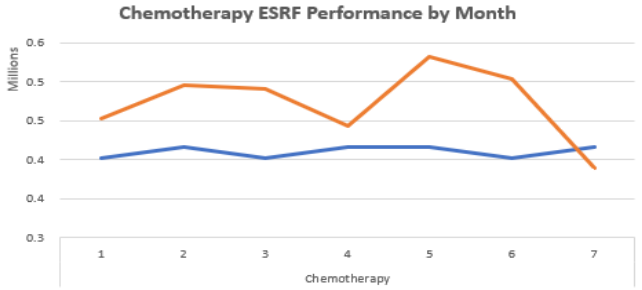
The Trust activity plan has been designed to meet the 104% value ESRF target. Due to the required reduction in Outpatient Follow Up activity to 75% of 2019/20 levels by March 2023 (85% as an average for the year), the expectation is that other areas need to rise to around 110% of the 2019/20 levels to compensate, which is proving to be very challenging.

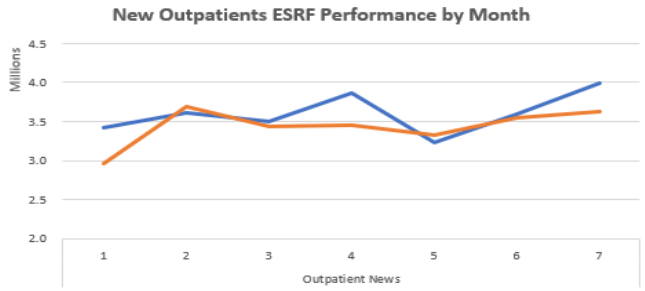
ESRF is paid against a threshold which is different to the activity plan and is phased differently. The ESRF plan was phased nationally, and doesn't ramp up due to expected additional capacity, which the Trust's plan does. Therefore, although the Trust underperformed against activity and income plan in month and YTD, when compared against the threshold, Elective inpatients have performed close to the target this month. Day case activity has performed significantly above the target in month in activity and financially by £1.25m.

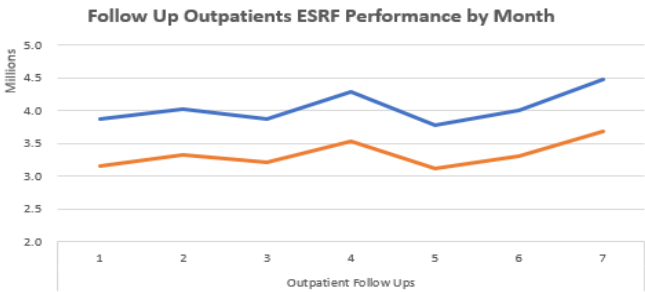
Income for Outpatient follow ups are fixed to 85% of the baseline, per national guidance. Outpatient new attendances are at 19/20 levels and Chemotherapy performance has slightly under performed this month against the targets. It should be noted that Chemotherapy recording is still struggling, although significant volumes of activity has been recorded retrospectively, some of which is after data has 'frozen'. A working group has been set up to address this.

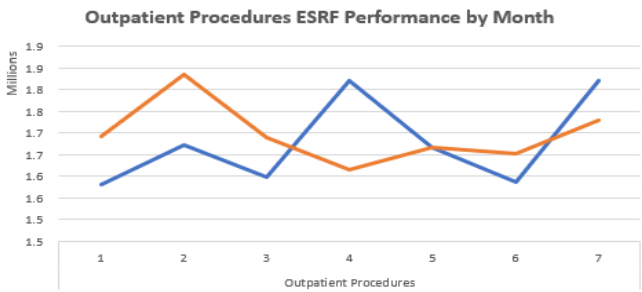






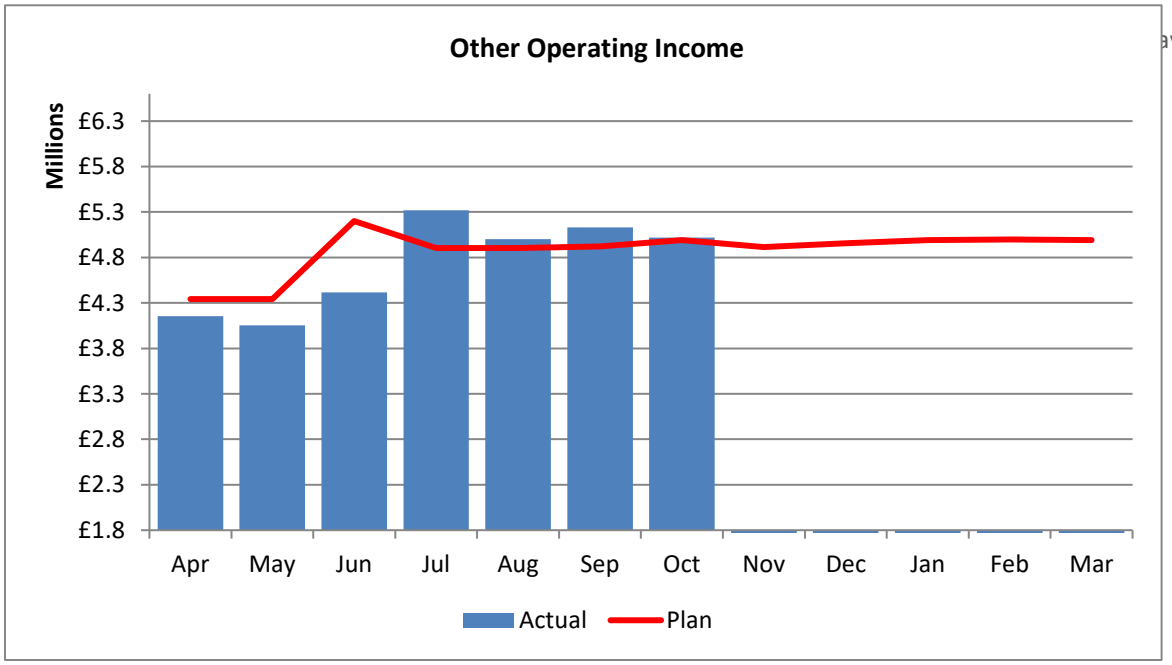






Other Operating Income
Month 07 (October) 2022/23

Other Operating Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,864	2,269	405	13,051	14,112	1,061	22,374
Research and development	219	180	(39)	1,532	1,316	(216)	2,626
Education and Training	1,522	1,779	257	10,657	11,040	382	18,272
Car Parking income	476	149	(327)	2,007	993	(1,014)	4,304
Staff accommodation rental	160	135	(26)	1,123	994	(129)	1,922
Property rental (not lease income)	36		(36)	255		(255)	436
Cash donations / grants for the purchase of capital assets	75	88	13	525	1,329	804	900
Charitable and other contributions to expenditure	14	13	(2)	100	84	(16)	171
Other	623	405	(217)	4,357	3,225	(1,131)	7,453
Total	**4,990**	**5,018**	**28**	**33,607**	**33,094**	**(513)**	**58,458**
			0.56%			-1.53%	
			avourable			Adverse	



Other operating income is marginally favourable to plan in October by less than £0.1m and adverse to plan by £0.5m YTD. In month, favourable variances on non-patient care and education and training income totalling £0.7m are offset by below plan income for car parking (mainly unachieved CIPs) and other income including Covid-19 totalling £0.5m.

YTD, above plan CIPs for VAT recovery on stock is partially offset by an adverse variance on other income following changes to the external plan in June and below plan income for Covid-19, leaving the adverse variance on other income at £1.1m. Income relating to car parking, property rental, staff accommodation and R&I are adverse to plan YTD by a total of £1.6m. These adverse variances are offset by donated income for Harmonia Village of £0.8m, and above plan income for education and training and non-patient care activities totalling £1.4m.

Employee Expenses
Month 07 (October) 2022/23

Employee Expenses	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,406	1,340	66	(11,843)	(11,657)	187	(82,309)	(79,204)	3,105	(141,274)
Nurses and Midwives	3,299	3,026	273	(10,802)	(11,384)	(583)	(71,472)	(77,611)	(6,139)	(127,151)
Scientific, Therapeutic and Technical	1,749	1,626	122	(5,808)	(5,868)	(60)	(40,577)	(40,986)	(409)	(69,780)
Admin and Clerical	1,766	1,559	207	(3,372)	(3,836)	(464)	(23,477)	(26,688)	(3,211)	(40,322)
Other Pay	1,813	1,718	95	(5,235)	(5,167)	68	(36,445)	(37,347)	(902)	(62,595)
Permanent Staff Total	**10,034**	**9,270**	**764**	**(37,061)**	**(37,913)**	**(852)**	**(254,280)**	**(261,836)**	**(7,557)**	**(441,121)**
Waiting List Payments										
Medical and Dental	0	0	0	(399)	(453)	(53)	(2,779)	(3,387)	(608)	(4,773)
Waiting List Payments Total	**0**	**0**	**0**	**(399)**	**(453)**	**(53)**	**(2,779)**	**(3,387)**	**(608)**	**(4,773)**
Medical Locums/Short Sessions										
Medical and Dental	0	55	(55)	(787)	(879)	(93)	(5,476)	(6,087)	(611)	(9,405)
Medical Locums/Short Sessions Total	**0**	**55**	**(55)**	**(787)**	**(879)**	**(93)**	**(5,476)**	**(6,087)**	**(611)**	**(9,405)**
Substantive	**10,034**	**9,325**	**709**	**(38,246)**	**(39,244)**	**(998)**	**(262,535)**	**(271,310)**	**(8,775)**	**(455,299)**
Bank										
Medical and Dental	0	61	(61)	(311)	(663)	(353)	(2,542)	(3,681)	(1,139)	(3,962)
Nurses and Midwives	11	318	(306)	(1,037)	(1,596)	(559)	(8,480)	(10,736)	(2,256)	(13,218)
Scientific, Therapeutic and Technical	1	2	(1)	(8)	(19)	(10)	(67)	(82)	(15)	(104)
Admin and Clerical	5	69	(65)	(175)	(252)	(77)	(1,431)	(1,639)	(207)	(2,231)
Other Pay	8	326	(319)	(682)	(999)	(316)	(5,581)	(6,874)	(1,293)	(8,700)
Bank Total	**25**	**777**	**(752)**	**(2,213)**	**(3,529)**	**(1,316)**	**(18,101)**	**(23,011)**	**(4,910)**	**(28,215)**
Agency										
Medical and Dental	2	48	(45)	(643)	(1,040)	(398)	(4,893)	(7,443)	(2,551)	(7,870)
Nurses and Midwives	3	239	(235)	(867)	(1,340)	(473)	(6,864)	(8,396)	(1,533)	(10,667)
Scientific, Therapeutic and Technical	0	0	0	18		(18)	(38)		38	(100)
Admin and Clerical	0	5	(5)	(8)	(68)	(60)	(62)	(331)	(269)	(96)
Other Pay	1	80	(79)	(130)	(310)	(181)	(829)	(1,900)	(1,071)	(1,263)
Agency Total	**7**	**371**	**(364)**	**(1,629)**	**(2,758)**	**(1,129)**	**(12,685)**	**(18,070)**	**(5,385)**	**(19,996)**
Direct Engagement - Agency										
Medical and Dental	2	72	(70)	(691)	(1,097)	(406)	(5,262)	(6,807)	(1,545)	(8,316)
Scientific, Therapeutic and Technical	0	2	(2)	(6)	(6)		(47)	(49)	(3)	(72)
Direct Engagement - Agency Total	**2**	**74**	**(72)**	**(697)**	**(1,102)**	**(405)**	**(5,309)**	**(6,857)**	**(1,547)**	**(8,388)**
Agency	**9**	**445**	**(436)**	**(2,326)**	**(3,860)**	**(1,534)**	**(17,994)**	**(24,927)**	**(6,933)**	**(28,384)**
Total	**10,068**	**10,547**	**(479)**	**(42,786)**	**(46,633)**	**(3,848)**	**(298,630)**	**(319,248)**	**(20,618)**	**(511,898)**
						-8.99%			-6.90%	
						Adverse			Adverse	

Employee expenses performance is adverse to plan in October by £3.8m and by £20.6m YTD (6.9%). This includes pay award and associated backdated costs to April for middle grade doctors following a national delay in implementing the pay award. Expenditure relating to all Covid-19 pay streams is £0.3m in month and £3.3m YTD. Indicative direct costs for escalation beds are at least £0.8m and £4.8m YTD and 1:1 specialling costs are £0.6m and £3.3m YTD.

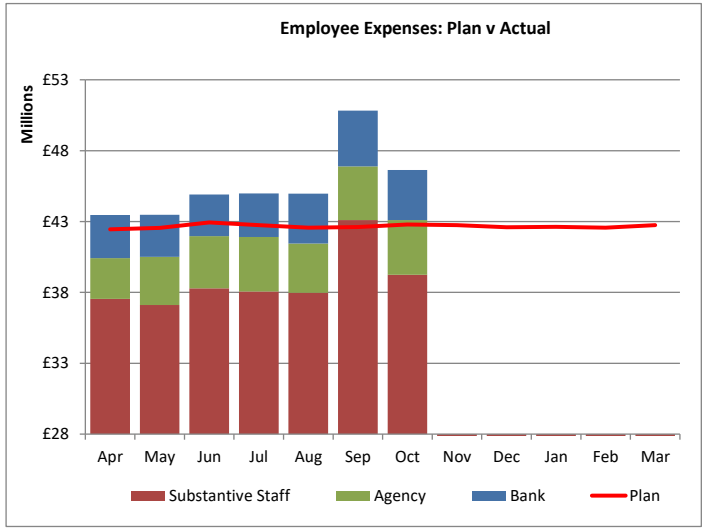
Total expenditure on pay in October was £46.6m, a reduction of £4.2m when compared to September.

Expenditure on permanent staffing in October reduced by £3.9m compared to expenditure in September, with reductions in all staff groups except middle grade doctors which increased £0.6m with the implementation of their pay award. There was further growth of 83 WTE contracted substantive staff, mainly qualified nurses and midwives.

Expenditure on bank staff fell by £0.4m, following recognition of increased pay award costs in September of £0.5m. Agency spend increased by £0.1m.

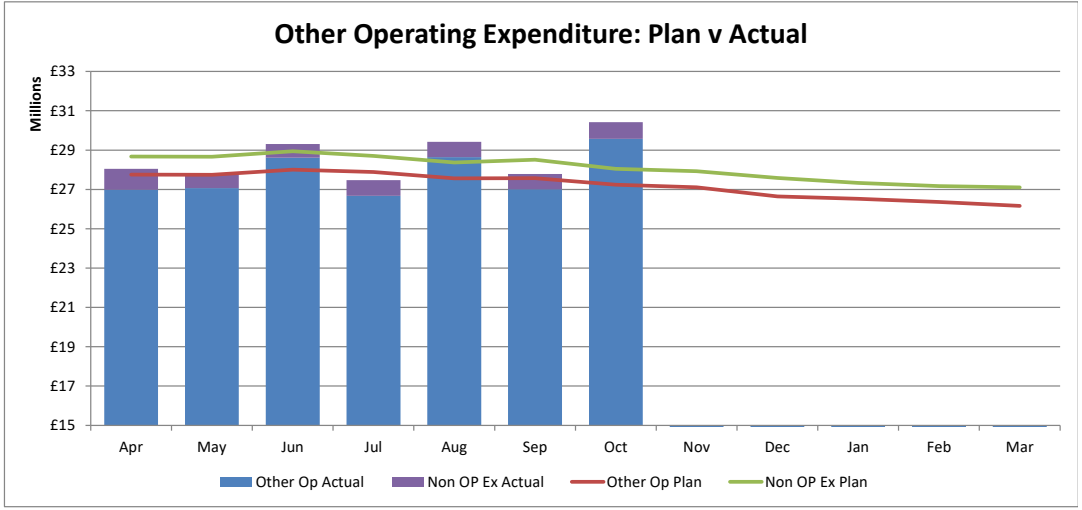
Expenditure on all substantive staff is adverse to plan in October by £1.0m and by £8.8m YTD inclusive of the pay award impact.

Expenditure on bank and agency staff combined is adverse to plan in October by £2.8m and by £11.8m YTD.



Other Operating Expenditure
Month 07 (October) 2022/23

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(6,678)	(6,898)	(220)	(46,963)	(48,930)	(1,967)	(80,094)
Supplies and Services – Clinical	(3,428)	(3,388)	39	(24,747)	(24,288)	459	(41,509)
Supplies and Services - Non-Clinical	(9,213)	(10,479)	(1,265)	(66,679)	(67,287)	(608)	(110,939)
Non Executive Directors	(19)	(14)	4	(132)	(103)	29	(229)
Purchase of Healthcare	(694)	(430)	264	(5,125)	(4,167)	958	(8,059)
Education & Training	(304)	(419)	(115)	(2,131)	(2,089)	42	(3,652)
Consultancy	(27)	(68)	(41)	(189)	(155)	35	(325)
Premises	(1,130)	(1,180)	(49)	(7,961)	(5,930)	2,032	(13,615)
Clinical Negligence	(2,210)	(2,139)	71	(15,536)	(14,974)	562	(26,591)
Transport	(250)	(272)	(22)	(1,799)	(1,689)	110	(2,935)
Establishment	(341)	(486)	(146)	(2,384)	(2,805)	(421)	(4,081)
Other	(961)	(1,774)	(812)	(6,241)	(9,180)	(2,939)	(10,752)
Depreciation & Amortisation-Owned Assets	(1,981)	(1,986)	(5)	(13,865)	(12,940)	925	(23,769)
Impairment Losses		(39)	(39)		(39)	(39)	
Total Other Operating Expenditure	**(27,237)**	**(29,573)**	**(2,337)**	**(193,751)**	**(194,575)**	**(824)**	**(326,549)**
Profit/Loss on Asset Disposals		(73)	(73)	(250)	(89)	161	(500)
PDC Dividend	(777)	(777)		(5,657)	(5,496)	161	(9,545)
Interest Receivable	181	218	37	1,266	1,493	227	2,171
Interest Payable	(218)	(216)	3	(1,528)	(1,552)	(24)	(2,619)
Total Non Operating Expenditure	**(814)**	**(847)**	**(33)**	**(6,169)**	**(5,645)**	**524**	**(10,493)**
Total Expenditure	**(28,051)**	**(30,420)**	**(2,370)**	**(199,920)**	**(200,220)**	**(300)**	**(337,043)**



Other operating expenditure is adverse to plan by £2.3m in October and by £0.8m YTD (0.40%). Expenditure on all Covid-19 non-pay streams is £0.2m in month and £2.3m YTD.

Drug spend is adverse to plan in October £0.2m and by £2.0m YTD. Drugs historically classed as rechargeable which includes blood product deliveries and issues to homecare patients are adverse to plan in October by £0.3m, and adverse to plan by £1.4m YTD. All other drugs are favourable to plan in month by £0.1m and adverse to plan by £0.6m YTD.

Supplies and services - clinical are marginally favourable to plan in month and favourable to plan by £0.5m YTD. The YTD position is driven mainly by adverse variances against CIP targets and pathology reagents (including Covid-19 testing) totalling £2.9m being offset by below plan spend on equipment purchase and maintenance and diagnostic services totalling £3.6m.

Supplies and services - non-clinical are adverse to plan by £1.3m in October and by £0.6m YTD. Variances in month and YTD relate predominantly to the Operated Healthcare Facility contract which is adverse to plan in month by £1.3m and adverse to plan by £0.7m YTD, including subsidiary pay award.

Purchase of healthcare from the independent sector is favourable to plan in month by £0.3m and by £1.0m YTD. This reflects the reduced use of Spencer beds and the transfer of provider invoicing for agreed procedures to the ICB with effect from August.

Premises costs are marginally adverse to plan in month and favourable to plan by £2.0m YTD. The YTD position is driven by underspends on the rental of premises, building works, licence fees and business rates totalling £1.9m.

Clinical negligence is favourable to plan in month by £0.1m and by £0.6m YTD, linked to the non-collection of the Maternity Incentive Scheme 22-23.

Other expenditure is adverse to plan by £0.8m in month and by £2.9m YTD. In-month and YTD variances are driven by overspends in Urgent Treatment Centres reflecting the new overnight GP telephony service and work permits.

Depreciation is favourable to plan in month and by £0.9m YTD. A small impairment was incurred relating to IT software purchased but not used.

Other operating expenditure was £29.6m in October, an increase of £2.6m when compared to September. The growth relates mainly to increased OHF costs of £0.5m, increased business rates of £0.6m, following receipt of rebates in September, increased court and legal costs of £0.4m, following release of provision in September, increased cost of contracted out services (mainly UTCs) of £0.4m and increased work permit and course fees totalling £0.3m.

Cost Improvement Summary

Month 07 (October) 2022/23

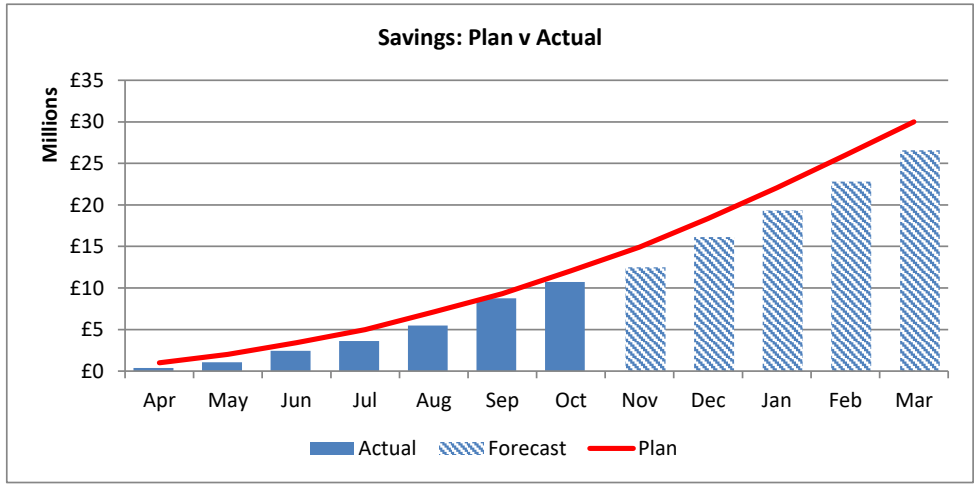
Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	476	509	33	2,334	1,925	(408)	4,819	(742)
Bank	-	12	12	-	35	35	77	77
Workforce	42	163	121	204	958	754	1,645	1,048
Outpatients	-	-	-	-	-	-	-	-
Procurement	147	25	(122)	664	116	(548)	801	(999)
Medicines Value	96	88	(8)	456	576	120	1,142	(58)
Theatres	300	15	(285)	1,164	73	(1,091)	94	(2,906)
Care Group Schemes *	1,474	960	(514)	6,129	5,076	(1,053)	10,162	(5,021)
Sub-total	**2,535**	**1,771**	**(764)**	**10,951**	**8,760**	**(2,191)**	**18,739**	**(8,602)**
Central	198	186	(12)	1,106	1,963	857	7,854	5,195
Grand Total	**2,733**	**1,957**	**(776)**	**12,057**	**10,723**	**(1,334)**	**26,594**	**(3,406)**

* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	**Target**	**Actual**
April	999	390
May	1,023	662
June	1,399	1,375
July	1,562	1,205
August	2,129	1,863
September	2,212	3,270
October	2,733	1,957
November	2,848	
December	3,446	
January	3,694	
February	3,945	
March	4,010	
	30,000	**10,722**

Efficiencies

The submitted Efficiencies plan for 2022-23 is £30m. The Trust achieved savings of £2.0m in October, which is below Plan. The in-month performance relates to shortfalls in Care Groups, Theatres & Procurement, offset by overperformance in Agency, Workforce and Bank. YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed. Recurrent savings in October amounted to £1.2m, with £0.8m being on a non-recurrent basis. Recurrent savings YTD amount to £4.6m with £6.1m on a non-recurrent basis. A pipeline of ideas is being developed as the basis for delivery of the 2022-23 efficiency programme. The forecast is updated and reviewed weekly to accelerate progress.



Capital Expenditure
Month 07 (October) 2022/23

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
ED Expansion WHH & QEQM	11,654	12,124	7,479	8,734	(1,255)
24 Bed ITU Kennington Carpark WHH	350	391	350	391	(41)
PEIC - Backlog maintenance/ Patient environment improvement	3,750	4,064	2,305	2,234	71
MDG - Medical equipment replacement (<£250k per item)	1,136	2,011	270	744	(474)
IDG - IT hardware/ systems replacement	3,310	4,343	2,590	1,765	825
New Interventional Radiology (IR) suite - K&C	160	203	160	203	(43)
Endovascular theatre (EVT) kit installation - K&C	937	937	575	516	59
Maternity Training		309			
Clinical Trials Unit	1,000	457	65	344	(279)
Community Diagnostic Hub - BHD	250	279	250	279	(29)
Maternity Estates Review	376	376	250	31	219
Refurbishment of SCBU QEQM and meeting IPC requirements	341	341	200	26	174
Theatre 4&5 - AHU Replacement - KCH	1,200	1,470	1,200	1,470	(270)
Restore and Recovery	250	230	250	187	63
East Kent Transformation Programme	178	178	178	134	44
Donated Assets	900	760	525	553	(28)
2gether Support Solutions		226		18	(18)
Spencer Private Hospitals		8		8	(8)
Other IFRS16 Assets		1,029		1,029	(1,029)
All Other		(281)		(182)	182
	25,792	**29,455**	**16,647**	**18,484**	**(1,837)**
Funded By:					
Operational Cash	23,368	22,032			
System Set Underutilisation	(4,168)	0			
Grants and Donations	900	1,676			
Disposals	500	500			
Front Line Digitisation PDC	910	910			
Other PDC	4,282	2,827			
Right of Use Asset Liabilities	0	1,277			
	25,792	**29,222**			
Under/(Over) Commitment		**(233)**			

2022/23 Summary Capital Spend position - M7 and Forecast Outturn

The group gross capital year-to-date spend to the end of Month 7 is £18.5m, against an YTD Plan of £16.7m. This represents a £1. 8m overspend against plan, as a result of the overall increase in the 2022/23 Capital Programme.

The estimated forecast for the year as at the end of M7 is £29.5m, representing a £3.7m increase from the original capital plan submitted in April 2022 of £25.8. The £3.7m increase to plan is due to:

- an increase of £0.8m in Donated Income received in relation to Harmonia Village;
- £1.3m worth of lease liabilities recognised as a result of the IFRS16 implementation; these, however, have a net-neutral impact on the System CDEL target allocation, as they do not count towards CDEL and are therefore excluded from the calculation via a technical accounting adjustment;
- £1.3m of additional PDC income received by the Trust in relation to the Diagnostic Digital Capability Programme (£1m) and Diagnostics Imaging Ultrasounds (£0.3m); and
- £0.3m relating to Maternity Training Equipment, investment which was approved by the Trust Board in September 2022; this is an additional amount included in this report this month.

Major projects updates:

- K&C EVT: New AHU delivered and craned into position. Project remains on programme and budget.
- QEQM Refurbishment of SCBU: Programme will be tendering in mid-November for 3 to 4 weeks and it is expected to commence on site in February 2023.
- ED Expansion WHH & QEQM:
- WHH Phase 1 has completed and was handed over on the 9th September 2022. Phase 2 commenced in October 2022 and is split into 3 sub-phases, 2 of which are expected to complete in early February 2023. Phase 3 is scheduled for completion in May 2023.
- QEQM Phase 2 will commence on 21st November 2022 and is expected to be finalised by mid-May 2023. Phase 3 is then scheduled for completion by the end of August 2023.

Overall, the project is experiencing significant cost pressures expected to impact 2023/24, which are being reported at the capital oversight meetings.

• **QEQM & WHH - Maternity Estates Review:** tendering expected to complete by the end of the year, with a plan to commence on site in late January 2023, for 7 months. Given the complexity of having this project and the SCBU project running adjacent and concurrently at QEQM, the team is considering awarding the maternity element of the project as a contract variation to the successful SCBU tenderer. This will avoid potential risks of having two separate contractors working side by side in a very sensitive part of the hospital, whilst also resulting in better value for money, by not doubling up on preliminary costs.

• **Clinical Trials Unit (QEQM):** project complete, with minor additional works required post project, which are awaiting clinical teams to agree drawings before proceeding.

Impact of IFRS16:

The Trust conducted an internal review of all leases on which IFRS16 implementation is applicable and based on the available information, the latest estimate for the total lease cash repayments in 2022/23 is circa £1.5m. This represents a £0.55m risk to the Capital Programme against the £0.95m provision that was made in the 2022/23 Capital Plan. However, of the total £0.4m cash repayments expected as at the end of M7, only £0.2m has so far materialised. This can be due to a number of reasons, including late invoicing by the lessor, late payment by the Trust or a mixture of both.

The team is currently working on identifying potential mitigating options, including deferring part of the payments to April 2022. The Trust will continue to monitor the position closely and a regular update will be provided in the upcoming reports.

Other risks

• The previously reported MDG risks totalling £0.5m have since been mitigated, along with an additional £0.3m allocated to PEIC to mitigate against the emergent risks reported.

• The Capital Programme is currently overcommitted by £0.2m against the available funding, due to the approval of the Maternity Training and Development business case by the Trust Board in September 2022, for which no capital provision has been made, given the emergent pressures on the MDG and PEIC programmes. The team is currently working on identifying mitigating options and will provide an update in due course.

Statement of Financial Position
Month 07 (October) 2022/23

£000	Opening	To Date	Movement	
Non-Current Assets	**419,046**	**423,546**	**4,499**	▲
Current Assets				
Inventories	5,527	7,487	1,960	▲
Trade Receivables	17,933	18,732	799	▲
Accrued Income and Other Receivables	16,715	17,951	1,236	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	27,372	9,431	(17,941)	▼
Total Current Assets	**67,547**	**53,602**	**(13,945)**	▼
Current Liabilities				
Payables	(37,923)	(50,695)	(12,772)	▲
Accruals and Deferred Income	(54,360)	(52,697)	1,663	▼
Provisions	(5,761)	(5,215)	546	▼
Borrowing	(1,136)	(1,492)	(356)	▲
Net Current Assets	**(31,633)**	**(56,497)**	**(24,864)**	▼
Non Current Liabilities				
Provisions	(4,417)	(4,342)	75	▼
Long Term Debt	(83,551)	(79,174)	4,377	▼
Total Assets Employed	**299,446**	**283,533**	**(15,912)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	425,777	425,777	-	
Retained Earnings	(181,901)	(197,692)	(15,791)	▼
Revaluation Reserve	55,569	55,448	(122)	▼
Total Taxpayers' Equity	**299,446**	**283,533**	**(15,912)**	▼

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions. A “full" revaluation of the Groups estate (carried out every 5 years) will be completed in 2022/23.

Trust closing cash balance was £9.4m (£6.8m September) £1.5m below plan. See cash report for further details.

An updated Treasury Policy will include a formal process for cash to be moved from the subsidiaries to the Trust in order to minimise or remove the need for borrowing and maximise the potential for interest receivable income. The Board of 2gether have received the request but have asked for additional external advice before considering - this delay potentially increases the likelihood of the Trust needing to borrow.

Trade and other receivables have increased from the 2021/22 opening position by £1.2m (£7.6m increase in September). Key drivers are detailed on the Cash report

Payables have increased by £12.7m (£16.4m increase in September) See Working Capital sheet for more detail on debtors and creditors.

The long-term debt entry relates to the long-term finance lease debtor with 2gether.

The movement in Retained earnings reflects the year-to-date unadjusted deficit.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MEDICAL REVALIDATION REPORT**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER (CMO)**				
PAPER AUTHOR:	**CHIEF MEDICAL OFFICER**				
APPENDICES:	**APPENDIX 1: MEDICAL APPRAISAL AND REVALIDATION**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To provide the Board with a 6-monthly update on the current status for Medical Appraisal and Revalidation.				
Summary of Key Issues:	Medical appraisal when delivered well promotes doctors' engagement and sense of value within an organisation and provide patients and the wider public with the assurance that doctors are up to date and practising within a clinical governance framework. The supporting information required for medical appraisal moves beyond technical competence and considers the wider context of a doctor's work. Over the last 6 months we have continued to make progress to strengthen our appraisal and revalidation for doctors. • Additional resource has been allocated during the year to the appraisal and revalidation team to support improving the quality of appraisals. • Key recommendations from the Quality Assurance review are being prioritised for implementation • There are initial improvements noted in appraisal quality and the standard of appraisals being delivered to our medical workforce. • Overall appraisal compliance for the medical workforce is 70% with efforts focussed to deliver appraisals by the end of this appraisal year				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** the progress and **DISCUSS** the report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**Principal Risk – BAF 33** There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.				
Link to the Corporate Risk Register (CRR):	**Principal Risk – CRR 123** There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs.				
Resource:	Y	Designated bodies are required to support the Responsible Officer (RO) in fulfilling statutory duties.			
Legal and regulatory:	Y	Compliance with The Medical Profession (ROs) (Amendment) Regulations 2013.			
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	None				

East Kent Hospitals University NHS Foundation Trust

APPENDIX 1

MEDICAL APPRAISAL AND REVALIDATION

1. Purpose of the report

1.1 Revalidation and appraisal are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop, so care continuously improves. This report summarises East Kent Hospitals position in respect to its performance as a Designated Body.

1.2 Two key actions identified following the Higher-Level Responsible Officer Quality Assurance visit in September 2022 were:

- a focus on appraisers and driving up appraisal quality through appraiser engagement and development.
- establishing a Responsible Officers Advisory Group (ROAG) incorporating Quality Governance and People & Culture representation.

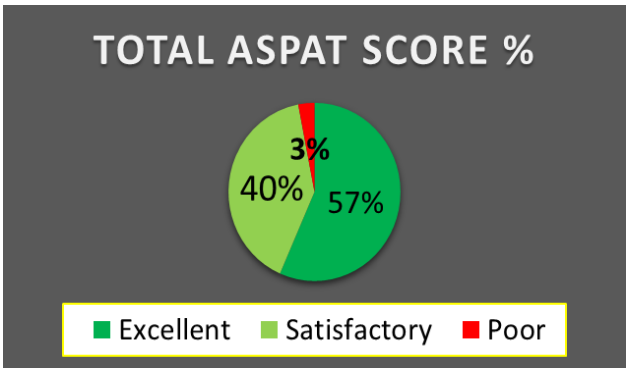
2. Quality Assurance audit comparison data 2021/22

2.1 Qualitative assessment of an individual appraiser's appraisal outputs (summaries and personal development plans (PDPs)) of the appraisals was carried out covering the 3-month period from 01/04/2022 to 31/06/2022 (Q1).

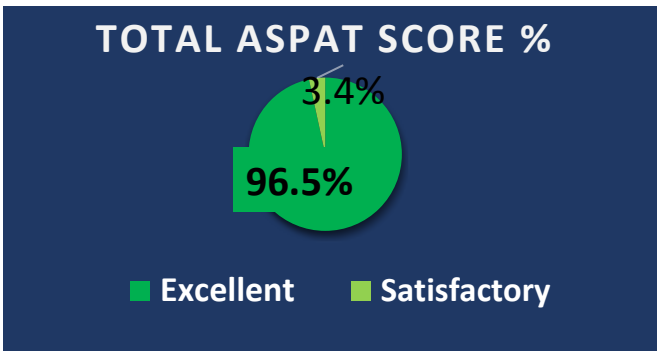
2.2 A total of 88 output forms were reviewed, scored using quality assurance tool, The Appraisal Summary and PDP Audit Tool (ASPAT) providing final general comment for each individual appraiser.

2.3 Comparative data is shown below from 2021 to 2022. The data is a small sample size from the total number of appraisals undertaken each year.

2021 ASPAT Scores



2022 ASPAT Scores



2.4 There has been significant improvement in the sampled appraisals in the quality of appraisers output forms with total ASPAT scores reaching 96.5%. This was achieved after appropriate actions for Quality Assurance were implemented from previous Audit 2021 action plan, including:

- Appraisal Lead acting as secondary appraiser, returning output form to appraisers to include missing statements in the outputs and sending them regular feedback.
- Receiving feedback from appraisers.
- Participation of appraisers in appraiser's refresher training sessions.
- Regular feedback to Appraisal & Revalidation Team in the Trust.

2.4 To continue to improve appraiser performance in 2022 the Appraiser Lead will continue to act as a secondary appraiser however this is not a long-term sustainable solution on its own. Approaches being considered are a network of senior appraisers to support the Appraisal Lead.

2.5 The medical appraisal policy is under review and the minimum and maximum numbers of appraisals agreed to create a smaller cohort of appraisers to drive up and maintain quality. Appraisers who have not undertaken recent appraisals have been addressed and appraiser role is included in job planning.

2.6 ASPAT will be used to score sample outputs of all appraisers. Consideration of additional support for new appraisers and a review of appraiser development sessions will be part of the role of the Responsible Officer Advisory Group (ROAG).

3. Responsible Officer Advisory Group (ROAG)

3.1 This group will monitor the performance of the Trust as a Designated Body in its delivery of medical appraisal and revalidation and will support the RO in their duties.

3.2 Legal responsibility for revalidation recommendations for an individual doctor cannot be delegated by the RO but by bringing together the appraisal team, senior clinicians, quality governance and people and culture representation the triangulation of data from the clinical governance framework in which a doctor practices will be strengthened and reduces the risk of bias.

3.3 Terms of reference have been drafted following advice and guidance from the NHS England Revalidation team visit on 8 September 2022.

3.4 An initial Responsible Officer Advisory group is scheduled to for January 2023.

4. Appraisal rates progress by quarter

4.1 The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions for the first 2 quarters of 2022 are recorded in the table below.

Name of organisation: East Kent Hospitals University NHS Foundation Trust	Q1 2022	Q2 2022
Total number of doctors with a prescribed connection	865	860
The number of doctors due to have an appraisal meeting in the reporting period	302	303
Total number of appraisals undertaken in this period	170	145
Total number of agreed exceptions	27	26

4.2 The appraisal system sends automated reminders to doctors and these are backed up by the revalidation manager following up overdue appraisals. This process has been strengthened to focus on all doctors unless a valid exemption agreed, for example due to long term sickness, to have completed their appraisal by the end of the appraisal year (31 March 2023).

5. Revalidation recommendations

5.1 211 recommendations have been submitted to the General Medical Council (GMC) in the last 12 months. Some of these may be for the same doctor, for example where we have deferred their submission due date to allow extra time for information to be provided to the RO.

5.2 The proportion of doctors receiving a positive recommendation has increased with 146 (70%) positive recommendations to revalidate made. There have been 65 deferrals of revalidation. The GMC are considering one non-engagement recommendation.

6. Conclusion

Medical appraisal when delivered well promotes doctors' engagement and sense of value within an organisation and provides patients and the wider public with assurance that doctors are up to date and practising within a clinical governance framework. The supporting information required for medical appraisal moves beyond technical competence and considers the wider context of a doctor's work.

Since the annual statement of compliance was presented to the Board there has been continued progress against the gaps identified in delivery of revalidation and medical appraisal that underpins this.

The additional resource made available is focussed on driving both the compliance and the quality of appraisals.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INFECTION PREVENTION AND CONTROL (IPC) QUARTERLY UPDATE**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**EXECUTIVE DIRECTOR OF INFECTION PREVENTION AND CONTROL (EDIPC)**				
PAPER AUTHOR:	**EXECUTIVE DIRECTOR OF INFECTION PREVENTION AND CONTROL**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To apprise the Board of Trust performance against external and internal Key Performance Indicators and any risks and issues arising in the previous quarter.				
Summary of Key Issues:	• Reportable infections: one case of Meticillin resistant *Staphylococcus aureus* (MRSA), an increase in Meticillin sensitive *Staphylococcus aureus* (MSSA) cases compared with previous year, Cdiff and *E. coli* not on target to achieve external trajectory. *Klebsiella species* and *Pseudomonas aeruginosa* on target to achieve external thresholds. • Outbreaks and incidents: Covid-19 case numbers are currently low. Cases of suspected and confirmed Diphtheria have been managed via the emergency pathway. • Rising numbers of Influenza and Respiratory Syncytial Virus (RSV) cases have been seen but there has been no Norovirus activity yet this winter. • An update to the 2022/23 work plan is given.				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the content of the update.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	BAF 31 – Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements, leading to harm.				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	Y/N	N			
Legal and regulatory:	Y/N	N			
Subsidiary:	Y/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

Trust Board - Infection Prevention and Control Quarterly Update to end November 2022

1. Nationally reportable infections with and without externally set thresholds.

Trust assigned MRSA bacteraemia: one single case in the reporting year to date.

Trust assigned MSSA bacteraemia (no external trajectory set): 43 cases in the reporting year to date, this is higher than the same period last year (36 cases). Comparisons with the previous year should be made with caution due to activity levels and the impacts of the Covid-19 pandemic.

Trust assigned *Clostridioides difficile* (Cdiff): The Trust continues to be off trajectory to achieve the external threshold, with 77 cases year to date. The threshold of 82 cases will be exceeded. This reflects a regional and national increase in Cdiff which, at this time, is not fully understood. Targeted and generic IPC activities have continued and there is no evidence of an outbreak, or of any cases of confirmed transmission. A detailed briefing of the position and IPC activities has been given to the Quality and Safety Board Committee and is included in the Trust Board Reading Room.

Trust assigned Gram negative bacteraemias: *E coli* bacteraemias remain over trajectory to achieve the external threshold with 100 cases year to date. If the typical seasonal pattern of *E coli* continues the final number of cases is likely to be above the external trajectory. The number of cases over the summer months was considerably higher than the same period last year. Speculatively the extreme temperatures seen over that period may have had some impact, given what is known about *E coli* epidemiology. Both *Klebsiella species* and *Pseudomonas aeruginosa* are on target to be below the external threshold with 44 and 24 cases respectively, year to date.

2. Outbreaks and incidents

Covid-19 – the most recent quarter has seen a continuation of the pattern of smaller surges of cases associated with new Omicron sub-variants, peaking at around 100 inpatients in mid-October. At the time of writing the number of inpatients with a positive test for Covid-19 is as low as at any point since the summer of 2021 with fewer than 20 cases.

Cases of Mpox (previously described at Monkeypox have declined and none have been seen in recent months. The issue of holes is sterile surgical wraps has been successfully mitigated with interim solutions, with very few rejected sets now being reported; the longer-term solution is still in train.

Cases of confirmed and suspected Diphtheria associated with the migrant and refugee facilities in Kent have been managed, primarily by urgent and emergency care services, with IPC and microbiology support as required.

3. Seasonal infection challenges

Cases of Influenza are rising and are currently higher than cases of Covid-19, the Influenza season is earlier than typical (pre-Covid-19, as there has been virtually no Influenza for the previous two winters). Cases of RSV have been seen, primarily in children as is expected. There has been some pressure on regional paediatric intensive care services associated with RSV season. To date there has been no significant Norovirus activity.

4. Update on the IPC Work Plan 2022/23

Overview
During November the IPC Team became fully established for the first time since before the beginning of the Covid-19 pandemic. Some colleagues are very new to the speciality and require further training and support, but the team will be fully functional and functioning before the end March 2023.

Priority	Element	Lead	Progress	Notes
Governance and Assurance	Review of committees	EDIPC		Complete revision of IPC, decontamination, water safety, ventilation and Antimicrobial Resistance and Stewardship structure to be presented to December IPC Committee (IPCC) for approval
	Business continuity plans	EDIPC		Delayed due to operational priorities
	Succession Planning	EDIPC		Updated as per Trust process
Infection Reduction Priorities	Driver metrics	EDIPC		Cdiff will not achieve external threshold. *E coli* unlikely to achieve external threshold
	Watch metrics	EDIPC		*C difficile* moved to Driver category
Team and Service Development	'Brilliant Teams' event	EDIPC		Completed – outputs to inform further team development
	IPC leads Trust Wide portfolios	Deputy DIPC		All leadership roles now filled and portfolios in progress
	Deputy DIPC decontamination lead role	Deputy DIPC		Training course cancelled at short notice (by host) – rebooked for January, Deputy DIPC has capacity now (see above)
	Kent Fundamentals training	Deputy DIPC		In progress
	Poster/publication	EDIPC		Project identified (automated hand hygiene monitoring system evaluation) – delayed by external factors
IPC Education and Link Practice	IPC education review	IPC Site Lead		In progress
	Link practice review	IPC Site Lead		Delayed due to operational pressures/staffing

Surveillance, Audit and Epidemiology	IPC audit programme review	Deputy DIPC		In progress – dependent on 'Tendable' audit implementation
	Surveillance activity	IPC Site Lead		Review of mandatory orthopaedic surgical site infection surveillance in progress (stage 1) – Surgical Site Infections (SSI) audit in general surgery at William Harvey Hospital (WHH) completed
	Increased epidemiological/ analytical capacity	EDIPC		No funding available in-year due to financial challenge
	Automated surveillance	EDIPC		Exploratory at this stage, in discussions with information colleagues
'Must Do'	Review of compliance with the 'Code of Practice	EDIPC		Preliminary review completed, still waiting for publication of revised code (EDIPC involved in review)
Antimicrobial Stewardship (AMS)	Improvement activity beyond Business As Usual (BAU) of AMS team and committee	EDIPC		Consultant pharmacist appointed, start date of February 2023 Internal Audit of AMS completed, final report awaited AMS Summit had to be postponed due to operational pressures, being rearranged.

Key

	Completed
	In progress - on track
	In progress - off track – mitigations in place/delays beyond local control
	Off track – mitigation required/not started

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**PANORAMA AND LEARNING DISABILITES AND OR AUTISM REPORT**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER**				
PAPER AUTHOR:	**INTERIM JOINT HEAD OF SAFEGUARDING**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The purpose of this paper is to provide a report to the Board in relation to the care of people with learning disabilities (LD) and or autism within the Trust following the Panorama programme, which outlined failings, abuse and neglect in care delivery within acute services.				
Summary of Key Issues:	One of the deliverables for the All Age Safeguarding Deliverables (AASD) action plan related to the impact of a lack of pathways and health inequalities for people with LD and or autism and the significance of this within the context of care delivery in the Trust. As a result of this, safeguarding impact assessments were continued to be undertaken with a key focus on the day to day concerns regarding care delivery, safeguarding referrals, complaints and serious incidents that involved people with LD and or autism. Therefore, the following were evident: 1. There is evidence of some excellent work where there had been joint working with the Trust LD nurses, the patient's own carers and placement, nurses, matrons and consultant that demonstrated what good looked like in relation to the care of people with LD and or autism. This ensured that there were prior arrangements made by all key individuals involved to provide an environment where reasonable adjustments were made to support the patient in a timely manner. This included the discharge that was also facilitated in a safe and timely manner, where the patient did not have to wait or spend a significant length of time on an acute ward, which is not consistent with best practice guidance. 2. There is evidence of health inequalities for supporting people with LD and or autism, complicated by a lack of pathways and commissioning issues, which are more system wide, as such this was identified as a risk and currently remains on the safeguarding risk register. 3. Until August 2022, there were 2 LD nurses across the 3 acute sites and 2 non-acute, now there is 1. The other has been redeployed to deliver the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) workstream to address the Care Quality Commission (CQC) requirements in relation to this.				

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	4. There has been safeguarding concerns, complaints and serious incidents raised in relation to people with LD and or autism within the Trust. 5. The Trust currently has patients with complex LD and or autism who are residing on acute wards due to a lack of specialist placement pathways for accommodation, and the wards continue to have challenges meeting their needs. 6. Patients with LD continue to be moved in between wards and departments without reasonable adjustments being made, this has an impact on their patient experience and staff challenges in managing behaviours that challenge.
Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** the report and **DISCUSS** the key issues highlighted. 2. **ASSURANCE** with regards to the mitigation factors in place and how these can be implemented with the required resources identified.

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

Link to the Board Assurance Framework (BAF):	CRR Ref 36: Patient outcomes may be compromised as a consequence of a failure to identify patients at risk of abuse, neglect and harm for both adults and children in line with relevant legislation (Children's Act, Care Act, Mental Capacity Act, Equalities Act, Human Rights Act and Mental Health Act).	
Link to the Corporate Risk Register (CRR):	As above.	
Resource:	**Y**/N	Safeguarding adults and children's teams to effectively deliver safeguarding activities.
Legal and regulatory:	**Y**/N	Statutory safeguarding duties as defined in the Care Act and Children's Act legislation and statutory guidance.
Subsidiary:	Y/**N**	None
Assurance Route:		
Previously Considered by:	None	

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PANORAMA AND LEARNING DISABILITES AND OR AUTISM REPORT

1. Purpose of the report

1.1 The purpose of this paper is to provide a report to the Board in relation to the care of people with LD and or autism within the Trust following the Panorama programme, which outlined failings, abuse and neglect in care delivery within acute services.

1.2 The Trust currently supports patients with a range of complex LD and or autism, and whilst there is evidence of good practice, there are ongoing challenges of maintaining the quality of care for these patients within an acute setting. This paper will examine the current challenges and concerns and the impact of this on patients with LD and or autism and the proposed mitigating factors to address these.

2. Background

2.1 Over the last few months, the Trust had been implementing the AASD action plan, of which one of the objectives was in relation to undertaking safeguarding impact assessments associated with health inequalities as a result of a lack of pathways for people with LD and or autism. This has included the length of time patients with LD and or autism remain in acute care when they are deemed medically optimised, as lengthy stays within acute hospitals are associated with poor outcomes.

2.2 The initial scoping indicated that there was evidence of health inequalities in the manner in which people with LD and or autism where being supported. This is completed by a lack of pathways, training for staff and workforce issues to ensure that more support was provided on the wards.

2.3 The Panorama programme identified key areas which had implications for the Trust and these included the following:

1. Lack of understanding/ education for around LD – this is also indicated as a system wide and national issue, as such there is a national drive in relation to this.
2. Lower employment rates of LD nurses in NHS.
3. Poor care due to poor staffing levels. No 1:1.
4. Lack of understanding/ implementation of MCA/BI.
5. Inappropriate use of medication – there has been no evidence of this within the Trust, however, a review if this is currently underway.
6. Prolonged waits for patients' pathways, treatment and surgery.
7. Patient's and family not feeling listened to.

3. Current Mitigations in Place

3.1 Oliver McGowan e-learning training is now on Electronic Staff Record (ESR) and the learning disability nurse is currently working on making this essential training for all staff. Next year when further guidance is launched, the Trust will move to more interactive training.

3.2 With regards to addressing the issues with MCA/DoLS, the Trust currently has an MCA/DoLS implementation plan, which is being led by the interim MCA/DoLS/LPS Clinical Lead with the Joint Head of Safeguarding in conjunction with the Integrated Care Board (ICB) and the NHS England (NHSE) Regional lead for MCA/DoLS/LPS.

3.3 With regards to the potential inappropriate use of medication being used to treat people with LD and or autism, the MCA/DoLS/LPS Clinical lead is currently undertaking a chemical restraint thematic review relating to people with dementia. This has been extended to include reviewing any incidents that involve people with LD and or autism and the restraint policy is also being reviewed and updated.

3.4 The safeguarding and LD nurse currently work with the Medical Director to identify any patients with LD and or autism who may be on the waiting list for surgery, and where there are delays to ensure that this is escalated and that they are seen in a timely manner. This is part of addressing the health inequalities associated with extended waiting time for essential treatment and surgery for people with LD and or autism.

3.5 The LD nurse attends the all Learning Disabilities Mortality Reviews (LEDER) and the Trust reports all deaths of patients with LD to the LEDER programme and lessons learned from these are disseminated to the Care Groups by the LD nurse. There is also easy to read project and information available on website focusing on LEDER themes, and the Trust news focusing on reasonable adjustments, LEDER, Oliver McGowan and the need for referrals to LD, Speech and Language Therapy (SALT), dietician and physiotherapist.

3.6 The LD nurse has developed a liaison pathway with community LD teams, which is a unique acute liaison pathway, which consists of regular joint working with community learning disability Multi-Disciplinary Team (MDT) and social care.

3.7 The Trust had a learning disability register to ensure that people who have a learning disability are identified in a timely manner. This leads to professionals working with them and better understanding their needs. There is now an autism register which is being developed and started in October 2022.

3.8 The Trust also has a system that enables them to refer patients with LD and or autism onto the NHSE Dynamic Risk Register if they are not on this to ensure that they have the multiagency support required as part of hospital admission avoidance.

3.9 There are further plans to provide similar approaches being used in dementia care to enhance the experiences of people with LD and or autism. This includes the provision of LD sensory support kit to make experience better in hospital, as well as LD activity co-ordinator/ activity box to make the experience better.

3.10 As there is evidence of health inequalities for supporting people with LD and or autism, complicated by a lack of pathways and commissioning issues, which are more systems-wide, this was identified as a risk and currently remains on the safeguarding risk register.

3.11 A draft specialist and complex cases Standard Operating Procedure has been developed to address the impact of the lack of system-wide pathways in the Trust. This includes patients with complex LD and or autism who do not meet the current discharge pathways commissioned by the ICB through the Rapid Transfer Service.

4. Challenges and Next Steps

4.1 Until August 2022, there were 2 LD nurses for the 3 acute sites and 2 non-acute, now there is only 1, as the other had to be redeployed to undertake MCA/DoLS workstream, where there are Care Quality Commission (CQC) requirements in relation to this. In similar size Trusts such as Leeds, there are 9 practitioners. There is an Options paper which has requested an additional 2 LD specialist nurses and 1 Autism Spectrum Disorder (ASD) specialist, as the Trust does not have any autism specialist nurses and this role is currently being undertaken by the LD nurse. There is

currently no provision for children with LD and/or ASD. **An increase in the number of LD and autism nurses is required, as indicated in the Safeguarding Workforce Option Paper to support the wards who no longer have this consistent level of expertise.**

4.2 When patients with complex learning disabilities are admitted in the Trust, staff from the patient's service are encouraged to continue to support the patient in hospital. However, this depends on the social care team as it is generally understood that care in acute hospital should be funded by them, which is not the case as social care indicates that this is the role of the acute hospital to do this. **Therefore, additional provision in the Enhanced Observation policy for funding to be agreed by EKHUFT for patients' own carers to continue to support in hospital is required. The Trust needs to recognise the need to consider these person-centred reasonable readjustments that will enable the patient with LD and or autism to have the support from staff who know them well.**

4.3 The following challenges remain as a result of system wide and commissioning issues and are known to the Kent and Medway Safeguarding Adults Board, ICB Health Reference Group:

1. A person with complex autism and mental health issues has for many months been residing on Trust premises at the Kent and Canterbury Hospital due to a lack of autism and complex mental health pathway. They are likely to be admitted as an inpatient within acute care if they continue to deteriorate, and they are now subject to a safeguarding investigation under section 42.

2. The Trust currently has patients with complex LD and or autism who have been on acute wards due to a lack of specialist placements pathways for accommodation, and the wards continue to have challenges in meeting their needs.

Therefore, consideration is required with regards to what other escalation is required to ensure that this is mitigated not just at system wide level, where these risks remain with the ICB, but to also consider this within an Integrated Care System (ICS) context to include NHSE.

NHS
East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**HEALTH & SAFETY (H&S), ESTATES STATUTORY COMPLIANCE AND BACKLOG MAINTENANCE UPDATE**				
MEETING DATE:	**8 DECEMBER 2022**				
BOARD SPONSOR:	**CHIEF STRATEGY OFFICER**				
PAPER AUTHOR:	**INTELLIGENT CLIENT / ASSOCIATE DIRECTOR OF SAFETY / DIRECTOR OF CAPITAL & ESTATES**				
APPENDICES:	**APPENDIX 1: ESTATES STATUTORY COMPLIANCE** **APPENDIX 2: PATIENT ENVIRONMENT & INVESTMENT COMMITTEE (PEIC) BUDGET SPEND 2022/23**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report updates the Board on the Trust's position in relation to statutory compliance, backlog, critical infrastructure and progress to date on the annual Health and Safety Toolkit Audit (HASTA) performance.				
Summary of Key Issues:	Health and Safety, Estates Statutory Compliance and Backlog maintenance update.				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** this report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people	Our future	Our sustainability	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	CRR 34 – Continuing to embed Health & Safety systems within the Care Groups.				
Link to the Corporate Risk Register (CRR):	CRR 34 – Inadequate Health & Safety systems embedded within the Care Groups.				
Resource:	N	N/A			
Legal and regulatory:	Y	Statutory Compliance and Health and Safety legislation.			
Subsidiary:	Y	2gether Support Solutions is providing health and safety advice and guidance in line with the Service Level Agreement.			
Assurance Route:					
Previously Considered by:	Strategic Health and Safety Committee have had HASTA information table and other elements summarised in a report that is consistent with this report.				

East Kent Hospitals University NHS Foundation Trust

HEALTH & SAFETY (H&S), ESTATES STATUTORY COMPLIANCE AND BACKLOG MAINTENANCE UPDATE

1. Background and Executive Summary

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

2. Estate Statutory Compliance

2.1. The table below shows the current statutory compliance cumulatively by site. The areas with the lowest compliance are HTM05, Fire and Smoke Statutory, Health and Safety Management and Site Records.

Compliance Overview Oct 2022 - Desk Top Audit	KCH					WHH					QEQM					Overall Total				
Category	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with
Fire & Smoke Statutory & HTM 05	12	9	75.00	0.00	25.00	18	13	72.22	0.00	27.78	13	8	61.54	0.00	38.46	43	30	69.77	0.00	30.23
Energy, environment & HTM 03	19	17	89.47	0.00	10.53	19	17	89.47	0.00	10.53	19	17	89.47	0.00	10.53	57	51	89.47	0.00	10.53
Electrical & HTM 06	16	15	93.75	0.00	6.25	16	13	81.25	18.75	0.00	17	14	82.35	17.65	0.00	49	42	85.71	14.29	0.00
Lifts, escalators lifting equipment,nurse call HTM08	10	10	100.00	0.00	0.00	9	9	100.00	0.00	0.00	11	11	100.00	0.00	0.00	30	30	100.00	0.00	0.00
Mechanical plant	15	12	80.00	0.00	20.00	16	13	81.25	6.25	12.50	16	11	68.75	0.00	31.25	47	36	76.60	2.13	21.28
H&S Management	2	1	50.00	50.00	0.00	2	1	50.00	50.00	0.00	2	1	50.00	50.00	0.00	6	3	50.00	50.00	0.00
Water management & HTM 04	26	25	96.15	3.85	0.00	26	25	96.15	3.85	0.00	25	24	96.00	4.00	0.00	77	74	96.10	3.90	0.00
Working at height	4	4	100.00	0.00	0.00	4	4	100.00	0.00	0.00	2	2	100.00	0.00	0.00	10	10	100.00	0.00	0.00
HTM 01 Decontamination	4	4	100.00	0.00	0.00	5	5	100.00	0.00	0.00	3	3	100.00	0.00	0.00	12	12	100.00	0.00	0.00
HTM 02 Medical Gases	9	9	100.00	0.00	0.00	9	9	100.00	0.00	0.00	9	9	100.00	0.00	0.00	27	27	100.00	0.00	0.00
Site records	7	4	57.14	28.57	14.29	7	4	57.14	28.57	14.29	7	4	57.14	28.57	14.29	21	12	57.14	28.57	14.29
Total	124	110	88.71	4.03	7.26	131	113	86.26	6.11	7.63	124	104	83.87	5.65	10.48	379	327	86.28	5.28	8.44

Background and Funding

2.2. The average statutory compliance levels have risen from 69% in Q1 20/21 to 86% to date, as a result of the agreed increased funding via a Contract Change Notice (CCN) in 20/21. There has been a drop-in compliance level since last report as notice was given company which carry out fire compliance work due to poor performance. A new company (TFS) has now been appointed.

2.3. The priority for statutory compliance remains water safety, electrical improvements and fire safety. As previously discussed there are gaps in statutory compliance requirements across all sites but in particular in the area of fire safety relating to:

a. fixed wire testing;

b. emergency lighting;
c. fire door inspection/maintenance;
d. fire smoke damper inspection and maintenance; and
e. ductwork inspection and cleaning.

2.4. For water safety the priority is checking the thermostatic mixing valves.

2.5. There is a four-year investment plan and programme to increase statutory compliance levels and to move to a real time asset monitoring system. This monitoring system has been fully adopted for water safety compliance and will be rolled out to fire safety compliance next. Completion of the monitoring system will be in 2023/24.

2.6. Moving forward, Zetasafe will be adopted as part of terms and conditions for all new service contracts to ensure all contracts will be reviewed and renewed in a timely manner.

Forecast Statutory Compliance Position

2.7. Within the business planning process undertaken by the Trust in April 2021, 2gether requested additional funding to support statutory compliance improvements. This led to the approval of CCN 24 and CCN 25 on 7 October 2021 which totalled an additional £1.5m in 2021/22 financial year, the target set by CCN 25 was to increase overall statutory compliance to 95% by the end of financial year 2022/23.

2.8. The table below shows the forecast for statutory compliance will actually be improved to 96% by 22/23.

2.9. This table is currently under review by 2gether Support Solutions as there is some category areas which are statutory compliance, and others which are HTM and HBN compliant guidance. These could be shown on a separate table making it clear the percentage of statutory compliance, and the percentage of HTM, HBN compliance areas.

Estates Forecasted Statutory Compliance:

Compliance Overview 22/23 Forecast	KCH					WHH					QEQM					Overall Total				
Category	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with	No of Compliance areas	No of areas fully complied with	% of areas fully complied with	% of areas part complied with	% of areas part not complied with
Fire & Smoke Statutory & HTM 05	12	10	83.33	16.67	0.00	18	16	88.89	11.11	0.00	13	11	84.62	15.38	0.00	43	37	86.05	13.95	0.00
Energy, environment & HTM 03	19	19	100.00	0.00	0.00	19	19	100.00	0.00	0.00	19	19	100.00	0.00	0.00	57	57	100.00	0.00	0.00
Electrical & HTM 06	16	16	100.00	0.00	0.00	16	16	100.00	0.00	0.00	17	17	100.00	0.00	0.00	49	49	100.00	0.00	0.00
Lifts, escalators lifting equipment,nurse call HTM08	10	10	100.00	0.00	0.00	9	9	100.00	0.00	0.00	11	11	100.00	0.00	0.00	30	30	100.00	0.00	0.00
Mechanical plant	15	15	100.00	0.00	0.00	16	16	100.00	0.00	0.00	16	16	100.00	0.00	0.00	47	47	100.00	0.00	0.00
H&S Management	2	2	100.00	0.00	0.00	2	2	100.00	0.00	0.00	2	2	100.00	0.00	0.00	6	6	100.00	0.00	0.00
Water management & HTM 04	26	26	100.00	0.00	0.00	26	26	100.00	0.00	0.00	25	25	100.00	0.00	0.00	77	77	100.00	0.00	0.00
Working at height	4	4	100.00	0.00	0.00	4	4	100.00	0.00	0.00	2	2	100.00	0.00	0.00	10	10	100.00	0.00	0.00
HTM 01 Decontamination	4	4	100.00	0.00	0.00	5	5	100.00	0.00	0.00	3	3	100.00	0.00	0.00	12	12	100.00	0.00	0.00
HTM 02 Medical Gases	9	9	100.00	0.00	0.00	9	9	100.00	0.00	0.00	9	9	100.00	0.00	0.00	27	27	100.00	0.00	0.00
Site records	7	4	57.14	42.86	0.00	7	4	57.14	42.86	0.00	7	4	57.14	42.86	0.00	21	12	57.14	42.86	0.00
Total	124	119	95.97	4.03	0.00	131	126	96.18	3.82	0.00	124	119	95.97	4.03	0.00	379	364	96.04	3.96	0.00

2.10. As per the Estates Forecasted Statutory Compliance table above, the remaining non-compliances relate predominantly to automatic fire dampers and audit updates. Given the complexities around access, enabling works and the ongoing fire compartmentalisation survey it hasn't been possible to schedule these works in before end of this financial year. These works will be prioritised for 2023/24.

2.11. Appendix 1 provides breakdown of planned and estimated spend against compliance areas. All assets detailed in each respective service area will aim to have planned preventative maintenance completed in compliance with statutory standards and best practice guidance e.g. HTMs where applicable. It should be noted that the aim is to demonstrate 'best practice' where compliance with HTMs exceeds standards stipulated in British Standards or the Approved Codes of Practise (ACOP).

3. Backlog Maintenance

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

3.2. SIG membership includes all care group operational directors who have oversight and influence on priority spending. Any amendments or additions to the PEIC programme agreed at the PEIC committee are recommended to SIG for approval.

3.3. Utilising the six-facet survey and initial findings of the ARUP critical infrastructure report, the Heads of Technical Services at William Harvey Hospital (WHH), Queen Elizabeth Queen Mother Hospital (QEQM) and Kent and Canterbury Hospital (K&C) have reviewed the backlog maintenance priorities for each site. These have been risk scored and ranked into medium, high and urgent priorities. 2gether's internal risk assessment was also looked at in detail by each of the Hospital Leadership Teams and the DIPC and Deputy and prioritised looking at patients safety. A combination of these processes gives a final risk allocation for use by the PEIC.

3.4. The £4.05m allocation for 2022/23 has all been allocated against urgent priority risks. Any additional capital and future funding will be allocated based on output of ARUP Critical Infrastructure Risk Survey and joint risk workshops. Full spend is included as Appendix 2.

3.5. The 2022/23 £4.05M PEIC allocation has been jointly reviewed by the Director of Technical Services, Managing Director and Financial Director of 2gether who are content this targets appropriate risk areas. However, it is recognised that additional funding is required to deal with other immediate risks in the short term.

3.6. It is worth noting that the phasing of spend for 2022/23 is reviewed by the PEIC and is reported on a monthly basis at the Capital Programme Meeting which is chaired by the Deputy CEO.

Critical Infrastructure

3.7. A critical infrastructure survey (undertaken by ARUP) was commissioned to assess, score and prioritise the critical infrastructure risk elements associated with backlog

maintenance identified. This was then followed by a review and re-prioritisation process as detailed in 3.3.

3.8. Critical infrastructure typically refers to the critical engineering services and plant that serve hospital buildings and keep the 'heat, light and power on' and, if they failed, would have a significantly impact on service delivery and / or patient safety. Guidance on the management and maintenance of critical infrastructure is prescribed in a suite of Department of Health (DOH) documents called Health Technical Memorandums (HTMs).

3.9. Through this process a joint agreement has been agreed on the timeline for future funding priorities. Also identified is the extent of any residual risk and the quantum of funding required to deal with critical infrastructure issues in the Trust.

3.10. Over the last two years the focus of our spend on infrastructure risks has been:

a. Fire safety i.e. replacement and modernisation of alarm systems and improvements in and upgrading of fire compartmentalisation standards, which includes this year the WHH fire alarm system failure which has required urgent works to be carried out to ensure the safety of patients, visitors and staff;
b. Renewal of air handling units in our theatres;
c. Maintenance of priority estate including roof and window infrastructure;
d. Installing new steam related equipment to improve our hot water and heating systems; and
e. Improving the resilience of our electrical infrastructure by installing new high voltage generators / equipment.

4. Health & Safety

4.1. **HASTA:** Audits are scheduled throughout the year in all clinical and non-clinical wards and departments and good results are evident for those audits undertaken so far.

Care Group	2020/21	2021/22	As at 18.11.2022[1]
Cancer	90%	97%	96%
Child Health	99%	97%	100%
Corporate	92%	93%	96%
Clinical Support Services	96%	97%	96%
General & Specialist Medicine	88%	90%	92%
Head & Neck	92%	89%	99%
Surgery & Anaesthetics	88%	85%	91%
Urgent & Emergency Care	83%	81%	91%
Women's Health	90%	87%	99%
Trust	91%	91%	94%

[1] The percentage is of the planned audits year to date.

Training

4.2. In Q2 2022/23 (thus far) there has been 3 link worker training sessions, a combination of both face to face and WebEx. Other training that has taken place during this quarter includes:

a. First Aid at Work;
b. IOSH (managing safely);
c. IOSH (working safely);
d. Control of Substances Hazardous to Health (COSHH);
e. Fire Safety, and
f. MAYBO.

4.3. In addition, a small number of ad-hoc training sessions have been undertaken in regard to the risk assessment process. These have taken place in the link workers working environment and are usually in the form of a walkthrough / talk trough of an actual risk assessment the link worker needs to undertake. These have proved to be popular and well regarded and the H&S team are looking at ways of expanding this work in the future.

Health and Safety Team Support

4.4. The Safety Team has been engaged in numerous areas of support across the Trust, in general this has involved accident investigations, welfare (room occupancy) risk assessments, assistance and support for risk assessments, as well as involvement in the numerous building projects across the whole of the estate.

4.5. The Trust's Health, Safety and Welfare Strategy has been approved at the Strategic Health & Safety Committee and is continuing through the governance process for approval.

Trust Health and Safety Leads

4.6. It should be noted that the Trust Health and Safety Leads continue to work well to embed Health and Safety standards in their Care Groups.

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

5. Conclusion

5.1. The Board is asked to note this report.

East Kent Hospitals University NHS Foundation Trust

Appendix 1
Estates Statutory Compliance

Service	Assets to be maintained/Services required		Forecast
Professional Services	**Statutory Compliance Manager**	£	60,000.00
	Statutory Compliance Admin Assistant	£	24,000.00
	Fire Manager	£	65,000.00
	Procurement Support	£	91,000.00
	MTC Tender	£	3,000.00
	Authorised Engineers and Specialist Advisers		
	HTM 01 Decontamination	£	6,500.00
	HTM 02 Medical Gas	£	7,100.00
	HTM 03 Ventilation	£	10,500.00
	HTM 04 Water	£	32,500.00
	HTM 05 Fire	£	33,000.00
	HTM 06 Electrical	£	20,700.00
	HTM 08 Lifts	£	13,600.00
	Asbestos	£	40,000.00
	Confined Spaces	£	10,000.00
	Pressure Vessels	£	10,000.00
	Water Consultancy	£	65,000.00
Water Services	**Water Risk Assessment**	£	79,941.00
	Water Hygiene Testing	£	146,184.00
	TMV Servicing	£	226,350.00
	Zeta Safe Software	£	9,310.00
	RPZ Testing	£	2,150.00
AC	**Air Conditioning**	£	66,700.00
	Prochill Steam Absorbtion Chiller	£	5,000.00
Controls	**Boiler & Calorifier Controls**		
	BMS	£	69,430.00
Fire	**Fire Risk Assessments**	£	94,875.00
	Fire Safety Software	£	3,000.00
	Fire Doors	£	75,500.00
	Fire Alarms/Interfaces	£	111,438.00
	Fire Fighting Equipment	£	21,598.00
	Emergency Lights	£	185,441.00
	Fire Suppression System	£	6,555.00
	Dry Risers	£	790.00
	Fire Hydrants	£	8,855.00
	Door Guards	£	30,000.00
	Fire Dampers & Smoke Relief Vents	£	45,000.00
Electrical	**HV Maintenance**	£	13,600.00
	Fixed Wire, Electrical & Switchgear Testing	£	220,000.00
	Portable Appliance Testing	£	20,100.00
	Medical IPS/UPS Maintenance	£	36,000.00
	General UPS Maintenance	£	24,000.00
	Lightning Conductors	£	5,550.00
	Generators	£	5,000.00
	Smart Scan Contract	£	3,577.00
Medical	**Medical Gases**	£	30,980.00
	Medical Equipment/Sterilizer/RO		
Mechanical	**Gas Boilers & Water Heaters**	£	13,200.00
	Steam Boilers	£	54,588.00
	Refrigeration	£	4,600.00
	Critical Ventilation Verification	£	67,500.00
	Ventilation Maintenance	£	91,000.00
	Compressors	£	6,300.00

	LEV	£	2,000.00
	Plate Heat Exchanger	£	30,000.00
	Condensate Receivers	£	5,000.00
	Pressurisation Units	£	5,000.00
	Lifts	£	23,760.00
	Automatic Doors	£	21,920.00
General	Oil/LPG Storage & Bundguards	£	9,300.00
	Drains	£	20,000.00
	Insurance Inspections	£	26,656.00
	Working at Height equipment servicing	£	4,950.00
	Chimney Inspections	£	2,000.00
Training		£	60,000.00
TOTAL SERVICE		£	2,506,598.00
TOTAL REPAIR		£	593,402.00
TOTAL INVESTMENT		£	3,100,000.00

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Appendix 2
PEIC Budget Spend 2022/23

CAPITAL PEIC PROJECTS	Project Code	FORECASTED	COMMITTED	RECEIPTED
KCH				
Fire Alarm Upgrade - Phase 2	10525	£250,000	£113,167	£85,748
Genset & Transformer	10585	£613,587	£618,131	£2,995
Fire Compartmentation	10186	£30,751	£0	£0
Roof Repairs and Window Repl.	10567	£79,832	£79,832	£79,832
Renal Water Booster	10611	£15,251	£15,251	£15,251
1937 Building Water Tanks	10398	£3,000	£3,000	£0
Power Upgrade Works (UKPN)	10594	£82,713	£82,713	£82,713
Indust. Zone Condense Line Replacement	10655	£76,312	£76,312	£0
Fire Investment - KCH	10254	£42,154	£42,154	£42,154
KCH TOTAL		£1,193,600	£1,030,561	£308,693
WHH				
Fire Alarm	10197	£515,282	£63,202	£0
HV & Generator	10584	£832,000	£852,215	£729,221
Re-bund Plant Rooms	10656	£0	£0	£0
Fire Compartmentation	10657	£0	£0	£0
Fire Alarm Sounder System	10658	£150,000	£150,000	£0
CT Scanner Reduced Duct	10501	£0	£0	£0
Fire Investment Fees	10256	£86,612	£86,612	£86,612
Refurb of Microbiology CL3	10632	£66,420	£66,420	£66,420
Medical Education Pods	10617	£50,053	£50,052	£50,052
WHH TOTAL		£1,700,367	£1,268,501	£932,305
QEQM				
Fire Alarm Works	10572	£300,000	£63,700	£0
HV Enabling Works	10583	£368,500	£305,715	£116,641
Isolation Rooms	10600	£96,569	£48,159	£48,159
Legionella Works	10404	£0	£0	£0
Replace AHU - Day Surgery Theatre 1	10570	£140,699	£162,095	£57,841
Fire Compartmentation	10573	£112,000	£116,366	£0
Roof Replacement - St Peters & Assoc	10596	£0	£9,150	£0
F Gas Systems	10659	£0	£0	£0
Red/Green Recovery -- QEQM	10604	£18,064	£18,064	£18,064
Refurbishment of main Theatres aesthetic rooms due to Infection Control risks	10634	£10,201	£10,201	£10,201
Emergency Lighting Systems	10660	£0	£0	£0
Power Upgrade Works (UKPN)		£110,000	-	-
QEQM TOTAL		£1,156,033	£733,450	£250,906
CAPITAL TOTAL		£ 4,050,000	£ 3,032,511	£ 1,491,904

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
People & Culture	29 November 2022	Stewart Baird, Non-Executive Director	Corporate Governance & Risk Consultant	**Yes (for the 2nd & 3rd hours)**	**No (for the 1st hour)**
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Meeting Quoracy	The meeting was inquorate during the first hour. No decisions were made by the Committee during this time.				

People and Culture Committee Performance Report October 2022	• Partial assurance received of the 'People' True North metrics for October 2022.
	• The following were the key highlights of the report to the Committee:
	  • Staff Engagement remains at 6.33. The Committee noted the new score will be available in January 2023.
	  • The Committee received re-assurance that the National Staff Survey take up by the Trust is lower than prior year but more in line with the national position. Further analysis will be required to understand why response rates have fallen.
	  • Staff Involvement score remains at 6.28. The Committee noted there have been subtle improvements against a backdrop of national decline.
	  • Premium pay spend has decreased by £0.4m. The drop is mainly related to the pay award back pay being paid in September. The Committee noted Premium pay is being tracked by the Finance and Performance Committee.
	  • Sickness absence increased to 5.5% in October. 47% of all sickness was due to coughs, colds and chest infections (including Covid). The Committee noted a significant reduction in sickness absence due to stress, anxiety and depression.
	  • The Committee noted recent activity on the well-being bus and the take up by more staff.
	  • Overall appraisal compliance has risen over the last four months and has stabilised at 69.8% in October.
	  • Assurance was received around interventions in place to improve appraisal compliance including the re-introduction as an alerting watch metric has led to renewed focus in Care Groups; appraisal training for managers; and robust challenge at the Performance Review Group meetings.
	  • Total turnover improved in October, falling below 10% for the first time since June. It stands at just 8.28% in-month.
	  • Healthcare Assistant (HCA) turnover fell to 8.89% in October - the lowest it has been in over a year.
	  • Nurse turnover at 9.23% is below the alerting threshold of 10%.
	  • The overall vacancy rate has improved to 10.9% in October, largely due to an increase in nursing staff through the Internationally Educated Nurse (IEN) recruitment plan and a decrease in trainee doctor vacancies.
	  • Premature turnover improved in October at 19.42 in-month.
	  • The Committee noted the HCA and nurse head count is the highest it has ever been.				

	• Statutory training compliance fell below the threshold of 91% in October and remains an important no-alerting watch metric at monthly Care Group performance review meeting. • The Committee felt statutory training compliance was an area of assurance to watch.

Board Assurance Framework (BAF) & Corporate Risk Register (CRR)	• Assurance received that risks in relation to 'Our People' are being appropriately mitigated.
	• The Committee discussed the latest update of the BAF and CRR in relation to 'Our People' and the Accommodation risk; and noted the key highlights of the report:
	  • There was no movement on the BAF and CRR in relation to 'Our People' during this reporting period.
	  • The Committee received the Quarter 2 Performance data against the strategic objectives alongside the BAF risks in relation to 'Our People' which supports the Committee and Board in determining whether the Principal risks are appropriately managed, whether the risk appetite is set at the right level and whether further mitigations are required for the risks.
	  • The Committee noted at a future Board Strategy Development session the Board will refresh its risk appetite and ensure it is set at the right level. This has not been reviewed for some time and was considered a priority.
	  • The Committee noted the BAF and CRR tracker report which shows there has been no movement on the 'Our People' risks for the past year.
	  • In relation to the target risk rating for Quarter 2, the Committee noted one Corporate risk (CRR 122 – midwifery staffing) had not met the projected risk score. The Committee received assurance of the planned actions to mitigate the risk including ongoing recruitment to vacancies and noted the high sickness absence in Maternity (William Harvey Hospital (WHH)) which resulted in the decision to leave the current risk at 20 (Extreme risk).
	  • The Committee noted that CRR 134 (sustainability of junior medical rotas) was likely to increase due to issues with the Resident Medical Officer (RMO) contract provider.

Vacancy and Recruitment update – pipeline against establishment	• Partial assurance received on the planned recruitment pipeline and actions being taken to reduce the gap.
	• The following were the key highlights of the report to the Committee:
	  • Band 5 nurse recruitment is currently behind plan but mitigation is in place to deliver the planned numbers by March 2023 (rather than December 2022).
	  • As at October 2022, an additional 549.5 whole time equivalent (wte) band 5 nurses have been recruited since November 2021.
	  • As at October 2022, there were 235.76 wte band 5 nurse vacancies.
	  • The Committee noted the challenge to support the IENs to get PIN ready and improve the Objective Structured Clinical Examination (OSCE) programme pass rate.
	  • The Committee noted there was no local OSCE centre in the South East, and the new IENs are required to travel further afield to sit the OSCE examinations.
	  • The Committee received re-assurance the Trust will have met the general ward safe staffing business case requirement by December 2022.

	• Consultant recruitment remains challenging although incentives and improved marketing and incentive payments has improved the position on some hard to fill posts. • There are currently 76.15 wte consultant vacancies. A project group is being created to identify underlying reasons for the recruitment challenges, what options there are to improve and put in place long term solutions. • Health care support workers will remain challenging due to the volume and turnover of these colleagues. The HCA analysis work will help shape an improved approach to recruitment and retention. • Interview and assessment centre days are held monthly to encourage a higher number of HCAs candidates. The Trust recently recruited 45 HCAs.
Freedom to Speak Up Guardians (FTSUG) Report	• Assurance received of the verbal update from the Freedom to Speak Up Guardian. • The following were the key highlights of the update to the Committee: • The FTSUGs are being embedded in the Trust and there is increased engagement with staff. • The team is being expanded with the recruitment of two deputy FTSUGs to meet demand of the service. • The team continue to hear concerns from staff about poor behaviour and bullying from colleagues; gaps in knowledge of managers around their line management responsibilities and plans to mitigate this. • The Committee received assurance that colleagues who have spoken up have felt supported. • The new FTSU policy is to be published this week. • The Committee requested for the People & Culture Team to share themes from FTSU work and triangulate this with staff survey results once analysed to come up with meaningful information for the Committee. • The Committee implored officers to ensure staff are given personal objectives and one to one time with their managers, adding that the starting point will be knowing who their line managers are.
Staff Survey – Care Group Action Plan Update	• Partial assurance received of the progress of Care Group action plans. • The following were the key highlights of the report to the Committee: • Details of individual Care Groups actions and progress. • Although many actions are specific to the individual specialities, there a number of interventions that are common across the groups. • The 2022 National NHS staff survey closed on 25 November. • The new staff survey dashboard will enable results to be collated and shared much earlier, providing the opportunity for the Care Groups to analyse their results and build on their current action plans. • The Committee felt the actions needed to be SMART and the Care groups should be supported to strengthen the plans. • The Committee commented that the CEO had positioned this as the culture change programme and felt the action plans needed to reflect this and that an overriding 'culture development' programme should be presented to the Committee to give a complete picture of the cultural work in place. • The Committee noted that initial discussions were had at the Board Development Day in November and the Chief People

	Officer will share the draft programme with the Chair of the P&CC in due course before it is brought to the Committee.

Tribunal Activity Report	• Assurance received of the Trust's tribunal activity of the past 18 months.
	• The following were the key highlights of the report to the Committee:
	  • The Trust takes and follows legal advice in relation to employment tribunal claims.
	  • Currently six live employment tribunal claims.
	  • Nine employment tribunal claims disposed of during this period.
	  • There have been six settlement agreements during this period.
	  • There have been no redundancies made during this period.
	  • There have been no severance payments made as part of settlement agreements.
	• The Committee received assurance that the number of employment tribunal claims reflects the size of the organisation.
	• The Committee requested to receive an annual report.

Allied Health Professional (AHP) Workforce Plan Project	• Partial assurance received regarding the National AHP workforce supply Strategy Implementation Project.
	• The following were the key highlights of the report to the Committee:
	  • There is a requirement for the AHP leadership to come together to progress the work required as outlined in the NHS long term plan and AHP Delivers Strategy.
	  • Some of the priority areas are review of workforce data and intelligence; improvement of retention and support for students; and further develop AHP apprenticeship.
	  • The Committee noted there is no strategic AHP lead in the Trust and therefore it has been challenging to take forward the full AHP strategy.
	  • The AHP strategy will be taken forward by the Executive Management Team and a report brought back to the Committee at a later stage.

Occupational Health Activity Report	• Assurance received of the verbal Occupational Health activity update.
	• The following were the key highlights of the report to the Committee:
	  • In the last quarter, there has been a significant increase in work health questionnaires due to increased recruitment.
	  • There has been a reduction in management referrals received and an increase in telephone enquiries. The main reasons for referrals have changed to muscular skeletal issues. Mental health disorders come out slightly higher than home and work-related stress.
	  • Recruitment of a psychiatrist to join the team is being explored.
	  • Sickness absence in terms of stress has continued to decline.
	  • Increase in well-being activities and attendance/ engagement from staff – including attendance at welcome day; world menopause day across the sites; financial well-being package; well-being Wednesdays – sleep hygiene sessions; well-being conversations – 35 managers attended so far.
	  • 130 well-being Champions are in place in the Trust.

Bi-annual Midwifery Workforce Oversight – Planning and Decision Making – Birthrate Plus	• Partial assurance received of the results of the Clinical Negligence Scheme for Trusts (CNST) bi-annual midwifery workforce report. • The following were the key highlights of the report to the Committee: • The Committee received and had a robust discussion on compliance evidence against the CNST Safety Action 5 standards including information regarding the supernumerary

	status of midwifery coordinators and the provision of 1:1 care in labour, both of which are outcome measures linked to safer maternity staffing. • Progress mitigation/escalation plans to cover shortfalls identified in workforce action plan including recruiting to business case posts. • The Committee noted the Trust midwife to birth ratio is 1: 24; as there is no national standard this is considered acceptable; and noted the Birth to Midwife Ratio is recorded as 1:21 on the maternity dashboard by applying the existing methodology but moving to Electronic Staff Record (ESR) recording shows 1:24 to be a more accurate position. • The Committee noted Supernumerary remains challenging • The Committee queried the issue of not meeting 1:1 and supernumerary; and received re-assurance that these were based on acuity. As sickness absence reduces and staff on maternity leave return to work, plans are in place to mitigate the risks. The Chief Nursing and Midwifery Officer (CNMO) reported that operational demand for midwifery support to mothers must always take priority and as such the focus on recruitment remains the key to unlocking both these metrics. • The Committee **APPROVED** and recommended to the Board of Directors to sign-off inclusion of the Midwifery Workforce Action Plan.
Integrated Education, Training and Leadership Development Group (IETLDG) – 6-month Update	• Assurance received of the six-monthly progress update of the IETLDG. • The following were the key highlights of the report to the Committee: • Three core leadership development programmes have been designed (team leader, firstline leader and mid-level leader). The first 2 of these were launched in early November and the 3rd will be launched in January 2023 • The nursing education team have developed a matron's development programme for NHS England (NHSE), based on the Matron's Handbook. • The Kent & Medway Integrated Care Board (ICB) has started work to develop a region-wide academy covering pre-employment, apprenticeships, T-levels and career development in the NHS. The Trust is leading the field in this work, particularly in the areas of and T-levels. • A nurse practice education council has been set up to ensure that all education changes are recognised and updated. • There are currently 7 statutory, 8 mandatory and 27 essential training subjects. The Head of Learning and Development has set up a steering group to ensure consistency in assessing existing and proposed topics.
Regulatory Improvement Plan Tracker Review	• Assurance received of the progress of plans recorded on the Regulatory Improvement Plan Tracker in the remit of the Committee. • The following were the key highlights of the report to the Committee: • There are 10 People & Culture actions (on the Recovery Support Programme (RSP) – RSP action plan) recorded on the Tracker. • The Board of Directors receive regular progress updates on the full RSP actions. The last update was presented to the Board on 3 November and reported a Finance workstream RAG rating of amber. • The Trust meets with NHSE and the ICB on a monthly basis through an oversight meeting to review progress of the RSP.

	• The current dates highlighted in the RSP tracker indicate completion by December 2022, although this is now almost certain to move due to risk in actions relating to finance. • The Committee sought to understand how they will receive assurance of the outcome of implementation of the action plans. • The Chief Nursing and Midwifery Officer commented on the workforce actions on the Maternity Improvement Action Plan which was included in the report and mentioned this was meant to be reviewed at the Maternity and Neonatal Assurance Group and not this Committee. • It was mentioned that these were agreed at the Regulatory Compliance Group (Executive Led Group) and the decisions of that Group were communicated by email to all Executives. • It was agreed that this will be addressed outside the meeting.
Feedback from Local Negotiating Committee	• The Committee received an assurance report on the activities of the Local Negotiating Committee on 14 October 2022.
Feedback from Staff Committee	• The Committee received an assurance report on the activities of Staff Committee on 20 October 2022.
Feedback from Equality Diversity and Inclusion (EDI) Steering Group	• The Committee received an assurance report on the activities of the Equality Diversity and Inclusion Steering Group on 1 November 2022.
Referrals from other Board Committees	None
Other items of business	• Committee Annual Work Programme 2022 (For information) – to restructure the agenda of this meeting and add a few additional items.

Items to come back to the Committee outside its routine business cycle:		
There was no specific item over those planned within its cycle that it asked to return.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
Board of Directors: **CNST bi-annual midwifery workforce report:** The Committee **APPROVED** and recommended to the Board of Directors to sign-off inclusion of the Midwifery Workforce Action Plan.	Approval	8 December 2022

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Finance & Performance Committee (FPC)	29 November 2022	Nigel Mansley, Non-Executive Director	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	**Appendix 1: Draft Treasury Policy**				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					

Month 7 Finance Report	• Assurance received of the Trust's financial performance and actions planned to address issues of concern.
	• The Committee discussed and noted the following key highlights of the report:
	  • The Trust reported a £2.4m deficit in October 2022, which brought the year-to-date position to a £15.3m deficit which is £11.4m adverse to the plan.
	  • The main drivers of the adverse position remained escalation areas of around 60 beds; staff parking charges; increased usage in bank and agency due to clinical pressures across the Trust; work permits for overseas staff; drugs and Cost Improvement Programme (CIP) slippage.
	  • The Committee queried how the Elective Recovery Fund (ERF) is being tracked. Assurance was received that there was no financial risk to the ERF as previously thought and the NHS England (NHSE) guidance states that Integrated Care Boards have been informed to not assume any clawback to NHSE in H2 2022/23.
	  • In response to a question raised by the Committee around the impact of phasing, the Committee received re-assurance that there are no material phasing issues.
	  • The Committee sought assurance on the maximisation of income the Trust is entitled to and received re-assurance that the Trust maximises all income received from Commissioners and all other funding received is being reviewed and maximised. Noting that temporary staffing is an area that required improvement and this was currently being addressed.
	  • The Trust achieved £2m efficiency savings in October which is £0.8m below plan bringing the year-to-date position to £1.3m below the plan of £12m.
	  • The Committee noted the forecast of £30m efficiency savings includes the Trust being successful in the CIPs and reduction of the use of escalation beds will alleviate the position.
	  • The Committee received assurance of the measures in place to improve the efficiency savings including bi-weekly with Care Groups and enhanced finance reporting and discussions at Performance Review Group meetings.
	  • The Group cash balance (including Subsidiaries) at the end of October 2022 was £39m which was a £2m decrease from September but remains £4m below plan.
	  • Total capital expenditure at the end of October was £18.5m against a plan of £16.6m. The overspend is not considered to be an issue. Re-assurance was received that the Trust is working closely with system partners to maximise the available funding to support required investments.				

	• The Committee requested inclusion of a paragraph for the Subsidiaries for future reports.

Forecast Update on EKHUFT 2022-23 Forecast Position and Assessment of further Financial Risks	• Assurance received of the latest 2022/23 forecast position and the actions planned to mitigate identified risks.
	• The Committee discussed and noted the following key highlights of the report:
	  • The Trust has received the protocol for changes to in-year revenue financial forecast which details a number of conditions that Providers and/or Integrated Care Boards (ICBs) have to achieve if a reforecast is required.
	  • The most notable is the implementation of a double-lock sign-off process for revenue investments above £50k with sign-off required by the provider and the ICB.
	  • Update on the Kent and Medway system financial position and forecast.
	• The Committee **APPROVED** the recommendation for discussions to proceed with Kent & Medway Integrated Care Board to revise the Trust's forecast.

Month 7 Savings and Efficiencies Update	• Partial assurance received of the savings achieved in October which were £1.96m versus a plan of £2.76m (£10.73m delivered year to date versus a plan of £12.06m).
	• The following were the key highlights of the report to the Committee:
	  • Current pipeline of ideas is valued at £23m, which is reduced from last month following confirmation of the ineligibility of the annual leave accrual reversal of £3.5m.
	  • The Committee received assurances of fortnightly meetings and workshops with care groups and corporate areas facilitated by the Programme Management Office (PMO); a revamped Financial Improvement Oversight Group (FIOG) is currently being drafted with a view to roll out in December 2022, as well as a new Clinical Leaders Efficiency Group supported by NHSE. In additional, a comprehensive "Grip and Control" checklist from NHSE is being undertaken.
	  • The Committee requested for an update on the 2023/24 target to be included in the slides for the next meeting.

Draft Treasury Policy	• The Committee **APPROVED** the revised Treasury Policy and recommended it to the Board of Directors for ratification.
	• The following were the key highlights of the report to the Committee:
	  • First update of the Policy since 2gether Support Solutions joined the Group.
	  • The policy has been updated in consultation with both Subsidiaries
	  • The key change to the policy is in respect of the group implications of cash management to include the Trust process for instigating the process for the Subsidiaries to consider upstreaming of cash.
	  • The Committee queried if the Finance team have the treasury skill to invest. It was agreed that this information will be brought back to a future meeting of the Committee.

HM Treasury VAT and the Public Sector: Reform to VAT Refund Rules	• The Committee received and noted the potential changes to section 41 of the VAT Act 1994, and the financial risk that these reforms could represent. • The Committee noted the mitigating actions being taken by the Trust and felt there was more to be done commercially which needed to be discussed with the 2gether Support Solutions Managing Director ahead of the next Board to Board meeting.
We Care Integrated Performance Report (IPR)	• Partial assurance received of the performance against key metrics for 2022/23. • The following were the key highlights of the report to the Committee: • 18 week (wk) Referral to Treatment (RTT): We have reduced 104wk waits with exception of patients with Covid or whom do not wish to

	proceed with surgery at the time. There has been good progress in addressing 78wk waits. • A risk area was noted as the first outpatient appointments as the waiting lists continue to grow. The Trust is working with the Kent and Medway System Team to develop a new approach for managing referrals in 2023/24. • Winter planning initiatives to maintain elective and diagnostic are a key priority for the Trust. • Emergency Department (ED) 12 hour Total time in department: The 12 hour trolley wait numbers have reduced in October to 1,028 v 1,126 in September. The number of over 21 days for October was the highest number of cases recorded in the last 12 months. • The key interventions in place include the review of all areas across the EDs and the use of the Surgical Admissions Lounge (SAL) as a dedicated area for patients in order to reduce the length of stay in main wards; industrial action preparation for the proposed strikes during the winter months. • Cancer 62day: An increase of 10% in the referrals for cancer services has resulted in a 5% decrease in performance at 62 days. The Trust remains in the top 3 performers nationally for 2 week wait access. • The Committee queried whether Staff Engagement had improved and noted the data provided was old. • The National Staff Survey was completed on 25 November and results will not be available until January 2023.
Board Assurance Framework (BAF) and Principal Mitigated Risks	• Assurance received that risks in relation to 'Our Future' and 'Our Sustainability' are being appropriately mitigated. • The Committee **APPROVED** the latest update of the BAF and Corporate Risk Register (CRR) in relation to 'Our Future' and 'Our Sustainability'; and noted the following: • There are 3 BAF risks and 8 risks on the CRR relating to 'Our Future' and 'Our Sustainability'. • There was no movement on the BAF and CRR in relation to 'Our Future' and 'Our Sustainability' during this reporting period. • The tracker report showing the risk movement over the past year has been minimal. • Changes to action implementation deadlines relating to five risks. • The Committee commented on CRR 137 (There is a risk that the Trust will not be able to meet its 2022/23 efficiencies target equating to £30m). Noting this had become an issue and not a risk. It was agreed this risk will be reviewed in light of the Committee's comments. • The Committee felt the risk information in relation to infrastructure (CRR 127: here is a risk of failure to adhere to statutory compliance and to rectify the identified backlog maintenance) needed strengthening as the strategic and current elements of the risk needed to be separated. It was agreed this discussion will be had at the Strategic Capital Planning & Performance Committee (SCP&PC) and any changes proposed will be brought back to a future meeting following approval by other Groups within the Governance Structure.
Summary of Approved Business Cases	• Assurance received of the approved business cases to date and the wider investments in the pipeline for 2022/23. • The following were the key highlights of the report to the Committee: • The Trust has approved a total of 15 investment proposals of which 10 relate to business cases either commenced or prioritised by the Executives in 2021/22. • The other 5 approved proposals are in relation to externally funded schemes and include the East Kent Virtual Wards, the Electronic Patients Records (EPR), the Community Diagnostic Centre (CDC)

	Strategy, Mechanical Thrombectomy and Imaging Transformation Programme (for the 3 x ultrasounds). • Schemes that are currently either in the pipeline, at different stages of approval as part of the Trust Governance process, or schemes which are yet to be commenced, but were previously expected to be fully approved by the end of the financial year. • The requirement of the Trust to refer all subsequent investment proposals with a revenue consequence of £0.05m or higher to the Kent & Medway ICB for scrutiny and agreement, prior to internal sign-off.
Capital Programme Update 2022/23 Update – M7	• Assurance received on the management and delivery of the 2022/23 Capital Programme as at M7. • The following were the key highlights of the report to the Committee: • The M7 Year to Date (YTD) capital spend position is £18.5m, representing a £1.8m overspend against the YTD Plan of £16,7m; • Impact of the IFRS16 accounting standard implementation; • Mechanical Thrombectomy funding awarded and proposed brokerage for managing expected slippage across financial years. • £0.7m of additional system capital funding is expected to be awarded to the Trust (not included in the M7 year-end forecast position). • The Committee noted the issue about power supply on each of the Trust sites emerging which required a major investment. • The Committee noted a phased plan was being developed by 2gether and will be brought to the Committee at a future meeting. • The Committee **APPROVED** the brokerage approach proposed on Mechanical Thrombectomy for managing slippage across financial years and any potential system allocation and; the additional funding of £0.7m of additional system capital funding which had not been accounted for in year.
Service Line Reporting (SLR) Management Update	• Assurance received of the update on the Trust's Service Line Reporting (SLR) alongside an update of the mandatory National Cost Collection (NCC) for the financial year 2021/22. • The following were the key highlights of the report to the Committee: • This is the first SLR report for 2022/23 due to the requirement to meet National Cost Collection deadlines. • The NCC data for the financial year 2020/21 was published in August 2022. This shows the Trust achieved an NCC index of 98. This ranks the Trust at 50, out of the 102 organisations that submitted. • An index below 100 means that services were delivered at lower cost when compared to the average for all other Trusts.
Workforce Quarterly Report – Update on Premium Pay Spend including Temporary Staffing	• Partial assurance received of the update on the level of premium pay spend, including temporary staffing, and the measures being taken to reduce the spend. • The following were the key highlights of the report to the Committee: • Premium pay spend is above target with the position deteriorating in Quarter 2. • This is as a result of vacancies and operational pressures, with some impact of Covid related sickness although this has now reduced. • Re-assurance received that the Premium Pay team objectives are achievable and a new dashboard will be included in future reports to the Committee. • Re-assurance received of actions being taken to improve the position including targeting recruitment to priority areas and ensuring exit plans are in place for long-term medical agency locums.
Commissioning for Quality and Innovation Programme (CQUIN)	• Assurance received of the progress of the CQUINs programme for 2022/23. • The following were the key highlights of the report to the Committee:

	• Q2 performance was submitted to the ICB on 14 November 2022 and will be submitted via the National CQUIN Portal on 21 November 2022. • Three out of five National CQUINs are being achieved in full; and the remaining two are not achieving. • In relation to the Specialised CQUINs, one out of three is being achieved in full; one is partially achieving; and the RAG rating of the third CQUIN will be confirmed in December 2022. • Assurance of measures to improve performance in areas of non and partial achievement were provided to the Committee.
Regulatory Improvement Plan Tracker Review	• Assurance received of the progress of plans recorded on the Regulatory Improvement Plan Tracker in the remit of the Committee. • The following were the key highlights of the report to the Committee: • There are four finance actions (on the Recovery Support Programme (RSP) – RSP action plan) recorded on the Tracker. • The Board of Directors receive regular progress updates on the full RSP actions. The last update was presented to the Board on 3 November and reported a Finance workstream RAG rating of amber. • The Trust meets with NHSE and the ICB on a monthly basis through an oversight meeting to review progress of the RSP. • The Committee felt it was a useful tool for the Trust to track regulatory action plans. • The current dates highlighted in the RSP tracker indicate completion by December 2022, although this is now almost certain to move due to risk in actions relating to finance.
Strategic Investment Group (SIG) Assurance Report	• The Committee received an assurance report on the activities of SIG on 15 September 2022.
Other items of business	**Harmonia village:** • The Committee noted that the Trust is working closely with the Care provider taking over the management of Harmonia and is expecting to open the facility once full CQC registration is achieved. Noting CQC approval already received. • The Committee requested for the position regarding the final execution of the contract to be circulated.
Referrals from other Board Committees	• There were no referrals from other Board Committees at this meeting.

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

Harmonia village:

- Circulate the latest position regarding execution of the contract.

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

Item	Purpose	Date
Board of Directors: 1. Draft Treasury Policy	Approval	8 December 2022

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University
NHS Foundation Trust

TRUST POLICY

Treasury Policy

Version:	4
Author (Title and Care Group):	Assistant Finance Director
Approving committee:	Board of Directors
Date approved:	
Date ratified by Policy Authorisation Group:	November 2022
Date issued:	
Next scheduled review date:	November 2025

Applies to (include subsidiary companies):	
Trust staff (specify groups e.g. clinical/non-clinical):	Finance Staff, Trust Executive Team
Subsidiaries	Yes - Spencer Private Hospitals
2gether Support Solutions Ltd. as a service provider (hard and soft facilities services)	Yes

Includes references to children/young people	No
Includes references to medicines	No

We care

Version Control Schedule

Version	Date	Author	Status	Comment
1	2008	Rupert Egginton / Chris Curd	Superseded	
2	2013	Lisa Marsh	Superseded	
3	2015	Lisa Marsh	Superseded	
4	2022	Stephen Hoaen		Addition of Cash management – Group implications. Updated to current policy document format.

Policy Reviewers

Title and Care Group of Individual	Date Consulted
Chief Finance Officer, Finance	August 2022
Deputy Chief Finance Officer, Finance	August 2022
Director of Finance, 2gether Support Solutions	October 2022
Commercial and Finance Director, Spencer Private Hospitals	October 2022

Name of Committee	Date Reviewed
Finance and Performance Committee	November 2022

Summary of Key Changes from Last Approved Version

Latest policy format
Updated references to titles
Addition of section 6.2.5 – Cash Management – Group implications to include the Trust process for instigating the process for the Subsidiaries to consider upstreaming of cash.

Associated Documentation

Standing Financial Instructions

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1. Policy Description

1.1. This policy governs the management and investment of all cash held by the Trust, the process of requesting the transferring cash from the subsidiaries to the Trust and the borrowing of funds.

2. Introduction

2.1. Treasury management generally refers to the set of policies, strategies and transactions that a company adopts and implements to manage its cash resources, to raise finance at acceptable cost and risk, and to reduce interest rate, foreign exchange and commodity price risks, as well as in the conduct of its relationships within its financial stakeholders (mainly banks).

2.2. Under section 17 of the Health and Social Care (Community Health and Standards) Act 2003, NHS foundation trusts have wide discretion to invest money (other than money held by them as a trustee) for the purposes of, or in connection with, their functions.

2.3. NHS Foundation Trusts also have the freedom to borrow from the public or private sector.

3. Definitions

3.1. A glossary of terms has been included in Appendix A.

4. Purpose and Scope

4.1. As a Foundation Trust we have discretion to invest surplus cash and to borrow. This policy established practices to ensure investments of surplus operating cash are safe and liquid, so that the risk to invested capital is minimised and the investments can be realised quickly. This document describes guidelines that are intended to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice), of such investments, while generating a competitive return. The policy covers the arrangements and responsibilities for cash management, bank relationships, reporting, forecasting and performance management.

4.2. The policy also considers how the Trust can raise finance at acceptable cost and risk, and our approach to interest rate, foreign exchange and commodity price risks.

4.3. The objectives of the Trust in relation to operating cash management are to

4.3.1. Provide a secure and controlled process for ensuring surplus cash with subsidiaries is transferred to the Trust

4.3.2. Ensure a competitive return on surplus cash, within an acceptable risk profile;

4.3.3. Manage the financial risk associated with operational activities, for instance, interest rate and foreign current risks; and

4.3.4. Ensure availability of competitively priced funding for working capital with an acceptable risk profile

4.4. This policy aims to promote fiscal responsibility and prudent investments that do not compromise effective, efficient, and economic delivery of services and to minimise potential reputational risks associated with investments.

5. Duties

5.1. **Trust Board**: The Trust Board will

5.1.1.1. Approve the level of Working Capital Facility

5.1.1.2. Approve the overall treasury policy

5.1.1.3. Approve longer term investments

5.1.1.4. Agree the authorised signatories for bank accounts and borrowings

5.1.1.5. Approve long term borrowing

5.1.1.6. Monitor the level of short-term borrowing

5.1.2. The main board delegates responsibility for approval of the Trust's treasury procedures, controls and detailed policies to the Finance and Investment Committee.

5.2. **Finance and Investment Committee**: Under the terms of reference for the Finance and Investment Committee they are required "To develop the Trust's Treasury Policy in line with Monitor's guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long-term loans if required, and investment of surplus cash"

5.2.1. The Finance and Investment Committee will

5.2.1.1. Approve the Trust's investment and borrowing strategy and policies in line with its appetite for risk

5.2.1.2. Approve the Trust's interest rate and foreign exchange risk management strategy and policies

5.2.1.3. Approve the relevant benchmarks for measuring performance

5.2.1.4. Review and monitor investment and borrowing policy and performance against the relevant benchmarks in respect of all Trust funds

5.2.1.5. Ensure proper safeguards are in place for security of the Trust's funds by:

5.2.1.5.1. Reviewing the treasury policy before Board approval to ensure the set limits and criteria for investments are suitable

5.2.1.5.2. Ensuring approved bank mandates are in place for all accounts and they are updated regularly for any changes in signatories and authority levels

5.2.1.6. Monitor compliance with treasury policies and procedures on investment/borrowing/interest rate/foreign exchange management in respect of limits, approved counterparties and types of investments/instruments.

5.2.1.7. Approve external funding arrangements within delegated authority

5.2.1.8. Monitor interest received as shown in the monthly performance report

5.2.1.9. Monitor the level of borrowing

5.2.1.10. Ensure a sufficient Working Capital Facility is available and review the facility periodically to ensure value for money

5.2.1.11. Delegate responsibility for treasury operations to the Chief Finance Officer

5.3. **Chief Finance Officer**: The Chief Finance Officer will

5.3.1. Approve cash plans and cash management systems

5.3.2. Define and develop key banking relationships

5.3.3. Hold regular meetings with the Assistant Finance Director (Financial Accounting) to discuss issues and consider any points that should be brought to the attention of the Finance and Investment Committee.

5.3.4. Approve and execute Working Capital Facility Arrangements

5.3.5. Revie the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders (at least every 5 years)

5.3.6. Reporting periodically the levels of loans/overdrafts

5.3.7. Authorise short-term borrowing (along with one other authorised signatory)

5.3.8. Authorise investments falling into Tier 3 (as described in section 10.5)

5.4. **Assistant Finance Director (Financial Accounting)**

5.4.1. Define the Trust's treasury approach for approval by the Finance and Investment Committee

5.4.2. Ensure treasury activities are reported on a timely and accurate basis

5.4.3. Manage key banking relationships

5.4.4. Manage treasury activities within the agreed policies and procedures

5.4.5. Co-ordinate treasury operations between the Trust and the Finance Consortium

5.4.6. Authorise investments falling into Tier 2 (as described in section 10.4)

5.5. **East Kent Finance Consortium (EKFC)**

5.5.1. EKFC are responsible for the day to day operation of banking transactions within strict operational procedures and authorisations from the Trust's Finance Department.

5.5.2. EKFC will place all investments following authorisation by the Trust.

5.5.3. They will ensure accurate and timely recording in the accounting records of all treasury transactions, undertake bank reconciliations and match bank/counterparty confirmations with internal documentation.

6. Monitor Guidance on Managing Operating Cash

6.1. Monitor's advice on managing operating cash, "Managing Operating Cash in NHS Foundation Trusts, 2005" is described as best practice advice rather than mandatory guidance. Their advice, drawn from examples of treasury management policies for profit-making and non-profit entities in the UK and elsewhere, is aimed at NHS Foundation Trust boards to help them mitigate risks arising from cash management activities, while allowing them to seek competitive returns. The emphasis on their advice is to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice).

6.2. Monitor assumes no responsibility for investment risk. NHS Foundation Trusts are encouraged to educate and inform themselves of the detailed processes and the risks and returns associated with managing their operating cash. Independent professional advice may be sought where appropriate. Boards of NHS Foundation Trusts need to ensure that surplus operating cash is invested in accordance with their duty to safeguard and properly account for the use of public money.

7. Safe Harbour Investments

7.1. Monitor defines a 'safe harbour' investment as one that meets all of the following criteria:

7.1.1. Meet permitted rating requirements issued by a recognised rating agency;

7.1.2. Are held at a permitted institution;

7.1.3. Have a defined maximum maturity date;

7.1.4. Are denominated in sterling, with any payments or repayments for the investment payable in sterling;

7.1.5. Pay interest at a fixed, floating, or discount rate; and

7.1.6. Are within the preferred concentration limit

7.2. Securities that meet all of the above are considered to be sufficiently safe and liquid. As these are deemed to have sufficiently low risk and high liquidity these, Monitor states that NHS Foundation Trust Boards do not need to undertake an individual investment review.

7.3. Safe harbour investments would include (but are not limited to) money market deposits, money market funds, Government and local authority bonds and debt obligations, certificates of deposit, and sterling commercial paper, provided that they meet the detailed criteria.

7.4. The following, from "Managing Operational Cash in NHS Foundation Trusts, 2005" (updated in the FT bulletin February 2012) elaborates on the above criteria:

Term	Advice
Recognised rating agency	Only the following are recognised rating agencies [1]: ■ Standard & Poor's; ■ Moody's Investors Service Ltd; and ■ Fitch Ratings.
Permitted rating requirement	The short-term rating should be at least: ■ A-1 Standard & Poor's rating; or ■ P-1 Moody's rating; or ■ F1 Fitch Ratings
Permitted institutions	Permitted institutions include: ■ institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority to do business with UK institutions provided it has an investment grade[2] credit rating of A1/A+ issued by a recognised rating agency; and ■ the UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility.

Maximum maturity date	■ The maximum maturity date for all investments should be 3 months. ■ The maturity date for any investment should be before or on the date when the invested funds will be needed.
Preferred concentration limit	■ Surpluses below £500k may be invested with one institution. ■ Surpluses above £500k should be invested across a number of permitted institutions to spread the investment risk. ■ Investment limits should be set for permitted institutions based on their credit rating and net worth. These limits should be reviewed annually and reset if there is a change in either the credit rating or the net worth of the financial institution. If an institution is either downgraded or put on credit watch by a recognised rating agency, the decision to invest with them should be reviewed. ■ Investments with permitted institutions should not exceed the set limit at any time.

1 Moody's, Standard and Poor's and Fitch Ratings are the three top agencies that deal with credit ratings for the investment world
2 Ratings lie on a spectrum ranging from highest credit quality at one end to default or "junk" at the other.

7.5. For the purpose of calculating the liquidity ratio used in deriving the financial sustainability risk rating of NHS Foundation Trusts, investment of surplus operating cash in safe harbour investments will be treated as cash.

8. Investments Outside of Safe Harbour

8.1. Investments that do not fulfil the criteria for safe harbour are higher risk instruments and include bonds, equities, commodities and products based on them, derivative products such as futures, options and swaps and contracts for differences, investments linked to other trade instruments, index-linked investments, private equity or venture capital investments, leveraged instruments, hedge funds and foreign currency-linked investments.

8.2. Monitor does not expect NHS Foundation Trusts to invest surplus operating cash outside of the safe harbour. To the extent that NHS Foundation Trust do so, it should only be for the management of operational risk (e.g. foreign exchange risk, interest rate risk) and never for speculative reasons. NHS Foundation Trusts should always define the risk management processes in place for use of such instruments. These processes should include scrutiny proportional to risk and the use of external expert advisers as appropriate.

8.3. Monitor considers investment of surplus operating cash outside of safe harbour as an exception which should be considered for reporting to Monitor under the Risk Assessment Framework (depending upon the value of the transaction). Monitor will accordingly assess the impact of such investments on the NHS Foundation Trust's financial sustainability risk rating. If an NHS Foundation Trust receives foreign current income which it uses as a hedge against future costs in that currency, Monitor will its discretion in deciding whether to treat the investment as cash for calculation of the liquidity ratio.

9. Trust Approach to Managing Operating Cash

9.1. The Trust's treasury activities will be undertaken in a manner that achieves the following key objectives

9.1.1. Surplus cash: To obtain the most competitive deposit rates using a group of relationship banks, in line with deposit guidelines ratified by the Finance and Investment Committee

9.1.2. Funding: Ensure the availability of flexible and competitively priced funding from alternative sources to meet the Trust's current and future requirements

9.1.3. Interest rate management: Maintain an interest rate structure which smooths the impact of rises or falls in interest rates on profiles

9.1.4. Foreign current management: Reduce the Trust's exchange rate movement risk by covering any significant foreign exchange exposures

9.1.5. Bank relationships: Develop and maintain strong, long-term relationship with a core group of quality banks that can meet current and future funding requirements

9.1.6. Forecasting cash requirements: Anticipate cash requirements on a regular and timely basis considering all other working capital balances and the Group's revenue and capital forecast and plans

10. Investments

10.1. All cash balances should remain in a comparatively liquid form and all investments resulting from them should be realisable.

10.2. The Trust has established three tiers of cash holdings with limits for the amounts that can be held at each tier to reflect the risk associated with them. Across all tiers (with the exception of the GBS) the maximum amount that can be held with a single institution at any time is £25m.

10.3. **1st Tier** - Cash held with the Government Banking Service (GBS) of the National Loans Fund are deemed to be at its safest, there is therefore no limit on the amounts that can be held in these accounts.

10.4. **2nd Tier** – Investments within their tier would comply with all of the Monitor criteria in section 7. This tier would include our current accounts held outside of GBS and any deposits placed for up to two months. Their credit rating would need to be A1 or above.

Up to £10m of cash can be held in organisations within this tier.

10.5. **3rd Tier** – Investments in this category are longer term and can be placed for up to twelve months. Monitor reserves the right to exclude investments with a maturity over three months from the liquidity calculations and this, along with the increased risks associated with committing cash for longer means no more than £1m can be held in this category at any time.

When assessing the return that will be archived from investing cash outside of the GBS or NLF it is critical that the impact on the Public Dividend Capital (PDC) charge is fully considered. The annual charge is calculated at 3.5% on the average relevant net assets. Relevant net assets are all assets less all liabilities, except for donated assets, average daily cash balances held with the GBS and NLF, (excluding cash balances held that relate to a short-term working capital facility), and any PDC dividend balance receivable or payable

11. Foreign Exchange Management

11.1. Subject to materiality:

11.1.1. Trust policy is to cover forward all known transaction exposures over £500k, as soon as they are identified

11.1.2. The Trust's approach to managing translation exposures is reviewed annually, considering taxation and accounting issues

11.1.3. The Trust's Statement of Financial Position is hedged against foreign exchange fluctuations in the major currencies by borrowings in those currencies to match a proportion of the foreign currency denominated net assets.

12. Borrowing

12.1. The reason and scope relating to borrowing funds are as follows:

12.1.1. To fund cash shortfalls resulting from the operations of the Trust, the use of any available working capital facility must first be considered for this

12.1.2. To obtain funding for capital developments at minimum cost

12.2. The Board of Directors will determine the need for borrowing through review of the current and forecasted cash position or the agreement of appropriate business case.

12.3. The appropriate lender will be determined by reference to the cash flow forecast and financial plans based on the rates and facilities available at the time. No long-term borrowing transaction shall be entered into without approval of the business case by the Trust Board.

12.4. All borrowing should be entered on the Trust's risk register.

13. Interest Rate Management

13.1. Should the Trust enter into any long-term borrowings, Trust treasury will maintain an interest rate structure which reduces the impact of rapidly increasing interest rates on profits. The Trust's policy is to hedge interest rate exposure using interest rate swaps or other suitable devices.

14. Cash Management – Group Implications

14.1. The existing Group structure has the following subsidiaries which are 100% owned by the Trust:

14.1.1. Spencer Private Hospitals

14.1.2. 2gether Support Solutions

14.2. Part of the Trusts management of its operating cash is to ensure that all subsidiaries maintain sufficient levels of cash and to ensure there are processes in place to allow the transfer of surplus cash from the subsidiaries to the Trust.

14.3. The Trust can formally request upstreaming of cash during a financial year. This will be a formal request from the CFO of the Trust to the Director of Finance of the subsidiary.

14.4. The Subsidiary will assess the request and will make a proposal based on ensuring sufficient cash remains to service creditors/commitments.

14.5. The Subsidiary will take this proposal through their Governance regime. This proposal must also include the proposed method of transferring cash, either through the accelerate repayment of loans, dividends or a combination of both.

14.6. Following approval at the relevant Subsidiary Governance Committee, cash will be moved within 7 working days of the Committee date.

14.7. The above process must align to the Group planning process and timetable. The organisations within the Group must agree estimated cash values to be considered for inclusion at the earliest opportunity. For information – planning processes commence in the October prior to the start of the financial year being planned for.

15. Responsibilities and Controls

15.1. The treasury controls proposed in this document are designed to ensure the Trust's treasury activities are undertaken in a controlled and properly reported manner. The key components of the overall treasury operating environment include the following

15.1.1. Clearly defined roles and responsibilities in treasury activities for the Board of Directors, the Finance and Investment Committee, the Chief Finance Officer, managers and staff of the Trust Finance Department and the East Kent Finance Consortium. These are set out in section 5;

15.1.2. Regular reporting of treasury activities;

15.1.3. Controls on who can operate bank accounts and authorisation limits;

15.1.4. Segregation of duties between those who deal, those who initiate payment and those who account for treasury activities, and;

15.1.5. Strict limits on the types of derivatives and the circumstances in which they may be used.

15.2. The procedures ensure the Trust is not exposed to undue operational risks. In particular:

15.2.1. Segregation of duties is specified between those who deal, those who initiate payments and those who account for transactions;

15.2.2. Treasury transactions are only carried out with authorised counterparties and within set counterparty exposure limits;

15.2.3. Confirmation of transactions received from third parties will be requested from all counterparties and checked by the Trust Financial Account team; (banks are to be instructed to send confirmations directly to this department);

15.2.4. All transactions are recorded within the ledge and are supported by an instruction/confirmation;

15.2.5. All payment instructions/confirmations will require two authorised signatories, in accordance with the limits under bank mandates approved by the Finance and Investment Committee;

15.2.6. Mandates will be regularly reviewed and sent to all counterparties; and,

15.2.7. Payment to third parties will only be made by the bank on receipt of instructions bearing original signatures in accordance with the mandate.

15.3. Detailed procedures will operate between the Finance Consortium and the Trust Finance Department.

16. Reporting, Forecasting and Performance Management

16.1. The regular reporting of treasury activities is crucial in ensuring all relevant parties are aware of transactions undertaken, appreciate the Trust's financial position and assess the on-going appropriateness of treasury objectives. The following reports are produced to meet these criteria

16.2. Daily Position

16.2.1. The East Kent Finance Consortium will provide the Trust Accounting Department with the daily cash position and forecast, the cash held will be broken down between the accounts the money is held in.

16.2.2. This report will be used for close monitoring of the position by the Financial Accounting team and will incorporate any material transactions of operating subsidiaries.

16.2.3. The Financial Accounting team will monitor the daily cash position against the planned daily balance.

16.3. Weekly Cash Report

16.3.1. At the start of each week the Financial Accounting team will review the actual cash position for the prior week and compare this to the previous forecast, significant variances will be investigated and explained and mitigating action will be taken where necessary. This will then be used to update the weekly forecast for the rest of the financial year, this will be reviewed to identify any weeks in which the forecast shows an overdrawn position.

16.4. Monthly Cash Report

16.4.1. The monthly cash report included in the Monthly Finance Report will include, at a group level:

16.4.1.1. An analysis of current cash position against plan

16.4.1.2. Details of any borrowings

16.4.1.3. A statement of our calculated liquidity days against plan

16.4.1.4. A summary cashflow for the year to date and current month

16.4.1.5. Commentary on significant cash issues

16.4.2. The Monthly Finance Report will also note interest received in the current month and for the year to date against the budget set. Significant under achievement against the plan for an extended period of time should be closely scrutinised by the Finance and Investment Committee.

16.5. Quarterly Rolling Cashflow Forecast

16.5.1. Cash forecasting activity will be undertaken by the Financial Accounting Department. This will specifically consider planned income and expenditure, capital expenditure and movements in working capital balances.

16.5.2. On a quarterly basis the Finance and Investment Committee will receive the 13-month rolling cashflow forecast at a Group level. This will include historic figures for the previous quarter along with the detailed cashflow for future periods. Significant variations from the original plan will be discussed.

16.5.3. This report will also provide details of investments for the year to date and the return on these investments and discuss any current or planned borrowings.

17. Banking Relationships

17.1. The development and maintenance of strong banking relationships is an important factor in enhancing the availability of debt to fund the Trust's future expansion. The provision of efficient cash management systems throughout the Trust ensures that banking requirements are served at the optimal cost. This section details the Trust's objectives in these areas of treasury, including procedures for the incorporation of new businesses into the Trust's cash management structure.

17.2. Key objectives are

17.2.1. To ensure the cost paid for banking services is competitive

17.2.2. To minimise the cost of borrowings and maximise the return on cash surpluses within acceptable risk parameters by maintaining efficient cash management systems throughout the Trust.

17.2.3. To develop and maintain strong relationships with a number of key banks

17.2.4. To monitor and ensure compliance with banking covenants

17.3. In order to achieve the above objectives, netting or "massing" arrangements will be maintained as appropriate with the group's UK clearers. Interest rate exposures will be covered by the use of interest rate swaps transacted in accordance with approved limits. The Assistant Finance Director (Financial Accounting) will be responsible for managing all banking relationships, ensuring consistency in relationships across different banking services (e.g. funding, risk management and cash management) to achieve the optimum benefit to the Trust. Meetings will be held with all relationship banks on a regular basis to discuss services provided and any new or improved products of potential interest to the Trust.

17.4. Operating subsidiaries will be responsible for the efficient operation of bank accounts within their control and for managing their day-to-day relationships.

18. Bank Mandates

18.1. Copies of all bank mandates are maintained by the East Kent Finance Consortium cash team. The Trust mandate setting out the signatories and appropriate limits is approved by the Board and copies are sent to all counterparties together with specimen signatures.

19. Policy Development, Approval and Authorisation

19.1. This policy will be approved by the Board of Directors.

19.2. This policy will be ratified by the Policy Authorisation Group.

20. Review and Revision Arrangements

20.1. This policy will be reviewed as scheduled in two years' time unless legislative or other changes necessitate an earlier review.

20.2. It will be ratified by the Policy Authorisation Group every three years, or when there are significant changes and/or changes to underpinning legislation in accordance with the policy for the Development and Management of Trust Policies.

21. Policy Implementation

21.1. Refer to Appendix C.

21.2. The policy will be placed on the Trust's policy management system for all staff to view.

22. Document Control including Archiving Arrangements

22.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.

22.2. This policy will be uploaded to the Trust's policy management system.

22.3. Version 3 of this policy, which this document supersedes, will be retained within the Finance Departments shared drive for future reference.

23. Monitoring Compliance

23.1. Compliance with this policy will be monitored by the Trust's Financial Accounting Team and reported to the Finance and Performance Committee by exception.

24. References

Monitor - Managing Operating Cash in NHS Foundation Trusts, 2005

Health and Social Care (Community Health and Standards) Act 2003

25. Appendices

Appendix A – Glossary of Terms

Bank covenants: These are financial covenants required of a borrower and frequently include maintenance of a ratio of earnings to interest payable, a ratio of borrowings to earnings and a ratio of current assets to current liabilities.

Certificate of deposit: A negotiable money market instrument that can usually be readily realised in the secondary market.

Covenants: Covenants impose obligations on a company to do, or not to do, something for the duration of the agreement. They are intended to ensure the continued soundness of a lender's asset and to give the lender certain inside information about the borrower.

Derivatives: Financial instruments that are off-balance sheet and may be used to manage risk or as speculative instruments. Examples include forwards, futures, swaps, options and credit derivatives.

Forward foreign exchange contract: This is a mutually binding contract between two parties to buy or sell a specific currency at a pre-specified price (the forward price) on a pre-determined date in the future.

Interest rate swap: A swap is a contract that commits two parties to exchange, over an agreed period, two streams of interest payments each calculated using a different interest rate index, but applied to a common notional principal.

Investment grade rating: Ratings provided by recognised rating agencies lie on a spectrum ranging from highest credit quality at one end to default or "junk" at the other. The highest credit quality for long-term ratings is AAA (Standard & Poor's/FitchRatings)/Aaa (Moody's) and the lowest is D (S&P/FitchRatings) or C (Moody's).

Money market fund: This is a specialised fund that invests in money market instruments on behalf of its clients. The fund has credit enhancement such that it is generally highly rated for credit purposes by rating agencies (often AAA or A1/P1), without compromise to the liquidity of investments.

Net worth: Total assets minus total liabilities and can be used to determine creditworthiness because it gives a snapshot of a company's investment history. It is also called owner's equity, shareholders' equity, or net assets.

Operational risk: Risks arising from the trading activities of a business.

Permitted institution: Institutions that have been granted permission, or any European institution that has been granted a passport by the Financial Services Authority to do business with UK institutions, provided it has a long-term credit rating of A1 or A+ issued by a recognised rating agency. Also includes investments with the UK Government and its departments.

Permitted rating requirement: The rating requirement for safe harbour investments which should be A1/P1/F1 for short-term ratings and A1/A+ for long-term ratings.

Preferred concentration limit: The requirement for NHS foundation trusts to invest their surpluses above a de minimus, across a number of permitted institutions, based on set investment limits.

Recognised rating agency: These are the three main international rating agencies, Moody's, Standard and Poor's and Fitch Ratings. Each of these agencies provides a rating system to help investors determine the risk associated with investing in a specific company, investing instrument or market.
Safe harbour investments: These are investments that fulfil the following criteria: meet the permitted rating requirement issued by a recognised rating agency; are held at a permitted institution; have a defined maximum maturity date; are denominated in sterling, with any payments/repayments of interest/principal also in sterling; pay interest at a fixed, floating or discount rate; and are within the preferred concentration limit.

Sterling commercial paper: Sterling commercial paper takes the form of negotiable short-term promissory notes, payable to bearer. They may be issued by UK-based or international companies or financial institutions, using the market as a flexible way of raising short-term funds.

Surplus operating cash: Cash likely to be needed within 12 months to support ongoing operations.

Transaction exposure: This is the risk that a company's cash flows and realised profits may be impacted by movements in foreign exchange markets. Generally foreign exchange transaction risk is short-term, is revenue in nature and arises where there is a firm commitment to pay or receive in a foreign currency.

Translation exposure: Arises for companies with overseas subsidiaries as the domestic value of the assets and liabilities of these subsidiaries fluctuates with exchange rate movements. In addition, the domestic equivalent of the foreign currency earnings of these subsidiaries will also be affected by movements in exchange rates.

Appendix B – Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	**Stephen Hoaen**	
Job title	Assistant Finance Director (Financial Accounting)	
Care Group / Department	Corporate – Finance	
Date completed	October 2022	
Who will be impacted by this policy?	☒ Staff (EKHUFT) ☒ Staff (Other) ☐ Service Users	☐ Carers ☐ Patients ☐ Relatives

Assess the impact of the policy on people with different protected characteristics.
When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.

Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	**All**	**Neutral**
Disability (please see additional information below)	**All**	**Neutral**
Gender reassignment	**All**	**Neutral**
Marriage and civil partnership	**All**	**Neutral**
Pregnancy and maternity	**All**	**Neutral**
Race	**All**	**Neutral**
Religion or belief	**All**	**Neutral**
Sex	**All**	**Neutral**
Sexual orientation	**All**	**Neutral**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	No
Did the consultation analysis reveal any difference in views across the protected characteristics?	
Disability Protected Characteristic	
We need to ensure that we meet the Accessible Information Standard (AIS) which aims to support people with a disability, sensory loss or impairment to receive information they can understand and any communication support they need. For more information: https://www.ekhuft.nhs.uk/staff/clinical/accessible-information-standard-ais/ https://www.england.nhs.uk/ourwork/patients/accessibleinfo/	

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	No negative impact identified

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	No equality issues implications

Appendix C – Policy Implementation Plan

To be completed for each version of policy submitted for approval.

Policy Title:	Treasury Policy
Version Number:	4
Implementation Lead:	Assistant Finance Director (Financial Accounting)

Staff Groups affected by policy:	All
Subsidiary Companies affected by policy:	All
Detail changes to current processes or practice:	None
Specify any training requirements:	None
How will policy changes be communicated to staff groups/ subsidiary companies?	Electronic notification, 4policies

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety Committee (Q&SC)	1 December 2022	Andrew Catto, Non-Executive Director (NED)	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					

Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	• Partial assurance received of the True North metrics and breakthrough objectives for October 2022.
	• The Committee had a robust discussion and noted the following key highlights/assurances:
	  • Mortality (Hospital Standardised Mortality Ratio (HSMR)): Assurance received of the ongoing work on the biliary tract disease safety alert reported last month.
	  • Incidents with harm: Re-assurance was received on the review being undertaken of the highest contributors - reviewing care/treatment and delay/failure categorisation of incidents and themes; and in-depth review by the site triumvirates to determine the site-based themes.
	  • The Committee noted there was no moderate harm or above incidents related to falls during October.
	  • Emergency Department (ED) 12 hour Total Time in Department: Assurance was received of the interventions in place to improve the total times in ED through the development of access pathways; assurance received of the Front Door Frailty service and implementation of a roving model to support the frailty cohort across the front door over winter.
	  • The Committee sought assurance on the trends and categories of patients with more fall's incidents. It was agreed this will be included in the Fundamentals of Care Chair's assurance report in January 2023.
	  • 104-week breach position: Assurance received that the risk of 104 week breach is reducing rapidly as the Trust is treating patients earlier in their pathway to minimise the risk of the 7week delay should a patient test positive.
	  • The Committee noted that the 52 weeks trajectory remains on track.
	  • Not fit to reside: Re-assurance was received that the process for understanding choice and early decision-making is part of the Trust's collaborative work with Kent County Council (KCC) and Kent Community Health NHS Foundation Trust (KCHFT).
	  • The Committee requested for clarity on interventions planned to achieve trajectory to be included in future reports to the Committee.
	  • The Committee noted that the Trust is working with NHS England (NHSE) 'Making Data Count' to improve the IPR.
	  • Patient Experience: Inpatient Survey: Assurance received that a patient champion/member of the public has now joined the monthly Fundamentals of Care Committee.				

Infection Prevention and Control Report	• Partial assurance received of the current performance with regard to nationally reportable infections and the on-going Covid-19 pandemic, noting the following:
	  • Cases of Pseudomonas aeruginosa and Klebsiella bacteraemia are below or close to trajectory.
	  • Cases of C. difficile remain high in the Trust and across Kent and Medway. The Committee noted that the trajectory will not be achieved in 2022/23.
	  • Cases of E coli remain over trajectory, noting there was a steep increase in the summer.
	  • Cases of *Meticillin-sensitive Staphylococcus aureus* (MSSA) are higher than the same period for the previous year.
	  • Numbers of Covid-19 cases are currently as low as at any period since the summer of 2021 but cases of influenza and respiratory syncytial virus (RSV) mainly in children are rising.
	  • Cases of confirmed and suspected diphtheria associated with the migrant and refugee facilities in Kent have been managed, primarily by urgent and emergency care services.
	  • The Committee sought assurance on the consequences to patients and requested for future reports to include insight on patient impact.

Care Quality Commission (CQC) Update Report	• Assurance received of the progress report against CQC inspection, engagement and regulatory activity since the last report to the Committee, noting the following:
	  • Action plans from previous inspections are progressing in all 5 Care Group action plans.
	  • Assurance mechanisms in place including monthly meetings with Care Groups which have resulted in closures within action plans.
	  • A trust level quality oversight and assurance framework is being developed to ensure that trust level governance oversight arrangements are in place.
	  • Well-led workshops have been arranged to prepare senior leadership teams for the CQC well-led inspection. A well-led desktop review is also underway.
	  • The Committee sought assurance with regards to Trust policies and noted this will form part of the well-led desk top review which will be reported back to the Committee once completed.
	  • Preparations have continued to support and prepare maternity services for CQC inspection.
	  • The Committee requested the outcome of the maternity mock inspection to be circulated to members.
	  • A review of the CQC registration regulations has commenced and will conclude in the next few weeks. A review of the fundamental standards and associated policies is also underway.

Corporate Principal Mitigated Quality Risks	• Assurance received that risks in relation to ‘Our Patients’, ‘Our People’ and ‘Our Quality and Safety’ are being appropriately mitigated. • The Committee **APPROVED** the latest update of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) in relation to ‘Our Patients’, ‘Our People’ and ‘Our Quality and Safety’; and noted the following: • Changes to the CRR in relation to ‘Our Quality and Safety’ during this reporting period – addition of 2 news risks in respect of: i) investigation of clinical incidents and identification of themes; and ii) Current CT and MRI reporting backlog.

	• Risk approved for closure in relation to 'Our Quality and Safety' during this reporting period – CRR 128 - Failure to ensure adequate controls and safeguarding arrangements are in place at mortuaries. • The Committee felt CRR 128 should not be closed as the independent enquiry into mortuary services at another Trust had not been concluded. Assurance was received that this risk had been approved through the appropriate governance route and sufficient assurance was provided that the controls were in place and effective. • The Committee noted the risk will be monitored on a local risk register and following release of the independent enquiry report, the risk will be further reviewed in light of the report to ensure the controls in place remain effective. • The Committee were concerned that all risks presented to the Committee are limited in terms of the overall assurance levels. • The Committee were informed that this was a fair reflection of the Trust and re-assurance was provided that the mitigating actions will start to improve the controls and it will be reflected on the risk register. • The Committee urged the Executive Leads to challenge and reflect on the effectiveness of the actions on the BAF ensuring they will deliver the outcomes intended. • The Committee noted that the risk report did not reflect the discussions on risks had at the recent Board Development Day. It was agreed that a discussion will be had with the Trust Risk Manager to take this forward.
Patient Safety Committee (PSC) Chair's Report	• The Committee received an assurance report on the activities of the PSC on 2 November 2022, noting the following: • The Committee sought assurance on the Central Alerting System (CAS) alerts process and assurances on medical devices governance to be brought to the next meeting.
Fundamentals of Care (FoC) Chair's Report	• The Committee received an assurance report on the activities of the Fundamentals of Care Committee on 18 October 2022 and 15 November 2022, noting the following: • Mixed sex accommodation breaches have increased. The Committee noted a review is underway at the William Harvey Hospital to ensure the Trust is complying with national guidance.
Clinical Audit and Effectiveness Chair's Report	• The Committee received an assurance report on the activities of the Clinical Audit and Effectiveness Committee on 16 November 2022, noting the following: • Prioritisation of audits and the capacity of the audit team to support clinical audits. • The Committee requested for an audit progress report to be include in future reports.
Mortality Steering & Surveillance Group (MSSG) Chair's Report	• The Committee received an assurance report on the activities of the Mortality Steering & Surveillance Group on 26 October 2022.
Mortality and Learning From Deaths - Quarterly Report	• Partial assurance received of the update report on Learning from Deaths (LfD) in line with the National Quality Board recommendations; and noted the following:

	• The Trust's mortality position continues to improve with a "statistically low HSMR" and "as expected Summary Hospital-level Morality Indicator (SHMI)". • The themes highlighted in Q2 are especially the impact of the current pressures in our emergency departments leading to overcrowding and corridor care. • In Q2, overall the majority of care falls within the good category. • Majority of reviews where there is a concern about the care that has been delivered are undertaken by the Medical examiner team. • The Committee mentioned it was open to having the Medical Examiner address the Committee periodically. • It was agreed the Mortality Surveillance Steering Group (MSSG) should review the Committee's proposal and return to the Committee with recommendations on how to progress this. • The Committee noted the Learning from deaths assurance mechanisms in place include sharing via Care Group governance processes including morbidity and mortality meetings; safety huddles; patient safety communications and via the Patient Safety Committee. • While many specialities are effectively Learning from Deaths, it is recognised this needs to be embedded across all specialities through the LfD programme. • The Committee received assurance that the LfD programme continues to focus on reducing the recurrent clinical themes and monitoring that actions already have impact on clinical care and outcomes for patients.
Maternity and Neonatal Assurance Group (MNAG) Chair's Report	• The Committee received an assurance report on the activities of the MNAG on 8 November 2022 and noted the following: • Predominant discussion around the wider clinical workforce that supports maternity services i.e. obstetric, anaesthetic, neonatal, medical etc. and review of these areas undertaken aligned to the maternity strategy. • Recognition that though updates had been made, further alignment is required in light of the Independent Investigation into East Kent Maternity Services (IIEKMS) report. • Update on the Queen Elizabeth the Queen Mother Hospital (QEQM) Entonox exposure being acted on and lessons learned applied to William Harvey Hospital (WHH). • The Committee noted the concerns have been mitigated and a note will be produced for Board.
Integrated Incidents, Patient Experience, Claims and Learning from Serious Incidents Report	• Partial assurance received of the update report showing an analysis of themes, trends and learning from incidents, complaints, Patient Advice and Liaison Service enquiries (PALs), compliments, claims and inquests; noting the following: • The Trust continues to demonstrate a good incident reporting culture. • Performance in relation to completion of investigations into incidents, serious incidents and complaints has improved since the last report. Assurance received that an additional investigator resource remains aligned to support Maternity with the aim of submitting the remaining breaches by the end of November 2022.

	• There has been some progress in reducing the number of overdue incidents. The Committee noted a further review of overdue incidents is planned for Q3. • Delays in diagnosis and treatment continue to represent the highest rate of incident reports. • The Committee queried the format of the report from a governance standpoint noting the information provided in the bullet points were too detailed and were operationally focused and queried if they were shared for the Committee to read and act on them. • The Committee received re-assurance that the report was currently being revised and the next report to the Committee will be more thematically focussed.
Ward Accreditation - progress update	• Assurance received of the progress update of the Ward Accreditation programme including the Accreditation rollout and the ongoing work of embedding it across the Trust; noting the following: • The Accreditation programme was launched in September 2022. • The implementation of the Ward Accreditation programme is behind schedule due to issues with resourcing the programme and increasing operational challenges throughout the summer. • The Committee received re-assurance on the mitigations in place and revised timelines. • The Committee noted the future reporting will be through the FoC Chair report.
Clinical Harm Review Update	• Assurance received of the progress update on the Clinical Harm Review Process (CHR) for elective patients waiting for intervention/treatment, and for cancer patients who have breached treatment dates; noting the following: • The Trust has refined the CHR process in line with national guidance to ensure the potential for harm is identified and mitigated as far as possible and duty of candour completed where harm occurs. • The incidence of moderate or severe harm remains extremely low - moderate (3%) and severe (0.01%). • The Committee noted that a process for electronic recording of 3 monthly clinical reviews for patients waiting for treatment will be agreed, to ensure monitoring of compliance. • The Committee requested for an update report to be brought back at a future meeting.
Radiology Serious Incident - Action Plan Update	• Assurance received of the progress update of the action plan following the clinical review as a result of the clinical and digital interface issues that were identified in July 2021; noting the following: • Significant progress has been made on the issues identified aided by a close working relationship developed between the cancer services and clinical support services patient safety teams. • One issue on the action plan remains unresolved in relation to the change of episodes of care when a clinician leaves the Trust. • The Committee noted this is being addressed through the Information Assurance Committee. • Given the scale of the incident, the Committee agreed that a report should be brought back to the Committee in two months.
Safe Staffing Review Update	• Assurance received of the safe staffing review update and recruitment plans, noting the following:

	• It was agreed this agenda item will be brought further up the agenda in future meetings. • The Committee received re-assurance on the authorisation process for rotas.
Nursing and Midwifery Safer Staffing - Annual Report	• Assurance received of the quarterly safer staffing report; noting the following: • All the establishments are accurate to the establishments set. • Recruitment of international nurses is progressing – 502 Internationally Educated Nurses (IENs) have been recruited between January and November 2022. • NHSE have agreed to part fund the recruitment of an additional 70 IENs in Q4 2022/23 which will help ensure we meet and maintain our safer staffing numbers. • The Committee noted the training/education measures in place including; the first Nursing and Midwifery Conference in November 2022 which was well attended; launch of the Matron development Programme– first session has been held, further five sessions is planned. • The Committee received re-assurance that by December 2022, the Trust will be in a much better place for safe staffing on its wards than it was in the previous year. • The Committee queried voids in accommodation modelling and were assured this was overseen by the People and Culture Committee and that significant improvements have been reported in that area. • The Committee received assurance that the Trust is accessing every piece of national support to get the optimum level of workforce.
Other items of business	• Quality & Safety Committee Work Programme (For information).
Referrals from other Board Committees	• There were no referrals from other Board Committees at this meeting.

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

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Nominations and Remuneration Committee (NRC)	**6 December 2022**	**Jane Ollis, Non-Executive Director (NED)**	**Board Support Secretary**	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
There were no new interests declared.					
Assurances received at the Committee meeting:					

Agenda item 1 (NRC Decisions outside the Committee)	• The Committee ratified decisions taken outside the NRC business cycle as noted below:
	  • Approval to appoint Geoff Bailey, as Chief Executive Officer (CEO), for Spencer Private Hospitals (SPH).
	  • Approval to appoint Dylan Jones, as Substantive Chief Operating Officer (COO).
	  • Agreed the submission for treasury approval of the salary of the Substantive COO of £160,000 per annum.				

Agenda item 2 (Succession Planning Interim Update – December 2022)	• The Committee received and discussed an update report on the Trust's succession planning process, noting the recommended steps to be taken to ensure this is effective and sustainable:
	  • Review of the current third iteration Board succession plan in an Executive Team succession planning workshop to validate the identified successors and the roles they cover, review priority risks/vacancies and mitigation actions, and next steps in the succession planning process.
	  • Review the cyclical and sustainable succession planning process, aiming to support the organisational re-structure.
	  • Continue following the principles for succession planning and career conversations in the absence of a published national framework, with a view that the internal framework will align to/or complement the national direction.
	• The Committee noted the succession plan around following best practice, career pathways and progression through the organisation and ensuring career conversations were taking place.
	• The Committee emphasised the importance of focusing on the vacancies/gaps in succession that were a risk for the organisation and needed to be mitigated to ensure stability within the Trust.				

Agenda item 3 (Employer Contribution Pension Recycling)	• The Committee received, discussed and approved the continuation of the current Employer Contribution Pension Recycling Policy.
	• The Committee noted:
	  • Policy reviewed annually.
	  • Scheme has been working well.
	  • Supporting to recruit and retain high calibre staff and its continuation will ensure the Trust maintained a competitive position.
	  • Not a mandated requirement and good practice to have this policy in place.				

Agenda item 4 (Proposal for Non-Executive Directors (NEDs) to SPH)	• The Committee received and approved the nominations of the appointments of two NEDs to the SPH Board filling vacant positions from 1 December 2022:
	  • Vanessa Purday (Deputy Chief Medical Officer (CMO)/Consultant Anaesthetist, East Kent Hospitals NHS Foundation Trust); and
	  • Julie Yanni (Deputy Chief Nursing Officer, East Kent Hospitals NHS Foundation Trust).
	• The Committee noted these appointments had been approved by SPH and were non-paid positions supported by the Trust.

Other items of business	• The Committee **NOTED** the Chief Executive will present a report to the next meeting in March 2023 covering:
	  • Reflection on the 2022/23 Executive Directors performance objectives and delivery against these; and
	  • Setting out Specific, Measurable, Achievable, Realistic and Time-Bound (SMART) Performance Objectives and Personal Development Plans (PDPs) for the Executive Directors for 2023/24. These needed to be robust, concise, specific and fit for purpose objectives for each individual Executive Director around leading, impacting and influencing positive changes within the organisation. These needed to cover key elements for culture change, behaviours, strategy, priorities, and governance with clear specific timescales for achievement, and also align with the Trust's objectives.
	• The Committee **NOTED** the Committee Chair, Trust Chairman, and Chief Executive would work together to consider:
	  • Undertaking an internal assessment in 2023 of the Board in respect of skills, composition, capabilities and size.
	  • Review the 2023 Board Development programme, evaluate training undertaken during 2022 (including the Institute of Director training) and future training requirements that needed to be tailored to the needs of the Board.
	  • Report to be presented to the next meeting in March 2023.
	• The Committee **NOTED** the 2023 Annual NRC Work Programme.
	• The Committee **NOTED** the Board Register of Interests.

Referrals to other Board Committees	There were no referrals to other Board Committees at this meeting.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

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

The Committee **AGREED** to receive a report at its March 2023 meeting with an improved format of SMART performance objectives for Executive Directors for 2023/24 and reflecting of the 2022/23 performance objectives and delivery against these.

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this NRC assurance report.	Assurance	8 December 2022

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Charitable Funds Committee (CFC)	**6 December 2022**	**Jane Ollis, Non-Executive Director (NED)**	**Board Support Secretary**	**~~Yes~~**	**No**
Appendices:	None				
Declarations of Interest made:					
None					
Assurances received at the Committee meeting:					

Meeting Quoracy	• The meeting was not quorate and the items for approval will be circulated outside the meeting for virtual approval:
	  • Minutes of the previous meeting held on 11 October 2022;
	  • Matters arising from the minutes on 11 October 2022;
	  • Forecast and investment strategy.				

Agenda item 1 (Finance Report)	• The Committee discussed and noted a report on the current financial position, income and expenditure of the East Kent Hospitals Charity (EKHC). The Committee received assurance of the Charity's financial position, achievement of its objectives and sustainability, and noted the following key elements (as at 31 October 2022):
	  • Fund Balances – £2.2m adjusted for commitments £1.9m;
	  • Cash position - £0.6m;
	  • Investments (portfolio) - £2.5m;
	  • Income 1 April 2022 to 31 October 2022 - £0.5m;
	  • Loss on Investments 1 April 2022 to 31 August 2022 £159k;
	  • Expenditure 1 April 2021 to 31 October 2022 - £0.9m of which:
	  • Grants to Trust 1 April 2022 to 31 October 2022 £0.8m with a further £0.2m committed.
	• The Committee noted the update on the annual 2021/22 audit that has commenced, with work anticipated to be completed mid to end of December. Approval of the completed Annual Accounts aimed to be achieved by the end of December 2022 by the Committee and Board that will be by virtual approval to ensure submission to the Charity Commission by the 31 January 2023 deadline.
	• The Committee noted the total investments decreased representing unrealised loss on portfolio held with Schroder's (Cazenove) and the recommendation that Investment Managers from Cazenove attend the next meeting in March 2023 to provide an update on the predicted market performance.
	• The Committee discussed the impact of the investment loss and to be cautious about expenditure against its portfolio, and confidence to continue to spend against its income funding.				

Agenda item 2 (Fundraising update/Major Appeal December 2022 update)	• The Committee received and discussed a presentation providing an update and assurance of the work of the Charity and its fundraising activities, noting: • Trust Physiotherapist completed the Royal Parks Half Marathon in October, raising more than £600 for the Trust's Tiny Toes campaign;				

	• Group of maternity staff had scaled Snowdon, the highest mountain in Wales during a weekend break from work, raising more than £3,000 for the Trust's Twinkling Stars campaign; • Thanet Wanderers Rugby Club donated a specially designed rugby shirt to the Queen Elizabeth the Queen Mother Hospital (QEQM) to say thank you to NHS staff; • WW Martin held a Golf Day at Canterbury Golf Club, welcoming guests from local businesses to compete in a pro-am tournament held in association with the Kent Professional Golfers' Association. This raised more than £5,300 for East Kent Hospitals Charity (EKHC) that will be used to support projects in the QEQM Emergency Department (ED); • Bauvill hosted a Gala Ball on 25 November in support of the Trust's 3 Wishes Project at the William Harvey Hospital (WHH) Critical Care Unit that is hoped to raise a significant amount. Bauvill have already donated over £12,000 for this project and have committed to continue to support this project next year as their ongoing Charity of the Year; • EKHC have been a Community Local Cause for the Sturry Co-Op store and Canterbury funeral directors for the past year. The EKHC's partnership with Co-Op as part of the Local Community Fund has now come to an end and Co-Op members have raised £1,712 for the Helping Your Hospitals appeal; • During September and October the Charity has funded projects worth £4,313, including privacy screens funded for the Dolphin Ward at Kent & Canterbury Hospital (K&C); • The Charity festive campaign that included sourcing chocolate for distribution to staff throughout the Trust, festive cards and newsletters sent out to supporters and donors, social media campaign, and Amazon Wish Lists for people to make a meaningful donation. • The Committee received, discussed and supported the draft 'Case for Support' approach for the EKHC's major appeal in supporting the Trust's Cancer Services delivered across the three main hospital sites in East Kent, with a focus on the Cancer Unit at K&C. The Committee recommended this to the Trust Board in supporting the Charity to deliver this major appeal by exploring potential fundraising opportunities with known associations and encouraging links with other community organisations and corporate partners. The Committee noted the appeal will be supported by fundraising, grants, sponsorship and other major funding applications. The Committee noted the need for additional administrative support to assist the Charity team in taking forward this appeal. A progress update report will be provided at the next meeting in March 2023.
Other items of business	• CFC 2023 Annual Work Programme (for information).

Items to come back to the Committee outside its routine business cycle:		
There was no specific item over those planned within its cycle that it asked to return.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Committee asks the BoD to **NOTE** this assurance report from the CFC.	Assurance	8 December 2022