Board of Directors - Open Meeting (Thursday 2 November 2023)

Thu 02 November 2023, 01:00 PM - 04:40 PM

WebEx teleconference

NHS
East Kent Hospitals University
NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:10 PM
10 min

23/103
Welcome and Apologies for Absence

To Note *Vice-Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

23/104
Confirmation of Quoracy

To Note *Vice-Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

23/105
Declaration of Interests

To Note *Vice-Chairman*

23-105 - Board of Directors register of interests - October 2023.pdf (3 pages)

01:10 PM - 01:10 PM
0 min

23/106
Minutes of Previous Meeting held on 5 October 2023

Approval *Vice-Chairman*

23-106 - Unconfirmed BoD 05.10.23 Open Minutes.pdf (16 pages)

01:10 PM - 01:10 PM
0 min

23/107
Matters Arising from the Minutes on 5 October 2023

Approval *Vice-Chairman*

23-107 - Front Sheet Open BoD Action Log.pdf (4 pages)

Patients

01:10 PM - 01:40 PM
30 min

23/108
Patient Story

Discussion *Chief Nursing and Midwifery Officer (CNMO)*

- 23-108.1 - Front sheet Patient Story Board November 2023 FINAL.pdf (2 pages)
- 23-108.2 - Appendix 1 Patient Experience Story Board 2 Nov 23.pdf (4 pages)

01:40 PM - 01:45 PM
5 min

TEA/COFFEE BREAK 1:40-1:45 (5 MINS)

REGULATORY AND GOVERNANCE

01:45 PM - 01:50 PM
5 min

23/109
Vice-Chairman's Report

Information *Vice-Chairman*

- 23-109 - Vice-Chairman BoD Report 02.11.23 FINAL.pdf (6 pages)

01:50 PM - 02:00 PM
10 min

23/110
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 23-110.1 - CEO Report to Board - November 2023.pdf (6 pages)
- 23-110.2 - App 1 Kent and Medway Provider Collaborative Context document.pdf (17 pages)
- 23-110.3 - App 2 Kent and Medway Provider Collaborative Board Draft ToR.pdf (12 pages)

02:00 PM - 02:30 PM
30 min

23/111
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

People

23/111.1
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (2.00 pm to 2.05 pm)

Assurance *Chair NRC - Stewart Baird*

- 23-111.1 - NRC Board Chair Assurance Report 10.10.23 FINAL.pdf (2 pages)

Patients - Quality and Safety

23/111.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report (2.05 pm to 2.15 pm)

Approval *Chair Q&SC - Andrew Catto*

- 23-111.2 - EK QSC Chair's Report 241023 v2.pdf (4 pages)

Partnerships - Sustainability

23/111.3
Finance and Performance Committee (FPC) - Chair Assurance Report (2.15 pm to 2.25

pm)

Assurance *Chair FPC - Richard Oirschot*

Verbal

23/111.4
Charitable Funds Committee (CFC) - Chair Assurance Report (2.25 pm to 2.30 pm)

Approval *Chair CFC - Claudia Sykes*

- 23-111.4.1 - CFC Board Assurance Report 02.11.23.pdf (2 pages)
- 23-111.4.2 - Appendix 1 ToR EKH Charity October 2023.pdf (6 pages)

Patients - Quality and Safety - People

02:30 PM - 02:40 PM
10 min

23/112
Maternity Incentive Scheme Year 5 Submissions

Discussion *CNMO/Director of Midwifery (DoM)*

- **Perinatal Mortality Review Tool (PMRT)**
- **Safety Action 3: Avoiding Term Admissions into Neonatal Unit (ATAIN)**
- **Obstetric Medical Workforce**
- **Safety Action 6: Saving Babies Lives**
- **Perinatal Quality Surveillance Tool (PQST)**

- 23-112 - Q2 BoD CNST Maternity overarching report.pdf (5 pages)

02:40 PM - 02:50 PM
10 min

23/113
Safe Nursing Staffing

Assurance *CNMO*

- 23-113.1 - Safe Staffing Front sheet Oct 2023.pdf (4 pages)
- 23-113.2 - Appendix 1 EKHUFT Safer Staffing September 2023.pdf (5 pages)

02:50 PM - 03:00 PM
10 min

23/114
Chief Medical Officer's (CMO's) Report

Interim Chief Medical Officer (CMO)

23/114.1
Learning from Deaths

Discussion *Interim CMO*

- 23-114.1 - BoD_LfD Paper for Nov 2.pdf (6 pages)

23/114.2
Statement of Compliance

Approval *Interim CMO*

- 23-114.2.1 - BoD SoC Front Sheet.pdf (2 pages)
- 23-114.2.2 - Appendix 1 SoC September 23.pdf (13 pages)

03:00 PM - 03:10 PM
10 min

23/115
Infection Prevention and Control (IPC)

Discussion *CNMO/Deputy Director of Infection Prevention & Control (DIPC)*

- 23-115.1 - Final IPC Report for Board November 2023.pdf (6 pages)
- 23-115.2 - Appendix 1- nipc BAF updated October 2023.pdf (7 pages)

03:10 PM - 03:20 PM
10 min

TEA/COFFEE BREAK 3:10 - 3:20

Partnerships - Sustainability

03:20 PM - 03:30 PM
10 min

23/116
Winter Plan 2023/24

Discussion *Interim Chief Operating Officer (Planned Care) / Interim Managing Director QEQM Care Group*

- 23-116.1 - Winter Plan Front Sheet_Trust Board_021123.pdf (4 pages)
- 23-116.2 - Appendix 1 EKHUFT Winter Plan 23-24_Board_November v4.pdf (75 pages)

03:30 PM - 04:00 PM
30 min

23/117
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 23-117.1 - Board IPR Front Sheet Nov 23.pdf (3 pages)
- 23-117.2 - Appendix 1 Board IPR_v5.0_Sep23_final.pdf (60 pages)

23/117.1
Month 6 Finance Report

Information *Interim Chief Finance Officer (CFO)*

- 23-117.1.1 - Front Sheet M6 Finance Report Board 021123.pdf (4 pages)
- 23-117.1.2 - Appendix 1 Short M6 Finance Report.pdf (8 pages)

04:00 PM - 04:10 PM
10 min

23/118
Journey to Exit NHS Oversight Framework (NOF4) - Integrated Improvement Plan (IIP) Update

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

- 23-118.1 - Board Front Sheet Journey to Exit NOF4 IIP Update FINAL 24.10.23.pdf (2 pages)
- 23-118.2 - Appendix 1 EKHUFT IIP Board Report FINAL 24.10.23.pdf (16 pages)
- 23-118.3 - Appendix 2 IIP Programme Risk Register FINAL 23.10.23.pdf (6 pages)

People

04:10 PM - 04:20 PM
10 min

23/119
Sexual Safety in Healthcare - Organisational Charter

Information *Chief People Officer (CPO)*

- 23-119 - Sexual Safety Charter.pdf (4 pages)

CLOSING MATTERS

04:20 PM - 04:25 PM
5 min

23/120
Any Other Business

Discussion *All*

Verbal

04:25 PM - 04:40 PM
15 min

23/121
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 7 December 2023

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM OCTOBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Chief People Officer	None	Appointed 1 September 2019
BAIRD, STEWART	Vice Chair/Non-Executive Director	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Non-Executive Director of Spencer Private Hospitals (started 1 November 2021) **(1)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)**	1 June 2021 (First term)
CATTO, ANDREW	Non-Executive Director	Chief Executive Officer, Integrated Care 24 (IC24) **(1)** Member of east Kent Health and Care Partnership (HCP) **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)**	1 October 2022 (First term)
DICKSON, JANE	Interim Chief Operating Officer (Urgent and Emergency Care)	Director, Holiday Letting, Scotland (Ltd company) **(1)**	2 October 2023
DICKSON, NIALL	Chair	Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)** Chair of the East Kent Health and Care Partnership (HCP) Board **(1)**	5 April 2021

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM OCTOBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)
GOODGER, NIC	Interim Chief Medical Officer	Surgeon, Chaucer Hospital **(5)**	7 August 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, Audit and Governance Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director (Adult Care), Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM OCTOBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
STEVENS, MICHELLE	Interim Chief Finance Officer	None	1 April 2023
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022)	1 March 2023 (First term)
WOOD, MICHAEL	Interim Group Company Secretary	None	April 2023
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

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

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

2gether Support Solutions Limited:
Simon Corben – Non-Executive Director in common

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY THIRD MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 5 OCTOBER 2023 AT 10.30 AM HELD AS A WEBEX TELECONFERENCE

PRESENT:

Mr S Baird	Non-Executive Director (NED)/People and Quality Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair/ Vice Chairman (Meeting Chair)	SB
Mr R Anakwe	NED	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Ms J Dickson	Acting Chief Operating Officer (COO), Unplanned and Emergency Care	JD
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)/Acting Chief Operating Officer (COO), Scheduled Care	BS
Mrs M Stevens	Interim Chief Finance Officer (CFO)	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals* Oversight Group Chair	CS

ATTENDEES:

Ms M Cudjoe	Director of Midwifery (DoM) (minute numbers 23/094 and 23/095)	MC
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Mr M Wood	Interim Group Company Secretary (GCS)	MW
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Mr T Cook	Special Adviser to the Chairman and Deputy GCS	TC
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs M Bonney	Governor
Ms V Brandon	NHSE
Mr J Casha	Governor
Mr S Cooper	Member of the Public
Mr N Daw	Member of Staff
Mr D Esson	Kent Online
Ms C Heggie	Member of the Public
Mr A Heselwood	Member of the Public
Ms N Lappage	NHSE
Ms S Mahmood	Governor
Mrs B Mayall	Lead Governor
Ms N Morley	Member of the Public
Mr M Norman	BBC South East
Mr D Richford	Member of the Public
Mr P Schofield	Governor
Mr C Shorter	Governor
Mr P Verrill	Governor
Ms J Yanni	Member of Staff

MINUTE NO.		ACTION
23/086	**VICE-CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Vice-Chairman opened the meeting, welcomed everyone present, and introduced Ms J Dickson, Acting COO and Ms S Hayes, CNMO. Apologies for absence were received from Mr S Corben (SC), NED/2gether Support Solutions (2gether) NED In-Common; Mr N Dickson (ND), Chairman; Mr Nic Goodger (NG), Interim Chief Medical Officer (CMO); Mr D Jones, COO; and Dr O Olasode (OO), NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair. The Vice-Chairman reported a Closed BoD meeting had been held that morning that included discussions about the Trust's current financial position and forecast, additional working capital borrowing, external governance review, fire compartmentation strategy for 2023 to 2028, and Board assurance following Letby verdict. The Vice-Chairman stated at the end of the meeting when inviting questions from the public, he would take written questions from members of the public in attendance via the Question and Answer function.	
23/087	**CONFIRMATION OF QUORACY** The Vice-Chairman **NOTED** and confirmed the meeting was quorate.	
23/088	**DECLARATION OF INTERESTS** There were no new interests declared.	
23/089	**MINUTES OF THE PREVIOUS MEETING HELD ON 7 SEPTEMBER 2023** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 7 September 2023 as an accurate record.	
23/090	**MATTERS ARISING FROM THE MINUTES ON 7 SEPTEMBER 2023** **B/09/23 – Transforming our Trust: Our Response to *Reading the Signals* – Update** The CSPO confirmed future reporting on progress would include additional information providing a brief overview of the results of actions detailing 'the what, impact and outcomes from these'. It was **AGREED** to close this action. **B/13/23 – Patient Voice and Involvement** The CNMO reported work had started on the triangulation of patients, families and communities feedback across the Trust, Friends and Family Test (FFT) responses, as well as complaints. This was around ensuring identification of any themes and any actions. She confirmed a report would be presented to the next Q&SC meeting, and an update provided to the Board from that Committee as part of the Q&SC Chair Assurance Report. It was **AGREED** to close this action. **B/14/23 – Patient Voice and Involvement** The CNMO reported the Fundamentals of Care (FoC) Committee would be presenting a report to the Q&SC on feedback of Patient-Led Assessments of the Care Environment (PLACE) audits and any themes identified from complaints. An update would be provided to the Board as part of the Q&SC Chair Assurance Report. It was **AGREED** to close this action.	

B/17/23 – Various Urgent and Emergency Care (UEC) patient pathways
The Acting COO reported the patient pathways to meet individual patient needs for ongoing treatment would be covered within the Trust's Winter Plan report that was being presented to the next Board meeting in November. It was noted this would include the Trust's internal and system wide response to addressing the demand and pressures over the winter period, and patient pathways through UEC.

The NEDs highlighted this was also around understanding and outlining the strategy for the various patient pathways, the Trust's strategic direction plan for the future, and what it wanted to achieve and where it wanted to be in two/three/five years. The Acting COO noted Action B/06/23 for a report to be presented to the Board in February 2024 on completion of the Emergency Department (ED) works, and agreed to provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.

B/23/23 – Lone working
The Acting COO reported on behalf of the CNMO that she had a call scheduled with Kent Community Health NHS Foundation Trust (KCHFT) about their procedures in place to keep their lone worker community staff safe, and would provide an update at the next Board meeting.

B/24/23 – Board Assurance Framework (BAF) Risk 41
The CNMO reported BAF Risk 41 - Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24, confirming the BAF had been updated for this risk, with a score of 20 and this not being reduced to 16. There had also been a wider review of risks. It was **AGREED** to close this action.

DECISION: The Board of Directors **NOTED** the action log, the updates on the actions from the previous meeting, **NOTED** the actions for future Board meetings, **APPROVED** the three actions recommended for closure, and the four actions agreed for closure as noted above.

23/091 **VICE-CHAIRMAN'S REPORT**

The Vice-Chairman highlighted key elements:

- Trust continued to be challenged in respect of increased activity and struggling to meet demand on its services, activity in accessing the EDs continued to be significantly high;
- Awareness that moving into the Winter period demand on services was likely to continue to grow, and the actions on how this would be tackled would be covered in the Trust's Winter Plan being presented the following month;
- Trust's financial pressures was a key area of focus and concern;
- One year on from the publication of Dr Kirkup's report, for discussion later in the meeting.

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

23/092 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported key points:

- Trust's full response to the Care Quality Commission's (CQC's) warning notice had been submitted on time along with the evidence requested, awaiting CQC's response on the unannounced core services visit and the Well-led inspection;
- Trust had signed up to the Charter for sexual safety in Healthcare, work was being undertaken to understand the Trust's position in respect of the ten principles and actions to achieve a zero-tolerance approach required to commit to;
- The recent continuous three days' industrial action by consultants and junior doctors, the required cover and support needed had been in place meeting the nationally required minimum level of cover. Services during this period were stretched and this would have an impact on elective pathways and waiting lists with reduced staff availability. Working with clinical colleagues to reduce impact for patients as a result of this industrial action, whilst being mindful of potential further industrial action.

The Vice-Chairman reported a question raised at the September Board meeting about NHS Counter Fraud Authority reporting the Trust to the NHS Financial Regulator. Noting this was covered in the report confirming NHS Counter Fraud Authority did not believe there had been any issue of fraud and this had been shared with NHSE.

The Vice-Chairman emphasised the annual NHS National Staff Survey (NSS) had been launched, encouraged Board members and staff to complete this, to enable the Trust to understand where it was and wasn't performing well, and how it was progressing against actions in previous surveys. The CE provided assurance that responses to the NSS were anonymous, noting the positive response rate to date.

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

23/093 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/093.1 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- Infection Prevention and Control (IPC) report received, highlighting Clostridioides difficile (C-diff) remained the main challenge for the Trust and was a key focus of the Antimicrobial Stewardship Group around mitigating actions to reduce the number of cases. Progress of actions and impact of these would continue to be monitored by the Committee, a further report would be presented later in the year;
- Staff uptake of the flu and Covid vaccinations was good;
- Evidence of improvements reducing impact on patient experience of noise at night;
- Assurance of Structured Judgement Reviews (SJR) being undertaken, along with deep dives as necessary, noting majority of cases identified care provided had been good;
- Maternity and Neonatal Assurance Group (MNAG) report received, noting the considerable improvements made in maternity services, whilst

recognising there was still more needed to be done. Rate of reportable neonatal and perinatal deaths remained lower than comparable peers;
- Following review of Trust's compliance with National Institute for Health and Care Excellence (NICE) Guidelines between January 2021 and June 2023. The Trust had no evidence of compliance with 46% of the NICE Guidelines, with work on-going to plan how this would be addressed as a priority. An update would be presented to the next Committee meeting;
- Endoscopy capacity remained a significant challenge with mitigations put in place to reduce the backlog.

The NEDs raised whether there was assurance of the review of deaths and that there was associated learning. The Q&SC Chair stated there was a robust mortality review process in place.

The Board of Directors **NOTED** the 26 September 2023 Q&SC Chair Assurance Report.

23/093.2 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted key points:

- Limited assurance of the Cost Improvement Programme (CIP) that was behind target;
- Continued pressures against the ED performance metrics, 12 hour (hr) stay in ED, 12hr trolley waits, and 4hr wait, with considerable activity of influx of ambulance arrivals and type 1 patients, with the highest numbers seen in the last 12 months;
- Operationally pressures with activity at continued high demand levels;
- PRISIM report presented providing an overview on the proposed inpatient flow and theatre productivity improvement programmes, who would be working with the Trust supporting to review and improve patient flow and productivity efficiency;
- As at month 5, Group position of £11.3m against a plan of £5.3m, deficit variance of £6m. Year to date (YTD) position at £50.3m against the plan of £35.9m, a variance of £14.4m, noting the overall year-end (YE) deficit of £72m, highlighting the Trust's finances remained extremely challenging;
- Committee approved the Endoscopy Procurement Outcome and Award and recommended this to the Board for approval;

DECISION: The Board of Directors:

- **NOTED** the 25 September 2023 FPC Chair Assurance Report;
- **APPROVED** the Endoscopy Procurement Outcome and Award.

23/093.3 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair provided a verbal report from the meeting held that week on 3 October 2023, noting the Committee had approved the appointment of new Auditors for the East Kent Hospitals Charity and recommended this for Board approval that would provide a saving of £15k.

DECISION: The Board of Directors:

- **NOTED** the 3 October 2023 verbal CFC Chair Assurance Report;
- **APPROVED** the appointment of new Auditors for the East Kent Hospitals Charity.

23/093.4 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair reported no P&CC meeting had been held in September.

23/094 **ASSURANCE PAPER ON BOARD ACTIONS FOLLOWING LETBY VERDICT**

The CE highlighted the following key developments:

- The paper before the Board set out the Trust's actions against the six decisive steps towards patient safety monitoring, in respect of Medical Examiners, Patient Safety Incident Framework (PSIF), Freedom to Speak Up, Strengthening Governance, and Neonatal CQC self-assessment;
- Assurance had been gained from reports and discussions in respect of the six areas noted above, self-assessment had been positive that these areas were monitored, whilst recognising more work was needed on the PSIF that was underway and to be completed by March 2024;
- Work had already been undertaken to strengthen the Trust's Governance, with the recent Care Group restructuring and the external review of Board governance which had been commissioned.

The NEDs sought assurance of the processes in place (including safeguarding) to ensure the ongoing mechanisms were doing what was needed specifically to address the issues of the Letby case. The CE commented on the processes in place around the mechanisms enabling staff to speak up (Freedom to Speak Up (FTSU)), examining and monitoring of incidents and data, and understanding patient outcomes. The CE further confirmed she was the overall responsible accountable officer, with the individual Executive Directors leading on specific areas. Related to effective monitoring was the need for staff to feel confident in being able to speak up, especially in relation to reviewing mortality and being assured that staff had awareness of this.

The CNMO commented the Trust and the Board, as with all other NHS organisations were reviewing and discussing what they needed to have true oversight, and key elements were organisational culture and progressing the quality governance and triangulation of data for staffing, speaking up, and incidents.

The Acting COO provided assurance at Care Group level of the review of mortality data with any unexplained deaths were being presented and discussed at Morality Reviews. In addition, Executive Directors and senior leadership teams remained vigilant and were curious in looking into any issues raised by staff.

The NED/Q&SC Chair confirmed and provided assurance of monitoring of the Medical Examiner service, and that the Lead Medical Examiner had recently presented to the Q&SC and would be invited to provide a further update in the near future. He highlighted it was important to identify any signalled anomalies in data, and that these appropriately trigger an alarm for scrutiny and investigation.

The Vice-Chairman commented on the FTSU service in place, including the greater number of the FTSU Guardians and the significant increase in staff speaking up and engaging with this service. The CPO reported that FTSU was included as part of the Trust's induction programme for new staff.

The CNMO highlighted safeguarding training was a key element ensuring all staff across the Trust were compliant with this training. She reported an improvement plan trajectory target was in place and expected this to be achieved in November. It was agreed an update on progress against trajectory target of staff training compliance to be provided at the next Board meeting in November 2023.

ACTION: Provide an update at the November 2023 Board meeting on progress against the staff safeguarding training compliance improvement plan trajectory target and position to achieve compliance in November. — CNMO

The Board of Directors **NOTED** the assurance paper and that the Trust was addressing the key actions outlined in the letter received from NHSE following the verdict in the trial of Lucy Letby.

23/095 ***READING THE SIGNALS* OVERSIGHT GROUP: ONE YEAR ON FROM *READING THE SIGNALS***

The CE noted:

- Trust reflection of the actions undertaken of the report recommendations and what actions and work was still needed;
- Acknowledged the hard work, commitment and support of the staff in maternity services and across the organisation to make improvements, and working together to provide a much better service to women, babies and families of East Kent.

The EDC&E reported:

- Report set out the changes that had been made and the initiatives to improve maternity services, whilst recognising there was still more to be done. Importance of continuing to review progress and outcomes for the East Kent population;
- Feedback from the *Reading the Signals* Oversight Group, including the families involved in this group, including ensuring future reporting was accessible, and that the Trust engages and involves patients and families that use its services, not just within maternity services but across the whole Trust;
- Themes from Dr Kirkup's report have been fed into the Trust's strategic objectives.

The Vice-Chairman and NEDs noted there had been a reduction in the number of women that had said they would be happy to return to the Trust, that was a surprise and a concern. It was important that the Trust continued to be open, honest and transparent, recognising the areas where progress was not as good as it wanted and to review this and what action was needed. The DoM commented on the reduction of women who would be happy to return and the continued negative coverage of the Trust and the impact on individuals. The Trust was liaising with the Maternity Voices Partnership (MVP) Chair, reviewing and collating feedback to ensure this was addressed, to build public confidence, and enabling quality improvement. There was a specific issue around post-natal care with ongoing work, with a focus on William Harvey Hospital (WHH) in respect of addressing staffing resources, reliance on temporary staff and working with agencies ensuring staff were trained meeting the Trust's requirements.

The CSPO extended thanks to the women and families for their continued engagement, involvement, and feedback as well as staff in its improvement journey. The Acting COO reported staff had fed back that they felt safe and supported about speaking up.

The NEDs recognised the significant impact of the report on Trust's staff in maternity services and Trust-wide, this was settling and improving, with improvements of staff morale, the benefits of having a stable embedded leadership team now in place, and things were moving in the right direction. It was noted the importance of data, this being monitored, continuing to be curious, and address issues as they arose. The DoM commented positive feedback from staff in speaking up, who felt they were being heard, increased staff engagement with the quarterly Pulse survey, staff bringing forward improvement initiatives and wanting to be involved in these.

The NED/Chair of the *Reading the Signals* Oversight Group commented it had been a learning process around changing how the Trust engaged with patients and families, listening to them and feedback on the information they wanted to have sight of. It was noted there had been a shift change, extending thanks to patients, families, Executive Directors, senior leadership staff, maternity staff, and staff throughout the organisation feeding into and improving patient engagement and involvement. She noted the need to look at and review how the Trust communicated with the wider East Kent population and how this could be improved, to be accessible, and liaising with patients and public on what information they would like to see. The Group had raised the need to have sight of evidence of culture change, and team working, as well as involvement from midwifery teams and the obstetricians. A Group meeting would be held at the end of October, that would focus on how the Group could be taken forward, what the families would like to see going forward and that this met their needs, with continued engagement and involvement. Listening and learning from patient feedback within maternity services and Trust-wide to ensure patients were listened to, issues raised were addressed and lessons were learnt. The CE reported the Interim CMO had met with the obstetricians, with ongoing work with them to further strengthen clinical leadership. It was important to recognise and consider clinical commitments when scheduling meetings around clinician availability, noting there had been clinical engagement and involvement with the maternity improvement plan.

The CNMO reported being new to the organisation, that there was more that could be done with the estate, staff felt able to speak up, confident to put forward ideas, they would be listened to, and were able to make changes. It was important to continue to support the maternity services team with communications to provide assurance to women, families and the public to increase their confidence about the Trust services, and its improvements.

The Board of Directors **NOTED** the *Reading the Signals* Oversight Group: One year on from *Reading the Signals*.

23/096 **MATERNITY INCENTIVE SCHEME YEAR 5 SUBMISSIONS**

- **SUMMARY OF MATERNITY PAPERS**
  - **MATERNITY DASHBOARD PERFORMANCE REPORT**
  - **PERINATAL QUALITY SURVEILLANCE TOOL (PQST)**
  - **ANAESTHETIC MATERNITY WORKFORCE UPDATE**
  - **NEONATAL MATERNITY WORKFORCE UPDATE AND ACTION PLAN**

The DoM highlighted key elements:

- No Serious Incidents (SIs) declared;
- No SIs or Healthcare Safety Investigation Branch (HSIB) referrals in August;
- FFT response rate good at 11%, average 90% of women providing a positive response. There had been a discussion about what the local threshold should be, agreed the Integrated Care Board (ICB) DoM would explore the Regional response rate, in the absence of a national average and this would be applied across the Local Maternity and Neonatal System (LMNS);
- Ten Internationally Educated Midwives (IEMs) had successfully completed Objective Structured Clinical Examination (OSCEs) and would be commencing towards the end of the year;
- Stillbirth rate remained at 2.56 per 1000 births compared to the comparator average of 3.92/1000. Trust was looking at and analysing any deprivation impact and whether there was a need for some targeted care for women in East Kent;
- One:One care in labour was 100% compliant;
- Safeguarding and Information Governance (IG) training remained non-compliant, training attendance had improved;
- Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) improved to 83% but remained below the national standard of 90%. The CNMO and Medical Director would be meeting with Care Group leads to explore the plan for achieving this safety action, and workforce action plans would be shared with the LMNS. All NHS organisations were challenged around training compliance due to the recent industrial action;
- Clinical Negligence Scheme for Trusts (CNST) declaration would be presented to the Board in December 2023;
- Team would be reviewing and refreshing its priorities, assessing how the team and staff were feeling, the progress made, and demonstrating and celebrating the successful improvements implemented.

The CNMO reported the current high vacancy rate at WHH would continue to be monitored. An external meeting with partners would be held in November to look at next steps and expectations to further improve maternity services provision.

The NEDs raised the issue about lack of theatre capacity and monitoring this and assessing any potential impact for women. The DoM reported this issue at Queen Elizabeth the Queen Mother Hospital (QEQM) had been discussed at MNAG, any incidents were reported as Datix cases, confirming there had not been any incidents or near misses, with continued review and assessment of risks. The Acting COO stated there was access to a theatre with mitigations in place to ensure patients were kept safe, with work ongoing to have access to a second theatre. This would continue to be a focus of MNAG, and progress updates would be provided to the Board in future as part of the Maternity Summary Papers.

The Board of Directors:

- **NOTED** the Summary of Maternity Papers report;
- **NOTED** Safety Action 9: PQST August 2023, received assurance that a monthly PQST report demonstrated full compliance in line with the Ockenden and CNST standard requirements had been discussed at MNAG;
- **NOTED** Maternity Dashboard August 2023: Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) had improved to 83% but remained below the national standard of 90%;
- **NOTED** the Care Group had a revised trajectory to achieve compliance with Safeguarding and Management and Supervision Tool (MAST) training;
- **NOTED** Safety Action 4: Medical Workforce: the action plan in relation to neonatal workforce and in line with CNST requirements this would also be shared with the LMNS;
- **NOTED** the Anaesthetic workforce paper, the impact of shortages on attendance at training and the lack of an identified Obstetric Anaesthetic Lead at WHH.

23/097 **2023/24 WINTER PLANNING AND CAPACITY – DELIVERING OPERATIONAL RESILIENCE**

The Acting COO reported the full report detailing the system-wide winter plan would be presented at the next Board meeting in November 2023. It was noted there was significant planning being undertaken across the system in respect of elective and non-elective activity. Trust was looking at internal processes around receiving patients, caring for patients and ensuring they were moved to the appropriate service for treatment, and discharged. As well as externally working with partners and support from the system in ensuring the needs of patients were met. Demand modelling reviewing activity of previous years and anticipated demand for the upcoming winter period around required numbers of bed provision, and a current identified gap in beds of 85 (equating to three wards), the work needed to address this gap and to reduce length of stay, improve patient flow, efficient utilisation of direct access pathways, prompt discharge of patients, virtual wards, and effectively managing the hospital sites. Plan to stress test the winter plan to review its robustness, and as progressing through the winter period there would need to be further review and reiterations of the plan.

The Vice-Chairman raised the use of escalation beds in the Trust and what was being done to reduce and remove these. The Acting COO reported WHH was currently at Operational Pressures Escalation Level (OPEL) 4 the highest level of capacity and demand, resulting in the need for greater system response and support. At QEQM was currently OPEL 3. She stated this meant continuing to utilise the escalation beds although had not yet entered the winter period, and the winter plan would include continuing to use these beds. The plan would address the bed gap, reducing demand and capacity on acute beds, patients being cared for across the system and appropriate pathways to meet their needs and avoid unnecessary admission to hospital.

The Associate NED commented that the Nursing and Midwifery Council (NMC) were going to be visiting the Canterbury Christ Church University (CCCU) undergraduate nursing programme, and as part of this planned to visit the Trust in the week beginning 6 November. He asked whether the CCCU and Trust had liaised in respect of being able to assess the operational pressure and demand on the day of the visit to identify whether a visit could take place. The CNMO provided

assurance of planning for the visit that would be over a period of a week, WHH would be visited as well as other local Trust hospitals, and working closely with CCCU and NMC. This was around the visit being effective and providing NMC with assurance of the student placements, students were confident and were receiving the support and learning they needed. Identified Trust member of staff would assess operationally on the day of the visit whether appropriate for this to take place.

The NEDs asked about virtual wards, where these were being used, and the effectiveness of these. It was also raised what Local Council Authorities were dong to provide support in respect of additional care capacity, any risks and potential impact for the Trust, and to receive a system-wide and Local Authority support update. The Acting COO confirmed the Trust's winter plan would encompass internal processes and actions, virtual wards, as well as system-wide support including Local Authority, social care, and better care fund, who were fundamental partners in managing demand and capacity over the winter period.

The NEDs highlighted it was important that the plan presented at the next meeting include any financial impact, taking into consideration the Trust's current challenging financial position. Setting out whether there would be any additional cost impact and that this would be supported and covered within the system, to reduce further detrimental impact on the Trust's financial deficit.

The Board of Directors **NOTED** the verbal update on progress of the 2023/24 Winter Planning.

23/098 **SERIOUS INCIDENTS AND SAFER NURSING STAFFING:**

23/098.1 **SERIOUS INCIDENT (SI) REPORT**

The CNMO highlighted key elements:

- Trust declared 12 SIs in August, none of which were being investigated by HSIB;
- SIs were reviewed, investigated, there was learning and actions, and importantly involvement from patients and families;
- 18 SI Declaration Panels held, with four SI Investigation Approval Panels;
- Good progress to reduce the number of overdue SIs, now minimal SI breaches;
- Improved Duty of Candour (DoC) compliance now demonstrating 100%, with challenge at panels of when discussions had taken place with patients and families.

The Vice-Chairman asked for assurance around the improvements reducing overdue SIs and this being sustained to eliminate any future backlog, and that for DoC the Trust was satisfying the needs of patients and families in respect of being open, honest and transparent and this process was being timely managed. The CNMO confirmed the SI backlog had been cleared. The Acting COO reported the Trust was complying with SI investigation and DoC in respect of involving patients and families, noting further work was needed to review and assess the quality of these investigations and that service users involved were satisfied with the process, their involvement, engagement, transparency and outcome. She highlighted it was important to sustain the improved position and going forward not having any SIs overdue.

The NEDs highlighted an incident example in the report about an elderly person who fell from an electric scooter, and the improvements required that appeared should already be in place. The CNMO acknowledged what was required should already be in place with this example, there was system learning and contributing human factors. It was noted the PSIRF when implemented would assist in taking forward improvements with having in place a robust investigation system and identifying the root cause, actions and learning for individuals, teams and across Care Groups.

The Board of Directors **NOTED** the SI Report and the information contained within it, took assurance of the efficacy of the overall incident management and Duty of Candour (DoC) compliance processes in place within the Trust.

23/098.2 **SAFER NURSING STAFFING**

The CNMO highlighted key elements:

- Monthly future short reports, with full establishment reports six monthly to be presented to the Board providing an update on workforce metrics, in relation to vacancy, turnover and fill rates, nurse staffing ratios, to meet NHSE guidance;
- There had been appropriate fill rate, with some overfill rate (escalation areas and staff moved to cover these areas);
- Going forward reports would provide Red Flag and Red Shift data, showing potential areas that had impacted patients (e.g. pain) and escalation;
- Assurance about Trust's safe staffing position, safe care, and mitigations and actions in place.

The Vice-Chairman commented on work to improve the rostering process. The CNMO commented rosters were agreed six weeks in advance, no excess hours, working with Care Groups to ensure these were more efficient, and Senior Managers were robustly managing these against the safe care system, ensuring appropriate numbers of staff to appropriately care for the acuity and dependency of the patients. As well as separating staffing rosters for escalation bed areas.

The Board of Directors received assurance and **NOTED** the content of the Safer Nursing Staffing report and the progress being made in relation to the recruitment pipeline and the actions that were being taken to mitigate potential foreseen issues.

23/099 **INTEGRATED PERFORMANCE REPORT (IPR)**

The CSPO highlighted key elements:

Patients – Planned Care

- Cancer 28 Faster Diagnosis Standard (FDS) deterioration in month to 59.1%, with improvement work that included reviewing patient pathways, administrative processes around informing patients of the results of their tests, and looking at systems that could support this work;
- Diagnostics performance further deterioration with key issues remaining in CT and endoscopy, with increased capacity to address demand and improve endoscopy performance (expected to be in place end of October/beginning of November). There was much more work to be done around the elective activity to improve performance;

- To look at and review the large co-hort of patients identified who did not have cancer;
- PRISM improvement programme funded by the Recovery Support Programme (RSP) to look at inpatient flow, patient pathways, and theatre efficiency, to improve and increase productivity to increase the number of patients seen. PRISM an external company with subject experts would work with the Trust, to progress diagnostic work over four to six weeks looking at processes and delivery of where improvements could be made, total period of programme expected to be approximately 28 weeks to assist with implementation of the recommendations for changes and actions. Programme to cover elective (theatre activity) across all hospital sites, unplanned with a focus at QEQM (focussing on the flow of patients) and the recommendations and actions from QEQM would be implemented across the Trust;
- Weekly governance oversight meetings with Care Groups to challenge and monitor delivery against metrics for planned care;
- Improvement plans and work would be in alignment with the Trust's winter plan to reduce any impact on elective activity.

The NEDs raised the work that had previously been undertaken to review theatre utilisation, the quality of performance data provided, and bringing in an external company to do a further review. It was important that meaningful, accurate performance data be provided to Board Committees and the Board that provided the required assurance. It was enquired how engaged clinical directors were with theatre productivity and ensuring full utilisation and it was vital that they be fully engaged with the PRISM work. The CE reported theatre utilisation was a strategic objective area of focus to improve performance around a Quality Improvement (QI) methodology that had not delivered improvements as quickly as needed. It was noted PRISM had high level experts, experience of what had worked in other organisations, as well as staff learning from their experience. The CSPO commented there had been some improvements but these had not been sustained and working with PRISM would support sustainable improvement. He stated the relevant Care Group Managing Director was already engaging with clinicians across the Trust about the PRISM work, as they were key in driving forward the necessary changes.

The NEDs raised the current waiting list backlog and what plans were in place to address and reduce this and the timeframe by when with the current resources, and whether support could be sourced from local partners. The CSPO stated the national requirements in respect of Referral to Treatment (RTT) waits for 2023/24 for no patients waiting no longer than 65 weeks for routine treatment, and the 2024/25 this would be no longer than 52 weeks. The Trust was currently behind, and there was work looking at the individual specialities for YE to identify a trajectory target against the planned activity, with updates to be presented to the Board at future meetings. Key factors included utilisation of staff resources, as well as mutual aid, noting patients were choosing to wait for treatment.

The Acting COO highlighted key elements:

Patients – Unplanned Care

- Uplift in Urgent and Emergency Care (UEC) pathway performance, particularly against the 4hr wait compliance, with a dip in August;
- Increased demand at both EDs at WHH and QEQM in September, working with support from the system to analyse the reasons;

- Winter plan would include the actions to address UEC compliance, and reduce the length of time patients were waiting in ED to improve patient flow through the hospital, improve patient outcomes and patient experience. Noting patients were being safely managed in the EDs, and thanks to all the staff who were working very hard under significant demand and pressure.

The NEDs noted it was important for the Board to have sight of the impact for patients experience and outcomes in respect of delays. The CNMO commented this would be for a deep dive discussion at Q&SC and triangulation of the data and this feeding into the IPR. The Acting COO stated patient harm reviews were undertaken.

The CE highlighted the need for the review work to also focus on out of hospital services, in hospital systems and early discharge systems, how these were working and their effectiveness. In respect of working collaboratively with partners as a system.

The Board of Directors discussed and **NOTED** metrics reported in the Integrated Performance Report.

23/099.1 **MONTH 5 FINANCE REPORT**

The Interim CFO reported:

- Group in-month position of £11.3m against a plan of £5.3m deficit, deficit variance of £6m, as a result increasing the YTD position of £50.3m against a plan of £35.9m, with a YTD variance of £14.4m;
- Elements that had not been factored within the original agreed £72m deficit financial plan, including industrial action costs, unfunded pay awards for agenda for change (AfC) staff, and medical and dental (no funding provision from ICB). This had impacted on the year-end (YE) plan and behind plan of around £11.4m, the main drivers of not achieving the YE plan were underperformance against the CIP, one to one care for mental health patients increased (impacting on increased in shift fill rates), and hard to recruit posts being filled by high cost agency staff;
- Risk to future month's financial position of an income underperformance of £8.8m at YE;
- As previously reported, all National control measures had been implemented, which would continuously be monitored and assessed in respect of quality impact, and that these did not impact on patient care and outcomes.

The Vice-Chairman provided assurance that the Board had held a lengthy discussion at its Closed meeting held earlier that morning about the Trust's current financial position and financial challenges. It had been highlighted the need to reduce the run rate, and an extra-ordinary Closed Board of Directors meeting would be held in the next couple of weeks for a focussed review and discussion on finances. This would include looking at all opportunities to reduce expenditure, including consideration of tough and unusual decisions.

The NEDs raised it was understood the Trust some years previously had looked at appointing a managed service provider to assist with reducing agency staff spend, and whether this had been considered to address the current challenges. The CPO would pick this issue up and look into this outside the meeting with the NED and what could be done to support the continued work to reduce agency costs.

The Board of Directors **NOTED** the Month 5 Finance Report, financial performance and actions being taken to address issues of concern.

23/100 **INTEGRATED IMPROVEMENT PLAN (IIP) REPORT INCLUDING METRICS**

The CSPO reported:

- Revised concise reporting format, providing overview of delivery of IIP, and RAG rated progress against the quarterly milestones of the Trust moving from NOF4 to NOF3;
- Leadership and Governance RAG rated green (on track/confident would be achieved). Quality and Safety; Maternity; and People and Culture RAG rated amber. Finance; and Operational Performance RAG rated red. Areas of challenge were finance and operational performance, with ongoing work to address and take forward the actions required to provide assurance of delivery. As well as progressing actions to move areas of amber to green;
- Continued close working with NHSE supporting to drive forward the necessary improvements.

NHSE's Improvement Director commented this had been discussed at the Closed Board of Directors meeting earlier that morning, and the need to consider and discuss further the robustness of the IIP, whether it would deliver and ensure Trust exited NOF4, or if not what more action was needed. To assess that investments were made within the right areas, noting the improvements that had been made.

The NEDs raised the lack of an overall strategy as well as strategies covering specific areas, to provide an overview and update of what the Trust was doing strategically and that the improvement plans fed into these. The need to look at and include patient experience across the Care Groups and that this was positive. The CSPO acknowledged the need for a clear, defined and owned Trust strategy by the Board and across the whole organisation, that would support sustainable change. It was noted this was a significant piece of work over a six month period, and progress was being made around procurement and ICB approval to commence this work, that would also review that there was the appropriate capability, capacity and skillset within the organisation.

The Vice-Chairman noted there would be a focussed discussion session at the next Closed Board of Directors meeting on IIP that was half way through the period of the plan. He highlighted it was important to have in place a three to five year strategy.

The Board of Directors **NOTED** the IIP report and progress of delivery of the IIP to date.

23/101 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/102 **QUESTIONS FROM THE PUBLIC**

The Vice-Chairman invited written questions from members of the public to be submitted via the Question and Answer function.

Ms M Bonney asked about patient welfare, bearing in mind the long waits in Accident & Emergency (A&E) and urgent care areas, and if the Trust could make available free water to waiting patients. She noted the vending machines were poorly functioning, and that this would benefit staff and patient experience and avoid the use of plastic bottles. The CNMO stated the Trust should be making water available to waiting patients, and asked for details of specific incidents where this was not being provided to ensure this was looked into. She agreed to liaise with Ms Bonney direct outside the meeting.

Mr S Cooper wished to make the Vice-Chairman and Board aware of an issue he was having with the Trust and wished to have a discussion about this. The Vice-Chairman stated that he would contact Mr Cooper direct outside the meeting about the issue he wished to raise.

The Vice-Chairman reported a question had been received about the Chairman, and he stated the Chairman had taken a leave of absence and hoped he would be back to work soon.

Post-meeting note: A written question submitted ahead of the Board was omitted from being noted at the meeting, in respect of the outpatient appointments line, patients not being able to get hold of someone to change/reschedule appointments and the system needed to be changed to ensure patients were able to ring and promptly speak to someone. The Acting COO was liaising directly with the member of the public that had raised this question, to understand her experience and that they had access to the appointment they needed.

The Chair closed the meeting at 1.20 pm.

Date of next meeting: Thursday 2 November 2023.

Signature _____

Date _____

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 5 October 2023**

Meeting date: **2 November 2023**

Board sponsor: **Vice-Chairman**

Paper Author: **Board Support Secretary**

Appendices:

NONE

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.
Summary of key issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.
Key recommendations:	The Board of Directors is asked to **NOTE** the action log, **NOTE** the updates on actions, and **NOTE** the actions for future Board meetings.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	None
Link to the Corporate Risk Register (CRR):	None
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 5 OCTOBER 2023

1. Purpose of the report

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

2. Background

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

2.2. The Board is asked to note the updates on the action log as noted below:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	~~Oct-23~~/ May-24	Integrated Audit and Governance Committee (IAGC) Chair/ Group Company Secretary (GCS)	Open	Amended IAGC ToR being circulated for virtual approval, with formal ratification at its next meeting in January 2023 and presented to the February 2023 Board meeting for approval, as part of the IAGC Chair Assurance Report. The ToR will be re-reviewed as part of the annual effectiveness review of the IAGC, when the IAGC will receive the outcome of the Board Committee annual effectiveness reviews. Following completion of the Governance Review. Item for future Board meeting.
B/06/23	01.06.23 - On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy. 05.10.23 - Provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.	Dec-23/ Feb-24	Interim Chief Operating Officer (COO)	Open	Item for future Board meeting.

B/17/23	Present report to October 2023 Board meeting setting out the various urgent and emergency care (UEC) patient pathways to meet individual patient needs for ongoing treatment, covering the period over the next six to twelve months. To also incorporate the collaborative work with the out of hours service and support from the community.	~~Oct-23~~/ Nov-23	Interim COO	Open	05.10.23 - Will be covered within the Trust's Winter Plan report to be presented to the next Board meeting in November. Will also include the Trust's internal and system wide response to addressing the demand and pressures over the winter period, and patient pathways through UEC.
B/21/23	Consider for a future Board of Directors meeting for the families engaged with the Reading the Signals Oversight Group being invited to present, as part of the Patient Experience Story, their feedback and comments about the Group, discussions, achievements, and whether they felt progress and improvements had been made.	Feb-24	Chief Strategy & Partnerships Officer (CSPO)	Open	Item for future Board meeting.
B/22/23	Present annually a Patient Advice and Liaison Service (PALS) report (December 2023), providing details about themes of complaints, timeline of responding to complaints, numbers of complaints and compliments received, lessons learnt, and any actions as a result of feedback received.	Dec-23	Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.
B/23/23	Liaise with Kent Community Health NHS Foundation Trust (KCHFT) to discuss what	~~Oct-23~~/ Nov-23	Interim COO (Previous Interim CNMO)	Open	05.10.23 - The Interim COO on behalf of CNMO reported she had a call scheduled with KCHFT, and would provide an

	procedures they had in place to keep their lone worker community staff safe.				update at the next Board meeting.
B/26/23	Provide an update at the November 2023 Board meeting on progress against the staff safeguarding training compliance improvement plan trajectory target and position to achieve compliance in November.	Nov-23	CNMO	Open	Verbal update to be provided at 02.11.23 Board meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Story**

Meeting date: **2 November 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Lead for Patient Voice and Involvement**

Appendices:

Appendix 1: Patient Story

Executive summary:

Action required:	**Information**
Purpose of the Report:	To hear the story of person who lives with a number of long-term conditions, including mental health and their experience of attending both the Emergency Department (ED) and Same Day Treatment Centre (SDEC) at Queen Elizabeth The Queen Mother Hospital (QEQM). This patient story highlights both a negative and positive experience and how care, compassion and good communication makes a positive patient experience more likely.
Summary of key issues:	• Communication between staff and patients • Medication being provided in a timely fashion • Pain relief • Treating patients with pre-existing conditions, particularly mental health.
Key recommendations:	The Board of Directors is asked to **NOTE** this Patient Story, and we need a commitment from Board to ward to: • Demonstrate compassion to those we look after; • Model compassionate leadership; • Improve the experience of people with pre-existing conditions, including mental health, when they are receiving care with the Trust.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.
Link to the Corporate Risk Register (CRR):	None.
Resource:	No
Legal and regulatory:	The Trust has a duty to comply with the Equality Act 2010, including making reasonable for disabled people.
Subsidiary:	No

Assurance route:

Previously considered by: Not applicable - Patient/family stories come direct to the Board.

We care

East Kent Hospitals University NHS Foundation Trust

PATIENT STORY

1. Purpose of the report

1.1 The report provides background for the patient story that will be heard at the Board meeting. The story relates to a woman, T, with pre-existing physical and mental health conditions who was admitted to the Queen Elizabeth the Queen Mother Hospital (QEQM), initially referred by her GP to attend the Emergency Department (ED) and returning to attend Same Day Emergency Care (SDEC). The subsequent range of experiences she had includes suboptimal and positive examples of care, highlighting a number of learning points for the Trust.

1.2 These learning points include communication between staff and with patients, pain management, prescribing medication, managing mental health in an acute setting and delivering compassionate care. T will attend the Board meeting to talk about her story and the impact it had on her wellbeing and how the experience has influenced her view of the care available at QEQM.

2. Background

2.1 T is a 31-year-old female with Bipolar Type 2, Emotionally Unstable Personality Disorder (now referred to as Complex Emotional Difficulties or CED), Ehlers Danlos Syndrome (hypermobile type), Fibromyalgia, Dysautonomia and long-term nerve damage in the left hand, thumb and wrist. She works full time.

2.2 T had been experiencing a stabbing pain around her waistline for 8 weeks and it became unmanageable and affected her sleep so she had an appointment with her GP in late August. At the appointment the GP ordered an ultrasound and a blood test for T who, while waiting for these tests, began to feel the pain residing. A Computed Tomography contrast scan was also booked for Tuesday 26 September to look at potential kidney stones.

2.3 On Monday 25 September, T attended her GP surgery in distress due to the pain she was in and was advised to go to the QEQM with suspected gall bladder issues or pancreatitis. On her arrival on Tuesday 26 September, her experience in the reception area of the ED was uncomfortable: It felt like all of the people waiting could hear what she was saying to the receptionist and after signing in, the waiting room was full of patients who were standing up due to a lack of seating.

2.4 T was given morphine in the assessment area then moved back to the waiting area. There was no explanation of how the morphine would affect her. She felt that she was not being listened to and didn't know what was going on, why there were tests being done or why she had a cannula in. She was then moved to a bed in the Medical Assessment Unit (MAU) and was there until the evening of Thursday 28 September. The team in the MAU told T that she had a distended gall bladder and abnormal liver function so would need to stay in the MAU for observation.

2.5 T takes daily medication including antidepressants. During the three days on the MAU she was provided with all of her regular medication except for the antidepressants. Upon her discharge she was advised that the Doctor who requested the antidepressants for her had not completed the correct form and her antidepressants were given to her upon leaving the MAU. By this point T was so

nauseous from withdrawal that she struggled to take her dosage. Her mental health was significantly impacted by this incident, as was her confidence that the Trust could take care of her.

2.6 Staff communication at QEQM also had a detrimental effect on T on a number of occasions.

- She was misdiagnosed by a Doctor with Viral Hepatitis and not given an explanation or understanding of whether it was contagious or not. This news, combined with her withdrawal from antidepressants, led to her becoming very upset and she was in tears in her bed. She then asked a Consultant how she may have contracted Hepatitis and whether she should advise her friends and family and the Consultant went back to the Doctor and within earshot told them they were mistaken.
- There was a conversation between clinicians about which medication to prescribe to T that made her question if they knew what they were treating. A nurse giving T her medication for Bipolar Type 2 told her that they were for treating epilepsy (the medication in question is used for both conditions).
- She was also advised in the morning not to eat after breakfast so she followed the advice and was then told at 8pm by another clinician that she could have eaten.
- Staff told a patient in a bed beside T what their diagnosis was, but they kept getting it wrong on the phone to her family. T intervened to make sure the patient's children had the correct information.
- There were occasions in the MAU and SDEC where she could hear staff talking about their personal lives. It was confusing and unsettling to be given upsetting information or be awaiting pain relief and then overhear clinicians making small talk with each other.

The lack of consistency and clear information made her question whether she was in receipt of the right care.

2.7 T did not feel that the pain she was experiencing was treated effectively. On one occasion she constantly requested pain relief for four hours. When someone told her it was going to be provided, she was then missed off the round. T felt that her mental health conditions were exacerbated by the constant pain and the non-uniform way that pain relief was provided. While she was issued morphine and anti-sickness medication there were no personal interventions from the ward staff to ask how her mental health was during her time at the MAU.

2.8 T was discharged from the QEQM at 5pm on Thursday 28 September. As previously mentioned, she was issued the missing antidepressants as well as the rest of her medication. The documentation she was given had incorrect information about the medication provided. She was given an appointment for an ultrasound on Friday 3 October but a Consultant said, "see you next Thursday" which was confusing.

2.9 T continued to feel unwell after her discharge but self-medicated with prescribed morphine at home as she did not want to go back to QEQM. She did not feel safe going back due to the trauma around her needs not being met on the MAU.

2.10 T arrived for her ultrasound at SDEC in QEQM on Friday 3 October. She noticed laminated information sheets explaining what the process was for receiving care and the details for contacting the Patient Advice and Liaison Service (PALS). She was offered a drink and biscuits and there was bottled water available. The surroundings were reassuring to her after her previous experience.

2.11 Staff communication at SDEC was also comprehensive:

- A Health Care Assistant (HCA) completed Observations and a blood test with T and spent time talking with her. This display of people skills put T at ease.
- The Sonographer completed an ultrasound and identified that T's gall bladder contained gallstones. This was then explained to T by a Doctor who remembered her from the week before. The fact that they remembered her was impactful. They were kind and clear, explaining her blood test results and the potential timescales for treatment.
- After the ultrasound, T was offered food and drink.
- As it was approaching 5pm, the Doctor went and found a Surgical Consultant to ask for a review so T did not have to stay overnight. The process for moving her care to Benenden was also explained as T is a patient with them and she went home feeling cared for and confident.

2.12 These variations in experience illustrate missed opportunities to have provided better-quality care and examples of how to reassure our patients in accordance with the Trust values and standards. Compassionate and dignified care is within the gift and responsibility of all our staff. T's story shows how information, communication and empathy can make a significant difference to how someone views their care, especially when there are comorbidities present.

3. Fundamentals of Care (FoC)

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

3.2 The Patient Voice and Involvement Team reports to the FoC Committee. T was aware of the Team and the fact that she knew she would be able to tell her story during her negative and positive experiences was reassuring. They have also escalated her request for a Consultant letter to be provided so she can continue her care with Benenden as she was told that she would likely have to wait months for this to be done due to administrative pressures.

4. Care for Patients with Mental Health Conditions

4.1 The Patient Voice and Involvement Team is currently gathering feedback from patients with a mental health condition and has set up a working group comprising voluntary services, statutory services and patients to influence this.

5. Conclusion

5.1 T's story raises issues around compassion and culture that are wider reaching than just ED services. We must be aware of the impact that a patient's surroundings have on their wellbeing. Patients should be issued medication that they are reliant on or have it explained to them why it is not being given to them. Their mental health should be considered when delivering information and medication, especially if they have an existing diagnosis. If they are in pain, this should be treated whenever possible and most of all communication should be clear and consistent.

5.2 We need a commitment from Board to ward to:

- Demonstrate compassion to those we look after;
- Model compassionate leadership;
- Improve the experience of people with pre-existing conditions, including mental health, when they are receiving care with us.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Vice-Chairman's Report**

Meeting date: **2 November 2023**

Board sponsor: **Vice-Chairman**

Paper Author: **Vice-Chairman**

Appendices:

Appendix 1: Non-Executive Director Commitments

Executive summary:

Action required:	Information
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.
Summary of key issues:	Update the Board on: • Current Updates/Introduction; • Activity of the CoG; • Visits/Meetings.
Key recommendations:	The Board of Directors is requested to **NOTE** the contents of this Vice-Chairman's report.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	N/A

East Kent Hospitals University NHS Foundation Trust

Link to the Corporate Risk Register (CRR):	N/A
Resource:	No
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

VICE-CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

Along with all other Trusts up and down the country, East Kent endures unprecedented demand as we move into the Winter period. Our Emergency Departments (EDs) have received an increase in walk-in attendances, which has resulted in a higher number of patients waiting for beds, with 132 patients on average awaiting beds in the ED each morning. In addition to our front door, the Trust has increased pressure across our planned care, with approximately 2,000-3,000 additional patients each month since the start of this year. The Trust has brought in multiple initiatives to tackle the growing backlog, which we will hear about at this Board meeting, including the next stages of our ED builds taking place across William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM).

As a result of this pressure on our services, the Trust has prioritised the development of a Winter Plan. The Winter Plan for 2023/24 has been created in collaboration with all partners across the East Kent Health and Care Partnership (HCP) which includes Community Health, Community Mental Health, Ambulance Services, Primary Care, Acute Care and Social Care.

The plan aims to address the increase in demand, with additional provisions in place to ensure the safety and effective care of our patients. Initial modelling has shown that in order to meet our projected demand across Winter, the Trust will be expected to have an increase in demand of 243 beds. On review of multiple schemes to mitigate this demand across the Trust, we continue to have an unmitigated bed gap of approximately 85 beds. This represents a large risk, to our patients, and conversations continue to take place across the East Kent HCP to review risk, and next steps. The plan aims to address other metrics to ensure we receive accurate, and appropriate information across our workforce, performance and quality data within the Trust.

Alongside the considerable operational strain on our services, there continues to also be strain on our financial position. As reported previously, there continues be two elements of the Trust's financial deficit which were unplanned, which include strike action (£1.5m) and the unfunded pay award funding for both Agenda for Change and Medical & Dental Staff (£2.2m). Alongside the increased levels of staffing utilisation due to escalation areas, and associated high agency costs, this has resulted with the Trust having a deficit position of £59.3m against the planned deficit of £40.9m at the end of September.

Financial controls to reduce the continued overspend, which have been adopted in line with the national requirements, are in place. The Trust can see that in September temporary staffing costs reduced by £0.9m, which indicates that the pay controls that were embedding in September are starting to work. The Trust continues to work at pace on efficiency plans and further interventions to reduce current spending levels. We are also pleased to announce that we have an Interim Chief Finance Officer (CFO) joining the Trust next week. The incoming CFO has also secured a package of support from NHS England to support a significant programme of work.

I am also pleased to announce that Dr Des Holden will be joining the Trust later this year as Chief Medical Officer (CMO). Dr Holden has over 10 years' experience as an acute Medical Director, and I know his contribution to the Executive Team and Medical workforce will be invaluable. I would also like to thank Dr Nic Goodger and Dr Jonathan Purday for their continued role in filling the vacant CMO position.

Finally, we should remember that we have just passed the first anniversary of the publication of Dr Kirkup's Report, *Reading the Signals*. As the Board had been advised previously, there was a disappointing inspection of our maternity services by the Care Quality Commission (CQC) in January of this year. We will hear later of the actions underway as a result of that inspection. However, there are a number of initiatives already implemented which are having a material impact in improving our maternity services.

1. Daily checks of standards including access to and regular checking of emergency equipment as well as checking the basics such as hand hygiene and Personal Protective Equipment (PPE) compliance.
2. We have implemented the Birmingham Specific Obstetric Triage System (BSOTS) to ensure all mothers are assessed promptly on arrival which has seen compliance increase to 99.1% in August 2023.
3. To improve the quality of care, we have invested to increase midwives and doctors including specialist role. However, recruitment at WHH remains very challenging. We have appointed 10 additional internationally educated midwives.
4. To ensure we have the right staff in the right places, we use a workforce acuity tool which is supported by a live tracker to ensure staff are where they are most needed. In September 2022 staffing met acuity needs 55.7% of the time – in September 2023 this figure had risen to 76.1%. One result of this improvement is that there were zero unit diverts by August – the second consecutive month of achieving zero.
5. In February 2023, student midwives were removed from their placements at WHH due to a number of concerns. In May, the Nursing and Midwifery Council (NMC) withdrew its approval for the midwifery programme at Canterbury Christ Church University due to broader concerns and students were removed from all Kent and Medway placements. We have been working closely with the University of Surrey to enable student midwives to return and we are delighted to have been able to welcome back midwifery students to the Trust. We have increased the practice development team and systems for student support and supervision. We are increasing the ways students can raise concerns about their clinical placement. We will continue to work with the NMC and the University of Surrey to ensure the standards students require in order to became safe and effective registered midwives are being met. Students on clinical placement with us are not counted in our staffing numbers, but they are an important part of our team and for our future workforce.

However, whilst there is some excellent progress being made we are acutely aware this is just the beginning of a lengthy and complex journey. We know our physical infrastructure is not fit for purpose and culture, teamworking and training were heavily criticised in Dr Kirkup's report. We have allocated funding to improve our infrastructure and we have started regular staff training and reflection on clinical practice to underpin delivery of safe services. Learning from mistakes was a significant point made by families and we have a new staff Safety Summit to share key safety learning with all staff – these happened twice monthly. We have also included

'Hot Topics' that require immediate dissemination and 'Safety Threads' used in safety huddles and handovers daily.

3. Council of Governors (CoG)

The Council of Governors continues to work and support the Trust's substantial pressures. The Council itself is under a period of change, and currently has five vacancies which we hope to start to fill by the end of this year.

The Council has suspended all joint site visits until early next year as it understands the current pressures that the Trust is experiencing with the increased demand on its services. The Council, however, remains committed to helping the Trust in any way possible.

East Kent Hospitals University NHS Foundation Trust

Appendix 1 – Non-Executive Director (NED) Commitments

NEDs October 2023 commitments have included:

Non-Executive Directors	NEDs meeting Nominations and Remuneration Committee (NRC) meeting Finance and Performance Committee (FPC) meeting Quality and Safety Committee (Q&SC) meeting Reading the Signals Oversight Group meeting Culture and Leadership Programme (CLP) Interviews Meetings with Executive Directors Meeting with Freedom to Speak Up (FTSU) Guardians

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chief Executive's Report**

Meeting date: **2 November 2023**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

Appendix 1: Kent and Medway (K&M) Provider Collaborative – Context document
Appendix 2: K&M Provider Collaborative Board – Draft Terms of Reference (ToR)

Executive summary:

Action required:	Discussion
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.
Summary of key issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.
Key recommendations:	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

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

2. Background

This report will include a summary of the CEMG as well as other key activities.

3. Clinical Executive Management Group (CEMG)

The CEMG approved a Business Case for the appointment of a Managed Service Provision (MSP) for temporary staffing (Agenda for Change and Medical Staff) given the Trust's current financial position and in line with our commitment to reduce agency expenditure/target reductions in usage. The appointment of the managed service will provide greater efficiency, streamline supply and align rates to deliver savings in the region of £15m - £23m over the three-year contract period.

4. Operations update

4.1 Winter planning

The Trust's winter plan provides an overview of the work underway both internally and externally with Health Care Partnership (HCP) colleagues and system partners as we prepare for the anticipated increase in demand this winter to ensure the Trust is able to meet the needs of our patients and reduce harm.

Analysis to date suggests that an additional 243 beds will be required across the Trust to cope with patient demand this winter. This uplift is against the base level bed position reported in August 2023 of 1,040 core open beds, with a projected uplift to 1,283.

The Winter Plan contains a summary of schemes proposed by the East Kent (EK) HCP to mitigate the bed gap. The schemes proposed have been reviewed by EKHUFT with key operational protocols considered to ensure the Trust is able to access the proposed capacity in a timely manner and monitor the success and impact of the schemes on an on-going basis.

The proposed schemes do however contain risk to delivery. Following an assessment of the risks associated with the proposed schemes, along with an assessment of the Trust's current bed position, the revised estimate is in the region of 85 beds. Conversations continue with our system partners, via the weekly EK HCP Urgent Care Improvement Delivery Group, to review the risk associated with this gap.

Escalation planning and trigger tools are in development being led by the Care Group Managing Directors. An initial options appraisal has been completed for each site outlining potential areas for escalation and the associated impact of escalating into those areas. It is recognised that, whilst all efforts will be made to ensure external

capacity is maximised, further internal resource will be required to meet demand to ensure patient safety and to ringfence the Trust's elective capacity. These plans will be presented in the next iteration of the plan in November.

There is also significant focus on internal processes and a recognised need for improvements supported by the implementation of SAFER and the PRISM Inpatient flow improvement programmes in train at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) respectively.

4.2 Planned Care

As outlined in last month's report, the number of patients on the Trust's waiting list for Referral to Treatment (RTT) has been increasing by approximately 2000 - 3000 patients per month since the start of 2023. In September the reported position is 88.9k, with increases in the number of patients breaching 78-week waits (August 145 vs September 233).

The Trust's Care Group and specialty leads have completed an exercise in recent weeks to ascertain what the revised year end position may be equating the known capacity, demand, activity run rates and any improvement schemes that can be realised to support the deteriorating position. These trajectories will outline the areas of focussed recovery that need to be implemented to ensure the Trust is able to address the growing waiting lists and meet the needs of our longest waiting patients.

Additional funding has been secured to enable the Trust to increase the number of endoscopy procedures completed on a monthly basis to address the increasing backlog of patients waiting for scopes. An insourcing supplier will be providing an additional 1,000 scopes per month, which will be in situ from early November 2023 and the Trust's Estates and Strategic Development teams are sourcing a location across the Trust to host a tailored Endoscopy suite to provide a further c.500-600 scopes per month. Surveillance patients and patients on cancer diagnostic pathways will be prioritised for this additional capacity.

4.3 Unplanned Care

Performance across the Trust's Emergency Departments (EDs) deteriorated for a second consecutive month reporting 74.0% in July, 72.2% in August, and 70.4% in September 2023.

Trust wide Type 1 performance deteriorated in month from 46.3% in August to 45.2% in September (QEQM 47.8% to 43.4%, WHH 44.9% to 46.7%).

Trust wide All types performance deteriorated in month from 72.2% in August to 70.4% in September (QEQM 65.9% to 62.1%, WHH 62.1% to 61.9%).

SAFER at WHH

SAFER is an inpatient flow improvement programme of work which has been in place at the WHH since July 2023. Initially scheduled for completion by the end of October 2023, the programme's timeline has been revised. Starting from November, KPMG will take over for further implementation and integration of the SAFER principles.

Initial results indicate consecutive week-on-week improvement and a reduction in the number of long stay patients, increased board round completion, increased fit to reside status completion, and an increased number of complex discharges. Whilst it is difficult to discern what impact is a direct result of the SAFER work, and what has been driven by concurrent improvements made to the Patient Tracking List (PTL) and improved communications with the wards and the Rapid Transfer Service (RTS) teams, the initial findings are positive.

Prism at QEQM

Running alongside the SAFER programme of work, the Trust has welcomed an external team of consultants from provider Prism to review inpatient flow at the QEQM with the key objective of the programme of work to improve flow across the back end of the hospital. Work commenced on 2 October 2023 and the Prism team are near the end of their four-week discovery phase. An Implementation plan for improvement is expected from Prism on Friday 27 October 2023.

4.4 WHH ED Build Update

The ED build at the WHH is nearing completion with the final fix works due to be completed in early November 2023. The second half of majors is now back in use with just one cubical remaining out of use due to final works at the ED entrance, while there are some minor works still in place on Corridor B to support the installation of fire doors. There has been a slight delay in finalising the Clinical Assessment Unit (CAU) area which is also anticipated to be complete in early November 2023.

4.5 QEQM ED Build Update

The next critical stage of the build at QEQM, phase 3b, will be in late October and will see the loss of the current corridor typically used for the Ambulance queue. Three key factors being considered for the next phase include corridor capacity, current use of Rapid Assessment and Treatment (RAT+), Aerosol Generating Procedures (AGP) loss of space and management of the Mental Health (MH) patients.

5. Financial performance and NHSE control measures

At the end of M6 (September) 2023 the Trust has a year to date (YTD) deficit of £59.3m against the planned YTD deficit of £40.9m. Two elements of the deficit are strike action (£1.5m) and shortfall in pay award funding for both Agenda for Change and Medical & Dental Staff (£2.2m) neither of which were part of the planned £72m deficit.

Key drivers of the YTD position continue to be the non-delivery of recurrent efficiency savings (£14.4m) and pay overspend including increased levels of staffing utilisation due to escalation areas, one to one care and the associated high cost of agency premium.

Financial controls to reduce the run-rate, which have been adopted in line with the national level 4 (NOF4) requirements, are in place and in September temporary staffing costs reduced by £0.9m, which indicates that the pay controls that were

embedding throughout September are working. The Trust continues to work at pace on efficiency plans and further interventions to reduce current spending levels.

6. Care Quality Commission (CQC) Well Led Review

The Care Quality Commission (CQC) carried out a 'well led' inspection of the Trust on 4 and 5 July of this year and invited clinicians to share examples of good practice in August 2023.

This followed unannounced inspections of general medicine, urgent and emergency care and paediatrics services in May 2023. Following these inspections, the CQC wrote to the Trust asking formally that we provide, by mid-September, evidence of how we are managing handover arrangements in the ED; improving medical and nurse staffing, skill mix and training compliance; and have systems and processes to mitigate risk relating to the environment, premises and equipment, cleanliness and infection, prevention and control.

We responded to this request and expect the final report/s to be published by the CQC in the coming weeks.

7. National Staff Survey

The annual NHS Staff Survey launched on Monday 18 September 2023 and is now half-way through the mandatory fieldwork.

As at midday on 20 October 2023, the response rate was 31% (3,028 respondents), with three more reminders to be issued before it closes on 24 November 2023.

Rob Fordham has been spearheading the campaign again this year supported by Mark Bailey from NHSE, who have been meeting with Care Group leaders to support and encourage activity to increase the level of completion as much as possible. Care Group leaders are also working with their teams to enable local uptake including releasing from individual duties to complete the survey. The Staff experience team have also been deployed to ward areas providing iPads and mobile devices to facilitate individual responses and increase accessibility.

The CEMG discussed the survey and endorsed the activity being undertaken with a particular focus on driving through a high completion rate in order that we can obtain the vital feedback that we wish to receive from our staff about their individual and collective experiences working for the Trust.

Responses to the national Staff Survey allow the Executive Board, Care Group and Specialty leads to understand the experiences of our people and to make the improvements that we all want to see.

8. Kent and Medway Provider Collaborative

Whilst collaboration between health and care providers already exists across Kent and Medway in various formats, in early 2023 Kent and Medway Integrated Care System (ICS) partners agreed in line with national context to create a provider collaborative structure that will formally bring together partner organisations and providers across Kent and Medway to collaborate on the design and delivery of care and to drive improvements in the delivery of services.

A Provider Collaborative Board will be established to bring together providers across East Kent to drive the delivery of four collaborative programmes of work, enabling partnership working to deliver greater impact and improve care outcomes for the population of K&M.

A presentation providing greater context on the development of the Provider Collaborative in K&M is included as an appendix, in addition to a proposed Terms of Reference for the Provider Collaborative Board.

9. Health Care Partnership Provider Collaborative

Similar to the K&M approach, the development of a Provider Collaborative between Kent Community Health NHS Foundation Trust, Kent County Council Social Care Services and the Trust are being explored. The three organisations are working very closely together on the management of urgent and emergency pathways and the establishment of a collaborative arrangements formalises this a little more, particularly in the provision of intermediate care services and support to that part of the pathway.

10. Executive Team update

Further to interviews held in September, I am pleased to announce that Dr Des Holden has been appointed as the Trust's Chief Medical Officer and will join the Trust at the end of the year. Des is currently the Chief Executive Officer of Health Innovation KSS (formerly Kent, Surrey & Sussex Academic Health Sciences Network – KSS AHSN) and has previously worked as Medical Director at Surrey and Sussex Healthcare NHS Trust (SASH), a post he held until 2019 when the CQC awarded the Trust an outstanding rating overall and in four of the six inspection domains.

11. Conclusion

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

Kent and Medway Provider Collaboratives

Supporting paper for:

Provider Chairs/CEOs

10th October 2023

Kent and Medway Integrated Care System

Attain

In this document you will find…

Context of provider collaborative development in Kent and Medway

- How provider collaboratives have been developed
- Role of provider collaboratives in the system
- Principles of provider collaboratives in Kent and Medway

Proposed **governance** (supported by Provider Collaborative Board Terms of Reference (separate Word document))

Areas of responsibility, authority, governance, membership and leadership of the proposed four at-scale provider collaboratives in Kent and Medway

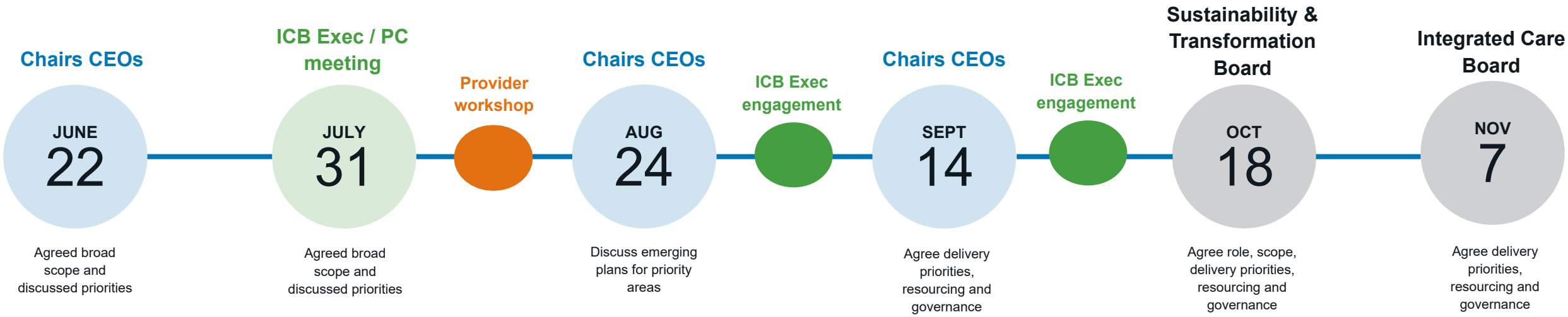
Resourcing

Early assessment and next steps of the at scale provider collaboratives' maturity against the NHS England **Provider Collaborative Maturity Matrix**

Milestone Plan

Attain

The design of Provider Collaboratives has been a partnership between the leaders of providers and the ICB



The provider collaborative development work has included:

- Support with early development work from the Kings Fund
- Leadership from provider Chairs and CEOs
- Wide engagement and contribution from provider executive teams
- Extensive engagement with the ICB Executive Team, including the ICB's Financial Recovery Programme and alignment to the ICB's pathway programmes

Concurrent provider board approvals

The principles of provider collaboration that were agreed in late 2022 have underpinned this development work

- any collaboration must be justified on the basis of its ability to demonstrate measurable improvements in patient and population outcomes, patient experience, efficiency/productivity, and the reduction of inequalities
- any collaboration needs to have decision making located at the appropriate level in the system and involve the appropriate individuals
- any collaboration should be based on the principles of subsidiarity and taking decisions as close to the patient and citizen as possible
- any collaboration must recognise that it may create 'winners and losers' and therefore encompass a commitment to manage the impact of any such problems
- any collaboration must be clear about the problems it is attempting to resolve and avoid creating additional tiers of bureaucracy
- any collaboration must demonstrate that it is added value over and above any existing approach
- any collaboration must be based on strong clinical and care professional engagement that has provided an evidence base for its work programme and a platform for its implementation
- any collaboration needs to be based recognise staffing and workforce issues as a driver to set priorities and as a conscious restriction on the pace and scope of its work programme
- any collaboration should recognise the time frames in which it may operate - delivering quick tactical benefits and longer term more strategic solutions
- any collaboration should operate by doing only what it can do best, and be coherent with work at HCP level and at the ICB level

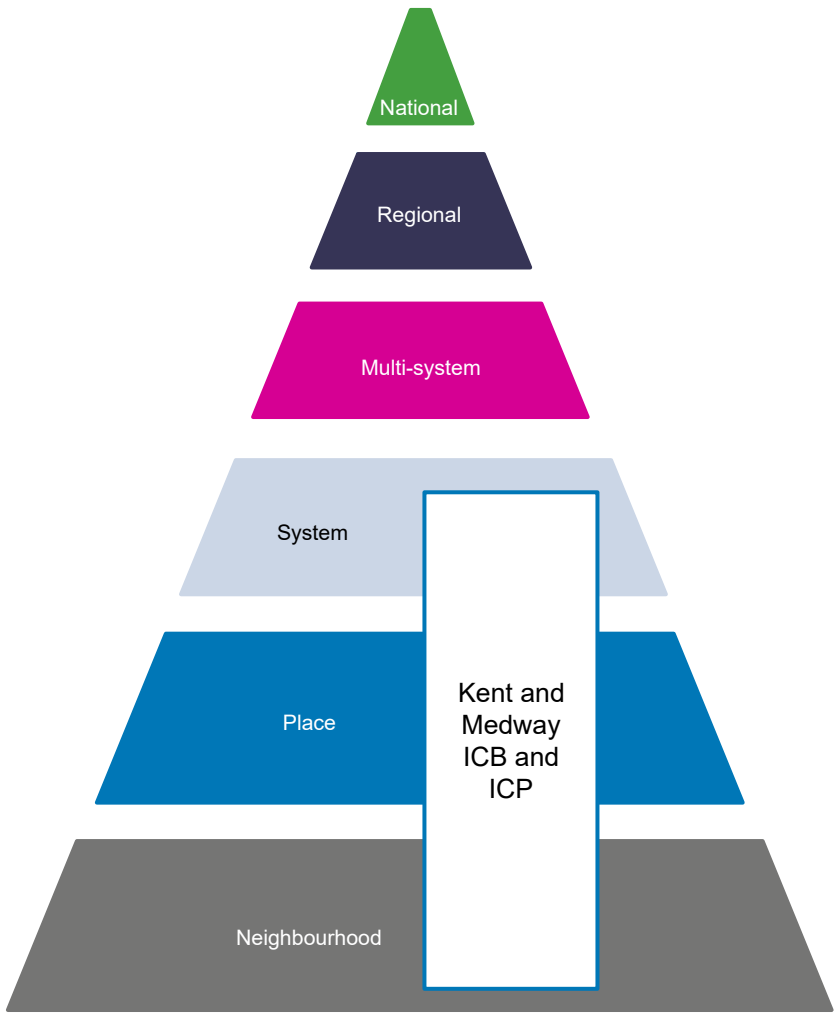
Recent engagement has added the following:

- any collaboration will only be to the depth required to have an impact
- any collaboration should start with the simple stuff, building complexity with our maturity – and keeping the list of priorities small
- any collaboration should be supported by the right resources and supporting governance – to enable us to deliver the ambition
- Any collaboration will support the Kent and Medway system to deliver its efficiency targets (Financial Recovery Programme)

The functions of the provider collaboratives in Kent and Medway

Scope of this paper, including how they relate to H&CPs and Neighbourhoods

System levels



Collaborative delivery of health services

Provider collaborative arrangements	Purpose of collaboration	Kent and Medway collaboratives	Partners	Example services
AHSNs, AHSCs, public-private partnerships	Collaborative arrangements to deliver specialised services across the region	E.g. Kent Surrey Sussex Academic Health Science Network	Specialist providers Research universities Industry	Highly specialist services Specialised services
Specialist clinical networks Provider collaboratives	Collaborative arrangements to deliver specialised services across **multiple systems**	E.g. Provider Collaborative Kent, Surrey and Sussex Kent and Sussex CAMHS Tier 4	Providers (including from outside Kent and Medway)	Highly specialised services Community and MH
Provider collaboratives	Collaboration between providers to work together **at scale** to benefit their populations	Provider Collaborative Board MHLDA Collaborative Community Collaborative Acute Collaborative	Providers, GPs, KCC and Medway Council, VCSE	Secondary care Community care (physical and mental)
H&CPs	Providers of health and care, collaborating to deliver **smaller 'place based' geographies**	Dartford & Gravesham H&CP East Kent H&CP West Kent H&CP Medway H&CP	Providers GPs KCC and Medway Council Voluntary sector	Community health Social care Urgent care
Neighbourhood Teams PCNs	Hyper local collaboration of **front-line teams** to delver integrated care to the population	Neighbourhood Teams PCNs	GPs Voluntary sector KCC and Medway Council Providers	Primary care Prevention, public health and wellbeing Community health Social care

What will be different? Provider collaboratives will supplement existing delivery mechanisms in the Kent and Medway ICS

*Provider collaboratives can take responsibility for delivering elements of the ICB's ambitions – including the ICB's **Financial Recovery Programme** and areas of system complexity that require providers to work together to tackle difficult problems*

ICB

Provider Boards

*Provider collaboratives will support their constituent provider organisations to **tackle areas where collaboration with other local providers will support them to address challenges** and provide improved services, more efficiently*

Existing provider collaboratives and networks

*A more strategic approach to provider collaboratives will provide a **mechanism for existing provider collaborative activity to be consolidated** (e.g., Diagnostics and Pathology Network)*

Kent and Medway at-scale health service provider collaboratives

*Provider collaboratives will be responsible for supporting **local delivery at an H&CP and neighbourhood level** by creating mechanisms for the sharing of resources (e.g., holding Section 75s with local authorities)*

H&CPs

Neighbourhoods

Where we can tackle complex problems better together **at scale, as providers of health services** we will collaborate to deliver (or enable the delivery of) improved outcomes, transformation and efficiencies for the population and system of Kent and Medway.

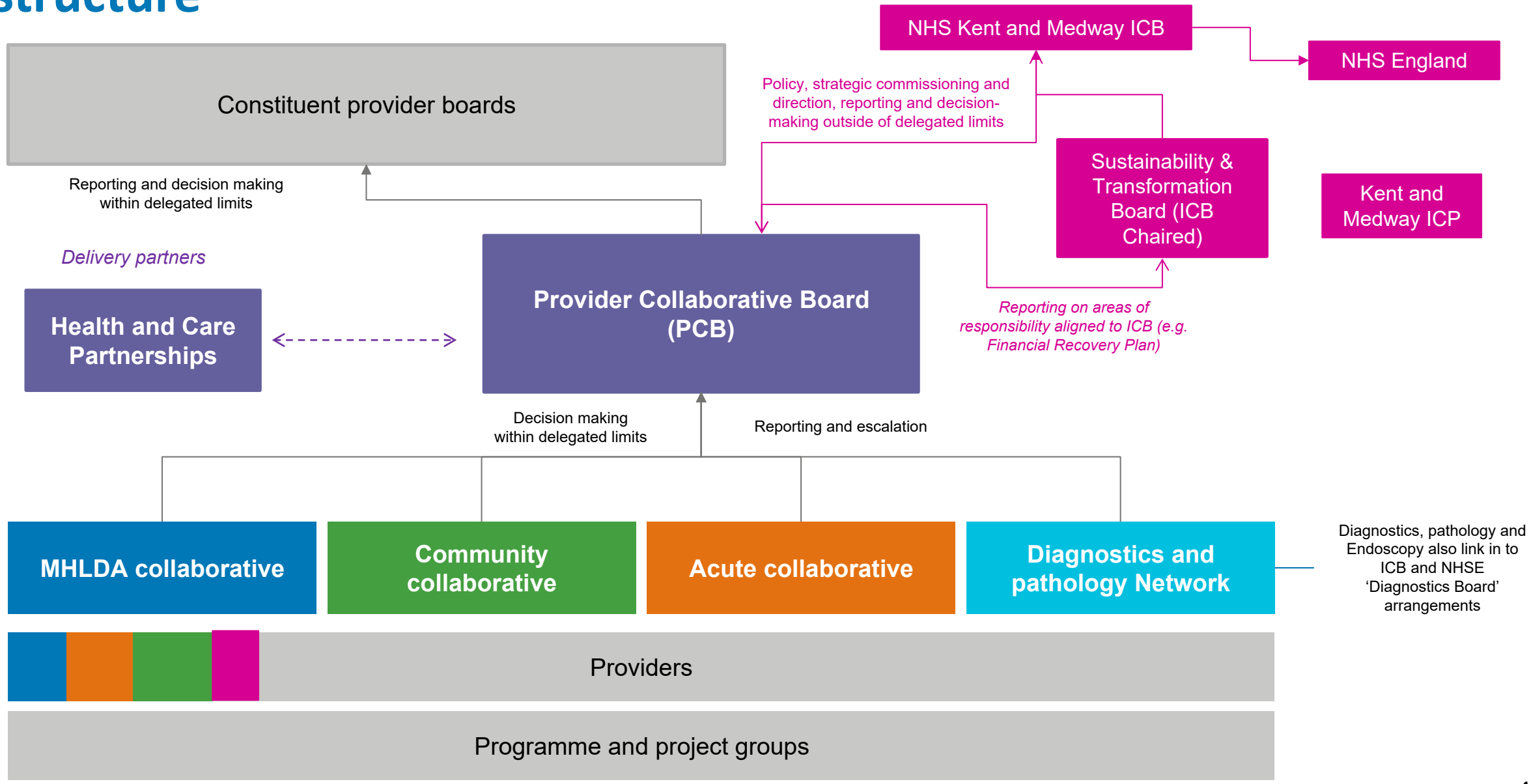
Four at scale collaboratives of health providers will provide a design, delivery and enabling function to supplement the existing delivery infrastructure in the system. These four provider collaboratives will be:

1. **[All] Provider Collaborative Board**
2. **MHLDA Provider Collaborative**
3. **Community Collaborative**
4. **Acute Collaborative**

Kent and Medway are proposing the development of four at scale provider collaboratives

Provider Collaborative Board	MHLDA	Community	Acute
To drive the delivery of collaborative programmes of work across all providers in Kent and Medway To provide leadership and assurance of and support to the work and development of the three provider collaboratives and the Diagnostics & Pathology Network	Building on the current collaborative and it's work programme, together tackle complex MHLDA services where a joined-up approach will drive improved outcomes for the population and system	To drive a collaborative approach to the delivery of complex community and primary care services at scale, including with our local authority partners	To drive transformation of secondary care services where collaboration will deliver improved outcomes for the population and the system
All providers • KMPT • Medway Community • HCRG • EKHUFT • KCHFT • MTW • DG • Medway • SECAM	**MHLDA partners** • KMPT • KCC • Medway Council • VCSE • KCHFT • Medway Community • ICB • Primary care • NELFT • SECAM	**Community partners** • KCHFT • Medway CT • HCRG • VCSE • KCC • Medway Council • ICB • Primary care • SECAM	**Acute partners** • EKHUFT • MTW • DG • Medway • ICB • SECAM

Proposed governance of the at scale provider collaborative structure



Provider Collaborative Board

Responsibility for the delivery of…

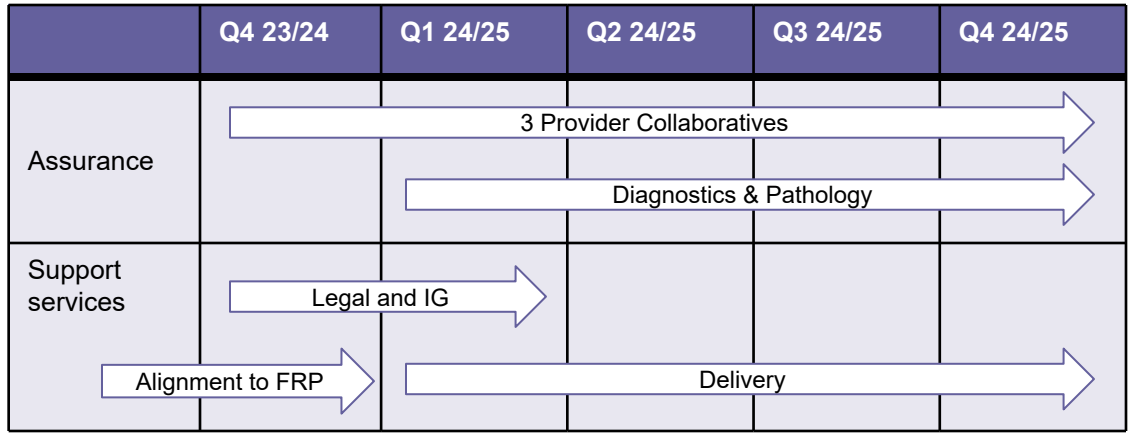
Assurance of work of other collaboratives and their development (through the maturity matrix)

Support Services Programme to drive efficiencies of a share approach to these organsiational functions (**aligned to the ICB's Financial Recovery Programme**), including:

1. Legal and IG
2. One Public Estate (inc. LAs)
3. Procurement

Assurance of the work of the Diagnostics and Pathology Network

Plan for 2024/25



Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Chairs and CEOs). **It does not have delegated authority from the ICB or from the Trust Boards. Delegation from provider boards, on specific issues related to the scope of this Board, will be explored in the coming weeks to ensure the effectiveness of this Board**
- For decisions outside the scope of these individuals (e.g., material in scope / significant financial impact / requiring public consultation (e.g., would not secure HOSC approval)), the Board will make recommendations to the provider boards and / or the Sustainability & Transformation Board.
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning.
- The Board will have no commissioning responsibilities
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- ICB membership will be non-voting and will reflect delegated areas of responsibility / the nature of the decision(s) in scope

Partners and membership

Chairs and CEOs from all eight providers – KMPT, Medway Community, HCRG, KCHFT, EKHUFT, SECAMB, MTW, DG and Medway and ICB

Leadership

Chair: David Highton

Exec Lead: Sheila Stenson

Exec Lead Support Services: Chris Wright

MHLDA Provider Collaborative

Responsibility for the delivery of…

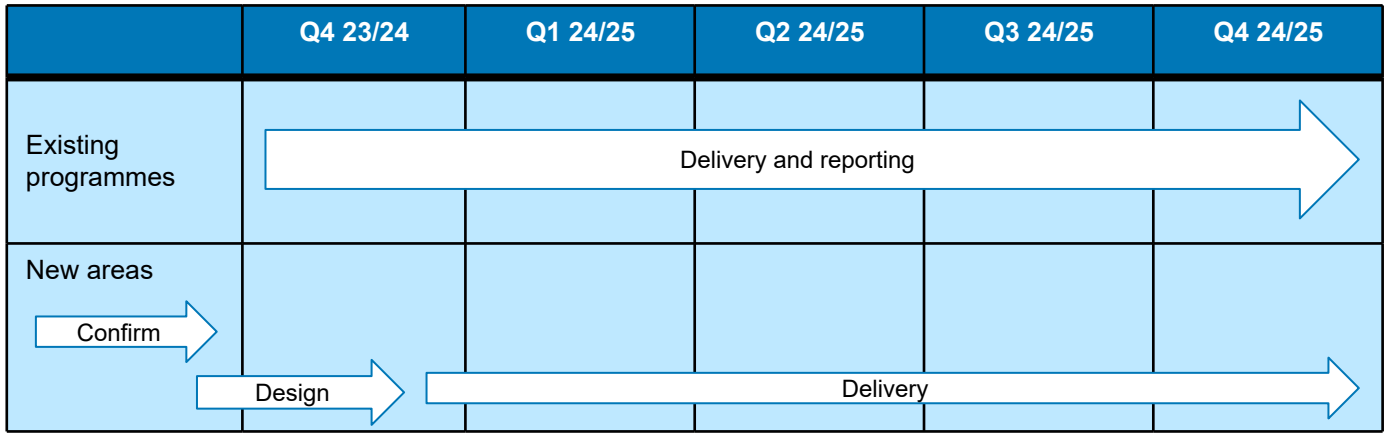
Continued delivery of programme areas that have historically sat with the MHDLA Provider Collaborative Board, including:

1. Community Mental Health Transformation Programme
2. LDA out of area placements Project
3. CYP transitions and out of area placements Project
4. Suicide Prevention Project
5. Mental health urgent and emergency care

Other areas in scope that may be delivered over a longer period, and require further development include:

1. Mental health frequent attenders project
2. Delivery of the Mental Health Digital Strategy
3. Neurodiversity project

Plan for 2024/25



Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold. It does not have delegated authority from the Provider Collaborative Board, ICB or from provider boards
- For decisions outside the scope of these individuals, recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

KMPT, KCC, Medway Council, VCSE, KCHFT, Medway Community, ICB, Primary care, NELFT

Leadership

Chair: Sheila Stenson

Exec Lead: TBC

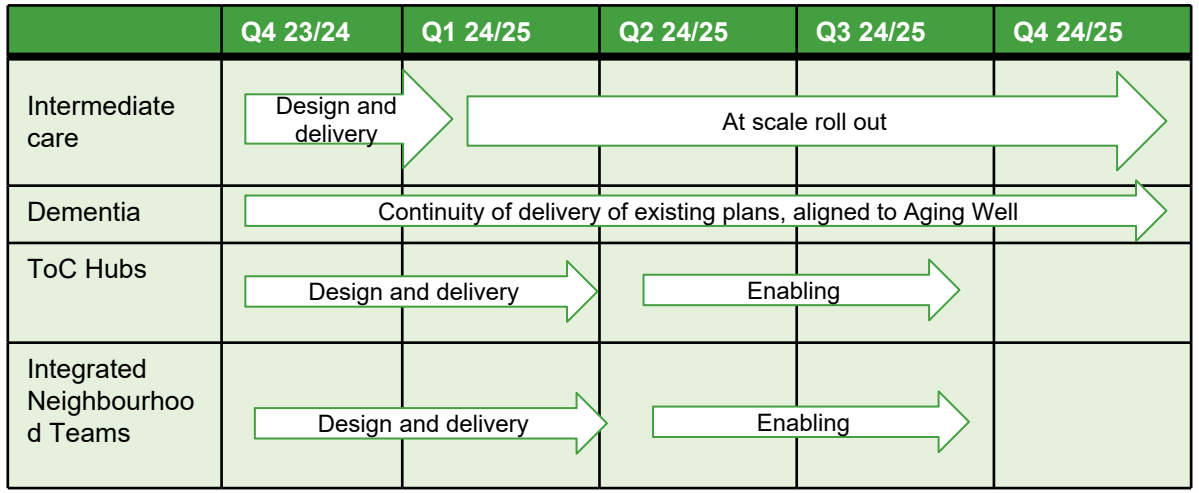
Community Provider Collaborative

Responsibility for the delivery of…

At-scale delivery of:

- Intermediate care model – building on the East Kent pilot of a winter integrated bed model toimprove provision of short-term services (and reduce spot purchasing of beds) (**aligned to FRP's Better Use of Beds**)
- Transfer of care hubs
- Dementia improvement project (final collaborative 'home' TBC through discussion with clinical colleagues – may be MHLDA provider collaborative)
- Enabling deployment of resources to the Integrated Neighbourhood Teams (with LA partners through Section 75s)

Plan for 2024



- In time, the delivery of the community transformation will be delivered through this forum

Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold. It does not have delegated authority from the Provider Collaborative Board, ICB or from provider boards
- For decisions outside the scope of these individuals, recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

KCHFT, Medway CT, HCRG, VCSE, KCC, Medway Council, ICB, primary care providers (PCNs/Confeds)

Leadership

Chair: Mairead McCormick

Exec Lead: TBC

Acute Provider Collaborative

Responsibility for the delivery of…

Service review (**aligned to the ICB's Financial Recovery Programme**)of all acute services (including, where significant, the interface with community, mental health and independent sector services) and specialised commissioning to establish the sustainability of services and opportunity for improvement of this position. Delivery of recommendations from review could be through individual providers, PCs, HCPs or ICB. Recommendations may include service improvement, service redesign and/or service reconfiguration

Service Review - factors of sustainability

Early focus on ENT and Dental GA to drive improvements in the service

Support to deliver the system's endoscopy work programme (including bids for estates)

Plan for 2024/25

	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Service Review	Service Review	Service Review: Detailed design and delivery Quick win delivery			
ENT	Discovery and design	Delivery of impact			
Endoscopy	Review and sign-off proposals				

Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Trust Executive Team members). It does not have delegated authority from the Provider Collaborative Board, ICB or from the Trust Boards
- For decisions outside the scope of these individuals' recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

Executive Team members from each of the four acute trusts and the Director of Delivery of the ICB

Leadership

Chair: Jayne Black

Exec Lead: TBC

The resourcing of the at scale provider collaboratives

ICB

Provider Collaborative Board	MHLDA	Community	Acute
Chair: David Highton Executive Lead: Sheila Stenson Executive Leadership of Support Services Programme: Chris Wright	Chair / Executive Lead: Sheila Stenson	Chair / Executive Lead: Mairead McCormick	Chair / Executive Lead: Jayne Black

Provider Collaborative Programme Director – JD drafted for a substantive, went to advert in September
Interim support is being provided by Attain

Additional provider resources to be determined as more detailed workplan emerges

External support provided to deliver elements of the Service Review

TBC (after restructure) | TBC (after restructure) | TBC (after restructure)

Population health

Information governance

Kent and Medway Provider Collaborative maturity – measured against the NHS England Provider Collaborative Maturity Matrix

Domain	Objective	Provider Collaborative Board	MHLDA Provider Collaborative	Community Collaborative	Acute Collaborative
Outcomes and benefits	Reduce unwarranted variation and inequalities in patient outcomes, access and experience Improve resilience Enhance productivity and value for money	**Emerging** Identifying areas for improvement with shared data sets and committing to addressing the challenges together – including sharing resources and mutual aid	**Developing** Co-designing collaborative transformation plans and programmes to address challenges	**Emerging/Developing** In some areas, co-designing collaborative transformation plans and programmes to address challenges	**Emerging** Identifying areas for improvement with shared data sets and committing to addressing the challenges together – including sharing resources and mutual aid
Governance and Leadership	Implement shared vision and governance Build a culture of mutual support and accountability Embed multi-professional clinical and care leadership	**Emerging/Developing** Developing and implementing shared governance, committing to an open culture, identifying shared approach to managing risks and collaborative resources	**Developing** Shared vision, implementing shared governance, identifying programmes for shared risk (CMHT), transformation designed with strong clinical leadership	**Emerging/Developing** Developing and implementing shared governance, committing to an open culture, identifying shared approach to managing risks and collaborative resources, strong clinical leadership	**Emerging** Agreeing governance, agreeing to share risk, committing to an open culture and data sharing, agreeing shared approach to continuous improvement, establishing links with clinical groups
System working	Support ICSs to deliver priorities Build strong relationships with partners Engage and co-design with people and communities	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Emerging/developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners

There are existing areas of provider collaboration (e.g., Diagnostics and Pathology Network) where there is greater maturity. This maturity matrix is focusing on the new Provider Collaborative Boards, but is actively seeking to learn the lessons from historic provider collaboration.

The Provider Collaborative Board will lead and support the collaboratives to develop

Domain	Objective	Provider Collaborative Board	MHLDA Provider Collaborative Board	Community Collaborative Board	Acute Collaborative Board
Outcomes and benefits	Reduce unwarranted variation and inequalities in patient outcomes, access and experience Improve resilience Enhance productivity and value for money	Working towards: • Delivering programmes to reduce inequalities, address fragile services and deliver efficiencies • Co-design of transformation plans • systematic approach to mutual aid and sharing resources • delivery of joint corporate functions			
Governance and Leadership	Implement shared vision and governance Build a culture of mutual support and accountability Embed multi-professional clinical and care leadership	Working towards: • Shared vision that drives all transformation programme • financial risk sharing • ensuring the fullest range of clinical and care leadership • delegation/decisions that are in the system interest and independent of all sovereign interests • Embedded common QI methodologies and embedding of best practice • Ensure member Boards are routinely abreast of outcomes			
System working	Support ICSs to deliver priorities Build strong relationships with partners Engage and co-design with people and communities	Working towards: • Defined and maturing interfaces and relationships with HCPs and local authorities • Integration of programmes with population health disciplines • Work with partners outside Kent and Medway • Routine evaluation and population engagement			

The development journey of provider collaboratives will be informed by the learning and experiences of the arrangements as they rollout, deliver and evolve.

There are already areas to be explored in the coming months, and then further into 24/25.

These will form part of a Provider Collaborative Operating Model and Development Plan to be developed in Q4 23/24.

Milestone Plan

Sustainability & Transformation Board

OCT 18

Agree role, scope, delivery priorities, resourcing and governance

Integrated Care Board

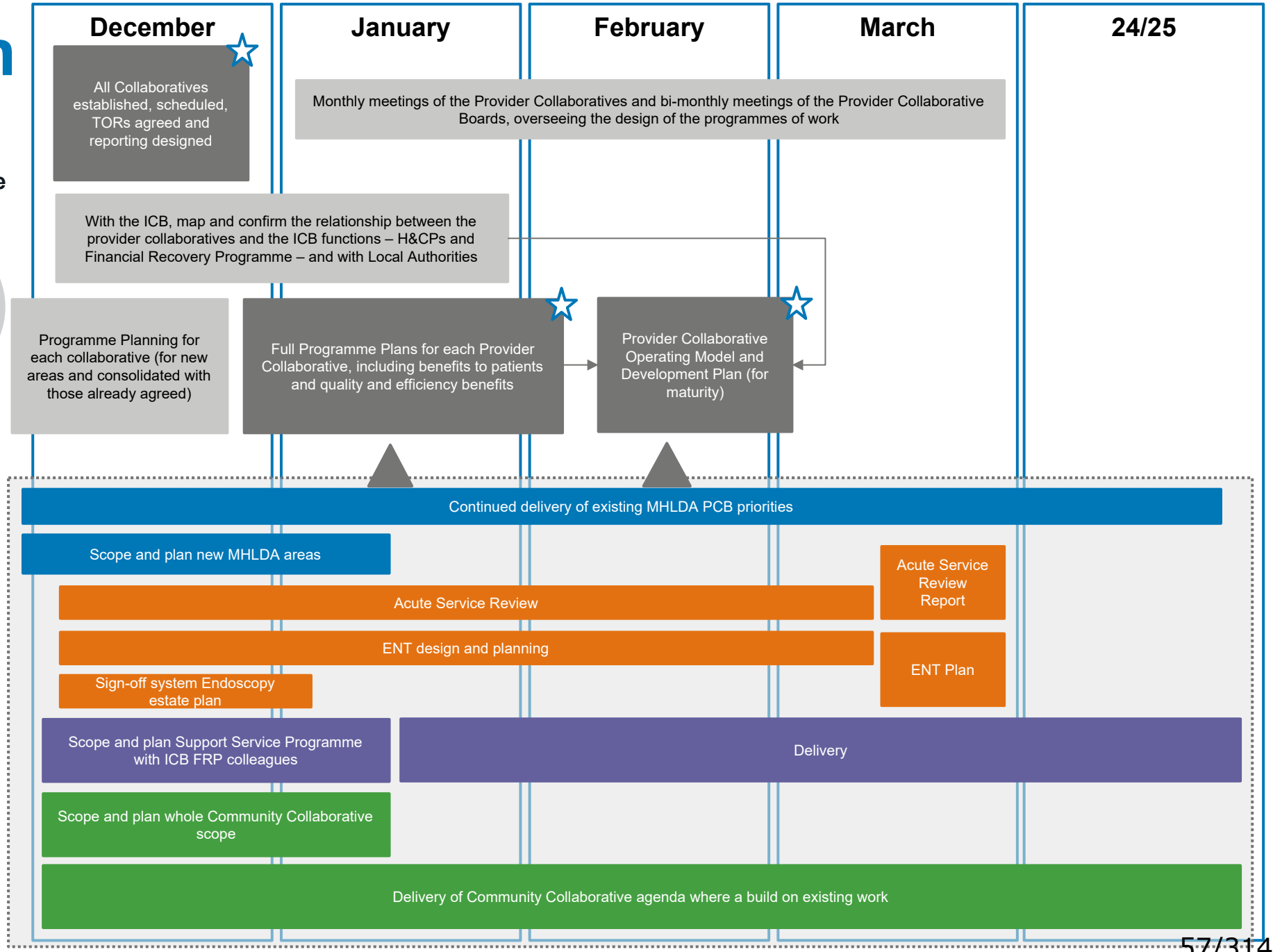
NOV 7

Agree delivery priorities, resourcing and governance

Concurrent provider board approvals

Milestones

- All Collaboratives established, scheduled, TORs agreed and reporting designed
- Full Programme Plans for each Provider Collaborative, including benefits to patients and quality and efficiency benefits
- Provider Collaborative Operating Model, to include a development plan (for maturity)



For further information please contact:

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KENT & MEDWAY – PROVIDER COLLABORATIVE BOARD

Terms of Reference

October 2023

Document History

Version	Date	Author	Comments
V0.1	06/09/23	Helen Pyecroft	Initial Draft
V0.2	07/09/23	Helen Pyecroft	With comments from David Highton, Provider Collaborative Chair
V0.3	08/09/23	Helen Pyecroft	With comments from Mike Gilbert, governance lead for K&M ICB
V0.4	12/09/23	Helen Pyecroft	With comments from Sheila Stenson, Provider Collaborative SRO
V0.5	18/09/23	Helen Pyecroft	With comments from the Chairs/CEO meeting on the 14th September
V0.6	05/10/23	Helen Pyecroft	With comments from K&M ICB and SROs
V0.7	10/10/23	Helen Pyecroft	With final comments from the provider Chairs/CEOs

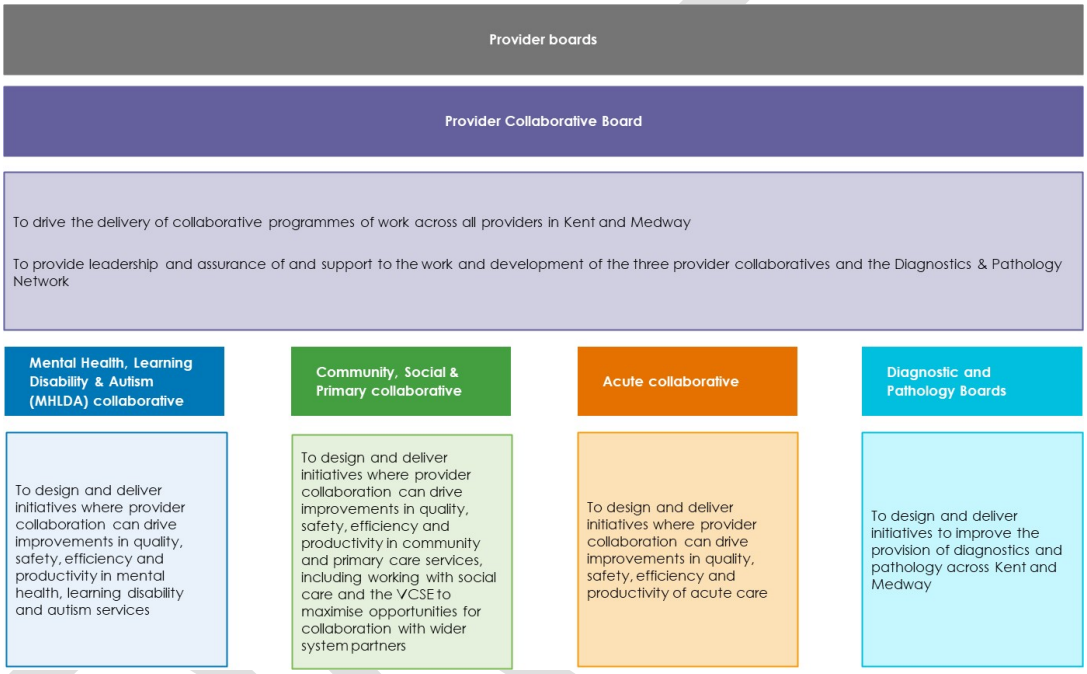
CONTENTS

INTRODUCTION AND CONTEXT

Collaboration between health and care providers already exists across Kent and Medway in various formats. Building on this to design structures for formal at scale provider collaboration is in line with the national context set out in the Health and Care Bill 2021 and furthers the goals set out in the creation of Integrated Care Systems (ICS).

In early 2023 Kent and Medway ICS partners agreed to create an at scale provider collaborative structure that will bring together partner organisations to collaborate on the design and delivery of care where collaboration supports delivering greater impact for the population and health and care system.

The provider collaborative structure in Kent and Medway



The scope of these Terms of Reference are for the Provider Collaborative Board.

In developing these Terms of Reference, and designing the scope and workplans for the provider collaboratives, it has been important to ensure that they are aligned to:

- Individual provider priorities and strategies
- NHS England published its Provider Collaborative Maturity Matrix
- ICS operating model – including the development of the scope of Health & Care Partnerships (H&CPs)
- The ICB Financial Recovery Programme (FRP)
- ICS Strategy
- ICB Pathway Programmes

1. PURPOSE

1.1. The Board exists to formally bring together providers across Kent and Medway to collaborate effectively and drive improvements in the delivery of services at scale. Strategic in nature, the Board will seek to

continually improve the function and delivery of care in Kent and Medway, ensuring that it's work aligns with existing programmes without overlap or duplication. The Board will:

- To drive the delivery of collaborative programmes of work across all providers in Kent and Medway
- To provide leadership and assurance of and support to the work and development of the three provider collaboratives and the Diagnostics & Pathology Network
- Take decisions relating to the delivery of projects in its own portfolio, but also those required to enable the constituent provider collaboratives to deliver their programmes of work

1.2. Specifically, the Board will:

- provide leadership, oversight, and enable partnership working to improve care outcomes of the population of Kent & Medway
- ensure a strategic focus, acknowledging wider development of the Kent and Medway system and the collaboration required to deliver our Long-Term Plan ambitions
- support strategic thinking about the ongoing development of provider collaboratives in Kent and Medway
- delivery of financial efficiencies
- maintain effective working relationships with other ICB and ICS groups, including the H&CPs and ICB, recognising interdependencies and other priorities across Kent and Medway
- identify risks and issues to delivery and agree to mitigations to effectively resolve these
- empower providers to deliver shared solutions that meet the needs of Kent and Medway collectively by providing a framework within which to operate where appropriate
- ensure that programmes of work are being delivered effectively, reviewing any specific reporting by exception

More detailed responsibilities are set out at 3.0 below.

2. PRINCIPLES

2.1. In October 2022, the Kent and Medway providers and ICB came together to develop a set of working principles for the establishment of provider collaboratives at scale. The principles agreed were:

- any collaboration must be justified on the basis of its ability to demonstrate measurable improvements in patient and population outcomes, patient experience, efficiency/productivity, and the reduction of inequalities
- any collaboration needs to have decision making located at the appropriate level in the system and involve the appropriate individuals
- any collaboration should be based on the principles of subsidiarity and taking decisions as close to the patient and citizen as possible
- any collaboration must recognise that it may create 'winners and losers' and therefore encompass a commitment to manage the impact of any such problems
- any collaboration must be clear about the problems it is attempting to resolve and avoid creating additional tiers of bureaucracy
- any collaboration must demonstrate that it is added value over and above any existing approach
- any collaboration must be based on strong clinical and care professional engagement that has provided an evidence base for its work programme and a platform for its implementation

- any collaboration needs to be based recognise staffing and workforce issues as a driver to set priorities and as a conscious restriction on the pace and scope of its work programme
- any collaboration should recognise the time frames in which it may operate - delivering quick tactical benefits and longer term more strategic solutions
- any collaboration should operate by doing only what it can do best, and be coherent with work at HCP level and at the ICB level.

2.2. These principles will guide the work of the Provider Collaborative Board.

3. SCOPE AND RESPONSIBILITIES

3.1. In designing the scope of the priorities for the at scale provider colalboratives, including the Provider Collborative Board, the following principles were applied:

- We collaborate where we can do better together (and can demonstrate so, including what will be better than current arrangements) – and only to a depth required to have an impact
- We are clear about the nature of the collaboration – e.g., agreeing shared standards, colalborating to deliver discreet projects and/or delegating authority for the delivery of services
- We collaborate where the evidence supports the decision to do so
- We collaborate on the simple stuff to start with
- We collaborate where the right resources and supporting governance can and will follow

Scope and responsibilities for 2023-2024

Scope	Description	Responsibilities
Coordinate and assure the work of the Kent and Medway provider collaboratives, signing off and taking decisions on matters required to ensure they deliver their programmes of work	The Provider Collaborative Board will oversee the work of the MHLDA, Community, Social and Primary Care, Acute, Diagnostic and Pathology provider collaboratives	• Hold the provider collaboratives to account for the delivery of their workplans • Make decisions on behalf of our constituent provider Boards where we have the relevant authority - to enable and support delivery of those workplans • Escalate decisions to Provider Boards and the Sustainability and Transformation Board (and ICB) where required • Support the allocation of resources and management of risk to enable the delivery of the workplans • Continue to identify and develop evidence-based priorities for the Board and constituent provider collaboratives, with ICB colleagues
Support the design and delivery of the FRP Support Services programme and wider	The Board will design and deliver a series of initiatives, including: • Legal and IG • One Public Estate (inc. LAs) • Procurement	• Agree scope and targets with the ICB before delivery • Agree detailed workplans for each area, with appropriate parties • Deliver workplans • Make decisions on behalf of our trust's Boards where we have the relevant

Scope	Description	Responsibilities
initiatives to improve the efficiency, productivity and quality of support services	• Digital Some areas will overlap with the ICB's FRP programme and will, therefore need to be aligned.	authority - to enable and support delivery of those workplans • Escalate decisions to Provider Boards and the Sustainability and Transformation Board (and ICB) where required • Support the allocation of resources and management of risk to enable the delivery of the workplans

3.2. Further priorities for the Board will be identified through analysis of an evidence-base and in agreement with Provider boards and the ICB.

4. MEMBERSHIP

4.1. The Board will be chaired by David Highton, Chair of Maidstone & Tunbridge Wells NHS Provider. David Goulston, Chair of KCHFT, is Vice Chair.

4.2. It is recognised that a number of individuals undertake dual roles across Kent and Medway representing both their own organisations and system roles. For the purposes of the Board, broad representation of views is required, and as such some members will be expected to represent the partnership(s) they represent (e.g., local Health and Care Partnership (H&CP)) as opposed to their employing organisation.

4.3. To ensure clarity, the organisation each member is expected to represent is indicated in the membership list below:

Name	Role Title	Employing Organisation	Representing at Board
David Highton (Chair)	Chair	Maidstone & Tunbridge Well NHS Provider	Maidstone & Tunbridge Well NHS Trust
Niall Dickinson	Chair	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust
Joanne Palmer	Chair	Medway NHS Foundation Trust	Medway NHS Foundation Trust
Jackie Craissati	Chair	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust
John Goulston (Vice Chair)	Chair	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Bruce Potter	Chair	Medway Community Healthcare	Medway Community Healthcare

David Astley	Chair	South East Coast Ambulance Service	South East Coast Ambulance Service
Simon Weldon	Chief Executive	South East Coast Ambulance Service	South East Coast Ambulance Service
Sheila Stenson	Chief Executive of KMPT and SRO of Provider Collaboratives	Kent & Medway NHS and Social Care Partnership Trust	Kent & Medway NHS and Social Care Partnership Trust
Miles Scott	Chief Executive	Maidstone & Tunbridge Well NHS Trust	Maidstone & Tunbridge Well NHS Trust
Jayne Black	Chief Executive	Medway NHS Foundation Trust	Medway NHS Foundation Trust
Mairead McCormick	Chief Executive	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Martin Riley	Chief Executive	Medway Community Healthcare	Medway Community Healthcare
Jon Wade	Chief Executive	Dartford & Gravesham NHS Trust	Dartford & Gravesham NHS Trust
Tracey Fletcher	Chief Executive	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust
Debbie Lindon Taylor	Head of HCRG Care Groups North Kent	Health Care Resourcing Group	Health Care Resourcing Group
In Attendance – Non-Voting Members			
Provider Collaborative Programme Director	TBA		
TBC	TBC	ICB	ICB

4.4. Deputies may be accepted with prior agreement of the Chair.

4.5. The Board may call additional individuals to attend adhoc meetings or to attend on a regular basis. Attendees may present at Board meetings and contribute to discussions, but are not allowed to participate in any decision making.

4.6. The Board may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Board discussion unless invited by the Chair and may not participate in any decision making.

5. QUORUM

5.1. There is a requirement for a minimum number of members to be present to enable the business of the Board to be effectively undertaken. For the purposes of these Terms of Reference this shall be known as the quorum and shall be noted as such in meeting agendas and minutes.

5.2. For the meeting to be considered quorate at least one representative from each member organisation needs to be in attendance, one of whom will be the Chair or Vice Chair of the Board.

5.3. Deputies may be appointed in the absence of a member, subject to the agreement of the Chair, but may not be another member of the Board or represent more than one member.

5.4. Members who are not physically present at a meeting but are present through the means of teleconference or other acceptable digital media shall be deemed to be present.

5.5. If any representative is conflicted on a particular item of business they may not participate in the discussion and may be asked to leave the meeting at the discretion of the Chair. These individuals shall not count towards the quorum for any decision/recommendation made. If this renders a meeting or part of a meeting non-quorate, subject to the discretion of the Chair:

- a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements; or
- the requirement for that category of member to be present may be relaxed.
- Members have a collective responsibility for the operation of the Board. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

6. MEETING FREQUENCY

6.1. Meetings shall be held bi-monthly – with every other meeting being in person.

6.2. The Board Chair may request additional meetings if they consider it necessary, including facilitating the function of assurance to the ICB and partner organisations.

7. AGENDA AND PARTICIPATION

7.1. The agenda and associated papers will be issued five working days in advance of each meeting.

7.2. Requests for agenda items should be sent a minimum of two weeks in advance of the meeting. The Chair will decide if items can be added, depending on previous commitments and time constraints.

7.3. To ensure that meetings run smoothly and effectively, members will be expected to:

- Read circulated papers and other materials in advance of meetings
- Follow planned agendas
- Show respect by listening to others and not interrupting
- Operate on a consensus and aim to seek general agreements
- Identify actions that result from discussions and commit to following through those actions
- Address items through the Chair of the meeting.

8. DECISION MAKING

8.1. The Board has the decision making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Chairs and CEOs).

8.2. For decisions outside the scope of these individuals (e.g. material in scope / significant financial impact / requiring public consultation (e.g. would not secure HOSC approval)), the Board will make recommendations to the provider boards and / or the Sustainability & Transformation Board.

8.3. Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.

8.4. Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning.

8.5. The Board will have no commissioning responsibilities.

9. DISPUTE RESOLUTION

9.1. Where a dispute or concern arises regarding the operation or management of the Provider Collaborative, this should be brought to the attention of the Chair in the first instance. The Chair will consider what appropriate action to take and whether the matter should be discussed with other partners, including Provider Boards and/or the ICB. Where a dispute or concern arises relating to the actions of the Chair, where possible the matter should be discussed with the Chair or Vice Chair and progressed as above.

9.2. For clarity, any decision made by the Board, including decisions not to support a proposal, cannot be challenged where the proposal has been put to a vote in accordance with these terms of reference, i.e. a concern cannot be formally escalated by a member simply because they do not like the outcome.

10. REPORTING PROCEDURE AND MINUTES

10.1. Actions and key decisions will be note at each meeting by the Provider Collaborative Managing Director and distributed to Board members no later than a week after each meeting.

10.2. The Board will provide quarterly progress reports to Provider Boards and the Kent and Medway Sustainability & Transformation Board. Routine highlight reports will be shared with local Health and Care Partnership across Kent & Medway to ensure at scale improvement and transformations are aligned with local place-based priorities.

11. POLICY AND BEST PRACTICE

11.1. The Board may instruct professional advisors and request the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its responsibilities.

11.2. The Board is authorised to establish such sub- groups as it deems appropriate in order to assist in discharging its responsibilities.

11.3. Unless stated otherwise in these terms of reference, the Board will be conducted in accordance with the Chair's organisations Standing Orders and Standards of Business Conduct and Managing Conflicts of Interest Policy. Specifically:

- There must be transparency and clear accountability
- The Group will hold a Register of Interests in accordance with good governance practice

- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take in discussion with the lead executive officer as appropriate. This may include requesting that individuals withdraw from any discussion/voting until the matter is concluded.
- The Board shall undertake a self-assessment of its effectiveness bi-annually at the face to face board development meetings.
- Members of the Board should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.
- Members, attendees and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:
    - The laws of England and Wales
    - The spirit and requirements of the NHS Constitution
    - The Nolan Principles
    - The standards of behavior set out in their employing organisation's policies, as they would be reasonably expected to know

12. CONFIDENTIALITY

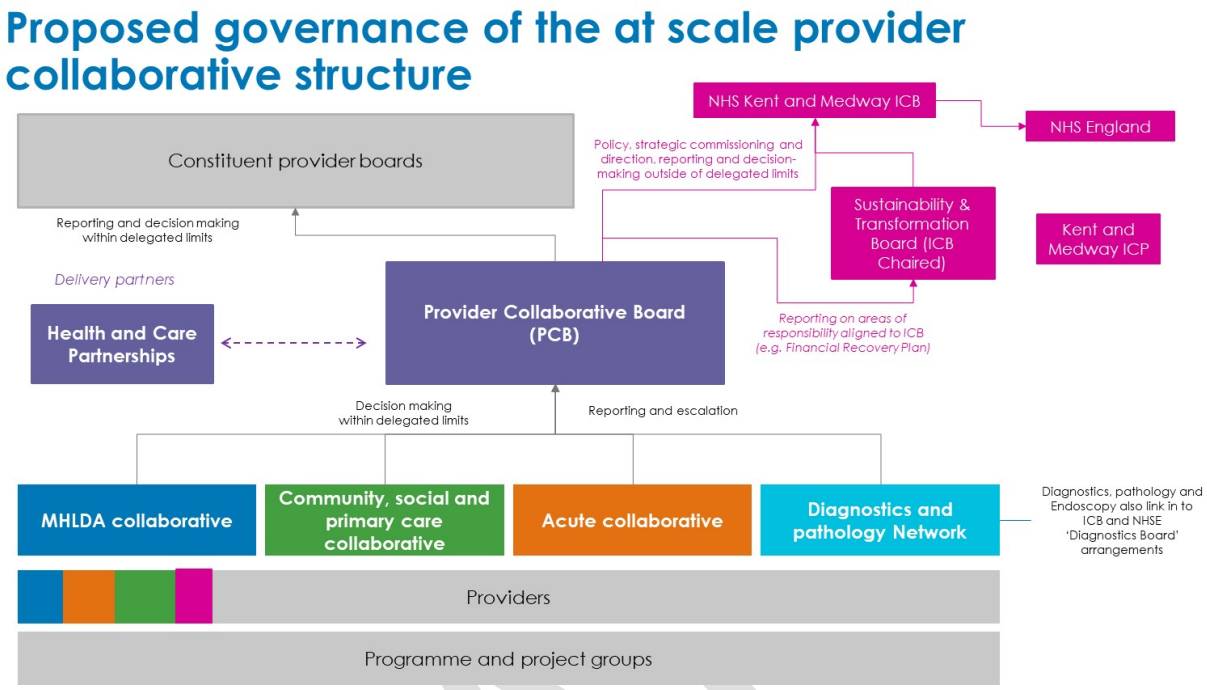
12.1. Members of the Board shall respect the confidentiality requirements set out in relevant corporate policies and these Terms of Reference, unless separate confidentiality requirements are set out for the Board, in which event these shall be observed.

12.2. Recommendations and actions of the Board will be detailed in the minutes of the meeting, and these shall be disclosable under the Freedom of Information Act, except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

13. REVIEW

13.1. The Terms of Reference of the Board shall be reviewed at regular intervals to reflect the priorities of the Board and the environment within which it is operating as part of the Kent and Medway ICS.

Apendix One – Kent and Medway at scale provider collaborative governance structure



East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Nominations and Remuneration Committee (NRC)**

Meeting date: **10 October 2023**

Chair: **Stewart Baird, Non-Executive Director/Vice Trust Chairman**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary
Executive Appointments • **Chief Medical Officer (CMO)** • **Director of Corporate Governance (DCG)** • **Chief Operating Officer (COO)**	The Committee received a report providing an update and **ASSURANCE** on the changes to the Executive team, current working arrangements and pending further appointment processes. The Committee: • Approved the appointments of the CMO and the DCG; • Noted the commencement of the Chief Nursing and Midwifery Officer (CNMO); • Noted the resignation of the COO; • Approved the interim COO arrangements; Jane Dickson, Interim COO Urgent and Emergency Care (UEC) (previous Interim CNMO; and Ben Stevens, Acting COO Planned Care (additional role to substantive Chief Strategy & Partnerships Officer (CSPO) role); • Approved the recruitment process for a substantive COO at the end of the financial year; • Approved plan for Chief Finance Officer (CFO).
Executive Directors' Pay Arrangements	The Committee noted it was anticipated a report would be presented to the December 2023 Committee meeting.
Remuneration and Bonus Arrangements for Executive and Senior	The Committee received **ASSURANCE** and noted the pay arrangements for each subsidiary company, and agreed:

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East Kent Hospitals University NHS Foundation Trust

Team Members of 2gether Support Solutions (2gether) and SPH	• Bonus pay recommendations for 2gether; • Bonus arrangements for SPH.
Relocation and Associated Expenses Policy	The Committee received **ASSURANCE** and noted the revised version of the Relocation and Associated Expenses Policy.

Other items of business

- The Committee noted the Non-Executive Director (NED) Commitments and Responsibilities exception report.
- The Committee noted the 2023 Annual NRC Work Programme.
- The Committee noted the Board Register of Interests.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The Committee asks the BoD to receive and note this assurance report.	Assurance	To Board on 2 November 2023

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Quality and Safety Committee (Q&SC)**

Meeting date: **24 October 2023**

Chair: **Dr Andrew Catto, Non-Executive Director**

Paper Author: **Executive Assistant/Interim Group Company Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No declarations of interest were made outside the current Board Register of Interests.

In attendance: Moira Durbridge, NHS England (NHSE) Improvement Director

Janice Smith, Senior Consultant, Good Governance Institute (GGI)

Assurances received at the Committee meeting:

Agenda item	Summary
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	**Partial assurance** was received by the Committee in considering the Integrated Performance Report (IPR). The following key points were noted: – 13 serious incidents (SIs) were declared in September 2023, deep dives into themes is being undertaken. – there was an increase in raising safeguarding concerns which may be attributed to improved compliance with safeguarding training in the Care Groups. – Hospital Standardised Mortality Ratio (HSMR) remains lower than expected at 93.4, and the mortality difference between William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) has stabilised. – diagnostic waiting times (DMO1) continued to be static overall with some improvement noted for MRI capacity. – 62-day cancer performance deteriorated further, largely due to the Endoscopy and Radiology backlog. – additional funding has been secured to address Endoscopy capacity.
Infection Prevention and Control (IPC) Report	The Committee received **partial assurance** of the current performance about nationally reportable infections noting the following: – Clostridioides difficile (C-diff) remains a challenge for the Trust with the current number of cases being at 94% of the annual threshold.

	– Cases of Klebsiella and E-coli infections are over trajectory. Other reportable infections are within or below trajectory. – improved surveillance of mandatory surgical site infections (SSI) continues to effectively identify cases.
Care Quality Commission (CQC) Update Report	– The Committee received the latest assurance report on the activities of the Journey to Outstanding Care Programme Steering Group (JTOCPSG). – Draft CQC report following the inspection of the core services for Urgent and Emergency Care, Medical care and Children and Young People Care in May 2023 was received and is being checked by the Trust for factual accuracy. – It is proposed that JTOCPSG is replaced by Regulatory Compliance and Oversight Group to oversee the Trust's compliance with multiple regulatory requirements.
Corporate Principal Mitigated Quality Risks	– The Committee noted a timetable for the review of risk management and agreed that a significant amount of work had been undertaken already to transform the risk management in the Trust.
Patient Safety Committee (PSC) Chair's Report	– The Committee considered the assurance report on the activities of the Patient Safety Committee, with discussion around two moderate harm incidents and one death due to a Transfusion Associated Circulatory Overload (TACO).
Fundamentals of Care (FoC) Chair's Report	The Committee considered an assurance report on the activities of the Fundamentals of Care Committee, the following key points were noted: – engagement work with external and internal stakeholders and examples of positive feedback received. – real time inpatient surveys – 94% of feedback was satisfactory. – improvements noted for inpatients finding it difficult to sleep at night due to noise. – 64 nutrition related incidents, mainly around feeding tubes and meals, were reported in August 2023. Supply chain issues continue to affect patient meals, this is currently being mitigated. – unwitnessed falls remain high as well as Category 2 and above pressure ulcers. Two ulcers had resulted in moderate harm. – first Ward Accreditation of all inpatient wards will be completed by December 2023.
Mortality Steering and Surveillance Group (MSSG) Chair's Report	The Committee considered an assurance report on the activities of the Mortality Steering and Surveillance Group noting the following: – there was a gap in engagement with the Structured Judgement Review (SJR) process within some specialties. – HSMR remained lower than expected but the data showed mortality rates were slightly higher at the weekends.

Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee received an assurance report on the activities of the Maternity and Neonatal Assurance Group and noted the following key matters: – the rate of reportable neonatal and perinatal deaths remained lower than comparable peers. – student midwives had returned to the clinic environment. – ongoing challenges with PRactical Obstetric Multi-Professional Training (PROMPT) for the anaesthetic colleagues, the compliance dropped to 80% for Consultants with the Clinical Negligence Scheme for Trusts (CNST) threshold being 90%. – the Trust did not achieve compliance in Q2 with surveillance in relation to the CNST Safety Action 1 being completed and closed within one calendar month. This was a recording/training issue and not a safety issue. Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE) confirmed that this oversight would not negatively impact on compliance.
Safeguarding Assurance Committee Chair's Report ***Delivery of Safeguarding Plan Update***	The Committee received the assurance report on the activities of the Safeguarding Assurance Committee and agreed that **significan**t assurance was continuing to be provided. The Committee noted that the substantive Joint Head of Safeguarding for the Trust had been appointed.
Clinical Audit and Effectiveness Committee (CAEC) Chair's Report	The Committee received and noted the content of the CAEC Chair's Report and acknowledged good progress made in improving engagement and compliance.
Lead Medical Examiner (LME) Report	The Committee received the Lead Medical Examiner's report and noted that the Medical Examiner Service currently reviews 72% of all community deaths and this is above the national average.
Endoscopy Harm and Risk Review	The Committee noted that there continued to be a significant backlog in respect of Endoscopy capacity. The Committee was informed of mitigations and plans in place to remedy the situation; however, it was noted that the service was not systematically assessing harm for overdue DMO1 or surveillance patients due to capacity constraints.
Theatre Utilisation Improvement Update	The Committee received the Theatre Utilisation Improvement Update with the following key points highlighted: – an external review into theatres productivity was commissioned across the sites and commenced a 28-week improvement progamme in October

	2023. It is anticipated that the benefits of the programme will be seen in three months' time. – The Committee asked to be presented with the findings of the external review and to be informed as to how the improvement will be measured.
Safe Systems for Controlled Drugs	– The Committee noted progress made around improving the level of assurance in regards to harm to patients and staff through poor management of controlled drugs. – The Committee acknowledged ongoing challenges such as lack of audit of controlled drugs prescribing on discharge and delay in deployment of automated dispensing cabinets in Emergency Departments (EDs).
Safe Staffing	The Committee received the Safe Staffing Report and noted that the Trust continued to monitor Nursing and Midwifery numbers and skill mix in response to clinical needs on a daily basis.

Referrals from other Board Committees
No referrals from other Board Committees were considered at this meeting.

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	2 November 2023
The Committee asks the BoD to discuss and **AGREE** Board Committees oversight of the IPR aspects.		2 November 2023
The Committee asks the BoD to discuss and **AGREE** the reporting sequence of the Serious Incidents Report.		2 November 2023

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee: **Charitable Funds Committee (CFC)**

Meeting date: **3 October 2023**

Chair: **Claudia Sykes, Non-Executive Director (NED)**

Paper Author: **Committee Chair**

Quorate: **Yes**

Appendices:

Appendix 1: CFC Terms of Reference (ToR)

Declarations of interest made:

None

Assurances received at the Committee meeting:

Financial update	The Committee received **ASSURANCE** on the charity's income and expenditure for the year to date.
Statutory accounts and audit	The Committee received **ASSURANCE** over the process of appointing new auditors for the charity, and recommended their appointment be approved by the main Trust Board (Subsequently approved by the main Trust Board, as Corporate Trustee, on 5 October). The charity's annual audited accounts are scheduled for approval at the Trust Board in December. An extraordinary CFC meeting has been called for 28 November to review the accounts and recommend these for approval to the Board.
Application for Grants	The Committee **APPROVED** 2 grants: (1) £34k for YAG Ophthalmology laser at Queen Elizabeth the Queen Mother Hospital (QEQM) to replace ageing equipment and improve patient experience and quality. (2) £30k for 10 anaesthetic pumps, Trust-wide, to support patient care during, and post, post-surgery. The Committee also considered 2 grants from the Wellbeing team. The Committee noted that further evidence of need, and value for money, needed to be presented within applications, as well as ensuring that key practical considerations had been addressed. The Committee noted that they welcomed applications relating to staff wellbeing, and further work should be done to support future applications being successful. The Chair will meet with the Head of the Wellbeing team to discuss this.

East Kent Hospitals University NHS Foundation Trust

Terms of Reference (ToR)	The Committee reviewed the ToR for membership of the Committee. It was noted that: - The charity's income had never exceeded £2m in recent years. - Any significant investments (over £100k) and activities needed to have specific Board approval. - The CFC membership currently included three NEDs, and four Executive Directors, who were required to attend 80% of meetings in the year. The Committee therefore **recommended** that the membership section within the ToR was amended to include only two NEDs, and two Executive Directors (the Chief Finance Officer (CFO) and the Chief Strategy and Partnerships Officer (CSPO)). Quoracy will remain the same with two NEDs and one Executive Director.

Other items of business

None

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
The Committee asks the BoD to **NOTE** this assurance report from the CFC and **APPROVE**: Amending the membership section within the CFC ToR to include only two NEDs, and two Executive Directors (the Chief Finance Officer and the Chief Strategy and Partnerships Officer).	**Approval**	To Board on 2 November 2023

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East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

1. CONSTITUTION

1.1 The East Kent Hospitals University NHS Foundation Trust (the Trust) is the Corporate Trustee and holds assets belonging to the charity. In addition, Part 9 s177 of the Charities Act 2011 defines 'charity trustees' as 'the persons having the general control and management of the administration of the charity'. The directors of the Corporate Trustee are not Trustees; however, they act on behalf of the Corporate Trustee. The Charity is separate from the Trust and independent of it, but the Trustees always aim to work closely with the Trust. The Corporate Trustee can delegate certain powers to agents and/or employees but will always retain the ultimate responsibility for the management of the Charity.

1.2 The Board of Directors has set up a committee, to be known as the Charitable Funds Committee in accordance with its Standing Orders. The Charitable Funds Committee will oversee the charity's operation on behalf of the Corporate Trustee. The Committee will apply scrutiny and constructive challenge to the Charity's financial information and systems of control, including the Annual Accounts, to provide assurance to the Board of Directors that the administration of charitable funds is distinct from its exchequer funds and compliant with legislation and Charity objectives.

2. PURPOSE

2.1 The purpose of the Committee is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy, specifically:-

2.1.1 Develop the strategy and objectives for the charity for consideration by the Board of Directors.

2.1.2 Oversee the implementation of an infrastructure appropriate to the efficient and effective running of the charity.

2.1.3 Oversee the charity's expenditure.

2.1.4 Oversee the charity's investment plans.

2.1.5 Monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements.

2.2 In order to comply with Charity Commission regulations the Committee can only act in an advisory capacity and cannot be an approving body. The Board of Directors must retain responsibility for strategic decisions and operational activities.[1] The practical application of this guidance is covered under section 6: Authority.

3. OBJECTIVES

The Committee has the following specific duties and functions.

3.1 Develop the strategy and objectives for the charity for consideration by the Board of Directors.

3.1.1 Monitor achievement of the Strategy and objectives. Consider annually whether any updating is to be recommended.

3.1.2 Ensure the Charity's strategy and objectives are consistent with the strategic direction of the Trust.

3.1.3 Review and submit the Annual Business plan and budget.

3.1.4 Provide assurance that the activities of the Charity function do not cause conflict with those undertaken by others supporting East Kent Hospitals University NHS Foundation Trust, e.g. Leagues of Friends.

3.2 Oversee the implementation of an infrastructure appropriate to the efficient and effective running of the charity.

3.2.1 Agree and make recommendations for the establishment of an appropriate internal infrastructure for the charitable function including suitable office space; equipment; charity database; cash handling; banking; insurance and legal services etc.

3.2.2 Review the infrastructure and resourcing requirements as necessary.

3.3 Oversee the development and delivery of the fundraising strategy.

3.3.1 Agree and recommend any change to the Brand and logo of the Charity and sub branding for Major Appeals.

3.3.2 Agree and recommend a comprehensive 3-year Fundraising strategy to be incorporated within the Charity Strategy.

3.3.3 Review and recommend all Fundraising policies and activities.

[1] Charity Commission Guidance 86 B3 & Trustee Act 2000 Section 11

3.3.4 Review and approve marketing materials for both the external and internal market place.

3.3.5 Oversee the development of the Charity website for public access.

3.3.6 Oversee all projects for Major Appeals.

3.4 Oversee the charity's expenditure.

3.4.1 Review policies and procedures for the identification of projects for charitable funding.

3.4.2 Review approval thresholds for expenditure from the Charity's funds.

3.4.3 Receive and recommend proposals for major fundraising appeals.

3.4.4 Oversee the rationalisation of existing funds.

3.4.5 Review all expenditures to ensure these meet objectives of the Charity.

3.4.6 Review proposals for annual commitments and capital projects for ratification by the Board of Directors.

3.5 Oversee the charity's Investment Plans.

3.5.1 Review investment strategies for the Charity's funds.

3.5.2 Oversee the periodic retendering of the investment management contract in line with EU regulations.

3.5.3 Monitor investment data and make recommendations to ensure investment performance is maximised. Report on the performance of Investments.

3.6 Monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements.

3.6.1 Monitor the effectiveness of fundraising spending and investment activities via a set of agreed metrics.

3.6.2 Ensure implemented policies are consistent with Charity Law and the Department of Health legislation and guidelines.

3.6.3 Approve the annual report and accounts prior to Audit Committee approval and ratification by Board of Directors.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The membership of the Committee shall consist of two Non-Executive Directors, together with the Chief Finance Officer and Chief Strategy and Partnerships Officer. The committee meetings shall be open to all members of the Board of Directors.

4.2 A Committee Member must make a declaration of interest at the start of meetings and must absent himself or herself from any discussions in which it is possible that a conflict may arise between his or her duty to act solely in the interests of the Charity and any personal interest (including but not limited to any personal financial interest).

4.3 The Chair of the Committee will be a Non-Executive Director appointed by the Board of Directors. If the Committee Chair is absent from the meeting, the directors present shall choose one of the other Non-Executive Director members to preside for that meeting.

Attendees

4.4 The Fundraising Manager, Charitable Funds Accountant, and Senior Charity Officer shall normally attend meetings of the committee. Others may be invited to attend meetings and or be co-opted onto the committee as and when the committee members feel it is necessary. Also, the committee may invite specialist advisors such as the investment managers etc to attend meetings or parts of meetings, as deemed appropriate by the Chair.

Quorum

4.5 At any meeting of the Committee, at least two Non-Executive Directors and one Executive Director must be present. If the Chair is in attendance, this will count towards the quoracy.

Attendance by Members

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

Attendance by Officers

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

Voting

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

5. FREQUENCY OF MEETINGS

5.1 Meetings of the Committee shall be held four times a year. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

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

6.2 The Committee is authorised by the Board to make decisions which are not of a significant nature. Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions of the Trust. In practice, what is significant will depend on the judgement of members but committees must refer the following types of issue to the Board of Directors:

6.2.1 Change the strategic direction of the Trust Charity.

6.2.2 Conflict with statutory obligations.

6.2.3 Contravene national policy decisions or governmental or Charity Commission directives.

6.2.4 Have significant revenue, capital or cash implications as determined by the Trust's Standing Financial Instructions.

6.2.5 Have significant governance implications.

6.2.6 Be likely to arouse significant public or media interest.

6.3 The Committee will review expenditure decisions made under delegated authority to officers, to ensure compliance with the charity's objectives and strategies.

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

6.3 A special meeting may be called at any time by the person elected to chair meetings of the Trustees or by any two Trustees. Not less than four days' clear notice must be given to the other Trustees of the matters to be discussed at the meeting. A special meeting may be called to take place immediately after or before an ordinary meeting.

6.3 The Committee is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chair of the Committee is properly made by the Committee.

6.4 The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary. Legal advice should normally be arranged through the Trust Secretary.

7. SERVICING ARRANGEMENTS

7.1 The Trust Group Company Secretary shall ensure an appropriate officer attends meetings to take minutes. Agendas and papers shall be distributed one week prior to the meeting.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

9. MONITORING EFFECTIVENESS AND REVIEW

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

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

OCTOBER 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Maternity Incentive Scheme Year 5 Submissions

Meeting date: 2 November 2023

Board sponsor: Chief Nursing & Midwifery Officer (CNMO)

Paper Author: Director of Midwifery (DoM)

Appendices:

APPENDICES PROVIDED IN READING ROOM (DOCUMENTS FOR INFORMATION)
APPENDIX 1: PERINATAL MORTALITY REVIEW TOOL (PMRT) REPORT
APPENDIX 2: AVOIDING TERM ADMISSIONS INTO NEONATAL UNIT (ATAIN)
APPENDIX 3: OBSETRIC MEDICAL WORKFORCE
APPENDIX 4: SAVING BABIES LIVES
APPENDIX 5: PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT
APPENDIX 6: MATERNITY DASHBOARD
APPENDIX 7: CARE QUALITY COMMISSION (CQC) UPDATE

Executive summary:

Action required:	Information
Purpose of the Report:	The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). The scheme incentivises ten maternity safety actions which if achieved enables the Trust to recover an element of the contribution to CNST. Within the majority of the 10 safety actions there is a requirement for reports to be presented to the Board for information and oversight. Alongside this report there are detailed reports which correspond to the relevant Safety Actions that have been presented to the Maternity and Neonatal Assurance Group (MNAG) for detailed review and discussion.
Summary of key issues:	For Quarter 2 of 2023/24 the following reports have been presented to MNAG and are brought to the Board for sight in compliance with the following CNST requirements: **Safety Action 1**: **Perinatal Mortality Review Tool (PMRT)**: A report that includes a review of all eligible deaths, themes identified and actions taken in line with the PMRT should be received by the Board each quarter. The paper is shared for information and oversight. **Safety Action 3: Avoiding Term Admissions to the Neonatal Unit (ATAIN):** A report is required to demonstrate evidence of a local pathway

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	being in place to minimise separation of mothers and their babies. The report should evidence joint maternity and neonatal reviews of all admissions to the Neonatal Unit (NNU) of babies equal to or greater than 37 weeks. An action plan should be agreed by both maternity and neonatal leads to minimise separation. The action plan should be signed off by the DoM and Clinical Directors (CDs) for both Obstetrics and Neonates. The evidence should also include a guideline for admission to Transitional Care (TC) for babies 34 weeks and above and data to evidence that this is occurring or an action plan signed off by the Board to move towards implementation with clear time scales. **Safety Action 4**: **Obstetric Medical Workforce:** A report that includes evidence that the service has audited compliance with the standards and where these have not been met that an action plan has been put in place to address deviation. Where there is an action plan this should be signed off by the Board, the Board Level Safety Champions and the Local Maternity and Neonatal System (LMNS). **Safety Action 6: Saving Babies Lives Care Bundle:** The service is required to provide assurance to the Board that it is on track to fully implement all elements of the Saving Babies Lives v3 tool by March 2024. The report provided demonstrates the current gap analysis against the standard, compliance will be calculated using the national implementation tool that was published at the end of June 2023 by December 2023. **Safety Action 9**: **Perinatal Quality Surveillance Tool** (**PQST):** This report is brought to the Board in compliance with Safety Action 9, which aims to ensure that discussions regarding safety intelligence including incidents, staff and user feedback, staffing and training compliance takes place at Board level monthly and that this is reflected in Board minutes. **Safety Action 10:** Quarter 2 (Q2) Serious Incident (SI) report including information of the reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB), NHS Resolutions (NHSR) Early Notification Scheme and Duty of Candour. The reports are shared with the Board for Board sight of evidence of compliance. These reports have all been presented and discussed at the MNAG on 10 October and subsequently at the October Quality & Safety Committee (Q&SC). The Obstetric Medical Workforce Paper was presented to the Clinical Executive Management Group (CEMG). **Other relevant reports:** **Care Quality Commission (CQC) Action Plan Update**

	The paper has been prepared to summarise progress against the CQC must and should do requirements. The service continues to submit a report and live action plan to the CQC on a monthly basis.
Key recommendations:	**Safety Action 1**: **PMRT**: The Board to receive **assurance** that a Quarterly PMRT paper has been received for Q2 2023/24 demonstrating compliance in line with CNST standard requirements for four areas of evidential requirement. In this quarter four surveillance tools were duly reviewed and uploaded but not closed within a month as the team were awaiting post mortem reports. The service has had confirmation from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACCE) that compliance has not been affected. **Safety Action 3: ATAIN:** In Q2 admission rate for William Harvey Hospital (WHH) was 3.4% and 4.5% at Queen Elizabeth the Queen Mother Hospital (QEQM). The national average for Term admissions is currently 4.4%. The main reason for admission was respiratory causes and as such the team will be undertaking a deep dive into these cases. Learning from the reviews have been shared with the team and posters shared in each of the areas which have been included in the report. **Safety Action 4**: **Obstetric Medical Workforce** **1.1** Neither unit has employed a short-term locum over the last year. If there was a need to employ a short-term locum an up to date guideline for this is available in the policy centre and includes the need for a certificate of eligibility as per the Royal College of Obstetricians and Gynaecologists (RCOG) guidance. **1.2** All long-term locums have a formal induction which is in line with the RCOG requirements. The Board is asked to note that there is an audit demonstrating this evidence for this group of doctors – Appendix 3. **1.3** The job plans are set up such that obstetricians have no clinical duties the day after our twilight/night on call. The rota can be used to evidence this. **1.4** Regarding consultant attendance when on call, a Datix is completed if/when this occurs and discussed at MNAG. In the last 18 months there has been one occasion where the consultant did not answer their phone. This was investigated and no additional actions were needed. (The case was discussed at MNAG). **Safety Action 6**: **Saving Babies Lives:** The report that was presented to MNAG provided a review of the initial gap analysis against the revised Safety Action and care bundle. Many of the required interventions have already been implemented at EKHUFT. However, there is an ongoing amount of work required to achieve implementation of all elements within the revised care bundle. As required, the service has shared the findings of this assessment with the Integrated Care Board (ICB).

	Safety Action 9: The **PQST** report dated 10 October 2023 was presented to MNAG**:** • Anaesthetic training compliance for PRactical Obstetric Multi-Professional Training (PROMPT) declined to 80% for Consultants and 51% for all other anaesthetists and remains below the national standard of 90%. • There were no HSIB referrals for the month of September. • Three SIs were declared and these are separately discussed in the Q2 SI report. • There was a reported decline in the Friends and Family Test (FFT) response, however, this was linked to a coding issue which has since been rectified. **Safety Action 10:** Q2 SI report including information of the reporting of all qualifying cases to HSIB, NHSR Early Notification Scheme and Duty of Candour (DoC). The report confirms that during the Q2 reporting period the service has reported 100% of qualifying cases to HSIB and to NHSR's Early Notification Scheme as set out in NHSR, CNST Maternity Incentive Scheme Year 5, from 30 May 2023 (for 01/07/2023 - 30/09/2023 Q2). • Four SIs were declared in Q2. One case met the threshold for referral to HSIB and NHSR. The family was given the required information regarding these schemes. Three cases were local SI incidents. Learning from incidents was shared in the form of hot topics and safety thread messages. Standard Operating Procedures (SOPs) were developed as indicated. • DOC was undertaken in all four cases. • The lack of key team members being Root Cause Analysis (RCA) trained was highlighted as a risk. The DoM has sourced a masterclass which will be facilitated in house for key staff. **CQC Must and Should do recommendations** The paper summarises action taken in response to the recommendations. The service received at total of 20 must do and 18 should do recommendations. 11 must do recommendations are complete. Seven are in progress and in the main link to estates work (such as a dedicated medicines room at WHH, Midwifery Led Unit (MLU) at WHH, relocation of the bereavement room at WHH, and access to a second theatre at QEQM). Two recommendations are currently off track but with a revised trajectory and actions to achieve compliance by November 2023.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Board Assurance Framework (BAF):	N/A

East Kent Hospitals University NHS Foundation Trust

Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Maternity and Neonatal Assurance Groups (MNAG) 10 October
Clinical Executive Management Group (CEMG) 18 October
Quality & Safety Committee (Q&SC) 24 October

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safer Nursing Staffing**

Meeting date: **2 November 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Deputy Chief Nursing Officer**

Appendices:

Appendix 1: EKHUFT Safer Staffing September 2023

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	It is a regulatory requirement that the Trust's Safe Staffing position should be reported to the Board monthly. This meets the National Quality Board guidance and Developing Workforce Safeguards guidance from NHS England and Improvement.
Summary of key issues:	• Update on key Registered Nursing and Midwifery workforce metrics (vacancy, turnover, fill rates) as per NHS England (NHSE) guidance. • Assurance/Mitigation.
Key recommendations:	The Board of Directors is invited to: 1. **NOTE** the content of the report; 2. Receive **ASSURANCE** that the hospital is safely staffed or has mitigations in place; and 3. **NOTE** the progress being made in relation to the recruitment pipeline and the actions that are being taken to mitigate potential foreseen issues.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships
Link to the Board Assurance Framework (BAF):	**BAF 35** - Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 116** - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs.

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	CRR 68 – Risk to the delivery of the operational constitutional standards and undertakings. **CRR 76** Care is potentially compromised as a consequence of staffing not meeting planned numbers per shift. **CRR 84** – Lack of timely recognition and response to the deteriorating patient.
Resource:	Y - Safer Staffing Business Case approved December 2021
Legal and regulatory:	Y – Care Quality Commission (CQC), National Quality Board and NHSE
Subsidiary:	N

Assurance route:

Previously considered by: Quality and Safety Committee (Q&SC)

East Kent Hospitals University NHS Foundation Trust

Safer Nursing Staffing

1. Purpose of the report

1.1 The purpose of the report is to provide assurance to the Board of the Trust's Safe Staffing position for September 2023.

2. Background

2.1 Safe Staffing is a regulatory requirement to meet the National Quality Board guidance and Developing Workforce Safeguards guidance from NHS England (NHSE).

3. Safer Staffing

3.1 Trust continues to monitor Nursing and Midwifery numbers and skill mix in response to clinical need daily and reports monthly to Q&SC and Board.

4. Registered Workforce Reported Data

4.1 Vacancy rate against establishment for substantive beds and clinical areas for all registered nurses and midwives is 9.6%.
4.2 Vacancy rate against establishment for substantive beds and clinical areas for band 5 nurses is 10%.
4.3 Sickness absence rate for all registered nurses and midwives is 5.1%.
4.4 Turnover rate for all registered nurses and midwives is 7.7%.

5. Unregistered Workforce Reported Data

5.1 Vacancy rate for Healthcare Support Worker (HCSW) is 8.6%.
5.2 Turnover rate for HCSW is 11.6%.

6. Average Fill Rates

6.1 Registered Nurse (RN) Fill Rate Day 90%.
6.2 RN Fill Rate Night 92%.
6.3 HCSW Fill Rate Day 93%.
6.4 HCSW Fill Rate Night 113%.
6.5 The wards under their planned fill rate are moving staff to support the unfunded bed base as demonstrated on the table in the report.

7. NHS Professionals (NHSP) Golden Key Process

7.1 Process implemented to gain control of bank and agency shifts across Trust.
7.2 Since the 23 August 2023 all NHSP bank shifts are authorised by Band 8a or above in hours and Band 7 or above out of hours using HealthRoster.
7.3 Since the 15 September all agency shifts are authorised by Head of Nursing (HoN)/Deputy HoD (DHoN).

7.4 Standard Operating Procedure (SOP) developed to support new process and safe decision making.

8. Unfunded Beds

8.1 William Harvey Hospital (WHH) – 48 beds.
8.2 Queen Elizabeth the Queen Mother Hospital (QEQM) – 56 beds.

9. Mitigation

9.1 Monthly Workforce Inpatient Scorecard, Planned v Actual Scorecard and HealthRoster Dashboard created and shared with Chief Nurses Office & Director of Nurses (DoN's).
9.2 Monthly Nursing & Midwifery (N&M) Workforce Key Performance Indicators (KPIs) held with all Care Groups to review staffing levels, vacancies, establishments and the ongoing need for additional staff.
9.3 Daily staffing reviewed by HoN with escalation of staffing three times daily at site meetings and additional discussions if levels are unsafe.
9.4 Twice weekly meetings with NHSP to review actions/data.
9.5 Review of golden keys for agency shifts are reviewed daily by HoN to ensure safe staffing levels are mitigated against establishment.
9.6 Agency code CSW03 stopped.
9.7 Enhanced care check list has been updated and is now being embedded to support staff.

10. Bi-annual Nursing Workforce Establishment Review

10.1 Safer Nursing Care Tool (SNCT) data collected in September 2023.
10.2 Establishment report being reviewed and will include escalation areas.
10.3 Emergency Department (ED) safe staffing review will also be undertaken and is to be included in next month's report.
10.4 Updated SNCT licences and implementation guidance available from Imperial College and Trust has applied.

11. Conclusion

11.1 In summary the Trust continues to monitor the Nursing and Midwifery workforce to ensure that staffing is safe for the provision of patient care.

East Kent Hospitals University NHS Foundation Trust

We are safe and healthy

Safer Staffing

Are we safe? – September 2023

Sponsor – **Sarah Hayes, Chief Nursing and Midwifery Officer (CNMO)**

Authors – Matron for Workforce and Retention
Deputy Chief Nursing Officer

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East Kent Hospitals University NHS Foundation Trust

Safer staffing

The Trust continues to monitor nursing and midwifery numbers and skill mix in response to clinical need on a daily basis. In September 2023 the Trust is showing an overall average compliance rate of 92% for registered nurses and 99% for Healthcare Support Workers (HCSWs), this includes the unfunded bed base.

Many of our clinical areas are working over their establishment, this is being reviewed by the Chief Nurses Office at monthly Nursing & Midwifery (N&M) Workforce Key Performance Indicators (KPI) with all the care groups. Early indicators are that these additional staff are covering the unfunded bed base, enhanced care (specialling) and incorrect rostering practices. To gain more accuracy and control on the additional shifts above establishment that are being requested the level of authorisation have been uplifted to:

- All shifts for NHS Professionals (NHSP) Bank are authorised by band 8a or above in hours (band 7 out of hours) on the HealthRoster system since the 23 August 2023.
- All agency to be authorised by Head of Nursing (or Deputy in their absence). This process (know as the 'golden key') went live on the NHSP system on Friday 15 September.
- Standard Operating Procedures have been produced to support these new processes and include guidance on how to review staffing to support decision making.

RN Fill Rate Day	HCSW Fill Rate Day
90%	93%

RN Fill Rate Night	HCSW Fill Rate Night
92%	113%

Bi-annual Nursing workforce establishment review undertaken using Safer Nursing Care Tool (SNCT) data collected in September.

Nursing and Midwifery (Registered) vacancies:

- In September 2023 the **vacancy rate** against establishment for substantive beds and clinical areas for **all** registered nurses and midwives is reported as 9.6%
- In September 2023 the **vacancy rate** against establishment for substantive beds and clinical areas for **band 5 nurses** is reported as 10%
- In September 2023 the **sickness absence rate** for registered **all** nurses and midwives is reported as 5.1%
- In September 2023 the **turnover rate** for **all** registered nursing and midwifery staff was 7.7%.

Nursing and Midwifery (Unregistered) vacancies:

- In September 2023 the **vacancy rate** for healthcare support workers 8.6%
- In September 2023 the **turnover rate** for healthcare support workers 11.6%

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East Kent Hospitals University Foundation NHS Trust : Ward Fill Rate Indicator
Staffing : Nursing, Midwifery and care staff - September '23

Monthly Ward Overview (fill rate) September 2023

						Average Fill Rate					
						Day			Night		
Hospital Site name	Ward name	Care Group	Specialty	Nurse to Patient Ratio	Skill Mix Ratio (RN/HCSW)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)
KENT AND CANTERBURY HOSPITAL	INVICTA T&O WARD K&C	KCH	Surgical	1 - 6	65/35	71%	61%	-	79%	45%	-
KENT AND CANTERBURY HOSPITAL	HARBLEDOWN WARD - K&C	KCH	Stroke/Neuro	1 - 4	69/31	84%	81%	-	98%	100%	-
KENT AND CANTERBURY HOSPITAL	NEUROREHAB NURSING	KCH	Stroke/Neuro	1 - 6	65/35	85%	93%	-	88%	125%	-
KENT AND CANTERBURY HOSPITAL	CRITICAL CARE - K&C	CCASS	Critical Care	1 - 1		86%	0%	-	93%	0%	-
KENT AND CANTERBURY HOSPITAL	ST LAWRENCE WARD - K&C	KCH	Surgical	1 - 6	65/35	78%	82%	100%	93%	95%	100%
KENT AND CANTERBURY HOSPITAL	KENT WARD - K&C	KCH	Surgical	1 - 6	65/35	94%	99%	100%	115%	107%	-
KENT AND CANTERBURY HOSPITAL	BRABOURNE HAEMATOLOGY WARD - K&C	Haematology Oncology	Cancer	1 - 4	73/27	75%	81%	-	100%	-	-
KENT AND CANTERBURY HOSPITAL	RENAL MARLOWE WARD - K&C	KCH	Medicine	1 - 6	66/34	66%	129%	-	95%	133%	-
KENT AND CANTERBURY HOSPITAL	CLARKE WARD - K&C	KCH	Surgical	1 - 6	66/34	101%	102%	100%	72%	101%	100%
KENT AND CANTERBURY HOSPITAL	KINGSTON WARD - K&C	KCH	Stroke/Neuro	1 - 6	62/38	80%	92%	-	97%	128%	-
KENT AND CANTERBURY HOSPITAL	MOUNT & MCMASTER WARD - K&C	KCH	Stroke/Neuro	1 - 6	62/38	81%	93%	-	89%	106%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	BIRCHINGTON WARD - QEQM	Womens & Childrens	Gynaecology	1 - 6	65/35	79%	113%	100%	92%	113%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ACUTE MEDICAL UNIT A - QEQM	QEQM	UEC	1 - 4	66/33	90%	94%	100%	97%	102%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	QUEX MEDICAL WARD - QEQM	QEQM	Medicine	1 - 6	62/38	91%	111%	100%	89%	134%	100%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	FORDWICH WARD - QEQM	QEQM	Medicine	1 - 4	66/34	95%	81%	100%	91%	107%	100%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CRITICAL CARE - QEQM	CCASS	Critical Care	1 - 1		82%	36%	100%	80%	84%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	DEAL WARD - QEQM	QEQM	Medicine	1 - 6	62/38	101%	109%	-	95%	115%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ACUTE MEDICAL UNIT B - QEQM	QEQM	UEC	1 - 4	66/34	82%	74%	-	93%	102%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	MATERNITY - QEQM	Womens & Childrens	Maternity			89%	87%	-	85%	89%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ST MARGARETS WARD - QEQM	QEQM	Medicine	1 - 6	61/39	96%	109%	-	82%	108%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SANDWICH BAY FRAILTY WARD - QEQM	QEQM	Medicine	Unfunded		94%	98%	100%	100%	221%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	RAINBOW WARD - QEQM	Womens & Childrens	Paediatrics	1 - 4	83/17	83%	18%	-	82%	-	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ST AUGUSTINE'S WARD - QEQM	QEQM	Medicine	1 - 6	62/38	81%	120%	-	78%	155%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SEABATHING WARD - QEQM	QEQM	Surgical	1 - 6	62/38	96%	90%	-	98%	135%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CHEERFUL SPARROWS WARD FEMALE - QEQM	QEQM	Surgical	1 - 6	63/37	96%	99%	100%	99%	143%	100%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	BISHOPSTONE WARD - QEQM	QEQM	Surgical	1 - 6	65/35	102%	88%	-	98%	119%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CORONARY CARE UNIT - QEQM	Cardiology	Cardiac	1 - 3	74/26	81%	80%	100%	89%	124%	100%

East Kent Hospitals University Foundation NHS Trust : Ward Fill Rate Indicator
Staffing : Nursing, Midwifery and care staff - September '23

Monthly Ward Overview (fill rate) September 2023

						Average Fill Rate					
						Day			Night		
Hospital Site name	Ward name	Care Group	Specialty	Nurse to Patient Ratio	Skill Mix Ratio (RN/HCSW)	Average fill rate - Registered Nurses/ Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Registered Nurse s/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SPECIAL CARE BABY UNIT - QEQM	Womens & Childrens	Neonatal	1 - 2 HDU 1 - 3 SCBU		64%	36%	-	78%	38%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	DISCHARGE LOUNGE - QEQM	QEQM				13%	50%	-	0%	0%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KENNINGTON FRAILTY WARD - WHH	WHH	Medicine	1 - 6	65/35	81%	136%	-	97%	169%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE L WARD - WHH	WHH	Medicine	1 - 6	66/34	94%	150%	-	102%	127%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE K WARD - WHH	WHH	Medicine	1 - 6	66/34	81%	102%	-	82%	110%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE M2 WARD - WHH	WHH	Medicine	1 - 6	60/40	91%	103%	-	99%	131%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE J1 WARD - WHH	WHH	Medicine	1 - 6	65/35	90%	96%	-	95%	117%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS C WARD - WHH	WHH	Surgical	1 - 6	64/36	102%	96%	-	97%	105%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS D WARD - WHH	WHH	Surgical	1 - 6	62/38	96%	129%	100%	97%	167%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS C2 MEDICAL WARD - WHH	WHH	Medicine	1 - 6	65/35	88%	95%	-	97%	107%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	DISCHARGE LOUNGE - WHH	WHH				256%	114%	-	-	-	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	OXFORD WARD - WHH	WHH	Medicine	1 - 4	65/35	91%	127%	-	97%	146%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	ACUTE MEDICAL UNIT (AMU) - WHH	WHH	UEC	1 - 4	66/34	110%	118%	100%	140%	152%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	RICHARD STEVENS WARD - WHH	WHH	Medicine	1 - 6	66/34	95%	153%	-	99%	157%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	MATERNITY - WHH	Womens & Childrens	Maternity			71%	65%	-	77%	71%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS B WARD - WHH	WHH	Surgical	1 - 6	63/37	85%	125%	100%	97%	158%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CORONARY CARE UNIT - WHH	Cardiology	Cardiac	1 - 3	83/17	94%	102%	-	99%	130%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	NEONATAL INTENSIVE CARE UNIT - WHH	Womens & Childrens	Neonates	1 - 1 ITU 1 - 2 HDU		76%	42%	-	85%	60%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE M1 WARD - WHH	WHH	Medicine	1 - 6	60/40	89%	108%	-	94%	147%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	BARTHOLOMEW UNIT - WHH	Cardiology	Cardiac	1 - 6	70/30	95%	107%	-	101%	107%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	ROTARY SUITE - WHH	CCASS	Head and Neck	1 - 5	65/35	109%	93%	-	98%	122%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE J2 WARD - WHH	WHH	Medicine	1 - 4	62/38	109%	87%	-	97%	94%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS A2 WARD - WHH	WHH	Surgical	1 - 6	68/32	86%	108%	-	88%	122%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	PADUA WARD - WHH	Womens & Childrens	Paediatrics	1 - 4	80/20	82%	-	-	93%	-	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	SEACOLE WARD - WHH	WHH	Medicine	Unfunded		91%	81%	-	98%	96%	-

Quality and Safety;
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NHS Foundation Trust

Assurance/Mitigation

Ward fill rate

The inpatient ward staffing is reviewed daily by the Director of Nursing (DoN) utilising Safe Care (part of the HealthRoster system). This allows the DoN to have full oversight of the hospitals bed base and redeploy staff across wards according to patients acuity and demand.

There is a significant unfunded bed base on each site:
William Harvey Hospital (WHH) – 48 (Seacole ward, Acute Medical Unit (AMU) part unfunded beds, CDSU part unfunded beds)
Queen Elizabeth the Queen Mother Hospital (QEQM) – 56 (CSM, Sandwich Bay)

These are on additional wards that have been created and do not include additional beds that are on wards as these are just one or two that can be absorbed into the nursing ratio of that ward.

The wards that are under their planned fill rate are moving staff to support the unfunded bed base this is demonstrated by the lower fill rate of some wards seen on the table, to mitigate the risk on the ward the ward manager is coming into the numbers, and the allocation of patients being reallocated so that the nursing ratio is 1- 7 rather than 1-6, safe staffing ratio's on our substantive wards allow us to have this flex for a limited period while the unfunded bed base is reviewed.

Site DoN's report:

- Daily staffing reviewed by Head of Nursing (HoN) with escalation of staffing three times daily at site meetings and additional discussions if levels are unsafe
- Twice weekly meetings with NHS Professionals (NHSP) to review actions/data
- Review of golden keys for agency shifts are reviewed daily by HoN to ensure safe staffing levels are mitigated against establishment – review 72 hours in advance
- Agency code CSW03 stopped
- Enhanced care check list has been updated and is now being embedded to support staff
- Monthly N&M Workforce KPI's to review staffing levels, vacancies, establishments and the ongoing need for additional staff for escalations to include the harm for each area
- Safer staffing review is to begin from NHSE in ED's then working through to wards
- Considering future re-allocation of staff across the site to support patient safety and finance

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chief Medical Officer's (CMO's) Report: Learning from Deaths – Quarter 2 (Q2) 2023/2024**

Meeting date: **2 November 2023**

Board sponsor: **Interim Chief Medical Officer (CMO)**

Paper Author: **Senior Business Operational Manager**

Appendices:

None

Executive summary:

Action required:	Discussion
Purpose of the Report:	To provide the Board of Directors with updates on how we are Learning from Deaths (LfD) in line with the National Quality Board recommendations.
Summary of key issues:	The Hospital Standardised Mortality Ratio (HSMR) continues to improve following an upward trend leading up to April 2023. Since April, HSMR has stabilised and now demonstrates a downward trend. Work is still ongoing through the Mortality Steering and Surveillance Group (MSSG) to understand the cause of the upward trend which is to be reported to the Quality and Safety Committee (Q&SC). Learning from Deaths continues to be delivered through the Structured Judgement Review (SJR) process supported by the Trust Mortality Lead, the Learning from Deaths Leads, and the Medical Examiners Office.
Key recommendations:	The Board of Directors is asked to review and discuss the contents of this report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Board Assurance Framework (BAF):	**Principal Risk – BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

East Kent Hospitals University NHS Foundation Trust

Link to the Corporate Risk Register (CRR):	**117 –** Patients may be harmed through poor medicines management due to poor culture towards medicines prescription and administration at ward and department level that may result in patient harm, poor patient experience and increased length of stay (16). **116** – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs (20). **123 -** There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs (15). **125 -** There is a risk of failure to meet patients' nutrition and hydration needs (12). **132 -**There is a failure to demonstrate compliance with national standards for VTE assessment in inpatients using VitalPAC assessment tool (12).
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Q1 report previously considered by Quality and Safety Committee in August 2023.

East Kent Hospitals University NHS Foundation Trust

Learning from Deaths

1. Introduction

This report highlights the activity undertaken in Q2 for Learning from Deaths (LfD).

1.1 Overview of mortality data

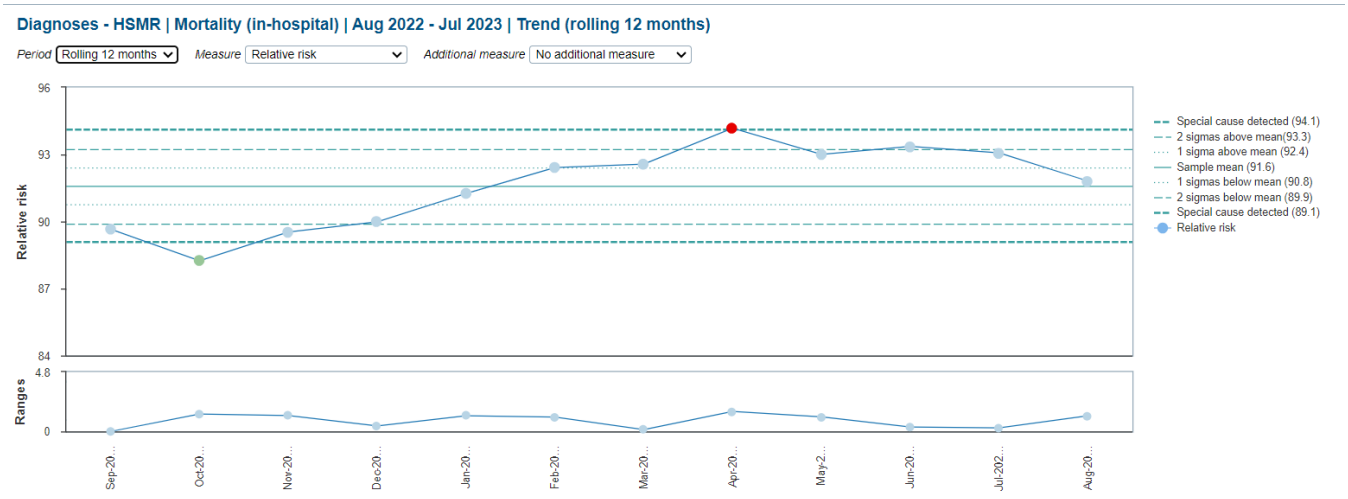
Mortality summary reports from the Telstra Health platform are received and reviewed in depth at the monthly Mortality Surveillance Steering Group (MSSG). These are used to identify positive and negative outlier diagnostic groups and also those at risk through review of confidence limits.

Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. Scored below 100 suggests a lower than expected mortality and a score above 100 suggests a higher than expected mortality.

The HSMR was developed to enable a more meaningful comparison of mortality rates between hospitals. The scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided. The HSMR is the relative risk of in-hospital mortality for patients admitted within the 56 diagnosis groups that account for 80% of in-hospital deaths.

Current HSMR performance is reported within the Integrated Performance Report (IPR) as a True North metric for reduction in mortality. Our last reported position demonstrates a rolling 12 month to March 2023 HSMR is 92.6, statistically 'lower than expected'. Key alerts and current position continue to be reported to Q&SC in the assurance report from MSSG. The current position declared by Telstra Health suggests Trust HSMR is forecast to improve even further than the figure presented in our most recent IPR (see fig. 1).

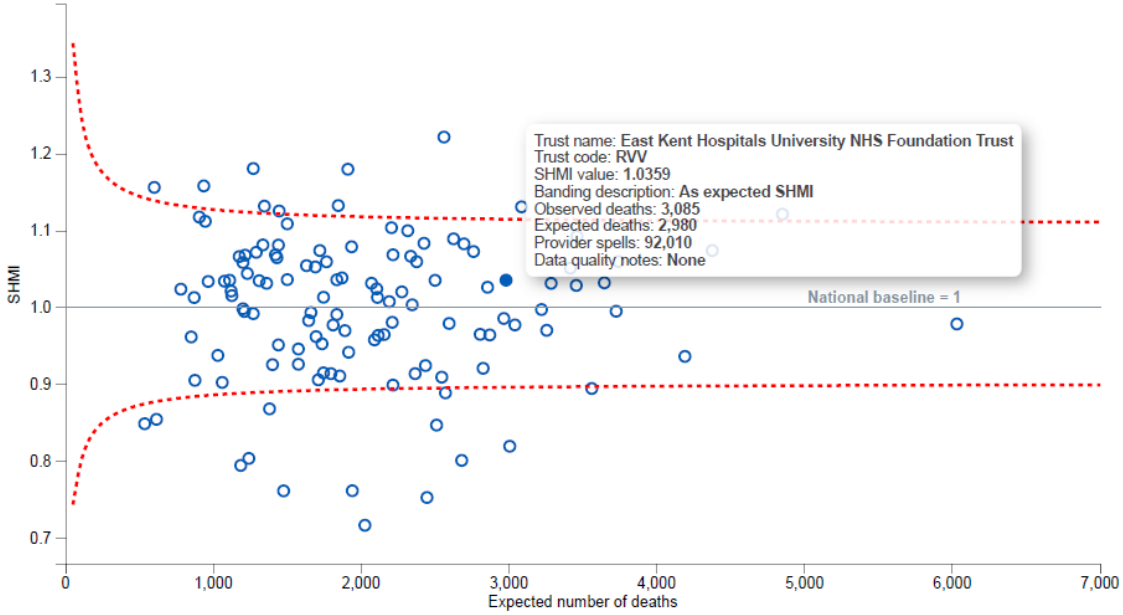
Figure 1. Rolling 12-month trend in HSMR over time for East Kent Hospitals



The Summary Hospital-level Mortality Index (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die, on the basis of average England figures and given the characteristics of the patients treated. Key differences are that SHMI includes deaths up to 30 days following a patient's discharge, includes all diagnostic groups and does not make an adjustment for palliative care. Figure 2 illustrates our SHMI against other providers. Please note, the SHMI data has not been updated by Telstra Health since the last report and will be updated as soon as a new report is made available.

Figure 2. SHMI

- Trusts whose SHMI falls above the upper control limit are categorised as '**higher than expected**'.
- Trusts whose SHMI falls between the upper and lower control limit are categorised as '**as expected**'.
- Trusts whose SHMI falls below the lower control limit are categorised as '**lower than expected**'.



From our data review any deep dives into diagnostic categories are commissioned and the results reviewed, including data quality and clinical pathways. Clinical recommendations are reported through to Patient Safety Committee (PSC) who determine how to embed and monitor effectiveness of actions.

2. Learning from Deaths

To learn from deaths there are two main governance processes for the majority of deaths. Deaths are now scrutinised by the Medical Examiner service as an initial screening review. The Medical Examiner service now scrutinises nearly all community deaths which supports our potential to learn from discharges in the community. If a patient's death is related to a failing or omission in care then it will be reviewed at the Serious Incident Declaration Panel and be managed through that process.

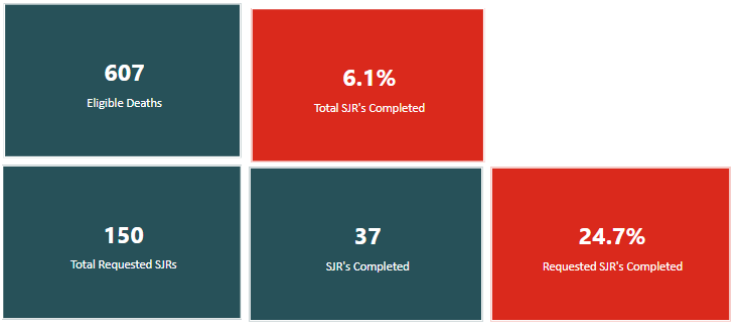
For those cases that do not meet criteria for serious incident a proportion will be put forward for SJR by trained reviewers. Selection is guided by locally and nationally mandated guidance and local priority is given to those cases identified by the Medical Examiners. There are specific

processes in place for perinatal deaths and stillbirths using the Perinatal Mortality Review Tool (PRMT), for child deaths and for deaths in patients with learning disabilities.

The LfD panel reviews second SJRs which are indicated when the overall care has been judged to be poor or a >50% chance of poor care contributing to the outcome.

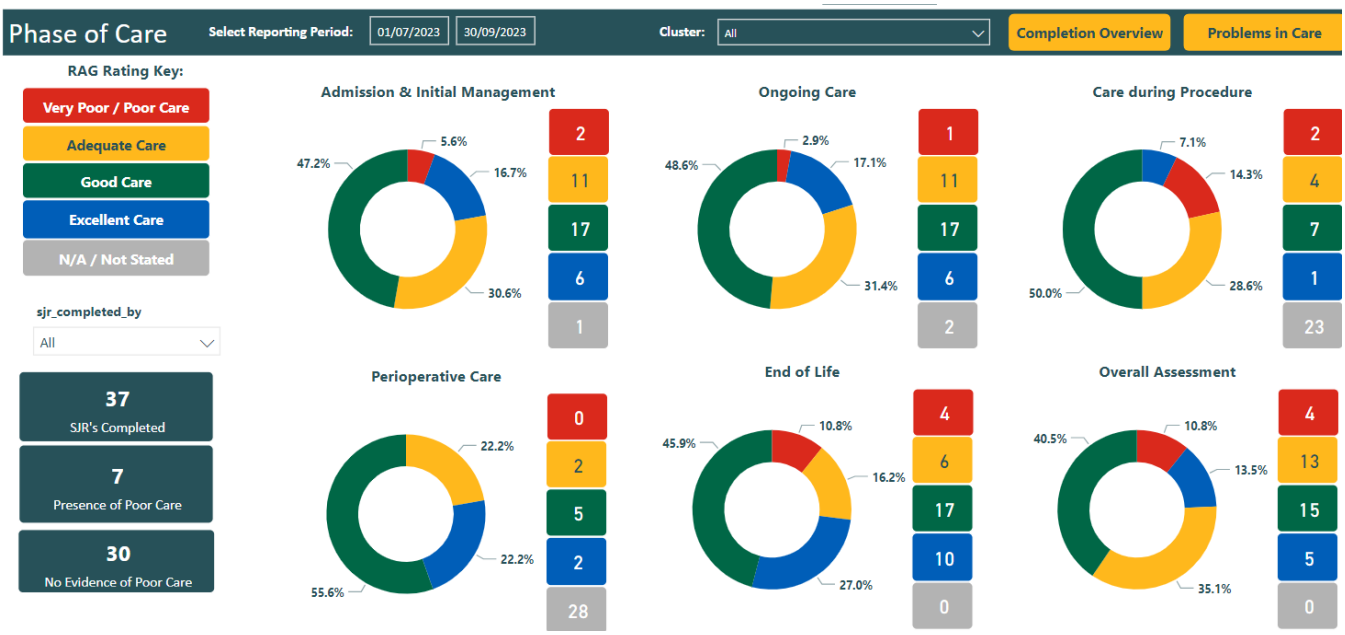
In Quarter 2 (Q2) 37 cases were reviewed through SJR as illustrated in Figure 3. Following the external review of mortality processes we are now completing reviews on a smaller percentage of deaths but this continues to include nationally mandated categories and those where the Medical Examiner has identified a learning opportunity. Where there are concerns raised in relation to clinical care these are managed through the Serious Incident (SI) process.

Figure 3: Overall Completion Q2 2023/24



The SJR reviews care across five phases of care as relevant to each patient and overall care. Phase of care scores for Q2 are illustrated in Figure 4.

Figure 4. Phase of Care Scores Q2

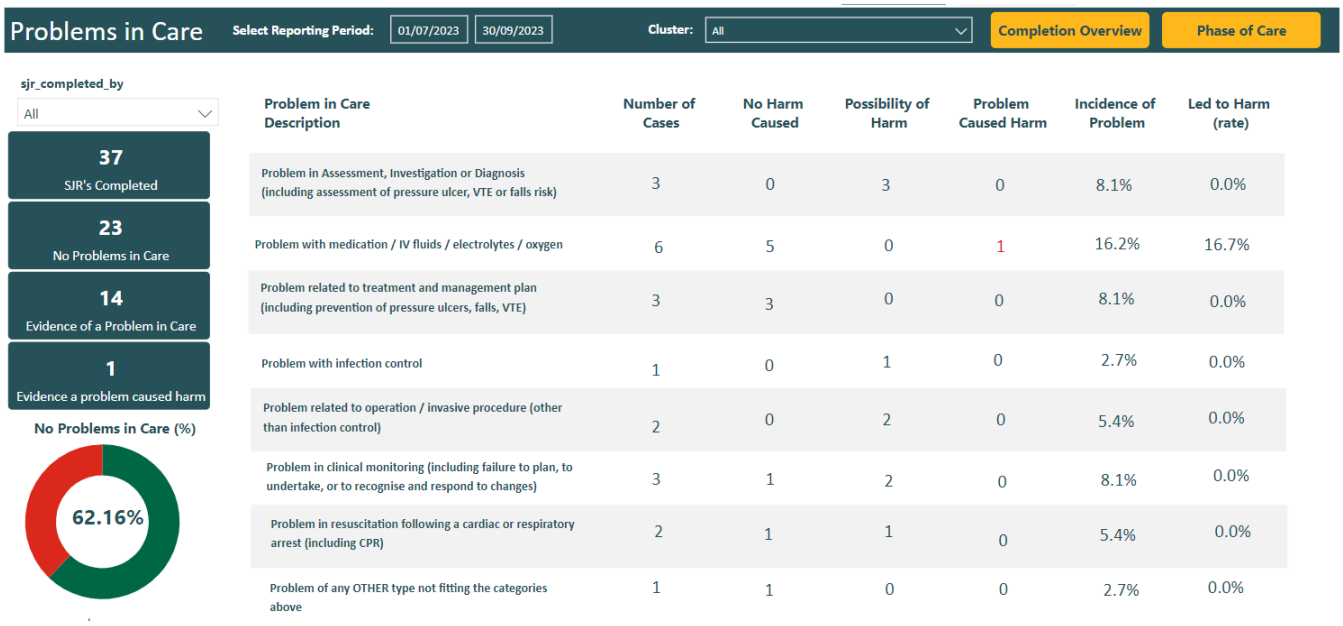


Overall the majority of care is judged to fall within the good or adequate category. Poor overall care was identified in seven cases in Q2 in any phase of care.

In Quarter 2 (figure 5), there were 14 cases where a problem in care was identified and for one patient, the problem caused harm. The identified issue was related to persistent

hypotension that was deemed to have not been sufficiently managed or escalated to the appropriate speciality.

Figure 5: Problems in Care Q1



Problem in Care Description	Number of Cases	No Harm Caused	Possibility of Harm	Problem Caused Harm	Incidence of Problem	Led to Harm (rate)
Problem in Assessment, Investigation or Diagnosis (including assessment of pressure ulcer, VTE or falls risk)	3	0	3	0	8.1%	0.0%
Problem with medication / IV fluids / electrolytes / oxygen	6	5	0	1	16.2%	16.7%
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	3	3	0	0	8.1%	0.0%
Problem with infection control	1	0	1	0	2.7%	0.0%
Problem related to operation / invasive procedure (other than infection control)	2	0	2	0	5.4%	0.0%
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	3	1	2	0	8.1%	0.0%
Problem in resuscitation following a cardiac or respiratory arrest (including CPR)	2	1	1	0	5.4%	0.0%
Problem of any OTHER type not fitting the categories above	1	1	0	0	2.7%	0.0%

Review of specialty level SJRs is part of the agenda for specialty level Morbidity and Mortality meetings and this is supported by attendance of the LfD facilitators, although there are speciality teams that are not consistently doing this and work continues to address gaps. Learning is also shared through key messages each month displayed in Education centres and disseminated electronically. We have recruited to a Trust Mortality Lead to provide additional support to the LfD facilitators and to chair the LfD review panels.

Data from the Medical Examiner's referrals to SJR and triangulated with review outcomes and additional data sources looking for trends or patterns of concern at ward and site level. Where possible concerns are identified these are fed through to the Quality Intelligence Forum and triangulated with other quality data, for example clinical incidents, and if validated this will inform further actions.

The LfD dashboard has been updated to allow reporting of the grading from the SJR of how likely or not a reviewed death would have been avoidable.

3. Conclusion

The LfD team continue to promote the use of the SJR programme to identify where we can learn from excellent care as well as were care is not delivered to the standards our patients should expect. The sharing of the outcomes with discussion and action by clinical teams remains an area for further improvement. This is inconsistent through different specialty local morbidity and mortality meetings. This will be a focus of the Trust Mortality Lead, working alongside our LfD facilitators to support specialty teams.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Statement of Compliance**

Meeting date: **2 November 2023**

Board sponsor: **Chief Medical Officer (CMO) & Responsible Officer**

Paper Author: **Senior Business Operational Manager**

Appendices:

Appendix 1: **Statement of Compliance Report**

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Statement of Compliance report is an annual requirement that informs part of the Framework of Quality Assurance for Responsible Officers and Revalidation. The purpose of the report is to highlight actions and comments from previous reports and to declare upcoming actions ahead of next year's report.
Summary of key issues:	The main actions from the report are for the Responsible Officer team to continue progress and delivery of the recommendations following the Higher Level Responsible Officer (HLRO) visit in 2022. All other actions are now to either continue to provide assurances or to confirm completion of actions in the coming 12-months.
Key recommendations:	The Board of Directors will need to review and **APPROVE** this report so that it can be returned to the HLRO.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People
Link to the Board Assurance Framework (BAF):	**Principal Risk – BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.
Link to the Corporate Risk Register (CRR):	**123 -** There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs (15).
Resource:	N

East Kent Hospitals University NHS Foundation Trust

Legal and regulatory:	Y: The Responsible Officer service and duties are a statutory requirement of Designated Bodies (in this instance: East Kent Hospitals University NHS Foundation Trust) under The Medical Profession (Responsible Officers) Regulations 2010.
Subsidiary:	N

Assurance route:

Previously considered by: This year's AOA paper was submitted to the Board of Directors meeting in July 2023.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of East Kent Hospitals University NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 6th July 2023 Action from last year: See comments Comments: Actions and comments captured in the AOA board report and summarised throughout this SoC Action for next year: AOA to continue

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Previous RO, Dr Rebecca Martin resigned from EKHUFT. New RO appointed: Dr Jonathan Purday. He has completed the appropriate training and engages in regional RO updates. Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Review funding/resources for the RO support team to ensure quality and compliance is being met following increase in medical workforce. Comments: New medical workforce lead now in post to support MHPS functions and ROAG. Action for next year: Continue to review resources and ensure RO services are being met in response to workforce changes.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to maintain accurate records Comments: Connection checks performed twice a month and are utilised to cross-check the processes in place to capture incoming and outgoing connections. Action for next year: Continue to maintain accurate records.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Appraisal policy to be updated Comments: Draft written and being reviewed by JLNC Action for next year: Confirm publication of updated policy

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Peer-review undertaken in 2022 Comments: Feedback and recommendations provided Action for next year: Confirm completion of all recommendations and actions following peer-review.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Perform gap analysis comparing Trust activities with the GMC 'Effective Clinical Governance for the Medical Profession' Comments: Gap analysis completed and work ongoing to address gaps. Action for next year: Confirm completion of actions to ensure temporary medical workforce is supported in appraisal and revalidation requirements.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Embed escalation process for delayed appraisals Comments: New process trialled in February 2023 with good response. Increased compliance seen. ROAG launched in March 2023 which involves a panel reviewing appraisal outputs to inform revalidation recommendations for the RO. Action for next year: Continue to monitor delayed appraisals and improve governance around revalidation recommendations.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Embed escalation process

Comments: Along with the delayed appraisal escalation process in which feedback and advice is provided to the appraisee. The ROAG also provides feedback to those that require more evidence (or stronger evidence) to support a revalidation recommendation.

For those with perceived non-engagement, the use of the Rev6 process has been implemented more frequently but with agreement from the ROAG members. Likewise, the non-engagement process is stood down when the ROAG members agree that suitable engagement has been seen.

Action for next year: Continue to monitor the outputs of appraisals leading up to revalidation.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Review appraisal policy

Comments: Following visit from HLRO, the appraisal and revalidation policy was updated with their recommendations. This has now been shared with our JLNC for comments.

Action for next year: Publish new Appraisal policy

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Review development needs for appraisers

Comments: New appraiser training has been halted as number of appraisers for our organisation is sufficient. Refresher training continues to be delivered and we are now in the process of identifying "senior appraisers" to support the Trusts Appraisal Lead.

Action for next year: Confirm appointment of senior appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action from last year: QA process to be undertaken

Comments: ASPAT score reported and reviewed every 6 months. The latest scores have improved greatly following the appointment of a Trust Appraisal Lead. There role has been utilised to review and strengthen the output forms written by appraisers and this has led to significant improvements in ASPAT scores.

Action for next year: Continue to review QA process.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: re-establish QA cycle including Board reporting

Comments: QA report generated every 6 months and presented to the Board.

Action for next year: None

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To introduce a ROAG

Comments: ROAG launched in March 2023. The membership has been recruited to including lay representation and continues to meet monthly to review and suggest recommendations.

Action for next year: Continue to work with the ROAG members to provide challenge and strengthen the governance process of providing recommendations.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue to embed and strengthen communication in relation to revalidation recommendations.

Comments: In the lead up to each ROAG meeting, the doctors are informed of the process and the possible outcomes on numerous occasions. Once the decisions in the ROAG have been made, the outcomes are recorded and communicated to the doctors in question prior to the recommendation being submitted.

Action for next year: Continue to monitor and uphold this practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Perform gap analysis and implement actions relating to the GMC 'Effective Clinical Governance for the Medical Profession' guidance. Comments: Gap analysis completed and a number of actions have been generated. All actions related to RO function have been completed as of July 2023. Action for next year: Continue to complete the remaining outstanding actions.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Implement effective cross-check that allows for relevant information to be included and reflected upon in appraisal. Comments: ROAG meetings now provide a forum to discuss issues around conduct and performance that should be included in subsequent appraisals. These are then communicated to the doctor with clear expectations and records that allow to chase/track this. Action for next year: Improvements to complaint/incidents governance expected January 2024. The expectation is that this new system will improve how we capture individuals named in complaints/incidents or named in actions in response to complaints/incidents.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Review MHPS policy in response to changes in medical leadership structures Comments: Restructure ongoing. Action for next year: Confirm new structure and review MHPS policy in line with new structure.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be

Action from last year: Further develop board reporting

Comments: Reports to the Board are submitted every-other-month.

Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None

Comments: MPIT process is now well-established and a process of collecting and providing MPIT's occurs daily.

Action for next year: Continue to share relevant information

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: As per question 1

Comments: As per question 1

Action for next year: As per question 1

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Review use of RMO model.

Comments: Work on-going to reduce the reliance on RMO and other longer-term temporary workforce.

Locum induction policy has been developed and published with the endorsement of the JLNC. Temporary workforce team established to monitor and audit compliance with this process.

Action for next year: Continue to reduce reliance on long-term temporary workers.

requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

The last statement of compliance was completed in 2022. The outstanding actions from the previous report are:

- **The update of the Appraisal and Revalidation policy: this was not progressed until the HLRO visit to ensure key recommendations could be captured in the new policy;**
- **Update of the MHPS policy to align with change in medical leadership structures: the restructure has not been completed at this time but the MHPS policy will be review once the restructure is complete; and**
- **Delivery of the actions following the gap analysis of the effective clinical governance guidance from the GMC: while the actions relating directly to the RO have been completed, there are a number of outstanding actions that require completion but are progressing.**

For all of the outstanding actions, there are plans in place to achieve them within the next 12 months.

Following the resignation of the previous Responsible Officer, a new RO has been appointed. This person is suitably trained and performed the role for the organisation previously. There are no concerns from the organisation that the change in RO will impact the continuity of any planned improvements or business as usual activities.

The introduction of a Responsible Officer Advisory Group (ROAG) has improved the efficiency and quality of revalidation recommendations in addition to addressing a key recommendation following our HLRO visit. The ROAG has allowed the organisation to embed a new escalation process for delayed/missed appraisals and capture individuals that are required to reflect and learn from significant events/complaints/incidents.

Overall, the Trust continues to deliver the statutory RO function and is committed to providing this service according to best practice guidance.

Section 7 – Statement of Compliance:

The Board of East Kent Hospitals University NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: East Kent Hospitals University NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Infection Prevention and Control (IPC) Quarterly Report**

Meeting date: **2 November 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Deputy Director of Infection Prevention and Control (DIPC)**

Appendices:

Appendix 1: Updated IPC Board Assurance Framework (BAF)

Executive summary:

Action required:	Discussion
Purpose of the Report:	To apprise the Board of the current performance with regard to nationally reportable infections, and to highlight any additional IPC issues of note or concern.
Summary of key issues:	• *Clostridioides difficile* remains a significant challenge for the Trust with the current cases already at 94% of the annual threshold. A range of interventions are in place to both attempt to understand and to address the current levels. The main focus is antimicrobial prescribing, however, there was one outbreak of a rare ribotype of c-dif accounting for six cases between June and August, which highlighted environmental and equipment cleaning issues, which have been addressed and a review of cleaning ratings undertaken. • Currently cases of Klebsiella and E-coli bloodstream infections are over trajectory, and work is ongoing to focus interventions for this. • Other reportable infections are well below trajectory. • Improved surveillance of mandatory Surgical site infections continues to effectively identify cases, and a weekly meeting chaired by the care group focusses upon learning and actions. • The updated IPC BAF assessment identifies level of compliance, and updates actions, this is appended.
Key recommendations:	The Board of Directors is asked to discuss and **NOTE** this IPC quarterly report.

Implications:

Links to Strategic Themes:	• Quality and Safety • Patients

We care

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	No
Link to the Corporate Risk Register (CRR):	CRR 147 - Failure to comply with the NHS standard contract for infection prevention and control due to the inconsistent application of IPC, hygiene and Antimicrobial Stewardship (AMS) practices and protocols and the fragility of infrastructure.
Resource:	N
Legal and regulatory:	Y - Supports compliance with The Code of Practice on the Prevention and Control of Infections (Health and Social Care Act).
Subsidiary:	N

Assurance route:

Previously considered by: This report and BAF have previously been discussed at the Quality and Safety Committee (Q&SC)

East Kent Hospitals University NHS Foundation Trust

Infection Prevention and Control (IPC)

1. Introduction

The enclosed report provides information on the current status of the Trust with respect to Healthcare Associated Infections (HCAI), to the end of September 2023.

All attributable HCAIs are classified as either hospital onset – health care associated, (HOHA) these are cases identified from samples taken on or after day 2 of admission, or community onset – health care associated (COHA) these are any patients testing positive for a case where they have been an inpatient in the preceding 28 days.

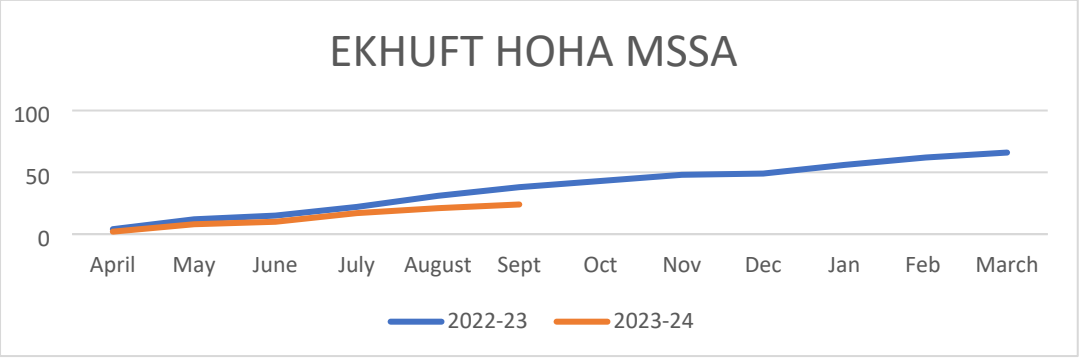
2. Meticillin resistant *Staphylococcus aureus* (MRSA)

There has been one hospital attributable MRSA bacteraemia case in this timeframe, which identified key learning for the Trust, including MRSA screening protocols not being adhered to, ineffective communication of results, and incorrect results being published, reported and changed. Actions have been implemented to address these, including a relaunch of Trust MRSA screening guidance, a change in reporting processes between the laboratory and the IPC team, and shared learning with the tissue viability team.

3. *Staphylococcus aureus* (MSSA)

Meticillin sensitive *Staphylococcus aureus* (MSSA) infections are common in both community and hospital settings. Healthcare associated infections are commonly related to vascular access catheters or surgical site infection. No threshold has been set for these infections.

Figure 1



The number of Hospital onset bacteraemias is consistently lower than last year with 24 reported in 2023 so far compared with 38 reported that same time last year. Ongoing work is continuing with the IPC team and clinicians to support good practice in relation to line insertion, and ongoing care, with Multi-Disciplinary Team (MDT) approaches to training.

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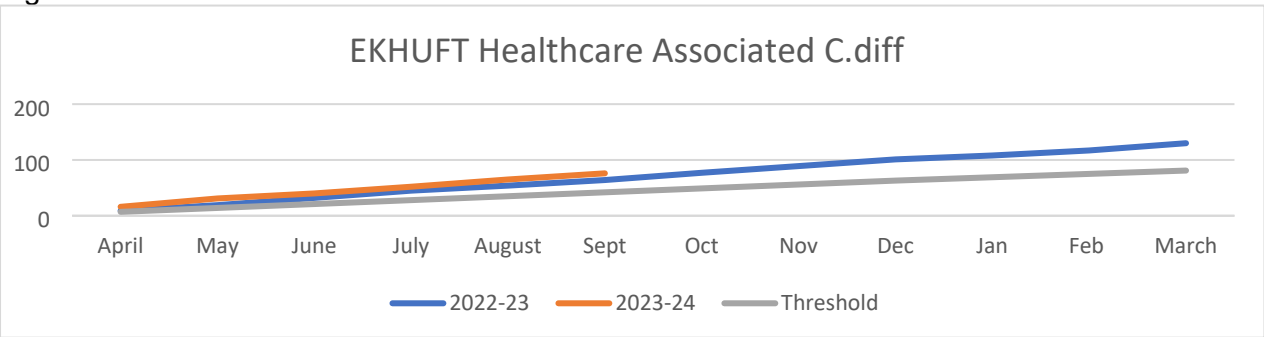
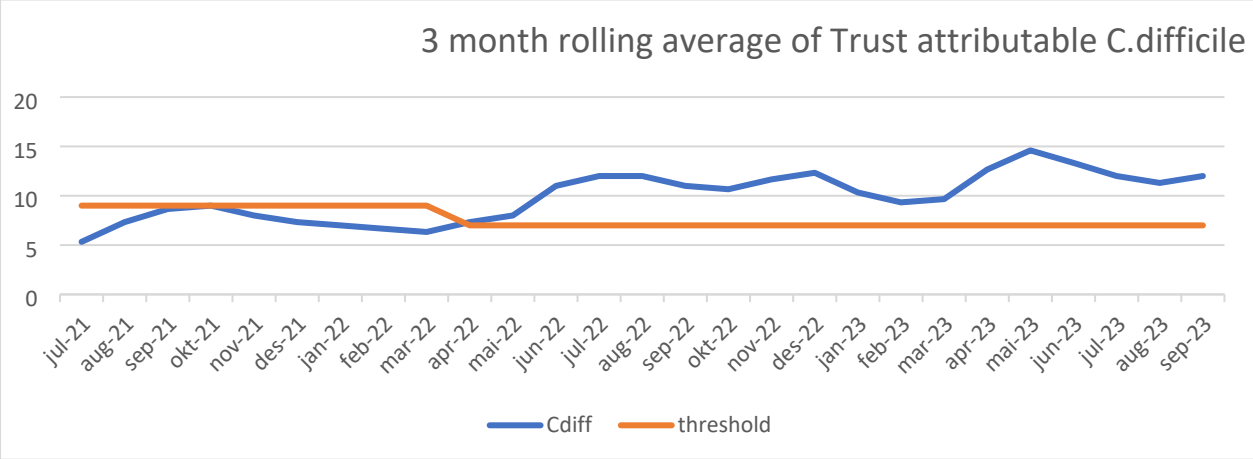
4. Clostridioides difficile

Figure 2





To end of September 2023 the Trust reported 76 cases of attributable *C. difficile,* 20 of which were 'Community Onset - Healthcare Associated'. The Trust is considerably off target to achieve the external threshold, having already reported 94% in the first 6 months. The Trust is not alone in this – with all Kent and Medway Trusts breaching their current trajectories. All Trusts have Clostridium difficile Infection (CDI) reduction programmes and actions in place and a new Regional CDI collaborative forum has been set up in an attempt to tackle this as a system.

There was an outbreak of a rare ribotype 181 across William Harvey Hospital (WHH) and Kent & Canterbury Hospital (K&C) between June and August, an outbreak meeting was held, enhanced cleaning and contact tracing have been completed, and the outbreak now appears to have closed, however, the Trust will not declare this closed until we have ongoing evidence of no further transmissions, and will review after three months.

Main focus for reducing c-dif continues to be antimicrobial stewardship, and reducing use of co-amoxiclav when broad spectrum antimicrobials are no longer required – the Trust Antimicrobials pharmacy lead has a full strategy focussing on this, and actions continue to be implemented, assisted by Electronic prescribing.

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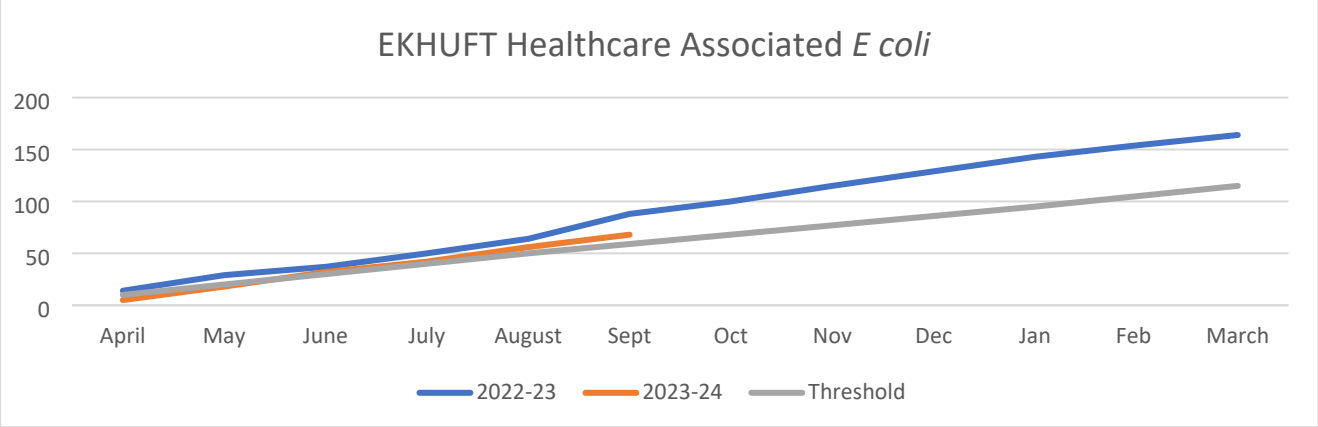
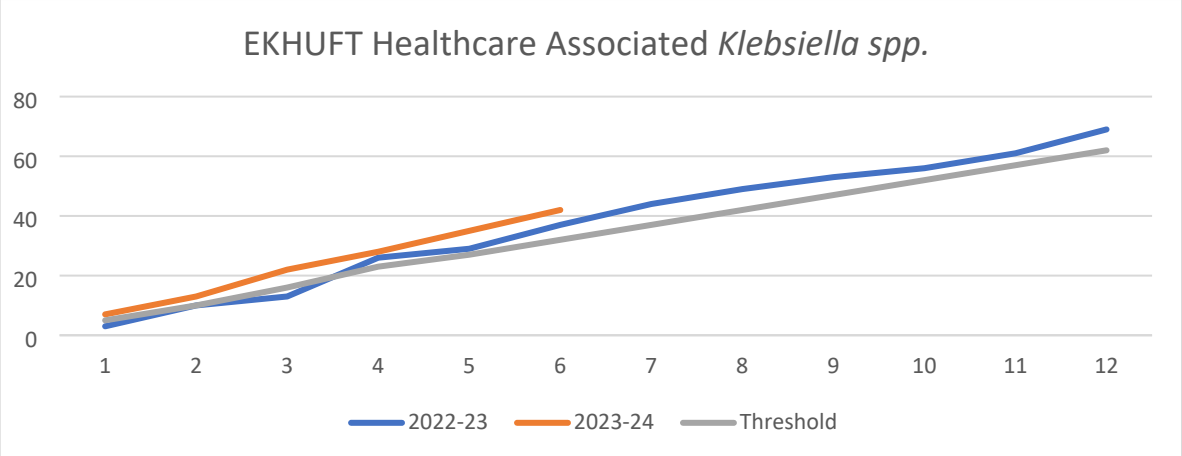
5. Gram negative bloodstream infections

There is a national commitment to reduce the number of avoidable healthcare associated Gram-negative bloodstream infections by 25% by the end of 2021/22 and the full 50% by 2023/24 compared with 2015/16. There is an acceptance nationally that this ambition is unlikely to be met.

(Figures 5 to 7).

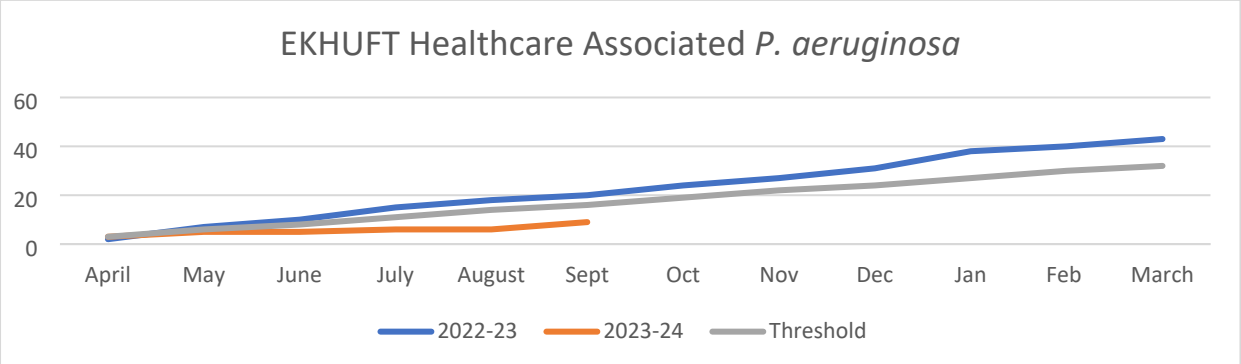
Figure 5: E-coli & Klebsiella





We are over trajectory for both E-coli and Klebsiella, for E-coli, we have made significant reduction compared to 2022/23, but remain slightly over the trajectory, whereas for Klebsiella we have seen a month on month increase. Whilst there are actions continuing to focus on reduction of these cases, a summer increase is a normal variation in these infections, but the targeted interventions for both of these gram negative infections are similar, therefore hard to understand why one is decreasing, whilst the other increasing.

Figure 6: Pseudomonas



Currently the Trust are reporting seven cases below the threshold.

The 'Device Related Infection Prevention Practice' resources are being utilised in areas in wards on all sites as part of quality improvement initiatives, and has seen improvements in urinary catheter care and line care - as reported through monthly IPC audits.

6. Outbreaks and incidents

COVID-19 numbers are now beginning to rise, and the patients and staff COVID-19 and Flu vaccination programme has commenced, and increased communication for staff regarding preparedness for this increase is in place. Despite new variants being identified, national guidance has not changed, and early indications do not identify increasing morbidity or mortality associated with this variant.

7. Surgical Site Infection Surveillance

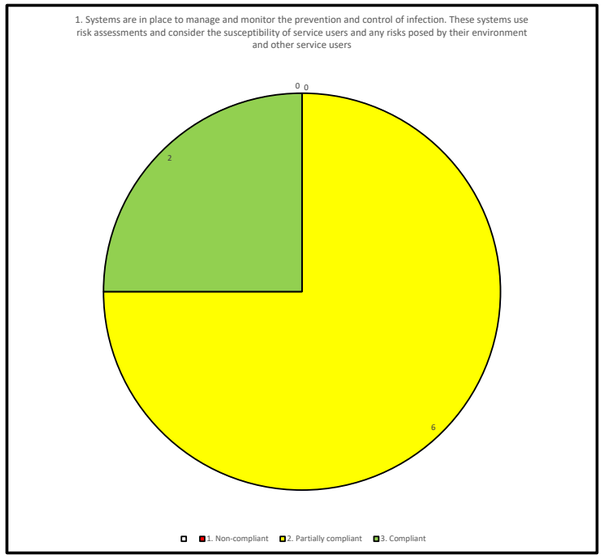
Since the employment of an infection surveillance nurse in May 2023, Surgical site infection surveillance in mandatory reporting areas (Total hip and knee replacements, and fractured neck of femur repairs) has identified 18 confirmed surgical site infections, two total knee replacements, four total hip replacements and 12 fracture neck of femur repairs. Five repair of fracture neck of femur patients subsequently died and these cases have been declared as Serious Incidents (SIs) and full Root Cause Analysis (RCA) undertaken. The care group are undertaking a full thematic review, operating theatres have been deep cleaned, practice audited, and a gap analysis undertaken against the National Institute for Health and Care Excellence (NICE) prevention of surgical site infections undertaken. The care group are holding weekly meetings to continually review practice, and implement actions identified following both ongoing audit and the gap analysis, with oversight from both the DIPC and Deputy DIPC. The Trust decontamination lead is also undertaking a review of practice in the central sterilisation service to ensure full compliance is in place, and we have commissioned an external review by Association for Perioperative Practice (AFPP), which will review this and other aspects of care provision across EKHUFT theatres.

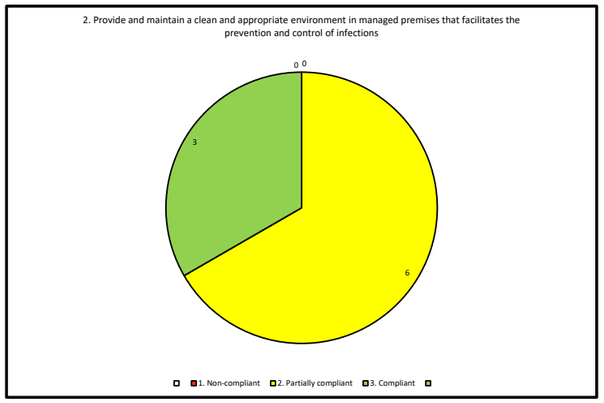
8. Infection Prevention and Control (IPC) - Board Assurance Framework (BAF)

Please see appended updated BAF for IPC.

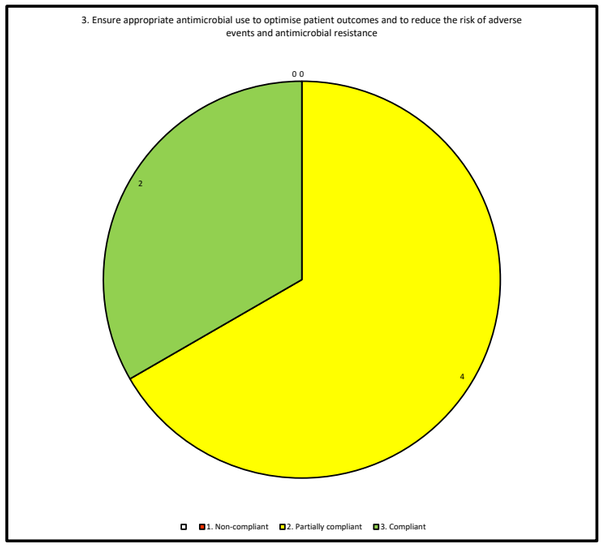
Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems 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 their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	1) Infection prevention control and antimicrobial stewardship committee - reports to Quality and Safety Committee, reports to board 2) decontamination committee, water safety and ventilation committee report to infection prevention and control and antimicrobial stewardship committee 3) evidence via minutes of all committees				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	1) see above for governance structure				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	1) Datix and Steis IPC Post infection reviews / Route cause analysis	1) lacks link through to governance in corporate /	good links with governance and risk teams		2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	1)NIPCM implemented July 2022 2) Annual clinical practice audit programme in place -reported through IPCAS 3) Monthly IPC audits of clinical practice 4) Monthly Hand hygiene and PPE audits all services	1) IPC audit identifies inconsistencies in compliance, and partial compliance with IPC policies and protocols	1) Back to basic' campaign and local support 2) daily walkabout to wards of IPC team		2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	1) Robust mandatory infectious agent surveillance and reporting 2) Annual workplan	1) SSIS historic issue with data collection. 2) Currently extremely over trajectory to achieve threshold for c-dif, slightly over for kleb and E coli.	1) new SSIS nurse appointed in May 2) C-dif reduction actions underway - focus -screening, antimicrobial prescribing and sampling 3) planned 'DRIPP' resources t be piloted for QIT		2. Partially compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	1) IPC team, 2) healthcare informatics team 3) Monthly audits 4) Annual clinical practice and environmental audits 5) information on Trust info portal	1) IPC audit identifies inconsistencies in compliance, and partial compliance with IPC policies and protocols 2) AMS budget limited and limited assurance on antimicrobial prescribing	daily ipc support for sites 2) review of general training 3) bespoke training and support 4) antimicrobial stewardship strategy		2. Partially compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Infection prevention and control training is statutory, Hand hygiene training mandatory. Link worker programmes	evidence of hand hygiene training through ESR appears low	link workers providing training, IPC team providing training - ESR providing different way to record and report	all IPC education currently under review. Jun 23 -IPC training compliance 93.3% Hand hygiene compliance 72.2%	2. Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	1.All areas risk assessed as part of pandemic response and engineering solutions added where feasible. 2.Post pandemic business as usual includes elimination, substitution, administrative controls and use of PPE as per the NIPCM	No formal assessment tool	IPC team support reviews when new areas open / change function		2. Partially compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	FR rating throughout Trust 2) Monthly Cleaning audits , 3) PLACE audit results 4) Annual environmental audits. All presented through IPCAS	1. equipment cleaning schedules manage by clinical teams. 2) local issues identified for key areas FR ratings and not meeting requirements 3) local concerns raised that audit not true reflection of cleaning compliance	1) additional cleaning put on for toilets in some areas 2. Trust wide review of FR ratings underway 3) education recleaning audits 4) senior clinical team member to attend cleaning audits		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	annual inspections and report	Aging estate and poor environment	PLACE action plan		2. Partially compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Decontamination of equipment and environment policy	audits identify partial compliance, and confusion over processes	Policy revised to clarify 'use of I am CLEAN stickers, Comms and campaign for equipment cleaning in 'back to basics' and mattress cleaning protocols and audit tools reshared.		2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	1.Water Safety Group terms of reference (TOR) and minutes. 2.Water Safety Plan 3.Ventilation Safety Group 4.Specific Ventilation Safety Plan appears to be a new requirement - clarification required.	Ventilation safety meetings commenced July 2023 Specific Ventilation Safety Plan is a new requirement - currently in progress	ventilation assessments and reports		2. Partially compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	1.Contractual agreement with 2gether Support Solutions for PPM 2.Statutory and mandatory compliance reports to Board quarterly 3.Capital (PEIC) and revenue plans for upgrades and investments 4.KPIs are assured via Contract Performance Meeting (monthly)	The aging estate means many areas are not meeting current HTM / HBN requirements. Areas of estate upgrade impacting IPC remain outstanding due to costs			2. Partially compliant

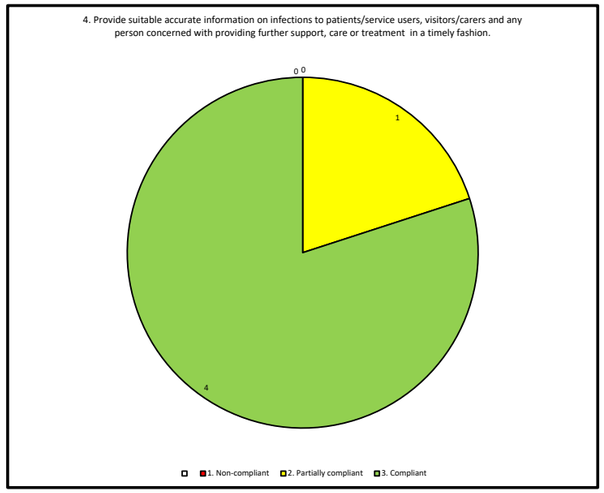


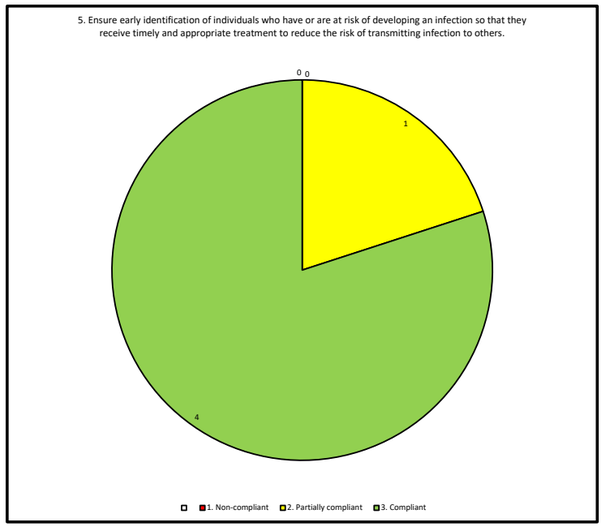


2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	1.IPC annual audits of environment and practice 2.Contract with 2gether Support Solutions for linen and reports to Decontamination Committee (to be Group from April 2023). 3. decontamination committee meeting minutes				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	1.Contract with 2gether Support Solutions for waste management and with external waste provide via above. 2.Annual IPC clinical and environmental audits for IPC specific waste disposal and segregation only (non-IPC waste types e.g. medicines, recycling are not covered by this BAF).	audits highlight partial compliance at local level for waste streams	Waste disposal campaign and training		2. Partially compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	1.Contractual agreement (managed by 2gether Support Solutions) with IHSS for decontamination of surgical instruments and reports to Decontamination Committee (group from April 2023). 2.Decontamination records for Endoscopy 3.Endoscopy Audit results 4.JAE(D) annual reports				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	1.Trust nutrition policy does not allow food to be brought in unless it can be stored at ambient temperature or eaten immediately. 2.Service level specification for catering services 3.Training level specification for food handlers (2gether support solutions). Food safety level 2 on induction and every 3 years (all housekeepers and catering staff).				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	1.Antimicrobial Stewardship (AMS) Policy 2.Guidelines on 'Microguide' 3.Job descriptions for AMS team 4.Terms of reference for AMS Group 5.Minutes of above and IPCAS	partial assurance from internal and external audit report			2. Partially compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	DIPC annual report				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	**DIPC**				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools [TARGET] are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.	1.AMS audits 2.AMS Policy 3.Guidelines on 'Microguide'	1) Trust audits identify non compliance 2) C-dif case reviews identify 25% non compliance to Trust antimicrobial guidelines	AMS strategy		2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •Total antimicrobial prescribing. •Broad-spectrum prescribing. •Intravenous route prescribing. •Treatment course length.	DIPC annual report	1.) annual reporting only - not 'live 'information. 2) formalising reporting to board still being developed via new IPCAS governance structure		previously no escalation to Board	2. Partially compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	1) AMS improvement plan and strategy 2) K&M strategy	1) Limited assurance from audit 2) limited AMS training 3)	AMS strategy		2. Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	1.Patient information leaflets and information for other formats and languages available here:	1) Unknown development process			2. Partially compliant

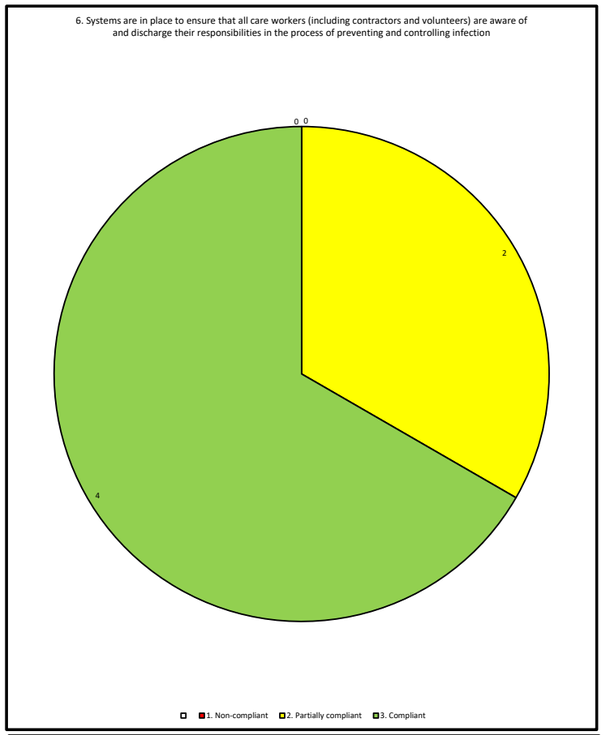


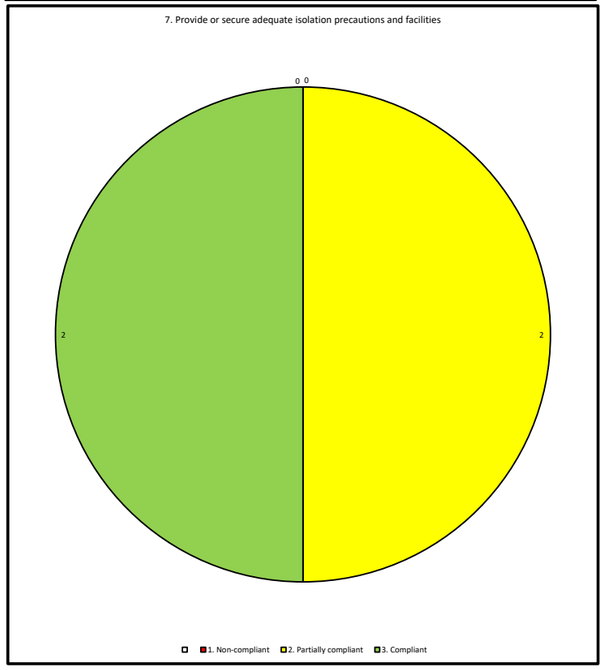
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Available on Trust internet, can be printed			all on intranet -can be obtained translated if requested through staffzone	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Available on Trust internet, can be printed				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Available on Trust internet within 'leaflets ' and within visitors information, can be printed				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	1.EKHUFT IPC Policy 'guidelines for admission, movement/transfer and discharge of patients with an infection/infectious illness 2. Urinary catheter passport 3. EDN's 4. c-dif and MRSA letters for GP's				3. Compliant
5. Ensure early identification of individuals 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 others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	1. Organism specific guidance on 'Microguide' and 'Staffzone' e.g. MRSA guidelines, c-dif, CPO and VRE guidelines 2. IPCT records of individual patient advice				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	1.Organism specific guidance on 'Microguide' and 'Staffzone' 2) records of IPC team advice				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	1. EKHUFT IPC Policy 'guidelines for admission, movement/transfer and discharge of patients with an infection/infectious illness 2. IPCT records of individual patient advice 3. Organism specific guidance on 'Microguide' and 'Staffzone' 4. Repatriation guidelines				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Information in visitor leaflets and on external website		Information in visitor leaflets and on external website	this should reviewed owing to the pandemic being endemic and relate to any potentially infectious illness	2. Partially compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	1. EKHUFT outbreak policy 2. Minutes of IPCC and sub-groups 3. Minutes of outbreak and incident meetings.				3. Compliant
6. Systems are in place 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						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	1.Induction and mandatory training records 2.Induction and mandatory training materials				3. Compliant



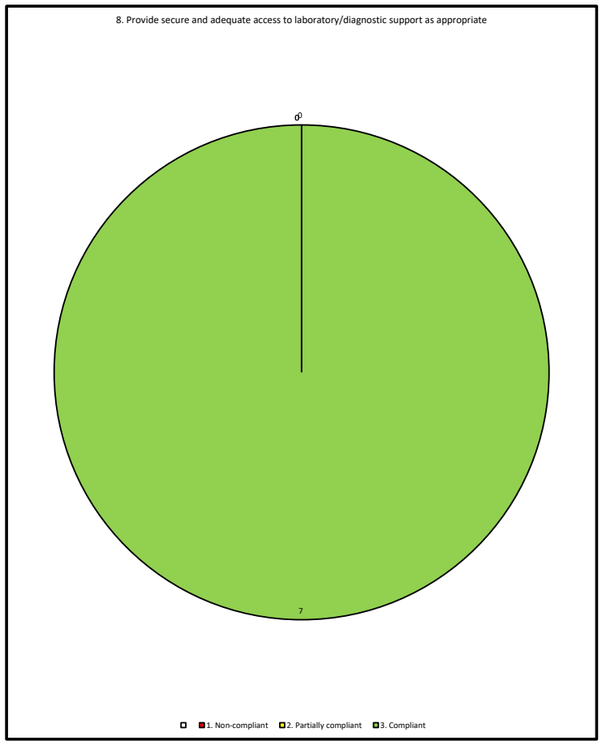


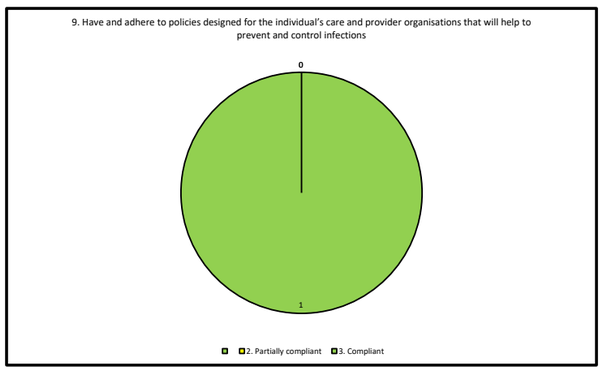
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	1.Link practitioner role description 2.Job description examples for a range of staff 3.Assurance from 2SS as part of contractual arrangements	NHSE published new educational framework - not yet reviewed by EKHUFT for evidence of full compliance	NHSE framework underpinned by Skills for health - EKHUFT staff IPC e learning are 'Skills for health' modules		3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	1) IPR metrics for statutory and mandatory training and workforce compliance data on information portal 2			Jun 23 -IPC training compliance 93.3% Hand hygiene compliance 72.2%	2. Partially compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	1.Induction and mandatory training records 2.Induction and mandatory training materials 3.TBP and SBP posters			Jun 23 -IPC training compliance 93.3%	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	staff were fit tested throughout pandemic, up to and including March 2023	Unknown baseline for staff requiring fit testing since return to -pre-covid' guidance.	1.) FFP3 only required when caring for patients with Tb, or undertaking AGP's on patients with suspected / confirmed respiratory infectious illnesses. 2) Full hoods available within settings for non fit tested staff 3) fit testing provided 3 days per week from October - all staff able to access - prioritising those in high risk areas. 4. DDIPC working with ER to identify staff who should be fit tested		2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Practice development nurses, Guidelines on clinical microguide & locally held competency records				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	1.EKHUFT IPC Policy on transmission based precautions (TBPs) is the NIPCM 2.TBs posters (revised 2023) 3.IPCT records of individual patient advice 4.Organism specific guidance on 'Microguide' and 'Staffzone'	MRSA screening audit identifies non compliances	additional training and support for staff, MRSA 'SOP'		3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	1.EKHUFT IPC Policy on transmission based precautions (TBPs) is the NIPCM 2.Isolation guidelines regularly reviewed 3.IPCT records of individual patient advice 4.Organism specific guidance on 'Microguide' and 'Staffzone' 5.Winter pressures planning via Trust strategic meeting 6.Strategic decision logs	Some wards have insufficient / no single rooms	1.) at times of escalation IPC team and site co-ordinators complete daily sideroom list reviews & daily huddle attendance 2) wards with no single rooms regularly reviewed by IPC team with Site Co's 3) currently reviewing potential for 'air scrubber' equipment	bed pressures may lead to infectious patients remaining in bays whilst non infectious patients are in siderooms with limited ability to swap, as require a bed space to move patents to whilst room cleaning etc completed	2. Partially compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	1.EKHUFT IPC Policy on transmission based precautions (TBPs) is the NIPCM 2.TBPs posters (revised 2023) 3.IPCT records of individual patient advice 4.Organism specific guidance on 'Microguide' and 'Staffzone'	Clinical practice audits undertaken by IPC team highlight non compliances	1) Audit results reported through clinical and service leads for actions - escalations to IPCAS 2) ongoing support and training 3) IPC 'campaign'	review of audit 'ownership'	2. Partially compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	1.EKHUFT IPC Policy 'guidelines for admission, movement/transfer and discharge of patients with an infection/infectious illness 2.IPCT records of individual patient advice 3.Organism specific guidance on 'Microguide' and 'Staffzone' 4.Covid-19 swabbing protocols (prior to transfer to care settings).				3. Compliant



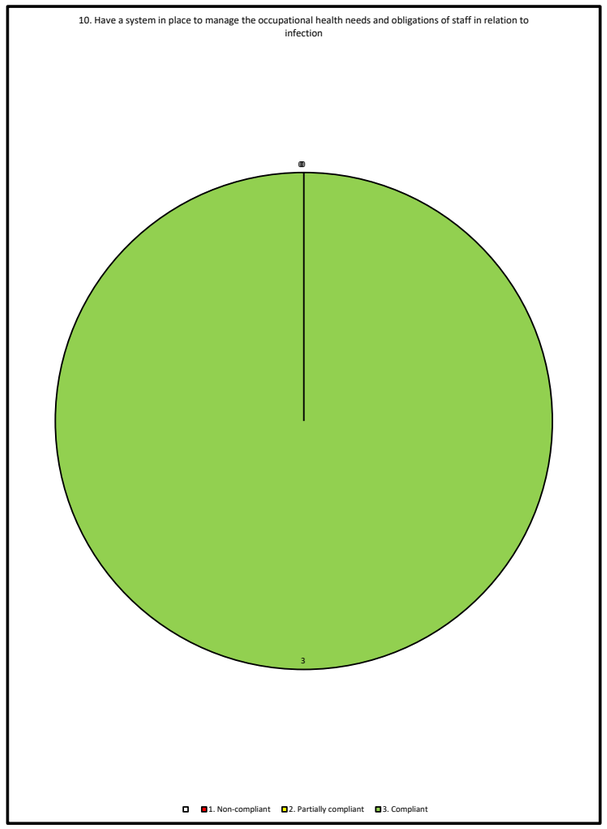


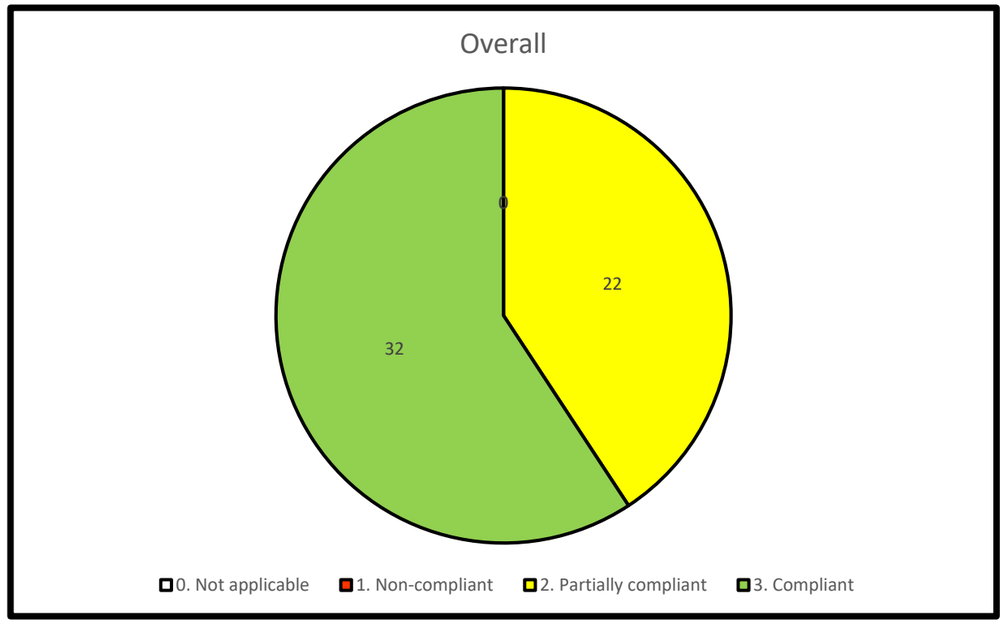
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	1) UKAS accreditation, ISO accreditation, training accreditation for Institute of Biomedical Science. National School of Healthcare Science approval: 2) https://www.ekhuft.nhs.uk/patients-and-visitors/services/pathology/microbiology/ 3) evidence available on UKAS website, IBMS website and in certificates held locally				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	1.Microbiology SOPs 2.Microbiological audit schedule to ensure ongoing suitability of tests and reporting procedure 3) EKHUFT IPC Policy on transmission based precautions (TBPs) is the NIPCM 4). Quarterly audit results for MRSA 5) Monthly reporting C -dif and other alert organisms				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	1.Microbiology SOPs 2.IRM data for Clinical Support Services Care Group as it pertains to microbiology/virology etc. 3.UKAS accreditation etc. as above 8(1).				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	1.EKHUFT IPC Policy on transmission based precautions (TBPs) is the NIPCM 2.IPCT records of individual patient advice 3.Organism specific guidance on 'Microguide' and 'Staffzone' 4.Microbiology SOPs 5.UKAS accreditation etc. as above 8(1).				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	1.EKHUFT IPC Policy on transmission based precautions (TBPs) is the NIPCM 2.IPCT records of individual patient advice 3.Organism specific guidance on 'Microguide' and 'Staffzone' 4.Microbiology SOPs 5.UKAS accreditation etc. as above 8(1).				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	1.EKHUFT outbreak policy 2.Organism specific guidance on 'Microguide' and 'Staffzone' 3.Microbiology SOPs				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	1.Pathology SOP 'DIR LP 112a' (on file) 2. UKAS accreditation etc. as above 8(1). 3. SLA between laboratory/EKHUFT transport and non-EKHUFT service users				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	1) NIPCM implemented July 2022, and A-Z of pathogens 2)All policies, guidelines and SOP's in date and updated when national requirements change (including outbreak management) 3) Annual IPC audit of Clinical practice and Environment 4) IPC outbreak meeting notes				3. Compliant





10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	1) Processes are in place to support staff who may be at high risk from infection.2) All staff have access to the relevant policies, i.e. Risk Assessment Policy, Health & Safety and Parents Policy, these have risk assessment templates for use, which include infection (biological agents) and potential exposures. All staff have a duty under the under the Health & Safety at Work etc. Act 1974 (HASAWA74) and the associated Regulations and Approved Codes of Practice to report concerns and risk, complete risk assessment and that control measures are in place, maintained, monitored and reviewed. 3) All staff have access to Occupational Health	No centralised system to ensure that the individual risk assessment/s have been completed.	Management are responsible to undertake, complete and review any risk assessment and keep securely at a local level.	Individual risk assessment/s must be kept locally and securely when personal health data is involved. Information within a risk assessment could be shared with the individual's consent.	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	1.EKHUFT Management of Occupational Exposure to Blood Borne Viruses (Including Post-Exposure Prophylaxis) policy. 2.Induction and mandatory training materials and records 3. Outbreak management policy			Long standing Managing of Blood Borne Virus policy being reviewed. Annual Audit of all needlestick injuries and blood or body fluid splashes undertaken by the Occupational Health Consultant and submitted to the health and safety Committee, this includes RCA and triangulation with Datix reporting. The OH department also undertake an internal audit to ensure reporting and assessing compliance.	3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	1) Policies and procedures in place for all staff to submit a work health questionnaire on offer of employment to the Occupational Health department. 2) Health checks, immunisations and clearance for work are undertaken by Registered Occupational Health Clinicians at pre-employment. Some vaccinations will be provided on commencement. 3) Immunity blood screening for those undertaking exposure prone procedures are completed at pre-employment before clearance for work.			All OH clinicians who undertake vaccinations follow the national immunisations standards for training and competency.	3. Compliant




Overall
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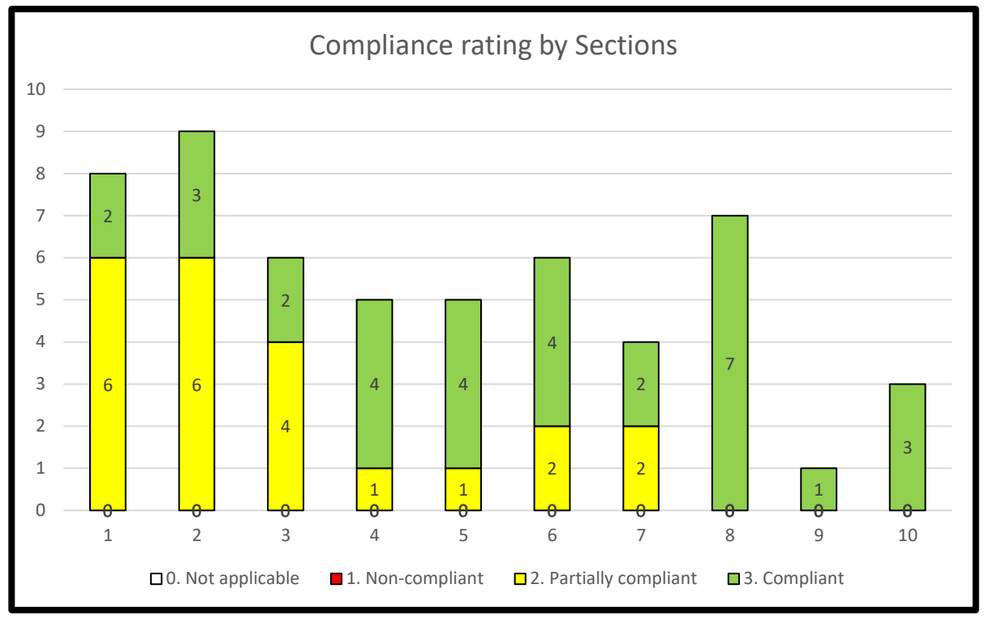
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
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0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: EKHUFT Winter Plan 2023/24

Meeting date: 2 November 2023

Board sponsor: Interim Chief Operating Officer (COO) for Unplanned Care

Paper Author: Programme Manager to the COO/Deputy COO for Unplanned Care

Appendices:

Appendix 1: EKHUFT Winter Plan 2023/24

Executive summary:

Action required:	Discussion
Purpose of the Report:	The purpose of this report is to inform Board of the current work being undertaken in preparation for the anticipated uplift in demand for care and interventions, and most notably beds, throughout Winter 2023/24. The detail of the plans for Winter can be found in Appendix 1. The Winter plan provides an overview of the work both internally and externally with Health and Care Partnership (HCP) and system partners as we prepare for the increase in demand coming through this winter to ensure the Trust is able to meet the needs of our patients and reduce harm. The Winter Plan is a work-in-progress document and will remain a live document that will be updated as plans are further developed and consolidated and confirmation of the status of the proposed schemes and funding are received. This document will be reviewed monthly at Clinical Executive Management Group (CEMG) throughout the winter period. Monthly updates will be provided to Trust Board following this first review at the November 2023 Board.
Summary of key issues:	Work to date: The plan presented contains an overview of the demand and capacity modelling for winter 2023/24 provided by Lightfoot, South East region partners for demand modelling. Analysis to date suggests that an additional 243 beds will be required across the Trust to cope with winter pressures. This uplift is against the base level bed position reported in August 2023 of 1040 core open beds, with a projected uplift to 1283.

	The Winter Plan contains a summary of schemes proposed by the East Kent (EK) HCP to mitigate the bed gap. The schemes proposed have been reviewed by EKHUFT with key operational protocols considered to ensure the Trust is able to access the proposed capacity in a timely manner and monitor the success and impact of the schemes on an on-going basis. The proposed schemes do contain risk to delivery. Following an assessment of the risks associated with the proposed schemes, along with an assessment of the Trust's current bed position, the revised estimate is in the region of 85 beds. Conversations continue with our system partners, via the weekly EK HCP Urgent Care Improvement Delivery Group, to review the risk associated with this bed gap. Winter plans for system partners are included for reference for Kent Community Health NHS Foundation Trust (KCHFT), Kent and Medway NHS and Social Care Partnership Trust (KMPT)/Integrated Care Board (ICB) Adult Mental Health, South East Coast Ambulance Service (SECAmb) Urgent and Emergency Care (UEC), Primary Care, and Adult Social Care. There is the potential for further additional funding and initiatives likely to be accessible throughout the Winter of 2023/24. Updates for the position of this funding will be included in future iterations of this winter plan. Preliminary information provided by the ICB outlines the following: • £2.89m Better Care Fund (BCF) for Kent and Medway (K&M) with a strong steer to utilise this in areas of greater need within East Kent; • Funding for additional Primary care capacity (Circa £1.3m), likely to be best delivered through four – six hubs; • Funding for additional work with care homes. Analysis across K&M of care homes that most frequently use ambulances indicated that more than half of these are in East Kent; • Roll out of pilot in West Kent (Single point of Access) – urgent two-hour community response to avert admission or enable direct access. The COO is engaged in ongoing discussions with ICB and HCP colleagues to ensure the Trust can maximise access to any additional funding. The winter planning for 2023/24 is further underpinned by the established workstreams in place across EKHUFTs Emergency Care Delivery Group (ECDG) and then East Kent UEC Improvement Programme. A summary of each of the action plans is included in this document. On-going work and next steps: Escalation planning and triggers tools are in development being led but the Care Group Medical Directors (MDs). An initial options appraisal has been completed for each site outlining potential areas for escalation and the associated impact of escalating into those areas. It is recognised that, whilst

	all efforts will be made to ensure external capacity is maximised, further internal resource will be required to meet demand to ensure patient safety and to ringfence the Trust's elective capacity. These plans will be presented in the next iteration of the plan at CEMG/Board in November/December. Escalation protocols, Operational Pressures Escalation Levels (OPEL), full capacity protocols are being reviewed. Further engagement with clinical teams is required to ensure we are effectively prioritising workforce, patient placement and treatment. Further scenario modelling at ward level is underway to identify further opportunities to reduce Length of Stay (LOS) and release additional capacity. Performance monitoring metrics have been stated within the winter plan, this will be expanded to ensure patient quality and safety metrics are being robustly monitored. Workforce plans will be requested and submitted throughout November. Significant focus on internal processes and a recognised need for those to improve supported by the implementation of SAFER and the PRISM Inpatient flow improvement programmes, early discharge planning, creative discharge planning, possibly discharging at risk. All aimed at ensuring the Trust is prepared to enable our acute beds to admit the number of patients required over this winter period. Provide communications to all staff for access to welfare and wellbeing services available to staff throughout the winter ensuring the Trust support and look after colleagues during periods of high pressure. Close monitoring of the impact of the PRISM theatre improvement programmes will continues as the Trust seeks to maximise the use of available theatres capacity over the winter period. The recommendations from Getting it Right First Time's (GIRFT's) UEC visit in September 2023, reference in Appendix 1, have been socialised with system partners with key workstreams set up and led by either system partners or EKHUFT and will be monitored through the East Kent UEC Board.
Key recommendations:	The Board of Directors is asked to **REVIEW** the winter plan presented, **DISCUSS** and propose any further actions that could be considered to assist in the Trust addressing the anticipated demand this winter. The Board of Directors is asked to acknowledge the presented risks to the proposed schemes and the impact if the schemes do not deliver. Through regular updates to the winter plan, the status and position of the schemes proposed by the HCP will be communicated through the Trust's internal committees and the Board.

East Kent Hospitals University NHS Foundation Trust

	The Board of Directors is asked to acknowledge the work in progress nature of the report.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 34:** Failure to deliver the operational constitutional standards.
Link to the Corporate Risk Register (CRR):	**CRR 78:** Risk of overcrowding in Emergency Department (ED) compromising patient safety and patient experience. **CRR 68:** Risk to the delivery of the operational constitutional standards and undertakings for planned care. **CRR 84**: Deteriorating Patient.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: CEMG 18 October 2023

East Kent Hospitals University NHS Foundation Trust

Winter Plan 2023/24

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Executive Summary

East Kent Hospitals University NHS Foundation Trust

- The purpose of the Winter Plan is to bring together all relevant activities across the Trust and across the East Kent system partners which relate to planning for winter 2023/24, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned. This plan forms part of the HCP and Integrated Care Board (ICB) overall winter plan.
- The key principles of the plan and the schemes developed look to:
  - Maximise capacity across acute and community settings, enabling the maximum number of people to access the care they required, to be discharged safely and quickly and providing supporting people in their own homes
  - Support patient safety in urgent care pathways across all services
  - To ensure that all health care providers in the region and working in partnership to provide the optimal patient care
  - To continue to provide planned procedures during a time of increased pressure on the Trust's services by ringfencing elective bed capacity and making staff available to continue with planned elective procedures
  - Support staff and maximise their availability
  - Ensure surge plans and processes are ready to be implemented if needed
- The system demand modelling provided by 'Lightfoot' has outlined an expected uplift in demand of 243 beds over the winter period, from a start baseline projection of demand at 1040 to a predicted demand of **1283**. Initial modelling of proposed schemes and the additional capacity identified mitigate up to 200 beds with a remaining unmitigated gap of approximately **20** beds.
- The document contains a summary of schemes proposed by the EK HCP to mitigate the bed gap. The schemes proposed have been reviewed by EKHUFT with key operational protocols considered to ensure the Trust is able to access the proposed capacity in a timely manner and monitor the success and impact of the schemes on an on-going basis.
- The proposed schemes do contain risk to delivery. Following an assessment of the risks associated with the proposed schemes, along with an assessment of the Trust's current bed position, the revised unmitigated bed gap is approximately **85** beds.
- Conversations continue with HCP partners to validate the potential impact of schemes. An update of the outcome of these further conversation will be brought to December Board.

Executive Summary

- Winter plans for system partners are included for reference for Kent Community Health NHS Foundation Trust (KCHFT), Kent and Medway NHS and Social Care Partnership Trust (KMPT)/ICB Adult Mental Health, South East Coast Ambulance Service (SECAmb) UEC, Primary Care, Adult Social Care
- The winter planning for 2023/24 is further underpinned by the established workstreams in place across EKHUFTs Emergency Care Delivery Group (ECDG) and then East Kent UEC Improvement Programme. A summary of each of the action plans is included in this document.

EKHUFT Emergency Care Delivery Group

- Emergency Department (ED) builds
- UEC future planning
- Same Day Emergency Care (SDEC) and direct access pathways
- ED front door pathways
- Simple discharges
- Patient flow (PRISM/SAFER)

East Kent UEC Improvement Programme

- Increasing UEC Capacity
- Improving discharge
- Making it Easier to Access the Right Care
- Expanding care outside of the hospital

- Subsequent to the Trust's visit from GIRFT colleagues in September 2023 a system response is in development, supported by both the EMDG and the EK UEC improvement plan to deliver against the GIRFT recommended key areas of focus:
  - Ambulance Conveyances
  - Frailty Pathway Support
  - Speciality Inter-Professional Standards
  - Data Quality Review
  - ED Related Harm Shared Learning
- There is the potential for further additional funding and initiatives likely to be accessible throughout the Winter of 2023/24. Updates for the position of this funding will be included in future iterations of this winter plan. Preliminary information provided by the ICB outlines the following:
  - £2.89m Better Care Fund (BCF) for Kent and Medway (K&M) with a strong steer to utilise this in areas of greater need within East Kent
  - Funding for additional Primary care capacity (Circa £1.3m), likely to be best delivered through four – six hubs
  - Funding for additional work with care homes. Analysis across K&M of care homes that most frequently use ambulances indicated that more than half of these are in East Kent
  - Roll out of pilot in West Kent – urgent two-hour community response to avert admission or enable direct access

Executive Summary (continued)

East Kent Hospitals University NHS Foundation Trust

The winter plan document will remain a live document that will updated as plans are further consolidated.

This document will be reviewed monthly at Clinical Executive Management Group (CEMG).

Updates will be provided to Trust Board with the first review proposed for the November 2023 Board.

Formal sign off of the Winter Plan will include a Quality Impact Assessment (QIA), signed off by the Chief Nursing & Midwifery Officer (CNMO) and Chief Medical Officer (CMO).

The development of the winter plan has been a cross-Trust effort with input for key contributors across the Trust leadership team.

For information:

- The Trust's Winter Plan is over seen by the Chief Operating Officers (COOs).
- The Trust Winter Plan is developed with K&M ICB and East Kent community colleagues and will be developed in conjunction with the regional framework.
- The Trust recognises that the winter period will be challenging with anticipated high demand and impacts from respiratory admissions, the impacts of severe weather and a cost of living crisis affecting vulnerable members of the East Kent community.
- The Trust is committed to working with our system partners to manage these challenges, learning from our experience of previous winters and the Covid-19 pandemic.
- A winter elective activity escalation plan is in development to maximise and protect elective activity. A monthly progress report to the Trust's Elective Care Delivery Group.
- The trigger tool for escalation which was developed in 2023/24 to manage elective activity, is being refreshed to support and inform decisions to managing the predicted increases in emergency bed demand and manage and maintain elective activity where at all possible.

East Kent Hospitals University NHS Foundation Trust

Demand and Capacity Modelling 2023/24

Undertaken by Lightfoot

Bed Demand Forecast and Gap EKHUFT

East Kent Hospitals University NHS Foundation Trust

	Last winter max beds Jan-23	Current beds Aug-23	Forecast Bed Demand Jan-24
core beds	1,090	1,040	
escalation beds	74	41	
Total beds	1,164	**1,081**	**1,283**
		Gap from current core beds	**243**

Forecast for next winter is based on predicted growth plus estimated bed demand to avoid corridor care. Estimation of corridor care was based on 12+ hr Accident & Emergency (A&E) activity that did not convert to admission.

In **EKHUFT**, last winter's corridor care estimates showed an additional **80** beds were required.
Based on growth forecasts, an additional **39** beds are required (excluding corridor care requirements).

The sum of the max bed position last winter, the 80 beds required for corridor care, and the growth forecast estimating a further 39 beds create the Forecast Bed Demand of 1,283.

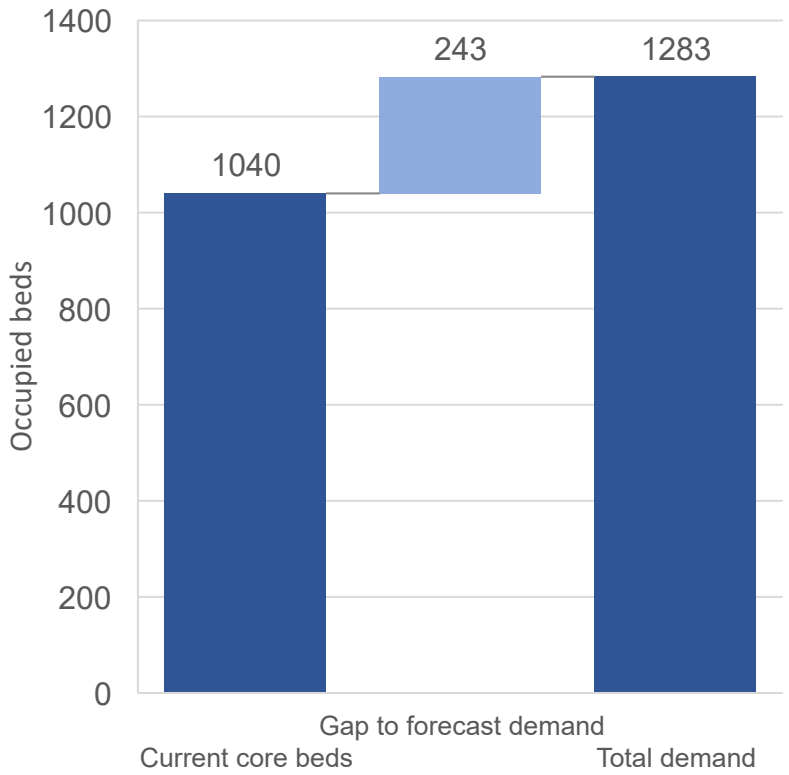
Winter 2022/23 max position vs current status

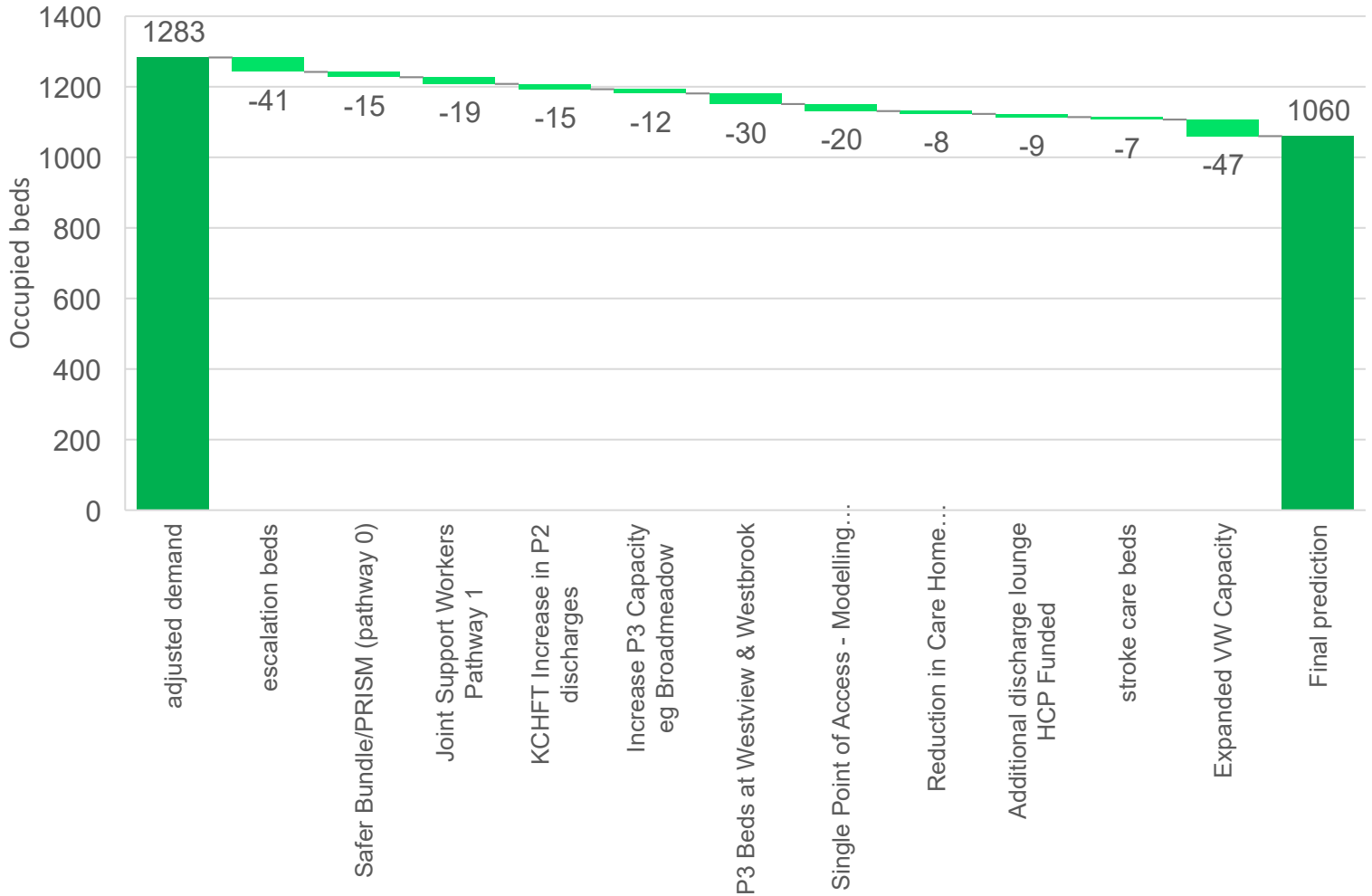
East Kent Hospitals University NHS Foundation Trust

Ward	Max (1/1/23)	Current (11/10/23)	Difference	
26 wards at same bed position				
KBRA - K&C BRABOURNE WARD	7	8	-1	
KINV - K&C INVICTA WARD	23	24	-1	
KKEN - K&C KENT WARD	31	30	1	
KMARL - K&C MARLOWE WARD	24	27	-3	
KMM - K&C MOUNT MCMASTER WARD	26	18	8	Mount McMaster – funded for 18 but can go up to 26. No supports PIU (taken out 4 beds for 5 trollies and have a bay for endoscopy inpatients that is used 3 times per week. If pressures on site develop within medical specialties we would have to either cancel the endoscopy (elective inpatients) and/or close the PIU (patients for LPs, infections, infusions).
KSLA - K&C ST LAWRENCE WARD	23	24	-1	
QAMUA - QEQM ACUTE MEDICAL UNIT A	30	13 **(30)**	17 **(0)**	30 spaces now converted to 13 AMU and 17 MAU. MAU is an assessment unit for assessing short term patients and preventing admission.
QBIR - QEQM BIRCHINGTON WARD	21	20	1	
QBIS - QEQM BISHOPSTONE WARD	21	24	-3.0	
QCSF - QEQM CHEERFUL SPARROWS WARD FEMALE	34	35	-1.0	
QDEA - QEQM DEAL WARD	30	32	-2.0	
QFAUW - QEQM FRAILTY ASSESSMENT UNIT	8	9	-1.0	
QFOR - QEQM FORDWICH WARD	25	19	6.0	Funded for 19. Flexed up with two patients per side room. Side rooms now closed due to staffing
QQX - QEQM QUEX WARD	29	28	1.0	
QRAI - QEQM RAINBOW WARD	26	27	-1.0	
QSAN - QEQM SANDWICH WARD	22	23	-1.0	
QSB - QEQM SEA BATHING WARD	30	33	-3.0	
QSTM - QEQM ST. MARGARETS WARD	26	29	-3.0	
QSWQ - QEQM SPENCER WING	21	18	3.0	
WAMUA - WHH ACUTE MEDICAL UNIT A	23	24	-1.0	
WBAR - WHH BARTHOLOMEW WARD	21	22	-1.0	
WCCU - WHH CARDIAC CARE UNIT	10	12	-2.0	
WCDSU - WHH CHANNEL DAY SURGERY	15	9	6.0	Impact on elective activity. Current use at 9 reflects elective activity so consider.
WKB - WHH KINGS B WARD	24	25	-1.0	
WKEN - WHH KENNINGTON WARD	16	14	2.0	
WMEAU - WHH MEDICAL EMERGENCY ADMISSION UNIT	14	0 **(14)**	14.0 (0)	WHH MEAU is now Majors Assessment (Chairs and assessment area only) – being considered for CDU. MAU supported by the SAL area (14-16 chairs and trollies).
WPAD - WHH PADUA WARD	35	36	-1.0	
WRSU - WHH RICHARD STEVENS WARD	34	30	4.0	
WSEAU - WHH SEAU	5	1	4.0	Impact on elective activity
TOTAL	**1151**	**1111 (1142)**	**40 (9)**	*nb 1164 stated as max position on previous slide – variance of 13 likely driven by time of day variance in the extraction of data*

Bed Modelling Waterfall – Calculating Likely Demand (Adjusted DOWN)

East Kent Hospitals University NHS Foundation Trust





Remaining Unmitigated Gap – 20 beds

Last year – 200 beds

Waterfall Analysis

Better Lives Together
East Kent
Health and Care Partnership

Intervention	Basis	Discharged Per Day	LoS	Beds Saved	Status and Risk considerations
Escalation Beds	Existing approved escalation beds	-	-	**41**	The reporting of escalation beds has changed. The reported core base of 1040 includes unfunded areas. The further escalation of 41 beds requires further clarification dependent on the East Kent Hospital site-specific escalation plans for Winter 23/24.
Safer Bundle & PRISM Support (Pathway 0)	Assumed additional discharges due to SAFER bundle work, PRISM support and national discharge programmes	10	1.5	**15**	Close monitoring of the SAFER work underway at the WHH East Kent need to determine the recognised impact and suggested modelling numbers Prism work due to commence at QEQM in early October, East Kent need to determine the recognised impact and suggested modelling numbers
Joint Support Worker Recruitment Pathway 1	Assumed recruitment of 25 staff	4	9.6	**38 @ 50% = 19**	P1 dom care capacity has been assumed at 50% of the plan i.e. 12 support workers. **Risks:** Currently 8/25 staff recruited with lead in times for start dates for the new recruits **Suggested protocols**: • Recruitment trajectory estimate up to April 24. • Phased planning required for the available capacity coming online with the onboarding of new recruits • Ongoing weekly update on anticipated capacity for the week ahead, over view of supported capacity in the week prior. • Clarity on how RTS access and monitor the additional capacity.
Additional discharge lounge - HCP Funded	Additional beds commissioned through HCP funding and in use since April 2023	-	-	**9**	**Risks:** Bed base is already being utilised at the QEQM as the new Frailty (FAU) area. The QE team exploring options to provide a Discharge Lounge facilities in other areas of the QEQM estate.
Stroke care beds	Additional beds commissioned through HCP funding	-	-	**7**	The position of the current available stroke care capacity and the additional stroke capacity needs further clarity. KCHFT will liaise with KCH site, RTS and site MD to ensure awareness of available capacity. **Suggested protocols**: • Ensure East Kent are able to patient plan into a capacity. Proactive daily updates required from facilities to provide East Kent with anticipated discharges from the facilities to allow discharge planning • Clear visibility with RTS on flow into and out of the additional bed base. Available reporting to site MDs on the utilisation of the capacity. • Provision of clear start dates, phased opening plans.

Waterfall Analysis

Better Lives Together
East Kent
Health and Care Partnership

Intervention	Basis	Discharged Per Day	LoS	Beds Saved	Status and Risk considerations
Increase P3 Capacity eg Broadmeadow Beds	Based on recent proposal from KCC to open these p3 beds	-	-	**12**	• 12 beds at Broadmeadow. KCC staff in place and GP funding now secured so confident this will be mobilised by end of October. • 30 beds for Westview and Westbrook. Funding approval meeting this Friday. Expecting approval and will plan to mobilise utilising a partly "managed service" offering. Confidence is high in terms of mobilisation as they were open last year. **Risks**: Staffing concerns as in winter 22/23 beds were not fully opened due to staff shortages and some beds were blocked. Critical element here is assurance around the deliverability of these beds and management of regular flow. **Suggested protocols**: • Ensure East Kent are able to patient plan into a capacity. Proactive daily updates are required from P3 facilities to provide East Kent with anticipated discharges from the facilities to allow discharge planning • Clear visibility with RTS on flow into and out of the additional bed base. Available reporting to site MDs on the utilisation of the capacity. • Provision of clear start dates, phased opening plans and confirmation of bed numbers and pathway type across each facility (Broadmeadow P3, Westview/Westbrook P2)
Expanded VW Capacity	Based on predicted trajectories as per VW programme. Large risk adjustment due to level of improvement required.	13	3.5	**47**	• 47 beds for Virtual Ward is on the basis of growth above last winter of 13 admission avoidance/additional discharges per day at 3.5 days LoS. This is reliant on the joint delivery plan from VW team. The number of 47 is 50% of the budgeted target so is half what is actually expected with the money we have allocated. July data: 445 admissions vs 971 plan. The gap of the actual vs plan has been used to calculate the additional beds saved. • This one is potentially high risk depending on your confidence in the delivery plan on VW. **Risks**: Low confidence in the delivery of VW to the volumes included in the waterfall and outlined potential for double counting across SPOA schemes. **Suggested protocols**: • Week-by-week phased planning that achieves the 'beds saved' target number
KCHFT Increase in P2 Discharges	Agreed as part of P2 Transformation work for KCHFT	1	14.6	**15**	**Suggested protocols**: • To determine the anticipated LoS and flow through the available additional capacity and the proposed start date.
Reduction in Care Home Conveyancing	Based on three identified care homes. 650 conveyances per year and assumed 50% admitted.	0.9	9.6	**8**	• 8 care home conveyance reductions are recruitment-related and led by Primary Care (supported by ICB). GP Confederation reported low confidence in the scheme.

Additional schemes (not featured in Waterfall)

Better Lives Together
East Kent
Health and Care Partnership

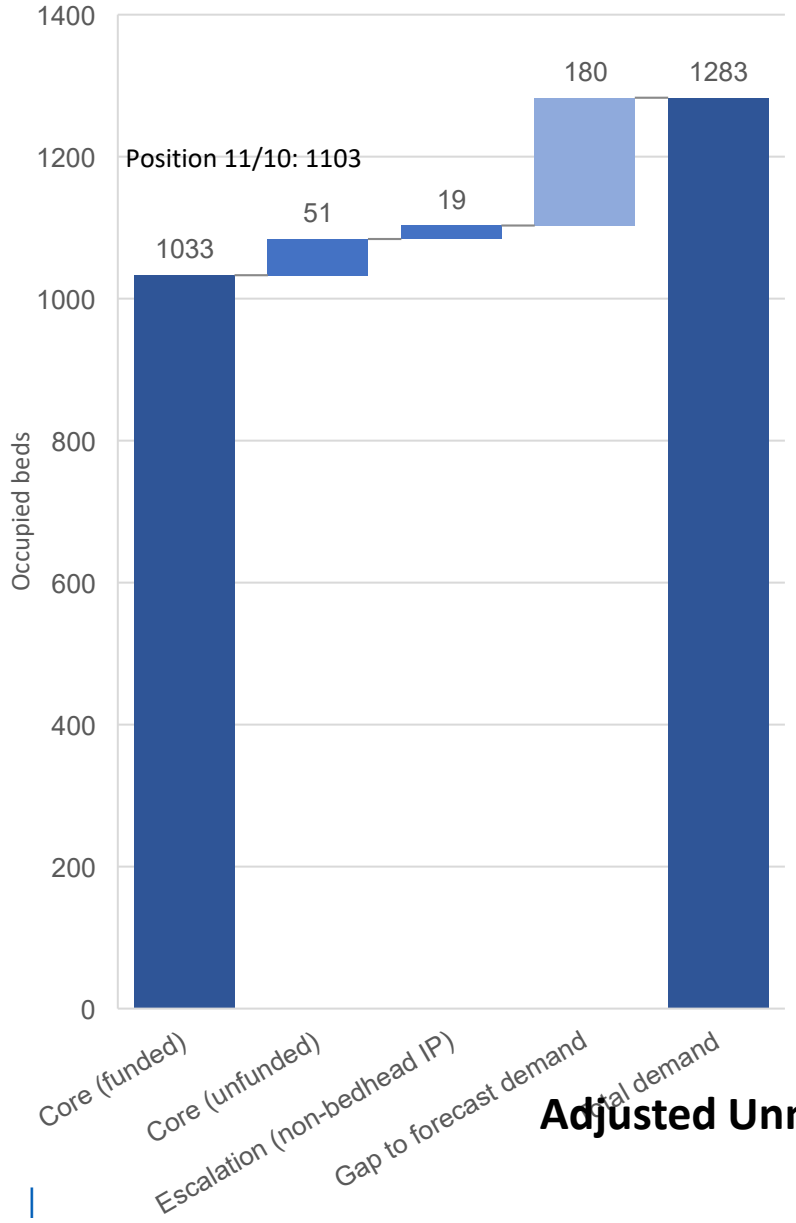
Intervention	Basis	Discharged Per Day	LoS	Beds Saved	Status and Risk considerations
Single point of access	Utilisation of West Kent Pilot into East Kent. Pilot delivered reduction in conveyances from 117 to 110 with further 5 direct to SDEC or UTC bypassing ED and 20 bed days saved. Principle of SPA agreed across system; LRU expanded to 24 hours to support virtual ward hub; two points of access in east Kent for urgent referrals, work is ongoing to address this; engaging with GIFRT a-TED (alternative to emergency department) programme.			**20**	• 20 beds for the SPOA comes direct from the West Kent pilot. **Risks** • Note a large proportion of the beds saved were from frailty conveyances moved directly to VW. View to consider reducing the VW number as could potentially be duplicated • EKHUFT are in the process of implementing Alt-Ed; a similar model to Single Point of Access. EKHUFT liaising with West Kent pilot lead to determine what overlaps exist between the two programmes of work. Modelling of Beds Saved will need to be revised based on the outcome of this exercise

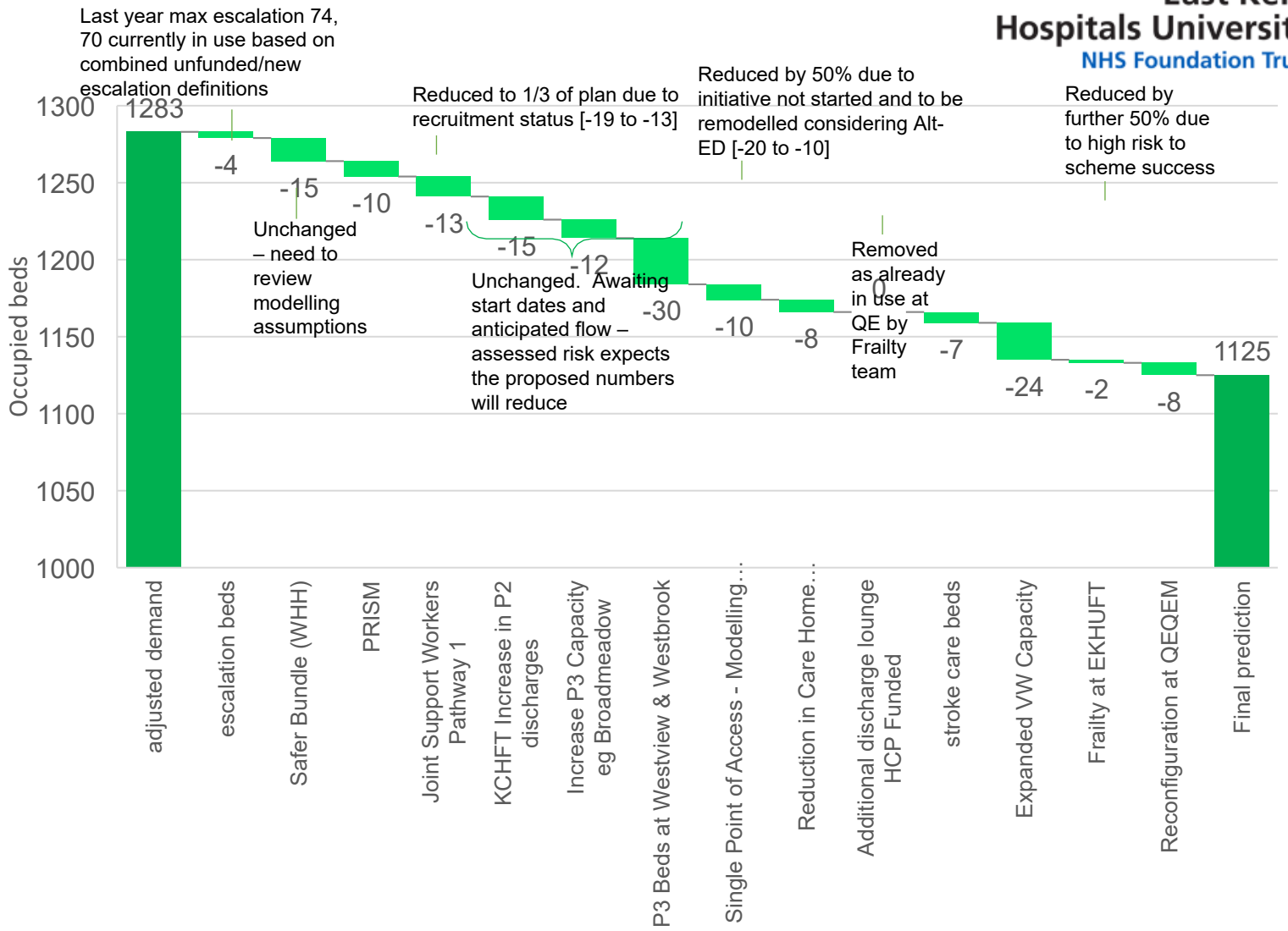
HCP Winter Risk Register & Associated Mitigations

Better Lives Together
East Kent
Health and Care Partnership

Priority Area	Key Risk	Mitigations	Risk Owner
Overall Winter Performance	Unexpected events impacting bed demand outside of plan and associated contingencies e.g. Strep A, IT Outage, exceptional workforce absence, super surge in demand within speciality.	1. OPEL Escalation Framework and associated action plans. 2. Clear system escalation triggers and actions. 3. EKHUFT Winter Governance Oversight meetings. 4. OCC Support across region and national. 5. Weekly review of performance and senior agreement to mitigations. 6. Provider Business Continuity Plans.	Provider Executive Teams & ICB Oversight
Overall Winter Performance	Non or delayed delivery of HCP Funded Schemes e.g. VCSE discharge schemes, Health & Social care support worker recruitment, etc…	1. Monthly review of spend and performance through delivery group. 2. Swift re-direction of funds to alternative schemes through delivery group chair. 3. List of alternative schemes held with HCP for early mobilisation.	HCP Delivery Group Chair – Karen Sharp
Expanding Care Outside of Hospital	Virtual Ward trajectories not meeting expectations	1. 50% of current expectations built into existing waterfall. 2. Regular review of activity through delivery group.	HCP VW Chair - Cathy Bellman
Making it Easier to Access the Right Care	Delayed implementation of revised Single Point of Access provision for East Kent.	1. iUEC recovery champions appointed to support this programme. 2. West Kent pilot in place. 3. ICB led model to be implemented in partnership with East Kent as business priority for ICB.	ICB UEC Improvement Director – Jacqui Sarakbi
Making it Easier to Access the Right Care	Risk that there will be continued high levels of mental health presentations in ED which will negatively impact patient and staff experience.	1. Full Mental Health Support Plan in place to include safe havens, ICB escalation processes & crisis houses. 2. Weekly EK Mental Health Governance focussed on support for EK.	EKHUFT Executive & HCP Director
Increasing Capacity within Urgent Care	Continued impact of junior/consultant doctor strikes & combined primary care strikes through winter may impact winter performance.	1. Ongoing support from OCC for management of strike plans. 2. Implementation of industrial action plans and monitored through EKHUFT governance. 3. Implementation of industrial action plans and monitored through Primary Care governance. 4. Local Health Economy (LHE) East Kent system calls to support.	Provider Executive Teams & ICB Oversight

Bed Modelling Waterfall – Caveated with risk





Adjusted Unmitigated position – 1125 vs previous estimate at 1060

Adjusted unmitigated position: 85

East Kent Hospitals University NHS Foundation Trust

EKHUFT Winter Planning

Winter Planning
EKHUFT and HCP Collaboration

East Kent Hospitals University NHS Foundation Trust

- The winter planning for 2023/24 is underpinned by the established workstreams in place across EKHUFTs Emergency Care Delivery Group and the East Kent UEC Improvement Programme

EKHUFT Emergency Care Delivery Group

- ED builds
- UEC future planning
- SDEC and direct access pathways
- ED front door pathways
- Simple discharges
- Patient flow (PRISM/SAFER)

GIRFT Recommended area of focus

- Ambulance Conveyances
- Frailty Pathway Support
- Speciality Inter-Professional Standards
- Data Quality Review
- ED Related Harm Shared Learning

The progress of these workstreams are monitored through the monthly EKHUFT Emergency Care Delivery Group

East Kent UEC Improvement Programme

- Increasing UEC Capacity
- Improving discharge
- Making it Easier to Access the Right Care
- Expanding care outside of the hospital

The progress of this improvement programme is monitored through the monthly EK Urgent Care Delivery Group

Winter planning

Winter plans and submission from system partners:
KCHFT
KMPT/ICB
SECAmb UEC
Primary Care
Adult Social Care

Winter Planning
Performance monitoring and review

East Kent Hospitals University NHS Foundation Trust

- Recovery and support programmes of work will be closely monitored throughout the winter period against the following key metrics

Recovery Support Programme (RSP) supporting by the Internal Integrated Programme (IIP)

- Exit from Recovery Support Programme driven by performance against key metrics:
- 4 hour performance (Type 1, All types)
- Over 12 hours in department
- Diagnostic 6 week performance
- Cancer backlog
- 78 week wait position

EKHUFT Tier 1 Metrics

- Type 1 performance
- Bed Occupancy
- Over 12 Hours in Dept (incl. UTC)
- 14 day Average Length of Stay
- Category 2 performance

SAFER/Prism Inpatient Flow programmes:

- Average length of stay
- No. Patients > 7 Days LOS (averaged by the end of the week)
- No. Patients >14 Days LOS (averaged by the end of the week)
- No. Patients >21 Days LOS (averaged by the end of the week)
- No. Discharges pre-12:00 per day
- No. Discharges per day (All)
- Weekend Discharges = No. Discharges Friday-Sunday
- PTL – Board-round entry compliance (per day)
- Reduce the time between when a patient is classed as NCTR and discharge
- Increase in conversions of likely discharges into reality

Winter schemes/Emergency Care Delivery Group

- P1-3 discharges
- Conveyance
- Arrivals
- Escalation bed usage
- Elective performance vs plan
- Direct access performance
- SDECs

EKHUFT Winter Planning
Trust-wide Winter Schemes

East Kent Hospitals University NHS Foundation Trust

- The schemes outlined below feature and are monitored through the **EKHUFT Emergency Care Delivery Group** but have been highlighted here as the key focus areas for planning this Winter

Scheme	Owner / Where being monitored	Impact	Estimated delivery	Risks	RAG
Same Day Emergency Care (SDEC) and Direct Access Pathways (DAP) developed to stream appropriate patients to alternative care settings Assurance that pathways and SDEC opportunity align using EKHUFT data and the NHS AEC Directory Medical SDEC Children's SDEC Surgical SDEC UTCs – working with partners to increase criteria and UTC capacity SDEC opening hours extended on both sites to reflect demand profile SDEC services open 7 days a week Hot slots to SDEC to support safe discharge and return for OOH	Deputy COO – Unplanned Care	**Modelled Assumed Impact:** Increased SDEC hours to 8-8 and throughput will allow additional opportunities identified by National Ambulatory Dashboards to be realised. For patients attending within Hours this opportunity is ~13 beds overall, though potentially more if patient groups outside of the Emergency Ambulatory directory of services are identified	Delivered – required monitoring of throughput	Staffing. Escalation.	
Development of the Medical Day Unit at K&C. Utilisation of the MDU (Medical Day Unit at KCH) for nurse led intervention , thereby increasing capacity in SDEC.	Deputy COO – Unplanned Care /KCH MD	Diversion of ambulatory care to a cold site – staffing impact	Q3 2023	Staffing – recruitment yet to commence	
Implementation of the Doctor Initial Assessment Model at the front door – this ensures pts are seen and initial plans for treatment started within 60 mins of arrival . This also strengthens the use of alternative direct access pathways.	Deputy COO – Unplanned Care	In place across QEQM /WHH – impact on the delivery of time to be seen < 60 mins by a senior decision maker	In place Q2		
Improving discharge – Roll-out of SAFER Bundles and optimising PTL to support discharge planning Daily review of all pathway zero pts led by the clinical site leads External support for QEQM focus on improving patient flow	Deputy COO – Unplanned Care / Acute Site Leads	**Modelled Assumed Impact:** 10 discharges per day, LoS for Cohort 1.5, Total beds saved 15. Modelling to be reviewed subsequent to initial SAFER findings and PRISM 4 week exploratory exercise	October – required monitoring for impact – Metrics in development	Recognised impact this winter	

EKHUFT Winter Planning
Trust-wide Winter Schemes

East Kent Hospitals University NHS Foundation Trust

Scheme	Owner	Estimated delivery	Risks	RAG
Established Medical and Surgical Assessment units /Clinical Decision Units • WHH/QEQM have established Medical and Surgical Assessment Units 12-24/7 • Take 50-60% of medical take with further plans for the WHH to increase capacity and criteria • ED Builds QEQM /WHH . WHH build is on track to complete October 2023 with the QEQM build early 24 Increasing capacity – Throughout the build , plans have been made to mitigate the loss of capacity across the ED footprint, utilising space to ensure critical space is retained	Deputy COO – Unplanned Care	September 23	Established. Need to monitor through put and impact to ensure full established. ED spaces to be review to ensure patients being streamed can be accommodated within the hospital	
Dedicated ED CDUs to manage patients requiring > 4 hours and < 12 hours care under the care of the ED team	Deputy COO – Unplanned Care	December 23	Specialty referrals	
Bed reconfiguration - right sizing bed base . Clinical forums established and programmes of work in place WHH – near completion QEQM – Commencing October 2023	Site MDs	Q4 2023	Long term transformation schemes	
Site and operational daily planning and Internal Escalation Plans in place for EDs / Critical areas and whole hospital response	Site MDs	November 2023	Available capacity for escalation Impact on elective activity	
Winter Staff Plans – overseen by the 6 care groups , to work across services to maintain critical services	Care Group MDs	November 2023		
Annual leave in line with Policy applied	Care Group MDs	November 2023		
Virtual wards – partnership working and plans established to optimise service	VW Ops Lead	October 2023	Impact of virtual wards on in-hospital admissions	
GIRFT – recommendations July 23. System partnership working to focus on the key actions required . Oversight via the EK UEC/HCP UEC AND ECDG with quarterly reviews with the National Team	Deputy COO – Unplanned Care	November 2023	Whole system response required.	
Alt-ED - Work in progress to implement the system ahead of Winter Pilot of the West Kent SPOA pilot (November 1 month) – plans developed for both sites to reduce conveyances to ED	Deputy COO – Unplanned Care	October 2023 November 2023	Resource required and funding to support roll-out over winter	

EKHUFT Winter Planning
Inpatient Flow Initiative support by the Prism Improvement Programme (QEQM)

East Kent Hospitals University NHS Foundation Trust

Key Objective: To improve flow across the back end of the hospital that supports East Kent's UEC programme and its delivery of the 4hr emergency access standard. Programme of work due to start early October.
Status: Work commenced on 2nd October. PRISM team are near the end of the four week discovery phase. Implementation plan expected Friday 27 October.
Priority improvement areas:

Improve Site Team and Bed Management Function

Objectives
• Improve the daily site management function and accountability rhythm
• Create an integrated bed management system that coordinates delivery of hospital wide response to waiting times in ED – generation of bed capacity by specialty in agreed timeframes

KPIs
• A left shift of discharges each day with emphasis on more before midday
• Increase in conversions of likely discharges into reality

Implement Effective Board Rounds/ Improve use of SAFER/ Red2Green

Objectives
• Ensure clear and timely discharge planning

KPIs
• Clear profile of discharges by time of day and day of week
• Left-shift profile of discharges by time of day and increase level of weekend discharges to support agreed targets
• Increase the total number of discharges on the exemplar wards

Improve management of patients who no longer meet the criteria to reside at an Acute Hospital on pathways 0 and 1

Objectives
• Reduce the number of avoidable bed days lost to the Trust and the System – reduce harm to patients

KPIs
• Reduce the time between when a patient is classed as NCTR and discharge
• Left shift the profile of bed-days by 7 day bands of LOS on wards

EKHUFT Winter Planning
Inpatient Flow SAFER (WHH)

East Kent Hospitals University NHS Foundation Trust

S	SENIOR REVIEW All patients will have a daily consultant board round review before 12am • All patients will have a clear documented plan. • Sick patients and those identified for discharge should be prioritised on each round. • All patients will have a weekend plan in the notes
A	ASSESSMENT • All patients will have an EDD agreed and set on the PTL within 24 hours of admission • Patients will be reviewed daily as to whether they have a physiological condition or treatment that requires an inpatient hospital stay. • All patients will have fundamentals of care assessments completed; VTE, Falls, Pressure Ulcers and Nutrition.
F	FLOW • Reasons and actions for delayed patient flow should be highlighted at the board/rounds and escalated appropriately. • The PTL will be updated in a live manor. The clinical site managers will allocate ED/AMU patients to ward beds based on the ward PTL • Aiming for patients to be placed on their correct speciality wards
E	EARLY DISCHARGE • Wards teams should ensure that 33% of discharges take place before 12.00pm using the discharge lounge early where appropriate. • TTO's should be completed as soon as the patient is identified for discharged. • Plan discharges in advance to ensure patients leave by 12.00 including writing up TTO's and booking the necessary transport the previous day. • If TTO's need amending they are to be updated immediately during the board round.
R	REGULAR REVIEW • Patients with LOS of >14 days will be discussed at a weekly 'Super Stranded MDT' • EDD to be reviewed and updated daily.

Key Objective: To improve flow across the back end of the hospital that supports East Kent's UEC programme and its delivery of the 4hr emergency access standard. Programme of work commenced July 2023 with an initial end point of October 2023.

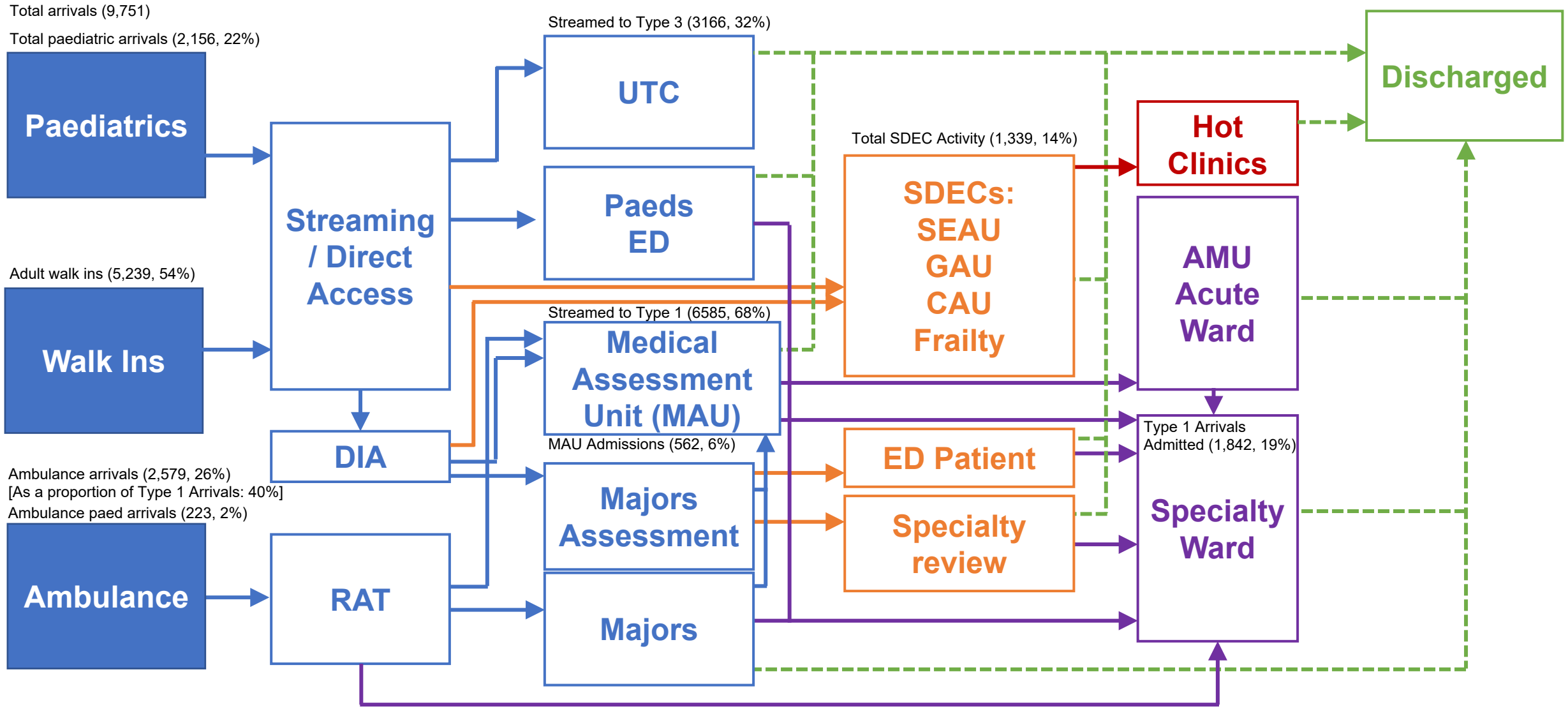
Status:

- Ward-by-ward timetable of roll out in place
- Meet and Greets with Ward teams and MDTs – Scheduled
- Internal Comms to clinical leads – inclusive of purpose, aims and objectives
- SAFER Champions – Identified for Wards, Care Group – including senior nursing, discharge team, therapy
- *Ward Observations – Environment, Materials, Rhythm*
- Standardised SAFER Board Round Check list, Next Day Patient (Golden) Ward Huddle Doc, Next Patient (TCI to ward) Ward Huddle Doc
- Friday Forums with Ward teams – local feedback and data feedback [scheduled] – this will include staff feedback shared on the staff portal following launches
- Ward-by-ward programme tracker established
- Initial results being monitored

Project being supported by KPMG from November onwards.

EKHUFT Winter Planning
Mapping through of Front Door pathways to support ED performance – WHH

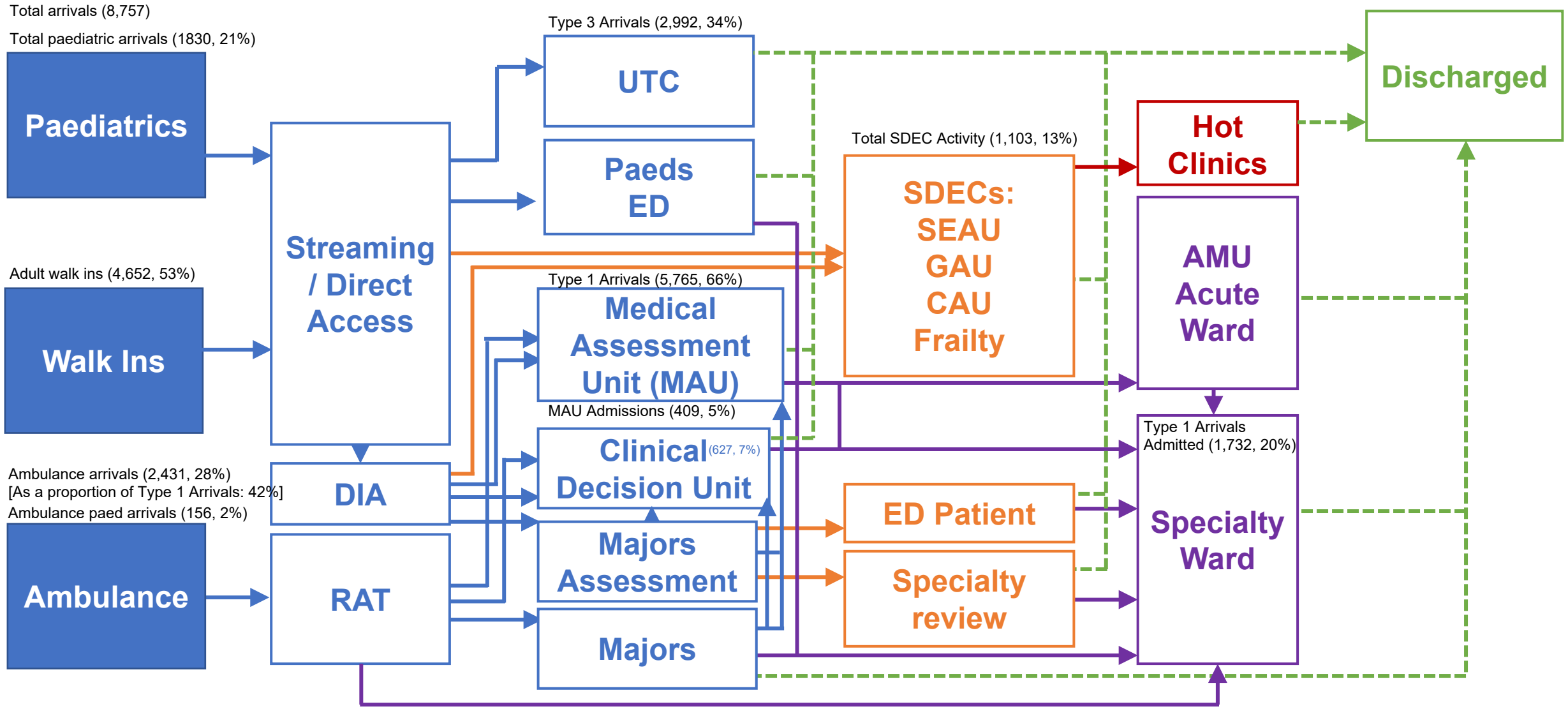
East Kent Hospitals University NHS Foundation Trust



September 2023 data (#) % of total arrivals unless stated otherwise
Paediatrics – Aged 0-16

EKHUFT Winter Planning
Mapping through of Front Door pathways to support ED performance – QEQM

East Kent Hospitals University NHS Foundation Trust



September 2023 data (#) % of total arrivals unless stated otherwise
Paediatrics – Aged 0-16

EKHUFT Winter Planning Funding

East Kent Hospitals University NHS Foundation Trust

- The Trust is currently receiving additional funding for 5 schemes that were proposed back in Q4 2022/23. The schemes were originally proposed for support during Winter 2022/23 however, the required supportive funding was not made available under the start of 2023/24. These schemes and schedule for funding are:

Trust/ Organisation	Scheme Name	Latest Update	Budget Report 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Actual spend to date (£'000)	Metric	Baseline activity/data
EKHUFT	**Discharge schemes:** SDEC capacity	Extention of hours - 5pm to 11pm at WHH 7 days a week. QEQM started 12th June - 5pm to 8pm 5 days a week.	**Budget 23/24**	£70	£70	£70	£70	£71	£94	£94	£94	£94	£94	£94	£94	**£1,010**	Number of patients seen in SDEC	Total patients seen in Q4 22/23= As average month
			Forecast spend	£60	£60	£70	£80	£81	£94	£94	£94	£94	£94	£94	£94	**£1,009**		
			Actual	£60	£60	£70	£80	£81								**£352**		
			Variance	£10	£10	£0	-£10	-£10	£94	£94	£94	£94	£94	£94	£94	**£658**		
EKHUFT	**Discharge schemes:** MDU capacity	Based at Kent & Canterbury. The pathways have been established. Work in progress to recruit as a next step. The pathways element of the action is complete but the service is yet to start.	**Budget 23/24**	£10	£10	£10	£10	£10	£20	£20	£20	£20	£20	£20	£20	**£192**	Nunber of patients seen in MDU	0 (not open yet)
			Forecast spend	£0	£0	£0	£0	£0	£0	£32	£32	£32	£32	£32	£32	**£192**		
			Actual	£0	£0	£0	£0	£0								**£0**		
			Variance	£10	£10	£10	£10	£10	£20	£20	£20	£20	£20	£20	£20	**£192**		
EKHUFT	**Discharge schemes:** Frailty - Extended 8-8 at QEQM and WHH (extend 2 hours per day)	Further update to be provided. Money to be directed to fund expansion of Frailty service.	**Budget 23/24**	£0	£0	£0	£0	£0	£0	£26	£26	£26	£26	£26	£26	**£155**	Number of patients seen in Frailty	Total patients seen in Q4 22/23= As average month
			Forecast spend	£0	£0	£0	£0	£0	£0	£26	£26	£26	£26	£26	£26	**£155**		
			Actual	£0	£0	£0	£0	£0								**£0**		
			Variance	£0	£0	£0	£0	£0	£0	£26	£26	£26	£26	£26	£26	**£155**		
EKHUFT	**Discharge schemes:** Discharge lounge	QEQM Discharge Lounge has been in place with additional 8 beds since April. Forecast reduction to budget as substantive staffing allocated to areas. Discharge Lounge currently re-housed in Physio area. The 8 additional beds created provide an extended FAU service. Proposed metrics updated.	**Budget 23/24**	£20	£20	£20	£20	£20	£78	£78	£78	£78	£78	£78	£78	**£645**	Proposed metrics: Frailty PTL - volume of patients seen. Assessment Unit Outcome Split - Discharge vs Admitted.	Total patients seen in Q4 22/23 = As average month
			Forecast spend	£55	£55	£55	£55	£55	£55	£55	£55	£55	£55	£55	£55	**£656**		
			Actual	£55	£55	£55	£55	£55								**£275**		
			Variance	-£35	-£35	-£35	-£35	-£35	£78	£78	£78	£78	£78	£78	£78	**£370**		
EKHUFT	**Discharge schemes:** WHH and QEQM reconfiguration	Scheme was primarily to support staffing for increased capacity at QEQM and reconfiguration at WHH. Money directed for staffing to support the reconfiguration of MAU and changes to front door pathways at WHH.	**Budget 23/24**	£0	£0	£0	£31	£31	£31	£74	£74	£74	£74	£123	£123	**£634**	Number of esculation beds open Proposed metrics: Volume of patients seen by unit. Volume of patients admitted / discharged	Average number of esculation beds open in Q4 22/23 = As average month
			Forecast spend	£0	£0	£0	£31	£31	£31	£74	£74	£74	£74	£123	£123	**£634**		
			Actual	£0	£0	£0	£31	£31								**£62**		
			Variance	£0	£0	£0	-£0	-£0	£31	£74	£74	£74	£74	£123	£123	**£572**		

- Further to the funding already being received, recent discussions with ICB colleagues have outlined further additional funding and initiatives likely to be accessible throughout the Winter of 2023/24:
  - 2.89m Better Care Fund (BCF) for Kent and Medway with a strong steer to utilise this in areas of greater need within East Kent
  - Funding for additional Primary care capacity (Circa 1.3m), likely to be best delivered through 4-6 hubs
  - Funding for additional work with care homes. Analysis across K&M of care homes that most frequently use ambulances indicated that more than half of these are in East Kent
  - Roll out of pilot in West Kent – urgent 2-hour community response to avert admission or enable direct access

East Kent HCP UEC Improvement Plan

Increasing UEC Capacity

Task	Start date	End date	Task owner	HCP Lead	RAG status	Local metrics
Review effectiveness of existing Frailty front door service and review MTW service as part of review with aim of reducing frailty admissions	01/05/2023	07/07/2023	Cathy Bellman	Cathy Bellman	AMBER	Reduction in Frailty admissions
Training & Development Programme for SECAMB call centre staff to enhance UCR referrals and reduce conveyances to ED	01/05/2023	30/09/2023	Daryl Devlia	Sunny Chada	AMBER (related to SPOA)	Reduction in See and Convey % Increase in Hear & Treat %
Implementation of Crisis Houses to reduced extended stays for mental health patients within ED.	01/06/2023	31/10/2023	Louise Clack	Sunny Chada	RED	Reduction in MH ED LOS.
Trial of additional weekend discharge MDT utilising best practice from Darent Valley Hospital's winter plan. Funding to be considered from HCP Funds.	01/07/2023	31/07/2023	Sandra Cotter	Sunny Chada	RED	Enhanced weekend discharges with no associated reduction in weekday discharges
Location and Model for Clinical Decision Unit (CDU) for both acute sites to be implemented.	01/06/2023	31/08/2023	Dylan Jones	Jim MacDonald	AMBER	N/A
HCP Funded - Short term pathways - Primary care capacity for winter	01/09/2023	31/03/2024	Clare Thomas	Sunny Chada	GREEN	Utilisation of Respiratory hubs
HCP Funded - Extending SDEC capacity at QEQM and WHH	01/04/2023	10/08/2023	Sandra Cotter	Sunny Chada	GREEN	Increase in SDEC activity
Development of Hospice capacity tracker and daily load to Shrewd.	01/07/2023	30/09/2023	Rachel Parris	Sunny Chada	GREEN	Enhanced utilisation of hospice capacity.
Consideration of physical frailty assessment unit for WHH, akin to QEQM model.	01/07/2023	31/08/2023	Sandra Cotter	Sunny Chada	AMBER	Improved utilisation of forms and reduced EOL care within acute setting.

Key:			
COMPLETED	Task fully completed in terms of action described	AMBER	Project behind schedule but expectation that planned intervention will deliver within 30 days of programme plan
GREEN	Project on track to deliver within timescale and deliverables expected to be met	RED	Project currently not expected to deliver on timescale and interventions not in place to resolve within 30 days of programme plan

Improving Discharge

Task	Start date	End date	Task owner	HCP Lead	RAG status	Local metrics
HCP funded -Implement and expand Transfer of Care Hub (1-7 day Length of Stay) on all 3 sites and review referral processes across all pathways.	01/04/2023	31/10/2023	Liz Sargeant	Tracy Brooks	AMBER	
Implement acute based Homelessness Pathway	01/01/2023	30/09/2023	Liz Sargeant	Tracy Brooks	GREEN	Reduction of acute hospital bed days for homeless patients across all acute sites
HCP Funded - Development of live in Care Schemes via joint working (EK HCP, KCC, KCHFT) to develop role for a generic health and social care (support worker)	01/04/2023	30/09/2023	Liz Sargeant	Tracy Brooks	GREEN	Reduced use of Pathway 3 Reduced LOS/NCTR numbers
Development of additional sheltered housing across East Kent.	01/04/2023	31/07/2023	Liz Sargeant	Tracy Brooks	AMBER	
Pathway 2 Transformation Programme - Aim is to Accurately define pathways 2 and 3 based on the principles of Home First, Discharge to Assess and 'What matters to me' Maximise the use of in-house bedded capacity within KCHFT and KCC with clearly defined pathways for rehabilitation, enablement and recovery	01/07/2023	31/08/2023	Clare Thomas	Tracy Brooks	GREEN	a community bed dashboard under development that reflects: o Referral to admission time o LOS o Discharge outcome o NLFTR o Pathway 2 and 3 trajectories
Completion of Single handed care training for all trust therapy staff	24/03/2023	31/10/2023	Liz Sargeant	Tracy Brooks	GREEN	Reduces pressure sourcing TDS/QDS DH care packages Reduced use of Pathways 2/3 bed capacity Reduced LOS/NCTR numbers
Development of K&M Choice Policy.	01/03/2023	31/08/2023	Liz Sargeant	Laura Counter	GREEN	Completion of policy and associated roll-out for winter.
Agreement on "One version of the truth" reporting on Pathway 1-3 patients across EKHUFT & RTS teams.	01/06/2023	25/08/2023	Liz Sargeant	Sunny Chada	AMBER	
Review effectiveness of existing LHE Calls with a view of development of a clear system OPEL escalation plan for East Kent.	01/07/2023	31/08/2023	Sunny Chada	Wendy Slator	GREEN	Revised OPEL Triggers in place.
Creation of clear discharge targets by pathway by site to deliver Tier 1 targets	12/06/2023	30/06/2023	Sunny Chada	Sunny Chada	RED	Pathway 1-3 targets agreed. Pathway 0 outstanding. Monitor of daily discharges by pathway through LHE and weekly delivery group.
Personalised funds scheme to enable earlier discharge to be shared and embedded into RTS services. Service to be set-up, teams trained and utilised.	01/07/2023	31/07/2023	Paul Nelhams	Cathy Bellman	AMBER	TBA
Review of care home capacity report with view to target key homes where with support utilisation can be improved.	01/07/2023	31/08/2023	Paul Nelhams	Sunny Chada	GREEN	Review of utilisation of care homes within East Kent & also targeted homes as opportunities arise.
HCP Funded - Additional capacity within P2 for re-enablement and rehabilitation.	01/04/2023	10/08/2023	Clare Thomas	Sunny Chada	GREEN	P2 discharges
External organisation - PRISM to commence at QEQM focussed on enhancement of middle and back door. Regular review at delivery group.	07/08/2023	31/08/2023	Sandra Cotter	Sunny Chada	GREEN	Increase in QEQM discharges

Key:			
COMPLETED	Task fully completed in terms of action described	AMBER	Project behind schedule but expectation that planned intervention will deliver within 30 days of programme plan
GREEN	Project on track to deliver within timescale and deliverables expected to be met	RED	Project currently not expected to deliver on timescale and interventions not in place to resolve within 30 days of programme plan

Making it Easier to Access the Right Care

Task	Start date	End date	Task owner	HCP Lead	RAG status	Local metrics
Creation of a community SDEC provision to prevent unnecessary attendance to ED.	01/07/2023	30/09/2023	Sadia Rashid	Sarah Connor	AMBER	TBA
Plan to set-up Integrated Neighbourhood Teams (INT) via 4 early adopter sites.	01/06/2023	31/10/2023	Anne Ford	Cathy Bellman	GREEN	Reduced inequality in healthy life expectancy among most deprived neighbourhoods in east Kent
Review of Urgent treatment centre utilisation with initial focus on co-located sites to enhance performance in immediate term.	01/06/2023	31/08/2023	Oena Windibank	Sunny Chada	GREEN	Increased performance at WHH UTC.
Active management plan to reduce existing delayed transfers of care (dtoc) within KMPT footprint. Multi-disciplinary team approach in place.	19/06/2023	31/07/2023	Jim Beale	Sunny Chada	GREEN	Monitor dtoc numbers within KMPT beds. Project started at 51 dtocs. Aim to get to 20.
Identification of suitable location for safe haven @ QEQM and opening of service	01/05/2023	25/08/2023	Sandra Cotter	Sunny Chada	AMBER	Reduction in Mental health presentations to ED
Review of existing UTC and SDEC Pathways – QEQM	15/07/2023	31/07/2023	Sandra Cotter	Sunny Chada	AMBER	Enhanced SDEC and UTC utilisation. Review of UTC Inclusion criteria standardised across UTC's and shared with SECAmb to promote conveyance to UTC's.
Development of a GP Liaison role to support the direction of clinical professionals via a single point of contact into our key UTC/SDEC/VW/Community Services. Would ultimately feed the UICC model from West Kent.	01/07/2023	31/07/2023	Sandra Cotter	Sunny Chada	GREEN	Reduction in ED attendances.
Coordinate my Care - Care planning pump priming for patients in last year of life. Pilot in East Kent	01/07/2023	31/07/2023	Rachel Parris	Cathy Bellman	AMBER	Reduction of patients EOL in hospital.
Targeted pilot Assess and Connect - person centred approach, inc mobilisation of community assets dependant on what matters to the target population (over 75's/carers). Keen for EK to identify an area of particular need to pilot	01/07/2023	31/07/2023	Paul Nelhams	Cathy Bellman	AMBER	
Development of a POELC Hub - Out of hours specialist triage for PEOLC (K&M Wide)	01/08/2023	30/09/2023	Rachel Parris	Cathy Bellman	GREEN	
Review of paediatric activity being streamed to UTC's including clarity on <1's and also to link with SECAMB over their policy.	14/07/2023	15/08/2023	Oena Windibank	Mark Gilbert	GREEN	Reduction in paediatric ED attendances
GIRFT review highlighted high conveyance levels for three care homes. Internal review required as per reference 19 above.	01/08/2023	31/08/2023	Rachel Parris	Cathy Bellman	GREEN	Reduction in conveyances from 3 care homes.

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Expanding Care Outside of Hospital

Task	Start date	End date	Task owner	HCP Lead	RAG status	Local metrics
Increase voluntary sector engagement via creation of a clear strategic alliance with EK VSCE	01/04/2023	30/08/2023	Cathy Bellman	Anne Ford	GREEN	VCSE engaged in development of pathways aligned to HCP priorities VCSE support embedded into discharge and short term services pathways
HCP Funded - Review of EKHUFT and KCHFT Virtual Ward Programme and develop clear improvement trajectory to meet agreed utilisation metrics.	01/05/2023	07/07/2023	Cathy Bellman	Sunny Chada	RED	> 90% utilisation of agreed virtual ward capacity
Pro-active planning of care being completed at Farrow Court in Ashford to understand health needs to prevent unnecessary primary care & hospital attendances	01/04/2023	31/07/2023	Anne Ford	Anne Ford	GREEN	Population health review in 2024/25.
Admission avoidance/Discharge acceleration service consistent across East Kent combining CART/HTS/VW utilising a trusted advisor model.	01/07/2023	30/09/2023	Clare Thomas	Cathy Bellman	GREEN	Enhanced utilisation of ART/HTS.
High Intensity Users Group - to be strengthened via monthly reviews - supported by Red Cross.	01/07/2023	31/07/2023	Sue Luff	Sunny Chada	AMBER	Reduction in unecessary usage of hospital care.
Review Community's access to diagnostics	14/09/2023	31/11/2023	Sandra Cotter	Cathy Bellman	GREEN	Timely access to diagnostic support to prevent unnecessary admission

Key:			
COMPLETED	Task fully completed in terms of action described	AMBER	Project behind schedule but expectation that planned intervention will deliver within 30 days of programme plan
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East Kent Hospitals University NHS Foundation Trust

East Kent Provider Winter Planning

KCHFT Winter Plan

East Kent Hospitals University NHS Foundation Trust

- **Same Day Emergency Care**: active liaison to enable community access to diagnostics in order to support delivery of the virtual ward.
- **Frailty**: engagement between community and acute frailty teams to identify patient groups to refer to virtual ward.
- **Inpatient flow and length of stay (acute)**: Rapid Transfer Service to work with acute and Kent County Council (KCC) colleagues to utilise discharge pathways 1-3.
- **Community bed productivity and flow**: bed management team in place leading to increased bed occupancy and shorter referral to admission times; developing model to test integrated health and social care reablement; testing trusted assessment for discharge; clinical pathways reviewed.
- **Care Transfer Hubs**: in place across 3 sites; refining use and definition of pathways for complex patients to reduce use of pathway 3 and spot bed purchase; developing shared assessment protocols for non-weight bearing and double handed care between health and social care.

KCHFT Winter Plan

East Kent Hospitals University NHS Foundation Trust

- **Intermediate Care demand and capacity**: new health and social care support worker recruitment to create additional pathway 1 capacity; waiting list management trajectories in place; stroke ESD modelling completed and partial expansion of capacity agreed.
- **Virtual wards**: virtual ward in place and delivering high activity; increased referrals from SECAmb and front door (due to in-reach system); initiated use of technology support to increase capacity
- **Urgent Community Response**: in place and meeting targets; working with SECAmb to take patients from stack (catagory3/4) with a particular focus on falls and the prevention of a long lie
- **Single point of access**: principle of SPA agreed across system; LRU expanded to 24 hours to support virtual ward hub; two points of access in east Kent for urgent referrals, work is ongoing to address this; engaging with GIFRT a-TED (alternative to emergency department) programme.
- **Acute Respiratory Infection Hubs**: engaging with model based on evaluation last winter

KMPT/ICB Adult Mental Health

Kent and Medway NHS and Social Care Partnership Trust

- Front door mental health Triage clinicians within the Emergency Department who, where appropriate are signposted away from the ED to alternative services. KMPT are working towards 24/7 cover, recruitment allowing.
- ICB Escalation Process - Working on criteria and clear process.
- 4 Community Safehavens (Folkestone/Thanet/Canterbury/Maidstone) VCSE led available 1800-2300hrs 7 days per week.
- Provision of 2 x 24/7 Safehavens collocated with Acute Trust site with phased implementation. Thanet Safe haven to open on the QEQM site 24/7 in April 2024. Service is out for procurement. Anticipated soft launch Winter, initially 6-11pm.
- Crisis Café provision open 7 evenings a week in Ramsgate.
- Phased provision of 13 Crisis Beds spread between 3 Crisis Houses delivered by VCSE, gatekept by KMPT for short term residential stay of up to 7 days as an alternative to Emergency Departments or KMPT Inpatient Admission. 5 bed house opening in Medway October 2023. Additional 2 x 4 bed Crisis House opening Q124/25.
- Extension of conveyance pilot (bespoke mental health secondary conveyance) to April 2024.
- Provision of 24/7 mental health conveyance service including Health Care Support worker sitting service for S136 in ED, implementation Q1 2024.
- Provision of 1hr, hear and treat/see and treat mental health response to SECAMB delivered by KMPT coming on line Q4 23/24.
- Crisis Peer Support Service delivered by VCSE providing 12/52 intensive follow up to individuals discharged following Liaison Psychiatry Assessment, Crisis Assessment or discharge from inpatient unit – operating in East Kent
- Provision of QWEL (mental health online service via an App) to individuals 18-35 yrs in mental health crisis
- Recruitment to a senior Social Work post (hosted by KMPT) who will across KMPT/KCC leading on reduction in numbers of Clinically Ready for Discharge.
- NHS 111 Select 2 for Mental Health, working in conjunction with VCSE delivered Mental Health Helpline

SECAmb UEC Improvement Plans

South East Coast Ambulance Service NHS Foundation Trust

- UCR Collaboration – Daily touchpoints, moving to Portal access
- GP located in West Kent PP Hub trial – potential to inform EK model
- West Kent Clinical Navigation Hub, enhanced SPoA – potential to inform EK model
- Promotion of community services (UTC, Safe Havens etc.)
- Internally ICS aligned assurance teams
- Workforce development – Clinical Supervision, ACP programmes
- Working with HCP to address care home conveyances as identified in the Alternatives to ED Programme

Primary Care Winter Plan

- Respiratory Hubs models established in 2022/23. Models to be agreed and implemented in readiness for this winter
- Identified specific care homes with high conveyance rates as part of GiRFT review. ICB agreed additional funding for GP/Paramedic for Top 20 care homes across K&M, which includes key care homes in east Kent
- Existing community SDEC in place at Estuary View, plan to review opportunities for further development of community SDECs across east Kent
- Working alongside newly formed Integrated Neighbourhood Teams (INTs). 4 early adopter sites in place.
- Supporting current Alternative to ED (A-tED) audits across QEQM and WHH. Plan to streamline referral pathways into SDEC and Virtual Wards

Adult Social Care Winter Plan

Making a difference every day

Service / system / team	How this will support system flow
Integrated Transfer of Care Hubs	Working closely with health colleagues to have oversight of all transfers of care and to co-ordinate demand and capacity. Integrated Discharge Teams (IDTs) will continue to support Acute Hospital Discharge management, working with the Hub. The hub will provide co-ordination and expertise for transfers of 'complex' people/ situations.
Kent Enablement at Home (KEAH)	Aims to ensure that people are able to remain at home with the appropriate levels of support with the emphasis on enablement. Supporting services within PW1 for a rapid transfer of care. Supporting market capacity at times of pressure by providing interim temporary care and support.
Technology Enabled Lives	Providing a 10 week short term service to support Acute Trusts, Cottage hospitals / step down beds, Early discharge Planning team (MH). For example - Digital medications management support. Remote monitoring for safety and welfare.
In-house short stay services	Efficient admissions/referral process. All adult age pathway that is needs led to maximise bed usage. Reduction in the use of external bed market and managing cost.
Purchasing / care home support	Weekend cover over the festive period to support care home access. Supporting all bank holidays, except Christmas Day.
Workforce -	Promoting take up of Covid and flu boosters is part of our resilience in terms of sickness

Adult Social Care Winter Plan

Service / System / team	How will this support system flow
AMHP (Approved Mental Health Practitioner)	Continue to work in partnership with mental health liaison services to ensure that referrals for Mental Health Act assessments are appropriate and adhere to the principles of the MH Act. By doing this we will ensure that only those who need a MH Act assessment receive them. Therefore improving response times for those in need of a MHA assessment. 24/7 cover 365 days per year. Covering Christmas and New Year.
Home First Health & Social care integrated team (East Kent)	These new roles will be working across health and social care to provide support for people leaving hospital. Referrals accepted within 2 hours based on capacity and trusted assessment. No duplication of assessments; supporting market capacity; improved flow through system; better partnership working; improved responsiveness for person and their carer
Occupational Therapy	OT Input into Integrated Triage at point of contact. More people getting access to enablement, fast track equipment, digital / technology support and specialist OT assessment.
Short Term Pathways	Supporting the reviews for people in all short term beds on a hospital pathway. To facilitate timely moves onto long term destination
Commissioning	Working with our Home Care providers to increase and ensure there is capacity.

Escalation Planning

EKHUFT Winter Planning
Escalation – Operational Pressures Escalation Level (OPEL)
OPEL Framework 2023

East Kent Hospitals University NHS Foundation Trust

The framework aims to provide a unified, systematic and structured approach to detection and assessment of acute hospital urgent and emergency care (UEC) operating pressures

To provide a consistent framework for the proportional representation of each acute trust hospital's OPEL score toward the corresponding integrated care system (ICS), NHS England regions, and NHS England nationally

To provide guidance to acute hospital trusts, ICS and NHS England regions that supports an effective, integrated and coordinated response to acute trust operational pressures and provide guidance on the alignment of, and interaction between, the OPEL Framework 2023/24 and the national Emergency Preparedness, Resilience and Response (EPRR) framework.

- The new Operational Pressures Escalation Levels (OPEL) Framework for 23/24 was released on the 9th August 2023.
- This new framework aims to provide a unified, systematic and structured approach to detection and assessment of acute hospital UEC operating pressures; achieved through standardisation of parameters and assessments.
- The OPEL framework focuses on assessment of each acute hospital, with a Type 1 ED, operational pressures.
- Each hospital with a Type 1 ED will be required to submit an OPEL score. Scores are calculated by measuring performance against 9 key metrics. The total score will then provide a corresponding OPEL level.
- Acute trusts with multiple hospitals will then calculate their provider score and consequent OPEL status.
- Proportionate contribution calculations for each hospital will be published with technical guidance supporting the new Framework and this is expected shortly.
- Hospital OPEL scores will be submitted to ICBs who in turn will use the score from each to calculate their System OPEL score and corresponding level.
- Region OPEL score and corresponding level will be calculated from each hospital score also.
- Further plans are in process to bring community social and mental health providers to standardise OPEL declarations in these areas also.

EKHUFT Winter Planning
Escalation – Test of New OPEL Framework Scoring

East Kent Hospitals University NHS Foundation Trust

- The Kent and Medway UEC team are testing the new OPEL Framework calculation process by calculating scores over a 4 week period from 29th August until 25th September 2023.
- The below table shows each parameter, the national guidance as well as the process the Regional team have taken when calculating scores for the purpose of this exercise;

Metric	OPEL Parameter Definitions
Mean Ambulance handover time:	• Average time ambulance patient arrival to clinical handover within the last 60 minutes (Clinical handover is defined as handover of clinical information and transfer of patient to hospital trolley.)
ED 4-hour all-type performance	• Percentage of all type attendances admitted discharge or transferred within 4 hours since midnight (This is excluding booked appointments.):
ED all-type attendances	• The number of all type attendances at the site within the past 60 minutes. • This should be compared to the expected or anticipated number of attendances, which must be established and agreed locally based upon historical demand. This can be a consistent hourly average or an average that considers varying attendances throughout a 24-hour period
Majors and resuscitation occupancy	• Percentage occupancy of majors and resus at time of review. • Occupancy should be calculated by the sum of all patients in ED that require an majors space regardless of their care being delivered in a traditional space or an escalation area), divided by the maximum number of patients able to be cared for in major and resus areas, as stated in acute-site OPEL Statement.
Time To Treatment	• Mean longest total time between patient arrival at ED and the time that the patient is seen by a clinical decision maker at time of review. Clinical decision makers is a care professional who can define the management plan and discharge the patient OR diagnose the problem and arrange or start definite treatment as necessary.
Percentage of patients over 12-hours from time of arrival	• Total number of patients waiting over 12 hours in department from time of arrival at time of review as a percentage of total number of patients in ED at time of review.
General and acute bed occupancy	• Percentage occupancy of hospital at time of OPEL assessment. • Bed occupancy should be calculated by the sum of patients occupying general and acute beds AND those in ED or assessment areas requiring admission (DTAs) divided by the number of available beds outlined in the site's acute-site OPEL Statement.
Escalation beds open	• Percentage of escalation beds as a proportion of the general and acute bed base open at time of OPEL assessment. • Escalation beds are those considered in line with A&E SitRep definitions. The denominator should be the G&A beds in the acute-site OPEL statement.
Patients no longer meeting criteria to reside	• Percentage of open beds occupied by patients no longer meeting criteria to reside at time of OPEL assessment. • Denominator should be the number of available beds on the acute-site OPEL Statement.

EKHUFT Winter Planning
Escalation – OPEL Parameters and Scoring Range

East Kent Hospitals University NHS Foundation Trust

OPEL parameter	Score						
	0	1	2	3	4	5	6
Mean ambulance handover time	<15 min		15–30 min		>30–60 min		>60 min
ED all-type 4-hour performance	>95%	76–95%	60–76%		≤60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120%		>120%
Median time to treatment	≤60 min	>60–90 min	90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2–4%	4–6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

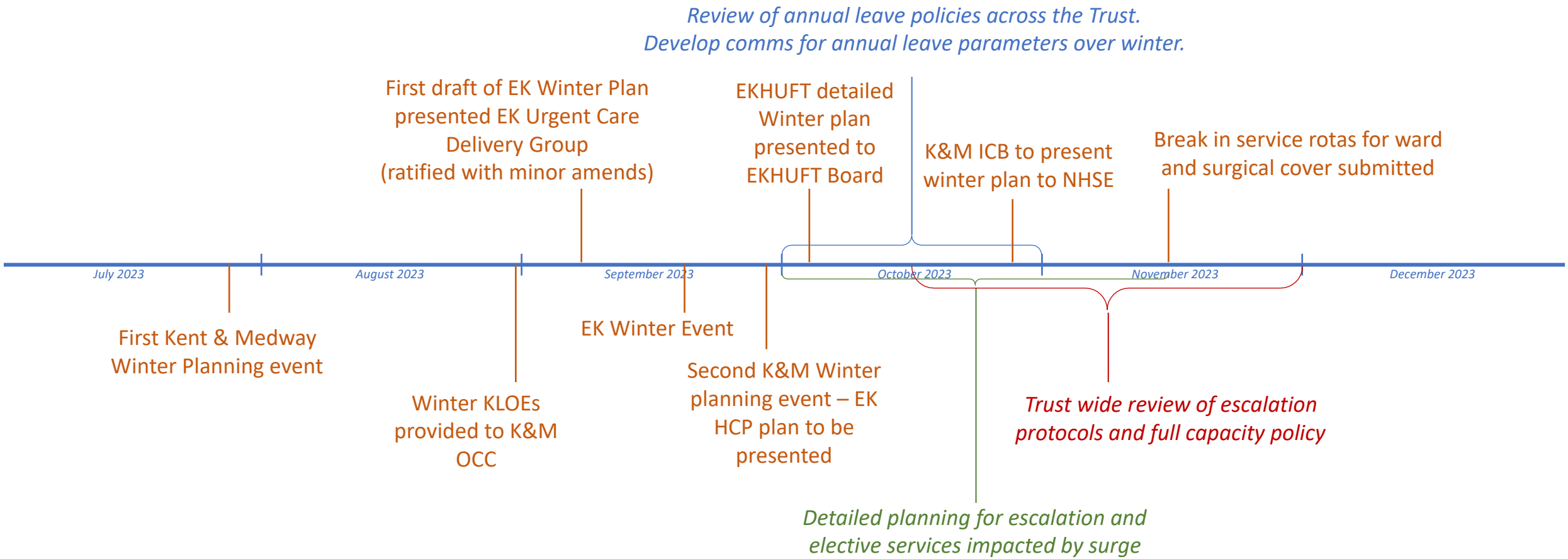
Aggregated OPEL Score	OPEL	Clinical Risk	Response
0–11	OPEL 1	Low	**See OPEL action card** (and local policy/ protocols)
12–22	OPEL 2	Medium	
23–33	OPEL 3	High	
34–44	OPEL 4	Very High	

East Kent Hospitals University NHS Foundation Trust

Timelines

EKHUFT Winter Planning
Timeline of events

East Kent Hospitals University NHS Foundation Trust



Governance

Governance
HCP Winter Governance aligning to EKHUFT Governance

East Kent Hospitals University NHS Foundation Trust

EK HCP - Weekly Urgent Care Improvement Delivery Group
Weekly meeting to review progress
EKHUFT, KCHUFT, KCC, PCNs in attendance

Weekly Tier 1 Meetings
Weekly Meeting to review progress and funding
Attended by ICB, NHSE, EKHUFT

East Kent Urgent Care Delivery Group
Monthly meeting – Highlight report on winter scheme progress

Urgent and Emergency Care Programme Board (ICB)
Monthly meeting – Highlight report on winter scheme progress

Daily K&M System Calls

Trust Strategic Group

Operational Inbox

EKHUFT Site Weekly Meetings

IIP – Fortnightly Operational Reviews

Planned and Emergency Care Delivery Groups
Monthly workstream updates to EKHUFT

CEMG
Monthly update

EKHUFT Board
Monthly update

Next steps

EKHUFT Winter Planning
Next Steps

East Kent Hospitals University NHS Foundation Trust

- **Escalation:** Options appraisals have been submitted by each site for escalation proposals and related impact on services. These options will now be worked into a 5-tier trigger plan with detailed and agreed actions for each stage of escalation based on the demand position of the Trust with a clear focus on reducing harm.
- **Community winter schemes:** Ascertain feedback on the Trust's challenge related to the realised benefit of the proposed winter schemes. Further discussions required to address the unmitigated bed gap.
- **Funding:** Ensure the Trust is able to maximise the potential impact of any confirmed additional funding. That the access to funds follows the Trust's internal process and monies are diverted to areas in most need.
- **Workforce:** Rota planning to ensure robust staff cover during the Christmas period.
- **Staff welfare:** Provide communications to all staff for access to welfare and well being services available to staff throughout the winter ensuring the Trust support and look after colleagues during periods of high pressure.

Appendices

- Departmental winter planning
- Workforce
- Demographical Context
- SWOT Analysis Review of Winter 2022/23
- Previous Winter Escalation plans for Winter 2022/23

Departmental winter planning

EKHUFT Winter Planning
ITU Surge

East Kent Hospitals University NHS Foundation Trust

The full ITU escalation plan is embedded in this page

The strategic aim of the document is to provide a safe and effective Critical Care service during in times of increased capacity within Critical care. This guidance aims to aid Trust level planning for how to respond during a period when demand for Critical Care services at the William Harvey Hospital, Queen Elizabeth the Queen Mother Hospital and the Kent and Canterbury Hospital exceeds the normal capacity.

- **The strategic aims of this guidance are to:**
    - **maintain a high quality of care to support the best possible outcomes for patients** with critical care needs working collaboratively with the operational teams.
    - **maintain access to Adult Critical Care for any patient that requires it** and thereby, prevent avoidable mortality and morbidity**.**
    - **maximise capacity in the critical care units** through a coordinated escalation and de-escalation approach.
    - **avoid the transfer of critically ill patients for capacity reasons wherever possible** by ensuring all options to increase capacity have been exhausted prior to the consideration of implementing capacity transfers.

Summary

- Crisis surge plans to be used for internal pressures. Capacity will not be offered for external aid if we have patients in EKHUFT requiring these beds.
- Regional and system support will continue to help as required to allow any decompression/mutual aid if available.
- There is a risk that we may not achieve the full staffing requirements although we *must* aim to do so. The 3 critical care units will continue to mitigate trust wide due to number of patients and acuity to aim to meet reduced nursing ratios within the recommended staffing guidance.

Microsoft Word Document

EKHUFT Winter Planning
Oxygen

East Kent Hospitals University NHS Foundation Trust

The Trust has an active and engaged medical gases committee in place and effective oxygen business continuity plan in place and also procedures for environmental monitoring of oxygen concentrations in areas at risk. The work the teams did and the system response during the impact of the first phase of the pandemic and then the impact of the Delta variant that the MGPS supplying oxygen will deliver a consistent supply within the bed base current configuration.

Site based capacity and plans are detailed below:

WHH

- 5000l/min capacity on an oxygen ring main with duplex VIE apparatus, with auto-changeover facilities on the evaporators. The flow into the system monitored by Ultrasonic flow meter as well as via the Trust Covid App that draws information recorded on VitalPAC about oxygen use that gives the Trust awareness to ward level on the system draw.

QEQMH

- 3000l/min capacity (Ramsgate road) and 917L/min St peters road. No auto-changeover facilities on the evaporators manual de-icing process in place. The flow into the system monitored by Ultrasonic flow meter as well as via the Trust Covid App that draws information recorded on VitalPAC about oxygen use that gives the Trust awareness to ward level on the system draw. System can be joined so that Ramsgate road supports the site with support from St Peter's road. Main Covid areas currently fed off Ramsgate Road. The site will be benefit from an Oxygen Ring Main due to be completed in November.

K&CH

- 917L/min capacity via a single VIE apparatus with no auto-changeover facilities on the evaporators (manual de-icing process in place.) Back up to the VIE is provided by ERM . The ERM is a UHF (ultra-high flow) manifold capable of a 3500L/m output. Connected down stream of the VIE on site. The manifold is fed from 2x10 banks of ''W'' size bottles. At an average demand of 200L/m, the ERM will provide the site with approx. 18.5Hrs of continuous Oxygen, in the event of a primary and secondary VIE failure. The flow into the system monitored by Ultrasonic flow meter as well as via the Trust Covid App that draws information recorded on VitalPAC about oxygen use that gives the Trust awareness to ward level on the system draw.

EKHUFT Winter Planning
EPRR

East Kent Hospitals University NHS Foundation Trust

- EKHUFT EPRR and 2gether review of winter weather plans has taken place in September.
- Robust comms plans and Switchboard messaging in place.
- EPRR team is reviewing the Severe Winter Weather Plan in line with revised National Adverse Weather alerts.

- **Snow and Ice Clearance**. Areas of High Risk across sites have been agreed between 2gether's Facilities department with the EPRR team. The Procurement team is undertaking an annual review of the Snow and Ice Plan with the contractor (Mitie) for each site.
- **Maintenance of front entrances**. Grit and salt can cause a "film" to appear on the corridor floors leading from main entrances. 2gether is considering the use of signage to avoid this having a negative impact on public perception.
- **Portable Heaters** – Estates are reviewing the process for issuing seasonal equipment e.g. fans and heaters to mitigate the financial impact of equipment not being returned.
- **Emergency accommodation** process in place.

- **Risk** - Transportation in snow and icy weather. MoU with the voluntary sector cannot be relied upon as business continuity arrangements for stranded staff. No viable alternative arrangement is in place.
- **Risk** – BHD flooding during episodes of high volumes of surface water with a wet winter forecast. 2gether's Estates team is obtaining a cost for the purchase and installation of flood protection of the main entrance.

EKHUFT Winter Planning
CSS Mortuary and Pathology services

East Kent Hospitals University NHS Foundation Trust

Mortuary

Primary focus for pathology is to assess the need for additional cold storage for mortuary. Each year the Trust has needed additional 'surge' capacity to cope with winter demand with this typically increasing Mid December to end of April.

In previous years the Trust hired an additional 40 spaces for 6 months with an associated cost of approximately £60k. Further to this there was additional cost for transport hired to move the deceased to and from the unit. This solution is not ideal from an estates perspective due to the size of the unit on site.

Jackson Hub have been identified as a preferred supplier for body store in Kent and provide transport arrangements as part of the agreed contract.

Risks: Elongated procurement process for competitive tender impacting the timing for contract sign off. Concern has been raised that other Trusts across K&M may procure the space ahead of East Kent leaving a capacity risk going in to Winter.

Phlebotomy

The team are planning for the anticipated uplift in required phlebotomists and are exploring options for an additional supplement on NHSP shift to attract phlebotomists to vacant shifts.

Pathology

Risks: The current ongoing provision of 24hr service for PCR, COVID and point of care testing. 24hr service provision decision taken 'at risk' during Covid and remains in place. Trust decision required subsequent to the winter period if the service remains at 24hr or if it can be reduced based on IPR requirements and recommendations.

Workforce

EKHUFT Winter Planning
Workforce

East Kent Hospitals University NHS Foundation Trust

Building on the principles of previous winter plans for workforce requirements the following reviews and plans are in development:

- Shadow staff lists – For staffing considerations and support to clinical areas as required throughout surge and super surge
- Redeployment of staffing i.e. theatre staff to ITU
- Adherence to Trust wide Annual Leave policy
- Staff wellbeing – linking in with HR and Comms to provide access to well being services and support
- Planned break in service – detailed staffing plans in place for the three week period over Christmas and New Year. Care Groups will be required to develop first draft rota plans mid-November with final plans provided w/c 27th November 23.
- Staff sickness and contingency planning
- The development of senior operational cover timetable for each site to ensure an even distribution of operational support on a daily basis.

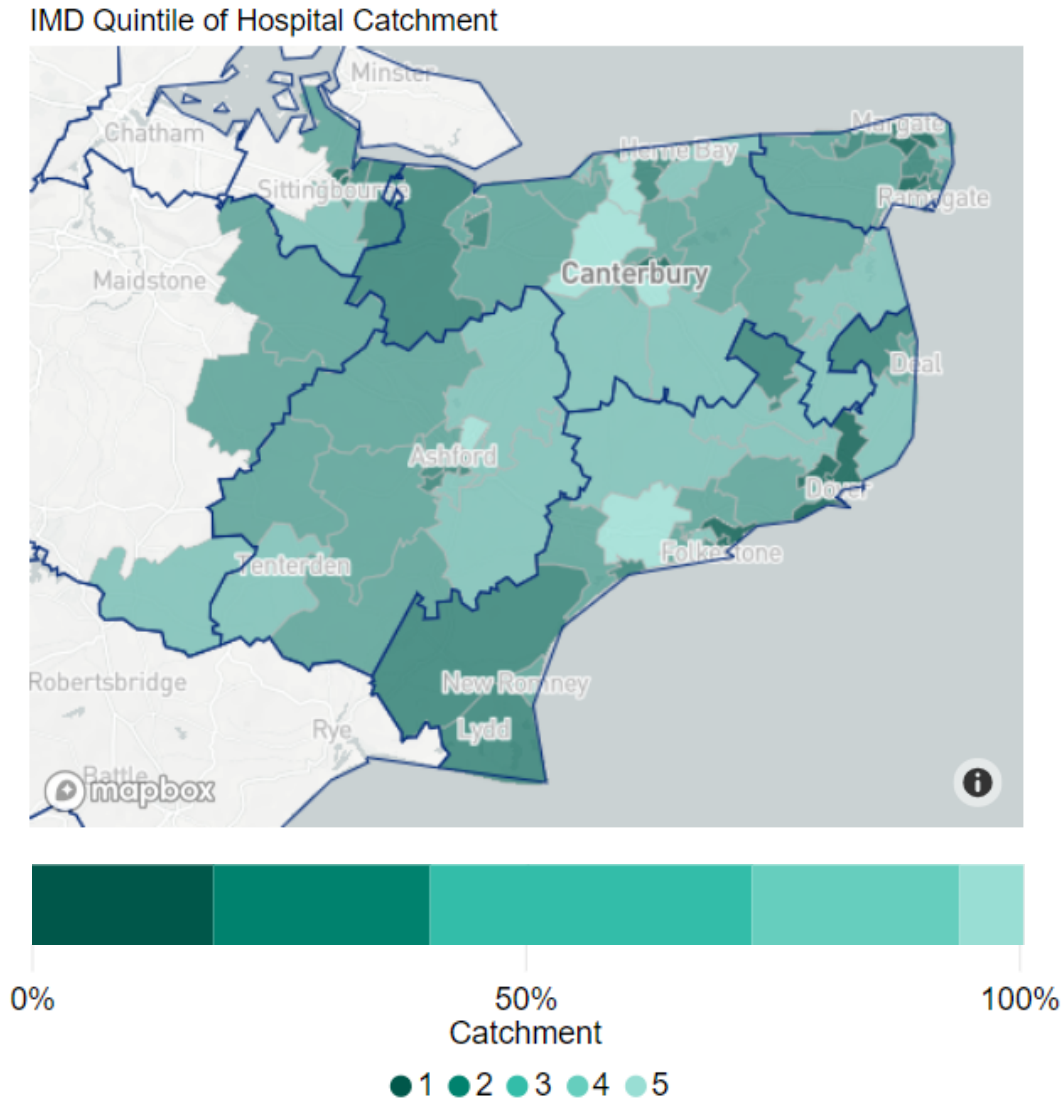
The detail of the workforce planning is in progress and will be completed throughout November 22 and shared at CEMG in early December.

Demographical Context

Deprivation

Trust Name	IMD Score	IMD Rank (out of 122, 1 is most deprived)
Medway	24.38	36
East Kent Hospitals	21.98	52
Dartford And Gravesham	19.05	74
Maidstone and Tunbridge Wells	13.95	104

- East Kent deprivation score is ranked mid-table across the national NHS Trust network.
- The most deprived areas (IMD = 1) are found in Dover, Folkestone the Margate and Ramsgate surroundings



Health inequalities

East Kent Hospitals University NHS Foundation Trust

'Coastal communities, the villages, towns and cities of England's coast have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases.'

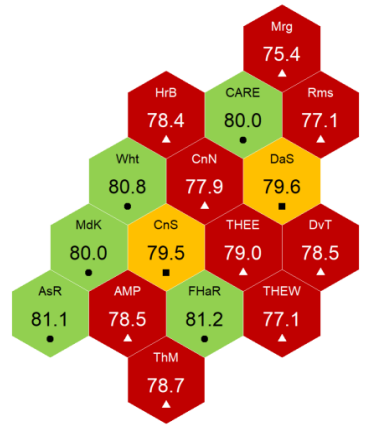
Chris Whitty, Chief Medical Officer
Health in Coastal Communities Report 2021

- Coastline is home to a quarter of the county's population. Highest levels of deprivation and poorest health outcomes are in coastal areas. Even after adjusting for deprivation and age, there remains a 'coastal excess' in the prevalence of disease and risk factors.
- People with a serious mental illness are at risk of dying 15 years earlier than the average. Higher rates of psychosis and bi-polar disorder than the Kent average. Thanet has the second highest rate of hospital admissions for mental illness in Kent and Medway (often a marker for the level of crisis in the mental health system).
- Over half of the self-harm attendances for young people at A&E were in east Kent (567/1000).
- HEE's analysis (for the CMO report) found despite coastal communities having an older and more deprived population, they have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient.
- Approximately one quarter of GPs and practice nurses in east Kent are over 55.

- People who live in the poorest parts of east Kent are **more likely to develop serious illnesses** and to die earlier than those in the most affluent areas.
- **25%** more **die from heart disease** in poorer areas.
- **20%** more from **cancer**.
- **50%** cent more from **lung disease** before the age of 75 than in the wealthiest areas.

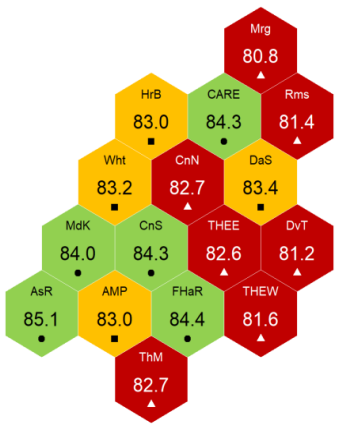
Life expectancy at birth (male)

PCNs in East Kent. Compared to England:
Better Similar Worse Not compared



Life expectancy at birth (female)

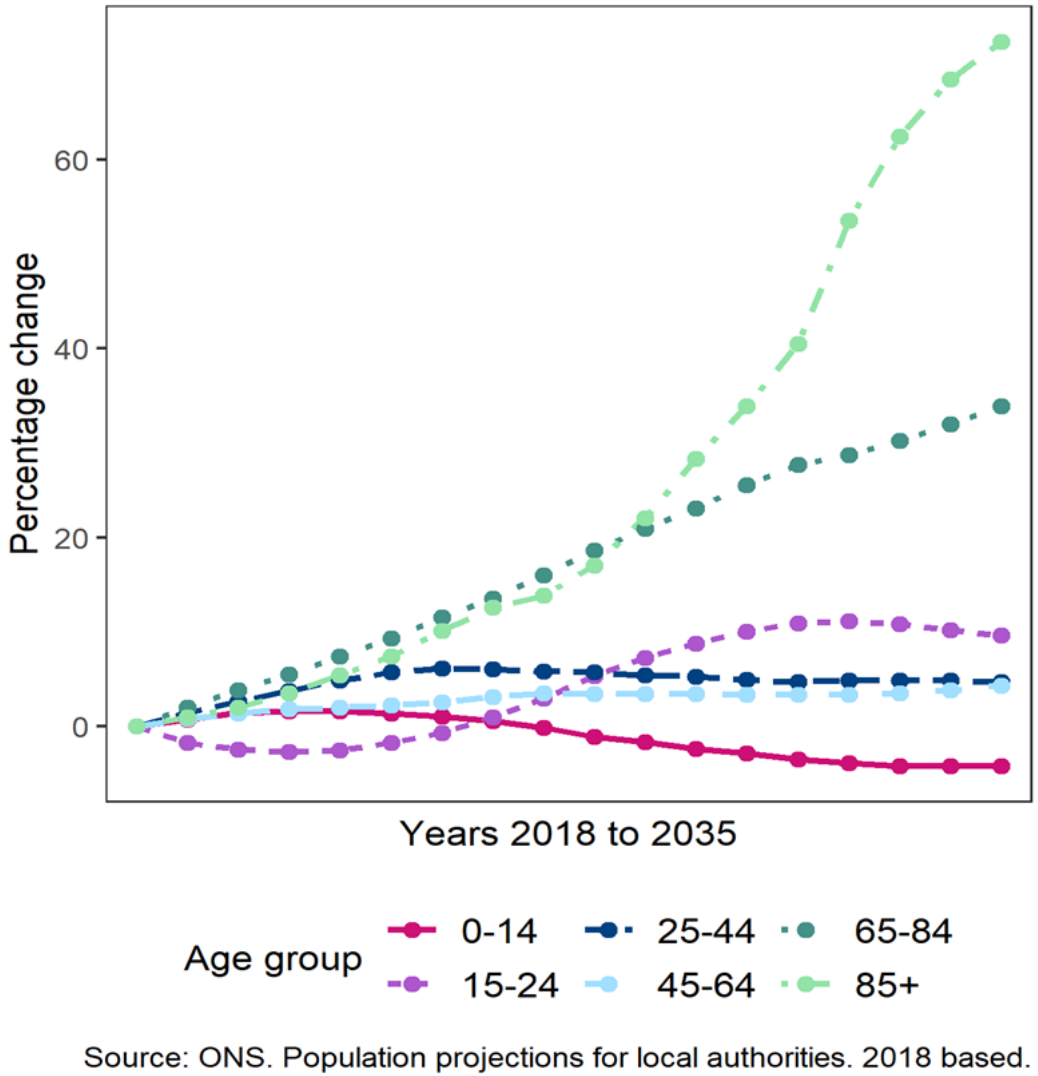
PCNs in East Kent. Compared to England:
Better Similar Worse Not compared



Ageing population

East Kent Hospitals University NHS Foundation Trust

- East Kent has one of the largest place-based partnerships in the country – population of more than **734,000**, forecast to **grow by 7.3 per cent** by 2028.
- The number of people aged **65 and over** is forecast to **increase by 35 per cent** by 2036.
- The number of people aged **85 and over** expected **to increase by 70 per cent** over the same period.



Source: ONS. Population projections for local authorities. 2018 based.

Kent and Medway – Emergency admissions by age

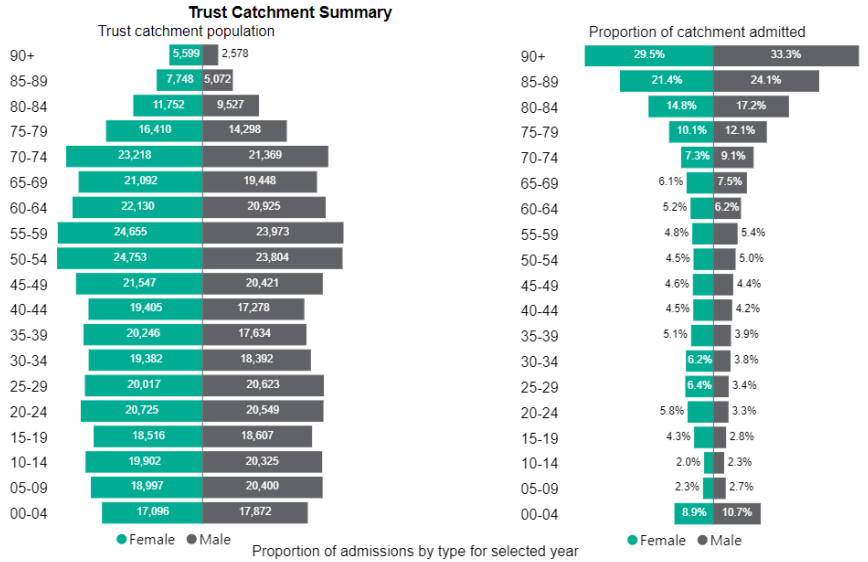
East Kent Hospitals University NHS

Trust Name: East Kent Hospitals University NHS Foundatio...

Admission Type: All Admissions / Elective / Emergency

Year: 2020

In 2020 the East Kent Hospitals University NHS Foundation Trust annualised number of patients admitted for Emergency was 43,335 from a catchment population of 686,285 with 6.3% of the catchment admitted

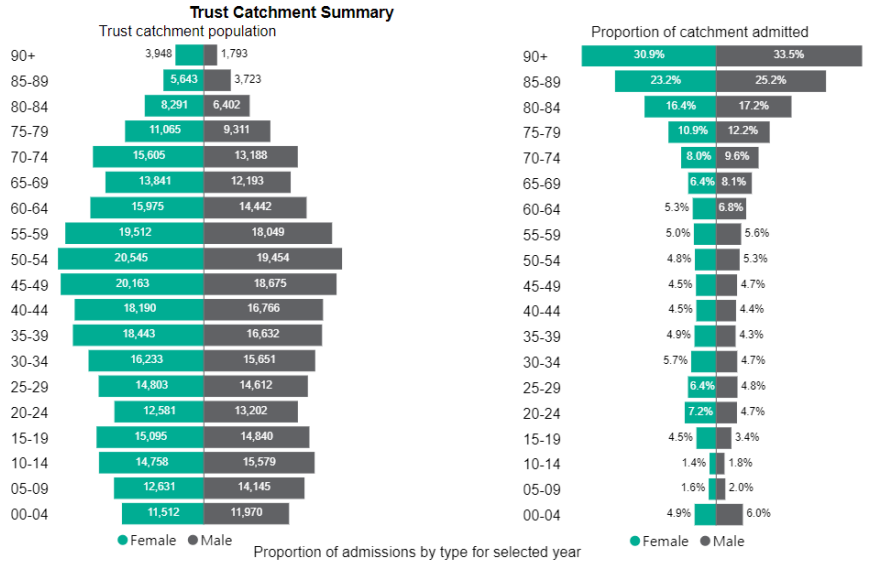


Trust Name: Maidstone And Tunbridge Wells NHS Trust

Admission Type: All Admissions / Elective / Emergency

Year: 2020

In 2020 the Maidstone And Tunbridge Wells NHS Trust annualised number of patients admitted for Emergency was 32,330 from a catchment population of 519,461 with 6.2% of the catchment admitted

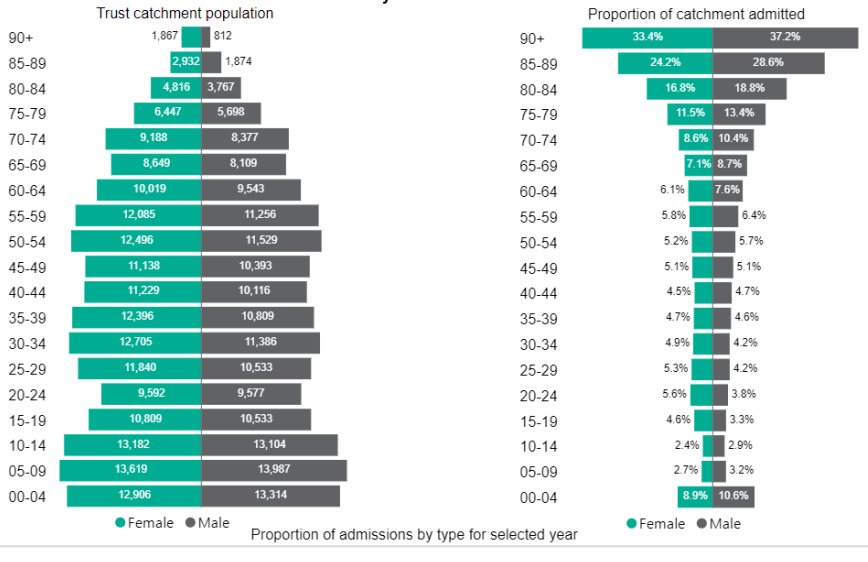


Trust Name: Medway NHS Foundation Trust

Admission Type: All Admissions / Elective / Emergency

Year: 2020

In 2020 the Medway NHS Foundation Trust annualised number of patients admitted for Emergency was 23,425 from a catchment population of 362,632 with 6.5% of the catchment admitted

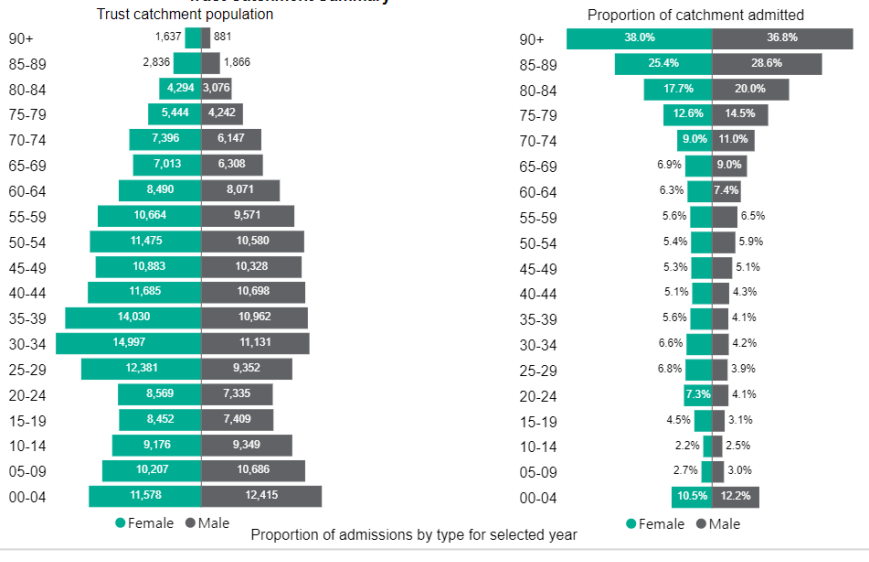


Trust Name: Dartford And Gravesham NHS Trust

Admission Type: All Admissions / Elective / Emergency

Year: 2020

In 2020 the Dartford And Gravesham NHS Trust annualised number of patients admitted for Emergency was 22,220 from a catchment population of 321,614 with 6.9% of the catchment admitted



SWOT Analysis Review of 2022/23

East Kent Hospitals University NHS Foundation Trust

STRENGTHS	WEAKNESSES
COLLABARATION Collaboration increase Goodwill of staff was evident Strong Partnership working across surgeries Engagement Good infrastructure compared to other localities (UTC sites and existing community frailty team) Daily system pressure meetings Improvements in Pathway 1 discharges - KEaH now also supporting acute hospital discharges Implementation of Transfer of Care hubs	Leads brought in from external areas which exacerbated lack of local knowledge Little discussion with primary care, limited understanding of pressures Assumptions made on the capacity available within UTCs Lack of system understanding of the UTCs
FINANCE £ Financial support enabled practices to cope better £ Funding provision for additional Pathway 3 patient placements in place throughout Q4 ensuring some of the Trust's longest-stay patients were placed in an appropriate care setting	£ Lack and late availability of funding £ Multiple sources & requests caused confusion £ Focus was for capital requests, need was for revenue funding £ HCP schemes with funding supported did not materialise £ Decision taken not to fund extended services required across the Trust (SDEC) to support flow and the management of patients in ED
WORKFORCE RESILIENCE Temporary extra staff could be found Some temporary staff converted into substantive posts Clear rota planning for all wards and staff	Coincided with changes to teams and therefore momentum was lost a little Staff Shortages: Ongoing challenges exacerbated during winter
GOVERNANCE Emerging HCP governance including the Improvement plan Increased clarity re the discharge pathways issues Improved communication through the regular oversight The employment of the winter directors provided a conduit for communication between the teams in the Trust and across the HCP Data provided by Lightfoot allowed the Trust to plan for the anticipated uplift in demand. However, no account taken for the nuances of inter-site transfers which was amended internally	Lack of understanding - it was system plan and not just for one organisation Poor advanced planning to cope with winter Responsibilities across HCP/ICB at times were unclear No time given to test and evaluate changes before further changes made Increased requests for information were repetitive Delays in making decisions especially around funding flows
ESTATES	Poor premises and IT for practices and community UTCs Overcrowded ED spaces with a high degree of corridor care

SWOT Analysis Review of 2022/23

East Kent Hospitals University NHS Foundation Trust

OPPORTUNITIES	THREATS
COLLABARATION Increase collaborative working between ICB, HCPs and LMC Shared ownership of the issues and risks Continue to develop the improved communications across the system to ensure consistent messaging Collaborative triaging systems - opportunities to be considered Local public campaigns: Targeted local public health campaigns alerting the Kent public to alternatives to coming to Emergency Departments. Providing clarity around primary and community care alternatives	Lack of consistent comms to patients from all system partners Increasing public expectations
FINANCE £ Funding to be given at practice level in next few weeks to increase capacity in all parts of NHS for winter now £ Increase in resources for UTCs and Hubs to support EDs £ Allow schemes to be fully tested and evaluated	£ Plans formulated on understanding of funding streams which did not necessarily come to fruition £ No funding considered for non-clinical essential work created by additional appointments £ Increasing costs of care home placements
GOVERNANCE Advanced planning early in the year Chance to do something different to previous winter plans and drive new ways of working. Longer term planning should enable better set up Ensure the whole system pressures are clear when making decisions	No opportunity to plan appropriately Emerging HCP and ICB delegation relationship A target driven approach that may not recognise incremental improvements
ESTATES Most IT systems ready to allow collaboration (primary care) Create short term estate solution (saga site) Increase use of technology to support discharge and voluntary sector support	Estate challenges do not always allow for fully collaborative approach Lack of investment in infrastructure that needs remedying urgently Short term-ism - impacts on estates/workforce
WORKFORCE RESILIENCE Development of Single Point of Access (SPOA) for east Kent post west Kent pilot Opening of Mental Health Safe Haven at QE and K&M Crisis House Recruitment of Support Workers to improve Pathway 1 discharges	Workforce capacity and availability Staff holidays: Managing staff leave over the Christmas period Industrial action
EXTEND / ESTABLISH SERVICES Roll out of Acute Response Teams (Thanet model) across Kent and Medway Improve secondary/primary care interface to reduce unnecessary workload in General Practice to create capacity Paediatric minor illness service 24-hour wrap around support for Pathway 1 – where people have cognitive impairment exacerbated by infection/hospital admission Support QOF (Jan-Mar) Implement Choice Policy CPCS is not working well in some areas	Fragile homecare market due to increasing pressures/demand from the system Number of people requiring 1:1 support in Pathway 3 beds whilst awaiting mental health input. The use of elective wards to support MFFD patients unable to access on-going care needs.
	Potential of Electrical/Power supply disturbances Weather related challenges:

Previous Winter Escalation plans for Winter 22/23

EKHUFT Escalation planning winter 22/23
Trust-wide escalation capacity schemes

East Kent Hospitals University NHS Foundation Trust

WHH

The use of escalation areas has formed an integral part of the site management to deliver front door flow throughout the year

- Escalation protocols presented to EcDG in September to determine the order of escalation in ED
- Escalation areas need to be seen as part of the BAU for the WHH and include the use of Richard Stevens, Secol ward therefore a greater focus to developing new models that support timely access to the right speciality is required to reduce the demand on in-patient beds.
- The ED build requires a greater focus on establishing direct access pathways to reduce the overloading of the ED which the emergency care improvement programme
- The proposed acute care model for WHH includes the transformation of the current AMU1 and 2 to provide Short stay, Assessment unit and SDEC
- This could potentially release the SDEC area currently in use for a winter escalation area of up to 14 beds
- The SEAU/newly established MAU/SDEC areas MUST be protected and taken out of the G&A bed stock to preserve their function over winter and beyond
- SAL will need to remain in place as an escalation area for winter and review in May 23 when the phase 3 build is complete

QEQM

The reconfiguration and re-purposing of areas will enable the site to support front door flow and maintain elective activity

- CSM (ITU 3) will cohort all cancer and elective patients creating an elective ward that can support level 1 care (minimising demand for post surgery ITU/HDU)
- Plan WHH colorectal move to QEQM to mitigate WHH theatre staffing issues and enable planned transition before winter trigger reached
- Extend day surgery to a 23hr unit
- Consider Birchington Ward released to GSM for shared care ward scheme
- Consider Gynae Assessment Unit re-located on site
- Gastro Assessment Unit - co-located with SEAU or QUEX ward
- SAL will remain in place
- SPH 10+ beds will be used for MFFD patients as appropriate (low acuity)
- Re-purpose Discharge Lounge creating one ward (3 offices will need re-locating and an alternate seated Discharge Lounge identified) *See site map slide for further detail*
- Trust-wide Emergency Care Improvement Plan schemes to be progressed to ensure assessment areas/direct access/front door schemes are implemented

K&C

Mount McMaster escalation beds have remained in use throughout the year, however this has delayed the installation of the new telemetry equipment and admissions of patients.

- Increasing the use of the MDU will release capacity at the WHH and QEQM .
- St Lawrence ward must be protected for elective inpatient Orthopaedic surgery – significant 78 and 104 week risks. Use of this ward for any other purpose will stop elective Orthopaedic joint replacements.
- Transfer of cancer work to the K&C site will require displacement of routine surgery.
- Kent ward provides vascular admissions for the trust and the system and sufficient beds must be available
- Clarke ward provides urology capacity for the trust and sufficient beds must be available.
- Harbledown provides stroke capacity for the trust and system and sufficient capacity must be available.

EKHUFT Escalation planning winter 22/23
Site Escalation – WHH

East Kent Hospitals University NHS Foundation Trust

ED Escalation

- Phase 1 – SAL x 14 spaces (currently in regular use)
- Phased 2 – Radiology x 6 spaces (currently in regular use)
- Phase 3 – Corridor A x 8 spaces (currently in regular use)

Escalation Beds for DTAs

Escalation Beds:

- Kennington x4
- Richard Stevens x4
- Singleton x6
- SEAU x13
- Spencer x4
- MEOW x12 - area is required from December to mitigate areas lost due to ED build for approximately 10 weeks – end of February

Reconfiguration of bed base:

Release of 18 spaces across the hospital site – work to be done with Care Groups to understand the opportunity

Further Escalation

Closing SDEC can potentially place 16 patients

Closing Endoscopy would provide a place for 8 patients

EKHUFT Escalation planning winter 22/23
Site Escalation – QEQM

East Kent Hospitals University NHS Foundation Trust

Discharge Lounge

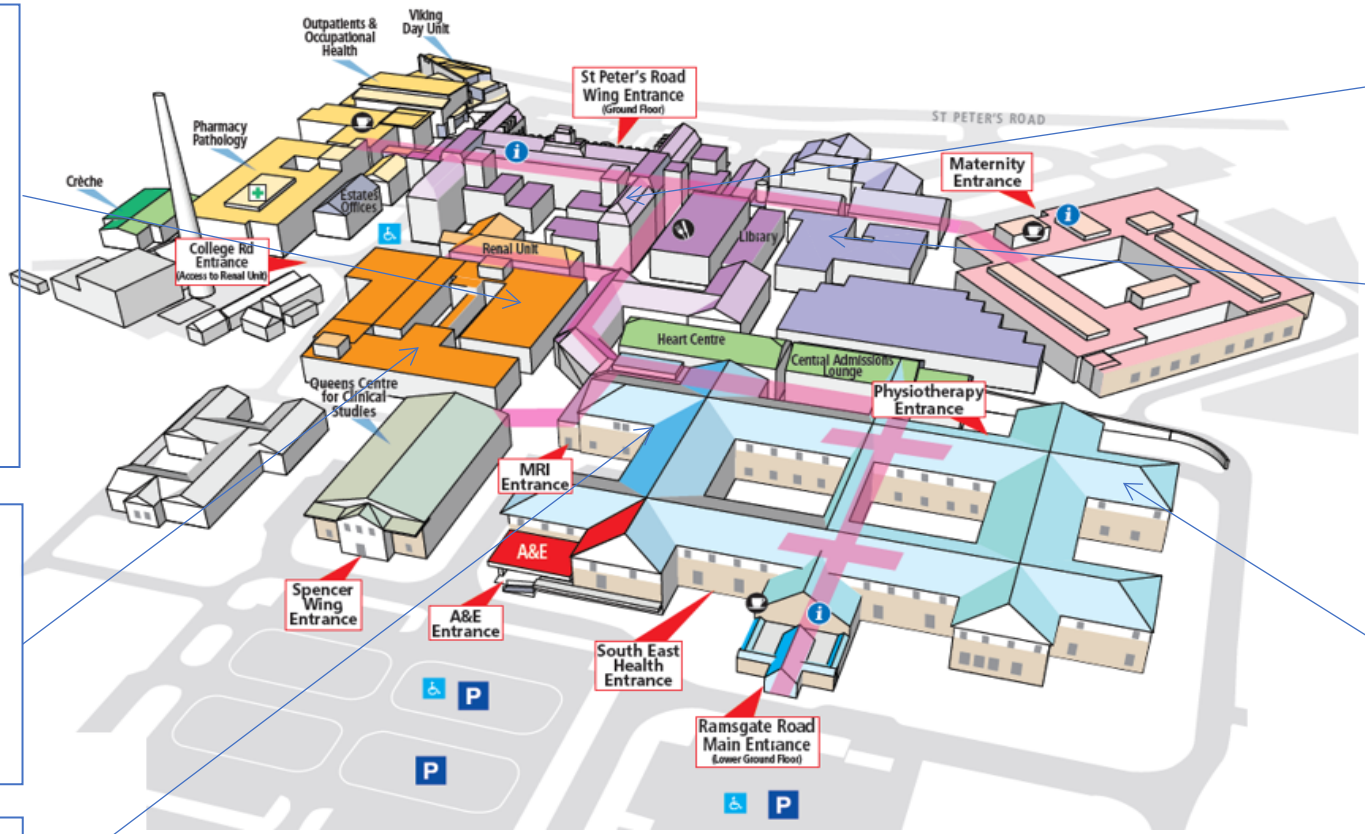
- Phase 1 -Existing Escalation Bedded Area – **5 beds**
- Phase 2 – Re-locate seated area to Gym space to create **4 beds**
- Phase 3 – Re-locate 3 offices to create **2 side rooms** and **1 double side room**

Doctors Mess

- Phase 4 – (requires investment) **8 beds** created in Doctors Mess which enables a full ward to be established aligned to discharge lounge

Radiology

- Phase 1 – Extend ED bedded area in the existing bed spaces used for CT/MRI patients



Day Surgery – 23 Hour Unit

- Create 23 hour DSU
- Re-locate GAU to DSU or Chronic Pain office Suite along St Peters Road Corridor

Birchington Ward

- Consider re-purpose for GSM shared care ward scheme

CSM (ITU 3)

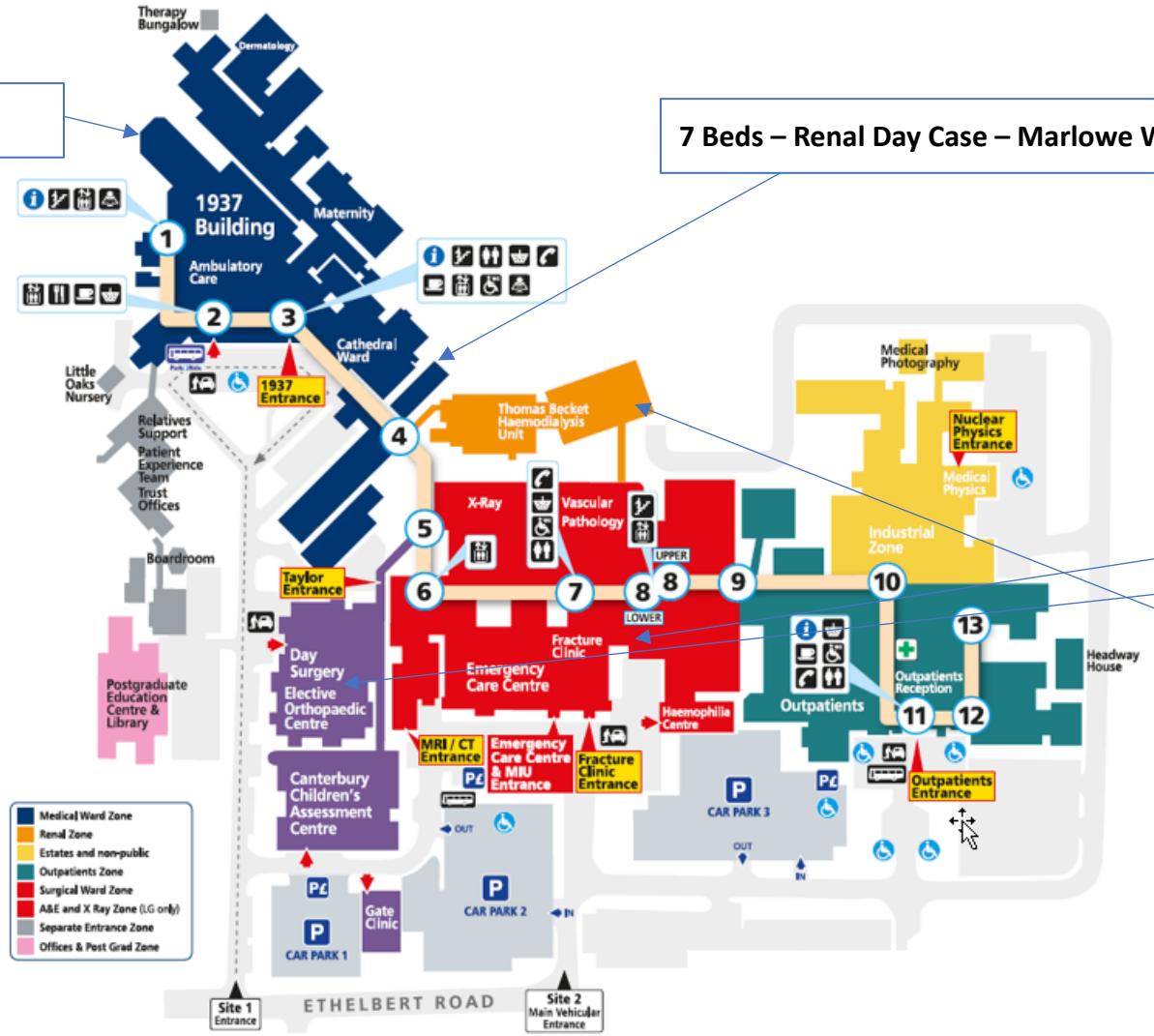
- Re-purpose use of area to elective shared care area with Surgery and Gynae (releasing Gynae IP beds on Birchington Ward)
- Provide level 1 care jointly to minimise ITU/HDU demand
- Creates 1 ward for GSM shared care ward scheme
- Trigger 4 Escalation or early move due to WHH theatre staffing – WHH Colorectal Cancer transfers to QEQM

EKHUFT Escalation planning winter 22/23
Site Escalation – KCH

East Kent Hospitals University NHS Foundation Trust

8 beds Mt McMaster

7 Beds – Renal Day Case – Marlowe Ward



Unstaffed areas

- Endoscopy – displace activity
- Day Surgery ward- displace activity
- Renal dialysis unit – displace activity

- Gyms
- OPD

EKHUFT Escalation planning winter 22/23
Elective surge escalation

Purpose	Actions	Other triggers to consider

• To maintain elective services for as long as possible in a safe and structured way.
• To provide Gold committee with a framework to make decisions on elective care
• Where elective service delivery is reduced, that we ensure that all patients with life threatening conditions receive the timely appropriate care.
• To give clear and timely guidance to the distribution of resources to meet emerging and changing demands on hospital capacity.
• To give clear guidance to departments and individuals as to their role in all scenarios.
• To provide enough notice of escalation to allow departments and individuals to prepare / reconfigure.
• To ensure that all Hospital capacity and resources are used to the maximum.
	This trigger tool is to provide a framework for decision making by the hospital triumvirate based on the site pressures and in discussion with the care groups.
	
	Each triumvirate will need to review the status of the site and agree what actions are needed to provide a safe environment for patients.
		• Variance on escalation triggers by site.
		• Staffing –
		  • Sickness rates / staff availability
		  • Over time demands
		  • Redeployment – Time frame to implement / impact on core services
		• Kent and Medway system triggers
		• ITU trigger tool

EKHUFT Escalation planning winter 22/23
Elective surge escalation

East Kent Hospitals University NHS Foundation Trust

Trust wide					
Escalation Level	Infection	ED DTAs am	ITU empty	Bed Predictor	Staffing
1	0%	< 15	4	- 30	Green
2	5%	<30	2	-40	Green
3	10%	<45	1	-80	Amber
4	20%	>50	Plus 1	-100	Amber
5	30%	>80	+3	> -120	Red

Average Escalation Level	Actions
1	All Elective work run across all sites and Theatres
2	Maintain Channel Day Surgery Unit (CDSU) for day case at WHH Continue cancer and routine work at QEQM and WHH
3	Review all TCIs . Work through daily demand and ITU requirements Review Spencer beds at WHH for admissions Maintain Channel Day Unit (CDU) for cancer day case only at WHH Maintain day surgery at QEQM St Lawrence required for long waiting Orthopaedic patients Kent required for Urology and Vascular
4	Cancel routine surgery to accommodate colorectal and gynaecology oncology at QEQM Reduce Rotary to 5 beds (release max capacity 11 however, some rotary are already in use) Maximise use of Spencer beds at QEQM – volumes to be confirmed Negotiate the use of Spencer beds at WHH 7/7 week for admissions Convert CDSU to provide space for surgical inpatients to create capacity on wards, maintain 30% capacity for Cancer electives and long waiters
5	Undertake limited cancer work, Release St Lawrence (Orthopaedic elective ward) to support flow – max capacity released +24 Reduce routine T&O work at WHH – release staff to support front door/medical take

Elective Trigger Level Plan

East Kent Hospitals University NHS Foundation Trust

All Elective work run across all sites and Theatres

Status	Actions	Reference

• Demand for services within normal limits
• Trust is maintaining routine work
• Trust can maintain patient flow
• Staff numbers are within normal limits
	• Maximise theatre, diagnostic and OPD capacity.
	• Ensure staffing models for redeployment are in place
	  ○ Nursing
	  ○ Medical
	  ○ AHP
	  ○ ADMIN
	• Gold Committee in place x2 per week. LHE cell calls established. SITREPS managed through Operational inbox
		• Maintain routine active monitoring of external risk factors including flu, weather
		• Ensure all pressures are communicated regularly to all local partners i.e.
		  ○ Mutual aid discussion to support another Acute Provider
		  ○ Major Incident Plan
		  ○ Winter Plan
		  ○ Monitoring and oversight of cancer performance

Elective Trigger Level Plan

East Kent Hospitals University NHS Foundation Trust

Maintain Channel Day Surgery Unit (CDSU) for day case at WHH
Continue cancer and routine work at QEQM and WHH

Status	Actions	Reference
• Reduction in availability of beds – impacting on some elective work • No of COVID patients increasing • Lower levels of staff available but sufficient to maintain services • ? A+E Attendance- Ambulance handovers	• Review theatre lists to identify urgent cases and long waiters • Review Critical Care " Critcon Levels". Provide update to Gold • Identify any shortfalls in supporting services that could be covered by non clinical staff – escalate to Gold • Review bed base usage in ITU and prepare for capacity escalation • Gold committee in action x 2 weekly – prepare to implement daily.	• Reference Level 1 • ITU escalation plan • Redeployment plan S & A (Theatres and ITU – medical and nursing)

Elective Trigger Level Plan

East Kent Hospitals University NHS Foundation Trust

3

Review all TCIs . Work through daily demand and ITU requirements
Review Spencer beds at WHH for admissions
Maintain Channel Day Unit (CDU) for cancer day case only at WHH
Maintain day surgery at QEQM
St Lawrence required for long waiting Orthopaedic patients
Kent required for Urology and Vascular

Status	Actions	Actions	External Actions
•Is ITU at capacity – review staffing requirements. Identify which theatres on all sites can be staffed without impacting on ITU. • Review NIV capacity • Reduction in availability of staff – impacting on elective work Escalation beds in use • No of COVID patients increasing • Lower levels of staff available and some impact on services • Number s in A & E – Ambulance handovers	**OPERATIONAL CONSIDERATIONS** • Consideration given to elective work including clinical prioritisation and cancellation of non elective work. • Review theatre lists to identify urgent cases and long waiters in preparation for potential cancellation • Review Critical Care " Critcon Levels". • Provide update to Gold • Identify any shortfalls in supporting services that could be covered by non clinical staff – escalate to Gold • Review bed base usage in ITU and prepare for capacity escalation • Gold committee in action daily. • Consider cessation of meetings and training	**CLINICAL CONSIDERATIONS** • Undertake additional ward rounds to maximise discharges • Clinicians to prioritise discharges and accept outliers from any ward as appropriate • Review bed base usage in ITU and prepare for capacity escalation • Identify any shortfalls in supporting services that could be covered by non clinical staff – escalate to Gold • Senior ED clinician to lead triage and increase streaming to UTCs and assessment units. • Review staffing levels for the next 48 hours and take action to ensure safe cover in all areas • Review staffing levels for the next 7 days to enable forward planning. • Care Group instigate care group escalation plan. Risk assess and redeploy "own staff" including deploy of supernumerary and senior nursing	• Alert CCG of internal pressures • Consideration of Elective work – escalate to CCGs/ ICS/STP – including IS Surge Plan • Notify CCG/LHE of bed pressures – request additional support
REFERENCE •Reference Level 1 and 2 •Refer to ITU CRITCON levels and ITU SOP			

Elective Trigger Level Plan

East Kent Hospitals University NHS Foundation Trust

4

Cancel routine surgery to accommodate colorectal and gynaecology oncology at QEQM
Reduce Rotary to 5 beds (release max capacity 11 however, some rotary are already in use)
Maximise use of Spencer beds at QEQM – volumes to be confirmed
Negotiate the use of Spencer beds at WHH 7/7 week for admissions
Convert CDSU to provide space for surgical inpatients to create capacity on wards, maintain 30% capacity for Cancer electives and long waiters

Status	Actions	Actions	External Actions
• Is ITU and escalation ITU full –consider move to theatre recovery areas. • Significant deterioration in performance in ED – Ambulance delays • Significant staffing issues causing operational challenges and risk to patient safety • No of COVID Increasing • Ward staffing levels critical • A & E requires specialty doctors in department • Inability to manage Red and Blue pathways independently. • Patient flow is significantly compromised	**OPERATIONAL CONSIDERATIONS** • Theatres/ theatre staff may used to support critical care. • Move activity to KCH – if possible. • Establish CRITCON level. • Implement COVID medical rotas • Gold command in place	**CLINICAL CONSIDERATIONS** • Active management of elective work including clinical prioritisation and cancellation of non urgent elective inpatients. to release clinical staff to support wards and ED. • Cancellation of routine OPD to release specialty doctors to support • Stage 3 medical rotas implemented. Reallocate junior doctors • Consider cancelling SPA , study leave etc and redeployment of staff to provide short term cover. • ED senior clinical decision maker to be in ED 24/7 where possible • Care Groups consider withdrawal / or reduction of specialist nurse led activity for redeploy to front line delivery. • Care Groups redeploy staff released from OPD, Corporate and other stepped down routine activity.	• Confirm approval to cancel electives • Escalate to CCG and LHE cell pressures on site and immediate actions required including possible cancellation of elective work • Brief NHSI on the need to cancel electives • Alert social services managers to expedite care packages etc. • Alert community trust to expedite community beds • Mutual aid discussion
REFERENCE • Reference levels 1-3 • Refer to ITU CRITCON levels and ITU SOP • Major Incident Plan			

Elective Trigger Level Plan

East Kent Hospitals University NHS Foundation Trust

5

Undertake limited cancer work,
Release St Lawrence (Orthopaedic elective ward) to support flow – max capacity released +24
Reduce routine T&O work at WHH – release staff to support front door/medical take

Status	Actions	Actions	External Actions
• No capacity across the acute sites • All Routine elective work suspended • Potentially stop cancer and urgent work • Increased staff redeployment • Unable to manage red and blue pathways. • Severe capacity issues on ITU beds and need to transfer critically ill patients to external facilities. • Staff absences causing major operational challenges and patient safety cannot be assured.	**OPERATIONAL CONSIDERATION** All previous actions continue as appropriate • Consider stopping all but essential trust functions and redeploy staff to clinically critical areas. • Consider cancelling planned leave. • Use of IS for cancer work if available • Consolidate as much complex cancer work at KCH if possible • Strategic call 7/7 to be led by CEO/Deputy	**CLINICAL CONSIDERATION** • Allocated senior clinical decision makers to be present on wards, in theatres and in ED 24/7, where possible; • Cancel SPA time, study leave, non essential meetings to provide short term cover • Cancel all elective work including OPD (including Non F2F). • Senior decision makers in ED. • Contact on call and ED senior decision makers to offer specialty support to ensure patients are seen and assessed as soon as possible. • Care Groups redeploys staff released from OPD, and other stepped down activity.	• Escalate to CCG and LHE cell pressures on site and immediate actions required including possible cancellation of elective work. • Alert social services managers to expedite care packages etc. • Alert community trust to expedite community beds • Mutual aid discussion • Brief NHSI on the need to cancel electives
REFERENCE • Reference levels 1-4 • Refer to ITU CRITCON levels and ITU SOP • Major Incident Plan			

EKHUFT Escalation planning winter 22/23
Elective bed capacity

East Kent Hospitals University NHS Foundation Trust

The ability to maintain elective activity on all 3 sites is dependant on a number of factors but will require availability of beds.

Current bed availability is :

WHH capacity

- Spencer 4 beds – Monday to Friday
- Rotary – 16
- Channel day - 15

QEQM capacity

- Spencer beds - 10 beds (TBC for winter)
- Birchington – ??

K&C capacity

- Kent - 30 beds (includes capacity for some emergency surgery)
- Clarke - 36 beds (includes capacity for some emergency surgery)
- St Lawrence - 24 beds
- Invicta - 24 beds (currently used to support MFFD, OrthoFFD and surgical emergencies)

The Trigger tool will indicate when this should be stepped down and reallocated to emergency care bed capacity or where staff could be released.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Integrated Performance Report (IPR)**

Meeting date: **2 November 2023**

Board sponsor: **Chief Strategy & Partnerships Officer (CSPO)/Interim Chief Finance Officer (CFO)**

Paper Author: **Chief Strategy & Partnerships Officer**

Appendices:

APPENDIX 1: September 2023 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the operational performance, Quality & Safety, Workforce and Financial organisational metrics. The metrics are directly linked to the We Care Strategic and Annual objectives. The reported metrics are derived from: 1. The Trust Integrated Improvement Plan 2. Other Statutory reporting 3. Other agreed key metrics.
Summary of key issues:	The IPR has been subject to a review and refresh and a revised format with a wider view of metrics is presented for the September Board meeting. The reported metrics have been expanded significantly within the report to provide clear visibility on all metrics associated with the Integrated Improvement Plan programmes of work, statutory reporting and other agreed key metrics. The attached IPR is now ordered into the following strategic themes: • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics. • **People,** incorporating people, leadership & culture metrics. • **Sustainability.** Incorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. At the start of each strategic theme section is a performance summary followed by a more detailed page for each of the reported metrics.

Key performance points (September Reported Month):

Patients

- All type Emergency Department (ED) performance is now behind plan at 70.7%.
- Type 1 ED performance is under plan at 45.5%.
- Cancer 28 Faster Diagnosis Standard (FDS) has deteriorated in month to 58.3%.
- Diagnostics performance has further deteriorated with key issues remaining in CT and endoscopy.

Quality & Safety

- 13 Serious Incidents (SIs) declared in the month.
- 0 never events reported in August.
- The number of overdue incidents increased in month by 311.
- Hospital Standardised Mortality Ratios (HSMR) remains below 100 and appears to have plateaued at an index figure of around 93.

People

- Sickness absence has tipped over the 5% threshold in month to 5.1%.
- Vacancy rate remains below the desired threshold, with improvements appearing to plateau.
- Staff turnover has reduced further to 9.0% and has now sat below the national standard (10%) for nine consecutive months.
- Staff engagement score improved from the prior quarter but remains below the target threshold.
- Completed medical job plans remains below the target at 58.1%.
- Appraisal rates further improved to 73.3%.

Sustainability

- The financial position is adverse to plan by £9 million in month 6.
- Cost Improvement Programme (CIP) delivery is significantly below the plan for month 6.
- The current value of the pipeline is £14.9m, a (£1.1m) (8%) increase in value vs. the prior month.
- Premium pay remains high with drivers that include escalation beds, and additional 1:1 care needs.

Maternity

- 2 SIs declared in the month of August for women's health in Gynaecology.
- Complaint response times are below the target threshold.
- Perinatal mortality remains low and in line with the prior month.
- FFT recommend rate is 90.8% for the month.
- Staff engagement score has improved on the prior quarter to 6.15.

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage.
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the Emergency Department (ED).
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Working through with the subsidiaries their involvement and impact on We Care.

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

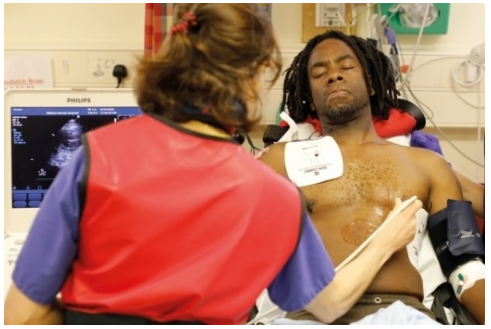
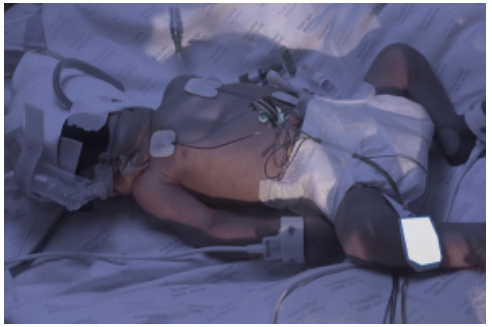
Integrated Performance Report

September 2023







Patients

Operational Performance

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Operational Performance	IIP		ED Compliance		73.0%	68.8%	69.9%	64.7%	68.4%	67.3%	67.1%	70.7%	71.7%	73.2%	74.3%	71.9%	70.7%
	IIP		Type 1 Compliance 4hrs		55.0%	43.4%	47.0%	40.2%	41.5%	40.7%	39.1%	44.0%	45.1%	48.1%	51.6%	46.5%	45.5%
	IIP		12Hr Trolley Waits (MTD unvalidated)		0	1028	1005	1190	1168	1021	1189	989	1136	929	769	908	867
	IIP		Ambulance Handovers within 30m		95.0%	76.4%	75.1%	70.4%	80.8%	81.1%	80.5%	86.0%	86.2%	90.4%	91.8%	89.7%	90.0%
	IIP		Super Stranded >21D		107	291	295	287	310	307	296	280	272	260	246	241	245
	IIP		Not Fit to Reside (pats/day)		300.0	211.5	204.5	217.6	240.7	255.7	232.8	226.1	213.4	218.5	192.3	193.0	199.8
	IIP		Cancer Over 62d on PTL		67	271	232	321	342	233	230	379	371	371	386	431	519
	IIP		Cancer Over 104d on PTL		0	57	40	48	64	57	54	49	77	66	73	84	98
	IIP		RTT 52w Breaches		Traj.	3,372	3,379	3,299	3,317	3,187	2,997	3,027	3,608	3,907	4,575	4,767	5,113
	IIP		RTT 65w Breaches		0	1,257	1,161	1,219	1,175	976	707	766	984	1,023	1,148	1,292	1,499
	IIP		DM01 Compliance		75.0%	65.1%	66.8%	60.6%	57.6%	62.0%	60.3%	56.3%	58.6%	59.0%	55.9%	53.6%	54.1%

September Performance Summary

Emergency Department: Performance deteriorated in September for the 2nd month in a row with Type 1 at 45.5% (-1%) and all types 70.7% (-1.2%), the previous month reflecting the national trend for September. The last 2 weeks of September saw an increase in the number of type 1 walk-in attendances and ambulance conveyances with associated increase in the number of admissions. There was a correlating increase in the number of patients awaiting beds in the ED each morning 132 in September v 65 in August. The ambulance handover standard < 15 minutes improved in month (+2.1%) with the associated improvement in the 30 minute standard. It is worth noting that the utilisation of corridor space increased in month with the WHH reporting high numbers of patients in escalation space within ED and an OPEL 4 status in place for the majority of the month. Drivers that affected performance: increase in type 1 presentations, ambulance conveyances (highest number reported since Nov 22), % discharges for both simple and complex deteriorated with simple discharges reporting the lowest weekly % in the last 6 months. The Emergency Care Delivery Group (ECDG) workstreams continue to focus on delivery of the new clinical models to reduce the number of patients dwelling in the ED. 12 hour total time in ED deteriorated in September (+0.8%) with the increase in the number of patients waiting over 12 hours reported across both admitted and non-admitted pathways.

Cancer: Increased number of patients waiting longer than 62 or 104 days, D62 and D104. Breach reports, Datix, harm reviews and learning documented and actions built into improvements needed. Highest contributing factors are within the Lower GI and Urology Cancer Pathway, with the endoscopy delays making highest contributing factor, followed by radiology delays, vetting, booking and reporting and biopsy delays. New weekly focused Cancer feeder pack for each team linked to Performance meetings and weekly PTL's will focus on agreed actions to clear back log and record progress within feeder week on week with embedded changes to ensure sustainable improvement, in all tumour sites

Diagnostics: Diagnostics: Diagnostic performance has improved slightly in month. Improvement continues to be observed in NOUS and the MRI position which was rapidly deteriorating has now stabilised.

Referral to Treatment Waiting Times: The impact of referral growth, waiting longer for first out patient appointments, diagnostic delays, reduced elective (inpatient and day case) activity and the accumulative impact of Industrial Action since April 2023 are hindering our ability to improve the position.

Type 1 Emergency Department 4h Compliance

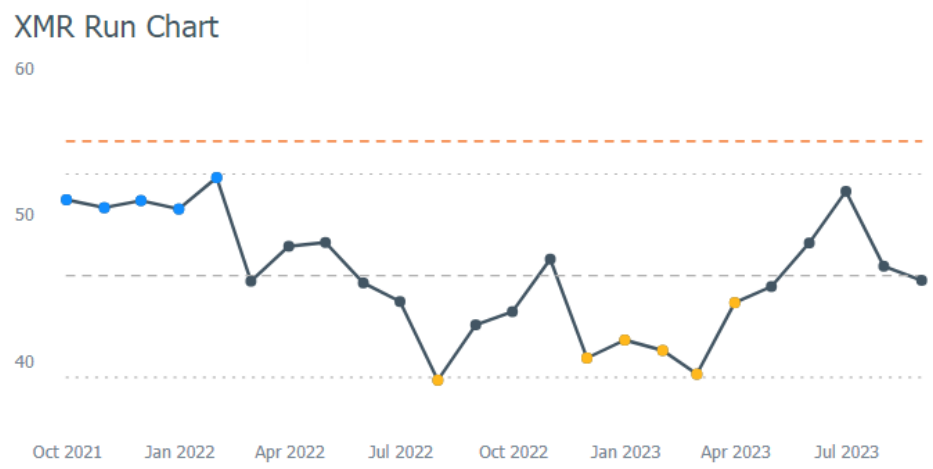
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This four-hour standard measures the total time patients spend in the emergency department from arrival time to admission, transfer [to another provider] or discharge. For patients arriving by ambulance, the clock starts when the patient is handed over from the ambulance staff to hospital staff or 15 minutes after the ambulance arrives at A&E (whichever is earlier). This metric only contains Type 1 (ED) attendances.

Type 1 Compliance 4hrs

Timescale	Value	SPC
Oct-22	43.4%	
Nov-22	47.0%	
Dec-22	40.2%	
Jan-23	41.5%	
Feb-23	40.7%	
Mar-23	39.1%	
Apr-23	44.0%	
May-23	45.1%	
Jun-23	48.1%	
Jul-23	51.6%	
Aug-23	46.5%	
Sep-23	45.5%	



Understanding the most recent data point

Performance

45.5% — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ED Single point of access for all patients requiring urgent and emergency care	• Direct Access Pathways (DAPs) implemented since March '23 and include pathways to SDEC/SEAU/CAU • Further work to undertake to increase the number of DAP and include the Medical Assessment Units on both sites • Training completed for the Medical staff at QEQM	• SC/DS/HT/RL • WK/SC/JW/DB	• On going monitoring in place • September	• Work to progress the DAPs ahead of the opening of the CAU end Sep. • Review of the DAP to MAU in readiness for the opening of the new MAU • Clinical lead will provide training over 2 weeks
Internal processes not fully aligned to operational delivery	• Implementation of internal escalation processes • External support to review internal escalation processes: daily rhythm: OPEL actions; Site team structure and review the Full Capacity protocol commences in October	• MDs • COO	• Sep 2023 • Oct 2023	• Internal plans for UEC both sites completed – forwarded to the CNO for approval • To go live from October • QEQM/WHH to provide training for the whole hospital in line with OPEL actions -November
Whole Hospital Response Establishing CDUs at WHH/QEQM	• Trust wide development of IPS. GIRFT recommendation • CDU Models agreed for QEQM and in place sept. • Next phase- to widen criteria post review to increase utilisation- will require a change of clinical model to realise • CDU Model being explored at WHH to go live Oct 23. Requires phase 3b of the build to be completed	• SC. • Clinical leads MDs DoN • MD/DCOO/DoN/Clincal Lead	• Dec 2023 • Nov 2023 • Nov 23	• Work the GIRFT team to support IPS implementation (forms part of the wider action plan) • QEQM leads working on the next phase • Further work to reduce the number of speciality patients in the proposed CDU | a focussed working group established with actions to achieve

Emergency Department 4h Compliance (all types)

Integrated Improvement Plan

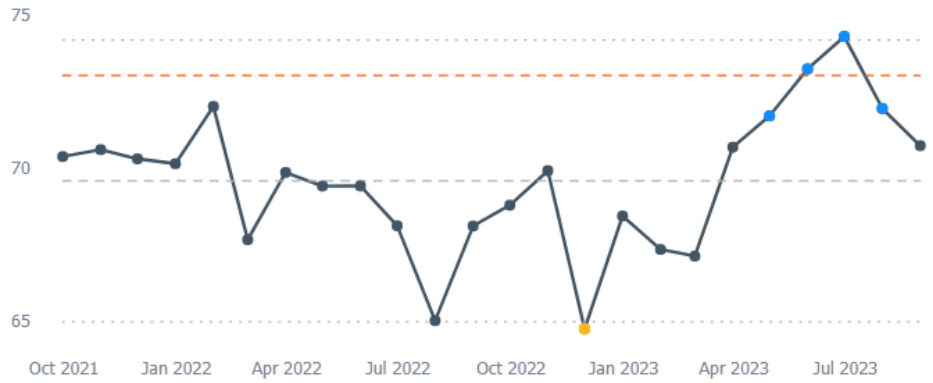
East Kent Hospitals University NHS Foundation Trust

This four-hour standard measures the total time patients spend in the emergency department from arrival time to admission, transfer [to another provider] or discharge. For patients arriving by ambulance, the clock starts when the patient is handed over from the ambulance staff to hospital staff or 15 minutes after the ambulance arrives at A&E (whichever is earlier). This metric combines Type 1 (ED) and Type 3 (UTC) attendances.

ED Compliance

Timescale	Value	SPC
Oct-22	68.8%	
Nov-22	69.9%	
Dec-22	64.7%	
Jan-23	68.4%	
Feb-23	67.3%	
Mar-23	67.1%	
Apr-23	70.7%	
May-23	71.7%	
Jun-23	73.2%	
Jul-23	74.3%	
Aug-23	71.9%	
Sep-23	70.7%	

XMR Run Chart



Understanding the most recent data point

Performance

70.7% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation Flags: Common cause (no significant change); No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Lack of timely UTC pathways and direct access from the front door. Requirement for direct access pathways GP/Secamb.	• Review of the UTC pathways supported by the ICB Clinical Lead • Further work progressing to increase activity and cohort into the UTC • Implement Alt-ED model led by ECIST	• Clinical ED leads /UTC leads/ Head of Ops	• Complete • Oct 23	• Pathways reviewed, work commenced through the HCP and SECAMB development for DAP to UTC • Work in train to develop DAP for GPs, linked to the work in West Kent . • Progressing the Alt-ED | review value with ECIST Oct and planned roll-out with SECAMB
Use of the ED as a single point of access. Develop direct access pathways, assessment units and optimise Same Day Emergency Care (SDEC) inc Paediatrics.	• Review SDEC criteria using the Ambulatory Care Condition Directory. • Expansion of hours to be established (both sites) • DAPs commenced June – September with further work planned to include DAPs to SDEC and MAU	• Care Group Ops and Clinical Team	• Sep 2023	• Highest number of patients seen in SDECs (Jul). • CAU pathway development to be progressed at QEQM and pilot started September with a review at the Oct ECDG
Safety of the ED when in overcapacity | Review new models in place with external guidance on plans to improve alt pathways, access & reduce ED atts.	• On site GIRFT visit July | recommendations reviewed and progress report to EK UEC board • Agree Task and finish system groups for over conveyances and frailty services	• COO • HCP leads	• Oct 23 | 3 mths	• Action plan submitted to EK UEC Board October • Shared action plan outlining the joint approach and task & finish action plan via the HCP delivery group • Weekly engagement with the GIRFT leads

Ambulance Handovers within 30m

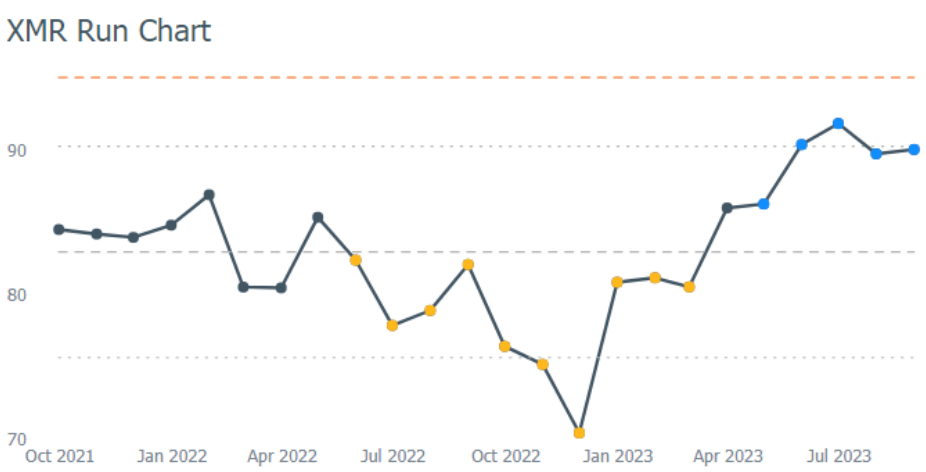
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of Ambulance handovers completed within 30 minutes of arrival. Incomplete timestamps are excluded from the performance.

Ambulance Handovers ...

Timescale	Value	SPC
Oct-22	76.4%	
Nov-22	75.1%	
Dec-22	70.4%	
Jan-23	80.8%	
Feb-23	81.1%	
Mar-23	80.5%	
Apr-23	86.0%	
May-23	86.2%	
Jun-23	90.4%	
Jul-23	91.8%	
Aug-23	89.7%	
Sep-23	90.0%	



Understanding the most recent data point

Performance

90.0%

Variation indicates consistently falling short of the target

Variation

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

Flags: Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High numbers of ambulance conveyances to the Emergency Departments at QEQM/WHH (national outlier)	• Working with the HCP and SECAMB partners . Implementation the Alt-ED model • Support from GIRFT – one of the key recommendations following the review in July	• HCP/Hospital Site teams /Secamb	• Sep 2023; 3 month plan	• Establishing the HCP action plan to support the Alt-ED roll-out and the GIRFT action plan to support UCR pathways
ED used as a single point of access increasing the risk of overcapacity and reduce the ability to manage handover Patients waiting outside the department due to process and space concerns at the WHH site	• Introduction of front door streaming and RAT to support early handover of patients. Early ED triggers in place to reduce risk for off-loading . • Streaming in place to support direct access to SDEC//SAEU/CAU/UTCs against patient criteria • Review of the process . To review environment and reception /streaming process and review the direct access for paediatrics to the Paeds ED	• Clinical lead ED and Head of Ops • MDs • DCOO /MDS/DoNS	• In place • October 23	• ED reviewing their internal plans to ensure early triggers resolve potential issues with off loads /Over capacity EDs • Plans to be developed for improving waiting environment / direct to paeds pathways / reception cover to reduce waits. Number of ambulance conveyances triaged to Waiting Room | review as part of GIRFT recommendations
Wait times to be seen by a senior clinician were over the standard 1 hour – with potential risks associated with waits	• Introduction of the Dr Initial Assessment(WHH) to support timely reviews and assessment of pts arriving on ambulances • Model in place at QEQM from September	• Clinical lead ED and Head of Ops	• In place and on-going	• Metrics in place • DAPs started with plans to expand to SDEC/MAU

>12h Total Time In Emergency Department

Integrated Improvement Plan

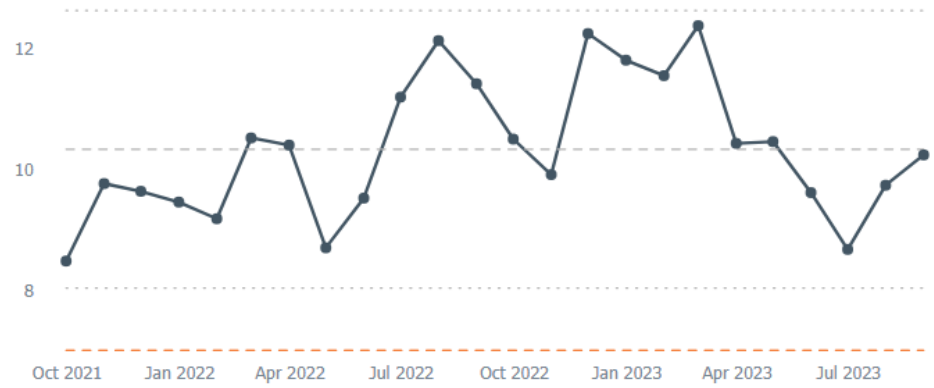
East Kent Hospitals University NHS Foundation Trust

This measure counts the proportion of patients whose total time in the emergency department exceeded 12 hours.

12 Hr Total Time in Dep...

Timescale	Value	SPC
Oct-22	10.5%	
Nov-22	9.9%	
Dec-22	12.2%	
Jan-23	11.8%	
Feb-23	11.5%	
Mar-23	12.4%	
Apr-23	10.4%	
May-23	10.5%	
Jun-23	9.6%	
Jul-23	8.7%	
Aug-23	9.7%	
Sep-23	10.2%	

XMR Run Chart



Understanding the most recent data point

Performance

10.2%

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Number of patients waiting for a bed (admitted cohort)	Implementation of; • Daily pathway zero meeting • Specialty in-reach to the front door • Frailty units established –both site • Clinical forums to right size bed base and ensure appropriate configuration WHH in place QEQM November	• Clinical leads /MDs /Head of Ops	• October for 3 months	• Creation of integrated hubs at the front door with access to domiciliary care to reduce P1 admissions • SAFER Bundle roll-out | Commenced WHH July – reviewed September with a plan to utilise KPMG to follow the work through at WHH – start Oct • Focussed work to improve patient flow at QEQM | External support PRISM starting October
Use of corridor to manage high numbers of pts in ED	• Implement SAFER Bundles • Protection of the DAP pathways and assessment units • Increase UTC/SDEC activity • Review of internal triggers aligned to the new OPEL Framework (live from Oct 23) and work with HCP to align system wide response requirements	• Clinical leads /MDs /Head of Ops • HCP/MDs	• On going • Sep 2023 for 3 months	• Internal triggers and access and use of escalation areas completed WHH pending approval. QEQM – in development • OPEL framework goes live Dec 23
High number of Mental Health (MH) patients in ED. Long waits due to lack of inpatient MH facilities	• Daily external escalation processes to be approved by the HCP to support oversight and planning • External ICB support to EKMHT to manage capacity access OOA	• DoNs/MDs/ MDs/COO/C NO/HCP leads	• On-going • Oct/Nov 2023	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4

Super Stranded Patients (>21d LoS)

Integrated Improvement Plan

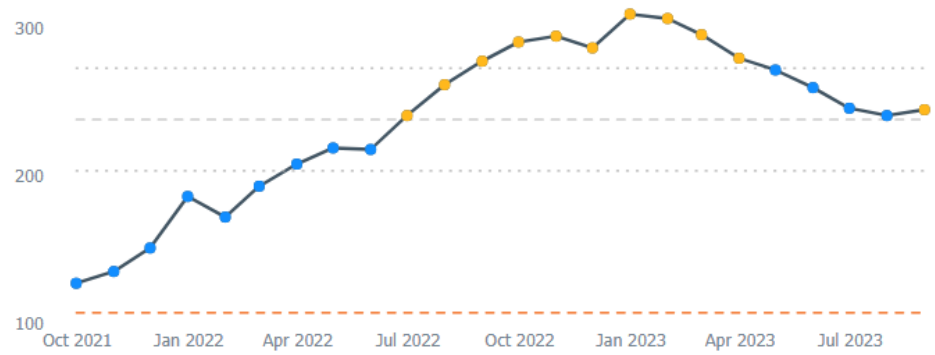
East Kent Hospitals University NHS Foundation Trust

The NHS defines a super stranded patient as someone who has spent 21 days or more in hospital.
This metric counts the number of Super Stranded patients at the time snapshot was taken, in this case the last day of the month.

Super Stranded >21D

Timescale	Value	SPC
Oct-22	291	
Nov-22	295	
Dec-22	287	
Jan-23	310	
Feb-23	307	
Mar-23	296	
Apr-23	280	
May-23	272	
Jun-23	260	
Jul-23	246	
Aug-23	241	
Sep-23	245	

XMR Run Chart



Understanding the most recent data point

Performance

245

Variation indicates consistently falling short of the target

Variation

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

Flags: Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Further support from KMPG will come online from early November. • Revised practice to include >14 day patients in the MFFD weekly RTS huddle. Roaming LoS management commenced at WHH where all patients >14d discussed with action workbook and accountable owners • QEQM PRISM Inpatient Flow Improvement Project commenced on 2nd October and is in the initial 4-week evaluation phase.
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) | 7 of the 25 are due to start on the 18th October, another seven posts have been offered this week. Introduction of this service will increase pathway 1 capacity. • Proposed capacity supporting P2, P3 discharges across KCHFT, Broadmeadow, Westview and Westbrooke facilities. Included as part of the EK HCP Winter Plans providing up to an additional 48 beds spaces. The Trust are working on close partnership will HCP to determine start dates and phased opening plans.

Patients No Longer Fit to Reside in Hospital

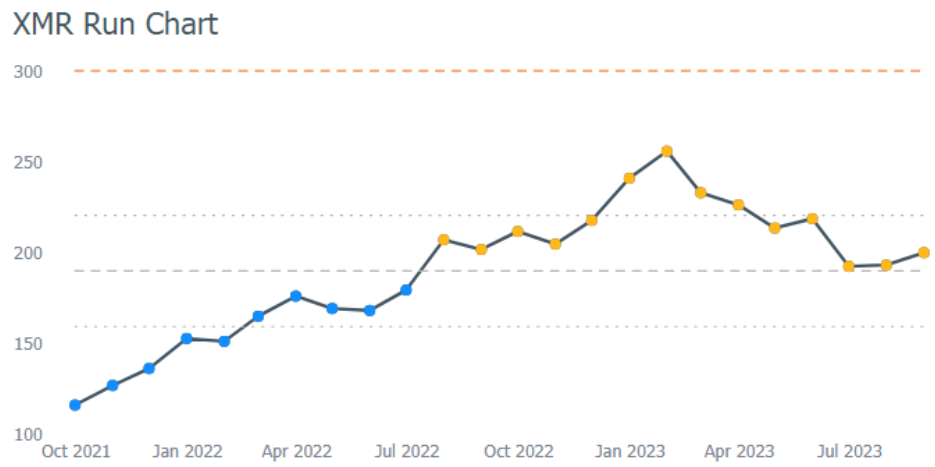
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The status of a patient is captured and recorded by clinical teams on a daily basis. Where a patient is deemed 'no longer fit to reside' (nlftr) this means that their care could be safely given in a setting outside of the acute hospital.
This metric measures the number of patients classified as nlftr each day in the month and expresses this as an average over the month.

Not Fit to Reside (pats/...

Timescale	Value	SPC
Oct-22	211.5	
Nov-22	204.5	
Dec-22	217.6	
Jan-23	240.7	
Feb-23	255.7	
Mar-23	232.8	
Apr-23	226.1	
May-23	213.4	
Jun-23	218.5	
Jul-23	192.3	
Aug-23	193.0	
Sep-23	199.8	



Understanding the most recent data point

Performance

199.8 — Variation indicates consistently passing the target

Variation

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

Flags — Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/ COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) – 7 of the 25 are due to start on the 18th October, another seven posts have been offered this week. Introduction of this service will increase pathway 1 capacity. • Proposed capacity supporting P2, P3 discharges across KCHFT, Broadmeadow, Westview and Westbrook facilities. Included as part of the EK HCP Winter Plans providing up to an additional 48 beds spaces. The Trust are working in close partnership will HCP to determine start dates and phased opening plans.
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Further support from KMPG will come online from early November. • QEQM PRISM Inpatient Flow Improvement Project commenced on 2nd October and is in the initial 4-week evaluation phase.
Ward/RTS comms.	• PTL improvements provide the ward and RTS with a traffic light system highlighting the patient status on the RTS caseload. Alert system rolled out to provide two-way communication between ward and RTS for patient reviews.	• GS and Gastro DHoN	• End Oct	• PTL updates complete for RTS discharge PTL which now feeds into the main discharge planning PTL. • A single referral form is in development for enhanced discharge pathway planning. The Trust are seeking to attain the position where all enhanced discharge pathways are determine by RTS and Integrated Hubs.

Cancer 28d Faster Diagnosis

Integrated Improvement Plan

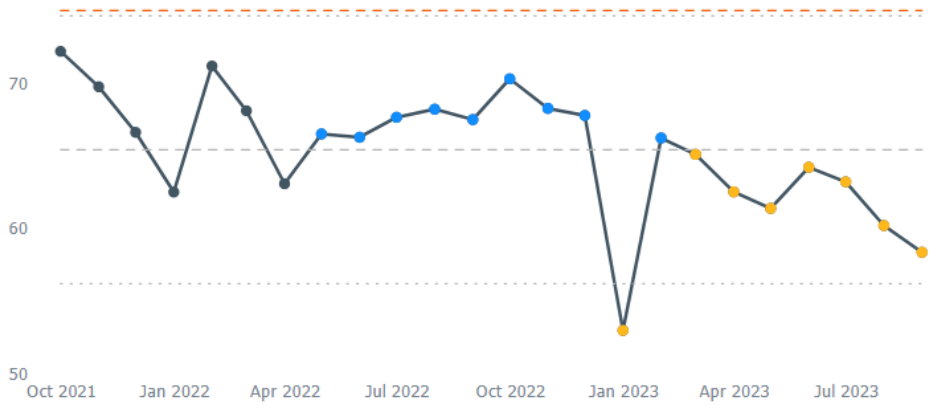
East Kent Hospitals University NHS Foundation Trust

There is a national requirement to diagnose or rule out cancer for patients referred on a cancer pathway within 28 days of receipt of referral.
This metric measures the % pf patients discharged or given a diagnosis in each month within 28 days of their referral.

Cancer 28d Performance

Timescale	Value	SPC
Oct-22	70.3%	
Nov-22	68.3%	
Dec-22	67.8%	
Jan-23	53.0%	
Feb-23	66.2%	
Mar-23	65.1%	
Apr-23	62.5%	
May-23	61.4%	
Jun-23	64.2%	
Jul-23	63.2%	
Aug-23	60.2%	
Sep-23	58.3%	

XMR Run Chart



Understanding the most recent data point

Performance

58.3%

Variation indicates consistently falling short of the target

Variation

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

Flags: Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic reporting for CT's & MRI's (current reporting time is 2 weeks for CT's and 6 weeks for MRI's) Ref to exam - CT- 2-3 days if bloods done, if not 14 days. MRI 11 days.	Reduce referral to reporting to 10 days for CT and MRI	• Radiology • Cancer Trackers • Phlebotomy	• End Oct 2023	• Improved escalation process being piloted for bloods, vetting, booking and reporting • Awaiting confirmation of 2 locum staff starting to support CTbx, NOUS BX and reporting
Qfit process not consistently applied and current waiting time for endoscopy booking is 4 weeks.	Qfit process to be consistently applied and sustained. To reduce waiting time to Scope to 10 days for 2ww and screening patients	• Endoscopy • Qfit Facilitator • AMD Surgery	• Dec 2023	• Task and finish group established that includes actions for Endoscopy and Qfit • STT implemented for Lower GI SOP being revised to extend criteria with learning from other organisations. • The endoscopy request form is being updated to include Qfit result as is the 2ww referral form within the community • Lead GP is contacting practices who are showing zero utilisation of Qfit to encourage them to utilise Qfit current utilisation 69% by GP's
Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging 8-12 weeks.	Typing of letters for those tumour sites to be completed within 7 days.	• Care Group Lead Medical Secs	• End Oct 2023	• Updates on progress circulated to teams 3 times a week to support improvement

Cancer Patients >62d on PTL

Integrated Improvement Plan

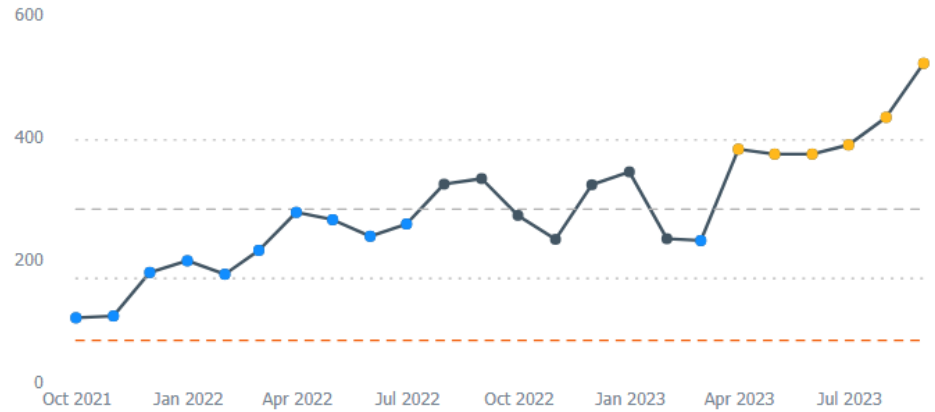
East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 62d or more from point of referral and have not yet received treatment. This metric is a snapshot count of patients as at month end.

Cancer Over 62d on PTL

Timescale	Value	SPC
Oct-22	271	
Nov-22	232	
Dec-22	321	
Jan-23	342	
Feb-23	233	
Mar-23	230	
Apr-23	379	
May-23	371	
Jun-23	371	
Jul-23	386	
Aug-23	431	
Sep-23	519	

XMR Run Chart



Understanding the most recent data point

Performance

519

Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic waiting time for U/S Guided Biopsies. Average wait time 4-5 weeks	• Reduce wait time to diagnostic to 7-10 days.	• Radiology • Cancer	• Jan 2024	• Radiology Improvement plan in place awaiting new interventionalists to start • Options for dedicated lists on the K&C site being explored • Options within the Alliance being explored to support the teams involved
Delays with radiology vetting, booking and reporting adding weeks to suspected cancer patient pathway	• 300 back log of reporting needs to be cleared asap and timeline of what can be delivered for suspected cancer patients agreed	• Radiology • Cancer	• Oct 2023	• Backlog included in weekly feeder pack, for update and discussion at Performance meetings and PTL's to ensure weekly improvement
Inadequate capacity within out-patients for F2F appointments post MDM to discuss treatment options post MDM	• Increase Outpatient capacity for decision to treat (DTT) OPA's. OPA to be available within 5 days following the MDM. • Provide Increased straight to test (STT) capacity to release medical time for F2F OPA's etc	• FDS Lead Clinician • Out-patient Lead	• Oct 2023	• 2ww Transformation and longer waiter Working Group established • STT for lower expanding capacity in September • STT prostate funding agreed posts due to be advertised • STT Lung and Upper in place, under review for additional learning/improvement following patients feedback

Cancer Patients >104d on PTL

Integrated Improvement Plan

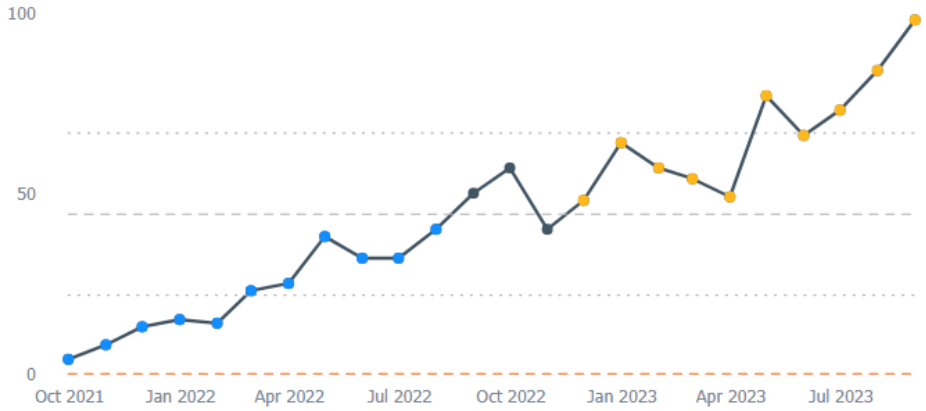
East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 104d or more from point of referral and have not yet received treatment.
This metric is a snapshot count of patients as at month end.

Cancer Over 104d on PTL

Timescale	Value	SPC
Oct-22	57	
Nov-22	40	
Dec-22	48	
Jan-23	64	
Feb-23	57	
Mar-23	54	
Apr-23	49	
May-23	77	
Jun-23	66	
Jul-23	73	
Aug-23	84	
Sep-23	98	

XMR Run Chart



Understanding the most recent data point

Performance

98 — Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Above Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Urology Surgical capacity	Increase surgical capacity by exploring mutual aid options with MFT for RALP and Cystectomy	• MD • AMD and MD K&C • MDT Lead for Urology	• Oct 2023	• Pathway agreed with MFT and local team. • K&M Cancer Alliance meeting being arranged. So far patients not engaging in having surgery elsewhere, but this is being reviewed to maximise offer
Tertiary referral – delays with receiving communication back from tertiary centres.	Improved collaboration between EKHUFT and tertiary centres.	• Senior Service Managers EKHUFT • Tertiary Centres • EKHUFT Compliance Managers	• Oct 2023	• Established weekly PTL meetings for UGI with our London colleagues. • Meetings with Kings taking place reguaarly to review IPT transfers, and correct completion of documents. • Joint Kent & Medway Escalation PTL to be set up with GSTT as issues across all Trusts.
Patient engagement throughout pathways, multiple cancellations/DNA's	Ensure GP's are informing the patients they are being referred on a cancer pathway and not all investigations will be at the hospital nearest to them.	• Care Group Leads/ CNS's • GP's/Support Workers/Patient Engagement Officer Kent & Medway Cancer Alliance	• Oct 2023	• 2ww Transformation Working Group. • Working with our GP Cancer Lead to ensure patients are being told they are on a cancer pathway at referral • STT implementation • Early escalation to Cancer CNS's to support patients • Development of 2ww information of Trust web page to support patients and their relatives/carers on a cancer pathway, being designed

Diagnostic Waiting Times: DM01

Integrated Improvement Plan

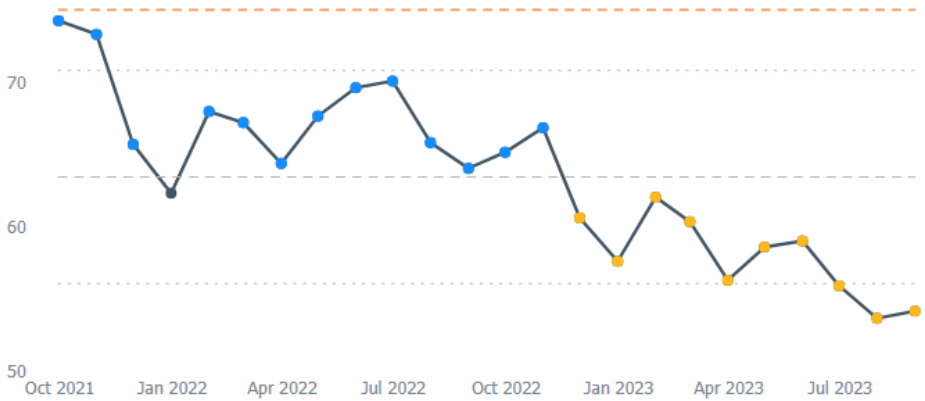
East Kent Hospitals University NHS Foundation Trust

Diagnostic tests/procedures are used to identify and monitor a person's disease or condition and which allows a medical diagnosis to be made. The national waiting time standard states that no more than 1% of patients should wait more than 6 week for their diagnostic test. The Trust currently has a stretch target to hit 75% by March 2024.

DM01 Compliance

Timescale	Value	SPC
Oct-22	65.1%	
Nov-22	66.8%	
Dec-22	60.6%	
Jan-23	57.6%	
Feb-23	62.0%	
Mar-23	60.3%	
Apr-23	56.3%	
May-23	58.6%	
Jun-23	59.0%	
Jul-23	55.9%	
Aug-23	53.6%	
Sep-23	54.1%	

XMR Run Chart



Understanding the most recent data point

Performance

54.1%

Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to lower values
Flags	Below Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT issues; • CT Cardiac • CT Vetting • Ranzac protocol	• Cardiac | awaiting review of external funding • Vetting | training plan for Junior Dr's • Ranzac | agree protocol	• DCOO • Rad: Clinical Lead • Rad: Clinical Lead	• tbc • Start Sep 24 • Start mid Sep 24	• Awaiting financial approval – no update • Vetting numbers improved & stabilising • protocol awaiting sign off – T&F group started – awaiting confirmation for sunrise actions to agree start date to start work
MRI scanning capacity	Additional MRI scanners X2 to meeting 19/20 plan of 120%. Trust agreed 100%	• Trust	• No agreement or timescale. To be reviewed at Business Planning	• 2 MRI's would achieve DM01 compliance in 6 months + reduced backlog position - no change – starting BP
Endoscopy Capacity | Demand outstrips capacity	Procurement insource 1,000 scopes per month for 12 months completed, STW in place whilst contract is mobilised concludes to deliver an additional 50 lists per month in the interim	• TS	• Implementation Nov '23	• Contract awarded, mobilisation phase

Referral to Treatment Waiting Times: 65w Waits

Integrated Improvement Plan

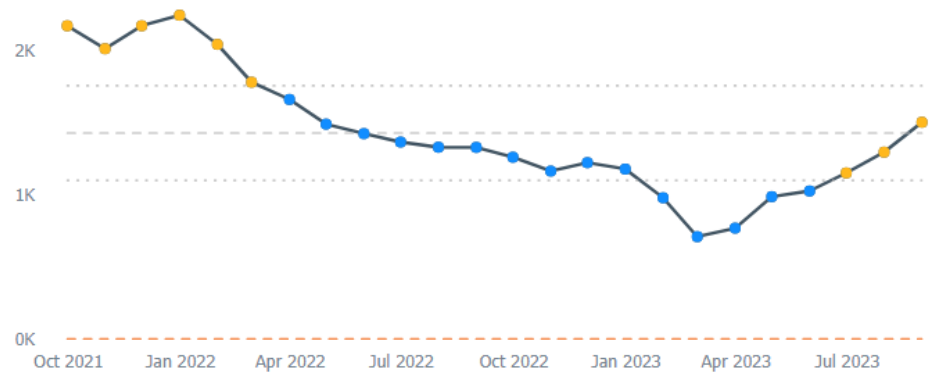
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 65 weeks to start treatment.
The Trust has a stretch target to eliminate 65w waits by the end of March 2024.

RTT 65w Breaches

Timescale	Value	SPC
Oct-22	1,257	
Nov-22	1,161	
Dec-22	1,219	
Jan-23	1,175	
Feb-23	976	
Mar-23	707	
Apr-23	766	
May-23	984	
Jun-23	1,023	
Jul-23	1,148	
Aug-23	1,292	
Sep-23	1,499	

XMR Run Chart



Understanding the most recent data point

Performance

1,499 — Variation indicates consistently falling short of the target

Variation

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

Flags — Ascending Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-admitted pathway delays impacting ability to reduce breaches	• Weekly recovery meetings re-set with MD's focussed on recovery actions (65 week risk cohort)	• COO/ • DCOO	• Oct 2023	• Deputy COO commenced in post for Planned Care (Cancer, Diagnostics and Elective) • Out patient transformation group to be refreshed aligned to national transformation requirements
Diagnostic delays – impacting ability to scan/scope routine (longer waiting RTT patients) creating significant increase in 78 week breaches	• Endoscopy Insourcing provision to be increased following conclusion of procurement process • Internal Diagnostic Group to be established in line with Planned Care governance refresh	• COO/ • DCOO	• Oct 2023	• Trajectories to be refreshed for each modality • MD for Cancer and Diagnostic Care Group appointed • Interim MD to be secured pending substantive MD commencing in post • Risk stratification of endoscopy waiting lists (surveillance, cancer and routine) underway via weekly endoscopy task and finish group established
Admitted pathway delays – volume of 65 and 78 week breaches increasing (104 weeks breaches have not been eliminated)	• ICB/EKHUFT to establish action plan to progress short/medium/long term otology plan	• COO/ DCOO	• Oct 2023	• Forecasting suggest increasing volumes of 65 and 78 week breaches monthly (trajectories being refreshed) • Significant reduction in endoscopy capacity is contributing to the greatest volume of 78 week breaches in colorectal and gastro deterioration forecast monthly

Referral to Treatment Waiting Times: 52w Waits

Integrated Improvement Plan

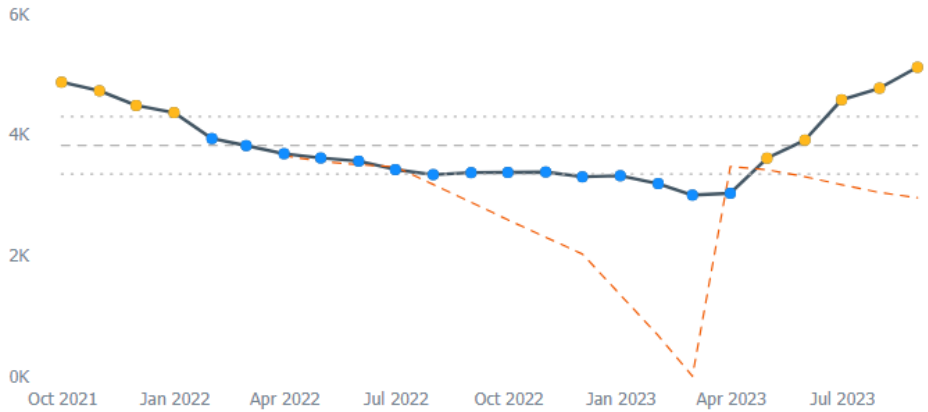
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 52 weeks to start treatment.

RTT 52w Breaches

Timescale	Value	SPC
Oct-22	3,372	
Nov-22	3,379	
Dec-22	3,299	
Jan-23	3,317	
Feb-23	3,187	
Mar-23	2,997	
Apr-23	3,027	
May-23	3,608	
Jun-23	3,907	
Jul-23	4,575	
Aug-23	4,767	
Sep-23	5,113	

XMR Run Chart



Understanding the most recent data point

Performance

5,113

Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point; Ascending Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Business Plan 23/4 Elective activity (IP and DC) below plan – delivering circa 92% of plan and OP FU above 75% threshold	• PRISM to commence programme of work to improve theatre productivity • Specialities to quantify plans to deliver elective activity business plan • Specialities to quantify plans to deliver 5% PIFU and 75% OP FU (national out patient transformation requirement)	• PRISM • MD's • MD's	• Oct 2023	• PRISM commenced diagnostic phase (4 week process) • ERF deficit and risk raised formally by ICB – ERF recovery plan required due to further financial risk to Trust and system
Validation - inability to deliver 90% target to clinically/administratively validate every patient over 12 weeks/every 12 weeks	• Implement two way text messaging for all patients to support requirement to validate requirement • Additional funding secured from NHSE to support initial validation requirement • Require significant investment to develop a sustainable validation and training programme across the Trust	• Elective Recovery Director	• 31 October 2023	• Approve logic for all admitted/non-admitted pathways and roll out with BI/IT team • COO/DCOO consideration re validation/training requirements in the short/medium/long term required

Cancer Performance

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Cancer 2ww Performance

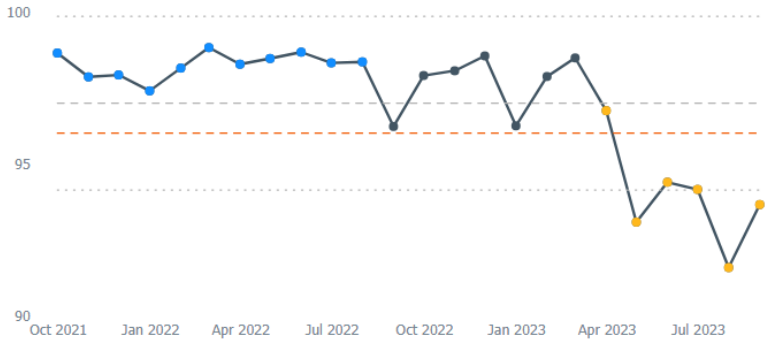
Timescale	Value	SPC
Oct-22	95.7%	
Nov-22	96.8%	
Dec-22	95.8%	
Jan-23	96.8%	
Feb-23	96.4%	
Mar-23	94.8%	
Apr-23	95.7%	
May-23	97.1%	
Jun-23	96.6%	
Jul-23	94.0%	
Aug-23	95.7%	
Sep-23	97.0%	

XMR Run Chart

Cancer 31d Performance

Timescale	Value	SPC
Oct-22	97.9%	
Nov-22	98.1%	
Dec-22	98.5%	
Jan-23	96.2%	
Feb-23	97.9%	
Mar-23	98.5%	
Apr-23	96.7%	
May-23	93.1%	
Jun-23	94.4%	
Jul-23	94.2%	
Aug-23	91.6%	
Sep-23	93.7%	

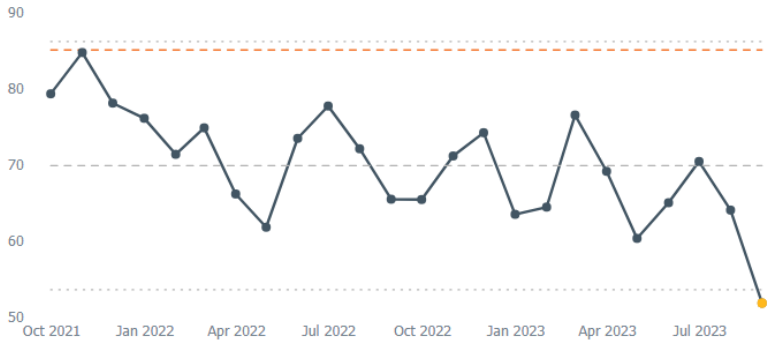
XMR Run Chart



Cancer 62d Performance

Timescale	Value	SPC
Oct-22	65.4%	
Nov-22	71.1%	
Dec-22	74.1%	
Jan-23	63.4%	
Feb-23	64.4%	
Mar-23	76.4%	
Apr-23	69.1%	
May-23	60.3%	
Jun-23	64.9%	
Jul-23	70.4%	
Aug-23	64.0%	
Sep-23	51.8%	

XMR Run Chart



PERFORMANCE UPDATE

2ww performance has improved again in month and remains compliant with the national standard. Waits within endoscopy remain long and there are continued delays with biopsy and diagnostic booking and reporting.

31 Day Performance improved within month and is highlighted weekly within Cancer Feeder pack to influence continued improvement

62d performance deteriorated further, due largely to backlog and delays within endoscopy and radiology

Improvement actions are;

- Additional escalation for radiology, plus support calls
- Endoscopy backlog reducing so will begin to see an improvement within lower going forward
- Straight to Test (STT) pathways for Lung, Lower GI, Upper GI and Haematuria being reviewed to share learning and improve further
- Enhanced escalation process in place for Consultant reviews, tertiary referrals, surgical dates and diagnostics to reduce the number of days on the pathway
- Engagement with Care Groups to support booking of patients through weekly feeder pack and PTL meetings to support teams juggling multiple demands
- Improving access to blood tests for cancer patients so that diagnostics can be booked earlier, this has made a huge improvement hand will continue to take days out of the pathway.

RTT Performance

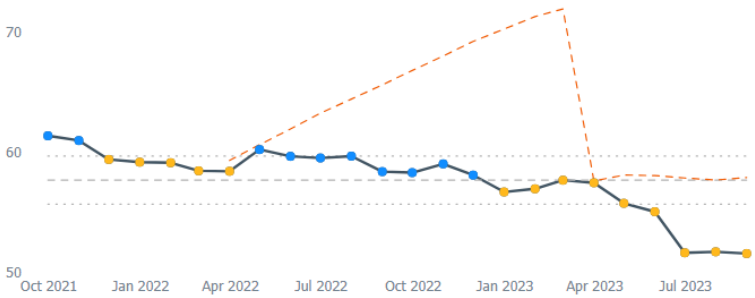
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

RTT Incomplete Perfor...

Timescale	Value	SPC
Oct-22	58.3%	
Nov-22	59.0%	
Dec-22	58.1%	
Jan-23	56.7%	
Feb-23	56.9%	
Mar-23	57.7%	
Apr-23	57.5%	
May-23	55.7%	
Jun-23	55.0%	
Jul-23	51.6%	
Aug-23	51.7%	
Sep-23	51.5%	

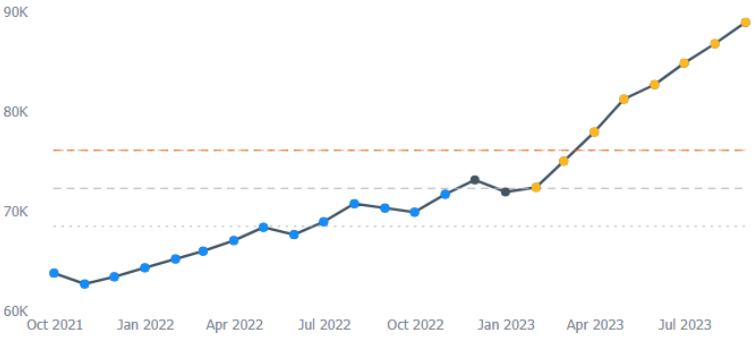
XMR Run Chart



RTT Total Incomplete P...

Timescale	Value	SPC
Oct-22	69.9K	
Nov-22	71.7K	
Dec-22	73.1K	
Jan-23	71.9K	
Feb-23	72.4K	
Mar-23	75.0K	
Apr-23	77.9K	
May-23	81.2K	
Jun-23	82.7K	
Jul-23	84.8K	
Aug-23	86.8K	
Sep-23	88.9K	

XMR Run Chart



PERFORMANCE UPDATE

Performance continues to deteriorate monthly due to our inability to increase capacity significantly beyond plan for patients waiting beyond 18 weeks for first definitive treatment.

The volume of total incomplete pathways is growing rapidly each week – a proportion of the referrals can be attributed to referral growth from primary care but a growing volume of out of area patients are being referred via non-primary care pathways to our clinicians.

Weekly more patient RTT pathways are being started (clock start) compared to those being ended (clock stop).

Elongated pathway waits in first, follow up and diagnostics are contributing to our ability to treat and end pathways before 78 weeks. The volume of 52, 65 and 78 week breaches are increasing weekly and are forecast to continue growing due to demand for cancer and lack of capacity to treat routine patients.

Validation has been a key focus for speciality teams since last year, approximately 50% of the total RTT PTL is validated. The plan to roll out a digital solution, to support teams validating, is progressing but needs significant investment to support validation/training in the short/medium/long term. Furthermore the option to utilise the patient portal to support this programme of work is being reviewed and considered but requires further investment and support to develop the system to its full potential.

DM01 performance is impacting waiting times – a radiology improvement plan to support recovery in the most challenged diagnostic modalities is in place, performance in month has seen marginal improvement to 54.1% from 53.6% in August (lowest recorded performance to date). The performance in diagnostics is contributing to the decline in RTT performance.

Efficiency Metrics

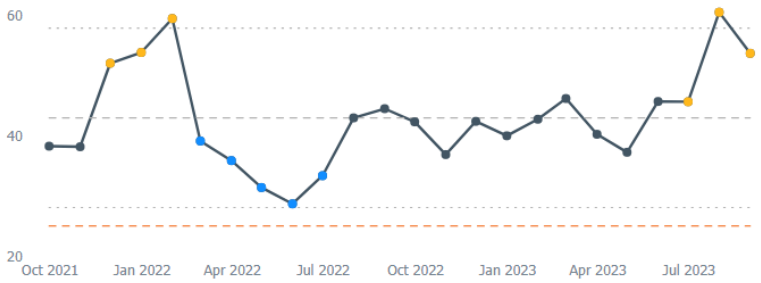
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

Timescale	Value	SPC
Oct-22	42	
Nov-22	37	
Dec-22	42	
Jan-23	40	
Feb-23	43	
Mar-23	46	
Apr-23	40	
May-23	37	
Jun-23	46	
Jul-23	46	
Aug-23	61	
Sep-23	54	

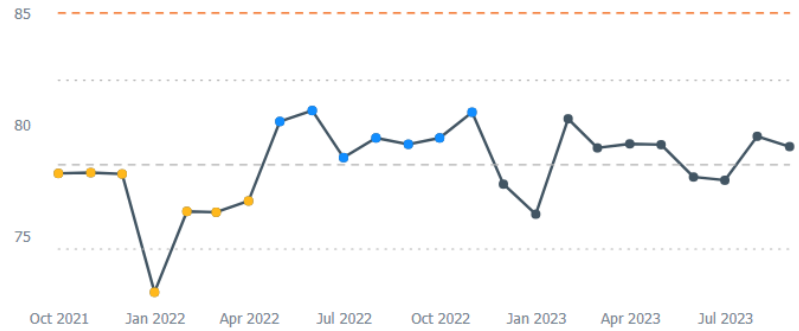
XMR Run Chart



Theatre Actual Utilisation

Timescale	Value	SPC
Oct-22	79.4%	
Nov-22	80.6%	
Dec-22	77.4%	
Jan-23	76.0%	
Feb-23	80.3%	
Mar-23	79.0%	
Apr-23	79.2%	
May-23	79.1%	
Jun-23	77.7%	
Jul-23	77.5%	
Aug-23	79.5%	
Sep-23	79.0%	

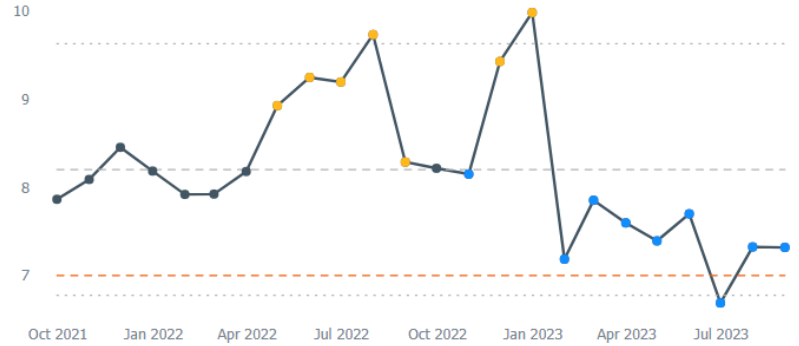
XMR Run Chart



DNA Rate OP New

Timescale	Value	SPC
Oct-22	8.2%	
Nov-22	8.1%	
Dec-22	9.4%	
Jan-23	10.0%	
Feb-23	7.2%	
Mar-23	7.9%	
Apr-23	7.6%	
May-23	7.4%	
Jun-23	7.7%	
Jul-23	6.7%	
Aug-23	7.3%	
Sep-23	7.3%	

XMR Run Chart



PERFORMANCE UPDATE

Doctor strike action continues to be a contributing factor to the high session opportunity and is likely to continue into Q3 with more strike action planned.

Theatre actual utilisation remains within normal variation around 78-79% utilised. Teams are being asked to book up to a minimum of 90% utilised in order to meet the aim of 85% actual utilisation moving forward. The Elective Orthopaedic Centre is aiming for an actual utilisation of 90%.

The theatre efficiency programme will be reviewed in line with new operational changes and specialty plans to improve theatre performance will be evaluated to ensure they are quantified and deliverable in line with theatre capacity and workforce.

DNA rates are improving but remain above the 7% threshold at 7.3% in September. Increasing numbers of patients now have the ability to choose their appointment date as specialties are moving back to the electronic referral service which appears to be having a positive impact and decreasing capacity lost due to DNA.

Quality & Safety

Quality & Safety

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Quality	IIP		Serious Incidents		Sigma	20	19	13	16	16	34	10	5	14	11	12	13
	IIP		Incidents - Moderate / Severe		Sigma	36	42	45	66	48	54	29	33	33	36	25	42
	IIP		Overdue Incidents		0	6,532	6,579	6,637	6,635	5,716	4,755	3,897	3,340	2,938	2,395	2,669	2,980
	IIP		Serious Incidents Breached exceed 60...		0	16	16	16	0	2	6	10	13	6	6	2	3
	IIP		HSMR		96.0	89.6	89.9	91.1	92.1	92.0	93.6	92.8	93.0	92.6			
	IIP		Pressure Ulcers		Sigma	119	116	135	137	104	115	127	127	123	104	113	94

September Performance Summary

Incident Reporting: There were 2,279 patient incidents reported in September, of which 13 were declared as serious incidents at the Serious Incident Declaration Panel, which is chaired by the Chief Nursing and Midwifery Officer, the Chief Medical Officer or the Director of Quality Governance. This compares with 2,339 in August, 2,194 in July and 2,353 in June. A detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November, however a summary of each is presented on the next two slides.

Mortality: Following an upward trend in HSMR between October 2022 and March 2023, HSMR has now stabilised and as expected, has improved further. Analysis by the Mortality Surveillance Steering Group will continue to investigate potential causes for the upward trend seen prior to March 2023 and deliver any findings to the committee. Progress at the October MSSG has been noted but the group are unable to provide an update at this time. The live data available for July suggests HSMR will improve once again.

Harm Events: The number of harm events continues to show a plateauing trend this financial year with a subsequent increase in cases taken to the Serious Incident Declaration Panel, although not all cases presented resulted in an SI being declared. There has been improved clinician presence at this panel and following in-depth discussion the number of cases deemed to reach SI thresholds has not increased.

Serious Incidents

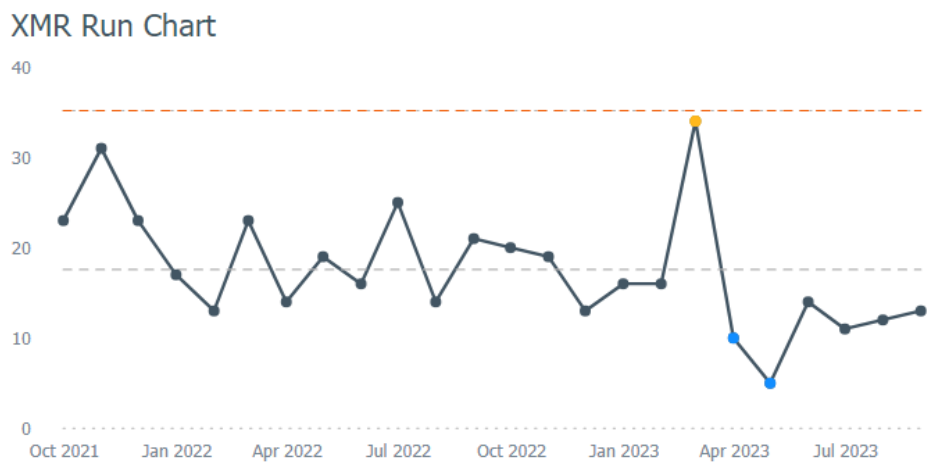
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents

Timescale	Value	SPC
Oct-22	20	
Nov-22	19	
Dec-22	13	
Jan-23	16	
Feb-23	16	
Mar-23	34	
Apr-23	10	
May-23	5	
Jun-23	14	
Jul-23	11	
Aug-23	12	
Sep-23	13	



Understanding the most recent data point

Performance

13

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

As described on the previous slide, there were 12 SIs reported in August and which are currently being investigated.
In summary these were:

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
• Four Deep Tissue injuries sustained.	• Deep tissue injury sustained on the Acute Medical Unit WHH and one was also sustained on the Acute Medical Unit at QEQM • Deep tissue injury sustained on Quex Ward. • Patient developed pressure ulcers secondary to a cast fitting. Complex case which resulted in an above knee amputation.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November 2023.
Please see next slide				→

Serious Incidents

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
• Five Delay/Failure incidents	• Failure to act on radiology results delaying diagnosis. • Failure to follow ID process in the mortuary. • Failure to follow process for expressed breast milk. • Delayed surgery resulted in hearing loss • Delay in diagnosing colon cancer.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November 2023.
• One Patient Fall	• A patient who should have had cohort or one-to-one nursing but was left by himself had an unwitnessed fall resulting in fractured neck of femur.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November 2023.
• One Safeguarding incident	• Patient was unlawfully detained in a side room for 28 minutes.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• A more detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November 2023.
• One care/treatment incident	• Neonatal death at the Evalina Hospital following transfer from the Neonatal Intensive Care Unit (NICU). Care in the NICU being reviewed.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• A more detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November 2023
• Infection control incident	• Missed opportunity to identify and treat C.diff infection.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• A more detailed report on these will be presented to CEMG on 1 November and Trust Board on 2 November 2023

Overdue Incidents

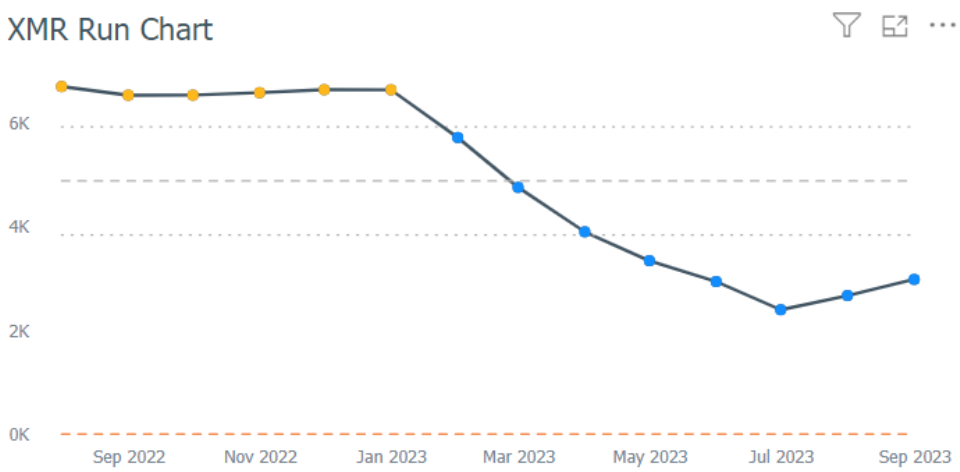
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of incidents which are overdue their agreed timescale for closure (all types) both overall and at each key stage of the investigation process: Awaiting review (AWAREV), In Review (INREV) and Awaiting Final Approval (AWAFA)

Overdue Incidents

Timescale	Value	SPC
Oct-22	6,532	
Nov-22	6,579	
Dec-22	6,637	
Jan-23	6,635	
Feb-23	5,716	
Mar-23	4,755	
Apr-23	3,897	
May-23	3,340	
Jun-23	2,938	
Jul-23	2,395	
Aug-23	2,669	
Sep-23	2,980	



Understanding the most recent data point

Performance

2,980

Variation indicates consistently falling short of the target

Variation

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

Flags: Below Mean Run Group; Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The target for closure of overdue incidents is 30/11/2023. The number of overdue incidents has risen by 287 in September. This is attributed to: • Maternity governance staff working in clinical practice 40% of the working week to address staffing shortfall. • Serious incidents being prioritised over overdue low harm incidents	• The focus remains on closing these incidents and a regular update is given by the Governance Matrons during weekly meetings with the Deputy Director of Quality Governance. • Patient safety staff assisting with WHH overdue incidents 1 day per week	• Director of Quality Governance	• 30since April overall November 2023	• Significant overall improvement has been seen across all care groups as seen in making this reduction. Additional support has been given to Women's Health and GSM care groups, who report the largest numbers and therefore require the greatest resource.

Incidents Causing Harm

Integrated Improvement Plan

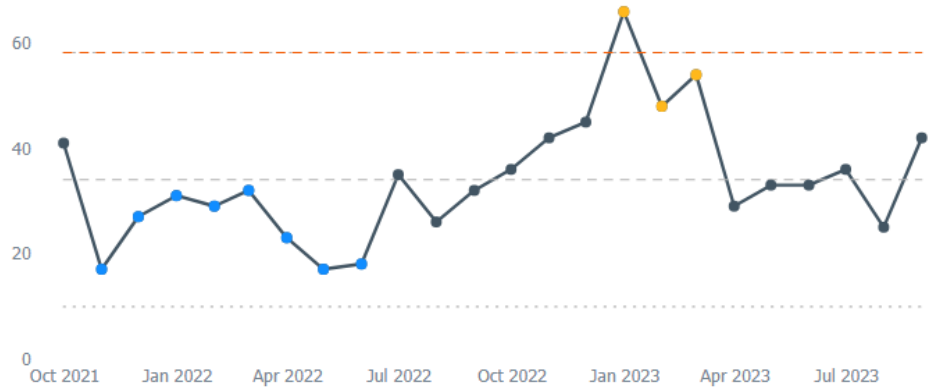
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of clinical incidents where the harm status was moderate or above.

Incidents - Moderate / ...

Timescale	Value	SPC
Oct-22	36	
Nov-22	42	
Dec-22	45	
Jan-23	66	
Feb-23	48	
Mar-23	54	
Apr-23	29	
May-23	33	
Jun-23	33	
Jul-23	36	
Aug-23	25	
Sep-23	42	

XMR Run Chart



Understanding the most recent data point

Performance

42

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
One moderate harm for psychological trauma after post partum haemorrhage and sepsis requiring return to theatre and ITU care	The patient's care was reviewed at maternity Rapid review meeting: • No acts or omissions in care identified on initial review • Consultant review in progress • HOM meeting with patient to discuss care • Patient expressed PTSD symptoms • No concerns raised by patient regarding obstetric care • Patient referred to women's counselling	Head of Midwifery	• Follow up meeting with patient planned	Analysis ongoing
One moderate harm. Medical device related hospital acquired unstageable pressure ulcer following removal of below knee plaster cast	• Patient having x 2 weekly wound care appointments • Weekly review by Consultant • Escalated to pressure ulcer and Falls panel for MDT discussion The Pressure Ulcer Trust Wide Improvement plan includes the following focus points: • Leadership and culture • Early identification and intervention • Learning and Prevention • Education and training • Equipment • Clinical Pathways • System wide working to develop system wide community of practice.	• Lead Nurse for Tissue Viability	• Trust wide Improvement plan on-going	Ongoing investigation- exploration into the advice given to patient on application of cast to identify learning. Trust-wide Tissue Viability Improvement action plan has ongoing elements which are in the process of being implemented: • 66% complete • 15% on schedule to complete • 8% in progress and overdue • 11% not started.

Hospital Standardised Mortality Ratio (HSMR)

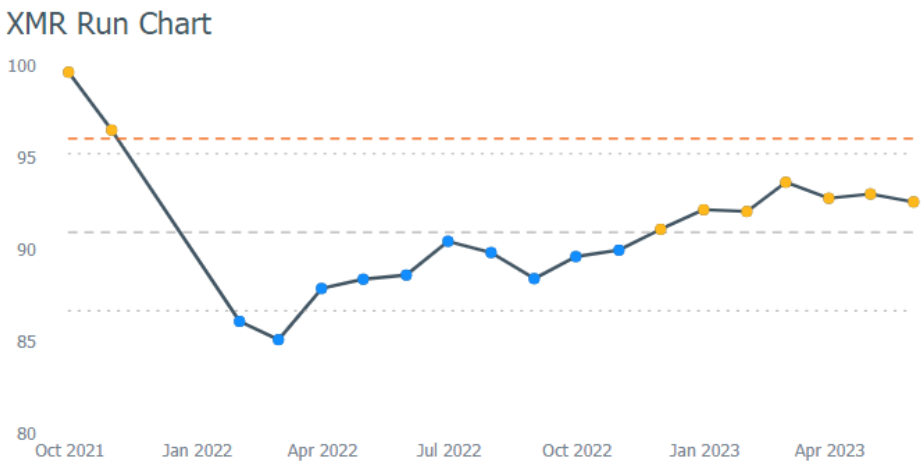
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

HSMR is a statistical number that enables the comparison of mortality rates between hospitals. This prediction takes account of factors such as the age and sex of the patient, their primary diagnosis, specialist palliative care and social deprivation of the area they live in. It is based on the 56 diagnostic groups which contribute to 80% of in-hospital deaths in England. HSMR is based on the likelihood of a patient dying of the condition with which they were admitted to hospital. If a Trust has an HSMR of 100 it means the number of patients who died is exactly as expected.

HSMR

Timescale	Value	SPC
Jul-22	90.4	
Aug-22	89.8	
Sep-22	88.4	
Oct-22	89.6	
Nov-22	89.9	
Dec-22	91.1	
Jan-23	92.1	
Feb-23	92.0	
Mar-23	93.6	
Apr-23	92.8	
May-23	93.0	
Jun-23	92.6	



Understanding the most recent data point

Performance

92.6 — Variation indicates consistently passing the target

Variation

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

Flags — Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
To agree, develop and implement a Trust-wide Fractured Neck of Femur Pathway that will address and improve the eight Key Performance Indicators on the National Hip fracture database	• Analyse the recent increase to relative risk reported on Telstra Health UK via MSSG • Confirm remaining comments from WHH regarding fast track process • Launch ring fencing/fast track pilot on Seabathing and Kings C1	• KCVH CG	• Ongoing	• Ongoing work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection.
Emergency Weekend Mortality is higher at the WHH site (specifically on Saturday) than national expected performance	• Review and analyse data in MSSG • Link and compare data through Telstra and integrate with the fractured neck of femur improvement plan • Review impact of higher than average patient complexity (Charlson Comorbidity) score.	• CMO	• Ongoing	• Identified at previous MSSG meeting for further investigation analysis.
"Rest of Miscellaneous Operations", "Viral Infection", and "Acute Myocardial Infarction" all have a higher than expected mortality rate	• Review and analyse data in MSSG • Identify any areas of concern and develop countermeasures for this to address relative risk above 100.	• CMO	• Ongoing	• Analysis ongoing • Progress noted at October MSSG but not able to finalise analysis at present.

Pressure Ulcers

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.
This measure counts the number of hospital acquired pressure ulcers graded 1 to 4.
Datasource: DATIX

Pressure Ulcers

Timescale	Value	SPC
Oct-22	119	
Nov-22	116	
Dec-22	135	
Jan-23	137	
Feb-23	104	
Mar-23	115	
Apr-23	127	
May-23	127	
Jun-23	123	
Jul-23	104	
Aug-23	113	
Sep-23	94	

XMR Run Chart

Understanding the most recent data point

Performance

94 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inaccurate Waterlow Risk assessment score resulting in delays or inappropriate pressure ulcer (PU) prevention interventions such as provision of an active mattress	• To rollout PURPOSE T risk assessment to replace Waterlow trust wide.	• Lead Tissue Viability Nurse (TVN) Specialist.	• Trust wide Rollout Jan 2024	• Training has been completed in both Emergency departments • Maternity: to commence use in November. • Rollout to general wards will commence in December/January teaching is underway
Lack of skin assessment particularly pre discharge	• SKINS bundle updated to encourage improved documented skin inspections. • PURPOSE T risk assessment, will provide prompts to examine all areas susceptible to pressure damage. • Main themes to be highlighted at the November Stop the Pressure campaign.	• TVN	• Nov 2023	• Training provided to QEQM. • Training to commence at WHH and K&C. • Trustwide Stop the Pressure awareness campaign in November. • Medical device care guide being updated to improve the care of skin under medical devices.
Prolonged length of stay in ED on a trolley increasing Patient harm from Hospital Acquired PU Trust wide.	• Increased TVN presence in ED ensuring appropriate risk assessment and equipment is in place. Targeted education.	• Lead TVN Specialist.	• Mar 2024	• Tissue Viability team presence in ED when on site. • Patients transferred onto beds and active mattresses whenever space allows.

Incident Reporting

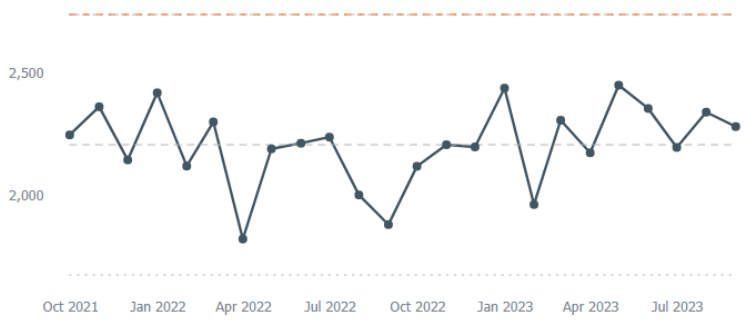
Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

Clinical Incidents

Timescale	Value	SPC
Oct-22	2,117	
Nov-22	2,205	
Dec-22	2,196	
Jan-23	2,436	
Feb-23	1,961	
Mar-23	2,305	
Apr-23	2,172	
May-23	2,448	
Jun-23	2,353	
Jul-23	2,194	
Aug-23	2,338	
Sep-23	2,279	

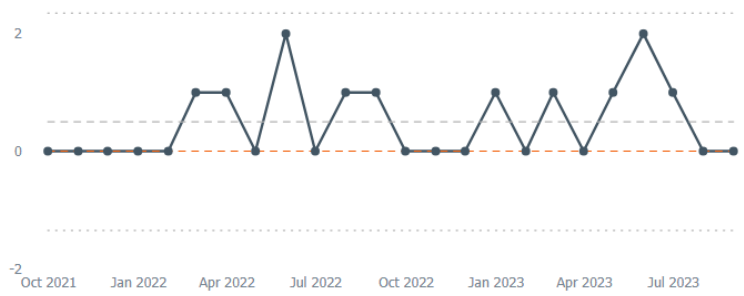
XMR Run Chart



Never Events

Timescale	Value	SPC
Oct-22	0	
Nov-22	0	
Dec-22	0	
Jan-23	1	
Feb-23	0	
Mar-23	1	
Apr-23	0	
May-23	1	
Jun-23	2	
Jul-23	1	
Aug-23	0	
Sep-23	0	

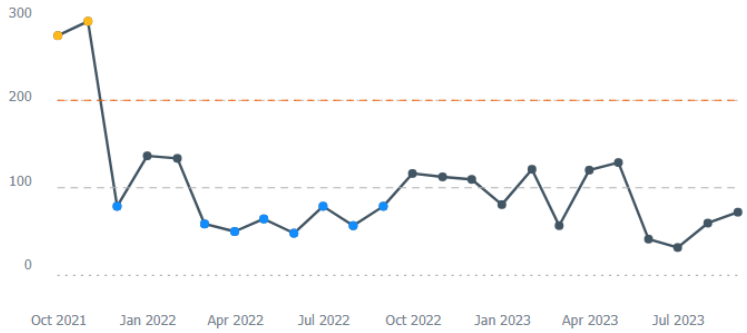
XMR Run Chart



Mixed Sex Breaches

Timescale	Value	SPC
Oct-22	108	
Nov-22	104	
Dec-22	101	
Jan-23	71	
Feb-23	113	
Mar-23	46	
Apr-23	112	
May-23	121	
Jun-23	30	
Jul-23	20	
Aug-23	49	
Sep-23	62	

XMR Run Chart



PERFORMANCE UPDATE

Clinical Incident reporting continues to show common cause variation and no significant change. It remains below the upper threshold set for clinical incidents. Ensuring that no-harm events are scrutinised gives assurance that all of these events are captured.

There were no Never Events in September 23.

Mixed sex breaches: The graph shows us incidences of unjustifiable Mixed Sex Accommodation breaches due to non clinical reasons. The key objective is to achieve zero Mixed sex accommodation breaches. In March 23 it was agreed with the ICB that SEAU would change to Surgical SDEC and therefore out of scope for national reporting, resulting in consistency across Kent and Medway. In July 23 a further agreement was reached with the ICB that MAU breaches are those sharing mixed sex accommodation for greater than 4 hours, with a decision to admit, but that the breach declared will be for the individual patient and not the unit as a whole.
No complaints have been received about mixed sex accommodation from patients during the last 3 months.

Duty of Candour

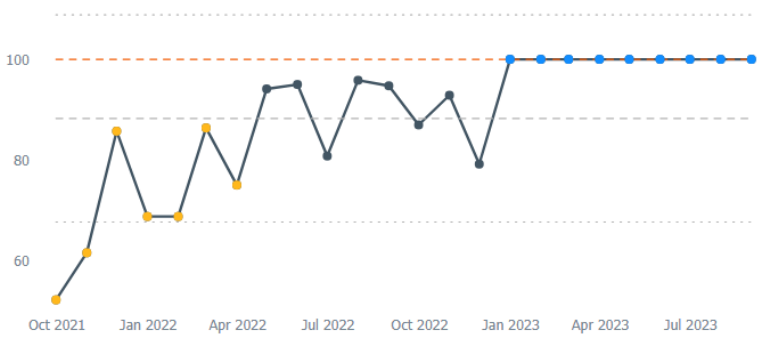
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Duty of Candour - Verbal

Timescale	Value	SPC
Oct-22	87.0%	
Nov-22	92.9%	
Dec-22	79.2%	
Jan-23	100%	
Feb-23	100%	
Mar-23	100%	
Apr-23	100%	
May-23	100%	
Jun-23	100%	
Jul-23	100%	
Aug-23	100%	
Sep-23	100%	

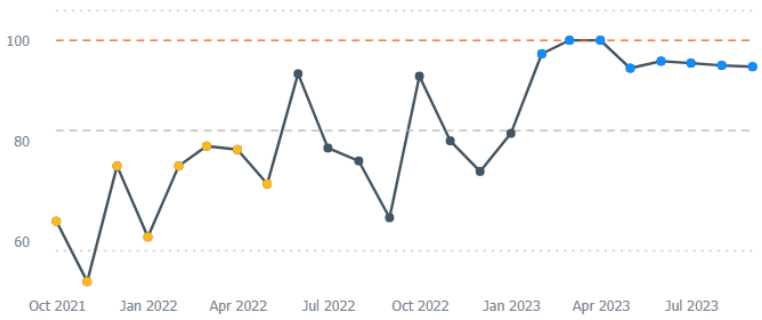
XMR Run Chart



Duty of Candour - Writt...

Timescale	Value	SPC
Oct-22	92.9%	
Nov-22	80.0%	
Dec-22	73.9%	
Jan-23	81.5%	
Feb-23	97.3%	
Mar-23	100%	
Apr-23	100%	
May-23	94.4%	
Jun-23	95.8%	
Jul-23	95.5%	
Aug-23	95.0%	
Sep-23	94.7%	

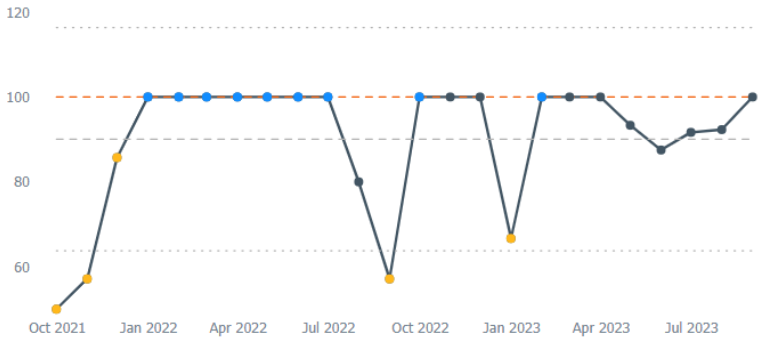
XMR Run Chart



Duty of Candour - Findi...

Timescale	Value	SPC
Oct-22	100%	
Nov-22	100%	
Dec-22	100%	
Jan-23	66.7%	
Feb-23	100%	
Mar-23	100%	
Apr-23	100%	
May-23	93.3%	
Jun-23	87.5%	
Jul-23	91.7%	
Aug-23	92.3%	
Sep-23	100%	

XMR Run Chart



PERFORMANCE UPDATE

Duty of Candour (DoC) metrics have been upheld since January 2023. The data for July had a discrepancy which has been resolved. Verbal DoC 100% compliant.

Written DoC within 15 working days was compliant for all but one incident which was completed by day 20.

The final DoC letter which accompanies the completion of the investigation report achieved 100% compliance.

Twice weekly meetings between Governance leads and DDQG continue to address non-compliance and barriers to completion

Complaints

Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Complaints Number

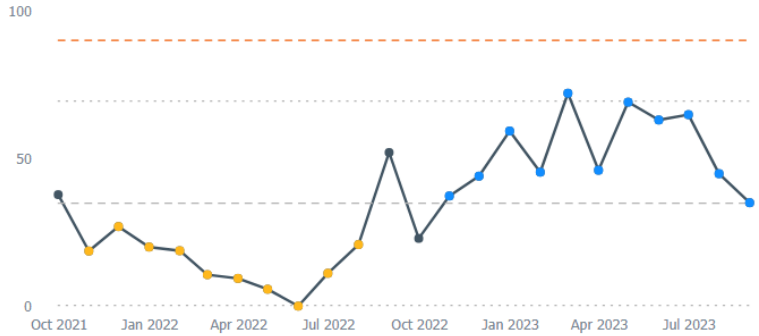
Timescale	Value	SPC
Oct-22	84	
Nov-22	76	
Dec-22	60	
Jan-23	95	
Feb-23	79	
Mar-23	82	
Apr-23	56	
May-23	84	
Jun-23	82	
Jul-23	91	
Aug-23	83	
Sep-23	87	

XMR Run Chart

Complaint Response

Timescale	Value	SPC
Oct-22	22.9%	
Nov-22	37.3%	
Dec-22	44.0%	
Jan-23	59.3%	
Feb-23	45.3%	
Mar-23	72.1%	
Apr-23	46.0%	
May-23	69.0%	
Jun-23	63.0%	
Jul-23	64.8%	
Aug-23	44.8%	
Sep-23	35.0%	

XMR Run Chart



PERFORMANCE UPDATE

September 2023 saw 985 contacts to the department resulting in 87 new formal complaints and 468 new PALS contacts being taken forward. 9% of contacts in September 2023 were taken forward as new formal complaints.

As a seasonal comparison of September 2023 to September 2022, there were 71 new formal complaints in 2021, a 23% increase and 549 PALS in 2021, a 15% decrease.

95% of the new complaints were acknowledged within three working days, this is above the target of 90%.

September 2023 saw a decrease in performance of responses within timescales to 35%, from 44.8% in August 2023. The increased number of new complaints continues, which impacts on complaint response performance. It is also noted that PALS and complaints received are more complex in nature, which affects the resolution timescales.

To improve complaints response timescales, there is work underway with the care groups governance teams to target the reduction of aged complaints. This is being supported with review meetings with the governance leads to monitor the trajectory and review progress.

Safeguarding

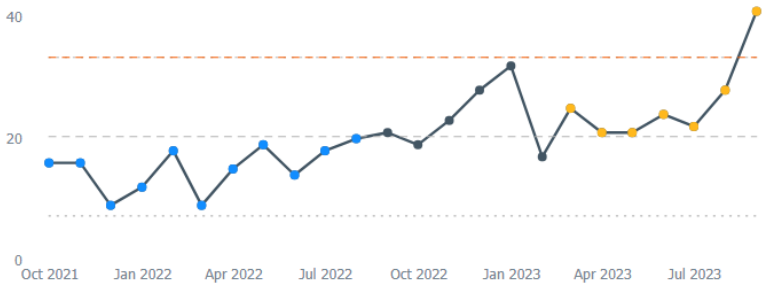
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Safeguarding Incidents

Timescale	Value	SPC
Oct-22	19	
Nov-22	23	
Dec-22	28	
Jan-23	32	
Feb-23	17	
Mar-23	25	
Apr-23	21	
May-23	21	
Jun-23	24	
Jul-23	22	
Aug-23	28	
Sep-23	41	

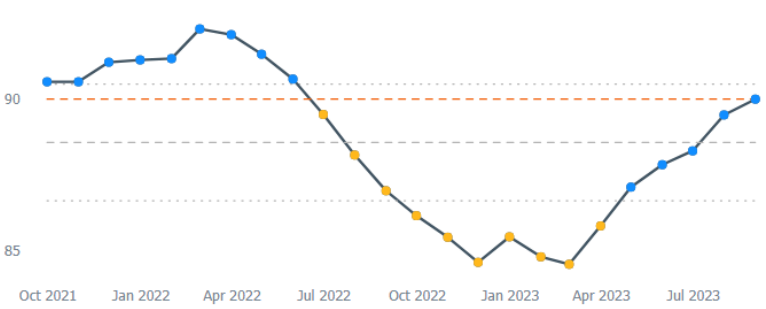
XMR Run Chart



Safeguarding Children T...

Timescale	Value	SPC
Oct-22	86.2%	
Nov-22	85.5%	
Dec-22	84.6%	
Jan-23	85.5%	
Feb-23	84.8%	
Mar-23	84.6%	
Apr-23	85.8%	
May-23	87.1%	
Jun-23	87.8%	
Jul-23	88.3%	
Aug-23	89.5%	
Sep-23	90.0%	

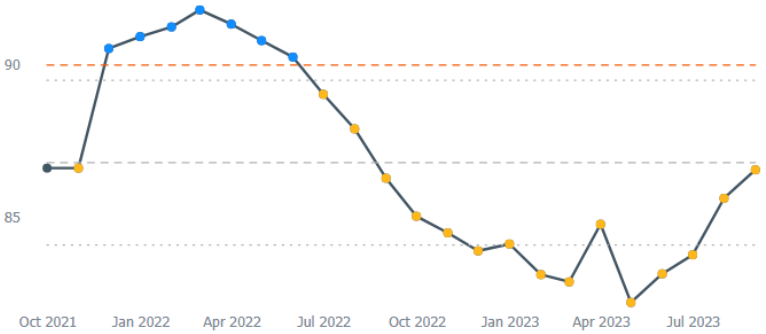
XMR Run Chart



Safeguarding Adults Tra...

Timescale	Value	SPC
Oct-22	85.0%	
Nov-22	84.5%	
Dec-22	83.9%	
Jan-23	84.1%	
Feb-23	83.1%	
Mar-23	82.9%	
Apr-23	84.8%	
May-23	82.2%	
Jun-23	83.1%	
Jul-23	83.7%	
Aug-23	85.6%	
Sep-23	86.5%	

XMR Run Chart



PERFORMANCE UPDATE

The reporting of all safeguarding metrics is outlined in the Business report and safeguarding dashboard with KPIs. This report goes to the Safeguarding Operational Group with exception to the Safeguarding Assurance Committee. Safeguarding metrics were also reported in the last Schedule 4 to the ICB.

The increase in safeguarding concerns raised appears to be more from people with complex mental health needs and relatives of patients with complex needs. Audit commenced, with the first undertaken in relation to incidents that involved allegations against people in a position of trust, which indicated that out of **37** incidents reported for Q1 and Q2, **26** of these were from patients with mental health needs, people with dementia and learning disabilities and or autism. Further audits are to be undertaken for the rest of the incidents.

The review of the number of open section 42s and overdue was undertaken and a paper presented to the closed section of the Safeguarding Assurance Committee in October 2023, which indicated that as of October 2023, **58** cases were overdue, with an additional **65** currently waiting for further actions from the LA. The mitigation for the backlog is that additional resources have been sourced to clear the backlog, which is due to start in November.

With regards to training - there remains a shortfall in training compliance at level 2 (children and adults) and 3 (children and adults) across the Care Groups at the agreed local level of **85% in line with national level** (end of September compliance).

There has been some improvements by Care Group, however, the compliance by December 2023 trajectories may not be achievable, therefore, the Safeguarding team will need to look for alternatives options to support with this.

The safeguarding team continue to provide more sessions and support, however, the DNA remains high. This is being addressed by the Deputy Chief Nurse and the Care Groups Governance.

This is also being addressed through the NHSE and ICB Safeguarding Oversight Meetings, ICB PQM through schedule 4 requirements and the CQC must do requirements relating to safeguarding training.

Infection Prevention Control

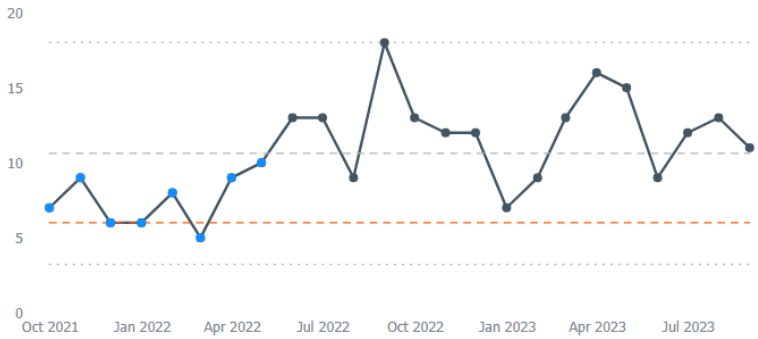
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

IPC: CDiff Infections

Timescale	Value	SPC
Oct-22	13	
Nov-22	12	
Dec-22	12	
Jan-23	7	
Feb-23	9	
Mar-23	13	
Apr-23	16	
May-23	15	
Jun-23	9	
Jul-23	12	
Aug-23	13	
Sep-23	11	

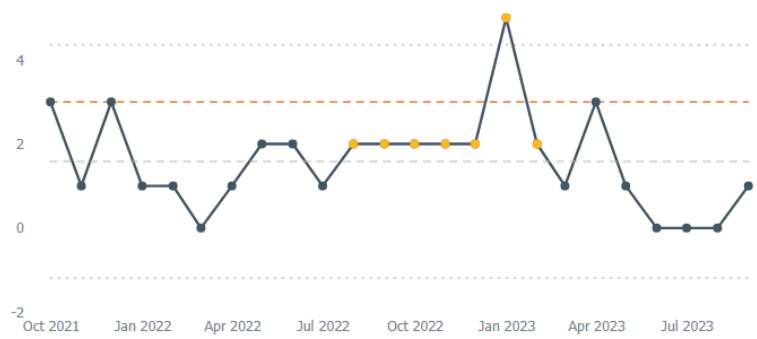
XMR Run Chart



IPC: Pseudomonas Infe...

Timescale	Value	SPC
Oct-22	2	
Nov-22	2	
Dec-22	2	
Jan-23	5	
Feb-23	2	
Mar-23	1	
Apr-23	3	
May-23	1	
Jun-23	0	
Jul-23	0	
Aug-23	0	
Sep-23	1	

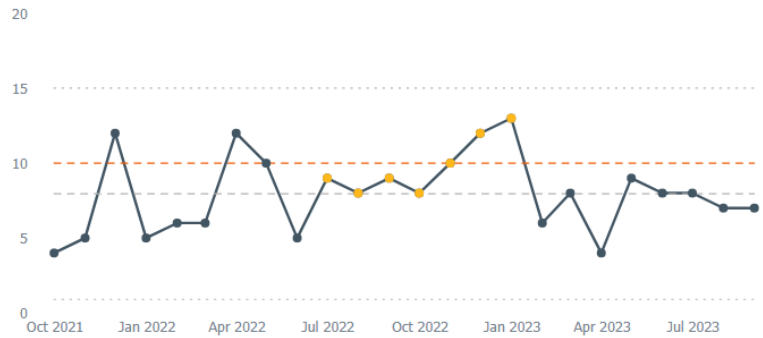
XMR Run Chart



IPC: EColi Infections

Timescale	Value	SPC
Oct-22	8	
Nov-22	10	
Dec-22	12	
Jan-23	13	
Feb-23	6	
Mar-23	8	
Apr-23	4	
May-23	9	
Jun-23	8	
Jul-23	8	
Aug-23	7	
Sep-23	7	

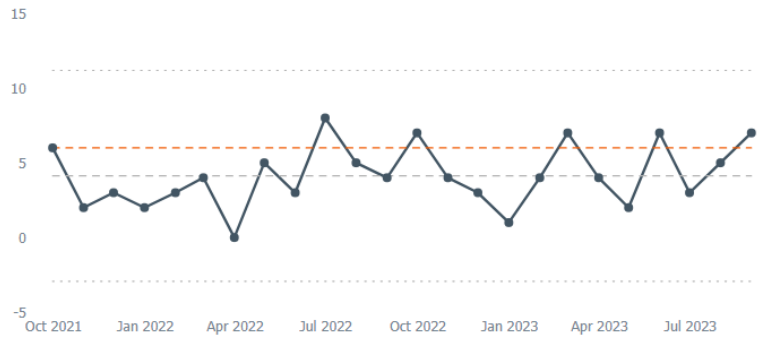
XMR Run Chart



IPC: Klebsiella Infections

Timescale	Value	SPC
Oct-22	7	
Nov-22	4	
Dec-22	3	
Jan-23	1	
Feb-23	4	
Mar-23	7	
Apr-23	4	
May-23	2	
Jun-23	7	
Jul-23	3	
Aug-23	5	
Sep-23	7	

XMR Run Chart



PERFORMANCE UPDATE

Performance against trajectories for the gram negative bacteraemias remains just above target, with ongoing monitoring and local actions underway where incidences occur.

The C-dif trajectory remains one of concern, and the Trust will not meet the planned threshold this year. All cases are reviewed for learning, and the main focus remains antimicrobial stewardship, and owing an increased number of cross infections (8 across 4 different areas) associated with environmental spread; cleaning of the environment and equipment. C-dif rates remain a regional concern, and the Trust are active participants in the regional c-dif reduction group, lead by the ICB.

Friends & Family Test

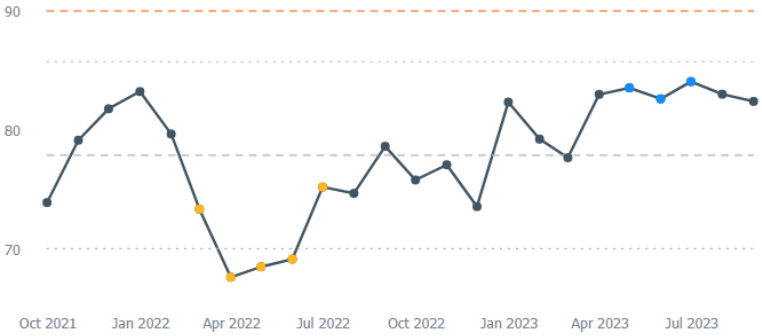
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

FFT_Satisfaction_ED

Timescale	Value	SPC
Oct-22	75.8%	
Nov-22	77.1%	
Dec-22	73.6%	
Jan-23	82.4%	
Feb-23	79.3%	
Mar-23	77.7%	
Apr-23	83.0%	
May-23	83.6%	
Jun-23	82.6%	
Jul-23	84.1%	
Aug-23	83.0%	
Sep-23	82.4%	

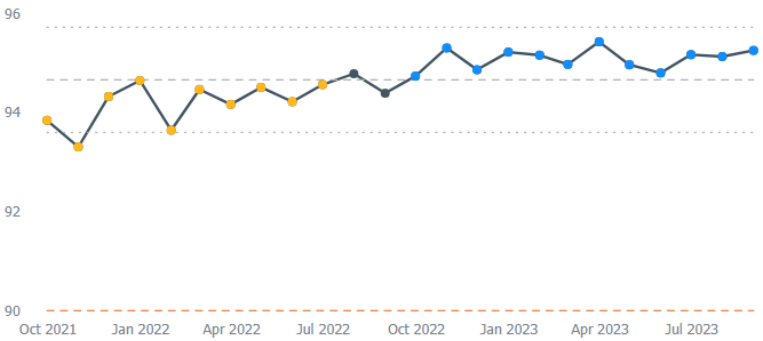
XMR Run Chart



FFT_Satisfaction_OP

Timescale	Value	SPC
Oct-22	94.7%	
Nov-22	95.3%	
Dec-22	94.9%	
Jan-23	95.2%	
Feb-23	95.2%	
Mar-23	95.0%	
Apr-23	95.4%	
May-23	95.0%	
Jun-23	94.8%	
Jul-23	95.2%	
Aug-23	95.1%	
Sep-23	95.2%	

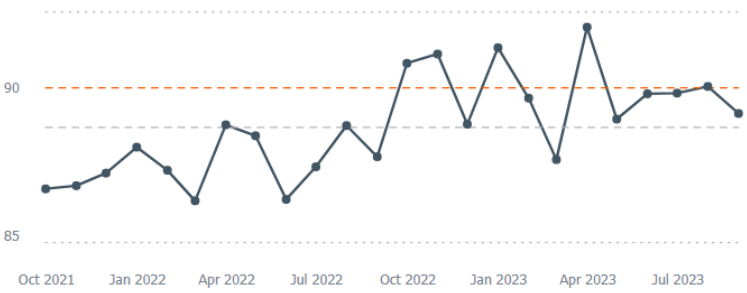
XMR Run Chart



FFT_Satisfaction_IP

Timescale	Value	SPC
Oct-22	90.8%	
Nov-22	91.1%	
Dec-22	88.8%	
Jan-23	91.4%	
Feb-23	89.7%	
Mar-23	87.6%	
Apr-23	92.1%	
May-23	88.9%	
Jun-23	89.8%	
Jul-23	89.8%	
Aug-23	90.0%	
Sep-23	89.1%	

XMR Run Chart



PERFORMANCE UPDATE

The trust's overall satisfaction level has remained over our target level of 90% for the past two years. **In September 2023 it was 93%.** The response rate was 19% overall. Looking at overall satisfaction by site it varied from 98% at Royal Victoria Folkestone to 89% at William Harvey Hospital.

Our Friends and Family Test (FFT) response rate for outpatients in September was 22%. **The satisfaction level was 96% overall**. This varied at each site, with the highest at Royal Victoria Hospital in Folkestone – 98% and lowest at William Harvey at 94%. **There is no longer a national target for response rates.**

Our FFT response rate for in-patients in September was 19%. **The overall satisfaction score across the three sites was 90%**, but varied at each site from 93% at KCH, 91% at QEQM and 85% at WHH. **Triangulation of theming from FFT, the national in-patient survey and our Trust in-patient survey shows that patients are dissatisfied with the discharge process and information given when leaving hospital.**

For **Urgent and Emergency Care** our FFT satisfaction level in September was **84% overall.** When breaking this down by site, QEQM ED scored 85%, William Harvey ED scored 74% and KCH Urgent Treatment Centre scored 92%. **Therefore, the average across the three sites alone is not sufficient to understand patient's experience.**

How we compare with national data:
The most recent national data available is for August 2023. For **Urgent and Emergency Care** the **national** overall satisfaction level it is **84%,** and **81% for ED.**
For in-patient care, the **national** satisfaction level is **94%** and for outpatient care it is **94%.** Therefore, in September our satisfaction level for in-patients of **90% overall** is **significantly lower** and for outpatients at **96% overall is higher.**

Friends and Family Test free text comments: the qualitative data (patient's comments) is a rich source of insight that satisfaction levels alone do not give. A new Theming Tracker enables our services to theme free text comments as positive or negative and by subject. In future IPR reports the Board may wish to see the overall dashboard. In September 2023, the top positive areas were care given by staff, staff attitude, quality of treatment and communication. The top negative areas were waiting time to be seen on site, poor communication and information, buildings and facilities and ensuring comfort / alleviating pain.

People

People, Leadership & Culture

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
People	IIP		Sickness		5.0%	5.6%	5.0%	5.9%	5.1%	4.9%	5.1%	4.3%	4.0%	4.2%	4.6%	4.7%	5.1%
	IIP		Vacancy Rate		10.0%	10.9%	9.7%	9.8%	9.1%	8.7%	8.4%	8.2%	8.2%	7.9%	7.2%	7.9%	7.4%
	IIP		Staff Turnover Rate		10.0%	10.5%	10.3%	10.2%	10.0%	9.9%	10.0%	9.8%	9.7%	9.6%	9.5%	9.2%	9.0%
	IIP		Premature Turnover Rate		25.0%	15.2%	15.8%	15.2%	15.1%	15.1%	15.0%	15.0%	14.1%	14.0%	13.8%	13.7%	13.3%
	IIP		Staff Engagement Score		6.80	6.35	6.35	6.35	6.17	6.17	6.17	6.20	6.20	6.20	6.27	6.27	6.27
	IIP		Statutory Training		91.0%	90.2%	90.5%	90.4%	90.5%	90.5%	91.0%	91.4%	91.9%	91.9%	91.7%	92.3%	92.1%
	IIP		Medical Job Planning Rate		90.0%	33.3%	33.9%	29.1%	50.1%	31.2%	38.3%	46.4%	50.4%	50.5%	58.7%	52.3%	58.1%

September Performance Summary

People Metrics: Sickness absence has increased for the fourth month in succession and has now exceeded the threshold at 5.1%. Annually, sickness absence is costing the Trust c.£16.5m with 2,425 episodes of sickness absence in September and 27,607 across the last 12m. Vacancy rate remains below the desired threshold, with some improvement in September. Staff turnover has reduced further to 9.0% and has now sat below the national standard (10%) for nine consecutive months. Premature turnover continues on a positive downward trend, falling to 13.3% - the best figure in over a year. Statutory training remains above the threshold and appears to have plateaued at 92.1%. Compliance is spread, with medical staff still 13% below the threshold (76.8%).

Engagement Metrics: The National Staff Survey launched on Monday 18th September, with 10 weeks of fieldwork underway and a closing date of Friday 24th November. The latest response rate is 29.3% - around 8% ahead of the national average (21.4%). Response rates currently vary considerably from 7% - 87%. Further engagement results will not be available until 2024 due to the national embargo. The latest results (in Q2) showed that staff engagement (6.27) is up 7 points and is in the second quartile nationally, against a revised national standard of 6.50. Motivation is up 8 points to 6.69 and involvement is up 6 points to 6.29. Both motivation and involvement are now within 0.1 of the national average. A comprehensive range of outreach-related fieldwork has and continues to take place to ensure response rates are as high as possible and to give a clearer mandate from the results.

Leadership Metrics: Staff Advocacy (5.83) was up 7 points to 5.83 in Q2 but remains in the lowest quartile nationally. As advocacy metrics fall within the national staff survey embargo, the next update on this will be in 2024. Advocacy continues to represent the domain of engagement which is furthest (0.6 away) from the national standard (6.4) and is the primary contributor to reduced staff engagement levels across the organisation. Recent evidence has demonstrated advocacy levels are considerably higher (up to 62 points) in We Care areas, and work is ongoing to roll this out further across more areas of the organisation through waves 7 and 8, with 337 further colleagues trained since Sept 22.

Staff Sickness

Integrated Improvement Plan

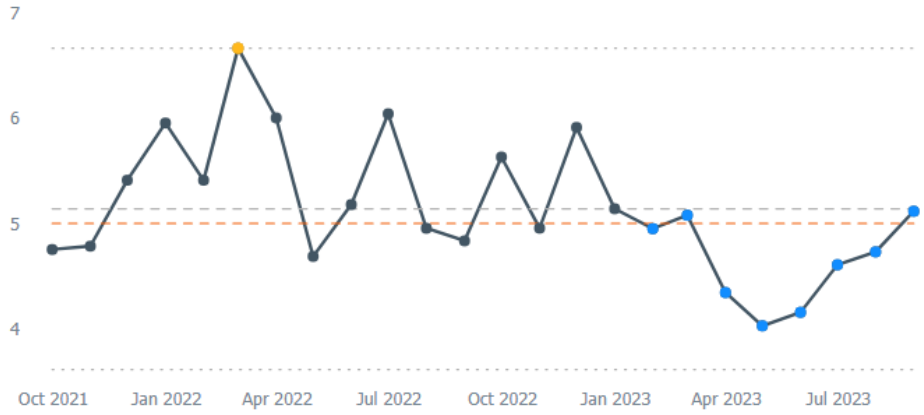
East Kent Hospitals University NHS Foundation Trust

The percentage of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs).
Data Source: Healthroster, eRostering for the current month (unvalidated) with previous months using the validated position from ESR.

Sickness

Timescale	Value	SPC
Oct-22	5.6%	
Nov-22	5.0%	
Dec-22	5.9%	
Jan-23	5.1%	
Feb-23	4.9%	
Mar-23	5.1%	
Apr-23	4.3%	
May-23	4.0%	
Jun-23	4.2%	
Jul-23	4.6%	
Aug-23	4.7%	
Sep-23	5.1%	

XMR Run Chart



Understanding the most recent data point

Performance

5.1%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **sickness absence** below 5%, and improved against our fellow Trusts in the ICB	• Working with NHSEI on the Absence Tool Kit to review current sickness management processes and develop actions for improvement.	• Heads of P&C, P&CBPs	• End Oct 23	• Sickness Absence Policy reviewed to take to Staff Committee end Oct 23, removing loop holes to support more effective and timely absence management.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	• Head of Staff Experience, Heads of P&C, P&CBPs, OH	• Ongoing	• Agreed focus from OH and P&C Care Group Teams to pro-actively work with main area of concern within each Care Group to speed up return to work and absence management.
Improved pro-active absence management	• New P&C Care Group Teams to focus on absences through a Care Group deep dive, and P&C support.	• P&C Care Group Teams	• Ongoing	• ED WHH identified as first area of focus, with circa 30 WTE absent in last 12 months, and 84 staff needing absence management.

Staff Vacancy Rate

Integrated Improvement Plan

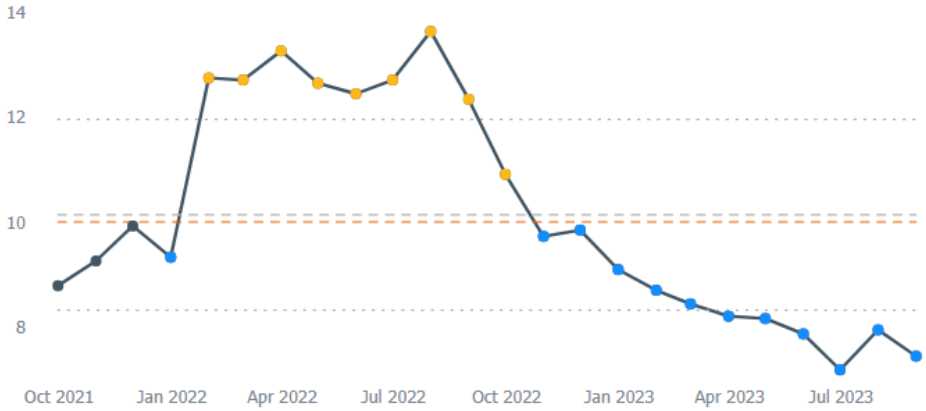
East Kent Hospitals University NHS Foundation Trust

The proportion of vacant positions against the number of Whole Time Equivalent (WTE) funded establishment.
Datasource: ESR

Vacancy Rate

Timescale	Value	SPC
Oct-22	10.9%	
Nov-22	9.7%	
Dec-22	9.8%	
Jan-23	9.1%	
Feb-23	8.7%	
Mar-23	8.4%	
Apr-23	8.2%	
May-23	8.2%	
Jun-23	7.9%	
Jul-23	7.2%	
Aug-23	7.9%	
Sep-23	7.4%	

XMR Run Chart



Understanding the most recent data point

Performance

7.4%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place.	• Heads of P&C • P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead • Heads of P&C • P&CBPs	• End Oct 23	• Top 7 Hard to Recruit Consultant roles vacancy rate decreased from 21.5% to 20.8% in July 23. Further hard to recruit roles out to advert with social media campaigns.
Minimising risk of turnover by improving retention and reducing time to hire.	• Focus on time to hire, with Dashboard set up to monitor.	• Head of Resourcing	• Ongoing	• Time to hire 9.1 weeks. • Band 5 Nursing vacancy rate down to 9.3% • HCSW vacancy rate down to 7.82%

Staff Turnover Rate

Integrated Improvement Plan

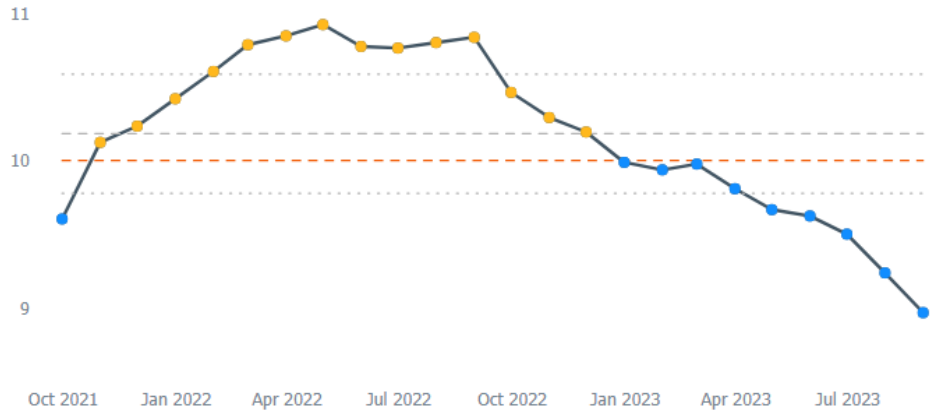
East Kent Hospitals University NHS Foundation Trust

The number of staff leaving & joining the Trust against Whole Time Equivalent (WTE).
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Staff Turnover Rate

Timescale	Value	SPC
Oct-22	10.5%	
Nov-22	10.3%	
Dec-22	10.2%	
Jan-23	10.0%	
Feb-23	9.9%	
Mar-23	10.0%	
Apr-23	9.8%	
May-23	9.7%	
Jun-23	9.6%	
Jul-23	9.5%	
Aug-23	9.2%	
Sep-23	9.0%	

XMR Run Chart



Understanding the most recent data point

Performance

9.0%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Below Mean Run Group; Astronomical Point; Descending Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	• Head of Staff Experience	• Ongoing	• Staff Turnover has been below the desired threshold for 9 consecutive months & stands at **9.0%**
Maintaining **Nurse Turnover** against a gold standard of 10%	• Implementation of actions against the Nursing Workforce Retention Action plan	• Associate Director of Nursing	• Ongoing	• Nurse Turnover has been below the desired threshold for >18 consecutive months & stands at **8.3%**
Reducing **Healthcare Support Worker** Turnover below 13.5%	• Introduction of the HCSW Voice Programme and continued delivery of the Ready to Care programme	• Matron for Recruitment & Career Dev.	• Ongoing	• HCSW Turnover has been below the desired threshold for 9 consecutive months & stands at **11.2%**

Premature Staff Turnover Rate

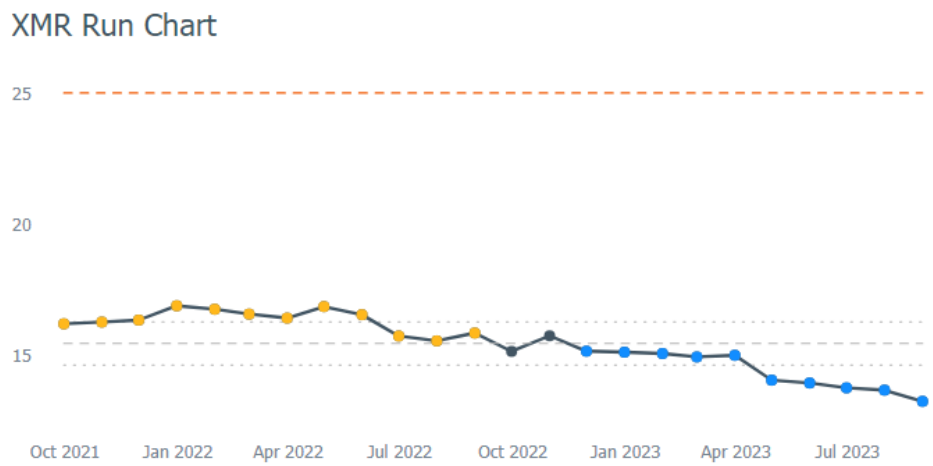
Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

The number of staff leaving the Trust within their first year of employment as a proportion of the total number of staff in the organisation with less than 12 months' service.
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Premature Turnover Rate

Timescale	Value	SPC
Oct-22	15.2%	
Nov-22	15.8%	
Dec-22	15.2%	
Jan-23	15.1%	
Feb-23	15.1%	
Mar-23	15.0%	
Apr-23	15.0%	
May-23	14.1%	
Jun-23	14.0%	
Jul-23	13.8%	
Aug-23	13.7%	
Sep-23	13.3%	



Understanding the most recent data point

Performance

13.3% — Variation indicates consistently passing the target

Variation

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

Flags — Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	• Head of Staff Experience	• Complete	• Premature turnover (**13.3%**) has been below the suggested new threshold (15%) for 5 consecutive months and on a positive downward trend
Reduction in **Premature Turnover** below desired threshold of 15%	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• Ongoing	• Premature turnover improved by 3% across 18-months. Evidence that initial experience is strong but needs bolstering from 30-100 days
Improvement in the **New Starter Experience** (as denoted by the Kent & Medway NSES)	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Jan 24	• Overall net engagement score for new starters (71%) 15% ahead of the K&M average (56%) as at 17/10/23

Staff Engagement Score

Integrated Improvement Plan

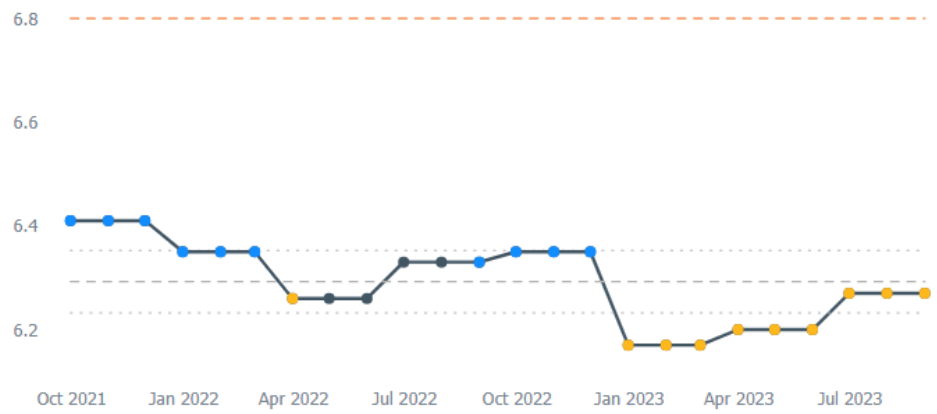
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide overall engagement score.

Staff Engagement Score

Timescale	Value	SPC
Oct-22	6.35	
Nov-22	6.35	
Dec-22	6.35	
Jan-23	6.17	
Feb-23	6.17	
Mar-23	6.17	
Apr-23	6.20	
May-23	6.20	
Jun-23	6.20	
Jul-23	6.27	
Aug-23	6.27	
Sep-23	6.27	

XMR Run Chart



Understanding the most recent data point

Performance

6.27 — Variation indicates consistently falling short of the target

Variation

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

Flags — Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• Next results available Jan/ Feb 24 (post-NSS)	• Staff Engagement levels have improved by 7 points quarter on quarter, with equitable improvements across each of the three domains of engagement
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• Ongoing	• Overall SE: 6.27 (up 7 points vs. Q1) • Motivation: 6.69 (up 8 points vs. Q1) • Involvement: 6.29 (up 6 points vs. Q1) • Advocacy: 5.83 (up 7 points vs. Q1)
National Staff Survey 2023	• Driving response rates across the 2023 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• Sept 23 – Nov 23	• NSS launched successfully, with 803 respondents on the first day. 2,877 respondents to-date representing a 29% return four-weeks in to fieldwork.

Statutory Training

Integrated Improvement Plan

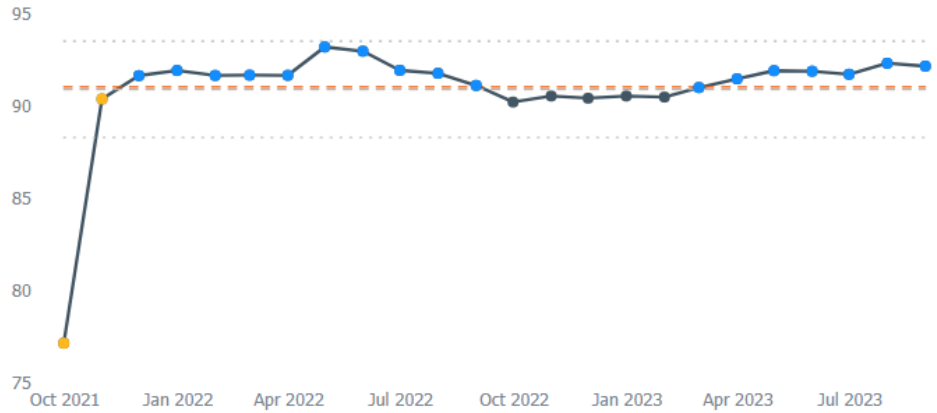
East Kent Hospitals University NHS Foundation Trust

The proportion of staff who have successfully completed Mandatory training in; Child Protection, Equality and Diversity, Fire Safety Awareness, Health and Safety Awareness, Infection Control, Information Governance and Manual Handling Awareness.
Data source: ESR

Statutory Training

Timescale	Value	SPC
Oct-22	90.2%	
Nov-22	90.5%	
Dec-22	90.4%	
Jan-23	90.5%	
Feb-23	90.5%	
Mar-23	91.0%	
Apr-23	91.4%	
May-23	91.9%	
Jun-23	91.9%	
Jul-23	91.7%	
Aug-23	92.3%	
Sep-23	92.1%	

XMR Run Chart



Understanding the most recent data point

Performance

92.1%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Medical staff levels of compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance.	• Head of L&D • Heads of P&C • P&CBPs • CMO	• End Oct 23	• Paper written to identify areas of lowest compliance. Policy to be updated to allow withholding of study leave if stat training not complete.
Capacity within face to face statutory learning, particularly Resus.	• Resus team currently at 50% capacity due to vacancies and sickness absence. Being addressed through the Corporate Team	• Deputy Chief Nurse • Resus Team	• End Nov 23	• Care Groups ensuring that the most essential, non-compliant staff are booked on Resus training first.
Low compliance with Trainee Drs, as they do not complete this on arrival, and no agreement to who chases this especially after rotation.	• P&C Leads to work with Med Ed on supporting improvements with this, particularly focusing on induction and rotation.	• DME • Head of L&D • P&C Senior Team	• End Nov 23	• Head of P&C to work with Care Groups to seek support from Med Ed management team.

Medical Job Planning Rate

Integrated Improvement Plan

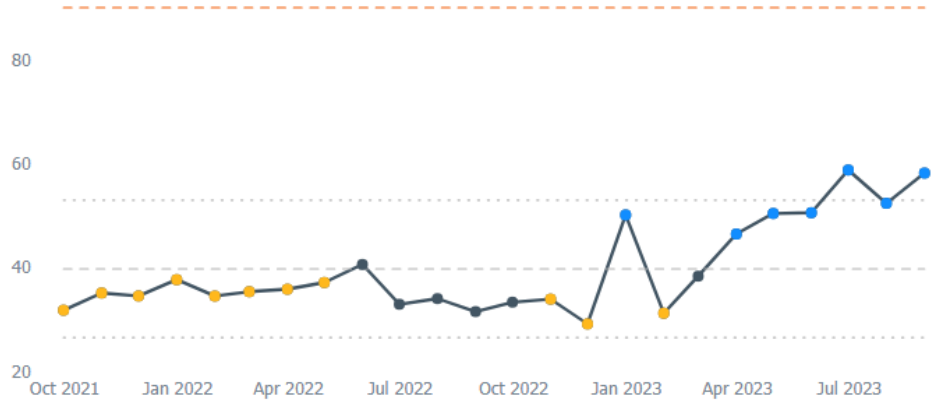
East Kent Hospitals University NHS Foundation Trust

Number of staff who have a fully signed off job plan in the current job planning cycle (1 April - 31 March), as a proportion of the total number of staff. A signed off job plan requires approval from the local Specialty Lead, the Care Group Clinical Director, and the Hospital Medical Director. Exclusions: This job planning data refers to non-training consultant and SAS grade doctors only and is not required by other doctor grades.

Medical Job Planning Rate

Timescale	Value	SPC
Oct-22	33.3%	
Nov-22	33.9%	
Dec-22	29.1%	
Jan-23	50.1%	
Feb-23	31.2%	
Mar-23	38.3%	
Apr-23	46.4%	
May-23	50.4%	
Jun-23	50.5%	
Jul-23	58.7%	
Aug-23	52.3%	
Sep-23	58.1%	

XMR Run Chart



Understanding the most recent data point

Performance

58.1% — Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Job planning compliance continues to improve across specialities, there are approximately 183 doctors (19%) that remain in discussion and 23% in the sign-off stages.	• Initial reminders sent to clinicians in September • Follow up reminders for those not engaging sent in October • Sign-off managers/leads contacted to chase decisions in October	• CMO	• End Dec 23	• Obstetrics and Gynaecology have now achieved 97% compliance • Gynae Oncology have now achieved 93% compliance • 7 other specialities have now achieved 100% compliance
The hierarchies for specialities and sign-off on e-JobPlan do not align to the new structure.	• CMO operational support team to phase the migration to the new structure by speciality	• CMO	• Nov 23	• Migration plan complete • Sign-off and compliance issues noted by Allocate. Mitigations discussed to prevent significant compliance impact
The previous process for managing LCEA's did not effectively encourage uptake of job planning	• LCEA applications to only be accepted if suitable engagement with the job planning process is evident, establishing a baseline with which to judge excellence. • LCEA competitive round to be launched • Awards Committee to be constructed for scoring and distribution	• CMO	• Oct 23	• Decision made by Trust to progress with a competitive CEA round • Application forms and guidance to be distributed in October 2023

Staff Advocacy Score

Integrated Improvement Plan

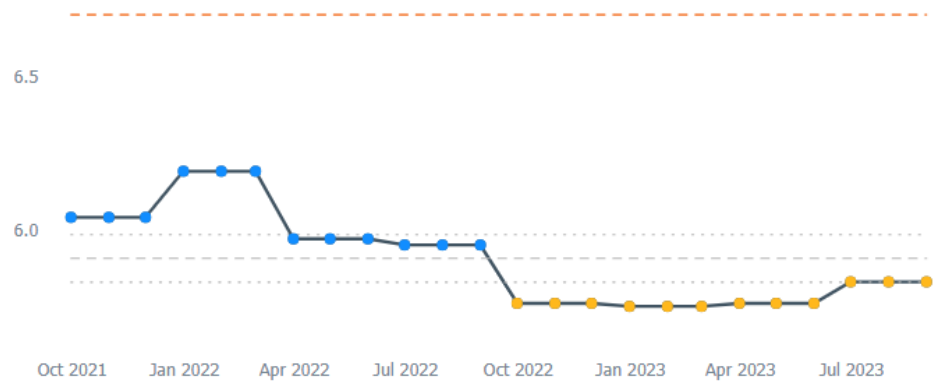
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff advocacy questions added to Staff Friends and Family quarterly surveys commencing March 2021.
3 advocacy questions in staff survey and replicated in quarterly staff FFT, these are a subset of the staff engagement score.

Staff Advocacy Score

Timescale	Value	SPC
Oct-22	5.76	
Nov-22	5.76	
Dec-22	5.76	
Jan-23	5.75	
Feb-23	5.75	
Mar-23	5.75	
Apr-23	5.76	
May-23	5.76	
Jun-23	5.76	
Jul-23	5.83	
Aug-23	5.83	
Sep-23	5.83	

XMR Run Chart



Understanding the most recent data point

Performance

5.83	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to lower values
Flags	Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Advocacy levels (5.8) are significantly below the national standard (6.4)	• Continued action is required to repair the reputation of the organisation & the extent to which staff would recommend as a place to work and be treated	• Executive Team	• End Nov 24 (post NSS)	• Staff Advocacy improved by 7 points quarter-on-quarter, from 5.76 (Q1) to 5.83 (Q2), but remain in quartile 1 when benchmarked nationally
Staff Advocacy levels remain in Quartile 1 when benchmarked nationally	• Increased rollout of We Care as a programme to drive staff engagement levels	• Head of Transformation	• Ongoing	• Staff Advocacy levels are 62 points higher in We Care areas than non-We Care counterparts – increased roll-out to 337 more staff and 1114 overall
The extent to which staff would recommend the Trust as a place to work or be treated	• Majority completion of the National Staff Survey which acts as a measure of engagement and advocacy in it's own right	• Head of Staff Experience	• End Nov 23	• Comprehensive activity taking place to drive responses. Outreach across all sites and 'live' dashboard in-place to track hotspots

Appraisal Rates

Statutory Metrics

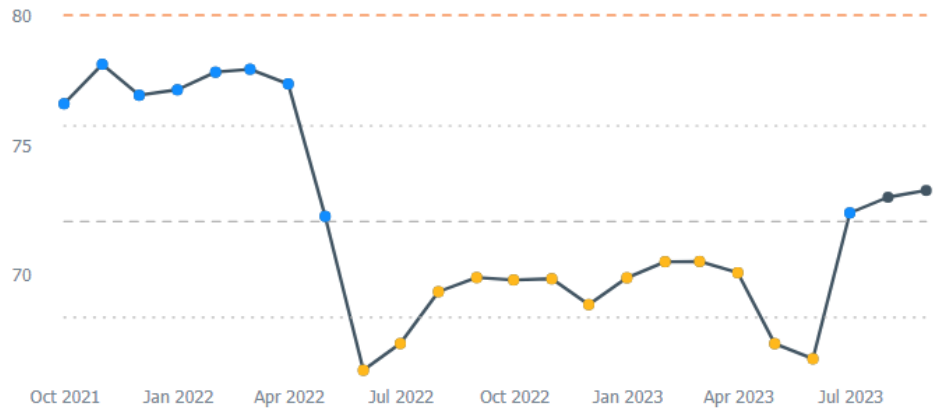
East Kent Hospitals University NHS Foundation Trust

Number of staff who have completed an appraisal and objective setting meeting in the preceding 12 months, as a proportion of the total number of staff.
Exclusions: Doctors, Secondary Assignments, Career Break, Maternity & Adoption, External Secondment and Unpaid Suspensions. Staff who have worked at the Trust for less than 12 months.
Datasource: ESR

Appraisals Compliance

Timescale	Value	SPC
Oct-22	69.8%	
Nov-22	69.9%	
Dec-22	68.9%	
Jan-23	69.9%	
Feb-23	70.5%	
Mar-23	70.5%	
Apr-23	70.1%	
May-23	67.4%	
Jun-23	66.8%	
Jul-23	72.4%	
Aug-23	73.0%	
Sep-23	73.3%	

XMR Run Chart



Understanding the most recent data point

Performance

73.3% — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)
Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Managers not uploading completion dates to ESR	• Each Care Group identifying the areas where no or few uploads to ESR have been identified. Supporting those managers with ESR self service training.	• Heads of P&C • PCBPs	• End Nov 23	• 350 names added to ESR that had previously not been updated • Identifying areas where support needed for updated ESR training
Admin & Clerical appraisal rates remain below threshold, with 642 outstanding appraisals.	• Focus within the new Care Groups on improving A&C appraisal rates, and ensuring they are uploaded to ESR.	• Care Group MDs • Heads of P&C • PCBPs	• End Oct 23	• New P&C Care Group teams to work locally with targeting areas of low A&C appraisal compliance – WHH Care Group being targeted during Oct/Nov 23
Quality of appraisal remains low, according to staff survey	• F2F meetings with line managers re: appraisal and Slido sent out to 600 staff asking for feedback on individual appraisals to identify reasons for low quality.	• P&CPs • Heads of P&C	• End Oct 23	• Currently approx. 10% response rate on Slido to identify quality issues. Resending email to improve feedback.

Sustainability

Financial Sustainability

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Finance	IIP		I&E Monthly Variance Group (£M)		Traj.	-15.3...	-19.323	-24.520	-28.9...	-23.5...	-19.3...	-9.379	-19.651	-9.244	-10.081	-11.314	-9.030
	IIP		Efficiencies Green Schemes (£M)		40	18	20	20	20	20	20	0	1	4	3	10	9
	IIP		Efficiencies YTD Variance (£M)		0.0	-1.3	-2.5	-4.6	-6.4	-8.8	-10.4	-1.5	-2.9	-4.8	-8.0	-6.3	-15.0
	IIP		Premium Pay		Traj.	9,178	8,577	8,413	9,034	8,689	9,058	8,839	10.2K	9,666	9,687	10.7K	8,847

September Performance Summary

Financial Position: The financial position YTD is £18.4m away from a plan of £40.9m, with a total deficit YTD of £59.3m. The key drivers behind the deficit variance are Strike action £1.5m by the Junior doctors and Consultants (excluding the impact of April industrial action, which has now been funded through the new ERF guidance), shortfall in funding for A4C pay award of £0.7m & Medical and Dental pay award £1.4m, non-delivery of recurrent efficiency savings £15.1m YTD (net of £0.4m delivery of income CIP) of which £9.3m has been allocated to Pay and £6.2m to Non pay. The agency spend YTD is £25.1m which is £11.2m away from the agency cap.

Efficiencies: The Care Groups recognised recurrent savings of £0.2m in September, and £0.9m on a YTD basis, which is significantly below Plan. As well as the £40m CIP requirement, the run rate is required to improve significantly in order to deliver the 23/24 Plan.
Additional non-recurrent efficiencies of £6.2m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialing).
The current value of the efficiencies pipeline is £14.9m, a (£1.1m, 8%) increase in value vs. the prior month.
The majority of ideas currently identified through the care group process are less than £50k (60%) or less than £250k (20%), but working across the cross-cutting themes of Workforce, Elective and Non-Elective productivity, Theatres, we are predominantly scoping larger group-wide to significantly increase the value of CIP schemes.

I&E YTD Actual Group (£m)

Integrated Improvement Plan

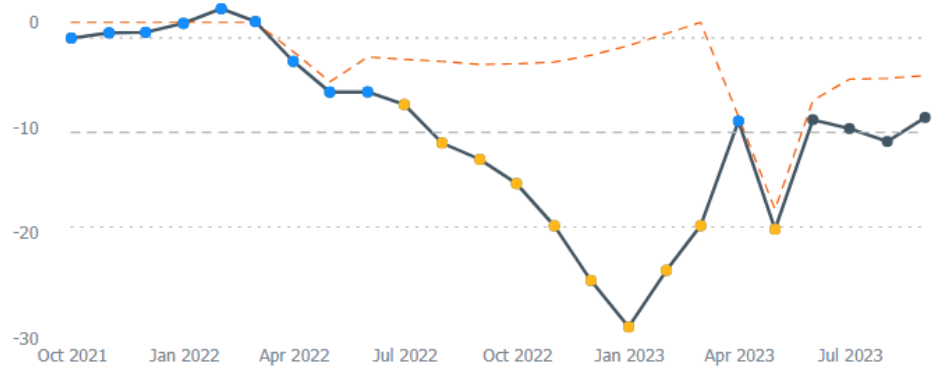
East Kent Hospitals University NHS Foundation Trust

The I&E Margin (£M) is the Group's technically adjusted profit or loss shown as a percentage of its technically adjusted Income result for each month. If the number is positive the Group is making a surplus

I&E Monthly Variance G...

Timescale	Value	SPC
Oct-22	-15.313	
Nov-22	-19.323	
Dec-22	-24.520	
Jan-23	-28.935	
Feb-23	-23.555	
Mar-23	-19.317	
Apr-23	-9.379	
May-23	-19.651	
Jun-23	-9.244	
Jul-23	-10.081	
Aug-23	-11.314	
Sep-23	-9.030	

XMR Run Chart



Understanding the most recent data point

Performance

-9.030

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure national grip and control level 4's are embededd into the Trust for pay & non pay areas	• All level 4 grip and controls are being rolled out to the wider Trust for both pay and non pay.	• CFO	• On-Going	• Vacancy panel for clinical posts embedded led by CPO. Nursing workforce review embedding led by CNMO. • Investment panel implemented led by CFO
Run rate continues to be above plan due to utilisation in excess of establishment	• Workforce plans included in the level 4 grip & controls are being embedded to review medical and nursing workforce arrangements	• CNMO & CMO	• On-Going	• Nursing deep dives continue. Golden key has been implemented • CMO has reviewing high cost agency for Medical & Dental
Non delivery of CIP to date and non achievement of a robust in year CIP plan.	• Increased levels of plans needed to close the CIP plan. Non recurrent CIP's to be externally reported	• Care group MD's • PMO • Exec Team	• End October -23	• Workforce & Financial Sustainability Recovery meetings have now commenced. • Further work is needed on the corporate areas to ensure CIP delivery • PMO working closely with Financial Recovery Director on forecast CIP

Financial Efficiencies: Green Rated Schemes

Integrated Improvement Plan

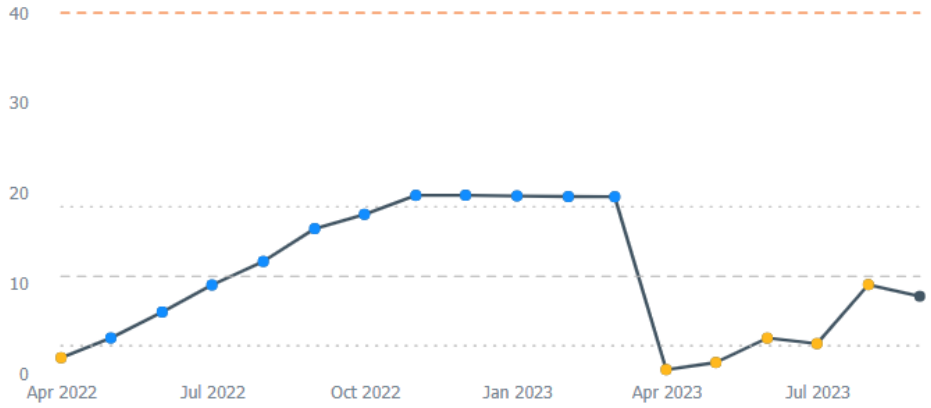
NHS East Kent Hospitals University NHS Foundation Trust

Efficiencies Green Schemes is the sum of delivered schemes YTD plus the sum of forecast of green rated schemes as a percentage of the annual efficiencies target. If the percentage rated Green is < 90% then overall rating is RED.

Efficiencies Green Sche...

Timescale	Value	SPC
Oct-22	18	
Nov-22	20	
Dec-22	20	
Jan-23	20	
Feb-23	20	
Mar-23	20	
Apr-23	0	
May-23	1	
Jun-23	4	
Jul-23	3	
Aug-23	10	
Sep-23	9	

XMR Run Chart



Understanding the most recent data point

Performance

9 — Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining organisational focus during restructure	• Move to 3 part Executive led PRMs from September (Wk1 Activity & Productivity, Wk3 Workforce and financial sustainability, Wk4 Performance management); • Continue CEO and CFO messaging to organisation on finance and efficiency; • PMO re-aligned to new care group structure, and to attend Wk1 and Wk3 meetings; • CIP targets for new care groups being re-calculated based on re-structured budgets	EMT CEO/CFO/ADFI ADFI Finance/PMO	01/09/23 Ongoing 30/09/23 30/09/23	• Meetings set up and in diaries until March 2024. Commenced September 2023. PMO invited to Week 1 and Week 3 care group recovery meetings. • CFO released enhanced controls 08/08. • CIP targets for new care groups have been re-calculated and issued. Schemes identified/in the pipeline also being realigned to new care groups.
Pace of scheme development	• CFO/CSPO led admin and clerical vacancy review; • CNO led deep dives on nursing agency spend rolled out with care groups; • Weekly meetings between CFO/CPSO and FID/ADFI on progress and rapid improvement opportunities;	CFO/CSPO CNO CFO/CSPO	Sept/Oct 23 Underway Underway	• Care group responses to be discussed during next Finance/Workforce recovery meetings. • £1m benefit from reducing pool nurses (run rate reduction)
Identification of opportunities sufficient to reach the required £40m	• EMT agreed 5 cross cutting themes for focus with Exec leads; • New Turnaround Director appointed, meeting with PMO	EMT/ADFI TD/PMO	Ongoing 25/09/23	• Theme values being developed. • FRD/ADFI met 21/09, PMO meeting 25/09. Meeting weekly.

Financial Efficiencies YTD Variance

Integrated Improvement Plan

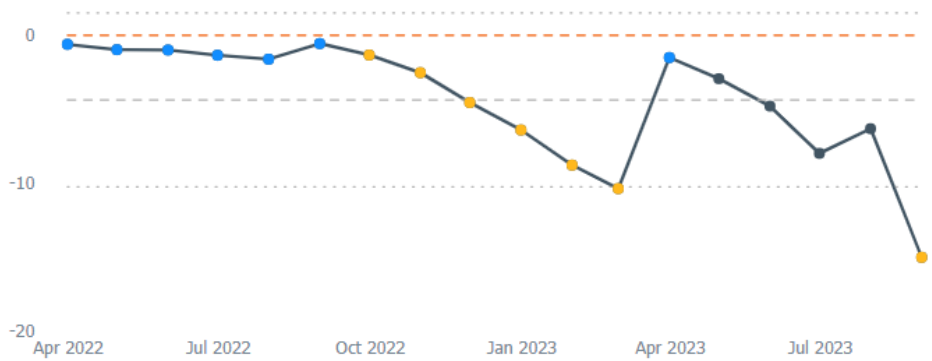
East Kent Hospitals University NHS Foundation Trust

Efficiencies YTD Variance (£M) is the difference between the YTD delivered efficiencies and YTD efficiencies target. If that number is zero or positive, the Trust is delivering the expected efficiencies.

Efficiencies YTD Varianc...

Timescale	Value	SPC
Oct-22	-1.3	
Nov-22	-2.5	
Dec-22	-4.6	
Jan-23	-6.4	
Feb-23	-8.8	
Mar-23	-10.4	
Apr-23	-1.5	
May-23	-2.9	
Jun-23	-4.8	
Jul-23	-8.0	
Aug-23	-6.3	
Sep-23	-15.0	

XMR Run Chart



Understanding the most recent data point

Performance

-15.0 — Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags — Outside Moving Range Limit; Astronomical Point

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring finance and CIP transparency while reflecting underlying organisational improvement	• Additional non-recurrent efficiencies of £6.2m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialling). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.	CFO/PMO PMO	Sept-23 On-going	• Methodology and calculation agreed at FPC, used for Mth5 reporting onwards • PMO continue to work with care groups to establish whether there are any recurrent savings inherent in the underspends
Agency usage and cost at a similar level to this time last year	Nursing agency costs remain high • Action: Greater controls through authorisation and "golden key" process • Action: Super-numery period reduced to two weeks for IENs • Context: High cost medical agency (HCMA) use remains high, ongoing issue. • Action: CPO/FRD/PMO working with care groups to review HCMA value add.	• CNMO • CNMO • FID/PMO	• Ongoing • 22/09 • Sept/Oct 23	• Golden Key went live 18/09/23 • Reduced supernumerary period implemented in inpatient areas • To combine deep dives to include medical and nursing, and to feed into Workforce and Financial Sustainability recovery meetings.

Premium Pay

Integrated Improvement Plan

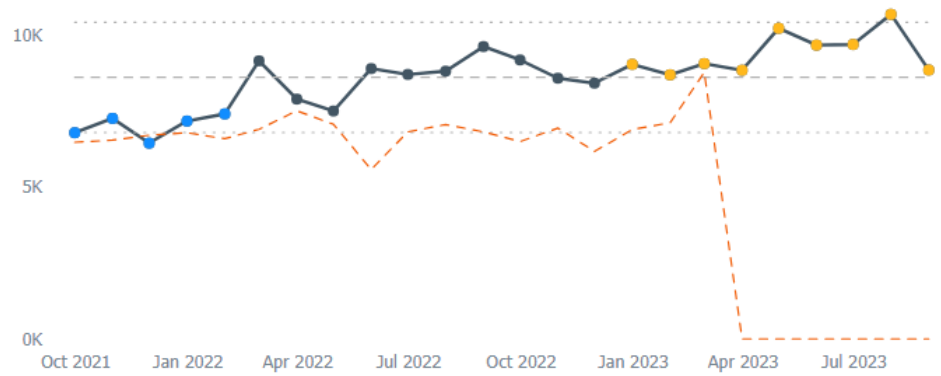
East Kent Hospitals University NHS Foundation Trust

Summary metric of Trust premium pay items Agency (NHSP and direct engagement), Bank, WLI payments, Locally Agreed Group, Medical Short Sessions, Other Medical Locum costs and Overtime (excl additional basic) in £.

Premium Pay

Timescale	Value	SPC
Oct-22	9,178	
Nov-22	8,577	
Dec-22	8,413	
Jan-23	9,034	
Feb-23	8,689	
Mar-23	9,058	
Apr-23	8,839	
May-23	10.2K	
Jun-23	9,666	
Jul-23	9,687	
Aug-23	10.7K	
Sep-23	8,847	

XMR Run Chart



Understanding the most recent data point

Performance

8,847

Variation indicates consistently falling short of the target

Variation

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

Flags: Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Timely information that can be used to target areas of high premium pay usage.	• Premium Pay Dashboard now live, and updated regularly.	• Information Lead • Strategic Workforce Lead • Heads of P&C	• End Sept 23	• CMO, Heads of P&C and P&CBPs to use this Dashboard and information to support Care Group Exec Efficiency meetings.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead, Heads of P&C, P&CBPs	• End Sept 23	• First draft Workforce Strategies in place, to be reviewed regularly with Care Groups and Resourcing
Appointment of managed service provider to reduce agency spend as above the Trust agency spend cap.	• Seek Board approval for procurement. • Onboard provider.	• CPO/ Procurement • Deputy CPO	• End Nov 23	• Approval and procurement process underway and on target.

East Kent Hospitals University NHS Foundation Trust

Maternity

Maternity

Integrated Improvement Plan

NHS
East Kent
Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Maternity	IIP		Serious Incidents Maternity		Sigma	3	1		2	4	4	4	1	3	2		2
	IIP		Maternity Incidents Moderate / Severe		Sigma	4	1	2	6	5	6		3	2		2	2
	IIP		Maternity Complaints		Sigma	9	10	6	9	12	8	9	8	3	6	1	16
	IIP		Maternity Complaint Response		90.0%	0.0%	50.0%	40.0%		0.0%	75.0%	25.0%	16.7%	35.3%	45.5%	66.7%	60.0%
	IIP		Extended Perinatal Mortality		5.87	4.44	4.94	4.64	4.33	4.53	4.44	4.62	4.47	3.87	3.40	3.58	3.11
	IIP		FFT Maternity Response Rate		15.0%	16.6%	17.0%	14.9%	16.2%	14.0%	12.2%	11.6%	11.7%	12.8%	13.0%	11.1%	9.3%
	IIP		FFT Maternity Recommended		90.0%	93.9%	90.5%	90.7%	95.2%	91.6%	92.2%	93.7%	92.1%	92.3%	91.6%	88.8%	90.8%
	IIP		FFT Maternity (IP) Recommended		90.0%	94.5%	90.9%	91.8%	95.2%	91.7%	96.2%	95.1%	92.6%	94.3%	94.3%	89.3%	90.7%
	IIP		WH Engagement Score		6.90	5.89	5.89	5.89	5.45	5.45	5.45	5.87	5.87	5.87	6.15	6.15	6.15

September Performance Summary

Incidents: There were 2 serious incidents reported in September in Women's Health for Maternity, and 2 moderate harm incidents.

Complaints: 16 Stage 1 complaints were received in September for Maternity. This is a significant increase. There are currently 25 open first complaints of which 1 has breached

Patient Involvement: FFT Response rate decreased to 9.3% - 90.8% extremely likely or likely to recommend

Staff Engagement: Score 6.15

Maternity Serious Incidents

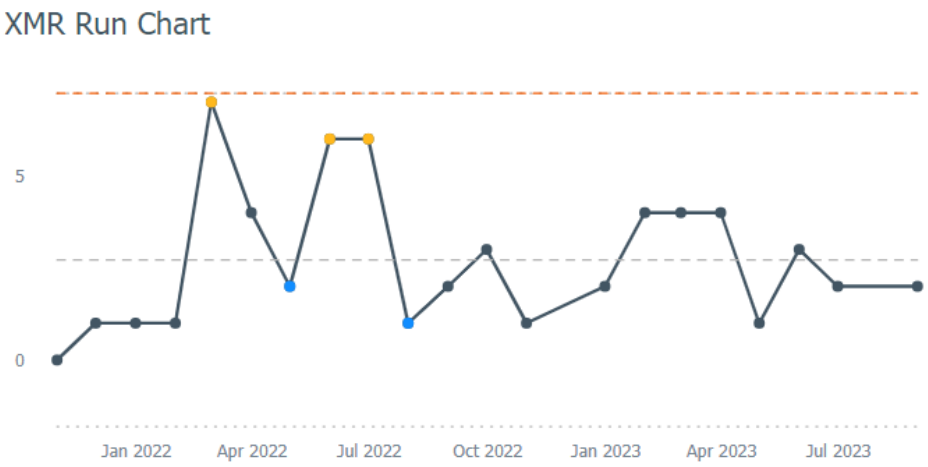
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any maternity incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any maternity incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents Mater...

Timescale	Value	SPC
Aug-22	1	
Sep-22	2	
Oct-22	3	
Nov-22	1	
Jan-23	2	
Feb-23	4	
Mar-23	4	
Apr-23	4	
May-23	1	
Jun-23	3	
Jul-23	2	
Sep-23	2	



Understanding the most recent data point

Performance

2 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 2 serious incidents reported in September for Maternity.	1. Mis-identification (mortuary) 2. Incorrect expressed breast milk	• Interim Head of Governance	• 14/12/23	RCA's commenced. Immediate actions implemented: • Support for patients and staff involved • Annual Midwifery training lesson plans updated • Updating of competencies • Hot-topic /Message of the week circulated • Update of SOP/guidance
At month end there are 11 open SI's in Maternity.	For all SI investigations to be completed within agreed timeframes.	• Interim Head of Governance	• Monthly - ongoing	• All open SI's under investigation are within agreed timeframes. • There are 2 NCR breaches that are anticipated to be submitted within the month.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of original June backlog and current position	• Interim Head of Governance	• 30/11/23	• The number of overdue actions from the original backlog (June) has reduced from 345 to 208 at 16/10/23. However, the overall current overdue actions has increased to 308 due to action plans being added to the module and further actions breaching. The Patient Safety Team continue to supporting clinical staffing at 40% until half-term and then reduce to 20%. There is additional agency resource focussing on open actions from October. Patient Safety Matron vacancy will go backout to advert following a recently recruited successful candidate withdrew

Maternity Incidents Causing Harm

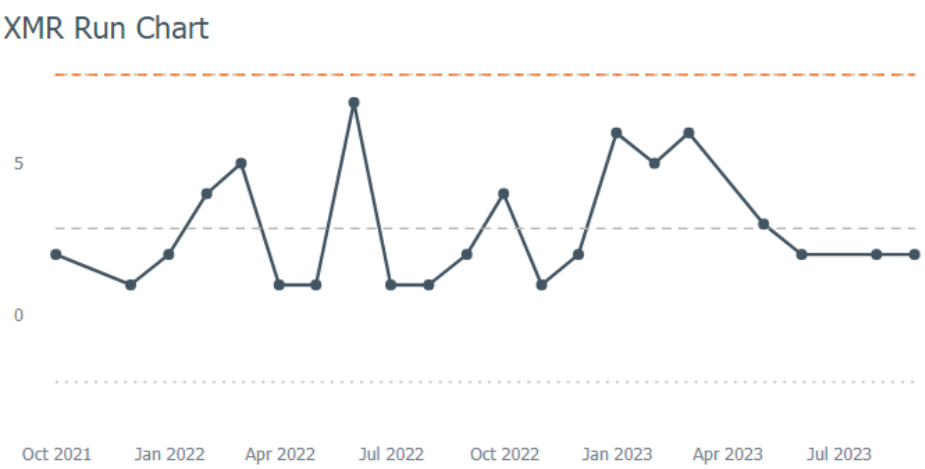
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of maternity incidents where the harm status was moderate or above.

Maternity Incidents Mo...

Timescale	Value	SPC
Aug-22	1	
Sep-22	2	
Oct-22	4	
Nov-22	1	
Dec-22	2	
Jan-23	6	
Feb-23	5	
Mar-23	6	
May-23	3	
Jun-23	2	
Aug-23	2	
Sep-23	2	



Understanding the most recent data point

Performance

2

Variation indicates inconsistently passing and falling short of the target

Variation

Variation	Common cause (no significant change)
Flags	No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	• Interim Head of Governance	• Monthly - ongoing	• Themes and learning identified from rapid reviews disseminated via Message of the Week and Safety Threads.
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 30/11/2023	• The number of open datix from the original June backlog for Maternity has reduced from 686 to 93 at 16.10.2023. However, the overall current overdue datix is 500. Incident handlers have been contacted to review their open incidences. This is a priority for the Patient Safety Team to close these open datix, all of which have had an initial review at the time of reporting.

Maternity Complaints

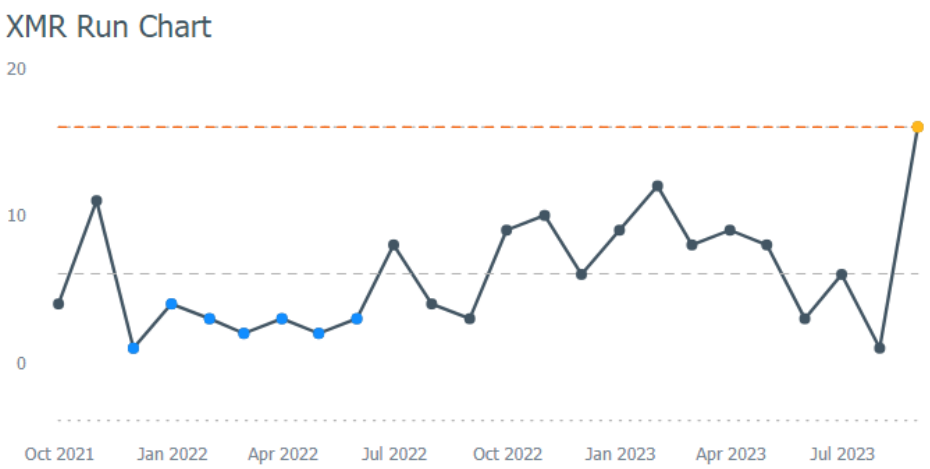
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of complaints made to Obstetrics, Midwifery or New-born Hearing Screening Services.

Maternity Complaints

Timescale	Value	SPC
Oct-22	9	
Nov-22	10	
Dec-22	6	
Jan-23	9	
Feb-23	12	
Mar-23	8	
Apr-23	9	
May-23	8	
Jun-23	3	
Jul-23	6	
Aug-23	1	
Sep-23	16	



Understanding the most recent data point

Performance

16

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Outside Moving Range Limit, Astronomical Point

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
16 Stage 1 complaints received in September 2023 for Maternity	Significant increase in the number of complaints received in September	Patient Experience and Complaints Coordinator	Monthly reporting	Complaint "sprint day" scheduled for 26/10/2023 to respond to increased complaint workload received in month in a timely manner.
Recurrent themes	The 4 main themes are • Post natal communication in relation to 'complicated' births (lack of informal debriefs/conversations to listen to their concerns) • Sonography input not matching realities at birth (placenta info, baby weights) • Busy post-natal wards causing people to feel uncared for in a timely way • Infant wellbeing checks delayed/phototherapy issues.	Adaline Smith DDOM	Monthly	We have commenced leave your troubles at the door initiative and posters can be seen at every entry point to support immediate response and action of any concerns.

Maternity Complaints Response Rate

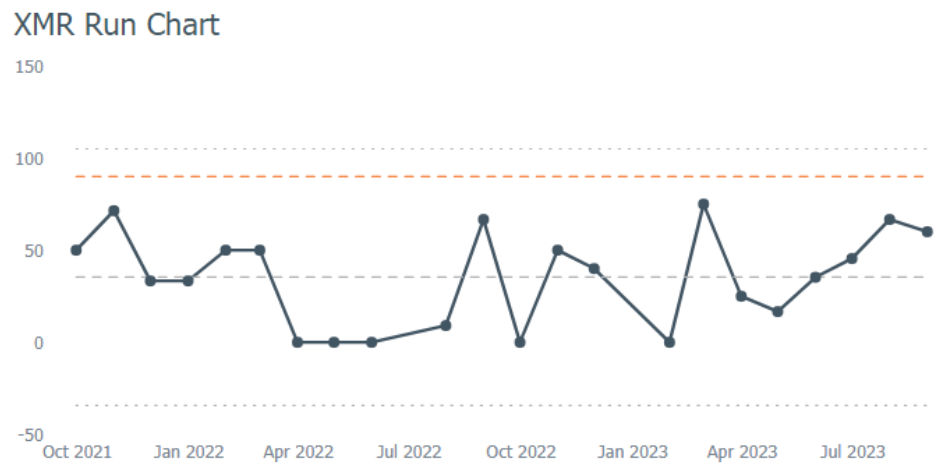
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the proportion of complaints which were responded to within the agreed timescale of the complaint being received. This includes both 30 and 45 working day timescale targets.
Complaint Types included are Formal, External and MP Formal that have not been rejected.
Complaint Stages included are extensions 1,2,3 and extensions agreed by Chief Nurse, Local Resolution, On Hold and Withdrawn.

Maternity Complaint Re...

Timescale	Value	SPC
Sep-22	66.7%	
Oct-22	0.0%	
Nov-22	50.0%	
Dec-22	40.0%	
Feb-23	0.0%	
Mar-23	75.0%	
Apr-23	25.0%	
May-23	16.7%	
Jun-23	35.3%	
Jul-23	45.5%	
Aug-23	66.7%	
Sep-23	60.0%	



Understanding the most recent data point

Performance

60.0%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation	Common cause (no significant change)
Flags	No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	• Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	• Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• There has been a significant improvement in the number of open/breached complaints in recent months. Positive feedback has been received on the quality of the complaint responses. • Sprint day 26/10/2023.

Extended Perinatal Mortality

Integrated Improvement Plan

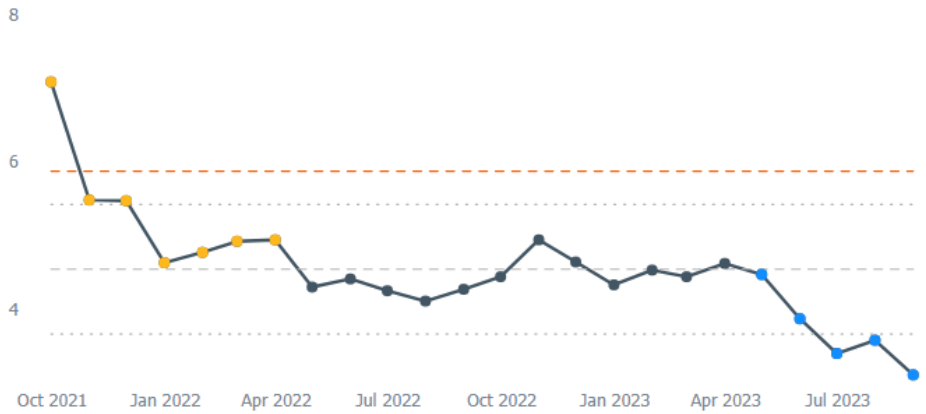
East Kent Hospitals University NHS Foundation Trust

Extended perinatal mortality refers to all stillbirths and neonatal deaths, MBRRACE methodology is used, which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is per 1000 total births.
Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (Trust with level 3 NICU) from the 2021 MBRRACE report.

Extended Perinatal Mort...

Timescale	Value	SPC
Oct-22	4.44	
Nov-22	4.94	
Dec-22	4.64	
Jan-23	4.33	
Feb-23	4.53	
Mar-23	4.44	
Apr-23	4.62	
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	

XMR Run Chart



Understanding the most recent data point

Performance

3.11	Variation indicates consistently passing the target

Variation

Variation	Special cause of improving nature or lower pressure due to lower values
Flags	Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In September there was 1 stillbirth (IUD) reportable to MBRRACE – born at 36+1 weeks gestation.	The rolling 12 month rate for stillbirths remains below the lower confidence limit at 2.25 stillbirths per 1,000 births.	PMRT Lead Midwife	Monthly	• Presented at Rapid Review 13/09/2023. • Presentation prepared for PMRT review in November
In September there were 0 neonatal deaths reportable to MBRRACE	The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 0.87 neonatal deaths per 1,000 livebirths, and has been so for 17 consecutive periods.	PMRT Lead Midwife	Monthly	
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	PMRT Lead Midwife	Monthly	• 100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

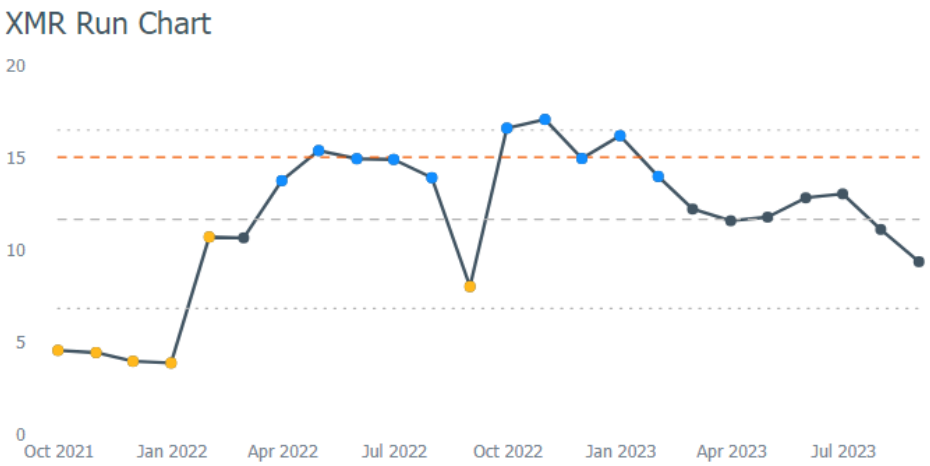
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of responses to the maternity friends and family questionnaires and displays as a % of the total questionnaires sent.

FFT Maternity Response...

Timescale	Value	SPC
Oct-22	16.6%	
Nov-22	17.0%	
Dec-22	14.9%	
Jan-23	16.2%	
Feb-23	14.0%	
Mar-23	12.2%	
Apr-23	11.6%	
May-23	11.7%	
Jun-23	12.8%	
Jul-23	13.0%	
Aug-23	11.1%	
Sep-23	9.3%	



Understanding the most recent data point

Performance

9.3%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rate decrease to 9.3%	Issues with coding in September. Data may not account for service users who were sent FFT at the end of the month of September- not all families respond straight away. FFT responses continue to come in throughout the following weeks/months after they have used the service and these are reported on a rolling basis.	• Patient Experience Midwives	• Monthly	• There is a new PTL for FFT- the aim that FFT feedback is themed in a standardised way and is comparable. There appears to be a discrepancy in the new theming and data. Meeting in October to discuss this and the reporting going forward. • The team shall continue to look at ways to increase the response rate.
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	• Patient Experience Midwives	• March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023 • The care group welcomed the new MNVP chair for EKHUFT who we will continue to work collaboratively with. The 2023/2024 work plan has now been finalised with next steps including walking the patch and 15 steps. • Feedback is being continually gathered through YVIH and FFT.

Maternity Friends & Family Test: Recommended

Integrated Improvement Plan

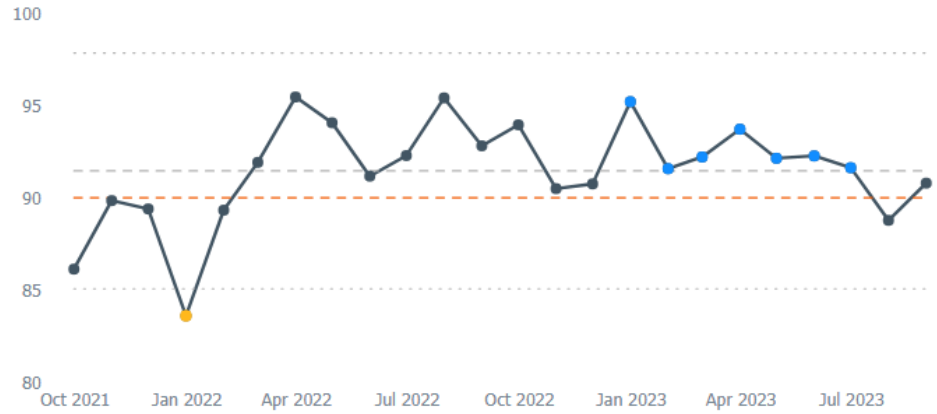
East Kent Hospitals University NHS Foundation Trust

This metric is a summary of all Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity Recomme...

Timescale	Value	SPC
Oct-22	93.9%	
Nov-22	90.5%	
Dec-22	90.7%	
Jan-23	95.2%	
Feb-23	91.6%	
Mar-23	92.2%	
Apr-23	93.7%	
May-23	92.1%	
Jun-23	92.3%	
Jul-23	91.6%	
Aug-23	88.8%	
Sep-23	90.8%	

XMR Run Chart



Understanding the most recent data point

Performance

90.8%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 90.8% extremely likely or likely to recommend which is an increase in month.	PEM feedback to staff on a regular basis via personalised email and update posters on the units/community offices and in the monthly newsletter.	• PEM	• Monthly	

Maternity Friends & Family Test: Inpatient Recommended

Integrated Improvement Plan

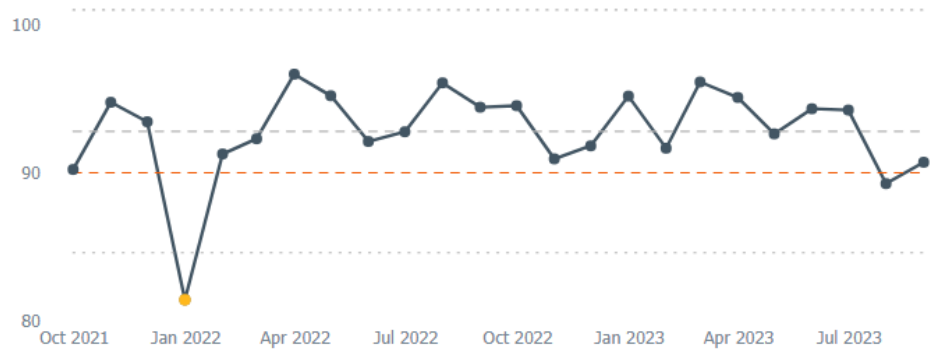
East Kent Hospitals University NHS Foundation Trust

This metric is a summary of Inpatient Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity (IP) Reco...

Timescale	Value	SPC
Oct-22	94.5%	
Nov-22	90.9%	
Dec-22	91.8%	
Jan-23	95.2%	
Feb-23	91.7%	
Mar-23	96.2%	
Apr-23	95.1%	
May-23	92.6%	
Jun-23	94.3%	
Jul-23	94.3%	
Aug-23	89.3%	
Sep-23	90.7%	

XMR Run Chart



Understanding the most recent data point

Performance

90.7%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code	• Liane Ashley	• December 23	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023

Women's Health Staff Engagement Score

Integrated Improvement Plan

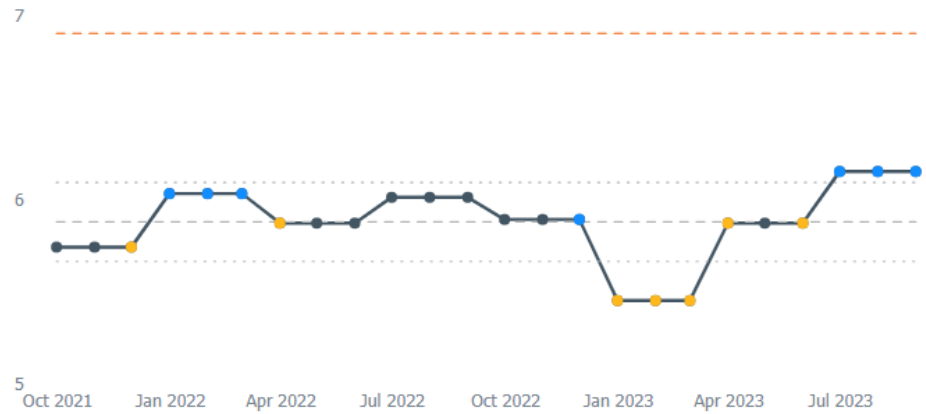
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide the overall engagement score.

WH Engagement Score

Timescale	Value	SPC
Oct-22	5.89	
Nov-22	5.89	
Dec-22	5.89	
Jan-23	5.45	
Feb-23	5.45	
Mar-23	5.45	
Apr-23	5.87	
May-23	5.87	
Jun-23	5.87	
Jul-23	6.15	
Aug-23	6.15	
Sep-23	6.15	

XMR Run Chart



Understanding the most recent data point

Performance

6.15 — Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Opportunities for Staff Engagement	• Introduction of " We Hear You " providing platform for feedback • Embedding Safety Champions Forum • Band specific Meetings /away days • Increase Appraisal rates and SMART objectives • Promoting Freedom to Speak Up Guardians and arrange dedicated walkarounds • Embedding retention conversations • Compassionate attendance at work conversations following absences	• Adaline Smith DDOM	• December 23	

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MONTH 6 (M6) FINANCE REPORT

Meeting date: 2 NOVEMBER 2023

Board sponsor: INTERIM CHIEF FINANCE OFFICER (CFO)

Paper Author: INTERIM DEPUTY CHIEF FINANCE OFFICER (DCFO)

Appendices:

APPENDIX 1: M6 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Trust Board on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	The Group reported an in-month position of £9.0m against a plan of £5.0m, resulting in a deficit variance of £4m. The Year to Date (YTD) position is £59.3m against a plan of £40.9m, giving a YTD variance to plan of £18.4m. The agreed financial plan for 2023/24 is a £72m deficit. Delivery of the 2023/24 financial plan is based upon some extremely challenging assumptions as it requires that the Trust: 1) Delivers £40m of efficiency savings on a cash releasing efficiency basis. 2) Delivers a stretch activity target. 3) Reduces not medically fit to reside patients. 4) Eliminates 65-week breaches. 5) No additional unknown cost pressures are presented without mitigation in year. 6) Non-elective pressures are within planning tolerances. 7) Full control measures are reintroduced.

Group Position

£'000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
EKHUFT Income	71,820	74,343	2,523	428,592	436,187	7,595
EKHUFT Employee Expenses	(48,111)	(51,595)	(3,484)	(292,437)	(308,479)	(16,041)
EKHUFT Non-Employee Expenses	(28,962)	(32,072)	(3,110)	(178,266)	(187,886)	(9,620)
EKHUFT Financial Position	(5,253)	(9,325)	(4,072)	(42,111)	(60,178)	(18,066)
Spencer Performance After Tax	61	56	(5)	219	99	(120)
2gether Performance After Tax	93	133	40	561	645	84
Rephasing/Consolidation Adjustments	(15)	(24)	(9)	23	(515)	(538)
Consolidated I&E Position (pre Technical	(5,114)	(9,159)	(4,046)	(41,309)	(59,948)	(18,640)
Technical Adjustments	65	129	64	350	628	278
Consolidated I&E Position (incl adjs)	(5,049)	(9,030)	(3,982)	(40,959)	(59,320)	(18,362)

Run-rate has reduced in Month 6 by £2.3m compared to Month 5 (Month 5 included an accrual for the medical pay award) and by an average of £1.2m YTD.

The key drivers to the Group's YTD deficit are:

Key Drivers	**£000**
Non-delivery of recurrent efficiency savings, against recurrent Cost Improvement Programme (CIP) plan	(£14,385)
Nursing drivers (Escalation Beds £541k / 1:1 care £2,650k / Supernumery Nurses £1,574k)	(£4,765)
Unfunded Pay Award (Medical and Dental, Agenda for Change (AfC) and AfC Bonus)	(£2,641)
Strike Action impact unfunded (Junior Doctors 16 days less April 4 days as now funded through the new Elective Recovery Fund (ERF) guidance)	(£1,320)
Strike Action Consultants (4 days YTD)	(£200)
Internationally Educated Nurse (IEN) Backpay 2022/23 above plan	(£449)
Non-recurrent savings, above non-recurrent CIP plan	£5,399
Group YTD Deficit	**(£18,361)**

Trust Pay is overspent by £16.0m YTD due to

- Non-delivery of Pay CIPs.
- Shortfall in funding for pay awards.
- High cost of agency premium to cover escalation areas still open above plan £0.6m.
- Increased levels of 121 nursing care £2.6m.
- IEN supernumery period above plan £1.6m (£1.3m relates to the 6-month supernumery period for 2022/23 Q3/4 cohorts).
- IEN backpay relating to 2022/23, paid in September, £0.4m above plan.
- Increased levels of staffing utilisation/high cost agency in Medical & Dental, particularly within Healthcare of Older People, Intermediate Care, Accident & Emergency (A&E) and Anaesthetics.

Trust Non-Pay is overspent by £9.6m primarily driven by

- Non-delivery of Non-Pay CIPs.
- Rechargeable drugs costs (offset by corresponding increase in income).
- IT systems contracts relating to Laboratory Information System (LIMS) (again, offset by an increase in income).

Trust Income is above plan YTD by £7.6m mainly due to

- Funded service developments not in plan, including Cancer Alliance income (Targeted lung checks) £0.8m, additional allocation from the Integrated Care Board (ICB) for Health and Care Partnership (HCP)

East Kent Hospitals University NHS Foundation Trust

	East Kent projects £0.6m and Pathology LIMS £0.5m. These are all offset by an increase in expenditure. • high cost drugs and devices overperformance £3.6m (matched by a corresponding increase in expenditure). • favourable non-recurrent CIP of £0.5m. In line with the previous ERF guidance, Trusts are now required to report the actual income performance against their plan. As at Month 6, the Trust is behind its activity plan by £3.5m, predominantly due to cancelled elective activity as a result of the Doctor's strikes. However, to compensate Trusts for the Doctors strike in April, annual targets have been reduced by 2% and the value has been converted into fixed funding (£3.2m) and allocated to April. This funding is to cover the expenditure consequence of the April strike (£0.4m) as well as the estimated activity loss in April. The net underperformance to M6 is therefore £0.3m. The Group cash balance (including subsidiaries) at the end of September was £18.4m. The Trust drew £8.2m of working capital (Public Dividend Capital (PDC)) in the month, making a YTD total of £40.9m. Total capital expenditure at the end of September was £10.2m spend against a plan of £10.9m. The Trust has achieved very little efficiency savings so far this year, with £1.4m achievement against the £16.5m YTD plan, of which £0.9m is recurrent. Additional non-recurrent efficiencies of £5.7m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialing). Controls and interventions for both pay and non-pay are in place to reduce our current run-rate. In month 6, we saw a reduction in temporary staffing usage of £0.9m (£0.3m bank and £0.6m agency), with Whole Time Equivalent (WTE) over-utilisation reducing from 322 WTE to 167 WTE, which is a good indication that the pay controls embedding in September are working.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.

Implications:

Links to Strategic Theme:	**Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).

East Kent Hospitals University NHS Foundation Trust

Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2023/24 efficiencies target equating to £40m.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee, 31 October 2023
Clinical Executive Management Group, 1 November 2023

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

September 2023

Chief Finance Officer
Michelle Stevens

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Month 06 (September) 2023/24

Executive Summary

The Group reported an in-month position of £9.0m against a plan of £5m, resulting in a deficit variance of £4m. The Groups YTD position is £59.3m against a plan of £40.9m, giving a YTD variance to plan of £18.4m.

From the 1st of April electives and outpatients (apart from follow ups) have been reinstated to payment by results, however current guidance states that Trusts need to report on full delivery of the activity plan due to timings of data collection.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2023/24 at the beginning of May. The plan is a deficit position of £72m. The rest of the ICB need to deliver a breakeven position to achieve the ICB target of £48m deficit. Delivery of this deficit plan for 2023/24 is a stretch for the Trust as it is based on a higher level of activity than 2022/23 and requires £40m of efficiency savings on a CRES basis and full adherence to cost control measures. 2023/24 is the first year of the three year trajectory to achieve financial balance.

In line with recent ERF guidance, Trusts are now required to report the actual income performance against their plans. £3.5m Income underperformance has been reported to M6, predominantly due to cancelled elective activity as a result of the Doctor's strikes. However, to compensate Trusts for the Doctors strike in April, annual targets have been reduced by 2% and the value has been converted into fixed funding (£3.2m) and allocated to April. This funding is to cover the expenditure consequence of the April strike (£0.4m) as well as the estimated activity loss in April. The net underperformance to M6 is therefore £0.3m. If there is no further change to the ERF guidance or targets, and the current activity run-rate continues, there is an income underperformance risk of £3.9m at year-end. The improvement from M5 is driven by changes to coding and classification of activity.

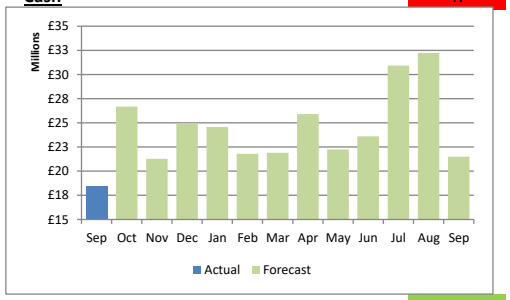
Group Position

£'000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
EKHUFT Income	71,820	74,343	2,523	428,592	436,187	7,595
EKHUFT Employee Expenses	(48,111)	(51,595)	(3,484)	(292,437)	(308,479)	(16,041)
EKHUFT Non-Employee Expenses	(28,962)	(32,072)	(3,110)	(178,266)	(187,886)	(9,620)
EKHUFT Financial Position	**(5,253)**	**(9,325)**	**(4,072)**	**(42,111)**	**(60,178)**	**(18,066)**
Spencer Performance After Tax	61	56	(5)	219	99	(120)
2gether Performance After Tax	93	133	40	561	645	84
Rephasing/Consolidation Adjustments	(15)	(24)	(9)	23	(515)	(538)
Consolidated I&E Position (pre Technical	**(5,114)**	**(9,159)**	**(4,046)**	**(41,309)**	**(59,948)**	**(18,640)**
Technical Adjustments	65	129	64	350	628	278
Consolidated I&E Position (incl adjs)	**(5,049)**	**(9,030)**	**(3,982)**	**(40,959)**	**(59,320)**	**(18,362)**

Income and Expenditure R

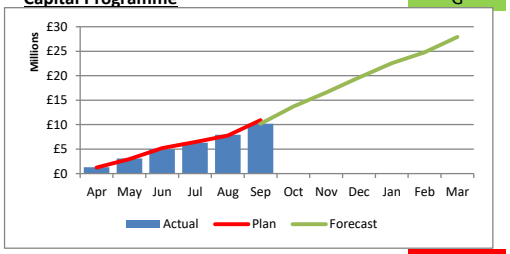
The key drivers behind the deficit variance are Strike action by the Junior doctors and Consultants £1.5m (excluding the impact of April industrial action, which has now been funded through the new ERF guidance), non-delivery of efficiency savings £15.1m YTD (net of £0.4m delivery of income CIP) of which £9.3m has been allocated to Pay and £6.2m to non pay. Pay is overspent by £16.0m YTD, however Wte over-utilisation fell by 155 wte in September from 322 wte to 167 wte, mainly relating to bank and agency usage. Total non-Pay overspend of £10.1m, predominantly driven by non-delivery of efficiency saving and rechargeable drugs costs (offset by corresponding increase in income).

Cash R



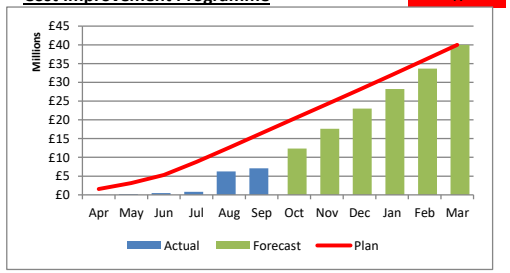
The Group cash balance (including subsidiaries) at the end of September was £18.4m.
The Trust drew £8.2m of working capital (PDC) in the month, making a YTD total of £40.9m.

Capital Programme G



Total capital expenditure at the end of September was broadly on plan, with a £10.2m spend against a plan of £10.9m plan.

Cost Improvement Programme R



The Trust has achieved £1.4m efficiency savings so far this year against a £16.5m plan. Additional non-recurrent efficiencies of £5.7m have been achieved YTD by recognising the reported financial position adjusted for known overspends.

Income and Expenditure Summary
Month 06 (September) 2023/24

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	10,161	9,077	(1,084)	52,501	48,340	(4,161)
Non-Electives	25,333	21,506	(3,827)	136,053	114,787	(21,266)
Accident and Emergency	4,761	3,604	(1,158)	25,835	23,231	(2,604)
Outpatients	11,095	11,501	406	58,371	59,991	1,620
High Cost Drugs	4,070	4,898	828	24,419	27,340	2,921
Private Patients	14	25	11	86	162	76
Other NHS Clinical Income	11,865	18,138	6,273	104,225	133,781	29,556
Other Clinical Income	133	99	(34)	799	727	(72)
Total Income from Patient Care Activities	**67,434**	**68,848**	**1,415**	**402,289**	**408,358**	**6,069**
Other Operating Income	4,386	5,494	1,108	26,303	27,829	1,526
Total Income	**71,820**	**74,343**	**2,523**	**428,592**	**436,187**	**7,595**
Expenditure						
Substantive Staff	(41,865)	(44,704)	(2,839)	(253,144)	(263,405)	(10,261)
Bank	(3,463)	(3,758)	(295)	(21,120)	(22,724)	(1,603)
Agency	(2,783)	(3,134)	(350)	(18,173)	(22,349)	(4,177)
Total Employee Expenses	**(48,111)**	**(51,595)**	**(3,484)**	**(292,437)**	**(308,479)**	**(16,041)**
Other Operating Expenses	(28,100)	(31,299)	(3,200)	(173,084)	(183,155)	(10,071)
Total Operating Expenditure	**(76,210)**	**(82,894)**	**(6,684)**	**(465,521)**	**(491,633)**	**(26,112)**
Non Operating Expenses	(863)	(773)	90	(5,182)	(4,731)	451
Income and Expenditure Surplus/(Deficit)	**(5,253)**	**(9,325)**	**(4,072)**	**(42,111)**	**(60,178)**	**(18,066)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	67,636	69,022	1,386	411,785	416,941	5,156
Other Operating Income	4,511	4,511	-	27,053	26,594	(459)
Total Income	**72,147**	**73,533**	**1,386**	**438,838**	**443,535**	**4,697**
Expenditure						
Employee Expenses	(50,488)	(51,874)	(1,386)	(317,215)	(333,288)	(16,072)
Other Operating Expenses	(25,843)	(25,843)	-	(157,348)	(165,355)	(8,007)
Total Expenditure	**(76,331)**	**(77,717)**	**(1,386)**	**(474,563)**	**(498,643)**	**(24,079)**
Non-Operating Expenses	(930)	(930)	-	(5,584)	(4,840)	744
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**(5,114)**	**(5,114)**	**()**	**(41,309)**	**(59,948)**	**(18,639)**
Technical Adjustments	65	129	64	350	628	278
Consolidated I&E Position (incl adjs)	**(5,049)**	**(4,985)**	**64**	**(40,959)**	**(59,320)**	**(18,361)**

Income from Patient Care Activities

The £6.1m overperformance YTD on clinical income is primarily due to funded service developments not included in the plan in the following areas:

- Additional Cancer Alliance (Targeted Lung Checks) new income stream confirmed (£0.8m)
- One-off funding for Pathology LIMS from the ICB to cover expenditure on digital Pathology system (£0.5m)
- EK Healthcare Partnership funding for Virtual Wards and schemes targeted at discharges (£0.6m)
- Vascular reconfiguration and Continuous Glucose Monitoring funding not included in plan (£0.7m)
- High cost drugs/devices overperformance (£3.6m) - matched by a corresponding increase in expenditure
- Prior year income benefit (£0.5m)

The majority of commissioner income is paid on a block basis with the exception of the Elective Recovery Fund Activity and NHS England high cost drugs and devices.

The full year Elective Recovery target has been reduced by 2% as a result of national guidance to compensate Trusts for the impact of the doctor's strike in April, and converted into fixed funding (£3.2m) allocated to April. This funding is to cover the expenditure consequence of the April strike as well as the estimated activity loss in April. Trusts are now required to report the actual income performance against their plan. Net of the £3.2m fixed funding, the underperformance on ERF is £0.3m YTD.

Other Operating Income and Expenditure

Other operating income is favourable to plan in September by £1.1m and by £1.5m YTD. The in month variance is driven mainly by above plan income for IENs, electronic medical records project and GP trainee salaries totalling £0.6m, and education and training income for endoscopy training and nursing CPD £0.4m.

Total operating expenditure is adverse to plan in September by £6.7m and by £26.1m YTD, including CIPs which are reported as £3.7m adverse in month and £15.5m adverse YTD.

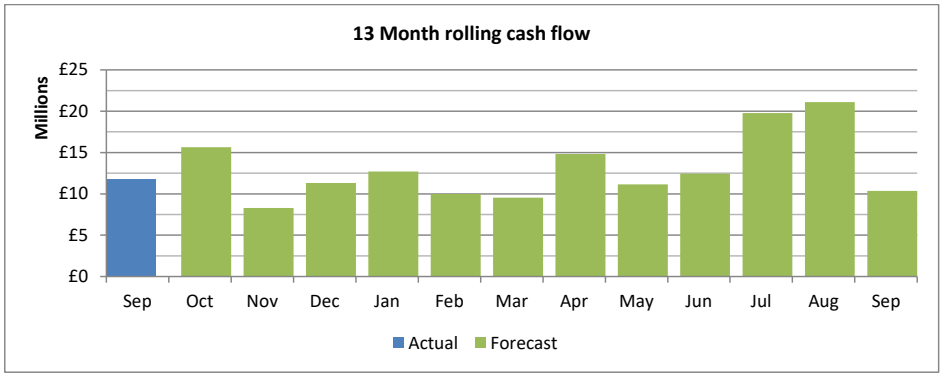
Employee expenses performance is adverse to plan in September by £3.5m and by £16.0m YTD. Pay CIP schemes are adverse to plan in month by £2.1m and by £9.3m YTD. The adverse variance due to the medical staff pay award was £0.2m in-month and £1.4m YTD. The backdated payments to IENs were also processed in September, which caused an adverse variance in mth and YTD of £0.4m The adverse position also reflects the impact of cover during strike action by Junior Doctors and Consultants, which is estimated at £0.4m in-month and £1.5m YTD, plus AfC pay award uplifts both for the 2022/23 backlog bonus and 23/24 pay settlement. There is an identified shortfall of £0.1m for 2022/23 YTD and a funding gap for 2023/24 of £0.1m in month and £0.6m YTD for these areas. Wte over-utilisation fell by 155 wte from 322 wte to 167 wte, mainly relating to bank and agency usage. Over-utilisation reflects the indicative variance to plan for escalation beds of breakeven in month and £0.6m YTD, and 1:1 specialing of £0.2m and £2.6m YTD.

Total expenditure on pay in September was £51.6m, a reduction of £3.3m when compared to August, mainly relating to the increased medical pay award provision in August. Bank and agency spend reduced by £0.9m and locum claims fell by £0.7m in-month, offset by an increase in total spend on qualified nurses of £0.6m relating to backdated IEN payments.

Other operating expenditure is adverse to plan by £3.2m in September and by £10.1m YTD. CIP schemes relating to other operating expenditure are adverse to plan by £1.6m in September and by £6.2m YTD. The other main drivers for the overspend in month are higher than planned spend on drugs and supplies and services - clinical totalling £1.5m and contracts with the subsidiary which are adverse to plan by £0.3m.

Other operating expenditure increased month on month by £0.1m, with reduced spend on drugs and clinical and non clinical supplies offset by increased spend on training, recruitment fees and staff permits.

Cash Flow
Month 06 (September) 2023/24



Unconsolidated Cash balance was £6.4m at the end of September 23, £5.4m below plan.

Cash receipts in month totalled £80.1m (£7.1m below plan):
K&M ICB paid £56.6m in September. (£1.5m above plan)
NHS England paid £12.5m in September (£1.2m above plan)
Other NHS receipts totalled £1.3m (£0.1m above plan)
Non NHS Receipts totalled £1.6m (£0.1m above plan)
No VAT reclaim was received in September (£3.5m below plan) - £11.5m received in October
Revenue Support received in month was £8.1m - £6.5m below plan

Cash payments in month totalled £90.2m (£6.2m above plan)
Creditor payment runs including Capital payments were £25.5m (£4.1m above plan)
Payments to 2gether were £1.8m below plan. Payroll was £4.7m above plan due to the medical pay award and IEN backpay arrears paid in month.

YTD cash receipts total £507.0m (£20.3m above plan - largely driven by receipts from NHS England over plan (£21.9m, of which £17.2m was unconsolidated pay award in June), VAT reclaims under plan (£10.9m - to be recovered in October), revenue support above plan by £7.2m).

YTD cash payments total £519.2m (£25.6m above the plan - driven by payments to 2gether below plan (£11.7m), Payroll over plan (£27.3m, predominantly due to the unconsolidated pay award) and creditor payments over plan (£10.8m, due to increase in bank and agency spend)).

2023/24 Plan

The revised plan submitted to NHSE in May 2023 shows a technically adjusted deficit position at the end of 2023/24 of £72.8m. Revenue support for the full deficit amount is forecast in the year.

Forecast

The majority of the monthly OHF invoices from 2gether Support Solutions were authorised for payment in Month 5. The VAT reclaimed against these, £11.5m, was received on the 9th October. 2 further invoices were authorised in Month 6. The VAT reclaim will be received in October/November and will enable a further significant payment to creditors.

The Trust has submitted a request for £18.2m Q3 revenue support. £7.8m in October, £4.3m in November and £6.1m in December, in line with the original planned £72m deficit.

The Trust submitted a request for exceptional working capital for £25.7m to NHSE in October, which was the value required to clear relevant outstanding creditor balances. The Trust has received approval for additional working capital of £15.4m of the requested £25.7m (£13m in November, £2.4m in December) to cover creditors overdue by more than 90days only.

Creditor Management

The Trust moved to 71 day creditor terms in Month 6.

In prior months, payments to one key supplier were being held and invoices cleared only if the funds were available. To avoid late payment charges being levied, it was agreed to clear their balance by the end of October at a rate of £2m per week. As at 30th September 23, £1.0m was overdue for payment to them, and a further £3.4m of current invoices. The Trust plans to bring payments back in line with other suppliers to make funds available to clear over 90 days invoices.

At the end of September 2023, the Trust was recording 76 creditor days (Calculated as invoiced creditors at 30th September/ Forecast non-pay expenditure x 365).

Cost Improvement Summary

Month 06 (September) 2023/24

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	843	-	(843)	3,314	0	(3,314)	7,246	(88)
Bank	-	-	-	-	-	-	6	6
Workforce	1,507	48	(1,459)	6,278	190	(6,088)	8,143	(6,103)
Outpatients	-	-	-	-	-	-	110	110
Procurement	(1,917)	31	1,947	136	327	190	2,076	1,368
Medicines Value	374	89	(285)	374	316	(58)	1,051	51
Theatres	235	-	(235)	988	-	(988)	2,606	106
Care Group Schemes *	3,131	135	(2,996)	5,424	554	(4,870)	13,076	(1,136)
Sub-total	**4,174**	**303**	**(3,871)**	**16,514**	**1,387**	**(15,127)**	**34,315**	**(5,685)**
Central	-	539	539	-	5,685	5,685	5,685	5,685
Grand Total	**4,174**	**842**	**(3,332)**	**16,514**	**7,072**	**(9,442)**	**40,000**	**(0)**

* Smaller divisional schemes not allocated to a work stream

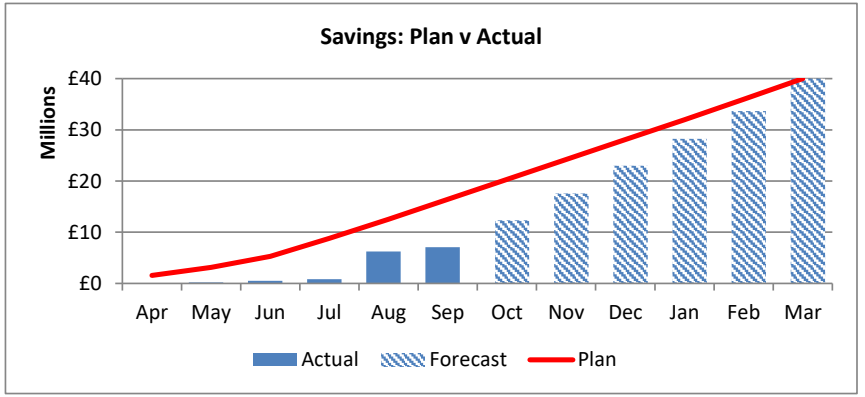
Delivered £000		
Month	**Target**	**Actual**
April	1,563	58
May	1,581	149
June	2,149	290
July	3,514	311
August	3,749	5,422
September	3,890	842
October	3,873	
November	3,874	
December	3,874	
January	3,929	
February	3,989	
March	4,015	
	40,000	**7,072**

The efficiencies plan for 2023/24 is £40m. The Trust recognised recurrent savings of £0.2m in September, and £0.9m on a YTD basis, which is significantly below Plan. The Trust has also recognised YTD non-recurrent savings of £0.4m. Underperformance is primarily due to timing of schemes in Agency, Workforce, Theatres, and Care Groups currently being developed.

Additional non-recurrent efficiencies of £5.7m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialing).

The current value of the pipeline is £12.9m, a (£0.9m, 6%) decrease in value vs. the prior month, but this relates predominantly to efficiencies being confirmed as reduction to run-rate overspends from FY23, rather than CIPs.

The majority of ideas currently identified through the care group process are less than £50k (60%) or less than £250k (20%), but working across the cross-cutting themes of Workforce, Elective and Non-Elective productivity, Theatres, we are predominantly scoping larger group-wide to significantly increase the value of CIP schemes next month. This work includes linking in with the Nursing Agency cost deep-dives, and a review of Admin and Clerical vacancies.



Capital Expenditure
Month 06 (September) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Emergency Department Expansions	4,271	4,952	3,277	4,952	(1,675)
Community Diagnostics Centre	2,845	2,845	406	38	368
Mechanical Thrombectomy	2,608	1,989	125	52	73
Diagnostics Clinical Equipment	2,550	2,550	0	0	0
Information Development Group	2,000	2,000	1,550	1,091	459
Medical Devices Group	1,666	1,666	828	440	388
Electronic Medical Records	1,545	1,545	785	1,159	(374)
Stroke HASU	1,463	1,463	67	682	(615)
Diagnostics Imaging Capacity	1,433	1,383	1,433	(0)	1,433
Patient Environment Investment Committee	3,771	3,271	940	61	879
Charity Donations	900	900	408	146	262
Other Build	736	1,173	686	515	171
Subsidiaries	519	589	156	104	52
Other IT	375	375	0	375	(375)
Other Medical Equipment	259	259	259	244	15
Trust IFRS16 Acquisitions	0	254	0	254	(254)
Lease Cars	0	302	0	8	(8)
All Other	0	0	0	76	(76)
	26,941	**27,518**	**10,920**	**10,197**	**723**

Funded By:	Plan	Forecast	Change
Operational Cash	21,515	21,515	0
System Set Underutilisation	(2,850)	(2,763)	87
Donations	900	900	0
Disposals	250	250	0
System Capital PDC	1,463	1,463	0
PDC	5,663	5,613	(50)
Carried Forward PDC	0	131	131
New Lease Loans	0	627	627
New Lease Repayments	0	(218)	(218)
	26,941	**27,518**	**577**

Under/(Over) Commitment	0	0

The Trust submitted the final 5-year Capital Plan to NHSE on 4th May 2023, totalling £26.94m in 2023/24.

The latest published forecast for the year, as at M6, is £27.52m, representing a £0.58m net increase from the original plan; this is due to New Lease Loans taken in-year totalling £0.63m, offset by a £0.05m reduction in the Diagnostic Imaging Capacity PDC funding assu med (and associated spend plans), to align it to the final funding figure provided in the MOU.

Capital Spend YTD

The Group's gross capital year-to-date spend to the end of Month 6 was £10.2m, against a YTD plan of £10.9m. This represents a £0.7m net underspend, as a result of:

- Underspends YTD totalling £4.1m (including £1.9m on Diagnostics Imaging Capacity, MDG and other Medical Equipment, £1.5m on PEIC, CDC and Other Build projects and £0.7m on IDG and Charity Donations, offset by;

- Overspends YTD totalling £3.4m (including £1.7m on the ED Expansion programme, £0.6m on Stroke HASU, £0.8m on Electronic Medical Records (EMR) and Other IT schemes and £0.3m on IFRS16 items other small overspend items).

Estimated Risks and Mitigations

As at M6, the Trust holds an estimated gross cost pressure risk of circa £6.6m. With a proposed redistribution of £4.1m of internal capital scheme slippage, the gross risk is reduced to a £2.5m net cost pressure risk. Details of the cost pressures and slippage mitigations are outlined below.

The Trust Board is asked to note the M6 reported position of £0.7m underspend YTD, but with a net unfunded cost pressure of circa £2.5m which is not currently reflected in the reported forecast for the year. However, this is predicated on the assumption that the Trust will secure approval from NHSE to broker the expected CDC slippage internally into 2024/25 and to secure K&M ICS system capital slippage of between £2m to £3m in 2023/24, though this will have to be repaid in 2024/25.

Cost Pressures totalling £6.6m, including:

• £2.1m Fire Compartmentation 23/24 Risk: detailed in the September 2023 2gether Fire Compartmentation Strategy paper;

• £2m ED Expansion: following the August 2023 CIG capital report, a revised cost pressure of £2m has been reported on the programme. Given the YTD spend incurred exceeded the planned budget of £4.3m, £0.7m slippage funding was allocated to ED, leaving a residual risk of £1.3m;

• £1.6m WHH Fire Alarm: approved by the Trust Board in June 2023; this was an ongoing cost pressure, as a funding source was yet to be identified. To date, the programme incurred £0.45m spend and was allocated a corresponding amount of budget in M6 from other scheme slippage, leaving a residual risk of £1.1m

• £0.9m Diagnostics Imaging: related to the enabling works required for the installation of the QEQM MRI, for which the Trust accepted central PDC Funding from NHSE to procure the MRI, without being able a funding source for the associated enabling works;

Slippages expected totalling £4.1m, including:

• £1.3m Fire Compartmentation 23/24 Risk: despite the paper citing a £2.1m risk in 23/24, the estates team have advised that the Trust is unlikely to be able to incur more than £0.8m in-year due to logistical implications of planning and conducting the works in clinical areas overwinter;

• £0.9m Diagnostics Imaging: the in-year risk related to the enabling works for the QEQM MRI could be mitigated by a formal decision to defer them to 24/25, though this is yet to be formally agreed and confirmed.

• £1.4m Mechanical Thrombectomy: £0.8m residual slippage is expected following a £0.6m re-distribution of capital funding at M5 and M6, to offset the YTD ED Programme cost pressure as the programme spend YTD has exceeded the full year planned cost.

• £0.5m QEQM Discharge Lounge and other estates schemes: final costs expected to be lower than the planned allocated budget for the Discharge Lounge and the estates schemes due to supply chain delays and accomodating acute site winter plans.

A further possible slippage benefit in 2023/24 of £1.25m could come from the Community Diagnostics Hub (CDC) scheme: enabling works slippage expected, due to significant lead times; the Trust will need to gain explicit approval from NHSE to be able to broker the slippage internally.

Statement of Financial Position
Month 06 (September) 2023/24

£000	Opening	To Date	Movement	
Non-Current Assets	**402,107**	**400,010**	**(2,097)**	▼
Current Assets				
Inventories	6,749	7,609	860	▲
Trade Receivables	11,677	11,803	127	▲
Accrued Income and Other Receivables	29,981	31,589	1,608	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	18,618	6,418	(12,200)	▼
Total Current Assets	**67,025**	**57,419**	**(9,606)**	▼
Current Liabilities				
Payables	(41,537)	(66,215)	(24,678)	▲
Accruals and Deferred Income	(46,653)	(33,848)	12,805	▼
Provisions	(2,887)	(2,809)	78	▼
Borrowing	(4,838)	(2,516)	2,322	▼
Net Current Assets	**(28,892)**	**(47,970)**	**(19,078)**	▼
Non Current Liabilities				
Provisions	(3,405)	(3,324)	81	▼
Long Term Debt	(77,371)	(75,585)	1,787	▼
Total Assets Employed	**292,439**	**273,131**	**(19,308)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	454,994	495,864	40,870	▲
Retained Earnings	(217,590)	(277,768)	(60,178)	▼
Revaluation Reserve	55,035	55,035	-	
Total Taxpayers' Equity	**292,439**	**273,131**	**(19,308)**	▼

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Trust closing cash balance was £6.4m (£16.5m in August) £5.4m below plan. See cash report for further details. Cash has been supported in year by £40.9m of PDC working capital.

The current I&E adverse variance to plan (c£14m) is having an impact on cash - and the Trust's ability to pay creditors to terms - this impact is clearly seen in the Better Payment Practice Code figures. The Trust has commenced discussions with NHS England around potential additional borrowing prior to any formal changes to forecast.

Trade and other receivables have reduced from the 2023/24 opening position by £0.1m (£0.7m reduction in August). Key drivers are detailed on the Cash report

Payables have increased by £24.7m (£20.4m increase in August), another clear indicator of the impact of a shortage of cash. See Working Capital sheet for more detail on debtors and creditors.

The long-term debt entry relates to the long-term finance lease debtor with 2gether.

PDC increased in month by Working Capital (£8.2m).

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Journey to Exit NHS Oversight Framework (NOF4) – Integrated Improvement Plan (IIP) Update**

Meeting date: **2 November 2023**

Board sponsor: **Chief Executive**

Paper Author: **Chief Strategy & Partnerships Officer**

Appendices:

Appendix 1: IIP Update
Appendix 2: IIP Risk Register

Executive summary:

Action required:	Information
Purpose of the Report:	To update the Board on progress of delivery of the IIP, performance against the agreed milestones including the Q2 overarching delivery requirements and to provide oversight of key risks to delivery.
Summary of key issues:	The IIP update report includes an update on progress against the programme milestones and Q2 overarching delivery requirements with a forward look at the required Q3 targets the Trust needs to reach. One programme of six (Leadership and Governance) is green following the progress that has been made, however, the governance project has turned amber in this period as it is acknowledged there is work to do to further embed governance across the organisation at all levels which will be progressed and monitored by this programme. Three of six programmes continue to be rated as amber with good progress noted in Quality and Safety, Maternity and People and Culture. The biggest areas of risk to delivery against the agreed milestones and exit criteria are in the Finance and Operational Performance programmes, (particularly in elective). Both the Finance and Operational Performance programmes are currently RAG rated red.
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report and progress of delivery of the Integrated Improvement Plan to date.

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 32** – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. **BAF 34** – There is a risk that our constitutional standards are not met. **BAF 38** – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	N/A
Resource:	Yes - Discussions with National team regarding the use of available resources.
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: Strategic Improvement Committee (SIC).

We care

East Kent Hospitals University NHS Foundation Trust Report on Integrated Improvement Plan (IIP)

Journey to Exit NHS Oversight Framework (NOF4) – IIP Update

October 2023 Summary

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

This report has been established to update the Board on progress of delivery of the Integrated Improvement Plan (IIP) and oversight of key risks to delivery to support exit from the Recovery Support Programme (RSP).

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Strategic Improvement Committee (SIC) which is chaired by the Chief Executive.

The Board receive an update on the IIP on a monthly basis focusing on successes, challenges and actions to mitigate any key risks to delivery. A quarterly deep dive to demonstrate impact and progress against the overall programme objectives is also provided.

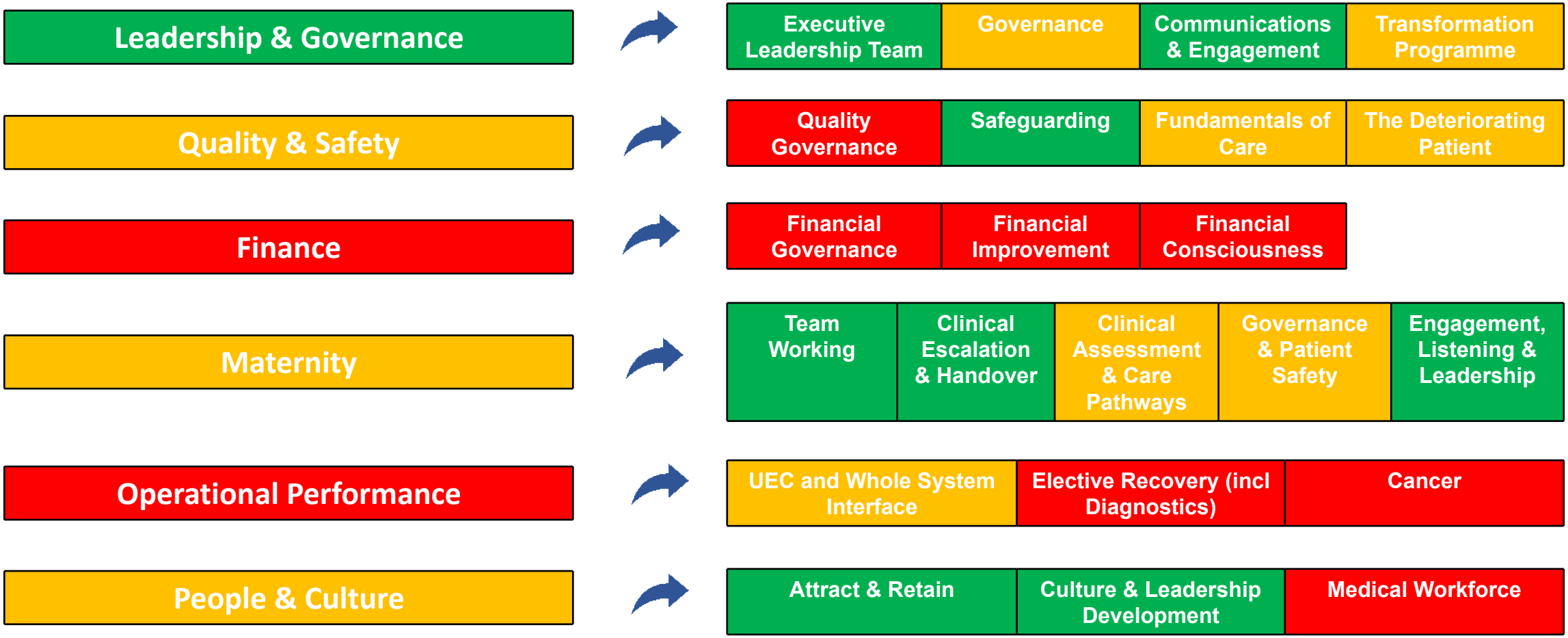
High-level Summary on Programme Delivery

	Summary & Assurance update
Leadership & Governance	The substantive Chief Medical Officer is expected to commence early Q4 following interviews last month and recruitment for the remaining Medical Director posts following the restructure is well underway. Interim arrangements now commenced for cover of the COO position with discussions taking place to explore next steps for substantive recruitment. Last month saw approval of the new organisational Governance Framework which has now moved to the implementation phase within the Care Groups in this period. It is acknowledged there is work to do to further embed governance across the organisation at all levels which will be progressed and monitored by this programme. The Board effectiveness review from the Good Governance Institute (GGI) has commenced and recommendations will follow soon after. Communications across the organisation have focused in this period a year on from 'Reading the Signals', next month will focus on the winter plan for our staff, public and stakeholders.
Maternity	Significant progress continues to be made in the Maternity programme with clear governance established and embedded to drive improvements. It is acknowledged there are several clinical pathways to be reviewed with focus agreed on 5 specifically before the end of March 24. Process mapping for Enhance Maternity Care, diabetes and FMU pathways have been undertaken in this period. There is continued progress against backlogs for open incidents, SI investigations, Complaints, expired guidelines and patient information leaflets.
Operational Performance	Overall position for UEC has deteriorated by 1.2% in the last period compared with September 23. This was not unusual nationally benchmarking against our peers, with typical drivers affecting performance such as increases in type 1 non-admitted presentations, ambulance conveyances increases, and highest number reported since Nov 22. There has been good engagement with GIRFT and recommendations now shared with our stakeholders and aligned to our winter planning. The review by Prism is in its fourth week reviewing flow and SAFER with expected recommendations to follow in the next period. It is acknowledged there is further work to undertake to embed processes and improvements relating to both admissions and discharges. The UEC project milestones have been analysed and amended in this period with an aim to drive improvements in metrics, ensure they support meeting the exit criteria and are sustainable. Elective teams continue to engage with Prism in the diagnostic phase to explore the 6:4:2 processes with an aim to improve theatre productivity and the output report is expected next week (current theatre utilisation overall is 79%, EOC 81% - target is 85/90%) . A key driver for the elective waiting list position is Endoscopy creating a substantial capacity challenge (circa 12,000 patient as at w/c 16th October). Thorough reviews are taking place to validate and understand the waiting list position, bid for additional funding to outsource activity and implement Endoscopy improvement plans to support recovery. The programme is also working on revised trajectories across all specialities in planned care and investigating key actions with teams to improve the waiting list position (current 'all patient over 12 week unvalidated position' at 30,451) whilst also aligning with regional and RSP requirements. A formal report will be shared over the next 2 weeks to support this and offer a robust plan to assure how this will be managed. The next stage for the elective project is to ensure the planned care governance is functioning and appropriate. The Elective project milestones have also been analysed and amended in this period with an aim to drive improvements in metrics, ensure they support meeting the exit criteria and are sustainable. The Cancer project milestones will be reviewed in the next period.
Quality & Safety	Timeframe for declaring SIs and closing is now consistently within compliance criteria and learning shared in the previous period at the Trust Board which will now feature as a regular output in the governance cycle to offer assurance. Learning from SIs now also feature in staff-wide bulletins. The road map for PSIRF design and delivery is now approved and work to progress is ongoing. As per the Leadership & Governance programme update, it is recognised there is further work to do to embed governance across the organisation at all levels following rollout of the governance framework. The Safeguarding project have been able to offer a range of robust evidence to support delivery of majority of milestones in this period and a thorough assessment will now take place with relevant colleagues to analyse the impact against exit criteria.
People & Culture	Good progress is being made in the People & Culture programme with sign off of the workforce speciality plans in this period. A significant amount of work has been undertaken in the diagnostic phase of the cultural and leadership development plan and aligning this to the 'we care' programme. A range of data from the review is appearing which will be shared across the organisation in due course when next steps are developed. The programme overall is reporting as expected.
Finance	While the Finance programme is reporting a red RAG status currently, we are starting to monitor and realise improvements in the run rate following the implementation of the controls established in previous periods. The programme will continue to review the controls to ensure they are fully embedded and intervene where required at the monthly Workforce & Finance Oversight meetings with each care group.

Integrated Improvement Programme – RAG Reported Progress

East Kent Hospitals University NHS Foundation Trust

Progress Summary by Programme:



Progress Summary by Individual Project:

The Quality Governance, Financial Governance, Financial Improvement, Financial Consciousness, Elective Recovery (including diagnostics), Cancer and Medical Workforce projects are reported as **off track** in this period, with a further 7 projects are rated as **having issues**. The remaining 8 projects are all **on track**.

Analysis and progress against the Q2 23/24 Overarching Delivery Improvement Milestones

East Kent Hospitals University NHS Foundation Trust

Leadership & Governance:

Q2 Milestone	Progress
All Executive posts appointed to and comms engagement plan approved and operational	• CMO recruitment completed - Des Holden • Deputy CMO (Helen Mackie) commences in post on 20 November 2023 • COO role covered by two existing Executives (Jane Dickson and Ben Stevens) • The Trust's comms and engagement plan is approved and published
Governance review completed and evidence that Board is sighted on key risks with aligned BAF and Board Level Risk Register	• Governance framework to be applied to new Care Group structure established, agreed with Care Groups and in the process of being implemented • Work undertaken with Good Governance Institute (GGI) to establish a proposal to examine the governance framework and assess the governance associated with the Board and sub-committees of the Board. • The governance between the Trust and the subsidiaries will be separately examined through a shorter piece of work

Financial Governance:

Q2 Milestone	Progress
Financial Governance – Medium term financial plan developed	• Submission of the MTFP to the ICB as per timetable and guidance.
Temp Staff Expend - £19.583 million	• Month 5 agency cap £11.6m, total spend £21.5m
Efficiency Delivery -£16.447 million	• Delivery at Month 5 is £6.2m (plan £12.6m), of which £5.5m is non-recurrent • £13.8 identified, £11.9m PYE • In year CIP delivery has increased by £0.6m since month 4.

Operational Performance:

Q2 Milestone	Progress
4 Hour Performance – 73%	• End of Q2 Position 70.4%
Type 1 Performance – reach 55% by the end of Q2	• End of Q2 Position 43.6%
12 hours – reduce to 7% by end Q2	• End of Q2 Position 10.1%
Diagnostics Performance – To attain 35%	• End of Q2 Position 45.6% (waiting >6 weeks)
Electives - Sustainable plan for Ology in place **Zero 78 weeks**	• End of Q2 Position 34 Otology over 78 weeks • The Trust with IC support has not been able to secure additional capacity. • The current plan/trajectory would see an elimination of 78 week risks in Otology by the end of Jan 2024.

Analysis and progress against the Q2 23/24 Overarching Delivery Improvement Milestones continued:

East Kent Hospitals University NHS Foundation Trust

Quality of Care:

Q2 Milestone	Progress
Clear evidence of learning from SI's and Board assurance of practice improvements	• SI reporting to Board, including themes, learnings and mechanisms for shared learning. • Timeframe for declaring Sis and closing now consistently within compliance criteria.
Deteriorating patient programme and dashboard in place	• *Detailed update provided in Quality and Safety update (slides 19 – 20)*
Quality governance structure and framework in place - to include robust safeguarding governance	• Quality governance structure agreed and implementation underway with milestones for review of effectiveness, includes safeguarding best practice and compliance. • Safeguarding strategy and structures ratified by ICB and region at oversight meetings • Substantive Head of Safeguarding post appointed to and will be based on site.
Safeguarding training needs analysis and trajectory completed	• This was a KLOE for the NHSE and ICB Safeguarding Oversight meeting in August 23 and assurance provided at that meeting.
Safeguarding policies ratified alongside a communication plan	• Policies all in date and ratified. • Communicated as per plan for all policies a part of the Trust sustainability workplan at the August meeting as above.
Annual safeguarding report completed and published/plan for publication.	• The Kent and Medway Safeguarding Adults Board (KMSAB) statutory agency annual report for adults completed in June and approved by the KMSAB. Quality and Assurance Working Group Subgroup. • The outcome of the NHSE and ICB Safeguarding Oversight Meetings in relation to the above was also presented to the August Trust PQM with the ICB.

Maternity:

Q2 Milestone	Progress
Maternity Transformation plan completed and approved by Board.	• Revised Maternity and Neonatal Improvement programme approved at Board on 07 September 23.
Obstetric oversight of triage services in place.	• Obstetric oversight of triage services in place. A three month of review of Obstetric oversight of triage was undertaken in Q1 which demonstrated compliance with oversight across both sites.
Obstetric consultant job planning completed.	• As at month 5: 57% completed (23% awaiting clinician sign off)
Scoping and reopening of WHH Midwifery Led Unit.	• Live drills and upskilling sessions have been undertaken • Estates work underway including works to ensure compliance with Entonox utilisation.

Forward look at the Q3 23/24 Overarching Delivery Improvement Milestones

The Trust need to reach the below overarching delivery requirements in Q3 which are being monitored closely by the Strategic Improvement Committee (SiC).

East Kent Hospitals University NHS Foundation Trust

Leadership & Governance:

Q3 Milestone
Culture & Leadership Programme having demonstrable impact (surveys)
New operational structure in place

Operational Performance:

Q3 Milestone
4 Hour Performance – 75%
Type 1 Performance – to maintain >60%
12 hours – reduce to 5% by end Q2
Diagnostics Performance – To attain 30%

Financial Governance:

Q3 Milestone
Recurrent efficiency schemes delivered
Temp Staff Expend - £28.958 million
Efficiency Delivery -£28.067m million

Quality of Care:

Q3 Milestone
Reduced number of SIs over the 60-day deadline for completion of investigation.
Evidence of improved clinical leadership and engagement.
Sustainable safeguarding workforce team in place

Maternity:

Q3 Milestone
Demonstrable improvement that staff feel listened to (quarterly survey)
All key obstetric safety roles assigned and operational

Programme: Leadership & Governance

Key progress in programme during last period
• Medical Director interviews have taken place. • Chief Medical Officer appointed, start date likely early 2024. • Quality Governance framework has been ratified in the appropriate governance framework and was submitted to Trust Board October 2023 for information. • Agreed start date of 23 October 2023 for Good Governance Institute (GGI) on board effectiveness. • Work with 'Reading the Signals' oversight group and publication of 'one year on' progress report. • This month's communications theme focused on maternity, progress shared in team brief on 17th October, briefing with East Kent MPs on 17th October and briefing of Health Overview and Scrutiny Committee completed. • Internal and external communications on maternity improvements including proactive media interviews, public communications and stakeholder bulletin completed. • MP visits to maternity units on 13th October 2023. • NHS Staff Survey communications campaign commenced and in progress. • Patient Information Leaflets and map to describe emergency pathway produced. • See 'ME First' Equality, Diversity and Inclusion campaign launched. • Accessible information campaign launched. • Culture and Leadership Programme Survey received 891 responses. • PRISM have commenced work at QEQM on inpatient flow. • PRISM have also commenced work on theatre productivity and efficiency - Trustwide 28 week programme.

Key Project Risks	Residual Score
Unable to appoint CFO substantively due to unsuitable candidates.	9
Loss of focus on operational delivery due to the ongoing effect of the restructure.	6
No substantive COO following the resignation from the current postholder.	9

Milestones off track	Target Date	What are we doing about it?
1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23	• Care group QUAD is enrolled onto NHS perinatal C&L programme which includes 8 separate development days, informing Phase 1 of the programme. Phase 2 of the NHSI perinatal CLP the SCORE culture survey will be repeated and goes live on 16th October 23. This will enable benchmarking against 2018 results. Phase 3 involves external change coaches coming in to form a change culture team to take outcomes of the SCORE Survey and implement local cultural improvements. • Confirmation of leadership and culture session from Frontier Leadership (Army Leadership model in the NHS) - booked for Women's Health Quality Board on 17 Oct 2023. • Additional 'Civility Saves Lives' sessions being planned for December (dates TBC) • Use of communication channels to ask for feedback re: experience of new leadership team • Continued promotion of dedicated Maternity FTSUG; now also provides high-level reporting into MNAG.
1.405: Develop and adopt the Behavioural Code in Maternity	Jun-23	• Maternity has received the link to the Trust level leadership behaviours survey through Trust News, published 7th Sep 23. • Circulation of the Trust Inclusion & Respect Charter, and Behaviours Leaflet through local communications. • Work identified to implement Inclusion & Respect Charter, and Behaviours into local appraisal discussions / reviews • Enrolment of Maternity staff onto Trust Leadership Development programme.

Programme: Quality & Safety

Key progress in programme during last period

- Road map for PSIRF design and delivery approved.
- First SI lessons learned report presented to the September Board.
- First audit (duty of candour) as part of Patient Safety audit programme undertaken and completed.
- Final approval of Quality Governance Framework given by CEMG.
- Submitted audits relating to safeguarding reported delays to the September SOG.
- Ward accreditation completion plan back on track and IIP risk closed.
- Next phase of 'Patient Portal testing competed and due to go live.
- Deteriorating patient education pilot programme evaluation report to be presented at next Nursing, Midwifery & AHP board to determine rollout plan for training.

Key Project Risks	Residual Score
Delay to PSIRF Implementation	12
Capacity in BI team to support deteriorating patient dashboard	12
Head of Nursing for FoC & Quality on an interim arrangement until end September 23	12

Milestones off track	Target Date	What are we doing about it?
4.105: Commence transitioning across to the new PSIRF	Aug-23	• Second Datix update on the test system has been completed (first test has shown IT technical issues). • The delay to LFPSE fields were due to problems with Datix and unavoidable by the trust and target date of milestone also missed due to provider Datix (who have reported this to NHSE as a national issue). • Target date revised to end of November for the Trust to transition to the new form. • Live system to start updating from 6th Oct 23, once fully updated it can be checked and sent to NHSE for approval to turn the live system on.
4.107: Review corporate risk register to ensure aligned with Board Assurance Framework and with clear cyclic process implemented for review.	Sep-23	Board have met and reviewed the risk appetite statement and risk tolerance levels. These are due to be aligned with the BAF at the November 23 Board.
4.206: Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements and monitor the effectiveness and sustainability of these.	Aug-23	Review currently underway to determine workstreams feeding into FOC committee or if requires aligning to other groups/committees following on from new governance structure being implemented across the Trust.
4.305: Publish FOC framework and KPIs	Jul-23	Further work required to understand how the FoC workstreams fit within the new governance framework as above prior to publishing FOC framework.
4.306: Develop trajectory for further reduction in FoC incidents resulting in moderate harm and above.	Jul-23	Initial conversations commenced with lead experts in falls, pressure ulcers and nutrition to understand current figures vs previous years figures. Leads now producing trajectory proposals to be presented initially to FOC Lead Nurse and FOC committee.
4.408: c) Implement deteriorating patient education programme across the organisation	Sep-23	New milestone linking with national overarching delivery targets to implement by Q2. Escalated to SiC as unable to meet national target date of Q2. Expected target date to be confirmed following review of required action.

Programme: Finance

Key progress in programme during last period
• Launch of Workforce and Finance Oversight meeting. • New Capital Investment Group (CIG) and Business Case Scrutiny Group (BCSG) embedding of processes continues. • Additional resources have commenced in this period to support the delivery of the IIP (Financial Recovery Director, ADOF Financial Planning). • FRP / Business Planning launched to internal stakeholders and well attended. • Trust MTFM submitted to ICB. • Grip and controls embedding continues.

Key Project Risks	Residual Score
Additional support needed with the updating of the Financial Recovery Programme	8
Risk to the delivery of the Trusts 2023/24 Efficiency Plan	12
Identify and prioritize development of "harder to achieve" improvements	12

Milestones off track	Target Date	What are we doing about it?
6.102: Effective Care Group oversight approach in place	Jun-23	• Recovery oversight meetings are now in the diary up until Mar 2024. • Restructure is complete with monthly exec-led oversight meetings commenced in September with ongoing review. • Financial control measures are very evident now throughout the Trust. • Reduction in run rate will demonstrate full effectiveness.
6.103: Embed monthly finance reviews with Care Groups	Jun-23	• As above, first finance and workforce oversight meetings held with Care Groups, jointly chaired by CFO and CPO - and in the diary until March 2024. • Standardised packs to be presented to meetings from October and action logs to be maintained.
6.204: Update FRP document	Jun-23	• The FRP will be updated concurrently with the development of the trusts Business Plans for 24-26. The business plan will be the underpinning vehicle for delivery of the FRP and the FRP will have aligned principals and assumptions. The development of the FRP will be iterative and updated with national/ICB guidance when published. • FRP / Business planning now launched to internal stakeholders and well attended.
6.205: Fully develop FY24 efficiencies	Sep-23	• Board approved additional resource to drive efficiency programmes, currently valued at £11.9M (mostly recurrent). A number of schemes need values to be worked through. Deputy Improvement Director starts Oct 23 funded by RSP to support developing the plans.
6.206: Identify and prioritize development of "harder to achieve" improvements	Jul-23	Financial Recovery Director and Deputy ID arrival will aim to support this work.
6.207: Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT	Jul-23	Focus required on 23/24 key themes initially, prior to 24/25 being considered. Additional support arranged for the PMO around GIRFT and Model System reporting.

East Kent Hospitals University NHS Foundation Trust

Programme: Maternity

Key progress in programme during last period

- Launch of the SCORE survey in Maternity and Neonatal services at WHH, QEQM and Community 16th October 23.
- DoM has circulated the Trusts inclusion and respect charter and leadership behaviours leaflet.
- Confirmation of leadership and culture sessions from Frontier Leadership (Army Leadership model in the NHS) booked for Women's Health Quality Board 17th October 2023.
- Maternity Escalation Rapid Insight events to be attended, focusing on what prevents staff escalating clinical concerns.
- Agreement of clinical audit priorities for service improvement; these are:
  - Triage, re-opening of MLUs, EMC, Antenatal Pathway (specifically Diabetes care in pregnancy, and Priorities 1 & 2).
- EMC process mapping day taken place and focused on training needs and development of a plan to upskill the workforce.
- Quality Board audits of MEWS assessments produced.
- MNIP approved by Trust Board which enables milestones to be planned out with clinical leads (includes recognition of the deteriorating woman (EMC) and clinical care pathways.
- Diabetes process mapping day held to scope out current state vs future state.
- FMU process mapping day held 18 October 23 to scope out current state vs future state.
- Agreed model for centralised telephone Triage service, and weekly project group established to progress centralised telephone Triage to operate from QEQM.
- 3 x Rapid Insight Reviews completed across Maternity to understand barriers to escalation.
- High-level Maternity Freedom to Speak Up Guardian reporting into MNAG.
- Improvement in the reduced number of open incidents from the original backlog, and reduced number of breached complaints.
- Trust-level governance framework complete and issued ..
- Ongoing use of comms e.g. Safety Threads, Message of the Week to share learning from incidents.
- Appointment of Patient Safety Matron, Consultant Midwife, Intrapartum Matron, and PMRT Lead Midwife.
- Quality Boards continue in order to address quality and raise standards.
- Imbedded monthly Safety Summit reporting into the Board.
- New 'Monday Message' to support 'Weekly wrap-up' on a Friday - voice notes to share weekly updates.
- Staff Survey 'Involvement' score has steadily increased and been sustained across the Women's Health care group from 5.36 (5.4) in Jan 23 to 5.89 (5.9) in August vs national average of 5.9.
- Roll-out of PCSPs in the community.
- Identification of EMC specialist course for Maternity, delivered at Medway, using one of our consultants who helped develop the accredited training programme. Availability and dates for enrolment being discussed
- Maternity / IT working groups established to take forward development of PAS / Patient Portal, and find digital solutions to known issues but also identifying learning opportunities within existing systems for issues previously unknown by IT e.g. Sunrise / Soliton.

Milestones off track	Target Date	What are we doing about it?
2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE	Jun-23	• Project plans for improvements to SBAR and VTE processes were developed and have progressed slowly; once implemented the new quarterly audits (aligned to the annual clinical audit plan) will demonstrate outcomes of these improvement interventions. • Clinical audit plan due to be agreed at clinical audit day (14.09.23). Audit lead midwife now appointed and currently going through induction process. Service improvements identified for VTE and SBAR dates to be reviewed.
2.301: Centralisation of telephone triage	Jul-23	• Agreed model for centralised telephone Triage service, and weekly project group established to progress centralised telephone Triage to operate from QEQM.
2.306: Implementation of revised bereavement pathway	Aug-23	• Pending approval of the Bereavement Guideline on 28 July 2023 guideline, some elements are in place but some are yet to implemented which continue to be progressed.
2.401: No overdue (breached) SIs / HSIB investigations	May-23	• Continued progress against backlogs for a range of maternity governance. AS at 23 Oct; • SI/HSIB Breaches - 12 current investigations of which 2 have breached • Open Incidents - 82 historical backlog (plus 460 open incidents over 6wks under review) • Overdue Complaint responses - 4 • No. of Expired Guidelines - 30 of 110 (stayed the same) • No. of Expired Patient Information Leaflets (PILs) - 43 of 63 8 of which are in the final stages of completion and a further 4 to be presented at PIG in October.

Key Project Risks	Residual Score
Revised model for telephone triage system not yet finalised	3
Revised Quality & Safety Framework not yet produced	2
Unfilled vacancies in maternity teams	12
Inadequate estates for maternity services	12

Programme:	Operational Performance

Key progress in programme during last period

- GIRFT post site visit updated their recommendations which have been aligned to the Winter plan/UEC EK Board and the HCP UEC delivery plan for oversight and monitoring ,coherence and assurance .
- Further training planned across the 2 sites to implement Direct Access pathways direct from streaming to SDEC. This will include condition based pathways to SDEC across both sites
- QEQM - ED Observation (CDU) established with further review of patient criteria to optimise utilisation. metrics in place .
- WHH MAU next phase - to include the medical take through the short stay unit for patients historically managed by the HCOOP take (10-15 patients a day) Requires the ongoing use of the SAL lounge at WHH . ECDG approved the model and use of the lounge over winter
- Al-ted - Work in the final phase with a completion and delivery plan by end October - in line with the start of the SPOA pilot .
- Interim Deputy COO for Planned Care (Cancer, Diagnostics and Elective) commenced in post
- PRISM commenced four week diagnostic phase in theatres
- Bid submitted to increase diagnostic capacity in EK (£80m underspend against CDC programme)
- Endoscopy Insourcing procurement process in final stages of completion
- Endoscopy task and finish group established to review and plan recovery of surveillance backlog
- Board Assurance self certification completed - outlining ability and assurance on key requirements related to validation and outpatient transformation
- Otology trajectory refreshed based on further impact of theatre equipment shortages/IA impact/increased volume of P2 patients (current run rate indicates 78 week breaches will not be eliminated at the end of March 2024)
- Endoscopy contract selection completed. Awaiting CFO sign off for final progression. Funding requested from the ICB to fund part/all of the Endoscopy insourcing contract.

Key Project Risks	Residual Score
Diagnostic delays in cancer pathways due to increased activity	16
Inability to comply with 2023/24 activity plan	12
NLFTR position to support emergency flow and 12 hour breach reduction	9
78 week elimination due to inability to secure additional endoscopy and otology capacity	15
Inability to fully validate patients at 12 week wait as per Board assurance letter	6
Inability to ensure that all endoscopy surveillance patients within target 6 weeks post clinical validation	6

Milestones off track / due in next 2 months	Target Date	What are we doing about it?
3.108: UTC new inclusion and exclusion criteria implemented	Apr-23	• Milestone in progress. The criteria went to Board on 18th October. Expected to operationalise in November 23. • ICB leading initiative and supporting across the region (UTCs). An audit was completed at EKHUFT. • Front door streaming has increased and training has been completed. COO for Unplanned Care to review the streaming processes at the front door.
3.111: Established pathways to the MDU at KCH (nurse led)	Jun-23	• Pathways established however, service yet to be activated. • Progress meeting being set for Site MDs and Nursing leads to develop MDU. • Confirmation received from ICB to fund majority of project for the remainder of the year is £32k per month. However, unlikely this funding will be recurrent.
3.113: WHH End of Life Model implemented	Jun-23	• The model of care has been agreed. The medical cover impacted by staffing constraints however, recruitment has been successful for consultant due to start in January 2024. • End of Life clinical forum now established and led by palliative care nurse consultant.
3.203: Trust Access Policy revised to incorporate clinical review policy and the new Kent and Medway Access Policy	May-23	• TAP revised accordingly and signed off at CEMG in July 23. • Elective lead working through final amendments and considering the relevant SOPs that need to be included. Exec sign off will be required for the high-level access policy and review the SOP to align with the site-based structure.
3.205: Validation plan agreed and implemented for all diagnostic modalities utilising digital transformation available within the Trust	Jul-23	• The Trust's validation team equate to 6WTEs. Insufficient to deal with the volume of validation required. NHSE funding up to £100k has been provided and a process of procuring support via and outsourced company is in process.
3.206: Actions agreed and implementation to Meet diagnostics quarterly targets – Q1 - To attain 40% (60%), Q2 To attain 35% (65%), Q3 To attain 30% (70%), Q4 To attain 22% (78%)	Sep-23	• September performance is at 54.1% compliance. The position has unfortunately deteriorated. To improve Endoscopy/NOUS requires insourcing and investment - schemes submitted to the ICB for funding.
3.207: Volume of 65-week breaches reduced before December 2023 (in line with winter planning and risk of elective cancellations)	Nov-23	• The 65 week trajectory is being reviewed alongside all year-end trajectories. Positional statements and agreed actions to address the position will be completed as part of this review. Aiming to be completed end October 2023 but the position to significantly reduce the position is likely to breach the target date.
3.209: Produce and ensure there is a sustainable plan for Otology long waiting patients.	Sep-23	• No external capacity can be sourced to support EKHUFT recovery. • Remap of capacity aligned to trajectory to eliminate breaches by the end of January 2024. Remodel capacity with returning long term sickness absent consultant. Capacity mapping expected to be completed w/c 25th September and to be reviewed at Planned Care Board thereafter.

Programme:	People & Culture

Key progress in programme during last period
• DCPO to complete the review of the Speciality Workforce plans. • Nursing pipeline plan trajectory to be finalised. • Continuation of diagnostics phase. • Engagement into staff survey commenced. • Submission of paper for Rostering and agree plan to launch LOOP as part of rostering support. • Agree with Interim CMO rostering plan, plan to achieve gap analysis for job planning, GMC survey engagement and actions, development of plan and output of clinical digital induction.

Key Project Risks	Residual Score
Capacity to scale up delivery of the Leadership Development Programme	9
Culture and Leadership Programme currently not aligned with wider IIP programmes	6
Lack of senior medical leadership, resource in information team, changes in personnel in care groups	8

Milestones off track	Target Date	What are we doing about it?
5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23	Strategy finalised and is now going through approval process, once approved by P&C committee this will be communicated across the organisation linking with the comms programme in 'Leader trust news' and socials. Unfortunately, the September meeting was postponed, this milestone has been escalated to CPO.
5.303: Dashboard for medical attraction and trends built	Jun-23	Delayed due to Information team required to prioritise time to focus on the alignment of the new organisational structure. Looking to produce skeleton dashboard early October 23.
5.304: Rostering trial	Sep-23	Interim CMO briefed, Comms team briefed and engaged to support, Inaugural Steering Group meeting booked in for mid October. Loop due to soft launch early October.
5.305: Medical Job Planning assessment of levels of attainment and trajectory developed to reach level 4	Sep-23	Gap analysis completed. Plan being developed for completion and trajectory.
5.306: Specialist Registration (CESR) programme development	Sep-23	CESR is already live in some specialties. Work has begun to develop a governance structure and a view to consolidate the protocol trustwide. Work continues to progress.
5.308: Development of a medical workforce dashboard	Sep-23	Delayed due to information team using time to focus on the alignment of the new organisational structure. Conversations continue with Interim CMO and P&C colleagues to discuss what is required within the dashboard. Completion target Dec 23.
5.3.10: Review of clinical digital induction	Sep-23	Scope yet to be developed with IT medical consultant.

Integrated Improvement Plan Communications and Engagement Update: October 2023

Key progress during last period:

- This month's communications theme was focused on reinforcing the messages in Dr Kirkup's report *Reading the signals/*sharing progress and outcomes in maternity.
- Discussion in Team Brief (17th Oct) on changes made, work still to do, importance of listening/acting on staff and patient feedback, followed up with written briefing for cascade.
- All staff webinar on the 24th October focussing on one year on from RTS
- Stakeholder visits to maternity service, briefings with East Kent MPs and briefing of Health Overview and Scrutiny Committee
- Internal and External communications reinforcing messages, apology and improvements including proactive media interviews, public communications and stakeholder bulletin
- Freedom to Speak UP sessions and NHS Staff Survey communications campaign
- Focus on PSIRF in the monthly team brief and staff forum
- Continued financial consciousness campaign – updates in team brief and promotion of ways all staff can contribute to reducing costs
- Patient Information leaflets and map to support patients using emergency pathway
- See 'ME First' Equality, Diversity and Inclusion communications begun, with a dedicated Staff Zone page and promotion through the desktop wallpaper and Trust News
- Accessible information standard campaign launched, including a dedicated area on Staff Zone, resources for managers and promotion through desktop wallpaper, Trust News, posters and a 'pop up' quiz on Staff Zone.

Plan for next month:

- Focus on winter communications including sharing winter plans with staff and stakeholders and promoting alternatives to A&E with the public
- Reading the signals oversight group on 31st October
- Attendance at Joint Health Overview and Scrutiny Committee to discuss the future of transformation of hospital services
- Briefings stakeholders to build support for capital investment
- Continue the NHS Staff Survey completion campaign
- Working with Medical Education department to recruit lay representatives to become involved in the education and training of doctors in training in East Kent
- Development of visitors charter and new extended visiting times starting from Monday 30th October.
- Continue to link patient and staff stories to improvement plan and use campaign approach to engage all staff in individual projects

Limitations to delivery of Comms & Engagement plan:

- Number and pace of initiatives for staff to be aware of/engaged in. Mitigation for this; 'joining the dots' in the narrative to describe how each supports our improvement journey; a monthly focus on one key theme.

Evidence of impact of actions undertaken:

- Staff survey response rate at 30.49% (as of 19 Oct), above average acute trust rate of 24.13%

High Level IIP Programme Risk Summary

Definitions

Movement in month – Key:

★	New Risk	⬇	A decrease in risk score
⬌	The score remains the same	⬆	A rise in risk score

East Kent Hospitals University NHS Foundation Trust

Key risks to delivery in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
3.3.01	14.06.23	Operational Performance	Jane Dickson	Diagnostic delays in cancer pathways due to increase in activity.	20	a) Radiology improvement meeting weekly b) Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. c) All diagnostics are aimed to be booked within 5-10 days of receiving referral. d) Specific focus underway in Endoscopy reviewing the waiting list position, bidding for additional funding to outsource activity and establishing Endoscopy improvement plans to support recovery. e) Mutual Aid plan for urology to be agreed.	23.10.23	16	⬌
6.1.03	07.08.23	Financially Sustainable	Michelle Stevens	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	16	a) Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation.	23.10.23	12	⬇
6.1.04	07.08.23	Financially Sustainable	Michelle Stevens	Risk of identifying and prioritising the development of “harder to achieve” improvements from Care Groups.	16	a) Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions.	23.10.23	12	⬇
3.4.01	23.08.23	Operational Performance	Jane Dickson	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	15	a) a) No immediate mitigation to reduce 78 week breaches before January 2024. Work continues to explore.	23.10.23	15	⬌

High Level IIP Programme Risk Summary

NHS East Kent Hospitals University NHS Foundation Trust

Opened risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
3.6.01	24.10.23	Operational Performance	Jane Dickson	Inability to ensure that all endoscopy surveillance patients which have been identified beyond a breach date will be treated within target 6 weeks post clinical validation	16	Identified admin validation team. Agreed clinical validation criteria. Assessment underway for resource required for clinical validation.	24.10.23	6	

Closed risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
4.3.01	20.6.23	Quality & Safety	Sarah Hayes	Ward Accreditation Team are currently small in number with a team member having long term sickness. They may not be able to complete a first accreditation for all inpatient wards by end of November 2023 as the original trajectory anticipated.	20	Sickness within the team has now resolved. Working practices and priorities have been reviewed. The first accreditation for all wards is now planned to be completed before the end of December, meaning that completion of this action will be delayed, but by only 3 weeks. The risk of lack of completion of the whole section of Quality & Safety is therefore greatly reduced. Risk agreed to be closed at SiC 10.10.23.	10.10.23	2	
6.1.01	14.06.23	Finance	Michelle Stevens	Due to vacancies within the Finance team there are currently no project leads within the IIP finance workstream. This is a risk to ensuring there is pace and delivery of the programme and could cause delays to ensuring financial savings and improvements are achieved in the organisation.	9	Additional resources have commenced in this period to support the delivery of the IIP. Risk agreed to be closed at SiC 10.10.23.	10.10.23	6	

Summary

- At the beginning of the reporting period 23 risks were recorded on the IIP risk register.
- 1 new risk has been added during this reporting period relating to Endoscopy.
- In total 24 key areas of risk discussed in this period relating to delivery against the IIP with 2 risks closed relating to the ward accreditation team and vacancies to support the finance programme which has since been resolved (as above).
- 1 risks during this period has increased it's Inherent score.
- 22 risks remain open on the IIP risk register, summary per programme is as follows; 3 Finance (reduction of 1), 3 Leadership & Governance, 5 Maternity, 6 Operational Performance (increase of 1), 3 People & Culture, 3 Quality & Safety risks (reduction of 1). There is strengthened risk monitoring within the IIP with particular focus on 'confirm & challenge'.
- Please see Appendix A for a full detailed IIP Risk Register.

IIP Open Risk Register (as at 23 October 2023)

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
Risk reference number	Date identified	IIP / BAF or Corporate risk	IIP Workstream	Risk raised by	Risk responsibility of	What is the risk to delivery? This is a risk that "something happens" due to the "cause" leading to "consequence/impact".	(1-5) & category	(1-5) & category	Severity of risk before controls implemented	What are the mitigating actions (ensure clear dates are provided)	Progress notes including date of update	(1-5) & category	(1-5) & category	Severity of risk after controls implemented	Date risk was last reviewed at SiC	Date risk was closed at SiC
1.101	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	Unable to appoint CFO substantively posing potential instability to executive team and financial workstreams / improvements required.	4 - likely	4 - likely	16	a) Interviews for the substantive Chief Finance Officer role were held on 25 April 2023. Agreed with regional colleagues at the unsuccessful interviews continuation of the current interim arrangement for up to 12 months to ensure cover during the period required to undertake a second substantive process to make a permanent appointment. b) Working with NHSE and SE Regional team to support recruitment for substantive position.	**14.09.2023** - Turnaround Director funded by RSP starts in October 2023 to support financial delivery	3 - possible	3 - moderate	9	23.10.23	
1.102	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	The current restructure has the potential to detract from the BAU operations of the Trust and impact on progress against the IIP.	3 - possible	3 - moderate	9	a) Ensure restructure is concluded by 16th August 2023 and appointment to leadership posts to progress IIP programmes at pace.	**26.06.23** - Restructure on track to conclude by 16th August at the latest. **22.08.23** - new organisational structure has gone live on 14th August 23. **20.09.23** - Some vacant positions are await recruitment. Residual score to remain the same at this time.	3 - possible	2 - low	6	23.10.23	
1.103	25.09.2023	IIP	Leadership & Governance	Andrea Ashman	Tracey Fletcher	No substantive COO following the resignation from the current postholder.	4 - likely	4 - likely	16	a) Interim COO in place for unplanned care who has experience, knowledge and understanding of the organisation	**20.09.2023** - Trust have engaged with an agency to start the recruitment process for the COO	3 - possible	3 - moderate	9	23.10.23	
2.101	29.06.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	Work commissioned to external adviser whose contract expired April/May 2023. Work incomplete, draft document still not received mid June 2023. This framework sets out Governance structures throughout the service, without which there are insufficient systems of control.	4 - likely	2 - low	8	a) The service is currently working towards V2.0 of the Maternity Quality & Safety Framework (Risk Management Strategy) until the refreshed version is available to ensure there continues to be structures for maintaining oversight, and managing of overdue governance related activities. b) Work progresses internally with an MDT to produce the final QSF. This will be ratified at the Women's Health Guidelines Group in Aug and assurance/ratification at MNAG in September. c) New QSF will be published by end August 2023.	Next MNIP governance group meeting 17th August (postponed from 10th) **15.09.23** Governance Review is complete at Trust level. Work to be undertaken with the Care Group to embed the process. **20.09.23** - residual score reduced.	2 - unlikely	1 - negligible	2	23.10.23	
2.301	29.06.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	The original model for this service has been revised by the incoming substantive DoM meaning that systems which underpin this service need to be reconsidered and revised. Until agreed and implemented, the current triage system remains in place.	3 - moderate	3 - moderate	9	a) Existing telephone triage system remains operational with supporting guideline in place. b) A planning meeting was held 06/07 to redefine the scope of work to be completed to enable centralisation. c) Weekly meetings to be reformed to facilitate revised model with much of the work completed through delivery of the original plan and other elements are underway i.e. triage PTL boards. d) This will appear as an agenda item on the next Women's Health Care Group Governance meeting on 28th July for agreement of way forward with a revised date for completion.	**15.09.23** DoM/DDoM to discuss way forward with Matrons and HoMs **20.09.23** - residual score reduced.	3 - moderate	1 - negligible	3	23.10.23	
2.102	22.09.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	Unfilled vacancies, combined with high levels of maternity leave and short term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	5 - almost certain	4 - likely	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed b) Line bookings of NHSP and agency, framework and off framework with applied incentive c) Specialist midwives redeployed to fill gaps d) Suspension of continuity of carer e) Utilisation of managers on call and community midwives	This is also on the Corporate Risk Register -CRR122.	3 - possible	4 - significant	12	23.10.23	
2.402	22.09.2023	IIP	Maternity	Leane Jeffrey	Michelle Cudjoe	Inadequate Estates in Maternity There are numerous issues with estates. A few examples are delivery rooms being too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	4 - likely	4 - significant	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity b) Introduction of quality rounds on both units that includes estate elements against CQC compliance c) Neonatal service attend postnatal ward daily to facilitate discharges d) Portable suction unit available in each labour room e) Pure air scavenging unit and ventilation in labour rooms on both sites f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size	This is also on the Corporate Risk Register -CRR144.	4 - likely	3 - moderate	12	23.10.23	

3.1.01	14.06.2023	IIP	Operational Performance	Sandra Cotter	Jane Dickson	The current process for accounting for the NLFTR has been reviewed in partnership with HCP in which there are a number of recommendations to be considered and taken forward. This will impact reducing the NLFTR position to support emergency flow and 12 hour breach reduction.	3 - possible	4 - significant	12	a) The recommendations will be monitored via the ECDG/HCP delivery groups. b) SAFER roll-out planned July 23 across all sites. c) Additional resource being secured to support enhanced discharging. Awaiting approval for 1 candidate. d) Future of the integrated hubs to determine pathways for patients will continue to be evolved over the next 6 months.	**26.06.23 -** update on SAFER/PTL roll out via the ECDG .	3 - possible	3 - moderate	9	23.10.23	
3.2.01	14.06.2023	IIP	Operational Performance	Lisa Neal	Jane Dickson	Inability to comply with 2023/24 activity plan at Trust level in order to stabilise waiting list and reduce long waiters due to increased theatre activity (cases per session), staffing issues, competency impacting on ability to deliver head & neck activity, consultant sickness in ENT, volume of paediatric patients due to limited access to paeds provision at K&CH and no elective provision at QEQM and WHH.	3 - possible	4 - significant	12	a) ENT system meeting 22 June 2023 chaired by Planned Care Lead (CEO Medway) to consider hub/spoke model and short term recovery actions to reduced breaches before January 2024. b) Increase frequency of PTL meetings in surgery agreeing daily tasks and actions to support breach reduction at pace. c) Analysis of cases per session completed for each speciality to review reason for reduced activity per session (based on slight increase in theatre time compared to pre covid) and quantify theatre actions to increase activity levels. d) Refreshed activity plan in Q2/3/4 for each speciality where activity needs to be increased to sustain waiting list position and eliminate breaches over 65 weeks by March 2024. Rate limiting steps identified (Theatre workforce and equipment, paediatric provision and ENT otology c capacity) require quantifiable and measurable actions to support elective activity and reduction in waiting list and waiting times. e) Specialities to articulate robust recovery actions through weekly activity/performance meetings and agree transformational actions to improve planned care across the trust through the monthly Planned Care Improvement Meeting.	**26.06.23** - Out patient activity is above plan in Q1 (year to date position). Elective and diagnostic activity is approximately 94% of plan. Referrals are not above plan and are in line with predicted levels based on the previous years(2019- 2022) referral pattern and growth.	4 - likely	3 - moderate	12	23.10.23	
3.3.01	14.06.2023	IIP	Operational Performance	Sarah Collins	Jane Dickson	Diagnostic delays in cancer pathways due to increase in activity.	5 - almost certain	4 - significant	20	a) Radiology improvement meeting weekly and Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. b) All diagnostics are aimed to be booked within 5-10 days of receiving referral. c) Specific focus underway in Endoscopy reviewing the waiting list position, bidding for additional funding to outsource activity and establishing Endoscopy improvement plans to support recovery. d) Mutual Aid plan for urology to be agreed.	**26.06.23 -** Updates and progress to be recorded at weekly performance meetings	4 - likely	4 - significant	16	23.10.23	
4.1.01	14.06.2023	IIP	Quality & Safety	Katy White	Jane Dickson/ Rebecca Martin	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	5 - almost certain	4 - significant	20	a) This has been escalated to a Director at Datix for their intervention. It is unlikely that we will meet the deadline for September 23 (as with all Trusts using Datix). b) Full cost of overspend being costed for the agency Datix Project Lead. c) A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts. d) A roadmap for delivery is to be presented to relevant governance committees in September 23. e) updated datix fields	**20.09.23 -** roadmap produced inline to deliver plan to implement. Residual score reduced at SiC.	4 - likely	3 - moderate	12	10.10.23	
4.4.02	14.06.2023	IIP	Quality & Safety	Ian Setchfield	Jane Dickson/ Rebecca Martin	The build of the deteriorating dashboard is dependent on the current integration of VitalPAC functionality within Sunrise which is a very complex process. The predicted timeline for rolling out this functionality is later this year or early next year with dates yet to be confirmed. This links with milestone 4.408 with a target date to achieve by March 24 and also CQC action on Sepsis screening. In the meantime, questions relating to deteriorating patient compliance have been included in Tenable and will be ready for reporting from July 23.	4 - likely	3 - moderate	12	a) Continue to discuss at Sunrise Vitals Integration Steering Group. b) Deteriorating patient is now available on the Tenable Ward platform (from August 23) as an interim measure posing additional challenging questions. Care Groups will be able to produce their own reports on deteriorating patients. Although this will not be as robust as Sunrise it will provide assurances against Trust Policy i.e. escalation. c) Risk owner member of Sunrise Vitals Integration Steering group – any changes to predicted timeline will be included in PSC deteriorating patient report, along with Tenable deteriorating patient reports.	**05.09.23** - discussions at SiC at length, Deteriorating Patient programme to discuss with ICB to ensure this action is appropriate and will be suffice as this is a quarterly RSP requirement.	4 - likely	3 - moderate	12	10.10.23	

5.2.03	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Culture and Leadership Programme currently not fully aligned with wider IIP programmes (including 'we care' programmes). This means there could be two separate culture pieces of work taking place causing conflicts for the organisation.	3 - possible	3 - moderate	9	a) Discussions continue regularly with IIP SRO & Programme SRO re: new strategy to align CLP with existing programmes and to reduce duplication.	**20.06.23** - Venue and budget code now booked to hold launch days in July 2023. **05.09.23** - residual score reduced.	3 - possible	2 - low	6	10.10.23	
5.2.04	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Capacity is limited (only 3.6wte available) in order to scale up delivery of the Leadership Development Programmes at each of the levels required (Leading Others, First Line Leader, Mid-level Leader) as planned. Each of these 5-day programmes are scheduled to run 3x per annum and to do so will require more facilitators. The team are also holding a vacancy due to the required financial efficiencies.	4 - likely	4 - significant	16	a) Consultation now complete with appointments made however some vacancies still remain which are to be advertised in September 23. b) Post recruitment the OD team will prioritise delivering the Leadership Development Programme fully as capacity will be available.	**05.09.23** - residual score reduced.	3 - possible	3 - moderate	9	10.10.23	
6.1.02	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	In order to support updating Financial Recovery Programme additional support is being explored. Current post holder leaving end of July 23, organisation off plan and further grip required.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover was undertaken with clear objectives. b) A draft version of the FRP was presented to the Trust Board in July 23, it was agreed further work with key stakeholders is required to finalise draft aimed at presenting again in October to achieve target date of Jan 24. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23. d) Comms to support with staff engagement to support financial consciousness.	**05.09.23** - discussion at SiC, RSP support available from October 23. Residual score reduced.	2 - unlikely	4 - significant	8	10.10.23	
5.02.05	09.08.23	IIP	People & Culture	Louise Goldup	Andrea Ashman	Lack of leadership and engagement from Medical Office to drive forward pace of People and Culture milestones for medical workforce and ensure this is consistently applied.	4 - likely	4 - significant	16	a) New interim CMO fully engaged in P&C workstreams and regular meetings in place to review milestones. b) Appointment of medical workforce lead in August 23, regular meetings in place to increase engagement and review milestones. c) Detailed plans currently being produced by medical office to support milestones with clear timescales and leads being identified. d) Medical workforce dashboard being progressed. e) Medical Office have implemented regular meetings with Care Group Medical Directors to drive pace. □	**05.09.23** - residual score added. **27.09.23** - Nature of risk updated	2 - unlikely	4 - significant	8	10.10.23	
6.1.03	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	4 - Likely	4 - Significant	20	a)Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation	**03.10.23** - Inherent Risk Score increased to 20 as per the CRR	4 - Likely	3 - moderate	12	10.10.23	
6.1.04	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Risk of identifying and prioritising the development of "harder to achieve" improvements from Care Groups.	4 - Likely	4 - Significant	16	a)Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions	**05.09.23** - discussion at SiC, residual score reduced.	4 - Likely	3 - moderate	12	10.10.23	
4.3.02	09.08.23	IIP	Quality & Safety	Wendy-Ling Relph	Jane Dickson	Head of Nursing for FoC & Quality (who is also clinical Lead for Nutrition) is currently recruited on an interim arrangement until end December 23 as a secondment. Post holder is chair of key quality strategic meetings, project lead for IIP FoC, line manager of specialist nurses, coach & mentor to nursing teams. Risk of instability to lead on FoC workstreams if future of post is not agreed promptly. □	4 - Likely	4 - significant	16	a) Corporate team restructure is currently being reviewed. □ b) There is a plan to substantively recruit and submit to vacancy panel prior to December 23 to ensure work continues.		4 - likely	3 -moderate	12	10.10.23	

3.4.01	23.08.23	IIP	Operational Performance		Jane Dickson	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	5 - almost certain	3 - moderate	15	a) No immediate mitigation to reduce 78 week breaches before January 2024. Work continues to explore.	**14.09.23** - No system capacity available to support EKHUFT otology recovery.	5 - almost certain	3 - moderate	15	23.10.23	
3.5.01	23.08.23	IIP	Operational Performance		Jane Dickson	Inability to fully validate all patients from 12 weeks wait as per Board Assurance letter received 4 August due to lack of capacity.	4 - likely	2 - low	8	a) System wide challenge acknowledged at Planned Care Board 22nd August 23. b) Proceed with two way text message roll out. Increased spend to be approved before roll out can commence c) Review of EKHUFT Access Governance/Validation workforce compared to MFT/MTW/DGH d) Progress patient portal opportunities with IT to consider role in validation.	**14.09.23** - Elective Leads across K&M unable to deliver/achieve national requirement. System review of Access Governance support in place confirms EKHUFT, based on size of Trust/PTL, have a significantly reduced team compared to neighbouring Trusts.	3 - possible	2 - low	6	23.10.23	
3.6.01	23.10.23	IIP	Operational Performance	Sunny Chada	Jane Dickson	Inability to ensure that all endoscopy surveillance patients which have been identified beyond a breach date will be treated within target 6 weeks post clinical validation	4 - likely	4 - significant	16	a) Weekly task and finish group has been set up and first meeting held 9th October. Aim to ensure all overdue surveillance patients (3527) are clinically validated and clear treatment plan in place b) Weekly meeting with ICB to provide assurance and support to EKHUFT with the recovery plan. Particularly clinical support has been requested due to lack of resources in EKHUFT. c) ID Medical additional capacity has been secured, commencing November 23 to assist with the backlog d) Surveillance project being considered by other departments to ensure this is not a wider problem	**24.10.23** - Identified admin validation team. Agreed clinical validation criteria. Assessment underway for resource required for clinical validation.	3 - possible	2 - low	6	23.10.23	

RISK MATRIX						
Impact	5. Extreme	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3.V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	2. Unlikely	3. Possible	4. Likely	5. Almost certain
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

IIP Closed Risks

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
2.303	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline supporting implementation of improved discharge pathways was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone target date of July 23 and until approved the service will continue to operate the current discharge model.			12	a) Postnatal Ward Manager (QEQM) to work with Guideline Midwife to circulate the postnatal guideline for review and approval. b)The postnatal guideline will be circulated via email, by exception for chairs action to agree the new model for implementation by end of July 23.	**18.07.23** - Discussed with programme manager, obtain approval at SiC on 26.07.23 that this risk is a duplicate and is now merged with risk 2.302 to enable closure. 26.07.23 - risk agreed to be closed at SiC as a duplication.				26.07.23	26.07.23
2.401	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Whist pending development and approval of the new maternity Quality & Safety framework, the service is working to the draft V2 of the QSF. Structures for maintaining oversight, and managing of overdue governance related activities require further work particularly to ensure there are no overdue/breached governance related activities including SIs/HSIB investigations.			16	a) To ensure there is some strengthened governance in the interim the maternity service is working to V2 of the QSF until the final version is published in August 2023. b) There are trackers being used to monitor progress of all governance related activities, including backlogs. c) In addition there is now a dedicated patient safety team progressing with overdue governance to ensure focus.	**18.07.23** - Discussed with programme manager, obtain approved at SiC on 26.07.23 that this risk is a duplicate and is now merged with 2.302 to enable closure. 26.07.23 - Risk agreed to be closed at SiC as now a duplication.				26.07.23	26.07.23
4.4.01	14.06.2023	IIP	Quality & Safe	Ian Setchfield	Jane Dickson/ Rebecca Martin	Unable to support deteriorating patient training across the organisations as proposed due to funding provided by HEE not available.	3 - possible	3 - moderate	9	a) Plan is to utilise money for additional resuscitation training provided by an external supplier, which improves the deteriorating patient pathway. b) Full resuscitation training needs and costings to be finalised & submitted to HEE. c) Funding since received in June 23 to enable rollout of training across the organisation (funding supports both training and posts). Allocation of remaining funding to support additional deteriorating patient workstreams need to be agreed with CNMO.	**19.06.23 -** Funding agreed for £300k one off via HEE (which supports both training and posts). Money has been transferred to the Trust from the ICB - risk can therefore now be closed. **18.07.23** - Project Lead to requested for closure to be submitted to the SiC on 26.07.23. **26.07.23** - Risk agreed to be closed at SiC now funding is received risk is removed.			6	26.07.23	26.07.23
2.302	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone date of July and until the service will continue to operate the current discharge model.	3 - possible	5 - extreme	15	a) Corresponding postnatal guideline has been updated which sets out the improved model for the discharge pathway. However, the guideline was not reviewed as planned by the Women's Health Guideline Group on 16 June 2023 due to insufficient time on the agenda to consider and approve. b) The postnatal guideline was planned to be circulated via email, by exception for chairs action however it has since been agreed for wider discussion at the Women's Health Audit Group on 18/07 for ratification.	**16.08.23** - guidance published on 4th August. Request to SiC to close risk.	3 - possible	3 - moderate	9	16.08.23	24.08.23
5.2.01	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	In order to support Culture and Leadership Programme trust wide, additional funding for 1 Programme Director and 1 seconded Programme Manager was requested from NHSE (RSP funding). Currently funding has not been approved and received however, NHSE confirmed to 'go at risk' to ensure the project is not delayed. If funding is not received this will be an overspend for the organisation.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up and regular updates received from RSP team. b) Posts are recruited to and programme has commenced, moving forward to diagnostics.	**20.06.23 -** still awaiting if funding has been allocated and amount. **07.09.23** - funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23** - risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23

5.2.02	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Due to insufficient funding within Culture and Leadership Programme unable to undertake practical arrangements for launch of Culture and Leadership Programme trust wide including events / booking venues.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up for posts to progress with programme. Internally also 'gone at risk' to account for additional revenue required to support events. b) Launch days and conference centre now booked to enable diagnostics to be commenced. b) Working with SRO to realign budgets to support future funding.	**07.09.23** - funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23** - risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23
4.3.01	20.6.23	IIP	Quality & Safe	Wendy-Ling Relph	Jane Dickson/ Rebecca Martin	Ward Accreditation Team are currently small in number with a team member having long term sickness. They may not be able to complete a first accreditation for all inpatient wards by end of November 2023 as the original trajectory anticipated.	5 - almost certain	4 - significant	20	a) Alternative solutions are being explored, including the potential of utilising additional internal staff and reviewing the current accreditation timetable. b) One staff member now returned from long term sick and progressing with plans.	**15.09.23** - Sickness within the team has now resolved. Working practices and priorities have been reviewed. The first accreditation for all wards is now planned to be completed before the end of December, meaning that completion of this action will be delayed, but by only 3 weeks. The risk of lack of completion of the whole section of Quality & Safety is therefore greatly reduced. Residual score now reduced.	4 - likely	4 - significant	2	10.10.23	10.10.23
6.1.01	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Due to vacancies within the Finance team there are currently no project leads within the IIP finance workstream. This is a risk to ensuring there is pace and delivery of the programme and could cause delays to ensuring financial savings and improvements are achieved in the organisation.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover has been undertaken with clear objectives. b) The CFO is currently both SRO and project lead for the finance programme within the IIP. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23 in order to bring pace to financial programme.	**05.09.23** - discussion at SiC, RSP support available from October 23. **03.10.23** - Additional resources have commenced in this period to support the delivery of the IIP (Turnaround Director, ADOF Financial Planning). Request SiC to close.	2 - unlikely	3 - moderate	6	10.10.23	10.10.23

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Sexual Safety in Healthcare – Organisational Charter**

Meeting date: **2 November 2023**

Board sponsor: **Chief Executive Officer (CEO)**

Paper Author: **Chief People Officer (CPO) Programme Director**

Appendices:

None

Executive summary:

Action required:	**Information**
Purpose of the Report:	This paper provides information regarding the NHS Sexual Safety in Healthcare - Organisational Charter.
Summary of key issues:	To note the Trust has signed the Charter.
Key recommendations:	The Board of Directors is asked to **NOTE** the contents of the paper and support the Trust in executing the ten commitments by July 2024.

Implications:

Links to Strategic Theme:	• Quality and Safety • People
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	CRR 118 - there is a risk the underlying organisational culture impacts on the improvements that are necessary to patients and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None.

We care

East Kent Hospitals University NHS Foundation Trust

Sexual Safety in Healthcare – Organisational Charter

1. Purpose of the report

1.1 This paper provides details of the Trust response to the NHS Sexual Safety in Healthcare – Organisational Charter.

2. Background

2.1 On 4 September 2023 NHS England (NHSE) launched its first ever sexual safety charter in collaboration with partners across the healthcare system. Signatories to the charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace and to ten core principles and actions to achieve this.

2.2 The charter was published in advance of the publication of survey results on 12 September 2023 by the British Journal of Surgery which revealed that 63.3% of female surgeons and 23.7% of male surgeons had been the target of sexual harassment by colleagues.

2.3 An in-depth study published by the British Journal of Surgery, 'Breaking the Silence: Addressing Sexual Misconduct in Healthcare' reveals the extent of sexual misconduct by colleagues - including sexual harassment, sexual assault, and rape - within the UK surgical workforce in the last five years.

2.4 Researchers from the University of Surrey and Exeter University analysed anonymous online survey responses from 1434 surgeons (51.5% of whom were women). The survey asked about their experiences of sexual misconduct, such as sexual harassment, sexual assault, and rape, among surgical colleagues in the past five years.
The study also identified a 'widespread lack of faith in accountable organisations' adequacy to deal with sexual misconduct. These included NHS Trusts who have a duty to protect the workforce, the General Medical Council (GMC), the British Medical Association (BMA), Health Education England, and the Royal Colleges.'

3. Trust Response and Statement of Commitment

3.1 The CEO has committed to the charter, contacting the relevant body directly. We have received confirmation that the Trust has made a public commitment to its workforce and also its patients.

3.2 Accordingly, we have pledged to implement all ten commitments by July 2024 and are currently undertaking an audit and gap analysis of our position against these.

3.3 In making our pledge we have acknowledged and agree with the following:

'Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work. Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual

behaviour in the workplace. We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.'

3.4 As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently. These commitments will apply to everyone in our organisation equally.

Where any of the above is not currently in place, we commit to work towards ensuring it is in place by **July 2024.**

4. Next steps

4.1 The analysis of our current state against each commitment is being undertaken currently which will be followed by a specific action plan to address each commitment. This is being developed by the lead Freedom to Speak Up (FTSU) Guardian with support from the CPO and colleagues. Each commitment will be addressed systematically with input from our staff to ensure that we make sure that individual voices are listened to and issues addressed.

4.2 Articles have been published on staff zone with open access to all staff and an invitation to speak up as people wish. The charter has also been published and with it a series of webinars are underway.

4.3 The FTSU is currently hosting weekly webinars, focussing on the commitments the Trust has made. They are joined by representatives from other teams across the organisation (e.g. employee relations, equality, diversity and inclusion (EDI), medical education, staff networks, hospital independent domestic violence Advisers (HIDVA), connectors and professional nurse advocates (PNA)) and reflect together on what we steps we currently

take to prevent and tackle sexual misconduct at work. This is also an opportunity to learn and make suggestions for improvement where there is more work to be done.

4.4 A gap analysis is being undertaken by the lead FTSU Guardian against the ten commitments within the charter which will also be informed by the interaction with staff as part of the series of commitment webinars. A suitable action plan will be developed to address the areas in which further activity and support is required for our staff.

5. Domestic Abuse and Sexual Violence (DASV)

5.1 The CPO is the Trust lead for DASV and is joined to the national response and support programme to assist all trusts in addressing these issues. There is a schedule of quarterly meetings planned for the next year with an inaugural meeting held 18 October.

6. Conclusion

6.1 The Board of Directors is asked to continue to support the Trust commitment to the charter and the activity required to meet each commitment.