Board of Directors Meeting - Open (Thursday 10 December 2020)

Thu 10 December 2020, 09:45 - 13:45

via WebEx Teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

09:45 - 09:45
0 min

Agenda

To Note

09:45 - 09:48
3 min

20/117.
Chairman's Welcome - (09:45)

To Note *Chair*

Verbal

09:48 - 09:49
1 min

20/118.
Apologies for Absence

To Note *Chair*

Verbal

09:49 - 09:50
1 min

20/119.
Declaration of Interests

To Note *Chair*

20-119 - REGISTER 2020-21 V10 - from October.pdf (4 pages)

09:50 - 09:55
5 min

20/120.
Minutes of Previous Meeting held on 12 November 2020

Approval *Chair*

20-120 - Unconfirmed Board of Directors public minutes 12.11.20.pdf (11 pages)

09:55 - 10:00
5 min

20/121.
Matters Arising from the Minutes on 12 November 2020

Approval *Chair*

20-121.1 - Front Sheet Open Actions from Public Board.pdf (2 pages)
20-121.2 - Appendix 1 Public Board of Directors Action Log.pdf (1 pages)

10:00 - 10:10
10 min

20/122.
Chair's Report - (10:00)

Discussion *Chair*

20-122 - Chair Report December 2020 BoD.pdf (4 pages)

10:10 - 10:20
10 min

20/123.
Chief Executive's Report - (10:10)

Discussion *Chief Executive*

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

20-123 - CEO Report Final.pdf (4 pages)

10:20 - 10:30
10 min

20/124.
Chief Medical Officer's (CMO) Report - (10:20)

Discussion *Chief Medical Officer*

- **Kent and Medway Medical School (KMMS)**

20-124 - CMO Report December 2020.pdf (2 pages)

10:30 - 10:40
10 min

20/125.
Medical Revalidation - (10:30)

Discussion *Chief Medical Officer*

20-125 - Medical Revalidation.pdf (6 pages)

10:40 - 10:50
10 min

20/126.
Maternity Improvement Committee (MIC) - Chair Report - (10:40)

Discussion *Chair Maternity Improvement Committee - Jane Ollis*

20-126.1 - Front Sheet MIC BoD report.pdf (2 pages)
20-126.2 - Appendix 1 Categories Summary Maternity Improvement Plan.pdf (1 pages)

10:50 - 11:05
15 min

20/127.
Quality Committee - Chair Report - (10:50)

Approval *Chair Quality Committee - Wendy Cookson*

20-127 - QC Chair December 2020 Report.pdf (4 pages)

11:05 - 11:15
10 min

20/128.
Infection Prevention and Control (IPC) Board Assurance Framework (BAF) - (11:05)

Discussion *CEO/CMO/Acting Chief Nurse & Director of Patient Experience and Quality/Director of IPC*

20-128.1 - IPC BAF Front sheet.pdf (2 pages)
20-128.2 - Appendix 1 - IPC Board Assurance review new version final.pdf (35 pages)

11:15 - 11:25
10 min

20/129.
Ethics Committee - Chair Report - (11:15)

Approval *Chair Ethics Committee - Wendy Cookson*

- **Ethics Committee Terms of Reference (ToR)**

20-129.1 - Front Sheet Revised ToR Ethics Committee.pdf (1 pages)
20-129.2 - Appendix 1 Ethics Committee (Covid) ToR v0.4.pdf (4 pages)

11:25 - 11:35
10 min

20/130.
Remote and Rural Excellence (RARE) Strategy - (11:25)

Discussion *Chief Executive / Associate Medical Director - Remote and Rural Strategy*

20-130 - Board Remote and Rural Strategy slides EKHUFT 2.pdf (12 pages)

11:35 - 11:45
10 min

TEA/COFFEE BREAK - 11:35-11:45 (10 Mins)

11:45 - 11:55
10 min

20/131.
Integrated Audit and Governance Committee - Chair Report - (11:45)

Approval *Chair Integrated Audit and Governance Committee - Barry Wilding*

- **Emergency Planning Annual Report**

20-131 - IAGC Chair Front Sheet November 2020.pdf (4 pages)

11:55 - 12:05
10 min

20/132.
Nominations and Remuneration Committee - Chair Report - (11:55)

Approval *Chair Nominations and Remuneration Committee - Sunny Adeusi*

20-132 - NRC Chair Report December 2020.pdf (2 pages)

12:05 - 12:35
30 min

20/133.
Corporate Reporting - (12:05)

Discussion

20/133.1.
Integrated Performance Report

Discussion *Chief Executive / Executive Team*

20-133.1.1 - Front Sheet IPR - December Board.pdf (5 pages)
20-133.1.2 - Appendix 1 IPR October 20 Final v2.pdf (51 pages)

20/133.2.

Strategic Risks Report

Discussion *Group Company Secretary*

- 20-133.2.1 - Board Assurance Framework Risk Register BoD 03.12.2020.pdf (3 pages)
- 20-133.2.2 - Appendix 1 - Board Assurance Framework Risk Register 03.12.2020.pdf (10 pages)
- 20-133.2.3 - Appendix 2 - Corporate Risks (Risks Outside Appetite) 03.12.2020.pdf (2 pages)

12:35 - 12:45
10 min

20/134.
Strategic Workforce Committee - Chair Report - (12:35)

Approval *Chair Strategic Workforce Committee - Jane Ollis*

- 20-134.1 - SWC public.pdf (2 pages)
- 20-134.2 - Appendix 1 SWC Biannual Report Front Sheet Nov 20 v2.pdf (2 pages)
- 20-134.3 - Appendix 1 Biannual CNST Report November 20 V4 Final.pdf (21 pages)
- 20-134.4 - Appendix 1 Guidance for Midwifery and Support Worker Staffing Levels.pdf (31 pages)

12:45 - 12:55
10 min

20/135.
Finance and Performance Committee - Chair Report - (12:45)

Approval *Chair Finance and Performance Committee - Nigel Mansley*

- **Month 7 Finance Report**
- **Business Cases**

- 20-135.1 - FPC December Chair Report.pdf (6 pages)
- 20-135.2 - APPENDIX 1 - M7 Finance Report.pdf (26 pages)
- 20-135.3 - Appendix 2 Surgical Emergency Assessment Unit Business Case.pdf (3 pages)
- 20-135.4 - Appendix 3 Statutory Compliance Business Case.pdf (2 pages)
- 20-135.5 - Appendix 4 Radiology Equipment Replacement Programme.pdf (2 pages)
- 20-135.6 - Appendix 5 ITU MoU.pdf (2 pages)
- 20-135.7 - Appendix 6 ED Expansion Business Case QEQMH WHH.pdf (2 pages)
- 20-135.8 - Appendix 7 Covid Testing Additional Resources.pdf (2 pages)
- 20-135.9 - Appendix 8 Extension Pathology Service Managed Contract.pdf (5 pages)

12:55 - 13:05
10 min

20/136.
Charitable Funds Committee - Chair Report - (12:55)

Approval *Chair Charitable Funds Committee - Sunny Adeusi*

- **Charitable Funds Annual Report and Accounts**
- **Charitable Funds Letter of Representation**

- 20-136.1 - CFC Chair Report December 2020.pdf (4 pages)
- 20-136.2 - Appendix 1 Annual Report Accounts saved 2020 1 Dec 2020.pdf (38 pages)
- 20-136.3 - Appendix 2 Letter of Representation - Trust Headed.pdf (3 pages)

13:05 - 13:20
15 min

20/137.
Health and Safety and Estates Statutory Compliance Update - (13:05)

Approval *Director of Strategic Development and Capital Planning*

- 20-137 - Trust Board Brief Dec 2020 Health and Safety and Statutory Compliance.pdf (5 pages)

13:20 - 13:25
5 min

20/138.
Any other business - (13:20)

Discussion *Chair*

Verbal

13:25 - 13:35
10 min

20/139.
QUESTIONS FROM THE PUBLIC (13:25)

Discussion *Chair*

Verbal

Date of Next Meeting: Thursday 11 February 2021 as a WebEx Teleconference

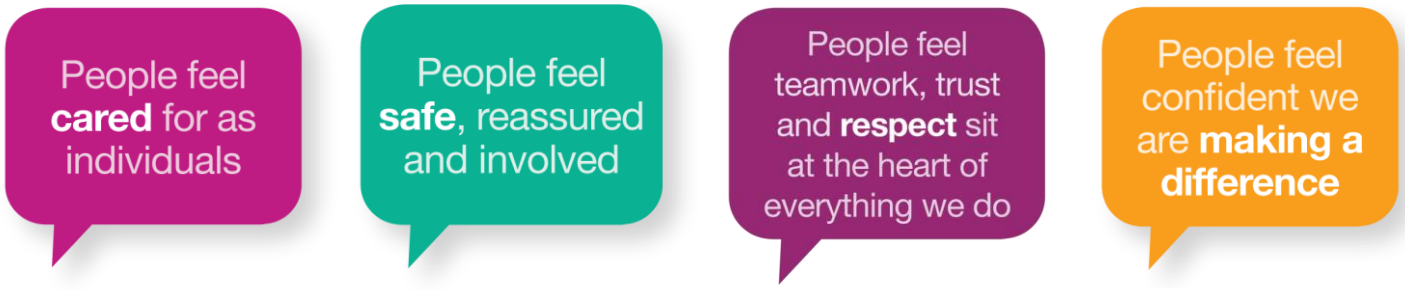
The public will be excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS MEETING – THURSDAY 10 DECEMBER 2020

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place **as a WebEx teleconference –** commencing at **9.45 am to 1.45 pm**.

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



AGENDA

20/

OPENING MATTERS

117	Chairman's welcome		**09:45**	Chair
118	Apologies for Absence			
119	Declaration of Interests			
120	Minutes of Previous Meeting held on 12 November 2020			
121	Matters Arising from the Minutes on 12 November 2020			
122	Chair's Report	**Discussion**	**10:00** **10 mins**	Chair
123	Chief Executive's Report • Kent & Medway (K&M) System Partnership Working	**Discussion**	**10:10** **10 mins**	Chief Executive

Our patients | Our people | Our quality and safety

124	Chief Medical Officer's (CMO) Report • Kent and Medway Medical School (KMMS)	**Discussion**	**10:20** **10 mins**	Chief Medical Officer
125	Medical Revalidation	**Discussion**	**10:30** **10 mins**	Chief Medical Officer

126	Maternity Improvement Committee (MIC) – Chair Report	**Discussion**	**10:40** **10 mins**	Chair Maternity Improvement Committee – Jane Ollis
127	Quality Committee - Chair Report	**Approval**	**10:50** **15 mins**	Chair Quality Committee - Wendy Cookson
128	Infection Prevention and Control (IPC) Board Assurance Framework (BAF)	**Discussion**	**11:05** **10 mins**	Chief Executive/ Chief Medical Officer/ Acting Chief Nurse and Director of Patient Experience and Quality/ Director of IPC
129	Ethics Committee - Chair Report • Ethics Committee Terms of Reference (ToR)	**Approval**	**11:15** **10 mins**	Chair Ethics Committee - Wendy Cookson

Our future

Our sustainability

130	Remote and Rural Excellence (RARE) Strategy	**Discussion**	**11:25** **10 mins**	Chief Executive/ Associate Medical Director – Remote and Rural Strategy
	TEA/COFFEE BREAK	**11:35 – 11:45** **10 mins**		
131	Integrated Audit and Governance Committee – Chair Report • Emergency Planning Annual Report	**Approval**	**11:45** **10 mins**	Chair Integrated Audit and Governance Committee – Barry Wilding
132	Nominations and Remuneration Committee – Chair Report	**Approval**	**11:55** **10 mins**	Chair Nominations and Remuneration Committee – Sunny Adeusi

Our patients

Our people

Our quality and safety

133	Corporate Reporting		**12:05** **30 mins**	
	133.1 Integrated Performance Report	**Discussion**		Chief Executive/ Executive Team
	133.2 Strategic Risks Report	**Discussion**		Group Company Secretary

We care

NHS
East Kent
Hospitals University
NHS Foundation Trust

Our future | Our sustainability

134	Strategic Workforce Committee – Chair Report	**Approval**	**12:35** **10 mins**	Chair Strategic Workforce Committee – Jane Ollis
135	Finance and Performance Committee – Chair Report • Month 7 Finance Report • Business Cases	**Approval**	**12:45** **10 mins**	Chair Finance and Performance Committee – Nigel Mansley
136	Charitable Funds Committee – Chair Report • Charitable Funds Annual Report and Accounts • Charitable Funds Letter of Representation	**Approval**	**12:55** **10 mins**	Chair Charitable Funds Committee – Sunny Adeusi
137	Health and Safety and Estates Statutory Compliance Update	**Approval**	**13:05** **15 mins**	Director of Strategic Development and Capital Planning
CLOSING MATTERS				
138	Any other business		**13:20** **5 mins**	
139	**QUESTIONS FROM THE PUBLIC**		**13:25** **10 mins**	

Date of Next Meeting: Thursday 11 February 2021 as a WebEx Teleconference

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

We care


Our mission:
Improve health and wellbeing
Our vision:
Great healthcare from great people
We care about...
Our patients
Our people
Our future
Our sustainability
Our quality and safety
People feel cared for as individuals
People feel safe, reassured and involved
People feel teamwork, trust and respect sit at the heart of everything we do
People feel confident we are making a difference

We care

REGISTER OF DIRECTOR INTERESTS – 2020/21 FROM OCTOBER 2020

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) (started 16 October 2017) **(4)**	Appointed 1 April 2018
ADEUSI, SUNNY	Non Executive Director	Leadership role for Zimmer Biomet (global US medical device/technology corporation in Europe, Middle East & Africa (EMEA) Regional Commercial & Marketing) (started 16 September 2019) **(4)**	1 November 2015 (Second term)
ASHMAN, ANDREA	Director of HR	MY Trust (started 11 November 2014) **(4)**	Appointed 1 September 2019
CAVE, PHILIP	Director of Finance and Performance	Wife works as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Group's (CCG's) of East Kent in their contracting (started 9 October 2017) **(5)** Non Executive Director of Beautiful Information Limited (started 3 November 2017) **(1)**	Appointed 9 October 2017
COOKSON, WENDY	Non Executive Director	Managing Director of IdeasFourHealth Ltd, a consultancy for the healthcare industry (started 22 July 2011) **(2)** Sole Shareholder for IdeasFourHealth Ltd (started 6 January 2017) **(3)** Chair of Bede House Charity, a local community charity in Bermondsey, London (started 28 August 2019) **(4)** Member of Health Advisory Board for OCS Group UK (started 15 March 2018) **(5)** Non Executive Director of Medway Community Healthcare (started 1 August 2018) **(1)**	6 January 2017 (Second Term)

REGISTER OF DIRECTOR INTERESTS – 2020/21 FROM OCTOBER 2020

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)** Member of Liberal Democrats, until 14 June 2020 **(6)**	Appointed 13 December 2019
LAYBOURNE, TARA	Acting Chief Nurse & Director of Patient Experience and Quality	None	1 October 2020
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd (started 1 July 2017) **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018) **(1)**	1 July 2017 (Second term)
MARTIN, LEE	Chief Operating Officer	None	Appointed 1 August 2018
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OLLIS, JANE	Non Executive Director	The Heating Hub (started 8 May 2017) **(1)** Non Executive Director of the Kent Surrey Sussex Academic Health Science Network (AHSN) (started 1 July 2018) **(1)** Founder of MindSpire (started 30 October 2018) **(1)** Non Executive Director of Community Energy South (started 30 October 2018) **(1)** Vice President of the British Red Cross in Kent (started November 2018) **(4)** Non Executive Director of 2gether Support Solutions (started 22 May 2019) **(1)** Non Executive Director of Riding Sunbeams (started February 2020) **(1)**	8 May 2017 (Second term)

REGISTER OF DIRECTOR INTERESTS – 2020/21 FROM OCTOBER 2020

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
SMITH, STEPHEN	Chair	Stephen Smith Ltd (started 27 March 2003) **(1)** Non Executive Director of NetScientific Plc (started 17 February 2016) **(1)** Trustee of Pancreatic Cancer UK (started 16 August 2016) **(1)** Trustee of Epilepsy Society UK (started 27 November 2018) **(4)** Chairman of Signum Health Ltd (started 17 April 2019) **(1)** Senior Advisor of Ministry of Health – Saudi Arabia **(4)** (started 23 September 2019) **Closed interests** Non Executive Director of uMed Ltd (started 1 March 2018/finished 1 March 2019) **(1)** Non Executive Director of Draper and Dash (started 27 November 2018/finished 14 October 2019) **(1)** Chairman of Biotechspert Ltd (started 4 September 2017/finished 7 February 2020) **(1)** Chair of Scientific Advisory Board (started 1 March 2018) **(4)**	1 March 2018
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive (started 16 May 2018) **(4 & 5)**	11 May 2015 (Second term)

REGISTER OF DIRECTOR INTERESTS – 2020/21 FROM OCTOBER 2020

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

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

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

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

Healthex Limited:
Elisa Llewellyn – Nominated Director
Bernard Pope – Nominated Director
Alison Fox – Nominated Company Secretary

Beautiful Information Limited:
Philip Cave, Nominated Director
Paul Stevens, Nominated Director
Alison Fox, Nominated Company Secretary

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED & FIFTH MEETING OF THE BOARD OF DIRECTORS THURSDAY 12 NOVEMBER 2020 AT 9.45 AM AS A WEBEX TELECONFERENCE

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive Officer	SAc
Mr S Adeusi	Non-Executive Director	SA
Mrs A Ashman	Director of Human Resources & Organisational Development	AA
Mr P Cave	Director of Finance and Performance Management	PC
Mrs W Cookson	Non-Executive Director	WC
Ms T Laybourne	Acting Chief Nurse and Director of Patient Experience and Quality	TL
Mr N Mansley	Non-Executive Director	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Mrs J Ollis	Non-Executive Director/Vice Chair	JO
Ms L Shutler	Director of Strategic Development and Capital Planning/ Deputy Chief Executive	LS
Mrs L White	Hospital Operational Director, Queen Elizabeth the Queen Mother Hospital (QEQMH) (on behalf of the Chief Operating Officer)	LW
Mr B Wilding	Non-Executive Director	BW

ATTENDEES:

Mrs A Fox	Group Company Secretary	AF
Professor C Holland	Associate Non-Executive Director	CH
Mrs N Yost	Director of Communications and Engagement	NY

IN ATTENDANCE:

Ms S Adam	Improvement Director, NHS England/NHS Improvement (NHSE/I)	SAd
Ms S Mumford	Director of Infection Prevention and Control (DIPC)	SM
Miss S Robson	Board Support Secretary (Minutes)	SR
Ms F Wise	Executive Maternity Services Strategic Programme Director	FW

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr S Carter	Member of the Public
Mrs J Chittenden	Governor
Ms C Gregory	Member of the Public
Mr J Ho	Member of the Public
Mr M Jones	Member of the Public
Mr A Lister	Governor
Mr B Thew	Member of the Public/Liaison Group
Mrs M Warburton	Governor
Mrs C Wearing	Governor

MINUTE NO.		ACTION
20/101	**CHAIRMAN'S WELCOME** The Chair welcomed members, attendees, Governors and representatives from NHSI and members of the public who had also joined the meeting.	

20/102 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Mr L Martin (LM), Chief Operating Officer, the QEQMH's Hospital Operational Director, LW, was in attendance on his behalf.

20/103 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

20/104 **MINUTES OF THE PREVIOUS MEETING HELD ON 15 OCTOBER 2020**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 15 October 2020 as an accurate record.

20/105 **MATTERS ARISING FROM THE MINUTES ON 15 OCTOBER 2020**

Action B/006/20 – Integrated Performance Report (IPR)
PC confirmed there were no known negative impacts for patients with regards to the deterioration in the reduced percentage of uncoded spells. He commented this was a live metric, had improved further through the month and was registering green for September. This action was agreed for closure.

Action B/007/20 – Strategic Risks Report
LS confirmed risk BAF 4 had been updated including the increased total backlog maintenance costs of £120m identified in the 6 facet estates survey. This action was agreed for closure.

Action B/008/20 – Strategic Risks Report
SAc confirmed risk BAF 30 had reviewed, the inherent risk score increased to 12 (moderate), residual risk score remained 9 (moderate), and controls and mitigating actions were in place. This action was agreed for closure.

Action B/009/20 – Update on Winter Planning and Capacity
LW explained the reduction in activity for the month of March 2021 in the plan was due to the forecast using the previous year's activity data that reflected the reduction in Emergency Department (ED) attendances as a result of Covid-19 first wave. She confirmed the plan had been adjusted to reflect normal activity. This action was agreed for closure.

Action B/010/20 – Questions from the public
AA confirmed the details regarding the staff listening events scheduled had been provided to the Royal College of Nursing (RCN). All these events had been held and during the second lock-down had taken place by WebEx, these had been well attended and received by staff with good discussions and responses. This action was agreed for closure.

DECISION: The Board of Directors noted the updates and **APPROVED** all the actions for closure.

20/106 **CHAIR'S REPORT**

The Chair reported his term of office ended in March 2021, would not be seeking a further term and would be leaving the Trust at the end of his fixed term. As he would be expanding his involvement in a major international health transformation programme in the Middle East. He expressed it had been a genuine privilege to be the Trust's Chair over the last two and a half years, working with such committed and dedicated staff in managing the major challenges faced in treating the large East Kent population. In particular the exceptional bravery, selflessness shown by staff by continuing to come to work, the personal sacrifices made by staff to ensure patients continued to be treated during the coronavirus pandemic. This was acknowledged during Thank You Week (at the end of October 2020). He extended thanks to the continued hard work and commitment of all the Trust staff as it prepared for the pandemic second wave.

The Chair reported Governor elections had been deferred to the New Year enabling operational focus of the Trust in managing the second wave. He congratulated Mr Alex Lister, who had been voted Lead Governor following the resignation of Mr John East and wished them both good luck in their new roles.

The Chair reported the Non-Executive Directors were adhering to Infection Prevention and Control (IPC) Personal Protective Equipment (PPE) guidance and not visiting the hospital sites and attending meetings by WebEx. He thanked the Executive Directors for their continued hard work and support to the Trust and its staff, providing leadership in visiting wards and departments talking and listening to staff.

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

20/107 **CHIEF EXECUTIVE'S REPORT**

- **COVID-19 GOVERNANCE**

SAc highlighted the key elements from her report as detailed below:

- Officially opened the new eight-bed Intensive Treatment Unit (ITU) and critical care service at William Harvey Hospital (WHH) enabling Covid and non-Covid patients to be treated in separate areas. This was an excellent facility providing state-of-the-art technology with good collaboration between clinical leads, estates staff and contractors to put this new unit in place;
- A ward at Queen Elizabeth the Queen Mother Hospital (QEQMH) had been transformed into an ITU enabling the separation of treating Covid and non-Covid patients;
- During Thank You week spent two days and evenings visiting as many wards and departments in the Trust's five hospitals talking to staff and thanking them for their dedication and continuing to come to work to treat patients;
- Currently 50 Covid positive patients were receiving treatment in the hospitals, this number was expected to increase until the mitigations and impact from this second lock-down were realised;
- Covid-19 governance structure in respect of the Strategic Gold Incident Management Committee in place, which included representation on the various meetings from Executive Directors, Non-Executive Directors,

Hospital Operational Management teams, lead clinicians, DIPC, and Director of Pharmacy. This provided a robust structure for high-level clinical decision-making ensuring rapid decisions were made as and when required and the appropriate tactical and operational support was in place and available;

- Operational pressures continued that were exacerbated with the on-going building work programme to manage Covid requirements, e.g. additional oxygen supplies, donning and doffing areas, social distancing;
- Virtual clinics continued to be held as much as possible to reduce footfall on the hospital sites with focus on ensuring elective work continued, cancer activity remained a priority as well as ensuring safe patient pathways during the pandemic.

In response to a question raised by NM regarding Covid patient numbers and when these would have an impact on elective activity; SAc reported an escalation process was in place and when triggered additional support transferred to the areas impacted. Provision of more senior staff had been put in place at the front door to limit unnecessary admissions.

SA enquired regarding the new heightened testing regime and the plans for testing Trust staff. SAc commented on the very good and encouraging news with regards to a vaccine being available more quickly than expected. The Trust would be looking at a vaccination programme for rollout and the logistical challenges regarding how the storage requirements would be managed. The Trust was also working on a programme to increase the frequency of staff testing with additional capacity and equipment now in place.

JO enquired regarding staff morale and the importance of ensuring staff felt safe and supported in managing their anxiety and concerns, noting the improved position with regards to PPE provision and staff testing. SAc reiterated her hospital visits and discussions with staff, some of whom remained anxious and others more resilient to the challenge ahead in managing the second wave. There was much better preparation following experience of the first wave, e.g. with PPE supplies and ITU capacity. The Trust remained focussed on retaining elective and emergency activity and conscious of the need to step-down other activity if escalations were triggered. She emphasised attendances to the Emergency Departments (EDs) had returned to pre-Covid numbers.

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

20/108 **CHIEF MEDICAL OFFICER'S (CMO) REPORT**

RM described the current key actions and plans to maintain safe and high-quality services to patients as noted below:

- Maintaining focussed delivery on the Trust's IPC plan with improved and clarified Standard Operating Procedures (SOPs);
- Improved Board visibility of the information it needs to have access to and be kept up to date on;
- Implementation of the new Royal College of Emergency Medicine (RCEM) standards on managing safe social distancing in the EDs with clear escalation plans in place for staff to follow. Mitigating actions in place that

included the expansion works to increase ED footprints;
- Review of the patient FIRST support tool designed by clinicians, for clinicians including practical solutions for implementation to support good, efficient and safe patient care in the EDs;
- Current quality and safety governance remained, membership of meetings was being reviewed to ensure these were streamlined and focussed on key risks and issues in line with the terms of reference (ToR);
- Suspension of large group face to face training events during national lockdown, and virtual learning continued to be supported as well as essential 1:1 clinical training.

The Chair enquired regarding nosocomial infection rates in respect of healthcare associated infections (HCAI). RM reported following the increase in Covid patients there had been a few cases of HCAIs, the Root Cause Analysis (RCA) were being reviewed to understand the reasons and identify lessons to be learnt. Some incidents were due to patients who were asymptomatic. SM stated there was on-going work to improve staff awareness to minimise and mitigate cross infection risks as much as possible and staff testing. She provided assurance that all patients were tested prior to admission and on day 5 to 7 following admission.

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

20/109 **MATERNITY IMPROVEMENT COMMITTEE (MIC) – CHAIR REPORT**

FW confirmed the key issues discussed at the MIC as detailed below:

- Next step in respect of the development of the Maternity Strategy was to produce a public facing document with input from HealthWatch and Maternity Partnership Voices;
- Further work to refine the 90-day stabilisation plan and check deliverability;
- The need to focus on the Overarching Improvement Action Plan, agreement to establish a Sub-Committee that would oversee the closure of the Maternity Improvement actions;
- Continued focus on maintaining and further development of the required safety culture with delivery of sustained clinical leadership;
- Further planned visit on 18 November as part of the National Maternity Safety Programme from the National Maternity team, which would provide the Trust with the opportunity to update the team regarding progress on their recommendations made.

FW responded to a question raised by the Chair confirming there was clear evidence that positive progress and improvements had been achieved. She commented these included the appointment of additional consultants and midwives, and the provision of robust consultant rota cover at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQMH). It was important to evaluate the impact and difference these had made to improving the outcome of experience to the users of Maternity Services.

SAc highlighted the positive feedback received following her hospital site visits from the Fetal Monitoring Midwives in relation to their work and positive impact improving patient outcomes.

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

20/110 **QUALITY COMMITTEE (QC) – CHAIR REPORT**

WC highlighted the key issues as noted below:

- Maternity update report;
- IPC Board Assurance Framework (BAF) discussed, noting the on-going challenge for the Trust with the lack of sufficient side rooms. Assurance was received regarding mitigations in place by ward staff to reduce the risks around cross infection to ensure the safety of patients and staff was maintained;
- Integrated Performance Report (IPR) – mixed sex accommodation (MSA) continued to be an area of concern, noted the challenges with managing this to reduce the number of breaches. This was being mitigated as much as possible, ward staff did everything they could to maintain patient dignity when there was a breach. The Trust was prioritising infection control in respect of Covid and non-Covid blue and red patient pathway streams that would continue to impact on MSA. This would continue to be closely monitored through the risk register;
- There was a new method of reporting falls resulting in increased number of falls with harm, which would continue to be closely monitored.

In response to a question raised by NM regarding community and hospital acquired C.Diff cases; SM confirmed the number of cases were reported to the QC and that the Trust was currently above its trajectory of 81 cases to date at the end of September. She commented this was significantly high compared to its trajectory of 47, highlighting a month on month reduction in the number of cases was being seen but it was unlikely that the trajectory would be achieved at year-end. She reported the target set by Public Health England (PHE) was realistic and had been assessed on the Trust's performance during the previous year. It was noted the Trust was now accountable for patient infections two days after being admitted to hospital.

SAc enquired regarding progress against the flow and management of linen new initiative and when this would be completed. SM reported a pilot had been successfully completed on one of the hospital sites and this was being rolled out across the Trust with targeted work to support Matrons with its implementation.

In response to a question raised by SA regarding the effective management of IPC and PPE; SM reported Executive Directors were undertaking Board to Ward rounds speaking to staff on the front-line and obtaining their comments and feedback. The Hospital site trivumulate teams, as well as the DIPC and IPC team were also carrying out ward and department visits with positive feedback on the improved senior management visibility. There was good engagement and improvements with local management teams publicising staff messages in respect of staff adhering to IPC, PPE policies and procedures and what was expected from every member of staff. She stated she had produced another staff video specifically targeting 2gether Support Solutions (2gether) staff in relation to IPC and PPE requirements for areas across the hospitals. New posters were being disseminated across wards and departments.

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

20/111 **PATIENT FIRST – PROJECT RESET IN EMERGENCY MEDICINE (CARE QUALITY COMMISSION) UPDATE**

TL summarised the patient FIRST toolkit produced on 1 October 2020, the gap analysis undertaken by the Trust in line with its principles to support emergency care as noted below:

- Practical solutions to support good, efficient and safe patient adult and paediatric care;
- Sharing experience and learning;
- The Trust had been successful in recruiting additional staff to its EDs over the last couple of months, along with a business case being progressed through the governance route for approval to increase the ED staffing modelling;
- Further work was needed to address patient flow and specialty assessment review as part of the Trust's winter plan, that included putting in place increasing the provision of the discharge lounge to 24/7;
- Bed modelling review.

BW highlighted the main issue for the Trust with regards to patient flow, ensuring patients were discharged when medically fit and the availability of adequate numbers of beds, as all Trusts had previously been asked to reduce its overall bed numbers. LW stated the Trust had successfully managed to close the gap in beds by 104 with the reopening of a ward, and blue and red patient pathways across the hospital sites. As well as during December the development with the frailty wards around closer collaborative working with the community of an ambulatory treatment pathway. This would ensure prompt treatment and discharging of patients, with additional capacity across the system to support each other and improve the support to patients.

LS reported the Trust had undertaken an analysis of its hospital beds with the Getting it Right First Time (GIRFT) team and within its Clinical Strategy there was provision of approximately 200 additional beds.

DECISION: The Board of Directors noted and **APPROVED** the Patient FIRST report.

20/112 **KENT & MEDWAY (K&M) INTEGRATED CARE SYSTEM (ICS) ACCREDITATION**

SAc stated the report set out the continued development towards system working in relation to the K&M ICS accreditation submission. ICS were more advanced forms of the current Sustainability and Transformation Partnership (STP) with greater responsibilities working as a system and for holding regionally delegated authorities/autonomies to further facilitate the integration of care. Oversight from NHS England/NHS Improvement would continue. She explained the Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs) would feed into the ICS. She emphasised the strong working relationships in place across the local health system and the Directors of Finance working collaboratively as a system to support future financial sustainability.

SAc highlighted the fundamental important element was the PCNs that involved GPs as the majority of patients visited their GPs, these were new and young organisations that needed time and support to develop.

SA enquired regarding the flow of financial allocation from the ICS to the local NHS organisations. PC reported formal guidance was awaited and commented that it was likely funding would be provided from NHSE to the Clinical Commissioning Group (CCG) for allocation, the local system would work together on this and it was expected a system wide control target would be required. The current system wide block contract arrangement would continue that provided a level of certainty.

The Board of Directors discussed and **NOTED** the K&M ICS Accreditation report.

20/113 **CORPORATE REPORTING:**

20/113.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

SAc highlighted the key elements regarding the Trust's performance in September as detailed below:

- The Trust remained under continued operational pressure, further impacted as a result of closed beds due to the on-going building programme works that would be eased once these had been completed;
- On plan with the Trust's Reset and Recovery in relation to cancer, elective, diagnostic and outpatient activity;
- MSA breaches continued to be an area of challenge, IPC remained the priority and reducing the movement of patients (unless for clinical reasons) to reduce IPC risks as much as possible. Highlighting this would result with increased numbers of MSA breaches.

JO commented on the good news regarding performance against the 18 weeks referral to treatment (RTT) standard, raising concern regarding the backlog size and what was being done to reduce this. SAc emphasised the Trust was a large acute trust with a high volume of patient referrals, including speciality treatment, the waiting list incorporated routine patients. She highlighted cancer activity had continued during wave one. LW confirmed potential harm reviews were carried out against all 104 day patients to provide assurance of no harms, currently there were three patients waiting 104 days or more for treatment or potential diagnosis against the cancer 62 day standard. The Trust continued waiting lists validation by telephoning patients to confirm they wished to continue to remain on the waiting list. It was noted some patients took the decision to wait until after the pandemic, these cases were reviewed by a clinician, a letter sent to their GP and recorded in their patient notes.

SA raised the reduction in staff turnover and sickness absence, and enquired whether staff were being encouraged to take their annual leave to ensure they had regular breaks and time to recuperate. AA commented it had been acknowledged that staff were tired as a result of managing wave one and had been actively encouraged to take their annual leave, which was happening and the message continued to be disseminated to staff.

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

20/113.2 **STRATEGIC RISKS REPORT**

AF reported there was on-going work to fill the gaps in assurance and new risks to be populated with mitigating actions being put in place.

BW noted the changes to residual risk scores and the risk for closure. He highlighted the risk currently outside of the Trust's risk appetite; CRR 85 - increased demand for emergency patients with a mental health issue. He emphasised the risk rating remained despite the controls in place and enquired when it was expected to see an improved movement of the risk score. AF stated the risk had been recently updated and suggested a deep dive be undertaken and reported to the Integrated Audit and Governance Committee (IAGC). To review the outstanding actions, whether these would achieve the required outcome in reducing the risk score and provide the level of assurance to the IAGC that the mitigating actions were appropriate and sufficient.

ACTION: Undertake a deep dive review of risk CRR 85 - increased demand for emergency patients with a mental health issue. In respect of reviewing the outstanding actions, whether these would achieve the required outcome in reducing the risk score, and recording the actions already put in place with provision of additional mental health staffing support in the EDs. Present the outcome to the Integrated Audit and Governance Committee (IAGC) providing the level of assurance that these mitigating actions are appropriate and sufficient. LW

SAc commented the Trust was seeing a higher than normal number of patients with a mental health issue with significantly increased acuity. The Trust continued to have discussions with the Mental Health Trust to address this area of concern. There had also been challenges locally in line with the national pattern with regards to increased demand for Child and Adolescent Mental Health Services (CAMHS) and sufficient capacity. She confirmed this had been escalated to the Regional Medical Director and was being addressed by the Trust to mitigate risks with the provision of mental health nursing support in the EDs.

TL reported the support provided by the Psychiatric Liaison team with the provision of training to ED staff.

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

20/114 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR REPORT**

- **MONTH 6 FINANCE REPORT**
- **RESTORE AND RECOVERY UPDATE**
- **WINTER PLANNING**
- **INTENSIVE THERAPY UNIT (ITU) WILLIAM HARVEY HOSPITAL (WHH) AND QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQMH) ADDITIONAL STAFFING BUSINESS CASE**
- **WE CARE – TRUE NORTH SUSTAINABILITY A3**

NM highlighted the key areas as noted below:

- The Trust at month 6 achieved a breakeven position in September 2020, which meant year-to-date (YTD) breakeven position consistent with the plan;

- The positive Kent & Medway collaborative working as a system continued;
- 2020/21 quarter 3 and quarter 4 financial plan - movement of each Trust's residual deficit to the CCG position in order to achieve a breakeven position in all Trusts;
- Provision had been made for the potential requirement for increased annual leave accrual in respect of the risk that staff might be unable to take leave due to the Covid-19 second wave;
- The Trust was working with its subsidiaries 2gether and Spencer Private Hospitals (SPH) in respect of optimising the group's tax position and reducing corporation tax payable;
- Good update on winter planning and capacity, the robust procedures (and challenges) in place around bed management ensuring segregation of Covid and non-Covid patients;
- ITU additional staffing business case considered and recommended to the Board for approval;
- The Surgical Emergency Assessment Unit (SEAU) business case was discussed and agreed to be re-presented to the next FPC meeting in December. As further work was required to identify and include its benefits, true costs and confirmation of funding source;
- Report providing a summary of approved business cases. The Committee provided a number of suggestions on how this could be improved when next presented to provide the required level of financial details, governance compliance and a review of approval levels;
- Fortnightly Director of Finance system meetings continued to be held to discuss system-wide collaborative working and support.

SA noted the discussion regarding the True North objectives, part of the Trust's Quality Improvement (QI) We Care programme, in respect of sustainability and the objective to deliver a 2% surplus in five to ten years, with a breakeven position by March 2022. He queried whether this was a sufficiently stretching target and if this could be delivered earlier. PC reported during the current financial climate this was a realistic target for achievement and aligned with the Trust's Clinical Strategy. LS explained areas of focus for this long-term period had been identified within the programme that had been analysed producing an initial metric. A continued improvement journey was expected and delivery against some of the objectives was anticipated to be achieved earlier than the predicted timeframe.

DECISION: The Board of Directors discussed and **APPROVED** the FPC Chair report and the ITU additional staffing business case at a cost of £4,919,638 over 5 years.

20/115 **ANY OTHER BUSINESS**

There were no other items of business raised for discussion.

20/116 **QUESTIONS FROM THE PUBLIC**

Mrs Warburton raised concerns that she had been made aware of regarding cases of MSA particularly on the surgical wards at QEQMH. She asked for reassurance that patients were given the opportunity to be moved if issues arose that impacted on their health and wellbeing. SAc reported in agreement with the Hospital

leadership teams that decisions were made on a risk prioritisation basis in line with maintaining IPC procedures with regards to movement of patients and that risks must be avoided. TL confirmed MSA process and policy meant patients were spoken to when placed in an MSA bay and risk assessed. She welcomed further details to be shared with her regarding individual cases as she was happy to investigate these.

Mrs Warburton enquired regarding the review of patients on the waiting lists, what the process was for patients that took the decision to wait for treatment until after the pandemic and whether they would have to re-start the referral process. LW reported patients would need to see their GP who would re-refer them, referrals received would then follow the normal route of being reviewed and assessed to identity and prioritise urgency of treatment.

The Chair closed the meeting at 12.15 pm.

Date of next meeting in public: Thursday 10 December 2020 as a WebEx teleconference.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 12 NOVEMBER 2020**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: PUBLIC BoD ACTION LOG**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

Action No.	Action	Target date	Action owner	Status	Progress Note (to include the date of the meeting the action was closed)
B/011/20	Undertake a deep dive review of risk CRR 85 - increased demand for emergency patients with a mental health issue. In respect of reviewing the outstanding actions, whether these would achieve the required outcome in reducing the risk score, and recording the actions already put in place with provision of additional mental health staffing support	Dec-20	LW	to Close	Meeting in place with the Mental Health Nursing Lead to review risk (meeting held on 03.12.20). Action referred to IAGC for presentation of the outcome of the review to the next IAGC meeting to be held in February 2021. **Action for agreement for closure at 10.12.20 Board meeting.**

	in the EDs. Present the outcome to the Integrated Audit and Governance Committee (IAGC) providing the level of assurance that these mitigating actions are appropriate and sufficient.					

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Board may lose sight of progress of key actions if the action list is not properly updated and maintained. The Trust Secretariat ensures there is an efficient process for maintaining the action list.	
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**	
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None	
RESOURCE IMPLICATIONS:	None	
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None	
SUBSIDIARY IMPLICATIONS:	None	
PRIVACY IMPACT ASSESSMENT: NO		**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the progress update and **APPROVE** the action for closure as detailed above.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - PUBLIC BOARD								
Action No.	**Date of Meeting**	**Min No.**	**Item**	**Action**	**Target date**	**Action owner**	**Status**	**Progress Note (to include the date of the meeting the action was closed)**
B/011/20	12.11.20	20/113.2	Strategic Risks Report	Undertake a deep dive review of risk CRR 85 - increased demand for emergency patients with a mental health issue. In respect of reviewing the outstanding actions, whether these would achieve the required outcome in reducing the risk score, and recording the actions already put in place with provision of additional mental health staffing support in the EDs. Present the outcome to the Integrated Audit and Governance Committee (IAGC) providing the level of assurance that these mitigating actions are appropriate and sufficient.	Dec-20	LW	to Close	Meeting in place with the Mental Health Nursing Lead to review risk (meeting held on 03.12.20). Action referred to IAGC for presentation of the outcome of the review to the next IAGC meeting to be held in February 2021. **Action for agreement for closure at 10.12.20 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**CHAIR'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The purpose of this report is to:

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

Key Events:

1. **Board Development Day**

1.1 The Board held a further development day on 4 December 2020 to the previous session held in August, which took place as a virtual WebEx event and was externally facilitated. This development session was around team development, future working partnerships and the future development of the Board.

2 **Covid-19**

2.1 The Trust continues to remind staff and keep them up to date in relation to latest information regarding the Coronavirus response, in respect of precautions to take to reduce transmission, which include keeping areas ventilated by opening windows and doors periodically, social distancing, wearing of masks and adhering to Personal Protective Equipment (PPE) and Infection Prevention and Control (IPC) guidance. Visiting restrictions remain in place with the exception of allowing additional visitors for patients at end of life.

2.2 Thank you to all the Trust staff for their continued support and hard work caring for Covid positive patients in the wards, as well as continuing to keep other services in operation. This continues to be a challenge, particularly with the continued high number of patients presenting in the Emergency Departments (EDs) and managing the complex multiple patient pathways.

3 **National NHS Recruitment Campaign**

3.1 The latest national staff recruitment adverts 'We Are the NHS' are being shown on TV, these feature some of the Trust's staff who appeared in the previous adverts filmed at William Harvey Hospital (WHH), Queen Elizabeth the Queen Mother Hospital (QEQMH) and Kent & Canterbury Hospital (K&CH) in 2018/19. Thank you to everyone involved in these adverts, including staff from urology/theatres, Barts ward, critical care, maternity/theatres, St Augustine's ward, Viking Day Unit and Rainbow ward.

4 **Department of Urology host teaching session**

4.1 The K&CH department of urology hosted an immersive and interactive day teaching session with the University of Kent School of Biosciences Undergraduate Science students and the students and faculty at the new Kent and Medway Medical School (KMMS). This provided over a hundred students with a live robotic surgery and clinical care exposure using the innovative Patient-Centred Engagement of Students (PaCES) programme.

4.2 PaCES is a clinical immersive, patient-centred experience using interactive, live surgical observation technology providing students with the view that the surgeon sees. Students were able to observe key points throughout the surgery and interact with the surgical team in re-time, positive feedback was received from students and the faculty.

5. **East Kent Rapid Transfer Dementia Service (EKRTDS)**

5.1 EKRTDS is a new specialist dementia service based at the K&CH offering specialist mental health and dementia care assessment for people with a diagnosis or probable diagnosis of dementia with complex needs and discharge support. This service consists of a team leader, community psychiatric nurses, occupational therapists and support workers, and following discharge their involvement is normally between four and six weeks following up on a patient's discharge from hospital for specialist follow up input.

6. **Charity Fundraising**

6.1 Captain Tom along with many other fundraisers raised an amazing £30 million for the NHS during the Summer, which has been distributed to hospital charities by way of grant from the NHS Charities Together member organisation, representing 240 hospital charities. The East Kent Hospitals Charity (EKHC) received grants of £150,000 that has been used to benefit patients and staff across the Trust.

6.2 EKHC has been overwhelmed by support from the local communities with in excess of £100,000 being donated. Thank you to everyone for their support and fantastic fundraising contributions.

6.3 Following the successful EKHC Amazon Wishlist in 2019, this is continuing to be made available this year for people who wish to donate a gift to child patients, or patients living with dementia in the Trust. The details of this Wishlist can be found https://www.amazon.co.uk/hz/wishlist/ls/17R0EZXSPVVCO. These are also available on Amazon smile by searching for EKHC to fundraise for the Charity.

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

7.1 The Council is currently engaged in undertaking two of its key roles: leading the recruitment process to fill Non-Executive Director vacancies on the Board; and drafting their commentary on the Trust's Quality Report, which will be published before the end of the year. Updates on these tasks will be presented at the next Council of Governors meeting, scheduled for 11 December. This meeting will also be attended by Jane Ollis, Deputy Trust Chair, to provide a report to Council in her capacity as Chair of the Maternity Improvement Committee.

7.2 I held an informal update meeting with Council on 19 November to appraise them of the Trust's current position, particularly with respect to the impact of the second wave of the pandemic, infection prevention and control.

7.3 There have been two recent resignations from Council. Graeme Sergeant, one of the two public Governors for the Canterbury constituency, resigned in October, as did the public Governor representing the Rest of England and Wales constituency, Julie Barker. Julie was newly elected as Lead Governor for the Council, which necessitated an election for the vacant post. Alex Lister, public Governor for Canterbury has been elected to the position.

7.4 As I reported to the last Board meeting, elections to existing vacancies on Council, and those arising at the end of February 2021 have been started. I am pleased to report that Bernie Mayall, currently public Governor representing Dover, has been elected unopposed for a further 3 year term. Mr Chris Pink has been elected unopposed to the vacancy in the Rest of England and Wales constituency; his term of office will start on 1 March 2021, the date that Julie Barker's term of office would have ended. The voting for the contested vacancies in other constituencies has been suspended following lockdown and will be resumed in January 2021.

Non-Executive Directors' (NEDs) Commitments

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

Chair	10 November – Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP) Partnership Board meeting 10 November - Individual feedback meeting with external facilitator ahead of Board Development Day to be held on 4 December 12 November – Extra-ordinary meetings of the Integrated Audit and Governance Committee (IAGC) and Nominations and Remuneration Committee (NRC) 12 November – South East (SE) Leaders Broadcast with NHS England/NHS Improvement's (NHSE/I's) Regional Director (SE) 13 November – Kent & Medway (K&M) Chair's meeting 16 November – Safeguarding Governance Review meeting with Clinical Commissioning Group (CCG) 19 November – Council of Governors (CoG) update meeting 19 November – East Kent (EK) Integrated Care Provider (ICP) Partnership Board meeting 26 November – SE Leaders Broadcast with NHSE/I's Regional Director (SE) 27 November – Non-Executive Directors (NEDs) briefing with Chief Executive 27 November – K&M Chair's meeting 3 December - Board of Directors and NHSE/I governance review session 4 December - Board Development Day
Non-Executive Directors	10 November - Independent Investigation into East Kent Maternity Services (IIEKMS) update meeting Individual feedback meetings with external facilitator ahead of Board Development Day to be held on 4 December 12 November – Extra-ordinary IAGC and NRC meetings 17 November – Maternity Improvement Committee meeting

	18 November – NHSE/I Chief Midwife and colleagues visit/meeting with Trust Executive Directors and senior clinicians and managers 24 November – IAGC and Ethics Committee meetings 24 November – 2gether Support Solutions Board meeting Individual Safeguarding Governance Review meetings with Clinical Commissioning Group (CCG) 27 November – NEDs briefing with Chief Executive 30 November – CoG Audit and Governance meeting 1 December – Finance and Performance Committee and Quality Committee meetings 2 December – Strategic Workforce Committee meeting 3 December - Board of Directors and NHSE/I governance review session 4 December - Board Development Day

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS Improvement (NHSI), NHS England (NHSE), Department of Health and other key stakeholders. This report is altered in content and will now include a summary of the Clinical Executive Management Group as well as other key activities:

1. Clinical Executive Management Group (CEMG) Update – Business Cases approved at October and November 2020 meetings;
2. Kent & Medway Partnership Working Update;
3. Operations Update – Covid-19 - collaborative system working across Kent, vaccinations, and rapid lateral flow testing;
4. New GP Surgery at Ethelbert Road, Canterbury;
5. Visit to Maternity Ward;
6. Frailty Assessment Unit.

1. CEMG Update

Business cases APPROVED at the October meeting of the CEMG included:

- Women's and Children's (W&C) Care Group - Restructure Business Case; This business case followed the advice from the national maternity support team
- Multidisciplinary Nutrition Service – Staffing investment Business Case.

Business cases APPROVED at the October meeting of the CEMG and were presented to the November Finance and Performance Committee (FPC) included:

- Intensive Therapy Unit (ITU) - Increased Staffing Business Case;
- Surgical Emergency Assessment Unit (SEAU) - Business Case to support moving to a seven day service.

Business cases APPROVED at the November meeting of the CEMG which were also presented to the December FPC:

- Cardiology Catheter Laboratory at Queen Elizabeth the Queen Mother Hospital (QEQMH) - (Capital Business Case) Urgent Capital;
- Radiology X-ray - Urgent Capital Business Case;
- Endoscopy Decontamination - Urgent Business Case;
- Statutory Compliance - Business Case.

3. Operations Update – Covid-19 collaborative system working across Kent, vaccinations, rapid lateral flow testing

As we find ourselves in the 2nd wave of the pandemic we are faced with extreme challenges, we are continuing to provide support to our external partners as detailed below.

System effectiveness

The following is in place to ensure we work as a system and can support external partners:

- Daily communication with system partners;
- Daily interaction with the operation centres (ICC) and clinical teams involved in emergency flow in each hospital;
- Weekly Multidisciplinary teams (MDT) review of all patients with a long length of stay (LLOS) over 7 days.
- Daily links with the Rapid transfer teams in the community (RTOC)

Mutual aid responsiveness

- EKHUFT responded with Mutual Aid from Saturday 14 November when we accepted ICU transfers to Kent & Canterbury Hospital (K&CH) and William Harvey Hospital (WHH). During the following week we accepted ICU and Emergency Department (ED) diverts to WHH in order to support other Trusts in Kent. We have been responsive in agreeing to diverts in partnership with system colleagues. On days of particularly high pressure Chief Medical Officers have been involved in the calls and decision making;
- At NHSE/ request we opened 8 ICU escalation beds at WHH within 24 hours and have taken critically ill patients from other areas since.

Lateral Flow Testing

The NHS has brought in a new testing programme for patient-facing staff called 'Lateral Flow' which is a rapid self-administered test using a Lateral Flow Device (LFD). The benefits are:

- results in 30 minutes;
- can be administered at home;
- easy to use hand held device;
- 25 testing kits per staff member.

This is to help avoid Covid transmission in hospital and to keep patients and staff safe.

A roll out plan has been devised with assistance from the Director of Infection Prevention and Control (DIPC).

We are now live with booking on the portal for lateral flow testing, with the first allocation of kits being deployed on 30 November. This is great progress for the organisation, leading the way with the booking portal that is being adopted throughout a number of organisations and also by Public Health England (PHE) for mass testing.

Vaccinations

Following the fantastic news regarding the licensing of the Pfizer/BioNTech vaccine, myself and Executive colleagues have been attending a series of calls in readiness of the vaccine's mobilisation from 8 December. Our priority as one of the national hubs, is to support the vaccination of over 80 year old citizens and staff in care homes. We will be provided with the order of activity from the CCGs. This is a huge logistical effort by the NHS to get this rolling out as soon as possible.

4. New GP Surgery at Ethelbert Road, Canterbury – See Appendix 1

There is to be a new GP surgery at Ethelbert Road, adjacent to K&CH, and this is on target to be ready in early February 2021, replacing the outdated Cossington House and London Road surgeries with a single, state-of-the-art building. It will provide much needed additional capacity to help meet the needs of our city's expanding population, provide an opportunity to extend the range of patient services available in the community and has been designed and built to meet the latest environmental standards. It will be fully Care Quality Commission (CQC) compliant with infection control and health and safety in line with national standards.

There will be patient bicycle and car parking with 2 electric car charging points.

The Surgery looks a fabulous hub for primary and indeed, integrated care for the city.

5. Visit to Maternity Ward

The week of 16 November was Maternity Support Workers Week; a promotion and celebration of those staff who are dedicated to providing support to the maternity team, mothers and their families and of course the new born.

In promoting the work of these staff, myself and some of the Executive team were invited to take a closer look at the work these staff do, day in day out.

I was buddied with a Maternity Support Worker at QEQMH, whose work is to ensure delivery by Caesarean section is family-focused. My day involved meeting the parents and accompanying them to Theatre. We met the team for the day, who then split into their sub teams - midwives, surgeons, anaesthetists, nursing teams - all preparing for the remarkable event of the birth of a baby.

Even in the clinical and sterile environment of a surgical theatre, there was a huge attempt to make the whole event family-focused, with Dad being involved as much as possible. The preparation for skin-to-skin introduction of Mum and baby was thoughtful and in advance of the appearance of baby. The care by the surgeon, the focus of all the staff, their pleasure and enjoyment in the monumental event of new life was a privilege to see.

6. Frailty Assessment Unit welcomes first patients

The Trust's new Acute Frailty Assessment Unit (FAU) at the WHH welcomed its first patients this week.

People living with frailty who are admitted for acute inpatient hospital care are at high risk of adverse events, long stays, re-admission and long-term care.

The FAU will help to develop a model of care that enables people to live as independently as possible by delivering high quality, person centred care that integrates hospital, social care, community and voluntary services around the networks of GP practices.

Keeping people with frailty at home is key to the model of care, however, there are inevitably times when a patient appropriately requires attendance or admission to an acute hospital. As part of proactive discharge planning within the FAU, the integrated model will enable timely discharge with the right level of care.

The Frailty team will also provide a specialty outreach service as of 2021, supporting frail older people admitted with surgical, orthopaedic or other medical conditions, to ensure they also have a comprehensive assessment and a care plan which reflects their personal care preferences.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**We care about...** • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	BAF 23: Integrated Frailty Pathways cannot be agreed resulting in patients being treated in a traditional hospital-based service.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is requested to discuss and **NOTE** the CEO report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**CHIEF MEDICAL OFFICER'S (CMO) REPORT**
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER**
PAPER AUTHOR:	**CHIEF MEDICAL OFFICER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The focus of this report is to update the Board following the virtual Quality Review meeting on 11 November 2020 held with Kings College London (KCL) in relation to our medical students. These student clinical placements are an important opportunity for us as around 40% of current Foundation Year 1 doctors are are King's graduates and many return in higher specialist training and consultant roles.

The quality review team made a number of commendations in relation to the student placements:

1. The approach and dedication of the Education Team and engagement of the wider Faculty to continue to deliver high quality education in changing, challenging circumstances.
2. Frequent engagement with students and rapid changes in education made in response to feedback.
3. Understanding the effect of COVID on students' wellbeing in addition to education and providing a holistic approach to care.
4. The drafting of a robust Service Level Agreement (SLA) for accommodation provision.

There were a number of requirements placed on the Trust which were related to the accommodation provided, with short term solutions needed in response to heating, laundry and wifi concerns and how issues reported by students are responded to. There are longer term plans required to materially improve the standard of accommodation and plans to address these are underway, including looking to see if there is an opportunity to work with the market to achieve this.

Fortnightly meetings with 2gether Support Solutions Facilities Management and Estates Directors are now in place with the Medical Education leadership team to ensure requests are being addressed in a timely manner.

The commitment and innovative approach of the Medical Education team to deliver a high standard of education under challenging circumstances was noted and some further recommendations were made to continue to strengthen the student experience.

East Kent Hospitals University NHS Foundation Trust

Update on Kent and Medway Medical School (KMMS)

In addition to the support given to the KCL students the Medical Education team are working closely with KMMS with recent progress in determining capacity for the various stages of medical students commencing in September 2022 and building a structure similar to the one we have for KCL to ensure excellent delivery of the curriculum.
Joint education fellows have been appointed with KMMS (funded by Medical Education, East Kent), who work for two days at KMMS and three days in East Kent. Future accommodation plans are being discussed with a focus on provision at Ashford site.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Poor student experience may influence their choice of postgraduate roles and impact on provision of doctors in training.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our people;** • **Our future.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	BAF 8: Inability to attract, recruit and retain high calibre staff (substantive) to the Trust.
RESOURCE IMPLICATIONS:	Upgrading student accommodation
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	Accommodation provision and estates work from 2gether Support Solutions.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is requested to discuss and **NOTE** the report and recommendations from the Quality Review Team and plans to address.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**MEDICAL REVALIDATION**
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER (CMO)**
PAPER AUTHOR:	**CHIEF MEDICAL OFFICER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

This report is an overview of the processes to support the Responsible Officer (RO) in providing the required assurance thus discharging statutory responsibilities for the period 1 April 2020 to 30 November 2020.

NHS England suspended the appraisal process between March and October 2020 to allow doctors to concentrate on dealing with the pressures of the COVID-19 pandemic. In October NHS England issued guidance for restarting the appraisal process using a flexible and phased approach with a view to returning to normal service from 1 April 2021. The Trust formally restarted the appraisal process from 1 November 2020 following the guidelines. The suspension has greatly impacted on the Trust's compliance with the appraisal process for this year.

At the start of 2020 the Trust took over Responsible Officer Duties for Ellenor Hospice from Dartford & Gravesham NHS Trust for two substantive doctors. Ellenor Hospice is charged for this service.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	N/A

East Kent Hospitals University NHS Foundation Trust

LINKS TO STRATEGIC OBJECTIVES:	All objectives depend upon an appropriately licensed and revalidated medical workforce: **We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR2: Failure to action and deliver our regulatory requirements. The Responsible Officer is legally responsible to Parliament to ensure effective processes are in place to enable licensed doctors to apply for revalidation every 5 years.
RESOURCE IMPLICATIONS:	Financial strategy dependent on same medical workforce.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: **N/A**	**EQUALITY IMPACT ASSESSMENT:** **N/A**

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss the progress and **NOTE** the Medical Revalidation Report.

1. Introduction

1.1 Successful annual appraisal is a pre-requisite of a doctor's license to practice. Trusts must be assured that their medical workforce prepares for successful revalidation and has systems and policies in place which mitigate risks in this process.

1.2 As at 30 November 2020, the number of doctors for whom EKHUFT is the Designated Body for Revalidation was 783.

- Substantive consultants: 434;
- Locum consultants: 30;
- Substantive staff grade, associate specialists or specialty doctors: 192;
- Trust Doctors: 118;
- Locum middle grade/other: 9.

2. Purpose of the Paper

2.1 This report seeks to inform the Board of Directors of progress in medical appraisal and revalidation between April 2020 and November 2020. The Board is asked to note the report, discuss and determine actions as appropriate.

3. Background

3.1 Licensing of medical practitioners took place nationally from the 16 November 2009 and revalidation was formally introduced on the 3 December 2012. EKHUFT introduced an e-Portfolio system (PReP) from Premier IT available to all doctors with a prescribed connection to the organisation to support appraisal and revalidation in August 2012.

3.2 A revised Appraisal and Revalidation Policy was approved in June 2020 by the Local Negotiating Committee (LNC). The policy clearly establishes all the main stakeholders' duties and responsibilities as well as the procedure to be followed to ensure appropriate engagement with the appraisal process.

3.3 Appraisers:

3.3.1 To date more than 250 doctors have been trained to be appraisers. There is a constant turnover of appraisers within the organisation. Currently there are 185 accredited appraisers in the Trust.

Care Group	Number of Appraisers
Urgent & Emergency Care	2
General & Specialist Medicine	42
Cancer	2
Clinical Support Services	16
Surgery & Anaesthetics	77
Upper Surgery - Head, Neck & Dermatology	18
Women's and Children's	26
Pilgrims Hospice	2
Ellenor Hospice	0

3.2.2 The last "strengthened appraisal" training programme to become an accredited appraiser took take place on 4 December 2019.

3.2.3 Annual refresher workshops for appraisers are mandatory. The Revalidation Project Manager organises the workshops at different dates throughout the year to allow appraisers to attend these with the least possible disruption to other commitments. The last refresher workshop took place on 1 October 2019.

3.2.4 No appraisal training or refresher workshops have been facilitated in 2020 due to COVID restrictions.

3.4 Appraisal Quality Audit

3.4.1 Once each year an appraisal quality audit is undertaken by a selected audit panel. Thirty appraisals are selected at random all from the current year. Each appraisal is independently scored by each member of the panel using the Appraisal Summary and PDP Audit Tool (ASPAT). Any quality issues highlighted by the panel are fed back to the appraisers. The last ASPAT audit was completed in May 2019. There was no audited in 2020 due to the suspension of the appraisal process.

3.5. A Revalidation Working Group (RWG), chaired by the Revalidation Officer, was set up in January 2012 to meet regularly to discuss revalidation and appraisal issues and develop processes. The last RWG meeting was held in March 2019. A meeting in autumn of 2019 was cancelled and no meetings were convened during 2020 due to the suspension of the appraisal process.

4. Medical Appraisal Rates

4.1 Annual Organisational Audit

4.1.1 At the end of each financial year Designated Bodies are requested to report to NHS England on a number of parameters, including appraisal rates. The table below shows comparative rates of appraisal completion for EKHUFT in the last four years:

	2016/17	**2017/18**	**2018/19**	**2019/20**
Number of Prescribed Connections	558	601	665	765
Number of completed appraisals	538	571	617	568
Approved incomplete or missed appraisals	10	17	10	112
Unapproved incomplete or missed appraisals	10	13	38	0
Accomplishment	**96.4%**	**95%**	**92.8%**	**74%**

4.1.2 NHS England did not request submission of the end of financial year Annual Organisational Audit due to COVID pressures and appraisal suspension.

4.1.3 Comparison of the data over the four years shows an increase in prescribed connections which is indirectly proportional to accomplishment. The figures for 2019/20 were affected in the last quarter by the initial COVID surge which has caused a decrease in accomplishment for the financial year.

4.1.4 Doctors are regularly advised of the escalation process associated with the failure to complete their annual appraisal within 3 months of the due date. Where non-engagement with the appraisal process occurs, a Rev6 form is submitted to the General Medical Council (GMC) for further action. Subsequent continued non-engagement incurs additional actions from the GMC culminating potentially in removal of that doctor's license to practice. This has not yet been necessary in East Kent Hospital University Foundation Trust but has occurred elsewhere in the country.

4.2 Quarterly reports to NHS England

In addition to the annual organisational audit appraisal rates are also reported quarterly to NHS England. The table shows the submitted reports for the last four quarters and shows a small decline in quarterly accomplishment over Q3 and Q4, 2019. The first two quarters of 2020 are extremely low due to the NHS England suspension of appraisals.

Appraisal rates	3rd Quarter 2019	4th Quarter 2019	1st Quarter 2020	2nd Quarter 2020
Total number of doctors with whom EKHUFT has a prescribed connection	724	754	768	744
The number of doctors due to have an appraisal meeting in the reporting period	147	205	184	248
The number of doctors within question 3 above, who had an appraisal meeting in the reporting period	138	187	13	36
The number of doctors above, who did not have an appraisal meeting in the reporting period	9	18	171	212
The number of doctors in question above, for whom the RO accepts the postponement is reasonable	3	13	167	212
Number of doctors in question above, for whom RO does not accept the postponement is reasonable	6	5	4	0
Quarterly accomplishment	**94%**	**91%**	**7%**	**15%**

4.3 Where doctors did not complete their annual appraisal within their due period the reasons have been reviewed and addressed with them. Examples of instances where the RO accepts postponement is reasonable include long term sickness absence or maternity leave.

5. Recommendations for Revalidation

5.1 The GMC suspended all revalidations in March 2020 until 1 April 2021. All revalidations due for recommendation in the suspension period have been automatically deferred by the GMC for a period of twelve months.

6. Responding to Concerns and Remediation

Where concerns are raised about any doctors' performance these are dealt with by the appropriate HR processes under the overarching policy of Maintaining High Professional Standards. The Trust's approach to remediation is laid out in the Remediation Policy.

7. Next Steps

The CMO is appointing a Medical Appraisal Lead to support the Revalidation Manager in delivering training for appraisers and doctors new to appraisal. They will also work with the Clinical Leads at a specialty level to agree relevant supporting information, for example relevant outcome data from national databases and audits.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**MATERNITY IMPROVEMENT COMMITTEE (MIC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF MIC**
PAPER AUTHOR:	**MATERNITY SERVICES STRATEGIC PROGRAMME DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: CATEGORIES SUMMARY MATERNITY IMPROVEMENT PLAN**

BACKGROUND AND EXECUTIVE SUMMARY

At the Maternity Improvement Committee meeting on 17 November 2020, the key areas for decision and sign off reported to the Quality Committee on 1 December and for discussion and noting by the Board of Directors, as below:

1. **Evidence Review Group**
   1.1 The MIC received a report from this sub group which included some suggested amendments to its Terms of Reference and a summary of discussion at its first meeting, where it considered a range of evidence to inform the decision to move a number of ratings from green to blue.

   1.2 In summary 20 of 37 actions in the 90-day plan were reviewed. A summary of progress is attached (Appendix 1). The MIC whilst noting the progress agreed that it should also receive a narrative highlight report identifying which areas progress was being made and the impact of the delivery of these actions and where the risks to delivery arose. This should be in place for the next MIC meeting on 15 December.

   1.3 It was also agreed that some of the recommendations in the plan could be considered for removal as they had now been superseded, for example no longer a requirement.

   1.4 It was further agreed that clear trajectories will need to be developed in some areas, for example the commitment to reduce perinatal mortality.

2. **Saving Lives Care Bundle**
   2.1 The Committee will be undertaking deep dives into the themes of the Maternity Improvement Plan to supplement assurance and understanding of the improvements being made. At its meeting it received a presentation on progress of implementing the Saving Lives Care Bundle. This is also one of the Clinical Negligence Scheme for Trusts (CNST) requirements.
   2.2 The Committee were really encouraged to hear of the progress in delivery and the role of the two Fetal Wellbeing Midwives in supporting the rollout of the Care Bundle.
   2.3 The Saving Lives Care Bundle addresses the variations by bringing together 4 key elements or care based on best available evidence and to help reduce stillborn and early neonatal death rates.

3. At the next MIC they will be considering the draft public summary of the recently agreed Maternity Strategy as well as a deep dive into ‘Continuity of Carer’.

East Kent Hospitals University NHS Foundation Trust

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	CR77 - Women may receive sub optimal quality of care and poor patient experience in our maternity services.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CR77 - Women may receive sub optimal quality of care and poor patient experience in our maternity services.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED: The Board of Directors is asked to discuss and **NOTE** the MIC Chair Report.

Regulator's Recommendations and Actions for Maternity Service

Overall	Action Status										Total	
	Complete - evidence received		In progress within timeframe		In progress with mitigations against extended deadline		Not started/ Won't achieve within mitigations		Awaiting update			
	5	*2%*	**186**	*66%*	**87**	*31%*	**4**	*1%*	**0**	*0%*	**282**	*100%*
Theme												
Workforce	**1**	*0%*	**31**	*11%*	**15**	*5%*	**2**	*1%*	**0**	*0%*	**49**	*17%*
Leadership	**3**	*1%*	**5**	*2%*	**1**	*0%*	**0**	*0%*	**0**	*0%*	**9**	*3%*
Education and Training	**0**	*0%*	**23**	*8%*	**6**	*2%*	**0**	*0%*	**0**	*0%*	**29**	*10%*
Fetal Monitoring	**1**	*0%*	**4**	*1%*	**1**	*0%*	**0**	*0%*	**0**	*0%*	**6**	*2%*
Governance	**0**	*0%*	**15**	*5%*	**4**	*1%*	**0**	*0%*	**0**	*0%*	**19**	*7%*
Use of Data and Supporting Tools	**0**	*0%*	**3**	*1%*	**2**	*1%*	**0**	*0%*	**0**	*0%*	**5**	*2%*
Safety	**0**	*0%*	**8**	*3%*	**3**	*1%*	**0**	*0%*	**0**	*0%*	**11**	*4%*
CNST	**0**	*0%*	**71**	*25%*	**36**	*13%*	**1**	*0%*	**0**	*0%*	**108**	*38%*
SBLCBv2	**0**	*0%*	**26**	*9%*	**19**	*7%*	**1**	*0%*	**0**	*0%*	**46**	*16%*
CQC		*0%*		*0%*		*0%*		*0%*		*0%*	**0**	*0%*

Action Status	Month									
	Aug-20	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**
Complete - evidence received	**14**	**13**	**5**							
	6%	*6%*	2%							
In progress within due date	**98**	**104**	**186**							
	45%	*50%*	66%							
In progress with mitigations against extended deadline	**46**	**47**	**87**							
	21%	*23%*	31%							
Not started/ Won't achieve within mitigations	**1**	**1**	**4**							
	0%	*0%*	1%							
Awaiting update	**57**	**43**	**0**							
	26%	*21%*	0%							

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**BARRY WILDING, ACTING QC CHAIR (ON BEHALF OF WENDY COOKSON, CHAIR OF THE QC)**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety. The report seeks to answer the following questions in relation to the quality and safety performance from the QC meeting held on 1 December 2020.

1. Integrated Performance Report

The Committee received and discussed the report which outlined the key indicators of note:

1.1. The Trust continued to manage the building and estate refurbishment work across the hospital sites in respect of Covid and winter planning requirements to ensure sustained provision of services.

1.2. The last ten days had been particularly challenging for the Trust, with increased number of Covid positive patients, and providing mutual aid to local acute trusts. Clinical staff and teams across the hospital sites continued to work tirelessly to ensure patient safety and Infection Prevention Control (IPC) remained a priority.

1.3. The Committee highlighted the declining performance against the 18 week referral to treatment (RTT) standard and raised concern regarding the increased waiting time for patients. The Committee requested an update at the January 2021 QC meeting regarding the actions in place, whether these were effective and having a positive impact, and if not what else could be implemented.

1.4. Friends and Family Test (FFT) performance for a) recommended and b) not recommended had declined.

1.5. Harm free care (related to Falls and Pressure Ulcer (PU) harms) showed a decrease in performance compared with the previous month. An investigation is underway to determine the underlying reasons for this to inform recovery action.

1.6. The Chief Nurse and Deputy Chief Nurse/Deputy Director of Risk, Governance and Patient Safety will review the Trust's current processes for PU reporting of harms. This was in respect of reviewing how other trusts reported PU harms and consideration whether a change is required to the Trust's processes.

1.7. A decrease in the month for category 3 and 4 PUs. The majority of hospital acquired PUs are category 2 with an increase in the month particularly at William Harvey Hospital (WHH). This will be addressed and monitored by the PU Steering Group.

1.8. Falls: Reported worsening overall position particularly at Kent & Canterbury Hospital (K&CH) and Queen Elizabeth the Queen Mother Hospital (QEQMH), with some improvement in the month at WHH. Falls is a key part of the Trust's Quality Improvement (QI) programme True North objectives.

1.9. Mixed Sex Accommodation (MSA) breaches has increased, due to the impact of the pandemic.
1.10. Overall fill rate of 105.4% compared to 97.8% in the previous month.
1.11. Care Hours per patient day (CHPPD) remains within control limit as does Midwife to birth ratio.
1.12. A ward staff establishment review was being undertaken and the outcome will be presented to the QC in February 2021.

The Committee also received and noted a verbal update regarding harm reviews. It had been identified one cancer patient had come to harm (delay waiting over 52 weeks) and a Root Cause Analysis (RCA) was being undertaken.

2. Maternity Update

The Committee received and discussed a monthly report from the Maternity Improvement Committee (MIC) outlining the key update areas as detailed below:

2.1. Received an update from the Evidence Review Group.
2.2. Clear trajectories will be developed.
2.3. Received a presentation on progress of implementing the Saving Lives Care Bundle. Good progress in delivery and the role of the two Fetal Wellbeing Midwives in supporting the rollout of the Care Bundle.
2.4. The Committee will be undertaking deep dives into the themes of the Maternity Improvement Plan to supplement assurance and understanding of the improvements being made.
2.5. The Risk Register was reviewed and discussed, it was agreed the Women's Health Management team will review and align the delivery of the action plan and any associated risks.

The Committee received and discussed a monthly update on Continuity of Carer (CoC) plans and year three of the Clinical Negligence Scheme for Trusts (CNST) as noted below:

2.6. The Committee received an update on current implementation on progress being made against the CoC implementation plans. However, the Committee was unable to take assurance that there was a robust plan in place to meet the CoC standard by the end of March 2021.
2.7. The Committee took assurance and noted from the report:
  2.7.1 The Maternity Services data sets scorecard presented and the oversight provided. This will be an on-going monthly requirement against Year Three relaunch of the scheme. This will be reviewed around how this can be improved.
  2.7.2 The Board Maternity and Neonatal Safety Champion has fed back on safety messages received from staff. A Safety Champion action plan repository has been developed capturing safety concerns raised at the feedback sessions with the Safety Board Champion.
2.8. The launch of the first Continuity of Carer team on 30 November 2020, revised plans to meet the standard will be supported by the national lead.
2.9. The Committee noted the Chair of QC (a Non-Executive Director) will be reviewing all the year three CNST evidence as part of the process for validation and sign-off by the Board.

3. Principal Mitigated Quality Risks

The Committee received and discussed the monthly update report regarding quality risks, which were reviewed live at the meeting. The Committee took assurance from the updates presented noting the key points below:

3.1. The Committee highlighted a number of residual risk scores had reduced and challenged whether these adequately reflected the current position. The

Committee requested these risks be reviewed by the Executive lead along with the residual risk score, the actions in place to mitigate the risks, if these were having a positive impact on reducing the level of risk and whether a reduction in the risk score was appropriate.

4. Care Quality Commission (CQC) Update

The Committee received and noted a monthly CQC update report. The CQC Improvement Group will oversee on-going proactive assurance activities (routine quality reviews, deep dives into closed plans, CQC Insight and desk top review), sharing of best practice and review of risks and mitigations. Daily staff huddles continued to be held.

5. IPC Board Assurance Framework (BAF)

The Committee received and discussed the monthly update report regarding IPC along with the IPC BAF. The Committee acknowledged the good work and progress made by the Interim Director of IPC (DIPC) and the IPC team, particularly in relation to the improvements in the reduction in the number of C.difficile cases in month, of which was five against the trajectory of eight. The Committee noted the key updates as below:

5.1. On-going Hygiene Code gap analysis being undertaken.
5.2. The responsibility of the IPC Committee in respect of on-going monitoring of compliance against IPC policies and procedures and the Hygiene Code, which will provide regularly update reports to the QC.
5.3. Monitoring of pathology swab result turnaround times.
5.4. Interviews for the DIPC role had been held and it was expected a successful appointment will be made.

6. Patient Experience Committee (PEC)

The Committee received and noted a PEC update report including key areas of focus:

6.1 Progress with regards to nutrition and improving the model of care.
6.2 Triangulation reviewing complaints data to identify and address any areas of themes.
6.3 Improvements to the discharge process and recruitment to increase the number of Discharge Co-ordinators.

7. Getting it Right First Time (GiRFT)

The Committee received and noted a verbal update from the Chief Medical Officer (CMO) regarding GiRFT.

8. Coroner's Cases

The Committee received and noted a verbal update from the CMO and Deputy Chief Nurse/Deputy Director of Risk, Governance and Patient Safety regarding Coroner's cases. The Committee noted there will be a Coroner inquest in the New Year regarding a Tuberculosis (TB) case.

9. Adult Safeguarding

The Committee received and discussed a report covering Q1 and Q2 in relation to adult safeguarding noting improvements that included:

9.1. Successful recruitment of additional specialist staff for learning disability, homelessness and generic safeguarding.
9.2. Level 1 training compliance at 100% compliance, and compliance of Level 2 training at 89%.

10. Children's Safeguarding

The Committee received and discussed a report covering Q2 regarding children's safeguarding noting the key areas as detailed below:

10.1. Achievement against Level 1 training at 100% compliance.

10.2. Compliance had declined against Level 2 training at 80% and Level 3 training at 82%, which is a risk and there was on-going focussed work to improve this compliance.
10.3. The Committee noted the significant number of referrals received annually.

11. Patient Safety Committee (PSC)
The Committee received and noted a verbal update from the CMO in relation to a recent reported never event regarding a wrong site block at QEQMH. This was being investigated along with the Local Safety Standards for Invasive Procedures (LocSSIPs), once completed an update will be reported to the QC.

12. NICE and Clinical Audit and Effectiveness Committee (CAEC)
The Committee received and noted a verbal update from the CMO in respect of an escalation regarding the Trust being a potential outlier in relation to diabetic care. This was being reviewed and will be reported to the QC through the NICE and CAEC report.

OTHER REPORTS RECEIVED AND DISCUSSED
13. QC annual work programme.

RECOMMENDATIONS AND ACTION REQUIRED:

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**INTERIM DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: IPC BAF**

BACKGROUND AND EXECUTIVE SUMMARY

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

Additional questions have been added to the BAF to reflect restore and recovery actions. These are identified in red on the document attached (Appendix 1). Additional key updates include:

- Section 1:
  - Additional procedures in place for immunosuppressed patients attending Emergency Departments (EDs); and
  - Results of discharge swabs are available prior to transfer to residential facility.
- Section 2:
  - Windows in ward bays and side rooms to be opened for 15 minutes, 3 times per day to improve ventilation.
- Section 3
  - Business case approved for Consultant pharmacist specialising in antimicrobial stewardship.
- Section 4
  - Arrangements planned to enable partners to attend anomaly scans from 7 December.
- Section 5
  - Covid and non-Covid streams segregate patients according to symptoms in ED;
  - Plans developed to be implemented in December to create Covid paediatric area in William Harvey Hospital (WHH) ED; and
  - Additional day 3 swab to be implemented from 30 November.
- Section 8
  - Near patient testing facility has been delayed.

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

	team (EMT) and Infection, Prevention and Control Committee (IPCC).
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR 47 – Inability to prevent Healthcare Associated Infections (HCAI). CRR 90 – Risk of death in service from Covid-19. CRR 91 – Risk that staff will contract hospital acquired Covid -19. CRR – 87 – Risk that patients will contract hospital-acquired Covid-19.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	No

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

RECOMMENDATIONS AND ACTION REQUIRED:
The Board of Directors is asked to discuss and **NOTE** the contents of the IPC BAF report.

Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users audit

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• ED triage in place. Patients are assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes. Pathway documented by a Navigating Decision Tree and Covid clerking proforma agreed by Gold command • All patients (including maternity), visitors and staff have temperature check at the front door. Mask provided to staff and to patients and visitors who do not have face coverings • All patients streamed to the Covid (blue) area of ED are swabbed. All admissions through the non-Covid (red) stream are swabbed • Swabbing audit run daily. Wards notified of any missed swabs • Obstetric patients are triaged in maternity triage and swabbed on admission • Renal Units and oncology check patient temperature on arrival and asked Covid questions	• Poor documentation identified and poor completion of Covid risk assessment on Covid medical proforma • Staff not all aware of the process	• Staff reminded to complete the proforma at huddles. Spot checks to ensure compliance • Triage document discussed at huddles daily • Daily huddle and sharing of information • Updated triage document in place to fully risk assess patients at the entrance to ED. Additional questions around previous admissions, contacts, travel and self-isolation have been added • Flag for contacts of positive cases added to PTL • Additional procedures in place for immunosuppressed individuals attending ED

• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from ICU care only. • Stated aim is to keep confirmed cases in the Covid cohort area throughout their inpatient stay. Where step-down is necessary for clinical reasons or due to bed pressures, patients can only be moved after 14 days from their first positive test and where they have been asymptomatic for at least 48 hours (no fever without medication and some respiratory improvement). Guidance published on Trust intranet page		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• National guidance followed in all cases • Patients swabbed within 48 hours of expected discharge date for discharge to residential care facility and result available before transfer		
• Monitoring of compliance with IPC practices, ensuring resources are in place to enable compliance with IPC practice	• Daily observations of hand hygiene and PPE practice undertaken • Results collated on electronic audit system and available to view by matrons • Peer audit in place • Infection control team audit for triangulation • Other IPC audits in place including commodes and saving lives • Audit data reported to IPCC		
• Monitoring of compliance with PPE, consider implementing the role of PPE	• PPE officers on duty • IPCT visit wards daily and review compliance with PPE		

guardians/safety champions to embed and encourage best practice	• IPC champions (medical) and IPC link nurses in place to encourage best practice		
• Staff testing and isolation strategies are in place and a process to respond if transmission rates of Covid-19 increase	• Staff testing available to all staff. • Information and SOP on staff testing and isolation available on staff zone • Lateral flow testing for patient facing staff roll out from 30 November 2020. • Occupational Health manage staff contact tracing and testing		
• Training in IPC standard infection control and transmission-based precautions are provided to all staff	• All staff have IPC training which includes transmission-based precautions and the use of PPE • In addition to national standard training package level 1 and level 2, viewing of local video is mandatory for all staff. • Further training provided co-located with fit testing		
• IPC measures in relation to Covid-19 should be included in all staff induction and mandatory training	• Training in IPC for Coivd-19 is included in training packages for induction and annual mandatory training		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Regular reminders through staff zone, CEO blog, the Leader newsletter for managers, daily safety huddles, IPC ward visits. • Posters displayed in communal areas, corridors and on wards		
• All staff (clinical and non clinical) are trained in putting on and removing PPE; know what PPE they should wear for	• All staff are trained in donning and doffing (See above) • Signage to support knowledge and	• Availability of differing types of FFP3 masks is variable	• Active management of stocks • Repeated FIT testing

each setting and context and have access to the PPE that protects them for the appropriate setting and context as per the national guidance	practice • PPE available in all clinical areas and other areas as required • National guidance for PPE implemented within the Trust. FIT testing for FFP3 masks in place with resources identified. Fit testing at times adjusted to suit different staff shifts • Ongoing FIT testing sessions on all sites. Certificates provided to staff once tested • PPE managed by the 2gether Procurement Services team 7 days per week with resilience plans in place. • PPE SOP available on Covid section of Trust intranet • Posters and signage with PPE information in donning and doffing areas.	• Some staff unable to pass FIT testing on any FFP3 mask	required on new mask stocks • Purchase of powered air respirators with hoods
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• DIPC and deputy DIPC check for updates to national guidance and advising executive team and Gold. • Changes to SOPs approved by Gold committee • Updates shared with staff in daily safety huddles and Covid intranet page • IPC team and matrons support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC is a member of the exec team and updates as required • DIPC reports to Trust Board through Quality Committee • BAF reviewed at Quality committee and Trust Board on a monthly basis		

• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• Corporate risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings • Board assurance framework recognises findings from CQC review		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place for non-Covid-19 infections • The site teams determine placement of patients with suspected or proven infections prioritised into side rooms as per trust guidance • Daily meeting between Clinical Site managers and IPC. • IPCT reinforce practice at ward level	• IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks recognised eg for C. difficile and Covid co-infection, line infection associated with staff in full PPE unable to be bare below the elbows • Limited assurance that Trust is fully compliant with Hygiene Code	• IPC team advising on a case-by-case basis. Variation to some policies required. • Gap analysis to be undertaken • Policies undergoing review
• Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measuring and testing of patient protocols are activated in a timely manner	• CEO or exec sign off for data submissions • DIPC signs off IIMARCH forms for outbreaks • Daily Sitrep analysis shared with senior staff		
• Ensure Trust Board has oversight of ongoing outbreaks and action plans	• Outbreaks discussed at Covid Gold committee • IPC discussed at Board and Quality committee • IPCC reports to Quality committee		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on all three acute sites including ICU escalation • Training in use of non-invasive ventilation provided on all 3 hospital sites • ICU training for non-ICU staff to work on ICU on all three sites. Staff who have returned to original workplace are continuing to have rotational days to keep up skills • Consultant anesthetist 24/7 on-site ICU cover during escalation • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist • Covid wards fully staffed. Named consultant for each ward. • Increased consultant cover at the front door • Safety officers and IPC Team support to Covid wards. • Nursing and medical staff upskilled in NIV		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Cleaning services provided by 2gether • IPC training for facilities staff includes PPE usage, donning/doffing and fit testing • Training videos for facilities staff have been developed including translated version for staff who do not have English		

	as their first language		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Decontamination and terminal cleaning completed according to national guidelines. • All surfaces cleaned with Tristel Fuse including walls • Hypochlorite wipes used alongside Tristel • HPV and UVC decontamination available when required	• Cleaning audits reported to the 2gether board and through to Partnership Forum	• Lapses in cleaning standards reported through daily report on cleaning audits.
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Cleaning frequencies follow national guidance, x2 daily as a minimum. • Regular audits undertaken and results monitored • Increased attention is given to the cleaning of bathrooms and toilets • Ongoing reminders to staff to ensure that this is maintained		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses	• Tristel Fuse confirmed as suitable cleaning agent for enveloped viruses by ICPT		
• Manufacturer's guidance and recommended product contact	• Manufacturer's guidance is followed in all areas		

time' must be followed for all cleaning/disinfectant solutions/products	• Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements • Workplace assessor audits		
• As per national guidance:			
○ 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• In place • Public area touch points cleaned by dedicated team		
○ Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance 'time out to clean'. • Disinfectant wipes and sanitizer are available in all offices	• Limited assurance that where nursing two hourly cleans are implemented, they are being completed and documented	• Cleaning discussed at handover and huddles. Completion of checklists and signing sheets emphasized • Spot checks by matrons and managers • Two hourly cleans are no longer required and not indicated in national guidance. Twice daily cleans in place
○ Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• In place – double amber clean team available. ICU has dedicated cleaning staff		

• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards is treated as infectious linen. • The policy mirrors the infected linen handling procedure as laid out in national guidance. • This is audited and all findings from the audits are shared with the IPC teams for action	• Audits not part of electronic audit system	• Development work is required to electronic audit system
• single use items are used where possible and according to Single Use Policy	• Single use items are used widely across the Trust • Policy in place and available on the Trust intranet		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• The provider of surgical reusable instrument decontamination for EKHUFT: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been put in place in line with local, PHE and national policy.		
• ensure cleaning standards and frequency are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning standards in non-clinical areas are monitored as part of the audit schedule. Scores are consistently >95% • Any required actions are implemented immediately with repeat audit the following day		

• Ensure the dilution of air with good ventilation eg. Open windows in admission and waiting areas to assist the dilution of air • There is evidence organisations have reviewed the low risk Covid-19 pathway, before choosing any decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	• Rolling programme of UVC decontamination in place for non-clinical areas • Given the age of the EKHUFT estate, the admission and waiting areas are all naturally ventilated with tempered fresh air ventilation only. Windows are opened to improve the dilution of airborne contaminants where possible • Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation • Tristel fuse remains the disinfectant of choice within the Trust for all areas including the low risk pathway • The exception is the kitchen where an alternative disinfectant is used		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• The Antimicrobial Stewardship Group (ASG) includes the consultant microbiologists, antimicrobial pharmacist. • Antimicrobial Stewardship Group reports to Infection Prevention and Control Committee	• The ASG did not meet during the period of pandemic escalation pandemic due to staff shortages caused by staff sickness and	• Key aspects of antimicrobial stewardship are reviewed in the daily microbiologist meetings and twice weekly IPC

	• Ward pharmacists review prescribing • Business case approved for Consultant pharmacist specializing in antimicrobial stewardship	shielding. • Meetings have now re-started • Insufficient time in microbiologist job plans for AMS	team virtual meetings • Addressed through job planning
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued throughout • IPCC has reported to Patient Safety in the past. In the new governance structure, the IPCC will report to Quality committee, a sub-committee of the Board		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• All visitors to the sites have their temperature checked at the entrance, asked to clean their hands and provided with a face mask if they do not already have a face-covering • Visitors to inpatients are permitted only on compassionate grounds and to assist patients with specific needs • A birth partner is allowed. • Out patients can have an accompanying person only when required for care needs • Mortuary viewings are not allowed	• Limited assurance around social distancing.	• Introduction of one way system for all hospital corridors and clinical areas • Floor signage to encourage patients and visitors to socially distance • Chairs removed from waiting areas • Additional waiting areas identified for ED

	• A parent or appropriate adult is able to visit their child • iPads and mobile phones are available for patients to communicate with loved ones • Booked updates to NoK by clinician in place • Families able to end photos and messages through PALS which are printed and laminated and given to patients		• Due to continuing concerns, visiting restrictions have not been lifted and remain the same except for ITU where visiting by appointment is permitted • Arrangements planned for partners to attend anomaly scans from 7th December
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• There are signs from the entrances to the hospital and throughout the corridors and hospital areas identifying the Covid areas - stop signs on doors • Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene • Masks are available at the exit of all Covid areas allowing change of mask on leaving the area	• Access is not restricted by locks. Signage restricts access to essential staff only.	• Access to all Covid areas is now through locked doors
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• There is a separate dedicated staff Covid area on the intranet and a patient information area on the website relating to Covid – these are accessible to all and describe the areas within the sites that are Covid, the PPE expectations and how staff and public are to conduct their business safely within the various EKHUFT sites and areas.		

• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• The national patient information leaflets are available through the website • https://www.ekhuft.nhs.uk/staff/news-centre/coronavirus/ • All policies and SOPs are also available on the intranet • Patient infection status is included on all inter hospital transfers and discharge documentation. • PHE guidance on discharge of patients is implemented • Discharge team manages complex discharge of patients to residential care facilities • Covid positive status is flagged on the patient administration system. • Patients are tested prior to discharge to a continuing care environment • Staff use appropriate PPE for all patient transfers • Any patients self-isolating following confirmed Covid contact are able to complete their self-isolation at home if medically fit. Patients are directed to the 'Stay at home' guidance and written confirmation of the day that their isolation ends • All patients have an EDN on discharge		
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information is prominently displayed on posters in public areas • Face masks provided at the main entrances • Floor signage to encourage 2m spacing in queuing areas		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases			
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non-Covid-19 cases to minimise the risk of cross-infection as per national guidance	• ED triage in place. Patients are assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes. Pathway documented by a Navigating Decision Tree and Covid clerking proforma agreed by Gold command • Updated triage document in place to fully risk assess patients at the entrance to ED. Additional questions around previous admissions, contacts, travel and self-isolation have been added • Covid and non-covid streams segregate patients according to symptoms in ED. • Additional isolation rooms identified for immunocompromised and shielding patients attending ED • Training for all staff in ED on the management of immunocompromised patients • Training videos developed including Q&A with DIPC	• Limited assurance that triage is undertaken consistently • Lack of understanding of the process by some staff • Covid medical proforma inconsistently completed • Estates work required to separate paediatric streams in WHH ED	• Discussed at huddles to remind staff to apply triage consistently • Training for those staff unsure of process • Spot checks to ensure compliance • Plans developed to be implemented in December to create Covid paediatric area in WHH ED

	• Blue (suspected Covid) patients are placed in a cohort bay pending swab results. A new bay is identified each day as the pending bay. If a patient has a positive swab they are moved out of the bay, bay is closed and the other (negative) patients remain in their cohort until they either go home, test positive or 14 days has passed. If all patients in a bay are negative they are placed into red stream beds after clinical review • Patients streamed to blue (covid) or red (non-covid) zones • Negative pressure isolation room available for patients requiring Aerosol Generating Procedure (AGP) in Emergency Department • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures All patients and visitors entering through main entrances have temperature check and are given masks • Non-elective paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • Triage at paediatric outpatients. Clinical review undertaken whenever temperature is high • Obstetric patients undergo triage in maternity triage. Covid side rooms available for suspected cases. All admissions to maternity are swabbed • All patients streamed to the Covid (blue) area of ED are swabbed immediately. All patients admitted through the non-Covid (red) stream are swabbed following a decision to admit		

	• Patients are cohorted into blue and red areas until results are known. • Positive patients are transferred from red to blue as soon as results are known. • Negative patients remain in their admission cohort until all results are known to avoid placing a contact of a positive case in a non-exposed bay. • Non-admitted patients who are swabbed and positive followed up by infection control	• Lack of side rooms results in cohorting of non-elective patients awaiting swab results. Potential for cross infection	• A live patient tracking system has been developed which identifies all Covid-19 positive patients showing which stream and wards the patient has been in on each day of admission together with any other Covid-19 positive patients enabling rapid identification of any contacts.
• staff are aware of agreed template for triage questions to ask	• Updated triage form has been developed and implemented • Training for ED staff implemented • Regular audit in place		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Registered nurse at front door allocates patient to correct pathway		
• face coverings are used by all outpatients and visitors	• All outpatients and visitors wear masks except for those carrying exemption certificates • Masks provided at front entrance if required		
• facemasks are available for patients with respiratory symptoms	• All patients (including those with respiratory symptoms) in ED encouraged to wear face masks		
• provide clear advice to patients	• All inpatients encouraged to wear face		

on use of facemasks to encourage the use of surgical facemasks by all inpatients in the medium and high risk pathways if this can be tolerated and does not compromise their clinical care	masks if tolerated, especially when leaving the bedside		
• ideally segregation should be with separate spaces, but there is potential to use screens eg to protect reception staff	• Reception staff are protected with screens • Patients in ED separated by clear curtains in majors • Social distancing in place in waiting areas		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• Inpatients who develop symptoms are isolated wherever possible, bay closed pending results • Contact tracing carried out on all inpatients who test positive • Patients who develop symptoms in a non-covid area are tested promptly. The rationale for testing is documented in the patient's notes • Patients admitted on the Covid pathway who test negative initially have a medical review and are reassessed to either no longer suspected or continuing high risk of Covid. The high risk patients are re-swabbed 48 hours after admission • All patients who test negative on admission are re-tested at 5-7 days in line with national guidance. Additional day 3 swab from 30th November		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Patients attending out-patient appointments have their temperature checked at the front door • If temperature is high, patients reviewed by clinician in ED		

	• Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimize contact between pathways. For example this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas	• Separation challenging due to estate. • Keep left signage in corridors • Additional entrances available for staff • Patients not permitted to use staff restaurants		
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• All staff undergo IPC, Health and safety e-learning and Fit testing. • Locum and agency staff are fit tested and have local induction in IPC • IPC link assessor checks hand hygiene competence and records on ESR • All new staff have induction training including IPC and FIT testing as appropriate • Staff PPE training repeated in all outbreak areas together with Fit test checking.	• Welcome webinar does not include Covid apart from mask wearing and social distancing	• Any concerns are raised in the daily morning site huddles attended by representatives from all staff areas including 2gether staff and the designated site clinical and management leads. • Updated induction

	• ICU training in place for non-ICU trained staff working in ICU. • Medical and nursing training and at induction. National IPC e-learning modules in use. Level 1 for non-clinical and level 2 for clinical. Recorded on ESR • Covid protocols on microguide for medical staff. ICS/RCA on-line COVID hub • PPE officers provide face to face training on wards • IPC team provide ad hoc training in clinical areas • Covid-secure areas identified in non-clinical areas • Risk assessments in place to assess the number of people able to occupy an area maintaining social distancing. Posters displayed on doors • Safety officers and IPC Team available in real time • Remobilisation IPC guidance implemented in full for surgery, theatre and ITU with supporting SOPs. Not implemented in other areas to provide consistency for staff and avoid confusion regarding AGP patients,		process to include infection prevention session in addition to on line package • DIPC PPE video is mandatory training for all staff. • Facilities staff have videos for different staff groups including translated version for staff who do not have English as their first language
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• PPE information materials to reinforce appropriate use of PPE available on staff area of the Trust Intranet • sessional and single use PPE information cascaded and available on the intranet • FIT testing available for all staff who need it. Repeat FIT testing undertaken for new types of mask • Signage and posters displayed on wards		

	and in donning and doffing areas • Estates work on Oxford and Cambridge J complete , providing donning and doffing areas		
• a record of staff training is maintained	• An electronic log of staff training is in place • A record of FIT testing is maintained		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• The continual training program also includes re-usable equipment and methods of cleaning • Respirator hoods are managed by EME. They are issued, once authorized, via the medical equipment libraries (MEL). Short term loans are returned (socially clean) to the MEL where they are cleaned again and ATP tested • Other PPE will only be re-used with Gold and IPC agreement and release of clear guidance		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• All incidents related to PPE reported as Datix incidents • Incidents investigated and learning shared • Product quality issues are sent to procurement for investigation and action • Gold command monitor incidents and takes urgent action as appropriate by cascading to procurement for response. • Incidents causing harm are raised as potential SI to panel – If agreed then 72 hour report and full RCA		
• adherence to PHE national	• PPE usage is audited as part of outbreak		

guidance on the use of PPE is regularly audited	investigation • Combined PPE and Hand hygiene audit in use in clinical areas		
hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimize Covid-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures	• All hand hygiene facilities have hand hygiene instructions on the splash back • All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated		
• maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional break areas available		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas	• Disinfectant wipes provided for non-clinical areas • Domestic and nursing cleaning tasks implemented in clinical areas. Records kept of cleaning • Advice available by posters, verbal advice at the entrances. • PPE policy available on staff zone		

• staff regularly undertake hand hygiene and observe standard infection control precautions	• In place. Daily audits of hand hygiene compliance reported to daily safety huddle and available electronically • Antimicrobial hand rub widely available and at the end of all beds • Updated audit covers hand hygiene and PPE reflecting current practice • Discussion at safety huddles and handover • Hand hygiene included in PPE video for mandatory and induction training • All staff given small bottles of hand rub and refilling stations provided • 2gether maintain all hand rub bottles (except those at the end of patients beds) • Additional stocks of hand rub for wall mounted dispensers identified • Hand rub provision reviewed on all wards to ensure that all entry and exit points have provision		
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• All clinical areas hand wash basins are co-located with paper towel dispensers • All portable sinks have back boards to hold soap and towel dispensers and hand washing instructions • Full review of placement of all portable hand wash basins ongoing		
• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets	• All hand wash soap dispensers have hand washing and drying guidance on back boards or posters in both clinical and public areas		

• staff understand the requirements for uniform laundering where this is not provided for on site	• Scrubs are worn on all Covid wards and several other wards and clinical areas by clinical and facilities staff. • Scrubs are laundered by the Trust and staff are advised not to take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on all acute sites		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• Staff are aware of and understand the process for reporting absence. • Information on symptoms of Covid shared widely including posters, staff Intranet site and daily huddles • On-line appointment system available to book testing • Occupational health available via email and phone to access advice from dedicated staff • Occupational Health staff explain the self-isolation process to symptomatic and Covid positive staff • Occupational health under-take contact tracing and staff screening as necessary. • Occupational Health are instrumental in providing advice, results and follow ups as and when required, keeping staff informed and managing their well-being. • Symptomatic positive staff self -isolate for a minimum of 14 days. Asymptomatic positive staff self-isolate for 10 day		

• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patients/individuals) • Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger and outbreak investigation and are reported • Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	• Community rates of infection are continuously monitored with information disseminated to senior managers • Daily sitrep analysis available to all managers • Discussion at daily exec Covid Gold committee • Outbreaks declared according to national guidance • All outbreaks are investigated and Serious incidents declared • IIMARCH forms completed for all outbreaks • Outbreak SOP in place • Active management by infection control team		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence	• Pathways clearly identified • Surgical green pathway implemented and reviewed according to prevalence of infection		

rate low/high) by other patients/individuals, visitors or staff • Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff understand the different risk areas	• Visitors not permitted in Covid positive areas • Ward doors are locked • Restricted access to covid areas • Signage in place		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated Covid wards. Suspected cases are cohorted chronologically until test results are available • Negative pressure side room in ED (at WHH) for Covid patients requiring Aerosol Generating Procedures. • Isolation ward is designated for Covid AGP during escalation • Covid ICU is negative pressure on all three sites.	• The lack of negative pressure rooms or sufficient side rooms throughout the organisations inpatient areas	• Changes to the estate to create more negative pressure and isolation areas have commenced on all 3 acute sites.
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Cohort bays have privacy curtains between the beds to minimize opportunities for close contact • Cohort wards are separated from non-segregated areas by closed doors • Signage displayed warning of the segregated area to control entry • Cohort areas differentiate the level of care (general and Covid ICU) • Suspected or confirmed paediatric patients accommodated in side rooms with en-suite facilities • Maternity has a green pathway for elective C-section	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors accessible using PIN number • Fob access to maternity/ paeds/NICU for staff. Intercom for patients and visitors • Not used as staff/visitor thoroughfare

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Pre-existing IPC policies continue to apply • Some variance required to meet the requirements of Covid levels of PPE in co-infected patients • Active management of side room provision between ICT and site managers through daily meetings	• Some pre-existing IPC policies are past their review date.	• Ongoing work to review and update
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Ensure screens taken on admission are given priority and reported within 24 hours	• Laboratory pathway in place to ensure priority for ED samples. Red bags in use		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Turnaround times closely monitored and reported daily	• Turnaround times not yet consistently below 24 hours • Unable to monitor patient-result TAT • Near patient testing facility has been delayed	• Additional small batch analysers introduced • Review of transport arrangements from QEQM • Delay in near patient testing machine escalated to CCG and region
• testing is undertaken by competent and trained individuals	• Testing undertaken by registered biomedical scientists with documented competencies • Methods validated prior to diagnostic testing		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Tests sent to Pillar 2 labs when demand outstrips capacity • Extended laboratory working hours to deliver service • All non-elective patients are tested on admission, on day 5-7 and weekly thereafter • Results available through electronic PTL in real time • Positive results followed up by IPC team • All results reported to PHE via Co-surv • All elective patients tested 72 hours prior to admission • On line booking system for staff testing • All staff tested as part of one-off screen at the end of July 2020 • Staff results sent by text message directly from the on-line system. Occupational health follow-up positive staff members • Antibody testing available to all patients and staff on request • Covid testing SOP is agreed by Gold and is available on the Trust intranet		•
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• Results monitored and flagged on PTL • Automatic reminders for swabs due appear on ward PTL		
• screening for other potential infections takes place	• All routine diagnostic tests remain available • Testing for other respiratory viruses available. Testing algorithm in place in microbiology. Consultation with clinical teams has been undertaken • MRSA, GRE and CPE screening		

	continues as in pre-covid policies • Routine testing for C. difficile in patients with diarrhoea continues		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC team supports wards. All wards visited daily by matrons and IPCT. Fully range of Covid SOPs in place • Advice available from IPC team and consultant microbiologists. On call rotas in place	• Some pre-existing IPC policies are past their review date.	• Ongoing work to review and update
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team • Updates shared with staff through Covid Gold, Team briefs, huddles and ward catch up meetings and through the staff page of the Trust intranet. Clinical areas have a nominated individual to check the intranet daily for updates • Trust wide emails sent to all staff as and when appropriate • PPE SOP is approved by Gold and available on the intranet • IPC team support ward staff in implementing any changes		

• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B(orange) clinical waste stream • PPE central stocks are held on all sites • Active management of stock levels by procurement to ensure safe levels of stock • Wards receive a top up delivery of PPE 2-3 times weekly and can order additional stock by phone from the stores on each site which is delivered promptly • Information for ward staff available on the Trust Intranet		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place • Redeployment opportunities and working from home for high risk staff • Employee assistance programme in place including 'grab bags', free parking, staff areas, psychological support, access to counselling, health and fitness advice. • Annual leave continues to be taken • Staff advised to observe track and trace rules and self-isolate if requested to do so.		

	• Staff advised to observe all quarantine rules when returning from other countries		
• that risk assessments are undertaken and documented for any staff members in an at risk shielding group, including Black, Asian and minority ethnic (BAME) and pregnant staff	• 99% of BAME staff risk assessments completed • Risk assessments on all staff undertaken		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• FIT testing in place. • A log of staff training is available • SOP available on staff intranet for reusable respirators • Staff given training and guidance on cleaning		
• staff who carry out fit test training are trained and competent to do so	• Fit testers all have recognised national training competence		
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• A central log of Fit testing is maintained • Staff given results identifying type of mask to be worn		
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of	• As above • Re-usable masks and hoods are available for staff who fail fit testing with disposable masks		

repeated testing on alternative respirators and hoods			
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Redeployment options are available. These are discussed with each member of staff where the risk assessment and fit testing identifies redeployment as suitable and appropriate mitigation.		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	• Records are kept and stored electronically		
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• An electronic system is in place to record and store details for risk assessments and any necessary mitigations to support individual members of staff. Any redeployment decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm. This is in place for current staff and forms part of the pre employment process for new starters.		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care	• A centrally held record is maintained. But this sits outside of ESR currently. This is being reviewed in order to facilitate routine reporting as part of statutory and mandatory training compliance to the		

across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	board		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Green pathways for elective care have been developed. SOP in place • Theatre SOP in place designating green and blue pathways to avoid cross over. SOP in place • Dedicated green elective surgical wards on all three sites		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Masks worn at all times in the hospital buildings except when in a designated covid-secure area or when eating and drinking • Staff social distancing in corridors and queues • Assessments undertaken in all work areas. The number of people able to occupy a room whilst maintaining social distancing is displayed on the door. • Staff working from home wherever possible • Rotation of teams in some services to maintain covid secure workplaces eg admin teams • Additional outdoor seating to provide extra socially distanced space for staff breaks	• Staff found not to be universally observing social distancing especially in break rooms and around nurses stations	• Maximum occupancy signage on doors of break rooms • Chairs removed from break areas • Social distancing messages reinforced in PPE video for all staff, safety huddles and hand over and as part of outbreak meetings • Spot checks by managers • Floor signage for social distancing
• health and care settings are COVID-19 secure workplaces	• All non-clinical areas assessed for Covid security.		

as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• Maximum occupancy identified on signage • Disinfectant wipes available to staff in non clinical areas to clean workstations		
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Advice given to staff to don masks whenever moving around Covid secure area		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Employee assistance programme in place including psychological support, access to counselling, health and fitness advice. • On-line booking for testing for all staff • Drive through testing centres on all 3 acute sites? • Occupational health monitor shielding staff at the request of employee and/or manager. • Staff who are self-isolating are monitored by their line-manager within the absence management process and can be review on request by occupational health		
• staff that test positive have adequate information and support to aid their recovery and return to work.	• Occupational Health staff explain the self-isolation process to symptomatic and Covid positive staff. Have updated PHE self-isolation information to reflect Trust policy • Occupational Health have provided return to work information on Trust Intranet for employees and managers. • Occupational health available via email and phone to access advice from dedicated staff. • Occupational Health and HR have		

	maintained staff wellbeing pages on intranet keeping staff informed on managing their well-being, signposting for both physical and mental health. This includes information regarding the Employee Assistance Programme, partnership working with Remploy and self-referral to OH Wellbeing Advisor.		

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**ETHICS COMMITTEE CHAIR REPORT – ETHICS COMMITTEE TERMS OF REFERENCE (TOR)**
BOARD SPONSOR:	**ETHICS COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: ETHICS COMMITTEE TOR**

BACKGROUND AND EXECUTIVE SUMMARY

The Ethics Committee considered and approved the proposed change of Chairmanship of the Committee at its meeting held on 24 November 2020. This Committee is currently Chaired by a Non-Executive Director, Wendy Cookson, who is also the Chair of the Quality Committee (Board Committee). It is proposed that from January 2021 the Chief Medical Officer, Rebecca Martin, take on the role of the Chair of the Ethics Committee.

The revised Ethics Committee ToR are attached (appendix 1) recommended by the Committee for consideration and approval by the Board of Directors.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Care to be given equally on the basis of need as in the NHS Constitution.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR 79: Risk to patient care due to the temporary suspension of services during the global coronavirus (Covid-19) pandemic.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Ethics Committee
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the revised ToR for the Ethics Committee.

East Kent Hospitals University NHS Foundation Trust

Ethics Committee (Covid-19)

TERMS OF REFERENCE

PURPOSE OF THE GROUP

1.1. The current novel coronavirus (COVID-19) outbreak, which began in December 2019, is having major implications for health and care services in the UK. Planning for and responding to COVID-19 as it develops will undoubtedly require making difficult decisions under new and exceptional pressures with limited time, resources or information.

1.2. In making decisions about healthcare, patients, service users, their family and carers, healthcare professionals will face difficult, changing situations. Such situations can raise ethically challenging questions about what would be the most appropriate or preferred course of action. The Ethics Committee (Covid-19) (the Committee), will lead in addressing ethical issues and ensure that all decisions are made in accordance with the law and official guidance issued and applicable at the time, while meeting statutory duties and professional responsibilities. This is to be an advisory Committee only and has no decision making powers.

1.3. To provide assurance to the Board that the Trust has a robust framework for addressing ethical issues that arise in patient care, to protect the interests of patients and to support prudent decision making when organising and delivering health care for those who use our services.

1.4. During this time, operational Trust decisions will need to be made in light of staffing and resource constraints, taking into account the best interests and safety of both our patients and staff. These decisions will be made in line with standard trust practices and processes and will NOT be reviewed by the Committee.

1.5. It is the role of the Committee, to review complex decisions, both prospectively and retrospectively where ethical considerations need to take into account the wider scope of this decision and the impact it may have on patients and staff.

1.6. Issues may be proposed for discussion if they are:

- Referred by any healthcare professional where they have a moral or ethical concern and require support from the Committee; and / or
- Referred by Gold Command (as references in the Major Incident Plan); and / or
- In Conflict with national guidance; and / or
- The wider impact of the decision needs to be taken into account.

1.7. The Committee will confirm that the decision proposed has received ethical consideration from the group and the lead proposer will receive feedback to this effect. The decision to be made and any actions relating to this decision REMAIN THE REPONSIBLITY of the lead proposer/clinical division.

2. Principles and Values

2.1. This section outlines each ethical value and principle and associated actions and best practice when considering and applying them. These should be considered alongside professional codes of conduct and the most recent official guidance and legislation where these apply.

2.2. There are no absolute answers to making the correct or most ethical decisions. Each principle must be considered to the extent possible in the context of each

circumstance with appropriate risk management and considerations of individual wellbeing, overall public good and available information and resources.

2.3. The following areas[1] will be evidenced by the lead proposer and be reviewed by the group:

- **Equal Respect:** everyone matters and everyone matters equally, but this does not mean that everyone will be treated the same;
- **Respect:** keep people as informed as possible; give people the chance to express their views on matters that affect them; respect people's personal choices about care and treatment;
- **Minimise the harm of the pandemic:** reduce spread, minimise disruption, learn what works;
- **Fairness:** everyone matters equally. People with an equal chance of benefiting from a resource should have an equal chance of receiving it – although it is not unfair to ask people to wait if they could get the same benefit later;
- **Working together:** we need to support each other, take responsibility for our own behaviour and share information appropriately;
- **Reciprocity**: those who take on increased burdens should be supported in doing so;
- **Keeping things in proportion:** information communicated must be proportionate to the risks; restrictions on rights must be proportionate to the goals;
- **Flexibility:** plans must be adaptable to changing circumstances;
- **Open and transparent decision-making:** good decisions will be as inclusive, transparent and reasonable as possible. They should be rational, evidence-based, the result of a reasonable process and practical in the circumstances.
- **Safeguarding issues considered and applied to the previous areas.**

3. THE AIM AND OBJECTIVES

3.1. Using guidance from Covid Gold Committee and other expert sources e.g. national guidance, specialist societies formulate advice on ethical issues arising from management of Covid 19 within the Trust.

3.2. To support clinicians in clinical decision making on ethical principles and reasoning in context of Covid 19.

3.3. To provide an ethical input into policy making, management and governance in context of Covid 19.

[1] British Medical Association – Covid-19 – ethical issues. A Guidance Note

East Kent Hospitals University NHS Foundation Trust

4. MEMBERSHIP AND ATTENDANCE

4.1. Members;

Name	Title
Chair	
Chief Medical Officer	Rebecca Martin
~~Non-Executive Director~~	~~Wendy Cookson~~
Core Group	
Non-Executive Director	Wendy Cookson (Deputy Chair)
Non-Executive Director	~~Sean Reynolds (Deputy Chair)~~Vacant
~~Chief Medical Officer~~	~~Rebecca Martin~~
Chief Nurse	~~Amanda Hallums~~Tara Laybourne
Clinical Director General Medicine	Richard Kingston
Clinical Director Surgery & Anaesthetics	Vanessa Purday
Medical Ethicist	Julia Hynes
Clinical Director (other Care Group)	TBC
Head of Adult Safeguarding	Sally Hyde

4.2. Others may be invited to attend meetings or parts of meetings, as deemed appropriate by the Chair. The following are agreed as regular attendees:

- Mark Snazelle, Consultant Anaesthetist
- Mike Delaney, Consultant, Renal Medicine

4.3. Members may nominate a deputy to attend the Committee (Covid-19) on their behalf but the individual must be fully briefed and / or must have delegated authority to act in their absence.

4.4. A quorum of 3 of the members (including either the Chairman of the group and one of Chief Medical Officer or Chief Nurse).

5. FREQUENCY OF MEETINGS

This Committee (Covid-19) will meet ~~a minimum~~ monthly~~weekly~~ using video conferencing facilities and teleconference facilities. Extraordinary meetings can be requested by Executive Team or any member of the Committee, via the admin support.

East Kent Hospitals University NHS Foundation Trust

6. SERVICING ARRANGEMENTS

The administration of the Committee~~board~~ will be provided by central Executive Admin team, who will be responsible for attending the meetings and taking actions. Agendas and supporting papers will be distributed in accordance with deadlines agreed.

7. REPORTING ARRANGEMENTS

This Group is accountable through the Board for the duration of the Covid-19 Pandemic.

Reporting will be by the use of an 'exception' using the Risk, Action, Issue and Decision template.

8. CONFIDENTIALITY

Confidential minutes will be maintained, where necessary for staff or patient or other necessary consideration of confidentiality.

Agreed by: Ethics Committee (Covid-19)

Date:

East Kent Hospitals University NHS Foundation Trust

Remote and Rural Excellence (RARE) Strategy

Identifying current challenges and developing solutions

Dr James Hadlow

Associate Medical Director - Remote and Rural Strategy, EKHUFT

What is ‘remote and rural’?

Health Education England (HEE) Report 2016 (Training in Smaller Places)

- Rural
  - a low density of housing, often with large gaps between settlements, if there are settlements at all.

Being ‘remote’ is important

  - isolated large populations or demographics are particularly susceptible if there is infrastructure, or other non-healthcare related challenges that isolate it from other areas.

However, geography alone may not be the issue and may be relative…

- Other areas can be isolated i.e. a poorly connected service in a urban area.

Definition may also be financial

- Small providers are defined as having an operating income of less than £300 million in 2012/13 year.

Monitor (2014), “*Facing the future: Smaller Acute Providers*”, London: Monitor

Why can being rural be a problem?

- Royal College of General Practitioners (RCGP) identified several factors in their report investigating ‘rurality’ issues in Scotland.
- Scotland specific but many of the issues can be extrapolated to the rest of the UK and for secondary care:
  - connectivity (mobile phone/broadband);
  - transport;
  - fragility of support services;
  - workload (including the 24 hour commitment);
  - professional development;
  - education and training;
  - professional and social isolation - including adverse effects on family life.

"*Being Rural: exploring sustainable solutions for remote and rural healthcare*“, RCGP, 2014

Remote and Rural Trusts are vital – but face challenges

Remote and rural trusts play a vital part in ensuring the health of the nation

- One third of inpatient episodes are delivered by smaller units (*Monitor, 2014*).
- 17.1% population of England live in rural areas.
- Populations in rural areas have a higher proportion of older people compared with urban areas.
- Rural populations have a higher proportion of those aged 65 and over (25.1%) compared with the urban population (17%).
- Sparse settings even higher – 30.2% over 65 years old.

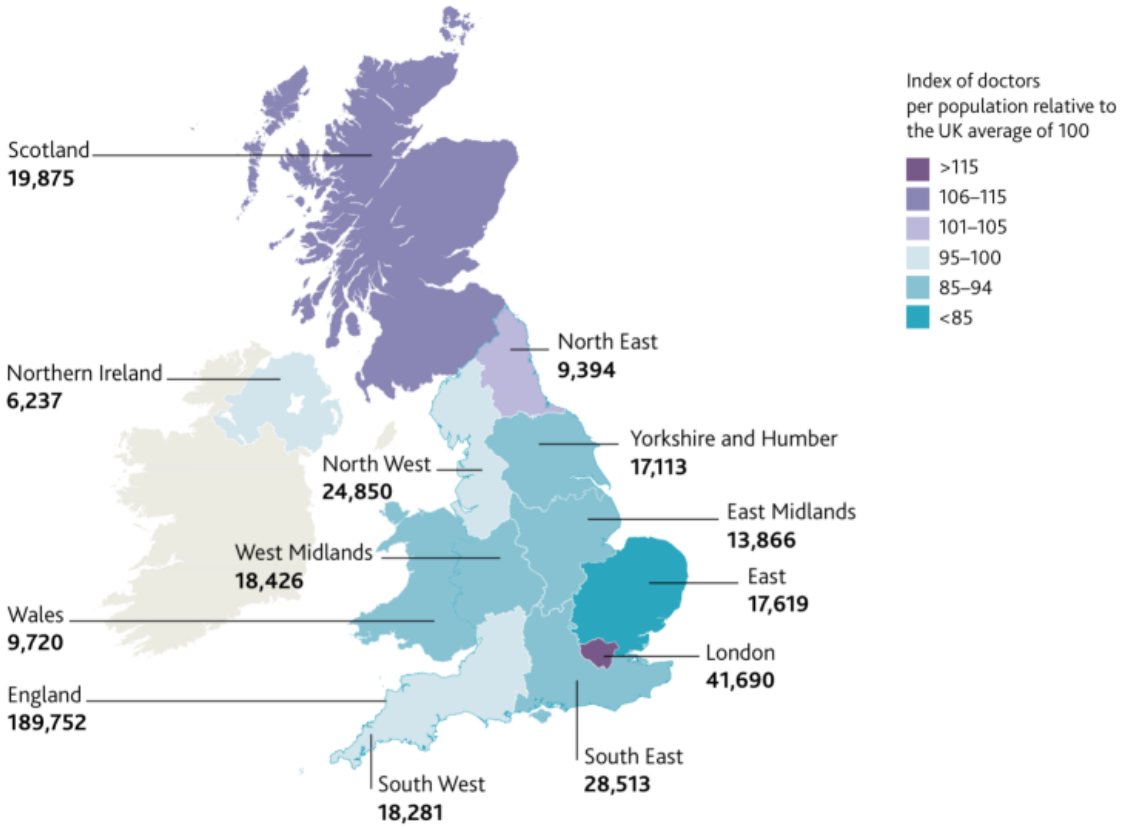
DEFRA, UK Government, November 2020

Recruitment and retention is particularly challenging

- Recent Royal College of Physicians (RCP) data indicated that only 13% of hospitals consultants recruited in 2019 went to rural hospitals. (*RCP Survey, 2019*).
- Knock on effect on nursing staff numbers and therefore patient outcomes (NHS England/NHS Improvement (NHSEI) work).

The UK picture

Figure 48: Number of licensed doctors relative to the population in 2015



Data are based on mid-year population estimates for 2015.[65]
Excludes 4% of licensed doctors with unknown location unless otherwise specified.

General Medical Council (GMC), The state of Medical Education and practice in the UK, 2016

Why is medical workforce distribution in rural areas an issue?

- Challenges in recruiting trainees and trained doctors in remote and rural areas for variety of historical, social and financial reasons.
- New medical schools such as Kent and Medway Medical School (KMMS) and work being led by HEE to boost recruitment of *training* workforce to these areas…
- …but we also need to consider the *trained* workforce, which has similar distribution issues.
- Challenges with retaining both sets of doctors.

- These challenges can, however, act as opportunities for innovation and change in terms of models of delivery of care as well as new ways of working.

- Whilst not unique to remote and rural areas, there are a number of issues which are particularly challenging in these areas:

Workforce issues in remote and rural areas

Many remote and rural trusts often struggle to attract, recruit and retain staff which leads to:

- Persistently understaffed services;
- High reliance on temporary staffing (with accompanying high expenditure and impact on care continuity);
- Differential levels of access to services – often with an emphasis on specific specialties – across different geographies;
- Potential impact on patient outcomes;
- Specialty shortages;
- Geographical challenges to meet service demand;
- Challenges in encouraging clinicians to create a life in more isolated locations away from urban centres;
- Rota gaps and associated impact on other activities such as teaching etc.

Therefore, whilst not unique to East Kent, EKHUFT and the wider East Kent healthcare community regularly experiences a number of the issues as detailed above.

Why do we need urgent action?

Nuffield Trust, Rural Health Care Report, January 2019

- *"Our analysis suggests that while the association between rurality, overstretched services and financial pressure are unclear, NHS trusts with 'unavoidably small' sites do appear to underperform: as well as having generally longer waiting times and lengths of stay, they are also in greater financial difficulty".*
- *"These trusts account for 3% of all trusts, but almost a quarter (23%) of the overall deficit for trusts, which is possibly indicative of unavoidable rural costs".*

Nuffield Trust, Rethinking acute care in smaller hospitals, October 2018

Recruitment to smaller organisations has always been difficult, but most smaller hospitals are now completely dependent on high levels of locum staffing.

- Nuffield - 48 sites studied, nine found with more than half the acute physician posts occupied by locums.
    - Some 80% of the sites found it difficult to ensure junior doctor cover for emergency work.

The national commitment to address this

NHS Long Term Plan

"Our aim is to ensure a sustainable overall balance between supply and demand across all staff groups. ***For doctors, we will focus on reducing geographical and specialty imbalances****."*

"So we will test a wide range of new incentives to ensure the balance between specialist and generalist doctors, and the balance of specialties within medicine, better matches patient needs. ***We will also work to ensure specialty choices made by doctors are better aligned to geographical shortages."***

"*(…) development of incentives to ensure that the specialty choices of trainees meet the needs of patients by* ***matching specialty and geographical needs****, especially in primary care, community care and mental health services".*

NHS Interim People Plan

"(…) continue to create innovative training opportunities to enhance recruitment and retention within the NHS, develop new skill-mix models, and ***address geographical and specialty shortages****."*

"Establish a ***national programme board to address geographical and specialty shortages in doctors****, including staffing models for rural and coastal hospitals and general practice".*

Forthcoming Chief Medical Officer (CMO) Report

- *Will focus on 'Coastal Medicine' – large overlap with remote and rural issues.*
- *Margate of particular interest.*

Projected areas of work as part of the strategy

Building on existing national and international evidence and working closely with our national partners e.g. as part of pilot schemes, potential areas and solutions to explore include:

In the short/medium term

- Financial incentives and other initiatives to boost recruitment.
- Dynamic and modern job adverts to attract clinicians to work in rural locations.
- Creating engaging and fulfilling clinical roles through greater flexibility.
- Work hygiene factors.
- Implementing steps to improve local culture.

In the long term

- Potential of digital technology.
- Engaging and fulfilling clinical roles through greater flexibility working in partnership with other organisations e.g. Higher Education Institutions (HEIs).
- Possibilities of modern multi-disciplinary working.
- Address regulatory issues (working in partnership with external regulatory bodies).
- New models of care.

Next steps:

Working with local and regional partners

- Kent and Medway NHS and Social Care Partnership Trust (KMPT), Kent Community Health Trust and others.

Working with System Partners

- Integrated Care Partnership.
- ‘Family first’ approach to recruitment.
- Other NHS career roles and expanding our offer as a region.

Managing and changing the way clinicians work

- Working closely with HR to explore:
  - Recruitment initiatives;
  - Exploring local opportunities for portfolio roles e.g. KMMS/Universities;
  - Culture;
  - Changing the way teams and groups work together through rostering, new care models, credentialing etc.

Summary

- Widespread medical workforce issues exist across the country.
- Problems are accentuated in rural and remote locations such as EKHUFT for variety of reasons.
- Shortages exist for both doctors in training and the trained medical workforce as well as the wider healthcare workforce.
- There is a need to prioritise the short term ‘wins’ vs medium and longer term solutions that can have maximum impact.
- Our work at Trust level, working closely in tandem with national policy work driven by NHSE/I and HEE and working with regional partners will help to identify these measures and build initiatives which will have an impact beyond the medical workforce.
- East Kent is perfectly placed to champion, lead and model this work at national level to address both short term and long-term workforce issues which will have a hugely positive impact on the local healthcare provision for East Kent and beyond.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) CHAIR**
BOARD SPONSOR:	**CHAIR OF THE IAGC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Audit and Governance Committee (IAGC) is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

The report seeks to answer the following questions in relation to risk, governance and assurance:

- What positive assurances were received?
- What concerns in relation to assurance were identified?
- Were any risks identified?
- What other reports were discussed?

MEETING HELD ON 24 NOVEMBER 2020

Positive assurance was received in relation to:

1. The Committee received and approved to waive standing orders in respect of normal notice periods not being fulfilled in relation to calling a number of extra-ordinary Board of Directors and Board Committee meetings at short notice. The Committee was also made aware of a breach of the Constitution in relation to membership on the Council of Governors, no action was required as the elected governor had since resigned.

2. The Committee received and discussed a Board Assurance Framework (BAF) risks report on the Highest Mitigated Risks (Strategic and Corporate Risk Registers), as well as Covid-19 risks that had been incorporated in these risk registers. The Committee took assurance from the progress updates presented and the actions being taken to mitigate these risks. The Committee challenged the proposed reduction for some of the residual risk scores and agreed an action for the Risk Manager to review the risks identified with the Executive Director lead and whether considering the current position the appropriateness of these risk scores being reduced. The Committee noted one risk remained outside the Trust's risk appetite CRR 85 – Increased demand for emergency patients with a mental health issue, despite controls in place.

3. The Committee received and discussed a Risk Register Review report that provided details following a review to determine how risks had moved in relation to actions taken to mitigate risks, the outcome and the impact of these actions and whether these had resulted in reducing the risk residual scores. The Committee noted this was a beneficial report in reviewing the risks and that appropriate policies and procedures are in place in respect of the management of risks. The Committee highlighted the key risk to the Trust in respect of BAF 4 – Estate condition, the significant level of funding required to address the Trust's estate and the insufficient funding available within the Trust's capital programme.

Other reports received and discussed:

4. The Committee received and noted an update summary report regarding 2019/20 Clinical Audit programme. The Committee noted the key risk to achieving the Trust's programme is improving performance in relation to the completion of audits, currently at a rate of 41%. The Committee emphasised the importance of clinical audits and the need for this to be an area of focussed priority of the Trust's Chief Medical Officer to ensure audits are completed, that these result in positive learning, as well as ensuring actions and recommendations are implemented and embedded.

   The Committee noted the National Clinical Audit and Patient Outcomes Programme (NCAPOP) remains suspended, unlikely to re-start in 2020 and this was likely to happen in March 2021. The forward audit planning process for 2021/22 audit programme will commence in January 2021. A programme of local clinical audits continued in Women's Health and Child Health.

5. The Committee received and noted an Emergency Planning Annual Report in relation to the Trust's duties as a Category 1 responder for emergency planning, response and recovery. As well as its duties as part of its contracts against the performance standards set by NHS England and Clinical Commissioning Groups. The report summarised the work of the Emergency Preparedness, Resilience and Response (EPRR) Team over the past year and the key issues affecting the resilience of the Trust.

   The Committee received assurance of alignment of the key areas including Covid-19, EU transition and winter planning/pressures. As well as the Trust's collaborative working and linking with other NHS organisations e.g. South East Coast Ambulance Service and the Community in respect of sharing approach to emergency planning management. The Trust was currently working on developing a vaccination plan in respect of Covid-19 vaccination.

6. The Committee received and noted a six monthly losses and special payments report for the period 1 April to 30 September 2020. The Trust's Overseas Visitor team had been increased to improve and reduce the number of cases and value of debt for overseas patients, which has improved the Trust's position.

7. The Committee received and noted a six monthly single tender waiver (STW) report for the period Q1 to Q2. The quantity of STWs was 14% lower than in 2019/20 with a 58% reduction in value compared to the Q1 to Q2 period in 2019/20. The Trust continues to focus on reducing the number and value of retrospective STWs, as well as on-going monitoring of STWs and reminding all budget holders of the requirement to competitively tender in line with the Trust's Standing Financial Instructions (SFIs) and EU Procurement Legislation.

8. The Committee received a verbal report regarding annual gifts and hospitality noting the Trust will be rolling out an electronic gifts and hospitality declaration system using the Electronic Staff Record (ESR). A successful pilot had been completed and this will be implemented throughout the Trust by the end of the year, it was expected a report will be available for presentation to the next IAGC meeting.

9. The Committee received and noted a quarterly Freedom to Speak Up Guardian (FTSUG) report providing an update on the activity of the FTSUGs in Q2 (July to September 2020). The line management of the FTSUG service has changed and now reports to the Director of Human Resources and Organisational Development, this will support better awareness and sharing of issues and concerns raised and the areas where targeted focussed work needed to be addressed. The FTSUG service had not received any anonymous concerns in Q2. There had been nine speak-ups during this period that related to Health & Safety (H&S) concerns in relation to Covid-19 and social distancing, the main area of concern related to behaviours. It was noted there had been good engagement and responsiveness from the Care Groups.

   The Committee acknowledged with no protected time the FTSUGs are only able to deliver the reactive component of this role and responding to concerns raised. The Committee supported the business case that was being produced for submission through the appropriate governance approval route with options to provide additional support and improve the service delivered.

10. The Committee received and noted the draft version of the Annual Quality Account/Report for 2019/20 and the revised suggested submission of 15 December 2020.

11. The Committee received and noted a report regarding the East Kent Hospitals Charity (EKHC) Annual Report and Accounts 2019/20 and the original planned timetable would have meant the draft being submitted to the IAGC. Due to the new timetable the draft will be presented to the Charitable Funds Committee (CFC) on 8 December ahead of the deadline for filing accounts in January 2021.

12. The Committee received and noted a progress report and sector update from the Trust's External Auditor. The Committee noted the timeline for the 2020/21 audit and a key sector change regarding the confirmation of an increase in audit scope in respect of the value for money responsibility of the auditor that will take effect in the 2020/21 audit.

13. The Committee received and discussed the Internal Audit progress report and the outcome of the finalised internal audit reports as detailed below:

    - Financial Governance (Substantial Assurance);
    - Capital Project Management (Reasonable Assurance);
    - Statutory and Mandatory training (Reasonable Assurance);
    - Risk Management (Advisory) – advisory notice provided due to the 4Action risk management system not being optimally and widely used within the Trust, the need for staff to have greater awareness of this system, its benefits and the efficiencies that can be realised from this system.

    The Committee acknowledged the positive position in relation to follow up of actions, which was the best reported position for quite some time. Ten management actions had reached their agreed implementation date, seven of which had been implemented, three were overdue and in the process of implementation. One action high priority related in respect of Standards of Business Conduct scheduled for completion by 30 November. Nine further management actions remain that have not yet reached the target date for implementation.

14. The Committee received and discussed a progress report from RSM Risk Assurance Services LLP Local Counter Fraud Specialist (LCFS), the Trust's Local Counter Fraud provider. The Committee noted there had been a reduction in the number of referrals that was also being seen nationally, the LCFS continued focussed fieldwork in respect of the Trust-wide Fraud and Bribery Risk Assessment. NHS Counter Fraud Authority (NHSCFA) has confirmed their Standards for Providers and Commissioners will be replaced by the Government Functional Standard GovSO13: Counter Fraud in 2021. NHS organisations are required to complete and submit a Fraud Prevention Guidance Impact Assessment (FPGIA) by 1 December, which will be signed off by the Trust's Director of Finance and Performance. The FPGIA measures whether NHS organisations are acting in response to the Fraud Prevention Notices (FPNs) and guides issued to quantify any savings associated with these to demonstrate the monetary value of proactive LCF activities.

15. The Committee received and approved the refreshed Anti-Fraud, Bribery and Corruption Policy, which had been refreshed following the appointment of the new LCFS aligning this to NHSCFA's requirements as well as the inclusion of updated contact information.

16. The Committee received and noted the annual work programme for IAGC for the upcoming year 2021.

17. The Committee received and noted a report from the Regulatory Compliance Committee (RCC) meeting held on 9 November.

RECOMMENDATIONS AND ACTION REQUIRED:

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE (NRC)**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR OF NRC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

MEETING HELD ON 8 DECEMBER 2020

The Committee received and discussed the following reports:

1.1 **Pension Recycling Applications – Review of Policy**

The Committee received and approved the continuation of the current scheme, which has helped to retain the services of senior clinicians. Following approval by the Committee the policy will be submitted to the Policy Authorisation Group (PAG) to confirm its review and subsequent continuation. The Committee was informed at previous meetings regarding the impact of tapered tax relief for senior clinicians and senior members of staff on Agenda for Change contracts, and agreed the policy at its

meeting in November 2019.

1.2 Special Responsibility Payment

The Committee received and approved the proposed Special Responsibility Payment that has been developed to enable the Trust to attract and retain the best staff, in respect of remunerating Clinical Directors of Care Groups.

1.2 National Position for Very Senior Managers (VSM)/Executive Directors Pay Uplifts

The Committee received and approved to award a pay uplift of 1.03% to VSM and Executive Director substantive staff in accordance with the National Pay Award Guidance from NHS England/NHS Improvement (NHSE/I). Payment will be made with immediate effect and backdated to April 2020 (i.e. start of the current financial year (FY) 2020/21.

1.3 Executive Directors, Chairman and Non-Executive Directors Recruitment

The Committee received and noted a verbal update regarding progress to recruit substantively to Executive Director, Chairman and Non-Executive Directors roles.

1.4 2gether Support Solutions (2gether) Arrangements for replacement of Managing Director (MD)

The Committee received and noted a report setting out the arrangements put in place to backfill the outgoing Managing Director of 2gether Support Solutions. This involves the appointment of an interim Managing Director for a period of 12 months commencing on 21 December 2020. Assurance was given that a full and seamless handover will be implemented along with support to ensure incoming interim Managing Director is sighted on all information required to enable success. The 12 months interim contract will enable consideration, review and determination of the strategic direction of the company, the requirements around the skills and experience needed of a permanent Managing Director. Additionally, 2gether Support Solutions also recruited an interim Project Delivery Director who will focus on working with the Trust to progress our clinical strategy and associated capital programmes.

RECOMMENDATIONS AND ACTION REQUIRED:

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: IPR – SEPTEMBER 2020 DATA**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Performance Report (IPR) is produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR provides assurance to the Board that all areas of performance are monitored with sentinel indicators, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions.
Below are the highlights from the October 2020 report. The report has been discussed in detail by the Board's Quality Committee, Finance and Performance Committee and Strategic Workforce Committee. A summary of discussions at these meetings are included in Chair Reports to the Board of Directors.

Performance

In October, the Trust performance against the agreed constitutional standards is:

- Accident & Emergency (A&E) 4 hour access standard 76.83%, excluding Kent Community Health NHS Foundation Trust (KCHFT) Minor Injury Unit (MIU).
- A&E 4 hour access standard 79.00%, including KCHFT MIU.
- 18 Week Referral to Treatment (RTT) 65.89%.
- 62 day Cancer Standard 85.06%.
- 6 week diagnostic standard 78.35%.

Accident & Emergency (A&E) 4 Hour Compliance

October performance for the 4 hour standard was 76.83%, which is a deterioration on the previous year (2019/20) of 80.4% and the first time the Trust has dipped below 80% since February 2020.

- The number of patients who received initial assessment within 15 minutes of arrival improved slightly to 95%.
- There were two 12 Hour Trolley Waits in October.
- The proportion of patients who left the department without being seen is compliant at 2.85%.
- The unplanned re-attendance position has increased slightly to 10.85%.
- Time to treatment within 60 minutes improved to 47.9%.

The number of patients attending Emergency Department (ED) have returned to pre-Covid levels across both majors and minor presentations. Managing the increased number of attendances continues to put additional pressure on the staff in ED due to patients having to be socially distanced across a wider clinical area and responding to surges in ambulances or attendances.

Patient acuity is also higher due to patients' conditions deteriorating through Wave 1 of Covid. October has also started to see increased Covid-19 presentations and indicates that Wave 2 has reached East Kent.

The number of patients attending with mental health conditions continues to increase. The level of risk is monitored daily by the Hospital Director triumvirates who are proactively involved in managing escalations to external partners and, where necessary to the Chief Executive Officer (CEO) for external support from NHS Improvement (NHSI) in order to identify Children and Adolescent Mental Health Services (CAMHs) beds.

Patients requiring admission have to be admitted into a specific stream, i.e. Covid or non-Covid beds and balancing the bed capacity within the strict infection control requirements is also a daily challenge.

Patients who require a complex discharge plan may have an extended hospital stay whilst suitable external capacity is identified. Clinical and Operational teams continue to work with external colleagues to identify discharge capacity early in the day and also to ensure that internal delays are reduced to enable patients who are medically optimised are discharge.

Weekly Director led reviews of every patient with a length of stay above 7 days is established.

18 Weeks Referral to Treatment (RTT) Standard

The 18 week performance has improved to 65.89%. The backlog size has decreased for the fifth consecutive month to 16,180 and waiting list has increased to 47,433. Primary Care Referrals have increased in month which is reflective of an increase in all activity.

The number of patients waiting over 52 weeks has increased due to the new national categorisation framework and also due to the number of patients who are now tipping into a 52 week wait due to the constraints on activity in Q2 and Q3. Consultants continue to review, and where necessary, contact patients to minimise any risk of potential harm. Harm reviews are in place with patients being reported on Datix.

Patients who are choosing not to proceed with their procedure or treatment are being referred back to the GP in accordance with the Access Policy. Clinical discussions to reassure and support patients with their decisions are regularly taking place. The new scripts which staff use when booking patients are in place to ensure that patients are being given assurance with regarding to attending hospital and followed up by a clinical discussion should the patient have any specific concerns.

There was a drop-in activity during October due to half term leave. Plans are in place to recover activity in November; however, this may be a risk due to the impact of Wave 2 of Covid-19 and patients declining to attend appointments as numbers increase in the local community and hospital.

Cancer 62 day Standard

October 62 day performance is currently compliant at 85.06%. Validation continues until the beginning of December in line with the national time table. The total number of patients on an active cancer pathway at the end of the month has increased to 3,921 and is compliant. There were 3 patients waiting 104 days or more for treatment or potential diagnosis.

2 week wait (2ww) and 31 day performance are again compliant across all standards with the exception of 31 day subsequent surgery at 93.24% and 62 day upgrades at 83.33%. This is a continued notable achievement and recognises the daily monitoring and active management by the Cancer and all Care Group teams particularly when referrals have continued to increase and are at their highest in month record since November 2019.

Improvement actions to sustainably reduce the number of >62 day breaches continue to be progressed with daily and weekly Director level oversight. The number of long waiting patients is decreasing overall with escalation at Chief Operating Officer (COO) level to tertiary centres.

There were 3 patients waiting over 104 days for treatment or potential diagnosis. Care Groups carry out potential harm reviews against all 104 day patients to give assurance that no harms have been reported.

The daily Director led meetings have continued with radiology, endoscopy and all 2ww tumour sites, together with, as required, escalations to partner Trusts in order to expedite patient pathways.

6 Week Referral to Diagnostic Standard

Compliance has improved to 78.35% and there were 3,576 patients who had waited over 6 weeks for their diagnostic procedure, which is an improvement on last month. The waiting list is now back to pre-Covid size. Breaches had increased due to the Royal Colleges guidance relating to the provision of diagnostic services during the pandemic, however, recovery plans are successfully clearing the backlog of diagnostics and this is reflected in the improved position overall.

The majority of breaches continue to be in Endoscopy for colonoscopy (1078), Radiology (1,322) and Cardiology (770) specialities, although all three specialities have improved on last month's position.

Improvement plans are in place to increase capacity in endoscopy and echo cardiology through use of the Independent Sector, insourcing and revised working arrangements.

Recovery Plans

Estates works continue on various wards and areas at Queen Elizabeth the Queen Mother Hospital (QEQMH) and William Harvey Hospital (WHH) to improve ward environments for patients and staff and also to improve patient flow and to further improve the streaming of Covid infections away from non-Covid areas.

All Care Groups are proactively implementing their improvement plans for elective and diagnostic pathways. Daily monitoring at Director level is in place to ensure that capacity is being maximised both internally and within the Independent Sector.

The EDs are also working innovatively to achieve social distancing and managing patients in high risk of Covid and non-Covid areas. Plans are being developed to redesign the WHH and QEQMH ED's and a business case has been approved.

Patient Experience and Patient Safety

- Infection prevention and control measures around Covid-19 continue to be a key focus as inpatient numbers have risen. Two outbreaks were opened at the end of October.
- C.difficile continues above annual trajectory but is an improved position in month. Other Healthcare Associated Infections (HCAIs) remain below the level for the previous year.

- The number of compliments has increased in October and 100% of complaints were acknowledged within 3 days.
- The number of Mixed Sex Accommodation breaches has increased. Performance in Friends and Family Test recommended and the percentage of "not recommended" has also declined (registering red).
- Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months to July 2020) has now reported as being maintained at expected rates.
- An integrated improvement plan has been developed including actions from the NHS England/NHS Improvement (NHSE/I) and Care Quality Commission (CQC) inspection with an implementation team who meets weekly to monitor progress.
- Venous Thromboembolism (VTE) assessment performance remains below national target and is a focus of a number of the care groups as part of We Care. The revised Serious Incident Panel process was agreed at Patient Safety Committee with a view to implementing by the new year. The revised process mandates clinical presentation of the investigation to the panel and decreases the layers of corporate review.

Financial Performance

The Trust achieved a £46k surplus in October, which brought the year-to-date (YTD) position to a £46k surplus, slightly ahead of the plan. The impact of Covid-19 has paused the NHS business planning process nationally. Nationally-mandated interim financial regime and contracting arrangements are in place for 2020/21.

The Trust has identified £3.7m of additional costs due to Covid-19 in October along with lost income of £0.6m, bringing the total financial impact of Covid-19 to £36.5m YTD. The Trust's cash balance at the end of October was £52m which was £47m above plan due to the NHSE/I block payment on account to cover anticipated operational costs in advance.

Human Resources

During the last seven months, the Trust's vacancy rate has mostly fallen, and continued to fall in October to 6.1%. This is the lowest vacancy rate the Trust has seen for almost two years.

Turnover in month, excluding junior doctors, continued to fall and fell to 11.1% for the month of October. The annual 12 month average, however, increased to 14.6% in October, and still shows a higher percentage than the previous 12 months due to higher turnover during Winter 2020. Sickness absence increased slightly in September, after falling below 4% in August. Sickness in April peaked at 8.89% across the Trust, and dropped to 7.12% in May and 5.14% in June. It fell again in July to 4.57% and in August to 3.63%. It has increased to 4.02% in September, mostly relating to increased short term sickness absence.

Daily Unavailability reports are sent out to all Care Group leadership teams, and HR Business Partners, to monitor trends and issues. This daily report will continue to be important with the increase in Covid-19 cases, to ensure we maintain and monitor sickness absence effectively and safely.

All metrics are reviewed and challenged at a Care Group level in the monthly Executive Performance Reviews. A detailed report is provided periodically to the Board's Strategic Workforce Committee and reported to Board through the Chair Report.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The report links to the corporate and strategic risk registers.

East Kent Hospitals University NHS Foundation Trust

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER:	The report links to the corporate and strategic risk registers.
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT:	Relevant sections of the IPR Performance have been considered by the following Board Committees: • Quality Committee. • Finance and Performance Committee. • Strategic Workforce Committee. Performance is discussed at an Executive and Care Group level at the following Groups: • Executive Management Team. • Executive Performance Review Meetings.
SUBSIDIARY IMPLICATIONS:	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

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

East Kent Hospitals University NHS Foundation Trust

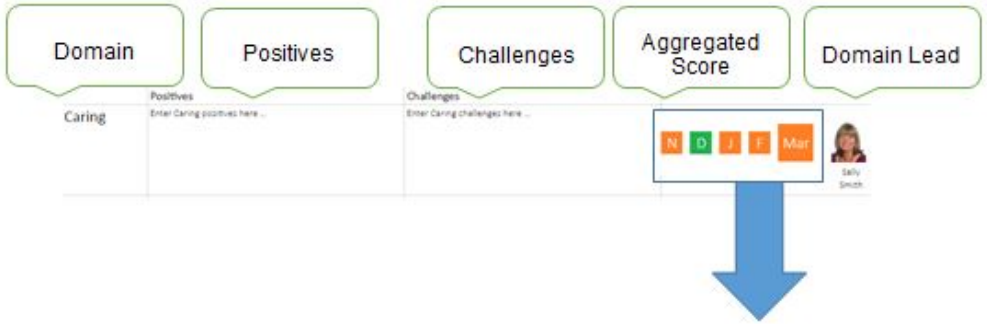
OCTOBER 2020

INTEGRATED PERFORMANCE REPORT

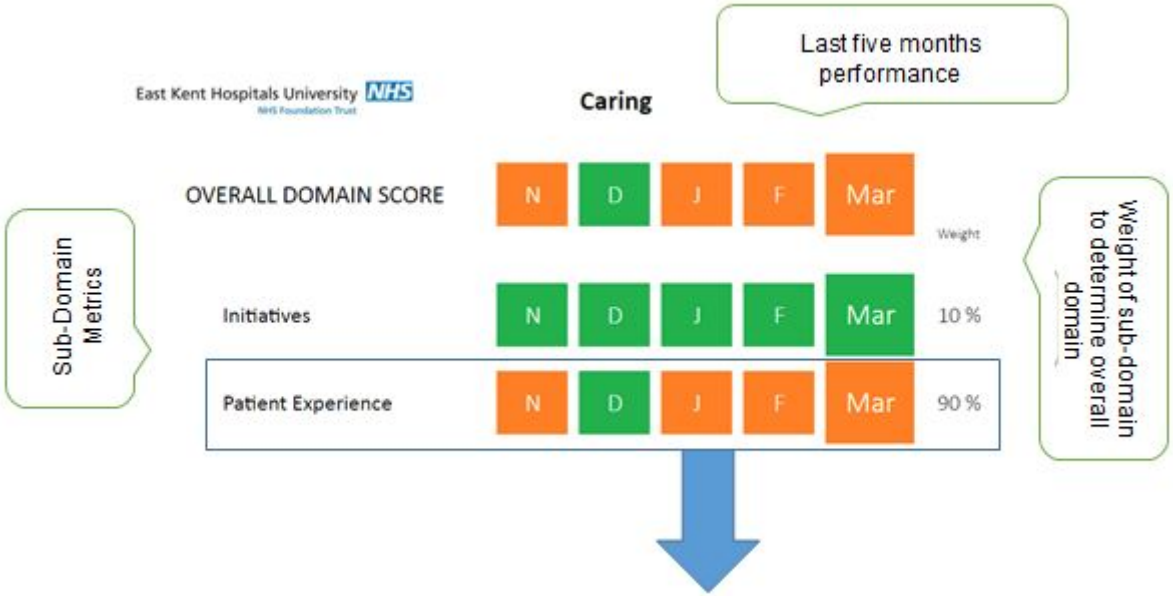
East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.

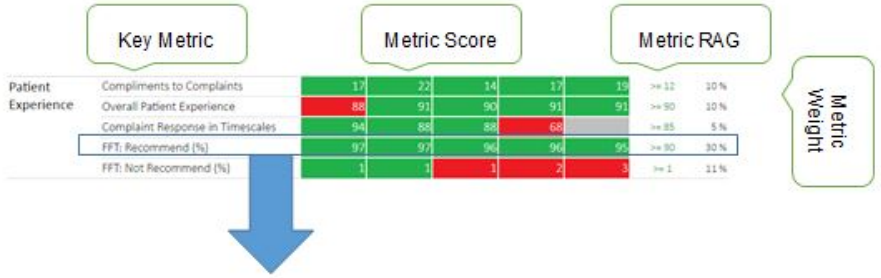


2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.



Understanding the IPR

3 **Key Metrics:** This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 **Strategic Themes**: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. A grey cell indicates that data is not yet available. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

NHS
East Kent Hospitals University
NHS Foundation Trust

Strategic Priorities

Headlines

	Positives	Challenges	
Caring	The number of compliments has increased in October and 100% of complaints were acknowledged within 3 days.	The number of Mixed Sex Breaches has increased. Performance in Friends and Family recommended and the percentage of "not recommended" has also declined (registering red).	J J A S Oct  Tara Laybourne
Effective	Bed Occupancy is 88%. The DNA rate for new and follow up out patients has improved to 8.4% and 7.4% respectively. Implementation of virtual outpatient appointments continue to increase and will be available to appropriate patients to ensure Infection prevention control measures and reduce attendance on hospital sites. 30-day Re-admissions have improved to 14.9%. Theatre utilisation has improved to 78%.	Inpatient discharges before midday continue to be static at 14%, Matrons are leading on a renewed focus on morning discharges and use of the discharge lounge. Fractured neck of femur performance (theatre within 36hrs) has deteriorated due to access to emergency theatres. Non clinical cancellations have increased to 2.1%.	J J A S Oct  Lee Martin
Responsive	2ww performance remains compliant across all pathways at 98.55%. All 31 day standards are also compliant. 62 day cancer performance is complaint at 85.06%, which is a significant achievement. DM01 performance is compliant 100% in Audiology. RTT performance has improved in month to 65.88%.	ED performance has been challenged due to increased attendances across major and minor pathways. Daily attendance numbers are back to pre-Covid-19 levels which is a challenge to manage due to social distancing requirements and increasing number of patient attending with Covid19. The Restore & Recovery programme continues to be a priority, although the number of 52 week patients is increasing due to the constraints of working within Covid19 and clinical priority to focus on Cancer patients or clinically urgent. New patient pathways have been rapidly adopted and efficiency is increasing.	J J A S Oct  Lee Martin

Safe	HSMR (rolling 12 months to July 2020) has now maintained 'as expected' Reduction in 'in month' hospital attributed C Difficile cases. The deep clean of the C. difficile outbreak wards at QEQM has been completed. Other HCAIs remain below the level for the previous year.	Infection prevention and control measures around Covid-19 continue to be a key focus as inpatient numbers have risen. Two outbreaks were opened at the end of October. An integrated improvement plan has been developed including actions from the NHSEI and CQC inspection with an implementation team who meets weekly to monitor progress. C difficile continues above annual trajectory but is an improved position in month. VTE assessment performance remains below national target and is a focus of a number of the care groups as part of We Care. The revised Serious Incident Panel process was agreed at Patient Safety Committee with a view to implementing by the new year. The revised process mandates clinical presentation of the investigation to the panel and decreases the layers of corporate review.	J J A S Oct  Rebecca Martin
Well Led	The Trust achieved a £46k surplus in October, which brought the year-to-date (YTD) position to a £46k surplus, slightly ahead of the plan. The impact of Covid-19 has paused the NHS business planning process nationally. Nationally-mandated interim financial regime and contracting arrangements are in place for 2020/21. The Trust's cash balance at the end of October was £52m which was £47m above plan due to the NHSE/I block payment on account to cover anticipated operational costs in advance.	The Trust has delivered £0.3m of savings in October which was £2.2m below the draft plan due to the Trust's reduced ability to deliver savings with the operational priority of dealing with the Covid-19 pandemic.	J J A S Oct  Susan Acott
Workforce	Recruitment has continued throughout Covid-19 across all grades and staff groups. The balance of permanent staff against temporary workers has continued to improve reflecting our positive recruitment position along with a reduction in staff turnover which has resulted in our lowest vacancy rate of 6.1%. We have now started three cohorts of overseas nurses following a postponement in their recruitment due to Covid-19 border restrictions and have plans for future cohorts every six weeks which will support our winter workforce planning.	Appraisal rates have fallen as a consequence of Covid-19 and were suspended formally earlier this year. It will be challenging to bring rates back up over the next quarter, however we have seen an further increase this month. Sickness levels have risen as a direct consequence of Covid-19, we have seen a further slight increase this month as we would expect at this time of year. Work is underway to review absence and manage supported returns to work with individuals. The impact of the virus on affected staff has been significant and incurred longer periods of absence than usual. Absence monitoring had been largely limited to Covid-19 support and wellbeing initiatives but has now recommenced to manage and reduce absence overall.	J J A S Oct  Andrea Ashman

East Kent Hospitals University NHS Foundation Trust

Caring

		Jun	Jul	Aug	Sep	Oct	Green	Weight
Patient Experience	Mixed Sex Breaches	524	369	399	780	1044	>= 0 & <1	10 %
	Number of Complaints	56	71	61	77	82		
	AE Mental Health Referrals	311	384	377	365	380		
	First Returner Complaints	11	9	12	8	15		4 %
	IP FFT: Recommend (%)	88	95	97	98	92	>= 95	30 %
	IP FFT: Not Recommend (%)	5.3	3.5	1.6	1.0	8.3	>= 0 & <2	30 %
	Number of PALS Received	420	500	489	523	574		
	Complaints acknowledged within 3	100	100	100	99	100		
	Maternity FFT: Recommended (%)		97.7	100.0	98.5	85.1		
	Maternity FFT: Not Recommended (%)		2.3	0.0	0.0	14.9		
	Compliments	1576	1600	1822	1054	1998	>= 1	
	Complaints Open < 31 Days (M/End)	47	71	74	77	98		
	Complaints Open 31 - 60 Days	17	30	35	51	60		
	Complaints Open 61 - 90 Days	4		2	12	15		
	Complaints Open > 90 Days (M/End)	3	2	3	7	10		
	Complaints Closed within 30 Working	20.0				85.7		
	Complaints Closed within 45 Working	65.1	91.3	81.3	72.5	57.7		
	Second Returner Complaints	1			4			
	PHSO Complaints		2	1				

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Effective

		Jun	Jul	Aug	Sep	Oct	Green	Weight
Beds	DToCs (Average per Day)	11	10	16	21	18	>= 0 & <35	30 %
	Bed Occupancy (%)	66	67	72	76	88	>= 0 & <92	60 %
	IP - Discharges Before Midday (%)	14	13	14	15	14	>= 35	10 %
	IP Spells with 3+ Ward Moves	466	454	424	445	434	Lower is Better	
Clinical Outcomes	FNoF (36h) (%)	73	55	40	53	53	>= 85	5 %
	Readmissions: EL dis. 30d (12M%)	4.2	4.3	3.3	4.6	4.0	>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	17.6	17.9	17.9	16.8	14.9	>= 0 & <15	15 %
	Audit of WHO Checklist %	96	95	97	96	97	>= 99	10 %
	Stroke BPT Achievement %	65	41	39	36	48		
Demand vs Capacity	DNA Rate: New %	7.9	8.6	9.6	9.9	8.4	>= 0 & <7	
	DNA Rate: Fup %	7.2	8.7	9.1	9.0	7.4	>= 0 & <7	
	New:FUp Ratio (1:#)	2.8	2.6	2.2	2.3	2.2	>= 0 & <2.13	
Productivity	LoS: Elective (Days)	2.9	2.5	3.0	2.8	2.7	Lower is Better	
	LoS: Non-Elective (Days)	5.8	5.8	5.9	6.0	5.9	Lower is Better	
	Theatres: Session Utilisation (%)	64	66	67	72	78	>= 85	25 %
	Theatres: On Time Start (% 15min)	21	29	35	34	36	>= 90	10 %
	Non-Clinical Cancellations (%)	0.7	0.6	0.5	0.9	2.1	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	25	38	43	10	13	>= 0 & <5	10 %

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Responsive

		Jun	Jul	Aug	Sep	Oct	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	90.48	87.32	83.94	83.44	80.42	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	89.33	85.80	81.85	81.47	78.58	>= 95	1 %
Cancer	Cancer: 2ww (All) %	95.67	98.40	97.95	98.58	98.55	>= 93	10 %
	Cancer: 2ww (Breast) %	100.00	97.73	100.00	98.99	99.14	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.09	98.91	96.77	98.37	99.15	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	93.18	90.57	96.61	95.71	94.52	>= 94	5 %
	Cancer: 31d (Drug) %	99.17	98.94	100.00	100.00	100.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	79.25	91.09	89.97	87.07	85.06	>= 85	50 %
	Cancer: 62d (Screening Ref) %	33.33		100.00	100.00	92.00	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	72.73	66.67	68.42	93.10	84.00	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	74.87	75.89	73.18	75.44	78.17	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
	Audio: Incomplete Path. 18wks (%)	45.63	59.74	100.00	100.00	100.00	>= 99	
RTT	RTT: Incompletes (%)	48.61	45.12	52.05	59.84	65.89	>= 92	100 %
	RTT: 52 Week Waits (Number)	768	1155	1555	2021	2215	>= 0	

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Safe

		Jun	Jul	Aug	Sep	Oct	Green	Weight
Incidents	Clinical Incidents: Total (#)	1,535	2,027	1,732	1,592	1,968		
	Serious Incidents (STEIS)	27	14	14	13	9		
	Falls (per 1,000 bed days)	7.02	6.20	5.57	4.99	5.09	>= 0 & <5	20 %
	Harms per 1000 bed days	5.4	5.2	4.9	4.9	6.1	>= 0 & <10	
Infection	Cases of C.Diff (Cumulative)	43	59	71	81	86		40 %
	Cases of MRSA (per month)	0	0	0	0	0	>= 0 & <1	40 %
	Cases of C.Diff (per month)	16	16	12	10	5		
Mortality	HSMR (Index)	100.0	99.2				>= 0 & <106	35 %
	Crude Mortality NEL (per 1,000)	34.0	23.8	23.5	25.6	22.1	>= 0 & <27.1	10 %
	SHMI	1.064					>= 0 & <0.95	15 %
Observations	VTE: Risk Assessment %	92.7	93.4	92.8	93.3	92.6	>= 95	20 %

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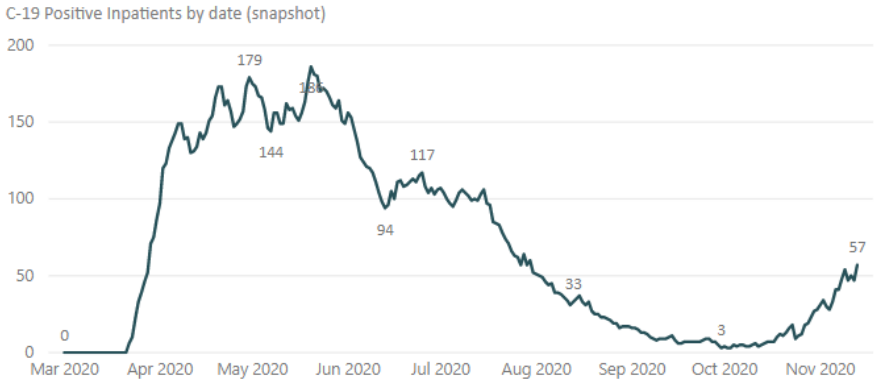
Well Led

		Jun	Jul	Aug	Sep	Oct	Green	Weight
Data Quality & Assurance	Uncoded Spells %	0.1	0.1	0.2	0.2	0.3	>= 0 & <0.25	25 %
Finance	Cash Balance £m (Trust Only)	60.2	55.0	56.7	61.1	51.8	>= 5	20 %
	I&E £m (Trust Only)	-0.3	0.1	-0.3	-0.1	0.1	>= Plan	30 %
Health & Safety	RIDDOR Reports	1	2	3	3	1	>= 0 & <3	20 %
Staffing	Agency %	7.0	7.5	7.8	7.7	8.0	>= 0 & <10	
	1:1 Care in labour	100.0	100.0	100.0	100.0	98.5	>= 99 & <99	
	Midwife:Birth Ratio (%)	22.6	21.7	22.0	24.7	25.4	>= 0 & <28	2 %
	Bank Filled Hours vs Total Agency Hours	67	66	67	67	67		1 %
	Shifts Filled - Day (%)	93	92	88	94	104	>= 80	15 %
	Shifts Filled - Night (%)	92	94	96	106	113	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	13.2	12.6	11.2	10.3	9.9		
	Staff Turnover (%)	10.4	10.6	10.5	10.4	10.5	>= 0 & <10	15 %
	Vacancy (Monthly) %	8.8	8.3	7.4	6.6	6.1	>= 0 & <10	15 %
	Sickness (Monthly) %	5.7	5.1	4.5	4.9	5.1	>= 3.3 & <3.7	10 %
Training	Appraisal Rate (%)	63.0	62.8	62.3	66.2	67.0	>= 85	50 %
	Statutory Training (%)	93	93	93	94	93	>= 85	50 %

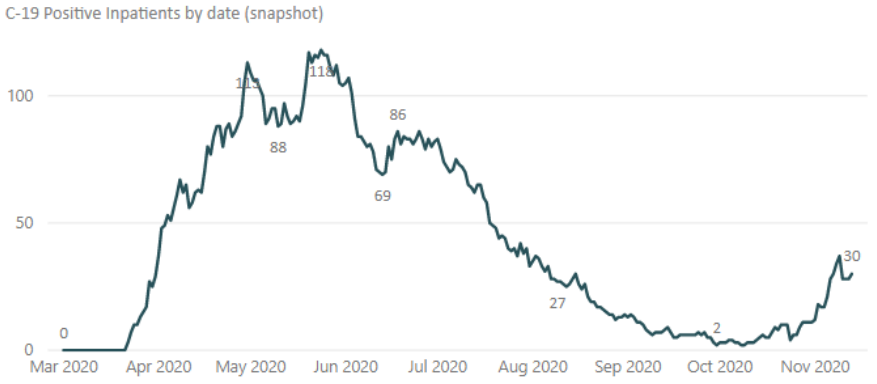
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: COVID-19 | Inpatients

57 TRUST

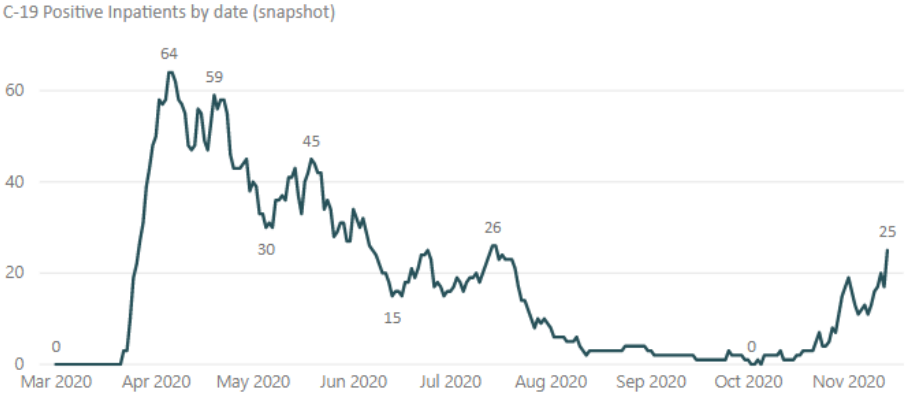


30 WHH



2 K&C

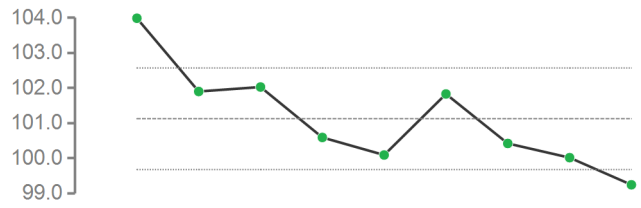
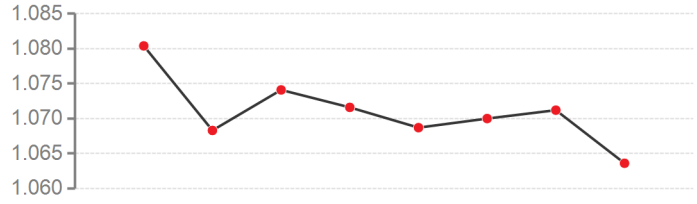
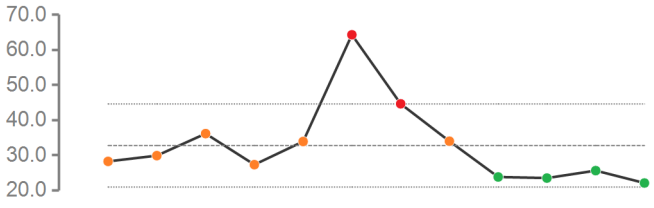
25 QEQM



East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Mortality

Oct	HSMR (Index)	101.1 (-4.0%)		Hospital Standardised Mortality Ratio (HSMR), via Dr Foster, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores the number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.
Oct	SHMI	1.071 (-1.4%)		"Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data."
Oct	Crude Mortality NEL (per 1,000)	31.9 (14.3%)		"The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

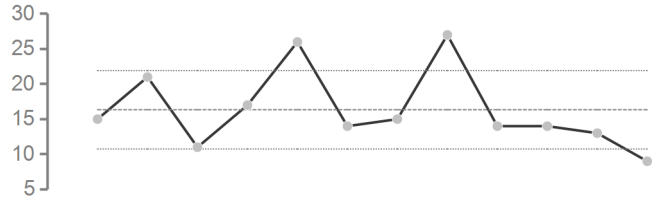
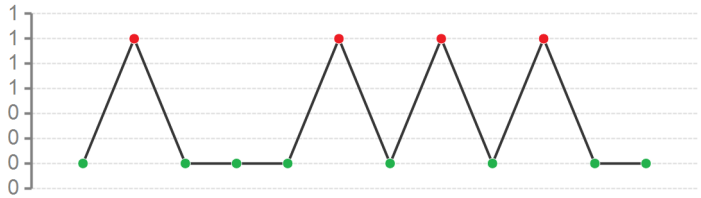
Overall, the HSMR is consistently reducing and currently the Trust remains 'as expected' in relation to national data. There has been a corresponding improvement in the capture and coding of palliative care activity which may account for some of this improvement. The crude mortality rate increased in April 2020, in line with the national average and has now fallen to expected levels for the time of year. There are three outlying groups attracting significantly higher than expected deaths, with no new alerts. The SHMI remains 'as expected'.

Mortality reduction is a breakthrough objective being delivered through We Care and current analysis will focus on the priorities to achieve this.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Serious Incidents

Oct	Serious Incidents (STEIS)	196 (33.3%)		"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."
Oct	Never Events (STEIS)	4 (-55.6%)		"Monthly number of Never Events. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."

Highlights and Actions:

There were 135 open serious incidents (SIs) at the end of October 2020. Nine new SIs were reported this month. The CCG agreed closure of 27 SIs and the downgrade of two SIs.

At month end there were three non-closure requests for further information from the CCG; generally these are addressed within a month and returned to the CCG with the majority being closed thereafter.

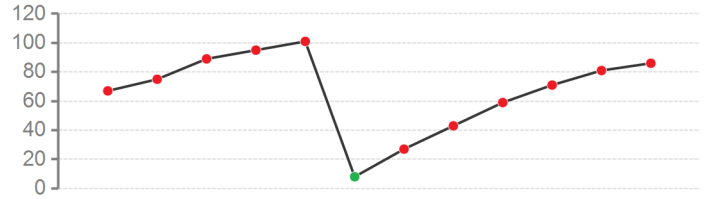
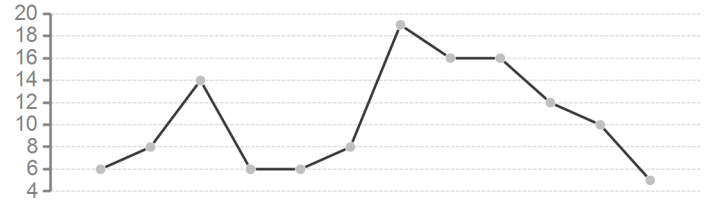
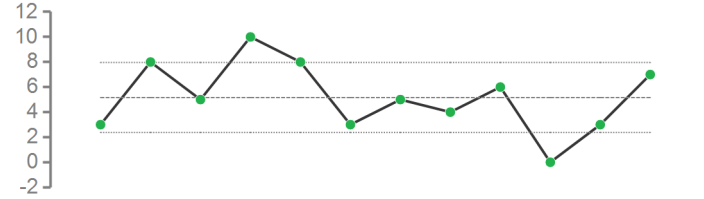
There were 51 SIs breaching investigation timeframes at month end. This month saw a decrease of 11 breaches and the care groups, supported by the patient safety team, continue to expedite completion of robust investigations and improvement plans.

The revised Serious Incident Panel process was agreed at Patient Safety Committee with a view to implementing by the new year. The revised process mandates clinical presentation of the investigation to the panel and decreases the layers of corporate review.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Infection Control

Oct	Cases of MRSA (per month)	0 (-100.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Oct	Cases of C.Diff (Cumulative)	130 (100.5%)		"Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01)."
Oct	Cases of C.Diff (per month)	5 (-50.0%)		Cases of C.Diff
Oct	E. Coli	62 (-27.9%)		"The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

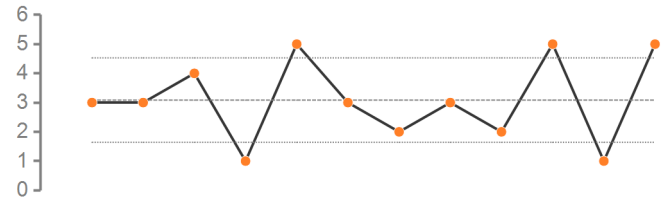
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Oct

MSSA

37
(15.6%)



"The total number of MSSA bacteraemia recorded, post 48hrs.

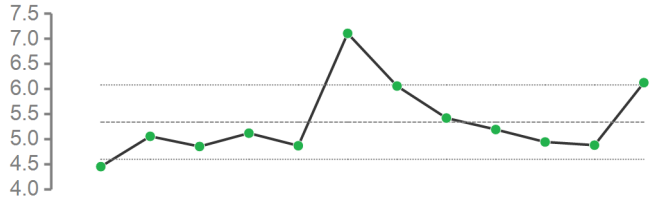
Highlights and Actions:

Infection prevention and control measures around Covid-19 continue to be a key focus. Two outbreaks were opened at the end of October. Three Covid-19 healthcare associated infections were seen in October. The strict front door policy with temperature checks, hand hygiene and face masks for all staff and patients and promotion of physical distancing remains in place. An integrated improvement plan has been developed including actions from the NHSEI and CQC inspection and the Safe Clean Care projects. An implementation team meets weekly to monitor progress. The improvement advisors continue to work with the matrons and the infection prevention team to improve standards. There have been 5 hospital attributable C. difficile cases for October against an expected 8 cases. This shows considerable improvement compared with previous months. Other HCAIs remain below the level for the previous year. The deep clean of the C. difficile outbreak wards at QEQM has been completed.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Harm Free Care

Oct	Harms per 1000 bed days	5.2 (-7.5%)		Harms per 1000 bed days for the wards included in the discontinued Safety Thermometer. Harms included: Fall (with harm) & Presure Ulcers

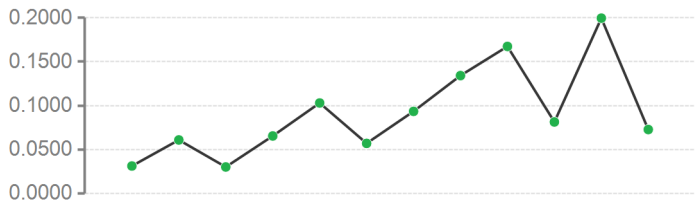
Highlights and Actions:

Harm Free care per 1000 bed days = 6.12745 (4.88058 September). In line with other patient experience scores for October, potentially reflecting the current Covid-19 related phase II crisis.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Pressure Care

Oct	Pressure Ulcers Cat 3/4 (per 1,000)	0.0874 (78.2%)		"Number of category ¾ hospital acquired pressure ulcers per 1,000 bed days. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

October 2020

General pressure Ulcers

• Twenty-five category 2 ulcers were reported. An increase of 8 from last month. Six of these were classed as a no harm meaning that all preventative measures were in place. Nineteen were reported at WHH and 4 at QEQM and 2 at K&C. The trust was under the set 10% reduction trajectory with a result of 0.842/1000 bed days.

• There were 2 confirmed category 3 ulcers. One reported on Kings B at WHH and one on Clarke ward at K&C. Both incidents were low harm. There were no category 4 pressure ulcers reported.

• Eleven potential deep ulcers were reported. 5 were suspected deep tissue injury (SDTI) and 6 were unstageable, four less than last month. Five at WHH and 6 at QEQM. One of these incidents was classed as moderate harm. This was on Kings B at WHH and an investigation is underway. The trust was over the set 10% trajectory for both metrics. Unstageables with a result of 0.202/1000 bed days and SDTIs with a result of 0.168/1000 bed days.

Medical Device Related incidents

• There were 7 category 2 medical device related pressure ulcers

• One suspected DTI low harm incident. Reported at WHH

Actions:

• Tamora active mattresses now rolled out at QEQM training continues

• Working with education team G, S&M care group to develop competency framework

• Learning from incidents workshop held in conjunction with patient safety team and ward manager from K&C and WHH. To ensure actions are reflected in the trust wide action plan

• Working with lead nurse for mouth care to develop care of medical device related mouth ulcer pathway

East Kent Hospitals University NHS Foundation Trust

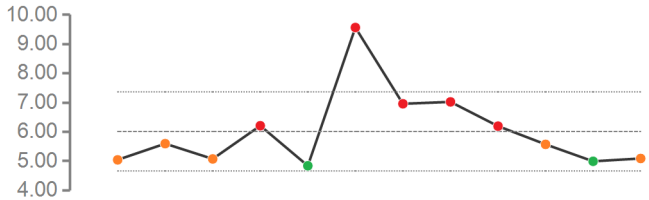
Strategic Theme: Patient Safety

Falls

Oct

Falls (per 1,000 bed days)

5.84
(7.0%)



"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

In October there were 128 falls (119 in September) with 16 at K&CH (previously 12), 48 at QEQMH (previously 32) and 63 at WHH (previously 75). 2 falls occurred outside of ward areas and a further fall was recorded at Maidstone renal satellite unit. This equates to rates per 1000 bed days of 3.36 at K&C, 4.35 at QEQM and 5.26 at WHH with a total across the 3 main sites of 4.46.

At WHH, wards with the highest number were AMU B (12) where one patient fell 3 times and another fell twice, Cambridge L (7), Cambridge J (6) where 1 patient fell twice and Kings B (6) where 1 patient fell 3 times and another fell twice.

At QEQMH there were 10 falls in A and E and 7 falls on AMU A where 1 patient fell twice.

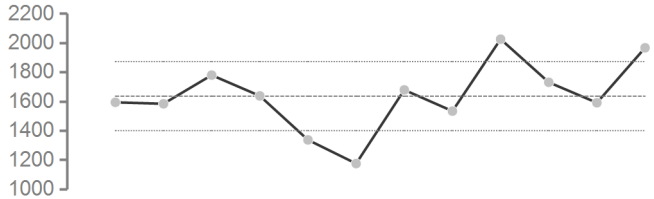
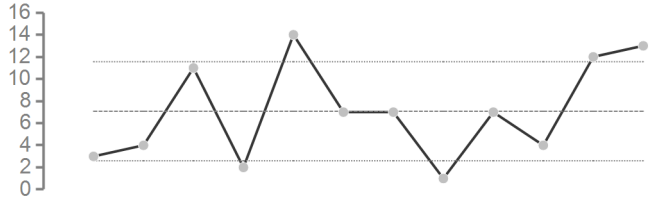
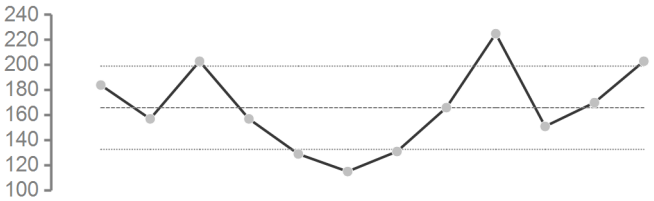
At K&CH there were 6 falls on the Invicta ward stroke unit, where one patient fell twice and another sustained a hip fracture. This was a result of equipment misuse and training was provided immediately to address it.

The Falls Prevention Team and Steering Group are working with the 'We Care' programme as one of the 5 breakthrough objectives, focusing on the integration of the multi-professional team, across the care groups, to prevent and manage falls. Particular focus is at the availability of FallStop training with mandatory status, improving measurement of lying and standing blood pressures, post fall neurological observations via Vitalpac and improving access to ward based information.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Incidents

Oct	Clinical Incidents: Total (#)	19,648 (1.7%)		"Number of Total Clinical Incidents reported, recorded on Datix.
Oct	Blood Transfusion Incidents	85 (-24.1%)		"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."
Oct	Medicines Mgmt. Incidents	1,991 (2.2%)		"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."

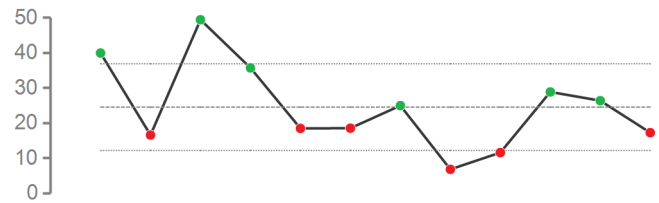
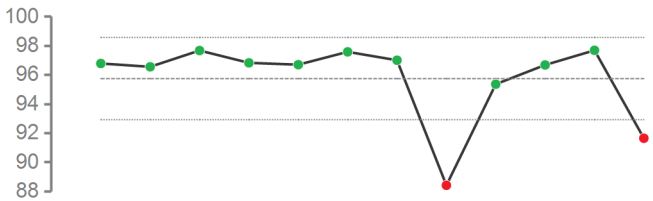
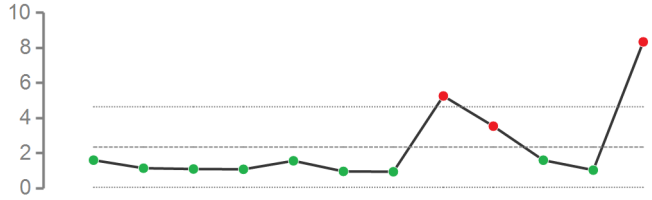
Highlights and Actions:

The incident reporting rate is a reflection of the safety culture within the Trust. Increased reporting over time may indicate an improved reporting culture and patterns should be interpreted alongside other information such as local safety issues, NHS staff survey data, etc.

A total of 1,968 clinical incidents were logged as occurring in Oct-20 compared with 1,592 recorded for Sep-20 and 1,575 in Oct-19. The total for Oct-20 could rise as incidents are often backdated (search based on incident date rather than reported date).

Strategic Theme: Patient Safety

Friends & Family Test

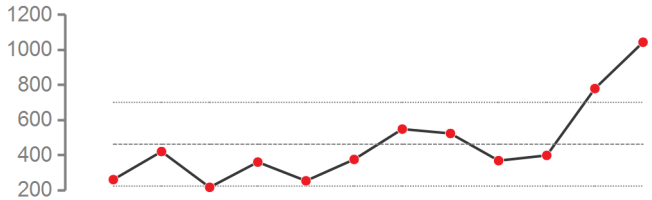
Oct	IP FFT: Response Rate (%)	24 (-33.3%)		"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Oct	IP FFT: Recommend (%)	96 (-0.7%)		
Oct	IP FFT: Not Recommend (%)	2.3 (76.7%)		"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

October FFT recommendation scores = Inpatients 91.65% (97.69%), Day case 97.31% (95.8%), UEC 87.37% (80.67%), Maternity 95.08% (98.5%) and Outpatients 93.91% (91.75%). The FFT process has now been brought in house, and a working group has been set up to review the process and the results for opportunity to learn and improve- the first meeting is arranged for 25.11.20.

Strategic Theme: Patient Safety

Mixed Sex

Oct	Mixed Sex Breaches	5555 1447.4%		"Number of patients experiencing mixed sex accommodation due to non-clinical reasons (un-justifiable). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

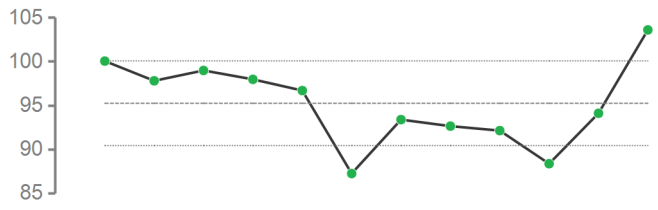
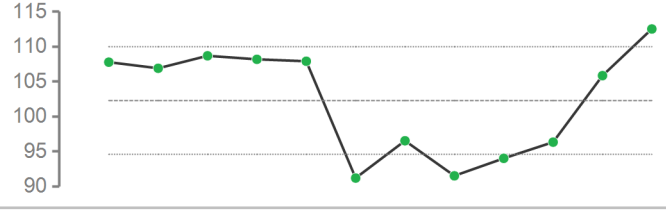
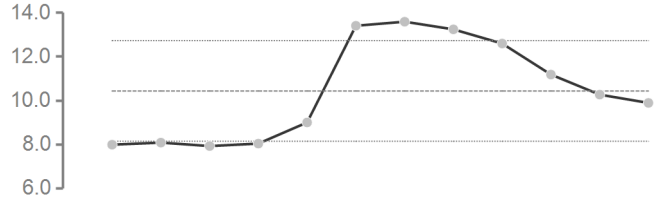
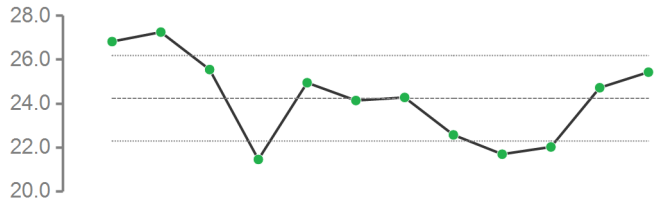
Highlights and Actions:

In relation to increased demand on clinical services more wards experienced MSA across the Trust. This is due to phase II of the Covid crisis. Total October MSA incidents - 522 = 53 justified & 469 unjustified (September 356= 67 justified & 389 unjustified)

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Safe Staffing

Oct	Shifts Filled - Day (%)	95 (-2.9%)		Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Oct	Shifts Filled - Night (%)	102 (-3.6%)		Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Oct	Care Hours Per Patient Day (CHPPD)	10.0 (20.8%)		Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Oct	Midwife:Birth Ratio (%)	24.1 (-6.2%)		The number of births compared to the number of whole time equivalent midwives per month (total midwife staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.

Highlights and Actions:

Percentage fill of planned (funded establishment) and actual (filled shifts) by hours is required to be reported monthly by registered nurse and care staff, by day and by night, in line with National Quality Board expectations. Reported data is derived from the Healthroster system which shows an overall average overall fill rate of 105.4% compared to 97.8% in Sept-20.

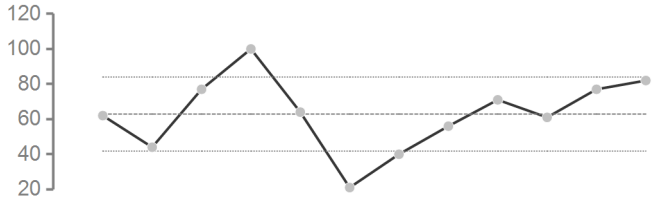
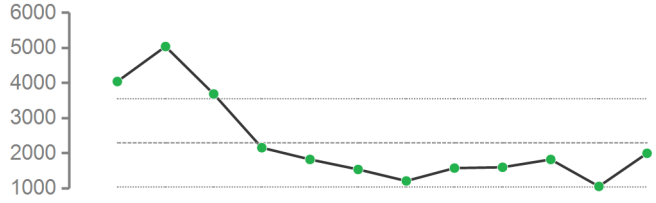
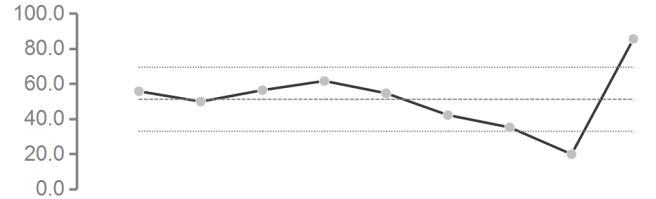
Care Hours per patient day (CHPPD) relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59hrs each day during the month. Average CHPPD is similar to last month and within control limits.

Further detail is provided in the appended paper submitted to the Quality Committee and reported by the Chair at Board of Directors.

East Kent Hospitals University NHS Foundation Trust

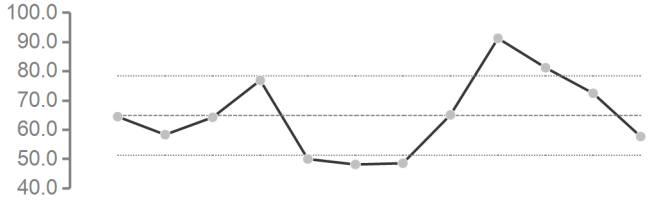
Strategic Theme: Patient Safety

Complaints & Compliments

Oct	Number of Complaints	755 (-4.3%)		The number of Complaints recorded for new complaints only (not returning complaints). Data source - DATIX
Oct	Complaints acknowledged within 3 working days	100 (1.1%)		Complaints acknowledged within 3 working days (%)
Oct	Compliments	27551 (-15.6%)		Number of compliments received
Oct	Complaints Closed within 30 Working Days or Agreed Extension (%)	52.8 (-36.4%)		Percentage of complaints closed within the 30 working day target (or an agreed extension)

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Oct	Complaints Closed within 45 Working Days or Agreed Extension (%)	64.9 (-16.7%)	

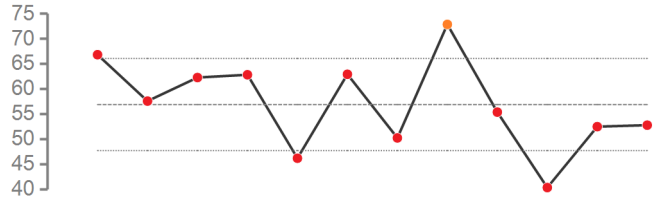
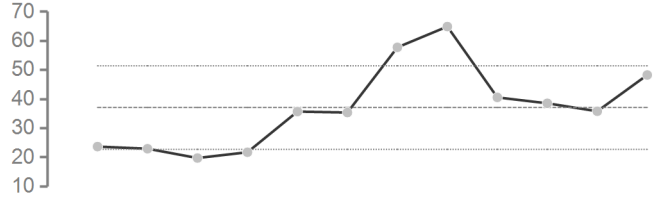
Percentage of complaints closed within the 45 working day target (or an agreed extension)

Highlights and Actions:

82 new complaints received in October 2020 (77 in September 2020), an increase of 6.5%. This is an increase of 39% from the 59 new complaints received in October 2019. The October figures for 2020 are in line with historically expected level of complaints.
100% of complaints received in September were acknowledged within three working days. Complaints during the height of the first Covid-19 period were set response targets of 45 working days; the 30 working day target was re-instated 01 September 2020
Compliance to the 30 working day target: 6 closed, 83%
Cancer 1 of 1 (100%)
Surgery and Anaesthetics 1 of 1 (100%)
Urgent and Emergency Care 3 of 3 (100%)
Women's and Children's 0 of 1 (0%)
Compliance to the 45 working day target – 49 closed, 43% Clinical Support, Surgery, Head and Neck and Women's and Cancer achieved 100%.
Urgent and Emergency Care 12 of 13 (92%)
General and Specialist Medicine 1 of 11 (9%)
Surgery and Anaesthetics 4 of 7 (57%)
Surgery – Head, Neck, Breast and Dermatology 3 of 3 (100%)
Women's and Children's 6 of 13 (46%)
Cancer 1 of 1 (100%)
Clinical Support Services 1 of 1 (100%)
The Complaints team are collaborating on a project with GSM and their new HON to reduce their aged complaints, improve their response timescales and response quality.

Strategic Theme: Clinical Outcomes

Clinical Outcomes

Oct	FNoF (36h) (%)	57 (-8.8%)		% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database - selecting 'Prompt Surgery%'. Reporting one month in arrears to ensure upload completeness.
Oct	Stroke BPT Achievement %	36 (57.2%)		Percentage of activity achieving the Stroke Best Practice Tariff

Highlights and Actions:

FNOF

The deterioration in time to theatre is a result of demand and capacity misalignment. Due to theatre staffing levels are QEQM and turnaround times the ability to increase capacity during peak times is impacting the time to theatre. Ad-hoc weekend lists are being provided when theatre staffing allows. Additional trauma lists are being prioritised over any elective activity.

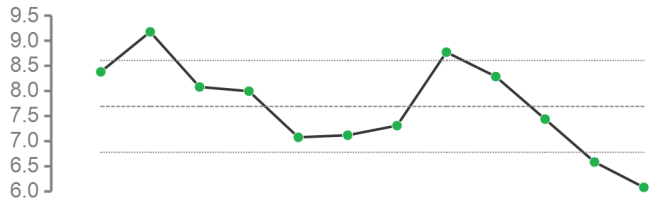
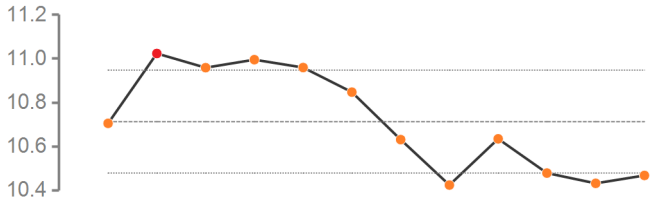
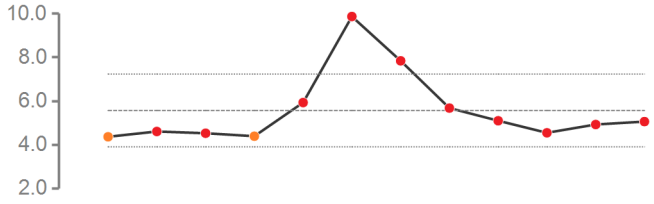
Stroke

We now have new metric setup which shows the % of activity meeting the Stroke Best Practice Tariff (BPT), which has been signed off at the Stroke Quality Committee. This replaces the previous 4hr % compliance from presentation to stroke ward metric and encapsulates all 3 of the BPT targets to show an overall % achievement.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

Oct	Vacancy (Monthly) %	7.7 (-20.8%)		Monthly % Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Oct	Staff Turnover (%)	10.7 (-0.9%)		"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Oct	Sickness (Monthly) %	5.6 (38.5%)		Monthly % of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the

Highlights and Actions:

During the last seven months, the Trust's vacancy rate has mostly fallen, and continued to fall in October to 6.1%. This is the lowest vacancy rate the Trust has seen for almost two years. There are now 7,925.57 WTE staff employed with the Trust and a vacancy of 509.24 WTE. Vacancy rates remain slightly above 10% in the General & Specialist Medicine and Urgent & Emergency Care Groups. However, most other clinical Care Groups are within a range of 2 to 5% vacancy.

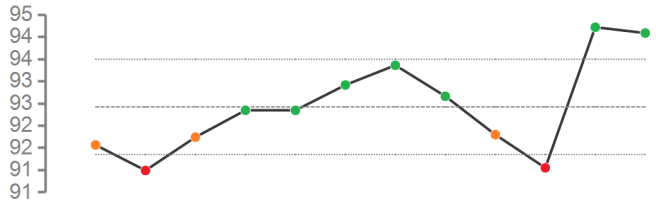
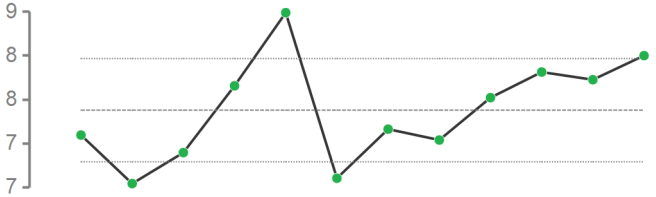
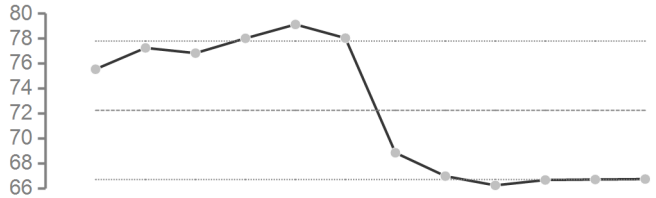
Turnover in month, excluding junior doctors, continued to fall and fell to 11.1% for the month of October. The annual 12 month average, however, increased to 14.6% in October, and still shows a higher percentage than the previous 12 months due to higher turnover during Winter 2020.

Sickness absence increased slightly in September, after falling below 4% in August. Sickness in April peaked at 8.89% across the Trust, and dropped to 7.12% in May and 5.14% in June. It fell again in July to 4.57% and in August to 3.63%. It increased to 4.02% in September, mostly relating to increased short term sickness absence. Daily Unavailability reports are sent out to all Care Group leadership teams, and HR Business Partners, to monitor trends and issues. This daily report will continue to be important with the increase in Covid-19 cases, to ensure we maintain and monitor sickness absence effectively and safely.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Temporary Staff

Oct	Employed vs Temporary Staff (%)	92.4 (2.4%)		"Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Oct	Agency %	7.4 (-4.3%)		% of temporary (Agency and Bank) staff of the total WTE
Oct	Bank Filled Hours vs Total Agency Hours	72 (9.2%)		% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff

Highlights and Actions:

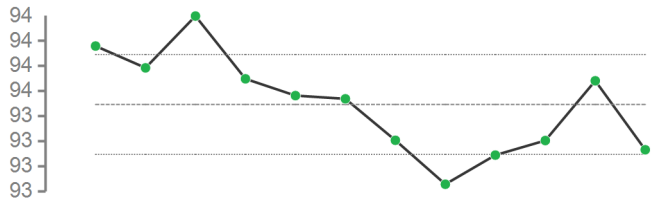
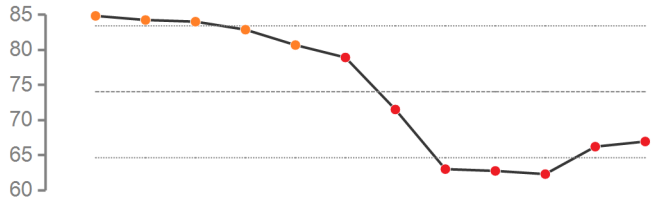
The percentage of permanent against temporary staff continues to improve as a trend, and remained approximately 94% in October. The rate has been on an upward trajectory for the past 12 months, and the 12 month average increased to 92.4%, remaining on a positive trajectory.

The percentage of agency staff 12 month average also continues to improve, at 7.4%. After increasing during February and March to a high of 9%, the percentage of agency and back staff has fallen back to approximately 8%. If sickness absence continues to remain lower than during the pandemic we would expect an ongoing improvement in agency and bank usage. However, with the recovery plan we anticipate an increase in agency and bank usage in the short term while the Trust employs the additional staff needed.

An issue that we are currently monitoring is the reduction in bank filled hours against total hours worked by temporary staff. This fell in October to approximately 66%, from a high of almost 80% in March.

Strategic Theme: Human Resources

Workforce & Culture

Oct	Statutory Training (%)	93 (-0.1%)		"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "
Oct	Appraisal Rate (%)	74.0 (-5.4%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Highlights and Actions:

Statutory training and appraisal compliance have both been adversely affected during the Covid-19 outbreak. The in month compliance for Statutory Training remained 93% and remains Green on the RAG rating. In addition, the 12 month trend shows an average of 93% completion. All Care Groups are over 90% compliant with Statutory Training.

The in month appraisal compliance for October increased to 67%, which has stopped the downward trend from the last five months. However, the 12 month average fell to 74%. Through many different communications, staff are being asked to carry out their appraisals where possible, including via Webex for those who are currently working from home. All Care Groups saw a reduction in compliance during April, May and June. Cancer, Clinical Support, Head & Neck and Women's & Childrens all had increases in compliance and are now at or above 75%.

East Kent Hospitals University NHS Foundation Trust

Third phase of NHS response to COVID-19 (Activity)

Point of Delivery		Sep-20	Oct-20
Total Outpatient Attendances	Plan	56,266	60,264
(face to face or virtually)	Actual	57,757	58,526
Consultant Led Outpatients	Plan	22,940	23,001
Attendances Conducted by telephone	Actual	23,874	22,765
Consultant Led Follow Up	Plan	17,269	17,649
Attendances Conducted by telephone	Actual	17,843	17,292
Daycase Electives	Plan	4,138	4,928
	Actual	4,117	4,632
Ordinary Electives	Plan	789	886
	Actual	721	906
Magnetic Resonance Imaging (MRI)	Plan	4,896	5,528
	Actual	4,669	4,915
Computed Tomography (CT)	Plan	7,060	7,080
	Actual	6,548	6,243
Non-Obstetric Ultrasound	Plan	4,749	4,391
	Actual	3,712	4,235
Colonscopy	Plan	512	662
	Actual	402	520
Flexi Signmoidoscopy	Plan	180	234
	Actual	169	197
Gastroscopy	Plan	595	766
	Actual	470	581

	Sep-20	Oct-20
Target	100%	100%
Performance	93%	86%
Target	25%	25%
Performance	41%	39%
Target	60%	60%
Performance	49%	49%
Target	80%	90%
Performance	86%	84%
Target	80%	90%
Performance	74%	81%
Target	90%	100%
Performance	74%	79%
Target	90%	100%
Performance	97%	89%
Target	90%	100%
Performance	89%	93%
Target	90%	100%
Performance	104%	92%
Target	90%	100%
Performance	79%	87%
Target	90%	100%
Performance	93%	90%

East Kent Hospitals University NHS Foundation Trust

4 Hour Emergency Access Standard

Key Performance Indicators

76.83%

	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Green
4 Hour Compliance (EKHUFT Sites) %*	74.00%	80.15%	89.73%	90.77%	89.33%	85.80%	81.44%	81.04%	76.83%	95%
4 Hour Compliance (inc KCHFT MIUs)	77.88%	83.14%	91.19%	92.07%	90.48%	87.32%	83.63%	83.12%	79.00%	95%
12 Hour Trolley Waits	6	0	0	0	0	0	0	0	2	0
Left without being seen	4.02%	2.74%	1.19%	2.24%	2.09%	2.63%	3.20%	2.71%	2.85%	<5%
Unplanned Reattenders	10.21%	9.80%	9.51%	10.07%	9.98%	9.84%	10.74%	10.21%	10.85%	<5%
Time to initial assessment (15 mins)	94.3%	94.9%	92.6%	90.5%	93.0%	94.1%	94.3%	94.9%	95.0%	90%
% Time to Treatment (60 Mins)	42.5%	48.8%	71.3%	58.1%	54.9%	50.9%	42.9%	45.5%	47.9%	50%

2020/21 Comparison to Previous Year

-3.54 %

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Green
Previous Year (19/20)	81.4%	80.2%	78.4%	80.4%	75.4%	73.9%	74.6%	74.0%	80.1%	
Performance	85.8%	81.4%	81.0%	76.8%						

The above table shows the ED performance, including the health economy MIU activity and also with EKHUFT only performance.

Summary Performance

October performance for the organisation against the 4-hour Emergency Access Standard was 76.83% excluding the health economy MIU activity and 79.00% including. This represents a decrease in performance compared to the previous month. There were two 12 Hour Trolley Waits in October. The proportion of patients who left the department without being seen remained at a compliant level but increased to 2.85%. The % of patients receiving initial assessment within 15 minutes is compliant and improved slightly to 95.0%. The unplanned re-attendance position declined to 10.85%. Time to treatment within 60 minutes increased to 47.9%. Attendances decreased slightly in October (16,475) compared to September (17,211), and to below pre-Covid-19 numbers.

Issues:

- Maintaining social distancing in ED waiting areas and major's department.
- Increasing number of Covid-19 presentations
- Increased emergency demand with high acuity in the majors stream.
- The number of patients attending with alcohol or mental health related conditions has continued to be above usual levels. Many of these patients require 1:1 clinical support and monitoring to maintain staff and patient safety within the department.
- Managing patient flow to appropriate ward areas to maintain strict clinical streaming.
- Impact of managing potential Covid-19 patients into dedicated ward areas, which may impact on wider bed base and may delay transfers of patients from ED to wards.

Action:

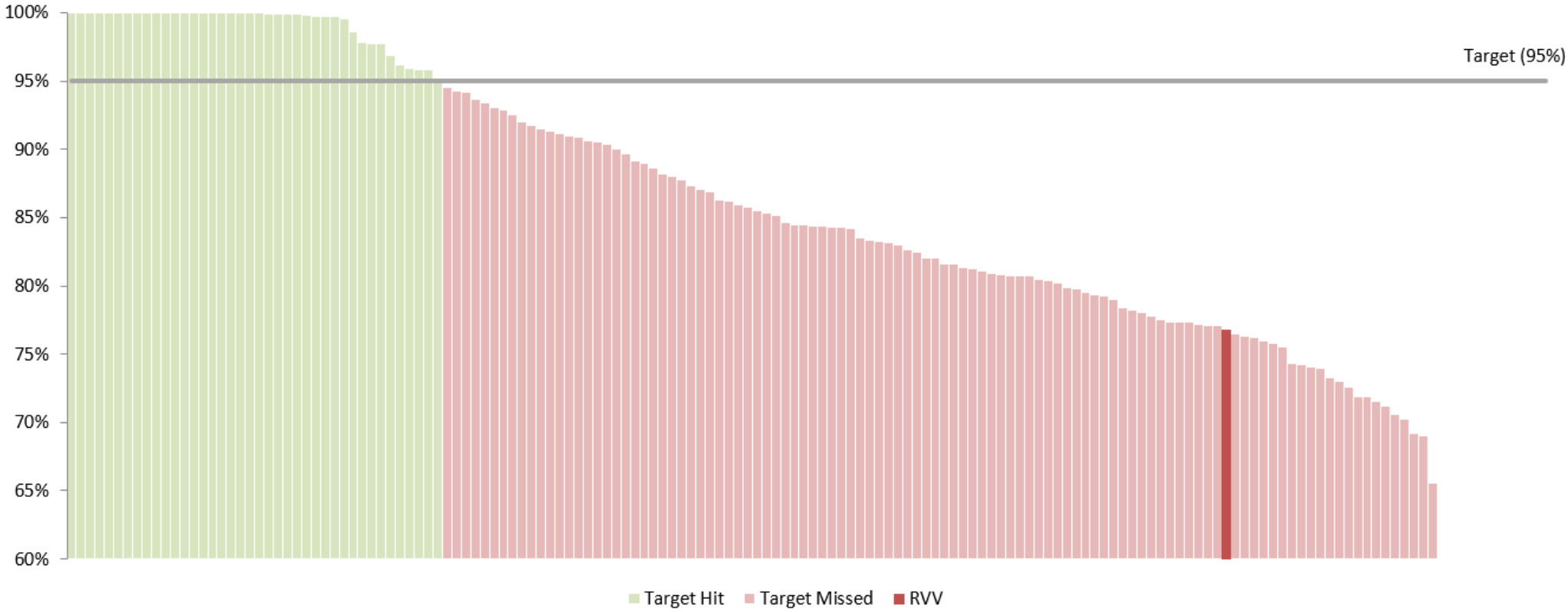
- Maximise streaming patients to Urgent Treatment Centres.
- Ensure patients are only being accompanied into the ED in accordance with Trust protocol.
- Implemented 111 direct booking into ED to give an attendance time and manage demand.
- Maintain senior clinical leadership to emergency floor to support early decision making and identification of potential COVID19 patients.
- 2 hourly board rounds to be reinforced, particularly overnight.
- Focus on zero 60-minute ambulance handover delays.
- Early escalation to KMPT mental health staff and Police to support management of patients.
- Executive and Director level oversight and management of infection control issues, including daily outbreak meetings and monitoring.
- Daily board rounds on wards with senior clinicians and matron in attendance to improve early discharge and flow.
- Weekly MDT reviews of all patients >7 days focussing on resolving internal delays in place.
- Daily COVID Local Health Economy calls with system partners to escalate and manage a system response.
- Increased system calls

East Kent Hospitals University NHS Foundation Trust

October 2020 | National A&E Benchmarking

East Kent Hospitals University NHS Trust ranked 125 of 148 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2019-20/



East Kent Hospitals University NHS Foundation Trust

Cancer Compliance

Key Performance Indicators

85.06 %

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Green
62 Day Treatments	82.42%	85.01%	75.45%	77.80%	81.40%	78.16%	70.85%	79.25%	91.09%	89.97%	87.07%	85.06%	>=85%
>104 day breaches	4	6	5	10	4	17	25	7	2	4	3	3	0
Demand: 2ww Refs	3,466	3,070	3,666	3,322	2,701	1,547	2,199	3,001	3,404	3,145	3,639	3,921	2935 - 3244
2ww Compliance	98.51%	98.36%	98.05%	98.29%	98.07%	96.77%	96.73%	95.67%	98.40%	97.95%	98.58%	98.58%	>=93%
Symptomatic Breast	97.28%	97.58%	99.19%	98.68%	96.34%	100.00%	96.97%	100.00%	97.73%	100.00%	98.99%	99.14%	>=93%
31 Day First Treatment	99.12%	99.07%	98.91%	99.38%	98.30%	99.36%	98.92%	96.09%	98.91%	96.77%	98.37%	99.15%	>=96%
31 Day Subsequent Surgery	95.24%	97.73%	96.92%	96.23%	95.71%	97.22%	97.37%	92.86%	86.21%	100.00%		93.24%	>=94%
31 Day Subsequent Drug	100.00%	100.00%	100.00%	100.00%	99.07%	100.00%	100.00%	99.17%	98.94%	100.00%	100.00%	100.00%	>=98%
62 Day Screening	88.24%	90.91%	89.47%	66.67%	87.50%	100.00%	100.00%	33.33%		100.00%	100.00%	92.00%	>=90%
62 Day Upgrades	88.46%	89.47%	70.00%	100.00%	78.95%	83.33%	71.43%	72.73%	66.67%	68.42%	93.10%	83.33%	>=85%

Summary Performance

October 62 day performance is currently compliant at 85.06%. Validation continues until the beginning of December in line with the national time table. The total number of patients on an active cancer pathway at the end of the month has increased to 3,921 and there have been three patients who have breached the >104-day standard. Six out of the eight national cancer performance targets have been met for four consecutive months, including the 62 day target, which is a huge achievement. There is a focused commitment to remove all 104 day breaches.

Issues:

- Managing endoscopy diagnostics and surgical treatments within the constraints of Covid-19.
- Gaining patients agreement to attend for endoscopy procedures and complete the isolation requirements pre procedure.
- Access to radiological diagnostics due to the constraints of Covid-19 on capacity.

Actions:

- Daily MDT calls with radiology and endoscopy which has reduced waiting times for diagnostics considerably.
- Daily 2ww and long waiters call to manage patients pathways.
- Endoscopy action plan continues to successfully increase capacity through use of independent sector and revised working arrangements to meet new infection control requirements.
- Daily review and escalation of patients awaiting a diagnostic to expedite the patients pathway.
- Action plans are in place for Endoscopy and Radiology with agreed trajectories to reduce the backlog of patients.
- Exploring options for insourcing in Endoscopy.
- Contiuing to increase options for additional activity through substantive workforce.

East Kent Hospitals University NHS Foundation Trust

62 Day Performance Breakdown by Tumour Site

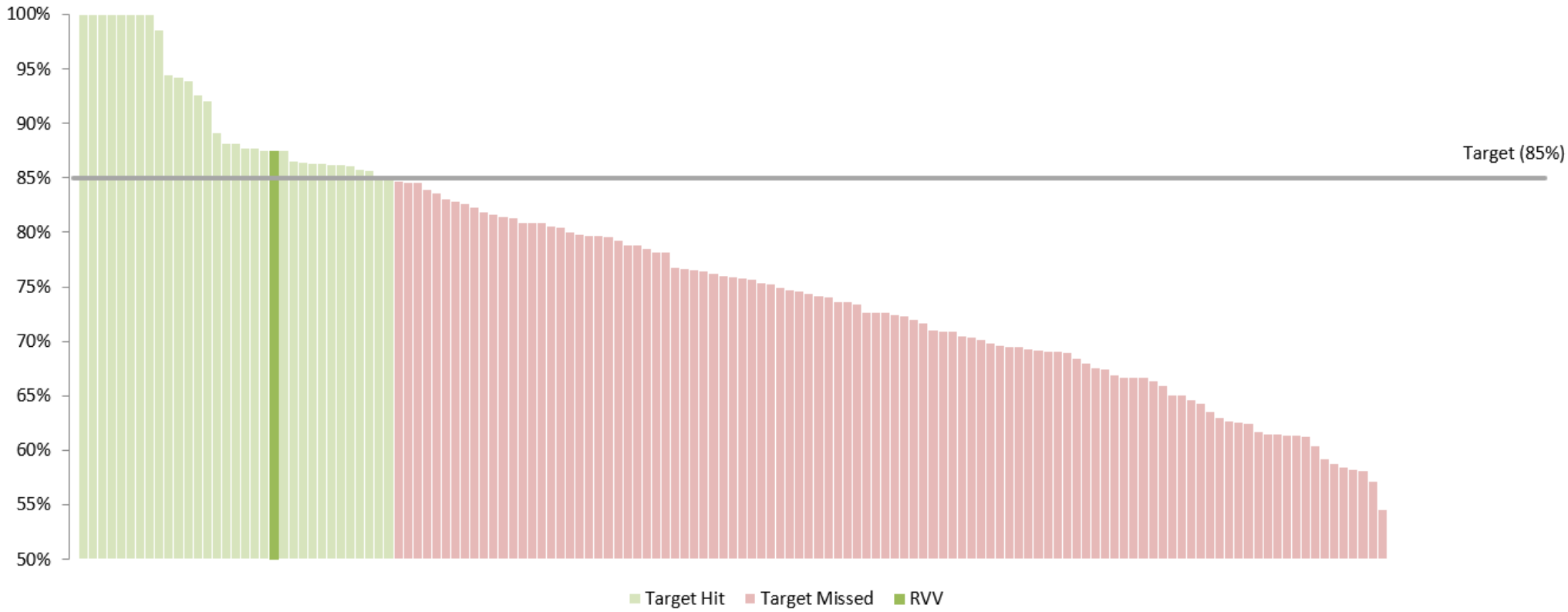
	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
01 - Breast	96.4%	95.7%	87.2%	75.0%	94.1%	91.7%	83.9%	92.6%	86.4%	97.0%	92.1%	94.3%
03 - Lung	52.5%	60.9%	55.6%	50.0%	50.0%	70.6%	55.6%	39.1%	86.7%	60.0%	80.0%	75.0%
04 - Haematological	80.0%	100.0%	100.0%	80.0%	42.9%	57.1%	50.0%	87.5%	100.0%	100.0%	83.3%	62.5%
06 - Upper GI	71.0%	88.9%	25.0%	80.0%	78.6%	40.0%	58.3%	68.0%	94.6%	66.7%	66.7%	85.7%
07 - Lower GI	35.9%	41.7%	30.8%	41.7%	57.1%	51.7%	34.8%	66.7%	66.7%	84.2%	56.7%	64.9%
08 - Skin	100.0%	100.0%	97.8%	100.0%	95.7%	97.7%	100.0%	97.5%	98.3%	97.4%	100.0%	100.0%
09 - Gynaecological	91.3%	92.3%	66.7%	100.0%	69.2%	72.0%	75.0%	50.0%	83.3%	60.0%	76.9%	80.0%
10 - Brain & CNS												
11 - Urological	88.4%	97.7%	82.4%	83.3%	86.5%	78.4%	50.0%	67.6%	97.1%	94.3%	94.3%	83.7%
13 - Head & Neck	66.7%	83.3%	100.0%	57.1%	61.9%	62.5%	42.9%	100.0%	77.8%	62.5%	63.6%	40.0%
14 - Sarcoma		0.0%	40.0%	100.0%		100.0%				100.0%		
15 - Other	100.0%		100.0%	66.7%			0.0%	100.0%			100.0%	

East Kent Hospitals University NHS Foundation Trust

September 2020 | National 62 Day Cancer Benchmarking

East Kent Hospitals University NHS Trust ranked 21 of 144 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/Cancer Waiting Times Data Extract (Provider) Provisional



*National Data is reported one month in arrears

East Kent Hospitals University NHS Foundation Trust

18 Week Referral to Treatment Standard

Key Performance Indicators

65.89 %

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Green
Performance	81.68%	80.32%	81.18%	81.07%	77.24%	68.63%	59.68%	48.61%	45.12%	52.05%	59.84%	65.89%	>=92%
52w+	5	5	4	2	14	155	410	768	1,155	1,555	2,021	2,215	0
Waiting list Size	47,445	46,686	46,211	47,331	45,907	42,632	42,795	42,702	45,037	45,873	46,811	47,433	<38,938
Backlog Size	8,690	9,189	8,695	8,962	10,447	13,374	17,255	21,945	24,717	21,994	18,797	16,180	<2,178

Summary Performance

October performance has improved to 65.89%, which has is the highest performance since May 2020 and has seen a sixth month improving position. The number of 52-week breaches has increased to 2,215 which is a deteriorating position and can be explained as due to the restriction on acute hospital elective surgery during Wave 1 of the Covid-19 pandemic, which has created a backlog of patients who are now tipping into 52 weeks wait. Theatre utilisation is reduced due to the continued required infection control measures between cases for PPE compliance and cleaning. Elective activity is being reinstated within the strict infection prevention controls for the management of elective surgical patients and through use of the Independent Sector capacity.

Outpatient clinics are continuing to managed via a range of mediums such as virtual and telephone. Face to face clinics are being reinstated within the reduced capacity constraints within waiting areas and strict infection control guidance. Virtual clinics continue to be very successful with approximately 50% of all Follow Up appointments being virtual and 41% of all first New appointments.

Issue:

- Providing out patients' services within the national infection control constraints and restrictions of Covid-19.
- 52-week breaches have increased due to the national Wave 1 restrictions for elective surgery, access to diagnostic and outpatient clinics.
- Identifying patients who are willing to isolate pre-procedure and also are willing to attend for their procedure whilst Covid-19 continues to be a risk.
- Patient choice to wait an unknown length of time for their procedure.

Actions:

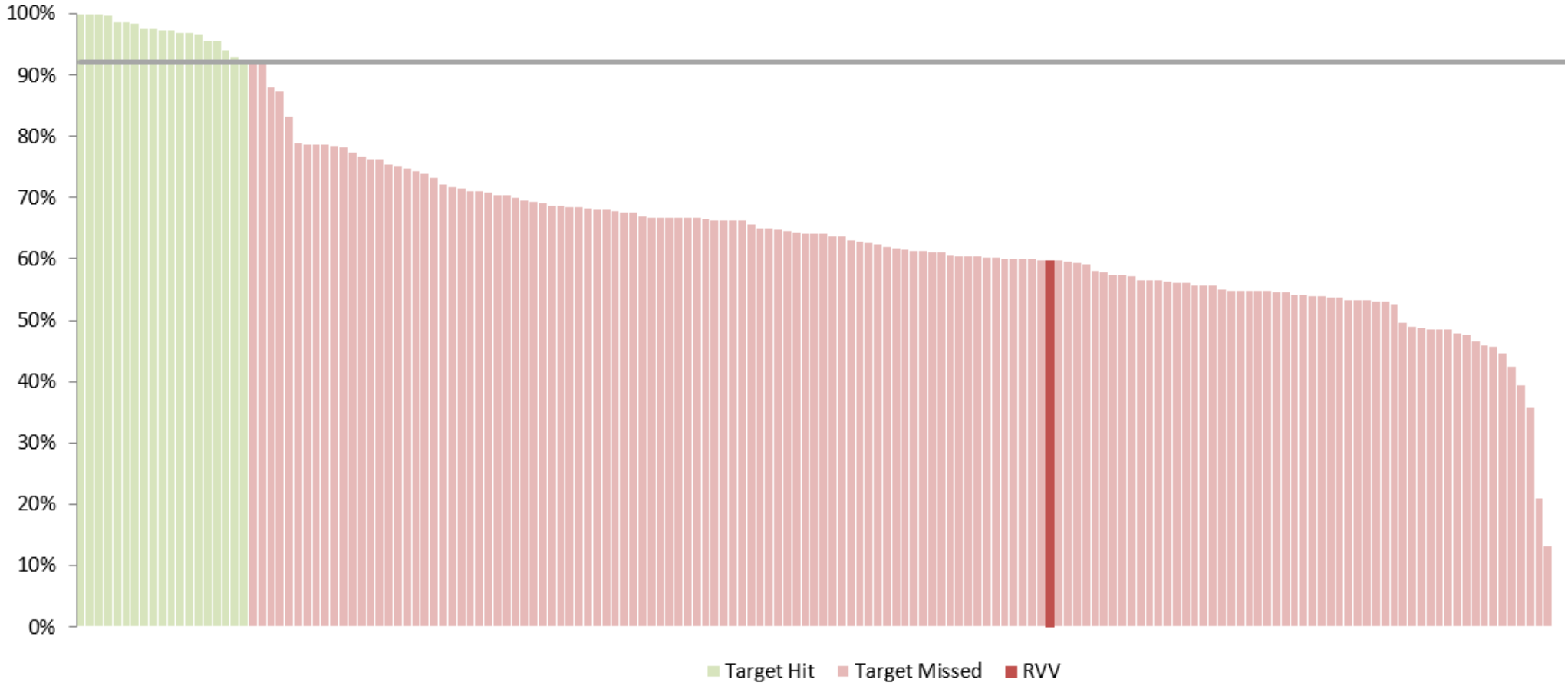
- Continued use of Independent Sector capacity for long waiting and cancer patients and maximising utilisation on all lists.
- Exploring options for insourcing to provide Day Case capacity at weekends.
- Exploring the opportunity for additional sessions provided by substantive staff.
- Clinically validating each waiting list to identify clinical priority in accordance with new national guidance.
- Liaising with patients and their GP's to mutually agree appointments and treatment plans within Access Policy and choice.
- Continuing to build on the success of virtual clinics.
- Reinstating face to face clinics within IPC guidelines.
- Increased booking and admin staff to support waiting list management.

East Kent Hospitals University NHS Foundation Trust

September 2020 | National RTT Benchmarking

East Kent Hospitals University NHS Trust ranked 108 of 164 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2019-20/Incomplete Provider



*National Data is reported one month in arrears

6 Week Referral to Diagnostic Standard

78.35 %

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Green
Performance	99.80%	99.55%	99.71%	99.80%	97.79%	57.25%	60.10%	74.87%	75.89%	73.18%	75.50%	78.35%	>=99%
Waiting list Size	16,605	15,621	15,320	16,053	10,460	5,500	7,922	11,721	15,486	16,174	16,644	16,521	<14,000
Waiting > 6 Week Breaches	34	71	44	32	231	2,351	3,161	2,945	3,733	4,338	4,078	3,576	<60

Summary Performance

October performance was 78.35% compliance in which is a 2.85% improvement on the previous month. In month breaches have continued to reduce from previous months at 3,576. The highest number of breaches continue to be in radiology (1,322), endoscopy for colonoscopy (1078) and echo Cardiology (770). The waiting list size has decreased to 16,521 which is around pre-Covid-19 levels.

Breaches by Speciality is below:-

- Radiology: 1,322
- Cardiology: 770
- Urodynamic: 137
- Cystoscopy :2
- Colonoscopy : 1,078
- Gastroscopy : 125
- Flexi Sigmoidoscopy : 89
- Neurophysiology: 53

Issue:

- Increase in radiology breaches due to increase in referrals
- Increase in echo cardiology breaches due to the constraints of Covid-19
- Increase in colonoscopy breaches due to the constraints of Covid-19

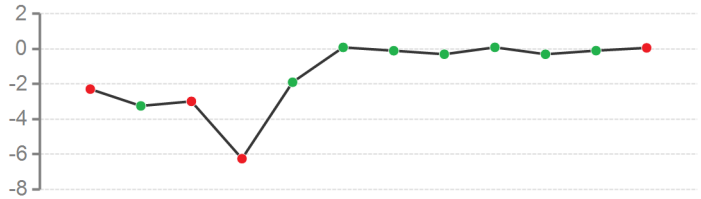
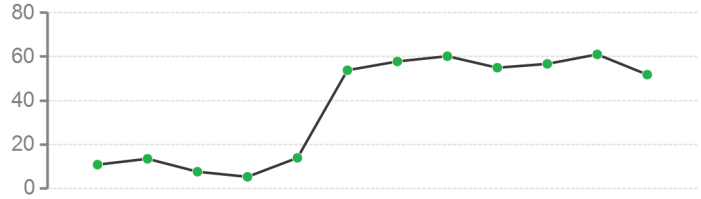
Action:

- Reinstatement of radiological activity to increase elective capacity through revised working arrangements, increased Independent Sector capacity and outsourcing non-obstetric ultrasound.
- Additional MRI machine has been installed.
- Endoscopy action plan and trajectory, split by modality, to increase capacity through increasing the number of procedures on each list due to new college guidance; increased Independent Sector capacity and exploring options to further increase insourcing capacity.
- Cardiology action plan and trajectory to provide echocardiology capacity through revised working arrangements.
- Clinical validation of the waiting list and direct contact with patient and GP regarding patient choice.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Finance

Finance

Oct	I&E £m (Trust Only)	-0.6 (-163.0%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.
Oct	Cash Balance £m (Trust Only)	51.8 (-15.1%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.

Highlights and Actions:

The Trust achieved a £46k surplus in October, which brought the year-to-date (YTD) position to a £46k surplus, slightly ahead of the plan.

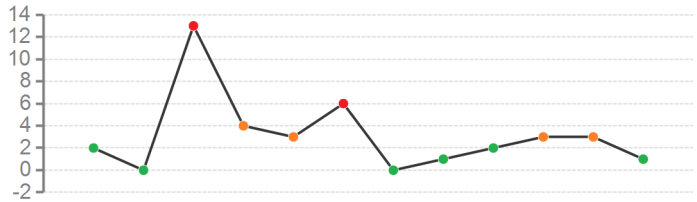
The impact of Covid-19 has paused the NHS business planning process nationally. Nationally-mandated interim financial regime and contracting arrangements are in place for 2020/21.

The Trust has identified £3.7m of additional costs due to Covid-19 in October along with lost income of £0.6m, bringing the total financial impact of Covid-19 to £36.5m YTD.

The Trust's cash balance at the end of October was £52m which was £47m above plan due to the NHSE/I block payment on account to cover anticipated operational costs in advance.

Strategic Theme: Health & Safety

Health & Safety 1

Oct	RIDDOR Reports	38 (22.6%)		"RIDDOR reports sent to HSE each month.(please note that Riddor uses the Field inc_dnotified (HSE date) rather than inc_dreported (Reported date)

Highlights and Actions:

RIDDOR
One case was reported to the HSE in October 2020 in relation to a member of staff who fell and damaged their pelvis while running to aid a patient.

NHS
East Kent Hospitals University
NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge, for only Acute Sites (K&C, QEQM, WHH, BHD). No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	1 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	>= 0 & <92	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	>= 0 & <35	30 %
	IP - Discharges Before Midday (%)	(Replaced by M_00122) % of Inpatients discharged before midday	>= 35	10 %
	IP Spells with 3+ Ward Moves	Total Patients with 3 or more Ward Moves in Spell	Lower is Better	
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %

Clinical Outcomes	Audit of WHO Checklist %	Driven from data brought as part of RP00109. An observational audit takes place to audit the World Health Organisation (WHO) checklist to ensure completion. After each procedure, the recovery staff check that each of the surgical checklists have been carried out. This compliance monitors against a random set of 10 patients each day from this process.	>= 99	10 %
	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database - selecting 'Prompt Surgery%'. Reporting one month in arrears to ensure upload completeness.	>= 85	5 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	>= 0 & <15	15 %
	Stroke BPT Achievement %	Percentage of activity achieving the Stroke Best Practice Tariff		
Data Quality & Assurance	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	>= 0 & <0.25	25 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	>= 0 & <7	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	>= 0 & <7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments	>= 0 & <2.13	
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m (Trust Only)	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 5	20 %
	I&E £m (Trust Only)	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.	>= Plan	30 %
Health & Safety	RIDDOR Reports	"RIDDOR reports sent to HSE each month.(please note that Riddor uses the Field inc_dnotified (HSE date) rather than inc_dreported (Reported date)	>= 0 & <3	20 %

Incidents	All Pressure Damage: Cat 2	"Number of all (old and new) Category 2 pressure ulcers. Data source - Datix."	>= 0 & <1	
	Blood Transfusion Incidents	"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Clinical Incidents closed within 6 weeks (%)	Percentage of Clinical Incidents closed within 6 weeks		
	Clinical Incidents: Minimal Harm	Number of Clinical Incidents resulting in Minimal Harm		
	Clinical Incidents: Moderate Harm	Number of Clinical Incidents resulting in Moderate Harm		
	Clinical Incidents: No Harm	Number of Clinical Incidents resulting in No Harm		
	Clinical Incidents: Severe Harm	Number of Clinical Incidents resulting in Severe Harm		
	Clinical Incidents: Total (#)	"Number of Total Clinical Incidents reported, recorded on Datix.		
	Falls (per 1,000 bed days)	"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <5	20 %
	Falls: Total	"Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix."	>= 0 & <3	0 %
	Harms per 1000 bed days	Harms per 1000 bed days for the wards included in the discontinued Safety Thermometer. Harms included: Fall (with harm) & Presure Ulcers	>= 0 & <10	
	Medicines Mgmt. Incidents	"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Never Events (STEIS)	"Monthly number of Never Events. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."	>= 0 & <1	30 %
	Pressure Ulcers Cat 3/4 (per 1,000)	"Number of category ¾ hospital acquired pressure ulcers per 1,000 bed days. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	Serious Incidents (STEIS)	"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Serious Incidents Open	Number of Serious Incidents currently open according to Datix		
Infection	Cases of C.Diff (Cumulative)	"Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01)."		40 %
	Cases of C.Diff (per month)	Cases of C.Diff		

Infection	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	>= 0 & <1	40 %
	E. Coli	"The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <44	10 %
	MSSA	"The total number of MSSA bacteraemia recorded, post 48hrs.	>= 0 & <1	10 %
Mortality	Crude Mortality NEL (per 1,000)	"The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via Dr Foster, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores the number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.	>= 0 & <106	35 %
	SHMI	"Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data."	>= 0 & <0.95	15 %
Observations	VTE: Risk Assessment %	"Adults (16+) who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant."	>= 95	20 %
Patient Experience	A&E FFT: Not Recommended (%)	A&E FFT: Not Recommended (%)		
	A&E FFT: Recommended (%)	A&E FFT: Recommended (%)		
	A&E FFT: Response Rate (%)	A&E FFT: Response Rate (%)		
	AE Mental Health Referrals	A&E Mental Health Referrals		
	Complaints acknowledged within 3 working days	Complaints acknowledged within 3 working days (%)		
	Complaints Closed within 30 Working Days or Agreed Extension (%)	Percentage of complaints closed within the 30 working day target (or an agreed extension)		
	Complaints Closed within 45 Working Days or Agreed Extension (%)	Percentage of complaints closed within the 45 working day target (or an agreed extension)		
	Complaints Open < 31 Days (M/End)	Number of Complaints open for less than 30 days as at the last day of the month (snapshot)		
	Complaints Open > 90 Days (M/End)	Number of Complaints open for more than 90 days as at the last day of the month (snapshot)		

Patient Experience	Complaints Open 31 - 60 Days (M/End)	Number of Complaints open for between 31 and 60 days as at the last day of the month (snapshot)		
	Complaints Open 61 - 90 Days (M/End)	Number of Complaints open for between 61 and 90 days as at the last day of the month (snapshot)		
	Complaints received with a 30 Day time frame agreed	Number of complaints received with an agreed time frame of 30 days		
	Complaints received with a 45 Day time frame agreed	Number of complaints received with a agreed time frame of 45 days		
	Compliments	Number of compliments received	>= 1	
	First Returner Complaints	Number of complaints returned by date of return		4 %
	IP FFT: Not Recommend (%)	"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <2	30 %
	IP FFT: Recommend (%)		>= 95	30 %
	IP FFT: Response Rate (%)	"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 22	1 %
	Maternity FFT: Not Recommended (%)	Maternity FFT: Not Recommended (%)		
	Maternity FFT: Recommended (%)	Maternity FFT: Recommended (%)		
	Maternity FFT: Response Rate (%)	Maternity FFT: Response Rate (%)		
	Mixed Sex Breaches	"Number of patients experiencing mixed sex accommodation due to non-clinical reasons (un-justifiable). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	Number of Complaints	The number of Complaints recorded for new complaints only (not returning complaints). Data source - DATIX		
	Number of PALS Received	"The number of concerns recorded per ward via the PALS department. Data source - Datix."		
	PHSO Complaints	Number of PHSO complaints receieved		
	Second Returner Complaints	Number of Second Returner Complaints received by date of returned complaint received		

Productivity	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.	Lower is Better	
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.	Lower is Better	
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	>= 0 & <5	10 %
	Theatres: On Time Start (% 15min)	The % of cases that start within 15 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	>= 0	
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	1:1 Care in labour	The number of women in labour compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 99 & <99	
	Agency %	% of temporary (Agency and Bank) staff of the total WTE	>= 0 & <10	
	Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff		1 %
	Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.		
	Employed vs Temporary Staff (%)	"Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 92.1	1 %
	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivalent midwives per month (total midwife staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 0 & <28	2 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %

Staffing	Sickness (Monthly) %	Monthly % of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 3.3 & <3.7	10 %
	Staff Turnover (%)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %
	Vacancy (Medical) %	"% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	Vacancy (Midwifery) %	"% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	Vacancy (Monthly) %	Monthly % Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %
	Vacancy (Nursing) %	"% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
	Statutory Training (%)	"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "	>= 85	50 %

Data Assurance Stars


Not captured on an electronic system, no assurance process, data is not robust


Data is either not captured on an electronic system or via a manual feeder sheet, does not follow an assured process, or not validated/reconciled


Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**GROUP COMPANY SECRETARY**
PAPER AUTHOR:	**RISK MANAGER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK RISK REGISTER DATED 3 DECEMBER 2020** **APPENDIX 2: CORPORATE RISK REGISTER (RISKS OUTSIDE OF RISK APPETITE) DATED 3 DECEMBER 2020**

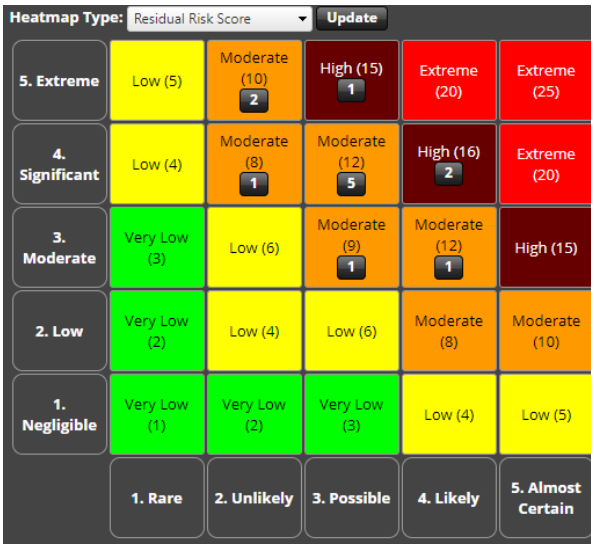
BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Board of Directors with an update of the full Board Assurance Framework Risk Register. The full Board Assurance Framework Risk Register and the risks outside of the risk appetite on the Corporate Risk Register were last reviewed by the Board on 12 November 2020. The highest mitigated risks on the Board Assurance Framework and Corporate Risk Registers were last reviewed by the Integrated Audit and Governance Committee (IAGC) on 24 November 2020.

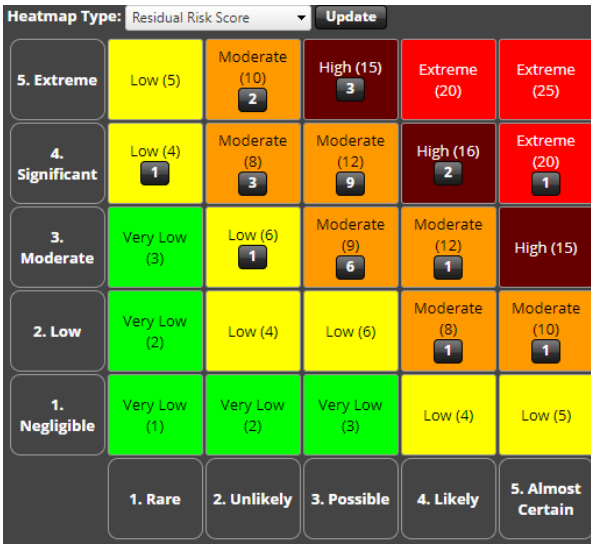
Monthly meetings are being held with the responsible Executive Lead to review the scoring, actions and the specific wording for each strategic and corporate risk.

Current Risk Register Heat Map (by Residual risk score)

Board Assurance Framework Risks (13)



Corporate Risks (31)



East Kent Hospitals University NHS Foundation Trust

Key Changes to the Board Assurance Framework and Corporate Risk Registers

Board Assurance Framework Risk Register
Changes to residual risk scores

1. There were no changes to residual or target risk scores during the period under review.

Risks approved for closure on the Board Assurance Framework Risk Register

2. There were no risks proposed for closure on the Board Assurance Framework Risk Register in November 2020.

New risks added to the Board Assurance Framework Risk Register

3. There were no new risks added to the Board Assurance Framework Risk Register in November 2020.

Corporate Risk Register
Risks outside of Trust risk appetite

4. There is one risk on the Corporate Risk Register that is outside of the Trust's risk appetite:
   - CRR 85 – Increased demand for emergency patients with a mental health issue.

5. The risk rating remains as is despite controls in place due to the increasing number of mental health patients attending the emergency department.

Key issues for the Board of Directors attention and/or discussion

6. There no further issues for the Board of Directors attention and/or discussion.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	As outlined in the appendices attached.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the Board Assurance Framework Risks to the Trust and the risks on the Corporate Risk Register that sit outside the Trust's risk appetite.
RESOURCE IMPLICATIONS:	None specifically identified other than in the Risk Registers.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Clinical Executive Management Group.
SUBSIDIARY IMPLICATIONS:	This paper does not have an impact on the business of any of the Trust Subsidiary Companies. The companies manage their risks separately to the Trust.

East Kent Hospitals University NHS Foundation Trust

PRIVACY IMPACT ASSESSMENT: NO	EQUALITY IMPACT ASSESSMENT: NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to:

1. Review the Board Assurance Framework Risk Register and the Corporate Risks Report that are appended; and
2. Consider the sufficiency of the corrective actions identified in relation to the risks and provide positive challenge where necessary.

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Report Date	03 Dec 2020
Comparison Date	In the past 30 Day(s)

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 19	07 Jun 2019	Patients may decline a date within breach and choose to delay their treatment until after their 52 week breach date **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 03 Aug 2020 **Latest Review Date:** 30 Nov 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Acting COO and Director of Performance. Due to the number of patients within the hospital who are covid-19 positive elective surgery will be cancelled which will have an impact on the year end position.	**Cause** The suspension of services during the covid-19 pandemic causing a backlog of patients and limited capacity to reduce the backlog and maintain social distancing **Effect** Increased risk of patient harm due to the length of time patients are waiting for treatment	Higher standards for patients - 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	I = 4 L = 4 High (16)	52ww - Monthly monitoring via the Executive Performance Reviews **Control Owner:** Lee Martin	Adequate	I = 4 L = 4 High (16)	Maximising use of independent sector. Review of surge capacity and how to maximise productivity. Review of outpatient areas to increase virtual outpatient appointments and safe attendance to face to face outpatient clinics. Maximise other capacity via CCG i.e. GP practices and treatment rooms. Provide advice and guidance to GPs to prevent patients being added to waiting lists. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2021	**30 Nov 2020** Harm reviews continue to be undertaken and increase use of the independent sector.	I = 4 L = 2 Moderate (8)
						Clinical review of patient risk conducted by the Care Groups **Control Owner:** Lee Martin	Adequate				
						Daily performance reporting via the Planned Care Report, which is sent to the COO, Deputy COO, Director of Performance and all Operational Directors, General Managers, Service Managers **Control Owner:** Karen Rowland	Adequate				
						Effective communication with external stakeholders and patients regarding waiting list policy **Control Owner:** Lee Martin	Adequate				
						Live reporting via RTT App on all Directors and General Managers telephone and is also available on iPads, laptop and desktop computers **Control Owner:** Lee Martin	Adequate				
						Revised Access Policy ratified by CEMG and published **Control Owner:** Karen Rowland	Adequate				
						Weekly monitoring at the PTL meeting which is Chaired by the Chief Operating Officer and attended by the Deputy COO for Elective Care, Director of Performance and the Operations Directors and their General Managers **Control Owner:** Lee Martin	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 4	20 Jan 2016	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Marion Clayton **Last Updated:** 06 Nov 2020 **Latest Review Date:** 17 Nov 2020 **Latest Review By:** Lee Foster **Latest Review Comments:** A business case for statutory compliance funding was submitted to the October SIG and supported. The case then went to CEMG in November and further supported. This case will increase funding to improve statutory compliance by £1million recurring over the next 4 years which will ultimately achieve improvements from 70% statutory compliance to 90% compliance. The case will be presented to the FPC on the 19th November for final sign off.	**Cause** - Backlog of work (£120 million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 4 L = 5 Extreme (20)	A 6 facet estates survey has been undertaken which will be used as a benchmark to prioritise backlog maintenance requirements. **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 4 High (16)	Request further emergency capital from the centre for 2020/21 financial year **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2021	**17 Nov 2020** A business case for statutory compliance funding was submitted to the October SIG and supported. The case then went to CEMG in November and further supported. This case will increase funding to improve statutory compliance by £1million recurring over the next 4 years which will ultimately achieve improvements from 70% statutory compliance to 90% compliance. The case will be presented to the FPC on the 19th November for final sign off.	I = 3 L = 2 Low (6)
						Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Adequate				
						Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2020/21. **Control Owner:** Elizabeth Shutler	Adequate		Use the 6 facet survey to identify areas that can be funded via the PEIC programme for 2020/21 **Person Responsible:** Marion Clayton **To be implemented by:** 31 Mar 2021	**17 Nov 2020** The PEIC programme which includes improvements based on the 6 Facet survey is ongoing through the last quarter of 20/21 and all funding will be spent by the end of the financial year. The PEIC committee will be assessing the requirements for capital spend for 21/22 in January 2021. The PEIC programme will be submitted to SIG by February 20201 for sign off to ensure the programme is supported by the Trust.	
						Statutory Compliance Audit dashboard in place **Control Owner:** Elizabeth Shutler	Adequate		To use 6 facet survey to prioritise Trust capital expenditure and STP capital requirements across Kent and Medway **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2021	**17 Nov 2020** If signed off at FPC, the case going forward will support ongoing actions of the higher risk areas first.	
BAF 26	10 Jun 2019	The Trust will be unable to make the changes to services needed if the Pre-Consultation Business Case (PCBC) is not signed off by external bodies **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 26 Nov 2019 **Latest Review Date:** 11 Nov 2020 **Latest Review By:** Nicky Bentley **Latest Review Comments:** Stage 2 Assurance of PCBC by NHSEI is taking place on 12th November 2020.	**Cause** Requirement for the PCBC to be signed off by external bodies **Effect** The Trust will not be able to make changes due to lack of capital	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 5 L = 4 Extreme (20)	PCBC submitted **Control Owner:** Nicky Bentley	Adequate	I = 5 L = 3 High (15)	Until the PCBC is signed off the Trust will review service design in light of COVID-19 pandemic and potential moves/ modifications to ensure safe service delivery **Person Responsible:** Susan Acott **To be implemented by:** 31 Dec 2020	**11 Nov 2020** Stage 2 Assurance process with NHSEI is taking place on 12th November 2020.	I = 5 L = 2 Moderate (10)
						STP Governance Process **Control Owner:** Elizabeth Shutler	Adequate				
						STP system leaders group **Control Owner:** Elizabeth Shutler	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 29	10 Jun 2019	If the Trust does not develop a positive and inclusive culture this will impact its ability to recruit and retain staff with the right skills **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** **Last Updated:** 26 Apr 2020 **Latest Review Date:** 03 Dec 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Deputy Director and HR and Assistant Director Learning & OD. One action closed and progress provided against additional action.	**Cause** Changes in structures and processes Lack of training and development for new leaders Values not sufficiently well embedded over a period of some years **Effect** Staff are disaffected and disengaged and seek alternative employment	Right skills, right time, right place - Developing teams with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients	I = 4 L = 4 High (16)	Ambassadors for Freedom to Speak Up **Control Owner:** Michelle Webb	Adequate	I = 4 L = 3 Moderate (12)	Deliver targeted cultural improvement programme **Person Responsible:** Jane Waters **To be implemented by:** 29 Apr 2022	**03 Dec 2020** Pilot of cultural improvement programme is due to be undertaken in January 2021 within Women's and Children's Care Groups. Roll out to the rest of the Trust will be dependent on the success of the pilot.	I = 4 L = 2 Moderate (8)
						Annual Staff Survey **Control Owner:** Andrea Ashman	Substantial				
						Executive sponsor in place for each of the staff networks **Control Owner:** Bruce Campion-Smith	Adequate				
						Health and Wellbeing support provided for staff during and post COVID-19 pandemic **Control Owner:** Andrea Ashman	Adequate				
						HR and Communications have developed a leaders weekly communication to support the restore and recovery programme which includes support and advice on developing an inclusive culture **Control Owner:** Andrea Ashman	Adequate				
						Leadership development programme in place **Control Owner:** Andrea Ashman	Adequate				
						Occupational Health service provide one to one support **Control Owner:** Andrea Ashman	Adequate				
						People Strategy developed and available on Trust website **Control Owner:** Andrea Ashman	Adequate				
						Refresh and relaunch of Trust Respect programme incorporating Equality, diversity and inclusion as a key element during 2019 **Control Owner:** Andrea Ashman	Adequate				
						Staff Networks in place **Control Owner:** Andrea Ashman	Adequate				
						WRES, WDES and BAME nurse and midwifery progression action plans which we engage staff and our diversity networks in developing and share these via our intranet. **Control Owner:** Andrea Ashman	Adequate				
BAF 18	07 Jun 2019	Integrated respiratory pathways will not be developed to enable patients to be managed in the community setting **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** 30 Nov 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Acting COO. System Improvement Group have recognised respiratory as an area of focus.	**Cause** Potential lack of engagement from primary and secondary care clinicians (GP/Respiratory CNS/EKHUFT Consultant and Specialist nurses) **Effect** Patients with a respiratory condition presenting to the ED and putting deliver of the 4 hour Emergency Access Standard at risk and increasing the risk of admission Risk to patient of contracting a hospital acquired infection or deconditioning resulting in increased length of stay.	Higher standards for patients - 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	I = 3 L = 4 Moderate (12)	Local care plan is an integrated plan which includes an integrated respiratory pathway which has been signed up to by the local health economy and led by the CCG **Control Owner:** Lee Martin	Adequate	I = 3 L = 4 Moderate (12)	Weekly monitoring of activity through respiratory pathway **Person Responsible:** Lee Martin **To be implemented by:** 31 Dec 2020	**13 Oct 2020** This will be undertaken by the COO group as part of this year's winter plan	I = 3 L = 2 Low (6)

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 22	07 Jun 2019	Urgent Treatment Centre may not become established and result in increased demand to ED **Risk Owner:** Lee Martin **Delegated Risk Owner:** Rebecca Carlton **Last Updated:** 30 Nov 2020 **Latest Review Date:** 30 Nov 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Acting COO. Risk will remain open whilst we continue to monitor the impact of the UTC.	**Cause** Lack of engagement between the CCG, GP colleagues and EKHUFT clinicians Lack of appropriate accommodation at the acute hospital site **Effect** Increased demand to ED Delivery of the 4 hour Emergency Access Standard Reduced workforce in ED Increased cost of service provision Increased attendance across the health economy	Higher standards for patients - 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	I = 4 L = 5 Extreme (20)	A&E Delivery Board, attended by the CEO and senior Executives from whole health economy have agreed to support the development of UTC **Control Owner:** Lee Martin	Adequate	I = 4 L = 3 Moderate (12)	Ensure new UTC model is embedded in to urgent and emergency pathway **Person Responsible:** Rebecca Carlton **To be implemented by:** 31 Dec 2020	**30 Nov 2020** UTC delivered at Buckland, RVH, QEQM, WHH and K&CH. Data has shown an improvement in streaming. Launch of Think 111 on 25 November.	I = 4 L = 3 Moderate (12)
						CCG review with Alliance Board to ensure implementation on schedule **Control Owner:** Lee Martin	Adequate				
						Clinicians from Primary Care and EKHUFT have been meeting for over a year to build strong working relationships and a commitment to develop an integrated UTC **Control Owner:** Lee Martin	Adequate				
						ED Improvement Plan in place **Control Owner:** Lee Martin	Adequate				
						Senior management support has been identified to support the project **Control Owner:** Lee Martin	Adequate				
						The project is being monitored monthly through the Local Care implementation group meetings **Control Owner:** Lee Martin	Adequate				
BAF 24	10 Jun 2019	If leadership and management is not effective staff may not be engaged to deliver a high quality, caring service **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** **Last Updated:** 20 Oct 2020 **Latest Review Date:** 03 Dec 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Deputy Director of HR and Assistant Director Learning & OD. One action closed, additional action added and progress provided against remaining actions.	**Cause** Insufficient targeted/specific learning and development for new managers Changes to Care Group structures have produced able people new to management positions **Effect** Poor standard of care High turnover Poor recruitment Lack of staff engagement	A great place to work - Making the Trust a great place to work for our current and future staff	I = 4 L = 4 High (16)	Freedom to speak up guardians available **Control Owner:** Andrea Ashman	Adequate	I = 4 L = 3 Moderate (12)	Review feedback from staff listening events undertaken in November **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Dec 2020	**03 Dec 2020** New action added 03 December 2020.	I = 4 L = 2 Moderate (8)
						Guidance and toolkits **Control Owner:** Andrea Ashman	Adequate		To finalise the Trust-wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 29 Jan 2021	**03 Dec 2020** Training to be developed as an online resource which has delayed the timeframe for implementation.	
						Leadership Development Plans and targeted development plans for individuals in place **Control Owner:** Andrea Ashman	Adequate				
						Leadership diagnostics **Control Owner:** Andrea Ashman	Adequate				
						Staff Survey local action plans **Control Owner:** Andrea Ashman	Adequate		Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2021	**03 Dec 2020** Middle manager leadership programme developed for both clinical and non-clinical staff. Clinical sessions due to start in January 2021 and non-clinical sessions due to start in February 2021.	
						Team Talk sessions **Control Owner:** Andrea Ashman	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 17	06 Jun 2019	Risk to safety, quality and experience as a result of not achieving the strategic objectives **Risk Owner:** Rebecca Martin **Delegated Risk Owner:** Tara Laybourne **Last Updated:** 25 Sep 2020 **Latest Review Date:** 03 Dec 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Acting Chief Nurse. Risk is recommended for closure. Risks to the delivery of We Care and True North will be established and escalated.	**Cause** Due to a lack of resources, skills deficit, engagement and appropriate systems **Effect** Patient harm from failure to deliver the improvement trajectories in relation to pressure ulcers, falls, deteriorating patients and medicines optimisation	Getting to good - Improve quality, safety and experience, resulting in Good and then Outstanding Care	I = 4 L = 4 High (16)	Agreed Improvement Plan in place with supporting Care Group Plans **Control Owner:** Tara Laybourne	Adequate	I = 4 L = 3 Moderate (12)	Improve support for managing difficult intravenous access out of hours **Person Responsible:** Gemma Oliver **To be implemented by:** 30 Oct 2020	**30 Oct 2020** Head of Nursing, Cancer and Acting Chief Nurse to discuss development of business case and risk that this addresses.	I = 4 L = 2 Moderate (8)
						Appropriate policies, procedures, guidelines and protocols in place **Control Owner:** Rebecca Martin	Adequate				
						Audit regime in place **Control Owner:** Tara Laybourne	Adequate				
						Benchmarking in place to assess performance against peers **Control Owner:** Lee Martin	Adequate				
						Coordination of information from Trust systems in a central information repository linking into Careflow as a vehicle to deliver targetted alerts **Control Owner:** Michael Bedford	Adequate				
						Dedicated areas in place for NIV patients **Control Owner:** Rebecca Martin	Adequate				
						Falls Steering Group meets monthly **Control Owner:** Tara Laybourne	Adequate				
						Launch of We Care **Control Owner:** Simon Hayward	Limited				
						Monthly medication incident reports are produced for Care Groups **Control Owner:** Tara Laybourne	Adequate				
						Pressure ulcer committee meets monthly **Control Owner:** Tara Laybourne	Adequate				
						Pressure ulcer panel in place **Control Owner:** Tara Laybourne	Adequate				
						Pressure ulcers, falls, medicines optimisation and the deteriorating patient are the 4 agreed quality areas for focus **Control Owner:** Rebecca Martin	Limited				
						QII hubs **Control Owner:** Tara Laybourne	Adequate				
						Recording of data against the Patient Safety Thermometer across all Trust inpatient areas **Control Owner:** Teena Larkins	Adequate				
						Skilled personnel and leadership in the areas of tissue viability, falls management, medicines optimisation and deteriorating patient **Control Owner:** Tara Laybourne	Adequate				
						Training and support **Control Owner:** Tara Laybourne	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 21	07 Jun 2019	Due to lack of capacity in tertiary centre patients may breach the 62 day standard waiting on diagnostic or treatment **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 12 Aug 2019 **Latest Review Date:** 13 Oct 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Director of Performance. This risk is being monitored as part of the tertiary centre PTL. Cancer targets are being met across the board. Risk to be considered for de-escalation to Cancer Care Group risk register.	**Cause** Lack of capacity Consultant based decision Availability of high tech interventions **Effect** Patients wait longer for diagnostics and treatment plan	Higher standards for patients - 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	I = 4 L = 4 High (16)	Business case approved by Finance and Performance Committee **Control Owner:** Sarah Collins	Adequate	I = 4 L = 3 Moderate (12)	**Person Responsible:** **To be implemented by:**		I = 4 L = 2 Moderate (8)
						Cancer Improvement Plan in place **Control Owner:** Sarah Collins	Adequate				
						Daily performance telephone call with Operations Director for Cancer Services, Out Patient booking managers and General Managers to monitor and resolve any capacity issues **Control Owner:** Sarah Collins	Adequate				
						Director of Operations or COO to expedite patient's treatment where necessary **Control Owner:** Sarah Collins	Limited				
						Independent sector availability will be in place until 31 March 2021 **Control Owner:** Lee Martin	Limited				
						Track patients through their pathway to ensure there are no internal delays and the pathway is optimal **Control Owner:** Sarah Collins	Adequate				
						Weekly call with Maidstone and Tunbridge Well NHS Trust **Control Owner:** Sarah Collins	Adequate				
						Weekly cancer PTL meeting to monitor all cancer standards **Control Owner:** Karen Rowland	Adequate				
						Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers **Control Owner:** Karen Rowland	Adequate				
						Weekly tertiary centre PTL to escalate any patients of concern **Control Owner:** Sarah Collins	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 8	23 Feb 2016	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** Louise Goldup **Last Updated:** 20 Oct 2020 **Latest Review Date:** 03 Dec 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Deputy Director of HR and Assistant Director Learning & OD. One action closed, remaining actions have progress provided.	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff * Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas **Effect** * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	A great place to work - Making the Trust a great place to work for our current and future staff	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of newly qualified nursing staff locally. **Control Owner:** Tara Laybourne	Adequate	I = 5 L = 2 Moderate (10)	Recruitment and Retention Strategy and Workforce plans to be reviewed in light of coronavirus and realigned to Trust Strategy including the introduction of new roles **Person Responsible:** Louise Goldup **To be implemented by:** 20 Nov 2020	**03 Dec 2020** Recruitment Strategy produced and circulated to SWC members. Formal ratification will happen as soon as possible. We currently have a low vacancy rate and low turnover.	I = 5 L = 1 Low (5)
						Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	Adequate				
						Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	Adequate		Pursue mutual aid passporting opportunities for OLM Trusts **Person Responsible:** Sam Bessant **To be implemented by:** 31 Mar 2021	**03 Dec 2020** Mutual aid passporting process in K&M agreed and due to be signed off.	
						Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Adequate				
						Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Adequate				
						People Strategy published **Control Owner:** Andrea Ashman	Adequate				
						Revised recruitment process has been implemented **Control Owner:** Andrea Ashman	Adequate				
						Staff Performance Appraisals in place **Control Owner:** Jane Waters	Adequate				
						Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 23	10 Jun 2019	Integrated frailty pathways cannot be agreed resulting in patients being treated in a traditional hopsital based service **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 15 Nov 2019 **Latest Review Date:** 30 Oct 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Director of Performance. Actions updated.	**Cause** Consultant geriatrician vacancies Lack of consultant engagement **Effect** Patients will be admitted and risk decompensating rather than have access to integrated ambulatory and community pathways Adding pressure to bed base Patients decompensating	Higher standards for patients - 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	I = 5 L = 3 High (15)	A joint clinical lead has been appointed to lead the service **Control Owner:** Lee Martin	Adequate	I = 5 L = 2 Moderate (10)	Implement frailty units at WHH and QEQM **Person Responsible:** Rebecca Carlton **To be implemented by:** 29 Jan 2021	**30 Nov 2020** Frailty unit at WHH progressing. Area to be identified at QEQM as part of the recovery plan. Action implementation date updated to reflect this.	I = 5 L = 1 Low (5)
						A&E Delivery Board, attended by the CEO and senior Executives from whole health economy have agreed to support the development of UTC **Control Owner:** Lee Martin	Adequate				
						Clinicians from Primary Care and EKHUFT have been meeting for over a year to build strong working relationships and a commitment to develop an integrated frailty service. **Control Owner:** Lee Martin	Adequate				
						Length of Stay (LOS) Improvement Plan in place **Control Owner:** Lee Martin	Adequate				
						Monthly steering group in place **Control Owner:** Natalie Acheson	Adequate				
						Senior management support has been identified to support the project **Control Owner:** Lee Martin	Adequate				
						The project is being monitored monthly through the Local Care implementation group meetings **Control Owner:** Elizabeth Shutler	Adequate				
BAF 30	26 May 2020	Failure to deliver full benefit of We Care improvement system **Risk Owner:** Susan Acott **Delegated Risk Owner:** Simon Hayward **Last Updated:** 04 Nov 2020 **Latest Review Date:** 04 Nov 2020 **Latest Review By:** Simon Hayward **Latest Review Comments:** Reviewed to increase inherent risk due to potential impact of wave 2 of covid however, the controls still stand. Have added action to move to virtual implementation during lockdown	**Cause** Time to dedicate to improvement plan whilst in recovery phase of COVID-19 pandemic Engagement with improvement plan Improvement system relies on face-to-face interaction which may be hindered by the need to social distance Skills of the internal team to deliver in house **Effect** Improvement plan will fail to deliver Sub-optimal implementation Financial impact HR impact Reputational risk	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 3 L = 4 Moderate (12)	Coaching and mentoring in place for Care Group Leadership teams **Control Owner:** Simon Hayward	Limited	I = 3 L = 3 Moderate (9)	Incorporate improvement plan in to Organisational Strategy **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Oct 2020	**29 Sep 2020** This action is being built in to the We Care road map at present.	I = 3 L = 2 Low (6)
						Communication and Engagement workstream in place **Control Owner:** Natalie Yost	Adequate		Review and amend deliverables to be completed virtually in November and December, where possible **Person Responsible:** Simon Hayward **To be implemented by:** 31 Dec 2020		
						Resource required clearly articulated with Executive Leads for each workstream. **Control Owner:** Susan Acott	Adequate				
						Roles for delivery agreed with a consultation undertaken of internal improvement team structure **Control Owner:** Simon Hayward	Adequate		Ensure language used is appropriate to increase engagement **Person Responsible:** Natalie Yost **To be implemented by:** 31 Mar 2021	**29 Sep 2020** Communications and engagement of We Care a priority for Trust's communications team and appropriate tone of language incorporated into all communications	
						System chosen has been proven to work at similar NHS Trusts and in international healthcare systems e.g. USA, Canada, Iceland **Control Owner:** Simon Hayward	Adequate				

Board Assurance Framework Risks Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
BAF 27	10 Jun 2019	If there are multiple change programmes ongoing there is a risk that the Trust will not have the capacity to successfully deliver the T3 programme **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Andy Barker **Last Updated:** 10 Jul 2020 **Latest Review Date:** 01 Oct 2020 **Latest Review By:** Robert Nelson **Latest Review Comments:** The T3 go-live date has been postponed for a short period. The programme continues to consider the impact of the new go-live date on other corporate changes taking place at that time.	**Cause** Multiple change programmes **Effect** Staff time and capacity to focus on all projects	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 4 L = 4 High (16)	East Kent Digital Strategy Group chaired by Director of IT **Control Owner:** Andy Barker	Adequate	I = 4 L = 2 Moderate (8)	Escalate any identified implementation conflict initially at SMT. This is an ongoing action leading up to T3 go live. **Person Responsible:** Andy Barker **To be implemented by:** 18 Dec 2020	**23 Oct 2020** Sunrise launched successfully with OrderComms. No impact from competing change activity. Action implementation date extended to Dec to accommodate all T3 modules	I = 4 L = 1 Low (4)
						External audit of capacity and capability undertaken **Control Owner:** Elizabeth Shutler	Substantial				
						Governance sign off by Finance and Performance Committee and Trust Board **Control Owner:** Elizabeth Shutler	Adequate				
						IDG Oversite of whole IT Programme **Control Owner:** Andy Barker	Adequate				
						Internal T3 Programme Board with Executive membership **Control Owner:** Elizabeth Shutler	Adequate				
						T3 clinical group **Control Owner:** Rebecca Martin	Adequate				
						T3 Programme governance structure in place reporting to CEMG **Control Owner:** Elizabeth Shutler	Adequate				

Corporate Risk Register Report (By Residual Risk Ranking)

Report Date	03 Dec 2020
Comparison Date	In the past 30 Day(s)

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 85	22 Jun 2020	Increased demand for emergency patients with a mental health issue since the covid-19 pandemic **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 30 Oct 2020 **Latest Review Date:** 30 Nov 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Acting COO and Director of Performance. Deep dive review to be undertaken on Thursday 02 December to determine whether the controls in place have had an impact on the risk rating. The increase in mental health patients presenting to ED continues with triple the number of attendances than previous years, however, severity of incidents of harm are reducing.	**Cause** Increased demand from patients known to mental health services, new patients and CAMHS patients needing mental health services due to social isolation and anxiety caused by pandemic **Effect** Increased patients attending emergency department Increased harm to patients Reputational risk Increased harm to staff Increased demand for safeguarding, security and police presence	Higher standards for patients - 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	I = 4 L = 5 Extreme (20)	Additional mental health care support workers to help manage patients **Control Owner:** Julia Bournes	Adequate	I = 4 L = 5 Extreme (20)	Increase in Maybo training for all staff in ED **Person Responsible:** Jane Christmas **To be implemented by:** 29 Jan 2021	**30 Nov 2020** Action added 30 November 2020.	I = 4 L = 4 High (16)
						Dedicated security in ED observation bays and department 24/7 to support staff **Control Owner:** Victoria Harrison	Adequate		Mental health pathway redesign and exploration of mental health lounge **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2021	**30 Nov 2020** £7million has been allocated for ED in this financial year. The building plans are looking at dedicated mental health areas.	
						Director level escalation to KMPT **Control Owner:** Lee Martin	Adequate		Hospital triumvirate to monitor and escalate on a daily basis to senior managers in KMPT and CAMHS **Person Responsible:** Rebecca Carlton **To be implemented by:** 30 Apr 2021	**30 Nov 2020** A&E Delivery Board has oversight of the mental health delays	
						Director level support at 8.30 huddle **Control Owner:** Lee Martin	Adequate		Escalate to NHSI/E on an individual case basis **Person Responsible:** Susan Acott **To be implemented by:** 30 Apr 2021	**30 Nov 2020** Escalation to NHSI/E is in place	
						Established specific review meeting to assess demand and actions taken to meet demand **Control Owner:** Julia Bournes	Adequate				
						Increased awareness in ED **Control Owner:** Julia Bournes	Adequate				
						Increased security response at front door to support **Control Owner:** Victoria Harrison	Adequate				
						Mental health has increased capacity to support community patients and also commenced mental health hubs virtually, which will become face to face in Canterbury and Dover in July **Control Owner:** Lee Martin	Limited				
						Mental health liaison team working closely with ED team **Control Owner:** David Bogard	Adequate				
						Mental health steering committee have reviewed response and are receiving data on patient demand to enable specific response **Control Owner:** Lee Martin	Adequate				
						QEQM from October have been allocated three mental health nurses to meet growing demand **Control Owner:** Zoe Newman	Adequate				
						Site Medical Director facilitate patient transfers to appropriate providers **Control Owner:** Rebecca Martin	Adequate				
						Use of section 5(2) of the Mental Health Act where necessary **Control Owner:** Rebecca Martin	Adequate				

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
SUBJECT:	**REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE (SWC)**
BOARD SPONSOR:	**CHAIR OF THE SWC**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MIDWIFERY SERVICES WORKFORCE PLANNING AND DECISION MAKING – BIRTH RATE PLUS – 6-MONTH REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

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

This report presented reflects Committee activity for the December 2020 meeting.

MEETING HELD ON 2 DECEMBER 2020

The Committee is met with a streamlined agenda as suggested by NHSI/E in response to Level 4 Pandemic.

1. STAFF TURNOVER AND EXIT INTERVIEW – QUARTER 2 REPORT

The Committee discussed the quarter 2 report and noted:

1.1 Total turnover (11.54%) is the best it has been in five years;
1.2 Premature turnover (21.54%) has reduced back to healthy levels;
1.3 Nurse turnover (22.73%) has risen by 5.25% in six months, although nurse recruitment is progressing well and this is reflective on the increase in substantive nurse establishment;
1.4 HCA turnover (17.47%) had improved, but appears the result of reductions across the first four months of the year (height of the pandemic); and;
1.5 There was a risk we will face more turnover challenges when the wider economy improves, and early interventions were suggested to mitigate against this, including bespoke tailored inductions (clinical and non-clinical) followed by a 6-month preceptorship.

2. MIDWIFERY SERVICES WORKFORCE PLANNING AND DECISION MAKING – BIRTH RATE PLUS – 6-MONTH REPORT

The Committee received the Bi-annual midwifery staffing oversight report covering staffing/safety issues in line with the maternity incentive scheme safety action 5. A full Birth Rate Plus exercise which had been paused due to COVID has now recommenced and will be brought back to the Committee. The Committee is highlighting the following to the Board.

2.1 Supernumerary labour ward co-ordinator – status was 94% - 100% - recorded regularly. There was a supporting action plan to achieve 100%.
2.2 All Band 7s have been recruited with a focus on development and leadership; there are 2 Band 7s on every shift and they wear a designated arm band when they are the supernumerary labour ward co-ordinator so easily identifiable.
2.3 There is more work required at the WHH around the triage service (24 hr triage service).
2.4 One to one care in labour – achieved 100% across both sites between May – October 2020. Primarily supported by out of hours safety huddles.
2.5 Home Birth Team commenced in November 2020

In line with the CNST requirements the full report is appended.

3. OTHER REPORTS CONSIDERED

3.1 Guardian of Safe Working Report – the committee received positive assurance that the processes were working well.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **APPROVE** the SWC Chair Report.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	**MIDWIFERY WORKFORCE BI-ANNUAL REPORT**
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER AND BOARD MATERNITY AND NEONATAL SAFETY CHAMPION**
PAPER AUTHOR:	**DIRECTOR OF MIDWIFERY**
PURPOSE:	**INFORMATION AND UPDATE OF MATERNITY WORKFORCE ACTIVITY** **INFORMATION AND APPROVAL OF THE APPENDED CLINICAL NEGLIGENCE SCHEMES FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME SAFETY ACTION 5 BI-ANNUAL WORKFORCE REPORT** ***(this document needs to be appended to Trust Board for CNST sign off). Includes update summary on Continuity of Carer plan***
APPENDICES:	**APPENDIX 1: CNST SAFETY ACTION 5 BI-ANNUAL MIDWIFERY WORKFORCE PAPER** **APPENDIX 2: SAFE STAFFING POLICY**

BACKGROUND AND EXECUTIVE SUMMARY

There are two parts to this bi-annual midwifery report

This paper provides the bi-annual update of all midwifery workforce activity aligned to Clinical Negligence Schemes for Trusts (CNST) Maternity Incentive Scheme Safety Action 5 to provide the Trust Board with assurance that Maternity has an effective system of midwifery workforce planning against the required standard

The paper outlines our compliance against Standards a-d

a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
c) All women in active labour receive one-to-one midwifery care.
d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board *.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	• Risk to achieving CNST year three due to reputational damage and removal of premium for year 2. Robust plans built, action plan in place and learning reviewed. COVID-19 pressures and a pause in reporting on some areas • Delay in Birthrate Plus Review-now in progress • Not meeting 100% compliance in Supernumerary status and 1:1 care in labour at all times. Action plan included on mitigations.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;**

East Kent Hospitals University NHS Foundation Trust

	• **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Departmental Risk Register only; Inability to provide 1:1 Care in Labour CNST
RESOURCE IMPLICATIONS:	Additional recruitment of staff to support Supernumerary Labour Suit Status Digital Midwifery Workforce Fetal Monitoring Midwives Time to progress desktop analysis of workforce
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Workforce Committee To be appended for Trust Board sign off
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

(a) The Committee is asked to note the results of the CNST bi-annual report and contents of the action plan with onward recommendation to the Board;
(b) Recommend the action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator and 1:1 care in labour to the Board; and
(c) Note challenge in accurately providing a full break down of the Midwifery establishment due to a delay in the Birthrate Plus review by the LMS.

East Kent Hospitals University NHS Foundation Trust

Board Assurance Report- NHS Resolution CNST Maternity Safety Incentive Scheme	
Safety Action Title	**Safety action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Date:	17 November 2020
Board Sponsor	**Chief Medical Officer, Maternity and Neonatal Board Safety Champion**
Paper Author:	Ursula Marsh Director of Midwifery
Safety Action Lead:	Ursula Marsh
Purpose:	Bi-annual midwifery staffing oversight report covering staffing/safety issues *
Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board *
Minimum evidential requirement for trust Board	The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing. • An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified. • Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. • The midwife: birth ratio. (Regular reviews and have plans to flexibly adjust midwife to woman ratio if needed due to Covid-19) • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the

	provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. • Did Covid-19 cause impact on staffing levels? - Was the staffing level affected by the changes to the organisation to deal with Covid-19? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	Any consecutive six month period between Wednesday 1st July 2020 and Thursday 20 May 2021.
What is the deadline for reporting to NHS Resolution?	Thursday 20 May 2021 at 12 noon.
Appendices	1. Staff Unavailable to Work during Covid-19 2. Midwifery Workforce Action Plan 3. Safe Staffing Policy
Documented in Trust Board minutes	Receipt of biannual Maternity Workforce paper and content of this report Note workforce action plan Appendix 2

- **BACKGROUND AND EXECUTIVE SUMMARY**

This paper is the biannual midwifery staffing oversight report covering staffing/safety issues between May to October 2020. The report aims to provide the Trust Board with assurance that Maternity has an effective system of midwifery workforce planning that meet the required standard laid out in the CNST Maternity Incentive Scheme Safety Action 5.

There are several tools and approaches used within the Maternity Directorate to monitor safe midwifery workforce and outcomes:

- Monitoring the midwife to birth ratio
- Monitoring key performance indicators
- Intrapartum Acuity tool data
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unit Diverts and closure of the MLUs
- Twice daily staff safety huddle
- Out of Hours Safety Huddle
- Electronic Health Roster
- Staffing Establishment- monthly update
- Maternity Dashboard – including 1:1 Care in Labour
- Supernumerary Labour Suite Status
- Clinical incidents and Datix reporting system
- Quality indicators e.g. complaints and Friends and Family Test (FFT) feedback
- Complaints

Between May and October 2020, the Maternity Staffing Red Flag events have continued to be captured through two data sources; Datix, incident reporting system and the Intrapartum Acuity Tool. Themes are summarised in this report.

Birth to Midwife ratio is tracked monthly and is currently 1:29, this is in adherence with the National safe staffing benchmark. The Maternity Dashboard current position shows a lower ratio 1:24 due to additional Covid Staffing remaining within the establishment figures.

Supernumerary Labour Suite Coordinator status is between 94%-100% for the 1st May to 31 October 2020 period and is continually audited. Additional Band 7 midwives have been recruited to which greatly supports this position. The 24-hour Triage service on the WHH site is to be commenced, away from Labour Suite, will further improve the position.

One to One care of women in established Labour has been 100% on both acute sites from May to October 2020. A weekly review of this data was started from May 2020 to review each case of noncompliance and extract learning.

There is a robust system of monitoring midwifery workforce and activity levels within the Maternity Directorate. However, the receipt of timely information can be improved by enhancing the current BirthRate Plus Intrapartum Acuity Tool. This has been approved by Procurement, IT and funding is in place through an NHSR action plan.

A full BirthRate Plus exercise had been commissioned by the Kent and Medway Local Maternity Service (LMS) and although delayed due to Covid-19, started in September 2020, with an additional focus on the Continuity of Care calculation. The previous exercise, shared with the Quality Committee and Trust Board, was last completed in 2018 and therefore no longer provides an accurate reflection of our current workforce profile. Once the review is complete, an update will be provided to the Quality Committee as subcommittee to Trust Board on findings and recommendations.

The impact of Covid and staff unavailable to work has called on creative remodelling and utilisation of skill and ways of working. This is outlined within this paper.

Recommendation

- The Trust Board are asked to note the results of this report and contents of the action plan

- An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator and 1:1 care in labour is requested to be signed off by the Trust Board, in line with this standard

- **Note** Unable to provide a full break down of the Midwifery establishment due to a delay in the BirthRate Plus review because of the Covid-19 pressures and restrictions. An update paper on this element will be provided to the Quality Committee once completed and data and recommendations are available.

- **UPDATE ON MEETING REQUIRED EVIDENCE AGAINST CNST STANDARD**

Purpose
This paper is to provide assurance of an effective system of midwifery workforce planning to meet the required Safety Action 5 for the CNST Maternity Incentive Scheme for a six-month period between May to October 2020

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

BirthRate Plus is a framework for workforce planning and strategic decision-making within the Maternity Services and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

The principles underpinning the BirthRate Plus methodology are consistent with the recommendations in the *NICE 'Safe Staffing Guideline for Midwives in Maternity Settings'* and have been endorsed by the RCM and RCOG.

Our last BirthRate Plus Desktop Exercise was conducted in June 2018 and showed the overall midwifery establishment within EKHUFT to be in line with the national parameters, but it is recognised that this was some time ago and refreshed analysis is required.

A full BirthRate Plus review was due to take place in May/June 2020, funded by the Local Maternity Systems (LMS) across the Kent and Medway trusts. This was delayed due to Covid-19. In September a decision was made to commence this but as a desktop refresh of the 2018 data with a particular focus on the requirements to support Continuity of Carer plans to achieve 35% of women to be on pathways by March 2021.

The midwife: birth ratio is reported monthly through the dashboard. This is showing as a low figure currently, due to the influence of Covid-19 funded posts being included. A desktop analysis review showed the worked ratio to be 1:29. This paper recognises that there is no national standard agreed for the midwife to birth ratio however, it is considered that reporting a ratio of 1:28 is acceptable.

The percentage of specialist midwives employed: BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. The percentage of specialist midwives employed is being reviewed and recalculated, as part of the BirthRate Plus analysis, in recognition of several new specialist midwife posts and changes to roles and ways of working.

Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.

The planned versus actual staffing data is captured on a monthly report and this information is reviewed on a daily basis.

A rolling, central monthly audit of midwifery staff captures the number of midwives, hours worked, posts offered, annual leave, sickness, maternity leave and leavers. This paper is reflective of the work that is undertaken on a daily, monthly and annual basis and continuous forward projections will be considered.

Maternity E Roster systems are utilised for the shift allocation of staff and the labour wards have an identified Band 7 midwifery coordinator. This will provide the clinical leadership within supernumerary status and supports the requirement for one-to-one care in active labour. (King Funds Study Safer Birth Standards – Everybody's Business; The Royal College of Midwives (RCM) and others recommend the BirthRate Plus® (BR+).

There are several approaches used within the Maternity Directorate to monitor safe midwifery workforce and outcomes:

- Monitoring the midwife to birth ratio
- Monitoring key performance indicators
- Intrapartum Acuity tool data
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unit Diverts and closure of the MLUs
- Twice daily staff safety huddle
- Out of Hours Safety Huddle
- Electronic Health Roster
- Staffing Establishment- monthly update
- Maternity Dashboard – including 1:1 Care in Labour
- Supernumerary Labour Suite Status

- Clinical incidents and Datix reporting system
- Quality indicators e.g. complaints and Friends and Family Test (FFT) feedback
- Complaints

Table 1: Workforce KPI's as reported through EPR

KPI	Sept 20	Aug 20	12 Month Average
Appraisal	71%	64%	71%
Mandatory Training	90%	91%	91%
Sickness (Figures from Aug 20)	5.44%	4.50%	4.97%
Vacancy	3.88%	4.52%	2.15%
Turnover	11.4%	11.1%	12.22%
Job Planning	59%	Not Reported	

Appraisal	85% or more	80% to 85%	Less than 80%
Sickness Absence Monthly Actual rate	3.50 or less%	3.51% to 3.99%	4.00% or more
Sickness Absence Year to Date	3.00 or less%	3.01% to 3.99%	4.00% or more
Vacancy %	10% or less	10.1% to 13.9%	14% or more
Turnover	13% or less	13.1% to 15.9%	16% or more

Table 2: Appraisals and Mandatory Training

Metric	Actions
Appraisals	▪ Appraisal data shared with Matrons / Managers showing outstanding names monitored monthly and updated ▪ Appraisal form altered to provide a wellbeing approach through Covid -19

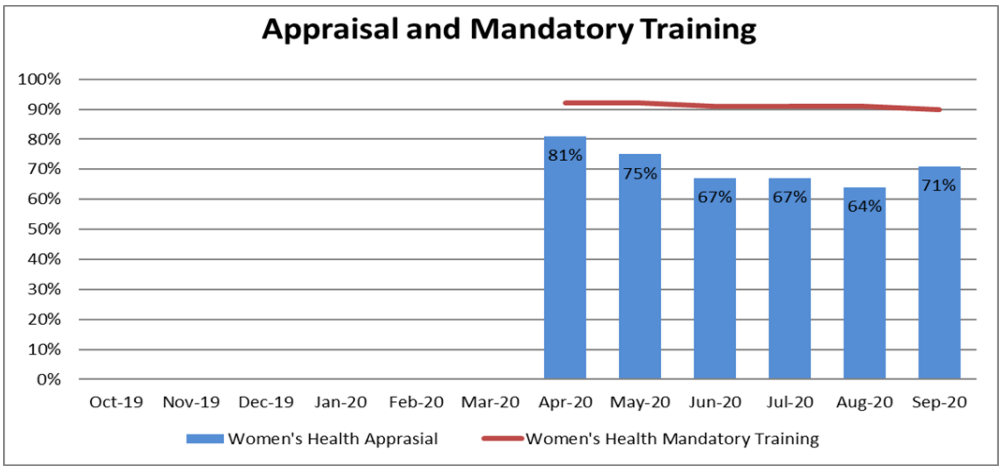


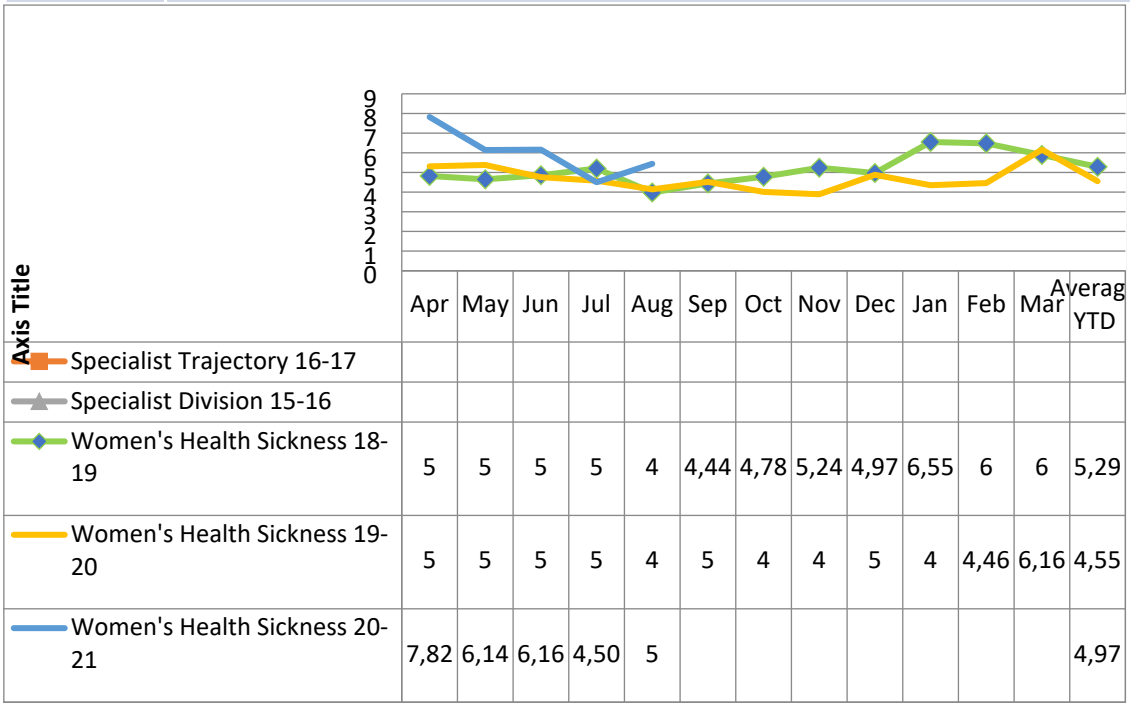
Table 3: Mandatory Training Compliance

Metric	Actions
Mandatory Training	▪ Names shared and line manager actions

Fire Safety	Health & Safety	Information Governance	Diversity Awareness	Infection Control Level 1	Infection Control Overall	Safeguarding Children Level 1	Safeguarding Children Level 2	Safeguarding Children Level 3	
71%	86%	93%	80%	92%	94%	100%	79%	87%	**86%**

Table 4: Sickness Absence Trend

Metric	Actions
Sickness	▪ Long Term sickness is 3.85% and short term 1.58% (70/30 split) ▪ Majority of sickness is in Maternity – most days lost in Community Canterbury and Coastal, then WHH, then QEQM ▪ 32% Sickness is related to Anxiety and Stress ▪ Continue TRIM and Health and Wellbeing support in Maternity – phone calls to staff off sick on a weekly basis ▪ Group support session planned for Community Midwifery Team in November 2020



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Averag YTD
Specialist Trajectory 16-17													
Specialist Division 15-16													
Women's Health Sickness 18-19	5	5	5	5	4	4,44	4,78	5,24	4,97	6,55	6	6	5,29
Women's Health Sickness 19-20	5	5	5	5	4	5	4	4	5	4	4,46	6,16	4,55
Women's Health Sickness 20-21	7,82	6,14	6,16	4,50	5								4,97

Table 5: Women's Health Vacancy Rates

	Metric Actions
Vacancy	▪ Positive picture however number of staff on reduced duties due to Covid does impact staffing levels

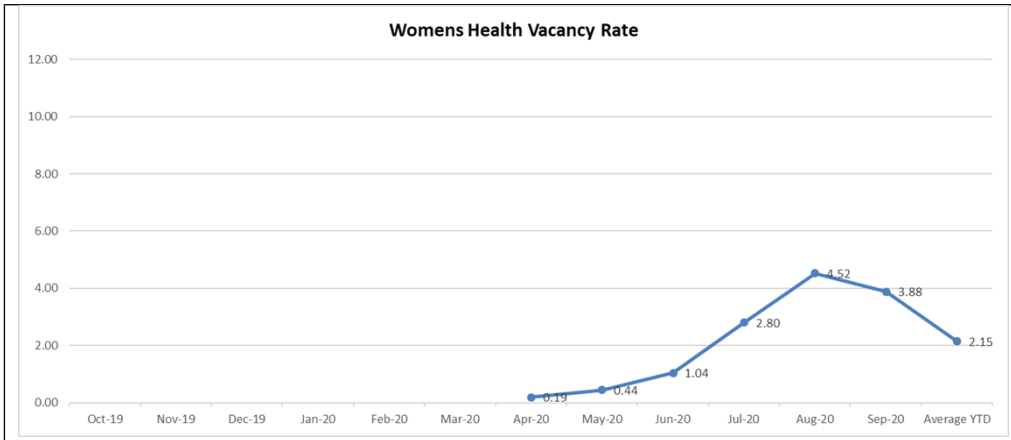


Table 6: Women's Health Turnover

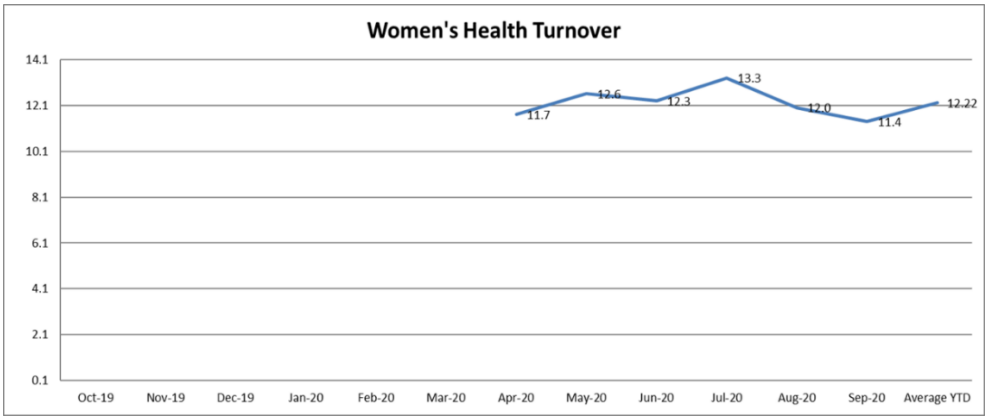


Table 7: Staff Survey Top 3 Areas of Success and Challenge

Our Priorities (2019 Survey)	Questions
Top 3 areas of success	1. 'Recommend as place to work' (52%) has increased by 7% on last year and is now 1% above Trust average 2. 'Recommend as place for treatment' (63%) has increased by 7% and is now 3% above Trust average **3.** 'Communication between Senior Management & staff is effective' (41%) has increased by 7% and is 4% above Trust average
Top 3 challenges	1. 'Able to make suggestions to improve the work of my team' (65%) has decreased by 9% and is 5% below Trust average 2. 'I look forward to going to work' has decreased by 3% and is 3% below Trust average **3.** 'Able to provide care that I aspire to' (49%) has reduced by 2% and is 13% below Trust average

Table 8: Staff Survey Themes and Priority Actions

Our Priorities (2019 Survey)	Actions
1) Motivation	• Civility Saves Lives Awareness Month • Thank you badges with personal letter for all staff – for their support during Covid • Monthly message to all staff

	• Opportunities for staff progression • Increase in Specialist roles
2) Involvement	• Team Development sessions Maternity QEQM – focussing on CSL, Behaviours and Human Factors • Monthly union meetings with Regional / Local Rep, Midwifery Leadership and HR Business Partner
3) Advocacy	• Continue with BESTT and Improvement programmes
4) Care	• Continue with BESTT and Improvement programmes
5) Leadership	• Daily Covid Call x3 per week with Managers/Matrons/Clinical Leads • Health and Wellbeing sessions in the Care group start 22/9/20 • Band 7 Development programme to start in October 2020 (postponed from March) • Increase in Senior Leadership visibility with new midwifery leadership structure

Supernumerary Labour Suite Status

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

The allocation of a band 7 midwife coordinator on each Labour Suite, where their role is supernumerary is the process put in place to ensure oversight is maintained without distraction.

EKHUFT Maternity has not had an electronic system/ tool to capture planned against actual compliance of labour suite Supernumerary status. The current acuity tool, an excel document that is developer protected, was adapted to capture **'Supernumerary Status of Labour Ward Co-ordinator Compromised'** and also **how this was escalated.**

This allows the position within a four-hour period to be recorded against the acuity of the Labour Suite at that time. Additional data is documented around the details of why supernumerary status has been compromised and the mitigations and escalations relating to the situation.

Going forward, we will be moving across to a Birth Rate Plus, web based intrapartum acuity tool that will capture all of this workforce information in one repository. This has been approved by Procurement, IT and funding is in place through an NHSR action plan. We hope to have staff trained and contractual agreement in place by end of November/December.

An ongoing audit is in place to monitor supernumerary status against the defined criteria. Findings between May and October are shown in **Table 9 and 10**

Table 9: Supernumerary Status WHH

Supernumerary WHH	
Month	% Supernumerary Status Maintained
May	100%
June	99%
July	99.5%
August	94.1%
September	94%
October	97%

Table 10: Supernumerary Status QEQM

Supernumerary QEQM	
Month	% Supernumerary Status Maintained
May	91%
June	99%
July	99.5%
August	99.5%
September	97%
October	99.5%

An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator is requested to be signed off by the Trust Board, in line with this standard.

The recruitment of additional Band 7 midwives has been completed to ensure there is always two on each shift and protect the supernumerary status of the Labour Suite coordinator.

Birthrate Plus Intrapartum Acuity Tool
The Acuity tool is used to:

- Assess workload v staffing
- Capture periods of negative/positive acuity by date and time
- Understand frequency of occurrence and actions taken for red flags

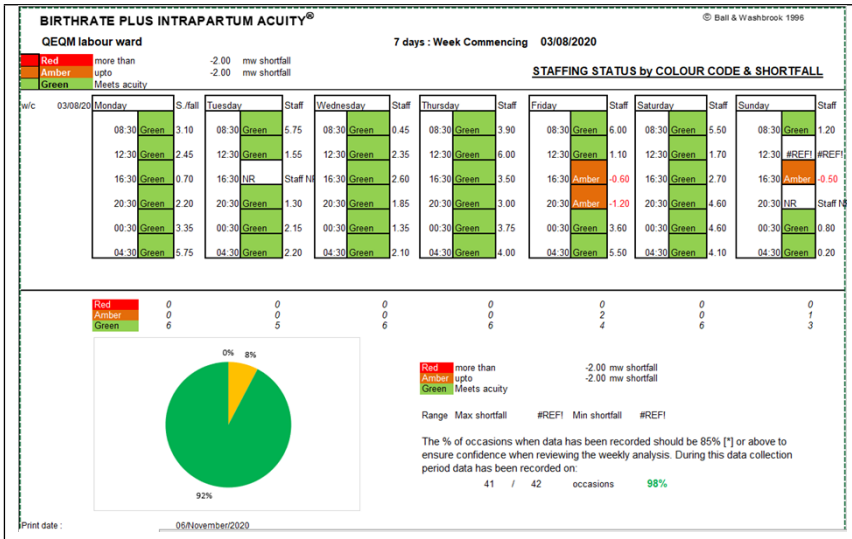
The tool is used in conjunction with incident reporting to review staffing at time of incident.
It enables midwives to assess their “real time” workload in the delivery suite arising from the numbers of women needing care, and their condition on admission and during the processes of labour and delivery. This is termed a measure of “Acuity”.

The system is based on an adaptation of the same clinical indicators for intrapartum care used in the well-established workforce planning system Birthrate Plus®.

All women admitted to delivery suite are given a score, dependant on need, based on the minimum standard of one to one care for all clients and increased ratios of midwife time for women in higher need categories. The tool also classifies non-labouring women requiring midwifery input, i.e. AN, PN, IOL and Triage. As women progress in labour and deliver, their needs change and they may require extra midwifery care. The score is recalculated to reflect this at unit defined intervals.

The shift leader enters a score for each woman onto a simple excel table at unit 4 hourly intervals. The tool calculates the number of midwives required to provide this care. (Workload)
The number of staff available to give care is entered and the tool calculates the Acuity. This figure is the number of Midwives (MW) over or short to provide care at the time of data entry.
A traffic light system enables the shift leader to see immediately whether the workload is safe or if measures need to be put in place to address shortfall. The traffic light value is unit specific.

Table 12: Example of Acuity Tool Reporting of Four Hourly Data Recordings



R1	unexpected staff absence	0
R5	Supernumerary coordinator status compromised	0
R6	no staff available	3
A1	no action needed	1
A2	delay inductions	0
A3	delay elective sections	0
A4	redeploy from community/MLU	1
A5	redeploy from ward	1
A6	use on call midwife	0
A7	Inform Matron/Midwifery Manager	0
A8	Midwifery manager contacted	1
A9	Close MLU	0
A10	Redeploy from Triage	0
A11	Divert to sister campus	0
A12	escalation policy implemented	0

One-to-one midwifery care in Labour

Our 1:1 care in labour between May and October has been 100%. The national and CNST defined standard is 100% 1:1 care for all women in established labour. From May, this data has been reported weekly along with supernumerary status and the site Matrons reviews each case of noncompliance to draw out learning and aim to improve (dashboard will be updated to reflect 100% for October). An action plan is attached to show staffing related actions to meet the requirements.

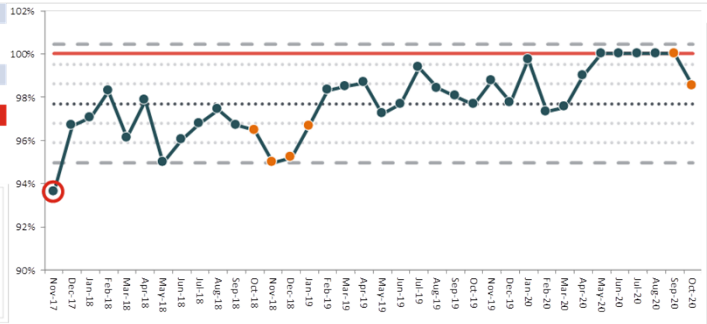
Table 13: WHH Dashboard Data

Monthly	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Threshold			Current Alert Status	Prev 12 Month Avg.
1:1 Care in labour	98.8%	97.8%	99.7%	97.3%	97.5%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	%	100%	Higher is Better	7 Points Above Average	Below Target of 100.0%

Prev 3 Year Monthly Avg. 97.7%

Prev 12 Month Avg. 99.1%

Below Target of 100.0%



Notes & Definitions

% of Women who are documented as receiving one to one care in labour.

Excludes women with a BBA delivery/born in transit, women with no labour (e.g. planned caesarean sections) and unplanned homebirths without a midwife in attendance

Comments

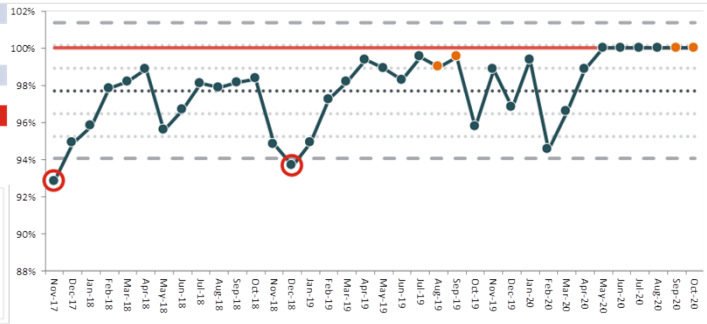
Table 14 QEQM Dashboard Data

Monthly	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Threshold			Current Alert Status	Prev 12 Month Avg.
1:1 Care in labour	98.8%	96.8%	99.4%	94.5%	96.6%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	%	100%	Higher is Better	7 Points Above Average	Below Target of 100.0%

Prev 3 Year Monthly Avg. 97.7%

Prev 12 Month Avg. 98.8%

Below Target of 100.0%



Notes & Definitions

% of Women who are documented as receiving one to one care in labour.

Excludes women with a BBA delivery/born in transit, women with no labour (e.g. planned caesarean sections) and unplanned homebirths without a midwife in attendance

Comments

Number of red flag incidents (associated with midwifery staffing)
Please note: it is for the trust to define what red flags they monitor

We currently collect data around Red Flag events in 2 different locations;

- Datix system when an incident is generated
- Intrapartum Acuity Tool

Datix- is the trust repository for the reporting of staffing related risks and issues. The system was reviewed for all staffing, workload and related poor outcome reporting for the same time period.

There were 30 Datix entries that relate to staffing Red Flags across the maternity sites between 1st May and 31st October 2020.

Red flag events may indicate that there may not be enough midwives available
NICE Recommend that during the day or night shift, the midwife in charge should look out for 'red flag events'. These are signs that there may not be enough midwives to give women and babies the care they need.
What midwifery red flag events could be included (examples only)?

- Supernumerary Status compromised
- Redeployment of staff to other services/sites/wards based on acuity
- Staff absences due to illness/isolation/shielding/symptoms
- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally.

Table 17: Red flag Events WHH

Month	Red Flag Incidents WHH	Numbers
May	Diverts to Sister Site	1
	MLU Closure	1
	Delayed IOL	5
	Supernumerary	17
June	Diverts to sister site	2
	MLU Closure	2
	Delayed IOL	4
	Supernumerary	2

July	Delayed IOL	6
	MLU Closure	3
	Supernumerary	1
August	Diverts	1
	MLU Closure	2
	Supernumerary	11
September	Supernumerary	11
October	Diverts	2
	MLU Closure	7
	Delayed IOL	1
	Home birth service Impacted	2
	Operational Manager called in to support	1
	Supernumerary	5

Table 18: Red Flag Event QEQM

Month	Red Flag Incidents QEQM	Numbers
May	Unit Divert	1
	Delayed IOL	4
	Supernumerary	17
June	Delayed IOL	3
	MLU Closure	3
	Supernumerary	3
July	MLU Closure	5
	Supernumerary	1
August	Supernumerary	5
	Delayed IOL	1
	Closure of MLU	3
September	Supernumerary status	5
	Delayed IOL	9
October	Supernumerary	1
	Delayed IOL	2

Covid-19 impact on staffing levels

Staffing level affected by the changes to the organisation to deal with Covid-19

- **Staff unavailable to work**-During the period of the 22nd April to 12th June 2020, staff unavailable to work due to Covid-19 was tracked. The staff unavailable ranged from 28.6% to 39.9% (31.2% average) See Appendix 1: Staff Unavailable to work during Covid-19.
- **Staff working from home-** Staff working arrangements were altered to maximise use of staff who were Shielding but still able to work from home. Administrative duties were allocated where appropriate. Virtual clinics, bookings, antenatal and postnatal virtual appointments were supported for staff and appropriate IT equipment was sourced and provided.
- Virtual appointments where appropriate as defined through Covid Standard Operating Procedures and risk assessments
- Redeployment of some staff
- Student Midwives appointed to posts early under University and RCM guidance
- Staff who were about to retire were invited/encouraged to stay on, supported by the pension scheme amendments put in place.
- Staff who had already retired or who had moved to other areas, returned early on to support.

- Better Births Midwife, Fetal Wellbeing Midwives, Clinical Skills Facilitators and other specialist role Midwives unable to continue to deliver usual work, were all redeployed to support the clinical needs.

How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?

- Covid Standard Operating Procedures developed to support services within the acute and community setting. These are supported by the Maternity Escalation Policy.
- Staffing levels monitored daily and advance planning takes place to ensure staffing is covered including bank and agency usage.
- Procedures put in place for wave one of the Covid-19 pandemic can be drawn upon again if required, in some cases i.e. virtual arrangements and redeployment of staff.

- Staffing levels are depleted due to high number of staff on maternity leave and on the QEQM site 10% of staff who were shielding have not been able to return. The low vacancy rate does not represent the true picture around staff available to work due to the above situation.
- Working closely with HR and the Occupational Health team to standardise return to work arrangements across sites.
- When demand exceeds capacity there is sometimes a need to divert activity to the other site this is supported through the escalation policy
- Cross site redeployment has been supported at times of need.
- An orientation package was developed based on the induction programme and mandatory training. Staff were supported by Specialist Midwives who were redeployed. This package is now readily available for use if required.
- Clinical Nurse Specialists are seeing staff by appointment between 1-7pm 1 day each site to support with Health and Wellbeing
- Take 5 rooms are available for staff to use to get time away from the clinical areas and maintain their wellbeing

Other Areas of key development;

Midwifery Leadership Team has been strengthened

- Director of Midwifery in post
- QEQM Head of Midwifery appointed
- WHH Head of Midwifery out to advert

New appointments

- 8 new consultant posts at WHH to provide 24 hour consultant presence, and 4 new consultant posts at QEQM to provide 14 hour presence at QEQM.
- 11 WTE Band 7s appointed to facilitate supernumerary and 1:1 care in labour.
- 15 Band 5 Midwives joining through September and October

Governance arrangements 2020

- Governance strengthened for Women's and Child Health
- Risk and Compliance Midwife in post
- Governance Matron for Child Health appointed
- New Consultant Lead for Governance

Continuity of Care

- Better Births Midwife in post
- Home Birth Team to commence in November 2020

- Phased roll out to achieve 35% by March 2021

Saving Babies Lives Care Bundle

- Two Fetal Wellbeing Midwives in post
- Smoking Cessation Midwife in post

Safety

- Multidisciplinary Out of hours Safety Huddle embedded
- 100% 1:1 care in labour in May, June and July 2020
- Reduction in referrals to Healthcare Safety Investigation Branch (HSIB)
- 62% reduction in neonatal deaths and stillbirths.
- Average Avoidable Term Admission 2.7% (National ATAIN Target 6%)
- 3rd and 4th Degree Tear Rate 2.8% (National 3.5%)
- Reduction in babies <37weeks gestation requiring cooling
- UNICEF BFI Stage 1 achieved, specialist infant feeding coordinators in post, increased breastfeeding rates and skin to skin contact following birth.
- Initial Duty of Candour is 100%

Fetal Monitoring

- Competency Framework implemented
- Embedded Physiological Interpretation model for fetal CTG monitoring.
- MOSOS centralised CTG monitoring embedded in practice.
- Two Fetal Surveillance midwives posts in progress

CQC Actions

- 100% of CQC Action Plan completed
- CQC Summary document of evidence produced

Civility Saves Lives Training

- Held in October. Cross section of staff attended via VC or on the QEQM site
- CSL grass roots organisation dedicated to raising awareness of behaviour on team and individual performance.
- Building blocks- first the evidence
- 2nd Calling it out with compassion

Bond Solon Training

- Coroner's Court – Witness Skills
- 5 Sessions so far held for a cross section of staff

Trauma Risk Management Resiliency Training (TRiM)

- Peer delivered risk assessment and ongoing support system, designed specifically to help in the management of traumatic events.
- The system allows peers to understand likely reactions to traumatic incidents and to conduct structured risk assessments
- aiming to identify people needing early referral to qualified medical support.
- Risk assessments are based around identifying common risk factors for the development of traumatic stress; a simple scoring system is applied.
- TRiM is highly effective because people are often more comfortable talking to peers.
- The system is an ongoing method of monitoring and support not just a single session intervention.

NEXT STEPS FOR SUCCESSFUL DELIVERY

- Implement BirthRate Plus Intrapartum Acuity Tool and reporting of staffing Red Flags
- Reporting through the Maternity Improvement Committee of Workforce Actions

- Share the BirthRate Plus Workforce Review with Strategic Workforce Committee once available
- Progress with Triage WHH site once Estates work completed
- Continue to monitor sickness levels and staff wellbeing.
- Continue to work on achieving Year Three CNST Maternity Incentive Scheme
- Continue against trajectory to deliver improvements in safety towards the ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 30% by 2020 and by 50% in 2025.
- Deliver full implementation of the Saving Babies' Lives Care Bundle V2.
- Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2021, 35% of women are booked on to a continuity of carer pathway.
- Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan. This is being progressed with EKHUFT being first of type pilot site for Maternity Personalised Healthcare records which has read and write functionality around birth preferences.
- Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings of their choice.
- Fully recruit to additional staff posts-Fetal Surveillance Midwives and Digital Workforce expansion
- **Note contents of action plan**
- **Note details of report in Trust Board minutes**

NHS
East Kent
Hospitals University
NHS Foundation Trust

Appendix 1: Staff Unavailable to work during Covid-19 22.4.20 to 12.06.20

Midwifery Unavailability WTE	22.4.20		1.5.20		8.5.20		15.5.20		29.5.20		12.6.20	
Rolling Month ending	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce
Total unavailability from clinical time in period (includes Study Leave, Maternity Leave, Annual Leave, Bereavement Leave, Sick Leave, Management time etc)	59.4	31.2%	57.7	28.9%	63.8	31.9%	57.3	28.6%	63.0	31.5%	69.8	34.9%

Reason	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce
COVID Shielding / Self Isolating	11.34	5.7%	10.8	5.4%	10.6	5.3%	10.0	5.0%	11.0	5.5%	11.5	5.7%
COVID Working from home	2	1.0%	2.3	1.1%	2.3	1.1%	2.2	1.1%	1.7	0.8%	1.5	0.8%
COVID Sickness	3.36	1.7%	2.4	1.2%	2.0	1.0%	1.4	0.7%	1.2	0.6%	0.9	0.5%
Other Sickness	9.31	4.7%	9.5	4.7%	11.9	6.0%	8.9	4.5%	9.4	4.7%	11.3	5.6%
Maternity Leave	5.92	3.0%	5.8	2.9%	6.8	3.4%	6.9	3.4%	6.7	3.4%	8.0	4.0%
Redeployed to non patient facing work via risk assessment	3	1.5%	6.0	3.0%	6.0	3.0%	6.0	3.0%	6.0	3.0%	6.0	3.0%
Redeployed to support COVID in other areas	0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Total	31.93	16.0%	30.7	15.4%	39.7	19.8%	35.5	17.7%	35.9	18.0%	39	19.6%

MCA Unavailability WTE	22.4.20		1.5.20		8.5.20		15.5.20		29.5.20		29.5.20	
Rolling Month ending	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce
Total unavailability from clinical time in period (includes Study Leave, Maternity Leave, Annual Leave, Bereavement Leave, Sick Leave, Management time etc)	9.98	17.8%	8.8	15.6%	8.4	14.9%	7.8	14.0%	6.8	12.2%	8.1	14.5%

Reason	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce	WTE	% of workforce
COVID Sheilding / Self Isolating	2.44	4.4%	1.6	2.8%	1.5	2.6%	1.6	2.9%	1.7	3.1%	2.3	4.1%
COVID Working from home	0	0.0%	0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
COVID Sickness	1.02	1.8%	0.9	1.6%	0.7	1.2%	0.4	0.7%	0.0	0.1%	0.1	0.2%
Other Sickness	1.96	3.5%	2.2	3.9%	2.3	4.0%	2.3	4.1%	2.2	3.9%	2.2	3.9%
Maternity Leave	0.77	1.4%	0.8	1.4%	0.8	1.4%	0.8	1.4%	0.7	1.3%	0.8	1.4%
Redeployed to non patient facing work via risk assessment	0.0	0.0	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Redeployed to support COVID in other areas	0.0	0.0	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Total	6.19	11.1%	5.42	9.7%	5.20	9.3%	5.07	9.06%	4.67	8.33%	5.41	9.67%

Appendix 2: Midwifery Workforce Planning Action Plan

Midwifery Workforce Action Plan						
No	**Action**	**Action Required to achieve standard**	**Lead**	**Timescales**	**Evidence**	**Status**
1	Achieving 100% 1:1 care in labour	Capture 1:1 care in labour on the Labour suite PTL. Information is reviewed around each case where not maintained to understand how to mitigate	Hannah Horne DHOM	March 2020	**2 November 20** 1:1 care in labour is now captured on the Labour suite PTL.	Closed
		Report 1:1 care in labour through governance reporting structure and monthly highlight reporting and maternity dashboard	Ursula Marsh HOM	Monthly	Process in place and reported through Getting to Good Board. **2 November 20-** Captured on dashboard and PTL. Getting to Good committee no longer in place.	**Closed**

		Continue to review route causes for 1:1 care in labour below 100% and update actions	Hannah Horne and Sharon Curtis DHOMs	Daily reviews on Coordinator rounds	Weekly reporting from 18th May with review of cases of non-compliance. **2 November20**- From May to October 100% compliance across sites	**Closed**
2	Implementation of a tool to capture acuity data, and 1:1 care in labour, supernumerary status and Red Flags	To commission the build of an Acuity Tool to monitor acuity	Ursula Marsh HOM	August 2020- extended to beginning of December	Presentation of BirthRate Plus Acuity Tool in May and plan to introduce as soon as can be procured. **3 November 2020** Slippage due to delay in procurement board feedback on status. Received now and approved subject to IGG and IT formal approval. Presented to IDG and approved subject to contractual approval. Next steps single tender waver and PO to be raised, training by Birthrate Plus provider.	**Slippage with mitigations in place to achieve**
3	Achieving 100% Supernumerary Labour Ward Status- launch 24-hour maternity Triage on the WHH site	**Triage Estates work WHH**- significant estates work. The Triage unit would support taking away non-labouring women activity from Labour suit and therefore be an enabler of 1:1 care in labour and supernumerary labour ward status. Costings for this work are in progress but are likely to be substantial and in the region of £250,000	Sharon Curtis DHOM	**Work to start 2 November 20**	Approval of NHSR Action plan which will support full costing of this work to be progressed**.** **2 November 20** Estates work commenced. Phased approach to minimise disruption to service. Majority of work to be complete by end December but some will continue into January	**In Progress**
		Implement 24-hour Maternity Triage Service on the WHH site.	**SC DHOM**	**Jan/Feb 21**	**2 November 20 -**24-hour Triage service provided but overnight this takes place on Labour Suit. The estates work will allow this to take place in a dedicated area within the Midwifery Day Care location**.**	**In progress**
		A Paper Audit is in progress on both sites, while waiting for a more permanent solution to be developed, to capture supernumerary status This	LW Leads	Ongoing	**2 November-**May-October 97% average	**In progress**

		is manually collected during the coordinator rounds				
4	Labour suite Leadership Development Training Programme	We wish to provide a development workshop to the Band 7 ward co-ordinators where they can explore their roles and responsibilities in respect of the National Safety actions that they are working with i.e. achieving 100% Supernumerary status and 100% 1:1 care in labour. We wish to bring small groups together providing a safe space for them to clarify how they work towards the 100% in the supernumerary performance and sustain the 100% 1:1 care. We envisage small groups of up to 6 ward co-ordinators with a facilitator, providing time for them to think together and plan – the workshops would be of 3-hour duration across the two sites, William Harvey Ashford and Queen Mother queen Elizabeth Margate	**HOM**	**May 2020**	Workshops will be £780 (ex VAT) per workshop plus expenses as necessary: Total £3120 plus vat and expenses. Funding approval for estates works through NHSR action plan We have met with EDC a leadership and team development consultancy working to support the capability of organisations, teams and individuals (at all levels) as executive coaches and team facilitators. They work extensively within the NHS, nationally and locally with clinicians and professional managers – Acute Hospitals, Commissioning teams and Mental Health Hospital trusts including across Kent and Medway recently. **2 November 20-** An initial session was held but further progress was halted due to Covid restrictions and staffing capacity to attend.	Slippage with mitigations in place
5	Commission Birth rate Plus Review	We also would like to commission a Birth Rate plus review or desktop analysis.	**LW Leads**	**June 2020**	A cost has been requested for this and amounts to £5000 (per trust) NHSR Action plan includes this cost. **2 November 20-** This was delayed during Covid by the Birthrate plus team but has now started. Because of the pressures on trusts, a full review has been considered too demanding by the LMS and instead a Birthrate	

					plus desktop refresh of 2018 data is in progress. All requested workforce data has been provided and we are waiting for the analysis report.	

East Kent Hospitals University NHS Foundation Trust

Guidance for Midwifery and Support Workers Staffing Levels:

For All Care Settings in Maternity Services

Version:	2
Ratified by:	Director of Midwifery
Date ratified:	22/09/2020
Name of originator/author:	Ursula Marsh, Director of Midwifery and Gynaecology Deborah McAllion, Professional Advisor to Head of Midwifery
Director responsible for implementation:	Chief Nurse and Director of Quality
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1. **Introduction**

Requirements around staffing levels for professionals involved in the provision of safe care to women and their babies are detailed in a number of key national recommendations. The main documents include:

- Safer Childbirth-(2007) Royal College of Obstetricians and Gynaecologists.
- National Institute for Health and Care Excellence (2015) Safe Midwifery Staffing for Maternity Settings
- RCM Guidance (2016). Implementing the NICE Safe Staffing Guideline on Midwifery Staffing in Maternity Settings,.
- National Quality Board (2018) Safe, Sustainable and Productive Staffing- An Improvement Resource for Maternity Services.

Where the recommended numbers of staff are not in place, business and contingency plans should be implemented and their effectiveness monitored in order to manage the situation (CQC, Regulation 18, 2014).

The Maternity Service provides packages of care, according to the woman's choice, which include home births, low risk births in the co-located midwifery led unit and birth in the hospital consultant led Delivery Suite and low risk births in the co-located midwifery led unit. Women should receive appropriate and safe care in which ever care setting that they decide to deliver in.

2. Purpose

This guideline provides guidance on the numbers of midwifery, nursing and support worker staffing levels required to deliver safe services across all areas in which women access maternity care. It outlines the organisation of care and processes for review of prospective staffing, audit and development of business and contingency plans. This ensures that when needed minimum safe standards and contingency measures for staffing shortfalls are managed in a smooth and standardised way.
This guideline also outlines a description of:

- The midwifery, nursing and support staff within the Maternity service.
- The recommended staffing levels.
- Process for conducting a safe staffing review.
- Process for the development of a business plan to address staffing shortfalls.
- Process for the development of a contingency plan to address short term and ongoing staffing shortfalls.

This staffing guidance applies to all care settings in which the Maternity Service provides care to women and their babies.

3. Focus of Care around Women's Health Needs

East Kent Hospitals University NHS Foundation Trust is the largest acute healthcare provider in both the Kent and South East area. It offers maternity provision to low and high risk pregnant women and their families in a variety of care models. The current 'care offer' and model is shown below and it is recognised that this will evolve in time:

Antenatal Care:

- Low risk care via community midwifery services

  (some GP's may also be active in some aspects of care for pregnant women)

- High risk care via consultant led and specialist midwifery - Antenatal Clinic, Day Care, Fetal Medicine, Maternity Triage and/or access to specialist midwifery services

Intrapartum Care:

- Home birth service via community midwifery services
- Co-located midwifery led birthing units via hospital/ community midwifery services
- Low risk care on Labour Ward via hospital midwifery services
- High risk care on Labour Ward led by obstetricians and hospital midwifery services

Postnatal Care

- At home via community midwifery services
- High risk care led by obstetricians, specialist and hospital midwifery services

Continuity of Care

Better Births, the report of the National Maternity Review, the Five Year Forward View for NHS maternity services in England, set out a vision for maternity services in England which are safe and personalised. A vision that puts the needs of the woman, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving.

At the heart of this vision is the ambition that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. This continuity of care and relationship between care giver and receiver has been shown to lead to better outcomes and safety for the woman and baby as well as offering a more positive and personal experience. Women told the review team how important it was for them to know and form a relationship with the professionals caring for them. They preferred to be cared for by one midwife or a small team of midwives throughout the maternity journey.

The Maternity Transformation Programme was established to deliver the vision set out in *Better Births*, working through Local Maternity Systems (LMS) to deliver change regionally and our EKHUFT BESTT Programme aligns to deliver these priorities locally.

To help generate momentum and ensure that the NHS is on track to deliver the ask that most women receive continuity of carer by March 2021, *Refreshing NHS Plans for 2018/19* requires LMS to ensure that from March 2019, 20% of women at booking are placed onto continuity of carer pathways and receive continuity of the person caring for them during pregnancy, birth, and postnatally.

The Local Maternity System (LMS) in Kent have come together with leadership, governance and the commitment to transform services to meet the expectations of their women and communities. These plans are expected to show how most women will receive continuity of the person caring for them during pregnancy, birth and postnatally.

Based on 7000 birth a year, each midwife has a caseload of 36 and a Team Leader has a caseload of 24. This is the proposed model from the King's Fund.

No of Midwives (WTE) working in MCoC		No women per team per year	No of Team to achieve 20%	No of midwives to achieve 20%	No of Team to achieve 35%	No of midwives to achieve 35%	No of Team to achieve 100%	No of midwives to achieve 100%
Team	8	276	5	40	9	72	25	274
	7	240	6	42	10	70	29	203
	6	204	7	42	6	72	34	204

So far, the Maternity Service have identified the pathways to meet continuity of care for the required 20% and scoped the project following 2 workshops with staff to capture their ideas, concerns and to generate enthusiasm around getting involved. The next steps are to agree the model, teams and individuals for the launch. There has been no national funding identified to support this model of working but it is recognised that it requires higher staffing numbers to deliver and needs to be considered within workforce planning.

4. Profile of Care Settings

Maternity Services are provided at a range of venues across East Kent:

- Ashford- William Harvey Hospital
- Margate- Queen Elizabeth, Queen Mother Hospital
- Kent and Canterbury Hospital- Canterbury Maternity Day Care- appointment and self-referral basis.
- Buckland Hospital, Dover- appointment and self-referral basis.
- Royal Victoria Hospital, Folkestone- Folkestone Community Midwifery Base- appointment only system for maternity bookings, postnatal clinics and some routine antenatal appointments.

- Community midwifery clinics are held in a variety of settings including children's centres and GP surgeries

Acute maternity care is centralised and coordinated in two venues, William Harvey and Queen Elizabeth Hospitals. The venues of Canterbury, Folkestone and Dover offer community/ day care facilities providing local maternity care provision via community and specialist midwifery teams.

Maternity Acute Units:

Inpatient antenatal, intrapartum and postnatal care is provided across 2 sites each of which has a low and high risk setting for birth:

William Harvey Hospital Ashford (WHH)

Providing high risk consultant led care including antenatal, intrapartum and postnatal care as well as day care services. This site also has a level three Neonatal Intensive Care Unit (NICU).

Singleton Midwifery Led Unit (MLU)

On the WHH site, provides intrapartum and immediate postnatal care to low risk women.

Queen Elizabeth Queen Mother Hospital Margate (QEQM)

Providing high risk consultant led care including antenatal, intrapartum and postnatal care, as well as day care services. This site also has a level one special care unit (SCU)

St Peter's Midwifery Led Unit (MLU)

On the QEQM site, provides intrapartum and immediate postnatal care to low risk women.

5. Profile of Midwives, Maternity Support Staff and Administration Staff

5.1 Midwives

Midwives work in all areas where maternity care is delivered and are involved in the care of all women using the service (acute maternity units, co-located midwifery led units, surrounding community and maternity day care centres). They are the lead professional in the care of women with uncomplicated pregnancies and coordinate care for high risk women with consultant support and advice. Midwives are present at 99% of all births.

5.2 Band 7 Midwives (Hospital) / Maternity Group Practice Leaders (Community)

Whilst East Kent Hospitals University NHS Foundation Trust currently provide a more traditional package of care for women, in that there are separate community and hospital-based Band 7 midwives, their leadership roles are primarily the same. They are required to:

- Actively lead the development of midwifery and be an innovative and enthusiastic practitioner.
- Facilitate and participate in audit and teaching programmes relating to all aspects of clinical practice.
- Deliver comprehensive midwifery care in acute and primary health care settings promoting and facilitating team cohesion, prioritising work effectively and efficiently.
- Provide 24-hour care, respecting individual needs and choices and ensuring the provision of a safe and effective service.
- Each Band 7 midwife may also hold a 'special interest position' e.g. birth after thoughts etc.
- Operational Band 7 midwives lead in the following areas: community midwifery group practice, Day Care, Maternity Triage, Midwifery Led Units, Fetal Medicine, Inpatients wards and Labour Ward.
- Specialist Midwives will provide clinical leadership in the defined area of expertise (see next section).

5.3 Band 6 Midwives (Community and Hospital)

The role of the band 6 midwife is to:

- Actively participate in the 24-hour provision of flexible midwifery care, respecting individual needs and choices and to work in partnership with colleagues.
- Deliver comprehensive midwifery care in acute and primary health care settings.
- Be a competent and confident practitioner encompassing the full scope of midwifery practice.
- Take charge of shifts/ case loading of women
- Lead and support junior staff

5.4 Band 5 Midwives (Community and Hospital)

The role of the band 5 midwife is to:

- Actively participate in the 24-hour provision of flexible midwifery care, respecting individual needs and choices and to work in partnership with colleagues.
- Deliver comprehensive midwifery care in acute settings.
- Undertake the necessary training to become a competent and confident practitioner encompassing the full scope of midwifery practice, through working towards consolidation of training by achieving competencies (See Clinical Skills Facilitator roles).
- Develop assertiveness skills, recognise the responsibility and accountability of one's practice ensuring it is reflective and evidence based.

5.5 Maternity Support Worker (MSW)/ Associate Practitioner/ Infant Feeding Support Workers

- These roles exist to provide a multi-skilled worker who supports the multidisciplinary team with clinical and non-clinical practices in order to provide women centred care.
- The post holders have undertaken extended training and undertake a range of delegated duties in acute and primary health care settings without direct supervision from a registered midwife. Case delegation, duties and discussion is undertaken by the midwife.

5.6 Postnatal Discharge Coordinator

- This role exists to support the daily discharge process for postnatal women and babies.
- This is a multiskilled role that supports the multidisciplinary team with specific job roles such as oxygen saturation testing of babies prior to discharge that are linked to the discharge process.
- This team member has competed additional training and undertakes a range of delegated duties, in the acute health care setting, without direct supervision from a registered nurse/ midwife.

5.7 Maternity Support Care Assistant (MCA)

- The MCA role exists to provide a multi-skilled worker who, under the supervision of a Registered Midwife, supports the multidisciplinary team with clinical and non-clinical practices within the acute health care setting.
- The MCA will have completed additional 'on the job' training and will work supporting the midwife in the acute setting.

5.8 Administration and Clerical Teams

- It is recognised that the maternity care team require clerical, reception, secretarial and administrative management for the smooth running of the Maternity Services. This workforce is critical for releasing clinical time to care for staff with clinical responsibilities.
- The administration workforce compliments the work of the clinical teams and is integral to the efficiency of the Maternity Service.

6. Profile of Managerial and Specialist Midwives

6.1 Director of Midwifery and Gynaecology (DOM)

- Reporting to the Chief Nurse, the Director of Midwifery and Gynaecology, a practising midwife, will provide professional leadership and strategic direction for midwifery and nursing staff within the Women's Care Group.
- The DOM will act as the main point of contact for strategic delivery and expertise on all matters relating to high standards of professional midwifery and gynaecology services.

6.2 Head of Midwifery and Gynaecology (HOM)

- Reporting to the Director of Midwifery, the Head of Midwifery and Gynaecology, a practising midwife, will provide leadership and direction for midwifery and nursing staff within the Women's Care Group.
- The HOM will act as a point of contact for advice and expertise on all matters relating to professional midwifery and gynaecology issues. The post-holder will hold the position of site lead for midwifery/ gynaecology.

6.3 Consultant Midwife

- Reporting to the Director of Midwifery, the Consultant Midwife will provide leadership and direction to the midwifery public health specialist midwives within the Women's Care Group. This includes; mental health, infant feeding, antenatal and newborn screening, and smoking cessation.

- The consultant midwife will act as a point of contact for advice and expertise on all matters relating to public health and women's experiences.

6.4 Community Midwifery Matron

- The Community Midwifery Matron takes the lead on community midwifery services, ensuring links between the Trust, local GP's and the Children's Centres.
- The role includes taking the lead on new government initiatives which impact on community services.

6.5 Women's Governance Matron

- Reporting to the Director of Midwifery, the Governance Matron is responsible for liaising and coordinating all governance and risk matters for the Maternity Services.
- The matron will ensure that maternity and Trust governance systems link and provide responses on internal and external quality assurance

6.6 Maternity Matron

- Reporting to the Head of Midwifery, the maternity matron is responsible for providing clinical leadership, organisation, standards setting and audit for all maternity staff within the acute care setting. This role involves ensuring that staffing levels are compliant with work demands.

- The matron liaises closely with the Head of Midwifery in the operational functioning of the Maternity Services.

6.7 Lead Midwife for Labour Ward and Labour Ward Coordinators

- Reporting to the Maternity Matron, the lead midwife for Labour Ward will manage the labour ward in the provision of safe and effective care within the Labour Ward setting.
- A Band 7 midwife will coordinate each shift on the Labour Ward.
- The Labour Ward Coordinator will hold supernumerary status in order to provide clinical oversight and leadership of the labour ward setting. The shifts for midwifery labour ward are rostered to ensure the labour ward coordinator holds supernumerary status. This means that the Labour Ward Coordinator will not have a case load of their own during that shift.
- The Labour Ward Coordinator will receive hand over from the previous shift co-ordinator regarding women on Labour Ward and note any concerns regarding other women on the maternity unit.
- The Labour Ward Coordinator will liaise with the obstetric /anaesthetic/ paediatric teams regarding women's management care plans and any concerns to the obstetric staff on duty, escalating to the consultant on duty/ on call as required.
- The Labour Ward Coordinator will ensure that there is appropriate allocation of staff to workload and re-deploy when necessary i.e. midwives with appropriate experience are allocated high risk cases and that midwives (including limited experienced staff) receive adequate leadership, supervision/support and advice when dealing with cases requiring a level of expertise above their experience.

- Leading the shift will also require checks to ensure equipment, stock and facilities are available and ready for use. This can be delegated to staff i.e. checking of resuscitation units, theatre, delivery rooms and maintenance of adequate stock levels.
- Prioritisation of workload will be an important leadership role, in conjunction with medical colleagues.
- The Labour Ward Coordinator will ensure staffing levels are appropriate for the following shifts and to report any deficiencies to the Lead Midwife for Labour Ward/ Maternity Matron.
- The Labour Ward Coordinator will hold the maternity bleep in the absence of the Maternity Operational Manager and on a rotational basis.
- The Labour Ward Coordinator will be the key point of contact for the on- call Midwifery Manager during out of hours management of the service.
- It is expected that the Lead Midwife for Labour Ward and the Labour Ward Coordinator are expert practitioners and competent in all aspects of midwifery care on Labour Ward.

6.8 Clinical Skills Facilitator

- The Clinical Skills Facilitator is clinically based and leads in the development of clinical practice and education, providing support to facilitate improvement of clinical skills, and thereby enhancing service delivery.
- This role is especially critical in supporting the Band 5 midwives in their preceptorship period and qualified midwives/ medical staff in their need for continuing professional development.

6.9 Professional Midwifery Advocate

- Professional Midwife Advocates (PMA) are responsible for: ensuring every midwife is allocated a PMA to provide support for accountable practice and professional registration.

- The PMA will adopt and delivery the NHS England A-EQUIP model of clinical supervision (advocating for clinical restorative supervision, education and quality improvement).

- A PMA will work closely with the midwifery management and clinical governance teams for serious risk issues.

- The Coordinating Professional Midwife Advocate is responsible for ensuring PMA activities are fulfilled in line with management requirements.

6.10 Other Roles

Several additional specialist roles exist in order to provide midwifery/specialist expertise to women for a range clinical requirements and system enablers. These include:

- Perinatal mental health specialist midwives
- Infant feeding coordinator
- Midwife frenulotomists
- Midwife lactation consultants
- Risk and compliance midwife
- Fetal wellbeing midwives

- Fetal Monitoring midwives
- VBAC (Birth Options) midwives
- Antenatal and newborn screening coordinator
- Screening support midwife
- Fetal medicine midwives
- Specialist midwife for smoking cessation
- 'Better Births' lead midwife
- Diabetes specialist midwives
- Birth afterthoughts midwives
- Women's health counsellors
- Bereavement midwives
- Practice development midwife
- Midwife NIPE examiners
- Midwife sonographer

7. Midwifery and Maternity Support Staffing Levels- Workforce Planning

Staffing levels and the principles of all maternity workforce planning are benchmarked against 'Safer Childbirth' (October 2007) and NICE (2015). NHS Resolution (2020) state that to demonstrate an effective system of midwifery workforce planning, Maternity Services should provide evidence of a systematic, evidence-based process to calculate midwifery staffing establishment.

The planning for staffing and skill mix reflects the local model of care, case mix, and the needs of women, their families and service design. The totality of midwifery care has an impact on the implications for antenatal, intrapartum and postnatal provision within the acute sector, as well as in primary care and community settings. The need for continuous care means that labour ward staffing requirements cannot be considered in isolation or separated from the total establishment of the maternity service. Staffing on the labour ward must not be at the expense of other areas of the Maternity Services (Safer Childbirth, 2007).

East Kent Hospitals University NHS Foundation Trust, alongside the Kent and Medway LMS have endorsed the use of *Birth Rate Plus* as the definitive workforce planning tool for Maternity Services. The *Birth Rate Plus* tool has been used to benchmark existing establishments for midwifery and support staff as it supports the documents of the Royal Colleges who highlight the need for a ratio of midwives to deliveries. The latest full *Birth Rate Plus* Report is shown in **Appendix 3**.

The underpinning principle of midwifery care in labour and the foundation of *Birth Rate Plus* is that labouring women receive one-to-one individual care by midwives throughout established labour. The minimum midwife-to-woman ratio is 1:30 for a safe level of service to ensure the capacity to achieve one-to-one care in labour (*Birth Rate Plus* evaluation data). The recommended total care ratios indicate the maximum number of women that a midwife can provide antenatal, intra partum and postnatal care for within the service.

8. Principles of Safe Midwifery Staffing for Maternity Services at East Kent

Staffing levels should be sufficient to ensure:

- Safe care at all times that allows women a positive birth experience
- Continuity of service provision
- Capacity for care in all settings
- 1:1 care in labour
- The ability to deal with fluctuations in demand

Skill Mix

- There is a locally agreed skill mix based on a 90% midwifery and 10% support worker ratio (known as the 90/10 skill mix)

Acuity

- *Birthrate Plus® (BR+)* has developed a tool for midwives to assess real time workload in the Labour Ward arising from the numbers of women needing care, and their condition on admission and during the processes of labour and delivery. This measure of 'Acuity' is in operation at both WHH and QEQM.
- Scoring is applied that produces an assessment of the numbers of midwives needed in the Labour Ward to meet the needs of the women, based on the minimum standard of one to one care for all women and increased ratios of midwife time for women in the higher need categories.
- On a four hourly basis, the Labour Ward Coordinator will input data onto the *Birthrate Plus® (BR+) Tool* (on each site). This includes the number of midwives on duty and the category of the women currently on the Labour ward as per *Birthrate Plus® (BR+)* guidance.

Case Mix

- Case mix is an important feature of midwifery staffing as it influences the amount of midwifery time taken per woman. This is a feature of Birthrate Plus analysis and is shown in Appendix 3. Case mix information enables a calculation of midwifery staffing based on the models of care for respective place of birth. The case mix is shown below for each site;

Case Mix QEQM	**Cat I**	**Cat II**	**Cat III**	**Cat IV**	**Cat V**
Delivery % Case Mix	5.2	11.7	14.5	32.4	36.2
Generic % case Mix	15.6	17.9	11.7	25.9	28.9
Case Mix WHH	**Cat I**	**Cat II**	**Cat III**	**Cat IV**	**Cat V**
Delivery Case Mix %	5.3	11.0	18.0	33.8	31.9
Generic Case Mix %	13.5	18.2	14.7	27.6	26.0

9. Management of the Midwifery and Maternity Support Staffing Workforce

Strategic Management

- The Director of Midwifery has overall strategic responsibility for ensuring appropriate safe staffing levels are maintained throughout the Maternity Service at East Kent Hospitals University NHS Foundation Trust.

- The Head of Midwifery (HOM) has overall responsibility for ensuring appropriate midwifery management support, including safe staffing, is maintained on each site and the community midwifery teams. The HOM are accountable to the Director of Midwifery (DOM) and will report any strategic or ongoing operational concerns to the DOM.

- Workforce planning is reviewed every 6 months by using the Birth Rate Plus tool (normally March and September each year) and a report is prepared for the Chief Nurse, Strategic Workforce Committee and Trust Board in line with the guidance contained in NICE '*Safe Midwifery Staffing for Maternity Setting'* and '*Safer Childbirth'* recommendations.

- The Director of Midwifery/ Head of Midwifery will review all care settings where women are cared for during a midwifery episode. This review will be presented at the Women's Health Clinical Governance Meeting.

- Every 24 months, a deeper review of all maternity staff in post will occur. Staffing establishments will also be reviewed when new developments are introduced or with any activity or staffing changes. Checks will be made and cross referencing against E-Roster staffing rotas, human resources/ workforce figures, finance data and local management systems.

- Maternity staffing establishment requirements are calculated by the midwifery management team supported by the HR Business Partner for the Women's Care Group. Reviews will consider predictors such as antenatal booking/ birth rates, women's preferences for care setting and other factors to ensure ability to meet demand.

- An allowance for uplift of 22% is standard at East Kent (annual, sick and study leave) is made to all establishment figures.

- Any variance from the funded establishment is acted on via the recruitment process. The Maternity Service follow all steps contained within the Trust Recruitment and Selection Policy.

- If any staffing shortfalls occur, a management plan will be developed for each staff group to address any deficiencies. Significant and chronic shortfalls of staff (25% or more below national standards) will be identified on the Women's Care Group risk register.

- Any requirement for establishment change is discussed with both the Clinical Director and Operational Director for the Women's Care Group. In circumstances when the staffing audit demonstrates that the current funded establishment falls below the recommended levels and there are concerns about quality safe care provision, a business case will be written and presented to the Strategic Workforce Committee and Trust Business Case Committee. The business case will be written by the Director of

Midwifery together with support from the finance team, Clinical Director and the Directorate Business Manager.

- Workforce information is displayed on the monthly Maternity Dashboard and published widely to the Trust and local maternity teams (via the Head of Midwifery team briefings).

- Monitoring of the midwifery workforce is from a variety of sources and this includes: Electronic Health Roster, Staffing Establishment- monthly update, Maternity Dashboard – including 1:1 Care in Labour, clinical incidents, quality indicators e.g. complaints, FFT feedback, key performance indicators

Operational Management

- The maternity matrons have daily responsibility for ensuring appropriate midwifery and support worker staffing levels are maintained on each site and the community midwifery teams. This includes the assurance of balance between activity, capacity and the continuing support of acuity.

- The maternity matrons (each site) are accountable for the staffing rosters within their area of responsibility. Safe staffing levels for each clinical area are outlined in **Appendix 1.**

- Each acute unit, WHH and QEQM, will have a daily operational manager who will hold the bleep. The Maternity Bleep Holder will be responsible for overseeing the safe staffing in line with the guidance contained in the Maternity Operational Manager Bleep Holding and On-Call Midwifery Manager guidelines.

- Out of hours and at weekends there is a designated midwifery manager on – call. The on- call manager will work with the maternity operational bleep holder to ensure midwifery staffing is safe across the Maternity Service. Additional information on this function is also contained within the Maternity Operational Manager Bleep Holding and On-Call Midwifery Manager guidelines.

- Midwifery labour ward shifts for the Band 7 Labour Ward Coordinator are rostered to allow the coordinator to have supernumerary status (defined as having no case load of their own during that shift). It is the responsibility of the Band 7 Labour Ward Coordinator or any other staff working on the unit to escalate to the Operational Bleep Holder or the manager on call, if the labour Ward Coordinator supernumerary status is compromised.

- Maternity E-Roster systems are utilised for the shift allocation of staff and the labour wards have an identified Band 7 midwifery coordinator. This will provide the clinical leadership within supernumerary status and supports the requirement for one-to-one care in active labour.

- It is the responsibility of all midwifery staff to inform the ward manager and / or the maternity bleep holder of any untoward developments or concerns within their clinical area. This includes issues relating to staff staffing and patient safety.

- All midwifery staff must notify their sickness to the maternity bleep holder. Sickness is monitored and appropriately managed according to the Trust's Sickness Absence Policy.

- The senior midwifery management team reviews all local workforce issues on a monthly basis, and this is discussed in the Care Group Matron Team Meeting. Operational changes, recruitment plans and changes to staff in post are included in discussions.

10. Escalation and Contingency Plans

10.1 Prevention of Escalation

- Maternity Services will prepare and manage staff rosters in line with the Trust Roster Policy. This identifies the principles of robust roster management and application of the Healthroster Allocate system for rostering of staff.

- Duty rotas must also be prepared in line with Trust Annual / Study Leave Guidelines to enable an even distribution of staff throughout the week/ month and year. The midwifery managers will then know in advance where the possible shortfall in staffing is and take appropriate action.

- Rota shortages, e.g. through sickness or special leave, may be covered with bank staff if the shift cannot be covered through redistribution of remaining staff.

- Whilst midwives are allocated according to a particular area of practice, there may be times when rotation to another working area takes place. This is in line with the changing levels of activity. Prior to the publishing of the rotas, the midwifery management team will review the requirement for flexibility to fill any identified shortfalls.

10.2 Escalation of Staffing Concerns: Hospital Sites

- In the event of a staffing or skill mix shortfall becoming apparent the Maternity Operational Manager Bleep Holder must endeavour to cover the clinical areas using available staff by assessing clinical need against staff numbers, skill mix and redeploying staff between areas. **The situation will be managed in line with the Maternity Escalation Policy (including Closure of the Unit).**

- Each main site unit has a core (internal) on call system at night that will be activated in the event of a staffing/skill mix shortfall. If additional staffing needs to be sought a group text will be sent to all staff asking for extra help as extra time or overtime. An alternative is to seek cover via National Health Service Professionals (NHSP) or requesting an agency midwife (after seeking senior management approval).

- Community midwives are asked to assist in the unit and midwifery managers/ specialist midwives asked to assist in the unit from 08.00 to 20.00 (or 09.00-17.000 for specialist

midwives). The area must be managed on an hourly basis by the midwifery manager to ensure safe care

- It is occasionally necessary to restrict admissions to the Maternity Unit, divert or 'close'. The prime concern is the safety of mothers and babies. Whilst it is extremely rare for a unit to have to close, it will only close or restrict admissions as a last resort after a clinical assessment of the risks within the Maternity Unit / Special Care Baby Unit/ Neonatal Intensive Care.

- Staff shortages can occur at times of unusually high workload or high dependency, at times of high staff sickness levels or when there are unfilled shifts on rotas. Before the final decision is made to close, the status of the neighbouring maternity units should be ascertained. All women contacting the unit should be assessed accordingly to clinical need. Every effort should be made to accommodate high risk women, e.g. Insulin dependent diabetic, bleeding, women in premature labour.

- The decision to close should be managed in line with the Maternity Escalation Policy. Closure of the unit will have major implications for all women booked for care, neighbouring hospitals and the Neonatal Services. Closure will only be considered when all other potential solutions are exhausted.

- Robust documentation is critical during periods of escalation and templates for record keeping are contained in the Maternity Escalation Policy. In addition a DATIX incident Form should be completed for any staffing shortfalls that impact on patient care.

10.3 Escalation of Staffing Concerns: Community

- Any concerns relating to staffing shortfall or skill mix must be discussed in the first instance within and between teams and with discussion with the Group Practice Leader to try and cover the shortfall by the redeployment of staff. The Maternity Operational Manager Bleep Holder or community matron must be notified.

- In the event of being unable to cover it from redeployment of staff attempts should be made to employ a midwife from NHSP.

- Consideration should be given to care of women booked for a home birth. The woman must be informed and advised to attend the midwifery led unit. The community matron may be able to undertake community clinics if necessary. Women should receive a telephone call to assess if they need a postnatal visit.

10.4 Contingency Plans to Address Ongoing Staffing Shortfalls

- Midwifery establishments should be reviewed by the Trust Board at least every six months and may be more often if judged to be necessary by either the Director of Midwifery or the Chief Nurse.

- The service should monitor and respond to future change using bookings numbers for next six months.

- Senior midwifery leaders should be made aware of contingency plans to meet fluctuations in demand. This would include assessing staff before the start of each shift for individual clinical areas on a daily basis.

- The Maternity Operational Manager Bleep Holder should reassess during the shift when there is unexpected variation in demand, unplanned staff absence, acuity increase and a midwifery red flag event occurs (Appendix 2).

11.0 Training and Implementation

All Band 7 midwives and midwifery managers must ensure that they have read this policy and the associated reading.

12. Monitoring Compliance

This will be monitored by the midwifery management team and reported to the Women's Health Governance Meeting. All red flag and safe staffing incidents need to be reported on DATIX.

Objective to be Monitored	**Measure/Tool**	**Frequency**	**Lead**	**Reporting arrangements**	**Actions arising Including identifying Leads to take actions Forward in agreed timescales**	**Changes to practice and lessons learned**
Availability of a Labour Ward Coordinator	Duty roster Labour Ward Acuity Tool	Daily	Labour Ward Lead Manager/ Maternity Matron	Head of Midwifery Matrons Team Meeting	Women's Health Governance Meeting	Change in roster, review of study leave, annual leave
Short term staffing levels	Duty roster Annual leave Study leave DATIX Forms	Daily	All Managers	Head of Midwifery Matrons Team Meeting	Maternity Escalation Guideline Women's Governance Meeting	Deployment of staff
Ongoing staffing shortfalls	Duty roster Annual leave Study leave Labour Ward Acuity Tool	Daily	All Managers	Head of midwifery Matrons Team Meeting	Women's Health Governance Meeting	Business plan to be formulated
Recommended staffing levels	Birth rate plus tool Annual audit of staffing levels.	Annual	Head of Midwifery	Executive review of the Care Group performance	Business plan for staff	Increase in staffing levels
Business plan	Annual audit of staffing levels (planned versus actual staff on duty). Unfiled NHSP shifts	6 monthly	Head of Midwifery	Executive review of the Care Group performance	Women's Health Governance Meeting	Increase in staffing levels
Number of times unit or MLU closed	Contingency Maternity Escalation policy	As necessary	Head of Midwifery	Executive review of the Care Group performance	Women's Health Governance Meeting	Increase in staffing levels

13. Associated Documents/Further Reading

- Trust Roster Policy
- Trust Recruitment and Selection Policy
- Trust Sickness Absence Policy
- Trust Flexible Working Policy
- Trust Annual Leave for Agenda for Change Staff Policy
- Trust Special Leave Policy
- Trust Study leave Policy
- Trust New Starters Policy
- Maternity Operational Manager Bleep Holding and On Call Midwifery Manager
- Maternity Escalation including Closure of the Unit in Maternity

14. References

Birthrate Plus (1996), A Framework for Workforce Planning and Decision Making for Midwifery Services.

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Centre for Workforce Intelligence (2013) Future Midwifery Workforce Projections. June 2013.

Kings Fund (2011). Staffing in Maternity Units: Getting the Right People in the Right Place at the Right Time. The King's Fund, London. Available at: www.kingsfund.org.uk/publications.

National Institute for Health and Care Excellence (2015) Safe Midwifery Staffing for Maternity Settings. NG 4.

National Maternity Review (2015). Better Births- Improving Outcomes of Maternity Services in England. A five year Forward View for Maternity.

National Quality Board (2016) How to ensure the right people, with the right skills, are in the right place, at the right time, A Guide for Nursing, Midwifery and Care Staffing Capacity and Capability.

National Quality Board (2018) Safe, Sustainable and Productive Staffing- An Improvement Resource for Maternity Services.

NHS Resolution (2020)- Maternity Incentive Scheme. Ten Safety Actions. www./resolution.nhs.uk/resources/maternity-incentive-scheme

Royal College of Midwives. Staffing Standard in Midwifery Services (May 2009) Guidance Paper.

Royal College of Midwives (2015). Support Workers in the Maternity Services. London. Royal College of Midwives.

Royal College of Midwives (2016) RCM Guidance on Implementing the NICE Safe Staffing Guideline on Midwifery Staffing in Maternity Settings.

Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health Safer Childbirth (October 2007)- Minimum Standards for the Organisation and Delivery of Care in Labour. Standards for Maternity Care (June 2008 report of 'Working Party from RCM, RCOG, RCA& RCPCH').

Appendix 1: Profile of Midwives and Maternity Support Staff

Acute Hospital Services

WHH

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Early	*12+3	*12+3	*12+3	12+3	12+3	11+3	11+3
Late	11+3	11+3	11+3	11+3	11+3	11+3	11+3
Night	11+2	11+2	11+2	11+2	11+2	11+2	11+2
On Call	1	1	1	1	1	1	1

- 12 on duty includes cover for the Caesarean Section Elective List
- Support workers include Maternity Postnatal Discharge Coordinator

QEQM

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Early	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4
Late	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4
Night	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4	7/8 +4
On Call	1	1	1	1	1	1	1

Co-Located Midwifery Led Units

WHH Singleton Midwifery Led Unit

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Early	2+1	2+1	2+1	2+1	2+1	2+1	2+1
Late	2+1	2+1	2+1	2+1	2+1	2+1	2+1
Night	2+1	2+1	2+1	2+1	2+1	2+1	2+1

QEQM St Peter's Midwifery Led Unit

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Early	2+1	2+1	2+1	2+1	2+1	2+1	2+1
Late	2+1	2+1	2+1	2+1	2+1	2+1	2+1
Night	2+1	2+1	2+1	2+1	2+1	2+1	2+1

WHH Maternity Triage

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Early	1	1	1	1	1	1	1
Late	1	1	1	1	1	1	1

QEQM Maternity Triage

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Day	2+2	2+2	2+2	2+2	2+2	1+1	1+1

Night	**1+1**	**1+1**	**1+1**	**1+1**	**1+1**	**1+1**	**1+1**

WHH Maternity Day Care*

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Day	**10.00-18.00**	**10.00-18.00**	**10.00-18.00**	**10.00-18.00**	**10.00-18.00**	**Closed**	**Closed**

*New staffing plans will be scheduled when Day Care combine with Fetal Medicine (without Triage activity)

QEQM Maternity Day Care

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Day	**08.30-16.30**	**08.30-16.30**	**08.30-16.30**	**08.30-16.30**	**08.30-16.30**	**Closed**	**Closed**

Dover

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Day	**Closed**	**Closed**	**Closed**	**Closed**	**Closed**	**Closed**	**Closed**

Kent and Canterbury- Maternity Day Care

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Day	**09.00-17.00**	**09.00-17.00**	**09.00-17.00**	**09.00-17.00**	**09.00-17.00**	**09.00-17.00**	**09.00-17.00**

Antenatal Clinics

WHH

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Day	**n/a**	**1+1**	**2 MCA's**	**n/a**	**n/a**	**Closed**	**Closed**

QEQM

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Day	**1 MCA**	**1 MCA**	**1 MCA**	**1 MCA**	**1 MCA**	**Closed**	**Closed**

Royal Victoria Hospital, **Folkestone**- one consultant clinic per week and offer 2 support staff (1 x MCA from Dover, 1 x MSW from RVH).

Buckland Hospital, Dover- one consultant clinic per week and 1 MCA to support.

Kent and Canterbury- consultant clinics Monday, Wednesday and Thursday with 1 x MCA in each clinic. On Wednesday, midwifery support in place as high-volume attendances.

Alternate weeks - Diabetic Clinic alongside- specialist diabetic midwife also in attendance.

Fetal Medicine Units

WHH

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Clinic	**n/a**	**1**	**n/a**	**1**	**n/a**	**Closed**	**Closed**

QEQM

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Clinic	**1**	**1**	**1**	**1**	**1**	**Closed**	**Closed**

Community Teams

Staffing in the community consists of 6 midwifery teams of between 12-20 midwives reflective of the population they serve. The ratio of midwife to client is 1:98 in line with Birthrate Plus recommendations. The skill mix is as follows:

Band	**7**	**6**	**5**	**3**
Wte	5.8	74.14	0.6	5.8
Staff	6	87	0	6

Community staff work a shift pattern of 8am-4pm with no late shift or night duty. There is an early, late and night duty on call midwife who is available to attend home births or any unplanned emergencies in the home e.g. unplanned home births.

Appendix 2: Midwifery Red Flag Events

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity
- Missed or delayed care – e.g. delay of more than 60 minutes in suturing or washing after delivery
- Missed medication
- Delay of more than 30 minutes in giving pain relief
- Delay of more than 30 minutes between a woman presenting and triage occurring
- Full clinical examination not carried out on admission in labour
- Delay or 2 hours or more between admission and planned induction of labour being initiated
- Delayed recognition and action on abnormal vital signs
- Not able to provide 1:1 care in labour
- Other items maybe included that are shown in the Birthrate Plus Acuity Tool

Appendix 3: Birth Rate Plus Report- 2018

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

EAST KENT HOSPITALS NHS FOUNDATION TRUST

October 2018

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Birth outcomes are not influenced by staff numbers alone. Nevertheless, a recognised and well-used tool like BR+ is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviates from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery. *Appendix 1 explains the Birthrate categories (p.9).*

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition, BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff have been applied.

Summary of results

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 22% for annual, sick & study leave allowance and 12.5% for travel in community. Non-clinical midwifery roles are included. *A detailed summary is included on page 6.*

The overall clinical establishment for total of births is summarised as follows:

(a) The Queen Elizabeth the Queen Mother Hospital	79.97 wte
(b) William Harvey Hospital	99.24 wte
(c) KCH & Canterbury Coastal Community	80.92 wte
(c) Total Clinical WTE Hospital & Community	**260.13 wte**
(d) Additional Non-Clinical midwifery roles @ 9%	23.41 wte

1. Annual activity data are from 2017/18 and provided by the senior midwifery team. Data sets for community, satellite clinics/outpatients' services, and birth centres activity were also obtained for both hospital sites.
2. Total Births are 6867 of which:
    a. Queen Elizabeth the Queen Mother Hospital :
        i. 2354 births on the Delivery Suite
        ii. 469 births in St Peter's Birth Centre
    b. William Harvey Hospital:
        i. 3028 births on the Delivery Suite
        ii. 750 on the Singleton Birth Centre
    c. 266 at home/BBAs.

Two months casemix data was obtained from the months of February & June 2018, however unfortunately this data was not reliable and therefore was not able to be used. The casemix data obtained in 2015 was applied, as the Head of Midwifery confirmed there was no anticipated change to the casemix from the previous study.

Casemix QEQM Hospital	Cat I	Cat II	Cat III	Cat IV	Cat V
D/S % Casemix	5.2	11.7	14.5	32.4	36.2
Generic % Casemix	15.6	17.9	11.7	25.9	28.9

Casemix William Harvey Hospital	Cat I	Cat II	Cat III	Cat IV	Cat V
D/S %Casemix	5.3	11.0	18.0	33.8	31.9
Generic %Casemix	13.5	18.2	14.7	27.6	26.0

3. The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Unit and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.
4. The Delivery Unit casemix will predominantly be those women in categories III to V thus impacting on the workload for this service and also for postnatal care in the ward. The Birth Centre models of care are based on a casemix of category I and II and any higher category activity is included as transfers and included in DS casemix. On both hospital sites 83% of DS births are in Categories III, IV & V which does impact on the staffing requirements.
5. The Generic Casemix indicates that 33.8% of births at QEQM and 31.7% at WHH are in the lower categories I & II with 66.5% at QEQM and 68.3% at WHH in the moderate to high categories, of which almost 54.8% at QEQM and 53.6% are in IV & V. Key contributory factors include obesity, Postpartum Haemorrhage, Massive Obstetric Haemorrhage, Prelabour Rupture of Membranes (requiring augmentation and IV antibiotics) method of delivery and vulnerability with specific reference to mental health issues. Of the 54 maternity units in England who have undertaken a BR+ assessment from 2015 to 2017, the average % of women in Categories IV & V is 56% ranging from 41 to 69%.
6. East Kent with 53 - 54% in Categories IV & V is within the national average.

7. The assessment of midwives for the Alongside Midwife Unit (AMU) activity is based on a 'package of care' that includes intra-partum care with 2 midwives at for the birth, postnatal care until transfer home and examination of the new-born. There are women who commence labour in the Birth Centre but transferred to Delivery Suite prior to or at delivery due to maternal or fetal complications. The care given to the women is included in the AMU staffing whilst the actual birth and post-delivery care is within the D/S establishment. In addition, there are women who attend with a labour query but not admitted.

8. The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital so used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters. The table on page 6 lists the full activity and services covered in the workforce assessment. The BR+ staffing is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care.

9. The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital so used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters.

10. The table on page 7 lists the full activity and services covered in the workforce assessment. The BR+ staffing is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care.

11. The overall total clinical wte with 22% uplift is 260.13wte, this figure will contain the contribution from suitably qualified and competent support staff in hospital and community postnatal services.

12. Applying a 90/10% skill mix to the total of 260.13wte equates to 234.12wte RMs & 26.01wte MSWs. In addition, there is a requirement for other support staff on the DS, Outpatients and Maternity Ward, usually Band 2s. The wte is calculated based on numbers per shift and not on a clinical dependency method.

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13. Most maternity units work with a minimum of 90/10% skill mix split of the clinical total wte, although this is a local decision by the Senior Midwifery Team. To have a skill mix adjustment greater than 85/15% would not ensure that midwives are available to cover peak activity on the Delivery Suite.

14. In addition, there is a requirement for other support staff on the BC, Outpatients and Maternity Ward, usually Band 2s. The wte is calculated based on numbers per shift and not on a clinical dependency method.

15. There are the non-clinical midwifery roles to add in to the overall total establishment and based on 9%, equates to 23.41wte.

16. The total clinical establishments do not include the following roles:
    - Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
    - Practice Development role
    - Clinical Governance role
    - Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
    - Additional hours for antenatal screening over & above the time provided in actual clinics
    - Coordination for such work as Safeguarding Children
    - PMAs (A-Equip)

17. The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 23.41wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties. Adding in a % means there is no duplication of roles between clinical and non-clinical.

Using ratios of births/cases to midwife wte for projecting staffing establishments

The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will consider an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (usually 9%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women.

For example:

A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 37 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

If the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 107 cases to 1 wte is the correct ratio to apply. To use the 1:28.7 ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

East Kent Ratios:

- Delivery Suite births (all hospital care)
  - QEQM — 35 births to 1 wte midwife
  - WHH — 38 births to 1 wte midwife
- AMU births
  - QEQM — 50 births to 1 wte midwife
  - WHH — 46 births to 1 wte midwife
- Home births — 35 births to 1 wte midwife
- Ante & Postnatal Community care only — 98 cases to 1 wte midwife
- **Overall ratio for all births — 26 births to 1 wte midwife**

The calculated overall ratio for East Kent Trust of 26 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte. This overall ratio is based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

COMPARISON OF BR+ WTE WITH CURRENT FUNDED WTE (22% UPLIFT)

East Kent Hospitals NHS Trust	**30/8/18**		
	Registered Midwives (RMs)	**Maternity Support Workers (MSWs)**	**Bands 3 – 7**
QEQM Hospital			
Current Funded Clinical	68.22 wte	7.40wte	75.62wte
BR + Clinical WTE			**79.97wte**
Skill Mix adjustment 90/10	71.98wte	7.99wte	
Variance	-3.76wte	+.59wte	
Total Clinical variance QEQM			**-3.17wte**
William Harvey Hospital			
Current funded Clinical	82.26wte	2.00wte (in post) 15.12wte (funded)	97.38wte
BR + Clinical WTE			**99.24wte**
Skill Mix adjustment 90/10	89.32wte	9.92wte	
Variance	-7.06wte	+5.2wte (funded)	
Total Clinical variance WHH			**-2.86wte**
KCH & Canterbury Coastal Community Services			
Current Total Clinical	82.94wte	4.80wte	87.74wte
BR+ Clinical WTE			**80.92wte**
Skill Mix adjustment 90/10	72.83wte	8.09wte	
Variance	+10.11wte	-3.29wte	
Total Clinical variance Community			**+6.82wte**
Non-Clinical Roles 9%	**BR+**	Current Funded Roles	Variance
	23.41wte	12.90wte	**-10.51wte**

Note: the current funded staffing has been checked and confirmed by the Head of Midwifery.

The summary of data table on page 3 provides the required WTE for the clinical areas, which will enable the Head of Midwifery to compare the current staffing against.

30/8/18 **QEQM Hospital**	Birthrate Plus staffing	Current funded wte	Variance
Delivery Suite • Births – based on casemix • Prostin/Propess/Balloons • Cats A1 & A2 – moderate & high-risk antenatal cases • In-utero transfers with m/w escort • PN readmissions • Non-viable pregnancies	32.99wte		
Alongside Midwife Unit – St Peters • Births inc. P/N care & NIPE • Unplanned a/n cases • Escorted transfers to DS	9.23wte		
Ante &/or Postnatal Ward (s) • A/N inpatients • A/N ward attenders • P/N women (D/S births) • P/N ward attenders • P/N readmissions • Extra care babies • NIPE/*BCGs*	26.53wte		
Outpatients Services: • Obstetric Clinics • Midwife Led Clinics • Specialist Clinics • Fetal Medicine • Day Unit	3.47wte 7.74wte		

30/8/18 **William Harvey Hospital**	Birthrate Plus staffing	Current funded wte	Variance
Delivery Suite • Births – based on casemix • Inductions of labour • Cats A1 & A2 – moderate & high-risk antenatal cases • In-utero transfers with m/w escort • PN readmissions • Non-viable pregnancies	41.89wte		
Alongside Midwife Unit – Singleton • Births inc. P/N care & NIPE • Unplanned a/n cases • Escorted transfers to DS	16.31wte		

Ante &/or Postnatal Ward • A/N inpatients • A/N ward attenders • P/N women (D/S births) • P/N ward attenders • P/N readmissions • Extra care babies • NIPE	31.39wte		
Outpatients Services: • Obstetric Clinics • Midwife Led Clinics • Specialist Clinics • Fetal Medicine • Day Unit	2.36wte 7.29wte		
East Kent Community Services • Home Births/*BBAs* • Community cases – A/N &/or P/N care includes out of area births (imports) & excludes women transferred to neighbouring Trusts (exports) • Attrition cases • Satellite Clinics (KCH/BHD)	80.92wte		

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, ACTING FPC CHAIR (ON BEHALF OF NIGEL MANSLEY, CHAIR OF THE FPC)**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MONTH 7 FINANCE REPORT** **APPENDIX 2: SURGICAL EMERGENCY ASSESSMENT UNIT (SEAU) BUSINESS CASE** **APPENDIX 3: STATUTORY COMPLIANCE BUSINESS CASE** **APPENDIX 4: RADIOLOGY EQUIPMENT BUSINESS CASE** **APPENDIX 5: ITENSIVE THERAPY UNIT (ITU) EXPANSION BUSINESS CASE** **APPENDIX 6: EMERGENCY DEPARTMENT (ED) EXPANSION BUSINESS CASE** **APPENDIX 7: COVID TESTING ADDITIONAL RESOURCES BUSINESS CASE** **APPENDIX 8: EXTENSION OF PATHOLOGY MANAGED SERVICE CONTRACT (MSC) BUSINESS CASE**

BACKGROUND AND EXECUTIVE SUMMARY:

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

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

The Committee also has a role in monitoring the performance and activity of the Trust.

The following provides feedback from the December 2020 FPC meeting.

1 Month 7 Finance Report

Appendix 1 provides the Board with oversight of the financial position and therefore only the highlights are provided below:

1.1 The Trust achieved a £46k surplus in October, bringing the year-to-date (YTD) position to a £46k surplus, slightly ahead of the plan. Income & Expenditure (I&E)

plan reset to match Board approved plan submitted to NHSE/I. Cash position ahead of plan.

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

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

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

1.4 The Trust has identified £3.7m of additional costs due to Covid-19 in October along with lost income of £0.6m, bringing the total financial impact of Covid-19 to £36.5m YTD.

1.5 The key drivers of financial pressure in October were:

- A non-clinical income variance of £1.3m income relating to additional funding received for staffing costs of trainee medical staff on community placements totalling £0.6m combined with additional 'out of cost envelope' Covid-19 funding of £0.6m which is funded nationally;
- A non-pay overspend of £1m due to mainly to overspends on drugs and non-clinical supplies offset by an underspend in clinical supplies due to elective activity being slightly below planned levels.

1.6 The Committee noted a potential risk in respect of achieving the capital spend against the annual capital plan by end of financial year, due to the level of high spend required during the winter period. The business cases presented to the Committee will support expediting this position.

1.7 The Committee will receive information regarding the significant impacts related to Covid in relation to expenditure and non-clinical income.

2 Deloitte's Review of VAT for 2gether Support Solutions (2gether) and Spencer Private Hospitals (SPH)

The Committee discussed and noted Deloitte's report on Group taxation along with recommended options for tax efficient initiatives. Additionally, FPC noted and endorsed a framework for Group tax strategy based on openness and transparency with HM Revenue and Customs (HMRC).

3 Agency Spend

The Committee discussed and noted an update report on agency spend and progress to reduce agency expenditure. Key messages include:

3.1 The challenges posed by Covid-19 has resulted in relying on the flexible extra-capacity provided by agency staffing.

3.2 The three highest spending Care Groups in Financial Year (FY) 2019/20 were Urgent and Emergency Care (UEC), General and Specialist Medicine (GSM) and Surgery and Anaesthetics (S&A). Compared to last FY 2019/20, UEC reduced spend by 6%; spend in GSM increased by 3%; and S&A remains constant.

3.3 UEC and GSM account for the biggest agency spend as a proportion of their respective budgets with particular challenges around middle grade doctors.

3.4 Progress continues with the recruitment of permanent staff in the Emergency Departments (EDs).

3.5 Progress made with the direct engagement model and staff encouraged to work on the bank, increasing the bank fill rate and reducing levels of overtime and agency usage.

3.6 There has been significant improvement in 'time-to-recruit' from 16 weeks to an average of 7 weeks. This 56% reduction in recruitment lead-time will further help reduce agency spend. The Committee commended the HR team for this achievement.

3.7 The Committee referred an action to the Strategic Workforce Committee regarding the need to create a staffing plan for expanding services to avoid future impacts on agency spend.

4 Managed Equipment Services (MES) business case for re-prioritisation of works

The Committee received and noted a report regarding the discussions with Kent & Medway (K&M) Sustainability and Transformation Partnership (STP) and NHSE/I in relation to capital funding required for major clinical equipment replacements.

5 Finance and Operational Risks

The Committee received and discussed the finance and operational risks noting no new risks added to the risk register. The Committee reviewed risk CRR13 – Inability to fund adequate asset replacement programme for high cost and high risk medical equipment approaching the end of their asset life, and its residual risk score confirming this was appropriately scored.

6 Highlight Report: on the National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostic

The FPC received a highlight report on the National Constitutional Standards, which is covered in detail in the Integrated Performance Report (IPR). Key areas were noted as detailed below:

6.1 The significant additional Trauma & Orthopaedic (T&O) capacity that will be in place with the upcoming Elective Orthopaedic Centre (EOC) opening in Spring 2021.

6.2 Independent Sector contract and availability of sufficient capacity noted as a risk.

6.3 South East Coast Ambulance Service (SECAmb) now using active divert of ambulances to avoid significant overcrowding at sites. This had recently been utilised to support Queen Elizabeth the Queen Mother Hospital (QEQMH).

6.4 The Trust recently appointed a highly experienced interim operations leader to provide oversight and help strengthen operations at QEQMH.

6.5 Elective activity has been slightly scaled back in order to tackle the resurgence of Covid-19 cases.

6.6 The provision of another CT scanner in January 2021 will further help reduce diagnostic backlog.

6.7 Accident & Emergency (A&E) 4-hour access standard was 76.83%, excluding Kent Community Health NHS Foundation Trust (KCHFT) Minor Injury Unit (MIU).

6.8 A&E 4-hour access standard was 79.00%, including KCHFT MIU.

6.9 18 Week RTT at 65.89%.

6.10 62-day Cancer Standard at 85.06%.

6.11 6-week diagnostic standard at 78.35%.

7 Update on Winter Planning and Capacity

The Committee received and discussed an update report regarding winter planning and capacity management. The Trust is using a five stage trigger tool to ensure escalation governance and operations are aligned to alert status, consistent with other NHS trusts.

8 2020/21 Capital Programme Projects

The Committee received and noted an update report regarding the Trust's capital programme. Capital plan has risen from £40m at the start of the financial year 2020/21 to current plan of £64m.

9 Business Cases

The Committee received and approved a number of business cases as detailed below:

Surgical Emergency Assessment Unit (SEAU) Same Day Emergency Care Surgical Service at William Harvey Hospital (WHH) and QEQMH

Approval of this business case (option three) and recommendation to the Board of Directors for approval of the total annual cost of £1.1m from 2021/22 and over five years total cost of £4.9m to increase the establishment at QEQMH and WHH SEAU to allow for 12 hour days, 7 days a week including bank holidays. This provision will help ease pressure at ED, reduce avoidable in-patient admissions and increase day surgery services.

Refit of Cardiac Catheter Suite at QEQMH

Approval of this business case for capital funding of £2.5m and revenue funding of £0.3m in 2020/21, noting the capital spend is included in the 2020/21 capital plan. This work is essential to ensure the continued provision of this service, which is vital in managing the Trust's waiting lists, RTT waits for elective procedures, reduce the number of 18 week and 52-week breaches on the elective pathways.

Endoscopy Decontamination Equipment Replacement

Approval of this business case to replace endoscopy decontamination equipment at QEQMH and Kent & Canterbury Hospital (K&CH), capital funding totalling £1.6m that is included in the 2020/21 capital plan. This is essential equipment and will support and improve patient experience and achievement of performance against operational targets.

Radiology Equipment Replacement Programme

Approval of this business case for capital funding for the replacement of Radiology Equipment over the next ten years. Year 1 of the proposed equipment replacement requiring capital funding of £2.0m for the replacement of six x-ray rooms Trust-wide, included in the 2020/21 capital plan and £70k revenue funding in 2020/21. Recommendation to the Board of Directors for approval of the total overall capital costs for five years of £6m. The provision of this new equipment will improve quality and safety, productivity, and imaging quality for diagnoses for patients.

Statutory Compliance

Approval of this business case committing £2m recurrent revenue spend over three years, noting phasing of this spend will be dependent on the Trust's priorities in relation to financial planning and budgetary allocations. This will significantly increase compliance levels to over 90%

Recommendation to the Board of Directors for approval to commit £2m recurring revenue spend by three years with phasing dependent on the Trust's financial planning and budget priorities.

Intensive Care Unit Expansion (ITU) (24 ITU Bed) Capital

Endorsement of the Memorandum of Understanding (MoU) with NHSE/I to receive £14m in this financial year to support the development of a new 24 bedded ITU and

recommendation to the Board of Directors for approval. The full business case will be submitted to FPC once completed. This unit will provide additional capacity to both the population of East Kent and the wider Kent and Medway population. This will provide additional critical care capacity within the NHS to manage any future demand placed on these services by a further surge in Covid-19 cases in the future.

ED Expansion at WHH and QEQMH (MoU with NHSE/I)
Endorsement of the MoU with NHSE/I to receive £7m in this financial year 2020/21 (£4m for QEQMH and £3m at WHH) and recommendation to the Board of Directors for approval. This funding is for ED expansion and the capital work is spread over 3 phases. Phase 1 is planned for this winter, and subsequent phases completed by March 2021 and December 2021 respectively. These works will enable better social distancing and separation of patient pathways, increasing the footprint of the EDs, improving patient flow and streaming, and support infection prevention and control (IPC) management. This will also enable the Trust to manage the increasing demand and continued growth in attendances at EDs.

Covid Testing Additional Resources
Approval in principle of this business case (which has now been given by NHSE) total 5 year costs of £34.4m and recommendation to the Board of Directors for approval. This is in response to the Covid-19 pandemic, the vital component for the Microbiology laboratory to implement Covid Polymerase Chain Reaction (PCR) testing and the requirement to employ additional staff to increase capacity. This is to ensure delivery of the laboratory normal business as well as increased levels of Covid-19 PCR testing.

10 Summary of Approved Business Cases
The Committee received and noted a report providing details of the 30 business cases approved for the period of April to October 2020 with a cost of investment of £7.3m in 2020/21 with a full year impact in 2021/22 of £9m.

11 Extension of Pathology Managed Service Contract (MSC)
Approval of the Extension of Pathology MSC (option 2) mobilising a new MSC until April 2026 at a cost of £3.2m per annum and a total cost of £18.8m over 6 years, recommendation to the Board of Directors for approval. The Committee highlighted the need to clarify the productivity, operational savings and benefits this extended contract will deliver.

12 Business Planning Update
The Committee received and discussed an update report regarding business planning for 2021/22 in relation to latest guidance and current known requirements for operational and financial planning.

13 Other Reports
The Committee received and discussed the following:

- The EOC was currently on time and on budget for completion in Spring 2021;
- Strategic Investment Committee;
- FPC Annual Work Programme for 2021 to be developed.

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

East Kent Hospitals University NHS Foundation Trust

	• **Our sustainability.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR5: Failure to achieve financial plans as agreed with NHSI under the Financial Special Measures Regime.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

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

- FPC Chair report
- Business cases:
  1. SEAU Same Day Emergency Care Surgical Service at WHH and QEQMH (option three) at a total annual cost of £1.1m and over five years total cost of £4.9m;
  2. Commitment to spend recurrent £2m revenue by 3 years on Statutory Compliance with phasing dependent on the Trust's financial planning and budget priorities;
  3. Radiology Equipment Replacement Programme capital funding of £2.0m for the replacement of 6 x-ray rooms Trust-wide and £70k revenue funding in 2020/21. Total overall costs for five years of £6.1m;
  4. ITU Expansion (24 ITU Bed) Capital endorsement of the MoU with NHSE/I to receive £14m in 2020/21 to support the development of a new 24 bedded ITU;
  5. ED Expansion at WHH and QEQMH - endorsement of the MoU with NHSE/I to receive £7m in this financial year (£4m for QEQMH and £3m at WHH);
  6. Covid Testing Additional Resources Business Case at a total cost of £34.4m over 5 years;
  7. Extension of Pathology Managed Service Contract (MSC) (option 2) mobilising a new MSC until April 2026 at a cost of £3.2m per annum and a total cost of £18.8m over 6 years.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2020/21

October 2020

Director of Finance and Performance Management
Philip Cave

Contents and Appendices

Month 07 (October) 2020/21

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Executive Summary
Month 07 (October) 2020/21

Executive Summary

The Trust achieved a £46k surplus in October, which brought the year-to-date (YTD) position to a £46k surplus, slightly ahead of the plan.

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

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

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

Under the new rules the EKHUFT financial plan for 2020/21 is breakeven, excluding an assessment for the value of un-used annual leave at year-end of £5m for which the Trust is awaiting national guidance.

The finance team has re-set our financial plan and budget to reflect the new finance regime. The table below outlines the in-month and YTD performance against this new plan.

Group 2020-21 I&E Performance	In Month			Year To Date		
£,000	Plan	Actuals	Variance	Plan	Actuals	Variance
EKHUFT Income	63,370	64,294	924	426,438	427,362	924
EKHUFT Pay	(38,859)	(38,624)	235	(262,723)	(262,488)	235
EKHUFT Non Pay	(24,654)	(25,609)	(955)	(164,410)	(165,429)	(1,020)
EKHUFT Financial Position	**(143)**	**61**	**204**	**(695)**	**(556)**	**139**
Spencer Performance After Tax	61	41	(20)	131	212	81
2gether Performance After Tax	82	200	118	591	670	79
Consolidated Deficit (-) / Surplus (+)	**0**	**302**	**302**	**25**	**326**	**301**
Remove capital donations/grants I&E impact	0	(256)	(256)	(25)	(280)	(255)
Consolidated Control Total Performance Deficit (-) /	**0**	**46**	**46**	**0**	**46**	**46**

The Trust has identified £3.7m of additional costs due to Covid-19 in October along with lost income of £0.6m, bringing the total financial impact of Covid-19 to £36.5m YTD.

The main drivers of the in-month position as compared to our revised 2020/21 financial plan were:

- A non-clinical income variance of £1.3m income relating to additional funding received for staffing costs of trainee medical staff on community placements totalling £0.6m combined with additional 'out of envelope' Covid-19 funding of £0.6m which is funded nationally.
- A non-pay overspend of £1m due to an driven mainly by overspends on drugs and non-clinical supplies offset by an underspend in clinical supplies due to elective activity being slightly below planned levels.

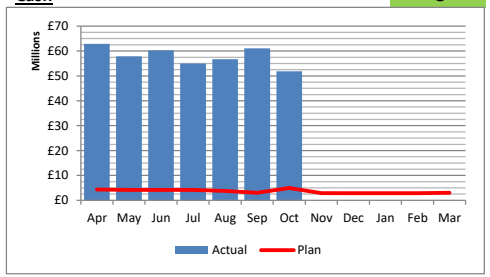
The rest of the report focusses on the variances including the budget adjustments made in M7 to align the budget to our new financial plan, which is based upon April to September actual spend and the budget in October-March consistent with our submitted NHSEI new financial plan.

Income and Expenditure G

The Trust achieved a £46k surplus in October, which brought the year-to-date (YTD) position to a £46k surplus, slightly ahead of the plan.

The main drivers of the in-month position as compared to our revised 2020/21 financial plan were a £1.3m non-clinical income variance due to additional funding received for staffing costs of trainee medical staff on community placements (£0.6m) combined with additional 'out of envelope' Covid-19 (£0.6m) which is funded nationally. This was offset by a non-pay overspend of £1m mainly due to a combination of overspends on drugs and non-clinical supplies offset by an underspend in clinical supplies

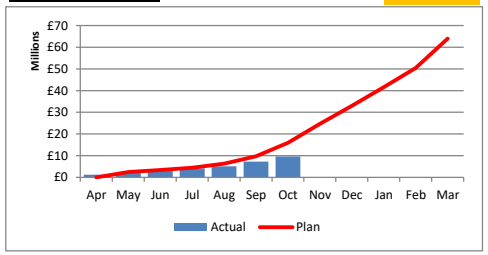
Cash G



The Trust's cash balance at the end of October was £52m which was £47m above plan due to the NHSE/I block payment on account to cover anticipated operational costs in advance.

As directed by DHSC, the Trust has converted £125m of revenue and capital loans to Public Dividend Capital (PDC) in September 2020, which attracts an interest rate of 3.5% but does not require repayment.

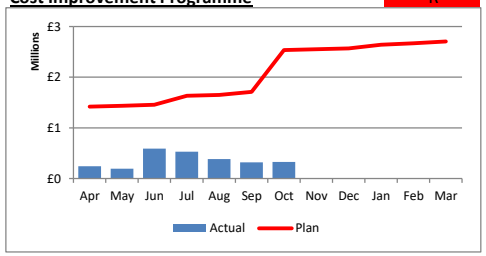
Capital Programme A



Total capital expenditure at the end of October was £9.7m which excludes £2.5m of Covid-19 expenditure which is assumed to be externally funded.

There remains risk around the assumption that the Trust will receive full reimbursement for Covid-19 capital expenditure and this would be required to fund this from internal generated resources (depreciation/ cash). Additionally, with c.£21m additional external funding anticipated for ED and ITU expansion there is a risk that the Trust cannot spend the full planned amount in 2020/21 due to operational pressures.

Cost Improvement Programme R



The Trust planned to deliver £25m of CIP in 2020/21 in our submitted NHSE/I draft plan. In light of the national directive to focus on the operational response to Covid-19 EKHUFT has a reduced ability to make efficiency savings and delivered £0.3m of savings against a plan of £2.5m in October.

Income and Expenditure Summary
Month 07 (October) 2020/21

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	(15,712)	7,334	23,046	31,650	30,599	(1,051)	71,122
Non-Electives	2,475	15,048	12,573	99,960	97,824	(2,135)	181,205
Accident and Emergency	367	2,856	2,489	18,574	18,264	(310)	33,750
Outpatients	(10,443)	5,573	16,016	31,981	29,937	(2,044)	67,338
High Cost Drugs	(23)	4,353	4,376	28,668	30,623	1,955	39,823
Private Patients	(204)	38	243	(42)	55	97	(126)
Other NHS Clinical Income	87,634	14,894	(72,740)	145,818	140,213	(5,606)	262,406
Other Clinical Income	(416)	9,662	10,078	1,550	10,309	8,759	2,890
Total Clinical Income	**63,678**	**59,759**	**(3,919)**	**358,159**	**357,824**	**(335)**	**658,408**
Non Clinical Income	46,818	4,535	(42,283)	68,279	69,537	1,259	85,151
Total Income	**110,496**	**64,294**	**(46,202)**	**426,438**	**427,362**	**924**	**743,559**
Expenditure							
Substantive Staff	(37,293)	(33,107)	4,186	(228,104)	(227,864)	240	(407,876)
Bank	(4,926)	(2,030)	2,897	(13,120)	(13,046)	74	(23,568)
Agency	(9,595)	(3,487)	6,108	(21,500)	(21,578)	(79)	(39,116)
Total Pay	**(51,815)**	**(38,624)**	**13,191**	**(262,723)**	**(262,488)**	**235**	**(470,560)**
Non Pay	(36,600)	(23,681)	12,918	(150,771)	(151,864)	(1,092)	(254,739)
Total Expenditure	**(88,415)**	**(62,305)**	**26,110**	**(413,494)**	**(414,352)**	**(857)**	**(725,299)**
Non-Operating Expenses	(382)	(1,928)	(1,545)	(13,638)	(13,566)	73	(24,484)
Income and Expenditure Surplus/(Deficit)	**21,699**	**61**	**(21,638)**	**(695)**	**(556)**	**139**	**(6,224)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	60,911	60,988	77	364,844	364,921	77	669,775
Non Clinical Income	3,034	3,881	847	67,362	68,209	847	83,024
Total Income	**63,945**	**64,869**	**924**	**432,206**	**433,130**	**924**	**752,799**
Expenditure						-	
Pay	(41,695)	(41,897)	(202)	(283,383)	(283,585)	(202)	(505,397)
Non Pay	(20,212)	(20,688)	(476)	(134,831)	(135,307)	(476)	(226,762)
Total Expenditure	**(61,907)**	**(62,585)**	**(678)**	**(418,214)**	**(418,892)**	**(678)**	**(732,159)**
Non-Operating Expenses	(2,038)	(1,982)	56	(13,967)	(13,911)	56	(25,615)
Income and Expenditure Surplus/(Deficit)	-	**302**	**302**	**25**	**327**	**302**	**(4,975)**

Clinical Income

The Covid-19 income regime changed in October- still supporting, but not guaranteeing, Group income at a level which delivers a break-even position (with the exception of the value of the Annual Leave accrual).

All NHS Trusts were required to submit a new plan reflecting the change in payment methodology and part of this was to reset the M1-6 plan to actuals. In Clinical Income this has been reflected by increasing the Month 7 plan by the value of the M1-6 favourable variance. For this reason, the cumulative variances now reflect the new plan's M7 variance of £0.3m adverse, but the in-month variances are adverse by an additional £3.6m.

The Commissioner allocated payments have remained, but there are a number of changes; We have been allocated a budget of £3m per month to cover covid-19 costs, the Top up funding has increased by £0.9m to £4m and we have received an additional £3.5m growth funding. These funding streams replace the retrospective top up received in M1-6. All these payments have moved from being funded by NHSE/I centrally to being commissioned by Kent and Medway CCG. The level should allow the Trust to breakeven with the exception of the value of the Annual Leave accrual.

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

The majority of NHS England drugs have moved from block to a passthrough payment mechanism.

Non-Clinical Income and Expenditure

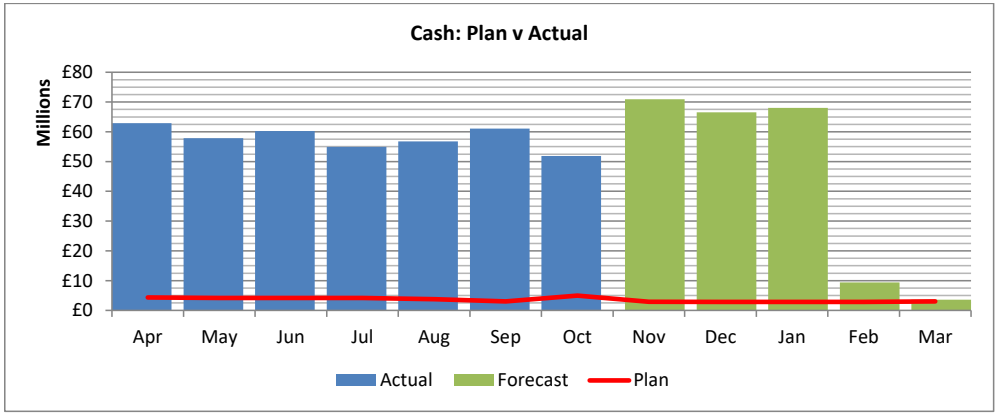
Non-clinical income is adverse to plan in October by £42.3m following a revision to the Trust's original plan backdated to April but implemented in October, and favourable to the revised plan by £1.3m ytd. This variance relates predominantly to donated asset income and income relating to trainee medical staff on community placements totalling £0.6m. It also incudes an assessment of an additional national Covid-19 funding of £0.6m

Total expenditure is favourable to the revised plan in October by £26.1m and adverse to plan ytd by £0.9m. The Trust has identified £3.7m of additional costs due to Covid-19 in October along with lost income of £0.6m, bringing the total financial impact of Covid-19 to £36.5m YTD.

Pay performance is favourable to the revised plan in October by £13.2m and by £0.2m ytd. Pay expenditure relating to the Covid-19 response is £1.7m and £15.0m ytd. The total pay bill in October was £38.6m, an increase of £0.6m when compared to September. Contracted staff in post increased by 40 in October and provisions for other pay risks totalled £0.6m.

Expenditure on non-pay is favourable to the revised plan in October by £12.9m and adverse to plan by £1.1m ytd, driven mainly by overspends on drugs and non-clinical supplies offset by an underspend in clinical supplies. Expenditure on Covid-19 stands at £1.3m in month and £15.5m ytd. Non-pay expenditure reduced by £0.3m in October, predominantly relating to clinical negligence costs which reduced by £1.5m, but this reduction is offset by increases in drugs, purchase of healthcare, provisions for management consultancy and impairment of receivables.

Cash Flow
Month 07 (October) 2020/21



Unconsolidated Cash balance was £51.9m at the end of October 20, £46.9m above plan.

Cash receipts in month totalled £60.2m (£1.1m above plan)

As part of the Covid-19 response, the Trust moved to block contract payments from April 20. November block payments were received in October, totalling £49.4m. NHS England paid an additional £3.4m to the Trust as top up payments.

No PDC revenue support was required in month.

Cash payments in month totalled £69.3m (£12.2m above plan)

Creditor payment runs inc Capital payments were £24.5m (£6.8m above plan).
Payments to 2gether Support Solutions were £11.8m (£3.0m above plan)
Payroll was £33.0m (£2.4m above plan).
Following DHSC guidance, the planned £2.4m PDC dividend payment was not made in month. Payment of £2.7m was made on the 6th November.

Working Capital Facility

In September, all revenue and capital loans were converted to PDC, reducing the Trusts borrowings to nil.
Any further borrowings in 2020/21 will be drawn down as PDC.

Revenue PDC

£4.0m was drawn down as PDC in April 2020 as per plan.
No additional support has been required since April due to the block and top up payments received.
DHSC will provide 2 months notice before block payments will cease.
It has been forecast that no block will be received in February and March's payment will be received next March (2021).

Creditor Management
In the closing 2 weeks of March 20, the Trust moved to pay invoices to 7 day terms to protect suppliers through 2020. This has continued throughout October.
At the end of October 2020 the Trust was recording 55 creditor days (Calculated as invoiced creditors at 31st October/ Forecast non pay expenditure x 365).

Clinical Income

Month 07 (October) 2020/21

Trust Income Plan	Trust Actual Income	Income Variance
£358.160m	£357.824m	£(0.335)m

2020/21 - Month 7 Model

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date			This Month vs. Run Rate		
Summary	Plan	Actual	Variance	Actual	Run Rate to	Var to M6 Rate
1a Total Non Elective Spells	97.7	95.8	(1.9)	14.5		
1b Total Non Elective Excess Bed Days	2.3	2.0	(0.2)	0.3		
2 Accident & Emergency	18.6	18.3	(0.3)	2.8		
3a Total Elective Spells	31.3	30.3	(1.0)	7.1		
3b Total Elective Excess Bed Days	0.3	0.3	(0.0)	0.0		
4a New Outpatient Attendances	12.6	11.4	(1.2)	2.2		
4b Outpatient Follow Up Attendances	18.7	17.9	(0.8)	2.9		
5a Other PbR Cost Per Case	22.4	22.5	0.2	3.5		
5b Non-PbR Cost Per Case	62.6	62.8	0.2	9.6		
6 Block Agreements	97.1	100.8	3.7	17.3		
7 Risks and Adjustments	(5.4)	(4.3)	1.1	(0.6)		
8 Contract Adjustments	(0.0)	(0.0)	-	-		
9c Adjust Prior Month Reported Position	(0.0)	-	0.0	0.0		
	(0.0)	-	0.0	0.0		
Grand Total	**358.2**	**357.8**	**(0.3)**	**59.8**	**49.7**	**10.1**

	This Month			Year to Date			Annual
Care Group Income £m	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cancer Services	4.2	4.2	(0.0)	27.8	27.8	(0.0)	47.9
Central	14.0	10.0	(3.9)	18.8	18.5	(0.3)	70.7
Clinical Support Services	5.2	5.2	0.0	35.2	35.2	0.0	59.7
General and Specialist Medicine	11.8	11.8	(0.0)	79.5	79.5	0.0	149.6
Surgery - Head and neck, Breast Surgery a...	4.0	4.0	0.0	26.1	26.1	0.0	44.2
Surgery and Anaesthetics	10.3	10.3	0.0	71.9	71.9	0.0	119.1
Urgent and Emergency Care	7.6	7.6	0.0	52.9	52.9	(0.0)	89.7
Women's and Children's Services	6.7	6.7	0.0	46.0	46.0	0.0	77.6
	63.7	**59.8**	**(3.9)**	**358.2**	**357.8**	**(0.3)**	**658.4**

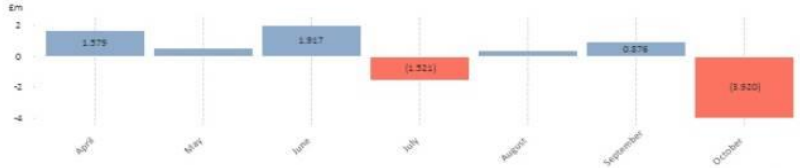
Income by Month

Activity by Month (Excl. DA & Refs)

	This Month			Year to Date			Annual
Commissioner Group	Plan	Actual	Variance	Plan	Actual	Variance	Plan
NHS Kent and Medway CCG	60.9	49.7	(11.2)	291.1	291.1	0.0	548.6
NHS England - Specialised Services Contract	6.0	7.7	1.7	52.5	52.3	(0.2)	92.0
South East Regional Office	8.5	1.2	(7.3)	8.5	8.5	-	14.5
Other Organisations	0.2	0.4	0.2	2.3	2.4	0.1	4.1
Cancer Drugs Fund	0.2	0.4	0.2	2.0	2.0	0.0	3.9
NHS South East London CCG	0.3	0.1	(0.2)	0.7	0.7	0.0	1.1
NHS East Sussex CCG	0.5	0.1	(0.4)	0.5	0.5	(0.0)	0.9
NHS Kent and Medway CCG - Direct	(0.5)	0.1	0.6	0.1	0.1	(0.1)	0.7
NHS England - Hep C	(0.3)	0.1	0.3	0.0	0.1	0.0	0.2
Adjust Prior Month Reported Position	(0.0)	0.0	0.0	(0.0)	-	0.0	(0.0)
Others	**(12.0)**	**(0.0)**	**12.0**	**0.6**	**0.3**	**(0.3)**	**(7.5)**
	63.7	**59.8**	**(3.9)**	**358.2**	**357.8**	**(0.3)**	**658.4**

Total Income Var

Income Variance



Almost all Income up to October 2020 has been set by NHSE/I and allocated to commissioners at a level of £49.4m per month due to the Covid-19 payment methodology.

The new Top-Up payments have transferred to Clinical Income from Other Income. In addition these payments are now paid by Kent and Medway CCG: - Covid-19 Prospective funding £3.0m, Central Top-Up £4.0m and Growth of £3.5m.

The majority of NHS England drugs are passthrough from October onwards, and Private and Overseas, Compensation Recovery Unit and Provider to Provider income will continue to vary. The Elective and Outpatient Incentive Scheme, supporting Trusts to increase activity back up towards 19/20 levels continues, having been introduced in September. Elective, Day case and Outpatient Procedure performance is required to be 90% for the remainder of the year. Outpatient targets are 100% of 19/20 levels from September onwards, but are based on a flat rate tariff methodology designed to incentivise the move from Face-to-Face to Non-Face-to-Face. The target is set at an STP level and it is anticipated that any financial opportunity or risk as a result of actual performance will be held with Kent & Medway CCG.

As part of the Plan resubmission, the Month 1-6 income variances have been reset and added into the Month 7 Plan. This means that the cumulative Month 7 variances are representative of performance, but the In-Month variances look unusual.

Activity plans have not been refreshed as the M7-12 planning was not developed at a granular enough level to translate into specific specialty and POD plans. Therefore plans remain at 19-20 outturn. In month Elective and Outpatient activity run rate has continued to improve. Elective and Day case Spells are over plan (6% October, 8% September), compared to an 16% adverse variance in August. Outpatients were 19% adverse against plan, although some of this could be late recording, as happened in September.

Activity

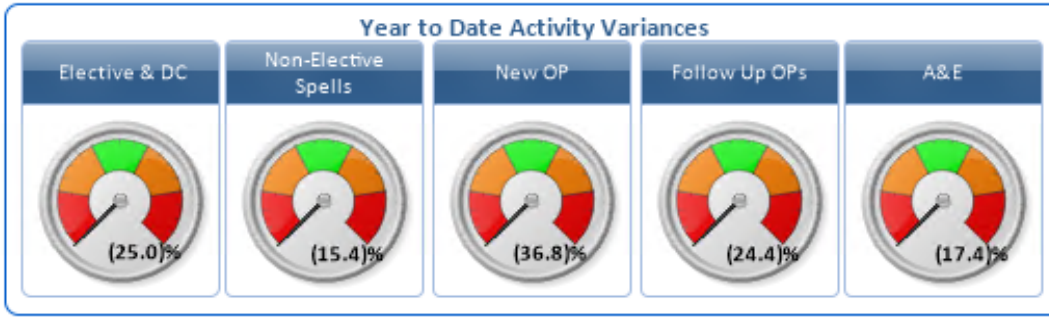
Month 07 (October) 2020/21

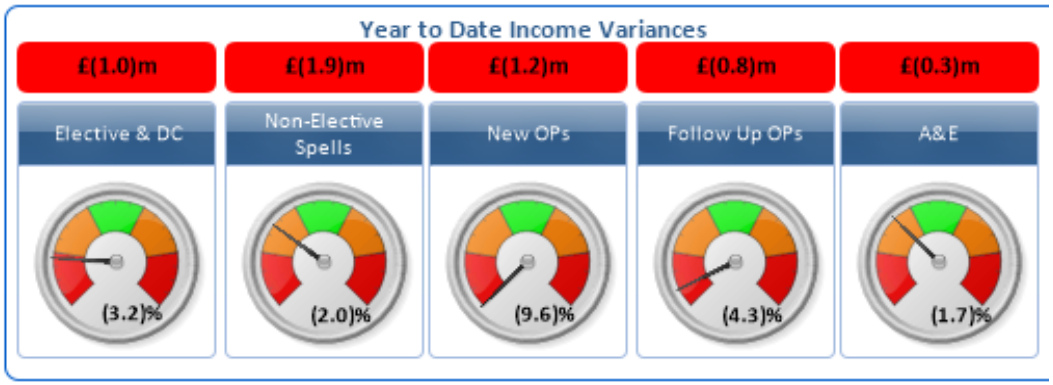
Trust Income Plan	Trust Actual Income	Income Variance
£358.160m	£357.824m	£(0.335)m

2020/21 - Month 7

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date Activity			Year to Date Income £m			Average Tariffs		Variances	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Casemix	Volume
1a Total Non Elective Spells	50,648	42,848	(7,800)	£97.7 m	£95.8 m	£(1.9)m	£1,929	£2,235	£13.8 m	£(15.7)m
2 Accident & Emergency	136,962	113,183	(23,779)	£18.6 m	£18.3 m	£(0.3)m	£136	£161	£3.2 m	£(3.5)m
3a Total Elective Spells	43,692	32,789	(10,903)	£31.3 m	£30.3 m	£(1.0)m	£717	£925	£7.6 m	£(8.7)m
4a New Outpatient Attendances	142,898	90,379	(52,519)	£12.6 m	£11.4 m	£(1.2)m	£88	£126	£5.2 m	£(6.4)m
4b Outpatient Follow Up Attendances	299,363	226,305	(73,058)	£18.7 m	£17.9 m	£(0.8)m	£63	£79	£4.5 m	£(5.3)m
	673,563	**505,504**	**(168,059)**	**£178.9 m**	**£173.7 m**	**£(5.3)m**	**£266**	**£344**	**£45.2 m**	**£(50.5)m**





Elective income in October is now over plan for the second month in a row, having been adverse in earlier months. The Trust has increased capacity across all services and is now able to see significantly more patients than at the peak of the Covid-19 period. The Elective and Daycase target increased to 90% in October which the Trust achieved.

The target for Outpatients is 100% of 19/20 levels, which is challenging.
Physical Outpatient capacity on the Hospital sites for has been reduced following Government guidance, but the Trust continues to work hard to increase virtual outpatient capacity up to the level required to fill the gap. The conversion of virtual capacity to over 50% of total possible Outpatient activity has been reached for the last four months and almost 8 times the levels delivered in October 2019. This is allowing the Trust to close in on the target and means that the Trust's services will be protected in any future recurrence.

The continued increase in virtual Outpatient capacity has seen performance increase to the highest levels this year, now 13% under 19/20 levels for all outpatient settings. Outpatient procedure capacity remains the most difficult area to improve as there is no virtual alternative.
The Urgent Treatment Centres went live from the 21st September and A&E activity levels will continue to be monitored as the new service is set up to receive direct bookings and also to relieve pressure in ED.

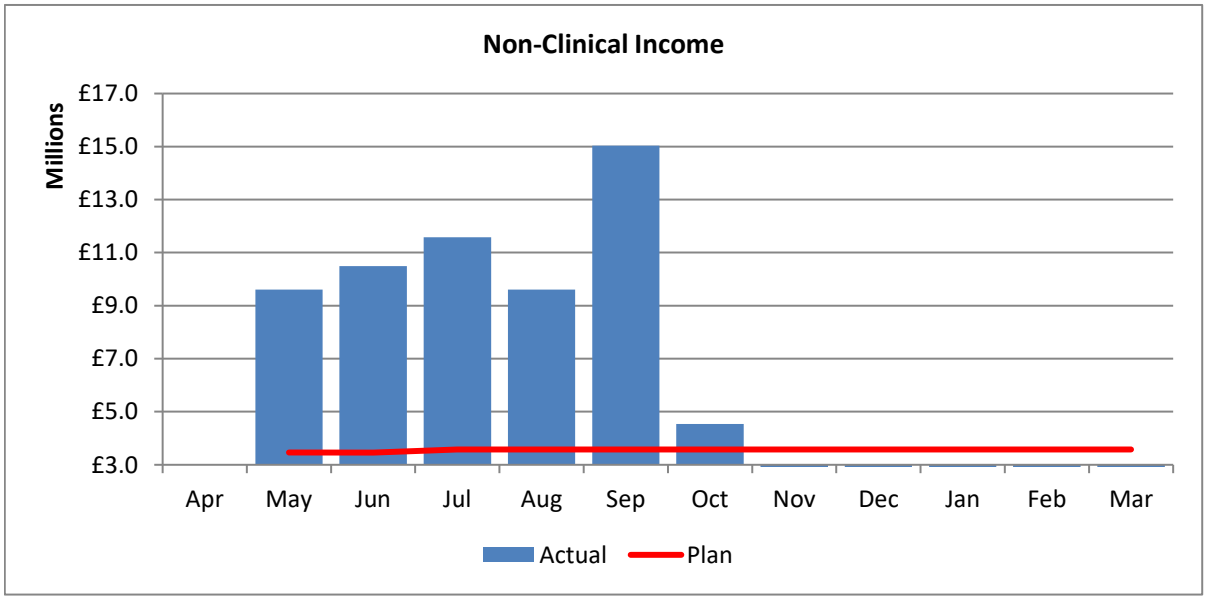
The levels of A&E attendances and Non-Elective spells have continued at similar levels per day for the last four months, although still remain lower than in 19/20 levels. Underperformance in A&E in October was 5% under 19/20 activity levels and plan compared to 8% September.

The Trust, Social Care, Primary care and Community providers have all worked incredibly hard to ensure that medically fit patients are discharged in a timely manner.

Non Clinical Income

Month 07 (October) 2020/21

Non-Clinical Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,798	1,663	(135)	9,184	9,691	508	14,958
Research and development	(25)	191	216	1,607	1,569	(38)	2,752
Education and Training	1,453	1,256	(197)	9,361	9,315	(46)	16,235
Car Parking income	(1,971)	80	2,052	327	362	36	541
Staff accommodation rental	178	177	(1)	1,324	1,321	(3)	2,224
Property rental (not lease income)	(48)		48			()	1
Cash donations / grants for the purchase of capital assets	269	336	67	539	820	281	899
Charitable and other contributions to expenditure	18	17	(1)	90	94	4	154
Other	45,147	815	(44,331)	45,847	46,365	518	47,387
Total	**46,818**	**4,535**	**(42,283)**	**68,279**	**69,537**	**1,259**	**85,151**
			-90.31%			1.84%	
			Adverse			Favourable	



Non-clinical income is adverse to plan in October by £42.3m following a revision to the Trust's original plan backdated to April mainly relating to the Top up/True up funding, and favourable to the revised plan by £1.3m ytd.

The car parking income target has been reset and income is now marginally favourable to plan. The ytd favourable variance relates predominantly to donations for the purchase of capital assets and income relating to the reimbursement staffing costs of trainee medical staff on community placements totalling £0.6m. It also incudes an assessment of additional national Covid-19 funding of £0.6m, reported against other income.

Pay
Month 07 (October) 2020/21

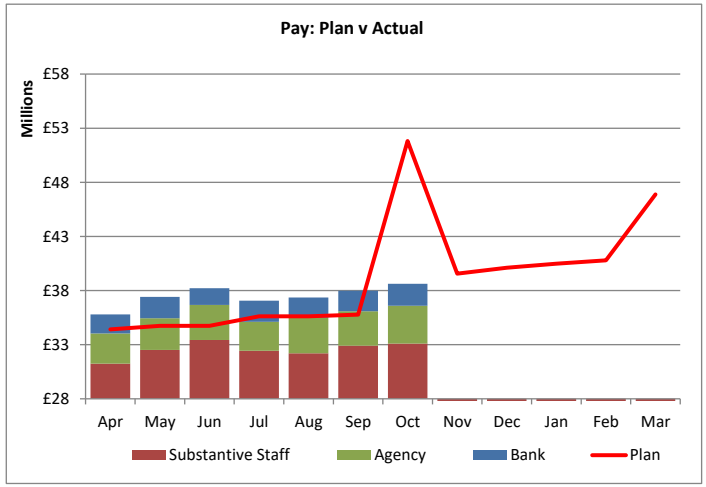
Pay Expenditure	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,259	1,231	28	(10,637)	(10,288)	349	(69,171)	(68,952)	219	(127,997)
Nurses and Midwives	2,629	2,252	377	(8,862)	(8,732)	130	(60,711)	(60,702)	8	(108,017)
Scientific, Therapeutic and Technical	1,512	1,455	57	(6,770)	(4,990)	1,781	(35,274)	(35,218)	56	(60,999)
Admin and Clerical	1,559	1,418	141	(2,307)	(3,201)	(894)	(22,587)	(22,561)	26	(41,221)
Other Pay	1,627	1,572	55	(6,029)	(5,070)	960	(34,933)	(34,999)	(66)	(60,095)
Permanent Staff Total	**8,587**	**7,928**	**658**	**(34,606)**	**(32,281)**	**2,325**	**(222,677)**	**(222,433)**	**243**	**(398,329)**
Waiting List Payments										
Medical and Dental	0	0	0	283	(424)	(706)	(453)	(764)	(311)	(1,019)
Waiting List Payments Total	**0**	**0**	**0**	**283**	**(424)**	**(706)**	**(453)**	**(764)**	**(311)**	**(1,019)**
Medical Locums/Short Sessions										
Medical and Dental	0	31	(31)	(2,971)	(403)	2,568	(4,974)	(4,667)	308	(8,527)
Medical Locums/Short Sessions Total	**0**	**31**	**(31)**	**(2,971)**	**(403)**	**2,568**	**(4,974)**	**(4,667)**	**308**	**(8,527)**
Substantive	**8,587**	**7,959**	**628**	**(37,293)**	**(33,107)**	**4,186**	**(228,104)**	**(227,864)**	**240**	**(407,876)**
Bank										
Medical and Dental	5	33	(28)	(887)	(454)	432	(2,491)	(2,590)	(99)	(4,271)
Nurses and Midwives	33	150	(118)	(2,609)	(728)	1,881	(5,337)	(5,073)	264	(10,226)
Scientific, Therapeutic and Technical	3	8	(5)	(206)	(57)	149	(355)	(361)	(6)	(608)
Admin and Clerical	16	68	(52)	(481)	(211)	270	(970)	(1,043)	(72)	(1,663)
Other Pay	57	210	(153)	(744)	(579)	164	(3,967)	(3,980)	(13)	(6,801)
Bank Total	**113**	**469**	**(355)**	**(4,926)**	**(2,030)**	**2,897**	**(13,120)**	**(13,046)**	**74**	**(23,568)**
Agency										
Medical and Dental	35	92	(57)	(4,089)	(1,321)	2,768	(8,724)	(8,749)	(25)	(15,813)
Nurses and Midwives	69	247	(178)	(3,617)	(1,255)	2,362	(7,249)	(7,223)	26	(13,625)
Scientific, Therapeutic and Technical	2	7	(5)	(18)	(38)	(21)	(161)	(339)	(178)	(291)
Admin and Clerical	0	0	0	288		(288)	(16)	(14)	2	(27)
Other Pay	0	128	(127)	(5)		5	(5)	(4)	1	(8)
Agency Total	**106**	**474**	**(368)**	**(7,440)**	**(2,615)**	**4,825**	**(16,155)**	**(16,329)**	**(173)**	**(29,766)**
Direct Engagement - Agency										
Medical and Dental	7	53	(46)	(2,044)	(793)	1,251	(4,666)	(4,752)	(86)	(8,204)
Scientific, Therapeutic and Technical	3	13	(10)	(112)	(79)	33	(678)	(498)	180	(1,147)
Direct Engagement - Agency Total	**10**	**66**	**(56)**	**(2,156)**	**(872)**	**1,283**	**(5,344)**	**(5,250)**	**95**	**(9,351)**
Agency	**116**	**540**	**(424)**	**(9,595)**	**(3,487)**	**6,108**	**(21,500)**	**(21,578)**	**(79)**	**(39,116)**
Total	**8,815**	**8,967**	**(152)**	**(51,815)**	**(38,624)**	**13,191**	**(262,723)**	**(262,488)**	**235**	**(470,560)**
						25.46%			0.09%	
						Favourable			Favourable	

Pay performance is favourable to plan in October by £13.2m following a revision to the Trust's original plan backdated to April, and by £0.2m ytd (0.09%). Expenditure relating to the Covid-19 response is £1.7m in month and £15.0m ytd.

Total expenditure on pay in October was £38.6m, an increase of £0.6m when compared to September. Waiting list payments grew by £0.3m, predominantly relating to a provision for rate changes and late claims, offset by a reduction in other internal locum claims of £0.2m. Bank and agency costs increased by £0.4m and expenditure on permanent staff increased by £0.1m. September included arrears for the 20-21 senior medical pay award but this has been offset by growth in WTE of 40, relating to planned service developments plus estimates for premium costs.

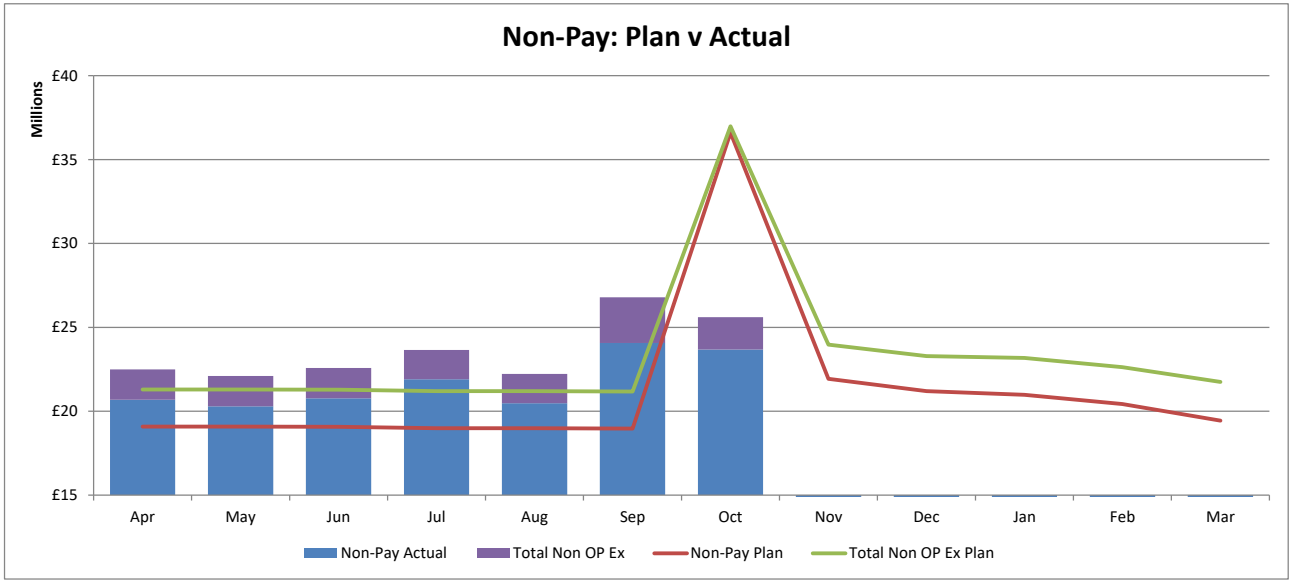
Expenditure on all substantive staff is favourable to plan in October by £4.2m and by £0.2m ytd.

Expenditure on bank and agency staff is adverse to plan in October by £9.0m and is breakeven against the Trust's revised plan ytd.



Non-Pay
Month 07 (October) 2020/21

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(4,478)	(5,730)	(1,252)	(36,152)	(36,798)	(646)	(62,058)
Clinical Supplies and Services - Clinical	3,127	(2,067)	(5,194)	(17,294)	(16,242)	1,053	(28,027)
Supplies and Services - Non-Clinical	(21,811)	(9,213)	12,598	(61,798)	(62,282)	(484)	(103,999)
Non Executive Directors	(15)	(14)	2	(111)	(109)	2	(192)
Purchase of Healthcare	(4,220)	(631)	3,588	(3,204)	(3,364)	(160)	(6,165)
Education & Training	340	(126)	(466)	(656)	(688)	(32)	(1,127)
Consultancy	157	(442)	(600)	(418)	(756)	(339)	(938)
Premises	(1,609)	(1,369)	240	(7,996)	(7,707)	289	(13,789)
Clinical Negligence	(3,386)	(2,030)	1,356	(15,686)	(15,686)		(25,836)
Transport	(460)	(180)	280	(1,216)	(1,221)	(5)	(2,087)
Establishment	(580)	(318)	261	(1,770)	(1,835)	(66)	(3,034)
Other	(3,666)	(1,560)	2,106	(4,470)	(5,176)	(706)	(7,488)
Total Non-Pay Expenditure	**(36,600)**	**(23,681)**	**12,918**	**(150,771)**	**(151,864)**	**(1,092)**	**(254,739)**
Depreciation & Amortisation-Owned Assets	509	(1,307)	(1,816)	(9,168)	(9,108)	59	(16,860)
Impairment Losses	252		(252)				
PDC Dividend	(1,570)	(565)	1,005	(4,042)	(4,037)	5	(6,893)
Interest Receivable	131	195	64	1,385	1,382	(3)	2,375
Interest Payable	297	(251)	(547)	(1,814)	(1,805)	8	(3,107)
Total Non-Operating Expenditure	**(382)**	**(1,928)**	**(1,545)**	**(13,638)**	**(13,569)**	**69**	**(24,484)**
Total Expenditure	**(36,982)**	**(25,609)**	**11,373**	**(164,410)**	**(165,433)**	**(1,023)**	**(279,222)**



Non-pay expenditure is favourable to plan in October by £12.9m following a revision to the Trust's original plan backdated to April, and adverse to plan by £1.1m ytd (0.7%). Trust Covid-19 spend on non-pay expenditure is £1.3m in month and £15.5m ytd.

Drug expenditure is adverse to plan in October by £1.3m and by £0.6m ytd. Pass-through drugs are adverse to plan ytd £0.5m. All other drugs are adverse to plan £0.1m ytd.

Supplies and services - clinical are adverse to plan in October by £5.2m and favourable to plan by £1.1m ytd. Actual spend compared to September is £0.1m lower. Although covid-19 spend in month is £0.4m it is comparable to last month. The variance ytd is predominately driven by slippage against the profile of planned developments in this category.

Supplies and services - non-clinical are favourable to plan in October by £12.6m and adverse to plan by £0.5m ytd. Covid-19 spend in month is £0.7m, which is a reduction of £1.8m month on month, mainly driven by high spend last month on estates works plus PPE costs which are now being sourced through a national procurement process. Charges continue for building works not classed as part of the covid-19 programme which were not anticipated in the revised plan, and above average trend spend on cardiac devices.

Purchase of healthcare from external organisations is favourable to plan in month by £3.6m and adverse to plan by £0.2m ytd. A further provision was made in October for endoscopy waiting lists sourced in the private sector totalling £0.2m.

Management consultancy is adverse to plan in month by £0.6m and by £0.3m ytd, which is inclusive of a provision made in October for the We Care programme.

Other expenditure is favourable to plan in October by £2.1m and adverse to plan by less than £0.7m ytd, which is inclusive of an impairment of receivables relating to national Covid funding assumed in non clinical income

Actual expenditure on non-pay in October was £23.7m, a reduction of £0.3m when compared to expenditure in September, predominantly relating to clinical negligence costs which reduced by £1.5m. This reduction is partially offset by increases in drugs, purchase of healthcare, provisions for management consultancy and impairment of receivables.

Year-to-date, Non-Operating Expenditure is £0.1m better than plan, primarily driven by depreciation.
The Trust is no longer incurring interest charges on its working capital loans - these were converted to PDC in September 2020.

Cost Improvement Summary

Month 07 (October) 2020/21

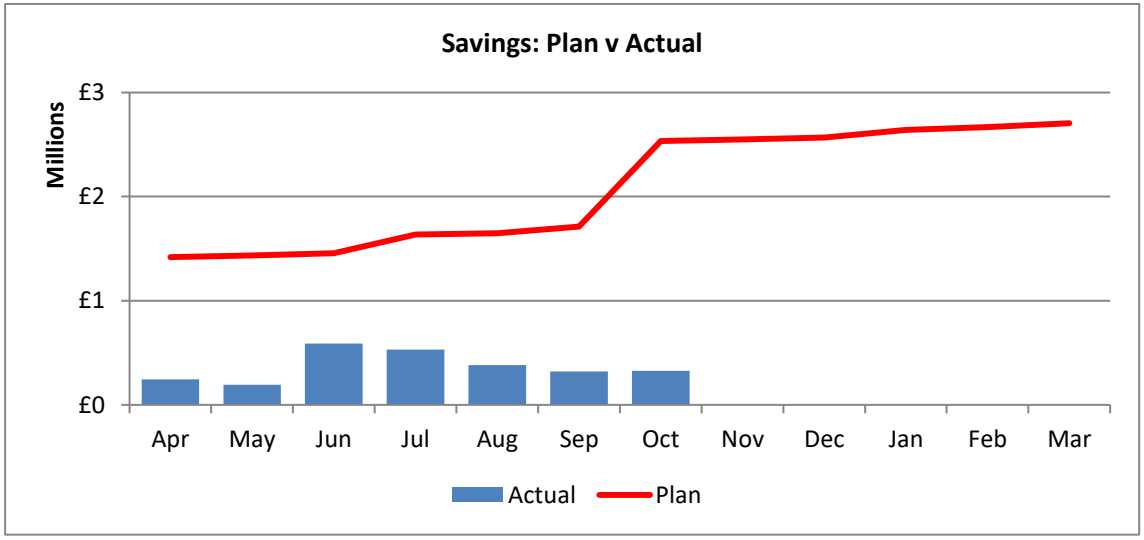
Delivery Summary	This Month			Year to Date		
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Agency	165	28	(137)	1,294	211	(1,082)
Bank	9	-	(9)	62	-	(62)
Workforce	128	83	(45)	684	616	(68)
Outpatients	20	-	(20)	90	-	(90)
Procurement	7	19	12	48	79	32
Medicines Value	80	11	(69)	536	377	(158)
Theatres	50	-	(50)	350	-	(350)
Care Group Schemes*	2,258	187	(2,071)	9,458	1,303	(8,155)
Sub-total	**2,717**	**328**	**(2,389)**	**12,521**	**2,588**	**(9,933)**
Central	(182)	-	182	(682)	-	682
Grand Total	**2,535**	**328**	**(2,207)**	**11,839**	**2,588**	**(9,251)**

* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	**Target**	**Actual**
April	1,419	244
May	1,434	194
June	1,457	589
July	1,635	530
August	1,648	382
September	1,711	320
October	2,535	328
November	2,550	
December	2,568	
January	2,642	
February	2,669	
March	2,705	
	24,973	**2,588**
		10.4%

Savings and Efficiencies

The draft 2020/21 savings plan of £25m is net of the cost of delivery. Savings achieved in October of £0.3m were below the plan of £2.5m. Most areas underperformed in month, due to the ongoing operational focus on Covid-19 and Restore & Recover programme. Recurrent savings in October amounted to £0.25m, with £0.08m being on a non-recurrent basis. The YTD position is recurrent £2.0m and non-recurrent £0.6m. The forecast outturn is currently based on the YTD actual delivery and will be adjusted by the care groups in due course. This shows a substantial decrease against the original plan.



Capital Expenditure
Month 07 (October) 2020/21

Capital Programme	Annual	Year to Date		
£000	Plan	Plan	Actual	Variance
Medical Equipment replacement (MDG)	2,500	1,185	741	444
Backlog maintenance/ patient environment (PEIC)	2,400	1,137	889	248
IT/ Systems replacement (IDG)	1,800	1,158	1,231	(73)
Electronic Medical Record (T3 system)	547	289	91	198
Replacement of Gamma cameras (CT SPECT)	605	605	436	169
Conversion of staff rooms QEQM	100	100	50	50
Installation of MRI QEQM	1,708	360	208	152
Installation of CT K&C	766	318	12	306
RAP area - ED WHH	1,983	1,116	134	982
New IR room K&C	500	83	4	79
Cardiac Catheter lab replacement	2,332	666		666
Radiology equipment (x-ray)	1,904	400		400
Endoscopy decontamination	1,563	400		400
COVID-19 - SEAU/ GAU tfr to OP from ED WHH	1,000	167	813	(646)
COVID-19 - 8 bed ITU WHH Build works	1,481	247	655	(408)
Right-sizing Womens Health (W&C 15)	40			
Right-sizing Gynae nursing (W&C 16)	84			
Costing Server	56			
Donning & Doffing	690	116	517	(401)
Pathology TAT testing	288	48		48
Closed circuit smoke evacuation AIRSEAL	208	35	187	(153)
CEMG small estates schemes agreed at risk	251	3	100	(97)
Nasoendoscopes	329	55		55
ITU Expansion WHH	16,487	470	56	415
Renal Unit MTW - Remedial works	97			
Medical Gases WHH - VIE	50			
Donated assets	1,054	525	319	206
Elective Orthopaedics Centre	9,941	3,093	1,717	1,376
Energy Performance Contract (EPC - Breathe)	3,018	1,277	926	350
NEEF Lighting Retrofit	1,254	727		727
Kent and Medway Care Record (KMCR)	190	162	89	73
UTC's - EKHUFT 'host' of Primary Care	250	42		42
Emergency Department Expansion	7,000	1,167		1,167
Maternity CTG machines - LMS	97		81	(81)
Medical equipment - prior year deferrals/ VAT recl	1,420		397	(397)
Total Trust position	**63,993**	**15,950**	**9,653**	**6,296**
2gether Support Solutions	350		17	(17)
Spencer Private Hospitals	176			
Total Group position	**64,519**	**15,950**	**9,670**	**6,279**

The Group gross capital spend to the end of October 2020 is c.£6.3m below the YTD phased plan. Actual capital spend against planned schemes in April to October amounted to £9.7m. This position excludes all Covid-19 related capital spend.

As required by NHSE/I, the Trust resubmitted its 2020/21 capital plan at the end of May 2020 to meet a reduced CDEL (capital spending limit) issued to the Kent & Medway STP/ ICS. Following discussion and agreement across the STP, the EKHUFT gross capital plan reduced by £6m, mainly through reducing the Energy Performance Contract. A re-profiled plan with Breath Energy on how this will be managed over the life of the contract into 2021/22 has now been agreed. Subsequently, the Trust was required to re-submit its capital plan in July following Critical Infrastructure Risk (CIR) funding of £8.2m being awarded to the Trust by NHSE/I.

Following Trust Board agreement and interim confirmation of additional external funding for A&E expansion (£30m with £7m in 2020/21) and ITU capacity (£14m build only), a further re-prioritisation of the 2020/21 capital programme took place at the end of August 2020. This re-prioritisation accommodates Covid-19 related schemes agreed by the Trust Board to proceed ahead of confirmation of external funding from NHSE/I.

The revised capital plan position incorporates all the confirmed additional funding streams and schemes are reflected in the reporting position for Month 7 (October 2020). The Trust is still awaiting final confirmation for funding of Phase 1 & 2 Covid-19 related capital bids.

Elective Orthopaedics Centre (ELOC) scheme funded through NHSI/E capital loan, this scheme was due to complete at the end of 2020/21. Initial delays due to Covid-19 have mostly been mitigated and the expectation is for the four theatres to open at the K&C in Spring 2021.

Designs, site surveys and enabling works are underway for both the A&E Expansion and 24 Bedded ITU WHH schemes. Full build programme plans are expected to be in place before the end of 2020. These two programmes, along with Critical Infrastructure Risk schemes are being heavily externally scrutinised by NHSE/I in terms of progress and delivery benefits expected.

Standing Committees – The Patient Environment Investment Committee (PEIC), Medical Devices Group (MDG) and Information Development Group (IDG) have a collective underspend of £0.6m at the end of October, with all Committees having recovery plans in place to deliver by the end of the financial year.

Covid-19 related capital spend at the end of October that has not been internally funded stands at £2.5m and assumes full reimbursement from NHSE/I. Reimbursement claims have been submitted to NHSE/I for all retrospective and known prospective capital spend. Feedback has been received and the Trust currently awaits confirmation of funding/ approval. Funding will be via PDC.

Group depreciation	17,061
Donations	1,054
NHSE/I PDC	34,861
SALIX Government loan - EPC	3,018
Other	8,525
Total Group Capital funding	**64,519**

Statement of Financial Position
Month 07 (October) 2020/21

£000	Opening	To Date	Movement	
Non-Current Assets	**349,404**	**351,161**	**1,757**	▲
Current Assets				
Inventories	4,118	3,957	(161)	▼
Trade and Other Receivables	38,525	35,760	(2,765)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	13,893	51,896	38,003	▲
Total Current Assets	**56,536**	**91,613**	**35,077**	▲
Current Liabilities				
Payables	(33,470)	(32,747)	723	▼
Accruals and Deferred Income	(43,220)	(81,558)	(38,338)	▲
Provisions	(1,088)	(1,236)	(147)	▲
Borrowing	(125,325)		125,325	▼
Net Current Assets	**(146,567)**	**(23,928)**	**122,639**	▲
Non Current Liabilities				
Provisions	(3,054)	(2,978)	76	▼
Long Term Debt	(101,349)	(88,472)	12,877	▼
Total Assets Employed	**98,435**	**235,784**	**137,349**	▲
Financed by Taxpayers Equity				
Public Dividend Capital	207,655	345,560	137,905	▲
Retained Earnings	(165,923)	(166,479)	(556)	▼
Revaluation Reserve	56,702	56,702	-	
Total Taxpayers' Equity	**98,435**	**235,784**	**137,349**	▲

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

Trust closing cash balances for October was £51.9m (£61.1m September) £46.9m above plan. See cash report for further details.

Trade and other receivables have decreased from the 2020/21 opening position by £2.8m (£5.6m decrease in September). Invoiced debtors have decreased from the opening position by £13.0m to £10.7m (£11.2m September) at the end of October.

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

Payables have decreased by £0.7m YTD (£1.4m decrease in September).

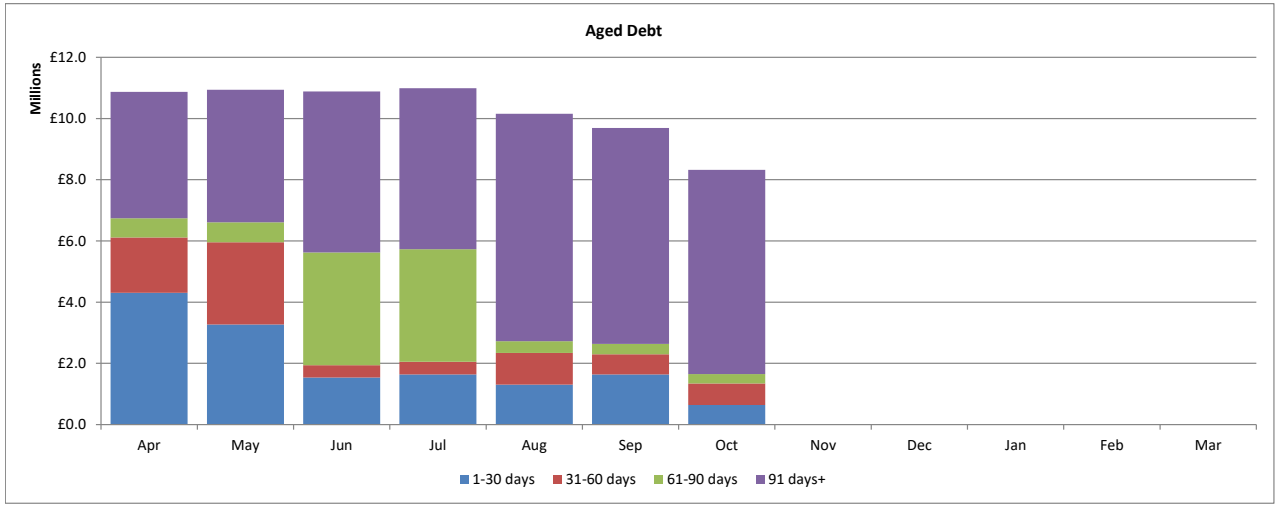
The large increase in deferred income relates to the additional contract payments made in April, paid on account to ensure sufficient cashflow during the first months of the financial year.

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

Working Capital
Month 07 (October) 2020/21

Top ten debtor balances outstanding as at 31/10/2020

Debtor Name	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total
NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)					3,000	3,000
SPENCER PRIVATE HOSPITALS LIMITED	377	266	331	4	124	1,101
HEALTHEX	24		12	12	785	834
MEDWAY NHS FOUNDATION TRUST	16	55	55	53	400	580
NHS KENT AND MEDWAY CCG	397	11	48	2	3	455
HEALTH EDUCATION ENGLAND T1510	305				46	351
DARTFORD AND GRAVESHAM NHS TRUST		128	48	112	36	324
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST					284	284
KINGS COLLEGE HOSPITAL NHS FOUNDATION TRUST	31	8	55	17	141	252
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	46	13	2		173	234
Total	**1,195**	**481**	**552**	**200**	**4,986**	**7,415**



Top ten creditor balances outstanding as at 31/10/2020

Supplier Name	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total
2gether Support Solutions Ltd		14,456			3	14,459
Abbott Medical UK Ltd		916			4	920
Medway NHS Foundation Trust (RPA)	12	33	43	1	692	781
NES Holdings (UK) Ltd	274	264				538
18 Week Support Ltd	472		1	5		478
Maidstone & Tunbridge Wells NHS Trust (RWF)	22	41	32	28	322	445
NHS Professionals Ltd	378					378
Spencer Private Hospitals Ltd		6	104	55	172	338
Beckman Coulter UK Ltd	253					253
NHS Blood & Transplant T1460	218					218
Total	**1,629**	**15,717**	**180**	**89**	**1,193**	**18,808**

Total invoiced debtors have decreased from the opening position of £23.7m by £13.0m to £10.7m (of which £2.3m is current debt) following good work clearing historic debts and improving inter-company processes.

At 31st October there were 2 debtors owing over £1m.

- NHS England South East Commissioning Hub owe £3.0m relating to outstanding issues at 19/20 year end.
- Spencer Private Hospitals owe £1.1m. Of which, £0.6m is less than 30 days old.

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	66,066	445,697	36,862	289,619
Total bills paid within target	43,059	349,877	33,630	257,713
Percentage of bills paid within target	**65.2%**	**78.5%**	**91.2%**	**89.0%**
NHS				
Total bills paid in the year	3,582	39,405	1,767	27,663
Total bills paid within target	1,822	29,348	1,268	23,855
Percentage of bills paid within target	**50.9%**	**74.5%**	**71.8%**	**86.2%**
Total				
Total bills paid in the year	69,648	485,102	38,629	317,282
Total bills paid within target	44,881	379,225	34,898	281,568
Percentage of bills paid within target	**64.4%**	**78.2%**	**90.3%**	**88.7%**

Invoiced creditors have decreased by £1.7m from the opening position to £23.4m.

19% relates to current invoices with 9% or £2.1m over 90 days.

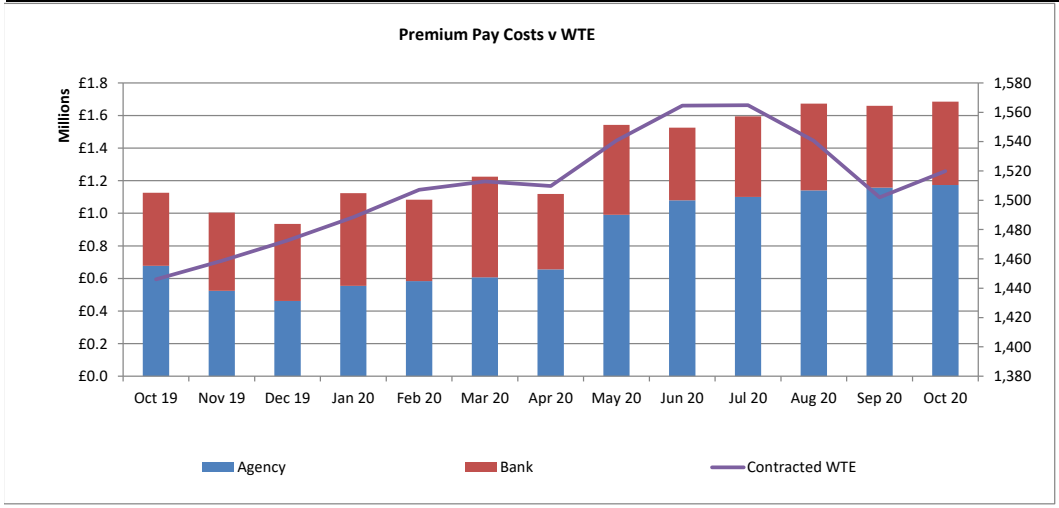
Overdue NHS creditors have decreased by £468k in Month.

- Kent Community Health NHS Foundation Trust (RYY) - £-29k
- Maidstone & Tunbridge Wells NHS Trust (RWF) - £-481k
- Medway NHS Foundation Trust (RPA) - £31k

A. General and Specialist Medicine

Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,272	1,620	348	7,445	8,280	836
Non-Electives	5,351	5,937	586	37,659	40,654	2,995
Accident and Emergency						
Outpatients	2,306	1,607	(698)	14,653	9,170	(5,484)
High Cost Drugs	802	803	1	5,617	5,608	(9)
Private Patients	5	0	(5)	34	4	(30)
Other NHS Clinical Income	2,006	1,778	(228)	13,976	15,722	1,746
Other Clinical Income	16	12	(4)	110	57	(54)
Total Clinical Income	**11,758**	**11,758**	**()**	**79,494**	**79,494**	**()**
Non Clinical Income	43	24	(19)	282	266	(16)
Total Income	**11,801**	**11,782**	**(19)**	**79,776**	**79,759**	**(16)**
Expenditure						
Substantive Staff	(5,951)	(5,700)	251	(41,217)	(40,725)	492
Bank	(618)	(512)	107	(4,606)	(3,503)	1,103
Agency	(833)	(1,174)	(341)	(5,830)	(7,299)	(1,469)
Total Pay	**(7,402)**	**(7,386)**	**16**	**(51,654)**	**(51,527)**	**126**
Purchase of Healthcare	(264)	(355)	(91)	(2,508)	(2,641)	(133)
Supplies and Services Clinical	(581)	(1,136)	(556)	(5,116)	(4,974)	142
Supplies and Services General	(78)	(46)	31	(536)	(466)	70
Drugs	(1,081)	(1,079)	2	(7,192)	(6,944)	248
All Other, incl Transport	(76)	(236)	(160)	(336)	(1,122)	(785)
Total Expenditure	**(9,482)**	**(10,238)**	**(756)**	**(67,342)**	**(67,674)**	**(332)**
Contribution	**2,319**	**1,544**	**(776)**	**12,434**	**12,086**	**(348)**



The Care Group is £0.3m adverse to plan YTD, a deterioration of £0.8m compared to last month. Income is on plan, Expenditure is adverse by £0.3m due to unachieved savings of £1.2m offset by favourable variances on clinical non-pay.

Income:

The cumulative SLA Income "top-up" to reflect lost activity through Covid-19 is £3.8m, a reduction of £0.1m compared to September. Non-elective and elective activity are both above plan year to date. Although Outpatients remain below plan, the phase 3 recovery plans have started to deliver increased elective activity through additional capacity particularly at weekends, and delivered through non-face to face where possible. Endoscopy continues to make progress recovering the backlog.

Pay:

Pay is unchanged at £0.1m favourable YTD. Agency costs are consistent at £1.2m, of which Covid-19 costs are £0.4m. Premium pay costs equate to approximately a third of total pay costs and have been selected as a driver metric through the We Care Programme.

Non-Pay:

Non-Pay deteriorated by £0.8m in month 7 and is £0.5m adverse YTD. Reduced activity in earlier months has driven underspends on drugs/clinical supplies £0.9m YTD. The favourable trend has slowed to the extent that overspends are emerging in specific Specialities where activity recovery is gaining momentum. This underspend is offset by unachieved savings of £1.2m YTD.

Covid-19:

Covid-19 costs of £0.8m have been incurred in Month 7, an increase of £0.1m from September but £0.1m below plan. Sickness cover is starting to increase but remains significantly under the levels experienced during the peak. Funding is added to the Care Group position to cover these costs.

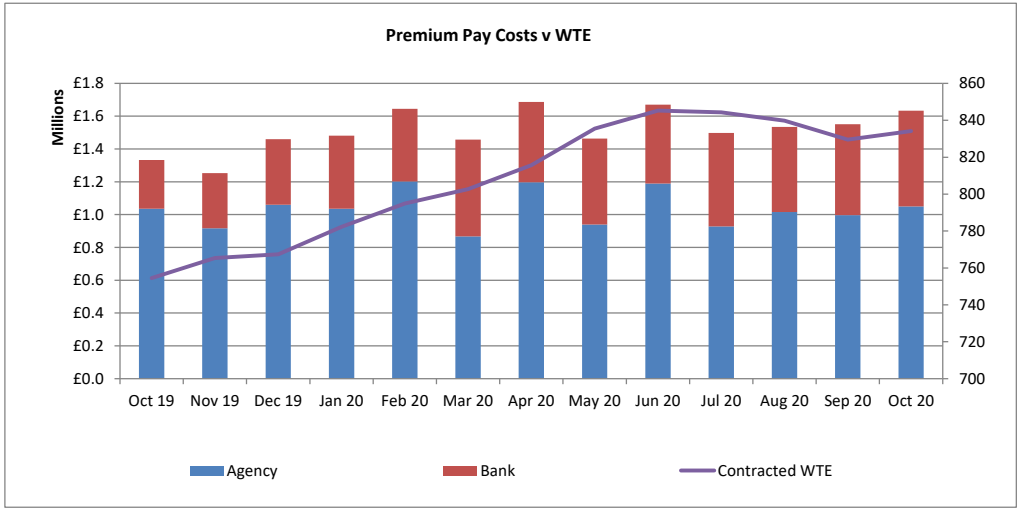
Savings:

Savings of £0.3m have been achieved against a YTD target of £1.5m, the shortfall being reflected within Non-Pay.

Prepared by: Joanne Smith
Reviewed by: Cherrie Knight

A. Urgent and Emergency Care
Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	126	88	(39)	898	468	(430)
Non-Electives	4,266	3,345	(921)	29,473	21,208	(8,265)
Accident and Emergency	3,066	2,856	(210)	21,560	18,264	(3,296)
Outpatients			()	1		(1)
High Cost Drugs	16	1	(15)	114	15	(99)
Private Patients						
Other NHS Clinical Income	0	1,207	1,207	0	12,352	12,352
Other Clinical Income	118	96	(22)	824	562	(262)
Total Clinical Income	**7,592**	**7,592**	**()**	**52,869**	**52,869**	**()**
Non Clinical Income		0	()	2	0	(2)
Total Income	**7,592**	**7,592**	**()**	**52,871**	**52,869**	**(2)**
Expenditure						
Substantive Staff	(3,763)	(3,571)	193	(26,254)	(25,845)	409
Bank	(469)	(583)	(115)	(3,097)	(3,720)	(623)
Agency	(958)	(1,050)	(92)	(6,593)	(7,317)	(724)
Total Pay	**(5,191)**	**(5,205)**	**(14)**	**(35,944)**	**(36,882)**	**(938)**
Purchase of Healthcare	0	(10)	(10)	0	(10)	(10)
Supplies and Services Clinical	(159)	(144)	15	(1,114)	(848)	266
Supplies and Services General	(19)	(25)	(6)	(137)	(131)	6
Drugs	(139)	(125)	14	(1,010)	(854)	155
All Other, incl Transport	(181)	(289)	(109)	(608)	(1,108)	(500)
Total Expenditure	**(5,689)**	**(5,798)**	**(109)**	**(38,813)**	**(39,833)**	**(1,021)**
Contribution	**1,903**	**1,794**	**(110)**	**14,058**	**13,036**	**(1,022)**



The Care Group's position deteriorated by £0.1m in October and is £1.0m adverse to the year to date (YTD) plan. The increase in the deficit in month is primarily driven by savings shortfalls.

Income:

Clinical income has been adjusted to breakeven by £1.2m for the impact of Covid-19 and £12.4m YTD. Attendances were 5% below plan in October, compared to 8% below last month. Activity has been steadily increasing since April but remains below pre Covid-19 levels.

Pay:

Pay was practically breakeven in month and is £0.9m adverse YTD, with unmet CIP targets being the primary factor. The improvement compared to previous months has been driven by a reduction in locum and overtime costs. Budgets have been increased for the remainder of the year according to average monthly Covid-19 claims during months 1-6 and this funding is now fixed. Covid-19 claims in October were actually £0.1m below average, although additional pressures are evident in nursing expenditure as ancillary areas are safely staffed due to service reconfigurations.

Non-Pay:

Non-pay was adverse by £0.1m in month and YTD. The main pressure on the budget is also the shortfall in CIP schemes, totalling £0.1m per month. This has been offset by lower expenditure as a consequence of reduced activity levels in previous months. However, as activity has risen, the savings shortfall is no longer fully offset. Additional porterage costs also continue to put pressure on the non-pay budget.

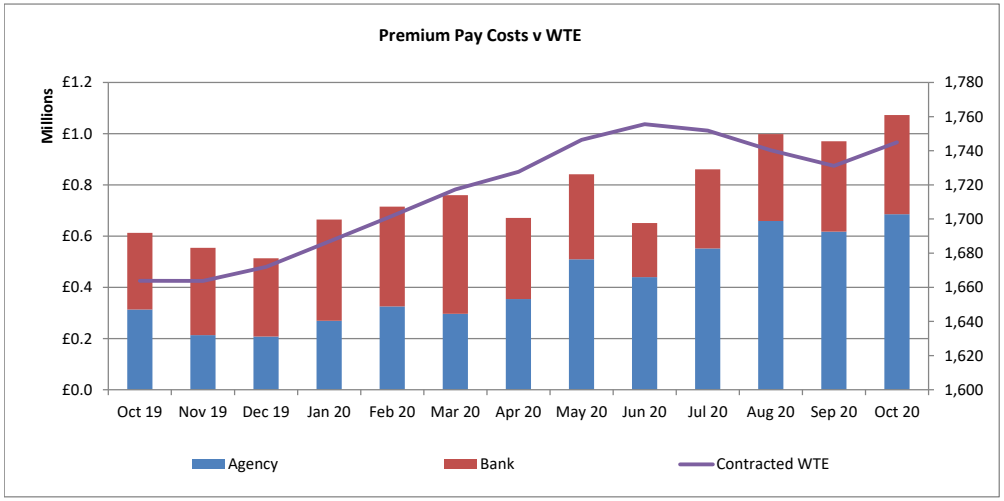
CIPs:

The annual CIP target for the Care Group is £2.5m. A relatively small value of non-recurrent pay savings was recognised due to vacancies, but schemes continued to perform considerably below plan in October. YTD performance is £1.1m adverse to plan.

Prepared by: Stephen Lazell
Reviewed by: Louise Hughes/Matt Pomeroy

A. Surgery and Anaesthetics
Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	3,888	3,381	(507)	26,818	12,113	(14,704)
Non-Electives	3,367	3,166	(202)	23,767	19,562	(4,206)
Accident and Emergency						
Outpatients	1,445	925	(521)	9,524	4,849	(4,675)
High Cost Drugs	32	32	()	222	172	(51)
Private Patients	11	38	27	77	40	(38)
Other NHS Clinical Income	1,499	2,721	1,221	11,297	35,063	23,766
Other Clinical Income	22	3	(19)	153	59	(93)
Total Clinical Income	**10,265**	**10,265**	**()**	**71,858**	**71,858**	**()**
Non Clinical Income	125	93	(31)	872	442	(429)
Total Income	**10,389**	**10,358**	**(31)**	**72,729**	**72,300**	**(429)**
Expenditure						
Substantive Staff	(7,476)	(7,434)	42	(52,170)	(52,646)	(476)
Bank	(300)	(387)	(87)	(2,254)	(2,249)	5
Agency	(437)	(686)	(249)	(2,927)	(3,817)	(889)
Total Pay	**(8,213)**	**(8,507)**	**(293)**	**(57,351)**	**(58,712)**	**(1,361)**
Purchase of Healthcare	(2)	()	2	(13)	(1)	12
Supplies and Services Clinical	(1,583)	(1,476)	107	(11,136)	(6,457)	4,679
Supplies and Services General	(40)	(24)	16	(366)	(134)	232
Drugs	(348)	(317)	31	(2,481)	(1,926)	555
All Other, incl Transport	302	(175)	(478)	1,275	(688)	(1,963)
Total Expenditure	**(9,884)**	**(10,500)**	**(616)**	**(70,071)**	**(67,917)**	**2,154**
Contribution	**505**	**(142)**	**(647)**	**2,658**	**4,383**	**1,725**



The Care Group is £1.7m favourable to plan YTD, a deterioration in month of £0.6m. This is mainly due to expenditure increases in line with budgets as activity increases, but the CIP target of £0.6m being unmet. Income is adverse by £0.4m from a reduction in Non-Clinical Income recharges, whilst Expenditure is favourable by £2.1m primarily from clinical supplies & drugs underspends.

Income:

SLA Income has been adjusted year to date to break-even by £23.9m, for the impact of Covid-19. The impact on activity has been considerably adverse, across all specialties and points of delivery. However, as activity has picked up this adjustment has reduced month on month from a high of £5.7m down to £1.3m for the latest month.

Restore & Recovery plans are being updated to safely increase Elective surgery with additional planned lists and Outpatient contacts via telephone and virtual clinics where possible. However, it will be some time before activity and income will be back to the original planned levels.

Non-Clinical Income is adverse £0.4m, with a reduction in services provided to other NHS organisations and Spencer Hospital due to Covid-19 measures.

Pay:

Pay is adverse £1.4m YTD, with unmet CIP targets across substantive and agency staff. Medical & Nursing agency costs have risen to support Covid-19 pressures, sickness and vacancies.

Non-Pay:

Non-Pay is favourable £3.5m YTD, with underspends on clinical supplies £4.7m and Drugs £0.6m from reduced patient activity. Non-pay CIPs are under performed by £2.3m.

Covid-19 additional costs of £3.7m have been funded in the above and relate to temporary staffing £3.5m and Non-Pay £0.2m, both of which mainly relate to costs incurred supporting Critical Care services.

CIP:

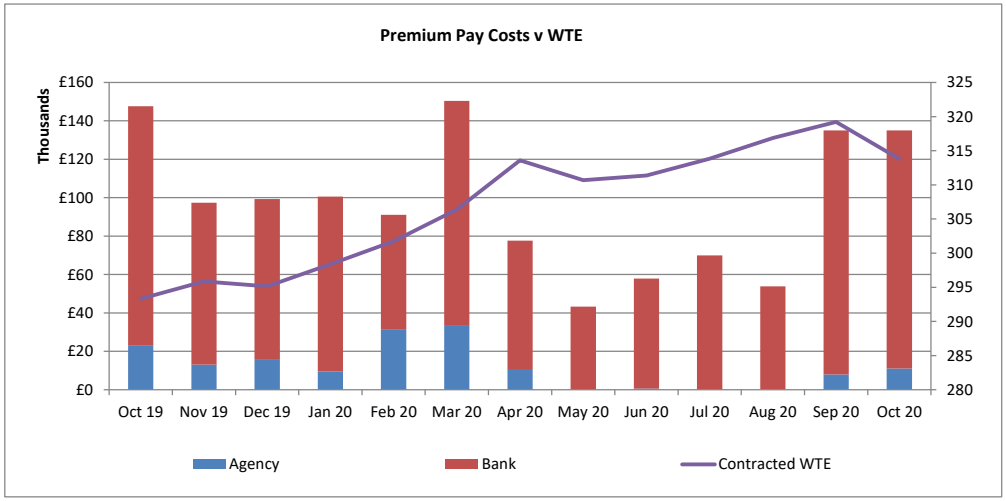
CIPs target of £3.3m YTD has been under achieved by £3.2m, of which £0.4m Income, £0.6m Pay and £2.3m Non-Pay are currently offset within the underspends.

Prepared by: James Isard
Reviewed by: Tori Harrison

A. Surgery - Head and neck, Breast Surgery and Dermatology

Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,382	1,237	(145)	8,873	4,903	(3,971)
Non-Electives	155	142	(13)	1,162	700	(461)
Accident and Emergency						
Outpatients	2,092	1,493	(599)	13,042	6,757	(6,285)
High Cost Drugs	327	193	(135)	2,290	1,379	(911)
Private Patients	4	0	(4)	31	3	(29)
Other NHS Clinical Income	74	964	891	735	12,387	11,651
Other Clinical Income		6	5	2	7	5
Total Clinical Income	**4,034**	**4,034**	**()**	**26,135**	**26,135**	
Non Clinical Income	10	6	(5)	73	41	(32)
Total Income	**4,045**	**4,040**	**(5)**	**26,208**	**26,176**	**(32)**
Expenditure						
Substantive Staff	(1,481)	(1,560)	(79)	(10,435)	(10,235)	201
Bank	(73)	(124)	(51)	(474)	(542)	(68)
Agency	(13)	(11)	2	(92)	(31)	61
Total Pay	**(1,568)**	**(1,696)**	**(128)**	**(11,001)**	**(10,807)**	**193**
Purchase of Healthcare	(149)	(58)	91	(1,043)	(351)	692
Supplies and Services Clinical	(89)	(70)	20	(626)	(391)	235
Supplies and Services General	(1)	()	1	(9)	(6)	3
Drugs	(286)	(332)	(46)	(2,068)	(2,016)	52
All Other, incl Transport	(10)	(31)	(21)	(124)	(197)	(72)
Total Expenditure	**(2,103)**	**(2,187)**	**(83)**	**(14,872)**	**(13,769)**	**1,103**
Contribution	**1,941**	**1,853**	**(88)**	**11,336**	**12,407**	**1,071**



The Care Group is £1.1m favourable to plan YTD, a slight reduction in month of £88k. Whilst Income is breakeven, Expenditure is favourable with underspends across both Pay and Non-Pay.

Income:

SLA Income has been adjusted year to date to break-even by £11.8m, for the impact of Covid-19. The impact on activity has been considerably adverse, across all specialties and points of delivery. However, as activity has picked up this adjustment has reduced month on month from a high of £2.5m down to £1.0m for the latest month.

Restore & Recovery plans are continually being updated to safely increase Elective surgery with additional planned lists and Outpatient contacts via telephone and virtual clinics where possible. However, it will be some time before activity and income will be back to the original planned levels, especially with reduced theatre capacity below pre Covid-19 levels. Access to additional theatre lists is a risk, with theatres still unable to run regular weekend lists. In November no Buckland Hospital lists will run as theatres are unable to provide support.

Pay:

Pay is favourable £0.2m YTD, with a significant reduction in medical waiting list payments as the additional lists & clinics had stopped under the Covid-19, although these have now restarted under the Restore & Recovery phase. Also, a number of vacancies were not requiring temporary staffing cover at the time.

Non-Pay:

Non-Pay is favourable £0.9m YTD, with underspends on clinical supplies £0.2m and drugs £0.1m from reduced patient activity, as well as the cessation of the external ophthalmology healthcare provider £0.7m.

Covid-19 additional costs of £72k have been funded in the above and relate to temporary staffing (£63k) and computer hardware (£9k).

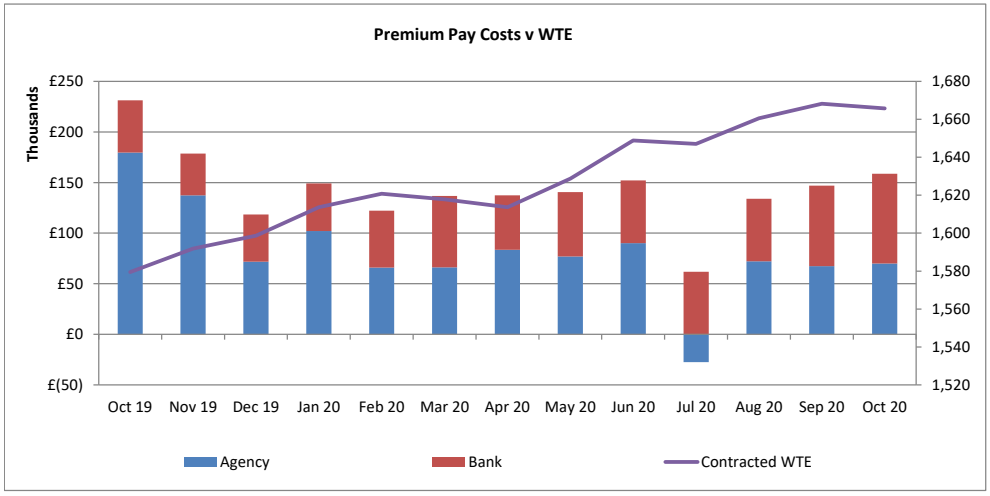
CIP:

CIPs target of £0.6m YTD has been under achieved by £0.2m, of which £0.1m Pay and £0.1m Non-Pay are currently offset within the underspends.

Prepared by: James Isard
Reviewed by: Sarah Hyett

A. Clinical Support
Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	80	81		562	345	(217)
Non-Electives	12	0	(12)	68	0	(68)
Accident and Emergency						
Outpatients	347	138	(209)	2,126	651	(1,475)
High Cost Drugs	1,297	1,228	(68)	9,076	9,642	566
Private Patients	7	0	(7)	50	8	(42)
Other NHS Clinical Income	3,504	3,800	296	23,281	24,518	1,237
Other Clinical Income		0	()		0	()
Total Clinical Income	**5,247**	**5,247**	**()**	**35,163**	**35,163**	
Non Clinical Income	675	820	144	4,614	4,628	14
Total Income	**5,922**	**6,066**	**144**	**39,777**	**39,792**	**14**
Expenditure						
Substantive Staff	(5,561)	(5,722)	(161)	(38,081)	(39,464)	(1,383)
Bank	(63)	(89)	(26)	(460)	(471)	(11)
Agency	(136)	(70)	66	(998)	(433)	565
Total Pay	**(5,760)**	**(5,881)**	**(121)**	**(39,539)**	**(40,368)**	**(829)**
Purchase of Healthcare	(5)	0	5	(33)	(23)	10
Supplies and Services Clinical	(2,209)	(2,217)	(8)	(16,842)	(15,507)	1,335
Supplies and Services General	(19)	(19)	()	(130)	(129)	1
Drugs	(1,377)	(1,529)	(152)	(10,633)	(10,741)	(107)
All Other, incl Transport	(264)	(324)	(60)	(622)	(1,864)	(1,243)
Total Expenditure	**(9,634)**	**(9,969)**	**(336)**	**(67,798)**	**(68,631)**	**(833)**
Contribution	**(3,711)**	**(3,903)**	**(192)**	**(28,021)**	**(28,840)**	**(819)**



The Clinical Support position worsened in October, predominantly due to a widening CIP gap as in previous months by £0.2m.

Income:

Non-Trust activity across all departments was under plan in October. Radiology and Pathology activity levels were on par with September, whilst Audiology and Therapies increased but were still below plan. Rechargeable Homecare drugs spend was above plan in October but reduced in comparison to last month. The Adjustment to balance the clinical income was £1m in October compared to £0.7m in September. The total adjustment to date is now £8.8m. Non-clinical income was above plan in month mainly due to Pharmacy income streams e.g. MPET and Spencer Wing.

Pay:

The increasing pay run-rate trend continued (excluding last month's medical pay award) and was overspent in October. Radiology, Therapies and Outpatients all overspent against budget and in particular medical staff expenditure was overspent in Radiology. These overspends are driven by increased WTE in all departments with lower vacancy rates than last year as well as recovery projects beginning to be implemented to deliver improvements in waiting lists. Radiology now has the highest pay overspend (£0.3m) followed by Therapies and then Outpatients. There is also an unmet pay CIP target of £0.4m in the position (YTD).

Non-Pay:

There was an increase in the non-pay run rate this month reflecting the positive impact of adjustments last month. There was increased expenditure on outsourced MRI scanning, CT reporting and Isotopes in line with increased backlog activity. Within Pathology there are increased Covid-19 testing costs (estimated in October), however other laboratory consumables are still underspending. Unmet CIP accounts for £0.3m in month and £2.1m year to date in Non-pay.

CIP:

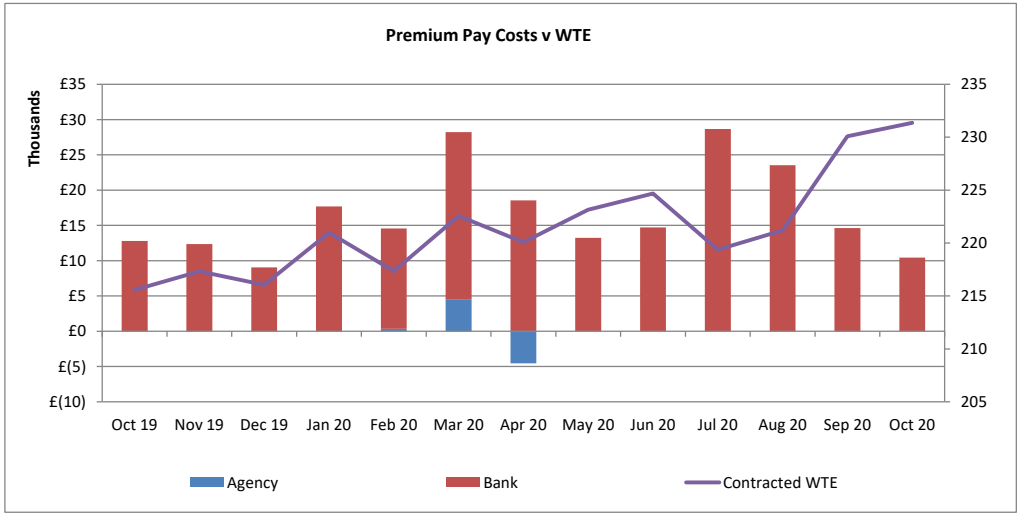
Total unmet CIP in the CSS Care Group now stands at £2.6m

Covid-19: Total Covid-19 cost increased in October by £0.9m due to an adjustment for Covid-19 testing. The total cost and income impact in CSS is now total £4.1m

Prepared by: Vivienne Bertram
Reviewed by: Chris Hudson

A. Cancer Services
Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	427	421	(7)	2,630	2,599	(30)
Non-Electives	24	8	(16)	158	60	(98)
Accident and Emergency						
Outpatients	787	732	(55)	5,102	4,980	(122)
High Cost Drugs	2,043	2,056	13	14,303	13,639	(664)
Private Patients						
Other NHS Clinical Income	886	870	(15)	5,609	6,443	834
Other Clinical Income	1	80	80	4	84	81
Total Clinical Income	**4,167**	**4,167**	**()**	**27,806**	**27,806**	**()**
Non Clinical Income	110	105	(5)	601	636	35
Total Income	**4,277**	**4,272**	**(5)**	**28,407**	**28,442**	**35**
Expenditure						
Substantive Staff	(1,045)	(851)	194	(5,696)	(5,784)	(87)
Bank	(14)	(10)	3	(102)	(124)	(22)
Agency	()	0		(3)	5	7
Total Pay	**(1,059)**	**(861)**	**198**	**(5,801)**	**(5,903)**	**(102)**
Purchase of Healthcare	()	(1)	()	(2)	(3)	()
Supplies and Services Clinical	(215)	(199)	16	(1,503)	(1,369)	134
Supplies and Services General	(8)	(7)	1	(54)	(50)	4
Drugs	(2,079)	(2,076)	3	(14,053)	(13,848)	205
All Other, incl Transport	(48)	(132)	(84)	(164)	(484)	(320)
Total Expenditure	**(3,410)**	**(3,275)**	**134**	**(21,578)**	**(21,656)**	**(79)**
Contribution	**867**	**997**	**129**	**6,829**	**6,786**	**(43)**



Income:

There was an under-performance against the CCHH income plan this month, driven mainly by High & Low-cost drugs in Haematology, along with variances in Clinical Haematology and Clinical Oncology offsetting previous overachievement.

Pay:

Pay cost in the Care Group remained in line with September, but Cancer Alliance funding in month has improved the variance by £231k. Management and Medical Staffing budgets are overspent YTD, but in month all staff costs are under plan. Unmet Pay CIP now total £(0.2m), with underspends in all other staff types, and particularly nursing staff reducing the overall deficit.

Non-pay:

Unmet CIP continues to be the main factor in the adverse non-pay variance (£0.25m). This is offset by underspends on drugs and clinical supplies (£0.15m). One off spends have cause the adverse in month position, with Covid-19 relate building costs, recruitment fee for Speciality doctor and GMT Intake charges for 20/21 being the most significant.

CIP:

Total Unmet CIP is now £0.43m.

Covid-19:

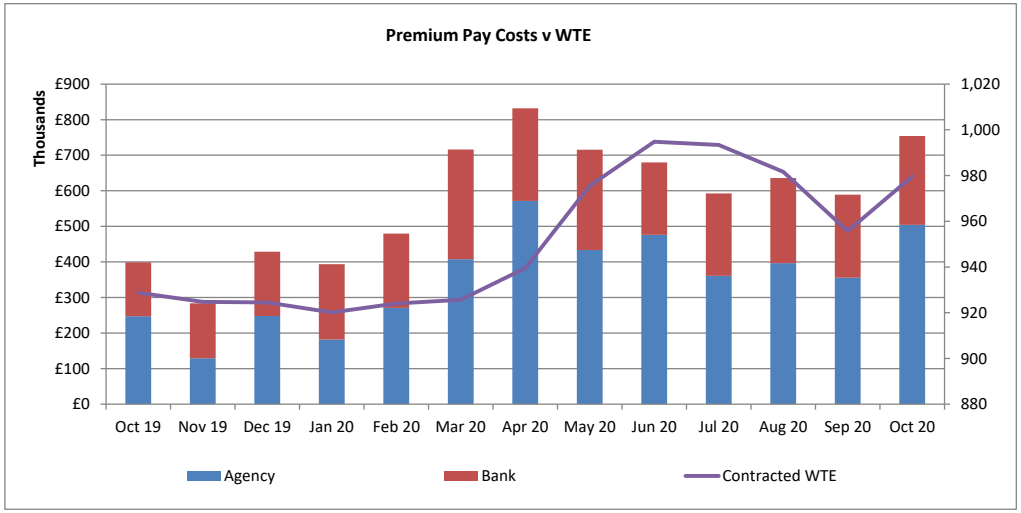
Total Covid-19 costs claimed is now £0.13m.

Prepared by: Vivienne Bertram
Reviewed by: Sarah Collins

A. Women's and Children's Services

Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	673	507	(165)	4,553	1,882	(2,671)
Non-Electives	2,438	2,451	13	17,056	15,640	(1,417)
Accident and Emergency						
Outpatients	818	678	(139)	5,225	3,530	(1,695)
High Cost Drugs	18	33	14	127	110	(17)
Private Patients		0	()	1	1	()
Other NHS Clinical Income	2,698	2,979	281	18,964	24,766	5,803
Other Clinical Income	9	6	(3)	66	63	(3)
Total Clinical Income	**6,654**	**6,654**		**45,992**	**45,992**	**()**
Non Clinical Income	90	93	3	635	645	10
Total Income	**6,744**	**6,747**	**3**	**46,627**	**46,637**	**10**
Expenditure						
Substantive Staff	(4,951)	(4,342)	609	(31,938)	(29,665)	2,274
Bank	(217)	(250)	(33)	(1,668)	(1,700)	(33)
Agency	(278)	(504)	(226)	(1,567)	(3,098)	(1,530)
Total Pay	**(5,446)**	**(5,096)**	**350**	**(35,174)**	**(34,463)**	**711**
Purchase of Healthcare	(2)	(2)	()	(13)	(28)	(15)
Supplies and Services Clinical	(250)	(266)	(17)	(1,786)	(1,459)	327
Supplies and Services General	(11)	(6)	6	(83)	(33)	49
Drugs	(174)	(171)	2	(1,103)	(1,093)	10
All Other, incl Transport	75	(114)	(189)	519	(566)	(1,085)
Total Expenditure	**(5,808)**	**(5,656)**	**152**	**(37,639)**	**(37,642)**	**(3)**
Contribution	**936**	**1,091**	**156**	**8,988**	**8,994**	**6**



The Care Group's position improved by £0.2m in October and is now breakeven to the year to date (YTD) plan. The improvement is primarily driven by funding being added to the budget following final approval of several business cases.

Income:

Clinical income has been adjusted to breakeven by £0.2m for the impact of Covid-19 and £6.0m YTD. 'Restore and Recovery' plans continue to lead to a notable increase in day case, elective and outpatient activity. Consequently, the value of the Covid-19 adjustment has continued to reduce significantly from previous months.

Pay:

Pay is £0.4m favourable in month and is £0.7m favourable YTD. Budgets have been increased for the remainder of the year according to average monthly Covid-19 claims during months 1-6 and this funding is now fixed. Covid-19 claims in October were actually £0.1m below average because of a reduction in the use of fixed term contract staff.

The overall pay run rate in October was £0.2m higher than average due to recruitment associated with business case investments and an increase in temporary staffing costs. Medical paediatric agency has particularly increased and requires further, more detailed, investigation.

Several business cases for staffing investment were approved during October. Consequently £0.4m of funding was added to the budget retrospectively for posts already recruited at risk.

Non-Pay:

Non-pay is adverse to plan by £0.2m in month and £0.7m YTD. The main pressure on the budget is the gap in CIP schemes, also totalling £0.2m per month- including a shortfall in the CNST rebate. This has been partially offset by clinical supply underspends resulting from reduced activity levels. However, as activity levels have increased, so too has non-pay expenditure, putting added pressure on the budget.

CIPs:

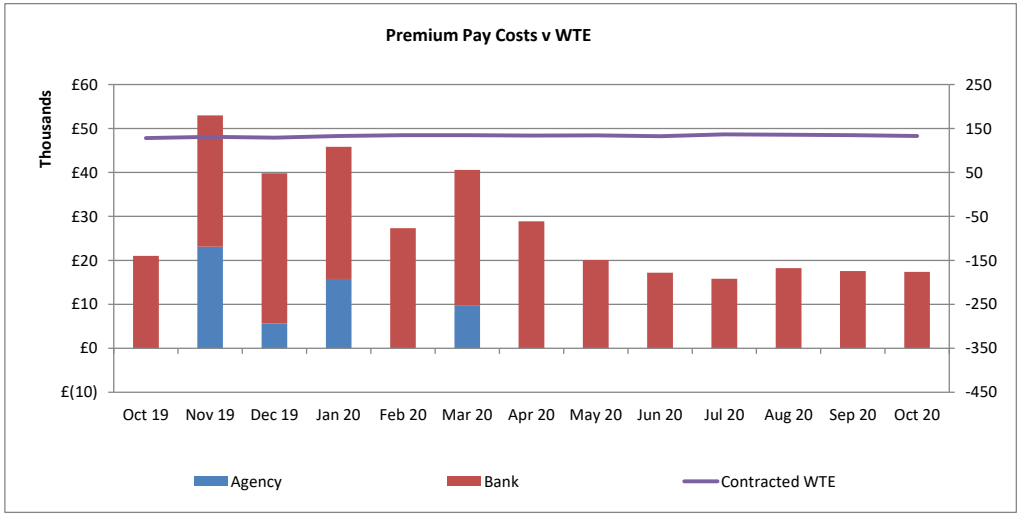
The annual CIP target for the Care Group is £3.0m. A relatively small value of non-recurrent pay savings was recognised due to vacancies, but schemes continued to perform considerably below plan in October. YTD performance is £0.9m adverse to plan.

Prepared by: Stephen Lazell
Reviewed by: Karen Costelloe

A. Strategic Development and Capital Planning

Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	16	20	4	111	117	6
Car Parking	38	86	48	269	368	100
Staff Accommodation	196	184	(13)	1,383	1,403	20
All Other Income	231	247	16	1,272	1,281	9
Total Income	**481**	**537**	**56**	**3,034**	**3,170**	**135**
Expenditure						
Substantive Staff	(540)	(512)	28	(3,778)	(3,591)	187
Bank	(32)	(17)	15	(225)	(135)	89
Agency	0	0	0	0	0	0
Total Pay	**(573)**	**(529)**	**43**	**(4,002)**	**(3,726)**	**276**
Supplies and Services General	(4,121)	(4,123)	(2)	(28,680)	(28,633)	46
Establishment	(133)	(102)	31	(926)	(857)	68
Premises and Rates	(249)	(246)	3	(1,742)	(1,739)	3
Premises Other	(718)	(818)	(100)	(5,140)	(5,420)	(280)
Transport	(23)	(10)	12	(158)	(78)	80
Education and Training	(7)	(28)	(21)	(48)	(51)	(3)
All Other	(1)	18	19	(96)	43	139
Total Expenditure	**(5,824)**	**(5,838)**	**(14)**	**(40,791)**	**(40,462)**	**330**
Contribution	**(5,343)**	**(5,301)**	**42**	**(37,757)**	**(37,292)**	**465**



Strategic Development and Capital Planning is favourable to budget by £465k as at the end of October, with a favourable swing in month of £42k.

Income:

Income is favourable £56k in month and £135k YTD. Car parking is £48k favourable in month and £100k favourable YTD, budget to be rebased to last years out turn. Accommodation is adverse £13k in month but favourable £20k YTD.

Pay:

Pay is favourable £43k in month and £276k favourable YTD. Facilities favourable £15k favourable in month and £92k favourable YTD which is attributable to inter site transfers (Oakleaf) service specification being reviewed. Strategic Development £22k favourable in month and £131k YTD due to vacant posts which are out to recruit/have been recruited into and awaiting to start. This has been reconciled and agreed with the department. IT £6k favourable in month and £54k favourable YTD.

Non-Pay:

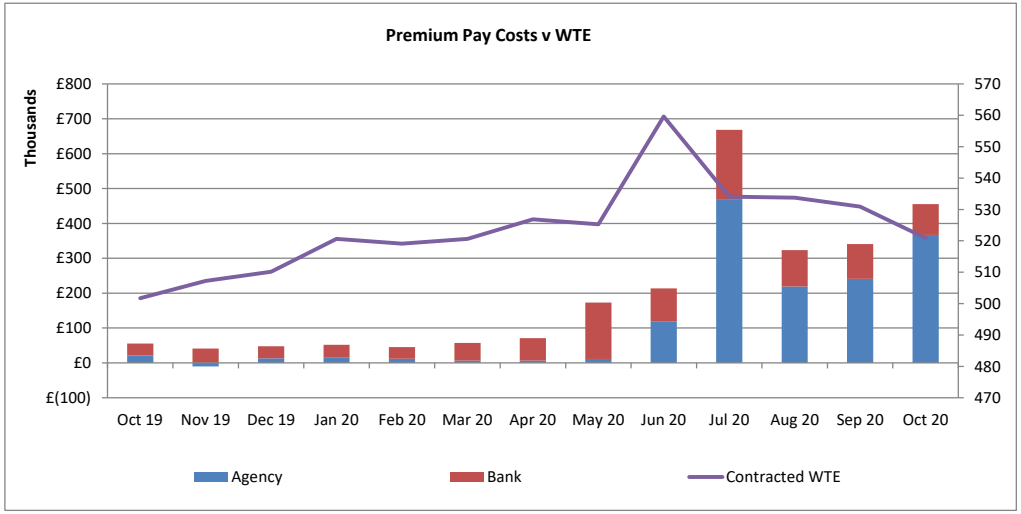
Non-Pay is adverse £57k in month but £54k favourable YTD. The adverse position in month is due to utilities £66k (KCH £28k, WHH £12k and QEQM £27k). These are partly offset by a small underspend within IT.

The YTD position is due to favourable variances within IT £57k, £184k within Strategic Estates (other fuels prev carbon tax) and Patient Transport in Facilities, these however are offset by an adverse YTD variance of £220k within utilities. Utility budgets are currently being reconciled in totality with the carbon tax funding stream and also with the OHF contract to improve the subjectivity. Activity & price are also being reviewed.

A. Corporate

Month 07 (October) 2020/21

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	(91)	12	103	142	113	(29)
Research and Innovation	170	165	(4)	1,462	1,443	(19)
Education and Training Income	1,121	1,125	4	8,460	8,592	132
All Other Income	67	57	(10)	(38)	(178)	(140)
Total Income	**1,267**	**1,359**	**92**	**10,026**	**9,970**	**(56)**
Expenditure						
Substantive Staff	(2,240)	(2,304)	(64)	(16,998)	(16,899)	99
Bank	(17)	(88)	(71)	(471)	(812)	(341)
Agency	(365)	(367)	(2)	(1,410)	(1,432)	(22)
Total Pay	**(2,622)**	**(2,759)**	**(137)**	**(18,878)**	**(19,144)**	**(265)**
Supplies and Services General	(186)	(180)	6	(2,980)	(2,985)	(5)
Establishment	(54)	(80)	(25)	(432)	(418)	14
Premises Other	(151)	(216)	(65)	(3,375)	(3,529)	(154)
Transport	(41)	(28)	14	(387)	(242)	145
Clinical Negligence	(2,030)	(2,030)		(14,211)	(14,211)	
Education and Training	(119)	(118)	1	(697)	(691)	6
All Other	(1,079)	(596)	483	(9,375)	(8,764)	611
Total Expenditure	**(6,282)**	**(6,006)**	**276**	**(50,334)**	**(49,983)**	**351**
Contribution	**(5,015)**	**(4,647)**	**368**	**(40,309)**	**(40,013)**	**296**



The Corporate position is favourable to budget by £296k YTD and is made up as follows: Clinical Quality & Patient Safety (CQ&PS) adverse £81k, HR adverse £320k, Finance favourable £23k, Operations favourable £512k, Trust Board favourable £92k, PGME and R&I favourable £69k.

Income:

Income is favourable £92k in month but adverse £56k YTD.

The position in month is due to £56k of Covid-19 funding within Operations, this is due to VAT adjustment on retail income, the funding allocated needs to be reviewed, as at month 7 this offsets under-achievement of £26k in Occupational Health, which is mostly due to the loss of KMPT contract and £8k of EKBI royalty reduction within Finance. Work is on-going with Occupational Health to ascertain what expenditure budgets can be given up to offset the loss of KMPT contract. The position YTD is also due to under-achievements in Occupational Health £201k YTD and EKBI £113k. These are partly offset by the Education & Training and Covid-19 income.

Pay:

Pay is adverse £137k in month and adverse £265k YTD. The position in month is due to overspends on Covid-19 £51k, this means adverse against the allocation for month 7 -12 due to revised plan, CQ&PS management £20k due to bank costs of the Associate Head of Nursing/Governance (left at the end of October) and the rest is mainly attributable to savings targets.

The corporate areas have a vacancy rate of 8% comparing contracted to budgeted WTE. The majority of the favourable benefit from these are being offset by the pay savings targets, pay savings year to date position adverse £571k YTD.

Non-Pay:

Non-Pay is favourable £412k in month and £617k favourable YTD.

CQ&PS adverse £64k in month and favourable £10k YTD. Adverse position in month due to overspend on legal costs £39k, ongoing monitoring in conjunction with Legal Team.

HR adverse £77k in month and £70k YTD. The position in month is due to £10k retainer fee and removal expenses £17k. Overseas nurses is adverse, annual plan of £250k is now exhausted and exp YTD £282k, revised plan needed.

Finance favourable £35k in month and £179k YTD. Favourable YTD position is due to underspends on internal audit £62k, contracted out £39k and computer software £47k.

Operations favourable £561k in month and £530k YTD due to Covid-19 underspends which are being investigated to ensure that the correct amount funding has been allocated.

Overall, Covid-19 underspend within non-pay was £522k in Month 7.

B. Spencer Private Hospitals
Month 07 (October) 2020/21

Summary Profit & Loss October 2020 and Outturn Forecast

£'000s	Month			YTD			Full Year 2020-21		
	Actual	Budget	Variance	Actual	Budget	Variance	Outturn	Budget	Variance
Income	1,263	1,193	70	7,562	7,987	(425)	13,503	13,718	(215)
Pay	(574)	(666)	92	(3,349)	(4,657)	1,308	(6,339)	(7,955)	1,616
Non Pay	(430)	(312)	(119)	(2,375)	(2,179)	(195)	(4,241)	(3,737)	(504)
Other Costs	(195)	(132)	(63)	(1,505)	(939)	(565)	(2,687)	(1,604)	(1,083)
Operating Profit	64	83	(20)	334	212	121	237	422	(185)
OP %	*5.0%*	*7.0%*	*-28.1%*	*4.4%*	*2.7%*	*-28.6%*	*1.8%*	*3.1%*	*86.4%*
Interest Receivable Interest Expense	(3)	(4)	1	(23)	(29)	6	(40)	(50)	10
Net Profit before Tax	60	79	(19)	310	183	127	197	372	(177)
NPBT %	*4.8%*	*6.6%*	*-26.5%*	*4.1%*	*2.3%*	*-29.9%*	*1.5%*	*2.7%*	*82.3%*
Tax	(19)	(18)	(1)	(98)	(52)	(46)	82	(101)	183
Net Profit after Tax	41	61	(20)	212	131	82	279	271	6
NPAT %	*3.3%*	*5.2%*	*-28.1%*	*2.8%*	*1.6%*	*-19.3%*	*2.1%*	*2.0%*	*-2.7%*

Salient comments on month / YTD results:

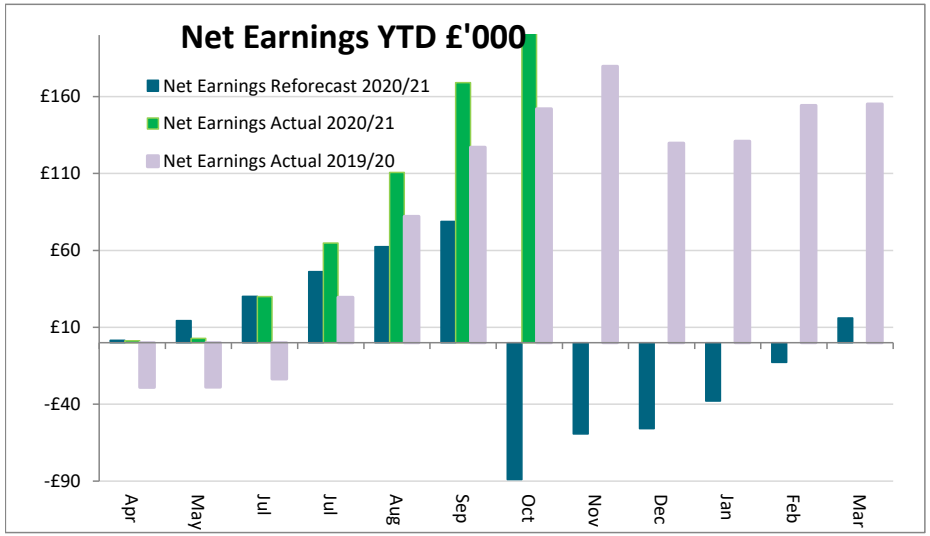
Spencer remained under the NHSE Covid-19 response contract throughout October.

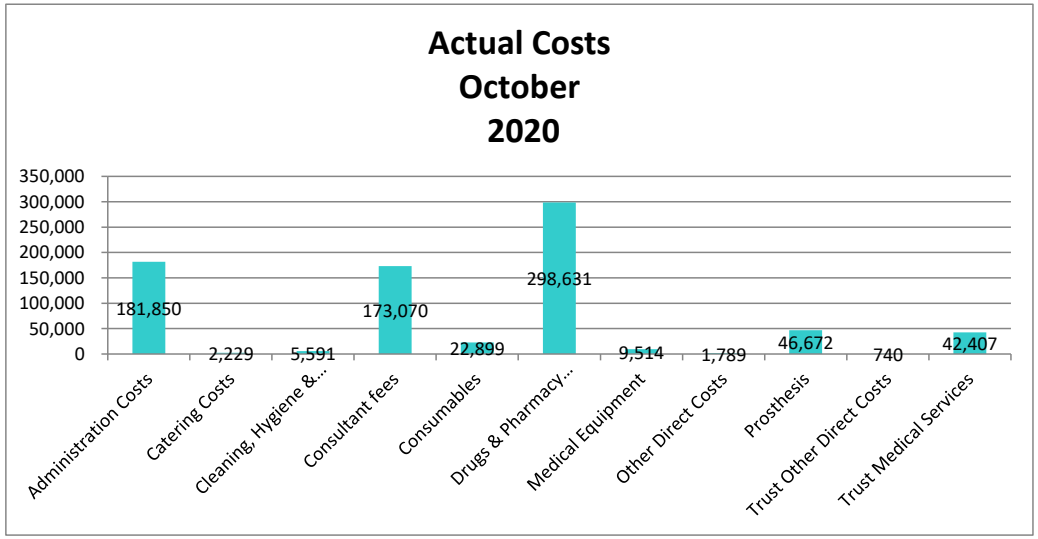
Weekend theatre access was available & utilised throughout October. As a consequence, private income of £117K were achieved for the month.

Unbudgeted costs of £293k relating to high cost drugs for CCG eye patients are included in October Non-Pay actuals. The unbudgeted high cost drug costs are offset by corresponding unbudgeted income.

Excluding these high cost drugs, other Non-Pay costs are £1.5m below budget YTD due to elective care activity significantly below budgeted activity levels.

Net earnings of £212K YTD against a budgeted profit of £131K. The surplus is attributable to the resumption of private inpatient activity since theatres reopened in August.





Summary Profit & Loss October 2020

£'000s	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Income	9,472	8,217	1,255	63,167	58,971	4,196
Costs	(9,228)	(8,090)	(1,139)	(62,356)	(58,272)	(4,084)
Operating Profit/(Loss)	244	128	116	811	698	113
OP %	(0)	(0)	(0)	*1.3%*	*1.2%*	*0.1%*
Interest Receivable	252	252	(0)	1,798	1,798	(0)
Interest Expense	(192)	(192)	1	(1,351)	(1,341)	(9)
Net Profit/(Loss) before Tax	304	188	116	1,259	1,155	103
NPBT %	*3.2%*	*2.3%*	*0.9%*	*2.0%*	*2.0%*	*0.0%*
Tax	(103)	(106)	4	(589)	(564)	(25)
Net Profit/(Loss) after Tax	202	82	120	669	591	78
NPAT %	*2.1%*	*1.0%*	*1.1%*	*1.1%*	*1.0%*	*0.1%*

Salient comments on month / YTD results:

- YTD the overall financial plan is slightly better than plan. Income and Costs variance primarily driven by COVID-19 recharges and a smaller element of Consumable Recharges ordered by EKHUFT.
- October performance was slightly better than expectations, primarily due to some vacancies, along with timing of spend in non-pay lines which are likely to catch up by year end.
- Controllable spend areas have been actively managed and will continue to be.

Actions for this quarter:

- Finalise new cleaning standards modelling costs & agree new CCN to cover, this is anticipated to be a material figure (£2M plus)
- Support the Trust with the expanded capital plan

D. Cash Flow

Month 07 (October) 2020/21

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast
13,893	**Opening Cash Balance**	2,997	61,060	58,063	13,893	62,893	57,842	60,246	54,984	56,745	61,060	51,896	70,965	66,557	67,997	9,380
	Prior Year Main Contract CCGs															
321,895	Kent & Medway CCG Contract	39,616	40,237	621	80,473	40,237	40,237	40,237	40,238	40,237	40,237	71,706	40,237	40,237		40,237
1,557	Prior Year Main Contract CCGs		72	72		(482)	1,297	(1)	657	14	72		7,018	7,018		7,018
1,527	Other CCG block Contracts		166	166	418	209	209	209	201	115	166	209	209			
123,481	NHS England	8,346	12,537	4,192	31,214	14,143	14,836	13,725	19,041	17,985	12,537	9,032	8,908	8,908		8,908
21,093	All Other NHS Organisations	5,869	1,631	(4,238)	7,786	797	1,332	3,181	4,880	1,486	1,631	5,533	1,275	6,054	1,088	1,275
0	Capital Receipts	750		(750)								750				31,379
172,740	All Other Receipts	3,012	5,527	2,515	7,148	7,792	2,013	8,863	2,086	139,311	5,527	8,726	3,557	3,462	3,474	3,857
0	Provider Sustainability Fund															
4,015	PDC Loans	1,491		(1,491)	4,015											
0	Loans Repaid															
646,308	**Total Receipts**	**59,084**	**60,170**	**1,086**	**131,054**	**62,696**	**59,923**	**66,213**	**67,104**	**199,147**	**60,170**	**95,958**	**61,203**	**65,678**	**4,563**	**92,673**
	Total Movement In Bank Balance															
(226,139)	Monthly Payroll inc NI & Super	(30,670)	(33,043)	(2,373)	(30,927)	(31,819)	(32,543)	(32,868)	(32,500)	(32,440)	(33,043)	(24,095)	(32,670)	(32,670)	(32,670)	(32,670)
(373,959)	Creditor Payment Run	(24,700)	(31,901)	(7,200)	(48,955)	(35,438)	(24,775)	(38,414)	(32,167)	(162,309)	(31,901)	(49,178)	(31,542)	(30,168)	(29,110)	(30,643)
(7,588)	Capital Payments	(1,750)	(4,391)	(2,641)	(2,172)	(491)	(200)	(193)	(58)	(83)	(4,391)	(919)	(1,400)	(1,400)	(1,400)	(32,779)
	PDC Dividend Payment											(2,696)				(2,400)
(619)	Interest Payments								(619)							
(608,305)	**Total Payments**	**(57,120)**	**(69,334)**	**(12,214)**	**(82,054)**	**(67,747)**	**(57,519)**	**(71,475)**	**(65,343)**	**(194,832)**	**(69,334)**	**(76,888)**	**(65,612)**	**(64,238)**	**(63,180)**	**(98,492)**
38,003	**Total Movement In Bank Balance**	**1,964**	**(9,164)**	**(11,128)**	**49,000**	**(5,051)**	**2,404**	**(5,262)**	**1,760**	**4,315**	**(9,164)**	**19,070**	**(4,409)**	**1,441**	**(58,617)**	**(5,820)**
51,896	**Closing Bank Balance**	**4,961**	**51,896**	**46,934**	**62,893**	**57,842**	**60,246**	**54,984**	**56,745**	**61,060**	**51,896**	**70,965**	**66,557**	**67,997**	**9,380**	**3,561**
	Plan				4,356	4,191	4,157	4,157	3,742	2,997	4,961	2,891	2,891	2,891	2,891	3,029
	Variance				58,537	53,651	56,090	50,827	53,003	58,063	46,934	68,074	63,666	65,106	6,489	531

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	SURGICAL EMERGENCY ASSESSMENT UNIT (SEAU) / SAME DAY EMERGENCY CARE SURGICAL SERVICE WHH/QEQMH

Response to November FPC queries are as follows -

The WHH and QEQM Surgical Emergency Assessment Unit (SEAU) is currently open Monday to Friday 12 hours a day. QEQM is funded to a lower staffing level as WHH, so the activity numbers are less than the demand on the service. By funding QEQM to the same staffing levels as WHH the service could double its activity levels to circa 216 a month. This would be better for the patients but also support the busy ED and in meeting the 4-hour target.

Neither the QEQM or WHH are expected to be open on bank holidays or weekends, despite the demand. If the funding for staff was made available, the surgical patients presenting at these times would be cared for in a dedicated unit set up for their needs.

Due to the current contractual arrangements, there will be no opportunity for additional income or penalty reductions as a result of implementing this business case. However, the Urgent Care team has suggested that staff cost savings could be made from the redirection of these patients if the Trust was able to reduce the demand on the wider Emergency Department (ED). The opportunity could be to the value of £913,000 across both sites Full Year Effect (FYE).

The performance improvement opportunity is 1% at the WHH for weekend and bank holiday working days, and 1% at QEQM. The Monday to Friday opportunity at QEQM, is an additional 1% per day.

BACKGROUND AND EXECUTIVE SUMMARY

The WHH SEAU opened in October 2014 and it was set up to provide an emergency surgical service to patients and initially provided a service between midday and 6pm. However, as the service evolved and due to patients remaining in ED overnight the opening times were eventually extended between 08:00 hours to 20:00 hours Monday to Friday. The current establishment has been able to provide longer opening hours, but it is challenging when covering A/L and then additional sickness absence. When this situation arises, it impacts on the number of patients SEAU can safely take. This unfortunately means surgical patients stay in the ED and do not benefit for the quick turnaround of treatment. This business case would allow patients to not only be seen outside of ED, in light of COVID-19 it will maximise space in the ED allowing for social distancing in SEAU and improve our ability to stream patients to a surgical area. The original business case did not include outpatient facilities, however due to COVID-19 we have re-located the SEAU and have realigned its location with elective surgical outpatient facilities.

The SEAU also offers a Monday to Friday hot clinic service where patients can return to the department for follow up reviews and scans to avoid being either admitted or re-admitted into hospital. Monday mornings become very challenged as the hot clinics pick up patients that have attended ED over the weekend. We have developed Key Performance Indicators (KPIs) to monitor our activity. We will be looking to measure and reduce surgical breaches in ED.

East Kent Hospitals University NHS Foundation Trust

Financial cost

	Option 1	Option 2	Option 3
Capital Investment	£ -	£ -	£ -

Income	0	0	£ -
Direct Costs	0	389,649	£ 1,054,353
Other Costs	0	18,489	£ 34,602
Cost Savings	0	0	£ -
I&E Surplus/ (Deficit)	**£ -**	**(£ 408,139)**	**(£ 1,088,955)**

OPTION 3

£1,001k Staffing costs

£ 88k Non-Pay costs

£1,089k Total cost (Full Year 21/22)

Activity

The A&E surgical referrals at the QEQM are on average 216 a month. This is slightly less than the WHH, but more than what is currently being seen in their SEAU. As such, if funding was approved the activity through SEAU could increase to WHH levels as the demand exists. With the increase in staff an addition 100 patients a month could be seen at QEQM.

Recommendation: Option 3

Increase the establishment at QEQM and WHH SEAU to allow for 12 hour days, 7 days a week. This will allow pts to access the services at weekends and bank holidays and increase the types of pathways available. It also allows elective pts to benefit from SEAU skills, reducing patient pathways and more treatments on the day.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	• Risk to 4-hour Emergency Department Breach • Risk of overcrowding in Emergency Department • Risk to patient safety/experience • Risk to length of stay • Inconsistency and inequalities in pathways
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No
RESOURCE IMPLICATIONS:	2wte speciality Drs 12.67Wte registered nurses 13.0 wte Band 2 1.0 Band 7 service manager
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Investment Group (SIG) Surgical and Anaesthetic Care Group Board

East Kent Hospitals University NHS Foundation Trust

SUBSIDIARY IMPLICATIONS:	No

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Finance and Performance Committee is asked to discuss and **APPROVE** option 3 of the Surgical Emergency Assessment Unit Business Case.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	STATUTORY COMPLIANCE BUSINESS CASE

BACKGROUND AND EXECUTIVE SUMMARY

- Our statutory compliance is at an unacceptably low level which leaves us open to criticism from inspection and regulatory bodies but more importantly puts our plant and equipment at risk of break down and failure, leading to potential adverse impact on patients and the delivery of critical patient services.

- The preferred option in this business case is to commit to an improvement plan of spending additional £0.5M in the remainder of 20/21 financial year with a further commitment of additional £1M in 21/22 financial year increasing statutory compliance by 5% each year and improvement in statutory compliance from 69% to 79% by end of 21/22. A further increase of £2M in 22/23 would realise an improvement in overall compliance of 20% from current levels to 89%. Maintaining this £2M investment in subsequent years would keep compliance levels >90% with further yearly improvement as service to repair cost ratio increases.

- The investment will be targeted in a risk-based approach to tackle higher risks earlier and by 23/24 be delivering a very high level of compliance and demonstrate a strong compliance across all areas and with relevant British Standards, Health Technical Memorandums and Approved Codes of Practices.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	• Without further investment our current position is to continue prioritising our revenue spend and accept a shortfall in terms of compliance levels. • Without increasing investment to improve compliance leaves the Trust at risk of adversely impacting patients and the delivery of critical patient services. • Without improving on our compliance levels, we will have to accept that business continuity may be adversely affected by increasing the potential to lose buildings and building services due to the failure of critical plant and equipment. • This will directly impact the safety of patients, the quality of care we offer and the experience we desire for our hospital users.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	

East Kent Hospitals University NHS Foundation Trust

RESOURCE IMPLICATIONS:	**Financial Summary (5 years) PREFERRED OPTION**

	2020-21	2021-22	2022-23	2023-24	2024-25
Capital Investment	£0	£0	£0	£0	£0
Income	£0	£0	£0	£0	£0
Direct Costs	£500,000	£1,500,000	£2,000,000	£2,000,000	£2,000,000
Other Costs	£0	£0	£0	£0	£0
I&E Surplus/ (Deficit)	(£500,000)	(£1,500,000)	(£2,000,000)	(£2,000,000)	(£2,000,000)
EBITDA %					

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Investment Group - October 2020 Executive Management Team – October 2020 Clinical Executive Management Group – November 2020
SUBSIDIARY IMPLICATIONS:	An Increase in Stat Compliance Investment will enable 2GS to support the Trust in delivering the high-quality standard of service expected from EKHUFT.

PRIVACY IMPACT ASSESSMENT: No	**EQUALITY IMPACT ASSESSMENT:** No

RECOMMENDATIONS AND ACTION REQUIRED:

The FPC is asked to discuss and **APPROVE** the Statutory Compliance Business Case.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	RADIOLOGY EQUIPMENT REPLACEMENT PROGRAMME

This case is requesting capital funding of £1.994m and revenue funding of £70k in 2020/21. The capital expenditure is included within the 2020/21 capital plan.

Final approval of this case sits with the FPC.

BACKGROUND AND EXECUTIVE SUMMARY

This report is summarising the business case put forward for capital funding to replace out-dated Radiology Equipment. The preferred solution aims to effectively replace the Trust-wide listed items of equipment within radiology, over the next 10 years.

Year 1 of the proposed equipment replacement will require capital funding of £1,993,920, for the replacement of 6 X-Ray rooms Trust wide.

These X-Ray rooms are suffering from at least 1 x breakdown per site, per month. This is leading to cancellation and reduce available capacity. This is adversely affecting the national six-week diagnostic pathway (DM01), Referral To Treatment (RTT) and cancer pathways and other services can be adversely affected including A&E, ward discharges, increased length of stays and overall affecting the core functions of hospital flow. The ongoing issues have been highlighted on the Trust's risk register.

The equipment currently being used in X-ray is first generation and now end of life. This means parts cannot be sourced. The replacement equipment will move forward to the current, fifth generation equivalent which processes faster imaging as well as running faster. This will lead to improvements in productivity as well as imaging quality for diagnoses for patients.

Furthermore, the preferred option will lead to improved efficiency and productivity with faster equipment. This new equipment will also introduce a new fail-safe measure which will in turn lead to improved quality and safety.

The proposed replacements have an anticipated 6 weeks turnaround time per room. The plan would be to phase the implementation for each site and room, to minimise downtime. Only 1 room on each site would be taken out of action at any given time. This will help mitigate any operational risks.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks to implementing: • Delays to approval will impact the procurement times and equipment installation • Equipment lead times due to demand and restricted production due to COVID-19 as well as potential Brexit delays on procurement. The Brexit risk has been mitigated as much as possible with the manufacture in Europe will be willing to move X-Ray parts into the UK as quickly as possible to avoid Brexit potential restrictions.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;**

East Kent Hospitals University NHS Foundation Trust

	• **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Risk Register Reference: • CRR – 13 Inability to fund an adequate asset replacement programme for high cost and high-risk medical equipment approaching the end of their asset life. • 432 - Radiological Sciences - Radiology Equipment Failure and Inadequate Imaging Equipment
RESOURCE IMPLICATIONS:	Capital ask of £1,993,920 Year 1 Revenue ask of £69,787 Year 1
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Investment Group Executive Management Team Clinical Executive Management Group
SUBSIDIARY IMPLICATIONS:	No

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

RECOMMENDATIONS AND ACTION REQUIRED:

The FPC is asked to support and **APPROVE** the recommended preferred option of the Endoscopy Decontamination Equipment Replacement Programme Business Case.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	ITU EXPANSION: WILLIAM HARVEY HOSPITAL

BACKGROUND AND EXECUTIVE SUMMARY

The 1st COVID-19 pandemic peak occurred in east Kent during April and early May of 2020. At that time, it was clear that the number of patients with COVID-19 disease requiring intensive care support was going to exceed the existing critical care capacity within East Kent Hospitals and also across the Kent and Medway system. An immediate rapid programme to develop and implement the provision of additional, temporary critical care beds into Intensive Therapy Unit (ITU) was put in place to respond to the peak in demand at this time. This included the use of areas such as theatres and recovery rooms.

Following the 1st COVID-19 peak, work was undertaken by the Dept. of Health and NHSE/I to understand what will be required within the NHS to manage any future demand placed on Critical Care services by a further surge in COVID-19 cases in the future. A review of the acute sites across Kent and Medway was undertaken and the William Harvey site (WHH) was agreed as the preferred option, both in terms of land availability and accessibility for the county as a whole.

As a result, the Trust has been asked to develop a new build 24 bedded ITU unit that would provide additional capacity to both the population of east Kent and the wider Kent and Medway population.

Current permanent ITU bed capacity at the WHH is 16 beds. At the height of the pandemic in April 2020 this was increased by 27 beds using temporary areas such as theatres and recovery areas. Using these areas has had a direct impact on elective surgery. The areas were also not ideal as their primary design was for an alternative use, making care of ITU patients in this environment less efficient and more stressful for staff.

The additional capacity will provide greater resilience, both at the Trust and across the wider Kent and Medway system.

The Trust has been working with NHSE/I and now has a Memorandum of Understanding (MOU) to receive £14m this financial year to support this development (appendix 1).

The case is supported by NHSE/I, both at a South East and a National level and by the Kent and Medway Clinical Commissioning Group (CCG). Clinicians within the Trust have been involved in the development and design of the solution and form a critical part of the weekly Project Team/User Group meetings. The scheme delivers a compliant, modern, new build ITU as required by both the CCG and NHSE/I commissioners.

A detailed business case is being finalised to support the MOU and will be submitted to FPC for information and endorsement following completion.

FPC are asked to note and endorse the offer of capital funding from NSHE/I conditional on the approval of the Trust business case.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Trust needs to accommodate the current demand and future forecast demand for ITU. The additional capacity will enable the Trust to provide appropriate facilities and continue to support elective surgery.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;**

East Kent Hospitals University NHS Foundation Trust

	• **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	BAF 4 - Estates condition
RESOURCE IMPLICATIONS:	£14m capital funded by NHSE/I, plus revenue impact of capital charges. Additional £2.5m capital supported from within the Trust capital plan and the system capital plan.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A
SUBSIDIARY IMPLICATIONS:	2gether Support Solutions will support the construction.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Finance and Performance Committee is asked to note and endorse the offer of capital funding from NSHE/I conditional on the approval of the Trust business case.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	ED EXPANSION: QEQM AND WHH

BACKGROUND AND EXECUTIVE SUMMARY

The Trust applied for emergency department funding of up to £30m (£15m for each site) from the centre. The Trust has been working with NHSE/I and now has a Memorandum of Understanding (MOU) to receive £7m this financial year (£4m QEQM and £3 at the WHH). This case is the short form business case that went to the centre after the initial application.

Overall the ED expansion is split into three phases, phase 1 is what changes can be in place for this winter, phase 2 is what changes can be in place by March 2021 and finally phase 3 is what can be ready for December 2021. Due to the short timeframe the changes this winter are smaller and because of the scale of change that is needed in the EDs most of the expansion is based upon what can be delivered by December 2021. The changes for this winter focus on enabling better social distancing and the separation of pathways. The longer-term changes for December 2021 are based upon a large build which would almost double the footprint of the EDs. This would also incorporate a redesign of the existing ED space to ensure a coherent total design that enables flow and streaming.

The EDs were originally built some decades ago and were designed to deal with far fewer people than they currently see. In recent years, pre-covid, the Trust saw record growth in the ED for two consecutive years which saw attendances climb 25,000 in just two years.

Summary of key benefits:

- Meet infection control guidelines and COVID recommendations reducing the risk of Hospital Acquired Infections.

- Improve patient flow through the department ensuring patients spend as little time in the ED as possible.

- Improve support and recreational areas for staff enhancing recruitment and retention.

- Modelling for 2019/20 and 2020/21 shows due to COVID spacing EKHUFT has reduced bed capacity and currently has a bed gap of 104 beds. A combination of operational pathway/process changes already underway targeting Discharge to Assess (DTA) and >21 day long stay patients with improved flow in ED would help to close this gap.

- The ED redevelopment will create increased spaces for COVID safe pathways throughout the department and into the assessment area. There will also be COVID safe waiting rooms, consultation rooms, treatments rooms, and resus area.

- With the proposed changes for Urgent Treatment Centres (UTCs) there will be improvements for the integrated pathways across the health system. The expansion of the UTC will enable more patients to be seen in this environment rather than going to majors or being admitted.

- A redesign of the emergency department will allow for a dedicated mental health area. This will lead to fewer delays in ED and fewer admissions into the hospital.

- Through a complete redesign the streaming of pathways will be more efficient and more comprehensive ensuring that the number of Same Day Emergency Care

(SDEC) patients will be higher leading to fewer admissions and less demand on beds.

FPC are asked to endorse these applications and accept the funding from NHS E.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Trust would not meet social distancing recommendations and that patients would be at increased risk of infection. Additionally, the Trust needs to accommodate the current demand and future forecast demand which has been growing above historical increases.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	BAF 4- Estates condition
RESOURCE IMPLICATIONS:	£30m capital funded by NHS E, plus revenue impact of capital charges.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A
SUBSIDIARY IMPLICATIONS:	2gether Support Solutions will support the construction.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Finance and Performance Committee is asked to endorse the application for funding and accept the capital of £30m.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	COVID TESTING ADDITIONAL RESOURCES

BACKGROUND AND EXECUTIVE SUMMARY

In response to the Covid-19 pandemic, it has been vital for the Microbiology laboratory to implement COVID Polymerase Chain Reaction (PCR) testing.

During the first wave of the pandemic this was mainly delivered using existing Microbiology staff who had spare capacity due to normal levels of testing activity reducing as services were paused / reduced. Now that the Trust and other organisations that send tests to the Microbiology laboratory are recovering and addressing backlogs, it is necessary to employ additional staff to increase capacity of the laboratory to deliver normal business as well as the increasing levels of Covid-19 PCR testing and also vital additional winter respiratory virus testing. The staff have initially been appointed on Fixed Term contracts of 2 years.

The laboratory is working in order to provide tests at a required level by NHSE/I. EKHUFT is at the forefront of this delivery in the region. NHSE/I have outlined that the costs of Covid-19 testing will be reimbursed to Trusts – the mechanism for this is to be confirmed, however we are including the costs in the monthly submissions to NHSE/I.

The impact on budgets to deliver the required level of testing is as follows:

COVID TESTING Op. 2	2020-21	2021-22	2022-23
PAY	£220,560	£342,261	£342,261
NON-PAY	£5,498,899	£5,498,899	£5,498,899
TOTAL	£5,719,459	£5,841,160	£5,841,160

The pay cost is for an additional 10.6 whole time equivalent staff in Microbiology. The non-pay laboratory consumables costs are purchased through the managed service contract with Beckman Coulter for which an increased purchase order is needed to procure these additional resources. The normal annual cost of this contract is c£1.76m per annum.

The FPC Committee are asked to approve the business case which will be funded by the NHS E Covid-19 cost reimbursement process.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:

- Increased number of outbreaks and infection control issues, increase in morbidity and mortality.
- Loss of service (private patient and GUM clinic)
- Increase in test-result turnaround times – maintaining excellence in quality would require same amount of staff time per specimen post-COVID as pre-COVID. If workload increases then the amount of staff time required must increase. This can only be achieved by increasing the number of staff otherwise turn-around-times for results will increase and the Trust would not be able to deliver the expected 1,200 tests per day.

LINKS TO STRATEGIC OBJECTIVES:	• Improve quality, safety and experience, resulting in Good and then Outstanding care • 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

East Kent Hospitals University NHS Foundation Trust

	• Transforming the way, we provide services across east Kent, enabling the whole system to offer excellent integrated services • Developing teams with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	N/A
RESOURCE IMPLICATIONS:	• Pay - £0.3m • Non-Pay - £5.5m
COMMITTEES WHO WILL / HAVE CONSIDERED THIS REPORT	**Outline report principle of extension to current contract** • Pathology Management Governance Committee (PMGC) • Strategic Investment Group (SIG) approved the Business Case to proceed subject to confirmation of National funding.
SUBSIDIARY IMPLICATIONS:	N/A

PRIVACY IMPACT ASSESSMENT: N/A	**EQUALITY IMPACT ASSESSMENT:**

RECOMMENDATIONS AND ACTION REQUIRED:

The Finance and Performance Committee is asked to discuss and **APPROVE** the Covid Testing Additional Resources Business Case.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	EXTENSION/ AWARD OF PATHOLOGY MANAGED SERVICE CONTRACT

BACKGROUND AND EXECUTIVE SUMMARY

The aim of this paper is to describe the financial and operational benefits of the Abbott managed service contract (MSC) options available to the Trust. The current Abbott MSC includes automated analytical systems in clinical biochemistry, haematology and haemophilia and have been in place now for 13 years. This contract has been extended already and expired in October 2020 (contract being extended month by month). Current Abbott MSC costs are £3,210,828 per annum and if the contract is rolled over year on year it will cost £20,659,337 after 6 years with 2% RPI per annum.

The options include an extension or a new contract (preferred option) with Abbott laboratories for a MSC for the next 6 years realising savings of c.10% per annum over the term of the contract. The new operating costs mobilising the preferred option (see below Table 1) over the term of the contract is £18,852,990 giving rise to savings £1,806,387 (£301,064). Note this option has an agreement with Abbott to terminate at March 2026 with no additional fees.

The new contract will allow EKHUFT to make immediate improvements in integrated clinical care and operational excellence, including resilience of services. It will avoid waiting for benefits to be realised for the Trust only after the South 8 network (Kent and Medway (K&M) Pathology Network). A typical procurement and implementation for a pathology MSC is complex and presents challenges and risks. Timescales for procurement and full implementation can be up to and beyond 24 months. By executing the new contract with Abbott, it will allow EKHUFT to immediately benefit from improvements and secure the service. It will also allow the network to align contract end dates (NB: North Kent Pathology Services (NKPS) MSC with Beckman Coulter expires 2025 as does Maidstone and Tunbridge wells MSC with Roche Diagnostics). There is an expectation that all of the three laboratories in the South 8 network will be planning a joint procurement exercise in 2024/25 after implementation of the laboratory information management system (LIMS) 2024.

Abbott diagnostics have provided the pathology team and procurement with the following options to consider;

Table 1 – Options

Option 1 - Do Nothing								
RPI Application		2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	
	Current Spend	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total Spend
Abbott Products with Serology Reduction	£1,814,336	£1,850,623	£1,887,635	£1,925,388	£1,963,896	£2,003,174	£2,043,237	**£11,673,953**
Third Party Products	£1,396,492	£1,424,422	£1,452,910	£1,481,968	£1,511,608	£1,541,840	£1,572,677	**£8,985,425**
Total	**£3,210,828**	**£3,275,045**	**£3,340,545**	**£3,407,356**	**£3,475,503**	**£3,545,014**	£3,615,914	**£20,659,377**

Option 2 - Preferred								
Reduced Serology								
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total Spend
Abbott Biochemistry Reduced Serology		£1,723,620	£1,637,439	£1,670,187	£1,703,591	£1,737,663	£1,772,416	**£10,244,916**
Abbott Haematology IN Year 2		£640,851	£490,000	£499,800	£509,796	£519,992	£530,392	**£3,190,831**
Stago Coagulation		£336,456	£343,185	£350,049	£357,050	£364,191	£371,475	**£2,122,405**
IMS		£30,000	£30,000	£30,000	£30,000	£30,000	£30,000	**£180,000**
Remaining Indexor		£57,600	£57,600	£57,600	£57,600	£57,600	£57,600	**£345,600**
Other third parties		£438,996	£447,776	£456,731	£465,866	£475,183	£484,687	**£2,769,239**
Total Spend		**£3,227,523**	**£3,006,000**	**£3,064,367**	**£3,123,903**	**£3,184,629**	£3,246,569	**£18,852,990**
Saving		**£47,522**	**£334,545**	**£342,989**	**£351,600**	**£360,385**	£369,345	**£1,806,387**

Table 2 - Summary of solution

Solution Option	Preferred option
A3600 Track	×
Continued Sysmex Haematology solution – including ESR	Year 1
Full Abbott serology	×
Interfacing of AMS for serology	×
Access to Business Intelligence System for Serology	×
Alinity analyser for serology department	×
GLP track	✓
Abbott Haematology at all sites	Year 2
Abbott provided ESR solution	Year 2
Abbott Haematology Track Connection	Year 2
Alinity Chemistry and Immunoassay at all sites	✓
Full Indexor	✓
Additional Star Max 3 analyser and Stago Refresh	✓
Replacement Stago Platelet Aggregometer	✓
Stago Coag one middleware and peer review IQC	✓
Upgraded Alin IQ AMS middleware	✓
Replacement AMS server	✓
Replacement water systems K&C and Margate	✓
Alin IQ Business Intelligence system interfaced to AMS	✓
Abbott solution training	✓

The proposal for option 2 includes financial benefits and many operational benefits with the new kit that will reduce total cost of ownership and improve service.

East Kent Hospitals University NHS Foundation Trust

Key Advantages of extending the Abbott Diagnostics contract through option 2

- All new clinical biochemistry 'Alinity' equipment for the Abbott solution - chemistry/haematology all sites
- Increased capacity on analysers at QEQMH and K&CH for business continuity
- Discount on your haematology and chemistry spend
- Discount on haemophilia contract and an additional 'Stago' analyser
- Indexor system – sample tracking and automated patient data entry system
- Inventory Management System (IMS)
- New GLP Track-latest automation
- New Alinity biochemistry, immunoassay at all sites
- New Alinity haematology at all sites year 2
- Provision for digital microscopy within the Abbott haematology bid
- Abbott provided ESR solution
- 1 x Extra haemophilia Coagulation Analyser
- Abbott AMS middleware software refresh
- Abbott AMS server refresh in year 3
- Abbott BIS Business Intelligence system (also includes Abbott resource to review and report back)
- Training on all new equipment and software-including the middleware
- Implementation Project Manager and Abbott team to support transition
- Standard implementation costs included
- New contract written, so that we can include scope to bring work into the MSC - e.g. ability to run mini competitions for further VAT savings/risk transfer

The principle of extending or pursuing a new Abbott MSC was presented to the Clinical Executive Management Group (CEMG) and Strategic Investment Group (SIG) in November 2019 and there was agreement provided that the contract provides flexibility to respond to the Pathology Transformation Project and the emerging Clinical Strategy. This has full backing of the Kent and Medway pathology transformation. Procurement advice has been taken and it is suggested that the most appropriate way in which to procure the services of Abbott under a new arrangement would be via the Shared Business Services (SBS) framework. A direct call off is possible under the terms of the framework provision, and therefore reducing any risk of challenge to the trust.

This paper therefore recommends a new contract with Abbott based on the 6 year option 2 which delivers a complete refresh of the current technology with inclusion further added value (see table 2).

It is worth noting also that the savings from option 2 will further reduce pathology's overall cost per test, which in terms of NHSI Model Hospital benchmarking against peers with similar trust size brings East Kent pathology into the same peer median position or lower, continuing the downward trend (see Figures 1 and 2 below).

Fig 1.

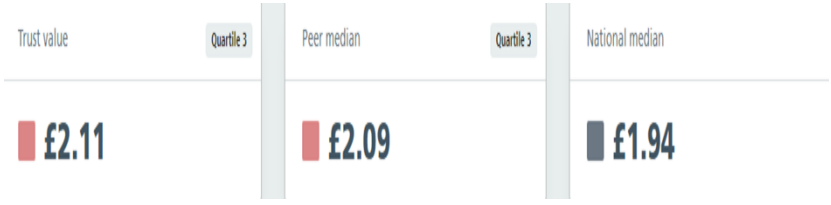
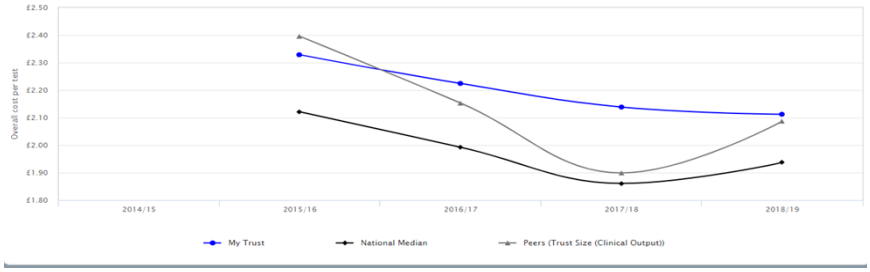


Fig 2.



In summary:

Option 1 'do minimum' (rolling annual contract) is not a viable option as it does not allow EKHUFT to embrace new innovation and technologies necessary for continual service improvement to deliver higher quality of care and service resilience, and ability to efficiency savings.

Option 2 will enable a full upgrade of the current solution to the latest technology and offer maximum financial savings. It will also have the highest impact on patient care, operational excellence and productivity. This option will also offer the largest reduction in total cost of ownership, offer the maximum quality improvements and support efficiencies outside the laboratory and across the sample collection to reporting process.

The opportunity of putting in place a new contract to provide a total equipment refresh and increasing capacity from Abbott Diagnostics under the preferred option (option 2) delivers a more sustainable and resilient services for our patients under a relatively short term arrangement (maximum of 6 years) and aligns with STP timescales and supported by Kent and Medway pathology transformation. This option also includes the ability to novate this contractual arrangement to any joint venture which may be formed as part of the STP pathology transformation project.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:

In relation to the MSC the current analytical and automation systems in place in EKHUFT pathology lack capacity on the Emergency Laboratory Sites (ESL's) at QEQMH and K&CH and with the contract extended on a monthly basis whilst this review process is carried out).

The preferred option of extending the current Abbott MSC as laid out in this document provides EKHUFT with the ability to improve and ensure a sustainable service within blood sciences, whilst releasing significant efficiencies and cost savings over the next six years, as we move forward with the Pathology Transformation project and providing flexibility to respond to the emerging clinical strategy of EKHUFT.

This option also includes up to £12,500 enabling costs

LINKS TO STRATEGIC OBJECTIVES:	
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	N/A
RESOURCE IMPLICATIONS:	• Mobilisation of new equipment / analysers • Verification of ALL new equipment, kits and reagents

East Kent Hospitals University NHS Foundation Trust

COMMITTEES WHO WILL / HAVE CONSIDERED THIS REPORT	**Outline report principle of extension to current contract** • Pathology Management Governance Committee (PMGC) • Clinical Support Services Care Group Committee • Clinical Executive Management Group (CEMG) • Strategic Investment Group (SIG)
SUBSIDIARY IMPLICATIONS:	

PRIVACY IMPACT ASSESSMENT: N/A	**EQUALITY IMPACT ASSESSMENT:**

RECOMMENDATIONS AND ACTION REQUIRED:

The recommendation is for the Committee to agree to option 2 mobilising a new Abbott MSC until April 2026 allowing pathology at EKHUFT to exploit the consolidation and operational efficiencies provided by the new technology to further reduce laboratory operating costs, deliver significant savings over the term of contract still allowing the flexibility to respond to the emerging clinical strategy and South 8 pathology transformation plans.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**CHARITABLE FUNDS COMMITTEE (CFC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR OF CHARITABLE FUNDS COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: ANNUAL REPORT AND ACCOUNTS 2019/20** **APPENDIX 2: REPRESENTATION LETTER**

BACKGROUND AND EXECUTIVE SUMMARY

The Charitable Funds Committee remit is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy.

Chair's summary of key deliberations and decisions at the CFC meeting held on 8 December 2020 are:

1. Applications for Grants

The Committee received and considered a number of applications for grants as detailed below:

1.1 Modification Livebirth Labour Room - Maternity:

1.1.1 The Committee received and approved an application for funding for £28k for the modification works of one of the existing livebirth labour rooms. This will provide a designated room where families can deliver, with privacy and in quiet surroundings. The Committee noted when the room was not in use for pregnancy loss it will be used as a standard labour room;

1.1.2 The Committee noted the key benefits of this application:

1.1.2.1 An important facility supporting families experiencing pregnancy loss at an emotional time and preventing additional distress to mother and family with the provision of a dedicated entrance, preventing access to the labour ward and delivery suite;

1.1.2.2 Soundproofed walls.

1.2 Ventilation Simulator:

1.2.1 The Committee received and approved an application for funding for £33k (circa £40k inclusive of VAT) to purchase an advanced ventilation simulator that will provide enhanced training for intensive unit care staff. The Committee noted the on-going revenue costs will be funded by the Trust;

1.2.2 The Committee noted the key benefits of this equipment:

1.2.2.1 The simulator can be programmed and attached to Trust ventilators for existing simulation patient mannequin, creating a range of complex lung pathologies including Acute Lung Injury, viral pneumonias and Covid-19;

1.2.2.2 Enhance and improve staff knowledge and understanding for respiratory support, leading to optimal clinical response and improved patient outcomes;

1.2.2.3 Can be used to train existing staff and those new to critical care;
1.2.2.4 The simulator is portable and will be able to be used across all three hospital sites.

1.3 Well-Being Roles:

1.3.1 The Committee received and discussed funding application of £190k for two members of Trust staff for two years to support delivery of Trust's well-being programme. Whilst the Committee acknowledged the benefits of supporting staff, this application was not approved as further work was required to provide assurance to the Committee that the funding of staff for this scheme fully satisfies the Charity's purpose particularly the links to Captain Tom's Funds.

1.4 OpenEyes Electronic Patient Record - Paediatrics:

1.4.1 The Committee received and approved an application for funding for £60k for the provision of the OpenEyes electronic patient record system. This will enable all clinical information to be accessed by all clinicians across the hospital sites without the need for paper medical records, and ensure continuous access to the most up to date patient medical record;

1.4.2 The Committee noted the key benefits of this application:

1.4.2.1 Addresses the current paper based medical patient record;
1.4.2.2 Will provide accessible electronic patient record;
1.4.2.3 Improve efficiency within the Ophthalmology team when recalling and recording patient information and generating correspondence to patients, GPs, and other health care providers;
1.4.2.4 Improve patient experience and outcomes;
1.4.2.5 Provision of an audit trail in respect of efficiency of treatment, links to databases to enable analysis of results and supporting future care decisions.

1.5 Diagnostic Ultrasound – Queen Elizabeth the Queen Mother Hospital (QEQMH) Emergency Department (ED):

1.5.1 The Committee received and approved an application for funding for £39k for the purchase of a second diagnostic ultrasound machine at QEQMH. The Committee noted the importance of this vital equipment and the need for this to be purchased and in place as soon as possible, this equipment is a key tool for fast and accurate diagnosis within the ED. The Committee noted the on-going revenue costs will be funded by the Care Group;

1.5.2 The Committee noted the key benefits of this application:

1.5.2.1 Provides advanced diagnostic imaging;
1.5.2.2 Enables clinical teams to make prompt point of care decision in making and identifying patient pathway;
1.5.2.3 Increases accessibility for the team and patients to diagnostic ultrasound;
1.5.2.4 Supports the dedicated Covid-19 patient streams providing ultrasound within each stream;
1.5.2.5 Improve patient experience and outcomes.

2. <u>Charity – Raising our game</u>

2.1 The Committee held a productive workshop session to discuss how the Charity can grow and increase its annual income. Several suggestions and proposals were made which need to be put into a comprehensive action plan with timelines. This action plan will be presented by the Charity team at the next Committee meeting in 2021.

3. Annual Report and Accounts 2019/20

3.1 The Committee received and approved the presented Annual Report and Accounts for 2019/20 (Appendix 1), recommending these to the Board of Directors for approval and signing, along with approval of the Letter of Representation (Appendix 2). The balance sheet, letter of representation and statement of Trustee's responsibilities once signed will be submitted to the External Auditors Grant Thornton to sign the independent examination statement. The full Annual Report and Accounts will be made available to the public on both the Charity and Trust websites. The Annual Accounts will be submitted to the Charity Commission ahead of the 31 January 2021 deadline.

4. Finance Report

4.1 The Committee discussed and noted a report on the current financial position, income and expenditure of the East Kent Hospitals Charity. This included the following key elements (as at 31 October 2020):

4.1.1 Charity fund balances of £3.3m adjusted for commitments £2.2m;
4.1.2 Cash position of £1.0m;
4.1.3 Investments (portfolio) of £2.2m;
4.1.4 Income for the period 1 April 2020 to 31 October 2020 of £0.8m;
4.1.5 Expenditure for the period 1 April 2020 to 31 October 2020 of £0.35m of which:
4.1.5.1 Grants to Trust 1 April 2020 to 31 October 2020 amounted to £0.25m with a further £1.1m committed.

5. CFC Fundraising Update

5.1 The Committee received and discussed an update report on current fundraising activities, along with reflecting on lessons learnt over recent months, as well as key appeals and events of the Charity.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Charity has to remain financially stable and cannot over commit to projects that could lead to an overreach of funding capacity. The Committee oversees the financial position and activities to ensure the Charity achieves its strategies and objectives.
LINKS TO STRATEGIC OBJECTIVES:	The broad objectives of the Charity link to all the strategic objectives of the Trust. **We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No
RESOURCE IMPLICATIONS:	Not applicable
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

East Kent Hospitals University NHS Foundation Trust

SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: No	**EQUALITY IMPACT ASSESSMENT:** No

RECOMMENDATIONS AND ACTION REQUIRED:

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

- Charitable Funds Committee Chair Report;
- Annual Report and Accounts 2019/20 and Letter of Representation.

East Kent Hospitals Charity

Registered Charity Number 1076555

Annual Report & Accounts
2019 - 2020

The Garden of Light installation at the Ashford Designer Outlet. Running throughout the 2019/20 festive season, this sensory experience raised over £47,000 for East Kent Hospitals Charity.

Helping your local Hospitals

East Kent Hospitals Charity

Registered Charity Number 1076555

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Sunny Adeusi
Chair,
Charitable Funds Committee

Chair of Charitable Funds Committee Foreword

The Annual Report provides financial information about the Charity and a summary of achievements made during 2019/20. At the time of writing, we are rapidly adjusting to the impact of the global pandemic on the NHS Charity.

I have had the privilege of being the Chair of the Charitable Funds Committee for part of the year and want to pay tribute and thank my colleague Keith Palmer who I took over from. Keith chaired the Charitable Funds Committee from January 2017 to January 2020 during which time he provided oversight, valuable advice and leadership to the Charity's activities with funded programmes totalling over £2.2m. On behalf of the Trustees, I wish Keith full recovery from ill health.

The kindness of others never ceases to amaze me. Every week we hear how our supporters give up their time and work hard to fundraise money for us.

Some run marathons, others climb mountains. Some hold events, raffles or sell cakes. And others leave a gift in their Will to give back and to show their appreciation of the staff here at East Kent Hospitals University NHS Foundation Trust.

It is truly touching and hugely inspirational to discover the selfless acts of all of you who do so much to support us. We work to enhance the care of patients across our hospitals and ensure that our staff work in an environment that enables optimum patient care and outcomes. So, the projects and schemes we fund reflect these aims and underlying values.

There are lots of smaller items that remain under the radar, but in like manner enhance treatment for patients and ensure that their stay is less stressful both for them and their families.

I hope you will enjoy reading about the fundraising campaigns and events on pages 6 and 10 – you may even want to get involved in some. So please, have a look.

Thank you to all our supporters. You ARE making a DIFFERENCE.

Sunny Adeusi
Chair of the Charitable Funds Committee
August 2020

Rupert Williamson
Head of Fundraising

Dee Neligan
Senior Charity Officer

Fundraising introduction

The East Kent Hospitals Charity is well supported by Trust staff and individuals and groups across the local communities who give throughout the year and take part in various fundraising events.

The valuable additional patient amenities that fundraising supports make considerable differences to the quality of service our patients receive.

We are continuing with our focus on dementia services and facilities through our Dementia Appeal. The Appeal is supplemented by other appeals spread across our services and hospital sites. Donations continue to be received from patients and their relatives as well as from funeral directors to acknowledge treatment and care received.

Gift Aid contributions from current UK taxpayers makes a vast difference to the income received by the charity and we are grateful to all those who are able to make this additional donation to our funds.

From the Fundraising Team, many thanks!

Rupert Williamson and Dee Neligan

The Role of the Charity

The core mission of the Charity is to enhance the care and treatment of patients and visitors accessing NHS services provided by East Kent Hospitals University NHS Foundation Trust, by raising funds to support the purchase of equipment and facilities which are beyond the scope of government funding.

We achieve this by involving NHS Clinicians and staff to identify and deliver projects that make a vital difference to patients by:

- Enhancing the quality of patient care
- Improving the environment for patients and visitors
- Supporting NHS staff development to enable them to provide excellent clinical and patient centred care
- Providing financial support for pioneering research that has the potential to impact on the treatment and well-being of patients

The Trustees confirm that they have referred to the guidance provided by the Charity Commission with regard to the need for public benefit. They are confident that the activities which contribute to the above mission have a clear public benefit. The Trust provides clinical services within the scope of their NHS requirements and the Charity works hard to enhance these services to benefit the patients and visitors (and therefore the public).

The Trustees are aware when making grants, of the distinction between the requirements of the NHS to provide their services and those grants made by the Charity to extend the scope of the service, either through new equipment, advanced technology and improving patient experience through the environment and/or additional activities and facilities which are not the responsibility of the NHS.

We achieve our mission by involving NHS clinicians and staff to deliver projects that make a vital difference to patients.

Luke Strong celebrates finishing the Prudential Ride 100, raising funds for the ITU Sensory Garden.

Fantastic Fundraisers!

We rely on our amazing supporters across our communities to fundraise for East Kent Hospitals Charity.

This report can only cover a few of the inspiring stories of people who gave up their precious time to help raise funds. To all, we say thank you- we are very grateful.

The Garden of Light installation, created by Pixel Artworks and hosted by the Ashford Designer Outlet, was launched in November 2019.

This spectacular sensory experience was free for all visitors to the Outlet to visit, and all donations received were made available to the William Harvey Hospital Intensive Care Unit Sensory Garden Project.

A total of **£46,378** was raised.

During 2019/20 East Kent Hospitals Charity have been chosen to be the Charity of The Year by the following businesses and organisations:

- Sleeping Giant Media
- Marks & Spencer's (Westwood Cross & Ashford Designer Outlet)
- Co-Ops across Thanet
- Charter Tax
- Folkestone Soroptimists
- Dover Grammar School for Boys
- Highworth Grammar School.

Dee and Maternity Matron Jo Olagboyega celebrate Charter Tax's fundraising for the William Harvey Hospital's 'Twinkling Stars' Maternal Bereavement Suite.

Thank you- we are so grateful for your support!

Dickie decided to fundraise for Rainbow Children's Ward after his son was admitted twice in two years.

He was so impressed by the dedication of the staff and the care that his son received, that he approached Canterbury Golf Club to organise a Golf Day, taking place in October 2019.

Dickie was delighted to raise **£11,603** in total- with help from the event's sponsors and all the generous players!

Co-ops across Thanet supported the Maternity Unit at QEQM Hospital, by fundraising in store and selecting our 'Heart In Hand' campaign as one of their 'local causes' for 2019-2020. In total, they raised **£3021.16!**

The Danny Hall Foundation raised an amazing **£200** that was presented to Padua Ward at William Harvey Hospital on the 9th of December 2019.

In September 2019, Walmer Lifeboat Crew undertook a 24-hour endurance feat, raising funds for the **ITU at Kent and Canterbury** Hospital, following a member of their crew receiving care in the unit.

The Crew ran, rowed and cycle for 24 hours non-stop, and raised **£4800!**

The Old Kent Barn in Swingfield, near Folkestone, hosted a fundraising ball in aid of Tiny Toes. They raised an amazing **£3290** for the Neonatal Intensive Care Unit at the William Harvey Hospital!

Tiny Toes
Part of **East Kent Hospitals Charity**

Steve Gray cycled 205 miles across Scotland to raise **£1473** for Tiny Toes. He said:

'I did this to raise money for the Special Baby Care Unit at Queen Elizabeth Queen Mother Hospital. This fantastic unit and its team of dedicated professionals saved my little boy's life when he went into Respiratory arrest following complications when he was born four years ago.

The team at the SCBU looked after our baby and my wife for two weeks and I will always be thankful for the care and commitment they

Kent Fire & Rescue Service raised **£1500** for Tiny Toes in December 2019, following their Christmas Collection in Canterbury City Centre.

Becky celebrates her successful Wing Walk Challenge with her niece, 'Dinky'. Becky raised **£1055** for Tiny Toes, following Dinky's stay at the NICU.

Hoath Women's Institute crafted over 100 'breast cushions' for patients recovering from breast surgery at the QEQM Hospital.

Charing Primary School organised a collection of items for the Twinkling Stars Maternal Bereavement Suite, presented to the Maternity Matron in December 2019.

Oskar's parents ran a local 10k in July 2019, raising over **£1100** for the Ponseti Service!

Oskar's parents said: 'The paediatric orthopaedic physio team has been fantastic in treating Osky and getting him to the point today where everything is as it should be.

We want to show our appreciation for all their work by raising money for that team.'

Adrian from the Birchington Lodge of Rectitude and Harmony (9093) presented the Viking Day Unit with a cheque for £500 in January 2020, following fundraising efforts during 2019.

East Kent Hospitals Charity
Dementia Appeal

We launched our Dementia Appeal in 2014, so that we could help our hospitals to become as dementia friendly as possible.

By the end of the financial year 2019/20, we had raised £149,000 from our generous donors and communities, for this work- as well as having phenomenal support from our many crafters who provide twiddlemuffs and blankets for our patients living with dementia!

We'd like to take this opportunity to thank our Fundraising Heroes and celebrate their achievements.

Their dedication and commitment to the Dementia Appeal means that we can continue to fund projects that directly benefit our patients.

Ann McGovern has been fundraising for the Dementia Appeal since 2018, and has raised in excess of **£5700** to date. This has funded an OMI Vista: an interactive floor or table top system which dynamically responds to gesture and movement. This has been very well received on the wards, and is fun way for patients to engage with play and sensory therapy.

On Valentines Day 2020, the Strategic Development Team held a cake sale at Kent & Canterbury Hospital with all proceeds going to the Dementia Appeal. This raised £300!

Sue Threadingham has been fundraising for the Dementia Appeal since 2016- raising over **£4500** to date! Thank you!

Looking forward - our plans for the future...

The financial pressures on the NHS and the Trust continue. The Trustees are greatly encouraged by the Charity's achievement in the year and will continue to monitor the future plans to provide as much financial support as possible to the Hospitals with grants over the next two years.

The Charity strategy will increase not only the total value of the grants given, but to ensure that the money is well spent and that the impact on the patients and families is identified in the application and is achieved.

The strategy has enabled the Trustees to monitor more closely the achievements and performance of the Charity. The introduction of a prioritisation matrix for significant projects will assist in providing a basis for allocation of grants to maximise the impact.

Key elements of the strategy are to maximise:-

• charitable income

• charitable impact to EKHUFT and ensure good governance and best practice in all charitable activities

To achieve these aims it is proposed to:

• seek to increase the level of income year on year through targeted fundraising, raising the profile of the Charity and optimising returns on investments

• work to maximise patient benefit by improving the grant making policy and increase the level of support to the Trust over the next two years.

• maintain the highest standards of governance and management whilst adhering to legislation and published best practice and is able to demonstrate value for money from the resources invested.

In order to understand the success of the projects supported, a selection of applicants will be requested to report on the impact the grant has made providing analysis and documented evidence of the difference it made to the medical care, treatment and/or the comfort and experience to the patient.

Significant projects identified for support in the coming year include the Dementia Appeal – Various facilities on all sites and numerous projects which go to support some of our most vulnerable patients.

The Charity can only achieve these plans with your support. Please go to our website for more information about our work and to donate.
www.ekhcharity.org.uk

Financial Summary

Financial Review Summary

The Charity's main source of income comes from the generosity and efforts of the public who give voluntary donations as a thank you for the care they or their friends and family have received, through fundraising, in memory of loved ones and in bequests and legacies from their estates.

Without this support the work of the Charity to provide additional facilities, support to patients, relatives and staff and enhance the services provided by the Trust would not be possible.

The following figures provide an overview and are drawn from the full Annual Accounts at the back of this report.

At the end of the financial year the charity's total funds held were £2.7m, of this total £1.6m was held in restricted funds. Restricted funds are those which the donor has made a binding restriction on the purpose or location where their monies can be spent) £1.1m of funds were held in unrestricted funds. Theses funds reflect the wishes or expectations of the donor by supporting the service or speciality identified.
The charity remaining balance is held in endowment. This fund allows the charity to spend the interest from the fund whilst holding the original value intact (capital value).

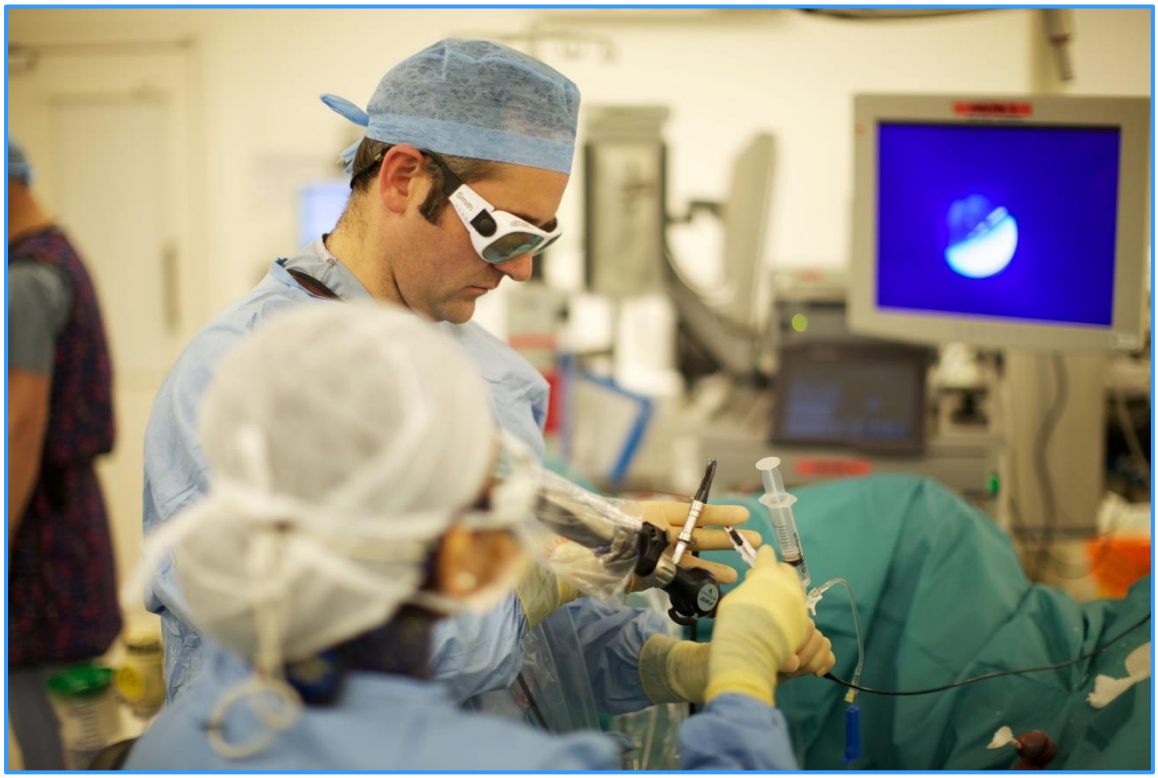
Where our income came from;

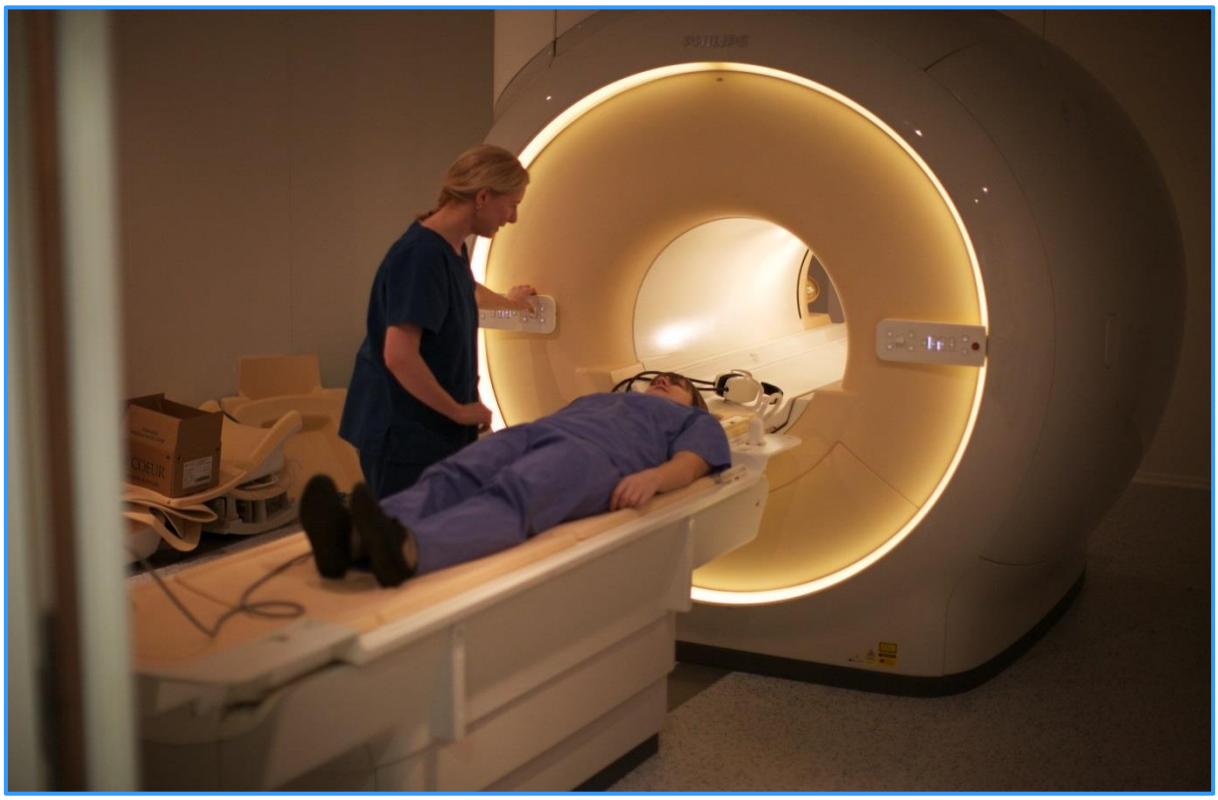
The Charity received a total of £0.9m income for the year. (£0.5m 2018/19) This substantial increase was principally due to two significant legacies (gifts made in a will) and an increase of £0.1m made by donors through fundraising and direct donations in appreciation of the care they, their friends & families received from the East Kent Hospitals University NHS Trust.

The charity was fortunate to receive £9k of income from Co-operate partners (an additional £2k from last year).

Whilst the charity saw loss in the value of investments held of £0.2m due to the decline in global markets as an impact of Covid-19. The charity has worked proactively with their Investment managers – Cazenove (part of the Schroders Group) to ensure recovery and resilience in 2020/21.

Investment income received in the year from dividends and interest was £82k a small increase of £4k from 2018/19.





Where we spent our funds

The Charity spends the funds received in accordance with charity law, its' grant making policy and respecting the wishes of the donors.

This year the charity spent 90% (including support costs) of its total expenditure in providing equipment and supporting the wellbeing of staff and patients of the East Kent Hospitals University NHS Trust.

The charity works hard to ensure that expenditure achieves benefits to the patients and visitors who use the facilities and the services which may not otherwise be possible within the constraint of the Trust's budgets.
Trustees consider each application (those over £25k) on merit and aim to support the patient, staff and visitor's wellbeing, experience and outcomes. This is achieved through investment in medical equipment that provides technological advances in treatments, supporting projects that include the equipping, refurbishment of staff and patient spaces. Providing respite for staff and reflective spaces for patients and their families and rooms for sensitive consultations.

A summary of the categories of grants given to the Trust are listed below;
Medical equipment £0.5m
Building and refurbishment £0.1m.
Patient education and welfare £0.2k

Accounting rules (FRS102) require that the governance and administrative costs to be included in the value of the grant (charity activity) and therefore the accounts report the value of the grant plus apportioned costs of £95k showing grants to the Trust of £0.8m (see note 3).
The Trustees review the costs on an annual basis to ensure that they reflect the requirements to administer the Charity in compliance with current legislation and effective day to day management of the funds.
The Charity is a member of the NHS charities Together (Previously Association of NHS Charities) and uses their data to benchmark administration and fundraising costs. This comparison looks at NHS Charities of a similar size and geographical spread.

Structure, Governance & Management

The East Kent Hospitals Charity is a registered charity (number 1076555)*.

The charity exists to raise and receive charity donations and covers the funds given to wards, departments and services provided by the East Kent Hospitals University NHS Foundation Trust. The following hospitals are the primary sites although outreach and other units and clinics are supported:

- William Harvey Hospital (WHH), Ashford
- Queen Elizabeth The Queen Mother Hospital (QEQM), Margate
- Kent & Canterbury Hospital (K&C), Canterbury
- Buckland Hospital (BHD), Dover
- Royal Victoria Hospital (RVH), Folkestone

The objectives of the Charity as stated in the governing document are: - 'The Trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose relating to the National Health Service'.

At the balance sheet date, 31st March 2020, there were a total of 44 individual funds established under this Umbrella registration. Of those funds 20 are restricted, or special purpose funds and some of these are registered under the Umbrella as subsidiary charities governed by separate objects within the Charities Commission guidelines for fund expenditure. See page 29.

The Charity has one small Endowment fund, which allows only the income to be spent, whilst the capital remains invested. The remaining 23 funds are Unrestricted or Designated Funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust. The major funds within these categories are disclosed in Note 8 in the accounts. The total value of funds held at 31st March 2020 was £2.7m.

The Umbrella registration allows for a single set of consolidated accounts for all the subsidiary charities and funds held under the umbrella. However, separate accounts for each fund are maintained to enable identification of transactions and balances.

*(*The charity was established in April 1999 by Declaration of Trust Deed as East Kent Hospitals NHS Trust Charitable Fund and amended by Trustee resolutions and supplemental deeds to incorporate name and structure changes.)*

The contact address is:

East Kent Hospitals Charity
3rd Floor Trust Offices
East Kent Hospitals University
NHS Foundation Trust
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
Kent. CT1 3NG.

Telephone: 01227 866356

The Trustees

East Kent Hospitals University NHS Foundation Trust (the Trust) is the Corporate Trustee, empowered by the NHS Act 2006. The Board of Directors effectively adopts the role of Trustee as defined by the Charity Commission.

Individual members of the Board are not trustees under Charity Law, but act as agents on behalf of the Corporate Trustee. The Council of Governors is responsible for the appointment of the Chairman and Non-Executive Directors (NEDs) and approving the appointment of the Chief Executive. The council of Governors are elected and appointed to post. For further details visit **www.ekhuft.nhs.uk.**

None of the Trustees have received reimbursements or remuneration from the Charity for either their work or expenses incurred in this financial year whilst undertaking their responsibilities for the Charity.

The following Trust Directors and Non-Executive Directors were/are members of the Charitable Funds Committee during the reported period and are considered to be the key management personnel for the charity:

Charitable Funds Committee - Executive Directors

Susan Acott
Chief Executive

April 2018 – Present
2/4 meetings attended

Liz Shutler
Director of Strategic Development and Capital Planning / Deputy Chief Executive

January 2004 – Present
3/4 meetings attended

Phil Cave
Director of Finance and Performance

October 2017 - Present
4/4 meetings attended

Dr Paul Stevens
Medical Director

January 2004 – December 2019

0/3 meetings attended

Dr Rebecca Martin
Chief Medical Officer

March 2020 - Present
1/1 meeting attended

Charitable Funds Committee - Non-Executive Directors

Sunny Adeusi
Chair of CFC/
Non-Executive Director

March 2020 (CFC Chair – Present. (CFC member January 2017 - Present)
4/4 meetings attended

Barry Wilding
Senior Independent Director/
Non-Executive Director

December 2015 - Present
3/4 meetings attended

Keith Palmer
Non-Executive Director

January 2017 (CFC Chair) – December 2019
(CFC member January 2020 – March 2020). 4/4 meetings attended

Structure

Administrative Structure

Charitable Funds Committee

Acting for the Corporate Trustee, the Charitable Funds Committee (CFC) was established as a separate committee in August 2008 to provide a dedicated team to manage the affairs of the Charity independently from the business of the Trust, whilst still linking closely with its strategic objectives.

It is responsible for the management of the Charitable Fund under the Terms of Reference which are reviewed annually and updated where required to meet the changing needs of the Charity. The CFC meets routinely (quarterly) and additional meetings are held if required.

All new members of the CFC attend an induction course for Charity Trustees within 6 months of appointment unless they have proven knowledge and experience as a Trustee. Delegated signatories are provided with guidelines and information regarding the Charity to ensure they understand their responsibilities.

The CFC review the Charity's affairs as outlined below:

- Performance and management of investments
- Financial matters relating to cash management
- Charity Policies
- Management of properties
- Review grant allocations to achieve objectives
- Approval of Grants over £25k as per the Scheme of Delegation
- Recommendation of grants over £100k to the Board of Directors
- Approve Strategy
- Agree administration, fundraising and audit budget

The recommendations of the CFC are taken to the next available Board of Directors meeting for ratification. Members are required to disclose all relevant interests at the start of meetings and withdraw from decisions when a conflict of interest arises.

Officers

The Charity has 3.4 whole time equivalent (wte) staff employed by the Trust under Staff benefits are in accordance with the NHS Agenda for Change terms and conditions. Staff costs are recharged to the Charity as per budget agreed annually by the Charitable Funds Committee. Professional services and advisors are appointed by the Charity as required.

1.9 wte staff are responsible for the daily administration of the funds including applications, all financial transactions and procedures, policies and financial reporting to the CFC including the production of the Annual Accounts and Report.

The remaining 1.4 wte are employed as Fundraisers to the Charity, responsible for the management of all aspects of fundraising for the Charity including supporting internal and external fundraisers, overseeing and arranging fundraising events, volunteers and the marketing and promotion of the Charity in all forms

Advisors

Investment Managers

Schroder & Co Ltd
T/as Cazenove Capital
12 Moorgate
London
EC2R 6DA

Bankers

Lloyds Banking Group
2 City Place
Beehive Ring Road
Gatwick
RH6 0PA

Auditors

Grant Thornton UK LLP
110 Bishopsgate | London
EC2N 4AY

Legal Advisors

Clyde & Co
St Boltolph Building
138 Houndsditch
London
EC3A 7AR

NHS Charities Together (formally Association of NHS Charities)

East Kent Hospitals Charity is an active member of the NHS Charities Together whose role is to support, and to be the voice of all NHS Charities in England and Wales.
The principal aim of the Association is to promote the effective working of NHS Charities. Collect donations from made to the NHS and distribute to members via grants.
Being a member offers our Charity a wide range of support, networking and information services as well as adopting best practice across the sector.

To find out more please visit:
www.nhscharitiestogether.co.uk

Objectives & Activities

Grant making policy

The Charity makes grants from its unrestricted and restricted funds. A Scheme of Delegation is maintained for the authorisation of grants and signatories are aligned to The Trust delegated signatories.

The staff are made aware of the Trust's Standing Financial Instructions and Orders which are also applicable to the Charitable Funds. All signatories receive a monthly financial statement of all the charity's funds.

Grants are made for specific purposes and projects under an application process. All application over £25k are reviewed by the Charitable Funds Committee (CFC) to ensure that they meet the objectives of the Charity.

The CFC review the applications for quality, value for money and patient benefit. Where any expenditure is considered inappropriate feedback is provided to the applicant.

No fund is permitted to operate in an overdrawn position and although an application may be approved this may be subject to the ward or department securing the fundraising to support all or part of the project.

Risk statement

During the year the Trustees continued to review the major risks to the Charity. The Charity uses the Trust procedures and processes. These systems undergo annual audit and risk reviews and action plans to mitigate the risks. The significant areas of risk have been identified as:

- Fall in investment capital and returns
- Reduction in income levels
- Reconfiguration of NHS services

The Trustees have mitigated these risks by: -

- Retaining expert investment managers
- Maintaining a diversified low risk portfolio
- Review performance against benchmarks
- Utilise cash holdings in Short Term Deposits to maximise returns and diversify investment opportunities
- Reviewing the investment in Fundraising and analysing major and specific appeals and projects to identify effectiveness of approach and performance
- Working with the Trust to understand the changes in strategic approach to delivery of services.

In the Trustees opinion all appropriate action has been taken to ensure the risks are mitigated.

Investment Powers

The investment powers are stated in the Declaration of Trust which provides for the following:

''to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustees in their discretion think fit but so that the trustees:

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures and traded options);

c) shall not have power under this clause to engage in trading ventures; and

d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.

Investment Objective

The investment objective is to seek to maximise the total return from the fund consistent with a relatively low degree of risk. The target is to achieve a 4% return annually.

Trustees have directed the investment managers to take an ethical approach to the portfolio and that no investments should be made in the shares of tobacco producing companies and will also avoid investment in companies that have more than 10% of their turnover in:

- Alcohol Manufacture
- Armaments
- Gambling
- Pornography

The ethical restrictions are not considered to be so restrictive as to be likely to impact on long term performance.

Investment Performance

The Investment Managers were granted discretionary management powers under contract in January 2013.

The total value of the investment portfolio at 31 March 2019 was £2.0m (excluding cash of £53k).

2019/20 saw an unrealised loss on investments held of £0.2m as part of the impact from Covid-19 on global markets. Dividends for 2019/20 were £77k a small increase of £6k against 2018/19.

The CFC monitored and reviewed the performance of the Investment Managers on a quarterly basis as part of the Finance report.

The investment managers are required to meet with the Trustees at least once in any one financial year, to explain any deviation from the anticipated rate of return in order that investment opportunities can be maximised. Investment managers are asked to explain exceptional losses and proposed recovery plans.

There is an annual review of the investment policy within the Charity Management Document to ensure that returns are maximised at medium to low risk. Unless the donor has expressed a specific request regarding investment, the investment of funds is in accordance with the Trustees Investment Act 1961.

Reserves Policy

The Trustees recognise their obligation to ensure that income received by the Charity should be spent effectively and promptly in accordance with the funds' objects.

It is however considered prudent that a minimum reserve of £0.3m should be held to cover contingencies, particularly stock market fluctuations. This sum has been identified as being equal to one year's operational costs and estimated outstanding commitments.

Charity Reserves as defined under SORP 2015 are those funds which become available to the charity to be spent at the Trustees' discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

Definition of Funds

Restricted Funds
Funds which are subject to specific trusts e.g. terms of will

Endowment Funds
Funds which are to be held as capital and only the income generated can be expended.

Designated Funds
Funds held for specific wards or services or a particular hospital in consideration of donors wishes. They do not form any binding Trust and can be transferred to general purpose funds at the discretion of the Trustees.

Unrestricted Funds
Funds which are expendable at the discretion of the Trustees, or designated in consideration of donors wishes.

The Trustees have reviewed Reserves Policy and have determined that it is necessary to retain reserves over the longer term to:

- *Reduce the impact of risks from the external environment should the levels of income reduce significantly*

- *Continue their programme of support to the Trust.*

- *Hold sufficient reserves to ensure the charity can cover its ongoing operational costs to process outstanding commitments.*

- *Meet the cost of closure or transfer of the charity's affairs should the need ever arise*

At the 31st March 2020 the reserves were identified as below: -

Total Unrestricted funds £ 1.1m
Less property funds (£0.1m)
Freely available reserves £1.0m

The level of reserves held at 31 March 2020 is £0.6m higher than the minimum requirement of £0.3m set out in the policy.

The majority of donations received are for specific wards and services and are held as designated to the Care Group or individual ward or department in recognition of the donor's wishes.

Our Funds

Objects

The East Kent Hospitals Charity is registered with the Charity Commission (England and Wales) as an 'umbrella' charity under registration number 1076555.

Under the terms of the governing document, the Trustees can use the unrestricted funds to 'hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose relating to the NHS'.

The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the umbrella Charity. Some of these are registered with the Charity Commission as subsidiary charities of the Umbrella Charity. See Note 8.3 page 36.

Fund Structure

Where a donation is received under a legally binding trust, for example under the terms of a will, the funds are classified as restricted. Where the restriction is removed, either by the spending of original funds, or where no binding agreement is held, funds are re-classified as unrestricted and placed into general purpose funds or a fund that achieves the donor's wishes.

The Trustees periodically review balances held in designated funds to determine whether these funds are likely to be committed in the near future and the extent to which there is a continuing need identified for any particular fund(s). In the event that the need no longer exists, those funds will be redirected to the appropriate Care Group General Fund.

Further rationalisation is undertaken for individual funds that are not considered financially viable, or have the same objective as another fund. These funds will also be redirected to General Purposes or amalgamated with a similar fund.

The dissolution of special purpose funds is managed under Clause I in the governing documents, without the need for referral to the Charity Commission.

A continuing programme of rationalisation of funds is maintained to support the objectives of the Charity. Where funds have been received without forming a binding Trust they are designated to the appropriate Divisional Fund which is responsible for delivering the service and are classified as unrestricted.

Care Group Funds

The following funds are held as general-purpose funds for the wards and services managed under the clinical care group and are classified as unrestricted.

Urgent and Emergency Care – incorporates the following specialties: - Medicine & A&E

General & Specialist Medicine
Respiratory, Diabetes, General Medicine, Neurological Services, Cardiology, Renal, Tissue Viability, Gastroenterology Stroke , Health Care of Older People and integrated discharge team.

Surgery & Anaesthetics Services – Anaesthetics, Critical Care, Pain Services General Surgery, Urology,

Upper Surgery – Head & Neck and Dermatology
Head and Neck, ENT, Maxillofacial, Ophthalmology, Breast Surgery & Dermatology.

Cancer Services:-
Cancer, Oncology and Blood Diseases and Haemophilia

Women's Services and Children's Services
Maternity, Child Health & Women's Health

Clinical Support Services – Pathology, Radiology Pharmacy, Audiology Therapies, Outpatients and Infection prevention & control

Registered Restricted Funds

The Charity holds funds for general purposes to benefit the specific NHS hospitals received through legacies and other binding agreements.

Buckland Hospital – Registration 1076555/5

Queen Elizabeth The Queen Mother Hospital – Registration 1076555/6

Royal Victoria Hospital – Registration 1076555/2

William Harvey Hospital – Registration 1076555/4

Kent & Canterbury Hospital - Registration 1076555/7

Other Restricted funds are held for specific purposes and/or wards and departments with the NHS Trust:-
Special Care Baby Unit – William Harvey Hospital Registration 1076555/1

Heart Research – Kent and Canterbury hospital Registration 1076555/20

Renal Unit Fund – Kent and Canterbury hospital Registration 1076555/43

Chest Clinic – Kent and Canterbury hospital Registration 1076555/18

Lesley Court Fund – Kent and Canterbury hospital Registration 1076555/15

P Hall Legacy HCOOP – Kent and Canterbury hospital Registration 1076555/12

Statement of Trustees' responsibilities in respect of the Trustees' annual report and the financial statements

Under charity law, the trustees are responsible for preparing a Trustees' Annual Report and financial statements for each financial year which show a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period. The trustees have elected to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 *the Financial Reporting Standard applicable in the UK and Republic of Ireland.*

In preparing these financial statements, generally accepted accounting practice entails that the Corporate Trustee:

- select suitable accounting policies and
- then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether the recommendations of the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements;
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

The Corporate Trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law.

They are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision.

They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the financial and other information included on the charity's website.

Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdiction.

As far as the trustees are aware, there is no relevant audit information of which the charity's' auditors are unaware and the trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts.

The financial statements attached have been compiled from and are in accordance with the financial records maintained by the trustees.

By Order of the Trustees;

Signed:

Chief Executive:

Date:

Signed

Director of Finance & Performance Management:

Date:

Independent examiner's report to the corporate trustee of East Kent Hospitals Charity

I report on the accounts of East Kent Hospitals Charity (the "charity") for the year ended 31 March 2020, which are set out on pages 12 to 38.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:

  to keep accounting records in accordance with section 130 of the Charities Act 2011; and

  to prepare accounts which accord with the accounting records; and

  to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met, or

to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Basis of independent examiner's statement

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as corporate trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement above.

Respective responsibilities of corporate trustee and examiner

The charity's corporate trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed. The charity's gross income exceeded £250,000 and I am qualified to undertake the examination by being a qualified member of the Chartered Institute of Public Finance and Accountancy.

It is my responsibility to:
examine the accounts under section 145 of the Charities Act 2011;

to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and

to state whether particular matters have come to my attention.

Your attention is drawn to the fact that the charity's trustees have prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustees have done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

Use of this report

This report is in respect of an examination carried out under section 145 of the Charities Act 2011. This report is made solely to the charity's corporate trustee, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

Darren Wells

CPFA

Grant Thornton UK LLP
Chartered Accountants

London

26/11/2020

Statement of Financial Activities

Statement of Financial Activities for the year ended 31 March 2020

					2019/20				2018/19
Income from	**Note**	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**
	2	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Donations and legacies		365	495	0	**860**	300	138	0	**438**
Other trading activities		0	0	0	**0**	0	0	0	**0**
Investment income		30	51	1	**82**	28	49	1	**78**
Total Income		**395**	**546**	**1**	**942**	**328**	**187**	**1**	**516**
Expenditure	**3**								
Raising funds	3.1	(39)	(49)	(1)	**(89)**	(33)	(48)	(1)	**(82)**
Charitable Activities	3.2								
Medical equipment		(201)	(292)	(1)	**(494)**	(200)	(290)	(1)	**(491)**
Building and refurbishment		(29)	(50)	0	**(79)**	(18)	(59)	0	**(77)**
Patient Education and welfare		(122)	(101)	0	**(223)**	(42)	(52)	0	**(94)**
Staff education and welfare		(4)	(14)	0	**(18)**	(77)	(4)	0	**(81)**
Research		0	0	0	**0**	0	0	0	**0**
Total expenditure on Charitable Activities		**(356)**	**(457)**	**(1)**	**(814)**	**(337)**	**(405)**	**(1)**	**(743)**
Total expenditure		**(395)**	**(506)**	**(2)**	**(903)**	**(370)**	**(453)**	**(2)**	**(825)**
Net gains/(losses) on investments	5	(50)	(142)	(2)	**(194)**	13	35	1	**49**
Net income/ (expenditure)	**4**	**(50)**	**(102)**	**(3)**	**(155)**	**(29)**	**(231)**	**0**	**(260)**
Net movement in funds		**(50)**	**(102)**	**(3)**	**(155)**	**(29)**	**(231)**	**0**	**(260)**
Fund balances brought forward		**1,116**	**1,673**	**25**	**2,814**	**1,145**	**1,904**	**25**	**3,074**
Fund balances carried forward		**1,066**	**1,571**	**22**	**2,659**	**1,116**	**1,673**	**25**	**2,814**

The accompanying notes form an integral part of these financial statements.

Balance Sheet

Balance Sheet as at 31 March 2020

					2019/20				2018/19
	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Fixed Assets	5								
Investments - Cazenove portfolio		801	1,182	22	**2,005**	834	1,390	25	**2,249**
Properties		80	0	0	80	48	0	0	48
Total Fixed Assets		**881**	**1,182**	**22**	**2,085**	**882**	**1,390**	**25**	**2,297**
Debtors due over one year	**6**	**18**	**0**	**0**	**18**	**16**	**0**	**0**	**16**
Current Assets									
Debtors due within one year		78	330	0	**408**	54	16	0	**70**
Cash held in investment portfolio		2121	32	0	**53**	16	27	0	**43**
Cash at bank and in hand		80	118	0	**198**	189	315	0	**504**
Total Current Assets		**179**	**480**	**0**	**659**	**259**	**358**	**0**	**617**
Liabilities									
Creditors: Amounts falling due within one year	**7**	**(12)**	**(91)**	**0**	**(103)**	**(41)**	**(75)**	**0**	**(116)**
Total Net Current Assets/(Liabilities)		**185**	**389**	**0**	**574**	**218**	**283**	**0**	**517**
Total Net Assets		**1,066**	**1,571**	**22**	**2,659**	**1,116**	**1,673**	**25**	**2,814**
Funds of the Charity	8								
Endowment Funds	**8.1**	**0**	**0**	**22**	**22**	**0**	**0**	**25**	**25**
Restricted	8.2	0	1,571	0	**1,571**	0	1,673	0	**1,673**
Unrestricted	8.3	1,066	0	0	**1,066**	1,116	0	0	**1,116**
Total Funds		**1,066**	**1,571**	**22**	**2,659**	**1,116**	**1,673**	**25**	**2,814**
The accompanying notes form an integral part of these financial statements.									
Signed:	Director of Finance & Performance Management								
Date:									

Notes to the financial statements for the year ended 31 March 2020

Principal accounting policies

1.1 Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective 1 January 2015 and the Charities Act 2011.

East Kent Hospitals Charity represents a public benefit entity as defined by FRS 102.

The Trustees consider that there are no material uncertainties about the Charity's' ability to continue as a going concern and uncertainties affecting the current year's accounts. In future years, the key risks are a fall in investment and voluntary income. Arrangements are in place to mitigate those risks (see the risk management and reserves sections).

1.2 Incoming Resources

Donations, grants, legacies and gifts in kind.

All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. It is not the Charity's policy to defer income.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed

Legacies are accounted for as incoming resource either on receipt or where the receipt of the legacy is probable. Receipt is probable when:

•Confirmation has been received from the representatives of the estate(s) that probate has been granted
•The executors have established that there are sufficient assets in the estate to pay the legacy and
•All conditions attached to the legacy have been fulfilled or are within the charity's control
•Where the amount of the legacy can be reliably estimated.
•Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is shown as a contingent asset.

Incoming resources from Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by Trustees.

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods

Intangible Income
Intangible income, which comprises donated services or use of Trust property, is included in income at a valuation which is an estimate of the financial cost borne by the donor where such a cost is material, quantifiable and measurable. No income is recognised when there is no financial cost borne by a third party.

1.3 Resources expended

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:
•There is a present legal or constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives
•It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
•The amount of the obligation can be measured or estimated reliably. The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs and overheads from East Kent Hospitals University NHS Foundation Trust and the East Kent Finance Consortium and are apportioned on an average fund balance monthly across all funds. See note 1.2 and note 3.

Fundraising costs
The costs of generating funds are the costs associated with generating income for the charity. This will include the costs associated with investment

managers, administration costs for management of investment properties and other promotional and fundraising events including any trading activities and for the salaries of the fundraisers as agreed with the Trust.

Charitable activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the Trustees and accepted by the beneficiaries. See note 3.

Analysis of grants
The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of its charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the statement of financial activities and further analysis in relation to activity is provided in note 3.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

1.4 Fixed assets
Investments fixed assets

Investments are a form of basic financial instrument. Investments held by the Trustees' investment managers are initially recognised at their transaction value and are subsequently measured at their fair (market) value as at the balance sheet date as reported by the Investment Managers (Schroders T/as Cazenove). The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the balance sheet at the current market value. The Trustees recognise that the main form of financial risk for the charity is the volatility in equity and other investment markets which are subject to global economic conditions and the investors' responses to global incidents. To minimise risk the Trustees have identified that longer term investment produces a more stable return than short term investments and holds a mixed portfolio to alleviate any single area of instability.

Notes continued on page 37

2 Income from

	Unrestricted	Restricted	Endowment	Total 2019/20	Unrestricted	Restricted	Endowment	Total 2018/19
Donations from Individuals	**241**	**27**	**0**	**268**	**140**	**24**	**0**	**164**
Donations from groups/orgs	**26**	**1**	**0**	**27**	**24**	**10**	**0**	**34**
Corporate donations	**9**	**0**	**0**	**9**	**7**	**0**	**0**	**7**
Legacies	**89**	**467**	**0**	**556**	**129**	**104**	**0**	**233**
Total Donations and Legacies	**365**	**495**	**0**	**860**	**300**	**138**	**0**	**438**
Other trading activities	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Investment								
Dividends from investment portfolio	**27**	**49**	**1**	**77**	**24**	**46**	**1**	**71**
Bank Interest	**3**	**2**	**0**	**5**	**4**	**3**	**0**	**7**
Total Investment income	**30**	**51**	**1**	**82**	**28**	**49**	**1**	**78**
Total incoming resources	**395**	**546**	**1**	**942**	**328**	**187**	**1**	**516**

3 Resources Expended

	Unrestricted Activity	Support Costs	Restricted Activity	Support Costs	2019/20 Total	Unrestricted Activity	Support Costs	Restricted Activity	Support Costs	2018/19 Total
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Raising Funds (note 3.1)										
Fundraising events	2	0	0	**0**	**2**	4	0	0	**0**	**4**
Fundraising salaries	23	0	42	**1**	**66**	15	0	43	**0**	**58**
Fundraising general	11	0	2	0	**13**	7	0	3	0	**10**
Investment - portfolio	3	0	5	**0**	**8**	7	0	2	**0**	**9**
Investment - properties	0	0	0	**0**	**0**	0	0	0	**0**	**0**
Total	**39**	**0**	**49**	**1**	**89**	**33**	**0**	**48**	**0**	**81**
Charitable Activities – (note 3.2)										
Medical equipment	180	21	256	36	**493**	180	20	247	44	**491**
Building and refurbishment	26	3	44	6	**79**	16	2	50	9	**77**
Patient Education and welfare	109	13	88	13	**223**	38	4	44	8	**94**
Staff education and welfare	4	1	11	2	**18**	69	8	4	0	**81**
Research	0	0	0	0	**0**	0	0	0	0	**0**
Total	**319**	**38**	**399**	**57**	**813**	**303**	**34**	**345**	**61**	**743**
Total Resources Expended (excl Endowment Fund)	**358**	**38**	**448**	**58**	**902**	**336**	**34**	**393**	**61**	**824**
Endowment - Gov costs (not apportioned to activities)	0	0	0	**0**	**1**	0	0	0	**0**	**1**
Total Resources Expended	**358**	**38**	**448**	**58**	**903**	**336**	**34**	**393**	**61**	**825**

3.3 Cashflow as at 31 March 2020		
Cash flows from operating activities:	**2019/20**	**2018/19**
	£000's	**£000's**
Net cash used in operating activities	**(396)**	**(283)**
Cash flows from investing activities:-		
Dividends, interest and rents from investments	**82**	**78**
Proceeds from sale of investments	**323**	**491**
Purchase of investments	**(305)**	**(217)**
Charges applied to investments	**8**	**9**
Net cash provided by (used in) investing activities	**108**	**361**
Cash flows from financing activities:		
Repayments of borrowing	**0**	**0**
Cash inflows from new borrowing	**0**	**0**
Receipt of endowment	**0**	**0**
Change in cash and cash equivalents in the reporting period	**(288)**	**78**
Cash and cash equivalents at the beginning of the reporting period	**504**	**469**
Cash and cash equivalent at the end of the reporting period	**216**	**547**
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	**(155)**	**(260)**
Adjustments for: -		
(Gains)/losses on investments	**194**	**(49)**
Dividends, interest and rents from investments	**(82)**	**(78)**
Loss/(profit) on sale of fixed assets	**0**	**0**
(Increase)/decrease in debtors	**(340)**	**212**
Increase/(decrease) in creditors	**(13)**	**(108)**
Net cash provided by (used in) operating activities	**(396)**	**(283)**
Analysis of cash and cash equivalents		
Cash in hand	**189**	**547**

4 Net Movement in Funds

				2019/20				2018/19
	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds	Unrestricted Funds	Restricted Funds	Endowment Funds	Total Funds
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Net resources of general donations and fundraising	(25)	(6)	(2)	**(33)**	(63)	(315)	(2)	**(380)**
Net gain from fundraising-events	(2)	0	0	**(2)0**	(4)	0	0	**(4)**
Net loss from investment properties	0	0	0		0	0	0	**0**
Net gain from investment portfolio/bank	27	46	1	**74**	25	49	1	**75**
Gains & Losses on investment Assets	(50)	(142)	(2)	**(194)**	13	35	1	**49**
Net movement in funds	**(50)**	**(102)**	**(3)**	**(155)**	**(29)**	**(231)**	**0**	**(260)**

5 Analysis of Fixed Asset Investments

Investments	Notes	Portfolio	Investment Properties	Total Fixed Assets
		£000's	£000's	£000's
Market value at 1st April 2019	**b/fwd**	**2,249**	**48**	**2,297**
Less: Disposals at carrying value		(323)	0	(323
add: Acquisitions - less cash		313	0	313
Net gain/loss on revaluation and sale		(226)	32	(194)
Charges applied to capital		(8)	0	(8)
Market value at 31 March 2020		**2,005**	**80**	**2,085**
Uk Equities		383		
Int equities		626		
Other assets		596		
Bonds (fixed assets)		400		
Total Portfolio		**2,005**	**0**	
Properties			**80**	

6 Analysis of Debtors

			31 March 2020			31 March 2019
Accrued income	Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	£000's	£000's	£000's	£000's	£000's	£000's
Amounts falling due within one year:						
Gift Aid	1	0	**1**	1	0	**1**
Legacies	77	330	**407**	53	16	**69**
Amounts falling due over one year						
Loan for property maintenance	18	0	**18**	16	0	**16**
Total debtors	96	330	**426**	70	16	**86**

Debtors are monies due to the Charity which have been identified but not yet received.
The Charity has a long term arrangement for upkeep of a property which is held in Trust in equal shares with the Margate Civic Society.
The Charity pays for maintenance and insurance and charges against the estate at basic rate of interest on funds expended which will be recovered from the estate on distribution, which is subject to a life tenancy and interest.

7 Analysis of Creditors

			31 March 2020			31 March 2019
Amounts falling due within one year:	**Unrestricted Funds**	**Restricted Funds**	**Total Funds**	**Unrestricted Funds**	**Restricted Funds**	**Total Funds**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Trade creditors (Trade Accruals)	0	3	**3**	0	0	**0**
Audit (KMPG)	1	2	**3**	1	3	**4**
East Kent Hospitals University NHS Foundation Trust	11	86	**97**	40	72	**112**
Total creditors falling due within one Year	**12**	**91**	**103**	**41**	**75**	**116**

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

8 Details of Funds

8.1 Analysis of Funds

Endowment Funds	**Balance 31st Mar 2019**	**Incoming Resources**	**Resources Expended**	**Transfers**	**Gains & Losses**	**Balance 31st Mar 2020**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
KCH Longbotham	**25**	1	**(1)**	0	(2)	**23**
Total	**25**	**1**	**(1)**	**0**	**(2)**	**23**

8.2 Restricted Funds	**Balance 31st Mar 2019**	**Incoming Resources**	**Resources Expended**	**Transfers**	**Gains & Losses**	**Balance 31st Mar 2020**
Name of fund	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
KCH Gen Purpose	**591**	18	(172)	(215)	(19)	203
QEQM General Purposes	**354**	415	(178)	0	(43)	548
QEQM Coronary Care Unit - CCU	**2**	0	(2)	0	0	0
KCH Heart Research	**127**	4	(8)	0	(10)	113
KCH Mermikedes ITU	**0**	6	(10)	215	(21)	190
WHH Gen Purpose	**104**	50	(83)	0	(7)	64
RVH Gen Purpose	**113**	3	(14)	0	(9)	93
KCH Renal Unit Fund	**78**	3	(8)	0	(6)	67
BHD Gen Purpose	**79**	2	(5)	0	(6)	70
WHH Celia Blakey Unit	**50**	11	(3)	0	(5)	53
Others	**175**	33	(22)	0	(16)	170
Total	**1,673**	**545**	**(505)**	**0**	**(142)**	**1,571**

8.3 Details of Material Funds	
Endowment Funds	
Name of fund	**Description of the nature and purpose of each fund**
KCH Longbotham	Promoting any charitable purpose related to Kent & Canterbury Hospital services as Trustees see fit
Restricted Funds	
Name of fund	**Description of the nature and purpose of each fund**
KCH Gen Purpose	Charitable purposes relating to NHS wholly or mainly for Kent & Canterbury Hospital
QEQM General Purpose	Any Charitable purpose relating to NHS wholly or mainly for Queen Elizabeth Hospital
QEQM Coronary Care Unit - CCU	Charitable purposes relating to Coronary Care Unit
KCH Heart Research	Charitable purposes relating to NHS to further Heart Research
KCH Mermikedes ITU	Charitable purposes relating to Intensive Care Unit Kent & Canterbury Hospital
WHH Gen Purpose	Any Charitable Purpose relating to NHS wholly or mainly for William Harvey Hospital
RVH Gen Purpose	Any Charitable Purpose relating to NHS wholly or mainly for Royal Victoria Hospital
KCH Renal Unit Fund	Charitable purposes relating to NHS & provision of additional equip & staff training for Renal Services
BHD Gen Purpose	Any Charitable Purpose relating to NHS wholly or mainly for Buckland Hospital
WHH Celia Blakey Unit	Charitable purposes relating to NHS & provision of additional equip & staff training
Designated Funds	
Name of fund	**Description of the nature and purpose of each fund**
QEQM Diabetes Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training
QEQM Property Fund	Any Charitable purpose relating to NHS wholly or mainly for Queen Elizabeth Hospital
QEQM Coronary Care Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training
QEQM Diabetes Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training
EKHT Urgent & Long Term Care Services Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training
EKHT Specialist Services Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training
KCH Coronary Care Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training

1.5 Investment properties

Property assets are not depreciated but are shown at market value. Valuations are generally carried out annually by an appropriate professional. Valuation gains and losses are recorded in the Statement of Financial Activities with the balance sheet reflecting the market value at 31st March 2020. Due to the restriction on the investment property held the valuers have identified a material uncertainty associated with the valuation.

Income and expenditure in respect of investment properties are reflected in the appropriate category in the Statement of Financial Activities. See notes 2 and 3.1.

1.6 Realised gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

Investment income and gains/losses are allocated monthly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.7 Cash and cash equivalents

Cash held in the bank and in hand is used to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term liquid investments usually held for a period of 3 months' notice interest bearing savings accounts. Cash held within the investment portfolio is identified in the balance sheet as reported by the investment managers.

1.8 Prior Year Adjustments

There has been no change to the accounts of the prior year.

1.9 Pensions

The Charity has no employees.

1.10 Irrecoverable VAT

Any irrecoverable VAT is charged to the Statement of Financial Activities.

9 Transfer of Funds

The Trustees review all unrestricted and restricted funds to ensure that there is a need and can meet the restriction of those funds.

10 Related party transactions

During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the East Kent Hospitals Charity. The Charity has made revenue and capital payments to the East Kent Hospitals University NHS Foundation Trust where the Trustees are also members of the Trust Board.

11 Charity Tax

East Kent Hospitals Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

12 Contingent Assets

The charity does not have any contingent assets.

13 Exemptions from Disclosure

The Charity has no exemptions from disclosure.

14 Funds held as custodian trustee on behalf of others

The Charity holds no funds on behalf of others as a custodian trustee.

Donation Form

East Kent Hospitals Charity

Full Name:

Home Address:

Post Code: Telephone:

Email:

giftaid it

Boost your donation by 25p of Gift Aid for every £1 you donate!

Gift Aid is reclaimed by the charity from the tax you pay for the current tax year. Your address is needed to identify you as a current UK taxpayer.

In order to Gift Aid your donation you must tick the box below:

☐ I want to Gift Aid my donation of £_____ to East Kent Hospitals Charity.

I am a UK taxpayer and understand that if I pay less Income Tax and/or Capital Gains Tax in the current tax year than the amount of Gift Aid claimed on all my donations it is my responsibility to pay any difference.

I wish to donate the sum of £ to East Kent Hospitals Charity.

I request that the donation be used for: (please tick)

☐ Wherever it is most needed

☐ Patients and staff at the Hospital

☐ The following specific purpose/department:

Method of payment

☐ Credit ☐ Card ☐ Cheque ☐ Cash ☐ Other (e.g CAF voucher)

Please make cheques payable to East Kent Hospitals Charity

Cardholder as appears on card

Card No ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Start Date/Issue No Expiry Date Three digit Security No

Please send to:

East Kent Hospitals Charity, 3rd Floor, Trust Offices, Kent & Canterbury Hospital, Ethelbert Road, Canterbury, Kent. CT1 3NG

We would like to be able to contact you about future events and appeals. The charity will not pass on your details to any third party. If you do not want to receive this information, please tick the box ☐

NHS
East Kent
Hospitals University
NHS Foundation Trust

Our Ref: MFTCF_LOE

Your Ref

Grant Thornton UK LLP

30 Finsbury Square

London

EC2A 1AG

8 December 2020

Dear Sirs

East Kent Hospitals NHS Foundation Trust Charitable Fund accounts for the year ended 31 March 2020

This representation letter is provided in connection with the independent examination of the accounts of East Kent Hospitals NHS Foundation Trust Charitable Fund for the year ended 31 March 2020 for the purpose of making of an independent examiner's report in accordance with Section 154 of the Charities Act 2011.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Accounts

i We have fulfilled our responsibilities, as set out in the terms of our engagement letter dated for the preparation of accounts in accordance with section 132 of the Charities Act 2011 and comply with the Statement of Recommended Practice for accounting and reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) ('Charities SORP (FRS 102)') [(effective 1 January 2019)], in particular the accounts give a true and fair view in accordance therewith.

ii We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

iii Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

iv Except as stated in the accounts:

a. there are no unrecorded liabilities, actual or contingent;

b. none of the assets of the charity has been assigned, pledged or mortgaged;

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

v Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement.

vi All events subsequent to the date of the accounts and for which the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vii We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your findings. The accounts have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

viii The accounts are free of material misstatements, including omissions.

ix We can confirm that:

a. all income has been recorded;

b. the restricted funds have been properly applied;

c. constructive obligations for grants have been recognised; and

d. we consider there to be appropriate controls in place to ensure overseas payments are applied for charitable purposes.

x The charity has complied with all aspects of contractual agreements that could have a material effect on the accounts in the event of non-compliance. There has been no non-compliance with requirements of regulatory authorities that could have a material effect on the accounts in the event of non-compliance.

xi We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the accounts.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.

xiii The charity meets the conditions for exemption from an audit of the accounts as set out in section 145 of the Charities Act 2011.

Information Provided

xiv We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the accounts such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your examination; and

c. unrestricted access to persons from whom you determine it necessary to obtain evidence.

xv We have communicated to you all deficiencies in internal control of which we are aware.

xvi We have disclosed to you the results of our assessment of the risk that the accounts may be materially misstated as a result of fraud.

xvii All transactions have been recorded in the accounting records and are reflected in the accounts.

xviii We have disclosed to you our knowledge of fraud or suspected fraud affecting the charity involving:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the accounts.

xix We have disclosed to you our knowledge of any allegations of fraud, or suspected fraud, affecting the charity's accounts communicated by employees, former employees, analysts, regulators or others.

xx We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing accounts.

xxi We have disclosed to you the identity of the charity's related parties and all the related party relationships and transactions of which we are aware.

xxii We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the accounts.

xxiii We confirm that we have reviewed all correspondence with regulators, which has also been made available to you, including the guidance 'How to report a serious incident in your charity' issued by the Charity Commission (updated in June 2019). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the date of signing of the balance sheet.

Yours faithfully

Name ……

Position ……..

Date ……..

Signed on behalf of East Kent Hospitals NHS Foundation Trust Charitable Fund

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**10 DECEMBER 2020**
REPORT TITLE:	**HEALTH & SAFETY (H&S) AND ESTATES STATUTORY COMPLIANCE UPDATE**
BOARD SPONSOR:	**DIRECTOR OF STRATEGIC DEVELOPMENT AND CAPITAL PLANNING/DEPUTY CHIEF EXECUTIVE**
PAPER AUTHOR:	**INTELLIGENT CLIENT / ASSOCIATE DIRECTOR OF SAFETY / DIRECTOR OF CAPITAL & TECHNICAL**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report updates the Trust Board on the Health and Safety Toolkit Audit (HASTA) performance.

Rescheduled HASTAs from earlier in the year and pre-scheduled audits have continued throughout the year, this is alongside the Health & Safety Team assisting with ward and departmental social distancing risk assessments across the Trust. Social distancing compliance is now being monitored as part of the HASTA audits.

The current cumulative Trust performance to date is 96% an improving picture when compared with former years (please see table below).

HASTA Audit Scores by Care Group:

	2020/21	2019/20	2018/19	2017/18
Cancer	93%	94%	72%	87%
Clinical Support Services	98%	96%	78%	87%
Corporate	99%	88%	82%	85%
General and Specialist Medicine	95%	88%	63%	81%
Head & Neck	94%	89%	58%	86%
Surgical & Anaesthetic	94%	92%	70%	79%
Urgent & Emergency	99%	62%	45%	66%
Women & Children	96%	90%	66%	73%
Trust	96%	90%	71%	82%

Health & Safety Team:
The team has adapted well to the operational changes that the Covid-19 situation has imposed upon them and responded very well to the short notice, high priority requests for assistance in patient facing areas. One member of the team received a 2gether Support Solutions (2gether) Team Award and both team members have been nominated for an Encouraging Praise in Colleagues (EPiC) award for their continued hard work.

East Kent Hospitals University NHS Foundation Trust

Link Worker Meetings:
Quarterly Link Worker meetings have continued via WebEx, the feedback from these meetings has been positive with regular attendance levels being over 50 link workers per meeting.

Taking the feedback into account and the flexibility WebEx offers to staff members the option to join these meetings via WebEx will continue after social distancing restrictions have been lifted.

Health and Safety Training:
During October 2020 Link Worker training was delivered to 63 members of staff utilising WebEx. Further Link Worker training sessions alongside risk assessment workshops have been planned for February and March 2021.

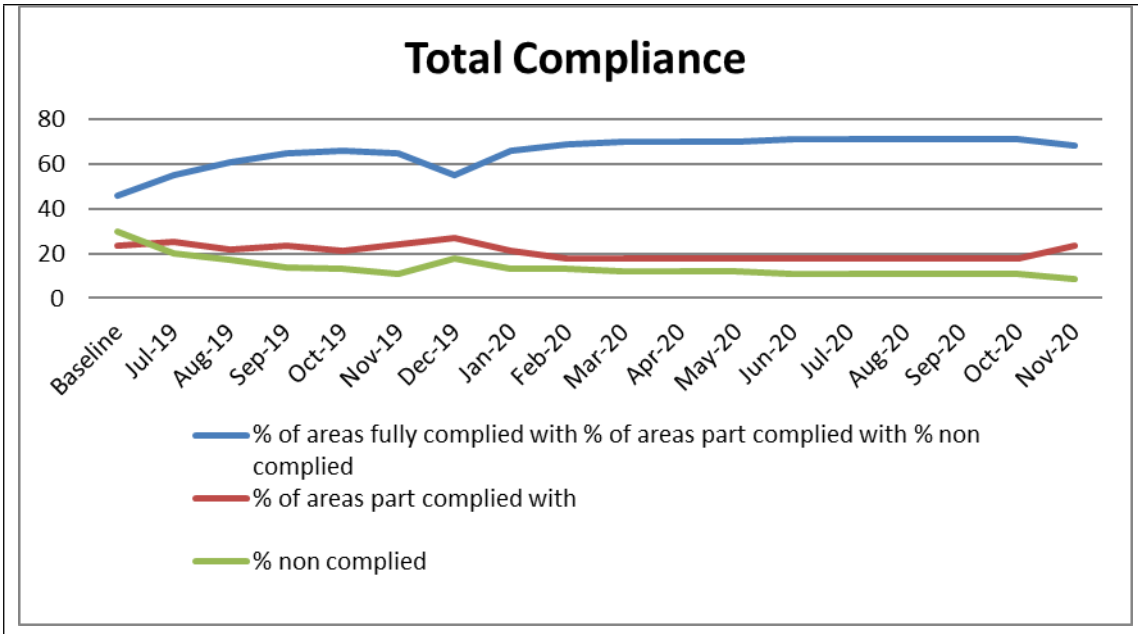
Care Group Health and Safety Leads:
Regular meetings with the Care Group Health and Safety Leads have continued through 2020 and have been essential in sharing vital information and co-ordinating social distancing risk assessments across the Trust. The Health and Safety Leads are senior members of the Trust who are responsible for providing assurance to their Care Group triumvirates that health and safety standards are being adhered to and/or identifying actions that are required to address any areas of non-compliance.

Conclusion:
Working closely with Trust colleagues the Health and Safety team has continued to ensure compliance against the HASTA framework and support areas as requested. The team will also adapt to the circumstances as and when required and will maintain a strong presence on all sites where conditions permit.

In addition, Trust Health and Safety Leads have worked with their teams and their Care Group triumvirates to establish, improve and sustain good practise in all areas of health and safety within their areas of responsibility resulting in an overall improvement which is demonstrated in the current level of HASTA percentage scores.

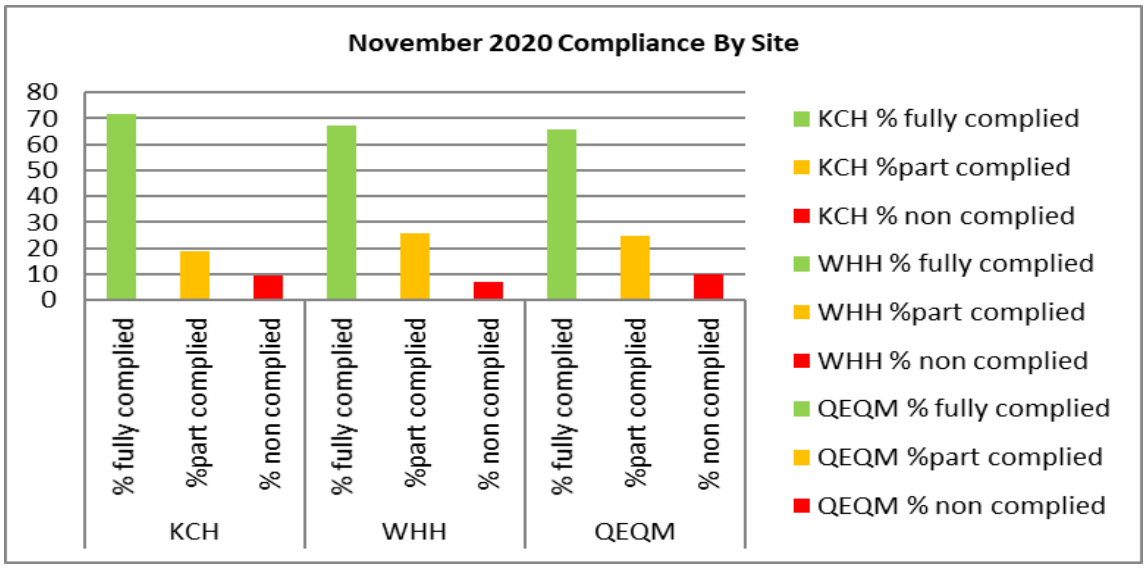
Estate Statutory Compliance Update:
The statutory compliance levels have decreased slightly across all Trust areas to 68.03% from 70% this quarter as detailed in the below table.

Compliance Overview November 2020 - Desk Top Audit	KCH					WHH					QEQM					Overall Total				
Category	No of Compliance areas	% of areas fully complied with	% of areas part complied with	% Compliance areas on Planet	% PPM on Planet	No of Compliance areas	% of areas fully complied with	% of areas part complied with	% Compliance areas on Planet	% PPM on Planet	No of Compliance areas	% of areas fully complied with	% of areas part complied with	% Compliance areas on Planet	% PPM on Planet	No of Compliance areas	% of areas fully complied with	% of areas part complied with	% Compliance areas on Planet	% PPM on Planet
Fire & Smoke Statutory & HTM 05	12	66.67	8.33	33.33	26.67	21	66.67	14.29	36.00	12.00	21	58.82	20.00	40.00	25.00	54	68.00	16.00	36.67	20.00
Energy, environment & HTM 03	19	68.42	15.79	52.63	26.32	18	61.11	22.00	44.44	27.78	18	63.16	33.33	61.11	27.78	55	64.29	17.86	52.73	27.27
Electrical & HTM 06	17	70.59	0.00	35.29	23.53	17	64.71	29.41	41.18	35.29	17	58.82	33.33	47.06	41.18	51	64.71	27.45	41.18	33.33
Lifts, escalators & lifting equipment	9	75.00	23.53	54.55	54.55	10	70.00	20.00	62.50	30.00	13	72.73	18.18	46.15	38.46	32	73.33	16.67	52.73	27.27
Mechanical plant	2	73.33	20.00	50.00	35.71	16	68.75	25.00	62.00	31.25	14	75.00	18.75	71.43	28.57	32	72.34	21.28	61.36	31.82
H&S Management	2	50.00	0.00	0.00	0.00	2	100.00	0.00	0.00	0.00	2	100.00	0.00	0.00	0.00	6	100.00	0.00	0.00	0.00
Water management & HTM 04	20	75.00	25.00	85.71	14.29	20	70.00	30.00	65.00	30.00	21	66.67	33.33	61.90	19.05	61	70.49	29.51	70.97	20.97
Working at height	4	100.00	0.00	75.00	26.32	4	100.00	0.00	0.00	25.00	3	100.00	0.00	33.33	33.33	11	100.00	0.00	27.27	18.18
HTM 01 Decontamination	3	66.67	33.33	42.86	28.57	5	60.00	40.00	40.00	0.00	1	100.00	0.00	100.00	0.00	9	66.67	33.33	66.67	22.22
HTM 02 Medical Gases	10	70.00	30.00	55.56	22.22	10	70.00	70.00	37.50	37.50	8	60.00	40.00	50.00	12.50	28	66.67	46.67	48.00	24.00
Site records	5	40.00	20.00	0.00	0.00	5	40.00	20.00	0.00	0.00	6	40.00	20.00	0.00	0.00	16	40.00	20.00	0.00	0.00
Total	103	71.55	18.97	52.07	25.62	128	67.19	25.78	44.27	23.66	124	65.57	24.59	49.59	26.02	355	68.03	23.22	48.53	25.07



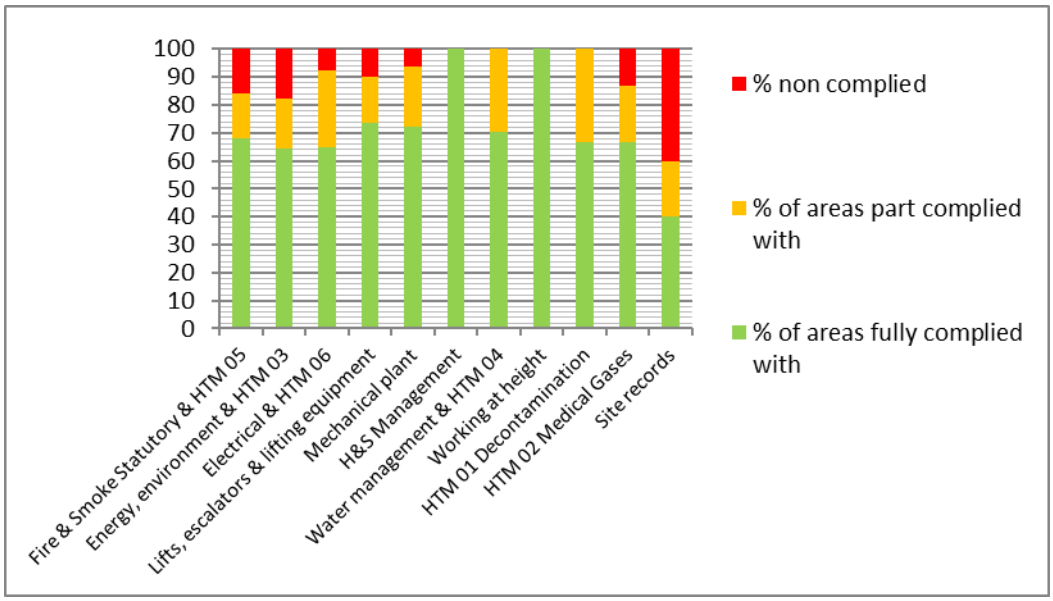
The level of compliance was expected to increase slightly over the latter part of the year following the asset survey completion, with associated Planned Preventative Management (PPM) being assigned to those assets within the Planet system. This work hasn't progressed as a direct result of Covid and Oakleaf (six facet survey), lack of site attendance. Contract review meetings was held last month to expedite this survey and planned to visit in December 2020 before recent lockdown announced. These works will now be delayed further into the new year but will commence again as soon as possible.

The 3 main sites are on par with regards to compliance with all disciplines seeing a slight decrease over recent months. All inspection certification is now held electronically and centrally, enabling improved transparency and auditability.



Toward the end of this Financial Year (FY) we expect to see an increase in circa 74% following increase of £0.5m investment in year and through targeted PPM works in electrical and fire safety disciplines. This increase in investment and subsequent compliance performance is expected to increase over the next three years and following the Financial Performance Committee's approval of the Statutory Compliance Business Case, compliance will increase to 99% over the next three years.

The top 3 areas for improvement remain fire, energy/environment and site records. Lifting equipment has seen an improvement. The fire contract is the first to be tendered, with the invitation to tender (ITT) going out imminently. Site records will dramatically improve once all assets are loaded in to Planet following the asset survey.



Fire Investment Plan:
The next phase of fire safety improvement works depends on completion of the comprehensive compartmentalisation desktop exercise which is at 98%. By next quarter these will be finalised and passed to Oakleaf for physical surveys to be conducted in advance of associated compartmentalisation maintenance works on Fire Smoke Dampers and Fire Doors etc out of increased funding. This will directly contribute to increased compliance in this area by Q4 2020/21. The Fire Safety Group is continuing to meet and monitor these improvements, with a continued focus on Fire Risk Assessments (FRAs) and Fire Training.

Conclusion:
Health and Safety standards and compliance continues to be embedded and improved in all Care Group and Corporate areas in the Trust. Health and Safety Leads have worked with their teams and their Care Group triumvirates to establish, improve and sustain good practise in all areas of health and safety within their areas of responsibility.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	CRR34 – Inadequate Health and Safety systems embedded within the Divisions.
LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR 34 – Inadequate Health & Safety systems embedded within the Divisions.
RESOURCE IMPLICATIONS:	Statutory Compliance Investment (Business Case attached).

East Kent Hospitals University NHS Foundation Trust

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Health and Safety Committee.
SUBSIDIARY IMPLICATIONS:	2gether is providing health and safety advice and guidance in line with the Service Level Agreement.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to note the progress statement and confirm **APPROVAL** of the Statutory Compliance Business Case.