Board of Directors Meeting - Open (Thursday 9 February 2023)

Thu 09 February 2023, 09:00 AM - 11:30 AM

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

NHS
East Kent Hospitals University
NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

09:00 AM - 09:05 AM
5 min

22/185
Welcome and Apologies for Absence (9:00) 5 mins

To Note *Chairman*

Verbal

09:05 AM - 09:05 AM
0 min

22/186
Confirmation of Quoracy

To Note *Chairman*

Verbal

09:05 AM - 09:05 AM
0 min

22/187
Declaration of Interests

To Note *Chairman*

22-187 - REGISTER 2022-23 V57 - from February 2023.pdf (5 pages)

09:05 AM - 09:05 AM
0 min

22/188
Minutes of Previous Meeting held on 8 December 2022

Approval *Chairman*

22-188 - Unconfirmed BoD 08.12.22 Open Minutes.pdf (17 pages)

09:05 AM - 09:05 AM
0 min

22/189
Matters Arising from the Minutes on 8 December 2022

Approval *Chairman*

22-189 - Front Sheet Public BoD Action Log.pdf (3 pages)
22-189.1 - Action App 1 Dec 2022 Maternity Dashboard FINAL.pdf (20 pages)

09:05 AM - 09:15 AM
10 min

22/190
Chairman's Report (9:05) 10 mins

Information *Chairman*

- 22-190.1 - Chairman Report Jan 23 Board ND FINAL 02.02.23.pdf (4 pages)
- 22-190.2 - App 1 Chairman Report NEDs commitments.pdf (2 pages)

09:15 AM - 09:25 AM
10 min

22/191
Chief Executive's (CE's) Report (9:15) 10 mins

Discussion *Chief Executive*

- 22-191 - CEO Report Board January 2023 v5.pdf (7 pages)

OUR PATIENTS OUR QUALITY AND SAFETY

09:25 AM - 09:45 AM
20 min

22/192
Reading the Signals – Delivering through Pillars of Change (9:25) 20 mins

Approval *Chief Executive*

- 22-192.1 - Front sheet Interim response to Reading the Signals BoD 03.02.23.pdf (1 pages)
- 22-192.2 - Interim response to Reading the signals v11.pdf (21 pages)

09:45 AM - 09:55 AM
10 min

22/193
Maternity Services: (9:45) 10 mins

CNMO / Interim Director of Midwifery (DoM)

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

22/193.1
Perinatal Quality Surveillance Tool (PQST) Report

Approval *CNMO / Interim DoM*

- 22-193.1 - PQST December 22 FINAL.pdf (12 pages)

09:55 AM - 10:05 AM
10 min

22/194
Maternity Care Quality Commission (CQC) Action Plan Update (9:55) 10 mins

Assurance *CNMO*

- 22-194.1 - CQC action plan.pdf (4 pages)
- 22-194.2 - App Maternity CQC Action Plan_v5.pdf (5 pages)

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

10:05 AM - 10:20 AM
15 min

22/195
Integrated Performance Report (IPR) (10:05) 15 mins

Discussion *Chief Executive/Executive Team*

- 22-195.1 - IPR Header February 09.02.23 Board.pdf (5 pages)
- 22-195.2 - Appendix 1 IPR v4.3 Dec 22 final.pdf (36 pages)

10:20 AM - 10:30 AM
10 min

22/196
Board Assurance Framework (BAF) Risk Register (10:20) 10 mins

Approval *Chief Executive*

- 22-196.1 - BAF Risk Register BoD 27.01.2023.pdf (10 pages)
- 22-196.2 - Appendix 1 BAF 2022-23 06.02.2023.pdf (12 pages)

10:30 AM - 10:40 AM
10 min

22/197
Forecast Update on EKHUFT 2022/23 Forecast Position and Assessment of further Financial Risks (10:30) 10 mins

Approval *Chief Finance Officer (CFO)*

- **Month 9 Finance Report**

Information

- 22-197.1 - Financial Forecast v1.pdf (5 pages)
- 22-197.1.1 - Front Sheet M9 Finance Report Board.pdf (2 pages)
- 22-197.1.2 - Appendix 1 M9 Finance Report.pdf (19 pages)

REGULATORY AND GOVERNANCE

10:40 AM - 10:50 AM
10 min

22/198
People and Culture Committee (P&CC) – Chair Assurance Report (10:40) 10 mins

Assurance *Chair People & Culture Committee - Stewart Baird*

- 22.198 - PCC Chair Assurance Report BoD 31 Jan 23 FINAL.pdf (2 pages)

10:50 AM - 11:00 AM
10 min

22/199
Finance and Performance Committee (FPC) - Chair Assurance Report (10:50) 10 mins

Approval *Chair Finance and Performance Committee - Nigel Mansley*

- 22-199.1 - FPC Chair Assurance Report BoD 31.01.23 Final.pdf (5 pages)

11:00 AM - 11:10 AM
10 min

22/200
Quality and Safety Committee (Q&SC) - Chair Assurance Report (11:00) 10

mins

Assurance *Chair Quality & Safety Committee - Dr Andrew Catto*

22-200 - QSC Chair Assurance Report 26.01.2023 BoD v3.pdf (8 pages)

11:10 AM - 11:15 AM
5 min

22/201
Integrated Audit and Governance Committee (IAGC) - Chair Assurance Report (11:10) 5 mins

Assurance *Integrated Audit and Governance Committee - Olu Olasode*

22-201 - IAGC Chair Board Assurance Report Jan 2023 v2.pdf (8 pages)

CLOSING MATTERS

11:15 AM - 11:20 AM
5 min

22/202
Any Other Business (11:15)

Discussion *All*

Verbal

11:20 AM - 11:30 AM
10 min

22/203
QUESTIONS FROM THE PUBLIC (11:20)

Discussion *All*

Verbal

Date of Next Meeting: Thursday 9 March 2023

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM FEBRUARY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Chief People Officer	None **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 FEBRUARY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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
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)

REGISTER OF DIRECTOR INTERESTS – 2022/23 FROM FEBRUARY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
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 FEBRUARY 2023

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)
POWLS, MATT	Interim Chief Operating Officer	None	Appointed 21 November 2022
SHINGLER, SARAH	Chief Nursing and Midwifery Officer	None	Appointed 7 June 2021
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 FEBRUARY 2023

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

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED & TWENTY FIFTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 8 DECEMBER 2022 AT 1.00 PM IN THE CORNWALLIS 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/Quality and Safety Committee (Q&SC) Chair	AC
Mr P Cave	Chief Finance Officer (CFO)	PC
Mr S Corben	NED (WebEx)	SC
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Mr N Mansley	NED/Finance and Performance Committee (FPO) Chair (WebEx)	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair (WebEx)	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)/Executive Board Maternity Safety Champion	SSh

ATTENDEES:

Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Ms A Fox	Group Company Secretary (WebEx)	AF
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Dr T Ivanov	Executive Director of Quality Governance (EDoQG)	TI
Mr M Powls	Interim COO	MP
Mr P Ryder	Managing Director, 2gether Support Solutions (2gether) (minute number 22/176)	PR
Dr N Wigglesworth	Executive Director of Infection Prevention & Control (EDIPC)	NW
Ms F Wise	Executive Maternity Services Strategic Programme Director (EMSSPD)	FW
Mrs N Yost	Executive Director of Communications and Engagement (EDoC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Ms K Edmunds	Head of Patient Voice and Involvement (HoPV&I) (minute number 22/166)	KE
Mrs A Kay	Patient Experience Story (minute number 22/166)	AK
Mrs S Hayward-Browne	Business Manager to the Chairman	SH-B
Miss S Robson	Board Support Secretary (Minutes)	SR
Ms L Rudd	End of Life Care (EoLC) Consultant Nurse (minute number 22/166)	LR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms M Bonney	Governor (WebEx)
Mr M Buchanan	Member of the Public (WebEx)
Mr J Casha	Governor (WebEx)
Mr J Fletcher	Governor (WebEx)
Ms C Heggie	Member of the Public (WebEx)
Ms V Jerram	Member of the Public (WebEx)
Ms A Mitchell	Member of the Public (WebEx)
Ms B Puxley	Member of the Public
Mr G Puxley	Member of the Public
Mr T Puxley	Member of the Public
Mr P Schofield	Governor
Mrs M Smith	Member of the Public
Ms Verier-Cordery	Member of the Public (WebEx)
Mrs M Warburton	Governor (WebEx)
Mr S Weller	Governor (WebEx)
Mr P Yeh	Member of the Public (WebEx)

MINUTE NO.		ACTION
22/161	**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 welcomed Mr M Powls, Interim COO; and wished Ms R Carlton, COO, good luck in taking up her new COO role at Barts Health NHS Trust in London. He reported the Trust had appointed a new COO, Mr D Jones who would commence the following year.	
	The Chairman stated a Closed BoD meeting had been held that morning, items covered included; Maternity Incentive Scheme, Maternity Serious Incidents, Board Committee Chair Exception Reports; CMO's Report; Professional Bodies Update, and Inquest Report.	
22/162	**CONFIRMATION OF QUORACY**	
	The Chairman **NOTED** and confirmed the meeting was quorate.	
22/163	**DECLARATION OF INTERESTS**	
	There were no new interests declared.	
22/164	**MINUTES OF THE PREVIOUS MEETING HELD ON 3 NOVEMBER 2022**	
	DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 3 November 2022 as an accurate record.	
22/165	**MATTERS ARISING FROM THE MINUTES ON 3 NOVEMBER 2022**	
	Action B/16/22 – Kent & Medway Mechanical Thrombectomy Services Business Case The CFO provided a verbal update about the power capacity and risk issue raised in this report, noting an updated position was taken to FPC of the Trust's capital funds subsequent to the business case being taken, and 2gether Support Solutions (2gether) had fully briefed the Trust on its position.	
	DECISION: The Board of Directors **NOTED** the updates on the actions from the previous meeting, those for future meetings and **APPROVED** the two actions recommended for closure.	
22/166	**PATIENT EXPERIENCE STORY**	
	Mrs A Kay presented the patient experience story about her son, a young man who was terminally ill with cancer of the oesophagus, admitted to the Queen Elizabeth the Queen Mother Hospital (QEQM). She thanked the Board for inviting her to present his story and the very poor experience of her family, who were also in attendance supporting her at this meeting, it would be hard for Board members to hear about the poor care and its devasting impact on her son and the family. She highlighted key elements: • Thanks to the CNMO, HoPV&I, and EoLC Consultant Nurse for their support, compassion, and for treating their experience with the candour it deserved; • Original complaint submitted identified 24 points of failure of care and over 100 were identified in the Serious Incident (SI) report. Following submission	

of her complaint the support, care, treatment, medication and personal hygiene care significantly improved;

- Raised their experience with the Safeguarding Team and Care Quality Commission (CQC), also had a discussion with the Ward Manager;
- Took ward staff prolonged time to provide the request for the provision of a bed pan, her son was left sitting on this for several hours, he was supported with personal hygiene care by his husband as there was no available support from staff;
- Her son fell attempting to get to the bathroom on his own and was left on the floor for several hours until her arrival, his dignity was not maintained as was not clothed and covered in faeces and urine. There was also the issue around no observation to assist him with getting back into bed, recognising the difficulties in respect of his bariatric needs, there was insufficient space in the room to meet these needs and the necessary equipment. Floor in room was not cleaned during the day, despite requests for it to be;
- No care plan in place, no regular personal hygiene care provided, no mouth care, no assistance with eating. Family provided personal hygiene care and the provisions to be able to do this, and assisted with eating;
- Staff did not listen to her son, his husband, or his family, all staff on the ward should have been aware of individual patient marital status, family support and patients at EoL;
- Pain relief was not appropriately administered, was in terminal agitation that was distressing for his family with no support from staff for her son or his family;
- Family had a visiting rota;
- Everyone deserved dignity, compassion, respect and good level of care at EoL;
- Themes in the Independent Review into East Kent Maternity Services (IIEKMS) Report were similar to those experienced by her son and his family;
- Need to know that changes were being made in the Trust, be assured that family members would be appropriately cared for and treated, and would receive the expected standard of care;
- Recognised it would take time to make the changes needed in the organisation;
- The challenges with the complaints process.

The Chairman expressed his apologies to Mrs Kay, her son, and the family for their poor experience and care, the Trust had failed them all, there was no excuse for the basic level of care around personal hygiene that everyone should receive. He commented on the issues raised in the IIEKMS Report that were not just focussed on maternity, were across the whole organisation with actions ongoing to address and improve culture, recognising vulnerable patients that needed to be looked after and supported.

The Executives thanked Mrs Kay in sharing her son's story and poor experience, was sorry for this, noting teams needed to work together and communicate, the importance of learning, all staff should be kind, compassionate and caring to patients and their families. It was key to hear and listen to patients and families and that any necessary action was taken to ensure no other families suffered poor care and experience.

The CNMO reported discussions held with Mrs Kay about the changes the Trust were making, and she would be working with the Trust on its improvement journey, and had taken on the role of Deputy Chair of the Patient Participation Group. She stated the Trust was committed to improving the care provided to all patients. She reported 2 hourly care rounds had been introduced where a trained nurse or

Healthcare Assistant reviewed every patient on the wards, against 12 standards, including pain relief, nutrition and bowel care, discussed at handovers. Monthly audits were undertaken and reported to the Fundamentals of Care Committee, who reported into the Q&SC. Matrons also had discussions with relatives on the wards, monthly back to the floor exercise visits continued that included talking to patients and relatives, monthly ward in-patient surveys, and introduction of the carer survey. Ward Managers had attended Ward Leaders training. There was also escalation of issues from families to senior nurse leadership, herself, the CMO and CE.

The EoLC Consultant Nurse raised the importance of empowering staff and providing an environment and culture where they felt confident to speak up and raise any concerns. She commented on a video that was being produced focussed on compassionate care for all staff to watch recognising the person behind each patient. There was also staff training and education around empathy, and were looking at the provision of palliative care beds in the Trust. These initiatives would support the Trust's culture improvement programme.

The NEDs expressed they were sorry for the poor experience and care, and the importance of learning in respect of education for students taking on careers within the NHS. It was questioned whether it was felt the impact of the care provision was a result of prejudice due to her son's specific characteristics. Mrs Kay felt there was an element of this around diversity, it had not been recognised his important family members, his marital status and staff not interacting and listening to his husband about his care, interacting and listening more to her.

The Chairman invited Mrs Kay to consider returning to present to the Board in about a year's time following her working with the Trust about what progress had been made, the changes implemented and impact.

The Board of Directors:

- **LISTENED** to the mother's experience and how this made her and her family feel;
- **ACKNOWLEDGED** the failures of the care provided; and
- **ENSURED** the Trust used the learning from this family's experience to ensure that patients who were at the EoL and patients deemed Bariatric received care that maintained their dignity and safety and ensured their pain was managed. And that patients and their family were listened to, and their concerns addressed with kindness and compassion at the time they were raised.

22/167 **CHAIRMAN'S REPORT**

The Chairman raised the Entonox withdrawal issue at William Harvey Hospital (WHH) reporting an independent review had been commissioned to be undertaken to understand why this had happened and its consequences. He highlighted the 14 action points detailed in the summary (appendix 1) of the next steps agreed by the Board following the IIEKMS Report. He noted progress had been made since the report publication, recognising there was still much more work to be done following the patient experience story presented earlier to the Board.

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

22/168 **CHIEF EXECUTIVE'S (CE'S) REPORT**

The CE reported:

- A review of the Recovery Support Programme (RSP) exit date and criteria between NHS England (NHSE), the Trust, and Integrated Care Board (ICB), in respect of moving from SOF4 to SOF3. The Trust's actions would be refreshed and the Board would be kept up to date on progress;
- Work in response to the *Reading the signals* (IIEKMS report) was a key part of the overall focus of the Trust's improvement agenda across the whole organisation. Noting specific maternity and neonatal improvement work would continue to be overseen by the Maternity and Neonatal Assurance Group (MNAG);
- The Entonox issues at WHH and prompt actions put in place along with mitigations, temporarily suspension (24 November) of its use due to increased risk associated with long-term exposure for midwifery staff and students. This was a collaborative decision with clinical and maternity staff. Women in labour during the period of suspension were offered alternative methods of pain relief, with the provision and availability of Entonox to women (2 December);
- In response to the Entonox issues, there would be a review of lessons learnt, how the situation had materialised in terms of design choices, the Trust's estate, monitoring, risk identification and overall governance. This would be supported by the 2gether Support Solutions (2gether) Managing Director.

The NEDs highlighted the importance of clinical input and engagement with the Entonox review in respect of its use as this was being reviewed by other hospitals and whether use of these gases should be removed.

The NEDs raised the refurbishment work in the Emergency Department (ED) at QEQM and commented on the limited size and space in the rooms within this unit. The CE reported this refurbishment work was ongoing, any issues with the programme of work would be escalated, with a review on completion of the work engaging with the operational staff on the benefits and outcome of these works.

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

22/169 ***READING THE SIGNALS* – DELIVERING THROUGH PILLARS OF CHANGE**

The CE highlighted key elements and first steps addressing the Reading the Signals report, and setting out the Trust-wide approach to delivering a process of change through Pillars of Change:

- Issues within the earlier presented Patient Experience Story were relevant to this report;
- Themes from this report were also reflected across other areas within the organisation;
- Important the Trust heard and listened to patients and their families about their concerns, and be made aware immediately if something went wrong and to understand the reasons why;
- All Trust staff needed to be aware of the contents of the report, its outcome, and the actions to address the issues and themes raised. Staff needed to be kept informed of progress to deliver change and improvements, which also needed to be communicated to patients, families and the community. It was important staff understood the themes did not just relate to maternity services but throughout the whole of the organisation;

- Programme of work to be delivered detailed in the Pillars of Change focussing on five key areas ensuring sustained change and culture of openness:
  - Reducing Harm and Service Delivery;
  - Care and Compassion;
  - Engagement, Listening and Leadership;
  - Organisational Governance and Development;
  - Patient and Family Voices.
- Ten immediate next steps to be put in place before the end of January 2023, providing consistent direction of travel for improvements, recognising some of these initiatives would take time in have an impact:
  - Alongside delivering the actions in the pillars discuss the plan with staff, families, communities and partner organisations and regulators to continue to develop the proposed Pillars of Change;
  - Develop five outcome measures for each of the pillars to be included in a '*Reading the signals* Outcome Framework' that would track improvements;
  - 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 was treated with courtesy, respect and kindness;
  - Produce a proposal to establish a Community Assurance Committee (previously taskforce), developing terms of reference (ToR) 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 was important that public confidence was restored through this process. It was noted draft ToR had been produced;
  - Establish Independent Case Review Process for managing responses to maternity care concerns from families to be in place for mid-December 2022;
  - Organisation Restructure Consultation Document to be launched;
  - Begin Team Brief in January 2023, standardised approach bringing managers together with the Executive and their teams, face-to-face on a monthly basis, so that information could be delivered, questions asked and feedback collected;
  - Establish an approach to Listening Events based on learning from the maternity listening events. To 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;
  - Pilot ' Civility Saves Lives ' across maternity services from January 2023 - 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.

The EMSSPD stated the report also included recommendations for National bodies, the Trust had yet to receive feedback and direction from the centre about these elements.

The NEDs highlighted the programme was ambitious and enquired about the bandwidth, how progress and success of the programme implementation would be monitored. The CE stated the need to establish metrics against the themes to be addressed, monitoring progress and achievement of the actions within a single document, consistently challenging teams on delivery and embedding the changes to be part of the day to day work of every member of staff.

The NEDs raised concern following a visit to WHH that week that staff had not read the report and the importance of its exposure and themes to staff, that is was covered in team huddles and staff training. It was noted staff were working at full capacity and the difficulties in ensuring staff read and evaluated the report and its outcome, highlighting the importance of provision of protected time to staff. Concern was also highlighted about mothers who might currently be having a poor experience and that there were mechanisms in place for people to raise any concerns. It was emphasised the real need for new maternity unit facilities and continuing to lobby for provision of additional funding to improve these units. The CE expressed the challenges around communications with staff and that everyone read the report, with repeated messages issued to staff, listening events continued to be held with maternity teams that had positive results with those in attendance speaking up and providing feedback. She commented the Trust would continue to look at effective methods to communicate and engage with staff. The CNMO reported all was being done to ensure robust communication, including continued walkabouts, and operational B7 midwives liaising with staff. She noted a Group had been set up that would meet after Christmas involving families that had poor experience working with them on what changes and improvements were needed, as well as consideration of having a QR code system in place.

The NEDs highlighted the need to move forwards at speed with progressing the actions and changes, remained concern about whether this was moving as fast as needed. It was positive the Trust's induction programme included dissemination to new staff starters about the report, listening to patient experience and that the issues were across all services and not just confined to maternity.

The NEDs asked for clarification in respect of governance and the Assurance Committee. The CE confirmed this would align with the Trust's current governance structure and also to the Council of Governors (CoG), providing the assurance and challenge needed from the CoG as well as representation from patients, families and the wider community. This would also link with the current work in progress around co-production and redesign, the Patient Participation Group and bereavement pathway work. As well as looking at broadening the collation of feedback from service users including patients, families, and the wider community.

The NEDs highlighted the importance of having in place an efficient and effective alert and indicator data system that provided the assurance needed of promptly alerting where metrics were not being met and performance poor that needed to be addressed, where effective changes were being achieved and actions were making a difference. The CE stated discussions were taking place about the Trust's IPR reporting data and whether this provided the necessary data and information to robustly monitor operational performance. It was noted National discussions needed to be held about data streams across all trusts and having a better warning system to highlight areas that needed to be addressed, not just focussing on maternity but across all services. It was noted discussions by MNAG looking at in-depth the data and maternity dashboard, and the need to look at developing a Trust-wide dashboard. The CNMO agreed to present the maternity dashboard in full to the Board at its next meeting along with an exception report on the current position with this.

ACTION: Present the full maternity dashboard along with an exception report on the current position to the next Board meeting. — CNMO

The NEDs acknowledged the work and innovative initiatives being progressed and asked for assurance of the methodology that would support this work, and felt this was not the current We Care programme. It was noted the agreement at the recent Board Development Strategy Day to explore external support and methods that were working well at other organisations. The CE commented the current We Care

programme structure needed to be reviewed around what aspects would be retained for taking forward, consideration of whether one methodology was needed or various methodologies. It was noted the CPO and EMSSPD were working together to produce in the New Year a mapping programme of work and metrics to assess and monitor progress and that the work was making a difference.

The COO commented on the Trust's appraisal process in respect of learning and protected time for discussions with Line Managers and utilising this supporting the culture change programme and the expected behaviours of staff.

DECISION: The Board of Directors discussed and **NOTED** the *Reading the Signals* – Delivering through Pillars of Change report and the approach being taken, and **AGREED** the immediate next steps.

22/170 **MATERNITY SERVICES:**

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

22/170.1 **PERINATAL QUALITY & SURVEILLANCE TOOL (PQST) REPORT**

The Interim DoM reported:

- Increased feedback from women and staff providing greater granularity about the actions and improvement work;
- Listening to staff who were speaking up and raising issues, that included concern about Entonox exposure acted on and applying lessons learnt.

The NEDs raised the Friends and Family Test (FFT) feedback, main themes and concern included the lack of compassion and explanations, and the actions feedback to Heads of Midwifery (HoM). It was emphasised the Board needed to be provided with assurance that meaningful action was being taken and staff being held to account. The CNMO stated conversations were held with staff, holding them to account, noting leadership changes had been made, providing a supportive environment for staff to work in.

DECISION: The Board of Directors:

1. Discussed and **NOTED** the contents of the PQST report;
2. Received **ASSURANCE** and **NOTED** that a monthly perinatal quality assurance report had been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements; and
3. **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 (ICS).

22/170.1.2 **SAFETY ACTION 5: BI-ANNUAL MIDWIFERY WORKFORCE OVERSIGHT REPORT COVERING STAFFING/SAFETY ISSUES**

The Interim DoM reported:

- The 6-month compliance average of 98.7%, noting the national and CNST defined standard of 100% 1:1 care for all women in established labour. Mitigations to improve compliance noted in the Midwifery Workforce Action Plan;
- 21 newly qualified midwives joined the Trust the last year and 18 would be starting in post in September;

- Continued challenge to recruit B6 midwives;
- Continuity of Carer (CoC) programme continued to be suspended due to the ongoing workforce challenges.

The CPO emphasised appendix 1 that provided an update on the ongoing programme of work around positive culture in maternity services, as well as the actions in response to issues that had been raised. The Trust would be looking at what other organisations had implemented and was working, learning from this and what the Trust could benefit from.

DECISION: The Board of Directors:

- **NOTED** 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
- **APPROVED FOR SIGNING** the inclusion of the Midwifery Workforce Action Plan.

22/170.1.3 **SAFETY ACTION 4: CLINICAL WORKFORCE**

The Interim DoM reported:

- Detailed papers and in-depth discussions for each discipline taken place at MNAG;
- Workforce calculator reports reviewed and checked externally by the LMNS and Royal College of Obstetricians and Gynaecologists (RCOG).

DECISION: The Board of Directors:

- **RECORDED** 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;
- **SIGNED OFF** the action plan presented and formally **RECORDED** it meet the recommendations of the neonatal medical workforce training action;
- **RECORDED** the neonatal nursing workforce calculator tool had been completed to assess staffing needs against service specification standards;
- **RECORDED** that the standard for neonatal nursing had not been met in both year 3 and year 4 of the CNST scheme but an action plan had been received to improve this; and
- **NOTED** that copy of actions related to the neonatal nursing workforce had been submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.

22/170.1.4 **MATERNITY SERIOUS INCIDENTS (SIs): Q2 SUMMARY REPORT**

The CNMO reported:

- 10 SIs declared (6 at WHH, and 4 at QEQM), currently no investigations had been completed;
- 22 SIs breached and assurance this backlog would be addressed by the end of January 2023;
- Assurance of immediate learning from incidents;
- Key learning themes highlighted included escalation of care and pain relief for women that were being addressed as part of the actions in the action plan;
- Positive impact of the established rapid review process that was multi-disciplinary and implementation of key learning;
- Ethnicity data and cases of those with Learning Disability and/or autism would be included in future reports;
- Key risk, 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.

The Chairman raised concern about the risk of completing RCAs. The CNMO noted the ongoing work to strengthen leadership within maternity services, the challenge in recruiting high calibre experienced staff to the Trust and to its governance team. She stated roles had recently been advertised with interest shown from strong applicants.

The Board of Directors:

- Discussed and **NOTED** the contents of the Maternity SI Q2 summary report;
- **NOTED** the recurring themes that had been identified and the actions being taken;
- **NOTED** the key risk raised in relation to capacity and competency to complete RCAs and the alternatives that were being explored to address the issue.

22/170.1.5 **CNST MATERNITY INCENTIVE SCHEME (MIS) DECLARATION PROCESS AND OCTOBER 2022 GUIDANCE CHANGES**

The Interim DoM reported:

- Revised guidance published in October 2022;
- Training standard compliance across 12 consecutive months within the reporting period, removal of the 18 month compliance period;
- Declaration of the IIEKMS published report;
- CQC inspection report in Maternity services in October 2021;
- Assurance of in-depth and robust review of the evidence, as well as external scrutiny by the LMNS;
- Declaration submission delayed to 2 February 2023, Board approval required for sign off by the CE;
- Trust likely to report non-compliant declaration as not all standards would have been achieved, related to PMRT surveillance period breached for reporting commencement of investigation at 2 months.

DECISION: The Board of Directors:

- **NOTED** the Guidance change and Declaration process paper received;

- **NOTED** the risks included within the report and the likelihood that the Trust would not be in a position to submit a compliant declaration;
- **NOTED** an action plan would be completed for areas of non-compliance, describing position and mitigations to improve;
- **APPROVED** the request for the MIS team to be contacted before Thursday 2 February 2023 to advise that there were two reports that related to the provision of maternity services that may provide conflicting information to our declaration; and
- **APPROVED** 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.

22/171 **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 remained below the lower control limit and lower than expected, Kent & Canterbury Hospital (K&C) driving this position;
- Continued intervention with the fracture Neck of Femur pathway to improve patient outcomes, with impacts reported to Q&SC.

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:

- In-depth site reviews looking at any site themes;
- Safe staffing remained a challenge;
- Triangulation of harm with increased patient activity and operational pressures;
- Continued use of escalation areas and corridors in providing care, with robust processes in place for care during peak periods;
- Repose trolley mattress toppers had been purchased and now in place in both EDs;
- Increased presence of specialty tissue viability (TV) team in both EDs supporting staff in the management of TV 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:

- Continued significant increased activity, everything was being done that could be done to minimise impact for patients;
- Reduction in the 12 hour trolley wait numbers in October (1,028) from September (1,126);
- Percentage for ambulance arrivals against attendances was above 28%;
- Currently 199 patients not fit to reside, awaiting care on discharge and care at home. Challenges remained with capacity in social and domiciliary care. Regular discussions held at system meetings about the challenges and

impact of insufficient capacity in the community to support patients to be discharged;
- Continued reduction of the 104 week breach position from 34 to 9;
- Continued growth of outpatient waiting lists, main risk for the Trust. Did Not Attend (DNA) rate in this area had reduced from 11% to 7.8%, with focussed work increasing volume of patients fully booked to further improve this rate;
- Scheduled 'super weeks' for orthopaedic elective surgery with planned extension to other specialities to support the 78 week recovery plan.

The NEDs commented on the increased number of patients accessing Urgent Treatment Centres (UTCs) as had been unable to get appointments with their GPs.

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:

- Positive responses to 9 of the 10 questions asked above target threshold of 7.7;
- Main issues of poor experience were disruption of sleep during the night, and moving patients between wards on numerous occasions, mitigations in place included provision of ear plugs and eye masks for patients, along with leaflets about patient flow through the hospital.

The Associate NED commented on smart LED lighting (and the proven benefits of having a blue light in morning and red light from mid-day) that could alleviate patient sleep disruption, he agreed to share information with the CNMO.

Staff Engagement: Staff Involvement Score

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

- Staff engagement remained at 6.33 against the national average 6.6;
- Trust had a range of other methods outside the staff survey to obtain staff feedback.

The NEDs emphasised the importance of disseminating the staff survey results promptly when received and the necessary actions to address the issues raised. The CPO stated results were under embargo and these would be published to the Executive Management Team and Board, as well as widely throughout the Trust as soon as the embargo was lifted.

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

The CFO reported:

- October 2022 position of £15.3m deficit against a plan of £4.0m deficit, key drivers impacting deficit included Cost Improvement Programme (CIP) plan behind, use of escalation areas (additional 60 beds), and the reduction in bank agency spend not seen;
- Discussions at FPC about the potential year-end position reforecasting a £30m deficit in year. Focussed review of finances, including Care Groups looking at potential efficiencies and reducing spend on agency staff;
- Integrated Care Board (ICB) required to sign off and approve expenditure above £50k.

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

22/172 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted:

- Board approval required of the draft Treasury Policy presented;
- Potential changes to section 41 of the VAT Act 1994, the financial risk of these reforms and the mitigating actions;
- Business cases presented for consideration for approval needed to have proven funding allocation with evidence of robust review of benefits.

DECISION: The Board of Directors:

- **NOTED** the 29 November 2022 FPC Chair Assurance Report;
- **APPROVED** the Treasury Policy.

22/173 **FINANCE REPORT**

- **MONTH 7 FINANCE REPORT**

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

The Board of Directors **NOTED** the Month 7 Finance Report, financial performance and actions being taken to address issues of concern.

22/174 **PANORAMA AND LEARNING DISABILITIES (LD) AND OR AUTISM REPORT**

The CNMO highlighted:

- Challenges in providing care for these patients, lack of pathways and health inequalities;
- Mitigations being put in place to address the challenges and deliver the actions required as part of the All Age Safeguarding Deliverables (AASD) action plan;
- Work would be supported around joint working with the LD nurses, clinicians, ward staff and community teams along with input from the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) lead, to address any issues with patient pathways and treatment;
- LD register in place, and an autism register was also now in place ensuring patients were identified in a timely manner and appropriately supported.

The Chairman enquired about the numbers of stranded patients that should no longer be within acute services and were deemed medically optimised for discharge.

ACTION: Clarify and confirm the numbers of stranded patients that were deemed medically optimised for discharge and should no longer be within acute services. CNMO

The NEDs raised the benefits of shared registers and records. The CNMO reported currently there was no shared record provision, there were national registers and local registers were used to ensure patients received the support needed when admitted.

The NEDs enquired about service user involvement and engagement, highlighting individuals that worked closely with KMMS, and agreed to introduce them to the CNMO in respect of working with the Trust. The CNMO commented about ongoing work with women with autism on the antenatal pathway and that this was supportive and met their needs.

The Board of Directors:

- Discussed and **NOTED** the Panorama and LD and or Autism report and the key issues highlighted.
- Received **ASSURANCE** in respect of the mitigation factors in place and how these would implemented with the required resources identified.

22/175 **HEALTH AND SAFETY (H&S), ESTATES STATUTORY COMPLIANCE AND BACKLOG MAINTENANCE UPDATE**

The 2gether Managing Director (MD) reported:

- Robust H&S structure, management process and control systems in place with good engagement with the Trust;
- Development of an improved format of future reports and how data was reported to clearly identify the current position in respect of statutory compliance requirements;
- Average statutory compliance levels had risen from 69% in Q1 2020/21 to 86% currently;
- Poor performance against fire compliance work, with new company appointed that should improve this position.

The NEDs raised the risk in respect of legionella and assurance around testing and monitoring. 2gether's MD provided assurance there were no risks within this area as appropriate testing systems were in place.

The NEDs questioned whether the target to increase the overall statutory compliance to 95% by the end of financial year 2022/23 was achievable. 2gether's MD confirmed was confident that this level of compliance would be achieved by March 2023.

The Board of Directors discussed and **NOTED** the H&S, Estates Statutory Compliance and Backlog Maintenance update report.

22/176 **INFECTION PREVENTION AND CONTROL (IPC) QUARTERLY REPORT**

The EDIPC reported:

- Trust assigned *Clostridioides difficile* (Cdiff) continued to be off trajectory to achieve the external threshold (of 82 cases) with 77 cases year to date. The Q&SC had requested a review be undertaken looking at the outcomes for these patients;
- E. coli bacteraemias remained over trajectory and a challenge to achieve the external threshold with 100 cases year to date;
- *Klebsiella species* and *Pseudomonas aeruginosa* on target to achieve external thresholds;
- IPC 2022/23 work plan anticipated to be completed by year-end;
- Fully established IPC team in place during November 2022;
- Antimicrobial Stewardship (AMS) progressing well, with the appointment of a Consultant Pharmacist to commence in February 2023.

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

22/177 **MEDICAL REVALIDATION REPORT**

The CMO reported:

- Recognition of the need to appropriately resource the appraisal and revalidation team, with additional support in place to improve the quality of appraisals, as well as improve engagement and feedback with staff. This in turn would increase staff work satisfaction;
- Establishment of a Responsible Officers Advisory Group (ROAG), incorporating Quality Governance, People & Culture, and Lay representation, to provide challenge around revalidation;
- Delays with appraisals being completed due to Covid had been addressed;
- No concerns had been raised about doctors as part of this process.

The CMO stated the Inaugural meeting of the full Clinical Ethics Committee (CEC) membership had been held, with diverse group of staff members represented. It was expected the CEC would meet a couple more times before extending invitation for clinical teams to present cases for consideration.

The NEDs enquired whether appraisers were in the same speciality as those being appraised. The CMO reported a system was in place that enabled individuals to choose their appraiser, and that the same appraiser could not be used more than three occasions.

The Board of Directors discussed and **NOTED** the Medical Revalidation progress report .

22/178 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

- **CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) BI-ANNUAL MIDWIFERY WORKFORCE REPORT – MIDWIFERY WORKFORCE ACTION PLAN**

The Chairman stated the Board Committee Chair Assurance Reports were important and he would consider the ordering of these for future Board meetings and whether these should be earlier on the agenda.

The P&CC Chair highlighted:

- Positive news of an additional 549.5 whole time equivalent (WTE) band 5 nurses recruited since November 2021, who were successfully being retained;
- Disappointment in the overall appraisal compliance at 69.8%, which had risen over the last four months and had stabilised, with a gap of staff receiving regular 1:1 meetings and being set objectives.

DECISION: The Board of Directors:

- **NOTED** the 29 November 2022 P&CC Chair Assurance Report;
- **APPROVED** the sign-off and inclusion of the Midwifery Workforce Action Plan – CNST Bi-Annual Midwifery Workforce Report.

22/179 **NOMINATIONS & REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair provided a verbal report from the meeting held that Tuesday highlighting the key elements and the written report would be published following this meeting:

- Progress was on-going on the Trust's succession planning to ensure this was robust, effective and sustainable;
- Approval of the appointment of Mr Geoff Bailey, as Chief Executive Officer (CEO), for Spencer Private Hospitals (SPH);
- Approval of the appointment of Mr Dylan Jones, as Substantive COO.

The Board of Directors **NOTED** the 6 December 2022 verbal NRC Chair Assurance Report.

22/180 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted:

- The significant volume of information presented and discussed at Q&SC, that would be reviewed as part of his role as the new Committee Chair in liaison with the Executive Directors, and looking at the governance reporting structure;
- Reports would be reviewed and whether these could be streamlined focussing on the key points the Committee needed to be aware of with focussed discussions on these points.

The Board of Directors **NOTED** the 1 December 2022 Q&SC Chair Assurance Report.

22/181 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair provided a verbal report from the meeting held that Tuesday highlighting the key elements and the written report would be published following this meeting:

- Supported a draft 'Case for Support' approach for the East Kent Hospitals Charity (EKHC) major appeal supporting the Trust's Cancer Services delivered across its three main hospital sites. Further updates would be presented on the development of this major appeal;
- Encouraged Board members to send EKHC Christmas cards promoting the Trust's Charity.

The Board of Directors **NOTED** the 6 December 2022 verbal CFC Chair Assurance Report.

22/182 **ANY OTHER BUSINESS**

There were no other items of business raised.

22/183 **QUESTIONS FROM THE PUBLIC**

Ms Heggie raised the *Reading the Signals* report and the issues raised within it for focus by the Trust across the whole organisation and not just in maternity. She commented on the current facilities for maternity services and the benefits of a new

modern unit and to look at this provision at the K&C site. The CE stated it was recognised elements for improvement in maternity as well as themes to be improved across the whole Trust, ensuring effective staff communication and what staff could do within their own areas.

Ms Heggie commented delayed discharges had been discussed at a recent meeting of the Health Overview and Scrutiny Committee (HOSC) and the support from Kent County Council (KCC) to address this issue. The Chief Executive stated challenging but fair discussions had taken place, the Trust was working closely and collaboratively with KCC and social care to support and improve patient care pathways.

Mrs Smith commented it was good to hear about the work being taken forward around changing the culture, emphasising the importance of communication and the benefits of senior leadership presence across the hospital sites and members of the Board visiting wards and departments, engaging with staff as well as patients. The Chairman acknowledged the point about visibility, noting he tried to undertake a weekly clinical visit and that Board members were committed to visiting and walking the floor as much as possible.

Mrs Warburton commented on the improvement work related to EoL care of the patient experience story presented, and enquired about the staff providing the 2 hour care rounds. The CNMO stated this was registered nurses and/or HCAs.

Ms Bonney highlighted it was harrowing to hear the patient experience story presented and that the issues identified in the IIEKMS Report were across the whole organisation and not just within maternity. She emphasised the need to implement the culture change programme at pace with a robust strategy disseminating the message to staff in team huddles and the need to make immediate changes. The Trust needed to look externally at its peers and what was being done to support the changes required, and also lobby for additional central funding. The CE accepted the need for learning from others, stronger awareness from staff to understand the outcome and issues in the IIEKMS Report, noting extensive staff communications had been issued and that a new team briefing process was being introduced, attendance would be mandatory for senior staff and leaders to then disseminate messages to their teams. She highlighted the future challenges in respect of funding across the NHS and the limited resources available. The Chairman commented reflecting on the points raised in the IIEKMS Report in around six months and feedback from staff on their reflection since its publication.

The Chairman wished everyone a Merry Christmas and a Happy New Year.

The Chairman closed the meeting at 5.20 pm.

Date of next meeting in public: Thursday 9 February 2023 in the Cornwallis Room, Spitfire Ground - Canterbury Cricket Ground.

Signature _____

Date _____

CHAIR'S INITIALS ……

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 8 DECEMBER 2022**				
MEETING DATE:	**9 FEBRUARY 2023**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**				
APPENDICES:	**APPENDIX 1: DECEMBER 2022 MATERNITY DASHBOARD**				
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 8 DECEMBER 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/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 to be presented to IAGC as part of its annual effectiveness review survey, approved ToR to be presented to the Board for approval as part of the IAGC Chair Assurance Report.
B/18/22	Present the full maternity dashboard along with an exception report on the current position to the next Board meeting.	Feb-23	Chief Nursing and Midwifery Officer (CNMO)	To Close	Maternity Dashboard for December 2022 presented to 09.02.23 Board meeting as appendix to the actions log. **Action for agreement for closure at 09.02.23 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

B/19/22	Clarify and confirm the numbers of Learning Disabilities (LD) and or Autism stranded patients that were deemed medically optimised for discharge and should no longer be within acute services.	Feb-23	Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update will be provided at 09.02.23 Board meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	MATERNITY DASHBOARD DECEMBER 2022
MEETING DATE:	9 FEBRUARY 2023
BOARD SPONSOR:	CHIEF NURSING AND MIDWIFERY OFFICER: EXECUTIVE BOARD MATERNITY SAFETY CHAMPION
PAPER AUTHOR:	INTERIM DIRECTOR OF MIDWIFERY: MATERNITY SAFETY CHAMPION
APPENDICES:	NONE

Executive Summary:

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

Purpose of the Report:

The maternity dashboard has been developed by the Maternity leadership team and is monitored monthly through Maternity and Neonatal Assurance Group (MNAG). The dashboard provides an overview of performance against a number of key areas related to outcomes in relation to:

- Governance/Learning from Incidents
- Complaints
- Patient Experience
- Workforce
- Training
- Clinical care/outcomes
- Operational
- Triage
- Saving Babies Lives
- Maternity Improvement programme

The exception report highlights areas where there is non-compliance and the actions that are being taken to improve performance and/or mitigate any immediate safety concerns.

The Chief Nursing and Midwifery Officer is currently reviewing the Key Performance Indicators (KPIs) included within the dashboard to align some of the metrics to the Pillars of Change Outcomes Framework.

Summary of Key Issues:

- Midwifery staffing remains a challenge, particularly at the William Harvey Hospital (WHH), but 1:1 care was maintained, and there was one validated episode where the B7 was not supernumerary.
- Concern raised around the non-compliance in month for checking emergency equipment at the WHH as well as community, although compliance is improving.
- Birthrate+ recording compliance at WHH remains low at 58.4% against a target of 80%, this is an ongoing concern.
- The use of on-call midwives, both from community and hospital continues. Whilst the number of hours that community midwives

	have been called into the acute units has reduced significantly, this continues to be a concern from an operational perspective. • Overall vacancies across midwifery are within acceptable levels, however, there are areas of concern for the WHH, in terms of vacancies, maternity leave, sickness and turnover. • Poor levels of compliance for 'other' mandatory training remain poor with the priority being on achieving compliance with mandatory maternity training. A trajectory has been set within the care group for compliance with all other training to be achieved by March 2023. • There has been an in month increase of forceps (7.8%) by 3.2% and also an increase on 0.6% in vacuum deliveries. Further analysis has identified that although December rates are high, when looking at the past few months we are seeing a gradual decline. • Work has been progressing to improve the medical staffing at the WHH for triage. A change has been made to middle grade and Senior House Officer (SHO) rotas at the end of December. This has resulted in additional cover for acute and triage at weekends. • During December there were 4 diverts. These were internal diverts between WHH and Queen Elizabeth the Queen Mother Hospital (QEQM), and due to the level of activity, especially the number of women requiring 1:1 care, outweighing the number of staff available, even after escalation pathways in place. This was impacted further by increased short terms sickness. No women came to harm as a result. • During November an audit of compliance for each stage for Venous Thromboembolism (VTE) assessment was undertaken across the pregnancy pathway. In total only 18% of women had all 9 assessments completed. • Foetal heart monitoring compliance is a concern across both units, actions in place to address. • CO monitoring at 36 weeks declined in December to 75.5% against a required of 80%. • This is the first month of reporting the outcomes of audits aligned to the maternity improvement programme.
Key Recommendation(s):	The Board is invited to: 1. **NOTE** the contents of the exception report and the KPIs included in the dashboard. 2. **DISCUSS** and **ADVISE** if the Board would like to see other information included within the dashboard. 3.
Implications:	
Links to 'We Care' Strategic Objectives:	

Our patients (women and Families)	Our people	Our future	Our sustainability	Our quality and safety

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	**BAF 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	Clinical Negligence Scheme for Trusts (CNST) NHS Long Term Plan-standard contract
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	Maternity and Neonatal Assurance Group January meeting	

East Kent Hospitals University NHS Foundation Trust

Maternity Dashboard

1.Purpose

1.1. The purpose of this report is:

1.1.1. To provide an overview of performance against a number of key areas related to outcomes in relation to:

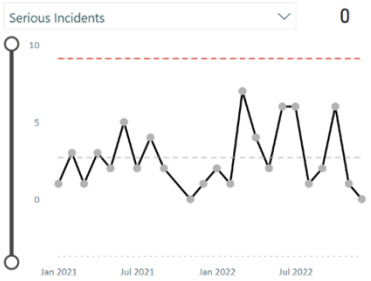
- Governance/Learning from Incidents
- Complaints
- Patient Experience
- Workforce
- Training
- Clinical care/outcomes
- Operational
- Triage
- Saving Babies Lives
- Maternity Improvement programme

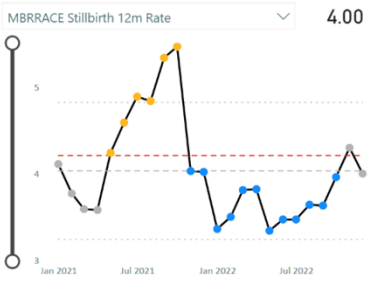
1.1.2. To highlight those areas where there is non-compliance with agreed targets.

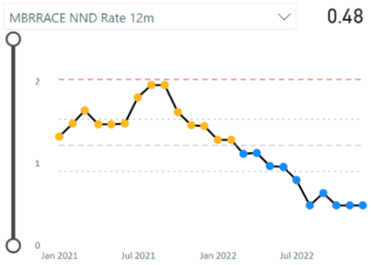
2. Dashboard

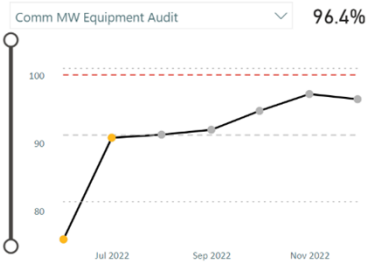
2.1 Governance

KPI	SPC	Oct-22	Nov-22	Dec-22
Serious Incidents		6	1	0
Total Incidents		251	219	197
Moderate+ Harm (C - E)		5	2	3
No/Low Harm (A & B)		246	217	194
HSIB Referrals		0	0	
MBRRACE Stillbirth 12m Rate		3.96	4.30	4.00
MBRRACE Stillbirths		4	2	0
MBRRACE Term Stillbirths		0	1	0
MBRRACE NND Rate 12m		0.48	0.48	0.48
MBRRACE Neonatal Deaths		0	0	0
MBRRACE Term Neonatal Deaths		0	0	0
MBRRACE Perinatal Rate 12m		4.44	4.78	4.48
Maternal Deaths		0	0	0
Maternal Readmissions		3.6%	3.1%	3.8%
Neonatal Readmissions		9.0%	10.6%	10.6%
ITU Admissions		2	0	1
Comm MW Equipment Audit		94.7%	97.2%	96.4%









During December 0 Serious Incidents were reported. A more in-depth analysis of Serious incidents (SI) has been provided in the quarter 3 report for Sis.

During December there were 3 moderate harms reported in month, which included;

- 2 unplanned returns to theatre. These cases are awaiting review through rapid review, and have been delayed to the unavailability of the postnatal notes, which are in paper format and stay with the women when they are discharged home. An issue has recently been highlighted around how notes are being returned and further investigation is underway to resolve this.
- 1 readmission for infection. There was a delay in accessing the postnatal notes, but this case is now being reviewed on Monday 9 January at rapid review.

During December there were no cases referred to Healthcare Safety Investigation Branch (HSIB), and there were 0 stillbirths. Due to there being no stillbirths in December this has reduced the overall rate to 4.0 for the 12 months.

Compliance for the community equipment checks has fallen during December to 96.4%. This is due to lower compliance within Canterbury and Thanet teams, which are at 92% and Dover which is at 94%. The remaining 3 teams are at 100%. The community matrons and the Head of Midwifery have been tasked to address this as a matter of urgency.

The table below summarises the compliance for December with safety checks across both units. There is still unacceptable variability in compliance and this seems to be linked to presence of senior midwifery leadership in particular at WHH. Further work is being taken forward with ward managers, by the Head of Midwifery, to ensure there is clarity over roles and responsibilities and the requirement for 100% compliance. Individual conversations will be held with band 7 midwives to ensure there is complete understanding of their accountability with regards to this matter. For the WHH the compliance fell below 100% due to non-compliance on the 24 November, and in December there were 6 days of non-compliance, whilst each piece of equipment had 1 safety check, 2 checks each 24-hour period is required. This period also coincided with when the Head of Midwifery was on leave. At QEQM there was an issue in relation to the compliance with checking the resuscitaire in the main theatre on one occasion, which has been addressed. Whilst overall this is a significant improvement to previous performance, when highlighted through an SI, the requirement remains100%.

Unit	November compliance	December compliance
WHH	98.75%	90.4%
QEQM	100%	94%

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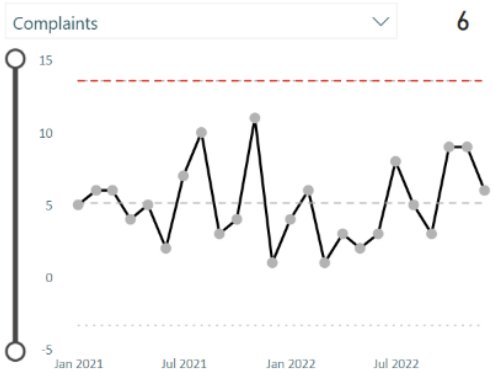
2.3 Complaints

KPI	SPC	Oct-22	Nov-22	Dec-22
Complaints		9	9	6



During December 6 complaints were received, which is a reduction to previous months:

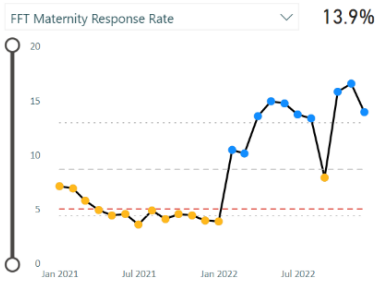
- 2 patients with difficulties during surgical procedures;
- 2 complaints relating to communication issues;
- 1 patient complained of privacy and dignity issues;
- 1 patient was unhappy with their treatment.

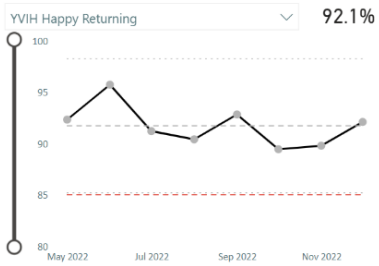
Investigations have commenced on all complaints received. Since receiving these complaints 1 has been withdrawn, and 3 local resolution meetings are planned.

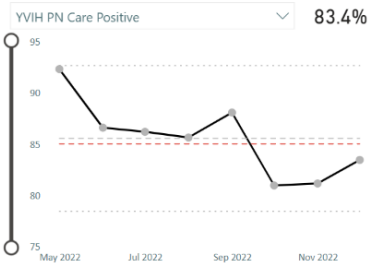
During December 6 complaints had breached the 45 days, however, they were all closed in month.

2.4 Patient Experience (Your Voice is Heard)

KPI	SPC	Oct-22	Nov-22	Dec-22
Complaints		9	9	6
FFT Maternity (All)		93.9%	91.6%	90.3%
FFT Maternity Response Rate		15.8%	16.5%	13.9%
YVIH Response Rate		63.0%	70.5%	74.3%
YVIH Happy Returning		89.4%	89.8%	92.1%
YVIH AN Care Positive		90.4%	92.6%	88.9%
YVIH Intrpartum Care Positive		90.8%	91.9%	95.5%
YVIH PN Care Positive		81.0%	81.1%	83.4%

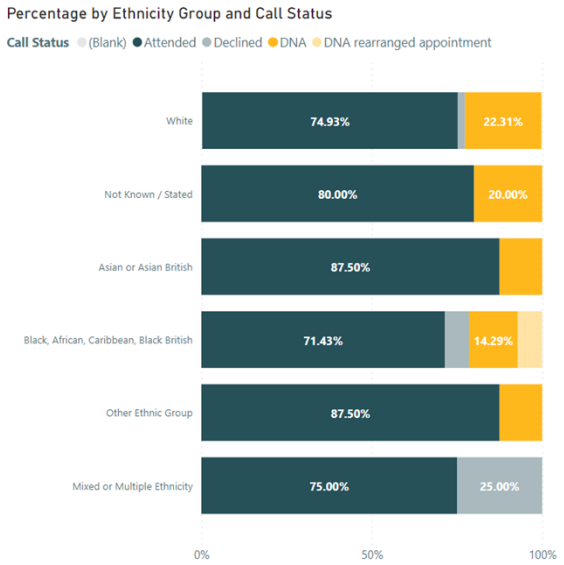


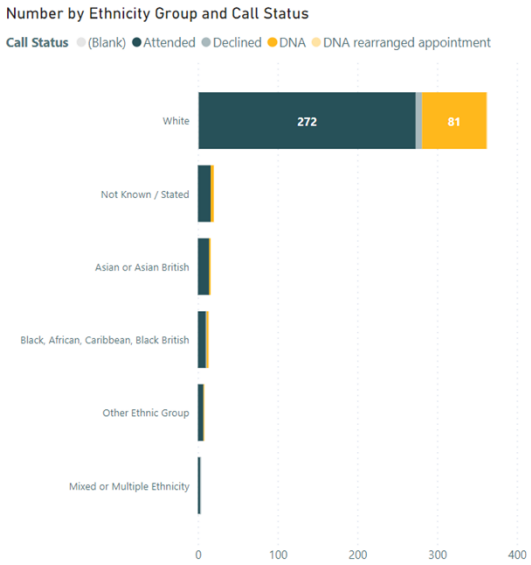




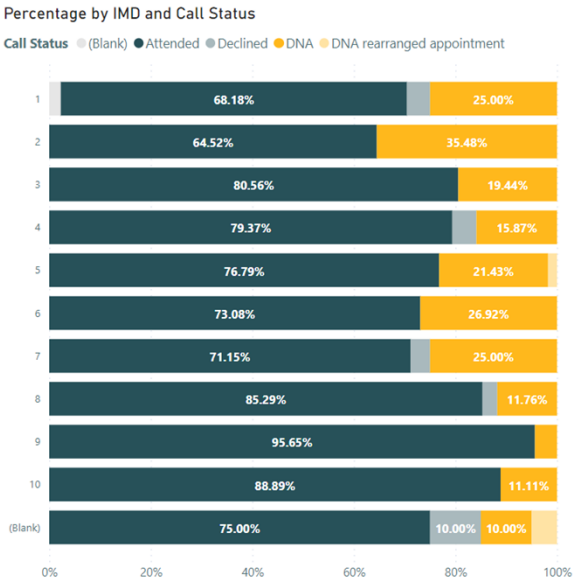
The Your Voice Is Heard team recorded their highest response rate in December, at 74.3%. The demographic analysis has been completed as shown below, to ensure appropriate inclusion of Black, Asian and Minority Ethnic (BAME) women and those identified using the

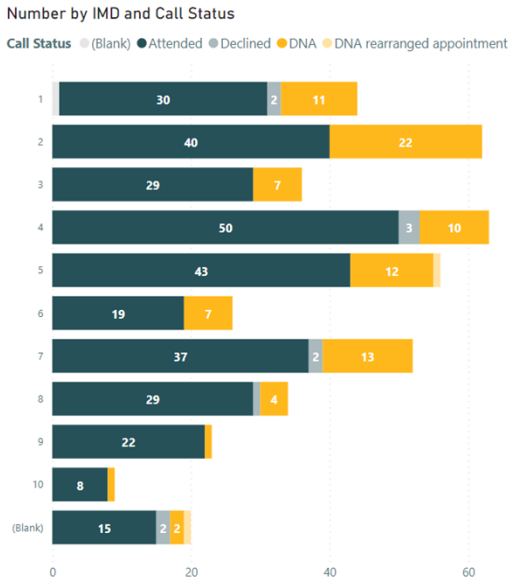
index of multiple deprivation (IMD). This shows that the team have achieved appropriate representation across all groups of women relevant to the total population served.





Ethnicity Group		Attended	Declined	DNA	DNA rearranged appointment	Total
White	1	272	8	81	1	363
Not Known / Stated		16		4		20
Asian or Asian British		14		2		16
Black, African, Caribbean, Black British		10	1	2	1	14
Other Ethnic Group		7		1		8
Mixed or Multiple Ethnicity		3	1			4
Total	**1**	**322**	**10**	**90**	**2**	**425**





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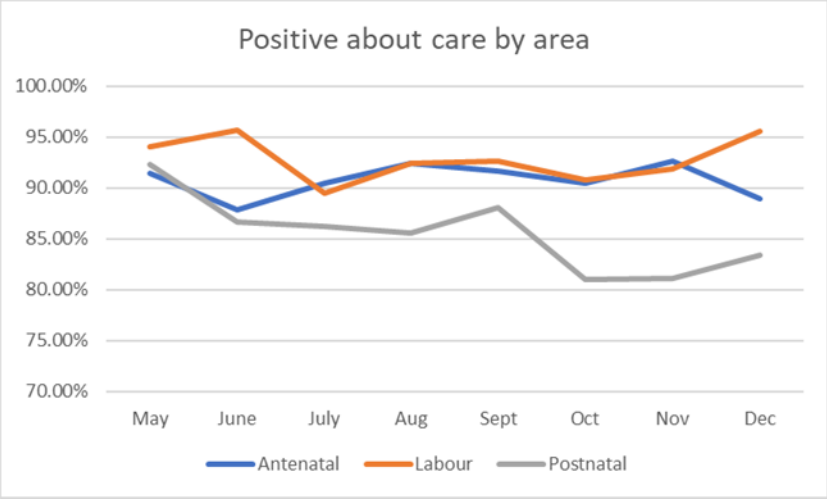
IMD		Attended	Declined	DNA	DNA rearranged appointment	Total
1	1	30	2	11		44
2		40		22		62
3		29		7		36
4		50	3	10		63
5		43		12	1	56
6		19		7		26
7		37	2	13		52
8		29	1	4		34
9		22		1		23
10		8		1		9
		15	2	2	1	20
Total	**1**	**322**	**10**	**90**	**2**	**425**

The charts below show the trends over time for the feedback received, which has been steadily increasing.



The chart above shows a steady improvement in the feedback related to labour care. Whilst antenatal care has fluctuated around a similar rate, postnatal care has declined.

If the above data is taken and examined by geographical area the following tables show that in general the more positive experience is recorded for Canterbury, Coastal and Thanet.

Geographical Team	Antenatal care	Postnatal care
Coastal	95.7%	89.1%
Thanet	89.6%	88.3%
Canterbury	97.6%	85.4%
Ashford	81.2%	82.6%
Dover/Deal	85.1%	76.1%
Folkestone	89.3%	75%

The table below splits the feedback by hospital site for labour care

Site	Labour care
QEQM	97%
WHH	94.4%

The improvement work has been focusing on the postnatal care in the hospital, but there is a need to move forward with a postnatal pathway review for both hospital and community.

The Patient experience team have been developing a new system to support the timely theming of feedback, which will support a more rapid turnaround of themes being reported. This will include a breakdown by site. It is currently in the last stages of production. Alongside this the monthly meetings are scheduled to begin in January with the Heads of Midwifery, matrons and managers on each site, so that the actions required from feedback themes can be taken forward by the operational teams.

The table below summarises the actions to date from the follow up to address themes raised by women and families

Theme	Action
Loud bins on the ward (WHH)	New bins have been ordered for Folkestone ward and some have already arrived. QEQM have advised they had all new one's last year and do not need them.
Chairs uncomfortable for partners to sleep on	Extra pillows and blankets are being costed. Investigating where these items has also begun.
Birth partners not being offered refreshments	Food and drink for partners is being looked into by procurement. Additionally, we are looking at a tea trolley round for triage to offer to those waiting in the waiting room. This is similar to the service that is offered in Accident & Emergency (A&E). We are

	awaiting costs and budget to be able to see if we can approve this.
No toilets and showers on the wards for partners	The inclusion of a shower and toilet unit to be on PN ward and Labour ward has been put forward for phase 2 of the estates plan.
Delay in pain relief postnatally and for induction of labour	Essential care rounds have commenced on both PN wards where medication should be offered every 4 hours. More work is required in looking at delays in pain relief during induction. Pain scoring assessment has been discussed and about how this may be able to aid us in offering adequate pain relief or a process of assessment for induction of labour to make birthing parents feel like they are also listened to in this period of care. Sterile water injections put forward as a project for good pain management although currently consultants are not keen at present and a further conversation is required to understand. John Hamilton is happy to do a presentation to consultants about sterile water injection. SAMs (self-administering medication) is also being looked at by the team. Diclofenac and ibuprofen clear guidance is needed as there is different opinions on this. PEM are contacting the pharmacist Anthony to get clear guidance on this to update staff.
Catheters not being checked or clean linen offered	Essential care rounds have commenced on both PN wards where catheters and linen should be checked every 4 hours.
Water jugs not being topped up / no access to water coolers for patients to use	Essential care rounds have commenced on both PN wards where water should be offered every 4 hours Water coolers are being installed on each ward. Managers are now in contact with procurement about assessing where to place these and the type required.
Sonographers not communicating and being rude	Patient Experience Midwives have had a meeting with ultrasound managers and this has been escalated to their higher manager. We will report to them on a monthly basis with any further feedback they can address.
Not having a visit from the community first day home after being discharged from the hospital Postnatally	All new patients are now to be offered first day visits not just a phone call which should lead to a change in this theme.

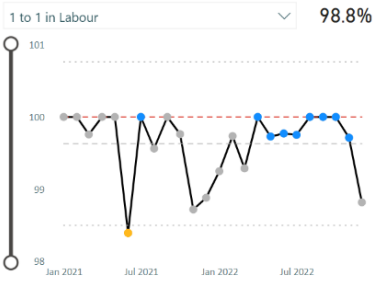
We had a few calls recently with birthing parents who have had their caesarean section wound break down post discharge from midwifery care and finding hard to see their GP and refused care in maternity triage.	The Gynaecology service has confirmed that after the 28 days we can give GAU at QEQM and Women's Health suite number to those who may contact us and need help and get an appointment to get the wound seen to. We have sent this information out to the community matrons and they have disseminated it out to their teams.
Not from a big theme in patients feedback but is mentioned sometimes e.g. lack of first day visit- or midwife not knowing what has happened in hospital) From creating our YVIH tracker we saw that sometimes the discharge sheet that is emailed to liaison is not always the same as the discharges on E3.	A meeting was held about the discharge process. Community matrons confirmed that not enough information is from the discharge sheets. There are site visits in the next few weeks to discuss this with the staff and other trusts being asked what they do to see if this process can become more streamlined and aid our community colleagues in the information provided.

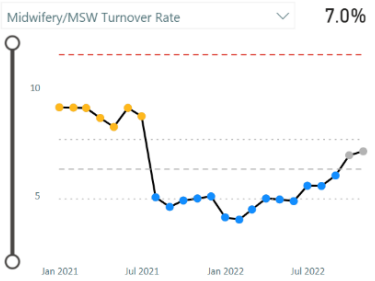
Further feedback from women has noted issues with the cleanliness of bathrooms on both sites. Since presenting this report to MNAG, deep cleans are being commissioned by 2gether Support Solutions (2gether) along with hourly checks.

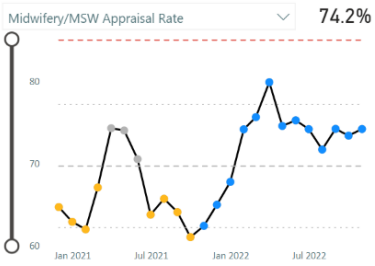
During December it has been noted that there has been a reduction in the number of issues raised about not having a face to face visit on the first day home postdelivery.

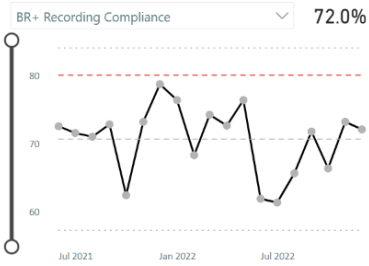
2.5 Workforce

KPI	SPC	Oct-22	Nov-22	Dec-22
1 to 1 in Labour		100%	99.7%	98.8%
Worked WTE: Birth Ratio		23.88	20.72	
Midwifery/MSW Turnover Rate		6.9%	7.0%	
Sickness Rate		7.2%	8.3%	
Midwifery/MSW Vacancy Rate		9.7%	9.9%	
Midwifery/MSW Appraisal Rate		73.4%	74.2%	
Total On-Call Hours		794.4	485.2	573.6
Occurance On-Call In		119	96	99
BR+ Recording Compliance		66.3%	73.1%	72.0%
BR+ Red Flags		22	21	16
BR+ Staffing Factors		12.2%	12.2%	12.3%
BR+ Clinical Actions		17.4%	17.4%	17.2%
BR+ Management Actions		6.7%	6.7%	6.7%
BR+ Staffing Meets Acuity		44.9%	58.9%	55.2%









During December there were 4 women reported as not receiving 1:1 in Labour; 2 at WHH and 2 at QEQM. Further review of the labour records has confirmed that 1:1 care was compliant on both sites.

Birthrate+ recording compliance at WHH remains low at 58.4% compared to 85.7% at QEQM. The expected level is 80%, to enable robust use of the data when determining the acuity and actions to be taken. The Head of Midwifery for the WHH, is working with the band 7 team to ensure this is improved, however there have been challenges in maintaining 2 band 7 midwives per shift, which supports an operational role, with oversight and ability to complete the acuity tool. During December there was an increase in short term sickness across all staff groups, including the 7s. In addition, there are 2 vacancies for band 7 positions which the team in in the process of trying to recruit to.

During December there was 1 episode of 2 hours where a band 7 at the WHH was not supernumerary, due to sudden increase in activity. The band 7 care for a woman in labour for a short period of time, whilst awaiting an on-call member of staff to arrive. There were no incidents as a result of this.

The use of on-call midwives, both from community and hospital continues. Whilst the number of hours community midwives have been called in for has dropped significantly, this has still been challenging for individuals who are trying to balance the work during the day across clinics and home visits with the demand of on-calls. However, there is growing concern around the continual use of the hospital on call midwives, which was implemented at the beginning of 2022, to balance the use of the community teams. These concerns were discussed at a joint meeting between senior midwives, Human Resources, and the Royal College of Midwives at the regular monthly meeting. Staff have escalated their unhappiness how it feels that it is inevitable they will be called in and so by default they are doing additional shifts. The main area of pressure is the WHH, where there are ongoing challenges with staffing. A task and finish group has been put in place to identify all the staff concerns across all areas and a co-produced plan is being developed to address concerns as far as is possible. This process is supported by the regional Royal College of Midwives (RCM) representative. The first meeting of the group took place on the 5 January and was well attended by all groups. Some initial suggestions are being explored and a further meeting to formulate a more robust plan will take place before the end of January. Since the presentation of this at MNAG, further discussions have happened with the staff and agreement made on how individual hours will be logged when called in as well as monitoring more closely the reasons for the use of the on-call.

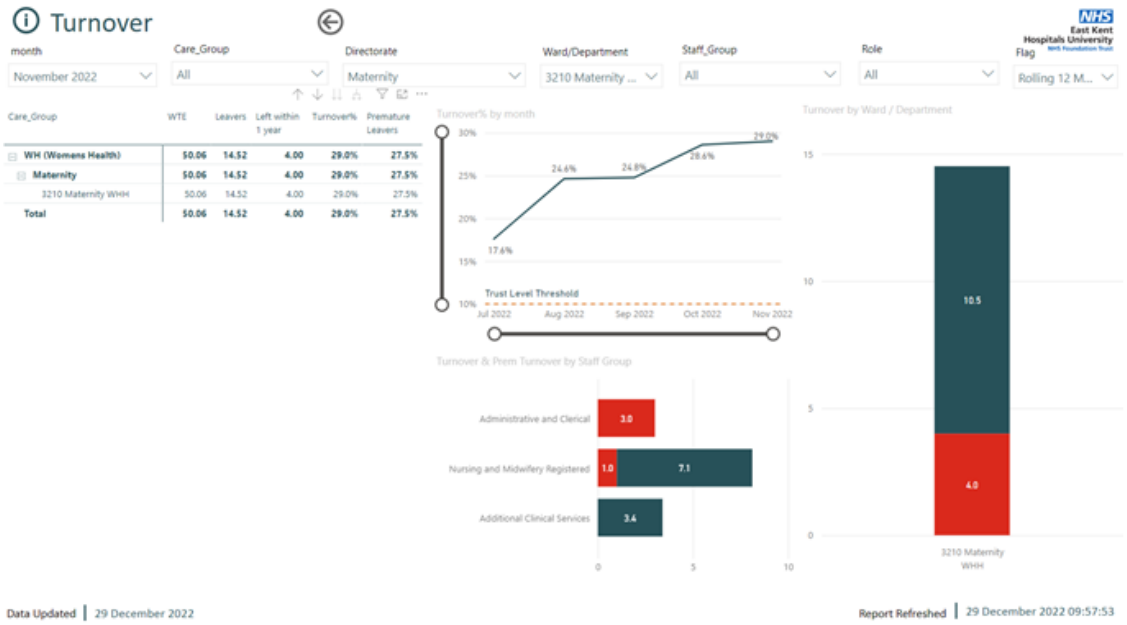
The table below summarises a breakdown of the number of on-call hours across community, hospital and managers. There is a growing requirement for managers when on-call to attend out of hours to support, the WHH, usually to implement a divert and fill gaps in staffing. Whilst the use of the community on-call midwives has stabilised, this is only because the hospital on-call system has been put in place, and fully utilised.

Domain	Sliced by	Thres.	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Workforce	TOTAL		350.5	401.4	717.3	433.8	558.8	822.7	807.5	535.1	404.8	794.4	485.2	573.6
	OTHER - Community	100.0	32.6	118.2	137.4	107.9	175.6	232.9	347.6	167.8	140.6	194.5	175.0	149.9
	OTHER - Management/Admin	75.0	92.5	25.5	178.2	80.1	135.2	132.8	140.2	39.0	22.0	153.0	141.3	197.4
	QEQM - Queen Elizabeth Queen Mother Hospital	125.0	65.8	111.5	130.8	71.3	46.9	159.8	75.0	54.2	77.3	177.5	30.8	76.4
	WHH - William Harvey Hospital	150.0	159.6	146.3	270.9	174.5	201.2	297.3	244.8	274.2	164.9	269.4	138.2	149.9

During December a detailed review was undertaken of the midwifery workforce across both hospitals and the community was undertaken by the senior midwifery team. The table below summarises the results of this review. Whilst overall vacancies across midwifery are within acceptable levels, the table highlights the areas of concern for the WHH, in terms of vacancies, maternity leave, sickness and turnover. However further analysis of turnover by each area has identified a month on month increase at the WHH, with a decline at QEQM. Community has been variable, where there have been retirements across the teams. Further work is required, linked to retention, culture and also recruitment for the WHH. Enhanced NHS Professionals (NHSP) rates and long line bookings through agency are already in place.

Adverts are out for midwifery posts and also nursing posts, but the number of applications so far is disappointing. The team are working with recruitment to find different ways to improve this situation. However, there is clearly a link with the continued pressure felt by staff high activity levels with increasing acuity. Further discussion with the midwifery NHS England (NHSE) lead has taken place to understand alternative approaches from other units, that may be possible to resolve this ongoing issue.

Midwifery workforce – combining bands 7,6 and 5, **EXCLUDES** Governance and Specialist roles							
Site	Vacancy	Maternity leave	Appraisal	Statutory Training	Mandatory training (general)	Turnover	Sickness
WHH	20%	8.8%	59.4%	87.4%	72.9%	29%	10.33%
QEQM	0%	2.7%	87%	91%	81.3%	2.6%	4.8%
Community	4.4%	11.1%	79.2%	86.7%	69%	6.1%	8.7%
Overall	**8.79%**	**7.7%**					



2.6 Training – Maternity Specific

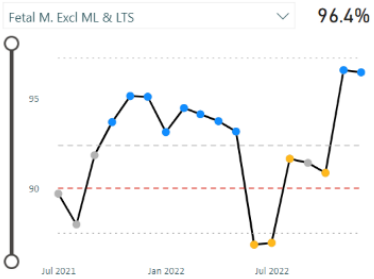
During December, for all areas of maternity mandatory training compliance was achieved for midwives, support workers and obstetric medical workforce.

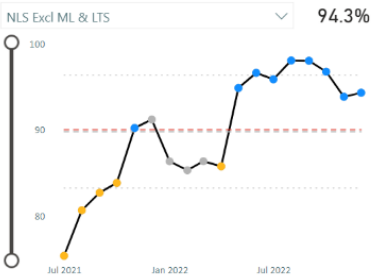
PRactical Obstetric Multi-Professional Training (PROMPT) training has recommenced face to face on both sites insitu. However, there are still challenges at times being able to secure the

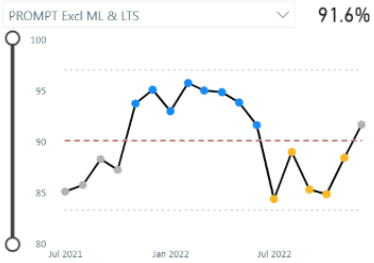
required Multi-Disciplinary Team (MDT) faculty to support the delivery, due to staffing pressures.

The Block training programme has been reviewed and for 2023, will be delivered over a 48 week period instead of the original 33 weeks

KPI	Oct-22	Nov-22	Dec-22
Fetal Monitoring Training	85.8%	90.6%	91.1%
NLS Training	91.4%	88.5%	89.5%
PROMPT	81.0%	83.8%	87.2%
Fetal M. Excl ML & LTS	90.9%	96.6%	96.4%
NLS Excl ML & LTS	96.7%	93.8%	94.3%
PROMPT Excl ML & LTS	84.8%	88.4%	91.6%

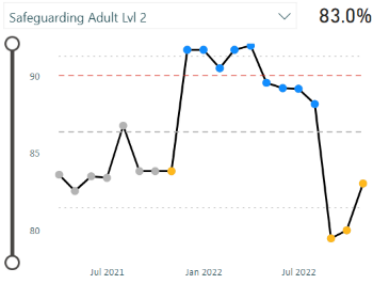


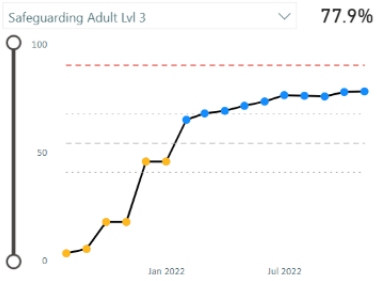


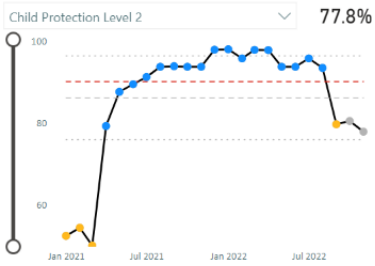


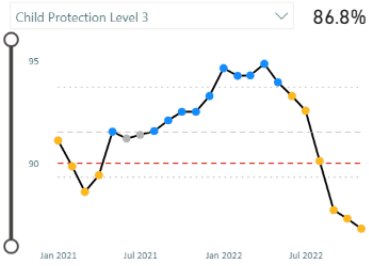
Other Training

KPI	Oct-22	Nov-22	Dec-22
Manual Handling	88.7%	88.3%	
Safeguarding Adult Lvl 1	100%	100%	
Child Protection Level 1	100%	100%	
Safeguarding Adult Lvl 2	80.0%	83.0%	
Child Protection Level 2	80.4%	77.8%	
Safeguarding Adult Lvl 3	77.6%	77.9%	
Child Protection Level 3	87.3%	86.8%	
Dementia	78.3%	79.0%	
Equality & Diversity	93.1%	92.2%	
Hand Hygiene	41.4%	53.8%	
Fire	87.1%	86.0%	
Prevent Lvl 1	100%	100%	
Health & Safety	90.5%	91.5%	
Prevent Lvl 2	84.6%	84.6%	
Infection Control	94.4%	89.8%	
Resus Adult	62.0%	72.0%	
Information Governance	87.1%	86.8%	









During December a review of all non-compliant staff was completed against each element of the mandatory and statutory training. A trajectory has been set with the aim to reach compliance by the end of March 2023. Balancing achievement for all areas of mandatory and statutory training for areas maternity specific and non-specific is dependent on being able to release staff at the times training is being undertaken. Analysing the areas where non-compliance is most significant has identified that:

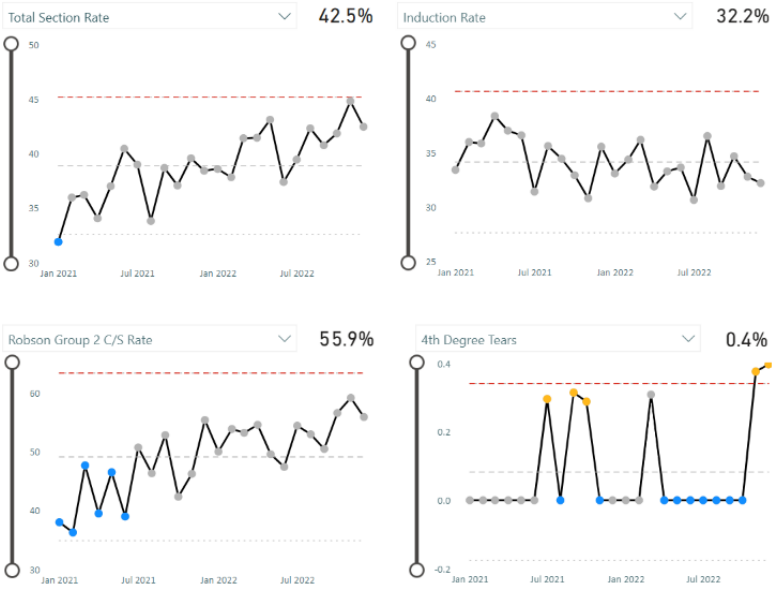
- For Adults safeguarding it is predominantly medical staff who are non-compliant. The review of this identified that there were some staff who no longer worked within

women's services and so the Electronic Staff Record (ESR) list was being cleansed and it is expected that improvements will be in seen in December and January.

- For children's safeguarding level 2 and 3, the issue is the same as for Adults.
- As part of the mandatory training, all aspects required improvement, across all staff groups. There have been challenges in the capacity to delivery some of the training adult resuscitation, which is now included as part of the maternity mandatory training going forward. For hand hygiene, links within the service have been identified and this work has begun.
- For Statutory training, apart from medical staff, all other staff are compliant with this training. The main area of focus is Infection Prevention and Control

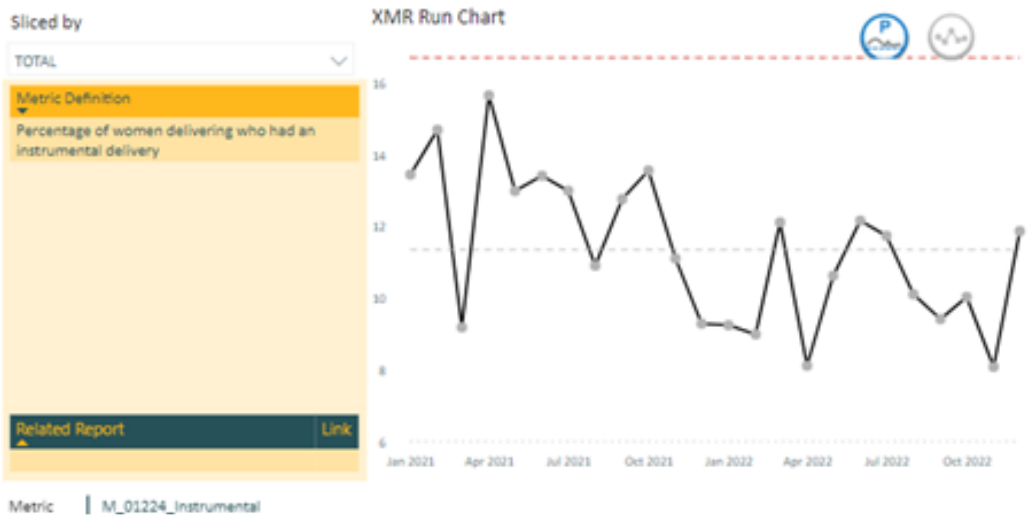
2.7 Clinical Care/Outcomes

KPI	SPC	Oct-22	Nov-22	Dec-22
Spon Vaginal Delivery Rate		48.1%	47.1%	45.7%
Total Section Rate		41.9%	44.8%	42.5%
Elective Section Rate		18.0%	19.3%	20.3%
Emergency Section Rate		23.9%	25.5%	22.1%
Cat 1 Section <30m		68.8%	88.5%	71.4%
Cat 2 Section <75m		65.8%	66.7%	80.0%
Robson Group 1 C/S Rate		26.6%	30.1%	25.6%
Robson Group 2 C/S Rate		56.6%	59.1%	55.9%
Robson Group 5 C/S Rate		84.4%	82.1%	87.1%
VBAC		16.5%	16.7%	16.2%
EL Sections >39w		80.8%	72.0%	70.1%
Instrumental Delivery Rate		10.0%	8.1%	11.9%
Vacuum Delivery Rate		2.7%	3.5%	4.1%
Forcep Delivery Rate		7.4%	4.6%	7.8%
Induction Rate		34.7%	32.8%	32.2%
MOH >1500ml		3.4%	3.3%	3.2%
3rd Degree Tears		3.6%	3.4%	2.8%
4th Degree Tears		0.0%	0.4%	0.4%
3rd & 4th Degree Tears		3.6%	3.8%	3.2%
Term Livebirth Delivery Rate		92.5%	89.6%	92.4%



During December the overall rate of 3rd and 4th degree tears was noted to be 3.2%, which is a reduction of 0.6% since November. All 3rd and 4th degree tears meet the threshold for rapid review and care is discussed; there has been no noted significant themes. A local audit has been commissioned to review and identify if there are any themes or learning to take place.

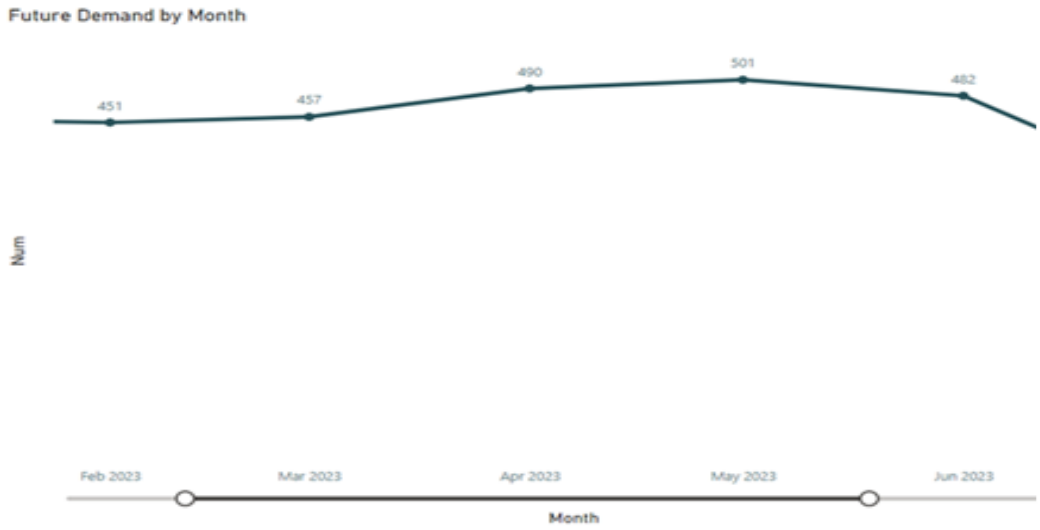
There has been an in month increase of forceps (7.8%) by 3.2% and also an increase on 0.6% in vacuum deliveries. Further analysis has identified, although December rates are high, when looking at the past few months we are seeing a gradual decline. The graph below highlights the trend over time.



Work has commenced across the Local Maternity and Neonatal System (LMNS) to agree how individual metrics are determined and defined. East Kent are part of this work, which will enable easier comparison of data.

2.8 Operational

During November it was previously noted that there had been and increase of 19% in the number of new bookings for antenatal care. The table below shows that the number of bookings for December has reduced back to the pre-November levels. An activity mapping exercise shows that the predicted deliveries are relatively stable.



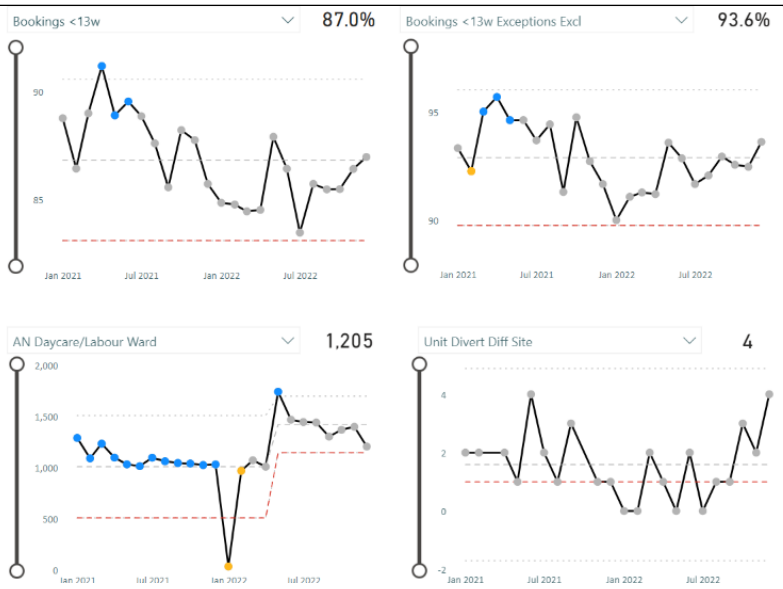
There is further work required to better analyse on a monthly basis the number of appointments by type and split by hospital or community. During the December the Standard Operating Procedure was agreed to guide the appropriate use of virtual appointments.

During December there were 4 diverts. These were internal diverts between WHH and QEQM, and due to the level of activity, especially the number of women requiring 1:1 care, outweighing the number of staff available, even after escalation pathways in place. This was impacted further by increased short terms sickness. No women came to harm as a result.

However, since presenting this paper at MNAG, discussions have commenced on a review of the activity for each unit to see how more activity can be moved to QEQM in a planned way.

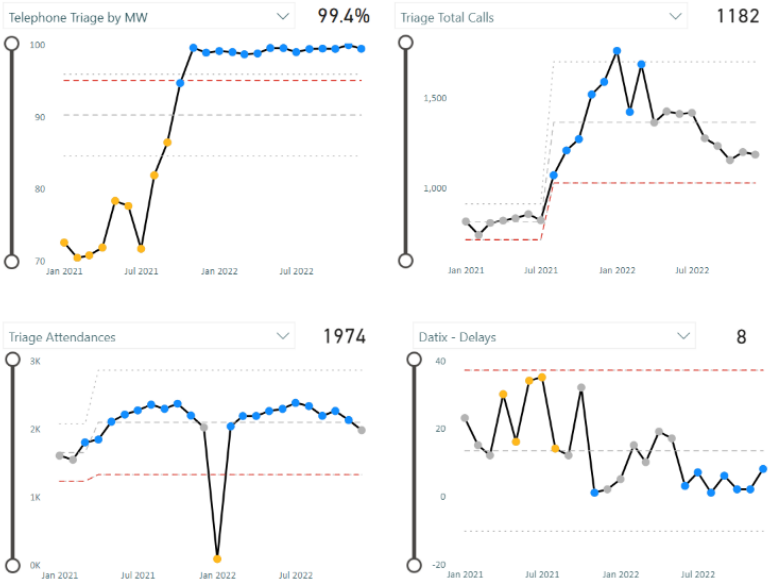
East Kent Hospitals University NHS Foundation Trust

KPI	SPC	Oct-22	Nov-22	Dec-22
Number of Bookings		534	624	524
Bookings <13w		85.5%	86.4%	87.0%
Bookings <13w Exceptions Excl		92.6%	92.5%	93.6%
Bookings <10w		45.0%	42.6%	41.0%
Women Aged <19 at Booking		21	15	9
Named Consultant		41.8%	39.0%	37.9%
Total Babies Born		539	487	462
Homebirth Rate		2.3%	2.1%	1.1%
Planned Homebirth Rate		0.9%	1.0%	0.9%
Homebirth Transfer in Labour		16.7%	20.0%	20.0%
Homebirth Transfer Postnatal		50.0%	20.0%	0.0%
MLU Transfer in Labour		22.2%	30.0%	0.0%
MLU Transfer Post Delivery		0.0%	0.0%	0.0%
Total AN Appointments		3,941	4,093	3,572
AN Daycare/Labour Ward		1,368	1,398	1,205
Total PN Appointments		412	275	153
PN Daycare/Labour Ward		101	77	101
First PN Visit at Home		3.4%	0.7%	11.8%
Total Virtual/Tel		8.2%	5.5%	2.8%
Unit Divert Diff Site		3	2	4
Unit Closure		0	0	0
Revised Birth Place at AN Appt		97.2%	97.3%	97.6%
Revised Care Plan at AN Appt		99.4%	99.2%	99.3%



2.9 Triage

KPI	SPC	Oct-22	Nov-22	Dec-22
Telephone Triage by MW		99.4%	99.9%	99.4%
Triage Total Calls		1151	1196	1182
Triage Attendances		2256	2123	1974
Datix - Delays		2	2	8



Work has been progressing to improve the medical staffing at the WHH for triage. A change has been made to middle grade and SHO rotas at the end of December. This has resulted in additional cover for acute and triage at weekends. This will allow a more timely review of women in triage, allowing the on call team being able to concentrate on labour ward and the antenatal patients. With present and recent appointments of consultants, triage can be covered Monday – Friday in the afternoon for 33 weeks a year, which is a significant improvement. To cover 52 weeks, a further revision of clinical work and how this is distributed, which may require further PA resources.

During December the noted compliance of midwifery telephone triage was 99.4%, however, on review of the data there were 7 incidences in total, 6 for QEQM and 1 for WHH. All cases have been reviewed and there is clear documentation that shows midwives gave advice accordingly to these women.

East Kent Hospitals University NHS Foundation Trust

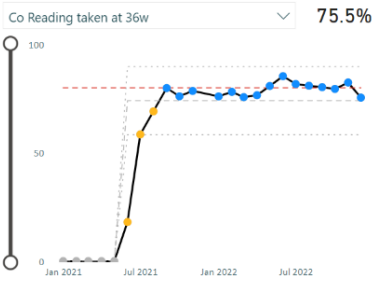
2.10 Saving Babies Lives

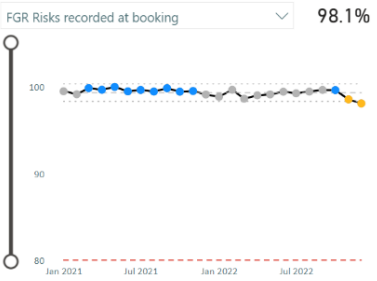
CO monitoring at 36 weeks declined in December to 75.5% against a required of 80%. The number of women who quit by 36 weeks significantly increased by 32.2%. The table below breaks down the compliance for CO monitoring at 36 weeks by each community team.

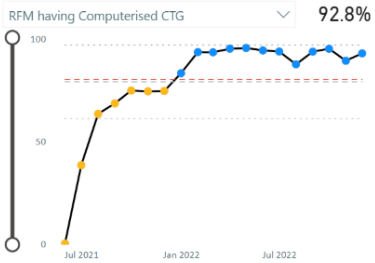
There was an increase in the number of babies who were born below the 3rd centile at 38 weeks and above, increased by 27.9%.

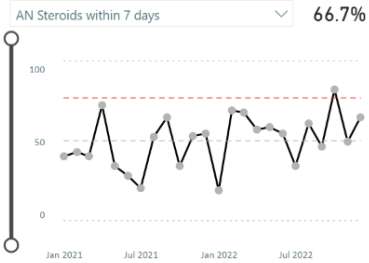
As part of optimising the health of babies born prematurely, the requirement is for magnesium sulphate to be given within 24 hours prior to birth. The number of cases this relates to is very small. In December 2 babies fell into this category. One of these was a spontaneous delivery, and there was not the window of opportunity to administer the magnesium sulphate.

KPI	SPC	Oct-22	Nov-22	Dec-22
Co Taken at Booking		96.4%	96.0%	96.2%
Co >=4ppm at Booking		16.3%	15.0%	15.9%
Co Reading taken at 36w		79.5%	82.4%	75.5%
Co >=4ppm at 36w		9.5%	11.5%	5.1%
Quit by 36w (>=4ppm & =<4ppm)		40.0%	34.5%	66.7%
FGR Risks recorded at booking		99.6%	98.6%	98.1%
SGA Detected Antenatally		1.7%	3.7%	3.0%
Babies <3rd Centile at 38w+		57.1%	36.4%	64.3%
Babies <10th Centile at 39w+		47.9%	43.8%	38.8%
RFM having Computerised CTG		95.0%	89.2%	92.8%
RFM Leaflet Given by 28w		91.5%	89.0%	86.9%
Fetal Monitoring Training		85.8%	90.6%	91.1%
AN Steroids within 7 days		85.7%	50.0%	66.7%
AN Steroids > 7 days		0.0%	12.5%	33.3%
Mag Sulph within 24hrs		100%	100%	50.0%
Appropriate Birth Setting		99.8%	99.6%	100%
Singleton Born 16+0-23+6w		0.2%	0.2%	0.4%
Singleton Born 24+0-36+6w		5.4%	9.0%	6.4%









Community team	% compliance for 36 weeks CO monitoring
Ashford	84.4%
Coastal	84.4%
Folkestone	74%
Thanet	72.8%
Canterbury	70.4%
Dover/Deal	64%

2.11 Monitoring of Maternity Improvement programme

As part of the ongoing maternity improvement programme and the associated key priorities a number of key metrics have been identified that require ongoing regular audit. Some these are built into the forward planner for audit across women's services, and others will be

monitored through regular quality rounds across the month. This component of the dashboard is new, and so very much still in development in terms of reporting.

An individual has been identified who is now working across both sites to complete ongoing audits.

VTE

During November an audit of compliance for each stage for VTE assessment was undertaken across the pregnancy pathway. The compliance across KEY areas where VTE assessment should be undertaken or documented ranged from 100% to 25%, as shown by the table below. In total only 18% of women had all 9 assessments completed. A new working group with membership across the MDT has been established and commenced in January to address this.

Assessment required	Compliance
Weighed at booking	100%
Booking VTE assessment	90%
Antenatal admission VTE risk assessment	31%
Admission for delivery VTE Risk assessment	25%
Postnatal VTE Risk assessment	60%
Correct LMWH management postnatal	53%
Discharge VTE risk assessment	73%
Score documented on E3	78%
Score documented on EDN	73%

Modified Early Obstetric Warning Score (MEOWS)

Data for MEOWs goes back to May 2022 in terms of reports, however, the ongoing data collection is being analysed so that reports can be generated.

Fetal Heart Monitoring

Area of audit	Compliance
Was the admission assessment tool for suitability for IA used if labour suspected.	63% QEQM 46% WHH
Was the baseline heart rate plotted on the partogram	50% QEQM 56% WHH
Completion of applicable fresh eyes/ears stickers	87% QEQM 56% WHH
Was the suspected type of hypoxia correct	57% QEQM 75% WHH

Were women managed in accordance with fetal monitoring guidelines regarding hypoxia	86% QEQM 88% WHH

The following steps have been taken to address the above results:

- The fetal heart monitoring guideline has been updated and is now live on Policy Centre.
- An audit of the partogram has been commissioned to better understand barriers to completion.
- Fresh care stickers to now be completed hourly, or when clinical picture changes,
- Laminated hypoxia cards have been attached to each of the CTG monitors to aid discussions regarding the type of hypoxia.

Situation-Background-Assessment-Recommendation (SBAR)

Following changes being made to the stickers used across the service for SBAR, a repeat audit has been undertaken, and will be ongoing. This data is currently being analysed for reporting.

3. Next Steps

3.1. To share the key variations in data with the wider MDT across Women's services.

3.2. To formalise a dashboard to monitor the improvement metrics.

3.3. To provide the detailed dashboard specific to triage in future reports.

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CHAIRMAN'S REPORT**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**CHAIRMAN**
APPENDICES:	**APPENDIX 1: NON-EXECUTIVE DIRECTORS' 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; • Reading the Signals; • Strategy and our Improvement Plan; • Learning Lessons; • Board changes; • East Kent Health and Care Partnership (HCP) Board; • 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	

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

As we expected this has been a very tough period for our patients and our staff. I should though pay tribute to everyone who has worked so hard over the last two months and acknowledge that on countless occasions patients and their families have been grateful and have appreciated the care we have provided and the kindness we have shown, sometimes in difficult circumstances. As leaders of this organisation, at every level, we need to make sure we constantly and consistently thank and support our front line and support staff, and acknowledge the pressures they are under. The fact that even on Christmas Day, normally a relatively quiet time, staff were coping both with much higher demand and with too many patients whom we should have been able to discharge but were not able to do so.

As our Chief Executive (CE) Tracey's report demonstrates, adapting to winter pressures has damaged our progress on waiting lists and times, and as we have opened escalation beds we have added to our costs at a time when we were already struggling to meet our budget. And for many reasons, some within and some outwith our control, patient flow and treatment backlogs remain our top concerns.

3. Reading the Signals

Today we will be considering the next steps in our response to the Reading the Signals report into our maternity service. We have already made clear will be a major driver and catalyst for change with the ambition to transform this organisation. As today's report says this will take time but we will be working with external experts such as Professor Michael West to drive this forward.

There are major commitments within that document, not least in adopting new ways of working and engaging every member of staff on that journey, as well signalling a determination to listen to, involve and work with patients and their families in new and different ways. All this will take time but we must measure and report on progress and be open to new ideas, learning from others as we reflect and adapt.

4. Strategy and our Improvement Plan

Today we welcome our new NHS England Improvement Director, Moira Durbridge, who will be working with us on our Improvement Plan which will set our objectives over the next 18 months. It will detail the immediate steps we need to take and it will aim to set out how we will take this organisation out of the national Recovery Support Programme. We recognise that this will be a significant task but we are committed to working with our colleagues at the Kent and Medway Integrated Care Board and the NHS south east region to agree and align our objectives, and agree a realistic but ambitious timetable to deliver what is required.

We are aware that the Improvement Plan and the transformation programme in response to Reading the Signals Report will need to shape and fit into our wider strategy. This will require us to co-ordinate and rationalise our longer-term ambitions, including our capital and clinical strategy, as well as bring together all the improvement work going forward, including how we shape our Quality Improvement programme We Care.

5. Learning lessons

As reported before Christmas we identified excessive levels of Entonox in labour rooms at the William Harvey Hospital. As Tracey reports we have commissioned an independent review covering both the technical and governance aspects which will come to the Board for consideration.

The recent Care Quality Commission (CQC) inspection into our maternity services was a disappointment – it acknowledges the commitment and dedication of clinical staff but it underlines the reality that we have still issues to address.

Likewise, we are investigating the circumstances behind our employment through an agency of a paediatric locum who subsequently appeared in court and pleaded guilty to child sexual offences. We must make sure we learn any lessons from this.

And in spite of a massive effort we have again not managed to comply with all the requirements set by NHS Resolution for their Clinical Negligence Scheme for Trusts which will cost us between £700k and £900k next year in higher premiums. There is, however, no reason why we should not comply next year and that must be our ambition.

6. Board changes

As Tracey's report makes clear, this is also a time of change within the Board with a number of Directors moving on to pastures new. The Board is currently large even by NHS standards and I have agreed with Tracey that when the present incumbents leave, the Director of Infection Prevention and Control and Director of Quality Governance posts, vital though they are, will no longer sit on the Board as non-voting members; however, both new appointees will be expected to report to the Board on a regular basis.

On behalf of the non-executive members of the Board, I also wish to thank our executive colleagues for their commitment and hard work in recent weeks and to acknowledge how difficult it is to escape from day to day operational pressures. I hope we are all clear that if we are to transform this organisation over the next few years, we will have to find ways of giving time to our managers and staff at all levels – time away from the immediate, time to reflect and challenge, and time to support each other and consider how we can all work differently and more effectively.

7. East Kent Health and Care Partnership (HCP) Board

The partnership dedicated its January Board session to prevention, a recognition that integrated approach to prevention will be central to our future work. It was also an opportunity to inform a submission for new health inequalities funding from the Integrated Care Board, which will be allocated from April 2023. East Kent is due to receive £1.9m.

At the workshop, we heard from a local resident who highlighted the local Multiple Sclerosis Therapy centre, and how its support had enabled her to keep working and engaged with others. It was a timely reminder of the value of voluntary sector support working in partnership with clinical and statutory provision. The fact that the workshop was held at district council offices, underlined the role wider partners in supporting improved health outcomes. There is more to do in developing this area but the session demonstrated that prevention needs to be part of what all partners do and the output will be incorporated into a first prevention plan for the health and care partnership.

The March Board will receive this plan and the East Kent health inequalities submission. It will also finalise arrangements with the Integrated Care Board in preparation for the delegated responsibilities that the partnership will hold from April 2023.

8. Council of Governors (CoG)

Since our last Board meeting Governors have continued to work with and hold to account our non-executive directors. A Council of Governors meeting will be held later this month together with a Development session with Board members.

Sadly, one of our public Governors for Folkestone/Hythe, Sophie Pettifer, lost her fight against Cancer in early December. Many of you will know Sophie from her time working within the Trust. Her dedication and enthusiasm to the Governor role, firstly as Staff Governor and more recently as a public Governor will be greatly missed.

The Council of Governors have agreed and ratified two new non-executive directors, Claudia Sykes and Richard Oirschot who will replace Jane Ollis and Nigel Mansley who are standing down after serving for two terms. Richard will chair our Finance and Performance Committee and Claudia our Charitable Funds Committee. They both bring a wealth of experience.

The Governors continue to work closely with the membership by way of the monthly newsletter which highlights a different Governor each month and looks at how the members can become Governors. Over Christmas they also attended the volunteer Christmas parties to thank them for their valued contribution. As we enter spring you should also see the Governors being more visible within the main sites as they conduct meet the Governor sessions, wearing their Governor tee-shirts. We will also be advertising the Governor role within the local Authority newsletters which will help to raise awareness.

The efforts that the Membership Engagement Communication Committee have been making to grow awareness of Governors can be seen in the response we have had to the Governor elections which are currently being held. We were able to fill the vacant seats in Ashford, Swale, Canterbury and the Staff vacancy. Especially pleasing was the response from the staff where we had 7 candidates for one Governor seat.

Since the last Board meeting joint site visits between the Governors and non-executives have been conducted to William Harvey Hospital (WHH) and Kent & Canterbury Hospital (K&C) where they visited Urgent Treatment Centre (UTC), Same Day Emergency Care (SDEC), Fracture clinic, Kings C1, Padua and Rotary wards.

9. Visits/Meetings/Talks

Chaired Interview panels for 2 non-executive director posts on the Board.
Canterbury Christchurch University - talk and discussion with nursing and allied health course students.
Institute of Directors course on of the Director and Board.
Meeting with Gary Fagg of the Paula Carr Centre.
Christmas site walks – visited Ashford, Margate, Canterbury, Folkestone and Dover.
Attended and gave eulogy at memorial service for Jeremy Voizey former Chair of League of Friends at Queen Elizabeth the Queen Mother Hospital (QEQM).
Met with Professor Rama Thirunamachandran DL, Vice-Chancellor and Principal.
Tour of Spencer Private Hospitals at Margate meeting new Chief Executive (CE) and other staff.
Meeting with Professor Michael West on compassionate leadership and culture change.
Visit to Integrated Care centre at Thanet at Westbrook House – met Dr Ash Peshen and colleagues.
Meetings with executives, Governors and non-executive directrors.
Hosted and spoke at fundraising dinner at Leeds Castle for Kent and Medway Medical School.

East Kent Hospitals University NHS Foundation Trust

Non-Executive Directors' (NEDs) Commitments

NEDs December 2022/January 2023 commitments have included:

Chairman	Meetings with individual NEDs Meetings with all NEDs Meetings with Executive Directors NED Interview Panels Meeting with Kent & Canterbury Hospital (K&C) Medical Director Meeting with Lead Governor Meeting with Governor Meeting with 2gether Support Solutions (2gether) Chair Meeting with Spencer Private Hospitals (SPH) Chairman Meeting with SPH Chief Executive Officer Meeting with Queen Elizabeth the Queen Mother Hospital (QEQM) Interim Hospital Director Meeting with NHS England Improvement Directors Kent and Medway (K&M) Chairs meetings Meeting with Integrated Care Board (ICB) Chair Meeting with East Kent Hospitals Chief Executive and ICB's Chair and Chief Executive Meeting with Kent & Medway (K&M) ICB Interim Executive Director of Communications and Engagement East Kent Health and Care Partnership (HCP) Chair, Senior Responsible Officer, and Programme Director meeting East Kent HCP Prevention Workshop East Kent Transformation Programme meeting Meeting with Paula Carr Diabetes Trust Chairman Extra-ordinary Closed Board of Directors (BoD) meeting Extra-ordinary Nominations and Remuneration Committee (NRC) meeting Institute of Directors (IoD) Training – Role of the Director and the Board NHS Confederation Chairs Group meeting Visit Kent & Canterbury Hospital (K&C) Christmas site walk Visit QEQM Christmas site walk Visit William Harvey Hospital (WHH) Christmas site walk Visit Buckland Hospital Dover (BHD) Christmas site walk Visit Royal Victoria Hospital Folkestone (RVH) Christmas site walk Visit to Canterbury Christchurch University South West and South East Regional Roadshow

Non-Executive Directors	Meetings with Chairman Meetings with Executive Directors All NEDs meeting with Chairman Extra-ordinary Closed BoD meeting Extra-ordinary Closed Integrated Audit and Governance Committee (IAGC) meeting IAGC meeting Extra-ordinary NRC meeting Quality and Safety Committee (Q&SC) meeting Finance and Performance Committee (FPC) meeting People and Culture Committee (P&CC) meeting Children and Adults Safeguarding Committee meeting Maternity and Neonatal Assurance Group (MNAG) meetings Patient Participation Action Group (PPAG) meeting 2gether BoD meeting Extra-ordinary 2gether BoD meeting SPH Board meeting Meeting with Deputy Executive Directors Meeting with Freedom to Speak Up Guardians Meeting with Wellbeing Lead

	Meeting with 2gether Chair Meeting with 2gether Managing Director NED Interview Panels Deputy Chief People Officer Interview Panel Digital Workforce Strategy Workshop Institute of Directors Training – Role of the Director and the Board Visit WHH Christmas site walk Joint NED/Governor site visit to WHH Joint NED/Governor site visit to K&C

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**
MEETING DATE:	**9 FEBRUARY 2023**
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			

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

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

2. Background

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

3. Clinical Executive Management Group (CEMG)

The Medical Specialty post expansion and Winter Funding Business Cases were approved by the CEMG at meetings held in January 2023.

4. Operational Update

4.1 2023/24 Operational Business Planning

Throughout the latter part of 2022 and continuing into January, the Trust's Care Group leads have been working with their HR, Information and Finance Business Partners to develop demand and capacity plans for 2023/24 business planning. These capacity plans outline, by specialty, the estimated quantity of first outpatient appointments, elective activity and follow up appointments that will be achievable across each specialty throughout the 2023/24 financial year.

It is anticipated that the Trust will be required to submit a draft operational plan (including activity, workforce and financial projections all triangulated) in mid-February.

Outlined below are the key objectives from the Guidance to recover core services and productivity:

Urgent and Emergency Care

- Improve Accident & Emergency (A&E) waiting times so that at least 76% of patients wait no more than four hours by March 2024 with further improvements in 2024/25.
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25.
- Reduce adult general and acute bed occupancy to 92% or below.

Elective Care

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties).
- Deliver the system specific activity target (agreed through the operational planning process).

Cancer

- Continue to reduce the number of patients waiting over 62 days.
- Meet the cancer faster diagnosis standard by March 2024, so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Maternity

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury.
- Increase fill rates against funded establishment for maternity staff.

Use of resources

- Deliver a balanced net system financial position for 2023/24 workforce.
- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise Mental health.

4.2 Elective 90-day Plan

As the Trust enters the last quarter of the financial year, there is significant focus on achieving the year-end target of zero patients waiting 78 weeks for treatment by the end of March. An elective 90 Day Plan has been developed and incorporates a series of actions, the aim of which is to deliver March targets through outpatient transformation, validation, pre-assessment, service efficiencies and increased theatre utilisation.

Reporting at the end of December outlined 357 patients now waiting longer than 78 weeks for treatment. The Trust also reported 6 breaches against the 104 week wait target, three of which are patient choice, with the others driven by COVID-19 or due to their complexity.

The Trust is working closely with colleagues across the Integrated Care Board (ICB) to provide the detail behind the 78-week position. This ongoing communication ensures the risks to achieving target are highlighted, mutual aid support is identified and service provision and efficiency across the Trust is being monitored.

4.3 Winter update

The Trust has seen significant levels of demand across its Emergency Departments and Urgent Treatment Centres throughout December, reporting the highest number of in-month attendances since records began, at 25,973. With this uplift in attendances comes a significant response as the services across the Trust flex to meet demand. Services and specialties are working to support winter escalation plans to provide more beds for patients with the unfortunate consequence of the need to cancel elective activity. Teams across the Trust are working to mitigate the impact of industrial action and continue to support the Trust's high number of long stay patients.

Community schemes supported by the Adult Social Care Discharge Fund have started to come to fruition providing additional capacity with enablement wards at Westview and Westbrook, further hospice capacity and further care home capacity specifically for some of the Trust Pathway 3 patients. The Trust's Rapid Transport Service (RTS) is supporting patient discharge to this newly accessible bed base and the Trust continues to monitor the flow of patients through these facilities.

In January, the Trust was informed that some slippage from the Adult Social Care Discharge Fund had been released to support the following additional specialty provisions:

- Locum Geriatrician consultant to support at Kent & Canterbury Hospital (K&C)
- ICB supported Homeless scheme to roll out for the Queen Elizabeth the Queen Mother Hospital (QEQM) in phase 1, to William Harvey Hospital (WHH) in phase 2.
- Increasing frailty services 8-8 at both WHH and QEQM sites
- Development of Medial Day Unit at K&C to centralise cold ambulatory to free up capacity at QEQM and WHH

These services will come into play from mid-January and will be monitored through the Clinical Executive Management Group (CEMG).

5. Finance Update

5.1 Financial performance Year to Date (YTD)

At the end of month 9 (December) the Trust has a year-to-date deficit of £24.5m, which is £21.4m adverse to plan, with an in-month deficit of £5.2m. This deficit position continues to be driven by the number of escalation areas opened across the Trust (60 beds) due to patient demand and flow (£6.87m), £4.6m of undelivered efficiency savings (Cost Improvement Programme (CIP)) and 3.0m in premium pay including other bank/ agency spend across the organisation.

The Trust is now forecasting a deficit of 30m for the 2022/23 financial year, which is being formally agreed with the ICB and NHSE, whilst internal financial controls continue to be heightened.

5.2 Financial Planning 2023/24

Planning guidance for the new financial year 2023/24 was published on 23 December 2022 with a focus on the recovery of core services and productivity, the long-term plan and transforming the NHS for the future.

NHSE will publish 2-year revenue allocations for 2023/24 and 2024/25 with a return to payment by results (PBR) for most elective care.

Trust, System and Provider activity targets will be agreed as part of the planning process with activity ‘around 130%’ of 2019/20 levels for 2024/25.

The Trust continues to work closely with Kent and Medway system partners to develop our operational plan for 2023/24, it should however be noted that the financial landscape is extremely challenging next year, with an underlaying deficit for the Trust of c.£45 - £50m included as part of the business planning process.

6. East Kent Maternity and Neonatal Services

The Clinical Executive Management Group (CEMG) discussed the Trusts response to the report, Reading the Signals, including the introduction and benefits of the Culture and Leadership programme (CLP) at its meeting on the 11 January 2023.

A paper for discussion on today's agenda will detail the work to date, including the pilot of the NHSE/I evidence based Culture and Leadership Programme (CLP), used as part of the Maternity Improvement Programme.

As previously reported, a review into how the Trust has failed to manage the delivery of Entonox in the Delivery Unit at William Harvey will take place and terms of reference for this work have been drawn up and an externally sourced individual is being identified. We expect the review work to take two months.

7. Industrial Action

Industrial action has been planned by the various Trade Unions across the Health and Social Care sector. Strike action days have been called by individual provider organisations, including South East Coast Ambulance Service (SECAmb), however, to date the Trust's employees have not been called to strike. Action by SECAmb will and has had some impact on ambulance handovers which have been planned for and will be mitigated by the operational planning team.

Strike Action Dates (NHS organisations):

- Royal College of Nursing (RCN): 18/19 January; 6/7 February; Kent Community Health NHS Foundation Trust (KCHFT) and NHS Kent & Medway affected;
- South East Coast Ambulance Service (SECAmb): 6 February, 20 February, 6 March, 20 March (GMB only, not Unison although Unison are re-balloting);
- Chartered Society of Physiotherapists (CSP): 26 January (not EKHUFT), 9 February (not EKHUFT);
- Unison – 11 January and 23 January (does not affect Kent & Medway);
- Hospital Consultants and Specialists Association (HCSA) – media advises that the ballot shows in favour of strike action, however no further update received.

Junior doctors are currently being balloted, although the results will not be known before 20 February 2023, with industrial action planned for March if the ballot is returned in favour and meets the required threshold of a fifty percent turnout.

We are also aware of the potential impact of strikes by non-NHS organisations such as schools and colleges and this is being factored into local operational plans and staffing availability.

8. Care Quality Commission (CQC)

After the unannounced visit on Tuesday 10 and Wednesday 11 January by the CQC, submissions of evidence and a response to the areas of concern highlighted have been made by the Trust in line with the CQC process. A proactive set of actions have been taken to address the concerns raised associated with provision of triage at William Harvey Hospital, foetal monitoring, maintenance of fire safety routes and adherence to cleanliness and infection control procedures. We will provide any further evidence should that be requested by the CQC in advance of their report being published.

9. Kent and Medway (K&M) Pathology Transformation

The Kent and Medway Pathology Network (KMPN) has been working as a collaboration of provider organisations for a number of years to address the critical issues being experienced across pathology services. The case for change clearly identifies that pathology services in their current state are not sustainable in terms of staffing, technology, clinical demand or financially.

As a result, a suite of Business Cases were produced to support; the adoption of a common Laboratory Information Management System (LIMS), a single Managed Equipment System (MES) contract and a single management structure.

The LIMS and MES outline Business Cases were approved by the Trust Board in July 2020 and the LIMS full Business Case was approved by the Trust Board in July 2021. During the approvals process, it was recognised that the focus of energy should be on the LIMS and MES implementation and that a move to a single management structure should follow at a more appropriate time.

The pathology transformation programme is now at a critical stage. By developing the network and successfully implementing these key projects, the network has an opportunity to secure a sustainable, high quality and cost-effective pathology service for many years to come. The NHS Long-Term Plan committed the NHS to establishing Pathology Networks across England by December 2021 and NHSE developed a self-assessment Maturity Network Tool which was completed by the KMPN. The Network Maturity Matrix assessment and action plan were approved by the K&M Pathology Transformation Board and endorsed by the Trust Chief Executive Officers (CEOs) in June 2022.

The Trust has been asked to re-confirm support for:

- Appointing a Clinical Director and Managing Director for the network in early 2023.
- Implementing a ‘single management’ reporting to the Clinical Director (CD) and Managing Director (MD) by April 2024.
- Enabling the Trust general managers to spend part of their week, from now until the full implementation of the ‘single management’, to provide dedicated leadership to network projects.
- Approving a collaboration agreement underpinning how the network works and the level of delegated authority, enabling the work required to reach a maturing network by March 2025.

These recommendations are believed to be essential for delivering the ambitious work programme of KMPN. In addition, the recommendations deliver the requirements of NHSE for pathology networks and secure the investment and ongoing funding commitments of the ICB.

10. Locum Registrar in Paediatrics, WHH/QEQM

A Locum registrar in paediatrics was employed through an NHS Framework agency by the Trust between January 2021 and January 2023 on an ad hoc basis to cover rota gaps for on call day or night duties at both WHH and the QEQM sites, a total of 111 shifts.

The doctor was arrested following a 'sting' operation by a member of the public, the doctor had been in contact with through social media in the early hours of the morning of Sunday 8 January 2023, while he was on duty at the QEQM hospital. He was subsequently charged and pleaded guilty to two offences under the Sexual Offences Act 2003. All appropriate action has been taken since his arrest and the doctor was referred to the General Medical Council. Police and safeguarding investigations are not yet complete.

We have undertaken a review of his employment at the Trust. While the findings of this review do not suggest that there were omissions or failures within the Trust's processes that would have directly predicted or prevented this criminal offence, there is undoubtedly further learning and actions recommended around the employment of temporary workers. Since the doctor was first employed we have introduced and embedded a Temporary workforce team that now hold the responsibility for ensuring all checks are in place. The most urgent recommendation of the review was a review of all current placements that have not been managed directly by the Temporary Workforce Team to ensure all checks are documented and this is nearly completed.

11. Executive Director of Quality Governance

Tina Ivanov, Executive Director of Quality Governance, leaves the Trust to take up a position elsewhere on 7 March 2023 and therefore, this is her last Board meeting. I would like thank Tina for her time and input to developing the quality governance processes within the Trust and to thank her for her support to me since I arrived.

12. Conclusion

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

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**TRANSFORMING OUR TRUST: OUR RESPONSE TO READING THE SIGNALS**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER**
PAPER AUTHOR:	**STRATEGIC PROGRAMME DIRECTOR**
APPENDICES:	**APPENDIX 1: TRANSFORMING OUR TRUST: OUR RESPONSE TO READING THE SIGNALS (INCLUDES THE DRAFT OPEN LETTER)**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	To update the Board on progress on the Pillars of Change and to approve the draft open letter to be published on 15 and 16 February 2023.				
Summary of Key Issues:	This is an interim report setting out our response to the *Reading the Signals* report into maternity and neonatal services at the Trust, almost four months after the report was published. It reflects the work the Board has been doing in that time and provides a factual update on the progress on the Pillars of Change. It includes a draft of an open letter, to be published in local media on 15 and 16 February. We are grateful to everyone who has contributed to this report and the draft letter, which is with the Board for sign off today. The letter has to be confirmed by 9am on Friday to meet the publication date of 15 and 16 February.				
Key Recommendation(s):	The Board of Directors is asked to **APPROVE** the draft open letter.				

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 39:** There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.			
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.			
Resource:	N			
Legal and regulatory:	N			
Subsidiary:	N			
Assurance Route:				
Previously Considered by:	NA			

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Transforming our Trust

Our response to *Reading the signals*: maternity and neonatal services in East Kent
- the report of the Independent Investigation

Interim report – February 2023

We care

Introduction

On 19 October 2022, the Independent Investigation published its report into our maternity and new-born services, *Reading the signals*.

The report describes the harm and suffering experienced by women, babies and their families, in our care between 2009 and 2020. We recognise that families came to us expecting that we would care for them safely, and we failed them. We unreservedly apologise for these unacceptable failings.

On 21 October 2022, the Trust Board formally accepted the report in full and committed to addressing the four areas for action in the report and breaking the cycle of endlessly repeating supposedly[1] one-off catastrophic failures which were for all NHS maternity services to consider:

- monitoring safe performance;
- standards of clinical behaviour;
- flawed team working;
- organisational behaviour, and;
- a recommendation specifically for the Trust to embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input.

Since the publication of the report we have held discussions internally and with partners including meetings of our Council of Governors, a Board Development Day, Kent County Council's Health Overview and Scrutiny Committee and our public Board meetings.

The Board recognised the need to develop a universal programme involving every member of staff, the need to set out the required leadership programmes and review current provision.

NHS England is also expected to set some national direction in responding to these recommendations which we are committed to implementing.

The importance of engaging our staff, families, partner organisations and regulators in all this will be essential.

The Board will be responsible for overseeing this major transformation programme with day-to-day responsibility for delivery and monitoring progress taken forward by our Clinical Executive Management Group. Specific improvements in maternity and neonatology services will continue to be overseen by the Maternity and Neonatal Assurance Group, again reporting to Trust Board.

We are also setting up a *Reading the Signals* Oversight Group. This forum will include representatives from patients and families as well as our Council of Governors, and will provide oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the report. The group will meet in public and report directly to the Board of Directors.

[1] Kirkup October 2022

22/192 – APPENDIX 1

The following initial steps are being taken, details of which are set out in this report.

1. We will use the report as a foundation document to transform this organisation over the next three years.
2. We will publish an open letter to all residents of East Kent responding to the Investigation and setting out what we intend to do to address the concerns it has raised
3. We will establish a comprehensive programme involving every member of staff drawing on external advice and engaging patients and their relatives in its design and development
4. We are publishing details of the Pillars of Change which will underpin the programme and address the key concerns raised in the report
5. We will set out key performance indicators that are time bound to measure progress over the next three years, which will include achievable short term, medium term and three year goals
6. We will establish a Reading the Signals Oversight Group with patients, families, our governors and external partners to monitor and help shape the transformation of the organisation.

An open letter from our Chair and Chief Executive

Intended statement to be issued after the Board of Directors meeting:

We are writing to you following the shocking report into our maternity and new-born services. It is four months since the report was published and we wanted you to know what we have been doing, and will be doing, to improve services for the families that come to us for care and to regain your trust.

The report from the independent investigation, published in October found that women, babies and their families had suffered significant harm because of poor care in our maternity and new-born services, between 2009 and 2020. The report also found that clinical care was not good enough and that we did not listen to women, their families and indeed at times, our own staff. The experience those families endured was unacceptably and distressingly poor.

The report highlighted care that repeatedly lacked kindness and compassion, both while families were in our care and afterwards, when families were coping with injuries and deaths. It also found at least eight opportunities where the Trust Board and other senior managers could and should have acted to tackle these problems effectively. This was simply not good enough.

The consequences were devastating. Of the 202 cases that agreed to be assessed by the panel, the outcome for babies, mothers and families could have been different in 97 cases, and the outcome could have been different in 45 of the 65 baby deaths, if the right standard of care had been given.

The Trust Board has apologised unreservedly for the pain and devastating loss endured by the families and for the failures of the Board to effectively act. These families came to us expecting that we would care for them safely and compassionately, but we failed to do that. We accept all that the report says, and we are determined to use the lessons within it to put things right.

We also want to apologise to those within our communities. We are aware of the anxiety that these failings will have caused among those who rely on our services. We are determined to make the necessary improvements and to make sure that in future we listen to patients, their families and staff when they raise concerns.

We are aware that saying sorry is not enough and that what is needed is meaningful action and real change. We are also clear that there is learning from the lessons in the report for every area of our organisation; these are not just confined to maternity.

That is why we are embarking on a fundamental transformation of the way we work. We are starting with a commitment to openness and honesty, so that whenever something goes wrong, everyone feels able to admit to and learn from our mistakes. Alongside this, everyone must feel able to raise concerns and to know they will be listened to, and their concerns acted upon.

The care we provide must be compassionate, not just sometimes but every time. We must do more to identify and address inequalities experienced both by patients and by staff.

22/192 – APPENDIX 1

In the last few years, we have worked hard to improve our services and have invested to increase the numbers of midwives and doctors, in staff training, and in listening to and acting on feedback from the people who receive our care. However, we know that we must do much more.

Right now, we are working on improving the way our teams work together so we can provide better, safer care; providing compassionate care across all our services; and making sure learning from our failings and mistakes is shared with all staff, so we can change the way we work so they do not happen again.

While we have made some progress, there have been previous efforts to tackle some of these problems and they have not been successful. We are determined to make sure that does not happen again.

We know there is a great deal more for us to do and we absolutely accept that. You can read more about the detail of our plans to improve the way we work on our website at www.ekhuft.nhs.uk . Some of this is new, some of it will build on work that has already begun. We will monitor this work closely and report on it and the progress we are making regularly and publicly.

We know the enormous pressures our hospitals are under, and we accept that changing how a large organisation operates will take time, but it is possible. We know too that if we are to succeed, we must learn from and involve patients and their families, and work in partnership with them to develop and deliver our response to the report.

If you would like to know more or to become involved, please do contact our Patient Voice and Involvement Team, or your Trust Governor. Their details are available on our website here https://www.ekhuft.nhs.uk/patients-and-visitors/members/

If you have used our maternity or neonatology services, or any of the services we provide, and have questions or concerns about your care, please contact us via our PALS team, by phone on 01227 783145 or via email at ekh-tr.pals@nhs.net.

We are here to listen, to learn and to work with you and all our staff to bring about effective change.

Niall Dickson CBE	Tracey Fletcher
Chairman	Chief Executive

Introduction to the Pillars of Change

The following pages outline the programmes of work, covering the key areas for action included in the *Reading the signals* report and the recommendation for the Trust. We have called these areas our Pillars of Change.

The Pillars of Change set out the practical steps we have already begun to put into place and include the further work to be delivered over the next three years. We will measure the effectiveness of the changes, as they are introduced.

Some of this work can be implemented quickly, but some outcomes may take longer to achieve. Sustained culture change takes time.

As noted above the Pillars of Change link to the areas for action in the independent investigation report and to our values: that people should feel cared for, safe, respected and confident that we will make a difference.
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Reading the Signals: Delivering through Pillars of Change

WHERE WE WANT TO BE 24-36 MONTHS

DEVELOPING & EVALUATING 6- 24 MONTHS

BUILDING FOUNDATIONS WITHIN 6 MONTHS

Monitoring Safe Performance — Reducing Harm & Safe Service Delivery

Chief Medical Officer

- We have effective systems and processes for responding to patient safety incidents, learning and improving patient safety
- We are an exemplar for involving patients/families in investigations
- We have improved the physical environment for staff and patients.

- Implement PSIRF across the Trust.
- Transform the approach to learning from complaints and incidents
- Review the approach and focus of Quality Improvement development (We Care) and prioritise roll-out
- Re-evaluate We Care Quality Improvement programme
- Develop digital strategy with clinicians.
- Undertake the planned environment improvement work in maternity and neonatal units
- Evaluate and roll out Calls for concern (Ryan's Rule)

- Eliminate the backlog of SI investigations and achieve compliance against clear timelines going forward
- Introduce revised complaints process
- Refocus to We Care for Winter
- Commence Calls for concern (Ryan's Rule) pilot

Standards of clinical behaviour — Care & Compassion

Chief Nursing and Midwifery Officer

- We treat each other with care and compassion and work in teams that value and respect each other
- Our teams work together in a way that delivers better outcomes for patients

- Implement 'Civility Saves Lives' in maternity, consider roll out across Trust according to local feedback
- Review the Trust Values with staff, patients and public
- Develop a Trust wide Behavioural Code
- Review the recruitment process to test care and compassion beyond technical competence, designed with patient involvement

- Pilot 'Civility Saves Lives' in maternity
- Re-state the Trust Values
- Establish a formal programme of engagement and listening with all Maternity staff
- Introduce a simple tool to assist staff to challenge poor behaviours
- Share and actively engage on the 'Importance of Caring' video
- Implement the Inclusion & Respect Charter
- Reinforce our Professional Clinical Standards and build those standards into work contracts, co-produced with our staff

Flawed team working — Engagement, Listening & Leadership

Chief People Officer

- We have effective, embedded ways of listening to and involving staff
- We are an employer of choice with high retention, low vacancies and improved staff satisfaction
- We are a diverse and inclusive employer

- Roll out a formal engagement and listening programme to involve all staff
- Roll out the Cultural and Leadership Programme across the Trust, and review effectiveness
- Embed the Just Culture approach
- Develop and adopt the new Behavioural Code
- All those appointed to leadership posts within the new structure engaged in Leadership Development
- Establish Staff forums

- Deliver a communications and engagement strategy to consistently reinforce the messages from *Reading the signals*
- Continue the Cultural and Leadership Programme focus in maternity (and review effectiveness.
- Develop our Leadership Framework
- Start the Leadership programme for team leader, first line, middle manager
- Introduce a mandatory Team Brief
- Establish junior doctor group

Organisational behaviour — Organisational Governance Development

Chief Executive Officer

- We have an embedded organisational structure with effective leadership open to challenge
- We have effective governance processes from ward to Board
- Partnership working is embedded and effective

- Create a process of external validation of progress in improvement in maternity services after 12 months
- Evaluate the organisation restructure and associated governance arrangements
- Review and adapt how we work with other stakeholders ie unions, HCP, ICB, regional office and CQC
- Complete a Board development programme

- Continue oversight of Maternity Improvement Programme in MNAG
- Revise the organisational structure of the Trust
- Achieve compliance with Duty of Candour
- Commission an external review of the effectiveness of our Board

Listening & Restoration — Patient, Family and Community Voices

Chief Nursing and Midwifery Officer

- Patients feel listened to, involved and their concerns acted upon
- We are honest and transparent in communicating with patients and admit when we get things wrong
- Services are designed with patients

- Introduce Patient Participation Group representatives to board sub-committees
- Implement Patient Voice and Involvement Strategy incorporating diversity and health inequalities as a priority

- Establish a Reading the Signals Oversight Group, which will involve patients and families, will meet in public and will be responsible and directly accountable to the Board of Directors
- Establish a programme of meetings with families
- Implement a Patient Participation Group which is fully inclusive, with a patient representative as joint chair
- Expand Your Voice Is Heard to include a process for women to feel safe raising concerns, co-produced with families
- Establish and implement a process of case review
- Lay chairs appointed to consultant appointment panels

Underpinned by our Values: People feel safe, cared for, respected and able to make a difference

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Below are explanations of what we aim to achieve under each of the pillars. It includes a number of initial outcome measures. The next step will be to develop key performance indicators and timescales for delivery.

Pillar one: Monitoring Safe Performance: Reducing Harm and Safe Service Delivery

Where we want to get to by 2025:

- Effective systems and processes for responding to patient safety incidents are in place and learning and we will have embedded a patient safety culture so that we learn when things go wrong and we eliminate recurrent themes occurring
- We will involve patients and families in investigations and ensure all their questions are answered
- We will continuously seek opportunities to improve the physical environment for staff and patients

Building our foundations (Dec 2022 – May 2023)

- We will eliminate the backlog of SI investigations and will be fully compliant against agreed timelines for all new reported incidents in order to give patients and families answers in a timely way
- We will introduce the new complaints process to ensure transparency and candour in our responses
- We will commence the pilot 'Calls for concern' (Ryan's Rule) to support patients of any age, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected
- We will refocus our Quality Improvement programme on We Care for Winter

Developing and evaluating (6-36 months)

- We will implement the national Patient Safety Incident Response Framework (PSIRF) across the Trust, to develop and maintain effective systems and processes for responding to incidents, learning and improving safety.
- We will transform the approach to learning from complaints and incidents
- We will evaluate and review the approach and focus of our Quality Improvement programme and roll out a revised programme across the Trust
- We will develop our digital strategy with clinicians.
- We will carry out planned improvements to the environment in our maternity and neonatal units
- We will evaluate the effectiveness of Calls for concern and roll out Trust-wide

How we are measuring our success within the first year:

- Percentage of SI investigations completed within agreed timescales
- Percentage of patients and families who have been involved in the investigation process who felt listened to and involved and their needs met
- Reduction in complaints returned as questions have not been fully answered
- Percentage reduction in maternity Sis

Examples of work we are building on: In 2021 we strengthened the quality of investigations and learning from incidents, including how we involve families. This

included introducing a rapid review process to review potential serious incidents and ensure immediate safety actions have been taken. We now ask external clinical experts to undertake investigations and be part of case reviews.

Pillar two: Standards of clinical behaviour: Care and Compassion

Where we want to get to by 2025

People feel **cared for as individuals**

- We will treat each other with care and compassion and work in teams that value and respect each other
- Our teams will work together in a way that delivers better outcomes for patients

Building our foundations (Dec 2022 – May 2023)

- We will pilot 'Civility Saves Lives' in maternity, a programme to eliminate rudeness and incivility, which has been shown to have a positive impact on patient care
- We will engage with staff in reviewing and renewing the Trust's values
- Establish a programme of engagement and listening with all Maternity staff
- We will introduce a simple tool to assist staff to challenge poor behaviours
- We will share and actively engage on the 'Importance of Caring' video which focusses on care and compassion for patients
- We will implement the Inclusion and Respect Charter which sets out the behaviours we should expect from ourselves and others. We will reinforce our Internal Professional Standards, the standards of clinical care patients can expect, and build into work contracts, co-produced with our staff

Developing and evaluating (6-36 months)

- We will Implement 'Civility Saves Lives' in maternity and consider roll out across the Trust according to local feedback
- We will review the Trust's Values with staff, patients and public
- We will develop a new Trust-wide behavioural code
- We will review the recruitment process to test care and compassion beyond technical competence, designing this with patients
- We will review the Freedom to Speak up Guardian Service and make sure we import best practice from other Trusts with the aim of becoming a leading Trust in national assessments.

How we are measuring our success within the first year:

- The standard of documentation will improve against recognised compliance tool
- We will see improvement in the Trust inpatient survey relating to medical staff attitude/behaviour/patients feeling involved and listened to
- Staff engaged in and attended 'Importance of Caring' sessions

Examples of work we are building on:
In March 2022 we appointed a full-time Freedom to Speak Up Guardian for maternity, dedicated to listening to and supporting staff to raise concerns. There are two lead-consultant "safety champions" in Women's Health and Neonatology and Lead Professional Midwifery Advocates.

Our Maternity and Neonatal Safety Champions include the Chief Nursing and Midwifery Officer, Interim Director of Midwifery, Non-Executive Director Maternity Champion and two lead consultants in women's health and neonatology.

Pillar three: Flawed team working: Engagement, Listening and Leadership

Where we want to get to by 2025

- We have effective, embedded ways of listening to and involving staff
- We are an employer of choice with high retention, low vacancies and improved staff satisfaction
- We are a diverse and inclusive employer

Building our foundations (Dec 2022 – May 2023)

- We will revise our Trust-wide Communications and Engagement Strategy and deliver a communications and engagement plan consistently to reinforce the messages from *Reading the signals*
- We will continue the Cultural and Leadership Programme, focussed on maternity, and review its effectiveness
- We will develop our Leadership Framework
- We will start the leadership programme to support the development of our team leaders, first-line and middle managers
- We will introduce a mandatory Team Brief to help leaders communicate with their teams
- We will establish a doctors in training group
- We will engage all students on placement in our transformation programme seeking their views and feeding back actions taken

Developing and evaluating (6-36 months)

- We will roll out a formal engagement and listening programme which will involve every member of staff working for the Trust and its subsidiaries
- We will roll out the Cultural and Leadership Programme across the Trust
- We will embed the Just Culture approach, aimed at supporting early resolution and learning from mistakes, and reducing formal disciplinary action where appropriate
- We will develop and adopt the new Behavioural Code
- We will establish an East Kent conversation so that every member of staff is consulted and involved as the transformation programme develops
- We will engage all of those appointed to leadership posts within the new organisational structure in Leadership Development
- We will establish Staff forums to give staff a greater voice and involvement
- We will make sure that every member of staff given managerial or leadership responsibility is given ongoing support and training to be effective in their role
- Our national staff survey results will improve year by year and we will set specific metrics to measure progress

How we are measuring our success in the next year:

- Staff say they feel engaged and involved in the future of the organisation
- The number of colleagues recommending us as a place to work increases
- Inclusive management and succession planning are embedded across the Trust
- Reduction of turnover of colleagues in the first year

Examples of work we are building on: In 2021 we introduced a culture and leadership programme aimed at building relationships and multi-disciplinary team work, across our different hospitals and between maternity and neonatal services. It includes vision and values workshops, staff drop-in sessions, a leadership development programme as well as opportunities for teams to learn together.

Pillar four: Organisational behaviour: Organisational Governance Development

Where we want to get to by 2025

- We have an embedded organisational structure with effective leadership open to challenge
- We have effective governance processes from ward to Board
- Partnership working is embedded and effective

Building our foundations (Dec 2022 – May 2023)

- We will continue oversight of the Maternity Improvement Programme through the Maternity and Neonatal Assurance group
- We will revise and consult on the new organisational structure of the Trust
- We will achieve compliance in Duty of Candour. Duty of Candour compels every health and care professional to be open and honest with patients when something goes wrong
- We will commission an external review of the effectiveness of our Board
-

Developing and evaluating (6-36 months)

- We will bring in external validation of the progress of improvement in maternity services, after 12 months
- We will evaluate the effectiveness of the organisation restructure and associated governance arrangements
- We will review and adapt how we work with other stakeholders, including the East Kent Health and Care Partnership, NHS Kent and Medway, NHS England's regional office, the Care Quality Commission and our unions
- We will complete a Board development programme based on the findings of the diagnostic

How we are measuring our success in the next year:

- Appointments to new structure with development programme in place
- Continue to make progress in our journey to outstanding and getting to good by 2024
- Compliance with Duty of Candour
- Developed our partnership working to have a joint approach to improvement

Examples of work we are building on: In September 2021 we established the Maternity and Neonatal Assurance group, chaired by the Chief Nursing and Midwifery Officer and attended by the non-executive director maternity champion (a senior clinician). The group reports monthly to the Quality and Safety Committee and directly to the Trust Board quarterly. It provides specific oversight of maternity and neonatal services, including training compliance, the monthly maternity dashboard which has 85 key performance indicators, maternity improvement plan, progress against CNST, Ockenden and CQC actions.

Pillar five: Listening & Restoration: Patient, Family and Community Voices

Where we want to get to by 2025

People feel **cared for, safe, respected** and confident we are **making a difference**

- Patients feel listened to, involved and their concerns acted upon
- We are honest and transparent in communicating with patients and admit when we get things wrong
- Services are designed with patients

Building our foundations (Dec 2022 – May 2023)

We will establish a Reading the Signals Oversight Group which will include representatives from patients and families as well as our Council of Governors. It will provide oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the report. The group will meet in public and report directly to the Board of Directors.

- We will establish a programme of meetings with families
- We will also implement a Trust-wide Patient Participation Group which is fully inclusive, with a patient representative as joint chair
- We will expand Your Voice Is Heard in maternity to include a process for women to feel safe raising concerns, co-produced with families
- We will establish and implement a process for case reviews for families where required
- Lay chairs will be appointed to consultant appointment panels

Developing and evaluating (6-36 months)

- We will introduce Patient Participation Group representatives to board sub-committees
- We will implement our Patient Voice and Involvement Strategy incorporating diversity and health inequalities as a priority
- We will review the effectiveness of the Oversight Group and act on any findings

How we are measuring our success in the next year:

- Patients feel listened to and their questions are answered
- Patients feel midwives and doctors worked as a team
  (The above measured through an additional question added to the Friends and Family survey and Your Voice is Heard feedback in maternity)
- People with protected characteristics and from areas of social deprivation do not have a poorer experience of care, measured by demographic data of patients who respond to FFT survey and triangulated with themes from SIs and complaints
- There is a reduction in number of formal complaints received about staff attitude, communication, patients not feeling listened to

Examples of work we are building on: We launched Your Voice is Heard in 2022, which means everyone is offered a follow-up call to discuss their experiences six weeks after giving birth, including their birthing partners, so that we can act on feedback and make changes. This work is supported by two patient experience

midwives who were recruited specifically to improve the experience of families using our services. Specialist bereavement midwives are also working with families to improve how we care for families after a bereavement.

Culture and Leadership Programme

Changing the culture of an organisation with long-term challenges takes time and active leadership. It needs to be led by the Board and demonstrated by all leaders in the Trust. But it is vital. Compassionate and inclusive leadership, and effective team-working are essential if we are to deliver safe and effective care.

The Trust has introduced cultural change and quality improvement programmes in the past, but they have not brought about the sustained and effective change that is needed.

In 2020 we introduced We Care, an internationally-recognised quality improvement approach, based on training, supporting and empowering front-line staff to lead improvements day-to-day. While this method of improvement is sound and we have seen some successes, rolling this out to our front-line teams has not been fast or comprehensive enough. We are reviewing and will strengthen how we use We Care.

In 2021 we started to pilot NHS England's Culture and Leadership Programme, which was developed by Professor Michael West and colleagues, as part of the national Maternity Improvement Programme, in our Women's Health and Children's Health care groups.

We are now discussing a plan to roll out this programme throughout the organisation. It covers compassionate leadership and development, team effectiveness, equality and diversity and civility programmes. We also recognise the need to bring together the planned programme work on cultural change and our work on continuous improvement, though We Care.

Communicating with our staff

While many staff will read the open letter, it's important that we communicate our determination to transform this organisation to everyone who works for the Trust. Everyone, no matter what they do, needs to understand what is expected of them and just as important how they can support and be involved in that transformation.

We will send a letter to every member of staff, and will initiate a communication programme which will require everyone to participate and reflect.

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The *Reading the signals* Oversight Group

The *Reading the signals* report includes a specific recommendation for the Trust to accept the reality of the report's findings and "embark on a restorative process addressing the problems identified in partnership with families, publicly and with external input".

The *Reading the signals* Oversight Group will include representatives from involve patients and families as well as our Council of Governors. It will meet in public and be responsible and directly accountable to the Board of Directors. It will provide oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the Reading the Signals report. The group will meet in public and report directly to the Board of Directors.

This group will have oversight of the programme set out in our Pillars of Change:

- Reducing Harm and Service Delivery
- Care and Compassion
- Engagement, Listening and Leadership
- Organisational Governance and Development
- Patient and Family Voices (the restorative process).

The Trust's senior leadership team, the Clinical Executive Management Group (CEMG), which has day to day Executive responsibility for implementing the programme will act on feedback from, and provide regular updates to, the oversight group.

The group will be chaired by a non-executive member of the Board, with a second non-executive as vice-chair.

Its membership will include families, governors and the Maternity Voices Partnership as well as representatives from NHS Kent & Medway and NHS England.

The Trust's Chief Executive, Chief Nursing and Midwifery Officer, Chief Medical Officer and Chief People Officer will be required to attend.

The Independent case review process

We recognise that there are families who have unanswered questions about their care and the care of their babies.

We have established an Independent Case Review process to respond to families who have concerns about maternity or neonatal care they received from the Trust.

Families will be offered the opportunity to meet with or speak to experts independent of the Trust, regardless of whether their care had previously been reviewed or investigated by the Trust. To date 29 requests have been received, 11 of these have already been agreed as full case reviews, and they will start in February.

The terms of reference of the Independent Review provide for the opportunity for families who have taken part in the investigation to receive feedback directly from Dr Kirkup and the investigation Panel. These meetings started late 2022.Following these meetings the families will be provided with Disclosure Letters setting out the key aspects of the findings of their individual case.

Some of the requests are from families who were part of the cases reviewed by the Independent Investigation. For these families, if the Trust were to agree to an Independent Case Review it would need to focus on questions or concerns over and above the concerns that had already been reviewed and considered as part of the IIEKMS Investigation or it would need to consider any subsequent learning or additional actions the Trust now needed to take. In order to make a decision on whether there can be an Independent Case Review, the independent investigation has agreed that a copy of the relevant disclosure letter will need to be shared with the Trust, although this will only be required if a family requests further information from the Trust. We expect that disclosure letters will be made available from mid-February onwards.

NHS England Response and next steps

Following the publication of Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation NHS England wrote the following letter to all NHS Trusts with maternity departments, as follows:

The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families for which we are deeply sorry.

This report reconfirms the requirement for your board to remain focused on delivering personalised and safe maternity and neonatal care. You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness.

The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.

We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

In 2023 we will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust. Immediate and sustainable action will save lives and improve the care and experience for women, babies and their families.

Yours sincerely,

Sir David Sloman, Chief Operating Officer, NHS England.
Dame Ruth May, Chief Nursing Officer, NHS England.
Professor Stephen Powis, National Medical Director, NHS England.

The Trust is committed to both responding to the Report about its Maternity and Neonatal Services and well as the recommendations from the Shrewsbury and Telford NHS Trust .The single delivery plan and its requirements will be incorporated into the Trust response and plans ,once it is published later this year .

How we will: Listen, communicate and engage

The Trust's response to *Reading the signals* identifies the importance of listening to and engaging with the public, our patients, families, staff, partner organisations and stakeholders, as well as the need to communicate the Trust's response to the report.

We recognise the significant changes the Trust needs to make in involving people; listening, responding and acting on feedback; honesty and transparency in communicating with patients; treating each other with care and compassion and working in teams that value and respect each other.

The Trust's Communications and Engagement Strategy is one of a number of supporting strategies, none of these in isolation will bring about the changes needed. It should be read alongside Our People Strategy (aimed at staff) and our Patient Voice and Involvement Strategy (aimed at patients, public and stakeholders).

The Communications and Engagement Strategy was first published in 2021 but has been refreshed to take into account the Trust's learning from and response to *Reading the signals*, and some of the new ways we are communicating and engaging which have been developed since 2021, following feedback from the public, patients, staff and partners.

It sets out the following aims. We recognise that we are not always achieving this at the moment and there is much more we need to do to make these aspirations a reality for all our patients, staff and stakeholders:

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

The strategy sets out work we will do over the next 3 years to support better listening, communication and involvement with the public, our patients, families, staff, partner organisations and stakeholders.

You can read the Trust's refreshed Communications and Engagement Strategy on our website at https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/

If you would like to give feedback on the strategy please email the communications team at ekh-tr.communications@nhs.net or call us on 01227 866384.

Thank you for reading this report.

We welcome your help and involvement in this work to transform your local hospitals Trust.

Please get in touch with our Patient Voice and Involvement Team, or your Trust Governor, if you would like to help us. Their contact details are available on our website here https://www.ekhuft.nhs.uk/patients-and-visitors/members/

Have a concern?

If you have used our maternity or neonatology services and have questions or concerns about your care, please get in touch with us. You can contact us via our PALS team Phone on 01227 783145 or via email at ekh-tr.pals@nhs.net

Keeping up-to-date

We will continue to publish our progress as we work to make improvements to both our maternity service and across our Trust as a whole.

We now 'live-stream' the meetings of our Trust Board, so it's easier for people to join the meeting and ask questions. You can join us via the web link that we publish on our website at https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER: EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY IMPROVEMENT AND TRANSFORMATION MANAGER**
APPENDICES:	**APPENDIX I: 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 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 (IEA).

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:
	  • Clinical Negligence Scheme for Trusts (CNST) declaration position has been reported as non-compliance against:
	  ○ Safety Action 1: Perinatal Mortality Review Tool (PMRT) standard ai) and aii);
	  ○ Safety Action 8: PRactical Obstetric Multi-Professional Training (PROMPT) Anaesthetic team Training compliance is below the 90% required standard.
	  • Ockenden IEA compliance 97%. Personalised Care and Support Planning (PCSP) Pilot to launch in January 2023 across 1 Ashford and 1 Thanet community team. Risk assessment for Physiological Fetal Monitoring is waiting to be taken through the peer review process.
	  • Supernumerary – 1 breach for 2 hours on William Harvey Hospital (WHH) labour ward in December 2022.
	  • Friends and Family Test Feedback generated 189 responses which is a 15.1% response rate with 85.2% extremely likely or likely to recommend.
	  • Midwifery workforce analysis has shown stabilisation on the Queen Elizabeth the Queen Mother Hospital (QEQM) site but

East Kent Hospitals University NHS Foundation Trust

	ongoing challenges on the WHH site.
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			

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Perinatal Quality Surveillance Reporting December 2022

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

Care Quality Commission (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 Healthcare Safety Investigation Branch (HSIB)

No cases in December

The number of incidents logged graded as moderate or above and what actions are being taken.

There were 3 incidents graded as moderate and **no Sis reported for December**. All cases will be taken through the rapid review process but issues with accessing hand held postnatal notes until the service user is discharged have delayed access to all information.

Site	Location	Category	Subcategory
WHH	Operating theatre (WHH)	Women's Health - obstetric complication	Unplanned return to theatre
WHH	Folkestone ward (maternity)	Women's Health - obstetric complication	Readmission for infection
WHH	Obstetric operating theatre (WHH)	Women's Health - obstetric complication	Unplanned return to theatre

Themes from reviews of perinatal deaths

Themes

The main themes identified remain:

- The follow up care aligned to the bereavement pathway
- The use of interpreter services to support women

Actions

- Aligned to the overall improvement pathway for bereavement care. Recruitment to new posts in progress
- This is linked to wider work around how as a service interpreter are used. HOM at WHH has linked with the central team to improve this.

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	221	246	89.8%
Midwife - Community	86	93	92.5%
Other Obstetric Doctor	32	35	91.4%
Obstetric Consultant	30	31	96.8%
Maternity Support Worker	0	0	NaN
Total	**369**	**405**	**91.1%**

Fetal Monitoring Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	213	220	96.8%
Midwife - Community	78	80	97.5%
Other Obstetric Doctor	31	34	91.2%
Obstetric Consultant	30	31	96.8%
Maternity Support Worker	0	0	NaN
Total	**352**	**365**	**96.4%**

Prompt All Maternity Staff

PROMPT Mat Leave and LTS Removed

Challenges:

- Please see CNST Safety Action 8 for greater detail
- Combining Community and Acute Midwifery compliance is above 90% for fetal monitoring
- Compliance met across PROMPT, Fetal Monitoring and NLS for all Maternity Staff Groups
- Compliance met across Neonatal Medical and Nursing Staff Groups for NLS
- PROMPT Compliance not met for Anaesthetic Consultants and Other Doctors covering Maternity. The challenges for anaesthetics has previously bee reported.

East Kent Hospitals University NHS Foundation Trust

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	213	244	87.3%
Midwife - Community	76	90	84.4%
Maternity Support Worker	68	79	86.1%
Obstetric Consultant	29	30	96.7%
Other Obstetric Doctor	29	33	87.9%
Total	**415**	**476**	**87.2%**

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	203	218	93.1%
Midwife - Community	67	77	87.0%
Maternity Support Worker	65	72	90.3%
Obstetric Consultant	29	30	96.7%
Other Obstetric Doctor	29	32	90.6%
Total	**393**	**429**	**91.6%**

Anaesthetists Covering Maternity	Number requiring training	Number of staff attended	Percentage compliance by staff group
Anaesthetic Consultant	42	29	69%
All other Anaesthetic Doctors	32	14	44%

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	214	245	87.3%
Midwife - Community	87	93	93.5%
Maternity Support Worker	71	80	88.8%
Obstetric Consultant	31	32	96.9%
Other Obstetric Doctor	29	33	87.9%
Total	**432**	**483**	**89.4%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	205	219	93.6%
Midwife - Community	77	80	96.3%
Maternity Support Worker	69	73	94.5%
Obstetric Consultant	31	32	96.9%
Other Obstetric Doctor	29	32	90.6%
Total	**411**	**436**	**94.3%**

Neonatal Medical

Neonatal Staff covering maternity WHH	Number requiring training	Number if staff attended	Percentage compliance by staff group
Neonatal Consultant	7	7	100%
Neonatal all other Doctors	15	15	100%

Neonatal Staff covering maternity QEQM	Number requiring training	Number if staff attended	Percentage compliance by staff group
Neonatal Consultant	10	9	90%
Neonatal all other Doctors	18	16	93%

Neonatal Nursing

Neonatal Nursing Staff covering maternity WHH	Percentage compliance by staff group
Neonatal Nurses	100%
Neonatal QIS Nurses	100%

Neonatal Nursing Staff covering maternity QEQM	Percentage compliance by staff group
Neonatal Nurses	100%
Neonatal QIS Nurses	100%

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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
July	100%	99.5%
August	100%	100%
September	100%	100%
October	100%	100%
November	100%	100%
December	98.8%	98.8%
Total Average	99.8%	99.7%

Supernumerary Maintained (target 100%)

Month	QEQM	WHH
July	98.7%	92.9%
August	99.4%	96.5%
September	99.4%	95.7%
October	100%	96.5%
November	100%	97.5%
December	100%	98.9%
Total Average	99.5%	96.3%

1:1 Care in Labour: 100% compliance achieved following data validation.

Supernumerary Status: Supernumerary – 1 breach for 2 hours on WHH labour ward in Dec, due to activity and staffing.

Midwifery
A detailed Midwifery Workforce Review was undertaken in December by the senior midwifery team. The table below summarises the results of this review.

Midwifery workforce – combining bands 7,6 and 5, EXCLUDES Governance and Specialist roles

Site	Vacancy	Maternity leave	Appraisal	Statutory Training	Mandatory training (general)	Turnover	Sickness
WHH	20%	8.8%	59.4%	87.4%	72.9%	29%	10.33%
QEQM	0%	2.7%	87%	91%	81.3%	2.6%	4.8%
Community	4.4%	11.1%	79.2%	86.7%	69%	6.1%	8.7%
Overall	**8.79%**	**7.7%**					

QEQM
Data shows improvement and stability resuming

WHH
Concerns remain over increase in vacancies, maternity leave, sickness and turnover and the impact this has on the continued pressure felt by staff in conjunction with high activity levels with increasing acuity.

Mitigations

- Enhanced NHSP rates and long line bookings through agency are in place
- Adverts are out for midwifery and also nursing posts, but applications are low.
- Working with recruitment to improve how roles are advertised
- Further discussion with the midwifery NHSE lead has taken place to understand alternative approaches from other units

Obstetric
WHH
2 new Consultant appointments

FFT Feedback

FFT Main Themes December 2022 (collated on 1st December)	Actions
189 responses which is a 15.1% response rate with 85.2% extremely likely or likely to recommend 121 comments in total, 91 positive comments Positive experiences and Named staff in comments- 18 members of staff named Good comments for Hearing screening feedback to them.	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
PN care and lack or delay in care/medications or discharge- Reoccurring theme.	Essential rounding started in October and some positive comments are coming through but still some negative comments. Reintroduction of drug rounds being taken forward. Review of discharge processes as commenced.
Delay in discharge	Medical rotas reviewed, junior Dr assigned to postnatal wards from 1 February to ensure early reviews and completion of EDNs
Rude Doctor/ Midwife	Feedback to consultant lead

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Not being listened to or involved in plans	Feedback discussed at monthly site consultant meetings
Not being updated in care plan	Feedback discussed at monthly site consultant meetings
Night care is not as good as Day care on the wards	Feedback to Ward Managers & concerns moving forwards should be addressed by essential rounding
Rushed and rude sonographer	There are ongoing concerns being raised about attitude and communication issues with the sonography team, conversations taking place with OD partners to support the sonography team.
Miscommunication between staff and handover lead to patients being upset going over history	Report back to managers

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – December	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
The Your Voice Is Heard team recorded their highest response rate in December, at 74.3%. 163 Complimentary emails sent to staff members	December is currently being themed- a new system is being worked on which should allow more timely theming to occur to hasten the reporting process it is still being tweaked to be effective. There have been more compliments and less complaints this month. It has been a positive month. The monthly meeting with the HOMs, Matrons and managers is to take place in January. Improvement in relation to first day postnatal visits at home post discharge from hospital as improved, since this was addressed by the community teams
Similar themes as the previous months: • More comfortable chairs for partners more at QEQM than WHH, some positive comments about the chairs at WHH • Food and drinks for partners Lack of pillows and blankets for partners	At the end of November PEM met with procurement and these items were discussed from this: • Alternative chairs are being researched and a chair event giving patients and partners chance to try chairs will happen in the new year with the 2 top chairs rated being tested in the clinical areas • Food and drink for partners is being looked into by procurement as well as tea trolley round for triage to offer those waiting in the waiting room awaiting costing and budget • Extra pillows and blankets are being costed to see how much they would be and storage areas of these.
Toilet and shower on wards for partners	Feedback has been shared to see if these can be included in estate plans phase 2
Lack of communication by community midwives Lack of First day visits in community	First day visits should now be offered to all families.
Lack of Analgesia, catheter care, bedding being changed and water offered on PN wards	Essential rounding started in October in line with this feedback – still continuing. Procurement have been asked about costing up lockable cupboards for the COWs for analgesia on the ward to aid in drug rounds. This needs to be further investigated and instilled as practice. A water cooler system is being looked into being placed on all area that do not have them, being followed up by estates and managers on the wards.
Lack of Analgesia in IOL and labour	This is being discussed and followed up with the pain management group on a monthly basis.
Rude Sonographers	We have met with some of the management from USS department and shall be updating them with themes monthly about the USS.
Lots of people coming into the Bays on the PN ward- lots of different people not a lot of time to rest as being seen all the time.	To discuss in meeting this month some parents have suggested a sign to put up to say asleep. To discuss with PN ward managers about continuity of the staff on the PN ward.

Number of Complaints

Site	Location	complaint subject	Complaint subject
WHH	OTH - OTHER	Surgical management	Difficulties during procedure
QEQM	QLAB - QEQM LABOUR WARD (MUMS)	Surgical management	Difficulties during procedure
WHH	OTH - OTHER	Communication	Doctor communication issues
QEQM	QLAB - QEQM LABOUR WARD (MUMS)	Privacy and dignity issues	Inappropriate clothing / state of undress
WHH	FF - WHH FOLKESTONE WARD	Communication	Other staff communication issues
WHH	WLAB - WHH LABOUR WARD	Clinical management	Unhappy with treatment

Number of PALS

Site	Location	Summary	Subject
WHH	OFFICW	patients mother received Friends and family feedback request but patient has not been to EKHUFT for years as now lives in London.	Communication
WHH	FOLKES	the client has raised concerns relating to obstetric cholestasis and not receiving the correct testing including delays in waiting for a scan	Concern around care management

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Listening to women engagement activities and evidence of co-production	• Personalised Care and Support Plan workstream • Ockenden Peer Review • CNST Evidence Review • Digital Strategy Day
Staff feedback from frontline safety champions and walk-abouts	Themes and actions

Safety Discussions/Themes	**Actions**
In response to the weekly wrap up asking for ideas, we have had ideas put forward by some midwives re:	
• Following a suggestion from one of our Midwives, we would like to explore an external offering called 'Sinking to Soaring - Foundations to Better Emotional Health for Midwives' It covers 4 main topics, Resilience and bounce-back, healthy mind, body connection, building confidence and self-esteem and identifying and challenging unhelpful triggers, perceptions and beliefs. Staff have been provided with details of how to contact the HR team leads if they would like to find out more about the course and book a place. • Some equipment/additional training to help staff undertake their roles more efficiently – this was at the WHH and Jo S is taking this forward with respects to improved stools for suturing as well as training around blood gas analyser. • Suggestion for virtual appraisal clinics will be implemented to assist improvement in accessing this	
Theme from walkabouts across all sites (WHH and QEQM)	**Actions**
1. Concerns raised around the impact on individuals regarding exposure to nitrous oxide and the need for supplements due to Vitamin B12 deficiency. 2. Concerns raised by the hospital teams regarding the over reliance on the on-call midwife, especially at the WHH 3. Positive feedback received from staff in community and QEQM in terms of improved team working with colleagues at WHH 4. Discussion with MCAs/MSWs – wanting to understand more about the MSW framework and impact on them as individuals. Keen to maintain skills and be recognised accordingly for them. 5. Concerns raised that the incentive payment was only for midwives and did not recognise the work of the MSWs/MCAs. 6. Following some recent incidents in one of the units, request for training to support how to de-escalate –	1. Staff have asked if the Trust will reimburse individuals for this. This is being addressed through HR with pharmacy. 2. Agreement made with the RCM local and regional representatives to form a task and finish group to develop a plan in partnership with staff to address the issues. An interim SOP has been developed for the community team, who have also raised concerns, and this will be used to build on for hospital staff 3. Share with wider team 4. We will be holding meetings with all support workers to explain in greater detail, including next steps for the whole team as well as individuals. This has been aligned to the guidance from HEE. 5. Director of midwifery has apologised, explaining that the rationale was in relation to the significant gaps for the midwifery numbers on a shift by shift basis, and that it was recognised how much value the support team provide to clinical care. She has also explained that this causes a significant financial challenge which has to be reviewed during January 6. To work with OD to facilitate this request

HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	No new concerns or Action requests for December
Coroner Reg 28 made directly to the Trust	NA

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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) has not been met** 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, using the tool, within one month of the death for 3 cases. The reports had been completed but not closed within the time period. It is acceptable for the surveillance to be closed and reopened when waiting for information but this was not understood by the lead new in post at that time. There was no impact to patient or families but learning has been shared and embedded within the team. 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. **Standard aii) has also not been met** for 3 cases- resulting in 87% compliance against required 95% Standard. The perinatal mortality review tool is used to review the care and draft reports are generated via the PMRT but for the three cases noted, the review had been completed but recorded outside of the tool. There was no impact to patient or families but learning has been shared and embedded within the team	
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 compliant in all standards Standard 1-Digital Strategy is in place following internal and external governance sign off 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.	
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 demonstrate compliance. Audits against Anaesthetic standards are complete and show compliance. Clinical Workforce Papers were presented to MNAG for October reporting and a paper is being taken to December Trust Board.	
5. Demonstrating an effective system of midwifery workforce planning to the required standard?	Supernumerary compliance against standard is being reviewed through a look back exercise. 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.	
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 95.7%, 36 weeks 82.4% in November 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.

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			Compliance for asking women if they smoke at booking 4-month average is 94%. Action plan is in place to achieve over 95% and was appended to Board papers as part of SBLCBv2 reporting in May and November 2022. Compliance for asking women if they smoke at 36 weeks is 4-month average is 80.7%. Action plan is in place to achieve over 95% and was appended to Board papers as part of SBLCBv2 reporting in May and November 2022.
	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 has been updated and is being presented at 2 December guideline group and audit of 40 cases to be completed.
	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		

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	207	218	95.0%
Midwife - Community	74	75	98.7%
Obstetric Consultant	30	30	100.0%
Other Obstetric Doctor	27	27	100.0%
Maternity Support Worker	0	0	NaN
Unknown	0	0	NaN
Total	**338**	**350**	**96.6%**

	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 updated and going through guideline group 2 December to be 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 has been confirmed and documents shared with MVP chair. Coproduction plan was signed off at the November LMNS Quality Assurance Board-awaiting minutes to confirm approval but verbal approval given.	
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	**Not achieved** CNST Standard due to Anaesthetic PROMPT Training compliance being below 90%. This should improve as face to face PROMPT has now been reinstated across both sites. Full compliance across all maternity staff groups for PROMPT, Fetal Monitoring and NLS Full compliance across Neonatal Medical and Nursing Staff Groups for NLS Training.	

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	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		
	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 continues to be suspended due to ongoing midwifery workforce pressures. 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.	
	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. 8 cases were reported to NHSRs Early Notification Scheme, two of which have been rejected and families are being directly communicated with via the Early Notification Scheme NHSR Team	

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

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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 of draft PCSP has completed and once delivered to sites, a 3 month pilot is to launch in January 2023. Pilot sites identified as WHH Ashford Community and Thanet Teams due to them being the areas of highest deprivation.
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. Risk assessments submitted and waiting to go through peer review at next meeting
Total	73%	97%		

Glossary

CCG: 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.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**MATERNITY CARE QUALITY COMMISSION (CQC) ACTION PLAN UPDATE**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER: EXECUTIVE BOARD MATERNITY SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY: MATERNITY SAFETY CHAMPION**
APPENDICES:	**APPENDIX 1: CQC ACTION PLAN**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	This paper has been prepared to summarise the findings following the unannounced visit by the CQC on the 10 and 11 January 2023, across maternity services within the Trust.				
Summary of Key Issues:	The key areas of concern that were escalated: • Fire Safety at Queen Elizabeth the Queen Mother Hospital (QEQM); • Effective processes for fetal monitoring and escalation at the William Harvey Hospital (WHH); • Timeliness and effectiveness of maternity triage processes at WHH; • Infection and prevention controls at WHH. An action plan has been developed to address the key themes above, along with other individual concerns that were identified across both sites. Further individual pieces of evidence were requested by the CQC for submission by the 1 February, and 3 February 2023, which have been submitted. Whilst there is evidence of improvement for the domain of well-led, there is still work to complete especially for the effective and safe domains, across the CQC framework. Summarising the progress against the attached CQC plan: **Fire Safety at QEQM** 4 key areas were highlighted: • The compliance with maintaining closed fire doors. • The working order of the automatic closure on fire doors. • The Mislabelling of fire doors.				

	• Maintenance of clear egress for secondary fire escape route. All actions to address above have been completed and regular walk arounds are conducted to ensure ongoing compliance. The Director of Operations for Women's Services, with Estates, is currently reviewing the previous fire risk assessments to ensure all other actions have been addressed or are in progress for completion by the 9 March. The Kent Fire and Rescue Service are conducting a Fire risk assessment on the 9 March. A review at WHH has been completed to ensure adherence to the above standards. **Effective processes for fetal monitoring and escalation at the WHH** 4 key areas were highlighted: • The Trust mitigations to address the effectiveness of processes for fetal monitoring were not embedded and understood by the clinical team. • Compliance with hourly ''fresh eyes''. • Lack of fetal heart monitoring midwife in post. • September and October incidents highlighting fetal heart monitoring issues. The action plan addresses each of the above points and additional processes have been deployed and monitored weekly. The actions are being implemented on both sites. A survey is being completed to determine staff understanding of the fetal heart monitoring processes. **Timeliness and effectiveness of maternity triage processes at WHH** 7 key areas were highlighted in relation to triage and flow women at the WHH: • The trust mitigations to address timeliness of processes in triage were identified as weak. • Women not being seen within 15 minutes of arrival due to staffing challenges. • Women not being reviewed by the doctor in the appropriate time due to lack of dedicated obstetric medical cover. • Staffing in triage. • Environmental and capacity challenges impacting on appropriate flow of women through service. • A Serious Incident (SI) in July identified the above risks.

	• Lack of triage audits. The action plan is in progress to address the above. The main area that needs to be developed and agreed is around how activity can be redirected to QEQM in a planned way as well as physical capacity at WHH. A key action is around the change in job plans for the medical team, and this is due for completion by the 1 May 2023. **Infection and prevention controls at WHH** There were 4 key areas highlighted: • Lack of effective systems in place to protect patients from infection. • Cleaning records were incomplete. • Standards of cleanliness were below those expected. • Adherence to appropriate use of Personal Protective Equipment (PPE) and hand hygiene. Immediate action has been taken in partnership with the Infection, Prevention and Control (IPC) team and 2gether Support Solutions. Deep cleans have been undertaken and weekly IPC environmental audits have been established. Again, all actions have been replicated at QEQM. All actions within the attached action plan have either been completed or are on track. The Chief Nursing and Midwifery Officer has made the decision that until there is evidence of sustained improved compliance around equipment checks, cleanliness and IPC – that partial assurance compliance will remain until there is confidence and evidence that the processes are embedded. A internal review is being undertaken by the Senior Responsible Officer (SRO) for Journey to Outstanding to understand how the issues associated with IPC and cleanliness were not identified or escalated through existing governance processes. This review will be presented to the Board in March 2023.
Key Recommendation(s):	The Board of Directors is invited to: 1. **NOTE** the content of the action plan and the progress being made to address the concerns raised by the CQC and; 2. **NOTE** that the outcome of the review will be presented to the Board in March 2023.

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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:	N			
Legal and regulatory:	Y	Clinical Negligence Scheme for Trusts (CNST) NHS Long Term Plan-standard contract		
Subsidiary:	N			
Assurance Route:				
Previously Considered by:	Action plan approved by CNMO before submission to the CQC			

Action Reference	Reference point	Issues raised in letter by CQC	Site	Individual action reference	Level of Assurance	Action	Responsible Lead	Priority Timeframe	Date to be completed by	Completion Date	Action Progress	Update/progress report	Evidence Required	Evidence Reference	risk register (Yes/No)	risk number	Executive Assurance and oversight	ongoing audit/monitoring to sustain improvement
Urgent – Section 31 of the Health and Social Care Act 2008																		
1	**Fire safety at Queen Elizabeth The Queen Mother Hospital**																	
	1.1	There was a significant risk to safety in the event of a fire. We followed the secondary fire evacuation route through the labour ward. We encountered a labelled automatic fire door which we were told would close automatically in the event of a fire, however, the closing mechanism had been removed.	QEQM	1.1.1	Fully Assured	Closing mechanism to be added to automatic closing fire door	2gether Operational Development Lead	1 week	20/01/2023	19/01/2023	✓	Nene valley undertaken fire door inspections. Auto closer removed (18/01/23), self closers I/O links to be installed on 20/01/23.	Photo of fire door	1.1.1 Photograph QEQM door closer removal	Yes	**Trust Corporate risk register:** Ref 1846: Failure of critical infrastructure Ref 3056: Unsafe fire evacuation routes compromised due to the need to store beds, materials and equipment Ref 2834: The quality of the switchboard service delivered by 2gether will deteriorate Ref 1844: Non-delivery of service level agreements		
			QEQM	1.1.2	Fully Assured	Video of fire route to confirm actions taken to ensure clear egress	2gether Estates Operational Development Lead	1 Week	20/01/2023	19/01/2023	✓	Walk though video planned for 18/01/23 @ 10:00	video walk through	1.1.2 Video walk through fire evacuation route 1.1.2.2 Video walk through fire evacuation route				checking of doors as part of the quality rounds (3 times a day)
	1.2	Every fire door on the route was mislabelled as to whether it was an automatic fire door or needed to be kept closed. None of the doors were labelled showing staff how long the door would hold them safely in the event of a fire, the labelling of fire doors is a requirement of the relevant HTM guidance.	QEQM	1.2.1	Fully Assured	- Installation of new fire labels to fire doors where missing or not visible on doors - Running man sign to be installed at exit point of the secondary fire route - clarity from 2gether around use of the blueman sign within hospital setting	2gether Estates Operational Development Lead	1 week	20/01/2023	20/01/2023	✓	Fire door survey complete. Labelling of the doors identified in survey is underway and will be completed by 20.01.23. ***Initial photos in evidence show the start of the works from the survey. Some doors have labels removed as not required (too much labelling) as per the survey*** Green man running sign installed 12/01/23.	- Photo of new running man sign - photos of identified fire doors - email confirmation of the use of a blue running man sign only in warehouses - not in hospital setting	1.2.1 IMG_0556-0592 (26 files) Fire door signs 1.2.1.2 IMG_0392-0394 (3 files) Fire exit signage 1.2.1.3 Email clarification on use of blue running man signage				
	1.3	fire doors (staff kitchen and doctors office) that should be closed, propped open. We repeatedly raised this with staff throughout our inspection as the doors continued to be propped open. There were several boxes alongside the corridor of a fire exit which meant a bed could not pass through the corridor during an evacuation.	QEQM	1.3.1	Fully Assured	signs on fire doors (staff kitchen and doctors office) to reiterate door must be closed. Snap tool (hourly checks to ensure doors are closed and staff awareness to do so)	2gether Estates Operational Development Lead	1 week	20/01/2023	18.01.2023	✓		attached 3 examplecs of photos of laminated poster and doors with the poster	1.3.1 door sign on doctors room 1.3.1 door sign on staff room 1.3.1 laminated poster			MNAG	checking of doors as part of the quality rounds (3 times a day) Dashboard data on compliance to MNAG monthly
			QEQM	1.3.2	Fully Assured	declutter of boxes alongside the corridor of a fire exit	Matron QEQM	1 week	20/01/2023	16/01/2023	✓		Photo's and video of clear area following declutter.	1.3.2 photo of fire exit after declutter 1.3.2 VIDEO-2023-01-17-15-34-02			MNAG	checking of doors as part of the quality rounds (3 times a day) Dashboard data on compliance to MNAG monthly
			QEQM	1.3.3	Fully Assured	alternative location of cages of stock - Longer term solution as part of Phase 1 estates plans	Matron QEQM Director of Facilities	1 Week	20/01/2023	17/01/2023	✓	1 cage of stock removed to alternative location. Only 1 cage left in corridor. Not obstructing the fire exit.	Photo's and video of clear area following declutter.	1.3.2 photo of fire exit after declutter 1.3.2 VIDEO-2023-01-17-15-34-02			MNAG	checking of doors as part of the quality rounds (3 times a day) Dashboard data on compliance to MNAG monthly
			WHH	1.3.4	Fully Assured	WHH to review primary and secondary fire routes to ensure clear egress	2gether Estates Operational Development Lead	1 Week	20/01/2023	16/01/2023	✓	Complete, awaiting video walk through.	video walk through staff education/briefing - Emergency Fire Actions for Staff (WHH, QEQM, KCH) - will be sent out in Trust news week commencing 23rd January	1.3.4 Rev1 Jan 23 Aide Memoire Evacuation Document 1.3.4 WHH1 1.3.4 WHH2 1.3.4 WHH3				checking of doors as part of the quality rounds (3 times a day)
	1.4	Kent Fire and Rescue Service under our memorandum of understanding with our concerns who will be visiting the service to look at compliance with fire safety regulations.	QEQM	1.4.1	Fully Assured	Review of FRA's for all areas within maternity to ensure are in date and identification of any works to be undertaken Review all Trustwide description of the framework of the Operated Healthcare Facility (OHF) and the Estates Managed Service (EMS) and the key services delivered by 2gether Support Solutions (2gether) via the OHF and the EMS with specific updates appertaining to service issues. Detail of the governance arrangements that are in place between the Trust and the subsidiary as well as information of the key issues for both the subsidiary and the Trust.	2gether Estates Operational Development Lead	1 Week	20/01/2023	18/01/2023	✓	All FRA's for QEQM maternity in date and reviewed	CQC briefing document: - Appendix 4 SLA H&S Fire - Appendix 5 CEMG HS and Estates LSMS - Appendix 6 risk register associated around Fire risks across the trust - Appendix 7 Fire safety terms of Reference - Appendix 8 Fire safety Plan 2022-23 - Appendix 9 Fire training compliance report - Appendix 10.1 to 10.8 Maternity fire risk assessments across WHH and QEQM	1.4.1 CQC Briefing Document Jan 2023 (003) APPENDIX 4 SLA H&S Fire LSMS APPENDIX 5 CEMG HS and Estates Report November 22 App5 APPENDIX 6 Risk Register APPENDIX 7 Fire Safety Terms of Reference Jan 23 APPENDIX 8 FIRE SAFETY PLAN 2022-23 Update Dec 2022 APPENDIX 9 Fire Training Compliance Report_ APPENDIX 10.1 QEQM-Birchington Ward APPENIDX 10.2 QEQM-Kingsgate Ward APPENDIX 10.3 QEQM Special Care Baby Unit APPENDIX 10.4 QEQM St Peters Midwifery Led Unit APPENDIX 10.5 WHH Maternity Day Care APPENDIX 10.6 WHH Singleton Unit APPENDIX 10.7 WHH Folkestone Ward APPENDIX 10.8 WHH Neonatal Unit			H&S committee	Weekly touch point call with head of estates, Matron or HoM to review progress against action plan Monthly report to H&S committee
			QEQM	1.4.2	Fully Assured	Workflow remedials from FRA review with actions and timeframes Twice weekly touch point call with head of estates, Matron or HoM to review progress against action plan	2gether Estates Operational Development Lead	2 Weeks	30/01/2023	30/01/2023	✓	Director of Ops leading touch point calls. Calls added to diaries. Action plan completed with time farmes for estates works to be undertaken. Some redmedial actions scehduled to be completed before 9th March FRA assessment	action plan	14.2 QEQM FRA action plan ***(submitted to CQC Friday 3rd February)***	No	N/A	H&S committee	- weekly touch point call with head of estates, Matron or HoM to review progress against action plan - Monthly report to H&S committee
2	**Effective processes for foetal monitoring and escalation at William Harvey Hospital**																	
	2.1	The effectiveness of processes for fetal monitoring was a known risk to the trust, but mitigations were not always sufficient to protect women and babies from avoidable harm.	WHH	2.1.1	Fully Assured	- review of guideline is in place	Head of Midwifery WHH Foetal monitoring lead	1 Week	20/01/2023	20/01/2023	✓	- Updated guideline live on in May 2022 with updated tools included - The tools are included within our fetal monitoring training module. All staff undergo an assessment as part of this training module. - There is a training needs identification, analysis and action planning process in place to ensure learning identified through any source of risk is integrated into the fetal monitoring module	Guideline - Fetal heart monitoring	2.1.1 Fetal Heart Monitoring	Yes	Ref: 249 Misinterpretation of cardio tocographs (CTG) by staff both antepartum and intrapartum Ref: 2569 Lack of USS Capacity for women's services at EKHUFT	EXECUTIVE RISK ASSURANCE GROUP (ERAG) -	Quarterly report to committee
			WHH	2.1.2	Partially Assured	- Slido/survey Monkey to be developed to be roled out by Tuesday 24th with specific questions on the guideline to ascertain staff understanding and awareness - Depending on results MSSP advisors for additional support on addressing any concerns identified	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	2 Weeks	30/01/2023		●	Surveymonkey rolled out with deadline for answers by 3rd February 23 ***remains partial assurance until outcome of survey assessed and actions put in place***					N/A	
	2.2	We looked at seven records and saw in three of them that the one hourly 'fresh eyes' review was not consistently recorded in line with trust policy	WHH	2.2.1	Fully Assured	Hour fresh eyes review: - form part of daily checklist review - alert on electronic whiteboard - assurance monitoring through audits ***separate action plan on Foetal monitoring tab***	Head of Midwifery WHH Foetal monitoring lead BI lead	1 week	20/01/2023	19/01/2023	✓		Fetal monitoring audit tool Fetal monitoring project plan quality check list - ***under section 5 bullet point 3***	2.2.1 Fetal Monitoring Project Plan 2.2.1 Proforma Fetal Monitoring Audit 5.1 QEQM Quality round check list Jan 23 5.1 WHH Master maternity daily quality round including staffing Jan 2023			MNAG	Dashboard compliance to MNAG monthly
			WHH & QEQM	2.2.2	Partially Assured	Undertake weekly fresh eyes audit by the Midwifery Operations Manager on shift as part of the rounding audit at 8am, 1pm and 8.30pm. - 5 sets of notes on each site to be reviewed and outcome data to be sent to BI team to be included in the monthly dashboard for MNAG	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	1 Week	20/01/2023	18/01/2023	✓	schedule discussed at band 7 meeting on 18/01/2023 and weekly audits to commence w/c 23/01/2023 ***remains partial assurance until progress is seen on fresh eyes compliance***					MNAG	Dashboard compliance to MNAG monthly
			WHH & QEQM	2.2.3	Fully Assured	Review of 5 retrospective cases at WHH 5 retrospective cases at QEQM	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	2 Weeks	30/01/223	18/01/2023	✓	Action completed whereby 5 sets of notes reviewed.					N/A	
	2.3	At the time of inspection, the service did not have a foetal monitoring midwife in post.	WHH	2.3.1	Fully Assured	Ascertain when the foetal monitoring midwife starts in post.	Head of Midwifery WHH	1 week	20/01/2023	17/01/2023	✓	confirmation from Jamie Disney-Goodwin (People and Culture business partner) of SH starling 6th February 2023	Email confirmation from People and Culture lead Jamie Disney. Induction programme for FM Midwife	2.3.1 Fetal Monitoring Midwife Confirmation Email 2.3.1 FM Midwife Induction Plan			N/A	
	2.4	Data showed recent incidents had exposed mothers and babies to risk of harm.	WHH	2.4.1	Fully Assured	Re - review of incidents (SIfs) highlighted in report through rapid review process AAR to be undertaken	Consultant Obstetrician and Gynaecologist Clinical Associate Director of Medical Education Director of Undergraduate Medical Education and Foetal Medicine lead	1 Week	20/01/2023	19/01/2023	✓	HSIB style investigation report to be completed by 19/01/2023 Recommendations / Learning points to be added to an action plan and taken through MNAG on progress	AAR reports on both cases				MNAG	Monthly SI reports
	2.4.1	Incident ID – 309750 - October 2022 – in summary delays in completing, escalating and recording foetal monitoring with outcome of baby born in poor condition by CAT 1B emergency caesarean section.	WHH											2.4.1 Case C-JT WEB230079				
	2.4.2	Incident ID – 307030 - September 2022 – in summary delays in accurately interpreting CTG and documenting in notes (CTG recording maternal pulse / hypoxia sticker not used when CTG accurately completed) outcome - CAT 1A GA Iscs at 29+1. Born in poor condition.	WHH											2.4.2 MD WEB307030 V2				
3	**Timeliness and effectiveness of maternity triage at William Harvey Hospital**																	
	3.1	The timeliness and effectiveness of processes in triage was a known risk to the trust, but mitigations were not always sufficient to protect women and babies from avoidable harm.	WHH	3.1.1	Fully Assured	review of activity that does not need to be undertaken through triage i.e. Day care activity review if this activity can be moved to alternative location. ***detailed action plan on Triage actions tab***	Head of Midwifery WHH	1 Week	20/01/2023	19/01/2023	✓		Obstetric Sonography staffing transfer business case Triage Action plan ***(Tab on excel spreadsheet)***	3.1..1 Business Case Obs Ultrasound Transfer to Maternity 2022 July 22 Triage Action plan ***(Tab on excel spreadsheet)***	Yes	Ref 2566: Inadequate Maternity triage pathway	EXECUTIVE RISK ASSURANCE GROUP (ERAG) -	Quarterly report to committee
	3.2	Women were not always seen by a midwife within 15 minutes of arriving in maternity triage due to staffing challenges	WHH	3.2.1	Fully Assured	Re-review of the KPI's within Audit tool to ensure all aspects are included	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	1 Week	20/01/2023	20/01/2023	✓		audit tool	3.2.1 Triage audit data collection template			MNAG	Dashboard data
	3.3	Women were not always reviewed by a doctor within recommended timeframes due to lack of dedicated obstetric medical cover. This negatively impacted the review of the women in line with the trust maternity triage policy.	WHH	3.3.1	Fully Assured	Review and implementation interim obstetric medical cover in triage.	Clinical Director Acting Operations Director	1 Week	20/01/2023	19/01/2023	✓	This is one of our improvement work streams given the cqc feedback, we have accelerated our actions around this. Adhoc middle grade cover put in place on a weekly basis by the Directorate Support Assistant team (rota team). Overall accountability of triage with hot week consultant		3.3.4 Consultant job plan changes action plan			MNAG	Part of Dailey SITREP
			WHH	3.3.2	Fully Assured	Review and implementation interim obstetric medical cover to support discharge and flow	Clinical Director Acting Operations Director	1 Week	20/01/2023	19/01/2023	✓	This is one of our improvement work streams given the cqc feedback, we have accelerated our actions around this. Dedicated SHO during weekends for EDN's and flow to facilitate timely discharges. Rota changed to implenent an SHO for during the week		3.3.4 Consultant job plan changes action plan			MNAG	Part of daily SITREP

			WHH,QEQM,KCH, BHD,RVH	3.3.3	Fully Assured	DSA team to be part of daily SITREP to provide named medical cover for triage and escalation/mitigations to senior team if any staffing gaps	Clinical Director Acting Operations Director	1 Week	20/01/2023	16/01/2023	✔	as part of daily SITREP meetings	SITREP outcomes emailed to care group and hospitals teams	3.3.3 MATERNITY SITREP REPORT - CROSS SITE- 12_1_23 3.3.3 UPDATE_MATERNITY SITREP REPORT -CROSS SITE- 9_1_2 3.3.3 UPDATE_MATERNITY SITREP REPOT - CROSS SITE 16_01_23-19_01_23			**N/A**	
			WHH	3.3.4	Partially Assured	Longer term - change to consultant job plans to implement medical cover in triage and facilitate discharges	Clinical Director Acting Operations Director	3 months	30/04/2023		●	staff engagement underway HR involved around consultation requirements	Action plan for medical cover in triage and prompt discharge of patients Email from Clinical Director to Consultants of job plan changes	3.3.4 Consultant job plan changes action plan			MNAG	progress report to MNAG
	3.4	Triage had one midwife at night. They relied on availability of staff from labour ward for support.	WHH	3.4.1	Fully Assured	review if current rota can be adapted to introduce additional midwife during high volume periods. ***detailed action plan on Triage actions tab***	Head of Midwifery WHH	1 Week	20/01/2023	19/02/203	✔		action plan ***(tab triage action plan)***	3.4.1 Triage shift patterns email			**N/A**	
	3.5	Women were not always cared for in appropriate environment due to challenges in managing flow across the maternity unit. For example, we saw women experienced delays to move onto labour ward or Folkestone ward for antenatal care due to lack of available beds.	WHH	3.5.1	Fully Assured	***linked to actions 3.3.1, 3.3.2, 3.3.3 & 3.4.1 around medical cover***											N/A	
	3.6	Data showed recent incidents had exposed mothers and babies to risk of harm.	WHH	3.6.1	Fully Assured	Review cases where delivery in triage has taken place in the last 6 months Review protocol by HoM to identify areas of improvement, risks and governance oversight	Head of Midwifery WHH	1 Week	20/01/2023	18/01/2023	✔	review undertaken	excel spreadsheet of data (1 case identified in pink)	3.6.1 & 3.6.2.1 RP06847_CQC_Non_Ward_Deliveries_230118			N/A	
			WHH	3.6.2	Fully Assured	review admin support: - status of recruitment to posts - can staff within care group be moved around and backfilled by NHSP (ward clerks)	Matron WHH	1 month	13/02/2023	19/01/2023	✔	review undertaken and shifts out to NHSP for interim measure	action plan ***(tab triage action plan)***	action plan ***(tab triage action plan)***			N/A	
	3.6.1	Incident ID – 300012 – July 2022 – in summary a woman was sent from triage to the labour ward in pain and was subsequently sent back to triage where they gave birth.	WHH	3.6.1.1	Fully Assured	Re - review of incident through rapid review process	Interim Quality Governance Matron	1 Week	20/01/2023	18/01/2023	✔	case discussed through rapid review in July 22 and declared SI at the time. Further AAR on SI to be undertaken and completed by **27/01/2023**	Rapid review report summary from July 22	3.6.1.1 rapid review case			N/A	
	3.6.2	We were told of an incident where a woman had been sent home from triage, who then gave birth in the emergency department toilet on the way home.	WHH	3.6.2.1	Fully Assured	- Review cases where delivery in emergency department has taken place in the last 6 months - Review protocol by HoM to identify areas of improvement, risks and governance oversight	Head of Midwifery WHH	1 Week	20/01/2023	18/01/2023	✔		excel spreadsheet of data (3 case identified in pink)	3.6.1 & 3.6.2.1 RP06847_CQC_Non_Ward_Deliveries_230118			N/A	
	3.7	The service was not completing regular triage audits at the time of inspection. Staff told us this was due to the triage manager was on long-term sick at the time of inspection.	WHH	3.7.1	Fully Assured	***Action linked to 3.2, 3.3,3.4,3.5 &3.6 - implementation of audit tool, roles and responsibility (detail of actions within triage action plan on tab)***					✔		action plan (tab triage action plan)	action plan ***(tab triage action plan)***			MNAG	Dashboard data against KPI's
4	**Infection control at William Harvey Hospital**																		
	4.1	The service did not have effective systems in place to protect patients against cross infection.	WHH	4.1.1	Fully Assured	Urgent IPC walk around to take place across all maternity areas	Head of Midwifery WHH Acting Operations Director Director of Nursing WHH	1 Week	20/01/2023	130/01/2023	✔	Immediate actions: - deep clean across Labour ward, Folkestone and Triage	4.2.3 Example of deep clean schedule	4.2.3 Example of deep clean schedule			N/A	
			QEQM	4.1.2	Fully Assured	Urgent IPC walk around to take place across all maternity areas	Head of Midwifery and Community Director of Nursing QEQM	1 Week	20/01/2023	17/01/2023	✔	Immediate actions: - deep clean across Labour ward, Kingsgate and triage	4.2.3 Example of deep clean schedule	4.2.3 Example of deep clean schedule			N/A	
	4.2	We found that cleaning records were not consistently completed. On Folkstone ward we saw staff did not always complete the daily cleaning records. For example, we saw that daily cleaning record was not completed for three dates in January 2023, nine dates in December 2022 and 11 in November 2022.	WHH	4.2.1	Fully Assured	clarification of Healthcare facilities agreement	2gether Estates Operational Development Lead	1 Week	20/01/2023	130/01/2023	✔		Appendix 1:Operated Healthcare facilities agreement in relation to the Trust sites Appendix 2.1 Joint stakeholders meeting terms of reference Appendix 2.2: Group annual board terms of reference Appendix 2.3: ToR Contract meeting Appendix 3.1: Contract performance meeting minutes November 22 Appendix 3.2: JSM minutes Oct 22 Appendix 3.3 CMPM Minutes Nov 22 - part 2 quality	4.2.1 APPENDIX 1- OHF 4.2.1 APPENDIX 2.1 Joint Stakeholder Meeting Terms of Reference 4.2.1 APPENDIX 2.2 Group Annual Board Terms of Reference 4.2.1 APPENDIX 2.3 ToR Contract Meeting Final 4.2.1 APPENDIX 3.1 Contract Performance Meeting minutes Nov 22 4.2.1 APPENDIX 3.2_JSM Minutes 04.10.22 4.2.1 APPENDIX 3.3 CMPM Minutes 011222 - Part 2 Quality docs			N/A	
			WHH & QEQM	4.2.2	Fully Assured	Roles and Responsibilities to be part of the environmental SOP to ensure staff are clear on expectations	Programme Director Senior Improvement Lead and SRO – Journey to Outstanding Care, Strategic Initiative Programme	1 Week	20/01/2023	19/01/2023	✔	Standard Operating Procedure for Clinically Led Environmental Audits due to commence 23/01/2023	Standard Operating Procedure for Clinically Led Environmental Audits	4.2.2 Final Environmental Audit SOP Jan 23			N/A	
			WHH & QEQM	4.2.3	Fully Assured	checking of cleaning audits to be part of the daily quality rounds	Head of Midwifery WHH Head of Midwifery and Community	1 Week	20/01/2023	19/01/2023	✔		quality check list - ***under section 5 bullet point 3***	5.1 QEQM Quality round check list Jan 23 5.1 WHH Master maternity daily quality round including staffing Jan 2023			MNAG	Dashboard data on quality audit
			WHH & QEQM	4.2.4	Fully Assured	Urgent action for deep cleans across both maternity units	2gether Estates Operational Development Lead	1 Week	20.01.203	19/01/2023	✔	priority of kitchens and bathrooms tomorrow. All areas expected to deep cleaned by 20.01.202	example of deep clean schedule on labour ward	4.2.3 Example of deep clean schedule			N/A	
			WHH, QEQM, KCH	4.2.5	Fully Assured	Weekly Clinically lead Environmental audits with IPC to be carried out over the next 6 months with IPC lead, HoM, lead facilities and WHH director of nursing More in-depth environmental cleaning audit to be undertaken on a quarterly basis. A schedule to be developed	Programme Director IPC Executive Director	1 Week	20/01/2023	19/01/2023	✔	weekly environmental audit tool developed and shared with teams schedule of weekly audits within Standard Operating Procedure for Clinically Led Environmental Audits	Environmental audit proforma Clinical practice audit proforma	4.2.5 Master Clinical Practice Audit Tool 4.2.5 Master Environmental Audit 4.2.2 Final Environmental Audit SOP Jan 23			MNAG	outcomes of audits to be shared with staff and reported monthly to MNAG
	4.3	We found not all areas were clean. For example, on Folkestone ward on 10 January 2023, we saw there were blood stains in the visitor toilet. In another toilet we saw urine contained in a cardboard bowl which was left on top of a bin, this was there for several hours.	WHH	4.3.1	Fully Assured	additional wipes and signage to be placed in toilets for women to clean area after use	Matron WHH	1 Week	20/01/2023	17/01/2023	✔		Photo of poster	4.3.1 Poster			N/A	
			WHH & QEQM	4.3.2	Fully Assured	- Hourly checks to be undertake by domestic 2gether and band 7/matron - Audit sheets laminated on toilet door to record summary of check and escalation/actions - Daily quality rounds to demonstrate checks have been completed and actions have been undertaken	Tracy Gilmore, Matron WHH Claire Lowe, 2gether Estates Operational Development Lead	1 Week	20/01/2023	19/01/2023	✔	2gether staff meeting taken place and schedule put in place for hour audit	checklist	4.3.2 Hourly Toilet Sign Off Maternity			MNAG	Dashboard data on quality audit
			WHH	4.3.3	Fully Assured	Hourly checks to include review of the toilet facilities to ensure urine is not left in toilet cubicle after weighing - Quality rounds to demonstrate checks have been completed and actions have been undertaken - Staff education and awareness - roles and responsibilities - ***linked to roles and responsibilities within environmental SOP under section 4.2***	Matron WHH Head of Midwifery WHH and Gynae	1 Week	20/01/2023	19/01/2023	✔		quality check list - ***under section 5 bullet point 3***				MNAG	Dashboard data on quality audit
	4.4	In Triage, day care and in the ward areas we saw multiple staff did not always clean their hands, and use personal protective equipment (PPE), such as gloves and aprons, when delivering care to women. We did not see staff challenging this practice.	WHH & QEQM	4.4.1	Fully Assured	- staff education of PPE standards - spot checks as part of daily quality rounds - weekly PPE and hand hygiene audits as part of the weekly environmental/IPC audit ***- link to roles and responsibilities within environmental SOP under section 4.2***	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	1 Week	20/01/2023	19/01/2023	✔	weekly audit tool developed and shared with teams	weekly HH & PPE audit tool quality check list - ***under section 5 bullet point 3***	5.1 QEQM Quality round check list Jan 23 5.1 WHH Master maternity daily quality round including staffing Jan 2023 4.2.2 Final Environmental Audit SOP Jan 23			MNAG	Dashboard data on quality audit
			WHH,QEQM,KCH, BHD,RVH	4.4.2	Partially Assured	Agreed timeline for all staff to be hand hygiene compliant	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	1 month	28.02.2023		●	Evidence of local records to date (ESR time lag)					MNAG	Dashboard data on quality audit

No. Actions	41	Status (%)
At risk / Not started	0	0%
In progress (overdue)	1	2%
In progress (on schedule)	2	5%
Complete	37	90%
No Status	0	0%
TOTAL	**40**	**98%**

	Post Feedback Actions																		
5	**Daily checks:**																		
	Bullet point 3:	On the QEQM site we saw fire doors propped open and the door to the notes store propped open despite us pointing this out more than once to staff on site this was a theme throughout the inspection- cleanliness (dust) On both sites we found gaps in weekly and daily equipment checklists, out of date equipment on resus trollies and dusty equipment.	WHH & QEQM	5.1	Fully Assured	To be part of daily quality round check list and weekly environmental / IPC audits	Matron WHH Matron QEQM	1 Week	20/01/2023	19/01/2023	✔		Quality round check list for QEQM and WHH clinical practice audit tool - ***part of section 4.2***	5.1 QEQM Quality round check list Jan 23 5.1 WHH Master maternity daily quality round including staffing Jan 2023			MNAG	on-going monthly audit data to to MNAG
			WHH & QEQM	5.2	Partially Assured	Monthly outcome / action report from weekly environmental / IPC audit to MNAG ***linked to section 4.2.5***	Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	2 Weeks	30/01/2023	27/01/2023	✔	daily check in place increased oversight of Hom reporting into the DoM. Will review assurance level again in 2 weeks to check compliance where further actions will be taken if remains a concern all equipment and drugs checked - environmental audit check completed. weekly commence from Monday ***remains partial assurance until progress is seen on fresh eyes compliance***	outcome themes, learning and actions from quality round audit to next MNAG on 14/02/2023				MNAG	on-going monthly audit data to to MNAG
	Challenging environments																		
6	Bullet point 4	The maternity areas on both the QEQM and The William Harvey Hospital (WHH) are challenging environments that do not meet with the needs of women and do not meet with HBN 09-02 maternity care facilities. Examples of this are the bereavement facilities at the WHH being down the triage corridor and the labour suites being too small creating a lack of availability of essential resuscitation equipment There has been no improvements in this since our 2021 report.	WHH & QEQM	4.1	Partially Assured	Estates strategy already developed. Up-date all risk assessments associated with issue: - bereavement facilities - labour suites being too small creating a lack of availability of essential resuscitation equipment	Acting Operations Director Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	2 Weeks	30/01/2023	30/01/2023	✔	Resusciation risk assessment completed	Maternity Estates – Capital Business cases Briefing Resusciation risk assessment WHH and QEQM bereavement facilities RA WHH	4.1 Maternity Estates – Capital Business cases Briefing 4.1 WHH Resusciation risk assessment ***(sent to CQC Friday 3rd February)*** 4.1 QEQM esusciation risk assessment ***(sent to CQC Friday 3rd February)*** 4.1 bereavement facilities WHH RA ***(sent to CQC Friday 3rd February)***	Yes	Ref 2567 : Inadequate estates within maternity at EKHUFT		
7	Bullet point 5	Both sites only have one maternity theatre which means patients have to be prioritised depending on level of need and transferred to the main theatres. This can take up to 15 mins (QEQM). There is a lack of privacy and dignity for mothers who have to be taken to main theatres in what would be an extremely stressful time for them, this is a poor patient experience and holds patient safety implications.	WHH & QEQM	5.1	Fully Assured	Estates strategy already developed. Up-date all risk assessments associated 2nd obstetric theatre	Acting Operations Director Head of Midwifery WHH and Gynae Head of Midwifery QEQM and Community	2 Weeks	30/01/2023	02/02/2023	✔	Risk assessment completed - Action closed	As above on briefing paper option appraisal presented at MNAG November 22 Risk Assessment	5.1 2nd Ostetrics Theatre at QEQM 5.1 Single obsetric thatres QEQM Risk Assessment ***(sent to CQC Friday 3rd February)***	Yes	Ref 2934: Inadequate theatre capacity at QEQM for maternity services		
8	Bullet point 6	The environment creates a poor experience for women and for staff to work in. With no en suite facilities and room for partners to stay comfortably during labour. We saw examples of leaking roofs, bowing doors, and a rusty shelf in patient bathrooms.	QEQM	6.1	Fully Assured	- Estates review leaking roofs, bowing doors, and a rusty shelf in patient bathrooms. - Works requests raised.	2gether Operational Development Lead	1 Week	20/01/2023	19/01/2023	✔	QEQM - leaking roof repaired WC 12/01/23, window repair 25/01/23 (side room 9 - non clinical). Side 2,3,4,6 repaired in Dec 2023, AIO						

			QEQM	6.2	Fully Assured	- Estates review of flooring issue - Works requests raised.	2gether Operational Development Lead	1 Week	20/01/2023	19/01/2023	✓	Order placed for £15K on 17/01/23, floor layers in 19/01/23 to assess area works, to start 26/01/23, ending 09/02/23.						
			WHH	6.3	Fully Assured	request and replace fire extinguisher	2gether Operational Development Lead	1 Week	20/01/2023	16.01.2023	✓		photo of replacement extinguisher	6.3 Fire extinguisher tag				
			WHH	6.4	Fully Assured	PAT review and testing on all non clinical equipment across all maternity area that have not been tested or out of date	2gether Operational Development Lead	2 weeks	30/01/2023	30/01/2023	✓	WHH PAT will take place on 21/01/23 (1 day process).						
			WHH	6.5	Fully Assured	PAT review and testing on all Clinical equipment across all maternity area that have not been tested or out of date	EME lead	2 Weeks	30/01/2023	30/01/2023	✓							
9	Bullet point 7	There are estates works planned for a second theatre, and to meet with the requirements HBN 09-02 but as we discussed in both meetings finances have not been secured and if secured this work will take a significant period of time to complete.	QEQM	7.1	Partially Assured	Estates strategy already developed.	Acting Operations Director	2 Weeks					Maternity Estates – Capital Business cases Briefing ***under section 4.1***					
10	Bullet point 8	At QEQM, we saw a newborn baby being cannulated in a space on the corridor which staff described as their paediatric area. This is unsuitable and appears to be normalised practice.	QEQM	8.1	Fully Assured	to complete risk assessment of the current space and identify how the safety, privacy and dignity can be improved	Head of Midwifery QEQM and Community	1 Week	20/01/2023	16/01/2023	✓	risk assessment not required as alternative location sourced.	N/A					
			QEQM	8.2	Fully Assured	consider alternative location	Head of Midwifery QEQM and Community	1 Week	20/01/2023	17/01/2023	✓	room 9 now used for paediatric interventions	Photos of new location and equipment in the room	8.2 pictures of new paeds room on labour ward 1-4 (4 files)				
	Fire																	
11	Bullet point 9	At QEQM there was a significant risk to safety during a fire. We followed the secondary fire evacuation route through the labour ward. We encountered a labelled automatic fire door which we were told would close automatically in the event of a fire. However, the closing mechanism removed. The Head of Estates for the site had no explanation for this. Every fire door on the route was mislabelled as to whether it was an automatic fire door or needed to be kept closed. None of the doors were labelled showing staff how long the door would hold them safely in the event of a fire, the labelling of fire doors is a requirement of the HTM guidance. We found fire doors (staff kitchen and doctors office) that should be closed propped open. We repeatedly raised this with staff throughout our inspection as the doors continued to be propped open. There were several boxes alongside the corridor of a fire exit which meant a bed could not pass through the corridor during an evacuation. The fire route was also missing signage (green running man) to direct staff in the correct direction. This has been rectified since the inspection. As discussed in the call later in the day we have contacted Kent Fire and Rescue Service who will be making an assurance assessment.	QEQM	9.1		***All actions linked to section 1 Fire safety at Queen Elizabeth The Queen Mother Hospital***												
	Procurement processes																	
12	Bullet point 10	QEQM had one Bedside scanner for whole department. The triumvirate described a trust replacement scheme process. But staff told us the procurement process had been frustrating and the scanner has still not been secured.	QEQM	10.1	Partially Assured	Confirm leading time of equipment already approved via MDG (Procurement)	Matron QEQM	1 Week	20/01/2023	19/01/2023	✓	confirmed 3 weeks from 19/01/2023 for delivery of scanner ***remain partially assured until delivery of scanner***						
13	**Access and Flow at WHH**																	
	Bullet point 11	WHH had issues with access and flow we found women were being cared for in inappropriate areas for example we saw women spending too long in triage with one woman arriving at 6.42am and was still in receiving treatment in triage at 4pm. we were told of an incident where a woman was sent from triage to labour suite and were sent back and gave birth in triage.	WHH	11.1	Partially Assured	Undertake an analysis of activity to identify potential of transferring in a planned way activity to QEQM	Head of Midwifery WHH	2 Weeks	30/01/2023		●	review of activity underway as part of the triage improvement workstream						
	Bullet point 12	At WHH there were six women at 4pm waiting to go home. One was waiting for medication with the other five waiting for medical review. There was a lack of dedicated medical cover in these areas including the consultant on call which is having an impact on care and treatment.	WHH	12.1	Partially Assured	To review job plans of consultants and junior doctor rotas to improve medical resources to facilitate prompt discharges	Clinical Director Acting Operations Director	1 week	20/01/2023	20/01/2023	✓	jobs role reviewed as to what is required to ensure sustficant medical cover. This action is part of actions under ***section 3 (3.3)*** *Review of discharge pathway and barriers to discharge underway. Actions linked to the* postnatal pathway working group ***remains partially assurance until actions completed under section 3 (3.3)***						
				12.2	Partially Assured	implementation of changes in rota	Clinical Director Acting Operations Director	3 months	03/04/2023		●	as part of actions under ***section 3 (3.3)*** ***remains partially assurance until actions completed under section 3 (3.3)***						
14	**Insufficient use of Fp10s**																	
	Bullet point 13	We asked that you review FFP10s prescription pads as multiple pads were in use with numbers recorded in a book but not sequential. This poses a potential risk of the misuse of prescriptions.	WHH, QEQM, KCH	13.1	Fully Assured	Review the books where FP10's are recorded to understand issue and provide instruction to triage staff to ensure sequential use.	Head of Midwifery WHH Head of Midwifery QEQM and Community	1 Week	20/01/2023	20/01/2023	✓	review undertaken and staff trained						
			WHH, QEQM, KCH	13.2	Fully Assured	pre - printed pads	Chief of Pharmacy	1 month	13/02/2023		●	on track to roll out by end of Feb 23						
15	**Fetal monitoring leadership**																	
	Bullet point 14	The fetal monitoring midwife at WHH has been appointed but not yet in post and staff told us that there was not a fetal monitoring obstetrician not in post. This is an Ockendon requirement so needs addressing. At feedback you informed us that there was a fetal monitoring obstetrician in post but that they had just returned from a period of sickness.	WHH	14.1		***Action linked to section 2 Effective processes for foetal monitoring and escalation at William Harvey Hospital 2.3 (2.3.1)***												
16	**Raise a call for help at KCH**																	
	Bullet point 15	At Canterbury outpatient clinic we found that the rooms either did not have call bells in situ or had call bells that had been disconnected. This meant staff were unable to call for assistance in these rooms. Staff appeared unclear about what they would do in an emergency.	KCH	15.1	Fully Assured	Review of call bell system and works requests to repair or install	2gether Operational Development Lead	1 Week	20/01/2023	20/01/2023	✓	review already undertaken. No call bell system in place. Interim call bell system to be installed by 26/01/2023 proposal to EMT for permeant solution if required						
17	**Governance processes in place to provide assurance of actions and learning**																	
	Bullet point 16	We found that the department were at the early stages of a "governance improvement journey". There was a lack of learning from incidents by staff on the ward. Action plans were not always translated to learning as not embedded, therefore there is a risk of recurrence of incidents. We also found that there was a lack of discussion of risk and governance with the staff team on the wards. We have agreed to further interviews with the risk and governance leads to ensure we have a complete picture of improvements in the area.	WHH,QEQM,KCH, BHD,RVH	16.1	Partially Assured	Governance improvement plan - part of maternity improvement plan. Early actions already identified to formulise process of dissemination of learning and embedding of action plans.	Interim Director of Midwifery	1 Week	20/01/2023	20/01/2023	✓	***remain partially assurnace until governance team and processes embedded to provide learning from incidents***						
			WHH,QEQM,KCH, BHD,RVH	16.2	Fully Assured	weekly communication to staff of themes from rapid review & closed SFs	Interim Quality Governance Matron	1 week	20/01/2023	20/01/2023	✓	detailed in message of the week sent out by governance team to all staff in the care group	copy of previous message of week	16.2 MOW 09.01.2023 , 16.2 MOW 12.12.2022 16.2 MOW draft to be sent 23.01.2023				
18	**Fresh eyes monitoring**																	
	Bullet point 17	We found that staff at the WHH were not following best practice with Fresh Eyes monitoring	WHH	17.1		***Action linked to section 2 Effective processes for foetal monitoring and escalation at William Harvey Hospital 2.2 (2.2.1 & 2.2.2)***												
19	**Infection Prevent and Control**																	
	Bullet point 18	We also found some examples of poor Infection prevention and control (IPC) practices at the WHH.	WHH	18.1		***Action linked to section 4 Infection control at William Harvey Hospital***												

Action Reference 2: Effective processes for foetal monitoring and escalation at William Harvey Hospital							
Fresh Eyes action plan							
Issue	Requirement	Actions	Date to be completed by	Progress Update	Date Completed	Action Progress	Responsible Lead
Poor compliance with CTG Fresh Eyes/Care hourly	ensure Fresh eyes is done hourly on all women on continuos monitoring	IT lead to add icon onto electronic white board to red flag when reach 1 hour for fresh eyes	20/01/23	completed. Midwife enters the time when the women needs fresh eye. The system then autamtically calaculates the hour to red flag on the system to alert the midwife	23/01/23	✓	Beautiful information Lead
		Electronic white board data to be downloaded onto maternity dashboard monthly to review compliance	18/01/23	Process in place by Information team	18/01/23	✓	Information Lead Women's Health Care Group
		All band 7's to be trained on use of icon on electronic white board	27/01/23	compelete - training ongoing for those staff who are returng from leave or new to the department	27/01/23	✓	Head of Midwifery WHH
		Go live with electronic white board icon and data collection	30/01/23	went live on 23rd. Data collection from 1st Feb. (alwso writing on the physical white baord	23/01/23	✓	Head of Midwifery WHH
		Short term - add all fresh eyes times required to be completed onto physical Labour ward SBAR white board and keep updated hourly	18/01/23	implemented as ongoing action	18/01/23	✓	Matron WHH Matron QEQM
		Audit 5 sets of labour notes per day to ensure compliance of fresh eyes	18/01/23	implemented as ongoing action	23/01/23	✓	Matron WHH Matron QEQM
		Discuss and explore with Mosos(electronic central monitoring system) ability to add alarms and documentation onto CTG in relation to Fresh eyes	18/01/23	discussions taken place to explore	18/01/23	✓	Matron WHH Head of Midwifery WHH
		Follow up meeting with MOSOS to discuss up grade to new system and time frame for installation	24/01/23	undertaken - new verion of upgrade anticipated by end of Feb 23.	23/01/23	✓	Matron WHH Head of Midwifery WHH

Action Reference 3: Timeliness and effectiveness of maternity triage at William Harvey Hospital							
Issue	**Requirement**	**Actions**	**Date to be completed by**	**progress update**	**Completion date**	**Action Progress**	**Responsible Lead**
Delay in completion audits against triage KPI's	Daily audit of times women waiting for initial assessment and rag rating	to review retrospective audits to identify the barrier	27/01/23	completed - indiactions around staffing issues	27/01/23	✓	Head of Midwifery WHH
	Review admin support for triage to support audits	out to advert -4WTE out to NHSP for interim support	20/01/23	Adverts out. No NHSP pick up as yet	20/01/23	✓	Matron WHH
Women were not always cared for in appropriate environment due to challenges in managing flow across the maternity unit.	Review to move maternity day care out of maternity triage	As part of the bed base review with WHH Site management, GSM and Cancer Care groups, the proposal for a Gynae ward on half of Kennington has been taken to Emergency care Board Jan23. It is envisage GAU will move to the new gynae ward and day care from current loaction in triage to be relocated to women's health suite. It is anticipated April for the moves to have been taken place	31/03/23	workstream underway with support from transformations team. Lead by WHH Site Director		●	Acting Operations Director
	Review of discharge pathway and barriers to discharge	Mapping of discharge process	18/01/23	Actions to be part of the postnatal pathway working group	16/01/23	✓	Head of Midwifery WHH
Triage had one midwife at night. They relied on availability of staff from labour ward for support.	Review staffing triage more robustly during busy times 12.00 to 23.00	Communication to staff requesting volunteers to trial new late twilight shift to start from next roster	20/01/2023	not enough volunteers to undertake trialchange in rota	19/01/2023	✓	Head of Midwifery WHH
		Commence 30 day staff consultation processes	06/03/2023	to be discussed at workforce meeting		●	Head of Midwifery WHH

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**INTEGRATED PERFORMANCE REPORT (IPR)**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHIEF FINANCE OFFICER (CFO)**
PAPER AUTHOR:	**CHIEF FINANCE OFFICER**
APPENDICES:	**APPENDIX 1: DECEMBER 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.** By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In December the potential opportunity increased to 44 lists, from 37 in the previous month. This is due to increased cancellations as a result of the high emergency demand and pressure across all sites with consistently high bed occupancy. • There was a slight deterioration in December of both booked and actual performance. This was impacted by a rise in cancellations, all specialities are individually				

	reviewing. Themes will be presented at January's Theatre Optimisation Group. • Elective Orthopaedic Centre (EOC) continues to focus on increasing productivity by holding a multidisciplinary 6-4-2 booking meeting. The number of cases per list in the most recent week improved to 2.3 from an average of 1.9 across the last 20 weeks. • Further improvement measures that have been implemented are continuously reviewed ensuring shared learning across the Care Groups; • Urology and General Surgery focus on creating standby patients to reduce cancellations on the day by increasing pre-assessment pool. • Ophthalmology utilising dedicated operational and pre-assessment to improve utilisation. • The Trust is optimising scheduling opportunities with the booking teams with an aim of booking all lists to 95% and increasing actual utilisation to over 85%. • Late starts remain a focus for General Surgery where it was identified that delays were due to Intensive Therapy Unit (ITU) bed. The action was to add a small case first on the list; as a result there has again been a further 1% improvement in December. • An improvement day has been scheduled for the EOC in January to further improve patient experience, theatre productivity and reduce length of stay. • The theatre optimisation group meets fortnightly led by the Surgery & Anaesthetic leadership team. This group continues to focus on the development of Standard Operating Procedures regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. The group has ensured specialities focus on key metrics to analyse themes and trends. We aim to reduce turnaround time by a further 5% over the next quarter and increase EOC utilisation to 95%. • **Same Day Emergency Care (SDEC) Admissions.** The SDEC activity across all services saw an increase in the number of attendances in month (2,228 v 2,080 in November). This was driven by an increase across both sites in both medical SDEC & gynaecology SDEC on the Queen Elizabeth the Queen Mother Hospital (QEQM) site and an increase in Frailty on the William Harvey Hospital (WHH) site (46 v 6 in November). However, SEAU at WHH was partially used in November and December to manage the increased inpatient bed requirements (Operational Pressures Escalation Level (OPEL4)) therefore reducing the numbers for SDEC through the unit compared to the previous months (269 v 322 in August 2022). • 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 from community clinicians and acute hospital specialists. Virtual Wards for Respiratory conditions are evolving and will provide further integration, these are planned to come on-line in February 2023. • As part of the workstreams within the Emergency Care Delivery Programme, clinical pathways have been developing in collaboration with the surgical, acute medical and orthopaedic leads to increase the cohort of patients accessing the SDEC services. The work continues to focus on the capacity requirements and accessibility for these services as the clinical leads work towards the clinical model to provide same day emergency care and assessment units across the sites. • The programme includes the expansion of the Medical Day Unit at the Kent & Canterbury Hospital (K&C) site, to provide an enhanced service for patients requiring this facility for their care, thereby releasing capacity for the expansion of SDEC services on the QEQM/WHH sites to increase the cohort opportunity of patients identified against the Ambulatory Care Conditions. • The roving frailty model at WHH is established with a team of specialists working within ED/Acute Medical Unit (AMU) with daily monitoring. The activity through this service has seen a marked improvement in December (49 v 6 in November) with the intention to re-establish a dedicated front door frailty unit once the ED Build has completed – July 2023. • Work continues in exploring potential changes to the hours of the QEQM service to maximise the opportunity for more patients to access the service. • The creation of 4 'Hot Slots' for referral into SDEC the next day for accessing medical care at the WHH introduced in November 2022 has proven successful reducing some patients waiting overnight to access the service. The number of slots increased to 8 in December and will continue to be monitored for use. • Plans being developed for access to specialty Hot Clinics within the SDEC are being progressed to enable more patients to be seen urgently as an outpatient reducing the need for in patient stay. • **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. • 45 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology. • The We Care rollout has been extended and will also include Urology and Cardiology. • Two of the priority areas identified as part of the National Staff Survey 2021 data review (those with the lowest scores for involvement) have completed the KENT Fundamentals programme. • The new staff intranet, Interact, 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 and will be launched to support work following release of 2022 Staff survey results.
	
	• **Premium Pay costs.** The Trust spends £87m per annum on premium pay with an aim to reduce this by 10% over the year. In December 2022 premium pay spend has decreased by £0.2m. This is the third month in a steady decline in usage.
	• 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.
	
	Watch Metrics - these are metrics we are keeping an eye on to ensure they don't deteriorate.

Key Recommendation(s):	To **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

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

Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage.
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services.

	CRR 78: There is a risk that patients do not receive timely access to emergency care within the ED.	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	Y	Working through with the subsidiaries their involvement and impact on We Care.
Assurance Route:		
Previously Considered by:	Clinical Executive Management Group (CEMG) 25/01/23, Quality & Safety Committee (QSC) 26/01/23, and Finance and Performance Committee (FPC) 31/03/23.	

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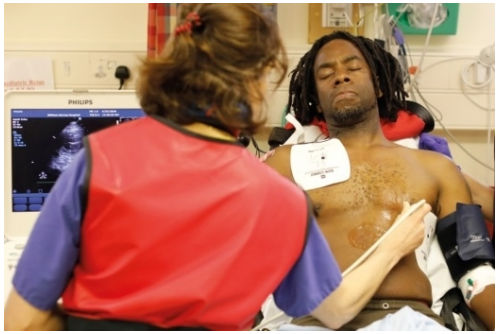
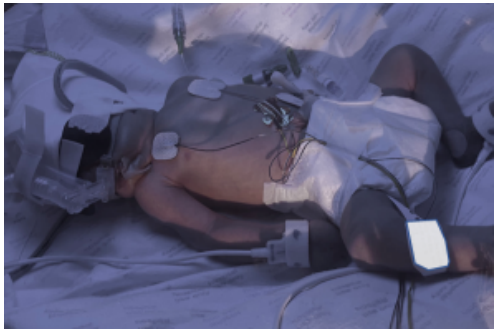
Integrated Performance Report

December 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)?

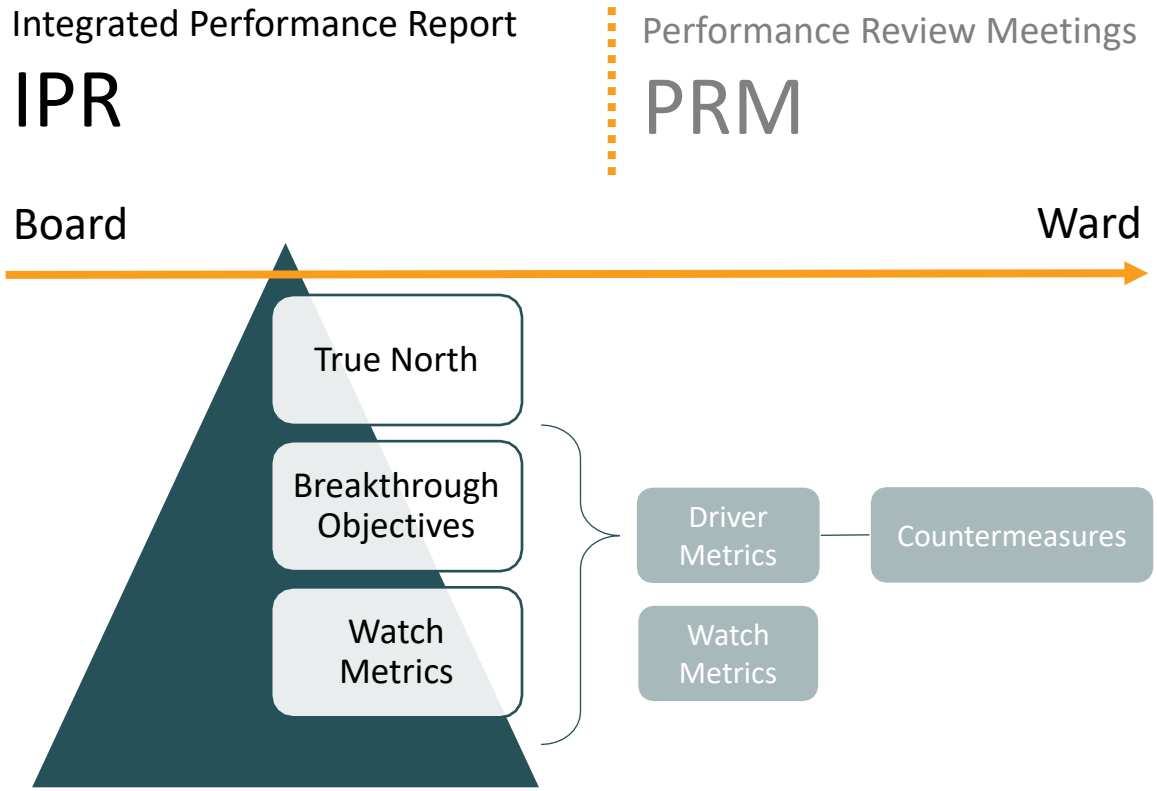
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- 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.

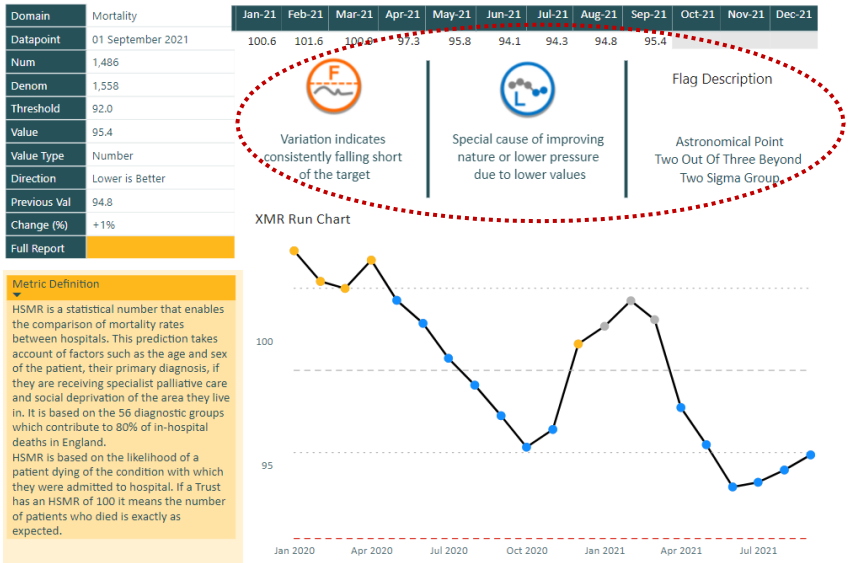
If data point falls outside these levels, an investigation would be triggered.

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		
	H L	H L	?	P	F
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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
88.7	87.4	85.9	87.1	87.9	88.9	90.2	90.0	88.7			

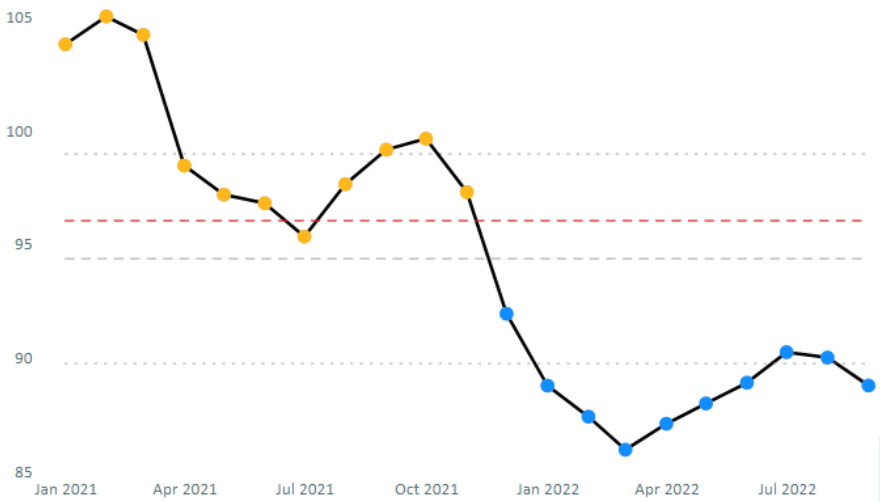
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

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 September 2022 which is the last data release. At time of reporting this remains 'lower then expected' for the Trust as a whole and the K&CH site, with WHH and QEQM both 'as expected'.

From last month the Trust has maintained its position remains 16th out of the 121 acute non-specialist Trusts on the Telstra Health platform for the third month, with 9 Trusts clustering within in one point

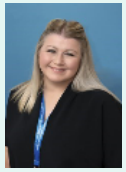
Intervention and Planned Impact

- 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 94.6 (to August 2022) and remains '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

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk with the national baseline not stabilised. The impact on health due to the consequences of the pandemic are still not fully understood and it is likely will impact on national and local mortality metrics.

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
26	29	25	21	13	21	30	22	33	35	40	40

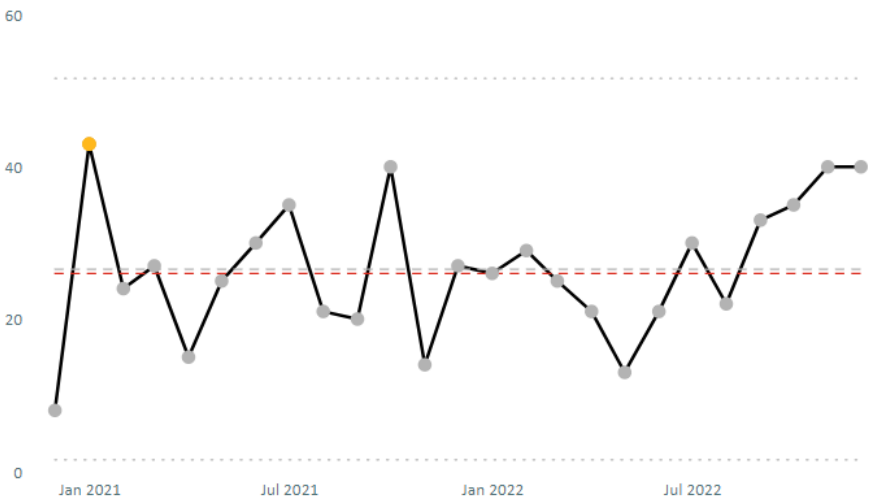
Variation indicates inconsistently passing and falling short of the target

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 December, which continues to be above threshold but has not increased from the previous month. The highest contributors to harm this month were care/treatment with 12 incidents, which is an increase from the previous month, patient falls was the second highest with 7 incidents which is an increase from the previous month. The third highest contributor were operations/procedures with 4 incidents all of which were related to recognised complications. This month there was a reduction in incidents relating to delay/failure from 17 to 4, despite the increased pressures currently faced by the Trust.

Intervention and Planned Impact

The site triumvirates continue to report the deteriorating patient themes at the Patient Safety Committee. As a result site based focus groups, facilitated by the governance team as part of the deteriorating patient pathway, Quality Intelligence Forums will commence In February. Task and finish groups at QEQM and WHH led by the site director's of nursing are exploring site specific issues and processes relating to the deteriorating patient.

An analysis of patients with a NEWs score ≥5 was undertaken which showed poor compliance with the deteriorating patient form and escalation process. The paper will be presented at the QSC, the issues identified are not new and are reflected in the CRR. The development of a deteriorating patient dashboard is still proving challenging due to the complexity of data retrieval required. Regular meetings with IT and BIU continue to resolve these problems.

There has been an increase in the number of patients admitted to ICU at WHH following cardiac arrest. A comprehensive review of all of the patients has been undertaken which reassuringly identified no correlation with patient location or significant deficits in the patients episode of care.

Safe staffing and our current capacity challenges continue to be a factor contributing to patient harm. These challenges have been further compounded with the recent industrial action by SECAMB.

December has seen an increase in the number of reported falls, with 75% being unwitnessed. Following review at SIDP only 1 of the 7 patient falls were considered an SI due to omissions in the risk assessment. Escalation areas which are not included within the ED staffing establishment continue to be utilised due to high numbers of patients being cared for in corridors and other non-clinical areas. As a result of increasing corridor care a dashboard has been developed on the information portal to record each patient who is allocated to the corridor for more than 30 minutes and will enable a more accurate analysis of patients being treated in the corridor. In both ED's there is direct correlation between audit compliance staffing and overcrowding.

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, Matron, Movement & Handling 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.

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.	Sep-22	Oct-22	Nov-22	Dec-22
Harm Events	W4		IPC: CDiff Infections		6	18	13	12	12
	W4		Medication Errors; Severity C+		1	2	2	3	4
			IPC: Audits Composite		85.0%	85.1%	86.4%	83.9%	85.5%
	W4		VTE Assessment Compliance		95.0%	94.1%	94.4%	93.5%	92.8%
			Safeguarding Incidents		Sigma	21	19	23	29
	W4		Serious Incidents Breached		0	21	16	16	16
	W4		Overdue Incidents		Traj.	6,531	6,532	6,579	6,637

IPC: C diff Infections

The Trust has exceeded 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. A pilot audit of patient outcomes is in progress.

IPC: Audits Composite

The audits are above the threshold in December after a small reduction in November. Monitoring will continue to ensure this is maintained.

VTE Assessment Compliance

Data flow has now been restored and the performance has deteriorated over the last 2 months when reporting was unavailable. The fall in performance is in the general and specialist medicine and urgent and emergency care groups. The care group clinical directors are reviewing their action plans and reinforcing with the team.

Serious Incidents Breached

There remains 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. All reports are in various stages of draft, with confirmed plans to ensure all are completed by end of January 2023.

Our patients

Our patients

Matt Powls

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 Health Care Partnership early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
59.2%	59.1%	58.4%	58.4%	60.2%	59.7%	59.5%	59.7%	58.4%	58.3%	59.0%	58.1%

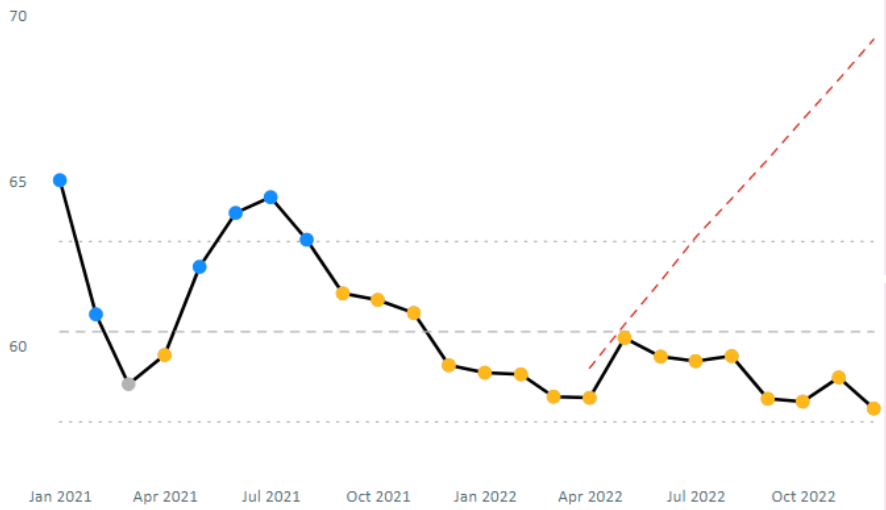
F — Variation indicates consistently falling short of the target

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

Performance in December has deteriorated, this is due to less patients receiving treatment as a result of winter pressures and the wait time for first outpatient now exceeding 18 weeks.
Despite the reduced treatments in month our most urgent and longest waiting patients were prioritised and will continue to be through January, February and March 2023. Our clinical and operational teams are committed to eliminating patients waiting longer than 78 weeks for treatment by the end of March 2023.

Intervention and Planned Impact

- The risk of 104 week breaches is reducing rapidly as EKHUFT is treating patients earlier in their pathway, in December 6 breaches were reported as a result of covid and patients choosing to wait longer for treatment.
- Patients are being offered choice of alternate providers, where Provider capacity and criteria allows. This will continue throughout January, February and March 2023.
- Business planning across all services has commenced and this will inform our recovery plans for 2023/24.
- Validating our patient pathways and making contact with patients has been a key focus in December and will continue routinely in the coming year ahead.
- Recruitment plans continue across our key priority areas: Theatre Operating Department Practitioners, Administration Booking Staff and Radiology Staff.
- Specialty teams continue to identify efficiencies and are actively seeking opportunities to reduce our DNA rate and increase the volume of patients we can see and treat in our services.

Risks/Mitigations

- Mitigating the risk of elective cancellations through the next three months of winter will continue to be our priority.
- Theatre staffing recruitment and sickness levels present a risk to our elective recovery journey. Oversight of staffing levels and scheduled activity are being monitored closely and solutions to address areas of risk will continue to be mitigated where possible.
- Outpatient waiting times continue to be elongated and will continue to impact the RTT 18 week performance target. Working in collaboration with our Integrated Care Board, we will seek to accelerate outpatient transformation opportunities in the short, medium and long term to improve the outpatient pathways. Focused work continues to reduce our DNA rate, increasing virtual appointments and increasing the opportunity using Patient Initiated Follow Up (PIFU).

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
54	60	39	36	32	30	34	43	45	43	37	44

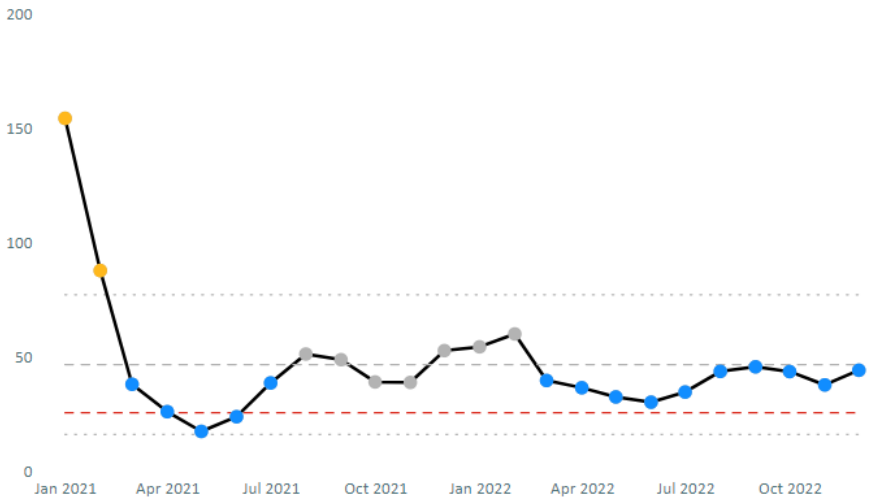
Variation indicates inconsistently passing and falling short of the target

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. In December the potential opportunity increased to 44 lists, from 37 in the previous month. This is due to increased cancellations as a result of the high emergency demand and pressure across all sites with consistently high bed occupancy.

Intervention and Planned Impact

- There was a slight deterioration in December of both booked and actual performance. This was impacted by a rise in cancellations, all specialities are individually reviewing. Themes will be presented at Januarys Theatre Optimisation Group.
- Elective Orthopaedic Centre (EOC) continues to focus on increasing productivity by holding a multidisciplinary 6-4-2 booking meeting. The number of cases per list in the most recent week improved to 2.3 from an average of 1.9 across the last 20 weeks.
- Further improvement measures that have been implemented are continuously reviewed ensuring shared learning across the Care groups;
    - Urology and General Surgery focus on creating standby patients to reduce cancellations on the day by increasing pre assessment pool.
    - Ophthalmology utilising dedicated operational and pre assessment to improve utilisation
- The Trust is optimising scheduling opportunities with the booking teams with an aim of booking all lists to 95% and increasing actual utilisation to over 85%.
- Late starts remain a focus for General Surgery where it was identified that delays were due to ITU bed. The action was to add a small case first on the list; as a result there has again been a further 1% improvement in December.
- An improvement day has been scheduled for the Elective Orthopaedic Centre in January to further improve patient experience, theatre productivity and reduce length of stay.
- The theatre optimisation group meets fortnightly led by the Surgery & Anaesthetic leadership team. This group continues to focus on the development of Standard Operating Procedures regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. The group has ensured specialities focus on key metrics to analyse themes and trends. We aim to reduce turn around time by a further 5% over the next quarter and increase EOC utilisation to 95%

Risks/Mitigations

- Theatre staff shortages continue mainly at WHH Active recruitment is ongoing with a trajectory to fully recruit by July 24 subject to business case approval.
- 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

Matt Powls

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
9.5%	9.2%	10.5%	10.4%	8.7%	9.5%	11.2%	12.1%	11.4%	10.5%	9.9%	12.2%

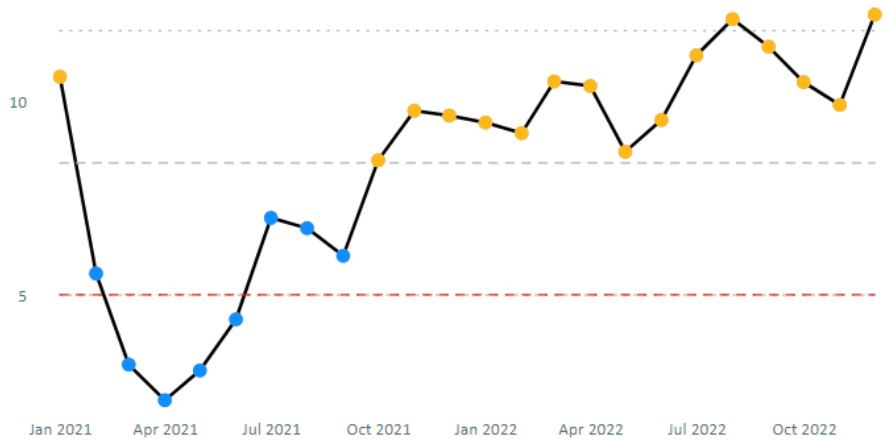
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group Astronomical Point

XMR Run Chart



What the chart tells us

In December 12.2% of patients attending ED remained in the department for more than 12 hours. This is an increased % on the previous month following 3 months of an improving position down to 9.9% in November.

For context both acute sites reported a decline in the 4 hour timed pathway in Dec (71.6% v 74.7% Nov 22) the deterioration was across both admitted and non-admitted pathways (14.3% v 17.8% Nov and 48% v 55.6% in Nov 22 respectively). There was a direct correlation with the increased numbers of patients waiting for beds in the EDs (76.3 v 59.7 Nov), with WHH reporting the highest spike from 34.3 (Nov) v 51.0 (Dec) with the marked increase in activity for all types (32.4k v 29.9k in Nov, ***the highest reported numbers since Jan 22).*** WHH declared an OPEL 4 on 2.12.22 formally stepping down to OPEL 3 on 11.1.23. There is however an overall upward increase in the numbers going to the UTC via the front door streaming (50.3% v 41.9% in Dec 22) together with the streaming to the SDEC services (2,228 v2,080 Nov 22)

Intervention and Planned Impact

These interventions aim to improve the total wait in ED through the development of direct access pathways:

- Increase opening hours of Medical SDEC at WHH with pathways for direct access to reduce footfall through ED
- Work with system partners to maximise planned complex discharge in advance of planned discharge date to improve timely access to care homes
- Daily pathway zero meetings with key internal stakeholders to improve discharge planning and mitigate delays
- Both sites undertaking fortnightly 1-7 LoS reviews with system partners to understand opportunities to improve flow out of the hospital
- RTS and KCC now providing planned discharges 24 hours before and matrons attending the daily meetings to ensure actions required are completed timely to avoid delays in discharge
- Front Door Frailty service at WHH has 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.
- Mental Health front door pilot is planned to extend to 5 days from Jan 23 following a review of the 2 day pilot undertaken in Nov/December

Risks/Mitigations.

WHH Opel 4 Status led to agreeing a whole hospital response plan with Clinical Leads–aligned with QEQM

- Specialty teams attend the ED/AMU each morning to improve the planning and discharge at the front door
- HCOOP and ED/Acute Medics undertake a daily round of all patients to support discharge at the front door
- Hospital a Home service attends ED daily to identify and move patients into the service
- SEAU agreement to increase direct access to the unit and expand the clinical conditions to reduce waits in ED
- Clinical leads agreed the deployment of junior medical staff to support medical take at the front door to reduce overall waits for decisions

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
2,144	1,940	2,302	1,945	2,076	1,972	2,032	1,793	2,007	1,909	2,080	2,228

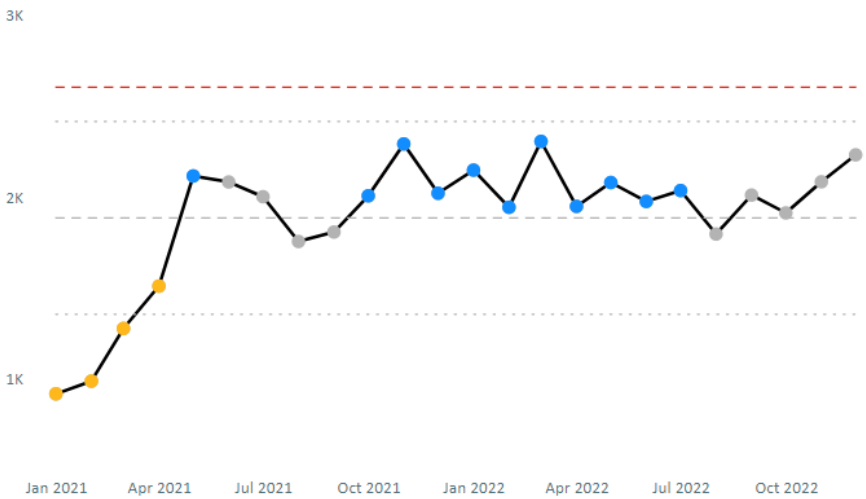
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The SDEC activity across all services saw an increase in the number of attendances in month (2,228 v 2,080 in Nov). This was driven by an increase across both sites in both medical SDEC & gynaecology SDEC on the QEQM site and an increase in Frailty on the WHH site (46 v 6 in Nov). However SEAU at WHH was partially used in November and December to manage the increased inpatient bed requirements (OPEL4) therefore reducing the numbers for SDEC through the unit compared to the previous months (269 v 322 in Aug 22).

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 from community clinicians and acute hospital specialists. Virtual Wards for Respiratory conditions are evolving and will provide further integration, these are planned to come on-line in February 23.
- As part of the workstreams within the Emergency Care Delivery Programme, clinical pathways have been developing in collaboration with the surgical, acute medical and orthopaedic leads to increase the cohort of patients accessing the SDEC services. The work continues to focus on the capacity requirements and accessibility for these services as the clinical leads work towards the clinical model to provide same day emergency care and assessment units across the sites.
- The programme includes the expansion of the Medical Day Unit at the KCH site, to provide an enhanced service for patients requiring this facility for their care, thereby releasing capacity for the expansion of SDEC services on the QEQM/WHH sites to increase the cohort opportunity of patients identified against the Ambulatory Care Conditions
- The roving frailty model at WHH is established with a team of specialists working within ED/AMU with daily monitoring. The activity through this service has seen a marked improvement in December (49 v 6 in Nov) with the intention to re-establish a dedicated front door frailty unit once the ED Build has completed –July 23
- Work continues in exploring potential changes to the hours of the QEQM service to maximise the opportunity for more patients to access the service.
- The creation of 4 'Hot Slots' for referral into SDEC the next day for accessing medical care at the WHH introduced in November 22 has proven successful reducing some patients waiting overnight to access the service. The number of slots increased to 8 in December and will continue to be monitored for use.
- Plans being developed for access to specialty Hot Clinics within the SDEC are being progressed to enable more patients to be seen urgently as an out patient reducing the need for in patient stay.

Risks/Mitigations

- January – specialty wide collaboration event to explore the expansion of clinical pathways into speciality SDEC
- Reducing risk of bedding the SDEC areas to be managed through the Site triumvirates – QEQM focussed work to release space back to Medical SDEC

Our patients

Matt Powls

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
75.6%	71.0%	74.5%	66.1%	61.7%	73.2%	78.0%	71.7%	65.8%	66.6%	70.9%	72.8%

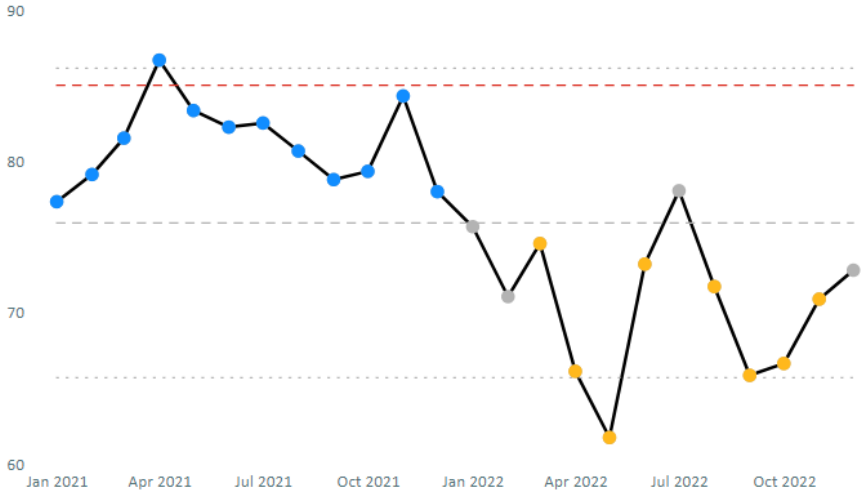
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Performance has improved again in December with a lower number of breaches in month. The Trust remains in the top 3 performers nationally for 2-week wait access.

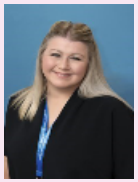
Intervention and Planned Impact

- New daily/weekly escalation that was implemented in November is working, with lead Clinical Nurse Specialist's involved to ensure prioritisation of most vulnerable patients and greater support and guidance.
- There remains a 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. The total number of patients waiting for treatment has reduced, as had the total PTL size (3,511 in Nov v 3,236 in Dec).
- A group, set up in September, with MTW colleagues aims to improve joint understanding of their pressures, benefit working relationships, reduce delays and improve patient experience.
- Endoscopy booking times has improved with 3 x weekly escalation meetings. Lower GI Straight to Test implementation planned for January, but ongoing work and support from CNS team regarding requesting of Colonoscopy/bowel prep. LGI STT nurses undergone PGD and eRS training and continue triage training with the consultants and wider team.
- Kent & Medway ICB agreed at the end of 2022, to support the Cancer Alliance in moving forward a local EUS service. Currently the service is provided by Kings College Hospital but due to capacity our patients can wait up to 3 weeks to have this procedure. The service will be provided across 2 sites DVH & MTW - 4 lists weekly. On completion of the training the service is planned to launch in February. This will reduce delays in the pathway for East Kent patients.
- All roles within CCHH Compliance team being reviewed to support improved learning, standardising practice for all teams, to help improve morale, co-design and share best practice.

Risks/Mitigations

- Delays to diagnostics vetting and booking remains a significant risk but pathway mapping and changes with process being implemented to support improvement.
- Radiological and Histopathological reporting remains a significant contributor to the teams ability to achieving sustainable compliance, again work in progress with CSS to support improved turnaround times.
- Theatre capacity for Specialities within Urology, Head & Neck, Breast and Lower continues to be a risk.
- Tertiary capacity for OPA's, diagnostics and treatments remains challenging, working with the Alliance to support improvements.

Our patients

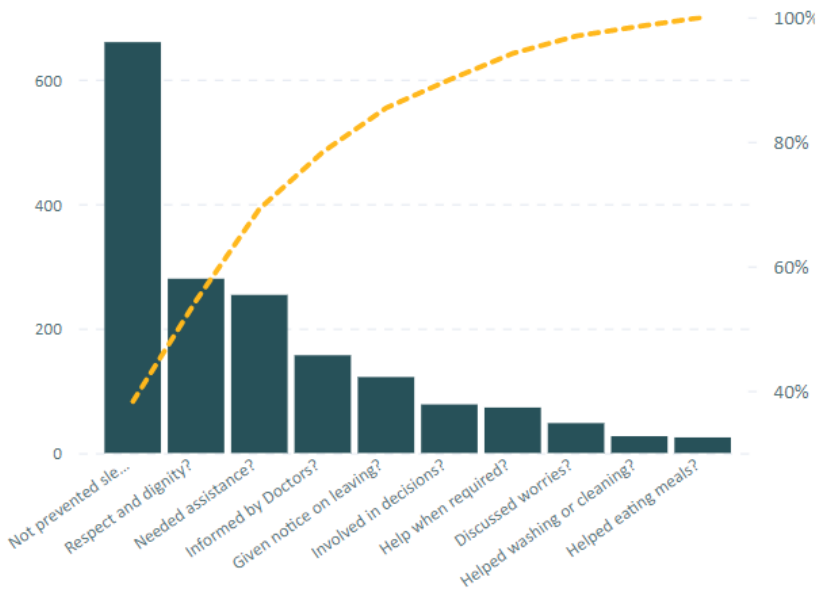


Sarah Shingler

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 - Dec 22



Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
Not prevented sleeping by noise?	1,187	1,847	6.4	7.7	660	38.3%
Respect and dignity?	1,642	1,922	8.5	7.7	280	54.5%
Needed assistance?	1,687	1,941	8.7	7.7	254	69.3%
Informed by Doctors?	1,720	1,877	9.2	7.7	157	78.4%
Given notice on leaving?	1,010	1,132	8.9	7.7	122	85.4%
Involved in decisions?	1,825	1,903	9.6	7.7	78	90.0%
Help when required?	1,848	1,921	9.6	7.7	73	94.2%
Discussed worries?	1,823	1,871	9.7	7.7	48	97.0%
Helped washing or cleaning?	1,557	1,584	9.8	7.7	27	98.5%
Helped eating meals?	1,117	1,142	9.8	7.7	25	100.0%

What the chart tells us
In December, 1,9098 Patient Experience Surveys were completed via Tendable across 52 wards which continues to be on an upward trajectory. Although the target of 2,050 has not been reached, there was an increase in the number of wards completing more than 50 surveys. On average the Trust had an overall score of 89.7% the Trust threshold is 77%. The exception being patients reporting that they had difficulty sleeping at night due to noise from other patients. It is worth noting that the 'No' response for this specific question is a positive, therefore the 64% (6.4) score is reflecting those patients that had a positive experience.

Intervention and Planned Impact
The accreditation team continues to support ward areas who are not currently reaching their target of 50 surveys per month and this is monitored daily for each site in adult and paediatric areas. Children and young people are now also undertaking the survey. There is an expectation that HoNs and DoNs support the wards to complete their surveys and develop actions to address poor responses, reporting monthly to the Nursing, Midwifery and AHP Board. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FoC).

Measures to counteract the noise disturbances at night continue to be raised with the frontline teams, including the provision of earplugs and eye masks for patients and sharing of guidelines for night duty staff, particularly in our escalation areas. Following feedback from Ward Managers and patients four of the ten patient experience questions, have been amended. Patient volunteers and champions will be able to support the quality improvement nurse to support the wards in the completion of the carer and inpatient experience surveys to the target of 50 per month.

There has been a gap identified in this feedback mechanism from non inpatient areas such as ED, outpatients and theatres. Feedback from these areas is currently gained via the national Friends and Family test. This is under review by the patient involvement team, including the governance arrangements around how these are shared at care group level.

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.	Sep-22	Oct-22	Nov-22	Dec-22
Cancer 62d			Cancer 2ww Performance		93.0%	95.7%	95.8%	96.8%	95.8%
	W4		Cancer 28d Performance		75.0%	67.6%	70.5%	68.3%	66.8%
	W4		Radiology Diags vs Plan		Traj.	17.5K	18.5K	18.7K	17.1K
	W4		Endoscopy vs Plan		Traj.	1,310	1,399	1,358	1,085
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	396	344	306	357
	W4		RTT 52w Breaches		Traj.	3,368	3,372	3,379	3,299
	W4		DM01 Compliance		75.0%	64.0%	65.1%	66.8%	60.6%
	W4		RTT OP Booking Breaches		14,000	27.2K	26.9K	26.9K	28.7K
	W4		Elective Admissions vs Plan		Traj.	8,831	8,845	9,295	7,948
ED Compliance	W4		ED Compliance		90.0%	68.1%	68.8%	69.9%	64.7%
	W4		Clinician First Seen within 1h		50.0%	48.4%	45.3%	47.5%	44.4%
	W4		Unplanned Re-attendance ED		10.0%	15.0%	14.0%	12.3%	12.5%
	W4		Super Stranded >21D		107	283	291	295	287
	W4		NEL Admissions vs Plan		Traj.	6,686	6,645	6,731	6,712

Cancer 2ww
Whilst this metric remains compliant with the 93% standard performance has reduced slightly and is now showing 7 data points below the mean of the period resulting in the SPC alert. Performance in January to date is compliant but remains around the 95% mark, the mean for the period is around 97%.

RTT 18 Weeks
The impact of winter pressures in the last two weeks of December has resulted in an increased number of patients breaching 78 weeks and this is evident in the reduced elective admissions. Plans to recover the increased volume of patients are underway. We have seen a positive reduction in the volume of patients breaching 52 weeks and this can be attributed to the increased focus through validating our pathways.
DM01 compliance, due to recued activity and validation, has seen performance deteriorate in month. Improvement work across Radiology, Endoscopy and Cardiology continues, with focus on reducing the request to reporting times for patients on our urgent and cancer pathways.

ED Compliance
Both acute sites reported a decline in the 4 hour timed pathway in Dec (71.6% v 74.7% Nov 22) the deterioration was across both admitted and non-admitted pathways (14.3% v 17.8% Nov and 48% v 55.6% in Nov 22 respectively). There was a direct correlation with the increased numbers of patients waiting for beds in the EDs (76.3 v 59.7 Nov), with WHH reporting the highest spike from 34.3 (Nov) v 51.0 (Dec) with the marked increase in activity for all types (32.4k v 29.9k in Nov, ***the highest reported numbers since Jan 22).*** WHH declared an OPEL 4 on 2.12.22 formally stepping down to OPEL 3 on 11.1.23. There is however an overall upward increase in the numbers going to the UTC via the front door streaming (50.3% v 41.9% in Dec 22) together with the streaming to the SDEC services (2,228 v2,080 Nov 22)

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. Numbers reduced slightly as at the end of December.

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.	Sep-22	Oct-22	Nov-22	Dec-22
FFT	W4		FFT Maternity Response Rate		18.0%	7.7%	16.6%	17.4%	15.5%
	W4		Complaint Response		90.0%	54.0%	20.4%	42.0%	38.3%
	W4		Duty of Candour - Verbal		100.0%	82.6%	78.6%	71.1%	60.6%
	W4		Duty of Candour - Written 15wd		100.0%	55.0%	80.0%	66.7%	58.8%

Duty of Candour DoC

Work has been ongoing to develop the understanding of the requirements of the duty of Candour within the Care Group Governance Teams. The DoC dashboard has also been presented to the Care Groups as part of this work to ensure that they have the tools to facilitate achieving the deadlines. During the months of October, November and December, extra temporary support was available to the department that focused solely on improving the DoC compliance. During these months there was an improvement in the compliance levels of both verbal, written and final report. When looking at the Quality Scorecard it will not show the improvement as this is cumulative data, so as we resolve the historic cases that were previously overdue the data will improve each month that it is pulled.

In order to make improvements in the compliance levels to >95% twice weekly meeting with the DDQG and the Governance Matrons of the key Care Groups that are not compliant that week, (Currently GSM, UEC and WH), have been set up. At that meeting each case is reviewed with the Care Group. This has already made a significant difference as it enables the Care Groups to focus on Duty of Candour regularly and troubleshoot specific issues in the meeting. These meetings will continue until we are able to sustain >95% compliance for more than 3 months then they will be reduced rather than removed.

Complaints

December 2022 has seen a reduction in the number of complaints received which is typical of the holiday period. The Trust continues to struggle to achieve a good level of compliance for complaint responses but has managed to steadily improve the acknowledgment of these complaints within three days. There had been turnover again in the corporate team, and this has now been strengthened with vacancies filled. Further improvements are planned with weekly meetings with each Care Group complaint leads to promote quality and timely submission of draft responses. The DDQG is also currently working with the Complaints Manager to further improve the processes and assure the Trust the new PHSO guidance is in place.

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.

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

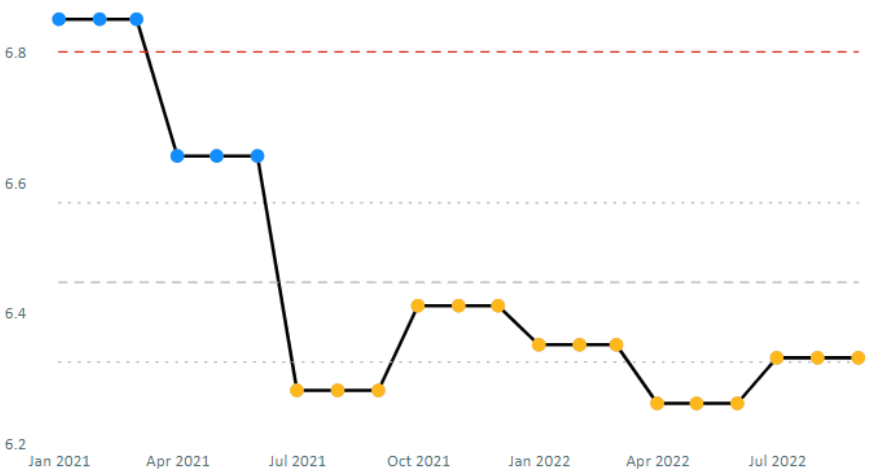
F — Variation indicates consistently falling short of the target

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

Results of the National Staff Survey 2022 are now available, albeit under a strict national embargo. The data cannot be shared publicly, meaning the graph opposite cannot be updated. The narrative below provides an overview and update. Staff Engagement has subtly improved quarter-on-quarter. The small improvement is largely attributable to an improvement in involvement and motivation, two of the domains of engagement. The overall improvement is blunted by a significant reduction in advocacy, the extent to which people would recommend our Trust.

Interventions and Planned Impact

Following publication of the 2022 National Staff Survey results, intensive work has been completed to deliver an evolved version of the NSS dashboard by the end of January. This will allow for more granular exploration of the data to glean intelligence and initiate action at an increased variety of levels. It will allow for tailored interventions to be articulated and initiated.

One of the key learnings from the response to the NSS in 2022 was the positive impact demonstrated across the board in GSM following action plans at Specialty-level. Work is underway to replicate this across all Specialties, led by those areas and supported by the PCBP's. Scoping is currently taking place with our PMO to identify the best means to project manage this throughout the year.

The Trust-level response to the NSS should reflect the positive improvements taking place across both the motivation and involvement domains. The Committee is encouraged to discuss specifically the approach to improving advocacy, and rebuilding the reputation of the organisation.

Risks/Mitigations

Nationally, staff engagement has been on a downward trajectory for each of the last four quarters; from 6.84 (Q3 2021/22) to 6.68 (Q4 2021/22) to 6.64 (Q1 (2022/23) and 6.62 (2023/23).

The Independent Investigation into East Kent Maternity services had a clear impact on staff advocacy, which fell considerably following publication. Work is required to rebuild the reputation of the Trust.

There is a risk that the restructure of the organisation has an impact on the level of engagement with NSS-related Action Plans which typically have previously been led by CG Triumvirates.

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
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

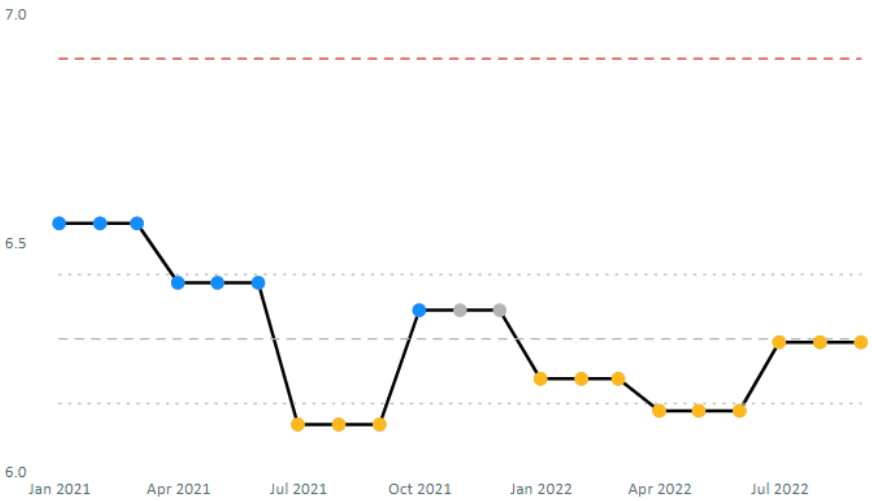
L

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

Staff Involvement has improved significantly both quarter-on-quarter (from Q2 to Q3) and year-on-year (from 2021 to 2022). High-performing bright spots have been identified along with more challenged hotspots. Intensive support will be provided to hotspots and learning will be applied from those performing well.

Intervention and Planned Impact

- 45 areas have now been trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology
- The We Care rollout has been extended and will also include Urology and Cardiology
- Two of the priority areas identified as part of the National Staff Survey 2021 data review (those with the lowest scores for involvement) have completed the KENT Fundamentals programme
- The new staff intranet, Interact, 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 and will be launched to support work following release of 2022 Staff survey results

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 staff morale and may have affect the way colleagues respond overall 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.	Sep-22	Oct-22	Nov-22	Dec-22
Staff Engagement	W4		Appraisals Compliance		80.0%	69.9%	69.8%	69.9%	68.9%
			Statutory Training		91.0%	91.1%	90.2%	90.1%	90.4%
	W4		Safeguarding Children Training		90.0%	87.0%	86.2%	85.5%	84.6%
	W4		Safeguarding Adults Training		90.0%	86.3%	85.0%	84.5%	83.9%
	W4		Staff Turnover: HCA		13.5%	14.3%	13.9%	13.9%	13.6%
			Premature Turnover Rate		25.0%	23.5%	23.6%	25.4%	25.1%
	W4		Medical Job Planning Rate		90.0%	31.5%	33.3%	33.9%	29.1%

Appraisal Compliance

Overall appraisal compliance had been on an upward trend, and plateaued between September and November '22. Compliance dropped to 68.9% in December and the metric remains below the reviewed alerting threshold of 80%. The compliance by Care Group ranges from 88% for Surgery HNBD to 63% for UEC. Corporate areas are the lowest of the groups at 53%.

Care Groups are identifying line managers who have not uploaded appraisals, or have not accessed ESR Self Service to ensure that true appraisal compliance is recorded. The People Manager Dashboard has also been rolled out so that managers can check their compliance directly and identify those who are non-compliant, or soon to be non-compliant.

Statutory Training

Statutory training compliance remains below the threshold of 91% in December, although it increased from the previous month to 90.4%. This continues to be an important 'watch' at monthly Care Group Performance Review Meetings, and will be closely monitored to ensure compliance improves. Compliance ranges from 94% for Clinical Support Services to 83% for Urgent & Emergency Care.

Staff Turnover

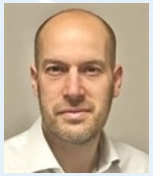
In-month Staff Turnover has been below 10% for three consecutive months. At 7.95% it is the lowest it has been in almost 2 years. This has led to a corresponding reduction in the 12-month rolling average, which has improved across each of the last 3 months and now stands at 10.19%. This is significantly below the desired threshold (11.5%).

In-month HCA turnover has improved by over 9% and currently stands at 8.89%. This is the lowest it has been in over a year (equal with October). When measured as a 12-m rolling average it is now within 0.1% of the desired threshold (13.5%) at 13.6% and has fallen steadily, and by 1.3% since August.

In-month premature turnover stands at 17.80% for December. Recent inflections (34.38% in November) meant the rolling 12-m average exceeded the desired threshold (25%), but improved performance in December has returned this to within 0.1% of the target threshold.

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
-0.090	1.307	0.076	-3.700	-6.624	-6.604	-7.795	-11.453	-13.015	-15.313	-19.323	-24.520

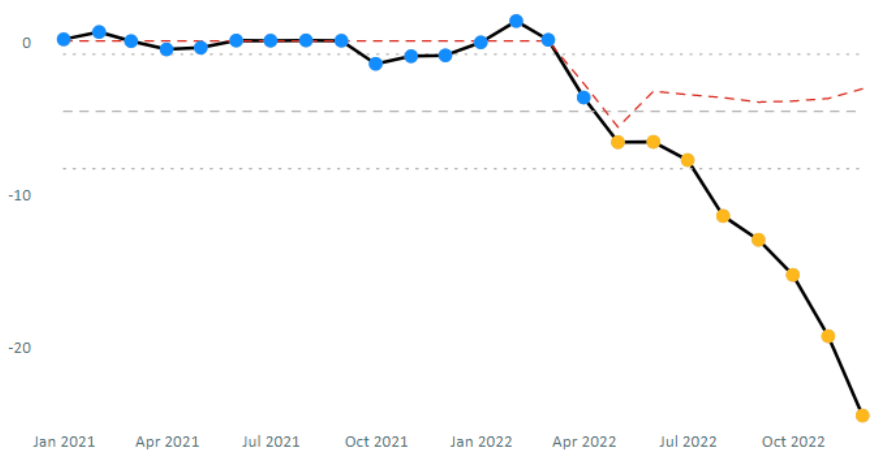
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group
Outside Moving Range Limit
Astronomical Point Descendi...

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 December which is a £24.5 deficit against a plan of £3.1m deficit. The key drivers behind the deficit are: £4.6m behind plan on CIPs, £6.7m on escalation areas (additional 60 beds), £1.8m on metal health staffing, £3.0m other staffing pressures due to demand, overspends on work permits £1.3m, drugs overspend £2.8m and not charging for parking £1.2m. The Trust is currently reforecasting the position to a £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.
- CEO/CFO finance deep dive held in December.
- Increased controls on pay/ non-pay introduced.
- System working to minimise overspends on escalation areas.

Risks/Mitigations

For 2022/23 the key risk and mitigations are:

- Increased usage of escalation areas, Trust working with system partners and increased national investment to reduce usage.
- 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
- 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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
7,168	7,403	9,148	7,890	7,497	8,894	8,702	8,809	9,618	9,178	8,577	8,413

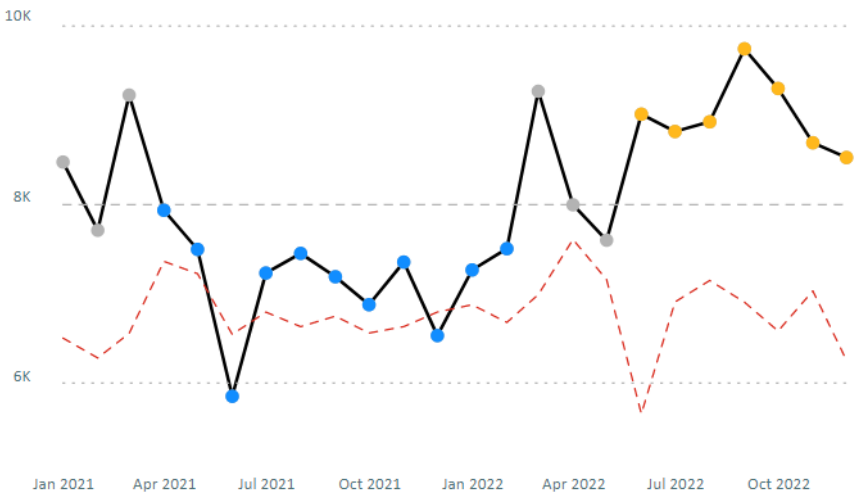
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group

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 December 2022 premium pay spend has decreased by £0.2m. This is the third month in a steady decline in usage.

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.
- 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.
- The increase in escalation beds and the increased need for specialing patients has increased the need for temporary staff?

Our sustainability

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
9.55	7.65	7.97	6.36	6.59	2.43	4.22	4.63	4.11	5.66	5.99	

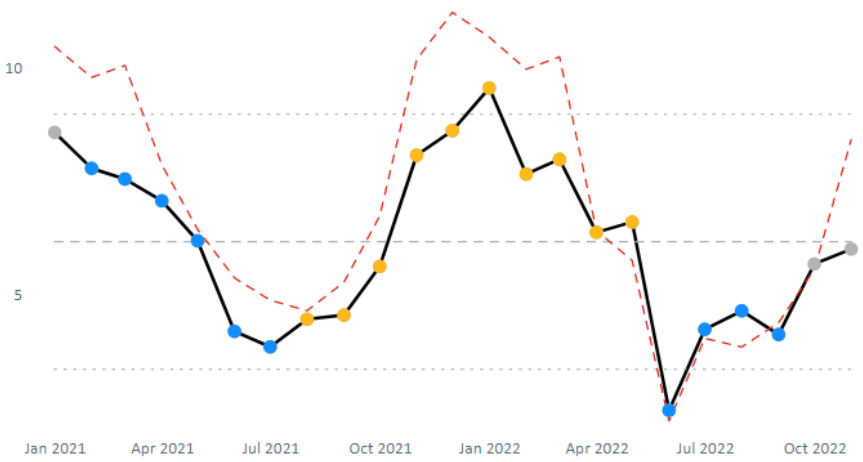
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

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 8.41 at 5.99 kgC02e per m2 and is below the same period last year (which reported at 8.06). 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 early 2023. 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.	Sep-22	Oct-22	Nov-22	Dec-22
Financial Position	W4		Total Pay		0.0%	-6.6%	-6.9%	-7.2%	-7.4%
	W4		Efficiencies YTD Variance (£M)		0.0	-0.6	-1.3	-2.5	-4.6
	W4		Efficiencies FOT Variance (£M)		0.0	-2.7	-3.4	-7.1	-7.7
	W4		Efficiencies Green Schemes		90.0%	53.6%	42.6%	49.3%	48.8%
	W4		I&E Monthly Variance Trust (£)		0	-1.4M	-2.4M	-4.1M	-5.8M
	W4		I&E YTD Variance (£)		0	-8.5M	-11M	-15M	-21M
			I&E FOT Variance (£)		0	0	-30M	-30M	-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 £23m 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: £4.6m behind plan on CIPs, £6.7m on escalation areas (additional 60 beds), £1.8m on metal health staffing, £3.0m other staffing pressures due to demand, overspends on work permits £1.3m, drugs overspend £2.8m and not charging for parking £1.2m. The Trust is currently reforecasting the position to a £30m deficit in year.

Our future


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

Our future

Matt Powls

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
314.3	320.4	336.2	351.1	352.9	354.9	402.6	385.9	358.3	362.2	350.4	354.1

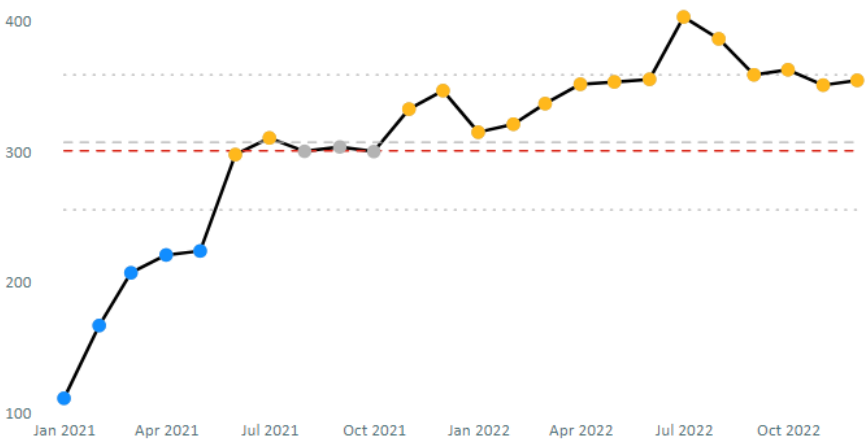
Variation indicates inconsistently passing and falling short of the target

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 number of patients who no longer meet the criteria to reside peaked in the summer at 402 and has consistently trended at the 350-360 throughout the last quarter; this number remains significant. This reported position largely reflects the lack of external capacity to enable patients to be discharged on the correct pathway. This chart should be seen in the context of the Total Time in Emergency Department True North. Patients who cannot leave hospital and are delayed will, in turn, reduce the available beds for emergency admissions from the Emergency Department.

One significant shift the Trust is experiencing is across the longer stay cohort of patients (>21 day LoS). Not only are there more patients residing for more than 21 days (283 Dec-22 vs 153 Dec-21), they are also remaining in acute care for longer periods of time (21+ avg. LoS in Dec-22 was 43.8 days, compared to 34.4 days in Dec-21). This is a key contributor to the deterioration in the health of these patients and also increases the pressure on the Trust's acute flow and services.

Intervention and Planned Impact

In December 22 the East Kent HCP was awarded funding from the Adult Social Care Discharge fund to support the provision of additional enablement ward capacity (up to 30 beds), additional hospice capacity (up to 8 beds) and funding for additional packages of care for the Trust's patients requiring Pathway 1 services.

The utilisation of the funded community capacity started to roll out in late December. The Trust were quickly able to commence the transfer of suitable patients to the first 15 community beds and progress to maximise the use of the available capacity has continued throughout late December/early Jan.

Whilst these schemes will impact flow to a degree, this additional capacity has come at a time of high demand on the Trust services and will likely only mitigate against the additional demand rather than improve the overall position.

Since late December both acute sites have ring-fenced designated ward space for medically fit for discharge patients supported with additional therapy and nursing staffing ensuring patient enablement and minimising patient deterioration. This provides the appropriate specification of care to those medically fit to leave and ensures the Trust's acute physicians can focus their care on acutely unwell patients.

Risks/Mitigations

- Over two-thirds of no longer fit to reside patients required an on-going package of care to leave the Trust.
- Continue the work with colleagues in the community to ensure the Trust fully utilises the additional capacity available and the flow of patients continues through the external facilities.
- QEQM is a pilot site for the Regional Improvement Therapy Hub, with external and internal therapy support provided by the ICB – daily meetings review all Pathway 1 to 3 patients and their on-going care needs.
- Regular pathway 0 meetings held across the acutes sites to ensure the Trust is discharging patients who do not require a package of care, in a safe and timely manner.
- Weekly deep dives have just commenced to assess the Trust's long stay Pathway 3 patients. The scope of this meeting is being broadened to incorporate community colleagues.

Our future

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.

Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
116	91	246	129	162	430	82	161	190	120	124	116

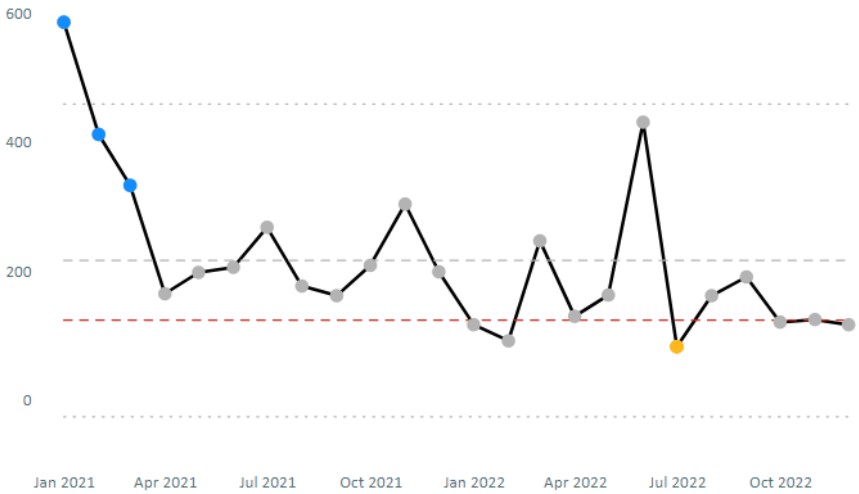
Variation indicates inconsistently passing and falling short of the target

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 December position of 116 participants is slightly below the monthly threshold of 123, as anticipated. However, the April – December cumulative position is 1,504 patients recruited to trials, which is 36% above the year to date trajectory of 1,107. The postal strikes have continued to interrupt recruitment to some studies that require bloods to be sent to sponsors. Despite the slight monthly reduction, there was an increase in recruitment to children's studies with 7 babies being enrolled in the HARMONIE vaccine study and 15 recruited to NeoAMRO – a study looking at Neonatal antimicrobial resistance and outcomes.

Intervention and Planned Impact

- Following a successful Expression of Interest, the Trust has submitted a bid to host the Central Research Network - hosting the Central Research Network would bring significant reputational benefit and status within the region as the 'go to place' for research. The bid is currently being evaluated by the National Institute of Health and Care Research.
- The Kent Medical school visited the Clinical Trials Unit at QEQM in early December for a tour and to discuss future collaboration opportunities.
- The Trust is in the process of designing its first real-world data project using the Trinetx platform (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators) with access to 114 million patient records globally.

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. Discussions continue.
- 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.	Sep-22	Oct-22	Nov-22	Dec-22
Harm Events	W		Falls		Sigma	157	152	145	175
	W		IPC: EColi Infections		10	9	8	10	12
	W		IPC: Klebsiella Infections		6	4	7	4	3
	W		IPC: Pseudomonas Infections		3	2	2	2	2
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	216	186	218	207
	W		Nutrition Incidents		Sigma	60	64	44	52
	W		Pressure Ulcers: Cat 2		Sigma	30	40	28	36
	W		Pressure Ulcers: Cat 3 & 4		Sigma	0	1	1	1
	W		Pressure Ulcers: DTI		Sigma	11	7	9	5
	W		Pressure Ulcers: Unstageable		Sigma	10	15	9	12
	W		Clinical Incidents		Sigma	1,879	2,118	2,204	2,195
	W		IP Spells with 3+ Ward Moves		Sigma	389	446	400	377
	W		Serious Incidents		Sigma	21	23	20	14
	W		Never Events		0	1	0	0	0
	W		Maternity Serious Incidents		2	3	6	1	
Mortality	W		Extended Perinatal Mortality		5.93	4.27	4.44	4.94	4.64

True North Domain	BR	Flag	KPI	SPC	Thres.	Sep-22	Oct-22	Nov-22	Dec-22
Staff Engagement	W		Sickness		5.0%	4.8%	5.6%	4.9%	5.6%
	W		Staff Turnover Rate		11.5%	10.8%	10.5%	10.3%	10.2%
	W		Vacancy Rate		10.0%	12.3%	10.9%	9.7%	9.8%
	W		Staff Turnover: Nursing		10.0%	9.5%	9.7%	9.5%	9.6%
Financial Position	W		Non Pay		0.0%	0.9%	-0.4%	-1.4%	-2.4%

True North Domain	BR	Flag	KPI	SPC	Thres.	Sep-22	Oct-22	Nov-22	Dec-22
Cancer 62d	W		Cancer 31d Performance		96.0%	96.2%	98.1%	98.1%	98.2%
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,616	1,531	1,502	1,580
	W		OPA vs Plan		Traj.	75.3K	75.3K	80.9K	63.2K
ED Compliance	W		A&E Atts vs Plan		Traj.	22.1K	24.1K	24.3K	25.4K
	W		Discharges by Midday		15.0%	15.1%	12.8%	14.6%	15.1%
	W		Pathway 0 Patients >7 Days		Sigma	134	149	140	125
	W		NEL Readmissions		15.0%	9.2%	9.0%	9.1%	10.1%
	W		Stroke Ward within 4 Hours		50.0%	56.0%	63.2%	64.4%	68.8%
FFT	W		FFT IP Response Rate		15.0%	20.9%	19.5%	20.1%	18.2%
	W		FFT DC Response Rate		27.0%	29.5%	29.8%	29.6%	28.3%
	W		FFT ED Response Rate		12.0%	15.1%	14.4%	13.7%	14.0%
	W		FFT OP Response Rate		17.0%	20.5%	19.2%	18.9%	18.5%
	W		Complaints Number		Sigma	71	85	81	63
	W		Mixed Sex Breaches		Sigma	69	108	104	101
	W		Duty of Candour - Findings		100.0%	62.5%	100%	50.0%	100%

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022 1st phase complete 2nd phase April 23	• Analysis of current MicroGuide Content and usage to better understand how the Trust uses this application. • Scoping/planning meetings undertaken with initial specialties for Roll-out, to begin preparations for transition to MicroGuide. • Clinical Guidelines Approval Group (CGAG) Terms of Reference approved by the Patient Safety Committee. • Trust document types (policy, clinical guideline, protocol/procedure) defined in conjunction with the Policy Manager to provide better understanding of terms and requirements.	• Continue working with/supporting initial specialties selected for transition to MicroGuide. • Begin scoping meetings with additional specialties for transition to MicroGuide. • Discuss membership of CGAG at the January Patient Safety Committee and seek their assistance with filling required positions.
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	April 23	• NHSE/I EoLC Getting to outstanding collaborative – project incorporated into the Emergency Care Delivery programme (Same Day Emergency Care SDEC, Break Through Objective. • QEQM SOP agreed and date to go to CEMG. WHH project plan in development. • NHSE/I EoLC Getting to outstanding collaborative – 60 day event 29 November. • ReSPECT – soft launch complete, however across K&M IT functionality and printing issues means comms and formal launch not ready – Judith Banks leading and in close contact with ReSPECT leads in CCG and working group. • Agreement between site nursing leads and pharmacy to trial EoL CD stock in EDs	**Process / System Workstream** • Formally launch beds at QEQM • Develop WHH plan and on-going project development with - monitor the outcomes of using these beds using plan, do study act (improvement tool) as appropriately. **Education workstream** • Review and consider roll-out plan – delayed due to operational pressures **Culture workstream** • Work with Flix production company to develop learning messages and poster campaign to go alongside film. • EoLC story at Dec Trust board
Fractured Neck of Femur	Rebecca Martin	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	April 23	• Both sites continue to meet and talk about the whole pathway. • Great progress was achieved at the WHH for treating hip fractures they achieved 35 patients out of 39 admitted in the 36 hours to theatre which is about 89% compliant.	• Continue to work with hospital teams getting patients to the right ward, getting the patients out of ED as quickly as possible wherever able to do so. • Working on prompt mobilisation at QEQM • Reduce length of stay by focusing on what can be done to get patients directly home with either a care package rather than waiting a rehab bed.

Appendix 2
Completed Trust Priority Improvement Projects

NHS
East Kent
Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
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.	Moved to 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	Moved to 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)	Moved to BAU Oct 22
Safe & Effective Discharge	Rebecca Martin	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Project to become more targeted within the Trust Emergency Care Delivery Group Nov 22
Maternity Ultrasound Booking	Rebecca Martin	All patients will have an Ultrasonography appointment that is linked to their pathway and consultant. To ensure the capacity and staffing is available to meet the demand of the service.	Moved to BAU Nov 22

Appendix 3: Glossary of Terms

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

Appendix 3: Glossary of Terms

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

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.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**BOARD ASSURANCE FRAMEWORK RISK REGISTER**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**GROUP COMPANY SECRETARY**
PAPER AUTHOR:	**RISK MANAGER**
APPENDICES:	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK 27.01.2023**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	This report provides the BoD with updates on and changes to risks on the Board Assurance Framework (BAF) as at 27 January 2023. It also includes an update on Board Committee risk activity during this reporting period.				
Summary of Key Issues:	• **Headline**: There are currently **10 risks on the BAF**. • **New risks:** There have been no new risks added to the BAF in this reporting period. • **Other changes:** Other changes to the risk records are included in the BAF risk register at Appendix 1. • **Quarter Three Performance:** The full quarter three performance data (i.e. October to December) and related commentary is shown on Pages 3 - 5. • **Tracker report:** A new BAF tracker report has been included on page 6 of this report. The tracker report includes the current risk rating for each risk. • **Board Committees:** Risk activity summaries for meetings held in quarter three are included on pages 7-9. This includes the IAGC meeting held on 24 January 2023.				
Key Recommendation(s):	The BoD is asked to **APPROVE** the latest update of the BAF; and discuss whether: • the correct risks are identified on the BAF; • any reports or assurances received in the work of the Board and its Committees impact on the assurance levels in the BAF; • controls, assurance, gaps and actions are appropriate; • any further controls may be required to mitigate the risks identified; • the projected target current risk scores for 2022/23 are appropriate given the actions planned to mitigate the risks; and • it is **assured** that risks on the BAF are being appropriately mitigated.				

East Kent Hospitals University NHS Foundation Trust

	Reassurance		Assurance
	It is okay because management say it is: • Strong management personalities may dominate • Track record of success • Professional background or expertise • No contradictory evidence	It is okay because how management have responded to questions from the Board has given me confidence: • Clear and logical explanations from board members • What has happened; why it has happened and what is the response • Management explanations are consistent	It is okay because I have reviewed various reliable sources of information: • Independence of information source • Evidence of historic progress, outcomes • Triangulation with other information

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

Link to the Board Assurance Framework (BAF):	This paper provides an update on the BAF	
Link to the Corporate Risk Register (CRR):	This paper provides an update on the CRR	
Resource:	N	Resource implications are considered as part of the risks.
Legal and regulatory:	N	Legal and Regulatory implications are considered as part of the risks.
Subsidiary:	N	The Trust has a Subsidiary Shared Risk Register that is monitored at the Contract Performance Meeting.
Assurance Route:		
Previously Considered by:	Corporate Risk Register (CRR) - Clinical Executive Management Group BAF and CRR - Board Committees – People & Culture Committee November 2022, Finance & Performance Committee October and November 2022 meetings, Quality & Safety Committee October and December 2022 meetings; and Integrated Audit & Governance Committee - January 2023.	

East Kent Hospitals University NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK RISK REGISTER

1. Purpose of the report

1.1. This report provides the BoD with an update on and changes to risks on the Board Assurance Framework (BAF) as at 27 January 2023.

2. Board Assurance Framework – key changes

2.1 The BAF contains the principal risks for the Board corporately to assure itself about successful delivery of the organisation's strategic objectives.

2.2 **Key changes** – Since the last report to the IAGC, there have been no key changes to the BAF. Other changes to the risk register have been highlighted in red font in Appendix 1.

2.3 **Quarterly Performance**: The Trust's risk management framework links risks to the Trust's strategic objectives. The BAF will be reported to the Board and its Committees alongside the Integrated Performance Report (IPR) on a quarterly basis.

2.3.1 The IPR forms the summary view of organisational performance against the strategic objectives and looking at the BAF risks in parallel will support the Board in determining whether the risks are appropriately managed, whether the risk appetite is set at the right level and whether further resources are required to control the risk.

2.3.2 The table below provides an aggregated overview of the performance against the True Norths as at quarter 3. The colour coding for "Performance" – "green" majority on-track; "amber" mixture of on-track/not met. Quarter 3 data (i.e. October to December) is shown in the table below:

True Norths		Q3 Performance	Related BAF Risk and Risk Movement	Risk Appetite and Risk Appetite status in bracket	Overall Assurance
Our Patients	Over 12 Hour Wait	Red	BAF 34 (High) =	High (within appetite)	Limited
	18 Weeks	Red			
	Cancer 62 day	Red			
Our People	Staff Engagement	Red	BAF 35 (High) =	Significant (within appetite)	Limited
Our Future	No related True Norths	N/A	BAF 36 (Extreme) =	Significant (within appetite)	Limited
Our Sustainability	I&E Margin	Red	BAF 38 (High) =	High (within appetite)	Limited
Our Quality and Safety	Actual Harm	Red	BAF 32 (High) =	High (within appetite)	Limited
	Mortality	Green	No related BAF risk.		

2.3.3 **Quarter Three Performance/BAF Commentary:**

Our Patients:

- Performance is red for all metrics with plans in place to address it within the IPR.
- The related risk (BAF 34: There is a risk that our constitutional targets are not met) level is high with limited assurance against controls.
- The risk appetite set by Board in relation to the broad heading 'Our Patients' is 'high' and this translates as 'within appetite'. The current risk being within appetite indicates that less management time should be spent mitigating the risk as it falls within the Board's set appetite. This is described as "the Trust has a high appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards."
- If the risk appetite is set at a lower level, this gives the Board the ability to manage up to the risk appetite, giving the Board more flexibility to manage the risks to a tolerable level or to target risk level. The Board may wish to consider a minimal/ low risk appetite for delivery of the constitutional standards when it sets its risk appetite for 2023/24 as this is related to compliance with national standards.
- There is one True North in relation to Our Patients (Patient Experience) with no aligned risks on the BAF. Further work is being undertaken with the Board sub-Committees to refresh the BAF to ensure it captures all the principal risks to delivery of the Trust's strategic objectives (True Norths).

Our People:

- Performance is red for the staff engagement metric with plans in place to address it within the IPR.
- The related risk (BAF 35: There is a risk of failure to recruit and retain high calibre staff) level is high with limited assurance against controls.
- The risk appetite set by Board is significant and this translates as 'within appetite'. This is described as "the Trust has a significant appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
- The current risk being within appetite indicates that less management time should be spent mitigating the risk as it falls within the Board's set appetite.
- If the risk appetite is set at a lower level, this gives the Board the ability to manage up to the risk appetite, giving the Board more flexibility to manage the risks to a tolerable level or to target risk level. The Board may wish to consider a minimal/ low risk appetite for levels of staff engagement when it sets its risk appetite in 2023/24 as this is related to compliance with national standards.

Our Future:

- The two True Norths in relation to Our Future are (i) Not fit to reside (patients/ day) and (ii) Recruitment to Clinical Trials.
- There are no related BAF risks aligned with the metrics in relation to Our Future.
- There are two risks on the BAF which are aligned to 'Our Future':
  – BAF 36: Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC); and

– BAF 30: Failure to deliver the full benefits of the We Care Improvement system.

- These risks may be considered as 'Enablers' to delivering Our Future metrics but do not directly impact on the successful delivery of the Our Future True Norths.
- Further work is being done with the Board sub-Committees to refresh the BAF to ensure it captures all the principal risks to delivery of the Trust's strategic objectives (True Norths).

Our Sustainability:

- Performance is red for the Income & Expenditure (I&E) margin metric. This metric will measure us against our long term aim to maintain a breakeven position.
- The related risk (BAF 38: Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE) current risk level is high with limited overall assurance against controls.
- The risk appetite set by Board in relation to the broad heading 'Our Sustainability' is 'high' and this translates as 'within appetite'. This is described as "the Trust has a high appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.
- The current risk being within appetite indicates that less management time should be spent on mitigating the risk as it falls within the Board's set appetite.
- If the risk appetite is set at a lower level, this gives the Board the ability to manage up to the risk appetite, giving the Board more flexibility to manage the risks to a tolerable level or to target risk level. The Board may wish to consider a more cautious risk appetite for its financial position (I&E margin) when it sets its risk appetite in 2023/24.
- There is one True North in relation to Our Sustainability (Carbon Footprint) with no aligned risks on the BAF. Further work is being done with the Board sub-Committees to refresh the BAF to ensure it captures all the principal risks to delivery of the Trust's strategic objectives (True Norths).

Our Quality and Safety:

- Performance is red against the Actual Harm metric. 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. During the third quarter, we recorded an average of 38 incidents with a severity score of moderate and above which is above the threshold set for 2022/23. Plans in place to achieve this target are within the IPR.
- The mortality data was last released in September 2022. We are currently achieving our ambition for our rolling 12-month Hospital Standardised Mortality Ratio (HSMR) to be below 90 by January 2027.
- The related risk (BAF 32: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered) level is high with limited assurance against controls.
- The risk appetite set by Board is high and this translates as 'within appetite'. This is described as "the Trust has a high appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by

considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards."

- The current risk being within appetite indicates that less management time should be spent mitigating the risk as it falls within the Board's set appetite.
- If the risk appetite is set at a lower level, this gives the Board the ability to manage up to the risk appetite, giving the Board more flexibility to manage the risks to a tolerable level or to target risk level. The Board may wish to consider a more cautious risk appetite for its incidents with harm when it sets its risk appetite in 2023/24.

East Kent Hospitals University NHS Foundation Trust

BAF Risks Movement Tracker:

Strategic Goal	BAF ref.	Risk Title	Movement of the current risk rating within the year												Target risk rating	Projected for 22/23			
			F	M	A	M	J	J	A	S	O	N	D	J		Q1	Q2	Q3	Q4
Our Patients	33	There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	5	10	10	10	5
	34	There is a risk that our constitutional standards are not met	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8	16	12	12	8
Our People	35	There is a risk of failure to recruit and retain high calibre staff	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	10	15	15	15	10
	40	There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals.							12 'N'	12 =	12 =	12 =	12 =	12 =	8		12	12	8
Our Quality and Safety	32	There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5	15	15	15	15
	31	Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5	15	15	15	10
	39	There is a risk that women and their families will not have confidence in east Kent maternity services if the Trust does not respond effectively to the recommended themes of 'Reading the Signals' report								20 'N'	20 =	20 =	20 =	20 =	5		20	20	15
Our Future	36	Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	5	20	20	20	20
	30	Failure to deliver the full benefits of the We Care Improvement system	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	4	12	12	12	12
Our Sustainability	38	Failure to deliver the financial plan of the Trust as requested by NHSE	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5	15	15	10	5

3. Board Committee Risk Activity

3.1 Quality and Safety Committee (Q&SC)

3.1.1 At the meeting on 27 October 2022, the Q&SC approved the latest update of the BAF and CRR in relation to 'Our Patients', 'Our People' and 'Our Quality and Safety' and received assurance that the risks are being appropriately mitigated.

3.1.2 The Committee received the Quarter 2 report that includes performance data. This enabled the Committee to look at the BAF risks in parallel to the related strategic objective.

3.1.3 The Committee noted the Board Strategy Development session in November 2022 will enable the Board to 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.

3.1.4 In relation to the target risk rating for Quarter 2, the Committee noted 1 BAF risk (BAF 24 – Constitutional targets) and 3 risks on the CRR (CRR 122 – midwifery staffing); CRR 110 – paediatric services; and CRR 125 – nutrition and hydration) had not met the projected risk scores. The Committee received assurance of the planned actions for each of the risks.

3.1.5 The Committee queried the existing control in relation to regular walk arounds by the Maternity Safety Champions in respect of BAF 39 (Investigation into East Kent Maternity Services (IIEKMS) risk) and felt this control may not be effective and other key controls needed to be considered. The Committee were re-assured that this risk was being reviewed in light of the IIEKMS report and will be further updated to include key controls to mitigate the risk.

3.1.6 The Committee commented on BAF 31 (infection control risk) and felt the risk needs to be reviewed in the context of C. difficile infections and harm.

3.1.7 At the meeting on 01 December 2022, the Q&SC approved the latest update of the BAF and CRR in relation to 'Our Patients', 'Our People' and 'Our Quality and Safety' and received assurance that the risks are being appropriately mitigated.

3.1.8 The Committee noted the addition of 2 new risks in respect of: 1) investigation of clinical incidents and identification of themes; and ii) current CT and MRI reporting backlog.

3.1.9 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.

3.1.10 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.

3.1.11 The Committee were concerned that all risks presented to the Committee are limited in terms of the overall assurance levels.

3.1.12 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.

3.1.13 The Committee urged the Executive Leads to challenge and reflect on the effectiveness of the actions on the BAF ensuring that they will deliver the outcomes intended.

3.1.14 The Committee noted that the risk report did not reflect the discussions on risks had at the Board Development Day. It was agreed that a discussion will be had with the Trust Risk Manager to take this forward.

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

3.2.1 At the meeting on 25 October 2022, the FPC noted the latest update of the BAF and CRR in relation to 'Our Future' and 'Our Sustainability' and received assurance that the risks are being appropriately mitigated.

3.2.2 The Committee received the Quarter 2 report that includes performance data. This enabled the Committee to look at the BAF risks in parallel to the related strategic objectives.

3.2.3 The Committee noted the Board Strategy Development session in November 2022 will enable the Board to refresh its risk appetite and ensure it is set at the right level.

3.2.4 In relation to the target risk rating for Quarter 2, the Committee noted one risk on the CRR (CRR 34 – health and safety) had not met the projected risk score due to timing of reporting through the governance structure. The risk had been considered by Executive Risk Assurance Group (ERAG) in September 2022 and was being recommended to the Clinical Executive Management Group (CEMG) at the next meeting for a reduction in risk rating to the target risk of 4. The outcome will be reported to the FPC following the CEMG approval.

3.2.5 At the meeting on 29 November 2022, the FPC approved the latest update of the BAF and CRR and received assurance that risks in relation to 'Our Future' and 'Our Sustainability' are being appropriately mitigated.

3.2.6 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.

3.2.7 The Committee felt the risk information in relation to infrastructure (CRR 127: There 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 that 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.

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

3.3.1 At the meeting on 29 November 2022, the P&CC discussed the latest update of the BAF and CRR and received assurance that risks in relation to 'Our People' are being appropriately mitigated.

3.3.2 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.

3.3.3 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.

3.3.4 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) which resulted in the decision to leave the current risk at 20 (Extreme risk).

3.3.5 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.

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

3.4.1 At the meeting on 24 January 2023, the IAGC discussed and noted assurance from the BAF and CRR reports, validation of the data presented following release of the Integrated Performance Report (IPR).

3.4.2 The Committee received assurance of improved alignment to the IPR, future IAGC meeting dates had been amended to ensure these aligned with IPR validated data publication, and monthly meetings are held with Executive Directors to discuss and review risks.

3.4.3 The Committee noted further work to be done on the risk definitions, aggregation and scoring, and the monitoring of control actions by the relevant Executives and Board Committee.

East Kent Hospitals University NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

QUARTER 3 – 2022/2023

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: The True North target is to achieve zero patient safety incidents of moderate and avoidable harm within 5 years. Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years.

Executive Owner: Chief Medical Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: January 2023
Next review scheduled: February 2023
Date risk identified: May 2021

Principal Risk – BAF 32
There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.

Effect: Poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers, financial impact

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
39 - There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS)
Aligned Corporate Risks
117 – Patients may be harmed through poor medicines management due to poor culture towards medicines prescription and administration at ward and department level that may result in patient harm, poor patient experience and increased length of stay (16)
77 – Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services (15)
110 – Children may receive sub-optimal quality of care and poor patient experience within our children's services (15)
36 – Patient outcome, experience and safety may be compromised as a consequence of failure to 1. Identify patients with additional vulnerabilities (adult and children) 2. Assess their needs 3. Plan appropriate care, including relevant safeguarding legislation and local safeguarding policies 4. Mitigate any risks 5. Work in line with relevant legislation (including Children Act, Care Act, Mental Capacity Act, Equalities Act, Mental Health Act) (12)
116 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs (20)
122 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate midwifery staffing levels and skill mix to meet patient's needs (20)
123 - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs (15)
78 – There is a risk of overcrowding in ED due to a lack of capacity in the system and increased local demand
139 – Trust fails to adequately investigate clinical incidents in a timely manner and identify themes in order to action change and avoid future repetition

Emergent Risks/Issues
- Difficult to evidence delivery of improvement workstreams
- Change in focus of We Care objectives
- Staffing levels

Future Opportunities
- Realisation of Safer Staffing Business Case
- We Care Improvement Programme – In Year Breakthrough Objectives
- RSP exit

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Clinical effectiveness structures reviewed by Site Medical Director and Chief Medical Officer, gaps identified and plan put in place to address. Framework is in place. New structures to be embedded to ensure effectiveness. Benchmarking data used in meetings. NICE CAEC meeting focused on patient outcomes. NICE guidance policy due to be presented to the next meeting of NICE CAEC. Review of Patient Safety Committee undertaken, action closed. Report to be presented to CEMG end Jan 23. Care Group governance reports implemented and will be reported to CEMG. Surgery and anaesthetics monthly clinical governance meetings in place with all specialties in attendance. These meetings are minuted and managed by the care group clinical governance team. Policy for clinical guideline governance approved and the terms of reference for the Clinical Guideline Authorisation Group (CGAG) agreed by Patient Safety Committee. A report will be presented to Patient Safety Committee on a quarterly basis following launch of CGAG in April. Paper to be presented to CEMG in February by the Executive Director of Quality Governance. Roll-out of MicroGuide has commenced focusing on palliative care and maternity guidelines initially. Action completion date amended to reflect full roll-out.

Actions (Planned)

Action required and date
1) Review of subsidiary governance and reporting structures and feed into Q&S reporting structures **Group Company Secretary Sep 22**
2a) Review clinical effectiveness structures and meetings **Chief Medical Officer ~~Sep 22~~ ~~Nov 22~~ Feb 23**
2b) Establish effective governance of NICE guidance **Chief Medical Officer ~~Sep 22~~ ~~Dec 22~~ Feb 23**
2c) Roll-out of MicroGuide across specialties **Executive Director of Quality Governance Mar 25**
3a) Provide assurance of effective morbidity and mortality programme within Care Group **Clinical Director, CCHH Dec 22**
3b) Provide assurance of effective morbidity and mortality programme within Care Group **Clinical Director, CSS Dec 22**
3c) Provide assurance of effective morbidity and mortality programme within Care Group **Clinical Director, GSM Dec 22**
3d) Provide assurance of effective morbidity and mortality programme within Care Group **Clinical Director, HNBD Dec 22**
3e) Provide assurance of effective morbidity and mortality programme within Care Group **Clinical Director, UEC Dec 22**
4) Recurrent themes to be presented to the Patient Safety Committee to determine how we engage with Care Groups to address and provide patient safety support **Chief Medical Officer Jun 23**

Controls in place (Existing)

1) The Quality Strategy (2022-2026), approved at Board of Directors (BoD), Sep 22
2) Reduction in harm and reduction in mortality are True North objectives agreed by the Executive team and progress monitored monthly at Executive management Team meetings and reported in the Board Integrated Performance Report (IPR)
3) NHSE led Governance review supported restructure and revised terms of reference for the Q&SC
4) Breakthrough Objectives aligned to True North are monitored at monthly Executive management Team meetings and reported in the Board IPR
5) Monthly performance Review Meetings established to ensure Care Group accountability against the delivery of quality and safety priorities, and to escalate new concerns to driver metric status through Catchball when identified
CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver safe care

Assurances

Internal
1) Approval and monitoring of the Trust Quality Strategy through SLT, Q&SC and BoD.
2) Approval and monitoring of the Trust Quality Strategy, We Care objectives and Trust priority improvement projects through SLT, Q&SC and BoD

External
1) CQC reports monitored by the BoD and action plans developed and monitored by CQC and NHSE

Gaps in controls and assurance

1) Improve oversight of health and safety governance that impacts on patient safety
2) Improve clinical outcomes through internal review, effective use of data and implementation of recommendations from national clinical audits and outcomes, NICE recommendations and Getting it Right First Time (GIRFT)
3) Embedding of morbidity and mortality and outcome reviews

East Kent Hospitals University NHS Foundation Trust

6) Systematic processes in place to review mortality		

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: The True North target is to achieve zero patient safety incidents of moderate and avoidable harm within 5 years. Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years.

Executive Owner: Executive Director of Infection Prevention and Control (DIPC)
Responsible Committee: Quality and Safety Committee

Date last reviewed: January 2023
Next review scheduled: February 2023
Date risk identified: May 2021

Principal Risk – BAF 31
Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements

Effect: Leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	10
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025 (to align with the Journey to Outstanding Care Programme)

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks

Emergent Risks/Issues
- Ongoing Covid-19 pandemic
- Fragility of infrastructure

Future Opportunities
- Plan to increase surveillance through annual plan

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Antimicrobial stewardship summit scheduled for 20 January 2023. Final audit report received with management actions and will be presented to the next Antimicrobial Stewardship Group before being signed off at the Infection Prevention and Control Committee. December Infection Prevention and Control Committee cancelled due to lack of attendance, next meeting to be held in January where revised IPC Committee structure will be presented.

Actions (Planned)

Action required and date
1) Delivery of annual IPC workplan **EDIPC Mar 23**
2) Antimicrobial Stewardship Summit **EDIPC ~~Sep 22 Dec 22~~ Jan 23**
3) Launch revised IPC Committee Structure **EDIPC Apr 23**

Controls in place (Existing)
1) Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS)
2) Compliance with requirements of the "hygiene code" with a plan to address any gaps
3) Collaboration and agreement with 2gether Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning
4) We Care Breakthrough Objective focussed on externally reportable HCAI organisms

Assurances
Internal
1) Formally reportable data are signed off by the CEO are reported monthly to the Quality and Safety Committee and annually, publicly via DIPC Annual Report
2) Infrastructure issues reported via Director of Strategic Development and Capital Planning (reference to strategic goal 4 and statutory compliance)
3) "Hygiene Code" gap analysis report to Quality and Safety Committee
External
1) Data are shared with ICB and are available to NHSE and CQC (automatically)

Gaps in controls and assurance
1) "Hygiene Code" gap analysis identified gaps in compliance and assurance

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STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics.

Executive Owners: Group Company Secretary (CoSec)
Responsible Committee: Quality and Safety Committee

Date last reviewed: November 2022
Next review scheduled: December 2022
Date risk identified: May 2021

Principal Risk – BAF 33
There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.

Effect: Poor delivery and quality and safety of services; failure to meet statutory and regulatory requirements resulting in damage to reputation, regulatory action, harm patients, legal challenge.

Risk Appetite
The Trust has a **HIGH** appetite for risks to improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L2 x S5 = 10
Current Risk Rating: L2 x S5 = 10

Movement of the current risk rating with the year												Projected for 22/23			
D	J	F	M	A	M	J	J	A	S	O	N	Q1	Q2	Q3	Q4
10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	5
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 December 2022

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
39 - There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS)
Aligned Corporate Risks
None

Emergent Risks/ Issues
- Strategies/policies not consistently followed and are not embedded
- Staffing structures may not be adequate to deliver the governance agenda.
- Knowledge and skills gaps identified

Future Opportunities
- CQC Well led review recognising improvements in governance.
- Trust evidencing improvements in the Leadership and Governance domain as part of the exit criteria of the Recovery Support Programme.

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (10) risk. The severity of the risk is scored as extreme (5), due to the potential for patient experience to be unsatisfactory; breaches of statutory duty and subsequent prosecution; adverse publicity undermining public confidence in organisation; inquest/ombudsman inquiry.
The likelihood of the risk is scored as unlikely (2), due to the expectation that the risk is not expected to crystallise due to the controls in place however it is possible it may do so.

Latest Commentary
Risk being reviewed and revised at Integrated Audit and Governance Committee on 24 January 2023.

Actions (Planned)

Action required and date
1) Communicate/train and embed strategies/policies in relation to the governance framework **CoSec/EDQG Jul 22**
2) Ensure the knowledge, qualification and skills in the Care Group governance job descriptions are fit for purpose **COO Jul 22**
3) Recovery Support Programme Action plan to be delivered **Chief Finance Officer (CFO) Dec 22**
4) Develop specific risk management training and roll out across the Trust **Corporate Governance and Risk Consultant ~~Jul~~ Dec 22**
5) Develop integrated governance document to support understanding **CoSec ~~Jul~~ Oct 22**

Controls in place (Existing)
1) Suite of governance policies in place
2) Additional Executive post created, and portfolios split to provide more capacity and expertise. Director of Quality Governance appointed and joined the Trust May 21
3) Organisational structure in place below Executive Level to support the governance agenda
4) Governance Review Action plan in place and agreed with NHSE
5) Terms of reference for various committees and groups approved
6) Risk registers in place, BAF, CRR and Care Group level
7) Incident Management, Complaints Management and Clinical Audit process in place
8) Statutory training in place that includes elements of risk management
9) Other training including incident investigation

Assurances

Internal
1) Policies are presented to PAG and BoD (if required) for ratification. Robust sign off process for policies including via groups and PAG
2) Challenge of BAF and CRR at Board and Board Committees
3) We Care meetings to provide evidence against progress for each metric
4) Calibration and challenge of risks on Care Group, Corporate and Board Assurance Framework (BAF) risk registers at ERAG

External
1) RSM independent audit program (Risk management planned)
2) Regional oversight committees
3) Well-led governance review (NHSE)

Gaps in controls and assurance
1) Strategies/policies not consistently followed and are not embedded
2) Possible gaps in understanding of the breadth of both the clinical and corporate governance agenda
3) Deliver and embed the actions from the Governance Review action plan and agree how outcomes will be measured
4) Gaps in knowledge due to a lack of specific training in risk and governance, for all levels and roles
5) A lack of integrated governance document for the Trust to support understanding

NHS
East Kent Hospitals University
NHS Foundation Trust

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The new national standard is for no more than 2% of patients to spend longer than a total of 12 hours in the emergency department, from arrival until being admitted, transferred or discharged. The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient.

Executive Owners: Chief Operating Officer
Responsible Committee: Quality and Safety Committee

Date last reviewed: December 2022
Next review scheduled: January 2023
Date risk identified: May 2021

Principal Risk – BAF 34
There is a risk that our constitutional ~~targets~~ standards are not met

The fluctuating nature of the Covid-19 pandemic necessitates a localised approach to escalation. When the number of positive patients admitted as emergencies exceeds trigger points for safe, effective cohorting there is a risk that elective care capacity is then compromised.

Effect:
Access for patients who are Covid and non-Covid is governed by the current IPC guidance. Patients who present in the emergency department are subject to point of care testing and the results of this test determine the IPC support required for admission. If ITU capacity is required there is a further risk to patient's elective procedures being cancelled. Patients who are requiring discharge from hospital on complex pathways for example if a nursing or residential placement is required will be delayed awaiting a suitable bed for a patient with a Covid positive status. Patient experience is impacted by cancellation of surgery or procedures by self-isolation prior to procedure. The prioritisation of only cancer or urgent elective care will increase the length of time for patients with routine but important surgery during the Covid surge. Patient experience in the ED is impacted as ED becomes more congested. This is driven by the restricted availability of an inpatient bed or assessment area. There is a financial impact of failing to deliver an elective recovery programme to the level of 19/20 pre-Covid activity. The Trust may remain in RSP if agreed thresholds for improvement aren't reached these include the reduction of very long waiting patients and deliver 110% activity

Risk Appetite
The Trust has a **HIGH** appetite for risks to improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L4 x S4 = 16

Movement of the current risk rating within the year												Projected for 22/23			
J	F	M	A	M	J	J	A	S	O	N	D	Q1	Q2	Q3	Q4
16	16	16	16	16	16	16	16	16	16	16	16	16	12	12	8
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L2 x S4 = 8
Projected Target Date: ~~31 December 2022~~ 31 March 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 78 – Risk of overcrowding in ED compromising patient safety and patient experience due to a lack of capacity in the system and increased local demand

Emergent Risks/ Issues
- ~~Reintroduction of national restriction in future waves of Covid-19~~
- ~~Electives temporarily suspended – patients in lower categories waiting longer~~
- ~~Changing IPC restrictions~~
- ~~The balance of demand and capacity and risk across the health and social care system~~
- ~~Virtual outpatient discharge 25% of the non-admitted patient pathway face to face appointments discharge 35%. There is also an increase in diagnostic requests linked to virtual appointments.~~
- Failure to manage the balance of demand and capacity and risk across the health and social care system
- With patients delayed in the hospital setting and the priority to off-load ambulances, care and treatment of patients is taking place outside an established inpatient and treatment area (escalation areas)
- Continued pressure on emergency department for both admitted and non0admitted patients
- The risk of a combined presence of covid-19 and influenza impacts on both restricted capacity and staff absence
- Cost of living crisis impacts on the health and well-being of vulnerable groups
- Possible industrial action in key health and care support services will have a cumulative impact
- Winter may impact on elective capacity and staff as emergency pressures build
- Capacity of the centralised booking team

Future Opportunities
- Structure services on cold and hot site scenario – allow us to have a clearer access pathway for patients

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the number of patients affected by the risk; potential for increased length of hospital stay; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.

Latest Commentary
Review of outpatient models of care and clinic space including the increase in advice, guidance and patient initiated follow up to release outpatient space. The DNA rate has reduced as part of work of this group from 11 to 7.8%, reviewed weekly through touchpoint meeting, action closed. The number of vacancies in the booking team has reduced from twenty to six. Pipeline in place for new starters and still out to advert. Move from recovery phase to business as usual undertaken, action closed. Formal collaboration with the HCP system partners to support winter planning and health and social care. This is reviewed through the Urgent Care Delivery Board and through winter plan and IPR at Trust Board. All patient escalation areas are assessed using a checklist and support of DoN for relevant hospital site. This includes review of clinical appropriateness of area and appropriate levels of staffing. Trust continues to work with Kent and Medway ICS to Kent wide approach to manage risk which includes mutual aid and escalation processes. Trust has a multi-professional group working with staff side to ensure risks of industrial action are understood and patients are supported. Trust Winter Plan contains specific triggers for elective on our winter services monitored by the Trust Board. Weekly winter planning meeting in place led by Programme Director and Hospital Leadership.

Actions (Planned)

Action required and date
1) Establish a workforce focus group to address the recruitment into the booking team **Programme Manager, Sep 22**
2) Systemwide programme implemented for elective recovery to reduce to zero 52-week breaches **Interim Director for Elective Care, Mar 23**
3) Delivery of Trust Winter Plan **Interim Director for Elective Care, Mar 23**

East Kent Hospitals University NHS Foundation Trust

• Independent sector and insourcing – extend resources and capacity to mitigate any delays • Continued focus on length of stay and new models of care i.e. virtual wards • Manage demand more effectively across the health and social care system to balance risk – cognisant and focused on quality issues around waiting list			
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Kent and Medway System Elective Care Programme Board and A&E Delivery Board provides system wide strategic direction attended by the COO. The A&E Delivery Board is chaired by the Trust CEO.	**Internal** 1) We Care Breakthrough Objective 'Improving theatre capacity' monitored monthly through the Integrated Performance Report presented to the BoD **External** 1) Kent and Medway System Elective Care Programme Board reports to the ICS Partnership Board		1) Delivery of 25% of all patient appointments and 60% of all follow ups to be conducted virtually
2) The Kent and Medway ICS have engaged a Winter Director who will report to the Trust CEO and attend the A&E Delivery Board.			2) Optimisation of additional capacity via ICB
3) ~~Waiting list validation of prioritisation codes by clinicians is at 97%~~ The Trust has established an elective care board that meets monthly and covers a range of workstreams including validation; theatre utilisation; diagnostic support cancer services and clinical harm reviews			3) Number of same day cancellations reducing theatre utilisation
4) Weekly monitoring at the PTL meeting is chaired by the COO. The Trust has weekly monitoring by a touch point meeting covering all RTT waiting list cohorts. It also monitors cancer and diagnostic performance. This meeting is support by ICS and NHSE improvement directors. It is led by the Trust Elective Director and the COO.			4) Waiting list patients exceeding 104 weeks
~~4) Live reporting via the Referral to Treatment (RTT) App is monitored by the Deputy COO for planned care~~			
5) Use of the independent sector and community providers is managed by the ~~Deputy COO~~ Trust Elective Delivery Director for planned care. Capacity is maximised.			
~~6) K&M Systemwide PTL established~~			
~~7) Contracts signed with community providers~~			
6) Trigger tool developed to move elective capacity to K&CH and ICS			
7) Clinical validation of patients needing procedures to reduce cancellation of the day target high risk groups			
8) Weekly meeting with Care Group Directors, COO and Recovery MD for individual case management of very long waiting patients			

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics.

Executive Owners: Chief Nursing and Midwifery Officer (CNMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: November 2022
Next review scheduled: December 2022
Date risk identified: August 2022

Principal Risk – BAF 39
There is a risk that women and their families will not have confidence in east Kent maternity services if ~~sufficient improvements cannot be evidence following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS)~~ the Trust does not respond effectively to the recommended themes of 'Reading the Signals' report

Effect:

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20

Movement of the current risk rating within the year												Projected for 22/23			
D	J	F	M	A	M	J	J	A	S	O	N	Q1	Q2	Q3	Q4
									20	20	20		20	20	15
									'N'	=	=				

Target Risk Rating: L3 x S5 = 5
Projected Target Date:

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities	**Risk and Scoring Commentary**		**Actions (Planned)**
Aligned BAF Risks **32 -** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered **Aligned Corporate Risks**	**Rationale for current risk score** The current risk score is rated as an extreme (20) risk. The severity of the risk is scored as significant (4), due to the Trust facing major difficulties which are likely to undermine its ability to deliver quality services. The likelihood of the risk is scored as almost certain (5), the severity is more likely to occur than not with the current controls in place.	**Latest Commentary** Enquiry line in place, action complete. Webinars underway with further webinars planned for staff across the Trust. Joined up working with Integrated Care Board and regional office in response to plan how we work with families moving forwards. Communications plan presented to Executive Management Team.	**Action required and date** 1) Deliver staff webinars to enable staff to ask questions **CEO Nov 22** 2) Implement robust action plan to ensure staff at all levels are supported and communication channels established including help line 3) Ensure coordinated response to recommendations from the report with external regulators and commissioners 4) Focused listening events taking place to explore staff feelings, reaction to report, readiness to accept findings of report and to make improvements 5) Families meeting with CNMO and CEO 6) Declaring retrospective serious incidents which are externally investigated with family involvement 7) Listening events for the whole Trust 8) Finalise Pillars of Change delivery plan **Dec 22** 9) Implement families case review process **Dec 22**
Emergent Risks/ Issues •			
Future Opportunities •			

East Kent Hospitals University NHS Foundation Trust

			10) Internal audit of effectiveness off MNAG **Feb 23**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Regular open forums for staff with the Care Group and Executive Leadership 2) Regular walk arounds by the Maternity Safety Champions 3) Your Voice Is Heard – 6 week follow up calls after birth 4) Continued representation and reporting from Director of Midwifery and Clinical Director to Trust Board	**Internal** 1) Maternity Improvement Plan monitored by Maternity and Neonatal Assurance Group and reported to the Board of Directors 2) Maternity Dashboard in place 3) Your Voice Is Heard reported to MNAG **External** 1) Maternity and Neonatal Assurance Group has external Maternity Voices Partnership representation, NHSE Improvement Director, Local Maternity and Neonatal System representation		

STRATEGIC GOAL: 3) Our People:
Strategic Objective: Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Executive Owner: Chief People Officer (CPO)
Responsible Committee: People and Culture Committee

Date last reviewed: January 2023
Next review scheduled: February 2023
Date risk identified: February 2016

Principal Risk – BAF 35
There is a risk of failure to recruit and retain high calibre staff

Effect: Negative patient outcomes, reputational damage, ability to deliver services, financial, patient harm, regulatory impact, staff wellbeing

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	10
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L2 x S5 = 10
Projected Target Date: 30 April 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities	**Risk and Scoring Commentary**		**Actions (Planned)**
Aligned BAF Risks **39 -** There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS) **Aligned Corporate Risks** CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace CRR 116 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs CRR 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs	**Rationale for current risk score** The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the potential for non-delivery of key services due to lack of staff or ongoing unsafe staffing levels The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Exploring with NHS Professionals and IT colleagues an application programming interface to deliver a collaborative medical bank approach. Involvement with ICB to explore options to continue with project as deadline will not be met. Meeting in January to determine baseline for 2023/24, anticipated to be 200 additional nurses. East Kent HCP working group continues to meet, EKHUFT hosting a secondment from the ICB to develop further with schools and higher education colleges. A number of workstreams are underway to recruit and retain workforce. New draft recruitment strategy developed, ensuring recruitment strategy aligned with specialty, to be presented to PCC in February for final approval.	**Action required and date** 1a) Development of collaborative medical bank approach across the system **Associate Director, People and Culture Apr 23** 1b) International and domestic nurse and midwifery recruitment pipeline utilisation with cohorts planned throughout 2022 to achieve 493 additional nurses by Mar 2023 **Associate Director, People and Culture Mar 23** 2a) Links with HCP and newly formed Kent and Medway Medical School (KMMS) to develop rotational and joint posts to support medical staff recruitment **Chief Medical Officer Mar 23** 2b) Active involvement in east Kent HCP recruitment and retention strategy **Associate Director, People and Culture ~~ongoing,~~ 30 Apr 2023** 3) Delivery of actions in Rural and Remote Strategy **Associate Medical Director Mar 24** 4) Revamping recruitment strategy focusing on organisational brand and targeted recruitment campaigns **Associate Director, People and Culture Feb 23**
Emergent Risks/ Issues • Do not have the right establishment • Accommodation • Agenda for change pay scales for lower banded staff			
Future Opportunities •			
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) A five-year People Strategy – People at the Heart 2020-2025 has been approved by Trust Board and is monitored via the People and Culture Committee (PCC).	**Internal**		1) Lack of supply of professional qualified staff including AHPs is a national issue

2) Engagement of staff scores are True North measures which are reported and monitored monthly via We Care and Staff Committee	1) Approval and monitoring of the agreed HR KPIs (inc vacancy rate and engagement scores) are monitored via We Care and PRMs and reported at PCC. 2) The People Dashboard has been developed with the aim of demonstrating progress against the key objectives identified in the People Strategy. The Dashboard brings together information in an accessible and co-ordinated format that is reviewed as part of our regular People team processes each month and reported through the People and Culture Committee. 3) Workstreams and project work is monitored via the HR Senior Leads meeting, We Care and reported through PCC to BoD. **External** 1) Review of EKHUFT's People Strategy via NHSE. Benchmarking and links with national People Team. 2) Director of HR and OD part of Future of NHS and OD national programme 3) Trust involvement in Kent and Medway Health and Wellbeing Board and Kent and Medway Recruitment and Retention Board	2) Hard to recruit areas such as Nursing and Consultants have been identified
3) A Recruitment and Retention Strategy with associated plans has been signed off and is monitored via the PCC		
4) A Rural and Coastal Strategy led by the Associate Medical Director has been developed and agreed at Trust Board and is monitored via the PCC		
5) The Director of HR and OD attends ICP workforce groups to align plans and develop other system side opportunities and agendas		
6) A Diversity and Inclusion action plan has been developed and published as part of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and is monitored via the Equality, Diversity and Inclusion (EDI) Steering Group, Staff Committee and reported to PCC		
7) Medical recruitment toolkit launched on 24 September 2021		
8) Developing a positive culture strategic initiative		
9) Refreshed EDI strategy		
10) Launch of cultural programme		
11) Revised People Strategy		
12) Ready to Care Programme in place		
13) Centralised booking team in place		

NHS East Kent Hospitals University

STRATEGIC GOAL: 3) Our People:
Strategic Objective: Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Executive Owner: Chief People Officer (CPO)
Responsible Committee: People and Culture Committee

Date last reviewed: December 2022
Next review scheduled: January 2023
Date risk identified: August 2022

Principal Risk – BAF 40
There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals.

Effect: Staff feel disengaged, discriminated against and excluded in the workplace resulting in a lack of opportunity to progress and meet their full potential; ultimately impacting negatively on patient care

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S4 = 12

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
						12	12	12	12	12	12		12	12	8
						'N'	=	=	=	=	=				

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 31 March 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 118 – Failure to address poor organisational culture
CRR 88 – Failure to support staff health & wellbeing

Emergent Risks/ Issues
- Lack of appreciation and understanding of the experiences of BAME, other under-represented groups and those with a protected characteristic
- Lack of opportunity to fulfil potential
- Lack of equality of opportunity through selection processes
- The Trust's management does not represent the diversity of the workforce

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the number of staff affected by the risk.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
New leadership programme has begun roll out with 20 people in each cohort. Completion date for reciprocal mentoring delayed in recognition of structural changes within the organisation. On track to deliver staff survey action plans by Mar 23, paper to be presented to PCC in January. Reasonable Adjustments policy ready for presentation through governance process. Ensuring EDI is embedded in the recruitment process continues with collaboration from EDI, resourcing and learning and development. New draft recruitment strategy developed, ensuring recruitment strategy aligned with specialty, to be presented to PCC in February for final approval.

Actions (Planned)

Action required and date
1a) Programme for aspiring new leaders **Assistant Director of Organisational Development Mar 23**
1b) Introduce reciprocal mentoring for Exec team ~~**Dec 22 Mar 23**~~ **Aug 23**
2a) Use staff survey results to create tailored plans for specialities **Mar 23**
2b) Review and update Reasonable Adjustments policy **Head of EDI Dec 22**
3a) As a result of pilot in recruitment for diverse panels seeking assurance EDI is embedded in the recruitment process and within recruitment related training to improve staff experience and reduce potential bias in recruitment processes **Head of EDI Mar 23**
3b) Update Recruitment Strategy – ensuring EDI focus

Controls in place (Existing)
1) New senior Head of EDI leading a small EDI team within P&C function working on project work
2) Equality, Diversity and Inclusion Policy, Strategy & action plan in place
3) Equality, Diversity and Inclusion mandatory training renewed three yearly
4) Staff networks in place for BAME, LGBTQ+, Disabilities and Women
5) Culture and Leadership programme – focus on Equity & Inclusion
6) External review in 2021 by Jagtar Singh Associates – informed approved EDI strategy
7) Part of regional programme to de-bias recruitment
8) Established P&C policy group to renew all staff policies to make them accessible for all, with thorough Equality Impact Assessments
9) Exec and NED sponsors for all staff network groups
10) Leadership programme has a focus and 'golden thread' of equality, diversity and inclusion
11) Inclusion and Respect Charter

Assurances

Internal
1) WRES and WDES reviewed and monitored via the EDI Steering Group, Staff Committee and reported to People and Culture Committee

External
1)

Gaps in controls and assurance
1) Lack of EDI awareness in leadership/management population
2) Staff Survey (2021) – staff with Long Term conditions report lack of adjustments in the workplace
3) WRES and WDES data analysis shows BAME and disabled staff less likely to be appointed via a recruitment process
4) Lack of EDI involvement in decision-making in the Trust

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: Develop a clinical strategy for the Trust that addresses key risks faced in terms of **service delivery, workforce and estate condition (backlog and statutory compliance).**

Executive Owner: Chief Strategy Officer
Responsible Committee: Finance and Performance Committee

Date last reviewed: January 2023
Next review scheduled: February 2023
Date risk identified: April 2021

Principal Risk – BAF 36
Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)

Effect: Result in lapses in core clinical standards and patient safety issues, and may affect adherence to estate statutory compliance, increased estate backlog risks this could result in further emergency service moves/restrictions and impact on the Trust's reputation

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 Mar 2032

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 127 – Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance
CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic
CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace
CRR 116 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs
CRR 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour
CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs

Emergent Risks/ Issues
- Reliance on locums
- Risks are increasing due to retirement and covid

Future Opportunities
- Recruitment strategy (BAF 35)
- New hospital programme
- Emergency capital
- Robotic strategy
- Development of medical school

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as catastrophic (5), due to the potential for permanent loss of core services, disruption to facility leading to significant 'knock-on' effect across local health economy and extended service closure.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
No notification received as yet by the Trust regarding the new hospital improvement programme, deadlines amended accordingly. PCBC presented to CEO, internal work remains ongoing.

Actions (Planned)

Action required and date
1a) Trust has put in an expression of interest to join the new hospital improvement programme. Due to be finalised by Autumn 22. **CSO ~~Sep Oct Dec 22 Jan 23~~ Mar 23**
1b) Continue to lobby key stakeholders to maximise success of EOI **CSO ~~Sep Oct Dec 22 Jan 23~~ Mar 23**
1c) Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the east Kent HCP/ICB Partnership Board Strategic Priorities **CEO ~~Sep 22~~ Mar 23**
1d) Continue lobbying NHSE if expression of interest for new hospital improvement programme is not successful **CSO Mar 23**
2a) Implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory for 22/23 **CSO Mar 23**
2b) Prioritise through SIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken by NHSE on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD **CSO Mar 23**

Controls in place (Existing)
1) The Chairman and CEO confirm that the Sustainability and Transformation Partnership (STP)/ICS Partnership Board prioritises and signs off the East Kent Transformation for agreement with NHSE.
2) The Director of Strategic Development and Capital Planning ensure that the PCBC is signed off by the Trust's FPC and BoD.
3) The Director of Strategic Development and Capital Planning ensures that the implementation of the clinical strategy receives oversight from the Joint Development Board, SCP&PC and FPC
4) The Trust's position in terms of statutory compliance is published, reported and reviewed six-monthly by CEMG and the BoD
5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD
6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD
7) Rural and Coastal Recruitment Strategy

Assurances

Internal
1) Approval and monitoring of the Trust framework proposals and workstreams through Strategic Investment Group (SIG), CEMG, JDB, SCP&PC, Q&SC, FPC and BoD (Controls 2 and 3)
2) Minutes of JDB, CEMG, FPC, SIG, SCP&PC Q&SC and BoD (Controls 4,5 and 6)

External
1) Sign off by HCP, ICB and NHSE (Control 1)
2) Stage 2 assurance process passed awaiting allocation of capital (Control 1)

Gaps in controls and assurance
1) Final sign off and approval of capital investment is outstanding from NHSE
2) Gaps and risks relating to backlog and statutory compliance have been identified
3) Unable to consult
4) Risk appetite reduced by regulators. Derogation required from regulators to maintain services
5) Interim capital required to meet the compliance of estate and equipment risks

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics

Executive Owner: Chief Executive Officer
Responsible Committee: Finance and Performance Committee

Date last reviewed: January 2023
Next review scheduled: February 2023
Date risk identified: May 2020

Principal Risk – BAF 30
Failure to deliver the full benefits of the We Care Improvement system

Effect: Improvement plan will fail to deliver, sub-optimal implementation, financial impact, HR impact, reputational risk

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S4 = 12

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S4 = 4
Projected Target Date: 31 March 2026 (due to the four-year delivery plan of the change system)

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
None

Emergent Risks/ Issues
- Change of executive directors

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for the Trust to face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long-term strategy. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Risk reviewed with Site Director, QEQM. Business case for expansion of team is on hold due to changes in organisational structure. Additional action added.

Actions (Planned)

Action required and date
1) Business case to be developed to extend team to meet demand **Head of Transformation ~~Jun Sep 22~~ Jun 23**
2) Review of We Care following delivery of winter plan and how this will change with new care organisations **Head of Transformation Jun 23**

Controls in place (Existing)
1) We Care Improvement Strategy approved by BoDs and implemented across the Trust.
2) SLT leads monthly cycle of the OMS and reports and update progress on implementation
3) Executive led workstreams in place (strategic deployment; OMS Frontline / Management; Leadership behaviours; Transformation and Step Change; Centre of Excellence; and Communications) reporting into SLT.
4) IPR linked into We Care and reports monthly to sub Board Committees and BoDs
5) Monthly PRMs with Care Groups wired in to We Care
6) Intensive Support process agreed for implementation as and when required.

Assurances

Internal
1) Coaching and mentoring in place for Executive Team; Care Groups; and Frontline Teams.
2) Skills matrix agreed for internal Improvement Team, which links to personal objectives

External
1) System has been implemented and proven to work in international healthcare systems (USA, Canada, Iceland) and in similarly complex NHS organisations.
2) VFM review undertaken by NHSE with positive findings reported.
3) Endorsement for the change model from the National Director for Lean Transformation

Gaps in controls and assurance
1) The system may not be sustained due to the size of the organisation and capacity of the transformation team to support

East Kent Hospitals University NHS Foundation Trust

STRATEGIC GOAL: 5) Our Sustainability:
Strategic Objective: Our long term aim is to maintain a breakeven position

Executive Owner: Chief Finance Officer (CFO)
Responsible Committee: Finance and Performance Committee

Date last reviewed: January 2023
Next review scheduled: February 2023
Date risk identified: May 2021

Principal Risk – BAF 38
Failure to deliver the financial plan of the Trust as requested by NHSE

Effect: not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 22/23			
F	M	A	M	J	J	A	S	O	N	D	J	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	15	15	15	10	5
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 30 Apr 2023

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned BAF Risks
39 - There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS)
Aligned Corporate Risks
- Efficiencies delivery
- Elective recovery fund delivery

Emergent Risks/ Issues
- Efficiencies delivery
- Elective recovery fund delivery
- Inflation

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as catastrophic (5), due to the financial impact being at least £5million non-recurrent or at least £10million over 3 years.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
A further £7million of efficiencies to be identified before the end of the financial year. Work underway to develop efficiencies plan for 2023/34. Procurement developing a summary of impact of inflation to be presented to FPC in March. Recommendation to be made to ERAG in Jan 23 to increase risk rating to an extreme (20).

Actions (Planned)

Action required and date
1) Care Groups to identify gap in efficiencies targets and turn identified efficiencies to green **CFO ~~Oct 22~~ Mar 23**
2) Develop efficiencies plan for 2023/24 **Head of PMO ~~Dec 22~~ Mar 23**
3) Summary of impact of inflation to be presented to Finance and Performance Committee **CFO Mar 23**

Controls in place (Existing)

1) There is a first half year financial plan in place which will be presented at BoD on 27 May 21.
2) The Director of Finance is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance and Investment Oversight Group, Performance Meetings with Care Groups and Directors
3) Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis
4) Other controls in place; annual business planning process, annual cost improvement programme developed, weekly activity review group in place.
5) Approved funding regime with Kent and Medway with a shared target across the Kent and Medway system.
6) Trust developed medium-term and long-term financial plans in conjunction with NHSE and Kent and Medway ICS

Assurances

Internal
1) The plan and monthly performance are monitored and minuted at monthly performance meetings with care groups, with the Finance and Performance Committee and the Trust Board

External
1) The financial performance of the Trust is monitored by NHSE through a monthly return. This is approved by the Director of Finance. In addition, the Trust has a monthly oversight meeting with the regional NHSE team to discuss financial performance (amongst other agenda items).

Gaps in controls and assurance

1) The Trust is likely to remain in Recovery Support Programme ~~financial special measures (FSM)~~ until a balanced longer-term plan is developed

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**FORECAST UPDATE ON EKHUFT 22-23 FORECAST POSITION AND ASSESSMENT OF FURTHER FINANCIAL RISKS**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHIEF FINANCE OFFICER (CFO)**
PAPER AUTHOR:	**DEPUTY CHIEF FINANCE OFFICER**
APPENDICES:	**NONE**

Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	To update the Trust Board on the 2022/23 forecast position and to seek approval to revise the Trust's forecast position.				
Summary of Key Issues:	The Trust has a financial plan to deliver breakeven this year. The financial position has been deteriorating throughout the year due to a number of known financial pressures. The Trust is suffering in year costs driven by high vacancy and sickness plus the opening of additional escalation areas and increasing departments working hours to cope with the patient demand and flow through the organisation. This paper sets out the factors hindering the Trust hitting its original and stretched plan and a revised proposed forecast for approval for national submission in line with the reforecasting protocol. Based on the current trajectory the Group Income & Expenditure (I&E) forecast deficit is expected to be at £30m achieved by significant and stretching mitigating factors, most of which are non-recurrent benefits in 2022/23. A number of cost control measures have been adopted by the Trust to also minimise the forecast variance in year. As previously reported the new protocol details a number of conditions that Providers and/or Integrated Care Board's (ICB's) have to achieve that will be applied if the protocol is enacted and the Trust and ICB require a reforecast. The most notable condition is for us is 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. The process is approval at Executive Management Team (EMT) then Clinical Executive Management Group (CEMG) and finally by the CFO. This is the required process by the ICB. When any request has followed that protocol it will then be sent to the ICB for approval. If the investment is above £100,000, regional approval is also required.				

East Kent Hospitals University NHS Foundation Trust

	This paper also includes an update on the Kent and Medway system financial position and forecast. Currently at M9 there is a £53.8m deficit across the County with a forecast of £35m deficit.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** and to **APPROVE** the Trust's revised forecast and to reforecast in line with Kent and Medway Integrated Care Board and national protocol for changes to in-year revenue forecasts.				
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 38:** Failure to deliver the financial breakeven position of the Trust as requested by NHSE/I may result in the Trust not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.				
Link to the Corporate Risk Register (CRR):	None				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	Finance and Performance Committee (FPC) 31 January 2023				

East Kent Hospitals University NHS Foundation Trust

FORECAST UPDATE ON EKHUFT 2022/23 FORECAST POSITION AND ASSESSMENT OF FURTHER FINANCIAL RISKS

1. Introduction

1.1 The purpose of this report is to provide the Board with an update on the Trust's I&E forecast position for 2022/23 and to agree recommendations to advise the Kent and Medway Integrated Care Board for the Trust's request to revise its forecast outturn.

2. Background

2.1 The Finance Team have conducted reviews on the expected financial outturn for 2022/23 against an over-arching breakeven plan and an assumed £30m efficiency target.

2.2 To date NHS England (NHSE) have set an expectation that no provider should move their forecast without having had a system discussion to consider the wider system position and options/implications. Accordingly, the Trust has reported a breakeven forecast both via the external Performance Finance Report (PFR) and to the Kent and Medway Integrated Care Board (ICB).

2.3 As at month 9, the consolidated year to date actual deficit of the Trust is £24.5m which is £21.4m adverse to plan and current run rates clearly demonstrate this is unlikely to improve over the remaining months of the year due to the significant pressures on the Trust for increased escalation areas, additional mental health nursing requirements and non-delivery of the efficiency programme.

3. Forecast update

3.1 The Finance Team have reviewed the progress of the Trust's financial delivery to date and have produced a technically adjusted forecast outturn of £30m, after considering known mitigations to support. The forecast has been discussed at length and has been agreed with the ICB and the reginal team.

3.2 To achieve the forecast £30m all potential mitigation from non-recurrent items has been utilised to minimise the forecast in line with the national requirements. Any region not able to achieve the required reforecast will potentially have a reduced level of capital allocation in 2023/24 and potentially a reduce allocation in 2024/25.

3.3 Opportunities to mitigate the financial pressures in 2022/23 are limited. Efficiencies remain under pressure to achieve the current £30m target. Options continue to be explored for either non-recurrent or recurrent schemes but these are very unlikely to give any additional headroom to address the bottom line forecast position.

Forecast High-level Breakdown	£0m
Unfunded escalation beds	12.0
1:1 Specialing inc Mental Health	4.9
Efficiency underperformance	10.0
Other Premium Pay / Site Pressures	6.4
Income Shortfall (Car Parking)	1.6
Drugs	4.7
Work Permits	1.8
Non Recurrent Benefits	-11.4
	30.0

3.4 Discussions are on going with the ICB regarding the allocation of any additional winter pressures at will fund projects that are currently underway and within the forecast. Additional income for the increased level of mental health nursing being provided by the Trust.

3.5 Additional reviews of the Group's balance sheet are continually underway to reduce spend in year. A non-clinical vacancy control panel has been created and the CFO & Chief People Officer (CPO) review any post which is non-clinical. A stop in 2022/23 has been put onto all corporate posts. Additional reviews for pay enhancements i.e. recruitment and retention payments etc. is underway.

3.6 Further work is being undertaken with 2gether Support Solutions (2gether) to understand the feasibility of tighter non-pay controls on non-clinical items. This work will be on-going.

4. Protocol for changes to in-year financial forecast

4.1 The protocol released to NHS organisations on the 7 November 2022 details the process for an organisation to revise their financial forecast. Revisions to forecast outturns can be made at month end at any point in the year but only in line with the protocol. The system and regional teams should be fully involved and kept informed of the process in advance of any change.

4.2 The protocol process must be started again for any further changes. A subsequent deterioration in financial position may also be viewed as lack of financial control, depending on the circumstances.

4.3 Changes would not be expected in the early months of the year given that this follows closely after the planning process. Changes in the final quarter will be looked on as a sign of very poor financial control likely to attract further scrutiny.

4.4 As soon as a system becomes aware of issues that may require this protocol to be followed, the regional team should be contacted and a timeframe for this process agreed. The timeframe must allow for completion of all of the actions set out above, and fit with the monthly reporting timetable.

4.5 Immediately prior to the change of financial position being submitted through the monthly reporting process, each relevant organisation must submit to the

system a board assurance statement (BAS) signed by the chair, chief executive, chief financial officer, and a non-executive director such as the finance committee chair. Protocol for changes to in-year revenue financial forecast to confirm adherence to this protocol and their commitment to the delivery of the recovery plan.

4.6 Where the system is to report a change of financial position, a report must be submitted to the NHSE regional team setting out how the conditions set out above have been complied with.

4.7 Provider conditions. Implement a double-lock sign-off process for any revenue investments above £50,000 with sign-off required by the provider and the ICB.

4.8 Complete a workforce review to describe changes in headcount which covers as a minimum:

- Movement in substantive/bank/agency Whole Time Equivalents (WTEs) and cost from Q4 2019/20 by workforce type and service;
- Sets out key controls over workforce currently in place and any to be introduced;
- Sets out key risks to workforce (e.g., sickness rates, vacancy hot-spots) and actions to mitigate these;
- Process for the sign-off of bank staff, and extent of embedding the same controls as agency staff;
- Self-certified monitoring of agency usage by Providers' Boards, and compliance with usage and rate limits.

4.9 Additional financial and other reporting requirements may be imposed on the provider by the system, including progress with efficiency plans and recovery actions.

4.10 The completed Healthcare Financial Management Association (HFMA) checklist internal audit report to be shared with NHSE regional team for review and follow up. This has already been undertaken by the Trust and audited. The outcome was that of the 72 questions asked in the assessment our internal auditors found 70 instances where the reasoning was adequately supported by evidence. Of the 72 questions asked, we rated ourselves good or above in 77.8% (56 questions). The Trust has two self-assessment findings.

5. Conclusion

5.1 Current income and expenditure performance will not deliver the breakeven plan in 2022/23. This paper is requesting the committee to approve, in line with the protocol requirements to amend the Forecast for 2022/23 to £30m deficit.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**MONTH 9 FINANCE REPORT**
MEETING DATE:	**9 FEBRUARY 2023**
BOARD SPONSOR:	**CHIEF FINANCE OFFICER (CFO)**
PAPER AUTHOR:	**DIRECTOR OF CONTRACTING, COMMISSIONING AND COSTING**
APPENDICES:	**APPENDIX 1: M9 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 Group achieved a £5.2m deficit in December, which brought the year-to-date (YTD) position to a £24.5m deficit which is £21.4m 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 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.

Group Position

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	70,669	71,204	535	634,882	647,383	12,501
EKHUFT Employee Expenses	(42,596)	(46,458)	(3,862)	(383,969)	(412,316)	(28,347)
EKHUFT Non-Employee Expenses	(27,587)	(30,068)	(2,481)	(255,432)	(260,476)	(5,044)
EKHUFT Financial Position	**486**	**(5,323)**	**(5,809)**	**(4,518)**	**(25,409)**	**(20,890)**
Spencer Performance After Tax	(15)	(79)	(63)	129	158	29
2gether Performance After Tax	100	145	45	897	1,112	215
Rephasing/Sub IFRS16 Adjustment	56	(22)	(78)	305	(34)	(339)
Consolidated I&E Position (pre Technical adjs)	**626**	**(5,278)**	**(5,905)**	**(3,187)**	**(24,172)**	**(20,986)**
Technical Adjustments	6	81	75	57	(348)	(405)
Consolidated I&E Position (incl adjs)	**632**	**(5,197)**	**(5,830)**	**(3,130)**	**(24,520)**	**(21,391)**

The key drivers to the YTD deficit are:

- Escalation Areas opened of around 60 beds across the Trust due to patient demand and flow £6.7m.
- Cost Improvement Programme (CIP) Slippage £4.6m.
- Drugs £2.8m.
- Premium pay around the organisation £3m.

East Kent Hospitals University NHS Foundation Trust

	• 1.1 speciality/mental health £1.8m. • Work permits £1.3m. • Parking income £1.2m. 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 March as it is expected that activity shortfalls for the full year are underwritten by national funding which has recently been announced. **The Trust is now forecasting a deficit of £30m for year end and is currently formally agreeing this with the Integrated Care Board (ICB) & NHS England (NHSE).** The Group cash balance (including subsidiaries) at the end of December was £40.7m which was a £1.7m decrease from November and is above plan by £1m. Total capital expenditure at the end of December was £23.7m against an £21.6m 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 £1.4m in December which is £2.0m below plan bringing the year-to-date position to £4.6m below the plan of £18.4m. 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 asked to review and **NOTE** the financial performance and actions being taken to address issues of concern. To **NOTE** the reforecasting of the financial position to a £30m deficit.

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 NHSE.			
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2022/23 efficiencies target equating to £30m. **CRR 136**: Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline.			
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			

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Finance Performance Report 2022/23

December 2022

Chief Finance Officer
Philip Cave

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Month 09 (December) 2022/23

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Executive Summary
Month 09 (December) 2022/23

Executive Summary

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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 £22m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing the overall plan to a breakeven position.

Delivery of this breakeven 2022/23 financial plan was extremely challenging as it requires that the Trust:
Delivers £30m of efficiency savings.
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Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.

Group Position

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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 March as it is expected that activity shortfalls for the full year are underwritten by national funding which has recently been announced.
The Trust is now forecasting a deficit of £30m for year end and is currently formally agreeing this with the ICB & NHSE.

Income and Expenditure R

The key drivers to the YTD deficit are:

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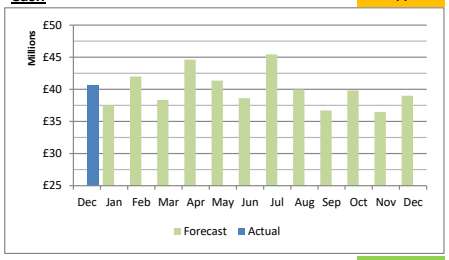
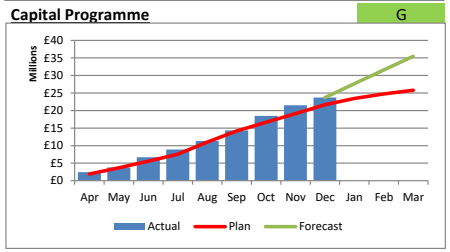
- CIP Slippage £4.6m
- Drugs £2.8m
- Premium pay around the organisation £3m
- 1.1 speciality/mental health £1.8m
- Work permits £1.3m
- Parking income £1.2m

Cash A



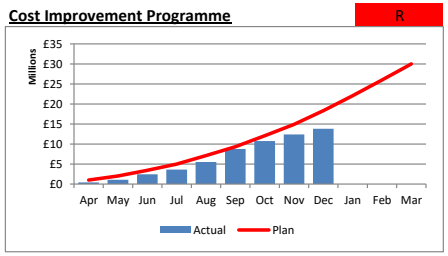
The Group cash balance (including subsidiaries) at the end of December was £40.7m which was a £1.7m decrease from November and is above plan by £1m

Capital Programme G



Total capital expenditure at the end of December was £23.7m against an £21.6m 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 £1.4m in December which is £2.0m below plan bringing the year-to-date position to £4.6m below the plan of £18.4m. 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 09 (December) 2022/23

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	8,749	7,830	(919)	80,653	74,308	(6,345)
Non-Electives	20,034	16,491	(3,543)	179,976	159,803	(20,173)
Accident and Emergency	3,449	4,129	680	34,535	34,848	313
Outpatients	9,144	8,124	(1,020)	86,318	79,376	(6,942)
High Cost Drugs	3,869	4,752	883	34,818	39,092	4,274
Private Patients	23	14	(10)	209	120	(90)
Other NHS Clinical Income	20,329	26,030	5,701	173,863	216,647	42,784
Other Clinical Income	115	127	13	1,031	1,192	161
Total Income from Patient Care Activities	**65,711**	**67,497**	**1,786**	**591,403**	**605,386**	**13,983**
Other Operating Income	4,958	3,707	(1,251)	43,479	41,997	(1,482)
Total Income	**70,669**	**71,204**	**535**	**634,882**	**647,383**	**12,501**
Expenditure						
Substantive Staff	(38,277)	(39,763)	(1,486)	(339,155)	(350,953)	(11,798)
Bank	(2,083)	(3,270)	(1,187)	(22,304)	(29,203)	(6,899)
Agency	(2,236)	(3,425)	(1,189)	(22,509)	(32,160)	(9,651)
Total Employee Expenses	**(42,596)**	**(46,458)**	**(3,862)**	**(383,969)**	**(412,316)**	**(28,347)**
Other Operating Expenses	(26,648)	(29,321)	(2,673)	(247,509)	(253,342)	(5,834)
Total Operating Expenditure	**(69,243)**	**(75,779)**	**(6,535)**	**(631,477)**	**(665,658)**	**(34,181)**
Non Operating Expenses	(939)	(747)	192	(7,923)	(7,134)	789
Income and Expenditure Surplus/(Deficit)	**486**	**(5,323)**	**(5,809)**	**(4,518)**	**(25,409)**	**(20,890)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	67,165	68,513	1,348	604,125	616,388	12,263
Other Operating Income	4,501	3,330	(1,171)	39,136	40,415	1,279
Total Income	**71,666**	**71,843**	**177**	**643,261**	**656,803**	**13,542**
Expenditure						-
Employee Expenses	(45,831)	(50,060)	(4,229)	(413,127)	(445,927)	(32,800)
Other Operating Expenses	(24,239)	(26,317)	(2,078)	(225,115)	(227,687)	(2,572)
Total Expenditure	**(70,070)**	**(76,377)**	**(6,307)**	**(638,242)**	**(673,614)**	**(35,372)**
Non-Operating Expenses	(970)	(744)	226	(8,206)	(7,361)	845
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**626**	**(5,278)**	**(5,904)**	**(3,187)**	**(24,172)**	**(20,985)**

Income from Patient Care Activities

In month the Trust saw an overperformance against plan of £1.8m (£14.0m YTD).

Other NHS Clinical Income over performed in month by £5.7m (£42.8m YTD). This is made up of:

- £1.0m of additional funding to cover the cost of the pay award (£9.1m YTD).
- £0.2m under performance due to unfunded service developments inherent in our plan (£1.6m YTD)
- £0.6m over performance on high cost drugs and devices (£3.5m YTD)
- £3.9m of contract income in excess of the activity performance (£28.6m YTD).

Rechargeable drugs over performed by £0.8m in month, with matching expenditure resulting in no impact on the overall financial bottom line. Additional funding of £0.2m is being received each month from October to fund the new telephone service run by the UTC and commissioned by K&M ICB

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.

As per national guidance, the current income position assumes no clawback for underperformance against the 104% Elective Recovery year-end target in either H1, or presently for H2.

Other Operating Income and Expenditure

Other operating income is adverse to plan in December by £1.3m and adverse to plan by £1.5m YTD. The main driver for the variance in month is reversal of the provision for recovery of VAT on the sale of stock for £0.8m pending formal confirmation. Below plan income for Covid-19 and parking charges total £0.4m in month. YTD, parking charges, property rental, research and innovation income and adverse variances resulting from plan changes in June total £2.8m. These adverse variances are offset by donated income including Harmonia Village of £0.9m, and above plan income for education and training £0.6m.

Total operating expenditure is adverse to plan in December by £6.5m and by £34.2m YTD.

Employee expenses performance is adverse to plan in December by £3.9m and by £28.3m YTD (7.4%) of which £0.6m and £7.1m respectively relates to the above plan pay award. Indicative direct costs for escalation beds continue to be at least £0.8m in month and £6.4m YTD, and 1:1 specialing costs are at least £0.6m and £4.5m YTD.

Other operating expenditure is adverse to plan by £2.7m in December and by £5.8m YTD (2.3%). The in-month variance is driven mainly by above plan spend on drugs of £1.2m and the Operated Healthcare Facility which is adverse to plan by £0.9m which is inclusive of the subsidiary pay award and unconfirmed CCN baseline uplift assumptions.

Other operating expenditure was £29.3m in December, a reduction of £0.1m when compared to November. Drug spend increased by £0.5m and business rates increased by £0.6m following receipt of rebates in November. These increases are offset by reduced spend on clinical supplies of £0.9m, mainly pathology reagents, radiological scanning and reporting services and ICDs and cardiac consumables, and legal costs which are showing a reduction of £0.3m following provisions made in November.

Income and Expenditure Summary

Month 09 (December) 2022/23

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
General and Specialist Medicine	3,470	2,121	(1,349)	31,000	23,894	(7,106)
Urgent and Emergency Care	1,984	1,010	(974)	19,752	13,276	(6,476)
Surgery and Anaesthetics	111	(1,575)	(1,686)	(681)	(7,874)	(7,193)
Surgery - Head and Neck, Breast Surgery and Dermatology	1,817	1,687	(131)	16,226	15,950	(275)
Clinical Support Services	(5,187)	(5,823)	(636)	(44,356)	(46,669)	(2,313)
Cancer Services	659	505	(154)	8,321	7,801	(520)
Child Health	(26)	(208)	(182)	(347)	(854)	(507)
Women's Health	401	193	(208)	4,744	3,862	(882)
Strategic Development and Capital Planning	(6,183)	(6,055)	128	(60,195)	(57,985)	2,210
Corporate	(4,296)	(4,157)	140	(39,619)	(41,308)	(1,689)
2gether Support Solutions	100	145	45	897	1,112	215
Spencer Private Hospitals	(15)	(79)	(64)	129	158	29

General and Specialist Medicine

December pay is £0.9m adverse to plan, and £5.7m adverse YTD. Staff in post have increased by 180 since April. Premium pay reduced by £0.3m to £2.6m, partly due to unfilled shifts and gaps in medical agency.

The key drivers to the financial position are:

- Escalation beds (ave 70) £0.5m December, £2.6m YTD
- 1:1 specials including mental health £0.3m December, £2.2m YTD
- Medical costs of escalation beds, outliers and additional site activity £0.2m December, £1.5m YTD

Premium pay costs are also being incurred due to the extended supernumerary period of IENs which is driven by OSCE delays and unforeseen training requirements.

Non-pay is £1.5m adverse YTD relating to efficiency shortfall and drugs overspend.

Urgent and Emergency Care

A summary of the main drivers behind the in month and YTD adverse £6.5M YTD adverse position is detailed below:

- Expansion of unfunded areas at the WHH and QEQMH sites; an estimated 64 additional beds are in use across the service;
- A growth in junior and middle grade doctor acute ward cover to meet increasing demand;
- Mental health agency nursing/bank costs to support an increase in patient attendances;
- Drugs and clinical supply overspends associated with additional activity and patients spending longer lengths of time in Care Group departments;
- Cleaning/catering/security charges associated with activity growth, escalation areas and Emergency Department expansion;
- UTC charges from Alliance Partners (charges/accruals are now under review)

The combined estimate of these budgetary pressures is £6.9m YTD. The savings shortfall is £1.1m YTD.

Surgery and Anaesthetics

Pay was £0.8m overspent in MTH and £4.8m YTD. Higher premium pay costs in relation to Bank £2.6m & Agency £1.1m staffing overspends are partly from covering Nursing & Medical vacancies, but also additional staffing requirements for escalation beds £0.4m, specialing care £0.8m, supernumerary overseas nursing £1.0m and theatres £1.2m.

Non-Pay was £0.9m overspent in MTH and £2.6m YTD, with unmet CIPs of £1.6m and increased prosthesis £0.7m and drugs costs £0.4m.

Surgery - Head and Neck, Breast Surgery and Dermatology

Non-pay costs were overspent by £0.1m in month and £0.5m YTD from underachievement of CIP target, although this has been partially met non-recurrently from Pay vacancies.

Substantive staffing is £0.7m underspent YTD, which is partially offset with overspends on agency £0.4m and bank £0.1m for Medical vacancies.

Clinical Support Services

Non-Patient-care income was reduced in Therapies this month regarding cessation of AHP funding previously provided by HEE which was for one year only. Non-pay cost pressures on Pathology laboratory consumables continue to adversly impact the CSS financial position which is £0.6m deficit in month and £2.3m year to date. This is driven by large increases in demand above the 2021/22 funded levels of activity of c1m tests for both acute and direct access across most disciplines including Blood sciences, Immunology and Histopathology and also tests referred to specialists' labs. Similarly, Direct Access and unbundled outpatient imaging demand is also driving high costs in procuring additional MRI & CT mobile capacity and reporting, including generator and fuel costs for the demountable CT scanner at KCH. The unmet CIP target in the Care Group is £0.4m in month and £1.35m year to date.

Cancer Services

Overspend in month mainly due to non-rechargeable drugs above plan, driven by additional activity above plan in Oncology and Clinical Haematology. Pay cost was slightly above plan in month.

Child Health

The key drivers behind the in month and £0.5m YTD adverse variance are cash releasing savings shortfalls, increases in premium pay and higher drugs and clinical supply costs associated with higher activity levels. Income is above plan by £2.3m but adjusted to breakeven under the terms of the commissioner contract.

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 ad hoc admissions requiring one-to-one specialist care;
- Medical consultant resource being used to reduce endoscopy waiting times.

The recurrent, cash releasing savings shortfall is £0.8m.

Women's Health

The key drivers behind the in month and YTD £0.9m adverse variance is a increase in premium pay to cover medical sickness, vacancies, the on-call rota and to reduce patient waiting lists. Also, due to continued concerns over midwifery staffing levels due to vacancies, sickness and maternity leave, bank shift incentives have been reinstated and are pushing up costs further. Medical and nursing/midwifery expenditure is comparable so both are impacting equally on the position. The pay budget is overspent by £0.5m YTD.

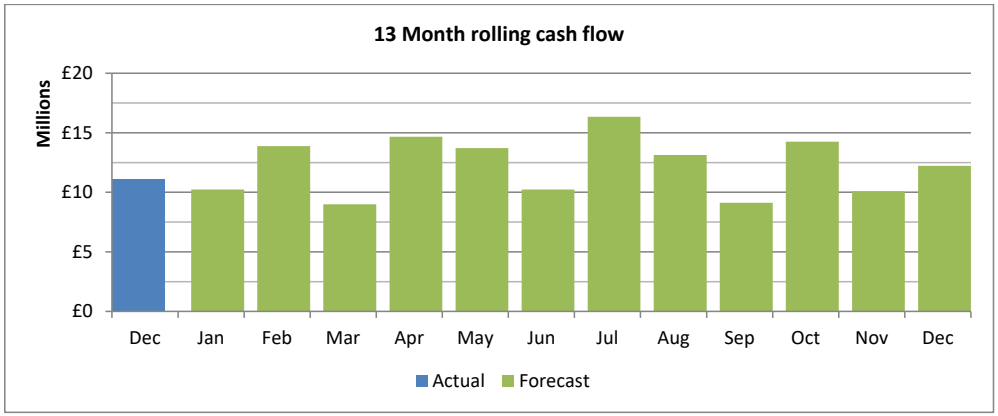
Non-Pay continues to overspend, driven mainly by clinical supply/drugs costs and savings shortfalls. The rise in clinical supply expenditure is thought to be due to additional activity (income is slightly ahead of plan) and an increase in caesareans. Policy changes to improve clinical outcomes has driven rising drug costs, and new community midwifery clinic rental charges have put further pressure on the budget. The non-pay budget is overspent by £0.4m YTD.

Strategic Development and Capital Planning

The main drivers for the £2.2m favourable the position is due to balance sheet review that was undertaken Mth 8. Pay is £0.9m favourable, this is mainly within IT where Pay is £0.62m favourable YTD, 12.76 WTE vacant. Recruitment is ongoing and historic vacancy rates are being looked into. This is being offset by overspends postage and printing, activity being looked at. Utilities is adverse £0.4m YTD activity / price being investigated.

Corporate

The position in month is due to Nightingale reimbursement and YTD is mostly attributable International nurses costs including increase in visa (including renewals)/work permit costs for doctors and International 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.



Unconsolidated Cash balance was £11.1m at the end of December 22, £0.9m above plan.

Cash receipts in month totalled £72.4m (£4.4m below plan)
K&M CCG paid £55.2m in December. £1.3m above plan. (plan of £53.9m)
NHS England receipts were over plan by £1.4m. (plan of £11.2m)
Health Education England receipts were £5.5m below plan due to payment being received in November, rather than December. Plan was based on schedule of receipts in prior years.
VAT reclaim was £2.5m below plan as a result of no 2gether OHF invoice being paid to 2gether in November. Approval of the invoice was slowed down by the reintroduction of additional required authorisations and it was paid in December. This will reflect in Januarys VAT reclaim.
Other receipts were £1.0m above plan in month (resulting from various receipts from 2gether, Spencer and other debtors)

Cash payments in month totalled £89.0m (£12.7m above plan)
Creditor payment runs including Capital payments were £19.3m (£3.9m below plan due to restrictions on creditor payments).
November and December OHF invoices totalling £29.3m were paid to 2gether Support Solutions in month (£13.5m above plan). Novembers invoice was not authorised to be paid in month due to additional steps being introduced to the authorisation process.

YTD cash receipts total £694.8m (£24.9m above plan - largely driven by block receipts from K&M ICB and additional receipts from NHS England).

YTD cash payments total £711.1m (£24.0m above the plan - mainly driven by creditor payments (£13.1m) and Payroll (£19.6m)) All spare cash received is being used to pay creditors as far as possible.

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 eliminated the option of borrowing cash and so all borrowing was removed from the forecast. (The Trust had expected to require additional 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.
Cash shortfalls are being managed by careful control of creditor payments.

Forecast

2023/24 receipts and payments are based on 2022/23 levels. A 1% uplift was assumed for K&M ICB and NHS England block payments as no further information was available.

No borrowing has currently been forecast in 2023/24.
Future year forecasting will be revised when further information is available.

Creditor Management

The Trust moved away from 30-day creditor terms in Month 9, closing the month at 36 day terms. This is still whilst withholding payment to one key supplier. As at 31st December 2022, £16.9m is overdue for payment to them. Weekly payment runs are being reviewed and this suppliers' invoices cleared when funds are available, although nothing was paid to them in December. In addition, payments to NHS organisations continued to be held throughout Month 9.

The Trust has applied to NHSE/I for revenue funding of £19.0m to be received in February 23. This funding will enable the Trust to clear some of the overdue invoices owing to creditors. Further revenue funding will be required in future months.

At the end of December 2022, the Trust was recording 74 creditor days (Calculated as invoiced creditors at 31st December/ Forecast non-pay expenditure x 365).

Cash Flow

Month 09 (December) 2022/23

	This Month			Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Plan	Actual	Variance	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Opening Cash Balance	10,891	27,755	16,864	27,755	11,126	10,232	13,875	8,992	14,664	13,711	10,246	16,343	13,138	9,125	14,244	10,094
Prior Year Main Contract CCGs																
Kent & Medway CCG Contract	53,880	54,591	711	54,591	51,754	51,754	51,754	53,854	53,854	53,854	53,854	53,854	53,854	53,854	53,854	53,854
Kent & Medway CCG - Other		574	574	574	2,236	2,126	2,126	539	539	539	539	539	539	539	539	539
NHS England	11,235	12,596	1,361	12,596	11,235	11,235	11,235	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341
All Other NHS Organisations	6,705	870	(5,836)	870	1,202	4,205	1,229	7,072	1,213	1,213	7,088	1,221	1,205	7,096	1,221	1,197
Capital Receipts																
All Other Receipts	4,940	3,751	(1,189)	3,751	6,659	4,742	10,084	4,741	4,804	4,904	4,804	4,835	4,872	4,835	4,714	4,810
Provider Sustainability Fund																
PDC Loans						19,000										
Total Receipts	**76,761**	**72,381**	**(4,380)**	**72,381**	**73,085**	**93,063**	**76,428**	**77,547**	**71,751**	**71,851**	**77,626**	**71,791**	**71,812**	**77,666**	**71,670**	**71,741**
Opening Cash Balance																
Monthly Payroll inc NI & Super	(37,290)	(40,376)	(3,086)	(40,376)	(39,005)	(39,255)	(39,355)	(38,890)	(38,890)	(38,890)	(38,890)	(38,890)	(38,890)	(38,890)	(38,890)	(38,890)
Creditor Payment Run	(39,007)	(48,634)	(9,627)	(48,634)	(32,874)	(48,087)	(35,625)	(31,738)	(32,568)	(34,868)	(31,393)	(34,547)	(31,689)	(32,409)	(35,372)	(29,481)
Capital Payments					(2,099)	(2,077)	(1,558)	(1,247)	(1,247)	(1,558)	(1,247)	(1,558)	(1,247)	(1,247)	(1,558)	(1,247)
PDC Dividend Payment							(4,773)						(4,000)			
Interest Payments																
Total Payments	**(76,297)**	**(89,011)**	**(12,714)**	**(89,011)**	**(73,979)**	**(89,419)**	**(81,311)**	**(71,875)**	**(72,704)**	**(75,316)**	**(71,529)**	**(74,995)**	**(75,825)**	**(72,546)**	**(75,820)**	**(69,618)**
Total Movement In Bank Balance	**464**	**(16,630)**	**(17,093)**	**(16,630)**	**(894)**	**3,643**	**(4,883)**	**5,672**	**(953)**	**(3,465)**	**6,097**	**(3,204)**	**(4,014)**	**5,120**	**(4,150)**	**2,124**
Closing Bank Balance	**11,354**	**11,126**	**(229)**	**11,126**	**10,232**	**13,875**	**8,992**	**14,664**	**13,711**	**10,246**	**16,343**	**13,138**	**9,125**	**14,244**	**10,094**	**12,218**
Plan				10,256	9,646	13,893	4,015	16,896	16,218	11,753	17,649	14,420	10,206	14,326	9,176	11,300
Variance				869	586	(18)	4,977	(2,232)	(2,507)	(1,507)	(1,307)	(1,282)	(1,082)	(82)	918	918
2gether Support Solutions Ltd				27,539	26,160	26,986	27,838	28,538	26,361	27,091	27,811	25,641	26,363	24,193	24,923	25,631
Spencer Private Hospitals Ltd				2,059	1,144	1,152	1,537	1,408	1,299	1,296	1,289	1,205	1,220	1,396	1,458	1,169
Group Closing Balance				**40,723**	**37,536**	**42,014**	**38,367**	**44,610**	**41,371**	**38,633**	**45,442**	**39,984**	**36,708**	**39,834**	**36,475**	**39,018**

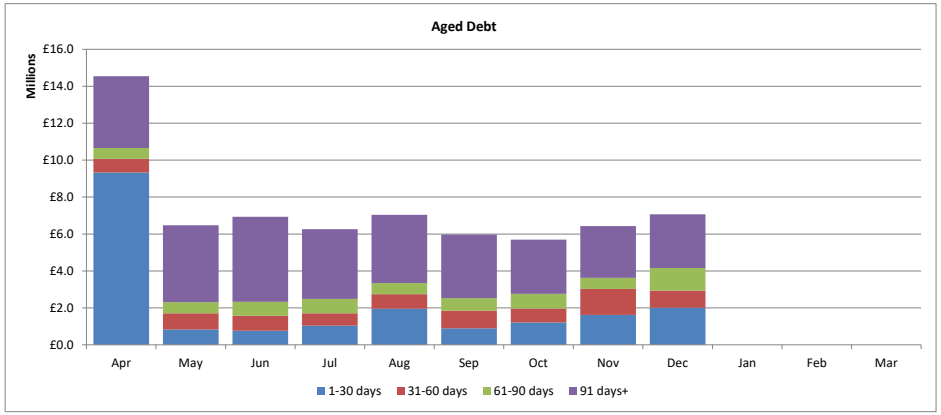
Working Capital
Month 09 (December) 2022/23

Top ten debtor balances outstanding as at 31/12/2022

Debtor Name	Current	1+	31+	61+	91+	Total
SPENCER PRIVATE HOSPITALS LIMITED	579	493	486	392	584	2,534
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	260	103	128	236	278	1,005
NHS KENT AND MEDWAY ICB	169	648	26	43	25	911
MEDWAY NHS FOUNDATION TRUST	16	66	1	90	252	425
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	99	132	6	148	35	419
SRCL LTD		264			0	265
2GETHER SUPPORT SOLUTIONS LTD	81	62			100	242
DANSAC LIMITED	103		122			225
DARTFORD AND GRAVESHAM NHS TRUST	35			100	19	154
ALLIANCE MEDICAL LTD	14	14	17	16	58	119
Total	**1,354**	**1,783**	**786**	**1,026**	**1,349**	**6,297**

Top ten creditor balances outstanding as at 31/12/2022

Supplier Name	Current	1+	31+	61+	91+	Total
NHS Professionals Ltd	3,348	5,962	4,803	5,986	109	20,208
Other Creditors	8,517	1,586	855	276	1,537	12,772
Maidstone & Tunbridge Wells NHS Trust (RWF)	363	655	18	188	333	1,558
Medway NHS Foundation Trust (RPA)	172	(95)	106	160	770	1,113
Spencer Private Hospitals Ltd		196	213	7	691	1,107
Abbott Laboratories Ltd			1,047			1,047
18 Week Support Ltd	496	487				982
2gether Support Solutions Ltd		600	131	0	1	732
Quantum Pharmaceutical Ltd	474	50			74	598
Roche Products Ltd	579					579
	13,949	**9,441**	**7,173**	**6,618**	**3,514**	**40,696**



Better Payment Practice Code	Last Year YTD Number	Last Year YTD £'000	This Year YTD Number	This Year YTD £'000
Non NHS				
Total bills paid in the year	52,327	440,836	52,237	444,050
Total bills paid within target	48,417	400,007	45,767	375,412
Percentage of bills paid within target	**92.5%**	**90.7%**	**87.6%**	**84.5%**
NHS				
Total bills paid in the year	2,007	8,554	1,483	7,810
Total bills paid within target	1,601	6,666	1,067	4,987
Percentage of bills paid within target	**79.8%**	**77.9%**	**71.9%**	**63.9%**
Total				
Total bills paid in the year	54,334	449,390	53,720	451,860
Total bills paid within target	50,018	406,673	46,834	380,399
Percentage of bills paid within target	**92.1%**	**90.5%**	**87.2%**	**84.2%**

Total invoiced debtors have decreased from the 2022/23 opening position of £16.8m by £8m to £8.8m (of which £1.8m is current debt)

This decrease is largely driven by an £8.3m decrease in Kent & Medway CCG/ICB debt. Spencer Hospitals debt increased by £0.8m, 2gether Support Solutions debt decreased by £0.4m and Kent Community Health FT debt increased by £0.5m.

At 31st December there were 2 debtors owing over £1m.

- Spencer Private Hospitals owe £2.5m - the Trust is working to bring reciprocal balances down
- Kent Community Health NHS FT owes £1.0m, of which £0.3m is current debt. Work has been ongoing to resolve

Invoiced creditors have increased by £19.9m from the opening position to £40.7m.

34% relates to current invoices with 9% or £3.5m over 90 days.

NHSP debt has grown significantly during the year from £2.74m to £20.2m. This is due to an increased reliance on premium pay staff to fill vacancies and sickness 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 09 (December) 2022/23

Trust Income Plan	Trust Actual Income	Income Variance
£591.403m	£605.364m	£13.961m

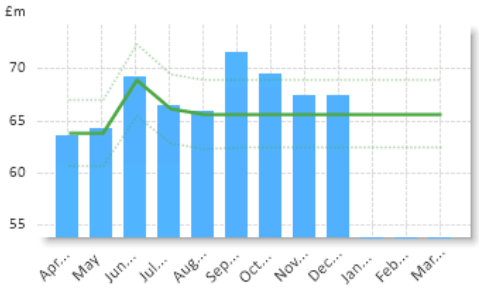
2022/23 - Month 9 Model

East Kent Hospitals University NHS
NHS Foundation Trust

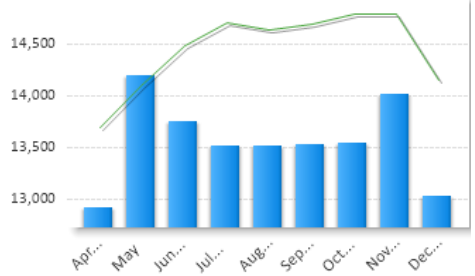
	Year to Date			This Month vs. Run Rate		
Summary	Plan	Actual	Variance	Actual	Run Rate to M8	Var to M8 Run Rate
1 Total Non Elective Spells	180.0	159.8	(20.2)	16.8	17.9	(1.1)
2 Accident & Emergency	34.5	34.8	0.3	4.2	3.8	0.3
3 Total Elective Spells	80.7	74.3	(6.3)	7.9	8.3	(0.4)
4a New Outpatient Attendances	38.6	36.0	(2.5)	3.6	4.1	(0.5)
4b Outpatient Follow Up Attendances	47.8	43.4	(4.4)	4.4	4.9	(0.5)
5 Other Cost Per Case	118.2	126.6	8.4	14.3	14.0	0.2
6 Block Agreements	17.7	17.5	(0.1)	1.9	1.9	(0.0)
7 Income Additional to PbR	58.9	98.9	40.0	12.8	10.8	2.1
8 Risks and Adjustments	(0.1)	(1.1)	(1.1)	(0.1)	(0.1)	0.1
9a Elective Recovery Fund	15.2	15.2	(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	**591.4**	**605.4**	**14.0**	**67.5**	**67.2**	**0.2**

	This Month			Year to Date			Annual
Care Group Income £m	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cancer Services	4.8	4.8	(0.0)	44.7	44.7	(0.0)	59.6
Central	8.6	10.3	1.8	67.7	81.6	14.0	91.4
Child Health	2.9	2.9	0.0	25.9	25.9	(0.0)	34.5
Clinical Support Services	5.8	5.8	0.0	52.8	52.8	0.0	70.5
General and Specialist Medicine	14.5	14.5	0.0	133.0	133.0	0.0	175.6
Surgery - Head and neck, Breast Surgery...	4.3	4.3	0.0	39.2	39.2	(0.0)	52.7
Surgery and Anaesthetics	11.6	11.6	0.0	106.0	106.0	0.0	142.0
Urgent and Emergency Care	8.7	8.7	0.0	80.7	80.7	0.0	106.8
Womens Health	4.5	4.5	0.0	41.4	41.4	(0.0)	55.5
	65.7	**67.5**	**1.8**	**591.4**	**605.4**	**14.0**	**788.5**

Income by Month



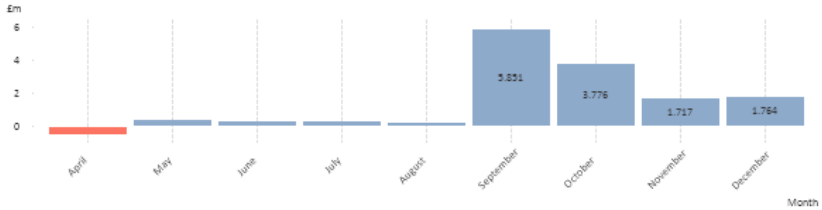
Monthly WAU - vs Plan



	This Month			Year to Date			Annual
Commissioner Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Kent and Medway CCG	53.5	54.8	1.3	481.6	492.1	10.5	642.1
NHS England SS	9.2	10.2	1.0	82.5	89.9	7.4	110.0
Public Health & Secondary Dental	1.3	0.9	(0.5)	11.9	8.7	(3.2)	15.9
Cancer Drugs Fund and Hep C	0.5	0.4	(0.2)	4.9	3.3	(1.6)	6.6
Out of Area CCGs	0.4	0.4	(0.0)	3.6	3.6	(0.0)	4.8
NHS England - Other	0.4	-	(0.4)	3.2	-	(3.2)	4.2
Other Organisations	0.3	0.3	(0.0)	2.9	2.9	(0.0)	3.9
Sussex Integrated Care Board	0.1	0.1	0.0	0.8	0.9	0.1	1.1
Prior Year Income	-	0.4	0.4	-	4.0	4.0	-
	65.7	**67.5**	**1.8**	**591.4**	**605.4**	**14.0**	**788.5**

Total Income Var

Income Variance



Actual income by care group is reported as equal to plan due to national guidance not to accrue risk against Elective Services Recovery Fund (ESRF).

Elective spells activity has underperformed by 16% against plan in December, and is showing a 10% underperformance against plan YTD. There is no financial impact in our position as a result of this shortfall.

The outpatient element is 14% under plan in month and 6% under plan YTD. There has continued to be a high number of escalation beds open across the Trust and there continues to be an increase in the number of patients over 24 hours and over 48 hours recorded as an A&E attendance rather than an admission.

The variable element of NHSE High Cost drugs is £4.3m above plan YTD, but are pass through costs and net with expenditure.

Activity

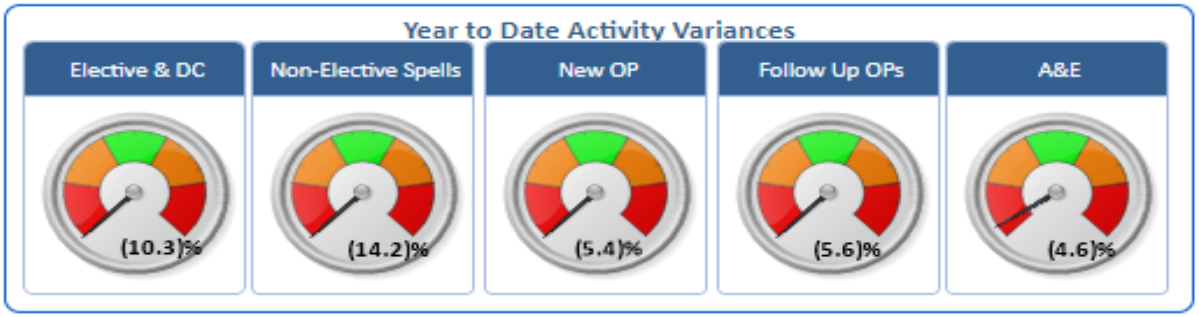
Month 09 (December) 2022/23

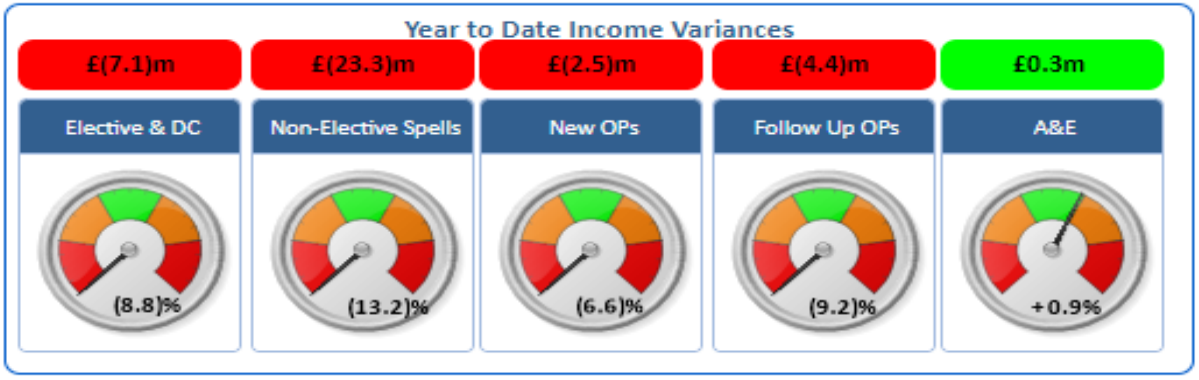
Trust Income Plan	Trust Actual Income	Income Variance
£591.403m	£605.364m	£13.961m

2022/23 - Month 9

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	66,789	57,285	(9,504)	£176.7 m	£153.4 m	£(23.3)m	£2,646	£2,678
2 Accident & Emergency	222,976	212,793	(10,183)	£34.5 m	£34.8 m	£0.3 m	£155	£164
3a Total Elective Spells	73,322	65,758	(7,564)	£80.3 m	£73.3 m	£(7.1)m	£1,096	£1,114
4a New Outpatient Attendances	198,275	187,520	(10,755)	£38.6 m	£36.0 m	£(2.5)m	£194	£192
4b Outpatient Follow Up Attendances	434,069	409,555	(24,514)	£47.8 m	£43.4 m	£(4.4)m	£110	£106





The Trust has investigated the Non-Elective underperformance against plan of 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. 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. The underlying reason is a lack of capacity of Non-Elective beds.

The outpatient element is 14% under plan in month and 6% under plan YTD.

Daycase and Elective inpatient activity has underperformed by 13% against plan in month, and is showing an 9% underperformance against plan YTD. The financial element of Elective Inpatients and Daycases is under plan by £0.8m in month and £6.2m YTD. T&O is £3.5m below plan YTD and Gastro/Endoscopy are £1.7m 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 overperformance against plan of 14% in month and an underperformance of 5% YTD. The financial variance is over by 21% in month and over by 1% YTD, which reflects a richer case mix of patients now seen and treated in A&E.

ESRF Income

Month 09 (December) 2022/23

Reporting POD	In-Month Income Target (104%) (£m)	In-Month Price Actual (£ m)	In-Month Financial Adjustment @ 75% (£ m)	IncomeTarget (104%) + 1.6% October Inflation (£m)	YTD Price Actual (£m)	YTD Financial Adjustment @ 75% (£m)	YTD Income Performance vs 104% Baseline (£m)	YTD Activity Performance vs 104% Baseline
Daycases	3,905	4,117	159	37,538	38,826	966	103%	102%
Elective Inpatients	3,399	3,686	215	34,379	31,444	(2,201)	91%	80%
Outpatient News	3,216	3,165	(39)	32,225	30,960	(948)	96%	96%
Outpatient Follow Ups	3,616	2,988	(471)	36,189	29,845	(4,758)	82%	96%
Outpatient Procedures	1,380	1,588	156	14,823	15,358	401	104%	105%
Chemotherapy	415	581	124	3,684	4,514	623	123%	109%
Reconcile to M6 National Position					3,088	2,316	N/A	N/A
Grand Total	**15,932**	**16,125**	**145**	**158,837**	**154,035**	**(3,602)**	**97%**	**98%**

IncomeTarget (104%) + 1.6% October Inflation

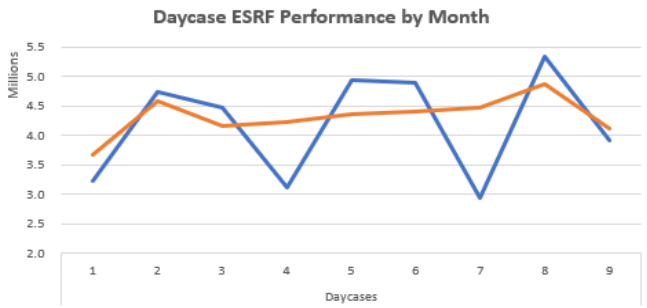
YTD Price Actual (£ '000)

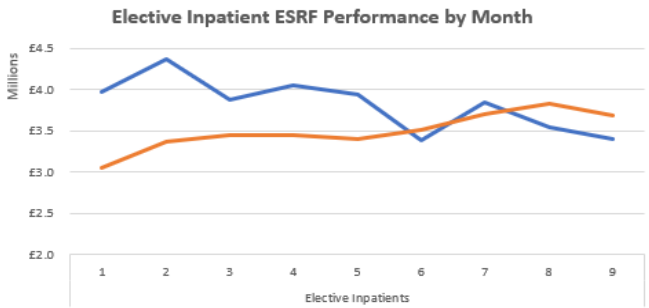
The Trust activity plan has been designed to meet the 104% value Elective Services Recovery Fund (ESRF) target. Due to the required reduction in Outpatient Follow Up activity to 75% of 2019/20 levels by March 2023 (85% as an average for the year), the expectation is that other areas need to rise to around 110% of the 2019/20 levels to compensate, which is proving to be very challenging.

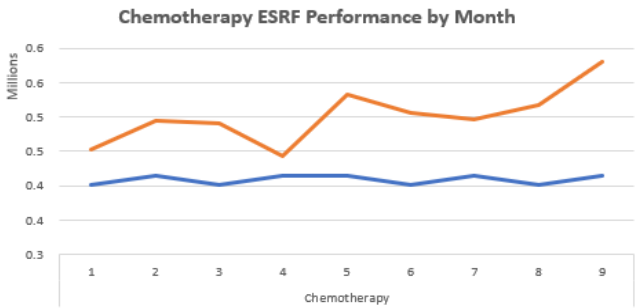
The Trust recently received national monitoring data which suggested the value of underperformance against the national target is lower than previously thought at £3.4m to M6, rather than £5.7m, hence the £2.3m adjustment line. The main difference appears to be a relaxing of the treatment of Outpatient follow ups, potentially by excluding them from the calculation. It has also been confirmed that there is no requirement to build risk into the position as there is no clawback expected for underperformance at this level, by either the ICB or by NHSEI.

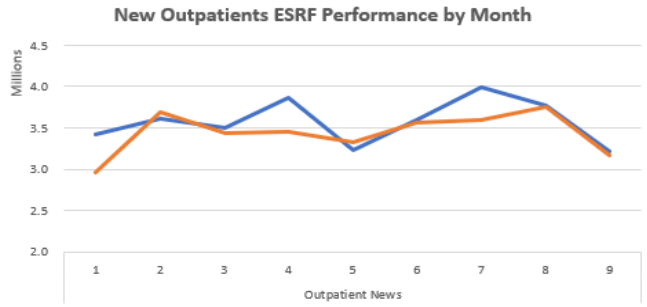
Throughout the year, ESRF has been calculated against a nationally set baseline which is phased differently to the internal activity plans. Therefore, although the Trust underperformed against the internal activity and income plan in month and YTD, when compared against the threshold, Elective inpatients and Daycases have both over performed against the ERF baseline this month.

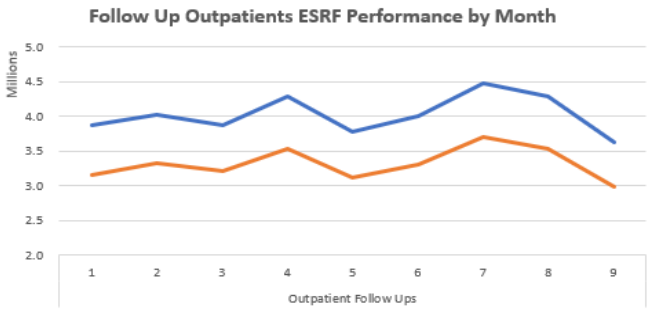
It can be seen from the graph that the Q3 is much closer to the targets in Elective inpatients, and Chemotherapy continues to grow above the target.

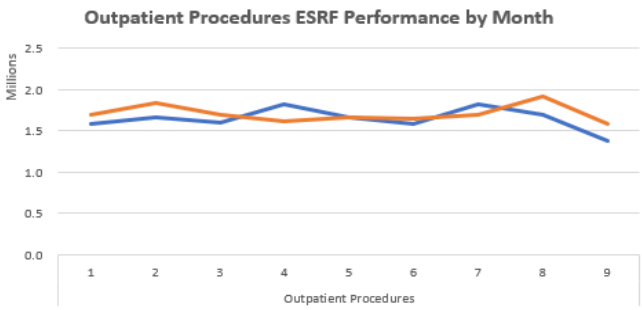








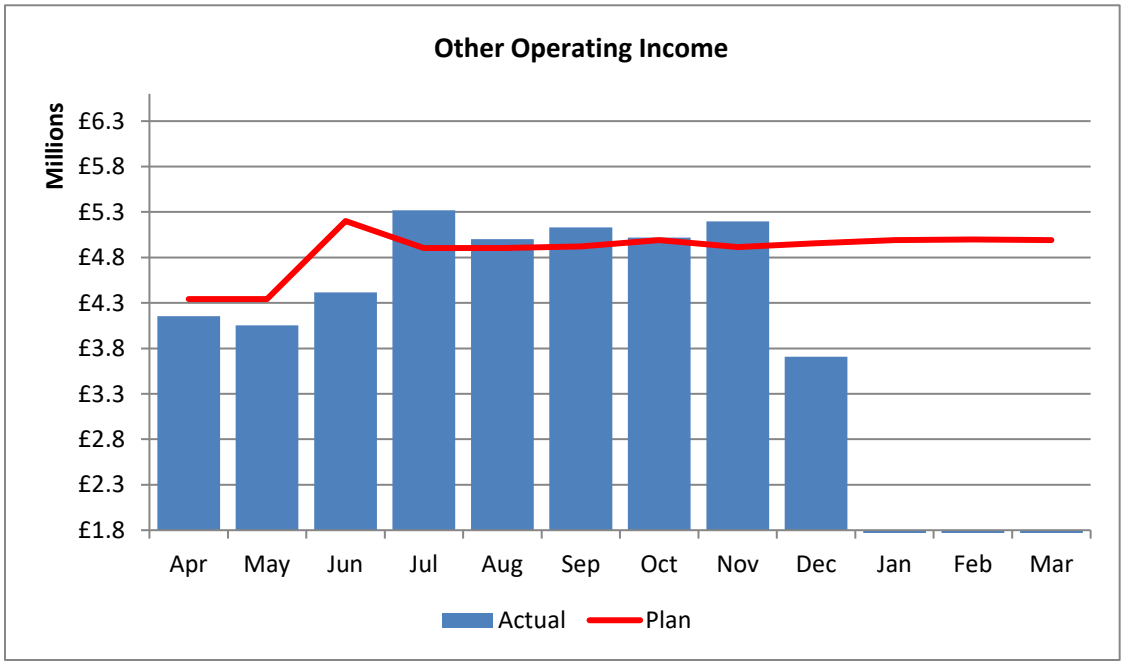




Other Operating Income

Month 09 (December) 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	2,145	280	16,780	18,685	1,904	22,374
Research and development	219	237	19	1,970	1,731	(239)	2,626
Education and Training	1,522	1,511	(11)	13,702	14,262	560	18,272
Car Parking income	444	162	(282)	2,851	1,347	(1,504)	4,304
Staff accommodation rental	160	119	(42)	1,443	1,242	(201)	1,922
Property rental (not lease income)	36		(36)	328		(328)	436
Cash donations / grants for the purchase of capital assets	75	52	(23)	675	1,625	950	900
Charitable and other contributions to expenditure	14	14	()	129	113	(16)	171
Other	622	(533)	(1,155)	5,601	2,993	(2,608)	7,453
Total	**4,958**	**3,707**	**(1,251)**	**43,479**	**41,997**	**(1,482)**	**58,458**
			-25.24%			-3.41%	
			Adverse			Adverse	



Other operating income is adverse to plan in December by £1.3m and adverse to plan by £1.5m YTD. The main driver for the variance in month is the reversal of the provision for recovery of VAT on the sale of stock £0.8m pending formal confirmation and below plan income for Covid-19 and parking charges totalling £0.4m.

YTD, parking charges, property rental, including staff accommodation, and research and innovation income are below plan by a total of £2.3m. These adverse variances are offset by donated income including Harmonia Village of £0.9m, and above plan income for education and training £0.6m.

Employee Expenses
Month 09 (December) 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	1,411	1,335	76	(11,792)	(11,722)	70	(105,942)	(102,761)	3,181	(141,322)
Nurses and Midwives	3,302	2,888	414	(10,880)	(11,667)	(787)	(93,262)	(100,692)	(7,430)	(127,151)
Scientific, Therapeutic and Technical	1,758	1,573	185	(5,828)	(5,867)	(38)	(52,209)	(52,673)	(464)	(69,732)
Admin and Clerical	1,763	1,550	213	(3,366)	(3,756)	(390)	(30,214)	(34,594)	(4,380)	(40,322)
Other Pay	1,813	1,578	235	(5,226)	(5,451)	(225)	(46,905)	(48,192)	(1,288)	(62,595)
Permanent Staff Total	**10,047**	**8,925**	**1,122**	**(37,093)**	**(38,464)**	**(1,371)**	**(328,531)**	**(338,912)**	**(10,381)**	**(441,121)**
Waiting List Payments										
Medical and Dental	0	0	0	(398)	(426)	(27)	(3,576)	(4,238)	(661)	(4,773)
Waiting List Payments Total	**0**	**0**	**0**	**(398)**	**(426)**	**(27)**	**(3,576)**	**(4,238)**	**(661)**	**(4,773)**
Medical Locums/Short Sessions										
Medical and Dental	0	54	(54)	(785)	(873)	(88)	(7,048)	(7,803)	(756)	(9,405)
Medical Locums/Short Sessions Total	**0**	**54**	**(54)**	**(785)**	**(873)**	**(88)**	**(7,048)**	**(7,803)**	**(756)**	**(9,405)**
Substantive	**10,047**	**8,979**	**1,068**	**(38,277)**	**(39,763)**	**(1,486)**	**(339,155)**	**(350,953)**	**(11,798)**	**(455,299)**
Bank										
Medical and Dental	0	48	(48)	(293)	(699)	(406)	(3,132)	(4,730)	(1,598)	(3,962)
Nurses and Midwives	7	264	(257)	(976)	(1,392)	(416)	(10,449)	(13,518)	(3,069)	(13,218)
Scientific, Therapeutic and Technical	2	16	(15)	(50)	(133)	(83)	(534)	(1,093)	(559)	(675)
Admin and Clerical	5	66	(61)	(165)	(224)	(59)	(1,764)	(2,131)	(368)	(2,231)
Other Pay	5	274	(269)	(600)	(823)	(223)	(6,426)	(7,730)	(1,304)	(8,129)
Bank Total	**18**	**669**	**(651)**	**(2,083)**	**(3,270)**	**(1,187)**	**(22,304)**	**(29,203)**	**(6,899)**	**(28,215)**
Agency										
Medical and Dental	2	46	(43)	(625)	(956)	(331)	(6,150)	(9,423)	(3,273)	(7,870)
Nurses and Midwives	3	201	(197)	(827)	(1,131)	(305)	(8,539)	(10,943)	(2,404)	(10,667)
Scientific, Therapeutic and Technical	0	3	(3)	(24)	(18)	6	(221)	(255)	(33)	(289)
Admin and Clerical	0	7	(7)	(7)	(134)	(126)	(77)	(563)	(486)	(96)
Other Pay	0	66	(65)	(83)	(255)	(172)	(861)	(2,218)	(1,357)	(1,074)
Agency Total	**6**	**322**	**(316)**	**(1,566)**	**(2,494)**	**(928)**	**(15,849)**	**(23,402)**	**(7,553)**	**(19,996)**
Direct Engagement - Agency										
Medical and Dental	1	63	(62)	(664)	(925)	(261)	(6,602)	(8,698)	(2,096)	(8,316)
Scientific, Therapeutic and Technical	0	1	(1)	(6)	(6)	(1)	(58)	(60)	(2)	(72)
Direct Engagement - Agency Total	**1**	**64**	**(63)**	**(670)**	**(931)**	**(261)**	**(6,660)**	**(8,758)**	**(2,098)**	**(8,388)**
Agency	**7**	**386**	**(379)**	**(2,236)**	**(3,425)**	**(1,189)**	**(22,509)**	**(32,160)**	**(9,651)**	**(28,384)**
Total	**10,072**	**10,033**	**39**	**(42,596)**	**(46,458)**	**(3,862)**	**(383,969)**	**(412,316)**	**(28,347)**	**(511,898)**
						-9.07%			-7.38%	
						Adverse			Adverse	

Employee expenses performance is adverse to plan in December by £3.9m and by £28.3m YTD (7.4%) of which £0.6m and £7.1m respectively relates to the above plan pay award. Indicative direct costs for escalation beds continue to be at least £0.8m in month and £6.4m YTD, and 1:1 specialing costs are at least £0.6m and £4.5m YTD.

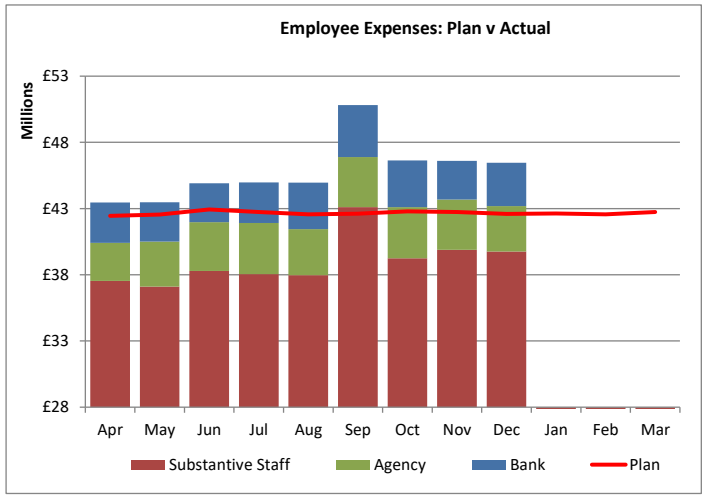
Total expenditure on pay in December was £46.5m, a reduction of £0.2m when compared to November, all relating to permanent staff including overtime.

The reduction in spend on permanent staff in December is predominantly due to reduced Apprenticeship Levy costs of £0.1m relating to recognition of VAT reclaims in December. Senior manager costs also reduced by less than £0.1m following payment of VSM pay award and arrears in November. Contracted wte increased by a further 60 wte overall.

Expenditure on bank staff Increased by £0.3m, all relating to medical staffing, offset by a reduction in spend on agency staff of £0.4m, mainly relating to qualified nurses and consultant medical staff.

Expenditure on all substantive staff is adverse to plan in December by £1.5m and by £11.8m YTD inclusive of the pay award impact.

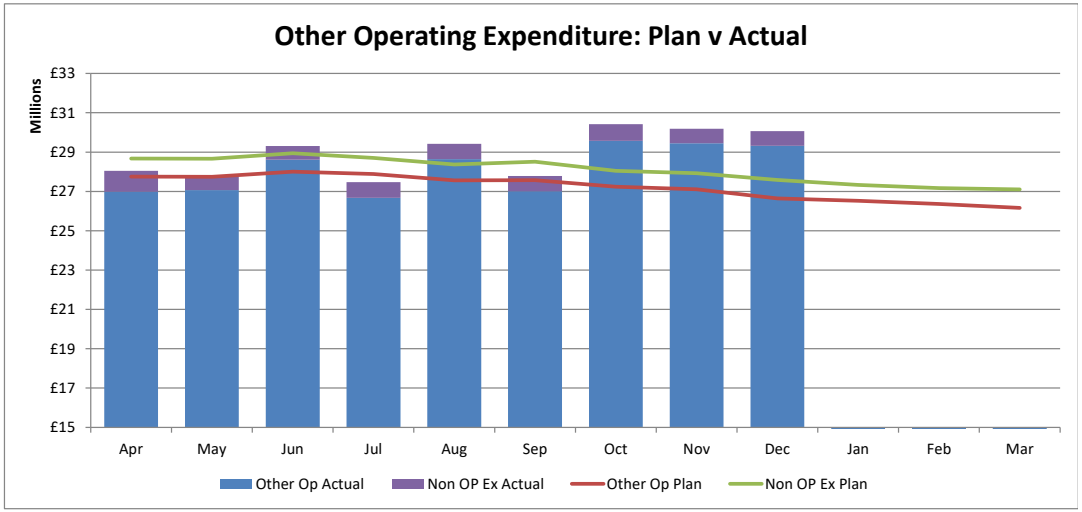
Expenditure on bank and agency staff combined is adverse to plan in December by £2.4m and by £16.5m YTD.



Other Operating Expenditure

Month 09 (December) 2022/23

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.	Annual Plan
Drugs	(6,619)	(7,816)	(1,197)	(60,260)	(64,105)	(3,845)	(80,094)
Supplies and Services – Clinical	(3,368)	(3,358)	11	(31,536)	(31,856)	(320)	(41,509)
Supplies and Services - Non-Clinical	(8,906)	(10,036)	(1,129)	(84,725)	(87,242)	(2,517)	(110,939)
Non Executive Directors	(19)	(17)	2	(169)	(134)	35	(229)
Purchase of Healthcare	(594)	(717)	(123)	(6,413)	(5,326)	1,087	(8,059)
Education & Training	(304)	(238)	67	(2,740)	(2,771)	(31)	(3,652)
Consultancy	(27)	(32)	(5)	(243)	(190)	53	(325)
Premises	(1,130)	(1,005)	126	(10,222)	(7,073)	3,149	(13,615)
Clinical Negligence	(2,210)	(2,139)	71	(19,956)	(19,252)	704	(26,591)
Transport	(228)	(342)	(114)	(2,273)	(2,323)	(50)	(2,935)
Establishment	(341)	(388)	(48)	(3,065)	(3,763)	(699)	(4,081)
Other	(920)	(1,285)	(365)	(8,080)	(12,388)	(4,308)	(10,752)
Depreciation & Amortisation-Owned Assets	(1,981)	(1,949)	32	(17,826)	(16,879)	948	(23,769)
Impairment Losses					(39)	(39)	
Total Other Operating Expenditure	**(26,648)**	**(29,321)**	**(2,673)**	**(247,509)**	**(253,342)**	**(5,834)**	**(326,549)**
Profit/Loss on Asset Disposals	(125)		125	(375)	(89)	286	(500)
PDC Dividend	(777)	(777)		(7,212)	(7,051)	161	(9,545)
Interest Receivable	181	245	64	1,628	1,990	362	2,171
Interest Payable	(218)	(215)	3	(1,965)	(1,983)	(19)	(2,619)
Total Non Operating Expenditure	**(939)**	**(747)**	**192**	**(7,923)**	**(7,134)**	**789**	**(10,493)**
Total Expenditure	**(27,587)**	**(30,068)**	**(2,481)**	**(255,432)**	**(260,476)**	**(5,044)**	**(337,043)**



Other operating expenditure is adverse to plan by £2.7m in December and by £5.8m YTD (2.3%).

Drug spend is adverse to plan in December by £1.2m and by £3.8m YTD. Drugs historically classed as rechargeable which includes blood product deliveries and issues to homecare patients are adverse to plan in December by £0.9m, and by £2.5m YTD. All other drugs are adverse to plan in month by £0.3m and adverse to plan by £1.4m YTD.

Supplies and services - clinical are break-even against plan in month and adverse to plan by £0.3m YTD. Slippage against CIP targets and overspends on pathology reagents (including Covid-19 testing) totalling £0.8m in month and £4.6m YTD are offset by below plan spend on equipment maintenance and purchases of £0.4m in month and £2.8m YTD, and radiological scanning and reporting services of £0.3m in month and £1.9m YTD.

Supplies and services - non-clinical are adverse to plan by £1.1m in December and by £2.5m YTD. Variances in month and YTD relate predominantly to the Operated Healthcare Facility contract which is adverse to plan in month by £0.9m and by £3.4m YTD, which is inclusive of the subsidiary pay award and unconfirmed CCN baseline uplift assumptions. Slippage on CIPs is £0.4m in month and £0.1m YTD.

Purchase of healthcare from the independent sector is adverse to plan in month by £0.1m and favourable to plan by £1.1m YTD. In month the variance is driven by increased insourcing of endoscopy activity and slippage on CIPs totalling £0.5m, offset by the reduced use of Spencer beds and the transfer of provider invoicing for agreed procedures to the ICB with effect from August, which also accounts for the YTD favourable variance.

Premises costs are favourable to plan in month by £0.1m and by £3.1m YTD. In month, building compliance works and computer equipment are underspent by a total of £0.1m. YTD the position is driven mainly by rates rebates £0.8m and below plan spend on building works totalling £2.4m.

Clinical negligence is favourable to plan in month by £0.1m and by £0.7m YTD, linked to the non-collection of the Maternity Incentive Scheme 2022/23.

Other expenditure is adverse to plan by £0.4m in month and by £4.3m YTD. In-month and YTD variances are mainly driven by overspends in Urgent Treatment Centres £0.2m in month and £0.6m YTD reflecting the new overnight GP telephony service which is offset in Patient Care Income, and work permits £1.3m YTD.

Depreciation is breakeven against plan in month and favourable to plan by £0.9m YTD.

Cost Improvement Summary

Month 09 (December) 2022/23

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Outturn	Forecast Variance
Agency	629	412	(217)	3,467	2,854	(613)	4,501	(1,059)
Bank	-	12	12	-	64	64	99	99
Workforce	78	130	53	331	1,233	902	1,654	1,057
Outpatients	-	-	-	-	-	-	-	-
Procurement	190	132	(58)	1,023	341	(682)	772	(1,028)
Medicines Value	156	54	(102)	708	708	(0)	1,056	(144)
Theatres	360	17	(343)	1,824	115	(1,709)	127	(2,873)
Care Group Schemes *	1,740	589	(1,151)	9,367	6,364	(3,003)	9,771	(5,412)
Sub-total	**3,152**	**1,346**	**(1,806)**	**16,720**	**11,679**	**(5,041)**	**17,981**	**(9,360)**
Central	294	77	(218)	1,631	2,116	485	4,354	1,695
Grand Total	**3,446**	**1,422**	**(2,024)**	**18,351**	**13,795**	**(4,556)**	**22,335**	**(7,665)**

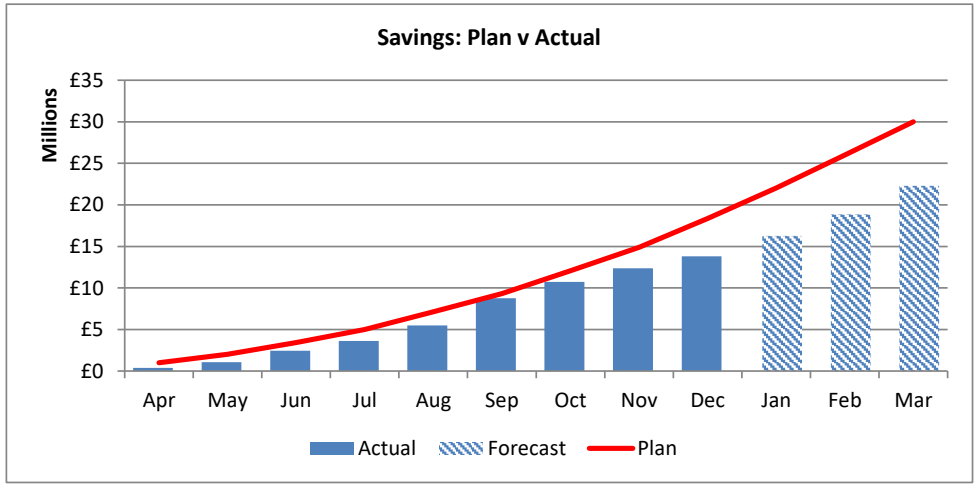
* Smaller divisional schemes not allocated to a work stream

Delivered £000

Month	Target	Actual
April	999	391
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	1,650
December	3,446	1,422
January	3,694	
February	3,945	
March	4,010	
	30,000	**13,795**

Efficiencies

The submitted Efficiencies plan for 2022/23 is £30m. The Trust achieved savings of £1.4m in December, which is below Plan. The in-month performance relates to shortfalls in Care Groups, Agency, Procurement, Theatres & Central, offset by overperformance in Workforce and Bank. YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed. Recurrent savings in December amounted to £0.9m, with £0.5m being on a non-recurrent basis. Recurrent savings YTD amount to £6.6m with £7.2m on a non-recurrent basis. We are looking to deliver as much of the forecast, and as recurrently as possible, and is updated and reviewed weekly to accelerate progress. Work has started on plans for 2023/24.



Capital Expenditure
Month 09 (December) 2022/23

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
ED Expansion WHH & QEQM	11,654	14,594	9,997	11,633	(1,636)
24 Bed ITU Kennington Carpark WHH	350	391	350	391	(41)
Electronic Medical Records	910	2,800	820	1,138	(318)
PEIC - Backlog maintenance/ Patient environment improvement	3,750	4,050	2,883	2,536	347
MDG - Medical equipment replacement (<£250k per item)	1,136	2,086	515	818	(303)
IDG - IT hardware/ systems replacement	2,400	1,421	2,220	1,602	618
New Interventional Radiology (IR) suite - K&C	160	203	160	203	(43)
Endovascular theatre (EVT) kit installation - K&C	937	937	875	782	93
Maternity Training		309			
Clinical Trials Unit	1,000	457	565	344	221
Community Diagnostic Hub - BHD	250	279	250	279	(29)
Maternity Estates Review	376	132	370	76	294
Refurbishment of SCBU QEQM and meeting IPC requirements	341	90	341	46	295
Theatre 4&5 - AHU Replacement - KCH	1,200	1,470	1,200	1,470	(270)
Restore and Recovery	250	210	250	206	44
East Kent Transformation Programme	178	178	178	156	22
Donated Assets	900	760	675	709	(34)
2gether Support Solutions		266		65	(65)
Spencer Private Hospitals		85		8	(8)
Other IFRS16 Assets		1,064		1,064	(1,064)
All Other		(245)		(203)	203
Other IT		1,033		379	(379)
Mechanical Thrombectomy		2,100			
Imaging Diagnostic Equipment		344			
Maternity - Entonox		469			
	25,792	**35,484**	**21,649**	**23,700**	**(2,051)**
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	1,820			
Other PDC	4,282	8,166			
Right of Use Asset Liabilities	0	1,290			
	25,792	**35,484**			
Under/(Over) Commitment		**0**			

2022/23 Summary Capital Spend position - M9 and Forecast Outturn

The group gross capital year-to-date spend to the end of Month 9 is £23.7m, against an YTD Plan of £21.6m. This represents a £2.1m 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 M9 is £35.5m, representing a £9.7m increase from the original capital plan submitted in April 2022 of £25.8. The new items of spend agreed since the M8 reported forecast position include:

• a net £1.65m increase in ED, funded as part of the internal Mechanical Thrombectomy brokerage in 2022/23, agreed with the K&M ICS and NHSE/I;

• a net reduction in MDG of £1.56m, as a result of a partial re-allocation of the Mechanical Thrombectomy funding of £2m initially agreed to the ED Expansion programme;

Major projects updates:

- K&C EVT: ventilation issues have delayed the project by 2 weeks, with final ventilation commissioning expected to take place in early February 2023;
- ED Expansion WHH & QEQM: Phase 2 commenced on both sites; the project is experiencing significant cost pressures, which in 2022/23 have been mitigated by the re-allocation of £2.1m Mechanical Thrombectomy funding to ED Expansion, along with circa £0.2m worth of System PDC Funding, approved by the K&M CFO Group in December 2022; the 2023/24 Draft Capital Plan (which includes the full extent of the remaining ED Risk) is currently under consideration by the Executive;
- QEQM - Clinical Trials Unit: changes have been requested to the agreed layouts to accommodate various items of equipment, which are programmed for February 2023; additional works are also required to supplement the ventilation on site, although these are expected to be within the existing budget;

Other risks

The M9 forecast position shows a fully mitigated and balanced Capital Programme for 2022/23. The only other additional cost pressures that have been raised with the Planning Team include:

• 2gether Support Solutions (2SS): the previously approved spend of £0.04m for the procurement of a clinical fridge requested by 2SS has likely been understated, as the team was informed that an additional £0.04m will be required; this is yet to be formally approved;

• IFRS16 Leases - Cash Repayments: the previously reported risk around the capital lease repayments remains; the latest estimate as at M9 for our 2022/23 Lease Capital Repayments totals £1.35m, representing a £0.4m risk against our planned provision of £0.95m; however, as at M9, repayments totalling £1m were expected to be made, although only £0.7m has actually materialised; this is likely to have been the result of a mixture of late invoicing by the lessors and/or late payments of the outstanding invoices by the Trust; this risk carries a significant degree of volatility and it is still early to ascertain where the year-end position will land;

The team will continue to monitor the development of this risk and a regular monthly update will be provided in the upcoming reports.

Mechanical Thrombectomy (2022/23 PDC Funding - £4.6m):

Following the receipt of the Mechanical Thrombectomy MOU in December 2022, the K&M ICS and NHSE/I approved the proposed approach of the Trust to partly broker the funding internally, as a means of mitigating slippage across financial years.

The £4.6m capital funding has therefore been allocated as follows in 2022/23:

• £2.1m to the Mechanical Thrombectomy for the procurement of the bi-plane machine and enabling estates works;

• £0.4m to MDG for the procurement of brought forward equipment from the 2023/24 planned priorities;

• £2.1m to the ED Expansion Programme, to partly mitigate against the emergent cost pressures;

Statement of Financial Position

Month 09 (December) 2022/23

£000	Opening	To Date	Movement	
Non-Current Assets	**419,046**	**424,347**	**5,301**	▲
Current Assets				
Inventories	5,527	7,769	2,242	▲
Trade Receivables	17,933	9,834	(8,099)	▼
Accrued Income and Other Receivables	16,715	22,859	6,143	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	27,372	11,126	(16,246)	▼
Total Current Assets	**67,547**	**51,588**	**(15,960)**	▼
Current Liabilities				
Payables	(37,923)	(60,274)	(22,351)	▲
Accruals and Deferred Income	(54,360)	(51,519)	2,841	▼
Provisions	(5,761)	(5,555)	206	▼
Borrowing	(1,136)	(2,145)	(1,008)	▲
Net Current Assets	**(31,633)**	**(67,904)**	**(36,271)**	▼
Non Current Liabilities				
Provisions	(4,417)	(4,304)	113	▼
Long Term Debt	(83,551)	(78,102)	5,449	▼
Total Assets Employed	**299,446**	**274,037**	**(25,409)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	425,777	425,777	-	
Retained Earnings	(181,901)	(207,188)	(25,287)	▼
Revaluation Reserve	55,569	55,448	(122)	▼
Total Taxpayers' Equity	**299,446**	**274,037**	**(25,409)**	▼

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 is underway and will be completed as at 31 March 2023.
Trust closing cash balance was £11.1m (£27.8m November) £0.9m above plan. See cash report for further details.

The Board of 2gether have received the request to move cash from them to the Trust but have asked for additional external advice before considering. The Trust is continuing to work with 2gether management to resolve. The year-to-date Month 8 deficit of £19m has been applied for to be drawn as PDC in February 2023 - utilising the May Board approval to borrow up to £22m. A report is also being sent to FPC in January to update on the in-year and forecast position.
Trade and other receivables have reduced from the 2021/22 opening position by £8.1m (£7.2m reduction in November). Key drivers are detailed on the Cash report

Payables have increased by £22.4m (£33.7m increase in November) 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.

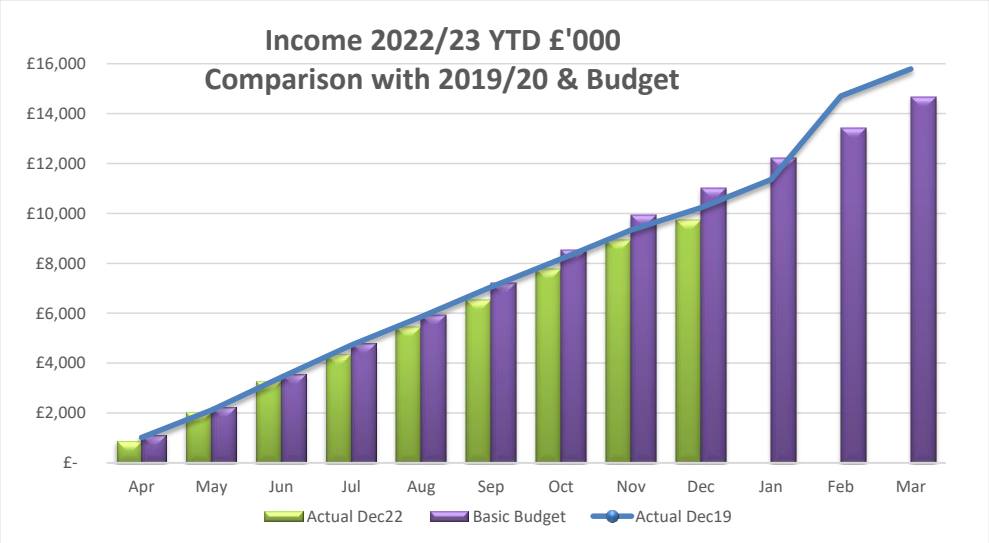
Summary Profit & Loss December 2022 and Outturn Forecast

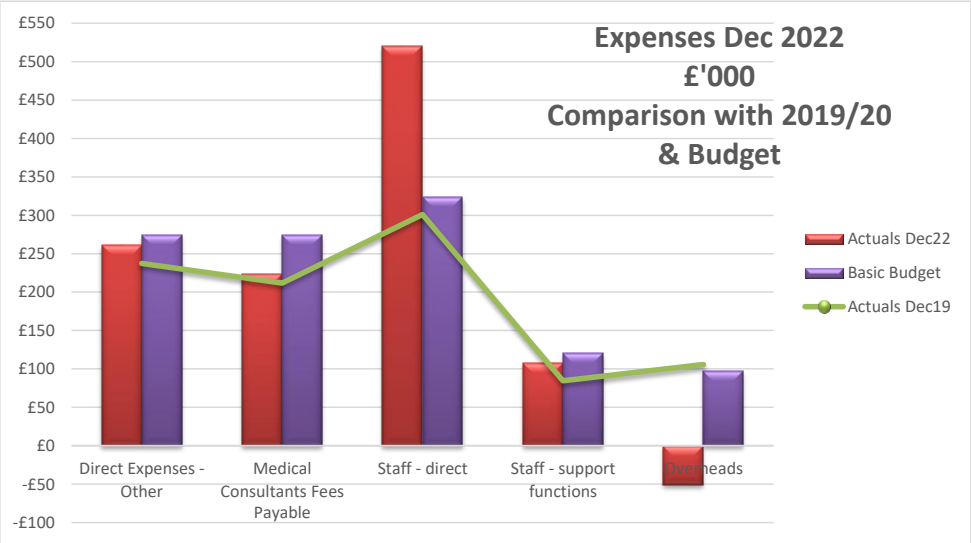
£'000s	Month			YTD			Full Year 2022-23		
	Actual	Budget	Variance	Actual	Budget	Variance	Outturn	Budget	Variance
Income	1,231	1,411	(180)	13,475	13,786	(311)	19,677	18,344	1,332
Pay	(861)	(717)	(144)	(6,900)	(6,666)	(234)	(10,229)	(8,881)	(1,348)
Non Pay	(597)	(596)	(1)	(5,516)	(5,696)	180	(7,312)	(7,590)	277
Other Costs	132	(113)	246	(841)	(1,231)	390	(1,803)	(1,571)	(232)
Operating Profit	(95)	(15)	(80)	219	193	25	332	302	30
OP %	*-7.7%*	*-1.1%*	*44.2%*	*1.6%*	*1.4%*	*-8.1%*	*1.7%*	*1.6%*	*2.3%*
Interest Receivable Interest Expense	1	(1)	2	3	(12)	15	(10)	(15)	5
Net Profit before Tax	(94)	(17)	(77)	222	182	40	322	287	35
NPBT %	*-7.6%*	*-1.2%*	*42.9%*	*1.6%*	*1.3%*	*-13.0%*	*1.6%*	*1.6%*	*2.7%*
Tax	15	1	14	(64)	(52)	(12)	(121)	(78)	(42)
Net Profit after Tax	(79)	(15)	(63)	158	129	29	202	209	(7)
NPAT %	*-6.4%*	*-1.1%*	*35.2%*	*1.2%*	*0.9%*	*-9.3%*	*1.0%*	*1.1%*	*-0.5%*

Salient comments on month / YTD results:

A net loss of £0.02m was incurred during December. Although December is traditionally a loss-making month, as a result of significantly reduced theatre activity during the final week of the month additional costs have been incurred in relation to agency theatre staff rates. These additional costs were, however, anticipated and measures have already been put in place to ensure that costs are reduced from January onwards.

However, we do continue to incur significant costs as a result of utilisation of agency nursing staff for theatres and ward.





Summary Profit & Loss December 2022

£'000s	Month Actual	Month Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Income	12,718	12,045	673	107,096	108,409	(1,313)
Costs	(12,585)	(11,922)	(663)	(105,876)	(107,299)	1,423
Operating Profit/(Loss)	**133**	**123**	**10**	**1,221**	**1,110**	**110**
OP %	*1%*	*1%*	*0%*	*1%*	*1%*	*0%*
Operating Profit/Loss EKHUFT	(23)	17	(40)	517	149	367
Operating Profit/Loss Retail	157	107	50	704	961	(257)
Interest Receivable	211	215	(4)	1,956	1,935	21
Interest Receivable (Bank)	44	()	44	165	()	165
Interest Expense	(179)	(180)	1	(1,631)	(1,624)	(7)
Net Profit/(Loss) before Tax	209	158	51	1,711	1,421	290
NPBT %	*1.6%*	*1.3%*	*0.3%*	*1.6%*	*1.3%*	*0.3%*
Tax	(64)	(58)	(6)	(599)	(524)	(75)
Net Profit/(Loss) after Tax	**145**	**100**	**45**	**1,112**	**897**	**215**
NPAT %	*1.1%*	*0.8%*	*0.3%*	*1.0%*	*0.8%*	*0.2%*

Salient comments
YTD

The Operating Profit and Profit after Tax level is a profit of £1.2m and £1.1m respectively.

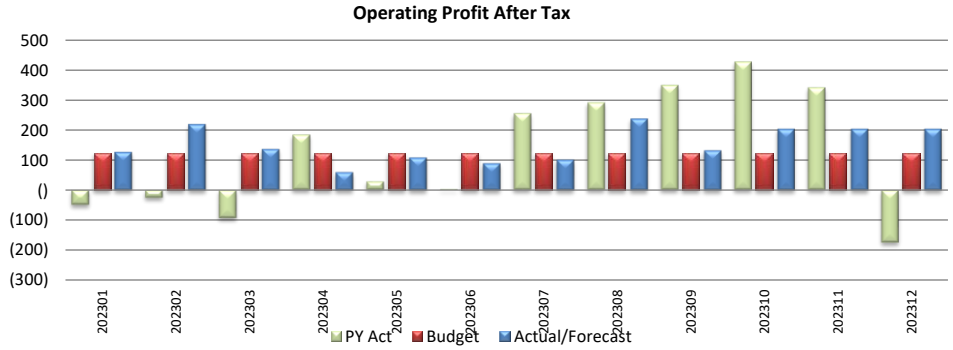
Income and cost variances relate to the budgeting assumption of capital; this is offset in the majority with consumables and ad-hoc recharges.

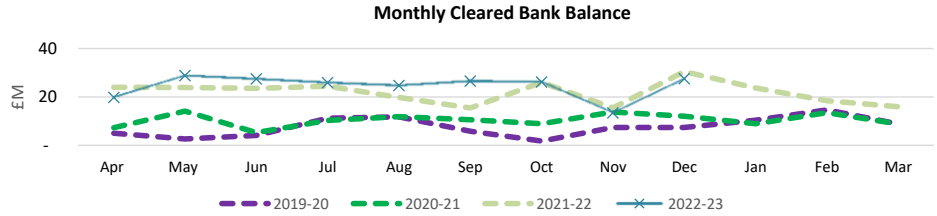
2gether is accruing contract income (and EKHUFT contract costs) relating to: above inflation cost pressures for patient feeding, volume and aged equipment maintence costs for EME; and, price & volume related costs for IHSS equipement sterilisation.

The Senior Leadership Team are actively managing their cost base given inflationary and service pressures to ensure that the budgeted profit level is delivered and the high level forecast outturn is to achieve this.

Operating Working Capital has increased to £24.3m. Cash is £27.5m. EKHUFT debt is £2.1m. EKHUFT creditor is £0.5m.

BALANCE SHEET £000's	**Mar-22**	**Dec-22**	**Movement**
Total non-Current Assets	**79,286**	**73,998**	**(5,288)**
Trade and other Receivables	22,868	2,249	(20,619)
Prepayments	2,240	5,739	3,499
Accrued Income	(276)	4,127	4,404
Total Debtors	**24,832**	**12,116**	**(12,716)**
Stocks	**4,824**	**4,824**	0
Creditors and other payables	(11,274)	(7,665)	**3,609**
Accruals	(14,827)	(12,518)	2,309
Deferred Revenue	(130)		130
Total Creditors	**(26,231)**	**(20,183)**	**6,048**
Cash	**15,997**	**27,539**	**11,542**
Operating Working Capital	**19,422**	**24,295**	**4,874**
Borrowings	**(63,801)**	**(62,278)**	**1,523**
Net Assets	**34,907**	**36,015**	**1,108**
Share Capital	30,267	30,267	0
Retained Profit/(Loss) - Prior Year	4,640	5,748	1,108
Shareholders Funds	**34,907**	**36,015**	**1,108**





East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)				
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**
People & Culture Committee (P&CC)	31 January 2023	Stewart Baird, Non-Executive Director	Executive Assistant	Yes
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:				
People and Culture Committee Performance Report November & December 2022	Partial Assurance was received of the 'People' True North metrics for November and December 2022. The Executive Team will provide an overview of the Culture Strategy Delivery Plan and HR Programmes at the next Committee meeting. Premium Pay Spend decreased for a third month in a row, however, remains above the planned position. The drop is mainly related to the pay award back pay being paid in September. The Committee noted is the work of the newly formed Premium Pay Team is being tracked by the Finance and Performance Committee. Sickness absence increased to 5.6% in December 2022. 56% of all sickness was due to coughs, colds and chest infections (including COVID-19). The Committee noted a significant reduction in sickness absence due to stress, anxiety and depression (6% down from a peak of 33% in March 2021). Overall appraisal compliance has fallen by 1% to 68.9% following a three-month plateau. It was noted that the replacement system used for medical appraisals had become stuck in the procurement process and the Chief Finance Officer (CFO) was asked to investigate how to move this forward urgently. December 2022 saw the lowest number of total leavers in over a year, falling by 40% since September 2022. In-month turnover has been below 10% for three consecutive months, at 7.95% is the lowest it has been in almost two years. The overall vacancy rate has improved to 9.8% in December 2022, largely due to an increase in nursing staff through the Internationally Educated Nurse (IEN) recruitment plan. The Committee noted that in 18 – 24 months' time there could be an increase in turnover for the IENs. A mitigation plan is in place along with support for IEN's from the date of appointment through to their employment including with their Objective Structured Clinical Examination (OSCE) exams and three months free accommodation. Committee members noted that the 'New Starter Experience Survey' launches on 30 January 2023, which can be benchmarked at a system level. Once this is operational, the Committee can start to gain assurance that the retention levels of these new staff are acceptable. The Committee received partial assurance that the Trust was doing everything possible to control staff turnover factors in its control, example onboarding experience, pastoral care and residential accommodation.			

Board Assurance Framework (BAF) & Corporate Risk Register (CRR)	Assurance received that the risks relating to 'Our People' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period. The Committee will undertake a detailed review of the BAF and CRR later in the year.
National Staff Survey 2022	The Committee members noted that the National Staff Survey response data is currently under embargo until Mid-March 2023.
Pensions Auto Enrolment	The Committee received assurance that the Trust was compliant with the Pensions Auto Re-enrolment regulations in accordance with the Pensions Act 2008. 500 eligible employees were re-enrolled into the NHS Pension Scheme, however, 323 staff opted out post re-enrolment, which represents 61% opt out rate. Employer contributions as a result of auto re-enrolment are estimated to be increased by £570k for the current year. The Trust is fully compliant with the 3-year cyclical Pensions Auto Re-enrolment, in accordance with statutory legislation.
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 to this meeting.
Other items of business	Feedback requested on the Committee Annual Work Programme 2022/23 to restructure the agenda for this Committee meeting. A proposal for the proposed People and Culture Department User Survey will be discussed at the next meeting of the Committee.

Items to come back to the Committee outside its routine business cycle:

N/A

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

Item	Purpose	Date
None	N/A	N/A

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Finance & Performance Committee (FPC)	31 January 2023	Nigel Mansley, Non-Executive Director	Ben Doble, Business Manager to Chief Executive Officer (CEO) Sarah Farrell, Executive Assistant (EA) to Chief Finance Officer	**Yes**	
Appendices:	**N/A**				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Month 9 Finance Report Forecast Cash Position	Partial Assurance received of the Trust's financial performance and actions planned to address issues of concern including delivery of the re-forecasted year-end deficit position of £30m currently being agreed by the Integrated Care Board (ICB) and NHS England (NHSE). The Group achieved a £5.2m deficit in December, which brought the year-to-date (YTD) position to a £24.5m deficit which is £21.4m adverse to the plan. Key drivers for the YTD deficit include Escalation Areas opened (60 beds) across the Trust due to patient demand and flow £6.7m; Cost Improvement Programme (CIP) Slippage £4.6m; Drugs £2.8m; Premium pay around the organisation £3m; 1.1 speciality/mental health £1.8m; Work permits £1.3m and Parking income £1.2m. The Group cash balance (including subsidiaries) at the end of December was £40.7m which was a £1.7m decrease from November and is above plan by £1m. Total capital expenditure at the end of December was £23.7m against an £21.6m 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. A macro review/bridge of Financial Year (FY2019/20) versus FY23 including costs and activity levels will be produced and shared at the next FPC meeting.				
Month 9 Savings and Efficiencies Update	Partial assurance received of the Trust's progress of the programme against a £30m target. Reported savings achieved in December were £1.4m vs a plan of £3.5m with all major areas underperforming in the month. YTD the reported savings are £13.8m vs a plan of £18.4m, with Clinical Support Services (CSS) (£1.4m), Surgery & Anaesthetics (S&A) (£1.3m) and Urgent Emergency Care (UEC) (£1.1m) the major contributors.				

	Non-recurrent efficiencies totalled £0.6m in the month, or 35% of the total (down from 36% last month, and now standing at 52% on a YTD basis). The forecasted value of which indicates c.£11m for the full year, as at M9, which will have to be played into the plan for 2023/24. The focus over the next three months will be on 2023/24 and helping Care Groups identify what is possible, so we can quickly populate the programme which is likely to be at least of a similar value to this year. As well as regular meetings and workshops with Care Groups and corporate areas, a revamped Financial Improvement Oversight Group (FIOG) launched in January 2023, alongside the new Clinical Leaders Efficiency Group, established in December 2022, chaired by Dr Ali Mehdi, Hospital Medical Director, to provide additional clinical focus. The proposed structural changes will present an opportunity to review the size and scale of the Finance team and the support they provide to Care Groups and Hospital teams.
Business Planning Update and Guidance	Partial Assurance received for the Trust's Business Planning process and guidance for the new financial year 2023/24. 2023/24 planning guidance was published in December 2022 with a focus on fewer national objectives including the recovery of core services and productivity, the long-term plan and transforming the NHS for the future. NHSE will publish 2-year revenue allocations for 2023/24 and 2024/25 with a return to payment by results (PBR) for most elective care, excluding follow up outpatient appointments. Trust, System and Provider activity targets will be agreed as part of the planning process with activity expected to be 'around 130%' of the 2019/20 levels for 2024/25. The financial landscape is extremely challenging next year, with an underlaying deficit for the Trust of c.£45 - £50m included as part of the business planning process. Investments in 2023/24 will be limited with no new investments considered, excluding those clinically essential. The Trust is currently agreeing its internal timetable to ensure completion of the business plan in line with governance for both the Trust and also the ICB, this will require Board approval whilst an interim meeting will be set up for members of the Committee to discuss the double/triple lock mechanic. The first initial draft financial bridge was included in the paper/s and references a deficit ranging between c.£62m and £112m, which includes additional risks such as costs pressures, CIP and depreciation. The capital plan for 2023/24 is currently £17m over the allocated system budget and therefore a capital prioritisation process will occur to reduce the capital budget to Trust and System levels alongside the income and expenditure planning.

	A revenue and Income/Expenditure update will be brought to the next meeting of the Committee.
Capital Plan 2022/23 Quarter 3	Assurance received on delivery of the Trust's year end capital spend forecast of £35.5m. M9 YTD Capital Spend position of £23.7m, represents a £2.1m overspend against the YTD Plan of £21.6m; this is within the available capital funding and therefore it is not a cost pressure, being due to an overall increase in the 2022/23 Capital Programme, which has been approved and reflected in the forecast. The latest agreed year-end forecast of £35.5m, as at M9; represents a break-even position against the Trust's Capital Funding envelope in 2022/23. Mechanical Thrombectomy internal brokerage agreed by the Trust, the Kent & Medway (K&M) Integrated Care System (ICS) and NHSE, as a means of mitigating slippage across financial years; the £2.5m slippage has now been agreed to be allocated between Medical Devices Group (MDG) (£0.42m) and Emergency Department (ED) Expansion (£2.1m).
Updated 2022/23 Borrowing Requirement and Proposed Inter-Company Loan Agreement	The Committee approved the Borrowing Requirement and Proposed Inter-Company Loan Agreement for escalation to the Board of Directors, including authorisation for the Chief Finance Officer or Deputy Chief Finance Officer as well as one of the Assistant Directors of Finance to sign and despatch all documents enabling drawdown or pay back of funds. Loan arrangements made with the Department of Health (DOH) to cover the expected Income & Expenditure (I&E) loss of £30m and an additional £10m of potential cash requirements in 2022/23 to make payments to creditors including NHS Professionals. Cash borrowing is drawn as Public Dividend Capital (PDC) and carries with it a 3.5% dividend. A "simplified" approach to allow inter-company short-term loans between the Trust and 2gether Support Solutions (2gether) established, with both parties agreed to the loan being a maximum of 6 months in duration, with interest payable at the Bank of England Base Rate +1%.
We Care Integrated Performance Report (IPR)	Partial assurance received of the performance against key metrics for 2022/23 including the Breakthrough objectives: Improving theatre capacity, Same Day Emergency Care, Staff involvement and Premium Pay costs. **Improving theatre capacity:** In December the potential opportunity increased to 44 lists, from 37 in the previous month, representing a decline in performance as a result of cancellations and longer waiting times for outpatients. There was a slight deterioration in December of both booked and actual performance. This was impacted by a rise in cancellations, all specialities are individually reviewing. Themes will be presented at Januarys Theatre Optimisation Group.

	Same Day Emergency Care (SDEC) Admissions: The SDEC activity across all services saw increased attendances in December (2,228 v 2,080 in November), driven by an increase across both sites in both medical SDEC & gynaecology SDEC on the Queen Elizabeth the Queen Mother Hospital (QEQM) site and an increase in Frailty on the William Harvey Hospital (WHH) site (46 v 6 in November). However, SEAU at WHH was partially used in November and December to manage the increased inpatient bed requirements (Operational Pressures Escalation Level (OPEL4)) therefore reducing the numbers for SDEC through the unit compared to the previous months (269 v 322 in August 2022). As a key part of the winter funding planning the Trust is working on delivering an extended SDEC model for winter. The opening hours of services at WHH have extended to 22:00. The programme also includes the expansion of the Medical Day Unit at the Kent & Canterbury Hospital (K&C) site, without additional funding, to provide an enhanced service for patients requiring this facility for their care, thereby releasing capacity for the expansion of SDEC services on the QEQM/WHH sites. **Staff Involvement:** The current staff involvement score remained at 6.28 in December with 45 areas now trained as part of the Team Engagement and Development (TED) pilot, including Cardiology and Rheumatology, whilst the We Care rollout has been extended and will also include Urology and Cardiology. **Premium Pay costs:** In December, premium pay costs decreased by £0.2m, the third month of a steady decline in usage. Key Interventions include a detailed focus by Care Groups on drivers of premium pay (including deep dives), a review of bank, agency and overtime rates across all staff groups, an improved sign off processes and governance across the Trust, as well as ensuring exit plans are in place for high cost medical agency locums.
Board Assurance Framework (BAF) and Principal Mitigated Risks	Partial Assurance received that the 11 risks relating to 'Our Future' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or Corporate Risk Register (CRR) in the reporting period. Further information and rigor was requested by the committee in relation to the CIP, changes in leadership, CRR 34 (Failure to sustain and improve health and safety standards across the Trust) and CRR 126 (There is a risk of failure to provide adequate accommodation (residential, training and office).
Proposed Approval process for Amendments to the Operated Health Facility (OHF) and Estate Managed Services (EMS) Contracts and Leases	The Committee approved the proposed process for capturing and approving amendments to the Operated Healthcare Facility (OHF) and Estate Managed Services (EMS) contracts, leases and site maps.

Maternity Estates Phase 1	The Committee approved the Maternity Estates Phase 1 Business Case to ensure safe delivery of services and achievement of the maternity improvement programme, NHSE care competency framework, Clinical Negligence Scheme for Trusts (CNST) and Care Quality Commission (CQC) mandatory requirements, subject to approval by the Clinical Executive Management Group (CEMG). The cost of £1.7m is within the FPC delegated limits.
Strategic Capital Planning and Performance Committee (SCPPC)	The Committee received an assurance report on the activities of the SCPPC on 17 November 2022.
Development of Medical Physics and Clinical Engineering – Update	The Committee received assurance that the Medical Physics and Clinical Engineering Business Case, approved by the Committee in May 2022, is on track and currently at 48% of its value and within the 50% funding agreed in the first year.
Strategic Investment Group (SIG) Assurance Report	The Committee received an assurance report on the activities of SIG on 17 November 2022.
Finance and Performance Committee Annual Work Programme 2022/23	The Committee received and noted the FPC Annual Work Programme for 2022/23.
Other items of business	A 2023/24 interim planning meeting will be arranged in advance of the February Board meeting (9 February 2023).
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:		
N/A		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
Board of Directors:		
1. 2022/23 Borrowing Requirement and Proposed Inter-Company Loan Agreement	Approval	09/02/23
2. Business Planning Update and Guidance	Approval	09/02/23
3. Updated forecast for 22/23 to a £30m deficit	Approval	09/02/23

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety Committee (Q&SC)	26 January 2023	Dr Andrew Catto, Non-Executive Director (NED)	Executive Assistant	**Yes**	
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
In attendance: The Chair welcomed Sir David Dalton from NHS England (NHSE) (Improvement Director) to his first meeting of the Q&SC.					
Assurances received at the Committee meeting:					
Safe Staffing Review Update	*Significant assurance* received of the safe staffing review update and recruitment plans: noting excellent support for Internationally Educated Nurses (IENs) with good retention to date. As at December 2022, there were 162.04 Whole Time Equivalent (WTE) band 5 Registered Nurse vacancies. Since April 2022, the Trust has recruited 401 IEN's, however, due to challenges with the international recruitment agency, 317 of the 401 nurses have arrived since September 2022. NHSE have agreed to part fund the recruitment of an additional 70 IENs in Q4 2022/23 to ensure the Trust can meet and maintain its safer staffing numbers. The current Healthcare Support Workers vacancy is 177 WTE for Bands 2-4; however, the wards are reporting that the majority of their Band 2 vacancies are now recruited to. In November 2022, an assessment centre was held at Queen Elizabeth the Queen Mother Hospital (QEQM), with a similar event held in January 2023 at William Harvey Hospital (WHH). Both were successful with over 40 successful applicants recruited to each site. The success of these assessment centres has resulted in the creation of a pool for each of the sites: WHH 41, QEQM 20 and Kent & Canterbury Hospital (K&C) 2, with the next to be held in February 2023.				
Nursing and Midwifery Safer Staffing Winter Preparedness – EKHUFT Assurance Framework 2022/23	The Committee received *partial assurance* with regards to compliance with the Winter Preparedness EKHUFT Assurance Framework. However, it was clear to the Q&SC that considerable work had been done. The Q&SC noted that the use of red flags and the resolving of on the SafeCare system remains inconsistent - targeted training and monitoring continues. The raising of the staffing level red flags in line with deployment plans and a clear induction policy for agency staff are currently RAG-rated "amber".				

Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	*Partial assurance* was received by the Committee of the True North metrics and Breakthrough Objectives for December 2022. Q&SC NEDs continue to challenge on theatre productivity and efficiency, although written evidence and verbal responses to questions indicate is a priority for the leadership team. The Chair was given assurance that theatre productivity best practice was being followed such as participation in the Getting it Right First Time (GIRFT) high volume/low complexity programme. The Chair raised a question about alignment of IPR objectives with the NHSE 2023/24 operating framework and how the Board obtained visibility on the recovery objectives, for example: - Meeting the cancer faster standard (75% referrals in 28 days). - 76% Emergency Department (ED) 4-hour target. 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 around the fractured neck of femur pathway in order to reduce mortality. – **Incidents with harm:** there was a reduction in incidents relating to delay/failure from 17 to 4 in December 2022, despite the increased pressures currently faced by the Trust. – **Deteriorating patients:** the site triumvirates continue to report the deteriorating patient themes at the Patient Safety Committee. As a result, site-based focus groups, facilitated by the governance team as part of the deteriorating patient pathway, Quality Intelligence Forums will commence in February 2023. – The Committee sought assurance that the patents at risk of falls are provided with yellow socks and yellow blankets, and that patients' nutritional requirements are clearly visible for catering staff. – **ED 12hr Total Time in Department:** the Committee noted that the number of patients who spent more than 12 hours in ED had increased in December 2022 (12.2% compared to 9.9% in November 2022). Assurance was received of the interventions in place to improve the total time. – **104-week breach position:** assurance was received that the risk of 104-week breach is reducing rapidly as the Trust is treating patients earlier in their pathway. In December 2022, six breaches were reported as a result of Covid-19 and patients choosing to wait longer for treatment. – The Committee noted that the Cancer 62 Day Referral to Treatment (RTT) performance improved in December 2022 with a lower number of breaches in the month. The Trust remains in the top three performers nationally for 2-week wait access. – **Not fit to reside:** assurance was again 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). – **RTT 18-week standard:** performance in December 2022 deteriorated, due to less patients receiving treatment as a result of

	winter pressures and the wait time for first outpatient appointments now exceeding 18 weeks. – **Patient Experience:** assurance received that although the target of 2,050 inpatient surveys was not achieved, in December 2022 there was an increase in the number of wards completing more than 50 surveys, with the general response positive.
Infection Prevention and Control (IPC) Report	The Committee received *partial assurance* of the current performance about nationally reportable infections and the on-going Covid-19 pandemic, noting the following: – Cases of Pseudomonas aeruginosa and Klebsiella bacteraemia are below trajectory. – Cases of C. difficile remain high in the Trust and across Kent and Medway, exceeding trajectory. There are 74 trusts in England that have exceeded the trajectory so far this year. The reason for this has not yet been fully understood. Cases of E coli also remain over trajectory. – The Chair of Q&SC noted he had held a *separate discussion* with the Director of Infection Prevention and Control (DIPC) on why C. difficile remained off trajectory: the DIPC explained that foremost national experts in the field could not account for the findings. The Chair obtained *significant assurance* that all reasonable steps were being taken. – The number of cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) are improving compared with the previous year. The Trust has had only a single MRSA bacteraemia case, year to date. – A moderate surge of Covid-19, combined with a peak of seasonal Influenza A cases has been very challenging in this period, alongside extraordinary operational pressures. – The Committee noted the findings of the recent Care Quality Commission (CQC) inspection of maternity services, the audit of the antimicrobial stewardship programme and changes to the IPC Committee structure. – The Committee sought assurance on the water safety reporting and the availability of this information.
Care Quality Commission (CQC) Update Report	The Q&SC Chair asked colleagues to reflect on the effectiveness of internal controls given the unannounced CQC maternity inspection leading to a view of *partial assurance*. He also asked colleagues to present the various groups involved in the assurance process as an organogram, so Q&SC members could understand the relationships between the various groups. Members commented that despite considerable effort, the Trust is starting from a “low base” when it should be a Business As Usual (BAU) activity. Members noted that meeting the expected standards of care required good leadership so that our people experience a change in culture and deliver care with “real pride”, “not ticking boxes”.

	– The Journey to Outstanding Care Programme continues to progress with some significant pieces of work being presented to the CQC Oversight & Assurance Group (CQC O&AG) and Journey to Outstanding Care Programme Steering Group (JTOCPSG) this month. – The CQC Assurance Thresholds Framework has been finalised and approved at the December 2022 JTOCPSG. This is to ensure there is consistency across the Trust in the assessment and closure decision making process. – Trust level Thematic review of self-assessments: A trust level analysis has been undertaken to identify the key trust level themes that emerged from the CQC self-assessment review and findings undertaken last year. – The Committee noted the progress in the Well Led workstream. – The review of CQC's registration regulations identified two areas where notifications to the CQC were not being submitted – in relation to deprivation of liberty safeguards (DoLS) applications and outcomes, and death of a patient detained under the Mental Health Act (MHA). The Chair sought assurance that this function was sufficiently resourced (enough people / right skills), given the risk to patients and regulatory imperative of the vulnerable patients who could be subjected to a DOLS or MHA restriction?
EKHUFT Maternity Core Services Mock Care Quality Commission Inspection Report	Considering the January 2023 mock unannounced CQC inspection, it was difficult to conclude anything more than *partial assurance*. The Chair acknowledged that the leadership team had delivered a detailed action plan in response to the January 2023 unannounced inspection, although it was not clear if the CQC would be sufficiently assured not to issue a S31 notice. It was also noted that the whole Board had sight of the action plan immediately prior to submission. The Committee noted that the mock inspection in August 2022 identified cleanliness issues which were also identified in January 2023. Assurance was received that the Committee will be updated on progress in relation to the identified cleanliness issues in the next month's report.
Corporate Principal Mitigated Quality Risks	The *Chair questioned the effectiveness of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR)* as most risks scored around 15-20 and there had been little movement on the risks for 12 months. Q&SC members expressed a range of views including: - The CRR appeared to be a list of issues but how we manage risk is important. - There is a need to articulate the risks more clearly and have clarity on the mitigating actions. - The mechanism for this work is the Executive Risk Assurance Group (ERAG). - What is the alignment with the organisational strategy? At this stage, the Q&SC had *partial assurance* on the process.

	The Committee noted the following: – An additional risk around the oversight of medical device training has been added to the CRR. – There has been an increase in the risk score related to overcrowding in ED. – The Committee sought assurance that the risks are being managed and the BAF is reviewed and aligned to the strategy.
Patient Safety Committee (PSC) Chair's Report	The Committee received an assurance report on activities of the PSC on 1 December 2022, noting the following: – **Of serious concern:** Ophthalmology has had six serious incidents involving moderate or above patient harm reported between 7 September and 13 October 2022. – The Trust has implemented failsafe officers and specialty risk stratification in response to Royal College of Ophthalmologist recommendations. – The Committee sought assurance that the Ophthalmology backlog was reducing and requested to see the data highlighting the patients referred to Community and very high-risk patients from the Ophthalmology backlog. – The impact of the Covid-19 pandemic on capacity has seen the backlog rise, which has stabilized at 11,500. – Quality Intelligence Forum (QIF) has begun to bring some important information to the PSC such as managing patients with mental health conditions in ED and deteriorating patients. – There was one CQC reportable incident in October 2022. This incident required considerable input from Medical Physics. This incident was due to an equipment failure of the gamma camera at WHH, which led to two patients receiving radiation exposure without a clinical outcome.
Fundamentals of Care (FoC) Chair's Report	The Committee noted the assurance report on the activities of the FoC on 13 December 2022. There was *significant assurance* about the progress made, although NEDs commented that they wanted assurance that the momentum would be maintained when the new Chief Nursing and Midwifery Officer (CNMO) came into post.
Clinical Audit and Effectiveness Chair's Report	The Q&SC Chair commented on the enthusiasm of the new clinical audit Chair and the good practice to be noted: - Clinical leadership engagement with the audit programme. - The innovation exhibited by the surgical audit programme. However, the Q&SC Chair noted that 59 (20%) of audits were yet to have an action plan in place. The Committee received an assurance report on the activities of the Clinical Audit and Effectiveness Committee on 13 December 2022, noting the following:

	– The prioritisation of audits and the capacity of the audit team is being monitored and addressed.
Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee received an assurance report on the activities of the MNAG on 12 December 2022 and noted the following: – Newborn Life Support (NLS) and fetal heart monitoring training were reported as compliant for all staff groups, however, PRactical Obstetric Multi-Professional Training (PROMPT) fell below 90%, impacted by workforce challenges. – There was one serious incident in November 2022 around pre-term delivery at WHH. – Two Obstetricians were appointed for WHH, one who has already started with the Trust and another due to start in April 2023. – The main concerns raised by staff were in relation to the issues associated with the exposure to Entonox and staffing levels. – A confidential report was presented, following observations made by an external obstetrician and senior midwife around culture and behaviours at the WHH. The Group reached agreement as to how this would be shared with senior teams across the Care Group and action to be taken to address the issue/s.
Terms of Reference (ToR) for Patient Participation and Action Group (PPAG)	The Committee approved the Terms of Reference for Patient participation and Action Group (PPAG).
Organ Donation	The Committee approved and was assured by the pandemic recovery efforts being made by the team as highlighted in the Organ Donation report: – In the last six months the Trust facilitated six solid organ donors which resulted in 17 patients receiving a transplant. – The number of registered organ donors is beginning to recover after the pandemic; however, has not reached the pre-pandemic level. – The Trust currently facilitates 16-18 transplants a year and this number is expected to increase in the next two years. – Two new Specialist Nurses have joined the team, while an Organ Donation Clinical Lead for QEQM has been appointed.
Other items of business	N/A
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:		
N/A		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**

BoD: Alignment of **IPR objectives** with the NHSE 2023/24 operating framework and how the Board obtained visibility on the recovery objectives, for example: - Meeting the cancer faster standard (75% referrals in 28 days). - 76% ED 4-hour target. There is a related discussion for the Board on the ***format of the IPR*** and the appropriateness / completeness of the *metrics* (a NED question on the inclusion of virtual ward data for example). The Board should reflect on **where** the IPR is discussed (Q&SC/Finance and Performance Committee (FPC)/BoD). Can we rationalise?	Internal assurance / external assurance 'managing up to Region and ICB'	February 2023 BoD
BoD: Effectiveness of CQC compliance processes. Although effective systems of internal control and processes are a given, the fundamental elements of good leadership, culture, and a great place to work must be in place to deliver and empower our people to make the change. CQC compliance is a symptom of the Trust's attitude, behaviour and culture as articulated by Kirkup. Until we turn the dial on behaviours, delivering compliance with basic standards of care will remain a substantial challenge. A NED question was raised on the Board's visibility of the culture programme. On the report (22/183), NEDs commented it could be improved by demonstrating more clearly if we are on track or not?	Internal and external assurance.	February 2023 BoD
BoD: review of CRR and BAF The Chair questioned the effectiveness of the BAF and CRR as most risks scored around 15-20 and there had been little movement on the risks. Q&SC members expressed a range of views including: - The CRR appeared to be a list of issues but how we manage risk is important. - There is a need to articulate the risks more clearly and have clarity on the mitigating actions. - The mechanism for this work is the ERAG.	Internal and external assurance.	February 2023 BoD & ERAG
Ophthalmology backlog and patient harm The Board is asked to note the follow-up backlog of circa 11,500 cases and 6 instances of harm between September and October 2022. The Q&SC received assurance that	Internal and external assurance.	February 2023 BoD

there was a process in place for managing the risk and that external Royal College of Ophthalmologist advice had been sought. *However, the serious personal cost of visual impairment and sight loss must not be underestimated by the Board.*		
Overall structure and duration of the Q&SC meeting Efforts are underway to restructure the meeting and reduce the duration down from 3.5 hours. Several agenda items could be considered by alternative groups and committees and the IPR content and reporting restructured.		Q&SC Ongoing – but aim to complete by April 2023.

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Integrated Audit and Governance Committee (IAGC)	24 January 2023	Olu Olasode Non-Executive Director (NED and SID)	Board Support Secretary	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No additional declarations of interest were made.					
Assurances received at the Committee meeting:					
Meeting with IAGC members	**Membership of the Committee** • As the high-level Committee with overarching responsibility for governance, risk management, and internal control, the IAGC is comprised of Chairs of the other Board Committees. It is, however, unclear why the Chair of the Finance and Performance Committee (FPC) is the only Board Committee Chair who was not a member and does not attend IAGC meetings. • Members discussed the potential gap in the assurance around the Trust's Financial Control, Fraud Prevention, Annual Accounts and Audits, beyond what is received from Internal and External Audits, and the vehicle for taking forward key issues in these areas. • The Committee agreed that the IAGC Chair will take this forward with the Trust Chairman and Group Company Secretary to recommend a change to the Trust's Constitution. **Closed meeting with External Auditors, Internal Auditors and Counter Fraud Service** • Members discussed the need for pace in management actions to address control gaps and the need for due diligence in the midst of the ongoing pressure. **Closed meeting on emerging risks, governance, and assurance matters** • IAGC members discussed the changes within the Executive Team and the gaps, risks and opportunities that these present to the organisation. Members also discussed potential risks identified during individual visits and conversations with colleagues. Details of these are included in separate sections below.				
IAGC Decisions outside the Committee	The Committee ratified the decisions taken outside the IAGC business cycle: • Confirmed agreement to the appointment of an interim Chief Operating Officer (COO) and the four-week early release of the current COO;				

	• Confirmed recommendation to the Nominations and Remuneration Committee (NRC) the approval of the appointment of an interim COO and the four-week early release of the current COO. • The Committee agreed with the extraordinary circumstances that led to the decision to breach the codes and ratified the retrospective approval of the risk reports and the need to include these as disclosures in the Trust's Annual Report. • However, members agreed to invite the Chief Executive to reassure the Committee of the existence of a more robust, planned and strategic approach to managing Executive colleagues' transition to minimise such future breaches. Executive Changes • IAGC members discussed the changes within the Executive Team and the gaps, risks, and opportunities that these present to the organisation. • It was agreed the Chief Executive to present a report to the next Committee meeting outlining the gaps and how these will be covered, risk analysis for each role, timeframe for recruiting substantive replacements, as well as a robust up to date succession plan providing assurance around succession and cover in respect of Deputy roles in place. • It was noted that a risk will be added to the risk register about these changes.
EKHUFT Constitution Advisory Report	• The Committee approved to waive the standing orders, as the normal notice period of six clear days before the meetings had not been fulfilled in respect of a meeting of the Extra-ordinary IAGC and Extra-ordinary NRC meetings held in January 2023.
Internal Audit RSM Risk Assurance Services LLP – Progress Report	The Committee discussed and noted assurance from the Internal Audit Progress Report, noting an increase in management of outstanding follow-up actions, and that since the report had been produced responses had been received about Pharmacy review actions. • The Committee expressed concerns about the increasing number of outstanding management actions on high-priority Internal Audit findings and the apparent lack of pace to address these. For examples, Locum records, risk management training, pharmacy stock. • The Committee agreed to ask the Chief Executive to consider how these will be addressed and closed as a matter of priority. The Committee noted the outcomes of internal audit reports since the last IAGC: • Infection Control – Partial Assurance. Trust managing anti-microbial stewardship, effective Committees in place and governance management, as well as patient safety. Anti-microbial policies needed to link to the Government's five-year plan, the need to ensure embedded anti-microbial stewardship audits undertaken with action plans

	implemented, sufficient staff resources required, and effective communication needed Trust-wide in respect of lessons learnt. • IT Strategy, Management and Disaster Recovery – Partial Assurance. Digital Strategy document in place that needed to be further developed to align with the Trust's Corporate Strategy. The need to have well-established controls and evidence of these of IT disaster recovery and management of IT incidents. • These reports provided reassurance around the processes in place and suggested that further improvement work was needed. Healthcare Review of 2021/22 Internal Audit High Priority Management Actions • As a form of development, the Committee received a report on pressing matters needing to be addressed following the outcomes of a national internal audit reviews of NHS organisations to gain an insight into the key themes arising.
Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – Progress Report	The Committee received and noted assurance from the LCFS progress report on the LCFS activity, noting that Fraud and bribery are inherent risks within the healthcare sector, with the potential to severely impact the Trust's finances, staff and ultimately its ability to deliver effective patient care. The Committee further noted as follows: • Work looking at counter fraud return for the year-end and that standards are being met. As part of this, meetings will be held with the Committee Chair and Chief Finance Officer. • Evaluation report released by the NHS Counter Fraud Authority (NHSCFA) following the national exercise on NHS procurement spent during Covid-19 undertaken. This identified the Trust as 148 of 210 participating organisations for non-Purchase Order (PO) spend as a percentage of total spend in 2019/20 in assessing Trusts' Financial Vulnerability Exposure (FVE). A percentage of 56.8% compared with the average of 36.0%. Action plan included a review and update of the existing procurement fraud prevention guidance by LCFS. • Continued monitoring of risks of potential fraud. • Fraud awareness sessions have been delivered and attended by 221 members of staff, recognising this could result in increased cases being raised. Nationally not seeing increase in cases of fraud, increased attempts of fraud (i.e. timesheet fraud) likely due to current economic environment. • Fraud Culture Survey issued. • LCFS will liaise with Trust to look at Counter Fraud training and whether this could be streamlined and mandatory for 2gether Support Solutions (2gether) staff.

External Audit Grant Thornton: External Audit Progress Report and Sector Update	The Committee received and noted assurance from the External Audit progress report and sector update, noting: • The overview timeline for the 2022/23 annual audit, planning work had commenced to ensure an effective audit, and learning from previous years, with staff assigned who would carry out initial testing. • The 2021/22 annual audit assessment lessons learnt will inform the 2022/23 annual audit and effective planning to ensure submission deadline is met.
Annual Accounts – 2022/23 Review of Accounting Policies	• The Committee received, noted assurance and approved the draft accounting policies for 2022/23.
Annual Presentation on the Process and Timetable of the Annual Quality Report 2022/23	• The Committee received, noted assurance and approved the planned timetable for completion of the Annual Quality Report for 2022/23 building on learning from last year. • The Committee supported the Executive Director of Quality Governance around the importance that Quality Leads assign and commit sufficient allocated focussed time to produce their sections required within the report and that these are submitted against this approved timeframe. This will ensure the timeframe is met and the draft versions are presented through the governance structure for final approval and submission. • The Committee noted a potential new template might be published that will make this report more streamlined and easier to produce.
Draft East Kent Hospitals Charity (EKHC) Annual Report and Accounts 2021/22	• The Committee received assurance and noted the EKHC Annual Report and Accounts for 2021/22, and the Audit Findings report. The Committee, however, did not receive direct input from the FPC.
2gether Annual Report and Financial Statements 31 March 2022 – Plus Audit Findings Report	• The Committee received assurance and noted the 2gether Annual Report and Financial Statements for the year ending 31 March 2022, and the Audit Findings report. The Committee, however, did not receive direct input from the FPC.
Spencer Private Hospitals (SPH) Annual Report and Financial Statements 31 March 2022 – Plus Audit Findings Report	• The Committee received assurance and noted the SPH Annual Report and Financial Statements for the year ending 31 March 2022 and the Audit Findings Report. The Committee, however, did not receive direct input from the FPC.
2gether Subsidiary Governance Review update	The Committee discussed and noted assurance from the 2gether Subsidiary Governance Review update report, noting the key elements included: • Affirming baseline services to help prioritise necessary funding requirements in respect to capital and critical investment plans.

	• Establishing an effective mature partnership relationship supporting the current model, setting out respective responsibilities as 'Intelligent Customer' and 'Intelligent Supplier'. • Establishing a robust overarching governance framework agreement, following this further work will be undertaken to update and strengthen the supporting policies and processes that underpin the respective transaction within the partnership.
Sponsored Study Leave Report	The Committee discussed and noted assurance from the Sponsored Senior Study Leave report noting: • Senior Study Leave Policy and digital application process in place, these will be reviewed and updated, the application will include some mandatory fields for completion. • Funding available and assurance of how this had been used for the purpose it was intended for. • Continued communications promoting the availability of this funding that will be supported by the appointment of a Specialty and Specialist (SAS) lead doctor with site leads driving forward communications to ensure everyone is aware of this funding. The Committee requested further assurance around equality, the next annual report presented include a table showing equality and demographics of staff accessing this training funding.
Risk Appetite	The Committee discussed and noted limited assurance from the Risk Appetite report setting out an alternative approach to developing a risk appetite statement for the Trust. • The Committee recognised the need for the Board to review the Trust's risk appetite once the Trust's Strategy, strategic objectives and True Norths were refreshed. • The Committee agreed the Board Committee meetings needed to ensure sufficient time allocated to review and discuss in detail risks, that these are still appropriate as too are the risk scores, and that the mitigating actions are having an impact to reduce the level of risks and if not what alternative action is needed. It was noted the importance that risk leads be present for these discussions, and that risks align to the Trust's strategic objectives. • The Committee further noted that the current risk appetite statement was developed in 2020 and requires a refresh. The risk appetite uses the Trust Strategic objectives which have not supported the Board in understanding the specific risks the Board is willing to take and tolerate to achieve its strategy. • Members agreed to invite the chief executive officer to produce a report on planned actions to refresh the current Risk Appetite statements of the Trust and integrate them with the emerging strategic objectives of the Trust.
Risk Governance	The Committee discussed and noted limited assurance from the Risk Governance report on the risk governance processes within the Trust.

	• The Committee requested a report be presented to the next Committee meeting providing assurance of robust management of risks and escalation throughout the organisation, and that the risk framework was being followed.
	
	• As well as assurance around the current gap with Executive Risk Assurance Group (ERAG) meetings not being held on a regular basis, that attendance was quorate and being attended by all members, and ongoing input and engagement from Care Groups.
	
	• The Committee noted that this was a key assurance group that reported into the IAGC and provided updates on progress of monitoring, managing risks and mitigating actions to reduce risk scores. Absence of which may lead to:
	  ○ The escalation of principal risks within the Trust may be hindered by the cancellation of the Executive Risk Assurance Group.
	  ○ Risks and issues are currently being managed together and may be misinterpreted.
	  ○ Risk management processes with system partners and subsidiaries may not be sufficiently robust.
	  ○ The Board Assurance Framework may not align with the Trust's strategic objectives.
	  ○ The Trust may not have a systematic approach to scanning for emerging risks.
	
	• The Committee also noted the Trust did not sufficiently horizon scan for emerging risks and supported the Group Company Secretary to take forward in liaison with the Trust Chair and Chief Executive. This was in respect of a future Board and Clinical Executive Management Group risk session about the management of risks by the leadership in the organisation once the Trust's Strategy was refreshed. This will ensure risk is seen as a priority, as well embedding risk management, the escalation and management of risks and that staff are given sufficient time to be able to appropriately manage risks.
	
	• Members agreed to invite the Chief Executive officer to present a report to the next Committee meeting providing assurance of robust management of risks throughout the organisation and the effectiveness of the risk framework; including gaps in assurance if Executive Risk Assurance Group (ERAG) meetings are not held regularly.

Regulatory Compliance Group (RCG)	The Committee received limited assurance from the RCG report, noting:
	• The Group reported into the IAGC, had not met recently, the current and proposed revised Terms of Reference, and what the Group was set up to achieve.
	  ○ The Trust's current governance map presented.
	  ○ The importance of the Group in adding value and assurance of reviewing regulatory and compliance issues for the Trust.
	
	• The Committee supported a discussion with the Executive Team on how regulatory issues can be monitored and reviewed going forward to assess the Trust's position in respect of compliance and non-compliance.

	• The Committee requested a report to be presented at the next Committee meeting providing assurance of identifying an appropriate governance of the monitoring and management of regulatory issues. In particular, that the chief executive officer should consider how regulatory issues will be monitored and reviewed going forward, assess the Trust's position in respect of compliance and non-compliance, and identify an appropriate governance structure that will provide the necessary assurance required by IAGC.
Policy Compliance	The Committee received an update on the activity of the Policy Authorisation Group (PAG) between September and December 2022. It also provides a snap-shot of the status of Trust policies as at the end of December 2022. • The Committee noted the assurance from the Policy Compliance report, noting the mapping of policies to governance framework to be expedited and guidance provided to the Chair of each Group/Committee on the process and purpose of policy review/approval.
Regulatory Improvement Tracker Update	The Committee received and noted reassurance from the Regulatory Improvement Tracker update report, confirmed its support of the use of 4Action as a single source for the management of regulatory action plans. • The Committee noted this will be further discussed by the Executive Management Team (EMT) who needed to support and provide input of this single source for action plans.
Board Assurance Framework (BAF) and Corporate Risk Registers (CRR)	The Committee discussed and noted assurance from the BAF and CRR reports, validation of the data presented following release of the Integrated Performance Report (IPR). • The Committee received assurance of improved alignment to the IPR, future IAGC meeting dates had been amended to ensure these aligned with IPR validated data publication, and monthly meetings are held with Executive Directors to discuss and review risks. • The Committee noted further work to be done on the risk definitions, aggregation and scoring, and the monitoring of control actions by the relevant Executives and Board Committee.
Governance Mapping	The Committee discussed and noted limited assurance from the Governance Mapping report, noting the on-going work on the governance structure and integrated governance guide. • The Committee acknowledged the incredible work taking place within the Trust and pressure on colleagues but noted the need for clear visibility on where both operational rigour on control actions, risk management, governance and assurance are gained in all areas, and questioned the drop in pace of the work on clarifying the Trust's governance processes and the development of a comprehensive assurance map.

	• The Committee agreed to invite the Chief Executive officer to provide a report at the next Committee meeting on the governance structure work, providing assurance on the governance map, escalation and de-escalation mechanisms and the adequacy of control assurance evidence. This should include arrangements with subsidiaries.
Annual Report 2022/23 – Process	The Committee received, noted assurance from and agreed the approval process and timescale for production of the 2022/23 Annual Report. • The Committee supported the draft versions to be circulated to NEDs for review, comment and input prior to the final version being presented for approval and submission. • The Committee noted the timescale for production based on the previous year and awaiting issue of the *NHS Foundation Trust Annual Reporting Manual* to confirm the required submission date.
Annual Self-Assessment of IAGC's Effectiveness	The Committee noted the annual effectiveness review survey had been published for IAGC members and non-members to complete. • A report on the results of the survey will be presented to the next IAGC meeting.
Other items of business	• The Committee received and noted the 2023 IAGC Annual Work Programme (for information). • The Committee noted there were no referrals from other Board Committees to the IAGC. Referrals to other Board Committees • The Committee noted the referral from IAGC to other Board Committees to ensure sufficient time allocated at future meetings to review and discuss in detail risks, that these are still appropriate as too are the risk scores, and that the mitigating actions are having an impact to reduce the level of risks and if not what alternative action is needed. The importance that risk leads be present for these discussions, and that risks align to the Trust's strategic objectives.

Actions taken by the Committee within its Terms of Reference:

None

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 discuss and **NOTE** this assurance report from the IAGC.	Assurance	To Board on 9 February 2023