Board of Directors Meeting - Open (Thursday 1 June 2023)

Thu 01 June 2023, 01:00 PM - 04:50 PM

Lecture Theatre, Education Centre, QEQM, Ramsgate Road, Margate CT9 4BG/WebEx

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:05 PM
5 min

23/33
Welcome and Apologies for Absence

To Note *Chairman*

Verbal

01:05 PM - 01:05 PM
0 min

23/34
Confirmation of Quoracy

To Note *Chairman*

Verbal

01:05 PM - 01:05 PM
0 min

23/35
Declaration of Interests

To Note *Chairman*

23-35 - Board of Directors register of interests - May 2023.pdf (3 pages)

01:05 PM - 01:05 PM
0 min

23/36
Minutes of Previous Meeting held on 4 May 2023

Approval *Chairman*

23-36 - Unconfirmed BoD 04.05.23 Open Minutes DRAFT.pdf (13 pages)

01:05 PM - 01:05 PM
0 min

23/37
Matters Arising from the Minutes on 4 May 2023

Approval *Chairman*

23-37 - Front Sheet Public BoD Action Log.pdf (5 pages)

01:05 PM - 01:10 PM
5 min

23/38
Chairman's Report

Information *Chairman*

- **Care Quality Commission (CQC) Maternity Report**
- **CQC Unannounced Inspection Visit**

23-38.1 - Chairman BoD Report June 2023 v1.0 23.05.23.pdf (4 pages)
23-38.2 - App 1 Chairman Report NEDs commitments.pdf (1 pages)

01:10 PM - 01:20 PM
10 min

23/39
Chief Executive's (CE's) Report

Discussion *Chief Executive*

23-39 - CEO Report to Board - June 2023.pdf (4 pages)

01:20 PM - 01:50 PM
30 min

23/40
Section 31 Reporting: Maternity and Midwifery Services Williams Harvey Hospital and Queen Elizabeth the Queen Mother Hospital

Assurance *Interim Chief Nursing and Midwifery Officer (CNMO)/Director of Midwifery (DoM)*

23-40.1 - Board S31 Submission Response May 23.pdf (9 pages)
23-40.2 - Appendix 1 CQC Maternity Action Plan.pdf (8 pages)
23-40.3 - Appendix 2 Section 31 April Submission WHH.pdf (9 pages)
23-40.4 - Appendix 2 Section 31 April Submission QEQM.pdf (4 pages)

01:50 PM - 02:10 PM
20 min

23/41
Board Committee - Chair Assurance Reports

Assurance *Board Committee Chairs*

23/41.1
People and Culture Committee (P&CC) - Chair Assurance Report

Assurance *Chair P&CC - Stewart Baird*

23-41.1 - PCC Chair Assurance Report BoD June 2023 FINAL SB.pdf (3 pages)

23/41.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report

Assurance *Chair Q&SC - Andrew Catto*

23-41.2 - QSC Assurance Report 230523 FINAL.pdf (6 pages)

23/41.3
Finance and Performance Committee (FPC) - Chair Assurance Report

Assurance *Chair FPC - Richard Oirschot*

23-41.3 - FPC May Chair Committee Assurance Report Final.pdf (4 pages)

OUR PATIENTS OUR QUALITY AND SAFETY

02:10 PM - 02:25 PM
15 min

23/42
Transforming our Trust: Our Response to 'Reading the Signals': Maternity and Neonatal Services in East Kent - Update Report

Approval *Chief Executive*

23-42 - Reading the Signals - June Board Report v2.pdf (11 pages)

02:25 PM - 02:55 PM
30 min

23/43
Maternity Governance:

Interim CNMO / DoM

23/43.1
Maternity Dashboard

Discussion *Interim CNMO / DoM*

23-43.1.1 - Maternity Dashboard front sheet June 2023.pdf (2 pages)
23-43.1.2 - Appendix Board Maternity Dashboard June 23.pdf (34 pages)

23/43.2
Perinatal Quality Surveillance Tool (PQST) Report

Assurance *Interim CNMO / DoM*

23-43.2 - PQST April 2023 BoD.pdf (10 pages)

23/43.3
Perinatal Mortality Review Tool (PMRT) Quarterly Report - Q4 2022/23

Assurance *Interim CNMO*

23-43.3.1 - Q4 PMRT Board.pdf (7 pages)

23/43.4
Clinical Negligence Scheme for Trusts (CNST) Safety Action 8 Compliance Plan

Assurance *Interim CNMO*

23-43.4 - CNST Safety Action 8 Assurance Paper.pdf (3 pages)

23/43.5
CNST Year 4 - Safety Action 3: Transitional Care Services Report

Information *Interim CNMO / DoM*

23-43.5 - ATAIN CNST Safety Action 3 Transitional Care Q3 Q4 2022-23.pdf (31 pages)

23/43.6
Maternity Transformation Programme (MTP)

To Note *Interim CNMO / DoM*

Verbal

23/43.6.1
Maternity Improvement Plan Highlight Report

Assurance *Interim CNMO / DoM*

23-43.6.1 - Maternity Improvement Plan highlight report May 2023 BoD.pdf (10 pages)

02:55 PM - 03:05 PM
10 min

TEA/COFFEE BREAK 2:55 - 3:05

03:05 PM - 03:15 PM
10 min

23/44
Chief Medical Officer's (CMO's) Report - Learning from Deaths (LfD) Quarter 4 2022/23

Discussion *CMO*

- 23-44 - CMO Board Q4 LfD June.pdf (6 pages)

03:15 PM - 03:25 PM
10 min

23/45
Patient Voice and Involvement Quarterly Report

Information *Interim CNMO*

- 23-45.1 - Front Sheet Patient Voice and Involvement Quarterly Report Board 1.6.23.pdf (2 pages)
- 23-45.2 - Appendix 1 Patient Voice and Involvement Report Jan to March 2023 FINAL.pdf (6 pages)

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

03:25 PM - 04:10 PM
45 min

23/46
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Team*

- 23-46.1 - Front Sheet April 23 IPR.pdf (4 pages)
- 23-46.2 - Appendix 1 IPR_v4.3_Apr23.pdf (34 pages)

23/46.1
Integrated Improvement Plan (IIP) Update

Discussion *Interim Executive Director of Strategic Development and Partnerships*

- 23-46.1.1 - Front Sheet Integrated Improvement Plan Report Final 26.05.23.pdf (4 pages)
- 23-46.1.2 - Appendix 1 EKHUFT IIP June Board Report FINAL 26.05.23v2.pdf (14 pages)

23/46.2
Month 1 Finance Report

Discussion *Interim Chief Finance Officer*

- 23-46.2.1 - Front Sheet M1 Finance Report.pdf (1 pages)
- 23-46.2.2 - Appendix 1 M1 Finance Report 2023.pdf (2 pages)

OUR FUTURE OUR SUSTAINABILITY

04:10 PM - 04:20 PM
10 min

23/47
Health and Safety and Statutory Compliance update

Assurance *Interim Executive Director of Strategic Development and Partnerships / Managing Director 2gether Support Solutions*

23-47 - BoD HS Stat Compliance Critical Infrastructure Report (June 2023).pdf (7 pages)

REGULATORY AND GOVERNANCE

04:20 PM - 04:30 PM
10 min

23/48
We Care progress update - 2023

Discussion *Chief People Officer*

23-48 - We Care Open Board Update.pdf (10 pages)

CLOSING MATTERS

04:30 PM - 04:35 PM
5 min

23/49
Any Other Business

Discussion *All*

Verbal

04:35 PM - 04:50 PM
15 min

23/50
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 6 July 2023

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM MAY 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 Nursing and Midwifery Officer	To be confirmed	15 May 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 MAY 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)
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)
JONES, DYLAN	Chief Operating Officer	None	Appointed 12 April 2023
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
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 MAY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
STEVENS, BEN	Interim Executive Director of Strategic Development and Partnerships	None	20 March 2023
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)
WIGGLESWORTH, NEIL	Executive Director of Infection Prevention and Control	Chair and Director of the International Federation of Infection Control (started 1 January 2018) **(1)** Trustee of the International Federation of Infection Control (started 1 January 2018) **(4)**	15 March 2021
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

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 & TWENTY NINTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 4 MAY 2023 AT 12.50 PM IN THE CORNWALLIS ROOM, CANTERBURY CRICKET GROUND, OLD DOVER ROAD, CANTERBURY, CT1 3NZ AND BY WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Mr R Anakwe	Non-Executive Director (NED) (joined at 2.35 pm by WebEx, left at 3.10 pm)	RA
Ms A Ashman	Chief People Officer (CPO)	AA
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Mr S Corben	NED	SC
Ms T Fletcher	Chief Executive (CE)	TF
Mr D Jones	Chief Operating Officer (COO)	DJ
Dr R Martin	Chief Medical Officer (CMO)	RM
Ms C Pelley	Interim Chief Nursing and Midwifery Officer (CNMO) (left at 3.30 pm)	CP
Mr B Stevens	Interim Executive Director of Strategic Development and Partnerships (EDSDP)	BS
Mrs M Stevens	Interim Chief Finance Officer (CFO)	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair	CS

ATTENDEES:

Ms K Clark	Maternity Freedom to Speak Up (FTSU) Guardian	KC
Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Prof C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Ms P Kumi	Head of Equality, Diversity and Inclusion (EDI)	PK
Mr O Marley	Staff Experience Story	OM
Ms A Smith	Deputy DoM	AS
Ms C Todd	Lead FTSU Guardian	CT
Dr N Wigglesworth	Executive Director of Infection Prevention & Control (EDIPC)	NW
Ms F Wise	Executive Maternity Services Strategic Programme Director (EMSSPD)	FW
Mr M Wood	Interim Group Company Secretary	MW
Mrs N Yost	Executive Director of Communications and Engagement (EDoC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Mr T Cook	Special Adviser to the Chairman and Deputy Trust Secretary	TC
Mrs H Pope	Executive PA	HP
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Chloe	Member of the Public (WebEx)
Mrs S Ballard	Staff Member (WebEx)
Mrs M Bonney	Governor (WebEx)
Mr R Brittain	Governor (WebEx)
Mr N Daw	Governor & Membership Lead
Ms C Heggie	Member of the Public
Mr N Kalli	Member of the Public (WebEx)
Mrs B Mayall	Lead Governor (WebEx)
Mr D Richford	Member of the Public (WebEx)
Mr P Schofield	Governor
Mrs M Warburton	Member of the Public (WebEx)

MINUTE NO.		ACTION
23/017	**WELCOME AND APOLOGIES FOR ABSENCE** The Chairman welcomed those in attendance, and noted apologies received from Mr S Baird (SB), NED/People and Culture Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair; Ms L Fulci (LF), NED; Mr R Oirschot (RO), NED/Finance and Performance Committee (FPC) Chair; and Dr O Olasode	

(OO), NED/Integrated Audit and Governance Committee (IAGC) Chair.

The Chairman welcomed Mr D Jones, COO to his first BoD meeting. He thanked Ms S Shingler, former CNMO for her support, who had left the Trust to join her local Trust in Worcestershire.

The Chairman reported a Closed BoD meeting had been held that morning, the issues discussed included the Integrated Improvement Plan (IIP) and financial position.

23/018 **CONFIRMATION OF QUORACY**

The Chairman **NOTED** and confirmed the meeting was quorate.

23/019 **DECLARATION OF INTERESTS**

There were no new interests declared.

23/020 **MINUTES OF THE PREVIOUS MEETINGS HELD ON 6 APRIL 2023**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 6 April 2023 as an accurate record.

23/021 **MATTERS ARISING FROM THE MINUTES ON 9 MARCH 2023**

The Board of Directors **NOTED** the update on the actions from the previous meeting and those for a future meeting.

23/022 **STAFF EXPERIENCE STORY**

Mr Marley highlighted key points from his experience working in IT and for the Trust during a challenging period in his life that impacted on his mental health:

- Carer looking after child with complex needs;
- Fully supported by line managers, when needed to leave work to look after his child;
- Initially did not share with his colleagues the challenges he was facing, was offered counselling that helped him to manage his mental health;
- Encouraged others and colleagues to seek support and the importance of looking after and listening to each other.

The Chairman asked whether there was anything more the Trust could have done to provide Mr Marley with support he needed. Mr Marley commented he received all the support necessary providing him with the confidence to continue to work.

The CMO quired whether Mr Marley felt staff were comfortable to be able to raise if they were having mental health issues and needed support. Mr Marley commented if some staff felt they were not able to raise this with their line manager, there were other avenues for staff to speak up and be comfortable to ask for help.

The NEDs asked what signposting was available for staff and how clear and accessible this was for staff. Mr Marley commented he had shared with staff signposting about the support available and was working with the Trust to share his experience.

The CPO stated the Trust's staff programme to implement Connectors, linking with staff forums and staff throughout the organisation in respect of signposting of the support available and how to access this. The CE commented on the staff networks and whether they needed any additional support. Mr Marley stated there

was also the disability network and that staff needed to be made aware of the IT solutions available to support them and their needs, there was also the Trust's Education team for staff to contact.

The Board of Directors **NOTED** the Staff Experience Story report.

23/023 **CHAIRMAN'S REPORT**

The Chairman reported the Board at its Closed meeting that morning had approved the 2023/24 business plan. He noted there was a lot of success stories across the Trust and it was important to recognise and communicate these.

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

23/024 **CHIEF EXECUTIVE'S (CE'S) REPORT**

The CE reported key points:

- The electronic Prescribing and Medicines Administration (ePMA) had gone live at Kent & Canterbury Hospital (K&C), with roll outs at Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) to follow in May. Welcomed by clinical teams and was a real step forward digitally and in respect of patient safety;
- Thanks to Sarah Shingler, CNMO, for her hard work and support to the Trust, Executive Team and to her personally, wishing her well in her new role;
- Midwifery students: Trust working with the Canterbury Christ Church University (CCCU) to secure on-going training provision elsewhere for the students working in the Trust hospitals. Presented a challenge and significant impact for the students and the Trust that would result in a gap in the pipeline of midwifery students. Noting those training locally tended to stay working in local hospitals, and that the previous year of the 24 students that qualified, 22 came to work with the Trust.

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

23/025 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/025.1 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The CPO reported on behalf of the P&CC Chair:

- Partial assurance received on the Integrated Performance Report, in respect of decline in staff engagement (30% response rate for Q4 pulse survey, noting Q1 was currently in progress);
- Lots of programmes in the early stages with green shoots started to be seen;
- Freedom to Speak Up (FTSU), significant increase in staff speaking up;
- New EDI Team, implementation of EDI strategy, with EDI training dissemination to the workforce and that racism or any discrimination would not be tolerated;
- Appraisal levels remained poor with commitment to improve this;
- Staff turnover was on plan at 10%, with nursing turnover at 8.8%;
- Vacancy rates lower than expected at 8.4% from 10%;
- Staff sickness good position, reducing with less than 5% of staff sick on a rolling basis;
- Statutory training close to target, all medical appraisals and revalidation up to date;

- A lot of Occupational Health work being undertaken to support staff with strong results;
- Programme checking the experience of new staff and how they were, surveyed at 1 week, 1 month, 100 days, 6 months and 1 year;
- Continued monitoring of premium pay and the controls in place to reduce these costs;
- Verbal discussion of hot items, including industrial action and restructure consultation.

The CMO confirmed quality assurance reviews of medical appraisals. The CE reported on the positive engagement and involvement of the Local Negotiating Committee (LNC) and Staff Committee Chairs attendance at P&CC meetings.

The Board of Directors **NOTED** the verbal 26 April 2023 P&CC Chair Assurance Report.

23/025.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- Assurance was received on the action to address the five incidents regarding intravenous infusion of lipid for neonates which did not contain vitamins, reported as serious incidents (SIs). Noting change of supplier of the Total Parenteral Nutrition (TPN) and both lipids and vitamins were now included. A report on this would be presented at the next Committee meeting;
- Concern about the prolonged length of stay in the Emergency Department (ED) for two patients with mental health issues and their poor experience, which the COO would be looking into to identify what could be done to improve support and care for these patients whilst in ED awaiting onward placement;
- Noted the encouraging ongoing work around a revised approach to risk management;
- Reasonable assurance of the thematic reviews into never events;
- Progress on the management of deteriorating patient and having safe systems of care in place;
- Importance of embedding learning from SIs, with a lot of work to strengthen assurance.

The Board of Directors **NOTED** the 25 April 2023 Q&SC Chair Assurance Report.

23/025.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The NED FPC member, SC, on behalf of the FPC Chair highlighted key elements:

- 2022/23 year end position of £19.3m deficit (£19.3m adverse to the plan);
- Lessons learnt from 2022/23 Cost Improvement Programme (CIP), approach and next steps to meet the £40m 2023/24 target. The Committee needed to see details of the CIP schemes to understand the level of risk, areas covered and monitor feasibility of achievement at year-end;
- Significant areas of challenge to achieve the 2023/24 business plan that was approved, particular area of risk to deliver reduction in the number of Not Fit to Reside (NFTR) patients;
- Review of additional two risks to the risk register.

The Board of Directors **NOTED** the 4 May 2023 FPC Chair Assurance Report.

23/025.4 **INTEGRATED AUDIT & GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

The NED IAGC member, AC, on behalf of the IAGC Chair reported:

- Risk management and governance review, good engagement and discussions with Care Groups and staff to support this work;
- Internal audit reports, good progress reducing the number of long outstanding overdue management actions and implementation of actions. A lot of work undertaken in respect of Consultant job planning and having a robust system in place;
- Assurance from the Data Security and Protection Toolkit (DSPT) 2022/23 submission progress report;
- Approval of the Provider Licence annual statutory non-compliance declaration, that had been evaluated and was reflective of the Trust's NOF4 position;
- 2022/23 Quality Account Report would be presented to IAGC following presentation to the May 2023 Q&SC meeting;
- Timeline of the annual audit, on track for the submission of 2022/23 annual accounts on 30 June;
- Approval of the revised Standing Financial Instructions (SFIs) recommended to the Board for approval.

The Interim CFO provided assurance of weekly meetings with External Auditors to monitor progress of the annual audit and ensure the submission deadline was met.

DECISION: The Board of Directors:

- **NOTED** the 28 April 2023 IAGC Chair Assurance Report;
- **APPROVED** the Standing Financial Instructions.

23/026 **TRANSFORMING OUR TRUST: OUR RESPONSE TO *READING THE SIGNALS* – UPDATE**

The EMSSPD reported:

- A further meeting of the Oversight Group would be held the following Tuesday, with further discussion of the Terms of Reference and membership;
- Key element was the culture and leadership programme (CLP) to improve the culture, with a good session held at the April Board Development session with Professor Michael West.

The EDSDP stated once the assurance framework was finalised this would be shared with the Board.

The Chairman highlighted the importance of raising staff awareness of the culture transformation programme and their support was key in taking this forward. He thanked the EMSSPD and Sarah Shingler for all their support and work with the families.

The CMO commented it was vital to ensure any additional learning from the investigations.

The Board of Directors discussed and **NOTED** progress to date and key next steps.

23/027 **MATERNITY GOVERNANCE:**

23/027.1 **MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) REPORT: CHAIR'S ASSURANCE REPORT**

The Chairman reported this was the Interim DoM, Carol Drummond's, last Board meeting and thanked her for all her hard work and support. He welcomed the new Deputy DoM, Adaline Smith, and that the new DoM would be commencing later that month.

The Interim CNMO reported:

- The April meeting had been stood down due to lack of quoracy (impact of the junior doctors strike);
- Good discussions about the maternity dashboard and reformatting this incorporating statistical process control dashboard;
- Introduction of fortnightly forums with staff;
- Really good progress monitoring quality of environment and improving compliance, previous week 100% compliant achieved at WHH, QEQM compliant, with teams working hard to sustain improvements.

The Board of Directors **NOTED** the content of the MNAG Chair's Assurance report.

23/027.2 **PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT**

The Interim DoM reported:

- One Healthcare Safety Investigation Branch (HSIB) referral reported in April;
- Really positive response rate to Your Voice is Heard, 71.2% in March (increase from 70.1% in February);
- Patient experience midwives had produced a register of women and families who were supportive in working with the Trust around co-production;
- Next steps included the introduction of lunch and learning sessions with staff that were being well received.

The Chairman enquired about an average for HSIB referrals and the Trust's position in comparison with other trusts. The Interim DoM stated the Trust was not an outlier.

The NEDs questioned the number of women that went elsewhere to other NHS organisations for maternity services and not to East Kent Hospitals. The Interim DoM would check and confirm this information.

ACTION: Check and confirm the number of women that took the decision and went elsewhere to other NHS organisations to access maternity services and not East Kent Hospitals (their local NHS Trust). Include this information in the next Board report. — Interim CNMO

DECISION: The Board of Directors:

- **NOTED** the contents of the PQST report;
- **NOTED** the key risks**:** non-compliance with PRactical Obstetric Multi-Professional Training (PROMPT) for Anaesthetists;
- Received **ASSURANCE** and **NOTED** that a monthly perinatal quality assurance report had been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements;
- **APPROVED** for the contents of this report to be shared through the

Perinatal Quality Surveillance Model Framework with the Local Midwifery and Neonatal System (LMNS), Region and Integrated Care Systems.

23/027.3 **BI-ANNUAL MIDWIFERY WORKFORCE OVERSIGHT REPORT COVERING STAFFING/SAFETY ISSUES**

The Interim CNMO reported:

- The last full BirthRate+ review had been completed in 2020/21 and a further review was currently underway;
- To date 23 midwifery students had confirmed acceptances to stay with the Trust. Discussions with the university and Health Education England (HEE) to support delivery of the actions to move forward with the next intake of pre-registration students for midwifery;
- Sustained improvement in 1:1 care in labour;
- Delay to inductions of labour (not specific to East Kent) impacted by staffing/activity levels and working with clinicians to ensure safe care for women and their babies;
- International Day of the Midwife the following day, plans in place to celebrate this acknowledging the hard work and support of midwifery staff.

The Chairman asked about assurance that staff were raising concerns about staff numbers and any safety concerns. The Interim DoM reported the Trust's vacancy rate was not an outlier and was around 10%, with the majority at the WHH, noting current staff maternity leave absence and sickness absence that remained high but was beginning to reduce. Sessions with staff providing opportunity to raise any safety concerns.

The Board of Directors:

- **NOTED** the contents of the Midwifery Workforce report;
- **NOTED** the key risks**:** regarding staffing levels at WHH;
- Received **ASSURANCE** and **NOTED** that a bi-annual workforce update had been received, demonstrating full compliance in line with CNST standards.

23/028 **SAFEGUARDING ADULTS AND CHILDREN QUARTER 4 REPORT**

The Interim CNMO highlighted:

- Report provided an update and assurance of how Trust was meeting its statutory duties in respect of safeguarding;
- Training compliance levels was below the expected 85% and additional training sessions had been provided throughout the year;
- Continued multi-agency partnership working;
- Homelessness nurse continued to work across all sites supporting wards with challenging discharges;
- Continued focus ensuring safeguarding practices were being adhered to.

The Chairman enquired about assurance on progress and that the Trust was on track to sustain the improvements. The Interim CNMO commented a lot of work had been done to achieve improvements and that focus was now to ensure these were sustained and that safeguarding practices were business as usual. The Trust would be working closely with the Integrated Care Board (ICB) and region, in respect of solutions as these were part of partnership working.

The Board of Directors:

- **NOTED** the Safeguarding Adults and Children report and the key issues highlighted;
- **NOTED** assurance on the Q4 activities and the progress of the sustainability plan for safeguarding adults and children.

23/029 **INTEGRATED PERFORMANCE REPORT (IPR)**

Mortality (Hospital Standardised Mortality Ratio (HSMR))

The CMO reported on the aim to reduce mortality and be in the top 20% of all trusts for the lowest mortality rates in 5 to 10 years, against the threshold set for rolling 12 month HSMR to be below 90 by January 2027.

- Trust's position as a whole remained 'lower than expected', K&C (69.5), QEQM (88.8) and WHH (100.2) that was 'as expected' with further work to understand the reasons for this;
- Palliative care rate of 2.96% above the national average and peer rates;
- Sustained improved position in respect of the focussed intervention with the fracture neck of femur pathway.

Reduce Incidents with Harm

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

- 48 incidents in March, continued to be above the threshold.

The NEDs enquired whether a more detailed review was needed by the Board of incidents with harm, noting the Trust remained off its target, and for consideration when the new CNMO commenced. The Q&SC Chair commented that detailed discussions took place at the Q&SC meetings.

Patient Experience: Inpatient Survey

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

- Target of 2,050 surveys again exceeded, with 2,274 completed across 52 wards, with focus on actions to improve patient experience.

The NEDs quired the focussed 10 questions and whether these needed to be looked at to focus on the areas where improvements were not being made. The Interim CNMO reported the data helped the Trust to understand the actions taken that resulted in improvements. She noted there were no areas that were not covered as there were other methods to obtain feedback and intelligence on how the Trust was doing.

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

The COO reported:

- Need for urgent work to look at and review management of elective care and urgent care activity;

- 12h total time improved position in April from that in March;
- Cancer performance had improved significantly for March, and Trust remained in the top 3 performers nationally for 2-week wait access. Teams working closely to optimise the radiology diagnostic capacity in the Community Diagnostic Centre (CDC) to support faster and early diagnosis;
- NFTR patients at its peak in February of 437, had reduced to 408. This continued to be a challenge to reduce the numbers and was a priority to review and ensure the right plans were in plan.

The Chairman commented on the opportunity to present performance information in a different way, and queried how confident the Trust was that improvements set out in its improvement plans would be achieved. The COO commented it would be challenging supported through transformation work to increase and improve patient pathways, as well as looking at opportunities to do things differently.

The NEDs enquired how NFTR patients would be managed throughout the year to reduce these significant numbers. The COO commented management and monitoring of this would continue through the Emergency Care Delivery Board, around the actions required to address and reduce the numbers, with the opportunity to seek additional support from the centre. The CE stated ongoing work at system level to support reducing these numbers, as well as avoiding unnecessary admission to hospital, effective discharge, and the need for system support in delivering the Trust's IIP targets.

Staff Engagement: Staff Involvement Score

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

- Work currently taking place with Care Group staff involving them to identify key challenges and to 'change three things' with support to identify these priorities and respective action.

Financial Position (Income and Expenditure Margin) and Month 12 Finance Report

The Interim CFO highlighted key points:

- Delivery of £19.6m efficiencies, additional allocation of £10.7m non recurrent benefits;
- Total capital expenditure of £35.7m;
- Trust's cash balance would remain an area of focus;
- Review of bank, agency and overtime rates across all staff groups;
- Impact of increased substantive staff resources.

The NEDs highlighted the significant capital investment required for the Trust and the impact and challenges with the limited capital allocation for that year of £26m.

Carbon Footprint (CO2e)
Recruitment to Clinical Trials

The Interim EDSDP highlighted key points:

- Position below the monthly trajectory of 9.21 at 8.66 CO2e per m2, slightly higher than the same period the previous year of 7.7;
- Trust had submitted a bid for carbon reduction, awaiting outcome, Board would be updated at future meetings;
- March position of 99 participants in clinical trials, below the monthly

threshold of 123, however, full year position for 2022/23 exceeded with 1,879 (27% above full year plan) participants recruited. 2023/24 ambition currently being set with more focus on interventional studies.

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

- True North and Breakthrough Objectives of the Trust;
- Month 12 financial report, financial performance and actions being taken to address issues of concern.

23/029.1 **INTEGRATED IMPROVEMENT PLAN (IIP) REPORT**

NHSE's Improvement Director highlighted key points:

- IIP now reporting against its plan, rating against delivery milestones, trajectories and targets, which had been reviewed with the Executive Directors;
- Reporting on the impact would be on a quarterly basis to the Board, to be presented at its July meeting;
- The Strategic Improvement Committee established was crucial in monitoring progress, with focus on the right areas to ensure delivery of the IIP.

The Interim EDSDP reported:

- A robust clinical and corporate governance and accountability oversight framework would be presented to the Board once finalised;
- The Strategic Improvement Committee, chaired by the CE, would have oversight of progress across all six programme areas, with leads providing progress reports.

The NEDs enquired about staff involvement and engagement with this Committee, in co-designing improvements, that was key to successfully delivering the IIP, and the need to improve engagement with staff that had not been good previously. The Interim EDSDP confirmed Senior Responsible Officers (SROs) would attend meetings, with workstreams below the programmes that would involve staff across the organisation. The EDoC&E commented team briefs and all staff webinars in place to encourage staff involvement as well as support to managers in delivering the IIP. The CPO highlighted the Staff Committee in place that provided another engagement forum with staff.

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

23/029.2 **2023/24 PLANNING UPDATE**

The Interim CFO reported:

- 2023/24 business plan would be submitted that day;
- Key activity challenges:
  - Reduce the number of NFTR patients;
  - Increase elective programme;
  - Reduce the financial deficit;
  - Achieving the £40m CIP target.
- Detailed discussion of the plan had been held at the Closed BoD meeting that morning.

DECISION: The Board of Directors reviewed the proposed 2023/24 plan including

the key risks and issues, and **APPROVED** the outline plan and next steps.

23/030 **BOARD ASSURANCE FRAMEWORK (BAF) RISK REGISTER**

The CE noted the BAF presented and the work on the IIP, alignment to the strategic and annual objectives and Pillars of Change, and the need to review the current BAF and assess the risks against the strategic and annual objectives.

ACTION: Review and reassess the current BAF, its contents and the risks, assessing the risks against achievement of the strategic annual objectives and the IIP over the next 12 month period. — CE/ Executive Team

The Board of Directors **NOTED** the latest update of the BAF.

23/031 **FREEDOM TO SPEAK UP (FTSU)**

The Lead FTSU and Maternity FTSU Guardians highlighted key points:

- Identified drop from the previous year, staff felt less able to speak up and less confident that their concerns would be addressed. There would be focus on rebuilding trust to create a psychologically safe environment to speak up, as positive culture to speak up was the responsibility of every member of staff. This would be supported by staff completing the three mandatory e-learning training modules (one module for every staff member, one module for those that managed staff, and one for staff bands 8 and above). Asked Board members who had not yet completed this e-training to do so;
- New FTSU Policy now in place;
- New leadership programme implemented, as well as listening events with staff;
- Working collaboratively with the People & Culture (P&C) and Patient Safety teams around a multi-disciplinary strategic approach to achieve changes and improvements;
- New staff Connectors whose role was to support and signpost staff to access support promptly;
- Continued focus to improve openness and transparency.

The Chairman enquired about the reasons for the drop in staff confidence to speak up. The Maternity FTSU Guardian reported that the Kirkup report had had an impact on the confidence of staff to speak up, noting 62% of midwives felt confident to speak up and raise issues, although only 15% felt the Trust would take action.

The CPO highlighted it was important to note staff felt much more able to report clinical concerns as opposed to anything that concerned them.

The CMO reported it was positive to see moving from a reactive approach to a proactive approach, and enquired about the areas of proactive focus to achieve the most benefit for staff. The Lead FTSU Guardian stated the data from the National Staff Survey results would be reviewed, drilling down into how each team were feeling. As well as working collaboratively with the P&C team to triangulate the rich source of data available from staff.

The NEDs asked whether staff on the front line felt there had been a step change since the publication of the Kirkup report. The Maternity FTSU Guardian explained she felt staff had wanted to see changes and issues resolved immediately following the report publication, they recognised things had changed and changes continued. A comprehensive improvement programme was being implemented with engagement from staff, concerns remained about staffing resources that continued

to be raised and communication had improved keeping staff updated on the work to recruit staff. The NEDs requested it would be beneficial to receive a report after 12 months following the publication of the report to review and evaluate the changes and improvements implemented, the impact and outcome of these on women, the service and its staff, as well as feedback from staff about how they felt working in maternity services.

ACTION: Present a report to the Board in November 2023 (12 months following the publication of the Kirkup report) providing a review and evaluation of the changes and improvements implemented, the impact and outcome of these on women, the service and its staff, along with feedback from staff about how they felt working in maternity services and what had changed and made a real difference for them. — Interim CNMO

The Associate NED enquired if a midwifery student raised concern whether this was shared and made aware to the university. He also highlighted the importance of ensuring a route to encourage and capture medical students feedback. The Maternity FTSU Guardian stated there had not been a case as yet and confirmed that any concerns would be shared with the appropriate stakeholders.

The Chairman enquired whether there was anything more the Trust could be doing that other trusts were around improving speaking up. The Lead FTSU Guardian reported monthly meetings were held with regional colleagues to share how organisations were working. She noted the extensive resources available in the Trust and the main element was around provision of 1:1s with staff providing the opportunity for them to speak up and raise concerns locally with their line managers.

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

23/032 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/033 **QUESTIONS FROM THE PUBLIC**

Ms Heggie enquired about the categorisation of patients NFTR, and whether this was due to not having appropriate care packages or placements available enabling them to be discharged. She also enquired whether there estimated discharge time was recorded on the patient health record on admission. The COO stated the main challenges enabling patients to be discharged, were the shortage of availability of nursing home care provision and patients awaiting packages of care, that were complex.

Ms Heggie asked for an update on what was happening to ensure the Harmonia Village would be open to accept residents. The EDSDP reported the Trust was working with a provider who managed residential people living with dementia who required CQC registration for Harmonia, which had now been granted. He confirmed progress was being made and the first residents were expected to be received in June. Mrs Mayall enquired whether the provider would be open to working with and involving the public Governor for Dover. The EDSDP commented that this would be discussed outside of the Board meeting with the provider.

Mrs Warburton raised the issue of poor levels of achieving appraisals that had been an ongoing issue at the Trust, which had also been raised by the Care Quality Commission (CQC). She emphasised it was vital in the environment of low staff morale and poor culture that staff had the allocated time to complete their appraisals and have protected time to have discussions with their line managers

about their training needs, and provide the opportunity to raise any issues or concerns. She would like to see commitment and focus to improve the appraisal rates and that 1:1 meetings were held. The CPO agreed it was important that appraisals took place, with these as a area of focus raised at the Performance Review Meetings with Care Groups that these were taking place, she noted levels were increasing. The HR Business Partners were also undertaking spot checks to review the quality of appraisals undertaken.

Mrs Warburton acknowledged and thanked the Interim DoM for her hard work and support recognising the improvements implemented in maternity services and the changes that she had helped to achieve.

Ms Heggie made a comment about cases she had been made aware of in respect of increases in cases of capability, that reasonable adjustments were not being made for staff and the aim to dismiss staff.

Ms Bonney asked how many staff within the maternity services had received their annual appraisal. She highlighted the importance of performance managing staff that were underperforming and that appraisals were vital in supporting this process. The CPO agreed to check and confirm the numbers of those that had received appraisals.

ACTION: Check and confirm the number of staff (percentage of staff) in maternity services that had received appraisals. — CPO

The Chairman closed the meeting at 4.00 pm.

Date of next meeting in public: Thursday 1 June 2023

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 4 MAY 2023**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.				
Summary of Key Issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** the action log and updates from the actions from the previous meeting, **NOTE** the actions for future Board meetings and **APPROVE** the three actions for closure.				

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

Link to the Board Assurance Framework (BAF):	None	
Link to the Corporate Risk Register (CRR):	None	
Resource:	Y/N	N
Legal and regulatory:	Y/N	N
Subsidiary:	Y/N	N
Assurance Route:		
Previously Considered by:	N/A	

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 4 MAY 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.

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/14/22	Undertake a repeat analysis in March 2023 of the impact of We Care on staff engagement levels on the data provided by the National Staff Survey 2022 and National Quarterly Pulse Survey (NQPS) Quarter 4.	~~Apr-23~~/ ~~May-23~~/ Jun-23	Chief People Officer (CPO)	To Close	The repeat analysis of the impact of We Care on staff engagement levels cannot yet be provided, as awaiting this data expected mid-April, that would then be reviewed and reported to Board. We Care Progress update -2023 report presented to 01.06.23 Board meeting. **Action for agreement for closure at 01.06.23 Board meeting.**
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	~~Feb-23~~/ Oct-23	Integrated Audit and Governance Committee (IAGC) Chair/ Group Company Secretary	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.
B/23/22	Present a progress update briefing to a future Board meeting on progress and	~~Jun-23~~/ Jul-23	Chief Medical Officer (CMO)	Open	Item for future Board meeting.

	the position of the diabetes work and the system working around this area.				
B/25/22	Raise with HCP the importance of improving EoL palliative patient pathways, to ensure patients died in their preferred place and that continued focussed discussions took place to address and improve this area.	~~Jun-23~~/ Jul-23	Chief Medical Officer (CMO)	To Close	Raised to the HCP Quality Chair to take forwards. **Action for agreement for closure at 01.06.23 Board meeting.**
B/26/22	Look into the delays in being assessed within the ED or being admitted to a ward, the outcome of the deep dive review, and provide details and data on the impact of these delays in the next report to be presented to the Board.	Jun-23	Chief Medical Officer (CMO)	To Close	Update within the Learning from Deaths Quarterly report presented to 01.06.23 Board meeting. **Action for agreement for closure at 01.06.23 Board meeting.**
B/01/23	Present report at the June meeting on the transformation work, covering the ED phased building works, evaluating the success of the changes in ED, the impact of the building works, management of patient flow, rapid assessment areas with reduced bed numbers, patient pathway (alternative pathways) and managing demand.	~~Jun-23~~/ Jul-23	Chief Operating Officer (COO)	Open	Item deferred from June 2023 to presentation to July 2023 Board meeting.

B/02/23	Check and confirm the number of women that took the decision and went elsewhere to other NHS organisations to access maternity services and not East Kent Hospitals (their local NHS Trust). Include this information in the next Board report.	Jun-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 01.06.23 Board meeting.
B/03/23	Review and reassess the current BAF, its contents and the risks, assessing the risks against achievement of the strategic annual objectives and the IIP over the next 12 month period.	Sep-23	Chief Executive/ Executive Team	Open	Item for future Board meeting.
B/04/23	Present a report to the Board in November 2023 (12 months following the publication of the Kirkup report) providing a review and evaluation of the changes and improvements implemented, the impact and outcome of these on women, the service and its staff, along with feedback from staff about how they felt working in maternity services and what had changed and whether had made a real difference for them.	Nov-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.
B/05/23	Check and confirm the number of staff (percentage of	Jun-23	Chief People Officer (CPO)	Open	Verbal update to be provided at 01.06.23 Board meeting.

	staff) in maternity services that had received appraisals.				

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHAIRMAN'S REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHAIRMAN**				
PAPER AUTHOR:	**CHAIRMAN**				
APPENDICES:	**APPENDIX 1: NON-EXECUTIVE DIRECTORS' COMMITMENTS**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.				
Summary of Key Issues:	Update the Board on: • Current Updates/Introduction; • East Kent Health and Care Partnership (HCP) Board; • Activity of the CoG; • Visits/Meetings.				
Key Recommendation(s):	The Board of Directors is requested to **NOTE** the contents of this Chairman's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	~~Y~~/N	N			
Legal and regulatory:	~~Y~~/N	N			
Subsidiary:	~~Y~~/N	N			
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

The latest Care Quality Commission (CQC) inspection reports into our maternity units which rated our service as inadequate underlines just how much we still need to do if we are to take maternity, and indeed all our services, to Good and Outstanding. We have accepted in full the failings identified by the inspectors. I am confident that the immediate measures demanded of us have been robustly implemented and we continue to work closely with the CQC. We also continue to work closely with NHS Kent and Medway Integrated Care Board (ICB), NHS England (NHSE) and our Local Maternity and Neonatal System (LMNS) to continue to drive improvements and provide safe services and a positive experience for families. Although the vast majority of those who use our services are positive about their experience, at the same time, we must use the serious and justified criticism to learn and improve.

However, it would be wrong of us to blame our staff for this. Indeed, in marked contrast to the Independent Investigation, the inspectors found that our staff worked well together and treated women with compassion and kindness. I believe we have skilled, dedicated and committed obstetricians, midwives as well as other professional and support staff who are committed to turning this around and who, with the right support and training, can do this. We are fortunate in having just recruited a new Director and a new deputy Director of Midwifery who have joined us from an Outstanding Trust. On my visit to the units a few days ago it was clear they had already begun to make their mark.

The CQC reports did recognise we are on an improvement journey and we are all agreed that if we are to deliver the changes needed, we will need to work with and alongside our front-line staff. Both reports also repeatedly pointed out that the facilities in which staff worked and in which women were treated were inadequate – this is not an excuse for the other failings that were identified but it echoes what we have said on many occasions and we must now redouble our efforts to seek the capital funds that will enable us to provide a modern and safe clinical environment for the benefit of women and their families and the staff who are caring from them.

The CQC reports have also highlighted concerns around governance and the ability of the Board to make judgements about assurance on the information it receives. We have started to review our governance arrangements and will scope how we can commission an external review to assess the strengths and weaknesses of the current arrangements for clinical and corporate governance and act on any recommendations for reforms that may be needed.

As Tracey's report explains, we have also recently had an unannounced CQC inspection into some of our other services and we await their feedback. The Board is focussed on delivering the specific objectives in our Integrated Improvement Plan (IIP). None of us on the Board have any doubt that delivering the Plan will be a significant challenge but it is one we must do everything we can to meet and be absolutely clear where we are and are not making progress.

External scrutiny and criticism can create uncertainty and anxiety among staff and patients. At East Kent Hospitals there may also be a feeling among some that 'we have heard all this before' and we have to recognise that many staff and indeed patients will not recognise their

own or their team's experience or practice in the ongoing negative coverage. So, there is a difficult balance to be struck – we need to reassure and celebrate the many things we are doing well, but accept that every one of us has a part to play in transforming the organisation and the care we provide.

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

The East Kent Health and Care Partnership has continued to work on the delegation of key responsibilities from NHS Kent & Medway (the ICB). The agreement for all of the local Partnerships state that Partnerships will:

- Work towards becoming integrated care organisations over the next 5 years;
- Commission and deliver at place level activities that address the wider determinants of health;
- Develop a compelling and widely owned vision for tackling health inequalities;
- Join up commissioning and planning functions;
- Develop asset-based approaches which build on the strengths of their communities;
- Invest in systems leadership, developing a collaborative approach to leadership.

The East Kent Partnership Board will become a formal sub-committee of NHS Kent & Medway, and will have responsibility for overseeing the delivery and impact of the delegated responsibilities. NHS Kent and Medway are expecting to sign-off a final Delegation Memorandum of Understanding in July.

The East Kent Partnership has also agreed its strategic priorities for the current year, which include:

- Continuing to build an **integrated partnership**;
- Developing **integrated neighbourhood teams**;
- Improving **urgent and emergency care and discharge** pathways;
- Working together to tackle **workforce** pressures;
- Ensuring **equal parity of mental and physical health** in line with population needs.

At its latest meeting in May, the partnership Board received updates from its Health & Care Delivery Committee, Clinical Cabinet, the Voluntary and Community Alliance, and the Wellbeing and Health Improvement Partnership.

The Board also received presentations showcasing innovative projects which have been driving service integration. These included:

- Home & Well Service – a pilot project delivered by the voluntary sector to support hospital discharge – the service was mobilised in 2 weeks and has supported 207 patients over winter.
- Rapid Discharge service - delivered by Kent Community Health NHS Foundation Trust – this service has placed 361 patients in Community Assessments Beds between February and April which resulted in savings of more than £2.5m over the 3-month period.
- Healthwatch Kent's analysis of voluntary sector work to support people from Folkestone's Nepalese community to get online and improve digital skills.

As the Partnership develops with its delegated responsibilities, it should enable further service integration.

4. Council of Governors (CoG)

Public Governor elections have been held for the vacant seats in Canterbury and Folkestone/Hythe. The only vacant seats on the Council are in Thanet and Rest of England. The Council of Governors meeting was held on 27 April, with discussions around *Reading*

The Signals, the National Staff Survey and Harmonia. The next meeting will be held on 13 July.

Joint site visits have taken place at Kent & Canterbury Hospital, where the team visited the Stroke Unit and Mc Master ward. Alongside a visit to William Harvey Hospital where Same Day Emergency Care, Acute Medical Unit, Medical Assessment Unit, Emergency Department and the CT unit were visited.

I am pleased to report that following the annual Lead and Deputy Lead Governors nominations, our Lead Governor Bernie Mayall has been returned unopposed and, following an election, Carl Shorter has been re-elected as Deputy Lead Governor.

5. Visits/Meetings/Talks

In addition to routine internal and external meetings:

- Addressed Trust welcome day for new starters in Canterbury
- Visited clinical staff and toured facilities in:
    - Frailty services at Queen Elizabeth the Queen Mother Hospital (QEQM)
    - Paediatrics at Queen Elizabeth the Queen Mother Hospital (QEQM)
    - Maternity services at Queen Elizabeth the Queen Mother Hospital (QEQM)
    - Maternity services at William Harvey Hospital (WHH)
- Meetings with individual Governors
- Meetings with individual NEDs
- Meeting with all NEDs
- Introductory meeting with the new Interim Chief Nursing and Midwifery Officer (CNMO)
- Meetings with Executive Directors
- Meetings with the Chief Executive Officer (CEO)
- End of year review with the Chief Executive Officer (CEO)
- Meeting with 2gether Support Solutions (2gether) Chair
- Appraisal with 2gether Support Solutions (2gether) Chair
- Meeting with Spencer Private Hospitals (SPH) Chair
- Appraisal with Spencer Private Hospitals (SPH) Chair
- Meeting with East Kent ICB Chair & Chief Executive Officer
- Spoke at the NHS Providers Governor Focus Conference

East Kent Hospitals University NHS Foundation Trust

Non-Executive Directors' (NEDs) Commitments

NEDs May 2023 commitments have included:

Non-Executive Directors	Meetings with Chairman Meeting with Chairman, Chief Executive and Governance Lead Finance and Performance Committee (FPC) meeting Quality and Safety Committee (Q&SC) meeting People and Culture Committee (P&CC) meeting Organ Donation Committee meeting Joint NED/Governor Site Visit to Kent and Canterbury Hospital Spencer Private Hospitals (SPH) Board meeting SPH Nominations and Remuneration Committee meeting Introductory meeting with NHS Kent and Medway Audit Committee Chair

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF EXECUTIVE (CE)**				
PAPER AUTHOR:	**CHIEF EXECUTIVE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.				
Summary of Key Issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.				
Key Recommendation(s):	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.				
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

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

2. Background

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

3. Clinical Executive Management Group (CEMG)

No Business Cases were approved or considered by the CEMG at meetings held in May 2023. The Group did, however, ratify the Health Records Policy and Clinical Record Keeping Standards and approve an Advice and Guidance Standards Standard Operating Procedure (SOP), a collaborative agreement for standards delivered by GPs and the Trust when responding to advice and guidance requests.

4. Operations update

4.1 Urgent and Emergency Care (UEC) Performance

In April 2023 the Trust reported an improvement in the number of patients spending more than 12 hours in the Trust's Emergency Departments (EDs) - a Trust wide improvement of 12.4% in March 2023 to 10.4% in April 2023. Whilst it is recognised that this performance remains some way off the national ambition of 2%, the improvements in this position can be tracked through to changes made to emergency pathways at the William Harvey Hospital (WHH).

The team at the WHH commenced a number of key initiatives in April to mitigate the loss of clinical capacity; the implementation of a Medical Assessment Unit (MAU) and a short-stay Acute Physician led department, taking 65% of the medical take away from the ED.

The impact of the changes to the clinical model at the WHH are demonstrated by an improved 12-hour position from 18.2% in March 2023 to 13.8% in April 2023 for the WHH site. Furthermore, the site's reported performance for compliance with the 4-hour standard for all Types is at 62.0% and for Type 1 at 47.8%; the best reported position since January 2022.

4.2 Emergency Department (ED) Build Progress

The team at Queen Elizabeth the Queen Mother Hospital (QEQM) are establishing a programme of work in readiness for their Phase 3 build which will begin in June 2023 and will see a reduction in majors' space. These plans aim to mirror changes made to the clinical model and pathways at the WHH, as reported above. Leads from QEQM ED, Care Groups and the Health and Care Partnership (HCP) have established plans ahead of the phase 3 build, with a focus on mitigating the loss of care spaces, which includes a review of the Same Day Emergency Care (SDEC)

medical model to ensure full optimisation of the service with the aim to increase the number of patients directed to the service.

4.3 Elective

As outlined in last month's report, detailed activity plans have been submitted to NHSE outlining the planned volumes of activity the Trust will deliver in 2023/24. This planned activity has been developed with two key criteria at its core:

- Maintaining the size of the Trust's elective waiting list.
- To meet the target of zero patients waiting 65 weeks for their treatment by year end 2023/24.

In order to ensure focus on the delivery of activity and alignment to the set activity targets, the Trust has recently established weekly Planned Care Oversight meetings with each of the Care Groups. These sessions, chaired by the Chief Operating Officer, will review performance against plan by specialty. The Care Groups have been asked to articulate the estimated forecast position against plan over the forthcoming months, to outline mitigations to address any shortfalls and highlight key risks to delivery.

The outcome of the actions agreed at these sessions will be monitored through the monthly Planned Care Improvement Group (formerly the Elective Care Delivery Group) whereby the action plans and progress against the agreed actions are observed and discussed. The outcomes from the Planned Care Improvement Group will report directly to the CEMG.

5. Finance Update

5.1 Financial performance and planning 2023/24

At the end of M1 (April) 2023 the Trust delivered a small deficit of £0.4m against plan with elective and outpatient activity lower than the Trust's activity plan.

As reported previously, the Trust has continued to work closely with Kent and Medway system partners to resubmit a stretch plan for the 2023/24 financial year.

The plan, a deficit position of £71.8m, which was accepted by the Integrated Care Board (ICB) earlier this month, is based on a higher level of activity, will require delivery of £40m of efficiency savings and working capital support from NHSE.

Care Group and Corporate teams will be supported by the Programme Management Office (PMO) to develop a pipeline of ideas focussed on cross-cutting themes, with a "thinking Outside the Box" group established. Notable areas of focus for the 2023/24 efficiency programme will include high cost medical agency, low contribution services and productivity through theatres, outpatients, and virtual wards.

6. Care Quality Commission (CQC) – Maternity Services report

The Care Quality Commission (CQC) published its reports into inspections in January at QEQM and WHH maternity units.

Despite the commitment and hard work of our staff, the CQC found that the Trust was not consistently providing the standards of maternity care women and families should expect. The service was downgraded to inadequate.

We acted on the immediate areas of concern highlighted in January and progress on this will be discussed today and is reported in today's Board papers.

We are committed to giving both the women and families using our service and the CQC confidence in the quality and safety of our care.

The CQC reports recognised the compassion and kindness staff have shown to women and families and the outstanding practice of the service in proactively listening to and seeking feedback from every person who gives birth with us about what we can improve.

We recognise that, despite the changes that have been made to the service so far, there is a lot more to do to ensure we are consistently providing high standards of care for every family, every time.

Earlier in May, myself, the Chief Medical Officer, previous Interim Chief Nursing and Midwifery Officer and Interim Director of Midwifery attended Kent County Council's (KCC's) Health Overview and Scrutiny Committee to update them and answer questions about the improvements the maternity team have been making, how we are responding to feedback from women and families and how we have responded to the CQC's initial findings.

The Committee agreed it would formally support our request for much needed national capital investment to improve the environment for women, families and staff in both units.

7. Care Quality Commission (CQC) - Urgent Care, Medical, including services for older people, and Children and Young People's services

An unannounced inspection was conducted by the CQC of the Trust's Urgent Care, Medical and Children and Young People's services at the William Harvey and QEQM hospitals on 17 & 18 May 2023.

Initial feedback received from the CQC was limited although this has been followed up with concerns raised about the number of paediatric nurses employed at William Harvey Hospital, the number of Consultants in Emergency Medicine at QEQM and regarding the handover arrangements at William Harvey hospital. A response to the areas of concern highlighted by this initial feedback has been made by the Trust in line with the CQC process.

A proactive set of actions have been taken to address the concerns raised, whilst we will continue to provide any further evidence should that be requested by the CQC in advance of any further feedback and their report being published.

8. Conclusion

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**SECTION 31 (S31) REPORTING: MATERNITY & MIDWIFERY SERVICES WILLIAM HARVEY HOSPITAL (WHH) & QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQM)**
MEETING DATE:	**1 JUNE 2023**
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER AND EXECUTIVE/BOARD MATERNITY AND NEONATAL SAFETY CHAMPION**
PAPER AUTHOR:	**ACTING OPERATIONS DIRECTOR WOMEN'S HEALTH CARE GROUP**
APPENDICES:	**APPENDIX 1: CARE QUALITY COMMISSION (CQC) ACTION PLAN** **APPENDIX 2: S31 SUBMISSION RESPONSE FOR WHH AND QEQM APRIL 2023 (FEBRUARY AND MARCH PROVIDED IN READING ROOM)**

Executive Summary:

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

Purpose of the Report:	**CQC Reference: RGP1-15004847857 (QEQM) RGP1-15003286303 (WHH)** This paper has been prepared to summarise the response to the letter dated 13 February 2023 received from the Director of Operations South, at the CQC, in relation to the regulated activity maternity and midwifery services, at WHH.

Summary of Key Issues:

As reported in the March return, an issue was identified around how the results of the daily quality rounds were collated. Since the last report, the team have worked to clearly define what is required for the following criteria:

- Neonatal resuscitaires.
- Equipment safety checks.

Following discussions with the resuscitation team and also comparing with other maternity departments, the decision was taken that the standard for the checks would be as follows:

- Neonatal resuscitaires – checks to be undertaken twice daily on labour ward and minimum of daily on the postnatal ward.
- Equipment safety checks, including adult resuscitation trolley – checks to be undertaken daily.

It was clear that in calculating the compliance with the daily equipment checks there was confusion in terms of numerators and denominators. This has taken longer than expected to conclude, but now the daily sheets that collate all the results of the individual checks can be used to calculate compliance. The daily sheets for the week ending the 21 April were included in the April's submission to provide assurance of this process.

Determining the denominator for daily equipment checks has been agreed at local level by unit with each Head of Midwifery.

Key Recommendation(s):	The Board of Directors is asked to **NOTE** the content of this report and refer to the CQC S31 submission reports for both WHH & QEQM with the evidence data.			
Implications:				
Links to 'We Care' Strategic Objectives				
Our patients (women and Families)	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.			
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.			
Resource:	**No**			
Legal and regulatory:	**Yes:** Clinical Negligence Scheme for Trusts (CNST), NHS Long Term Plan-standard contract			
Subsidiary:	**No**			
Assurance Route:				
Previously Considered by:	**N/A**			

Section 31 reporting: Maternity & Midwifery services William Harvey Hospital (WHH) & Queen Elizabeth and Queen Mother Hospital (QEQM)

1. The purpose of report

1.1 To provide an update on the progress of response to the section 31 concern raised by the Care Quality Commission (CQC).

1.2 To provide clarity to the Board on the compliance against the requirements.

2. Evidence of systematic implementation for submission:

The Senior Midwifery team (Director of Midwifery, Heads of Midwifery and Matrons) implemented a systematic approach on the 19 January 2023 to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM. The process includes:

- Daily rounds by the matron or Band 7 ward manager which commenced on the 19 January 2023 to ensure compliance with equipment checks for emergency equipment and resuscitaires in the previous 24 hours. During these rounds the environment is checked for general cleanliness as well as ensuring there is no blockage to fire egress routes. Any issues are dealt with immediately.

- Formal joint weekly Infection, Prevention and Control (IPC) rounds, supported by a Standard Operating Procedure (SOP), with a matron or the Head of Midwifery commenced on the 19 January 2023. This is a 3-hour audit and incorporates:

  - Cleanliness of all general, clinical and sanitary areas as well as clinical equipment and soft furnishings.
  - Issues identified are actioned at the time and conversations where necessary take place.

3. Summary of key points:

CQC Reference: RGP1-15004847857 (QEQM)

Daily Checks:

The table below summarises the results of the daily checks for:

- Environmental
- Hand Hygiene
- Personal Protective Equipment (PPE)
- Neonatal Resuscitation
- Equipment identified as requiring daily safety checks.

Areas improved / meeting compliance targets:

QEQM Hospital Maternity							
Metric	**Frequency**	**Target**	**24/3/23**	**31/3/23**	**6/4/23**	**14/4/23**	**21/4/23**
Weekly Environmental Audit	Weekly	**95%**		93.3%	99%	99%	98%

Kingsgate							
Weekly Environmental Audit Labour Ward	Weekly	**95%**	97.8%	94.4%	97%	98%	97%
Weekly Environmental Audit MLU	Weekly	**95%**			100%	100%	100%
Daily Equipment Safety Checks Labour ward	Daily	**100%**	85.71%	85.71%	100%	100%	100%
Daily Equipment Safety Checks Kingsgate	Daily	**100%**	92.85%	71.42%	100%	100%	100%
Daily neonatal Resuscitaire safety checks Labour ward	Twice Daily	**100%**	96.4%	94.7%	100%	100%	100%
Daily Resuscitaire safety checks Kingsgate ward	Twice Daily	**100%**	92%	92%	100%	100%	100%
Hand Hygiene – 5 audits completed each day	Daily	**100%**	100%	100%	100%	100%	100%
Hand Hygiene – audit results	Weekly	**90%**	97.2%	95.7%	95.2%	100%	100%
PPE compliance	Weekly	**90%**	100%	100%	100%	100%	100%

Areas deteriorating against target compliance:

Metric	Frequency	Target	24/3/23	31/3/23	6/4/23	14/4/23	21/4/23
Weekly Environmental Audit Triage				Initial audit deep dive not scored	88.9%	88.9%	89%

Key

Results not available	
Target met	
Up to 10% below target	
Greater than 10% below target	

Medical devices:

The table below shows the service status of all medical devices at QEQM based on the assigned risk level of each device:

Total No of devices:	**387**		**Site:**	**QEQM**
Risk Level	In service date	Due service in < 30 days	Overdue service	Total
Very High	16	3	0	19
High	64	1	7	72

Medium	77	3	16	96
Low	145	25	30	200
Total	302	32	53	387
%	**78%**	**8%**	**14%**	**100%**

Currently, 86% of medical devices at the QEQM are within service date with 14% identified as being overdue the planned preventative maintenance (PPM) date

One of the overdue 'high' risk devices is currently in the Electronics and Medical Engineering (EME) workshop for planned maintenance, another of these devices has not been seen on the ward since 2021 so needs to be reallocated / updated on the Trust's asset register. Nine of the overdue 'medium' risk devices are in EME workshop or sent to manufacturer for repair. A detailed list of all items of equipment that are beyond their planned preventative maintenance (PPM) date has been shared with the local Maternity management team so that to ensure they are aware of the asset numbers of any devices beyond their PPM date to take them out of use on the Maternity unit, whilst booking in the maintenance and planning for temporary replacement devices.

CQC reference: RGP1-15003286303 (WHH)

Daily Checks:

The table below summarises the results of the daily checks for:

- Environmental
- Hand Hygiene
- PPE
- Neonatal Resuscitation
- Equipment identified as requiring daily safety checks

Areas improved / meeting compliance targets:

William Harvey Hospital Maternity							
Metric	**Frequency**	**Target**	**24/3/23**	**31/3/23**	**6/4/23**	**14/4/23**	**21/4/23**
Daily Equipment Safety Checks Labour ward	Daily	**100%**	93.1%	82.7%	100%	100%	100%
Daily Equipment Safety Checks Folkestone ward	Daily		88%	85.7%*	85.7%*	100%	100%
Daily neonatal Resuscitaire safety checks Labour ward	Twice Daily	**100%**	100%	100%	100%	100%	100%
Daily Resuscitaire safety checks	Twice Daily	**100%**	100%	78.5%*	78.5%*	93%	100%

Folkestone ward							
Hand Hygiene – 5 audits completed each day	Daily	**100%**	100%	100%	100%	100% (20)	Not completed
Hand Hygiene – audit results	Weekly	**90%**	100%	100%	100%	100%	N/A

Areas deteriorating against target compliance:

Metric	Frequency	Target	24/3/23	31/3/23	6/4/23	14/4/23	21/4/23
Weekly Environmental Audit: Folkestone	Weekly	**95%**	88%	89%	93%	91%	93%
Weekly Environmental Audit: Labour Ward	Weekly	**95%**	90%	90%	93%	93%	94%
Weekly Environmental Audit: Triage					89%	90%	91%
PPE compliance	Weekly	**90%**	100%	100%	86.7%	80%	80%

Key

Results not available	
Target met	
Up to 10% below target	
Greater than 10% below target	

Prior to the week ending the 6 April 2023, triage environmental audits were included as part of Folkestone ward. These audits are now separated.

*Sheets with details of neonatal resus and daily equipment checks for Folkestone Ward (FW) missing for 30/3 & 31/3 so unable to validate checks. All other days fully compliant.

PPE compliance – issues with bare below elbow for individuals visiting unit. Relevant departments contacted and reminded regarding requirements.

Fresh Cares Daily Audit WHH 27 March to 21 April 2023

For the week ending 21 April 2023 compliance had significantly improved for hourly fresh eyes being undertaken, as shown in the table below:

William Harvey Hospital Maternity							
Metric	**Frequency**	**Target**	**24/3/23**	**31/3/23**	**6/4/23**	**14/4/23**	**21/4/23**

Fresh Eyes – Completed Hourly (Up to 5 sets of notes)	Daily	**85%**	81%	79%	72%	81%	86%
Two signatures on CTG sticker		**85%**	77%	65%	63.7%	76%	86%
Two signatures on CTG trace		**85%**	70%	55%	53.1%	64%	81%

In addition to the daily checks of hourly fresh eyes and cardiotocography (CTG) recording, audits have been completed throughout March and April 2023, with results shared as below. The plan for April has been to audit 2-3 sets of notes per week throughout the month, with the aim of auditing 10 sets of notes per week by the end of the month:

Triage activity:

The table below summarises the triage activity and performance metrics for March-April 2023.

Criteria	**March 2023**	**01.04.23 to 19.04.23**
Attendances	903	580
BSOTS Red RAG	5	8
BSOTS Orange RAG	222	135
BSOTS Yellow RAG	330	91
BSOTS Green RAG	138	207
BSOTS N/A	205	138
BSOTS not recorded where applicable	8	1

WHH 6A Triage Audit Data Collection - April 2023.

There were 6 delays in transferring women from Triage. The data shows the time delays as well as the reason for admission for each woman. The Head of Midwifery and Matron for the unit are working with the Band 7 Coordinators to ensure improved oversight of Triage activity to manage flow and reduce delays.

Month	**Seen within 15 min by Midwife**	**Seen within required time by Dr**
March 2023	98.3%	92.4%
April 2023	99.1%	86.3%

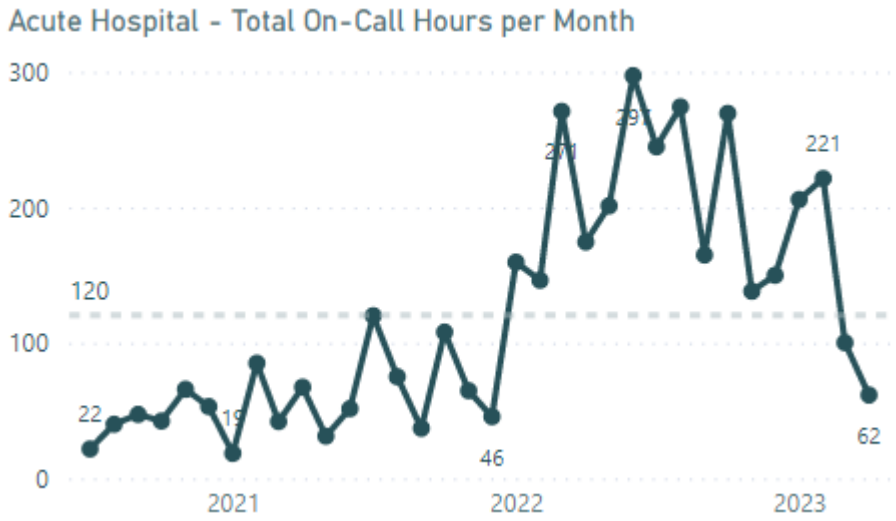
The midwifery staffing template for Triage is currently:

Shift	**Telephone triage**	**Clinical triage**
Day	1	2
Night	1	1

The results of the Triage performance is reported through Maternity and Neonatal Assurance Group (MNAG). Unfortunately, due to non-quoracy for the April meeting that was subsequently postponed, this review will be completed in May 2023.

Staffing:

The on-call midwife should only be called in to support where activity is such that 1:1 care cannot be provided safely. The weekly graph below shows the trends for the use of on call midwives for the WHH up to the 21 April 2023. The total number of on-call hours is down from 221 in February 2023 to 62 in April 2023:



The Maternity Service has deployed the Birthrate Plus (BR+) acuity tool, which includes a number of 'red flags' as part of a safer staffing methodology. Compliance with recording the acuity on a 4-hourly basis needs to meet a threshold of 80% for data validity. For WHH, there is a known non-compliance so as part of the Maternity improvement agenda this is monitored through the MNAG within the Maternity Dashboard.

Compliance with recording of Birthrate+ for the period 27 March to 21 April 2023:

- WHH Labour Ward = 76.3%
- WHH Folkestone Ward = 33.3%

Gaps in the midwifery rota are monitored on a shift by shift basis and actions are determined aligned to activity and acuity. The escalation policy is utilised appropriately with on-call midwives being used as well as unit diverts activated where required.

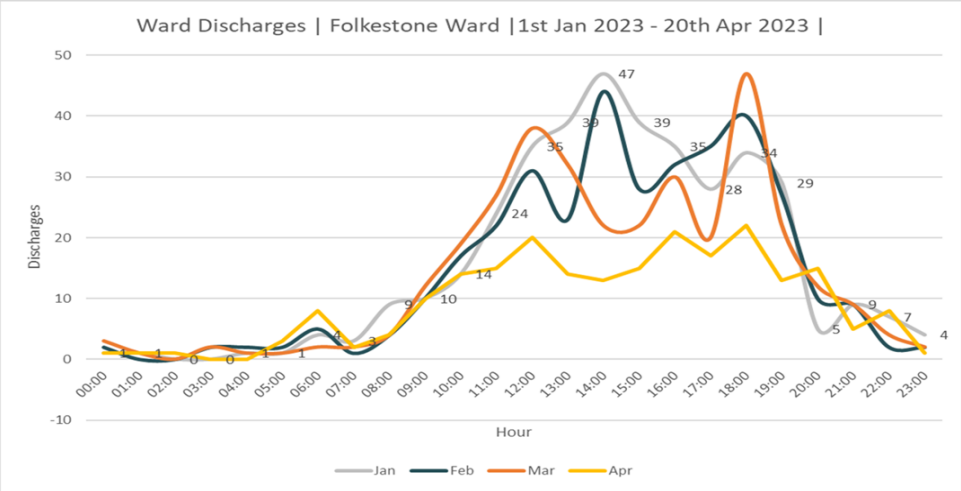
During the reporting period, red flags were recorded as shown:

Date	Red Flag
28/03/2023	Coordinator unable to maintain supernumerary status on Labour Ward
01/04/2023	Coordinator unable to maintain supernumerary status on Labour Ward
08/04/2023	Delayed Induction of Labour on Labour Ward x 2
14/04/2023	Coordinator unable to maintain supernumerary status on Labour Ward
	Delayed Induction of Labour on Labour Ward
	Delayed Induction of Labour on Folkestone Ward
18/04/2023	Delayed Induction of Labour on Labour Ward x 2

Discharge planning:

The Discharge Processes Project Plan is being reviewed as part of the new Maternity Transformation Programme (MTP) to build on improvements that can be made following our understanding for causes of late-afternoon / evening discharges. The project plan is due for completion by July 2023.

Below is a trend chart that presents the number of delayed (late) discharges from Folkestone Ward, and compares data between January and April 2023 (up to 20.04.23). This information is being used to inform conversations with the multidisciplinary team to understand causes for discharges occurring beyond 18:00 and those that happen late into the evening.



Mitigations and changes to ways of working, that support the project plan, include earlier paediatrician rounds on the postnatal ward starting at 08:30 and Newborn and Infant Physical Examination (NIPE) doctors being available from 09:30 (this was previously after 10:00) with ward rounds finishing at approximately 12:30, depending on ward acuity. At the WHH, a new cohort of midwives has also commenced NIPE training to support capacity to complete these assessments. In addition, a request has been placed for additional funding to extend the Discharge Co-ordinators rotas to allow for a 7-day service to reduce the workload of the midwife.

4. Summary:

A systematic approach has been implemented and is embedded to ensure there is daily oversight to maintaining a safe environment across the maternity units at WHH and QEQM.

The outcomes of the daily oversight are then captured on a weekly basis in the “stop the clock” meeting with the Interim Director of Midwifery, Head of Midwifery and Acting Operations Director. This evidence along with actions undertaken is collated into the submission response template ready to be submitted on a monthly basis by the deadline stipulated by the CQC.

Action Reference	Reference point	Issues raised in letter by CQC	Site	Individual action reference	Level of Assurance	Action	Responsible Lead	Priority Timeframe	Date to be completed by	Completion Date	Action Progress	Update/progress report	Evidence Required	Evidence Reference	risk register (Yes/No)	risk number	Executive Assurance and oversight	ongoing audit/monitoring to sustain improvement
Urgent – Section 31 of the Health and Social Care Act 2008																		
CQC referenceL INS2-14478126091																		
1	**Fire safety at Queen Elizabeth The Queen Mother Hospital**																	
	1.1	There was a significant risk to safety in the event of a fire. We followed the secondary fire evacuation route through the labour ward. We encountered a labelled automatic fire door which we were told would close automatically in the event of a fire, however, the closing mechanism had been removed.	QEQM	1.1.1	Fully Assured	Closing mechanism to be added to automatic closing fire door	Claire Lowe, 2gether Operational Development Lead	1 week	20/01/2023	19/01/2023	✔	Nene valley undertaken fire door inspections. Auto closer removed (18/01/23), self closers I/O links to be installed on 20/01/23.	Photo of fire door	1.1.1 Photograph QEQM door closer removal	Yes	**Trust Corporate risk register:** Ref 1846: Failure of critical infrastructure Ref 3056: Unsafe fire evacuation routes compromised due to the need to store beds, materials and equipment Ref 2834: The quality of the switchboard service delivered by 2gether will deteriorate Ref 1844: Non-delivery of service level agreements		
			QEQM	1.1.2	Fully Assured	Video of fire route to confirm actions taken to ensure clear egress	Claire Lowe, 2gether Estates Operational Development Lead	1 Week	20/01/2023	19/01/2023	✔	Walk though video planned for 18/01/23 @ 10:00	video walk through	1.1.2 Video walk through fire evacuation route 1.1.2.2 Video walk through fire evacuation route				checking of doors as part of the quality rounds (3 times a day)
	1.2	Every fire door on the route was mislabelled as to whether it was an automatic fire door or needed to be kept closed. None of the doors were labelled showing staff how long the door would hold them safely in the event of a fire, the labelling of fire doors is a requirement of the relevant HTM guidance.	QEQM	1.2.1	Fully Assured	- Installation of new fire labels to fire doors where missing or not visible on doors - Running man sign to be installed at exit point of the secondary fire route - clarity from 2gether around use of the blueman sign within hospital setting	Claire Lowe, 2gether Estates Operational Development Lead	1 week	20/01/2023	20/01/2023	✔	Fire door survey complete. Labelling of the doors identified in survey is underway and will be completed by 20.01.23. ***Initial photos in evidence show the start of the works from the survey. Some doors have labels removed as not required (too much labelling) as per the survey*** Green man running sign installed 12/01/23.	- Photo of new running man sign - photos of identified fire doors - email confirmation of the use of a blue running man sign only in warehouses - not in hospital setting	1.2.1 IMG_0556-0592 (26 files) Fire door signs 1.2.1.2 IMG_0392-0394 (3 files) Fire exit signage 1.2.1.3 Email clarification on use of blue running man signage				
	1.3	fire doors (staff kitchen and doctors office) that should be closed, propped open. We repeatedly raised this with staff throughout our inspection as the doors continued to be propped open. There were several boxes alongside the corridor of a fire exit which meant a bed could not pass through the corridor during an evacuation.	QEQM	1.3.1	Fully Assured	signs on fire doors (staff kitchen and doctors office) to reiterate door must be closed. Snap tool (hourly checks to ensure doors are closed and staff awareness to do so)	Claire Lowe, 2gether Estates Operational Development Lead	1 week	20/01/2023	18.01.2023	✔		attached 3 exampleos of photos of laminated poster and doors with the poster	1.3.1 door sign on doctors room 1.3.1 door sign on staff room 1.3.1 laminated poster			MNAG	checking of doors as part of the quality rounds (3 times a day) Dashboard data on compliance to MNAG monthly
			QEQM	1.3.2	Fully Assured	declutter of boxes alongside the corridor of a fire exit	Peyma Hajilou, Matron QEQM	1 week	20/01/2023	16/01/2023	✔		Photo's and video of clear area following declutter.	1.3.2 photo of fire exit after declutter 1.3.2 VIDEO-2023-01-17-15-34-02			MNAG	checking of doors as part of the quality rounds (3 times a day) Dashboard data on compliance to MNAG monthly
			QEQM	1.3.3	Fully Assured	alternative location of cages of stock - Longer term solution as part of Phase 1 estates plans	Peyma Hajilou, Matron QEQM Trudy Gleeson, Director of Facilities	1 Week	20/01/2023	17/01/2023	✔	1 cage of stock removed to alternative location. Only 1 cage left in corridor. Not obstructing the fire exit.	Photo's and video of clear area following declutter.	1.3.2 photo of fire exit after declutter 1.3.2 VIDEO-2023-01-17-15-34-02			MNAG	checking of doors as part of the quality rounds (3 times a day) Dashboard data on compliance to MNAG monthly
			WHH	1.3.4	Fully Assured	WHH to review primary and secondary fire routes to ensure clear egress	Claire Lowe, 2gether Estates Operational Development Lead	1 Week	20/01/2023	16/01/2023	✔	Complete, awaiting video walk through.	video walk through staff education/briefing - Emergency Fire Actions for Staff (WHH, QEQM, KCH) - will be sent out in Trust news week commencing 23rd January	1.3.4 Rev1 Jan 23 Aide Memoire Evacuation Document 1.3.4 WHH1 1.3.4 WHH2 1.3.4 WHH3				checking of doors as part of the quality rounds (3 times a day)
	1.4	Kent Fire and Rescue Service under our memorandum of understanding with our concerns who will be visiting the service to look at compliance with fire safety regulations.	QEQM	1.4.1	Fully Assured	Review of FRA's for all areas within maternity to ensure are in date and identification of any works to be undertaken Review all Trustwide description of the framework of the Operated Healthcare Facility (OHF) and the Estates Managed Service (EMS) and the key services delivered by 2gether Support Solutions (2gether) via the OHF and the EMS with specific updates appertaining to service issues. Detail of the governance arrangements that are in place between the Trust and the subsidiary as well as information of the key issues for both the subsidiary and the Trust.	Claire Lowe, 2gether Estates Operational Development Lead	1 Week	20/01/2023	18/01/2023	✔	All FRA's for QEQM maternity in date and reviewed	CQC briefing document: - Appendix 4 SLA H&S Fire - Appendix 5 CEMG HS and Estates LSMS - Appendix 6 risk register associated around Fire risks across the trust - Appendix 7 Fire safety terms of Reference - Appendix 8 Fire safety Plan 2022-23 - Appendix 9 Fire training compliance report - Appendix 10.1 to 10.8 Maternity fire risk assessments across WHH and QEQM	1.4.1 CQC Briefing Document Jan 2023 (003) APPENDIX 4 SLA H&S Fire LSMS APPENDIX 5 CEMG HS and Estates Report November 22 App5 APPENDIX 6 Risk Register APPENDIX 7 Fire Safety Terms of Reference Jan 23 APPENDIX 8 FIRE SAFETY PLAN 2022-23 Update Dec 2022 APPENDIX 9 Fire Training Compliance Report_ APPENDIX 10.1 QEQM-Birchington Ward APPENDIX 10.2 QEQM-Kingsgate Ward APPENDIX 10.3 QEQM Special Care Baby Unit APPENDIX 10.4 QEQM St Peters Midwifery Led Unit APPENDIX 10.5 WHH Maternity Day Care APPENDIX 10.6 WHH Singleton Unit APPENDIX 10.7 WHH Folkestone Ward APPENDIX 10.8 WHH Neonatal Unit			H&S committee	Weekly touch point call with head of estates, Matron or HoM to review progress against action plan Monthly report to H&S committee
			QEQM	1.4.2	Fully Assured	Workflow remedials from FRA review with actions and timeframes Twice weekly touch point call with head of estates, Matron or HoM to review progress against action plan	Claire Lowe, 2gether Estates Operational Development Lead	2 Weeks	30/01/2023	30/01/2023	✔	Director of Ops leading touch point calls. Calls added to diaries. Action plan completed with time farmes for estates works to be undertaken. Some redmedial actions scehduled to be completed before 9th March FRA assessment	action plan	14.2 QEQM FRA action plan ***(submitted to CQC Friday 3rd February)***	No	N/A	H&S committee	- weekly touch point call with head of estates, Matron or HoM to review progress against action plan - Monthly report to H&S committee
2	**Effective processes for foetal monitoring and escalation at William Harvey Hospital**																	
	2.1	The effectiveness of processes for fetal monitoring was a known risk to the trust, but mitigations were not always sufficient to protect women and babies from avoidable harm.	WHH	2.1.1	Fully Assured	- review of guideline is in place	Jo Shayler, Head of Midwifery WHH Ciaran Crowe - Foetal monitoring lead	1 Week	20/01/2023	20/01/2023	✔	- Updated guideline live on in May 2022 with updated tools included - The tools are included within our fetal monitoring training module. All staff undergo an assessment as part of this training module. - There is a training needs identification, analysis and action planning process in place to ensure learning identified through any source of risk is integrated into the fetal monitoring module	Guideline - Fetal heart monitoring	2.1.1 Fetal Heart Monitoring	Yes	Ref: 249 Misinterpretation of cardio tocographs (CTG) by staff both antepartum and intrapartum Ref: 2569 Lack of USS Capacity for women's services at EKHUFT	EXECUTIVE RISK ASSURANCE GROUP (ERAG) -	Quarterly report to committee
			WHH	2.1.2	Fully Assured	- Slido/survey Monkey to be developed to be roled out by Tuesday 24th with specific questions on the guideline to ascertain staff understanding and awareness - Depending on results MSSP advisors for additional support on addressing any concerns identified	Jo Shayler, Head of Midwifery WHH and Gynae Hannah Horne, Head of Midwifery QEQM and Community	2 Weeks	30/01/2023	10/02/2023	✔	Surveymonkey rolled out with deadline for answers by 3rd February 23					N/A	
	2.2	We looked at seven records and saw in three of them that the one hourly 'fresh eyes' review was not consistently recorded in line with trust policy	WHH	2.2.1	Fully Assured	Hour fresh eyes review: - form part of daily checklist review - alert on electronic whiteboard - assurance monitoring through audits ***separate action plan on Foetal monitoring tab***	Jo Shayler, Head of Midwifery WHH Ciaran Crowe - Foetal monitoring lead Richard Ewins - BI lead	1 week	20/01/2023	19/01/2023	✔		Fetal monitoring audit tool Fetal monitoring project plan quality check list - ***under section 5 bullet point 3***	2.2.1 Fetal Monitoring Project Plan 2.2.1 Proforma Fetal Monitoring Audit 5.1 QEQM Quality round check list Jan 23 5.1 WHH Master maternity daily quality round including staffing Jan 2023			MNAG	Dashboard compliance to MNAG monthly
			WHH & QEQM	2.2.2	Fully Assured	Undertake weekly fresh eyes audit by the Midwifery Operations Manager on shift as part of the rounding audit at 8am, 1pm and 8.30pm. - 5 sets of notes on each site to be reviewed and outcome data to be sent to BI team to be included in the monthly dashboard for MNAG	Jo Shayler, Head of Midwifery WHH and Gynae Hannah Horne, Head of Midwifery QEQM and Community	1 Week	20/01/2023	18/01/2023	✔	schedule discussed at band 7 meeting on 18/01/2023 and weekly audits to commence w/c 23/01/2023 ***remains partial assurance until progress is seen on fresh eyes compliance***.					MNAG	Dashboard compliance to MNAG monthly
			WHH & QEQM	2.2.3	Fully Assured	Review of 5 retrospective cases at WHH 5 retrospective cases at QEQM	Jo Shayler, Head of Midwifery WHH and Gynae Hannah Horne, Head of Midwifery QEQM and Community	2 Weeks	30/01/223	18/01/2023	✔	Action completed whereby 5 sets of notes reviewed.					N/A	
	2.3	At the time of inspection, the service did not have a foetal monitoring midwife in post.	WHH	2.3.1	Fully Assured	Ascertain when the foetal monitoring midwife starts in post.	Jo Shayler, Head of Midwifery WHH	1 week	20/01/2023	17/01/2023	✔	confirmation from Jamie Disney-Goodwin (People and Culture business partner) of SH starting 6th February 2023	Email confirmation from People and Culture lead Jamie Disney. Induction programme for FM Midwife	2.3.1 Fetal Monitoring Midwife Confirmation Email 2.3.1 FM Midwife Induction Plan			N/A	
	2.4	Data showed recent incidents had exposed mothers and babies to risk of harm.	WHH	2.4.1	Fully Assured	Re - review of incidents (SI's) highlighted in report through rapid review process AAR to be undertaken	Consultant Obstetrician and Gynaecologist Clinical Associate Director of Medical Education Director of Undergraduate Medical Education and Foetal Medicine lead	1 Week	20/01/2023	19/01/2023	✔	HSIB style investigation report to be completed by 19/01/2023 Recommendations / Learning points to be added to an action plan and taken through MNAG on progress	AAR reports on both cases				MNAG	Monthly SI reports
	2.4.1	Incident ID – 309750 - October 2022 – in summary delays in completing, escalating and recording foetal monitoring with outcome of baby born in poor condition by CAT 1B emergency caesarean section.	WHH											2.4.1 Case C-JT WEB230079				
	2.4.2	Incident ID – 307030 - September 2022 – in summary delays in accurately interpreting CTG and documenting in notes (CTG recording maternal pulse / hypoxia sticker not used when CTG accurately completed) outcome - CAT 1A GA Iscs at 29+1. Born in poor condition.	WHH											2.4.2 MD WEB307030 V2				
3	**Timeliness and effectiveness of maternity triage at William Harvey Hospital**																	
	3.1	The timeliness and effectiveness of processes in triage was a known risk to the trust, but mitigations were not always sufficient to protect women and babies from avoidable harm.	WHH	3.1.1	Fully Assured	review of activity that does not need to be undertaken through triage i.e. Day care activity review if this activity can be moved to alternative location. ***detailed action plan on Triage actions tab***	Jo Shayler, Head of Midwifery WHH	1 Week	20/01/2023	19/01/2023	✔		Obstetric Sonography staffing transfer business case Triage Action plan ***(Tab on excel spreadsheet)***	3.1..1 Business Case Obs Ultrasound Transfer to Maternity 2022 July 22 Triage Action plan ***(Tab on excel spreadsheet)***	Yes	Ref 2566: Inadequate Maternity triage pathway	EXECUTIVE RISK ASSURANCE GROUP (ERAG) -	Quarterly report to committee
	3.2	Women were not always seen by a midwife within 15 minutes of arriving in maternity triage due to staffing challenges	WHH	3.2.1	Fully Assured	Re-review of the KPI's within Audit tool to ensure all aspects are included	Jo Shayler, Head of Midwifery WHH and Gynae Hannah Horne, Head of Midwifery QEQM and Community	1 Week	20/01/2023	20/01/2023	✔		audit tool	3.2.1 Triage audit data collection template			MNAG	Dashboard data
	3.3	Women were not always reviewed by a doctor within recommended timeframes due to lack of dedicated obstetric medical cover. This negatively impacted the review of the women in line with the trust maternity triage policy.	WHH	3.3.1	Fully Assured	Review and implementation interim obstetric medical cover in triage.	Zoe Woodward, Clinical Director Cherrie Knight, Acting Operations Director	1 Week	20/01/2023	19/01/2023	✔	This is one of our improvement work streams given the cqc feedback, we have accelerated our actions around this. Adhoc middle grade cover put in place on a weekly basis by the Directorate Support Assistant team (rota team). Overall accountability of triage with hot week consultant		3.3.4 Consultant job plan changes action plan			MNAG	Part of Dailey SITREP
			WHH	3.3.2	Fully Assured	Review and implementation interim obstetric medical cover to support discharge and flow	Zoe Woodward, Clinical Director Cherrie Knight, Acting Operations Director	1 Week	20/01/2023	19/01/2023	✔	This is one of our improvement work streams given the cqc feedback, we have accelerated our actions around this. Dedicated SHO during weekends for EDN's and flow to facilitate timely discharges. Rota changed to implenent an SHO for during the week		3.3.4 Consultant job plan changes action plan			MNAG	Part of daily SITREP

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

No. Actions	41	Status (%)
At risk / Not started	0	0%
In progress (overdue)	0	0%
In progress (on schedule)	1	2%
Complete	39	95%
No Status	0	0%
TOTAL	**40**	**98%**

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

			QEQM	6.2	Fully Assured	- Estates review of flooring issue - Works requests raised.	Claire Lowe, 2gether Operational Development Lead	1 Week	20/01/2023	19/01/2023	✓	Order placed for £15K on 17/01/23, floor layers in 19/01/23 to assess area works, to start 26/01/23, ending 09/02/23.						
			WHH	6.3	Fully Assured	request and replace fire extinguisher	Claire Lowe, 2gether Operational Development Lead	1 Week	20/01/2023	16.01.2023	✓		photo of replacement extinguisher	6.3 Fire extinguisher tag				
			WHH	6.4	Fully Assured	PAT review and testing on all non clinical equipment across all maternity area that have not been tested or out of date	Claire Lowe, 2gether Operational Development Lead	2 weeks	30/01/2023	30/01/2023	✓	WHH PAT completed on 21/01/23 (1 day process).						
			WHH	6.5	Fully Assured	PAT review and testing on all Clinical equipment across all maternity area that have not been tested or out of date	Andy Burrow, EME lead	2 Weeks	30/01/2023	30/01/2023	✓							
9	Bullet point 7	There are estates works planned for a second theatre, and to meet with the requirements HBN 09-02 but as we discussed in both meetings finances have not been secured and if secured this work will take a significant period of time to complete.	QEQM	7.1	Partially Assured	Estates strategy already developed.	Cherrie Knight Acting Operations Director	2 Weeks			●	Business case agreed through governanace routes. Final sign off at FPC confirmed on 31st January 2023. **update 27.02.23 - Next steps is tendering for contractor with a view of works to commence June/July 2023**	Maternity Estates – Capital Business cases Briefing ***under section 4.1***					
10	Bullet point 8	At QEQM, we saw a newborn baby being cannulated in a space on the corridor which staff described as their paediatric area. This is unsuitable and appears to be normalised practice.	QEQM	8.1	Fully Assured	to complete risk assessment of the current space and identify how the safety, privacy and dignity can be improved	Hannah Horne, Head of Midwifery QEQM and Community	1 Week	20/01/2023	16/01/2023	✓	risk assessment not required as alternative location sourced.	N/A					
			QEQM	8.2	Fully Assured	consider alternative location	Hannah Horne, Head of Midwifery QEQM and Community	1 Week	20/01/2023	17/01/2023	✓	room 9 now used for paediatric interventions	Photos of new location and equipment in the room	8.2 pictures of new paeds room on labour ward 1-4 (4 files)				
	Fire																	
11	Bullet point 9	At QEQM there was a significant risk to safety during a fire. We followed the secondary fire evacuation route through the labour ward. We encountered a labelled automatic fire door which we were told would close automatically in the event of a fire. However, the closing mechanism removed. The Head of Estates for the site had no explanation for this. Every fire door on the route was mislabelled as to whether it was an automatic fire door or needed to be kept closed. None of the doors were labelled showing staff how long the door would hold them safely in the event of a fire, the labelling of fire doors is a requirement of the HTM guidance. We found fire doors (staff kitchen and doctors office) that should be closed propped open. We repeatedly raised this with staff throughout our inspection as the doors continued to be propped open. There were several boxes alongside the corridor of a fire exit which meant a bed could not pass through the corridor during an evacuation. The fire route was also missing signage (green running man) to direct staff in the correct direction. This has been rectified since the inspection. As discussed in the call later in the day we have contacted Kent Fire and Rescue Service who will be making an assurance assessment.	QEQM	9.1		***All actions linked to section 1 Fire safety at Queen Elizabeth The Queen Mother Hospital***					✓							
	Procurement processes																	
12	Bullet point 10	QEQM had one Bedside scanner for whole department. The triumvirate described a trust replacement scheme process. But staff told us the procurement process had been frustrating and the scanner has still not been secured.	QEQM	10.1	Fully Assured	Confirm leading time of equipment already approved via MDG (Procurement)	Peyma Hajilou, Matron QEQM	1 Week	20/01/2023	19/01/2023	✓	The Voluson P8 ordered on trust Po 42000285 will be delivered on Tuesday 21st						
13	**Access and Flow at WHH**																	
	Bullet point 11	WHH had issues with access and flow we found women were being cared for in inappropriate areas for example we saw women spending too long in triage with one woman arriving at 6.42am and was still in receiving treatment in triage at 4pm. we were told of an incident where a woman was sent from triage to labour suite and were sent back and gave birth in triage.	WHH	11.1	Fully Assured	Undertake an analysis of activity to identify potential of transferring in a planned way activity to QEQM	Jo Shayler, Head of Midwifery WHH	2 Weeks	30/01/2023	01/03/2023	✓	update 2702.23 - Option appriaals to remove activity from WHH site due to be presneted at EMT 1st march 23.	action plan sent to EMT					
	Bullet point 12	At WHH there were six women at 4pm waiting to go home. One was waiting for medication with the other five waiting for medical review. There was a lack of dedicated medical cover in these areas including the consultant on call which is having an impact on care and treatment.	WHH	12.1	Fully Assured	To review job plans of consultants and junior doctor rotas to improve medical resources to facilitate prompt discharges	Zoe Woodward, Clinical Director Cherrie Knight, Acting Operations Director	1 week	20/01/2023	20/01/2023	✓	jobs role reviewed as to what is required to ensure susficant medical cover. This action is part of actions under ***section 3 (3.3)*** ***update 27.02.23 Review of discharge pathway and barriers to discharge comp;lete. Action plan in place linked to the activity option paper***						
				12.2	Partially Assured	implementation of changes in rota	Zoe Woodward, Clinical Director Cherrie Knight, Acting Operations Director	3 months	03/04/2023		●	as part of actions under ***section 3 (3.3)*** ***remains partially assurance until actions completed under section 3 (3.3)***						
14	**Insufficient use of Fp10s**																	
	Bullet point 13	We asked that you review FFP10s prescription pads as multiple pads were in use with numbers recorded in a book but not sequential. This poses a potential risk of the misuse of prescriptions.	WHH, QEQM, KCH	13.1	Fully Assured	Review the books where FP10's are recorded to understand issue and provide instruction to triage staff to ensure sequential use.	Jo Shayler, Head of Midwifery WHH Hannah Horne, Head of Midwifery QEQM and Community	1 Week	20/01/2023	20/01/2023	✓	review undertaken and staff trained						
			WHH, QEQM, KCH	13.2	Fully Assured	pre - printed pads	Will Willson, Chief of Pharmacy	1 month	13/02/2023	28/02/2023	✓	on track to roll out by end of Feb 23						
15	**Fetal monitoring leadership**																	
	Bullet point 14	The fetal monitoring midwife at WHH has been appointed but not yet in post and staff told us that there was not a fetal monitoring obstetrician not in post. This is an Ockendon requirement so needs addressing. At feedback you informed us that there was a fetal monitoring obstetrician in post but that they had just returned from a period of sickness.	WHH	14.1		***Action linked to section 2 Effective processes for foetal monitoring and escalation at William Harvey Hospital 2.3 (2.3.1)***					✓							
16	**Raise a call for help at KCH**																	
	Bullet point 15	At Canterbury outpatient clinic we found that the rooms either did not have call bells in situ or had call bells that had been disconnected. This meant staff were unable to call for assistance in these rooms. Staff appeared unclear about what they would do in an emergency.	KCH	15.1	Fully Assured	Review of call bell system and works requests to repair or install	Claire Lowe, 2gether Operational Development Lead	1 Week	20/01/2023	20/01/2023	✓	review already undertaken. No call bell system in place. Interim call bell system to be installed by 26/01/2023 proposal to EMT for permeant solution if required						
17	**Governance processes in place to provide assurance of actions and learning**																	
	Bullet point 16	We found that the department were at the early stages of a "governance improvement journey". There was a lack of learning from incidents by staff on the ward. Action plans were not always translated to learning as not embedded, therefore there is a risk of recurrence of incidents. We also found that there was a lack of discussion of risk and governance with the staff team on the wards. We have agreed to further interviews with the risk and governance leads to ensure we have a complete picture of improvements in the area.	WHH,QEQM,KCH, BHD,RVH	16.1	Partially Assured	Governance improvement plan - part of maternity improvement plan. Early actions already identified to formulise process of dissemination of learning and embedding of action plans.	Carol Drummond, Interim Director of Midwifery	1 Week	20/01/2023	20/01/2023	✓	***remain partially assurnace until governance team and processes embedded to provide learning from incidents***						
			WHH,QEQM,KCH, BHD,RVH	16.2	Fully Assured	weekly communication to staff of themes from rapid review & closed SI's	Jaynie Hollister, Interim Quality Governance Matron	1 week	20/01/2023	20/01/2023	✓	detailed in message of the week sent out by governance team to all staff in the care group	copy of previous message of week	16.2 MOW 09.01.2023 , 16.2 MOW 12.12.2022 16.2 MOW draft to be sent 23.01.2023				
18	**Fresh eyes monitoring**																	
	Bullet point 17	We found that staff at the WHH were not following best practice with Fresh Eyes monitoring	WHH	17.1		***Action linked to section 2 Effective processes for foetal monitoring and escalation at William Harvey Hospital 2.2 (2.2.1 & 2.2.2)***					✓							
19	**Infection Prevent and Control**																	
	Bullet point 18	We also found some examples of poor Infection prevention and control (IPC) practices at the WHH.	WHH	18.1		***Action linked to section 4 Infection control at William Harvey Hospital***					✓							

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

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

Action Reference	Issues raised in letter by CQC	Site	Individual action reference	Level of Assurance	Action	Responsible Lead	Priority Timeframe	Date to be completed by	Completion Date	Action Progress	Update/progress report	Evidence Required
Urgent – Section 31 of the Health and Social Care Act 2008												
CQC referenceL RGP1-15003286303 (WHH)												
1	Effective assessing, managing and monitoring the safety of the environment and equipment at the maternity department at William Harvey Hospital	WHH	1.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 week	20.02.23	19.02.23	✓	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\WHH\Section 1\1.1 SOP for clinically led IPC enviromental audits cleaning roles and responsibilities
2			2.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points ***below (a, b, c, d, e)***	Carol Drummond, Interim Director of Midwifery	2 Weeks	24.02.23	24.02.23	✓	assuranace report created by Director of Midwifery to include the below assurnace data a.Daily quality round checklist audit; b.Clinically led environmental audit; c.Master environmental audit and; d.Equipment checks in the monthly environmental audit.	
			2.2	Fully Assured	a.Daily quality round checklist audit;	Jo Shayler, Head of Midwifery WHH and Gynae			03.03.23	✓	The Head of Midwifery collates the results of the weeks assurance checks, detailed above and provides a report to the Director of Midwifery as part of a "Stop the Clock" process, which was implemented on the 7th February 2023 for each Friday to review the results of pre-ceding weeks compliance audits, discuss issues raised and confirm actions taken and/or further actions required to improve compliance. This is also an opportunity for further escalation and action if required.	
			2.3	Fully Assured	b.Clinically led environmental audit;				03.03.23	✓	There are clearly defined roles and responsibilities in relation to who cleans which areas and or equipment i.e. what clinical staff are responsible for and what cleaning staff are responsible for.	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\WHH\Section 2
			2.4	Fully Assured	c.Master environmental audit and;				03.03.23	✓		monthly dashboard
			2.5	Fully Assured	d.Equipment checks in the monthly environmental audit.				03.03.23	✓	The audits are completed each week by the IPC and midwifery team on a Tuesday	monthly dashboard
3	Effective system for assessing, managing and monitoring the safety of women and babies using Cardiotocography (CTG) monitoring and fresh eyes/ears at the maternity service at the William Harvey Hospital	WHH	3.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 Week	20.02.23	19.02.23	✓	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	
4			4.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points ***below (a)***	Carol Drummond, Interim Director of Midwifery	2 Weeks		24.02.23	✓	assuranace report created by Director of Midwifery to include the below assurnace data (a Intermittent auscultation (IA) and CTG audits.)	monthly dashboard
			4.2	Fully Assured	a.Intermittent auscultation (IA) and CTG audits.	Jo Shayler, Head of Midwifery WHH and Gynae		24.02.23		✓	A daily fresh eyes audit has been implemented of 5 cases per day, results and actions are presented to the Director of Midwifery at the weekly "Stop the Clock". A prospective audit for ongoing monitoring of compliance with guidance has been agreed, which will include escalation for medical review/support. This will commence on 6 March 2023.	monthly dashboard
5	Effective system for assessing, managing and monitoring the safety of women and babies using triage services at the maternity service at the William Harvey Hospital.	WHH	5.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 Week	20.02.23	19.02.23	✓	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	
6			6.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points ***below (a)***	Carol Drummond, Interim Director of Midwifery	2 Weeks		24.02.23	✓	assuranace report created by Director of Midwifery to include the below assurnace data (a Triage audit tool data.)	monthly dashboard
			6.2	Fully Assured	a.Triage audit tool data.	Jo Shayler, Head of Midwifery WHH and Gynae		24.02.23		✓	There is an overarching working group to oversee the implementation of the triage process for maternity services. This is an MDT approach. The guideline below has been developed, coordinated through the group, with oversight through the Women's Clinical leadership team. A score card is in place, which will provide the ability to map progress in future reports. The triage data will be reported in full on a monthly basis to the Executive Maternity and Neonatal Assurance Group (MNAG) chaired by the Chief Nursing and Midwifery Officer	Maternity triage guidleine
7	Effective system for assessing, managing and monitoring infection prevention and control practices at the maternity service at the William Harvey Hospital	WHH	7.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 Week	20.02.23	19.02.23	✓	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	
8			8.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points ***below (a and b)***	Carol Drummond, Interim Director of Midwifery	2 Weeks	24.02.23	24.02.23	✓	assuranace report created by Director of Midwifery to include the below assurnace data a.Weekly Personal Protective Equipment (PPE) audits and; b.Weekly hand hygiene audits.	monthly dashboard
			8.2	Fully Assured	a.Weekly Personal Protective Equipment (PPE) audits and;	Jo Shayler, Head of Midwifery WHH and Gynae			16.01.2023	✓	There is a formal joint weekly IPC round with a senior midwifery representative in place: -Cleanliness of all general, clinical and sanitary areas as well as clinical equipment and soft furnishings -Issues identified are actioned at the time	monthly dashboard
			8.3	Fully Assured	b.Weekly hand hygiene audits.				03.03.23	✓	Hand hygiene audits are completed on a daily basis and reported weekly by the Head of Midwifery to the Director of Midwifery and reviewed at the Stop the Clock weekly meeting.	monthly dashboard
9	Implement an effective system for assessing, managing and monitoring the safety of staffing levels to keep women safe from avoidable harm and there is appropriate escalation to provide the right care and treatment at the maternity service at the William Harvey Hospital.	WHH	9.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 Week	20.02.23	19.02.23	✓	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	
10			10.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points below ***(a, b, c and d)***	Carol Drummond, Interim Director of Midwifery	2 Weeks	24.02.23	24.02.23	✓	assuranace report created by Director of Midwifery to include the below assurnace data a.Emergency second on-call consultant rota; b.Where there are gaps in the rota, a rationale for how gaps are covered; c.Update on progress of recruitment into the vacant medical and midwifery posts and; d. Staffing arrangements to make sure women are protected from risk of unsafe care.	
			10.2	Fully Assured	a.Emergency second on-call consultant rota;	Jo Shayler, Head of Midwifery WHH and Gynae			24.12.22	✓	The process for obtaining a 2nd consultant in an emergency has been implemented	Consultant Obstetricians Referral to and attendance on delivery suite when on call/resident shift
			10.3	Fully Assured	b.Where there are gaps in the rota, a rationale for how gaps are covered;				ongoing	✓	On a day by day basis the medical rotas are managed by the Directorate Support Assistant to ensure gaps created through sickness, vacancy etc are managed. Where gaps become difficult to fill this is escalated to the Site Obstetric lead and Director of Operations for decisions to made in terms of locum use or cancellation of elective work within gynaecology. Every effort is made in advance to cover gaps by working with locum services. Midwifery rotas are managed on a continuous basis across the day. Due to vacancies and maternity leave levels, coupled with short term sickness, there are known gaps at the beginning of each rota. Gaps are addressed through the use of NHSP and long line bookings for agency midwives. Any remaining gaps and additional gaps that occur due to short term sickness on the day are managed by the senior midwifery team and supported by the manager on call out of hours. If required, depending on the acuity/activity midwives are deployed from other areas, including on calls to address shortfall. If this is not sufficient then using the escalation guideline, a divert will be activated. This may also result in suspension of the homebirth service. Below are the rotas for the last 2 weeks for WHH for midwifery. During this time gaps were managed accordingly as well as the escalation process. No harms have been identified as a result of the remaining gaps.	

			10.4	Fully Assured	c. Update on progress of recruitment into the vacant medical and midwifery posts and;				ongoing	✔	**Medical:** Consultant vacancy: there has been 2 new consultant appointments and remaining vacancies (1.1 FTE) are subject to ongoing recruitment with Locum arrangements in place to back fill Non-Career grade doctor vacancies for WHH are 4.2 FTE. Recruitment is ongoing and locums used accordingly. **Midwifery:** The establishment table below provides the current status of the midwifery recruitment for the WHH. There is ongoing recruitment, including international midwives, of which 7 have been appointed and start dates are dependent on the completion of the required processes. In addition, recent agreement to increase the number of support roles, as well as introduce a nurse model to reduce the workload for midwifery team.	
			10.5	Fully Assured	d. Staffing arrangements to make sure women are protected from risk of unsafe care.				23.02.23	✔	Immediate actions have been taken to ensure that the staffing levels are safe over the next 2 weeks which include: • Commencing Saturday 25/2/23 a senior midwife, band 7 manager or above will be onsite at the WHH to provide support and operational oversight during the day. • Commencing Monday 27/2/23 the number of IOLs will be limited to 3 per day at WHH with an additional IOL transferred to QEQM each day to support. • Midwives in specialist roles are developing a rota to provide 0.4 clinical shifts at WHH from the week beginning 6/3/23 • Commencing the 28/2/23 the telephone triage will be centralised at night to QEQM, to reduce midwifery staffing requirements at WHH • The threshold for activating a divert from WHH to QEQM has been adjusted to a lower threshold to ensure acuity is managed aligned to staffing and activity, this will continue to be monitored by the HOM in the twice daily safety huddles. • Fast track the recruitment checks of 10 Health care assistants to work in maternity to support roles currently undertaken by midwives. Prior to commencement on the unit individuals will undertake a 2 week induction programme, followed by supported induction in the unit aligned to a competency framework.	
11	Implement an effective system for assessing, managing and monitoring the safety and timeliness of discharge to keep women safe from avoidable harm and to provide the right care and treatment at the maternity service at the William Harvey Hospital	WHH	11.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 Week	20.02.23	19.02.23	✔	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	
12			12.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points below ***(a, b and c)***	Carol Drummond, Interim Director of Midwifery	2 Weeks	24.02.23	24.02.23	✔	assuranace report created by Director of Midwifery to include the below assurnace data a. The number of delayed discharges at triage and postnatal; b. Reason for delayed discharge and; c. Update on progress against the mapping of discharge process review.	
			12.2	Fully Assured	a. The number of delayed discharges at triage and postnatal;	Jo Shayler, Head of Midwifery WHH and Gynae			24.02.23	✔	A system being established in triage to record all women where the transfer to the labour ward or antenatal ward is delayed by more than 30 minutes and the reason why and the actions taken/escalation.	
			12.3	Fully Assured	b. Reason for delayed discharge and;				24.02.23	✔	A review of the discharge pathway has been mapped and a reason for delay identified. Actions need to be developed with the MDT and implemented. The number of discharges is also reviewed at the 10 am sit rep. (see example in section 10)	
			12.4	Fully Assured	c. Update on progress against the mapping of discharge process review.				24.02.23	✔	An end to end review of the discharge process has been completed. A task and finish group has been established to action the issues identified through the review of the discharge processes. The issues identified include: - Delay in preparation of take-home medications. - Delay in neonatal discharges - Incomplete records that need to be collated - Delay in EDNs being completed	

Action Reference	Issues raised in letter by CQC	Site	Individual action reference	Level of Assurance	Action	Responsible Lead	Priority Timeframe	Date to be completed by	Completion Date	Action Progress	Update/progress report	Evidence Required
Urgent – Section 31 of the Health and Social Care Act 2008												
CQC referenceL RGP1-15004847857 (QEQM)												
1	Effective assessing, managing and monitoring the safety of the environment and equipment at the maternity department at William Harvey Hospital	QEQM	1.1	Fully Assured	To implement an effective system for assessment	Carol Drummond, Interim Director of Midwifery	1 week	20.02.23	19.02.23	✔	The Senior Midwifery Team (Director of Midwifery, Heads of Midwifery and Matrons) a systematic approach on the 19th January, which is now embedded to ensure there is daily oversight to maintaining a safe environment across the maternity unit at QEQM.	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\QEQM\QEQM Section 1 SOP for clinically led IPC enviromental audits cleaning roles and responsibilities
2			2.1	Fully Assured	By 12 noon on 24 February 2023 and by 12 noon on the last Friday of each month thereafter assurance report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and should include the following points below (a, b, c, d, e)	Carol Drummond, Interim Director of Midwifery	2 Weeks	24.02.23	24.02.23	✔	assuranace report created by Director of Midwifery to include the below assurnace data (a, b, c, d and e)	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\QEQM\Section 2\example of 531 assurance report to Trust Board
			2.2	Fully Assured	a. Daily quality round checklist audit;	Hannah Horne, Head of Midwifery QEQM and Community			7.02.23	✔	The Head of Midwifery collates the results of the weeks assurance checks, detailed above and provides a report to the Director of Midwifery as part of a "Stop the Clock" process, which was implemented on the 7th February 2023 for each Friday to review the results of pre-ceding weeks compliance audits, discuss issues raised and confirm actions taken and/or further actions required to improve compliance. This is also an opportunity for further escalation and action if required.	
			2.3	Fully Assured	b. Clinically led environmental audit;				03.03.23	✔	There are clearly defined roles and responsibilities in relation to who cleans which areas and or equipment i.e. what clinical staff are responsible for and what cleaning staff are responsible for.	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\QEQM\Section 2\Evidence of IPC audits covering points b, c and d S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\QEQM\Section 2\b. clinically led enviromental audit
			2.4	Fully Assured	c. Master environmental audit;				03.03.23	✔	The audits are completed each week by the IPC and midwifery team on a Tuesday	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\QEQM\Section 2\Evidence of IPC audits covering points b, c and d
			2.5	Fully Assured	d. Equipment checks in the monthly environmental audit;				03.03.23	✔		S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters amd supporting evidence\QEQM\Section 2\Evidence of IPC audits covering points b, c and d
			2.6	Fully Assured	e. Evidence of works request completion for: the leaking roofs and bowing doors in the midwifery led unit and rusty shelf and flooring in the patient bathroom in the triage department at the Queen Elizabeth the Queen Mother Hospital.	Cherrie Knight Acting Operations Director			24.02.23	✔	Immediate actions were taken to address the leaking roofs and bowing doors in the midwifery led unit and rusty shelf and flooring in the patient bathroom in the triage department €	S:\SpecServDiv\Mgmt\CQC\CQC 2023\CQC 2nd letters and supporting evidence\QEQM\Section 2\e. Evidence of works request completion pictures of evidences to demonstrate works have been completed

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**CARE QUALITY COMMISSION**
REPORT TITLE:	**SECTION 31 REPORTING: MATERNITY & MIDWIFERY SERVICES WILLIAM HARVEY HOSPITAL (WHH)**
DATE:	**27 APRIL 2023**
FROM:	**INTERIM CHIEF NURSING & MIDWIFERY OFFICER**

CQC Reference: RGP1-15004847857 (QEQM) RGP1-15003286303 (WHH)
Organisation: RYY

This report provides the organisation's response to the letter dated 13 February 2023 received from Deane Westwood, Director of Operations South, at the Care Quality Commission, in relation to the regulated activity maternity and midwifery services, at William Harvey Hospital (WHH).

2. By 24.02.23 and by 12 noon on the last Friday of each month thereafter: Provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the William Harvey Hospital is effective

As reported in the March return, an issue was identified around how the results of the daily quality rounds were collated. Since the last report, the team have worked to clearly define what is required for the following criteria:

- Neonatal resuscitaires
- Equipment safety checks.

Following discussions with the resuscitation team and also comparing with other maternity departments, the decision was taken that the standard for the checks would be as follows:

- Neonatal resuscitaires – checks to be undertaken twice daily for labour ward and minimum of daily on the postnatal ward.
- Equipment safety checks, including adult resuscitation trolley – checks to be undertaken daily

It was clear that in calculating the compliance with the daily equipment checks there was confusion in terms of numerators and denominators. This has taken longer than expected to conclude, but now the daily sheets that collate all the results of the individual checks can be used to calculate compliance. The daily sheets for the week ending the 21st April have been included to provide assurance of this process.

Determining the denominator for daily equipment checks has been agreed at local level by unit with each Head of Midwifery.

Results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following:

a. Daily quality round checklist audit

The table below summarises the results of the daily checks for:

- Environmental
- Hand Hygiene
- PPE
- Neonatal Resuscitation
- Equipment identified as requiring daily safety checks.

William Harvey Hospital Maternity							
Metric	**Frequency**	**Target**	**24/3/23**	**31/3/23**	**6/4/23**	**14/4/23**	**21/4/23**
Weekly Environmental Audit: Folkestone	Weekly	**95%**	88%	89%	93%	91%	93%
Weekly Environmental Audit: Labour Ward	Weekly	**95%**	90%	90%	93%	93%	94%
Weekly Environmental Audit: Triage					89%	90%	91%
Daily Equipment Safety Checks Labour ward	Daily	**100%**	93.1%	82.7%	100%	100%	100%
Daily Equipment Safety Checks Folkestone ward	Daily		88%	85.7%*	85.7%*	100%	100%
Daily neonatal Resuscitaire safety checks Labour ward	Twice Daily	**100%**	100%	100%	100%	100%	100%
Daily Resuscitaire safety checks Folkestone ward	Twice Daily	**100%**	100%	78.5%*	78.5%*	93%	100%
Hand Hygiene – 5 audits completed each day	Daily	**100%**	100%	100%	100%	100% (20)	Not completed
Hand Hygiene – audit results	Weekly	**90%**	100%	100%	100%	100%	N/A
PPE compliance	Weekly	**90%**	100%	100%	86.7%	80%	80%

Key

Results not available	
Target met	
Up to 10% below target	
Greater than 10% below target	

Prior to the week ending the 6th April 2023, triage environmental audits were included as part of Folkestone ward. These audits are now separated.

*Sheets with details of neonatal resus and daily equipment checks for Folkestone Ward (FW) missing for 30/3 & 31/3 so unable to validate checks. All other days fully compliant.

PPE compliance – issues with bare below elbow for individuals visiting unit. Relevant departments contacted and reminded regarding requirements.

2b. Clinically led environmental audit
2c. Master environmental audit
8a. Weekly Personal Protective Equipment (PPE) audits
8b. Weekly hand hygiene audits

Below are the individual reports for each area following the weekly environmental audits:

WHH 2B 180423 FW maternity weekly audit tool V2 1 1
WHH 2B FW Weekly Environmental Audit 04.04.23
WHH 2B FW Weekly Environmental Audit 11.04.23
WHH 2B LW Weekly Environmental Audit 04.04.23
WHH 2B LW Weekly Environmental Audit 11.04.23
WHH 2B Triage Weekly Environmental Audit 04.04.23
WHH 2B Triage Weekly Environmental Audit 11.04.23
WHH 2B LW Weekly Environmental Audit 18.04.23
WHH 2B Triage Weekly Environmental Audit 18.04.23
WHH 2B FW Weekly Environmental Audit 18.04.23
WHH 2B WHH Estates Work

d. Equipment checks in the monthly environmental audit.

Daily equipment checks sheets included for the last week of this reporting period demonstrating the new format for resuscitaires and agreed equipment by area

WHH 2D April 2023 Resus daily
WHH 2D FW Daily Resuscitaire Checklist pg.1 we 31.03.23
WHH 2D LW Daily Equipment checks 010423 070423
WHH 2D LW Daily Equipment checks 080423 140423
WHH 2D LW Daily Equipment checks 150423 210423
WHH 2D LW Daily Equipment checks 280323 310223
WHH 2D LW Daily Equipment Checklist 25.03.23
WHH 2D LW Daily Equipment Checklist 26.03.23
WHH 2D LW Daily Equipment Checklist 27.03.23 (2)
WHH 2D LW Daily Equipment Checklist 27.03.23
WHH 2D LW Resuscitaire Asset 113437 date 230223 200423
WHH 2D LW Resuscitaire Asset 113868 date 230223 210423
WHH 2D LW Resuscitaire asset 134019 date 23032 190423
WHH 2D LW Resuscitaire Asset 134035 date 24023 200423
WHH 2D LW Resuscitaire Asset 185012 date 230223 210423
WHH 2D LW Resuscitaire Asset 185015 date 230223 180423
WHH 2D Triage EMU Checklist
WHH EME Equipment PPM List 24.04.23
WHH 2D FW Resuscitaire Checklist pg.1 we 20-21 Apr 23
WHH 2D FW Resuscitaire Checklist pg.2 we 19.04.23
WHH 2D FW Resuscitaire Checklist pg.2 we 20-21 Apr 23
WHH 2D FW Resuscitaire Checklist pg.1 we 19.04.23
WHH 2D FW Daily Resuscitaire Checklist pg. 1 we 14.04.23
WHH 2D FW Daily Resuscitaire Checklist pg. 2 we 14.04.23
WHH 2D FW Daily Resuscitaire Checklist pg.1 we 07.04.23
WHH 2D FW Daily Resuscitaire Checklist pg.1 we 08.04.23

4. By 24.02.24 and by 12 noon on the last Friday of each month thereafter Provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of women and babies using Cardiotocography (CTG) monitoring and fresh eyes/ears at the maternity service at the William Harvey Hospital is effective.

Daily Fresh Eyes audits have continued. The Band 7s have worked with the Matron, and Head of Midwifery, to continually improve how compliance is achieved. During this reporting month they instigated ''On the Hour Every Hour'' as a trial – this means that irrespective of when continuous CTG monitoring is commenced on the hour every hour fresh eyes are completed, making it easier for the coordinator to manage this and ensure compliance. An improvement in compliance has been noted and we will continue with this trial to obtain a larger data sample on which to make an informed decision for a permanent and robust system of assessing, managing and monitoring the safety of women and babies. In support of this trial, if areas for learning are identified or people proactively ask for further support there are training opportunities available with a specialist foetal monitoring midwives.

Results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and patients are escalated appropriately for medical support and review in line with national clinical guidelines and must include

a. Intermittent auscultation (IA) and CTG audits

Fresh Cares Daily Audit WHH 27 March to 21 April 2023

For the week ending 21st April 2023 compliance had significantly improved for hourly fresh eyes being undertaken, as shown in the table below:

William Harvey Hospital Maternity							
Metric	**Frequency**	**Target**	**24/3/23**	**31/3/23**	**6/4/23**	**14/4/23**	**21/4/23**
Fresh Eyes – Completed Hourly (Up to 5 sets of notes)	Daily	**85%**	81%	79%	72%	81%	86%
Two signatures on CTG sticker		**85%**	77%	65%	63.7%	76%	86%
Two signatures on CTG trace		**85%**	70%	55%	53.1%	64%	81%

In addition to the daily checks of hourly fresh eyes and CTG recording, audits have been completed throughout March and April 2023, with results shared as below. The plan for April has been to audit 2-3 sets of notes per week throughout the month, with the aim of auditing 10 sets of notes per week by the end of the month:

WHH 4A Fresh Care Monthly Audit Data Collection Sheet Apr 2023
WHH 4A Fresh Eyes Audit Data Collection Sheet 07.04.23
WHH 4A Fresh Eyes Audit Data Collection Sheet 14.04.23
WHH 4A Fresh Eyes Audit Data Collection Sheet 21.04.23
WHH 4A Fresh Eyes Audit Data Collection Sheet 31.03.23
WHH 4A Foetal Monitoring Audit Summary
WHH 4A Report Responses
WHH 4A Foetal Monitoring Audit Results

6. By 24.02.23 and by 12 noon on the last Friday of each month thereafter: provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of women and babies using triage services at the maternity service at the William Harvey Hospital is effective

The team have continued to monitor the Triage activity and compliance against the BSOTs criteria

There has not been any further progress in relation to removing any additional non-triage activity, although the team are continuing to explore ways in which this can be achieved for example, through the implementation of a scan plotting shift utilising NHSP staffing. The aim would be to have this in place by the 12th May 2023.

Midwife and Doctor breaches have significantly reduced.

Results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and patients are escalated appropriately for medical support and review in line with national clinical guidelines. The report must include:

a. Triage audit tool data

The table below summarises the triage activity and performance metrics for March-April 2023

Triage activity data week March and April 2023

Criteria	March 2023	01.04.23 to 19.04.23
Attendances	903	580
BSOTS Red RAG	5	8
BSOTS Orange RAG	222	135
BSOTS Yellow RAG	330	91
BSOTS Green RAG	138	207
BSOTS N/A	205	138
BSOTS not recorded where applicable	8	1

The enclosed spreadsheet contains data for April 2023:

WHH 6A Triage Audit Data Collection - April 2023

The spreadsheet identifies there were 6 delays in transferring women from Triage. The data shows the time delays as well as the reason for admission for each woman. The Head of Midwifery and Matron for the unit are working with the Band 7 Coordinators to ensure improved oversight of Triage activity to manage flow and reduce delays.

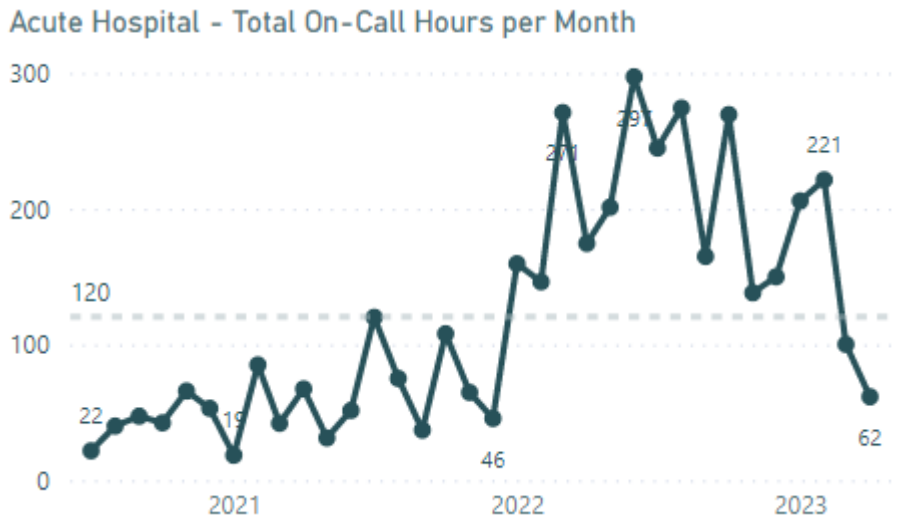
Month	Seen within 15 min by Midwife	Seen within required time by Dr
March 2023	98.3%	92.4%
April 2023	99.1%	86.3%

The midwifery staffing template for Triage is currently:

Shift	Telephone triage	Clinical triage
Day	1	2
Night	1	1

The results of the Triage performance is reported through MNAG. Unfortunately, due to non-quoracy for the April meeting that was subsequently postponed, this review will be completed in May 2023.

8. By 24.02.23 and by 12 noon on the last Friday of each month thereafter: provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for

assessing, managing and monitoring infection prevention and control practices at the maternity service at the William Harvey Hospital is effective
Please see Section 2 above
The report must include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include: **a. Weekly Personal Protective Equipment (PPE) audits and;**
Please see Section 2 above – incorporated in Environmental audits
b. Weekly hand hygiene audits.
Please see Section 2 above
10. By 24.02.23 and by 12 noon on the last Friday of each month thereafter: provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of staffing levels to keep women safe from avoidable harm and there is appropriate escalation to provide the right care and treatment at the maternity service at the William Harvey Hospital is effective
Previously reported actions remain in place.
Results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following: **a. Emergency second on-call consultant rota;**
Below are the staffing rotas for the reporting period. WHH 10A DC 030423 WHH 10A DC 100423 WHH 10A DC 170423 WHH 10A FW LW Workforce Rota - April 2023 WHH 10A Triage Workforce Rota - April 2023 WHH 10A WOC 030423 WHH 10A WOC 100423 WHH 10A WOC 170423 The on-call midwife should only be called in to support where activity is such that 1:1 care cannot be provided safely. The weekly graph below shows the trends for the use of on call midwives for the WHH up to the 21 April 2023. The total number of on-call hours is down from 221 in February 2023 to 62 in April 2023:   

The Maternity Service has deployed the Birthrate Plus (BR+) acuity tool, which includes a number of 'red flags' as part of a safer staffing methodology. Compliance with recording the acuity on a 4-hourly basis needs to meet a threshold of 80% for data validity. For WHH, there is a known non-compliance so as part of the Maternity improvement agenda this is monitored through the Maternity and Neonatal Assurance Group (MNAG) within the Maternity Dashboard.

Compliance with recording of Birthrate+ for the period 27 March to 21 April 2023:

- WHH Labour Ward = 76.3%
- WHH Folkestone Ward = 33.3%

b. Where there are gaps in the rota, a rationale for how gaps are covered;

Gaps in the midwifery rota are monitored on a shift by shift basis and actions are determined aligned to activity and acuity. The escalation policy is utilised appropriately with on-call midwives being used as well as unit diverts activated where required.

During the reporting period, red flags were recorded as shown:

Date	Red Flag
28/03/2023	Coordinator unable to maintain supernumerary status on Labour Ward
01/04/2023	Coordinator unable to maintain supernumerary status on Labour Ward
08/04/2023	Delayed Induction of Labour on Labour Ward x 2
14/04/2023	Coordinator unable to maintain supernumerary status on Labour Ward
	Delayed Induction of Labour on Labour Ward
	Delayed Induction of Labour on Folkestone Ward
18/04/2023	Delayed Induction of Labour on Labour Ward x 2

c. Update on progress of recruitment into the vacant medical and midwifery posts

The table below shows the midwifery pipeline for the WHH:

	Current vacancy April	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Band 7 Midwives	-2.67	0.96	1																					
Band 6 midwives	-16.6		1			1	0		1			1			1			1			1			
Band 5 Nurses/Midwives	-3.7				1.2																			
Total new starters with PIN'S		0.96	2	0	1.2	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0
Internationally Educated Nurses (Planned arrivals)	8 per year			5	3	2								2	2	2								
OSCE Exam Passed							5	3	2									3	3	2				
NQMs from CCU	19 yearly								11												10			
Return to Practice	0 yearly																							
Total PIN ready per month		0.96	2	0	1.2	1	5	3	14	0	0	1	0	0	1	0	0	4	3	2	11	0	0	0
Estimated trained leavers	19 monthly Average	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1
Rolling Total	-22.97	-22.98	-22.48	-23.48	-23.78	-23.78	-20.23	-18.23	-5.73	-6.73	-8.23	-8.23	-9.73	-10.73	-11.23	-12.23	-13.73	-10.73	-9.23	-8.23	9.5	8.5	7	6

Key	
-22.97	Current Band 5 RN, Band 6 MW and Band 7 MW Vacancy as of 01/03/ 2023 - taken into account in this pipeline.
	Expected Trust Intake
	The planned/actual number of IEN'S to arrive in country - at this point they go into a band 5 vacancy
	Increase calculated on the following:
	Number of IEN's we predict will receive their PIN - 4 months from arrival based on NMC current turnaround.
	University intake on training programme
	Total of Band 5 Registered nursing commencing working in the Trust that month
	Rolling total of additional RN/RMs recruited - starting in minus figure as starting from current vacancy

Medical Recruitment:

WHH:

- 1 x Consultant obstetrician due to commence post from 2nd May with an induction period and block training commencing 15th May 23.
- 2 x Registrars appointed. One doctor is due to start in the next couple of weeks following the completion of all paperwork/checks. The other doctor is still pursuing the oversea required documentation before a commence date can be confirmed. It is envisaged June/July time start.

d. Staffing arrangements to make sure women are protected from risk of unsafe care.

See sections 10a, 10b, 10c (above)

12. By 24.02.23 and by 12 noon on the last Friday of each month thereafter: provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety and timeliness of discharge to keep women safe from avoidable harm and to provide the right care and treatment at the maternity service at the William Harvey Hospital is effective.

The Discharge Processes Project Plan is being reviewed as part of the new Maternity Transformation Programme (MTP) to build on improvements that can be made following our understanding for causes of late-afternoon / evening discharges. The project plan is due for completion by July 2023.

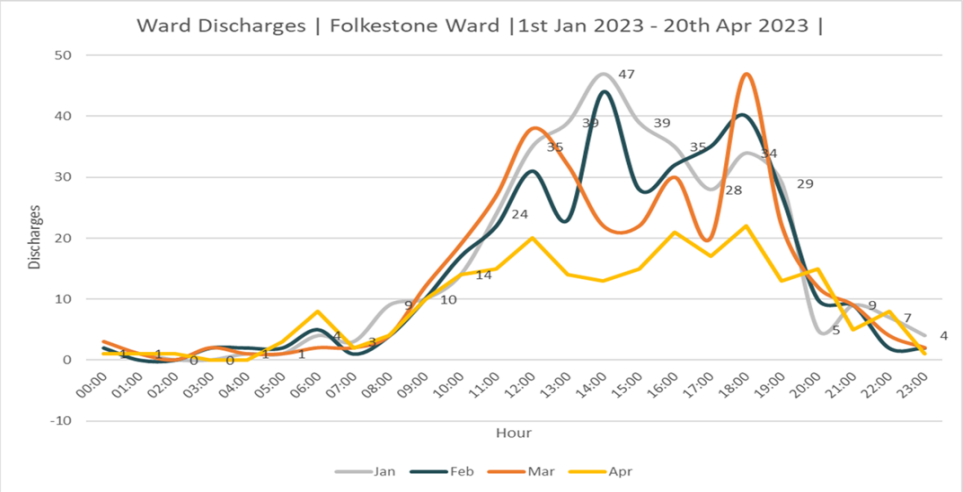
The report must include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following:

a. The number of delayed discharges at triage and postnatal;

Below is a trend chart that presents the number of delayed (late) discharges from Folkestone Ward, and compares data between January and April 2023 (up to 20.04.23). This information is being used to inform

conversations with the multidisciplinary team to understand causes for discharges occurring beyond 18:00 and those that happen late into the evening.

Mitigations and changes to ways of working, that support the project plan, include earlier paediatrician rounds on the postnatal ward starting at 08:30 and NIPE doctors being available from 09:30 (this was previously after 10:00) with ward rounds finishing at approximately 12:30, depending on ward acuity. At the WHH, a new cohort of midwives has also commenced NIPE training to support capacity to complete these assessments. In addition, a request has been placed for additional funding to extend the Discharge Co-ordinators rotas to allow for a 7-day service to reduce the workload of the midwife.



WHH 12A Discharge Trends 20.04.23

b. Reason for delayed discharge and;

See section 12a above

c Update on progress against the mapping of discharge process review.

See section 12 and 12a above

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**CARE QUALITY COMMISSION**
REPORT TITLE:	**SECTION 31 REPORTING: MATERNITY & MIDWIFERY SERVICES QEQM**
DATE:	**27 APRIL 2023**
FROM:	**INTERIM CHIEF NURSING & MIDWIFERY OFFICER**

CQC Reference: RGP1-15004847857 (QEQM)
Organisation: RYY

This report provides the organisation's response to the letter dated 13 February 2023 received from Deane Westwood, Director of Operations South, at the Care Quality Commission, in relation to the regulated activity maternity and midwifery services, at Queen Elizabeth the Queen Mother Hospital (QEQM).

2. By 24.02.23 and by 12 noon on the last Friday of each month thereafter: Provide a report to the Care Quality Commission setting out the actions taken to ensure the system in place for assessing, managing and monitoring the safety of the environment and equipment at the maternity department at the Queen Elizabeth the Queen Mother Hospital is effective

As reported in the March return, an issue was identified around how the results of the daily quality rounds were collated. Since the last report, the team have worked to clearly define what is required for the following criteria:

- Neonatal resuscitaires
- Equipment safety checks.

Following discussions with the resuscitation team and also comparing with other maternity departments, the decision was taken that the standard for the checks would be as follows:

- Neonatal resuscitaires – checks to be undertaken twice daily on labour ward and minimum of daily on the postnatal ward.
- Equipment safety checks, including adult resuscitation trolley – checks to be undertaken daily

It was clear that in calculating the compliance with the daily equipment checks there was confusion in terms of numerators and denominators. This has taken longer than expected to conclude, but now the daily sheets that collate all the results of the individual checks can be used to calculate compliance. The daily sheets for the week ending the 21st April have been included to provide assurance of this process.

Determining the denominator for daily equipment checks has been agreed at local level by unit with each Head of Midwifery.

Results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place and must include the following:

a. Daily quality round checklist audit

The table below summarises the results of the daily checks for:

- Environmental
- Hand Hygiene
- PPE
- Neonatal Resuscitation
- Equipment identified as requiring daily safety checks.

QEQM Hospital Maternity							
Metric	**Frequency**	**Target**	**24/3/23**	**31/3/23**	**6/4/23**	**14/4/23**	**21/4/23**
Weekly Environmental Audit Kingsgate	Weekly	**95%**		93.3%	99%	99%	98%
Weekly Environmental Audit Labour Ward	Weekly	**95%**	97.8%	94.4%	97%	98%	97%
Weekly Environmental Audit MLU	Weekly	**95%**			100%	100%	100%
Weekly Environmental Audit Triage				Initial audit deep dive not scored	88.9%	88.9%	89%
Daily Equipment Safety Checks Labour ward	Daily	**100%**	85.71%	85.71%	100%	100%	100%
Daily Equipment Safety Checks Kingsgate	Daily	**100%**	92.85%	71.42%	100%	100%	100%
Daily neonatal Resuscitaire safety checks Labour ward	Twice Daily	**100%**	96.4%	94.7%	100%	100%	100%
Daily Resuscitaire safety checks Kingsgate ward	Twice Daily	**100%**	92%	92%	100%	100%	100%
Hand Hygiene – 5 audits completed each day	Daily	**100%**	100%	100%	100%	100%	100%
Hand Hygiene – audit results	Weekly	**90%**	97.2%	95.7%	95.2%	100%	100%
PPE compliance	Weekly	**90%**	100%	100%	100%	100%	100%

Key

Results not available	
Target met	
Up to 10% below target	
Greater than 10% below target	

QEQM 2A All Area Emergency Equipment Checklist 05.04.23
QEQM 2A All Area Emergency Equipment Checklist 06.04.23
QEQM 2A All Area Emergency Equipment Checklist 07.04.23
QEQM 2A All Areas Emergency Equipment Checklist 08.04.23
QEQM 2A All Areas Emergency Equipment Checklist 09.04.23
QEQM 2A All Areas Emergency Equipment Checklist 10.04.23
QEQM 2A All Areas Emergency Equipment Checklist 11.04.23
QEQM 2A All Areas Emergency Equipment Checklist 12.04.23
QEQM 2A All Areas Emergency Equipment Checklist 13.04.23
QEQM 2A All Areas Emergency Equipment Checklist 14.04.23
QEQM 2A All Areas Emergency Equipment Checklist 15.04.23
QEQM 2A All Areas Emergency Equipment Checklist 16.04.23
QEQM 2A All Areas Emergency Equipment Checklist 17.04.23
QEQM 2A All Areas Emergency Equipment Checklist 18.04.23
QEQM 2A All Areas Emergency Equipment Checklist 19.04.23
QEQM 2A All Areas Emergency Equipment Checklist 20.04.23
QEQM 2A All Areas Emergency Equipment Checklist 21.04.23

QEQM 2A All Areas Emergency Equipment Checklist 22.04.23
QEQM 2A All Areas Emergency Equipment Checklist 23.04.23
QEQM 2A KG Daily Equipment Checklist 01.04.23
QEQM 2A KG Daily Equipment Checklist 02.04.23
QEQM 2A KG Daily Equipment Checklist 03.04.23
QEQM 2A KG Daily Equipment Checklist 04.04.23
QEQM 2A KG Daily Equipment Checklist 05.04.23
QEQM 2A KG Daily Equipment Checklist 06.04.23
QEQM 2A KG Daily Equipment Checklist 07.04.23
QEQM 2A KG Daily Equipment Checklist 27.03.23
QEQM 2A KG Daily Equipment Checklist 28.03.23
QEQM 2A KG Daily Equipment Checklist 29.03.23
QEQM 2A KG Daily Equipment Checklist 31.03.23

b. Clinically Led Environmental Audit
c. Master environmental audit

QEQM 2B KG Weekly Environmental Audit 03.04.23
QEQM 2B KG Weekly Environmental Audit 10.04.23
QEQM 2B KG Weekly Environmental Audit 27.03.23
QEQM 2B LW Weekly Environmental Audit 03.04.23
QEQM 2B LW Weekly Environmental Audit 10.04.23
QEQM 2B LW Weekly Environmental Audit 28.03.23
QEQM 2B MLU Weekly Environmental Audit 03.04.23
QEQM 2B MLU Weekly Environmental Audit 10.04.23
QEQM 2B MLU Weekly Environmental Audit 27.03.23
QEQM 2B Triage Weekly Environmental Audit 05.04.23
QEQM 2B Triage Weekly Environmental Audit 13.04.23
QEQM Estates Summary
QEQM 2B MLU Weekly Environmental Audit 17.04.23
QEQM 2B Triage Weekly Environmental Audit 17.04.23
QEQM 2B KG Weekly Environmental Audit 17.04.23
QEQM 2B LW Weekly Environmental Audit 17.04.23

d. Equipment checks in the monthly environmental audit.

Daily equipment check sheets included for the last week of this reporting period demonstrating the new format for resuscitaires and agreed equipment by area

QEQM 2D EME Equipment PPM List 24.04.23
QEQM 2D KG Daily Resus Checklist we 02.04.23
QEQM 2D KG Daily Resus Checklist we 09.04.23
QEQM 2D KG Daily Resus Checklist we 16.04.23
QEQM 2D LW Lay-up Daily Resus Checklist pg.1 we 09.04.23
QEQM 2D LW Lay-up Daily Resus Checklist we 02.04.23
QEQM 2D LW Lay-up Daily Resus Checklist we 16.04.23
QEQM 2D LW Main Theatre Daily Resus Checklist pg.1 we 09.04.23
QEQM 2D LW Main Theatre Daily Resus Checklist we 02.04.23
QEQM 2D LW Main Theatre Daily Resus Checklist we 16.04.23
QEQM 2D LW Main Theatre Pull-down Daily Resus Checklist we 02.04.23
QEQM 2D LW Main Theatre Pull-down Daily Resus Checklist we 09.04.23
QEQM 2D LW Main Theatre Pull-down Daily Resus Checklist we 16.04.23
QEQM 2D LW Obs Theatre Daily Resus Checklist pg.1 we 09.04.23
QEQM 2D LW Obs Theatre Daily Resus Checklist we 02.04.23
QEQM 2D LW Rm3 Daily Resus Checklist pg.1 we 09.04.23

QEQM 2D LW Rm3 Daily Resus Checklist we 02.04.23
QEQM 2D LW Rm3 Daily Resus Checklist we 16.04.23
QEQM 2D LW Rm11 Daily Resus Checklist pg.1 we 09.04.23
QEQM 2D LW Rm11 Daily Resus Checklist we 02.04.23
QEQM 2D LW Rm11 Daily Resus Checklist we 16.04.23
QEQM 2D Mobile-Recovery Daily Resus Checklist we 02.04.23
QEQM 2D Triage Daily Resus Checklist we 02.04.23
QEQM 2D Triage Daily Resus Checklist we 03.04.23
QEQM 2D KG Daily Resuscitaire Checklist we 23.04.23
QEQM 2D LW Lay-up Daily Resuscitaire Checklist we 23.04.23
QEQM 2D LW MLU Daily Resuscitaire Checklist we 23.04.23
QEQM 2D LW Obs Theatre Daily Resuscitaire Checklist we 23.04.23
QEQM 2D LW Rm 3 Daily Resuscitaire Checklist we 23.04.23
QEQM 2D LW Rm 11 Daily Resuscitaire Checklist we 23.04.23
QEQM 2D Main Theatre Daily Resuscitaire Checklist we 23.04.23
QEQM 2D Theatre Pull-down Daily Resuscitaire Checklist we 23.04.23
QEQM 2D Triage Daily Resuscitaire Checklist we 23.04.23

The table below shows the service status of all medical devices at QEQM based on the assigned risk level of each device:

Total No of devices:	**387**		**Site:**	**QEQM**
Risk Level	In service date	Due service in < 30 days	Overdue service	Total
Very High	16	3	0	19
High	64	1	7	72
Medium	77	3	16	96
Low	145	25	30	200
Total	302	32	53	387
%	**78%**	**8%**	**14%**	**100%**

Currently, 86% of medical devices at the QEQM are within service date with 14% identified as being overdue the planned preventative maintenance (PPM) date.

One of the overdue ‘high’ risk devices is currently in the EME workshop for planned maintenance, another of these devices has not been seen on the ward since 2021 so needs to be reallocated / updated on the Trust’s asset register. Nine of the overdue ‘medium’ risk devices are in EME workshop or sent to manufacturer for repair. A detailed list of all items of equipment that are beyond their planned preventative maintenance (PPM) date has been shared with the local Maternity management team so that to ensure they are aware of the asset numbers of any devices beyond their PPM date to take them out of use on the Maternity unit, whilst booking in the maintenance and planning for temporary replacement devices.

East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)				
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**
People & Culture Committee (P&CC)	24 May 2023	Stewart Baird Non-Executive Director	Stewart Baird Non-Executive Director	**Yes**
Appendices:	None			
Declarations of Interest made:				
No declaration of interest was made outside the current Board Register of Interest.				
Assurances received at the Committee meeting:				
Actions	**Deployment of new Nursing & Healthcare Assistant (HCA) colleagues** It was noted frontline staff were struggling to train new colleagues. This is particularly due to unfunded escalation areas taking experienced staff off wards. As such, temporary staffing costs remained high. The Committee received **partial assurance** that this situation would likely be resolved in the coming month or two. The Committee will continue to monitor.			
Integrated Performance Report (IPR)	**Staff Engagement – Not Assured** Despite multiple cultural development and support programmes, the results from staff surveys remain disappointing and do not show signs of improvement. The Executive Team were asked to provide a road map showing the various initiatives / programmes with an expected up turn in staff engagement score to enable the Committee to track performance. **Staff Involvement – Not Assured** Primarily for the same reasons as staff engagement. Again a road map was requested to plot initiatives and expected performance improvements. **Premium Pay – Not Assured** This metric is tracked by the Finance & Performance Committee so not discussed at length in P&CC. **Sickness Absence – Assured** Sickness is running at around 4% which is below the threshold. **Appraisals – Not Assured** Appraisal rates remain disappointingly low and despite previous assurances from line managers, there has not been an improvement. Executive colleagues were tasked to review the interventions and particularly around appraisal time rostered and the number of appraisers available and report back to the Committee. **Staff Turnover – Assured** Staff turnover reduced again to 9.8% which reflects the impact of various workstreams deployed, such as wellbeing and staff experience.			

	Undoubtedly the significant recruitment in 2022 is also starting to ease some of the pressures. **HCA Turnover – Assured** This metric is below the threshold and again reflects the significant work done in recruiting HCA colleagues in 2022. **Nurse Turnover – Assured** As above. **Vacancy Rates – Assured** Given the low turnover in Nursing and HCA we are naturally seeing a lower vacancy rate. However, it was noted Medical colleague vacancies (and turnover) were not reported at this Committee and so the Executive Team were asked to include these metrics going forward. **Vacancy & Recruitment Update - Assured** The final number of Internationally Educated Nurses (IENs) recruited across 2022 was 407 versus a target of 400. It was noted that NHS England (NHSE) advised they expect international recruitment to slow as staff shortages are seen locally. NHSE bid for an additional 70 IENs was successful and these colleagues have already been recruited in early 2023. A new bid for a further 150 IENs between April and December 2023 has been submitted. There was a small decrease in Hard to Recruit Consultant posts but overall this remains a challenge. In midwifery, there were 5 new international colleagues recruited with another 5 expected in the second round. 30 student midwives have received offers of employment pending them passing their degree course. There are currently 16 vacancies for midwives.
Hot Items – verbal discussion	Industrial action across junior doctors, consultants and nursing colleagues was discussed. The consultation on the Trust restructure closed last week and as such the Committee expects to see the outcome shortly. Medical colleague rates of pay were discussed – this is a system wide initiative.
Workforce Race & Disability Equality Standard	**Partial Assurance** The Committee saw details of the initial metrics. However, these were purely to approve for submission to NHSE for the official report. The Committee shall review the official report on receipt.

East Kent Hospitals University NHS Foundation Trust

Board Assurance Framework (BAF) and Corporate Risk Register	**Partial Assurance** The Committee asked the Trust Risk Team to review the key risks and risk ratings with the Executive Team and report back to the Committee at the next full meeting.

Items to come back to the Committee outside its routine business cycle:		
N/A		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Board of Directors is asked to **NOTE** this assurance report.	Assurance	1 June 2023

NHS
East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety Committee (Q&SC)	23 May 2023	Dr Andrew Catto, Non-Executive Director (NED)	Committee Chair	**Yes**	
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
In attendance: Moira Durbridge, NHS England (NHSE) Improvement Director.					
Assurances received at the Committee meeting:					
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	*Partial assurance* was received by the Committee of the True North metrics and Breakthrough Objectives for April 2023. The Committee noted the content of the report and raised the following points: – The Interim Chief Nursing and Midwifery Officer (CNMO) highlighted that the organisation aspired to reduce and eradicate harm, especially severe harm. Reporting of incidents and investigating them in a timely manner must be encouraged. – Management of deteriorating patient remains one of the key priorities for the Interim CNMO. This includes access for training to identify deteriorating patient and ways of auditing if improvements were made. CNMO noted that a clear distinction was to be made between the deteriorating patient pathway and the end of life pathway. – The Interim CNMO made the Committee aware of the £300k funding received from Integrated Care Board (ICB) to support the improvement in managing deteriorating patient. – NHSE Improvement Director advised that there was an additional funding of approximately £100k within the Recovery Support Programme (RSP) resource for the year 2023/24 to support safety improvement. – The Committee acknowledged a significant improvement in patient engagement over the last 18 months and urged not to lose this focus during the transitions the Trust is undergoing currently. – The Chief Operating Officer (COO) highlighted a number of improvements in the urgent care position in April 2023 in terms of 12-hour wait and 4-hour performance. The other operational metrics were reported as stable. – The Committee did not feel assured that there was clarity on referral pathways and how these pathways should be used by GPs and other referrers. – The Committee sought clarity on the timeframe of the Cancer Referral Pathway review. – The Committee highlighted the importance of having a uniform Trust-wide strategy of managing inbound and outbound patient calls although acknowledged that due to current pressures finding a solution would take time.				

Infection Prevention and Control (IPC) Report	The Committee received *partial assurance* of the current performance about nationally reportable infections noting the following: – NHSE thresholds for reportable infections for this reporting year have been published and the revised threshold calculation methodology creates a significant challenge for EKHUFT. – Updates to the IPC Board Assurance Framework (BAF) and IPC work plan were published along with the Kent and Medway IPC Strategy 2023/2026 to the development of which EKHUFT had contributed. – April 2023 was a very challenging month with regards to C. difficile infections with 16 cases reported. – The Committee received assurance on the work of C. difficile Review Group to establish what could be done differently to address this issue and to feedback to clinical colleagues. There are plans in place to learn from Frimley Park NHS Foundation Trust experience of reducing C. difficile infections. – The Committee sought clarity as to whether certain groups of patients were at greater risk of contracting C.difficile. – The Committed received assurance on the work of newly established antimicrobial stewardship team.
Care Quality Commission (CQC) Update Report	The Committee noted the following: – The Interim CNMO, having acknowledged the progress made, queried the number of open must-do CQC actions and will be discussing these actions urgently with the relevant teams. – The Interim CNMO is keen to determine where the progress on action was reported to before CQC, why the outstanding actions had not been escalated and what was preventing their completion. – The Committee noted that 100% of must-do actions for Maternity Services had been completed.
Care Quality Commission (CQC) Urgent and Emergency Care Patient Survey Results	The Committee received the results of the Urgent and Emergency Care Patient Surveys for 2022 undertaken by Picker, with the following key points to note: – The surveys presented the top five and bottom five scores, it also included the most improved and declined scores. – The Committee noted the plans in place to improve performance and changes put in place since the patient survey was undertaken. – The Committee expressed concern that one of the surveys did not have any respondents from ethnic minorities backgrounds and emphasised the importance of addressing this inequality. – The Committee acknowledged positive feedback highlighted in the surveys but were concerned that only 56% of respondents rated their experience as 7/10 or more and this is a much lower figure than the Trust's internal patient surveys.
Corporate Principal Mitigated Quality Risks	The Committee received and noted the content of the report highlighting that revision of the Corporate Risk Register (CRR) was progressing.

Mortality and Learning from Deaths	*Significant assurance* was received that the Trust's mortality position continues to report a "statistically low" Hospital Standardised Mortality Ratio (HSMR) and learning from deaths is shared via Care Groups governance processes including morbidity and mortality meetings, patient safety communications and via the Patient Safety Committee.
Clinical Ethics Committee (CEC) Chair's Report	The Committee received and noted the content of the Clinical Ethics Committee Chair's report.
Patient Safety Committee Chair's Report	The Committee noted the assurance report on the activities of the Patient Safety Committee on the 3 May 2023 with the following key points to note: – There were 39 Serious Incidents (SIs) in March 2023, nine of which resulted in severe harm. – Safeguarding and resuscitation training compliance remains an ongoing concern due to provision. Staff were continuing to book onto the training when available and Care Groups were identifying the barriers for training attendance. – During the scanning of patient records there was an issue with the server and some of the records were lost. Thirty-five sets of patient notes were affected and the patients or their relatives have been written to. – There was an issue with the external provider which resulted in 400 patients not receiving their clinic letters which may have resulted in patients not attending their appointments and their removal from waiting lists. The patients affected were now being reviewed by the Care Groups.
Fundamentals of Care (FoC) Chair's Report	The Committee noted the assurance report on the activities of the Fundamentals of Care Committee on the 18 April 2023. The Committee agreed that the new CNMO needed time to understand the issues and bring back interim reflections to the Q&SC meeting in June 2023.
Mortality Steering & Surveillance Group (MSSG) Chair's Report	The Committee noted the assurance report on the activities of the Mortality Steering and Surveillance Group on the 19 April 2023 and noted the following: – A higher number of deaths had occurred in the Trust's Emergency Departments (EDs) during December 2022 and the data had been investigated by the Chief Analytical Officer. – While patients were in the ED awaiting inpatient beds their access to clinical reviews and senior clinical oversight is reduced compared to being in their specialty ward, which may have impeded their recovery and increased their length of stay. – 21 Structured Judgement Reviews (SJR) were carried out during March 2023 and the positive themes that had been identified in recent SJRs were comprehensive junior doctor reviews and clerking and documentation of end of life discussion with families.

Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee received the assurance report on the activities of the Maternity and Neonatal Assurance Group on the 9 May 2023. The Committee agreed that the Director of Midwifery (DoM) to be included into Q&SC membership. The Q&SC Chair again requested that numeric evidence of PRactical Obstetric Multi-Professional Training (PROMPT) compliance was provided to the Q&SC. The Committee sought clarity on Trust involvement in managing the situation with pre-registration midwifery programme at Canterbury Christ Church University.
Safe Systems for Controlled Drugs	The Committee received the update report from the Controlled Drug Accountable Officer (CDAO). The Committee noted current issues and challenges and highlighted again that this was an area of serious concern with limited assurance. The Committee sought clarity as to what was driving the limited assurance position. An urgent meeting will be arranged between Chief Medical Officer (CMO), Interim CNMO and CDAO to discuss the risks and report to the Committee at the next meeting.
Integrated incidents, patient experience and learning from serious incidents report	The Committee received Integrated Incidents, Patient Experience and Learning from Serious Incidents Report for Q4 2022/23 and noted the following: – There was a significant reduction in incidents (from 16,000 to 5,500 incidents) as of the end of April 2023 and this trend continues. – The majority of incidents are of no or low harm and the main themes are medicine management, staffing and pressure ulcers. – Duty of Candour (DoC) compliance was 100% in April 2023. – The Committee was assured that the changes made to the serious incident investigation process in April 2023 started to produce positive outcomes. – The number of complaints for Q4 had increased from 65 to 86 per month on average. The response time has improved; however, the Committee was made aware that the response timeline the Trust is working to is 45 days whereas for the majority of the Trusts it is 30 days. – The Committee was made aware that the compliment rate had increased by 14% and to every one complaint received by the Trust, there are 29 compliments. – The Committee expressed concerns about the steady increase in the incidents with harm and that learning was not effective or not taking place.
Ophthalmology Serious Incidents Update Report	The Committee received the Ophthalmology Serious Incidents Update Report in relation to the serious incidents involving moderate or above patient harm reported between 7 September 2022 and 27 April 2023. The Committee noted the actions taken and mitigations put in place and received assurance on the longer-terms plans including the

	recruitment of two additional Ophthalmology Consultants and introducing sub-speciality leads. The Committee concluded that although a considerable progress had been made, the overall assurance is partial.
Update on the Total Parenteral Nutrition (TPN) Serious Incident (SI)	The Committee received and noted the update report on clinical review of five pre-term infants who were identified to have biochemical abnormalities and steps taken to mitigate this risk. The Committee agreed that the report was comprehensive and felt able to take assurance from it.
Safe Staffing Review Update	The Committee noted the partial assurance in the Safe Staffing Review with the following key points to note: – The additional escalation areas plus additional unfunded beds on most wards continues to put pressure on the current nursing establishment as well as the significant corridor care in our Emergency Departments (EDs) has resulted in substantive nursing staff being moved to support. – A working group with the Care Groups, temporary staffing team and NHS Professionals has commenced to actively look at ways to reduce agency usage, this group is reporting into the Financial Improvement Oversight Group. – The vacancy rate for Registered Nurses (RN) and Health Care Support Workers (HCSW) significantly decreased and is now under the threshold of 10%. – There were no falls with harm reported in April 2023. – There was a slight increase in medication errors in April 2023. This will be reviewed by Heads of Nursing (HoN) and reported to the Committee at the next meeting.
Quality Account	The Committee received the draft of the Quality Account and noted the following: – The report for 2023 shows an improvement in progress against the quality priorities set out in 2022. – The Committee highlighted the importance of involving patients and public by seeking their opinion on the report and emphasised the urgency of this engagement. – The Committee highlighted the importance of how the improvement topic was introduced and that it did not contradict the Integrated Improvement Plan (IIP). – The Committee agreed that the Maternity section of the Quality Account needed further details on the transformation journey. – The Committee sought clarity on the next steps of the Quality Account approval process.
Central Alert System (CAS) Report	The Committee received the report and noted that there were no open CAS alerts and the plans to manage CAS alerts going forward.
Any other business	There was no other business to discuss.

Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

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

None (but Q&SC Chair in discussion with former interim CNMO (CP) and current interim CNMO on governance arrangements and Q&SC reporting.

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

Item	Purpose	Date
Management of deteriorating patient	Noted the steps taken since the last report and that progress was on going.	Remains under Q&SC review
Challenges around new C. difficile targets	The revised national 2023/24 C Difficile target is more exacting. The IPC team have further intensified their efforts and confidence that performance improvement likely with enhanced antibiotic stewardship.	Remains under Q&SC review
CQC reporting	The new interim CNMO has acted regarding the persistent must do and should dos from previous CQC action plans in an effort to understand 'why' they remain open, despite considerable Care Group efforts. Interim CNMO noted the imminent CQC well-led inspection and open actions may not be regarded as 'well-led'.	Remains under Q&SC review
Governance arrangements and quality reporting	The work of the former interim CNMO (CP) was noted and Catherine had met the Chair of Q&SC on 26/05/23 to update on her governance improvement plan. Q&SC members noted a significant number of compliments.	Remains under Q&SC and Board review
Serious concerns regarding controlled drugs assurance	The controlled drugs accountable officer (CDOA) was invited back to Q&SC at the request of the Q&SC Chair for an assurance update. It was agreed that the interim CNMO and CMO would meet with the CDAO outside of Q&SC for an in-depth discussion to fully understand the issues and clarity on the priorities for the CDAO.	Remains under Q&SC review
Good progress with Ophthalmology backlog was made but risks remain.	Although good progress has been made, the size of ophthalmology backlog means there is a risk of recurrence, despite appropriate mitigating actions	Remains under Q&SC review

NHS
East Kent Hospitals University NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Finance & Performance Committee (FPC)	23 May 2023	Richard Oirschot Non-Executive Director	Sarah Farrell, EA/Chief Finance Officer	**Yes**	
Appendices:					
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Month 1 Finance Report Forecast Cash Position	The Group reported a £0.4m deficit in April against plan. Activity was below plan for electives and outpatients. From the 1 April electives and outpatients (apart from follow ups) have been reinstated to payment by results. Efficiency achievement is still being reviewed and will be reported from month 2.				

2023/24 Update on Savings and Efficiencies	• There was not a national requirement to report efficiencies in Month 1, although forecasts suggest around £0.3m could have been posted
	
	• The focus over the next three months will be on 2023/24 and helping Care Groups identify what is possible, so we can quickly populate the programme.
	
	• Working across cross-cutting themes the Programme Management Office (PMO) team will be transferring to the Strategic Development team from June.
	
	• Notable areas of continued focus, include:
	  • High cost medical agency;
	  • Low contribution services;
	  • Productivity through theatres, outpatients, and virtual wards.
	
	• Additionally, we are working through business planning in all areas to scope opportunities from Model Hospital, Service Line Reporting (SLR), Getting it Right First Time (GIRFT) and internal ideas, and through a communications plan to encourage everybody in the Group to come forward with their ideas.
	
	• Currently, approximately £8m of ideas has been identified, and with many of those being less than £50k (or less than £250k), the Group will need to make some difficult decisions to make substantial progress toward the £40m target.
	
	The Committee discussed and **NOTED** the M1 Savings and Efficiencies Update and **LIMITED ASSURANCE** received of the Trust's progress of the programme against a £40m target.				

Patients No Longer Fitting	In April the Trust reported 411 patients as no longer fit to reside (NLFTR).				

the Criteria to Reside	Outlined last month there are numerous ways to review this data: • Locally reported numbers provide a snap shot solely of the NLFTR status at 5pm each day (which represents the Integrated Performance Report (IPR) reported information - April at 411). • Nationally reported numbers provide a summary of the data collected at the board rounds throughout the day and also factor in patients who are NLFTR and medically optimised. • Further to this there is an additional cut of data that looks at status of patients residing at midnight. i.e. the nationally reported numbers less all of the discharges for that day. The Committee discussed and **NOTED** the Patients No Longer Fitting the Criteria To Reside and **LIMITED ASSURANCE** received.
2023/24 Deficit Funding	1) Updated Group deficit plan of £71.8m has been submitted by the Integrated Care Board (ICB) – this level of deficit will require cash support. 2) The Group has a robust cash management process in place as per section 2.2. 3) A range of potential cash generating/saving/delaying options are shown in section 2.3. 4) Additional information is required to support any borrowing, including this updated Board approval. The Committee members discussed and **APPROVED** the 2023/24 Deficit Funding. The Committee has agreed to recommend this to the Board.
Internationally Educated Nurse (IEN) Paper	The total cost for the 468 IEN's recruited in 2022 was c£13,5m. 2022 vacancy Whole Time Equivalent (WTE) has reduced from its highest at 452.1 to 162.04, and continues to do so going into 2023. Having large cohort commenced at the end of the year impacting operational support. Length of supernumerary was longer than expected at 6 months per IEN as opposed to expected 6/8 weeks. This was mainly due to the change in the Objective Structured Clinical Examination (OSCE) process which affected all Trusts undertaking and IEN cohort programme. Agency & Bank spend not reducing due to high volumes of IENs and long supernumerary periods. Higher level of a junior workforce, requiring support. The Committee discussed and **NOTED** the Internationally Educated Nurse (IEN) Paper.
We Care Integrated Performance Report (IPR)	The Committee members discussed and noted the We Care IPR with partial assurance received of the performance against key metrics for 2022/23 including the Breakthrough objectives: Improving theatre capacity, Actual utilisation, Elective Orthopaedic Centre (EOC) utilisation, Same Day Emergency Care admissions, Emergency Care Delivery Programme, Direct Access Pathways, Phase 3 William Harvey Hospital (WHH) Emergency Department (ED) build, Use of Hot Slots, Hot Clinics, Staff involvement,

	National Staff Survey, Team Engagement and Development (TED) pilot, We Care Rollout and Premium Pay Costs.
Board Assurance Framework (BAF) and Principal Mitigated Risks	• **Headlines**: There are 3 BAF risks and 8 risks on the Corporate Risk Register (CRR) relating to 'Our Future' and 'Our Sustainability'. • **Changes to the BAF during this reporting period**: There are no new 'Our Future' and 'Our Sustainability' risks added to the BAF and CRR during this reporting period. • **Changes to the CRR during this reporting period**: There are no new 'Our Future' and 'Our Sustainability' risks added. • **Other key changes**: Other changes to the risk records are included in the risk register summaries on Pages 5-12. **Tracker report**: The tracker report is presented to the Committee on Page 4 to enable the Committee to have oversight of risk movement over the past year. The Committee members did not fully discuss the BAF and Principal Mitigated Financial and Performance Risks (as no Executive/Risk Manager present at meeting.
HEC Harmonia Update	A number of update papers had been provided to FPC that set out the background to Harmonia Village. The most recent of these, prior to this report, was February 2023. These papers provide an overview of the development of the facilities, the impact of Covid-19 on the opening and use of Harmonia and the process that has been undertaken subsequent to identify and contract with an external expert organisation to run it, with the Trust taking on the role of landlord only. Following a formal procurement process, Graham Care were identified as the successful bidder. **Care Quality Commission (CQC) Registration** On 3 April 2023, Graham Care received full CQC approval to deliver services from Harmonia. The full CQC registration covers nursing and personal care and supported living services. Expected the first patients will be in Harmonia by the end of June. Current legal advice was that there is minimal risk of the grant funding be claimed back. The Committee members discussed and **NOTED** the HEC Harmonia Update.
Strategic Capital Planning and Performance Committee Update	The Committee discussed and **NOTED** the Strategic Capital Planning and Performance Committee Update.
Workforce Quarterly Report	Premium pay spend is above target. There was an increase in spend by approximately £600k during Q4 when compared to Q3. The adverse position is a combination of vacancies and operational pressures, with some impact of Covid related sickness although expenditure relating to this continues to reduce.

	Actions being taken to address the key contributory factors include: • Ongoing detailed analysis of the drivers of spend to identify additional actions to reduce spend. • Targeting recruitment to priority areas and ensuring a consequent reduction in temporary staffing. • Ensure that best practice and policy are applied to temporary staffing for escalation and specialling. • Ensure exit plans are in place for all long-term medical agency locums. • New rates have been agreed, which the Trust intends to adhere, along with attempting to remove overtime work. The Committee discussed and **NOTED** the Workforce Quarterly Report.
Strategic Investment Group (SIG) Assurance Report	The Committee received an assurance report on the activities of SIG on 16 March 2023.
Financial Improvement Oversight Group (FIOG)	The Committee received an assurance report on the activities of the FIOG on 18 April 2023.
Other items of business	None.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

Items to come back to the Committee outside its routine business cycle:		
N/A		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Board of Directors is asked to **NOTE** this assurance report.	Assurance	1 June 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**TRANSFORMING OUR TRUST: OUR RESPONSE TO "READING THE SIGNALS: MATERNITY AND NEONATAL SERVICES IN EAST KENT" – UPDATE REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER CEO)**				
PAPER AUTHOR:	**STRATEGIC PROGRAMME DIRECTOR AND EXECUTIVE DIRECTOR STRATEGIC DEVELOPMENT AND PARTNERSHIPS**				
APPENDICES:	**APPENDIX 1: PILLARS OF CHANGE PROGRESS REPORT** **APPENDIX 2: TERMS OF REFERENCE OF THE READING THE SIGNALS OVERSIGHT GROUP**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	To update the Board on progress on Transforming our Trust - the Trust's Interim response to *Reading the Signals*, the independent report into maternity and neonatal services in East Kent. To approve the Terms of Reference for the Oversight Group				
Summary of Key Issues:	This report provides an update on the approach to responding to the Reading the Signals Report to provide safer care and improved staff engagement.				
Key Recommendation(s):	The Board of Directors are asked to **NOTE** and discuss progress to date and **APPROVE** the Terms of Reference of the Reading the Signals Oversight Group.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 39:** There is a risk that women and their families will not have confidence in East Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.				
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

TRANSFORMING OUR TRUST: OUR RESPONSE TO "READING THE SIGNALS: MATERNITY AND NEONATAL SERVICES IN EAST KENT – UPDATE REPORT

1. Background

On 19 October 2022, the Independent Investigation published its report into our maternity and new-born services, *Reading the signals*. The Trust Board has accepted the report in full and apologised unreservedly for the Trust's unacceptable failings which led to the harm and suffering experienced by women, babies and their families, in our care. This report provides an update on the key elements of the Trust's response.

The end of May marked the first 6 months of the Pillars of Change Transformation Programme which is an important milestone and opportunity to share the improvements made and their impact.

2. The Pillars of Change and Assurance Framework

2.1. The Pillars of Change cover the key areas for action included in the *Reading the signals* Deliverables are both specifically focused on Maternity and Neonatal services but some are applicable to the whole Trust. They cover the practical steps the Trust has already begun to put into place and include the further work to be delivered over the next three years. The Pillars link to the areas in the Independent Investigation Report and to the Trust values that people should feel cared for, safe and respected.

2.2. A review has been undertaken of the current improvement programmes, including the Pillars of Change, to ensure there is clear understanding and alignment of the key themes in each of the programmes. The Pillars of Change form a fundamental part of the agreed organisational strategic objectives. The We Care improvement programme will provide the framework under which the Pillars of Change actions are delivered.

3. Culture and Leadership Programme (CLP)

3.1. In 2021 we started to pilot NHS England's Culture and Leadership Programme, which was developed by Professor Michael West and colleagues, as part of the National Maternity Improvement Programme, in our Women's Health and Children's Health Care Groups. It is planned to roll out this programme throughout the organisation and an implementation plan will be included in the Integrated Improvement Plan (IIP).

3.2. CLP isn't a training programme or course and there are distinct phases over the next 18 months and the Trust is currently in the first phase of scoping to find out what the Trust wants to achieve from it, involving engagement all levels.

3.3. To support the programme the Clinical Executive Management Group (CEMG) have agreed to establish a Steering Group accountable to the newly formed Strategic Transformation Board.

3.4. The CEO will be the Executive Sponsor for the Programme and the Chief People Officer the Senior Responsible Officer (SRO).

3.5. Over the next six weeks expressions of interest will be invited from all levels of staff across all services including 2gether Support Solutions (2gether) staff to become Change Champions. The plan is to recruit more than a 100 champions by the end of June.

4. The Reading the Signals Oversight Group

4.1. The *Reading the signals* Oversight Group will meet in public and is responsible and directly accountable to the Board of Directors. It provides oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the Reading the Signals report.

4.2. The group includes representatives from patients and families as well as our Council of Governors.

4.3. The second meeting of the Group was held on 9 May 2023. The group signed of the draft terms of reference (TOR) which are presented to the Board of Directors (BoD) for approval today – Appendix 2. The BoD is asked to note that there are currently 5 family representatives, but the TOR do not specific an absolute number. The Group is committed to be flexible in its approach to family representation and if other families come forward wishing to join membership of the Group this should be facilitated

4.4. At the meeting the group also agreed to establish a programme of Family Voices sessions in accessible community locations. The initial plan is to initially hold 2 meetings late June/early July led jointly by the Trust's Patient & Involvement team and Maternity & Neonatal Voices Partnership. Further sessions are expected to be planned in the Autumn following an evaluation of the first 2 sessions.

4.5. The next meeting of the Oversight group will be held on 20 June and an item on the agenda will be an update on Pillars of Change Transformation Programme and framework for evaluating the effectiveness of the Group in September 2023

4.6. At this meeting it is also intended to discuss proposals for a series of community focused family meetings, to provide additional feedback opportunities further to family and community representation on the Oversight Group.

5. The Independent Case Review Process

5.1. We have established an Independent Case Review process. Families who have concerns about the maternity or neonatal care they received from the Trust will be offered the opportunity to meet with or speak to experts independent of the Trust, regardless of whether their care had previously been reviewed or investigated by the Trust.

5.2. At the last meeting it was reported there were 21 potential Case Reviews to be undertaken. Following discussions with families this has potentially reduced to 15. The Key Lines of Enquiry (KLOES) have at the time of writing this report been agreed with ten families and 1 review complete but yet to be shared with the family.

Appendix 1: Pillars of Change Update

The Pillars of Change were developed in response to the reading the signals report
The Pillars of Change cover the key areas for action included in the Reading the Signals Report. They cover the practical steps the Trust has already begun to put into place and include the further work to be delivered over the next three years. The first phase of action was to build the foundations in the first six months. Below are the progress updates for the Building the Foundations stage.

Pillar 1 - Reducing Harm and Safe Service Delivery

	Action	Progress Update	RAG Status
Building Foundations Within First 6 Months	Eliminate the backlog of SI Investigations and achieve compliance going forward	SI backlog now cleared. The Serious Incident Policy, SI Declaration Panel and SI Investigations Panel Terms of References are all under review, due for completion by end February. Revised TOR for the SI Declaration Panel function and membership was approved at CEMG in March 2023. A further review of the SI Investigations Approval Panel is nearing completion, this will ensure high quality SI reports being produced and approved thus preventing undue delays.	Green
	introduce the new complaints process to ensure transparency and candour in our responses	25/05/23: The revised complaints process is in place. A self assessment against the PHSO Complaints Standards (December 2022) is now underway and will identify any further action that may be required to ensure that the Trust is compliant with these standards.This review will also incorporate alignment with the Duty of Candour process. Training for the Corporate and Care Group staff that manage the complaints process has commenced with further training planned.	Green
	Refocus to We Care for winter	The We Care programme was refocused during the winter period. A review has been undertaken of the We Care programme, Pillars of Change and the Integrated Improvement Plan to bring the improvement programmes into a single framework. The We Care framework for governance, oversight and delivery of the improvement programmes including the Pillars of Change.	Green
	commence the pilot 'Calls for concern' (Ryan's Rule) to support patients of any age, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected	The Pilot has been planned at WHH site. The Patient information team has produced the leaflet for relatives of patients. This will be reviewed by the staff and patient panels.	Amber

Pillar 2 – Care and Compassion

	Action	Progress Update	RAG Status
Building Foundations Within First 6 Months	We will pilot 'Civility Saves Lives' in maternity, a programme to eliminate rudeness and incivility, which has been shown to have a positive impact on patient care	First session completed 28th March 2023, second session was agreed for end of April to give eight weeks notice for consultant job plans.	Green
	Re-state the Trust Values	Staff engaged in discussions about values, staff survey and how it feels to work here at Team Brief and Staff Forum. Refreshed induction. Values prominent on sites with new posters/banners and in all internal and external communications. Appraisals include guided discussion on values.	Green
	Establish a formal programme of engagement and listening with all Maternity staff	Formal programme implemented	Green
	Introduce a simple tool to assist staff to challenge poor behaviours	The people strategy and inclusion promise provides the structure that will deliver a positive culture for the organisation including the ability to challenge poor behaviours. Both the people strategy and inclusion promise are in place.	Green
	Share and actively engage on the 'Importance of Caring' video	Film launched and engagement with staff through meet the team sessions held in Dying Matters Week in May 2023. Included in internal and external communications, shared with other Trusts who have asked to use it. Film will be incorporated into mandatory training for all staff, recorded through ESR. Film focusses on compassionate care and the role of every member of staff at all levels.	Green
	Implement the Inclusion & Respect Charter	Charter shared and promoted by staff experience team, discussed in CEMG in Jan 23 with clear call to action to use with staff. Charter included in working well together booklet printed and online and in Our Journey newsletter, distributed to all wards and departments.	Green
	Reinforce our Professional Clinical Standards and build those standards into work contracts, co-produced with our staff	Clinical standards agreed and published on staff zone, CEMG asked to share and discuss with staff (Jan 23)	Green

Pillar 3 – Engagement, Listening and Leadership

	Action	Progress Update	RAG Status
Building Foundations Within First 6 Months	We will revise our Trust-wide Communications and Engagement Strategy and deliver a communications and engagement plan consistently to reinforce the messages from Reading the signals	Refreshed strategy incorporates learning from RTS and actions within pillars of change and published February 2023. Updates on plan sent to Board and Governors quarterly. Patient Voice and Involvement Team and EDoC&E working with RTS Oversight Group on engagement with families in community settings. Monthly themed programme of engagement with staff and communications to public and stakeholders, links to IIP.	Green
	Continue the Cultural and Leadership Programme focus in maternity (and review effectiveness.	Trust CLP Programme Director appointed. CLP continuing in maternity supported by local OD Business Partner. Effectiveness due to be reviewed as part of development work for trust wide programme.	Green
	Develop our Leadership Behavioural Framework	Framework developed and incorporated into the development programme.	Green
	Start the Leadership programme for team leader, first line, middle manager	Programmes underway and initial cohorts for first line leader delivered with positive feedback. These have been supported by the design team sponsored by NHSE. Delivery as part of suite of leadership offers to staff.	Green
	Introduce a mandatory Team Brief	Team brief started January 2023, held monthly.	Green
	Establish junior doctor group on each site.	First junior doctors forum undertaken and supported by CMO and CEO.	Green

Pillar 4 – Organisational Governance Development

	Action	Progress Update	RAG Status
Building Foundations Within First 6 Months	We will continue oversight of the Maternity Improvement Programme through the Maternity and Neonatal Assurance group	The MNAG group is meeting monthly with a reporting line directloy into the Quality Committee. A comprehensive maternity dashboard provides the medium through which the agreed qualitative metrics are overseen	Green
	Revise the organisational structure of the Trust	The consultation on the proposed operational structure is underway and concluded on the 16th May 2023. Full implementation of the revised nstructure is expected to be completed by August 23 at the latest.	Green
	Achieve compliance with training in the Duty of Candour and its use	The Trust is compliant with applying the Duty of Candour (DoC) 100% of the time. The opportunity is being taken to undertake a review of the application of the DoC process and is due to be completed by 31/07/23. The outputs from this audit will be used to inform the content and delivery model of the future training plan for the application of the statutory Duty of Candour, due to roll out 30/09/23. This will run in parallel with the Culture and Leadership Programme .	Green
	Undertake an external diagnostic on Board effectiveness	Following changes at board level, with a number new appointments, the action will be reviewed with a potential emphasis on the development of the board.	Amber

Pillar 5 – Patient, Family and Community Voices

	Action	Progress Update	RAG Status
Building Foundations Within First 6 Months	We will establish a Reading the Signals Oversight Group to include representatives from patients and families as well as our Council of Governors	The oversight group has started with two meetings held to date, involves families and family representatives. Further work is underway to agree what will be reported and presented at the June meeting. Further engagement with families in community settings being arranged.	Green
	Implement a Patient Participation Group which is fully inclusive, with a patient representative as joint chair	The group has been implemented.	Green
	Expand Your Voice Is Heard to include a process for women to feel safe raising concerns, co-produced with families	First project meeting held in March 2023.	Green
	Conduct case reviews for families where required and be clear on the process	The process for case reviews is now in place and the first case is in the process of being reviewed.	Green
	Lay chairs appointed to consultant appointment panels	All consultant interview panels now have a lay chair as lead of the panel.	Green

Appendix 2: Oversight Group ToR

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

READING THE SIGNALS OVERSIGHT GROUP

1. CONSTITUTION

1.1 The Board of Directors approved the establishment of an Oversight Group which will report to the Trust Board. It will meet in public. The effectiveness of the Group will be reviewed in 6 months time.

2. PURPOSE

2.1 To provide oversight of the Trust's response to the Reading the Signals report and to make sure there is appropriate engagement with patients, their families and the Community and specifically to oversee, influence, challenge and advise on how the Trust embarks and embeds the restorative process required to address the problems identified in Reading the Signals Report.

2.2 To support the establishment of Community Family Voices meetings to develop the focus of the Trust's response to reflect the issues of importance to families as the organisation transforms its services

3. OBJECTIVES

3.1. To have oversight of the Trust wide approach to transforming the way the organisation delivers its services through the Five Pillars of Change:

a. Reducing Harm and Safe Service Delivery (Monitoring safe performance)
b. Care and Compassion (Standards of Clinical Behaviour)
c. Engagement, Listening and Leadership (Flawed team working)
d. Organisational Governance and Development (Organisational behaviour)
e. Patient, Family and Community Voices (Listening and Restoration)

3.2 The work programme set out in Pillars of Change details the Trust's transformation ambition over the next 3 years and for year one will predominantly be managed through the Trust wide Integrated Improvement Plan (IIP)which has a set of outcome measures associated with the actions)

3.3 The Clinical Executive Management Group (CEMG) will have day to day responsibility for delivery of the transformation programme and will provide regular updates for the Group using the opportunity to test and refine plans following input from members of the Group. The CEMG will also provide assurance to the Trust Board on the delivery of this restorative process

3.4 Specific improvements in maternity and neonatal services will continue to be overseen by the Maternity and Neonatal Assurance Group (MNAG) providing assurance to Trust Board.

The Maternity transformation process will be aligned with the national Maternity and Neonatal Delivery Plan focusing on:

Listening to and working with women and families with compassion
Growing, retaining and supporting the workforce
Developing and sustaining a culture of safety and learning and support
Standards and Structure, more personalised and equitable care

3.5 To receive feedback from the Community Families Voices Meetings on issues of importance to families across East Kent

3.6 To make sure that evidence of progress is publicly available and reported, and that the Group is consulted and involved in the development of the transformation programme.

3.7 To oversee and provide input into the communications and engagement strategy to support the transformation programme.

3.8 To ensure that the work of the Group is described and presented in a way that is user friendly, concise, meaningful and respectful to families.

4 MEMBERSHIP AND ATTENDANCE

4.1 Members

EKHUFT NED (Chair)

EKHUFT NED (Vice Chair)

Chief Executive Officer

Chief Nurse and Midwifery Officer

Chief Medical Officer

Chief People Officer

Executive Director Strategic Development and Partnerships

Public Governors x 3

Maternity Voices Partnership

Community Representation (1)

Patient and Family Representation (currently 5 -number to be confirmed)

4.2 Attendees

Executive Director of Communications and Engagement

Kent and Medway Integrated Care Board (ICB)

NHS England (NHSE) Representation

Quorum

4.3. The meeting will be quorate when one Non Executive Director and two Executive Directors are present and four members of external representation (including at least one family representative)

Attendance by Members

4.4. The Chair or the nominated deputy of the Committee will be expected to attend every meeting. Other members should attend 75% of meetings and send an alternate on occasions of absence. The alternate should be agreed with the Chair.

Attendance by Officers

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

5. FREQUENCY

5.1 The Group shall meet every 6/8 weeks. The Chair may call additional meetings.

6. AUTHORITY

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

6.2. The Group is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers (unless expressly authorised by the Board of Directors) and remains accountable for the work of any such group.

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by [INSERT]

7.2. Papers will be sent at least five working days before meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. ACCOUNTABILITY AND REPORTING

8.1. The Group is accountable to the Trust Board of Directors.

8.2. Minutes will be reported to the Trust Board once they have been approved by the Group Chair along with exception reports as agreed by the membership of this Group.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1 The Role of the Group and its effectiveness will be reviewed by the Group in 6 months' time ,making recommendations to Board of Directors where appropriate

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATERNITY DASHBOARD**				
MEETING DATE:	**1JUNE 2023**				
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER AND MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**				
PAPER AUTHOR:	**DIRECTOR OF MIDWIFERY**				
APPENDICES:	**APPENDIX 1: MATERNITY DASHBOARD PERFORMANCE REPORT**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The purpose of this paper is to share and present the maternity dashboard data and performance. The maternity dashboard is presented monthly to the Board as well as the Maternity and Neonatal Assurance Group (MNAG) where a more in-depth review of the dashboard is undertaken. This report details data and performance from April 2023. Following the March 2023 MNAG meeting, discussions took place with NHS England (NHSE) regarding the use of **statistical process control (SPC)** as a more informative way for reporting performance and tracking improvement. This month's dashboard has aligned the format to the use of SPC where appropriate. Metrics which are flagging under the SPC rules will have a separate exception report slide, outlining the metric definition, what the data is telling us, any interventions, impacts and risks/mitigations will be discussed.				
Summary of Key Issues:	• The staff engagement score is the lowest it has been at 5.36. • There have been 4 serious incidents reported in April.				
Key Recommendation(s):	The Board of Directors is asked to: • **DISCUSS** the contents of this report and; • **NOTE** the key issues and plans to tackle and address them.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.				

East Kent Hospitals University NHS Foundation Trust

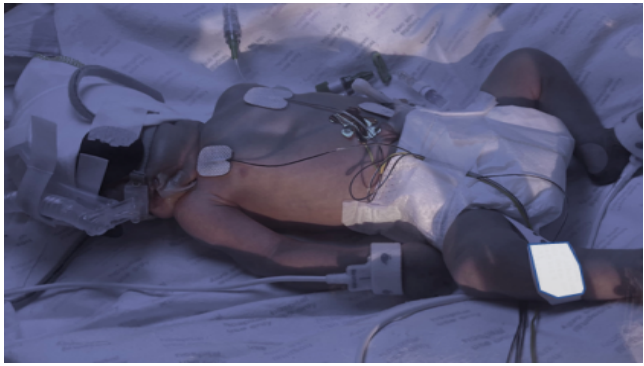
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services.	
Resource:	Y	Additional resource will be required to implement the Final Ockenden Report Immediate and Essential Actions.
Legal and regulatory:	Y	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	N/A	

East Kent Hospitals University NHS Foundation Trust

Maternity Dashboard Performance Report

April 2023



Maternity Dashboard - Revised

Following the March Maternity and Neonatal Assurance Group (MNAG) meeting, discussions took place NHSE regarding the use of **statistical process control (SPC)** as a more informative way for reporting performance and tracking improvement.

This month's dashboard has aligned the format to the use of SPC where appropriate. Metrics which are flagging under the SPC rules will have a separate exception report slide, outlining the metric definition, what the data is telling us, any interventions, impacts and risks/mitigations will be discussed.
The SPC rules used to indicate the need for an exception report are:

- These symbols indicate that performance is significantly worse; either above/below average over a longer period, a run of 6 or more increases or decreases, 1 or more periods outside of the upper or lower confidence limits, or 2 out of 3 points close to the confidence limits – these are **special cause variation**

- These symbols indicate that performance is significantly better (defined above). Once the metric has been discussed and performance remains good (i.e. better than average for a number of consecutive months) the graph and a brief description will be given on a combined slide, in order to keep the dashboard pack as succinct but informative as possible

- This symbol shows a metric which is consistently falling short of the target/threshold.

Governance, Risk & Compliance

To embed robust governance structures that underpin continuous improvement and delivery of high quality, person-centred care

Governance, Risk & Compliance: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Incidents	Serious Incidents	3	Apr-23	4			3	0	9
	Total Incidents	Sigma	Apr-23	216			243	109	376
	Moderate+ Harm (C - E)	Sigma	Apr-23	1			3	0	8
	No/Low Harm (A & B)	Sigma	Apr-23	215			240	107	373
	HSIB Referrals	1	Apr-23	1			1	0	3
	Unit Divert Diff Site	1	Apr-23	3			2	0	6
	Unit Closure	0	Apr-23	0			0	0	1
	Birthrate+ Red Flags	Sigma	Apr-23	11	L		24	0	52
Morbidity & Mortality	MBRRACE Stillbirth 12m Rate	4.21	Apr-23	3.63			4.15	3.23	4.96
	MBRRACE Stillbirths	2	Apr-23	2			2	0	6
	MBRRACE NND Rate 12m	2.02	Apr-23	0.99	L	P	1.17	0.79	1.38
	MBRRACE Neonatal Deaths	1	Apr-23	0			1	0	3
	MBRRACE Perinatal Rate 12m	5.93	Apr-23	4.62	L		5.29	4.26	5.95
	Maternal Deaths	0	Apr-23	0	L		0	0	1
Regulatory Compliance	Comm MW Equipment Audit	100.0%	Apr-23	98.5%	H		93.4%	86.8%	100%
	Fresh Eyes	90.0%	Apr-23	43.6%		F	45.4%	30.5%	60.4%

Governance, Risk & Compliance: Exception Report

Birthrate+ Red Flags

Red flag data is collected on each ward at 4 to 6 hourly intervals each day. Red flags can be delays in admission for inductions, coordinator not able to maintain supernumerary status, delays in triage, inability to provide 1:1 care, delays in pain relief, missed medication or general delayed care.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
14	43	51	23	14	22	21	16	19	17	9	11

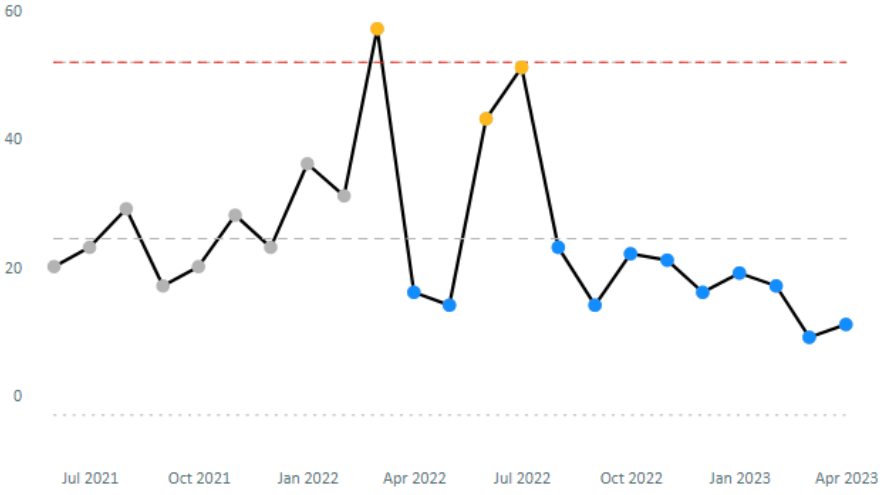
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Below Mean Run Group

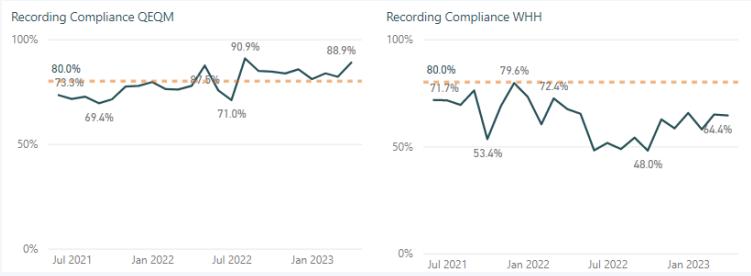
XMR Run Chart



What the chart tells us

The number of reported red flags recorded on Birthrate+ has remained lower than average for 9 consecutive months

However – only QEQM is consistently achieving the 80% recording compliance which gives assurance of the accuracy of this data. WHH is improving – 64% overall in April, but is still short of the target level. WHH Labour ward is 77%
and Folkestone is 42%



Intervention and Planned Impact

Reporting compliance static noted for WHH.
Further work by HOM with matron and band 7 team required to increase compliance and accurate recording.

Red flags include:

- Delay between admission for induction - 9 at WHH
- Co-Ordinator not able to maintain supernumerary status – 2 at WHH

It should be noted that the recording of 1:1 care is currently in 2 systems the Birth rate acuity as well as from the patient record in E3. Retrospective reviews of all women who do not have 1:1 care recorded undertaken.

Risks/Mitigations

Reporting compliance is improving but further work is required to ensure the accuracy of the data particularly at WHH site. This is likely affected by staffing and acuity of the unit.

Governance, Risk & Compliance: Exception Report

East Kent Hospitals University NHS Foundation Trust

Fresh Eyes

Compliance for Fresh Eyes recording – the target is to review each eligible patient within 60 minutes, with a 15 minute tolerance added for physical recording on the whiteboard system

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
								54.1%	43.9%	40.4%	43.6%

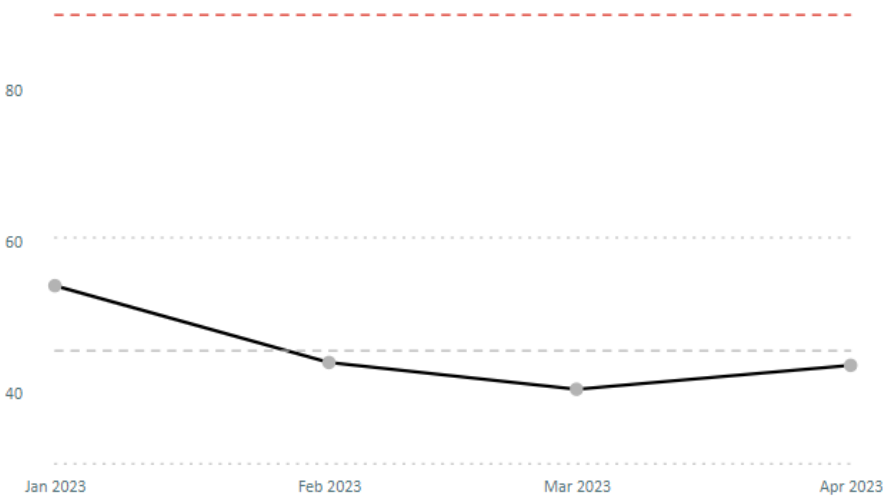
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Performance is consistently under the threshold of 90%. However, data for this metric only started in January, and as such, not enough data is available to accurately use an SPC chart.

Intervention and Planned Impact

Fresh eyes and fresh care is monitored daily on each site by the labour ward coordinators and midwifery matron's. The data is reported weekly to the HoMs and DoM which is then reported to the CQC.

The matron's and HoM's are driving forward improvements in practice and recording – this work is supported by the fetal monitoring lead specialists.

This performance metric was only added to the dashboard in January following the QCQ inspection however, weekly deep dives continue. The units have seen huge improvements in their performance however, work continues to ensure these improvements remain consistent.

Governance, Risk & Compliance: Exception Report

East Kent Hospitals University NHS Foundation Trust

Community Equipment

Weekly audits of the community teams day, on-call and homebirth bags are carried out to assess equipment compliance

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
	75.8%	90.8%	91.2%	91.9%	94.7%	97.2%	96.4%	96.1%	97.5%	98.3%	98.5%

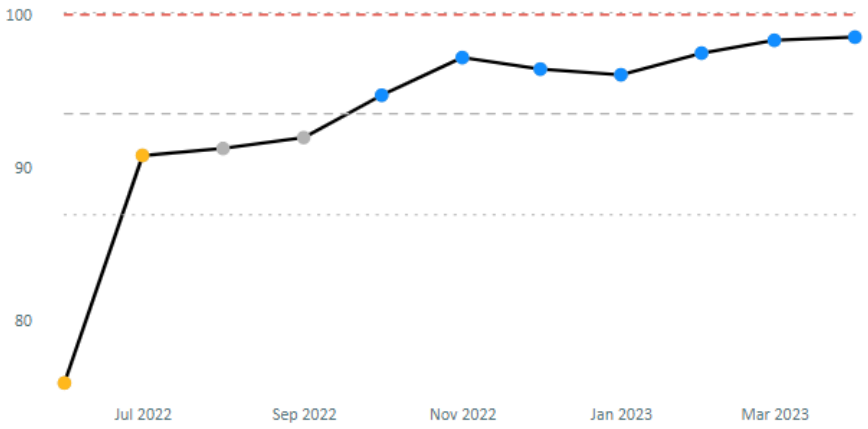
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

Compliance has been slowly increasing and is the highest recorded so far in April. However – the compliance is still short of the 100% target level.

All teams and bags were 100% compliant, except:

- Canterbury Homebirth (87%)
- Dover Homebirth (9^%)
- Dover Day Bag (96%)

Intervention and Planned Impact

Daily and weekly checks now standard practice which is monitored by the community matron's and reported to the HoM weekly.

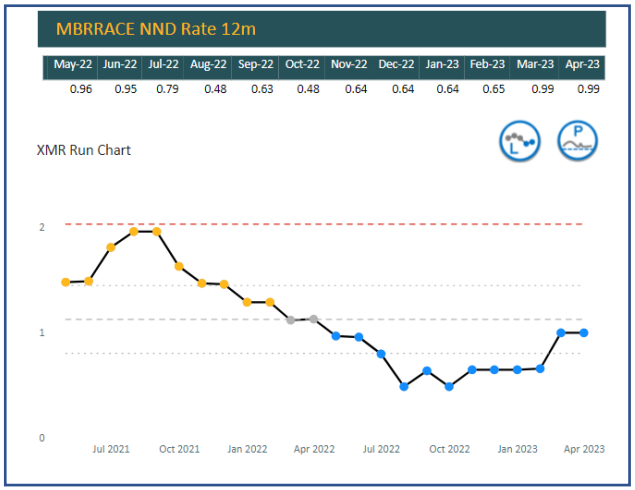
Spot check audits are also completed

Risks/Mitigations

Small community teams impact the percentage numbers when compliance is not at 100% - when investigations undertaken the midwife can evidence that checking has been undertaken however, IT issues within the community including connectivity issues can impact how this data is uploaded to the dashboard.

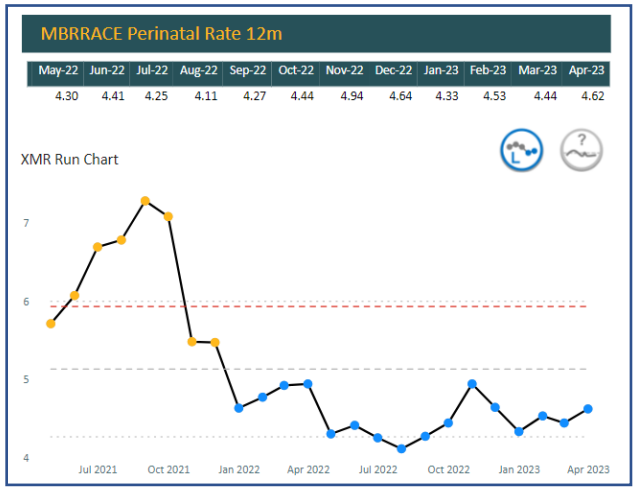
Community digital concerns included within the MTP.

Governance, Risk & Compliance : Key Performance Indicators (KPIs) consistently achieving threshold or sustained improvement (exception reported in previous months)



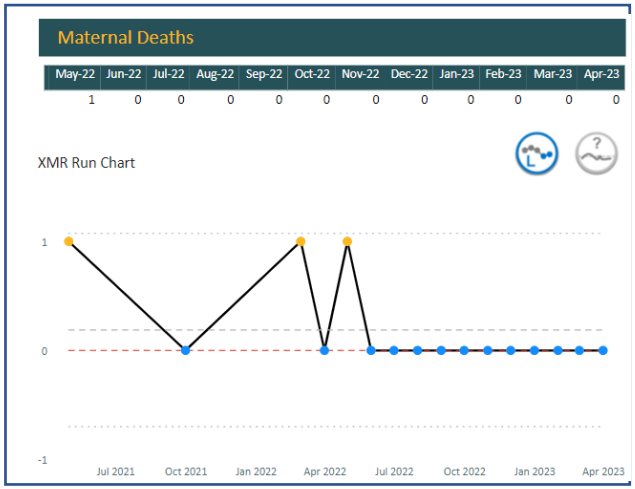
Neonatal Death Rate (12 month rolling) remains significantly lower than the target, and below average.

There was 0 NNDs in April, but 6 in the rolling 12 month period



Perinatal Death Rate (12 month rolling) remains significantly lower than the target, and below average.

There were 2 stillbirths in April, but 28 included deaths in the rolling 12 month period – 6 neonatal deaths and 22 stillbirths



11 consecutive months with 0 maternal deaths

Maternal deaths include women who died either during pregnancy , or within 6 weeks of delivery. May include deaths unrelated to obstetric health or care

People & Culture, Workforce Sustainability

To build an inclusive culture where staff feel safe, valued, listened to and supported to deliver kind and compassionate, person-centred care

To embed a process of continuous review and planning that produces and retains a competent, supported and sustainable workforce

People & Culture, Workforce Sustainability: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Workforce	1 to 1 in Labour	100.0%	Apr-23	99.4%			99.5%	98.4%	100%
	Total On-Call Hours	Sigma	Apr-23	391.2			562.2	0	1097.8
	Occurance On-Call In	Sigma	Apr-23	94			101	34	168
	Birthrate+ Meets Acuity	Sigma	Apr-23	57.5%			55.0%	34.5%	75.5%
	Supernumerary Status	100.0%	Apr-23	99.3%			96.3%	90.8%	100%
Maternity Training	Fetal Monitoring Training	90.0%	Apr-23	94.0%			88.2%	83.2%	93.2%
	PROMPT Excl ML & LTS	90.0%	Apr-23	97.1%			90.1%	83.5%	96.7%
	Fetal M. Excl ML & LTS	90.0%	Apr-23	97.7%			91.8%	87.3%	96.3%
	PROMPT	90.0%	Apr-23	93.1%			86.5%	79.3%	93.8%
	NLS Training	90.0%	Apr-23	91.3%			82.6%	75.4%	89.7%
	NLS Excl ML & LTS	90.0%	Apr-23	94.3%			84.7%	77.8%	91.6%

People & Culture, Workforce Sustainability: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Staff Survey	Staff Involvement Score	6.90	Mar-23	5.36			5.02	5.43	5.74
Workforce	Worked WTE: Birth Ratio	24.00	Mar-23	19.27			21.99	17.40	25.98
	Midwifery/MSW Turnover Rate	11.5%	Mar-23	10.2%			6.22%	4.58%	7.86%
	Midwifery/MSW Vacancy Rate	10.0%	Mar-23	10.3%			11.7%	0%	10.1%
	Midwifery/MSW Appraisal Rate	85.0%	Mar-23	63.2%			70.1%	63.0%	77.1%
	Sickness Rate	5.0%	Mar-23	7.8%			7.80%	4.95%	10.6%
Mandatory Training	Safeguarding Adult Lvl 1	90.0%	Mar-23	100%			100%	100%	100%
	Safeguarding Adult Lvl 2	90.0%	Mar-23	80.3%			85.6%	81.2%	90.0%
	Safeguarding Adult Lvl 3	90.0%	Mar-23	83.3%			22.4%	0%	45.0%
	Prevent Lvl 1	85.0%	Mar-23	100%			100%	100%	100%
	Prevent Lvl 2	85.0%	Mar-23	80.4%			83.2%	66.0%	100%
	Hand Hygiene	85.0%	Mar-23	56.3%			47.6%	40.7%	54.5%
	Dementia	85.0%	Mar-23	84.6%			19.0%	0%	43.4%
	Resus Adult	85.0%	Mar-23	82.1%			65.3%	52.4%	78.3%
Statutory Training	Equality & Diversity	85.0%	Mar-23	93.0%			92.7%	91.0%	94.4%
	Child Protection Level 1	90.0%	Mar-23	100%			100%	100%	100%
	Child Protection Level 2	90.0%	Mar-23	79.6%			89.6%	83.9%	95.3%
	Child Protection Level 3	90.0%	Mar-23	76.3%			89.9%	87.1%	92.7%
	Manual Handling	85.0%	Mar-23	90.7%			88.0%	86.0%	89.9%
	Fire	85.0%	Mar-23	89.1%			87.7%	85.0%	90.3%
	Health & Safety	85.0%	Mar-23	92.8%			92.1%	90.4%	93.7%
	Infection Control	85.0%	Mar-23	96.3%			92.9%	85.1%	100%
	Information Governance	85.0%	Mar-23	84.8%			86.6%	83.1%	90.2%

People & Culture, Workforce Sustainability: Exception Report

Staff Involvement Score
National annual staff survey results provided by Picker in March each year.
Staff engagement questions added to Staff Friends & Family quarterly surveys, commended in March 2021.
3 questions in staff survey and replicated in quarterly staff Friends & Family Test (FFT) which provides the overall involvement score.

This metric is for the whole of Women's Health, not just maternity.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
5.52	5.52	5.52	5.96	5.96	5.96	5.83	5.83	5.83	5.36	5.36	5.36

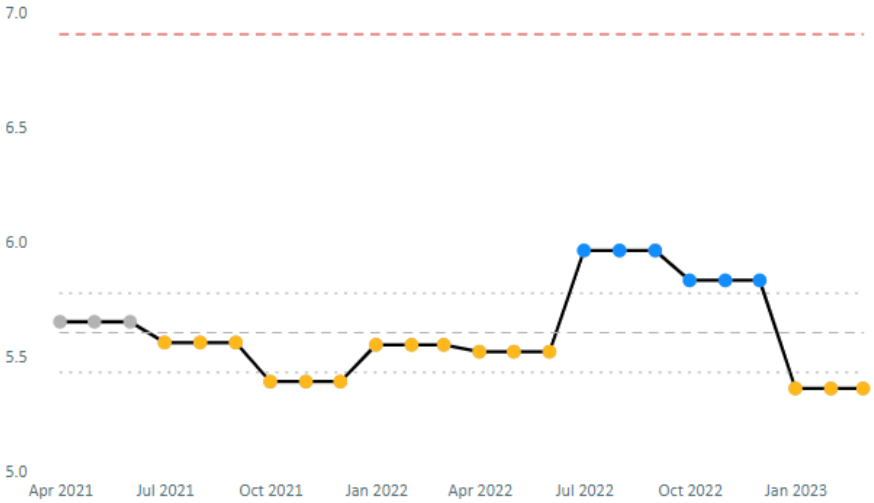
F — Variation indicates consistently falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us
This data is quarterly, and as such an SPC chart is less appropriate – however, the scores for March are the lowest seen so far, at 5.36.

Intervention and Planned Impact

Engagement work is planned and linked to the Maternity Transformation Plan (MTP)

Newly appointed Director of Midwifery (DoM) and DDoM undertaking staff forums and increasing visibility to gain an understanding of the staff holistic well-being and rationale behind the engagement scores.

Gynaecology matron post currently vacant

"Civility Saves Lives" training sessions being held in May and plans to refresh the "Human Factors" training underway.

Risks/Mitigations

This data is for the whole of women's health and not specifically maternity or gynaecology separately.

A number of interim posts have been held within the maternity department including the Director of Midwifery. However, substantial Director and Deputy Director of Midwifery now in post.

Continuing inspections, press reporting, rising waiting lists, outliers on the gynaecology and the latest CQC report that is due to be published 26 May 2023 are all adding to unrest and unhappiness with all staff groups.

People & Culture, Workforce Sustainability: Exception Report

Midwifery / MSW Turnover Rate
WTE (whole time equivalent) leavers in month, divided by the total WTE. This is a rolling 12 month rate, 1 month in arrears.

This metric includes all nursing and midwifery registered staff under 560 midwifery, and all 'additional clinical services' – all MSW/MCAs apart from those recorded under the budget code of 3208 Midwifery Management.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
4.9%	4.8%	4.7%	5.4%	5.4%	5.9%	6.9%	7.0%	7.5%	8.9%	9.5%	10.2%

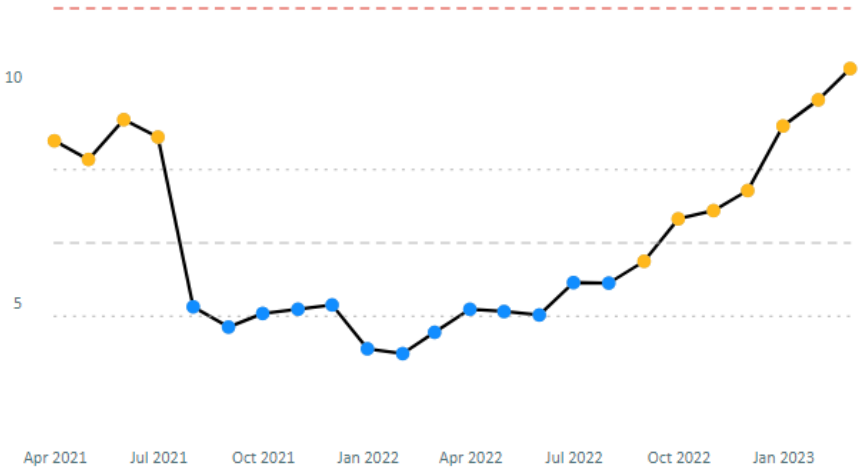
P — Variation indicates consistently passing the target

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

Flag Description

Astronomical Point
Ascending Run Group
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us
There has been a significant rise in turnover up to March, at 10.2% for maternity (midwives and support staff)
Within this figure, the turnover rate at WHH is the driving factor – with a significantly high rate of 22.1%, compared to the QEQM rate of 2%, and Community at 4.1%.

Intervention and Planned Impact
Work has been completed to develop a mitigation plan to address staffing on a day to day basis. This has significant financial implications and has been submitted to the Executive team for consideration. The plan includes:

- The implementation of a flexible team that can be deployed on a shift by shift basis to areas where there is the greatest challenge in terms of staffing and acuity. The model has been developed in partnership with staff and involves the use of enhanced NHSP rates.
- The increase in the number of hours available for the discharge coordinator role
- Increase to the number of support staff including the move forward with the MSW competency framework

Risks/Mitigations
The increase in turnover further adds to the impact on the day to day staffing levels.

Until the plan above has been agreed the following steps will continue to be deployed;

- Use of NHSP and agency midwives
- Review of service wide staffing activity and acuity using MOPEL system at 10 am sit rep
- Lower threshold for divert between units to equalise activity
- Close management of Inductions of labour
- Ongoing recruitment
- Deployment of additional HCA to release midwifery time

People & Culture, Workforce Sustainability: Exception Report

Midwifery / MSW Appraisal Rate
Appraisal rate for all staff under 560 maternity, excluding admin and clerical staff

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
79.9%	74.5%	75.2%	74.2%	71.7%	74.2%	73.4%	74.2%	71.2%	68.0%	65.2%	63.2%

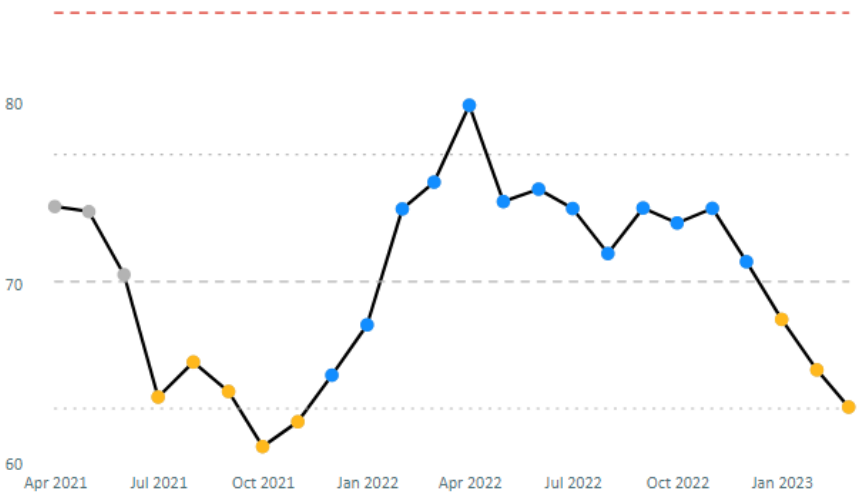
F — Variation indicates consistently falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us
Appraisal rates continue to fall, with 3 months beyond the 2 sigma group. There is significant disparity between the sites:

- WHH compliance is 36% - 47 midwives and 11 support staff non-compliant
- QEQM compliance is 83% - 11 midwives and 8 support staff non-compliant
- Community compliance is 68% - 29 midwives and 1 support staff non-compliant
- Management (including governance/specialised MW) compliance is 52%

Intervention and Planned Impact

Targeted work underway by the matron's and HoM's to improve appraisal rates. This includes:

- Group appraisals if appropriate
- Increase number of midwives who can undertake appraisals
- Prompt recording of the appraisal on ESR

A deep dive at the WHH identified that there was an issue with "uploading" the appraisal onto the ESR system – this has now been rectified.

Risks/Mitigations

Appraisal

People & Culture, Workforce Sustainability: Exception Report

Safeguarding Adults Training

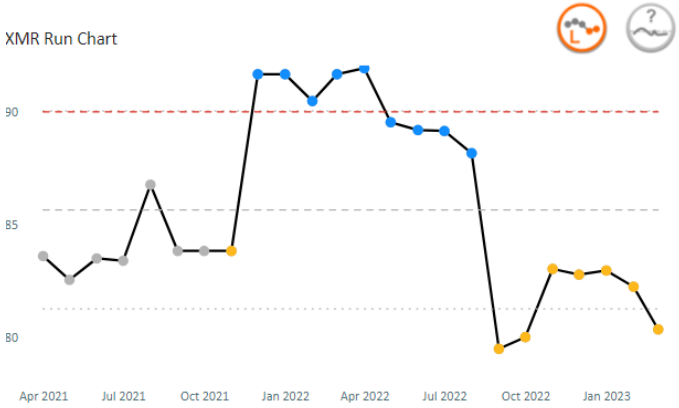
Safeguarding Adults Level 2 training compliance for staff on ward/department 344 3210 Maternity WHH, 344 3211 Maternity QEQM and 344 3212 Maternity K&C and Canterbury Coastal Community. This training is required for the majority of the staff

Safeguarding Adults Level 3 training compliance for staff on ward/department 344 3210 Maternity WHH, 344 3211 Maternity QEQM and 344 3212 Maternity K&C and Canterbury Coastal Community. Note – this level of training relates to a small number of staff

Safeguarding Adult Lvl 2

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
91.9%	89.5%	89.2%	89.1%	88.2%	79.5%	80.0%	83.0%	82.8%	83.0%	82.2%	80.3%

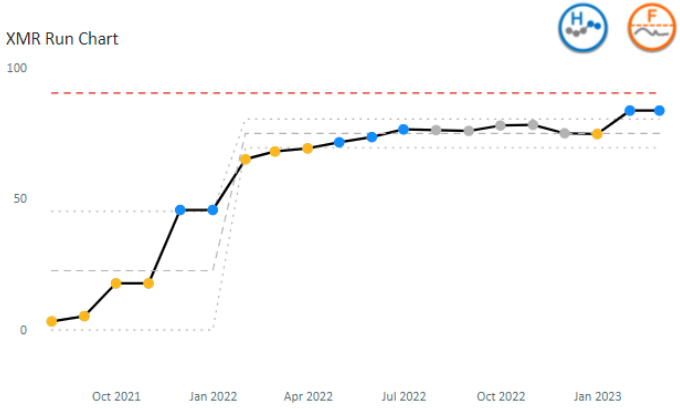
XMR Run Chart



Safeguarding Adult Lvl 3

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
69.0%	71.3%	73.3%	76.2%	75.9%	75.6%	77.6%	77.9%	74.7%	74.4%	83.3%	83.3%

XMR Run Chart



What the chart tells us

Level 2

Compliance has not been achieved for 11 consecutive months, and the March figure has now dropped below the lower confidence limit

- WHH compliance : 77%
- QEQM compliance : 79%
- KCH/Community compliance : 86%

Level 3

There has been a significant improvement in Level 3 training over the past 2 months – with compliance above the upper confidence limit. However, this has not been quite enough to tip into compliance (90%)

Intervention and Planned Impact

There remain challenges in terms of capacity for safeguarding training, and dates where there remains availability have been shared with teams to ensure individuals who are non compliant are rostered to attend.

Risks/Mitigations

Capacity for safeguarding training remains a challenge –following the departure of the interim DoM the Matron for education and training is going to establish improved lines of communication with the safeguarding lead to ensure robust oversight and forward planning of the training.

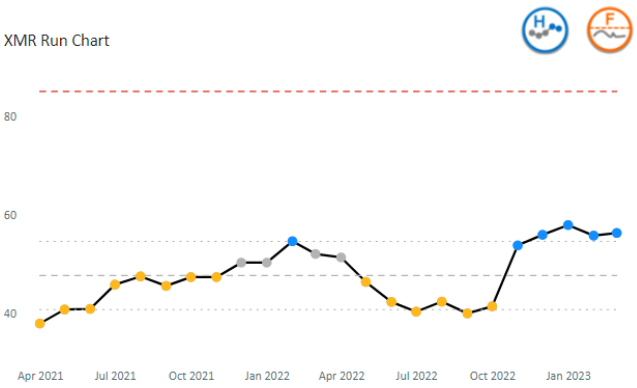
People & Culture, Workforce Sustainability: Exception Report

Hand Hygiene, Dementia and Resus Adult Training

Hand Hygiene, Dementia and Resus Adult training compliance for staff on ward/department 344 3210 Maternity WHH, 344 3211 Maternity QEQM and 344 3212 Maternity K&C and Canterbury Coastal Community

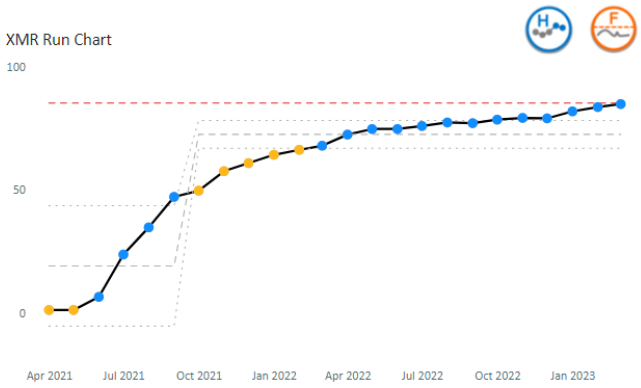
Hand Hygiene

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
51.3%	46.4%	42.3%	40.4%	42.4%	40.0%	41.4%	53.8%	55.9%	57.9%	55.8%	56.3%



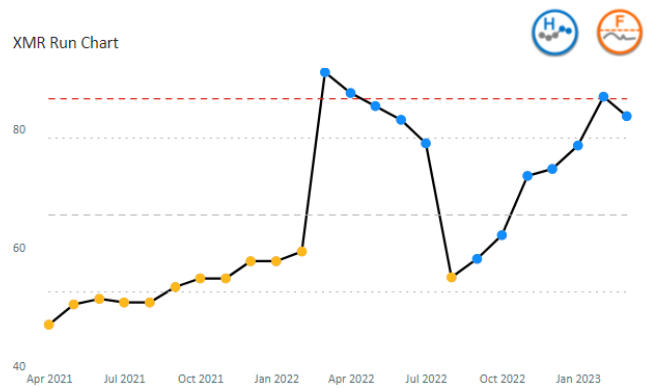
Dementia

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
72.2%	74.5%	74.5%	75.7%	77.1%	76.9%	78.3%	79.0%	78.8%	81.6%	83.4%	84.6%



Resus Adult

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
86.0%	83.8%	81.4%	77.5%	54.9%	58.0%	62.0%	72.0%	73.2%	77.1%	85.4%	82.1%



What the chart tells us

Hand Hygiene compliance remains static, above the average and upper confidence limit – however falls short of compliance (85%). WHH : 47%, QEQM : 66%, KCH/Community : 55%
Dementia compliance continues to improve month on month, falling just short of compliance in March (threshold is 85%). WHH : 76%, QEQM : 92%, KCH/Community : 86%
Resus Audit compliance continues to improve, but fell short of compliance in March (threshold is 85%). WHH : 72%, QEQM : 85%, KCH/Community : 90%
In all cases – WHH staff have the lowest compliance levels

Intervention and Planned Impact

All maternity departments have introduced robust methodologies to monitor hand hygiene compliance:

- Weekly environmental audits which include hand hygiene
- Daily monitoring recorded via tendable
- Increased number of staff who can undertake hand hygiene training

Risks/Mitigations

Hand hygiene training and compliance are recorded on ESR and Tendable. Glitches within ESR recording has been noticed across the Trust and the teams are escalating and working with the people and culture lead to address these reporting errors.

People & Culture, Workforce Sustainability: Exception Report

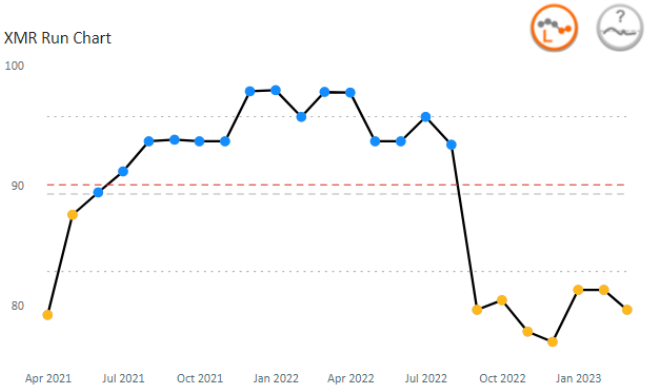
East Kent Hospitals University NHS Foundation Trust

Child Protection Training

Child Protection Level 2 training compliance for staff under 344 3212 Maternity K&C and Canterbury Coastal Community, 344 3211 Maternity QEQM and 344 3210 Maternity WHH.
Note – this level of training relates to a small number of staff
Child Protection Level 3 training compliance for staff under 344 3212 Maternity K&C and Canterbury Coastal Community, 344 3211 Maternity QEQM and 344 3210 Maternity WHH.
This training is required for the majority of the staff

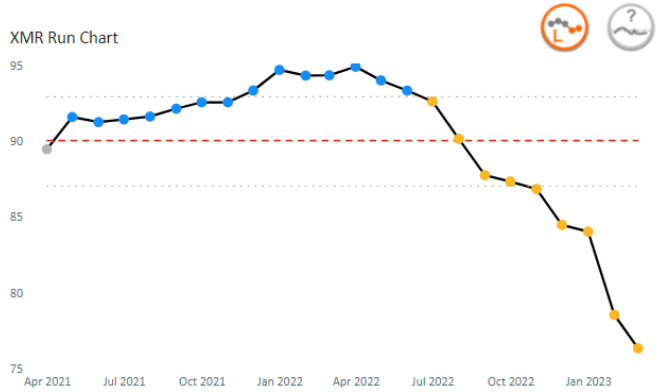
Child Protection Level 2

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
97.7%	93.6%	93.6%	95.7%	93.3%	79.6%	80.4%	77.8%	76.9%	81.3%	81.3%	79.6%



Child Protection Level 3

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
94.9%	94.0%	93.3%	92.6%	90.1%	87.7%	87.3%	86.8%	84.4%	84.0%	78.5%	76.3%



What the chart tells us

Level 2

Compliance has not been achieved for 7 consecutive months, with all months below the lower confidence limit

- WHH compliance : 70%
- QEQM compliance : 91%
- KCH/Community compliance : 75%

Level 3

There has been a significant reduction in Level 3 training over the past 4 months – with compliance below the lower confidence limit. All sites have similar compliance levels

- WHH compliance : 74%
- QEQM compliance : 77%
- KCH/Community compliance : 78%

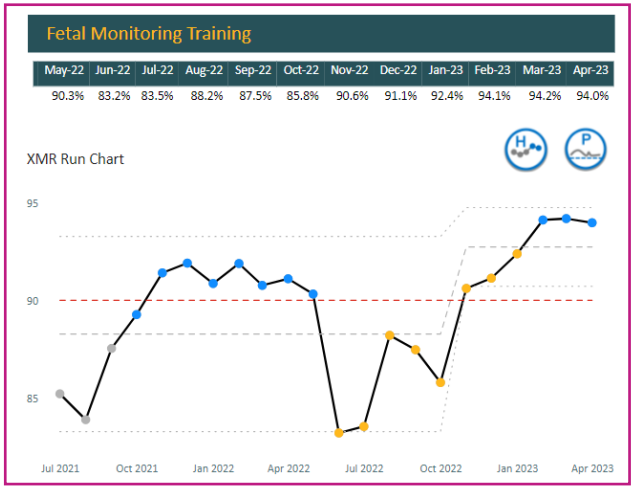
Intervention and Planned Impact

There remain challenges in terms of capacity for safeguarding training, and dates where there remains availability have been shared with teams to ensure individuals who are non compliant are rostered to attend.

Risks/Mitigations

Capacity for safeguarding training remains a challenge –following the departure of the interim DoM the Matron for education and training is going to establish improved lines of communication with the safeguarding lead to ensure robust oversight and forward planning of the training.

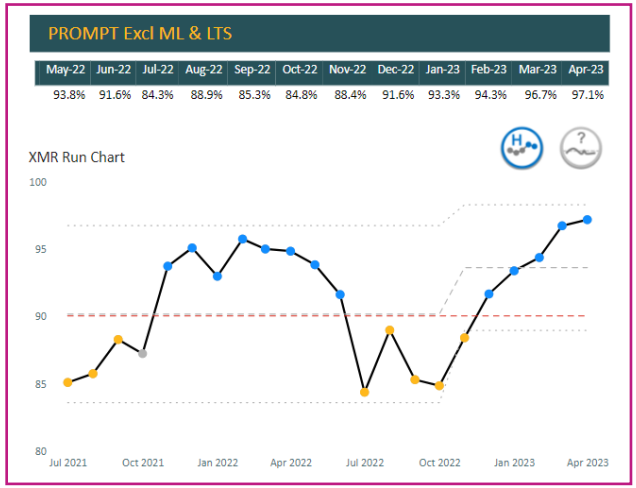
People & Culture, Workforce Sustainability: KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)



Fetal Monitoring training
All staff (includes staff on maternity and long term sick)
Compliance achieved for 6 consecutive months – last 3 months near the upper confidence limit.

Percentage of compliance for staff exc LTS and maternity leave is 97.7%

Only two training weeks were held during April due to bank holidays and due to room availability all training other MDT training was held virtually.

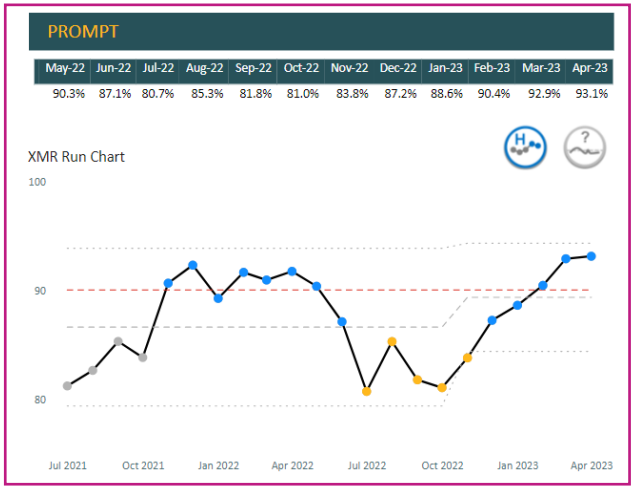


PROMPT training
All staff (excludes staff on maternity and long term sick)

Compliance achieved for 5 consecutive months, with an upwards trend near the upper confidence limit.

Only two training weeks were held during April due to bank holidays and due to room availability all training was held virtually.

Due to limited availability of MDT faculty (obstetric) , one of the two sessions were held virtually

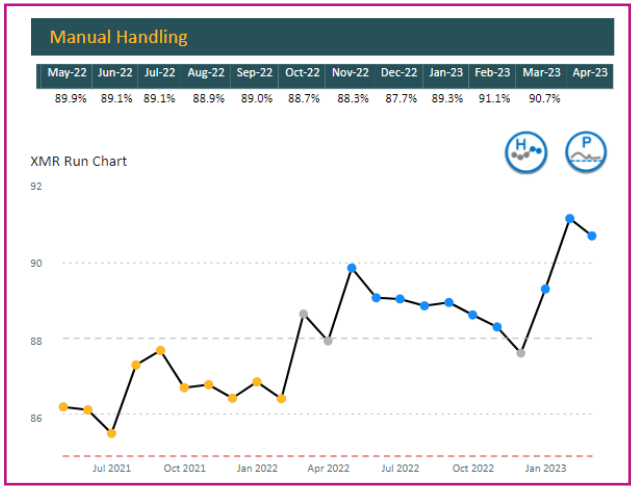


PROMPT training
All staff (includes staff on maternity and long term sick)

Compliance achieved for 3 consecutive months

Only two training weeks were held during April due to bank holidays and due to room availability all training was held virtually.

Due to limited availability of MDT faculty (obstetric) , one of the two sessions were held virtually



Manual Handling training
Compliance improved for 2 months, and sits well clear of the target of 85%

Clinical Pathways

To progress evidence-based clinical care pathways to consistently deliver equitable, high quality, safe care and treatment

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Antenatal	Number of Bookings	Sigma	Apr-23	485			556	362	750
	Bookings <13w Exceptions Excl	Sigma	Apr-23	95.4%			93.3%	90.8%	95.8%
	Bookings <13w	Sigma	Apr-23	89.1%			87.1%	83.9%	90.2%
	Bookings <10w	Sigma	Apr-23	51.0%			47.5%	38.9%	56.2%
	Women Aged <19 at Booking	Sigma	Apr-23	10			11	0	21
	Total AN Appointments	Sigma	Apr-23	3,883			4,570	3,569	5,571
	Total AN Appts Virtual	Sigma	Apr-23	5.3%			16.0%	12.8%	10.5%
	Revised Birth Place at AN Appt	95.0%	Apr-23	97.9%			97.5%	97.0%	98.0%
	Revised Care Plan at AN Appt	95.0%	Apr-23	99.8%			99.5%	99.1%	99.9%
Triage	Telephone Triage by MW	95.0%	Apr-23	99.5%			81.7%	65.9%	100%
	BSOTS Total Seen	Sigma	Apr-23	2,174			2,276	1,638	2,914
	BSOTS Midwife Assessment	Sigma	Apr-23	98.6%			97.9%	94.1%	100%
	BSOTS Dr Assessment	Sigma	Apr-23	91.4%			92.1%	85.2%	98.9%
	BSOTS Datix Completed	Sigma	Apr-23	82.1%			57.3%	16.7%	98.0%
	BSOTS Non Triage Activity	Sigma	Apr-23	689			810	502	1,118

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Delivery	Total Babies Born	Sigma	Apr-23	466			515	432	597
	Term Livebirth Delivery Rate	Sigma	Apr-23	92.2%			91.6%	87.7%	95.5%
	Induction Rate	Sigma	Apr-23	34.3%			33.9%	26.6%	41.2%
	Spon Vaginal Delivery Rate	Sigma	Apr-23	47.8%			48.8%	42.1%	55.4%
	Instrumental Delivery Rate	Sigma	Apr-23	9.3%			11.0%	7.06%	15.0%
	Forcep Delivery Rate	Sigma	Apr-23	6.1%			7.21%	3.32%	11.1%
	Vacuum Delivery Rate	Sigma	Apr-23	3.3%			3.82%	1.34%	6.31%
	Total Section Rate	Sigma	Apr-23	42.6%			38.0%	30.3%	45.6%
	Elective Section Rate	Sigma	Apr-23	20.4%			16.3%	13.1%	22.2%
	Emergency Section Rate	Sigma	Apr-23	22.2%			21.6%	18.3%	24.9%
	Cat 1 Section <30m	Sigma	Apr-23	80.0%			79.1%	61.3%	97.0%
	Cat 2 Section <75m	Sigma	Apr-23	60.3%			68.1%	47.7%	88.6%
	Robson Group 1 C/S Rate	Sigma	Apr-23	20.5%			17.9%	10.9%	29.0%
	Robson Group 2 C/S Rate	Sigma	Apr-23	62.0%			50.3%	32.0%	65.7%
	Robson Group 5 C/S Rate	Sigma	Apr-23	88.5%			81.3%	71.0%	91.7%
	VBAC	Sigma	Apr-23	11.1%			15.3%	8.41%	20.9%
	Homebirth Rate	Sigma	Apr-23	2.6%			2.00%	0.25%	3.75%
	Planned Homebirth Rate	Sigma	Apr-23	2.2%			0.98%	0%	2.14%

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Delivery Outcomes	3rd & 4th Degree Tears	Sigma	Apr-23	2.3%			3.10%	0.24%	5.97%
	MOH >1500ml	Sigma	Apr-23	2.0%			2.85%	0.68%	5.02%
	Shoulder Dystocia	Sigma	Apr-23	0.9%			1.52%	0%	3.68%
	Apgar <7 @ 5mins	Sigma	Apr-23	0.5%			0.87%	0%	2.59%
	Premature birth <37w	Sigma	Apr-23	7.6%			8.31%	4.58%	12.0%
Postnatal	Total PN Appointments	Sigma	Apr-23	53			392	16	167
	First PN Visit at Home	Sigma	Apr-23	11.4%			10.3%	0%	24.1%
	Total PN Appts Virtual	Sigma	Apr-23	54.7%			62.6%	34.4%	90.8%
	Maternal Readmissions	Sigma	Apr-23	4.1%			3.59%	1.05%	6.13%
	Neonatal Readmissions	Sigma	Apr-23	11.0%			8.43%	4.95%	11.9%
Anaesthetics	Anaesthetic within 30mins	80.0%	Apr-23	95.4%			92.6%	83.0%	100%
	Anaesthetic within 60mins	100.0%	Apr-23	97.7%			97.0%	91.6%	100%
	Anaesthetic Timeliness DQ	Sigma	Apr-23	5			5	0	14
Public Health	Skin to Skin Contact	Sigma	Apr-23	77.5%			77.4%	71.2%	83.6%
	Breastfeeding First Feed	Sigma	Apr-23	63.2%			68.4%	60.2%	76.6%
Other	ITU Admissions	Sigma	Apr-23	1			2	0	6

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
SBLCB	E1 - Co Taken at Booking	80.0%	Apr-23	97.5%			9.52%	0%	58.2%
	E1 - Co >=4ppm at Booking	Sigma	Apr-23	12.3%			0%	12.2%	21.6%
	E1 - Co Reading taken at 36w	80.0%	Apr-23	88.3%			0%	61.5%	89.8%
	E1 - Co >=4ppm at 36w	Sigma	Apr-23	11.5%			0%	3.79%	15.3%
	E1 - Quit by 36w	Sigma	Apr-23	53.3%			52.1%	10.4%	93.7%
	E2 - SGA Detected Antenatally	Sigma	Apr-23	4.3%			4.28%	0.97%	7.59%
	E2 - Babies <3rd Centile 38w+	Sigma	Apr-23	45.0%			50.8%	18.1%	83.4%
	E2 - Babies <10th Centile 39w+	Sigma	Apr-23	38.7%			45.5%	25.1%	65.9%
	E2 - FGR Risks recorded	80.0%	Apr-23	99.6%			99.3%	98.6%	100%
	E3 - RFM Computerised CTG	80.0%	Apr-23	96.1%			19.1%	0%	100%
	E3 - RFM Leaflet Given by 28w	80.0%	Apr-23	87.5%			90.7%	86.9%	94.5%
	E4 - Fetal Monitoring Training	90.0%	Apr-23	94.0%			88.2%	83.2%	93.2%
	E5 - AN Steroids within 7 days	80.0%	Apr-23	25.0%			49.7%	6.44%	93.0%
	E5 - AN Steroids > 7 days	Sigma	Apr-23	0.0%			15.0%	0%	49.1%
	E5 - Mag Sulph within 24hrs	80.0%	Apr-23	50.0%			77.3%	0%	100%
	E5 - Appropriate Birth Setting	80.0%	Apr-23	99.3%			99.6%	98.9%	100%
	E5 - Singleton Born 16+0-23+6w	Sigma	Apr-23	0.2%			0.12%	0%	0.47%
	E5 - Singleton Born 24+0-36+6w	Sigma	Apr-23	6.7%			7.03%	3.43%	10.6%

Clinical Pathways: Exception Report

Antenatal Appointments

Total number of antenatal clinic appointments – midwife and obstetric, including virtual appointments

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
5,114	4,812	4,368	4,699	4,549	4,271	4,481	3,900	4,422	3,877	4,393	3,883

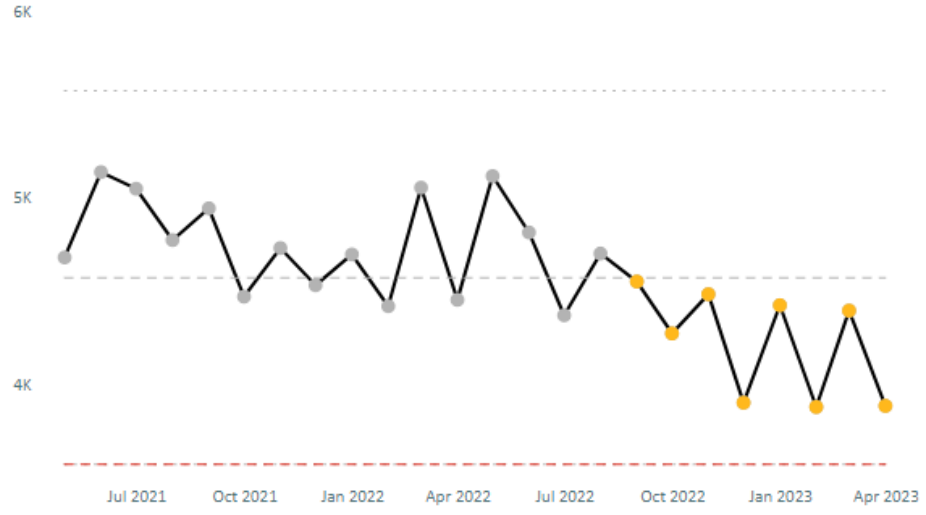
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

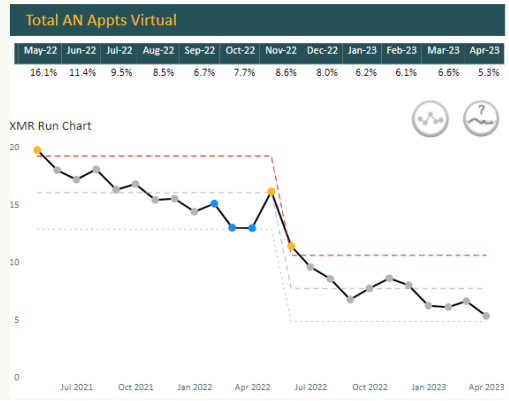
Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of antenatal appointments has been falling and has been below average for 8 consecutive months. This follows a reduction in virtual appointments – but a corresponding increase in face to face appointments has not been observed.



Interventions and Planned Impact

The community teams have worked hard to reintroduce face to face appointments for women attending community clinics.

As part of the ongoing improvement work across the antenatal pathway the work will now focus on the obstetric clinics across both hospital sites. Workforce and physical space constraints have meant some clinic appointments have remained virtual. The majority of obstetricians are onboard with the need to re-introduce face to face appointments for women.

The MTP has a workstream reviewing antenatal appointments – the team are working to understand the narrative behind this data and working collaboratively with the team to address any concerns.

Risks/Mitigations

The key impact for women is the need for duplicate appointments where virtual appointments maintained. This can only be addressed once more obstetric appointments are face to face and there is appropriate midwifery support for the hospital based appointments at WHH and QEQM.

Clinical Pathways: Exception Report

East Kent Hospitals University NHS Foundation Trust

Babies Born

Number of Babies born

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
522	568	557	540	527	539	487	462	498	446	457	466

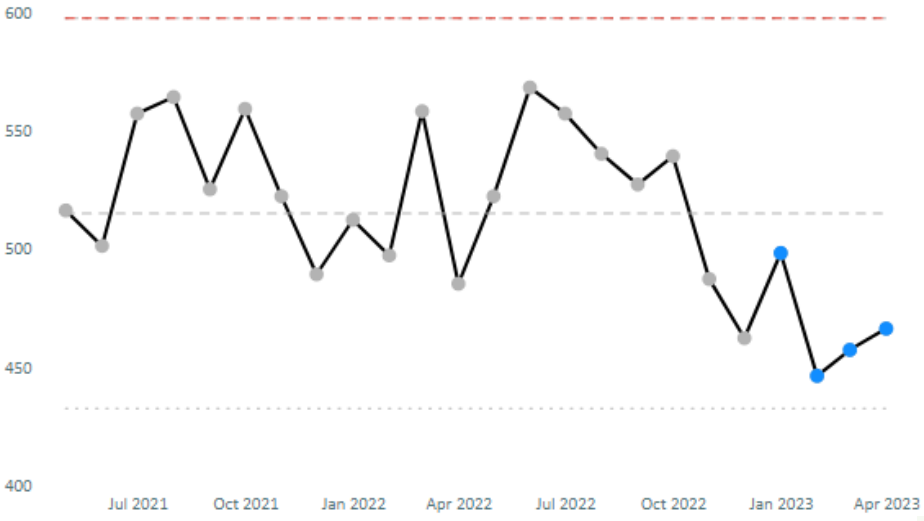
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



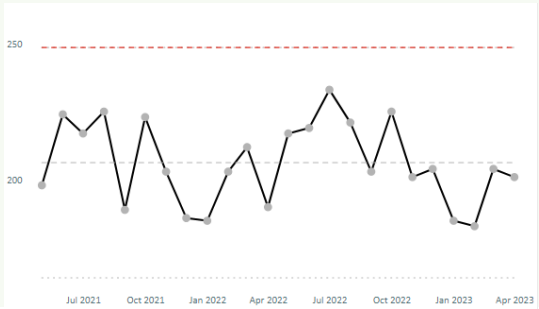
What the chart tells us

There has been a reduction in birth numbers for 6 consecutive months below average – this is seen at WHH primarily, in the chart below (WHH on the left, QEQM on the right)

Forecast deliveries have been lower due to lower bookings last summer, and look likely to remain around 500 per month until June, when numbers of bookings increased

WHH

QEQM



Interventions and Planned Impact

Work has been undertaken to ensure there is greater oversight in terms of how activity is distributed between sites, especially in relation to the inductions of labour. With the increase in the number of inductions, the band 7 coordinators have now taken over the monitoring of this on a day to day basis to ensure an even spread across the week , with the ideal maximum number per site being set at 3 per day.

Discussions have happened with colleagues across the LMNS, and there is work being undertaken, led by the LMNS on how the approach to out of area bookings is standardised to ensure no woman or service is disadvantaged.

A full workforce review is planned within the next 3 months to understand the impact on the falling birth rate for workforce planning and deployment.

Clinical Pathways: Exception Report

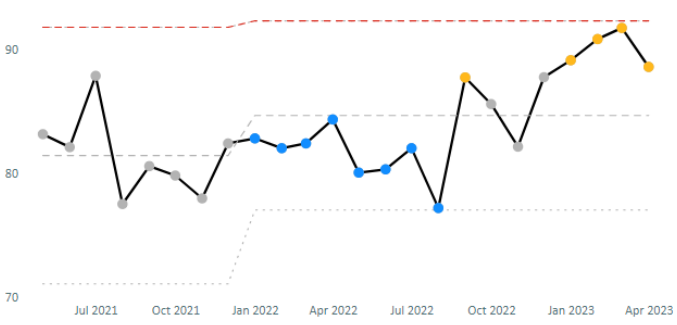
Robson group 5 Caesarean Section Rate , VBAC Rate and Spontaneous Vaginal Delivery Rate

- Of all Robson Group 5 women delivering, what % had a section. Robson group 5 = previous caesarean section, singleton cephalic, >=37+0 weeks gestation
- All of women who delivered and had a previous section, how many had a vaginal birth (assisted or unassisted)
- Percentage of all women delivering who had a spontaneous vaginal delivery (i.e. not an instrumental or caesarean section delivery)

Robson Group 5 C/S Rate

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
80.0%	80.3%	82.0%	77.1%	87.7%	85.5%	82.1%	87.7%	89.1%	90.8%	91.7%	88.5%

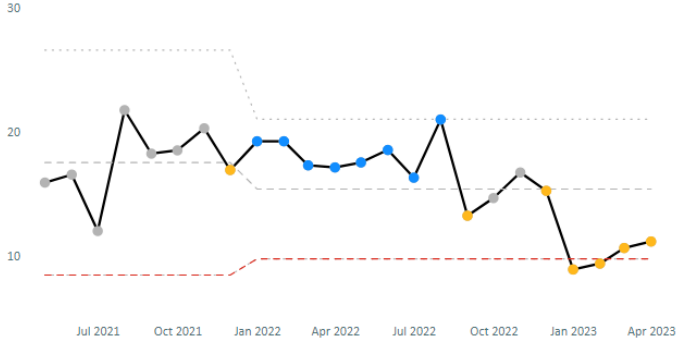
XMR Run Chart



VBAC

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
17.5%	18.5%	16.3%	20.9%	13.2%	14.6%	16.7%	15.2%	8.9%	9.3%	10.6%	11.1%

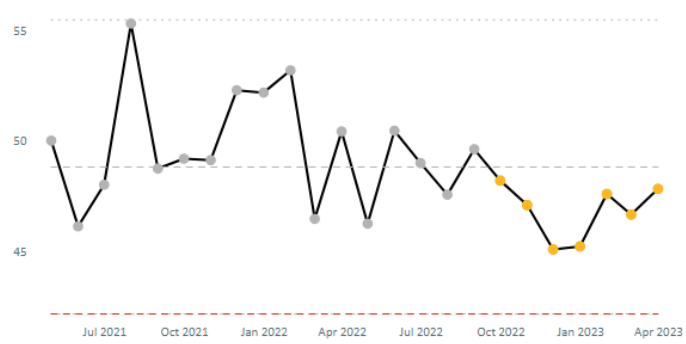
XMR Run Chart



Spon Vaginal Delivery Rate

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
46.3%	50.4%	49.0%	47.6%	49.6%	48.2%	47.1%	45.1%	45.2%	47.6%	46.7%	47.8%

XMR Run Chart



What the chart tells us

The section rate for Robson Group 5 women has been increasing, with the 4 most recent months close to the upper confidence limit.

A similar increase is seen across both sites.

In a related metric – the Vaginal Birth after Caesarean Section (VBAC) rate has decreased, with the last 4 months close to the lower confidence limit.

This is expected, as the women in the VBAC group are the same women in Robson Group 5 (having had a previous section) – so if more are having a section, then less will be having a vaginal birth

The VBAC rate has dropped significantly at WHH – from an average of 20% to 10%, whereas the rate at QEQM has routinely been around 12% for the past year

Because the section rate has increased, the vaginal delivery rate has seen a corresponding decrease, with 7 consecutive months below average

Interventions and Planned Impact

Increased section rates have an impact on beds and staffing numbers – with longer lengths of stay, potential surgical complications and theatre usage. Staff to monitor activity across the sites.

Section lists availability also impacted on both sites due to the high number of sections being planned/booked. Working collaboratively with the operations director to increase section lists availability without impacting other disciplines.

Clinical Pathways: Exception Report

East Kent Hospitals University NHS Foundation Trust

Planned Homebirth Rate

Percentage of women who delivered at home, and who had planned to do so.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
1.2%	1.4%	1.5%	0.6%	1.7%	0.9%	1.0%	0.9%	1.0%	0.5%	1.8%	2.2%

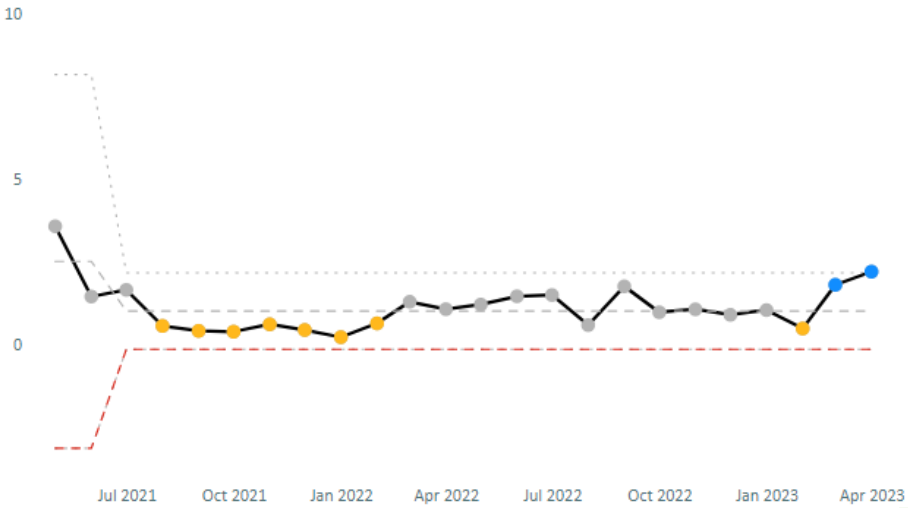
P — Variation indicates consistently passing the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There has been an increase over the upper confidence limit – demonstrating improved choice for labouring women.

Interventions and Planned Impact

The provision for homebirth is reviewed daily at the 10am SITREP – increased staffing numbers and reduced sickness has increased the availability of midwives to provide a homebirth service. In addition:

- On-call community midwives are used less frequently to support the acute labour wards – which ensures they are free to support homebirths.
- A DATIX report is completed when the homebirth service is suspended – the community matron's then undertake an investigation into the rationale behind the suspension.

Risks/Mitigations

Sickness and unplanned absence will continue to be managed daily to ensure appropriate cover to support the homebirth service.

Clinical Pathways: Exception Report

Neonatal Readmissions

Percentage of babies who are readmitted non-electively within 28 days of birth.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
5.3%	9.2%	8.9%	7.3%	8.4%	8.2%	9.1%	9.2%	10.1%	9.7%	12.0%	11.0%

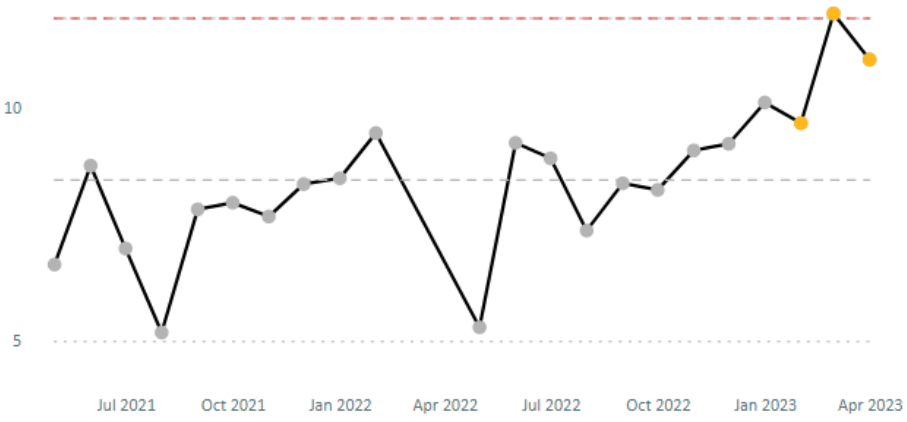
P — Variation indicates consistently passing the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Although there has been a reduction in April, there have been 3 consecutive months of high neonatal readmissions – with the significant rise happening at WHH
This splits by site with WHH (29 readmissions, 13%) compared to QEQM (17 readmissions, 8.6%)

28% of the readmission were for Jaundice. This is routinely the main reason for neonatal readmission

The majority of babies (circa 65%) are readmitted via the Children's Assessment Units

Interventions and Planned Impact

The earlier detection and management of jaundice in community will be improved with the introduction of the bilirubinometers. These have been purchased

To understand the best course of action a deep dive has just been completed, which also identified that 35% of readmissions were within the first 14 days of life. The audit found that jaundice and feeding problems accounted for the majority of the readmissions/visits to paediatrics under 7 days of age, but as babies got older the more likely cause was infection and general illness.

The audit identified that:

- Feeding assessments and feeding plans on discharge were not consistently completed to support appropriate feeding and early recognition of problems.
- Lack of consistency with providing parents with information about jaundice
- Lack of instruction on how to make up formula feeds correctly, through postnatal conversations.

Increased breastfeeding support teams are available on site to offer support and guidance prior to discharge.

Risks/Mitigations

Infant team are working with ward and community based teams to increase support and education to ensure there is compliance with guidance, including assessment, communication with parents and between teams

Clinical Pathways: Exception Report

Reduced Fetal Movement Leaflet given by 28 weeks

Of all women having an antenatal contact during 27+0 to 28+6 weeks, how many had been given a leaflet regarding reduced fetal movements before 28+0 weeks.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
91.5%	91.4%	93.4%	91.6%	88.1%	91.3%	89.9%	90.0%	86.3%	87.1%	85.3%	87.5%

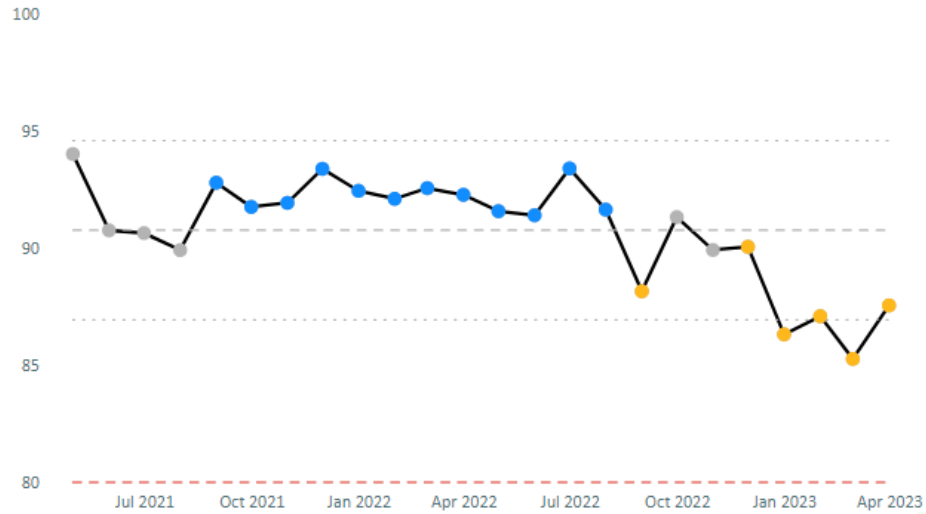
Variation indicates consistently passing the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Whilst there has been a slight improvement in performance in April, the last 4 months have been below or around the lower confidence limit. However – the threshold of 80% is still being achieved consistently

All areas (WHH, QE and Community) are seeing a reduction

Interventions and Planned Impact

The specialist fetal well-being midwives are working with the maternity triage leads to understand the gaps and changes in the data performance. They have adopted an agile methodology which includes speaking to women and midwives to understand how information is communicated and recorded regarding information and leaflets given following reports of reduced fetal movements. The fetal wellbeing midwives and Matron of public health recognise: Early findings suggest:

- Information leaflets are recorded in the women's hand-held records and not electronically which impacts data collection.
- Women who attend multiple times for reduced fetal movements are not given a leaflet each time – however, the midwife checks they do have the leaflets and understand the importance of monitoring fetal movements. This discussion is recorded in the electronic and handheld records.

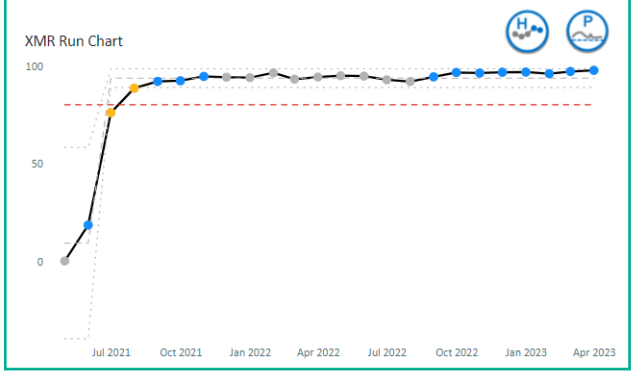
Risks/Mitigations

Electronic records are not sensitive enough to capture discussions had with women – the discussions are captured in the notes section. The fetal well-being midwife is working with the digital lead midwife to develop Euroking questions which capture the data more accurately.

Clinical Pathways: KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)

E1 - Co Taken at Booking

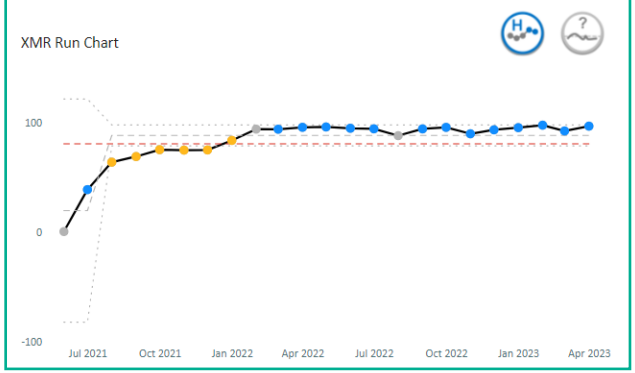
May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
94.8%	94.6%	92.7%	91.8%	94.2%	96.4%	96.2%	96.6%	96.7%	95.8%	96.9%	97.5%



Co monitoring
Compliance remains high and achieving the threshold of 80%

E3 - RFM Computerised CTG

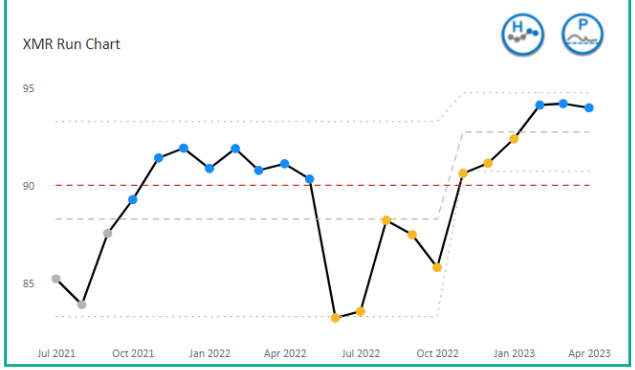
May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
95.4%	94.2%	93.7%	87.4%	93.6%	95.0%	89.2%	92.8%	94.7%	97.0%	91.7%	96.1%



Reduced Fetal Monitoring
Compliance remains high and achieving the threshold of 80%

E4 - Fetal Monitoring Training

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
90.3%	83.2%	83.5%	88.2%	87.5%	85.8%	90.6%	91.1%	92.4%	94.1%	94.2%	94.0%



Fetal Monitoring training
All staff (includes staff on maternity and long term sick)

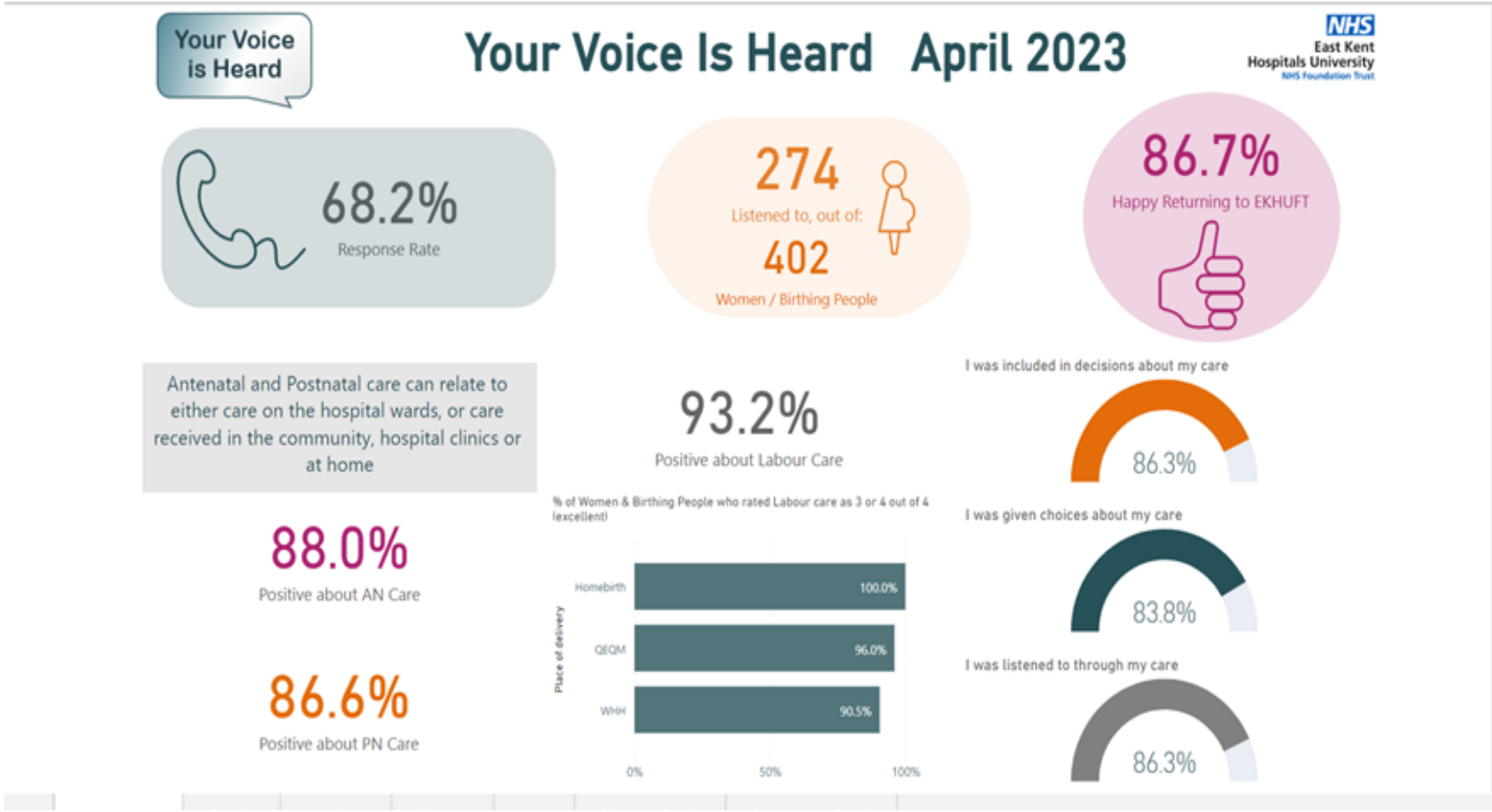
Compliance achieved for 6 consecutive months

Engagement

To listen to our birthing people and our workforce to design coproduced, personalised and equitable Maternity & Neonatal Services

Engagement: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Patient Experience	Complaints	Sigma	Apr-23	11			6	0	15
	FFT Maternity Response Rate	5.0%	Apr-23	6.7%			12.7%	2.80%	18.6%
	FFT Maternity (All)	90.0%	Apr-23	85.4%			90.2%	82.6%	97.9%



Engagement: Exception Report

East Kent Hospitals University NHS Foundation Trust

Complaints

Number of complaints made to obstetrics, Midwifery or Newborn Hearing Screening

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
2	3	8	4	2	9	10	6	9	12	8	11

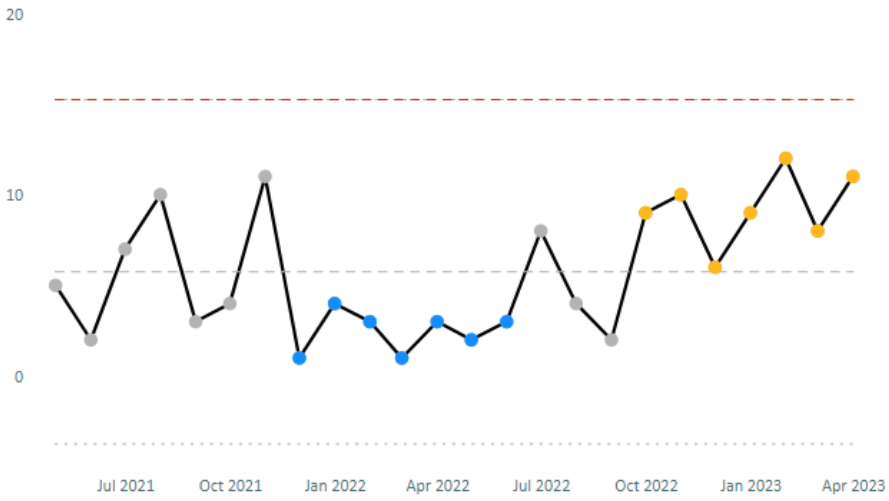
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

There have been 7 consecutive months of complaints above the average.

- 4 complaints regarding surgical management (2 'Other', 1 WHH Labour, 1 Folkestone)
- 3 complaints relating to communication (1 QE Labour, 1 QE Kingsgate, 1 'Other')
- 2 complaints relating to diagnosis ('other' location)
- 1 complaint for clinical management (WHH Kennington)
- 1 complaint for discharge arrangements (WHH Labour ward)

Interventions and Planned Impact

The team within "your Voice is Heard" work closely with the complaints team to ensure we capture complaints and concerns raised. This raises the profile of the woman's voice and ensures that there are robust feedback mechanisms to embed learning from complaints.

The newly appointed patient complaints officer is working with the governance team and HoM's to ensure the themes and learning are highlighted and shared with staff.

The MTP will also monitor and synthesis complaint data.

The new DoM and DDoM are introducing monthly quality boards with the HoM's, matrons and ward managers which will monitor performance including complaint themes and actions.

Risk / Mitigations

East Kent Hospitals University NHS Foundation Trust

Engagement: Exception Report

Friends & Family – Maternity Response Rate

Questionnaires sent to patients after maternity contacts

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
14.9%	14.7%	13.7%	13.3%	7.9%	15.8%	16.5%	14.5%	14.7%	12.6%	11.0%	6.7%

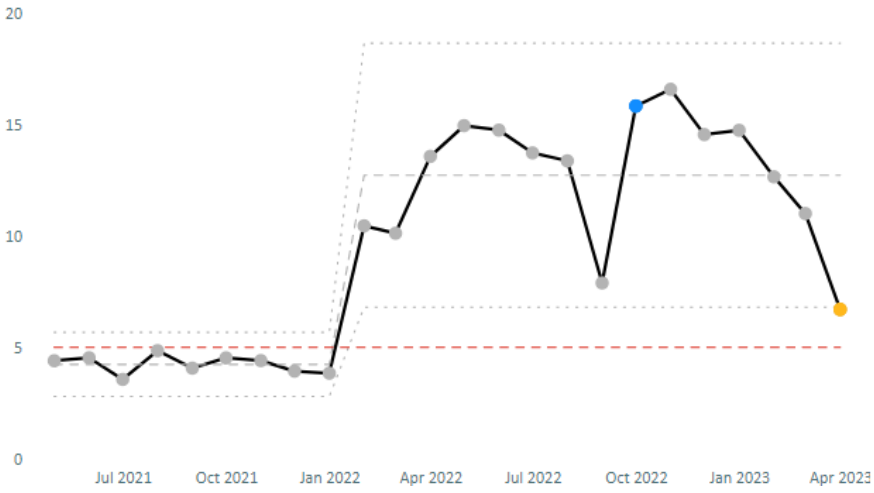
P — Variation indicates consistently passing the target

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

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

April data has dropped below the lower confidence limit. There have only been 42 responses out of 627 questionnaires sent.

Interventions and Planned Impact

A refresh and review of maternity FFT and Your Voice Is Heard is planned – this work will be supported by the MVP and service users.

The patient experience midwives will also review how the FFT data is uploaded and sent – whether sickness or changes in personnel has lead to this reduction in responses.

Risk / Mitigations

Maternity staff discuss and facilitate the discussions regarding “your voice is heard” and this could have led to staff failing to discuss FFT. Staff to remind women and their families about FFT and its importance is assessing the holistic health of women and families.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**PERINATAL SURVEILLANCE TOOL (PQST) REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER: EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**				
PAPER AUTHOR:	**DIRECTOR OF MIDWIFERY** **INTERIM HEAD OF GOVERNANCE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The purpose of this report is: • To update the Board on East Kent Maternity's services alignment to the key elements included within the perinatal and assurance framework as defined by NHS England (NHSE). • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 9, which aims to continue to support the safer maternity and Ockenden report recommendations • Provide assurance that the service is using the tool and reporting to the required standard set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Repot December 2020, NHS resolution Clinical Negligence Scheme for trusts (CNST) Maternity Incentive Scheme year 4- Safety Action nine and Ockenden 1 Report Immediate and Essential Actions.				

Summary of Key Issues:	• The report confirms that the service is using the tool to the required standard, as set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020.
	• The report includes the following key messages for the Board's attention:
	  • There has been 1 **Health Care Safety Investigation Branch (HSIB) referral.**
	  • Supernumerary status and 1:1 care compliance was not reported at 100%, however, the figures have been validated and records will be updated to confirm 100% 1:1 achieved on both units for April.
	  • There were 4 reported serious incidents (SIs) during April, all at William Harvey Hospital (WHH).
	  • The Your Voice Is Heard team recorded a response rate of 68.5% in April (a decrease from March which was 71.21%).
	  • Friends and Family Test (FFT) had a significant drop in responses recorded, but there was a system error which is being resolved.
	  • There were 11 complaints received in April; 7 at WHH and 4 at Queen Elizabeth the Queen Mother Hospital (QEQM).
	  • Training compliance was met across all maternity staff groups for fetal monitoring PRactical Obsetric Multi-Professional Training (PROMPT) and Newborn Life Support (NLS).
	  • Anaesthetic and obstetric attendance and faculty remains an issue due to their workforce challenges therefore one of the two sessions were held virtually for PROMPT but this remains a challenge
	  • **Anaesthetic training compliance for PROMPT remains below the national standard of 90%, but is improving.**
	
	It should be noted that the data reflects April's status for Workforce, prior to the decision by the Nursing and Midwifery Council (NMC) to withdraw the midwifery programme from Canterbury Christ Church University (CCCU).				

Key Recommendation(s):	The Board of Directors are asked to **NOTE** the content within the PQST.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients (women and Families)	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.				
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.				
Resource:	N				
Legal and regulatory:	Y	Clinical Negligence Scheme for Trusts (CNST) NHS Long Term Plan-standard contract			
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals Perinatal Quality Surveillance April 2023

Month: April 2023	East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting

CQC Maternity Ratings

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

Maternity Safety Support Programme

Yes — Support Lead: Mai Buckley

Findings of review of cases eligible for referral to HSIB

1 referral on 03/04/2023 for neonatal death that occurred in the month of March. We have had no closed cases during this reporting month.

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

At month end there was 1 reported moderate harm incident in April at WHH which was reviewed and downgraded to low harm, the baby was stablished and discharged.

Site	Location	Category	Subcategory
WHH	Labour Ward / Delivery Suite	Women's Health - unexpected problem/outcome for baby	Neonatal collapse

There were 4 reported serious incidents during April, all at WHH. The table below summarises the serious incidents:

Site	Location	Category	Subcategory
WHH	Patient's home	Women's Health - unexpected problem/outcome for baby	Neonatal death
WHH	Labour ward / delivery suite (WHH)	Women's Health - obstetric complication	3rd or 4th degree perineal trauma
WHH	Operating theatre (WHH)	Operations / procedures	Unplanned return to theatre
WHH	Fetal Medicine unit WHH	Delay / failure	Delay - OPD clinic changes / error in referral process

Themes from reviews of perinatal deaths

Themes

- Swabs of baby and placenta not taken.
- Partograms not completed
- Labour pain management

Actions

- Education with individual staff
- Update on TNIA for mandatory training

100% of perinatal mortality reviews include an external reviewer

Yes

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

Fetal Monitoring All Maternity Staff

Fetal Monitoring Mat Leave and LTS Removed

Challenges:

- Prompt room availability at the WHH is variable due to wider bed issues across the Trust and the use of the MLU as an escalation area. Discussions planned with WHH site leadership team

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	208	224	92.9%
Midwife - Community	104	109	95.4%
Other Obstetric Doctor	44	46	95.7%
Obstetric Consultant	29	31	93.5%
Unknown	5	5	100.0%
Maternity Support Worker	0	0	NaN
Total	**390**	**415**	**94.0%**

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	200	206	97.1%
Midwife - Community	98	98	100.0%
Other Obstetric Doctor	43	45	95.6%
Obstetric Consultant	29	30	96.7%
Unknown	5	5	100.0%
Maternity Support Worker	0	0	NaN
Total	**375**	**384**	**97.7%**

Prompt All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	205	224	91.5%
Midwife - Community	103	109	94.5%
Maternity Support Worker	76	81	93.8%
Other Obstetric Doctor	40	42	95.2%
Obstetric Consultant	29	31	93.5%
Unknown	5	5	100.0%
Total	**458**	**492**	**93.1%**

PROMPT Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	198	206	96.1%
Midwife - Community	98	98	100.0%
Maternity Support Worker	73	75	97.3%
Other Obstetric Doctor	39	41	95.1%
Obstetric Consultant	29	30	96.7%
Unknown	5	5	100.0%
Total	**442**	**455**	**97.1%**

Anaesthetics covering maternity	Number requiring training	Number of staff trained	Percentage Compliance by staff group
Anaesthetic consultants	**42**	**30**	**71%**
All other anaesthetic Doctors	**35**	**21**	**62%**

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	203	224	90.6%
Midwife - Community	104	110	94.5%
Maternity Support Worker	73	82	89.0%
Other Obstetric Doctor	38	42	90.5%
Obstetric Consultant	29	32	90.6%
Unknown	5	5	100.0%
Total	**452**	**495**	**91.3%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	193	206	93.7%
Midwife - Community	98	99	99.0%
Maternity Support Worker	70	76	92.1%
Other Obstetric Doctor	37	41	90.2%
Obstetric Consultant	29	31	93.5%
Unknown	5	5	100.0%
Total	**432**	**458**	**94.3%**

- Anaesthetic and obstetric attendance and faculty are an issue due to their workforce challenges therefore one of the two sessions were held virtually for PROMPT but this remains a challenge
- Only two training weeks were held during April due to bank holidays and due to room availability all training other MDT training was held virtually.

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

Supernumerary Status Maintained		
Month	QEQM	WHH
Nov-22	99.3%	100.0%
Dec-22	98.7%	100.0%
Jan-23	99.2%	99.6%
Feb-23	99.3%	99.5%
Mar-23	97.9%	100.0%
Apr-23	100.0%	98.9%
Total	99.1%	99.7%

1 to 1 care in Labour		
Month	QEQM	WHH
Nov-22	100.0%	97.5%
Dec-22	100.0%	97.6%
Jan-23	100.0%	97.9%
Feb-23	99.3%	97.4%
Mar-23	100.0%	97.9%
Apr-23	100.0%	98.5%
Total	99.9%	97.8%

Supernumerary Status
Supernumerary Status: there were 2 incidences of supernumerary status not being met at the WHH – the Head of Midwifery (HoM) has validated that full compliance was met. However, the HOM is working with the band 7's to highlight the importance of escalating to the HoM and /or MoC when supernumerary status is compromised. Moreover, work continues on the definition of supernumerary status for band 7 midwives.

1:1 care in labour:
Compliance of 1:1 in Labour was reported at 99.3% Trust-wide, this related to 2 patients reported as not having received 1:1 care in labour at WHH. This has been reviewed and confirmed that 1:1 care was fully compliant.

Midwifery
The Midwifery workforce numbers remain primarily unchanged in terms of vacancy, sickness and maternity leave.

5 Internationally educated Midwives commenced at WHH during March. 3 commenced in April and a further 2 are due to arrive in May.

All 3rd year student midwives were contacted and so far, 25 out of 32 have replied with 23 indicating they wish to take up roles as newly qualified Midwives in September at East Kent (11 WHH and 12 QEQM).

The pipelines below are as reported in April, but it must be noted this is now being reviewed in light of the recent update regarding the midwifery programme being halted at CCU, and the impact on delay for the 3rd year students qualifying.

WHH Pipeline

	Current vacancy April	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Band 7 Midwives	-2.6	0.96	1																					
Band 6 midwives	16.6		1			1	0		1			1			1			1			1			
Band 5 Nurses/Midwives	-3.7				1.2																			
Total new starters with PINS		0.96	2	0	1.2	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0
Internationally Educated Nurses (Planned arrivals)	8 per year			5	3	2								2	2	2								
OSCE Exam Passed							5	3	2									3	3	2				
NQMs from CCU	19 yearly								11												10			
Return to Practice	10 yearly																							
Total PIN ready per month		0.96	2	0	1.2	1	5	3	14	0	0	1	0	0	1	0	0	4	3	2	11	0	0	0
Estimated trained leavers	19 monthly Average	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1
Rolling Total	-22.97	-22.93	-22.43	-23.63	-23.73	-23.73	-20.23	-18.23	-5.73	-4.73	-3.23	-3.23	-3.73	-10.73	-11.23	-12.23	-13.73	-10.73	-9.23	-8.23	9.5	8.5	7	6

Key	
-22.97	Current Band 5 RN, Band 6 MW and Band 7 MW Vacancy as of 01/03/2023 - taken into account in this pipeline.
	Expected Trust Intake
	The planned/actual number of IENS to arrive in country - at this point they go into a band 5 vacancy
	Increase caviated on the following:
	Number of IENs we predict will receive their PIN - 4 months from arrival based on NMC current turnaround.
	University intake on training programme
	Total of Band 5 Registered nursing commencing working in the Trust that month
	Rolling total of additional RN/RMs recruited - starting in minus figure as starting from current vacancy

QEQM Pipeline

	QEQM 2023/2024																							
	Current vacan	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Band 7 Midwives	1		1																					
Band 6 midwives	0.6			0.6																				
Band 5 Midwives	0																							
Total new starters with PINS																								
Internationally Educated Nurses (Planned arrivals)	0																							
OSCE Exam Passed	0																							
NQMs from CCU	5								12												5			
Return to Practice	0 yearly																							
Total PIN ready per month		0	1	0.6	0	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0
Estimated trained leavers																								
Rolling Total	1.6	1.6	2.6	3.2	3.2	3.2	3.2	3.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	20.2	20.2	20.2	20.2

Key	
1.6	Current Band 5 RN, Band 6 MW and Band 7 MW Vacancy as of 01/03/2023 - taken into account in this pipeline.
	Expected Trust Intake
	The planned/actual number of IENS to arrive in country - at this point they go into a band 5 vacancy
	Increase caviated on the following:
	Number of IENs we predict will receive their PIN - 4 months from arrival based on NMC current turnaround.
12	University intake on training programme
	Total of Band 5 Registered nursing commencing working in the Trust that month
	Rolling total of additional RN/RMs recruited - starting in minus figure as starting from current vacancy

Community Pipeline:
The community midwifery pipeline is currently under review by the HoM for community and both community matron's – due to rotational posts and changes in staffing templates. We expect this review within the next week and will report back at the next MNAG meeting in June.

FFT Feedback

FFT Main Themes March 2023 (collated on 3/4/23)	Actions
16 responses which is a response rate of 5.8% only 275 FFT messages sent. There was only 11 comments and 8 were from unknown area of maternity. 75% extremely like/likely to recommend.	Have emailed Head of information and data architect about response rate there has been a mapping issues that is being looked at. Issue not resolved at time of submitting this report. When issues are resolved the FFT shall be reported back to the HoMs, Matrons and Managers

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – March Data • The YVIH service achieved a response rate of 68.5% which is a decrease from March (71.21%). With a set KPI of a 70% response rate. • Some additional work has been carried out looking at women from an ethnic minority background and IMD (index of multiple deprivation) representation in the responses received. • Of the 274 conversations had 216 were positive- 78.8% increase from last month of 72.2% 16 were neutral – 5.8% decrease from 17.6% last month 42 were negative – 15.4% increase from last month of 10.2% • Of the families that responded,85.8% said that they would return to East Kent for their maternity care. This is an increase from March of 82.7% but still down from 89.1% in February. 7.6% ↑ (6.7% March) (21 people) were unsure if they would return to EKHUFT, 5.5% ↓ (10.2% March) (15 people) said no they wouldn't return to EKHUFT for their care • 201 compliment emails sent to staff members concerning areas such as:	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes The reduced response rate may be due to the Easter Holidays – on Good Friday the response rate was about 43 %. Going forward on Major bank holidays no calls will be made e.g. Christmas and Easter as well as Father's and Mother's day. Calls on Sunday appear to have a better response rate than Saturdays. Also there had been annual leave in the team where calls had to be moved and more calls than normal made meaning not everyone could be called the normal 3 times in a day due to time restrictions. These may affect the response rate. No calls will be made in May on the Kings Coronation day.
Similar themes as the previous months (ongoing theme): • More comfortable chairs for partners more at QEQM than WHH, some positive comments about the chairs at WHH Food and drinks for partners	PEM are still in discussion with procurement scoping out the size of the available space at QEQM and which chairs would be suitable for the space and then to organise an event for families to try them and be involved in choosing the chairs- Chasing this up for QEQM. Awaiting cost from head of facilities around this should have costs soon and shall be sent to HoMs and Matrons to cost up what they would like.
Lack of Analgesia, catheter care, bedding being changed and water offered on PN wards	Essential rounding is still occurring but is not consistent. Drug rounds have now been commenced on the ward and an extra drugs trolleys order has been submitted to procurement. We are hoping this will make the drug rounds easier for the staff. Drug rounds have commenced on the Folkestone ward now a second drug trolley has been acquired awaiting reply from QEQM to see if this is happening there.
Lack of Analgesia in IOL and labour	This is being discussed and followed up with the pain management group on a monthly basis on how we can assess our birthing parents pain score. TENS machines are now at both sites and a SOP is in production, with adhoc training being requested so that these can commence to be offered and used on the labour wards
Delay in the Discharge Process on the Postnatal wards	There has been a discharge group set up to look at the processes and what could be improved In speeding up this process. Also discussion around managing expectations and information around discharge
Postnatal wards lots of comments about the environment of the postnatal wards, extreme temperature fluctuation, cramped rooms, on the ward not fit for purpose toilets at the QEQM site. Lack of toilets on the ward for partners.	Limitations due to the estates that PEM have put forward some suggestions from the YVIH calls about the estates.

Limited Birth plan appointments/Antenatal education in the community	Rooms and dates have been booked in June for co-production events for public. A staff event will be discussed and arranged for May. PEM and Community Matron working together on this.

MVP Feedback	**NIL in month**

Number of Complaints

11 Complaints were received during April of these 7 related to care at the WHH, and 4 at QEQM.

Site	Location	Category	Subcategory
WHH	OTH - OTHER	Communication	Misleading or contradictory information given
WHH	OTH - OTHER	Diagnosis	Missed fracture / or other medical problem
WHH	WKEN - WHH KENNINGTON WARD	Clinical management	Unhappy with treatment
WHH	WLAB - WHH LABOUR WARD	Surgical management	Unexpected outcome / post op complications
WHH	WLAB - WHH LABOUR WARD	Discharge arrangements	Unfit for discharge / or poor arrangements
WHH	FF - WHH FOLKESTONE WARD	Surgical management	Unexpected outcome / post op complications
WHH	OTH - OTHER	Surgical management	Unexpected outcome / post op complications
QEQM	QLAB - QEQM LABOUR WARD (MUMS)	Communication	Misleading or contradictory information given
QEQM	OTH - OTHER	Surgical management	Unexpected outcome / post op complications
QEQM	OTH - OTHER	Diagnosis	Mis-diagnosis
QEQM	KIN - QEQM KINGSGATE WARD	Communication	Other staff communication issues

Listening to women engagement activities and evidence of co-production	There were no events held however feedback was continually gathered through YVIH and FFT.
Staff feedback from frontline safety champions and walk-abouts	During April the focus has been around engaging staff in the Maternity Transformation Programme. There has been a great response form staff identifying key workstreams they want to be involved in.
HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	No further notifications received during April
Coroner Reg 28 made directly to the Trust	N/A

Progress in achievement of CNST 10 Safety Standards

Safety Action	Rational for Red/Green status	BRAG status (not due to deliver until 30 June 2022)
1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Fully compliant against standards. Quarterly 3 report received by MNAG January 2022 and Board for February. Risk - Need to ensure that the review panel is made up of the right multidisciplinary teams and include Bereavement leads, Neonatal medical staff and external reviewer. Access to an external reviewer frequently causes concern and is an ongoing risk. Ockenden and CNST require 100% compliance. LMNS are setting up a bureau to access external reviewers. Action plan development and completion needs to be completed in a timely way to reduce risk of breeching standard requirements.	
2. Submitting data to the Maternity Services Data Set to the required standard	Risk around Maternity Information System Provider-Euroking, developing system capability to meet data input quality and submission requirements. Data being submitted more accurately bypassing Euroking. Working as a region to find solutions	
3. Demonstrating transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme	Q3 and Q4 report to MNAG April 2023. Need clarity on process for sharing report and action plan with LMNS, ICS and commissioners. Transitional Care will be included on the audit programme from April which will improve data capture and reporting that is currently completed manually. Areas of risk are around capture of ATAIN actions within a central repository to better understand repeat themes. Template to be developed to allow this to be captured within the weekly ATAIN meetings. Need to have an explicit staffing model in place for TC. This is in place for Midwifery team but not Neonatal. Not built into workforce Business case.	
4. Demonstrating an effective system of clinical* workforce planning to the required standard	Risks around progression of Neonatal Nursing actions from year 3, which require significant investment to increase the workforce. Audits against BAPM standards not yet started but will be led by Dr Munn. .	
5. Demonstrating an effective system of midwifery workforce planning to the required standard?	Confident standard can be met. Biannual Midwifery Workforce Paper submitted for May to October reporting period. Supernumerary status and 1:1 care in labour remain under 100%-action plan for year 3 has been incorporated into the workforce workstream.	
6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2	A quarterly report including all risks, mitigating actions and escalations is included in February Maternity and Neonatal Assurance Group (MNAG) Reporting.	

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

5 Elements of SBLCBV2	RAG	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks - 88.3% In April compliance level
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 96.1% for women attending with reduced fetal movements. Requirement 80%. Fetal Movements having Computerised CTGs. 99.6% of women have FGR risks recorded at booking (requirement 80%)
ELEMENT 4: Effective fetal monitoring during labour		Compliant for all staff groups
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. National challenge- will not fail if isn't achieved. Action plan and Mat Neo Quality Improvement work in progress to support

	7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services	Work continues with the MVP to coproduce plans to address concerns raised by women	
	8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4	Severe Risk- Anaesthetic workforce attending multi-professional maternity emergencies training day. Attendance is improving. Working with anaesthetic leads to address gap, supported by CMO. Compliance is improving	
	9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	MatNeoSip Quality Improvement work aligned to the National Driver continue around Perinatal Optimisation bundle of care. Safety Champion Walkabouts and feedback sessions continue monthly on each site. Actioning of concerns are captured in a repository and themes are included in PQST report. Midwifery Continuity of Carer remains on hold as previously reported.	
	10. Reporting 100% of qualifying 2019/20 incidents under NHS Resolution Early Notification scheme	No cases for this reporting year	
Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Outstanding Ockenden recommendations		Ongoing work around • Training needs analysis (TNA) - update to reflect requirements for 23/24 • LMS reports showing regular review of training data and minutes. Criteria and greed pathways for referrals to Maternal Medicines Centre (MMC) • Personal Care and Support plans – pilot has commenced • Improving the practice & raising the profile of fetal wellbeing monitoring • Submission from MVP chair rating trust information in terms of: accessibility and quality of info available to service users • An audit of 5% of notes, on women who have specifically requested a care pathway, and also a selection of women who request a caesarean section during labour or induction. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Risk assessments required for policies not in date – fetal monitoring is completed	

Glossary

CCG: Care Quality Commission

CNST: Clinical Negligence Scheme for Trusts. An insurance scheme whereby NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims

CNST: Maternity Incentive Scheme. Aims to support the delivery of safer maternity care through an incentive element to trusts CNST insurance contributions. The maternity pricing is inflated by 10% which trusts are incentivised to recover through the delivery of 10 safety actions.

DATIX: The trusts incident reporting system

ENS: Early Notification Scheme. FFT-Friends and Family Test. A quick anonymous survey for service users to give views after receiving care or treatment and for staff to feedback on whether they would recommend as a place to work or receive treatment.

HSIB: Healthcare Safety Investigation Branch. Independent investigation body tasked with carrying out investigations and reporting using a standardised approach without attributing blame or liability

IEA: Immediate and Essential Actions (in relation to the Ockenden Report Recommendations December 2020)

Kleihhauer test: A test performed to understand if there is any fetal blood in the maternal circulation on Rh-negative mothers. The test should be done and any subsequent Anti D immunoglobulin administered within 72 hours of delivery, sensitising event (i.e. abdominal trauma) or invasive procedure.

MIS: Maternity Information System. At East Kent we use Euroking as our MIS provider

MNAG: Maternity and Neonatal Assurance Group. Governance reporting forum.

MSDS: Maternity Services Data Sets. A patient level data set that captures information about activity carried out by Maternity Services relating to mother and baby(s), from the point of the first booking appointment until discharge from maternity services

MVP: Maternity Voices Partnership. A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

NLS: Neonatal Life Support Training

NHSR: NHR Resolution

Partogram: A tool used to monitor labour and prevent prolonged and obstructed labour focusing on observations related to maternal, fetal condition and labour progress.

PMRT: Perinatal Mortality Review Tool. Aims to support a standardised process of perinatal mortality reviews, learning reporting and actions to improve care across NHS maternity and neonatal units.

PROMPT: Practical Obstetric Multi-Professional Training. Covers the management of a range of obstetric emergency situations

SBLCBv2: Saving Babies Lives Care Bundle Version 2. A care bundle for reducing perinatal mortality

Uterine artery Doppler screening: An ultrasound scan that uses waveform analysis in the second trimester of pregnancy as a predictive marker for the later development of preeclampsia and fetal growth restriction.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT - Q4 2022/23**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER: MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**				
PAPER AUTHOR:	**MATRON FOR QUALITY GOVERNANCE** **DIRECTOR OF MIDWIFERY**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required:	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	• The purpose of this report is to assure the Board that all stillbirths and neonatal deaths are reviewed using the national electronic Perinatal Mortality Review Tool (PMRT). • This is in accordance with the standards set out in NHS Resolutions Maternity Incentive Scheme which aim to continue to support the delivery of safer maternity care.				
Summary of Key Issues:	• The report confirms that during the Quarter 4 reporting period the service has used the tool to the required standard as set out in NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4, and identifies learning to improve. • CNST year 4 concluded on the 5 December 2022, therefore this report running from 1 January to 31 March extends beyond CNST Year 4 reporting. • During Quarter 4, there have been a total of 6 cases reported of which 2 were stillbirths and 4 neonatal deaths. • A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion but because of sensitive information is not appended to this report. • Within the last quarter the Trust reported all cases to MBRRACE within 7 days of the death. • Within the last quarter the Trust had a100% compliance with surveillance being completed. • Within the last quarter the Trust had a 100% compliance rate of commencing the review within the allocated time scales. • On 18/04/2023 the Trust held interviews for the PMRT lead Midwife role and successfully recruited to the role. The Bereavement Lead Midwife for William Harvey Hospital (WHH) has continued to undertake the role with support from the Patient Safety Matron as an interim arrangement. • The new Integrated Bereavement Pathway has been implemented at EKHUFT and the new team are working closely with the Multidisciplinary team to establish their new roles and ways of working. Implementation of the pathway will aide with the resolution of some of the reoccurring themes identified through the PMRT review. • In line with Ockenden recommendations, organisations should				

	provide a 7-day specialist bereavement service for maternity and neonatal services. The transformation work led by the Head of Midwifery will address this and a band 4 post to support administration and coordination processes has recently been recruited, along with 2 x band 6 Midwives and 1 x Whole Time Equivalent (WTE) band 7 Bereavement Lead Midwife. • There is a 100% compliance with external reviewers at PMRT meetings, however this is as a result of the bereavement and governance midwives from neighbouring trusts supporting one another. This quarter has seen an easier transition within the meetings for quoracy. There is a plan being discussed to potentially hold one Local Maternity and Neonatal System (LMNS) wide PMRT meeting where all Trusts join to review and discuss their cases. • The Board generated report shows no data as the reports have not been completed. There were no cases to report in January and the cases in February have 4 months to go to a Multi-Disciplinary Team (MDT) meeting. All cases are on schedule to be completed in the time frame and despite the CNST finishing we are still adhering to the time frames set by the national framework.
Key Recommendation(s):	The Board of Directors are invited to: • Receive **ASSURANCE** that a Quarterly Perinatal Mortality Review Tool paper has been received for Q4 2022/23 demonstrating full compliance in line with CNST standard requirements.

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

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate. **CRR 2742:** (on neonatal RR) There is a risk that the Trust will not be able to provide responsive post bereavement care to bereaved parents in neonatal areas.	
Resource:	N	
Legal and regulatory:	Y	NHSR, CNST, Ockenden.
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	Paper noted at MNAG 9 May 2023	

East Kent Hospitals University NHS Foundation Trust

PERINATAL MORTALITY REVIEW TOOL QUARTERLY REPORT - Q4 2022/23

1. The purpose of report

1.1. The purpose of this report is to assure the Board that all stillbirths and neonatal deaths are reviewed using the national electronic Perinatal Mortality Review Tool (PMRT).

1.2. This is in accordance with the standards set out in NHS Resolutions Maternity Incentive Scheme which aim to continue to support the delivery of safer maternity care.

2. Executive summary

2.1. The report confirms that the service is using the tool to the required standard, set out in NHS Resolutions, CNST Maternity Incentive Scheme Year 4, Safety Action One, and also identifies learning to improve.

2.2. A report was last received by this Group for Quarter 3 in October 2022 for the reporting period of October, November and December 2022.

2.3. The time period, for this quarterly reporting to trust board, is from 1 January to 31 March 2022 and includes 6 cases.

2.4. A PMRT Generated Board Report provides a summary of all reviews carried out using the tool during this reporting period.

2.5. As cases are reported through the PMRT tool, reports are generated and presented using the PMRT Tool.

2.6. A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion but because of sensitive information is not appended to this report.
This detail is captured against each standard below and shows100% compliance.

2.7. The current standard as received from NHSR May 2022 relaunch of CNST Year 4 is detailed below:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
No	**Standard**	**Current Compliance for Q3 reporting period**
ai)	All perinatal deaths eligible to be notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	Met
aii)	A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT will have been started within two months of each death. This includes deaths	Met

	after home births where care was provided by your Trust.	
b)	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	Met
c)	For at least 95% of all deaths of babies who died in your Trust, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions or concerns they have, have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated, parents should be advised that this is the case and given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	Met
d)	Quarterly reports will have been submitted to the Trust Board from onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust Maternity Safety and Board level Safety Champions.	Met

3. Safety Action 1 Quarterly Report Covering period October, November and December 2022

3.1. The time period, for this quarterly reporting to trust board, is from 1 January to 31 March 2023 and includes 2 stillbirths and 4 neonatal deaths.

3.2. All cases are reported through the PMRT tool, reports are generated using the PMRT Tool and learning disseminated through the monthly perinatal mortality meetings.

3.3. A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion but because of sensitive information is not appended to this report.
This detail is captured against each standard below and shows compliance in all areas with the exception of Standard ai).

4. Compliance against standards required

4.1. **Standard ai)** All perinatal deaths eligible to be notified to MBRRACE-UK must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. There were 2 stillbirths and 4 neonatal deaths and all cases that the Trust were responsible for reporting were reported to MBRRACE and the notification was reported within 7 days and surveillance within 1 month.

4.2. **Standard aii)** A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

Reporting period 01 January 2023 to 31 March 2023	Number of Cases	Number of PMRT Started	% Compliance within standard timeframe
Stillbirths	2	2	100%
Neonatal Deaths	4	4	100%

4.3. **Standard b)** At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

Reporting period 01 January 2023 to 31 March 2023	Number of Cases	Draft Report Generated	% Compliance within standard timeframe
Stillbirths	2	2	100%
Neonatal Deaths	4	0	100%
Overall 100% compliant against this standard			

- All deaths have had an initial review by a multi-disciplinary team.
- All of the deaths apart from 2 have had a final multi-disciplinary review with an external auditor at the PMRT monthly meeting. The outstanding 2 are scheduled for 04/05/2023 MDT meeting.
- The learning from the review is disseminated to the wider team at the monthly perinatal mortality and morbidity meetings in the usual way, and themes reported through to the monthly Women's Health Governance Meeting.

4.3.1. **Opportunities for improvement**

- Overall perinatal review attendance numbers are good and the team have taken on board the feedback around ensuring all team members names and job roles are documented on the review tool to give assurance of the quoracy of the meetings.
- Now the Trust has recruited into the role of PMRT Lead Midwife there will be a period of notice that the successful applicant will have to give and then a robust induction period which ensures the National standards are continually met.
- Within EKHUFT there is a challenge to offer the debrief service at 6 week postnatal due to Obstetric Consultant availability and clinic capacity. Work continues with NHS England (NHSE) to review job plans.
- It remains challenging for the Bereavement Midwives, who are required clinicians identified by MBRRACE, to attend the review meetings. The Bereavement Lead Midwife at The William Harvey Hospital attends and leads every PMRT meeting with support from the Governance team and the MDT panel. However with the appointment of an extended bereavement team, this will improve.
- A wider MDT group of clinicians willing to support with action planning would be

valuable as the actions which would make lasting change require group ownership

- Administrative support is currently being established within the governance team to aide with the preparation recording all discussions and documenting. In addition, an administrator dedicated for bereavement services has been identified and appointed.
- The PMRT role has a lead Obstetrician with an allocated PA for the Queen Elizabeth the Queen Mother Hospital (QEQM) but does not have one for the William Harvey Hospital (WHH).

4.4. **Standard c)** For at least 95% of all deaths of babies who died in your Trust the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required

4.4.1. All parents are advised by the Bereavement midwives or PMRT Lead midwife of the reviews and their perspectives and concerns are included in the report.

4.4.2. **Opportunities for improvement**

- MBRRACE advise that parents should be informed of the review prior to discharge from the hospital. With the appointment of the new bereavement midwives, this does happen consistently for all families. Streamlining the PMRT process to ensure parents are aware of the review and anticipating a call would be better received by families. Having one key contact as advised by MBRRACE, particularly when there are multiple investigations and different clinicians collecting parents' questions, is essential for families. This now sits with the Bereavement Lead Midwives.
- Where families have agreed to be visited at home as part of the review process, their engagement has been more comprehensive and has offered more learning opportunities for the Trust. Opportunity to provide this more widely or offer the 6 weeks follow up across both sites with a bereavement midwife/ PMRT midwife attendance would offer more opportunity for parental involvement, answer their questions, offer support and may enhance learning.

4.5. **Standard d)** Quarterly reports will have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions

4.5.1. We are 100% compliant against this standard.
Quarterly reports have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans – completed to date

5 PMRT Issues themes Extract for East Kent Hospitals University NHSFT from reviews of deaths completed between 1/1/2023 and 31/03/2023

5.1 As previously mentioned as there have been no reports finalised in this quarter there are no official themes created. Following the monthly PMRT meeting the team produces an upward report and it is presented at the Monthly Patient Safety meeting. A current theme is that the documentation for bereaved families is sometimes disjointed and the 'packs' have to be made in advance so the Bereavement Pathway have taken the action to review the documentation and consider using national paperwork.

6. Next Steps

a. To induct new PMRT midwife into the role.
b. With the recruitment to the new bereavement posts, establish the team to support the implementation of the new pathway across 7 days a week.
c. Implement the approved PMRT process to ensure follow up arrangements are clear and consistent across both sites.
d. Have a broader MDT review on the action plans once the reviews are pre-published.
e. Review documentation options for bereaved families.
f. Review the options of the interpretation services that the service offers and potentially consider having face to face service for bereaved families.
g. Scope the potential to offer the routine 6 week de brief appointment so it is performed in a timely manner.
h. Ensure the PMRT reviews align to other investigations within the Trust i.e.: ongoing Serious Incidents (SIs) so actions are the same in both reviews and parents are involved.
i. Improve parental involvement in the review process by ensuring parents are informed of the review prior to discharge from the hospital, and a key contact is identified to support parents through the review process.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) SAFTEY ACTION 8 COMPLIANCE PLAN**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**INTERIM CHIEF NURSING AND MIDWIFERY OFFICER (CNMO)**				
PAPER AUTHOR:	**QUALITY AND EDUCATION MATRON**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	To offer assurance to the Board relating the ongoing plan to achieve CNST Safety action 8 by the Q3.				
Summary of Key Issues:	• The provision of job planned faculty time to facilitated in-situ PRactical Obstetric Multi-Professional Training (PROMPT). • Not have a designated obstetric anaesthetic team which therefore requires impacts the need for the whole workforce to be trained.				
Key Recommendation(s):	• Undertake a review of the methodology of the facilitation of PROMPT across sites. • Increase the amount of training weeks undertaken when new Multi-Disciplinary Team (MDT) members (Foundation Year (FY) & Trainees) which usually fall in august to ensure we maintain compliance and safety. • To ensure the anaesthetic and obstetric teams understand the provisions needed to facilitate PROMPT.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.				
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.				
Resource:	Y	Staffing and training resource required to develop Transitional Care into a fully functioning service.			
Legal and regulatory:	Y	Clinical Negligence Scheme for Trusts (CNST), BAPM standards.			
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

East Kent Hospitals University NHS Foundation Trust

PROMPT

1. Purpose of the report

To update the group on the ongoing plan for MDT PROMPT training and faculty.

2. Background

PROMPT has been established within the midwifery core training mandatory block week since April 2022. The training programme is facilitated on 33 weeks of the financial year and delivered in-situ. Currently EKHUFT are the only trust within the Local Maternity and Neonatal System (LMNS) that facilitate 'in-situ' prompt training.

Below highlights the faculty which is required to teach in-situ prompt on each site:

- 2 midwives (1 Practice Development Midwife (PDM))
- 1 Anaesthetist
- 2 Obstetrician
- Resus Officer
- 1 Newborn Life Support (NLS) instructor
- 1 NLS facilitator

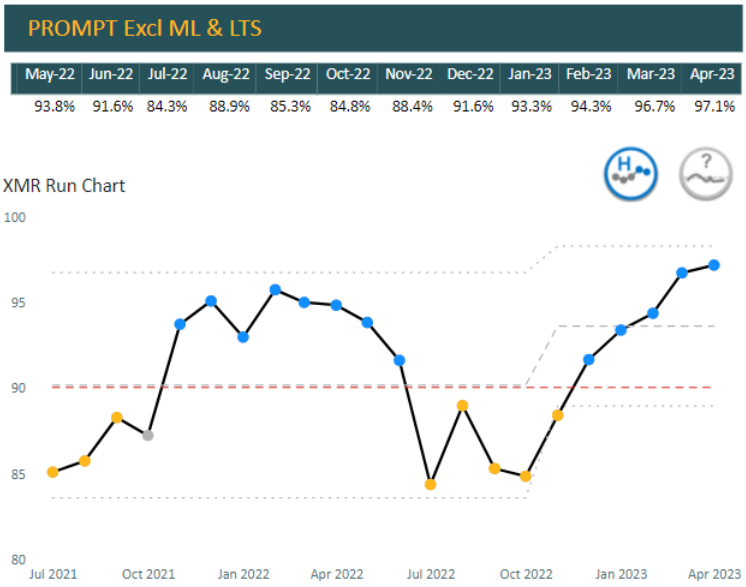
Throughout the compliance year there have been a number of occasions where by the PROMPT faculty has not been quorate due to the unavailability of anaesthetic and/or obstetric faculty and therefore moved to a virtual session.

Each in-situ training session has Below highlighted the faculty which is required to receive in-situ prompt on each site:

- Support Workers
- Associate Practitioners
- Midwives
- Obstetricians
- Locums (working >6 weeks within EKHUFT)
- Anaesthetists
- Maternity Theatre Team staff

2.1 Compliance

The threshold for compliance has been set at 90%. Compliance achieved for 5 consecutive months, for the maternity and obstetric work force with the exclusion of long-term sickness and maternity leave.



The current compliance for anaesthetic training for PROMPT is as highlighted below:

Anaesthetics covering maternity	Number requiring training	Number of staff trained	Percentage Compliance by staff group
Anaesthetic consultants	**42**	**32**	**76%**
All other anaesthetic Doctors	**39**	**26**	**67%**

One of the key issues relating to compliance is that all of the trust anaesthetist have to attend PROMPT as unlike other trust how have a designated anaesthetic team.

Further issues that impact the compliance of the training are the availability of on-site space.

2.2 CNST

For CNST Year 4, the Trust reported non-compliance for safety action 1 & 8 (Perinatal Mortality Review Tool (PMRT) and MDT Training). Safety action 2 compliance was not met due to MDT training compliance (90%) due to anaesthetic compliance with training. Following the submission of the action plan to enable the trust to meet future CNST requirements we have been awarded £350,000 from CNST discretionary funding. Finance have been contacted regarding information relating to the monies, the confirmed amount and funding transfer.

3. Next steps

- The Education team are currently in the process of underting a reviewing the methodology of the facilitation of PROMPT across sites.
- Reviewing the number of weeks that training is facilitated on.
- Working with anaesthetic and obstetric teams to understand service provisions that are needed to facilitate PROMPT.
- To consider introducing an anaesthetist into the faculty to support training and MDT working with further finical support.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BOD)**
REPORT TITLE:	**CNST MATERNITY INCENTIVE SCHEME YEAR 4 SAFETY ACTION 3: TRANSITIONAL CARE SERVICES TO MINIMISE SEPARATION OF MOTHERS AND THEIR BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING TERM ADMISSIONS INTO NEONATAL UNITS PROGRAMME QUARTERLY REPORT Q3 & Q4 2022/23**
MEETING DATE:	**1 JUNE 2023**
BOARD SPONSOR:	**CHIEF NURSING OFFICER AND EXECUTIVE/BOARD MATERNITY AND NEONATAL SAFETY CHAMPION**
PAPER AUTHOR:	**DIRECTOR OF MIDWIFERY AND MIDWIFERY SAFETY CHAMPION**
APPENDICES:	**APPENDIX 1: TRANSITIONAL CARE (TC) AND AVOIDING TERM ADMISSIONS INTO NEONATAL UNIT (ATAIN) ACTION PLAN**

Executive Summary:

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

Purpose of the Report:	• The purpose of this report is to update the Board on East Kent Maternity's progress in implementing Safety Action 3 and provide a quarter 3 & 4 2022/23 update on the audits required against the standards. • Raise awareness of risks in achieving CNST Standards and actions developed in response to case reviews and the action plans in place to improve (see Appendix 1: ATAIN and Transitional Care Action Plan). • Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.
Summary of Key Issues:	Weekly ATAIN review meetings and Monthly Transitional Care audits continue with Transitional Care now included in the formal Trust Audit programme to support visibility of themes and learning through reviews.
Key Recommendation(s):	The Board of Directors are asked to: 1. **NOTE** and **DISCUSS** the report. 2. Receive **ASSURANCE** that there is an effective process established of ongoing assessment and that the evidence provided is sufficiently robust. 3. **NOTE** the receipt and content of this CNST Safety Action 3 Quarterly update report. 4. **NOTE** review of the Transitional Care and ATAIN action plan. 5. **SUPPORT** the broader considerations and the development of further improvements as defined within the appended action plan. 6. Require formal **agreement** that the Transitional Care and ATAIN reviews and action plan findings will also be shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care System (ICS) quality surveillance meeting.

East Kent Hospitals University NHS Foundation Trust

Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**		**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.				
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.				
Resource:	Y	Staffing and training resource required to develop Transitional Care into a fully functioning service.			
Legal and regulatory:	Y	Clinical Negligence Scheme for Trusts (CNST), British Association of Perinatal Medicine (BAPM) standards.			
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	Paper noted at Maternity and Neonatal Assurance Group (MNAG) 9 May 2023				

East Kent Hospitals University NHS Foundation Trust

CNST Maternity Incentive Scheme Year 4

Safety action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme

Quarterly Report Q3 2022/23

1. Purpose of the report

2.2. The purpose of this report is to update the Trust Board on East Kent Maternity's progress in implementing Safety Action 3 and provide a quarter 3 & 4 2022/23 update on the audits required against the standards.

2.3. Raise awareness of risks in achieving CNST Standards and actions developed in response to case reviews and the action plans in place to improve (see Appendix 1: ATAIN and Transitional Care Action Plan).

2.4. Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.

2. Background

3.1. It is recognised that Nationally, over 20% of admissions of full-term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together, the harm caused by separation can be reduced.

3.2. The Avoiding Term Admissions (ATAIN) campaign encourages maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.

3.3. There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child.

3.4. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

3.5. ATAIN focuses on four areas of significant potential harm to babies. It is believed that these areas are where there can be the greatest impact:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

3.6. Weekly cross site, Multiprofessional ATAIN meeting take place at East Kent where all applicable baby admissions are reviewed to identify any learning around missed risks or care management that could potentially have avoided admission to the Neonatal Unit and opportunities to inform future care delivery through shared learning of cases.

3.7. Learning theme posters are developed and shared with the wider Team around impact of care management on Neonatal Admissions of babies i.e. delayed feeding support impacting on hypoglycaemia and not giving antibiotics, where indicated, to a mother in labour resulting in baby needing IV antibiotics.

3.8. Transitional Care was developed in partnership with BAPM to enable the safe management of babies with medical conditions, whilst allowing baby to remain with mother.

3.9. Babies suitable for management in a fully equipped TC unit;

- Of at Least 34weeks gestation and at least 1600g birth weight who do not fur fill criteria for High Dependency Unit (HDC)/Neonatal Intensive Care Unit (NICU) admission
- Well babies with Suspected Sepsis requiring IV Antibiotics
- Congenital Anomalies requiring nasogastric (NG) assisted feeding
- Jaundiced babies requiring phototherapy (Single or Enhanced)
- Babies requiring feeding support with NG assisted feeding
- Babies under observation or treatment for Neonatal Abstinence Syndrome
- Babies who require assistance with thermoregulation

3.10. Transitional Care services were launched on each acute site at East Kent in 2018.

3.11. The service is provided on the postnatal wards, led by Midwifery staff but with care involvement by the Neonatal team.

3.12. The following sections provide East Kent's current position against each of the CNST Safety Action 3 Standards a to g**.**

4. Standard a)

Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

4.1. The Neonatal Transitional Care (NTC) Guideline was developed in 2018, updated in September 2021 and is based on the principles of British Association of Perinatal Medicine (BAPM) transitional care.

4.2. The policy was developed jointly by maternity/neonatal clinical leads and includes auditable standards that inform the quarterly audits that are in progress.

4.3. There is evidence of neonatal involvement in care planning through discussions that take place at board rounds, ward rounds and documentation in care records and discharge summaries.

4.4. Admission criteria is defined within the 'Bobble Hat' risk assessment proforma that is completed on all babies and identifies the appropriate care setting based on need. NTC admission criteria meets a minimum of at least one element of HRG XA04

4.5. There is an explicit staffing model with maternity staff identified on the e-Roster system as NTC on each shift. Midwives lead on the care of NTC mothers and babies There is an allocated Neonatal Nurse also allocated as point of contact.

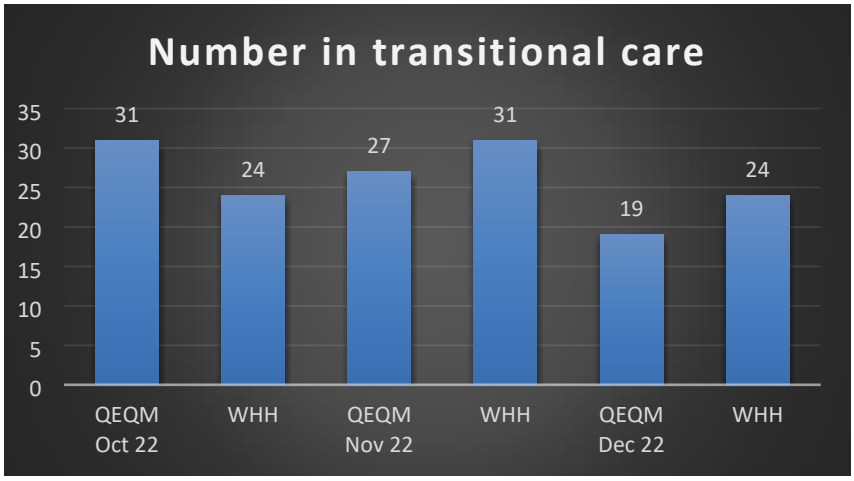
4.6. **To develop the service into a fully functioning NTC, Neonatal and Midwifery staffing, training, equipment and estates resource investment is required. The estates requirements are captured within the maternity estates workstream.**

5. Standard b)

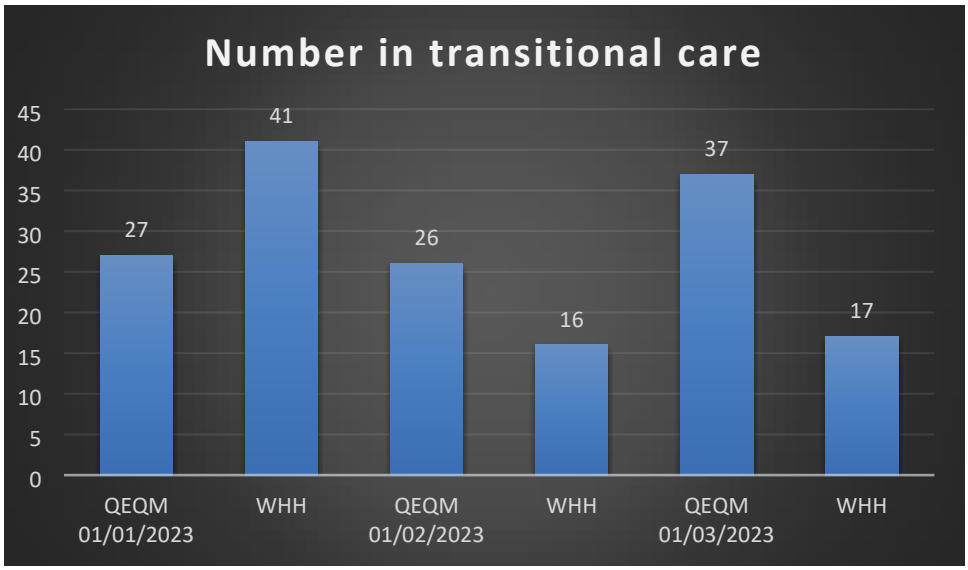
The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

5.1. Audit data is captured on all babies who have care within NTC to monitor compliance against the guideline and auditable standards

Graph 1: Number of Transitional Care Admissions for Quarter 3 &4

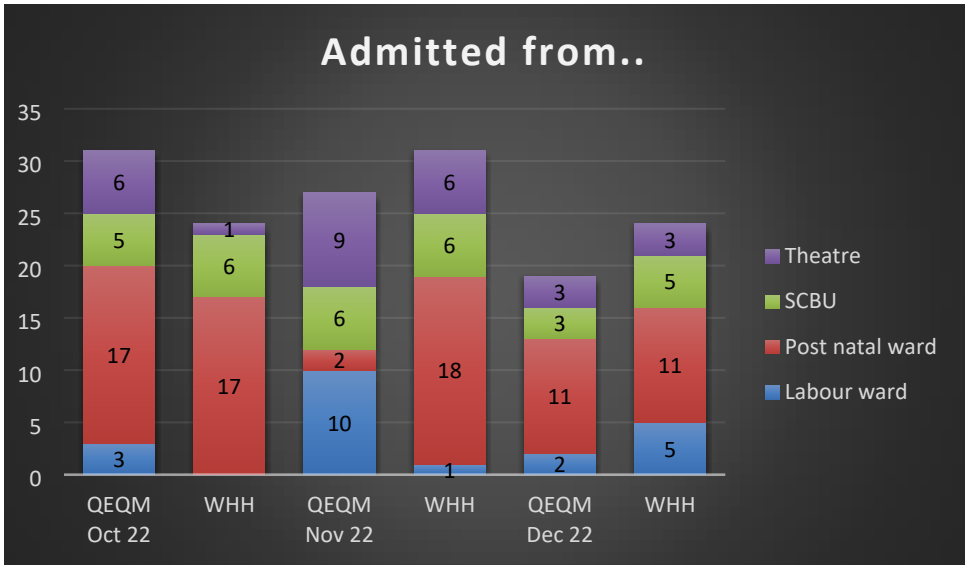


All babies admitted to Transitional Care are included in this audit. A total of **156** babies were admitted to Transitional Care at EKHUFT in quarter 3 of 2022/23. This is up 8 babies since Q2. Queen Elizabeth the Queen Mother Hospital (QEQM) had a total of **77** babies admitted. William Harvey Hospital (WHH) had a total of **79** babies admitted.



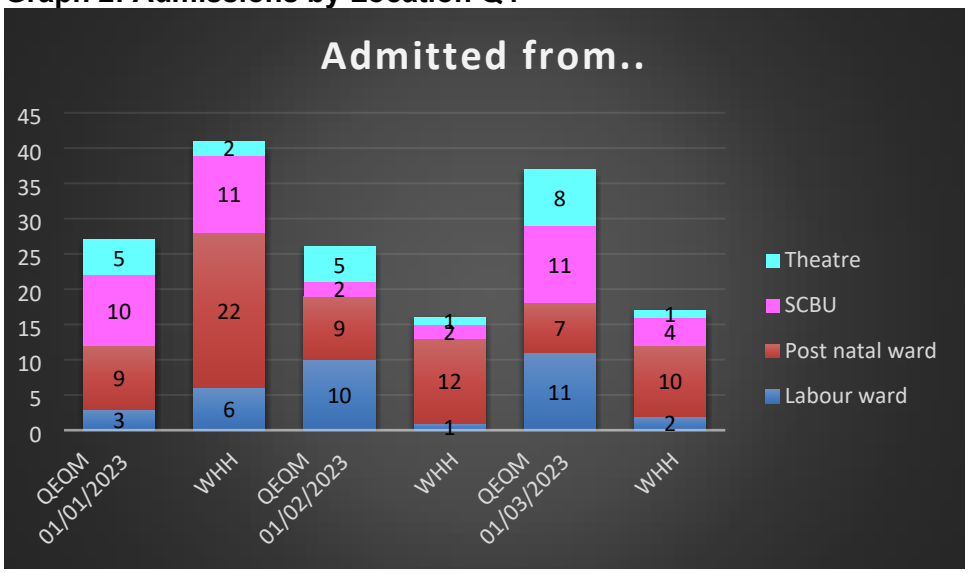
All babies admitted to Transitional Care are included in this audit. A total of **164** babies were admitted to Transitional Care at EKHUFT in quarter 4 of 2022/23. This is up 8 babies since Q3. QEQM had a total of **90** babies admitted. WHH had a total of **74** babies admitted.

Graph 2: Admissions by Location Q3



QEQM	Babies were admitted to Transitional Care from the Postnatal Ward (**39%**), Labour Ward (**19%**), SBCU (**18%**), Theatres (**24%**) and no Re-admission.
WHH	Babies were admitted to Transitional Care from the Postnatal Ward (**59%**), Labour Ward (**8%**), SBCU (**21%)**, Theatres (**1%**) with no Re-admission.

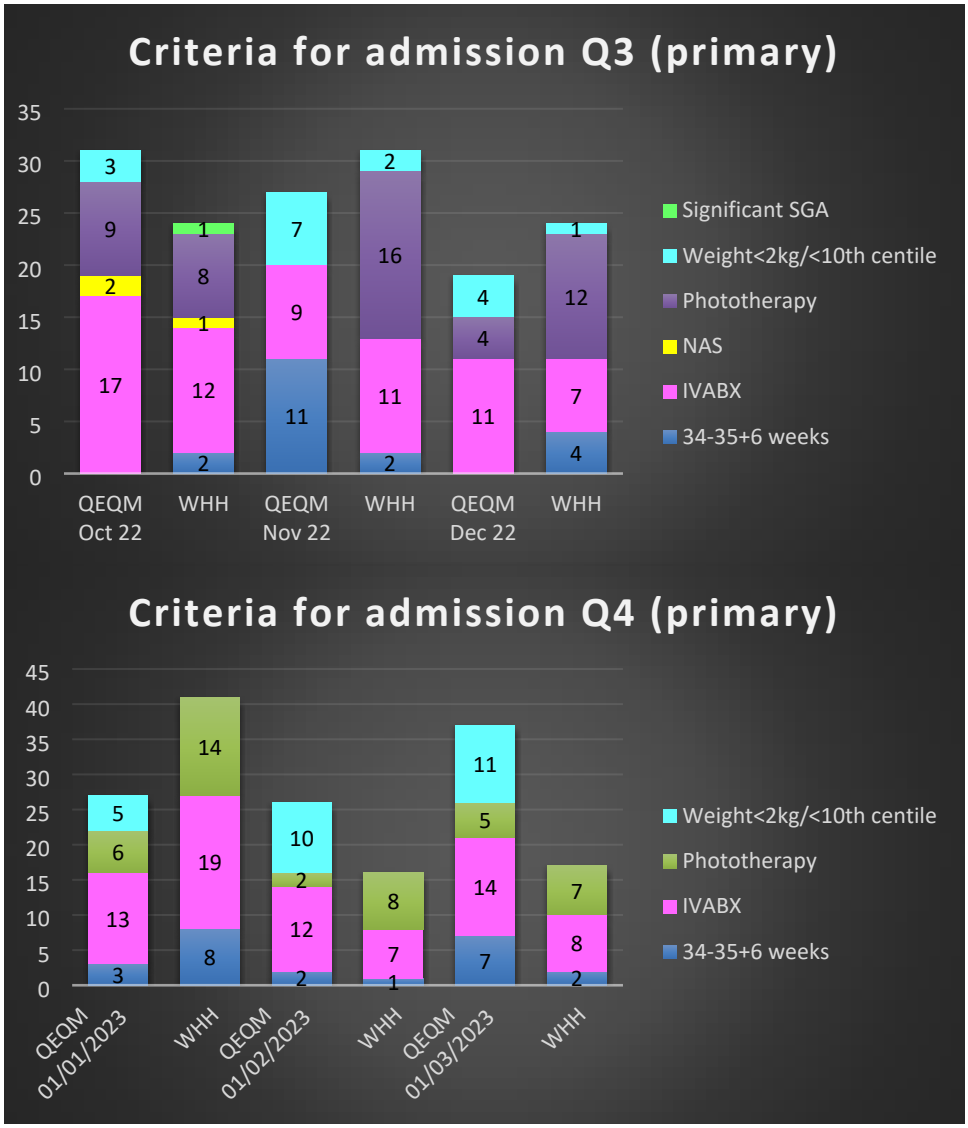
Graph 2: Admissions by Location Q4



QEQM	Babies were admitted to Transitional Care from the Postnatal Ward (27**%**), Labour Ward (26**%**), SBCU (26**%**), Theatres (**20%**) and no Re-admission.
WHH	Babies were admitted to Transitional Care from the Postnatal Ward (**59%**), Labour Ward (12**%**), SBCU (**24%)**, Theatres (5**%**) with no Re-admission.

East Kent Hospitals University NHS Foundation Trust

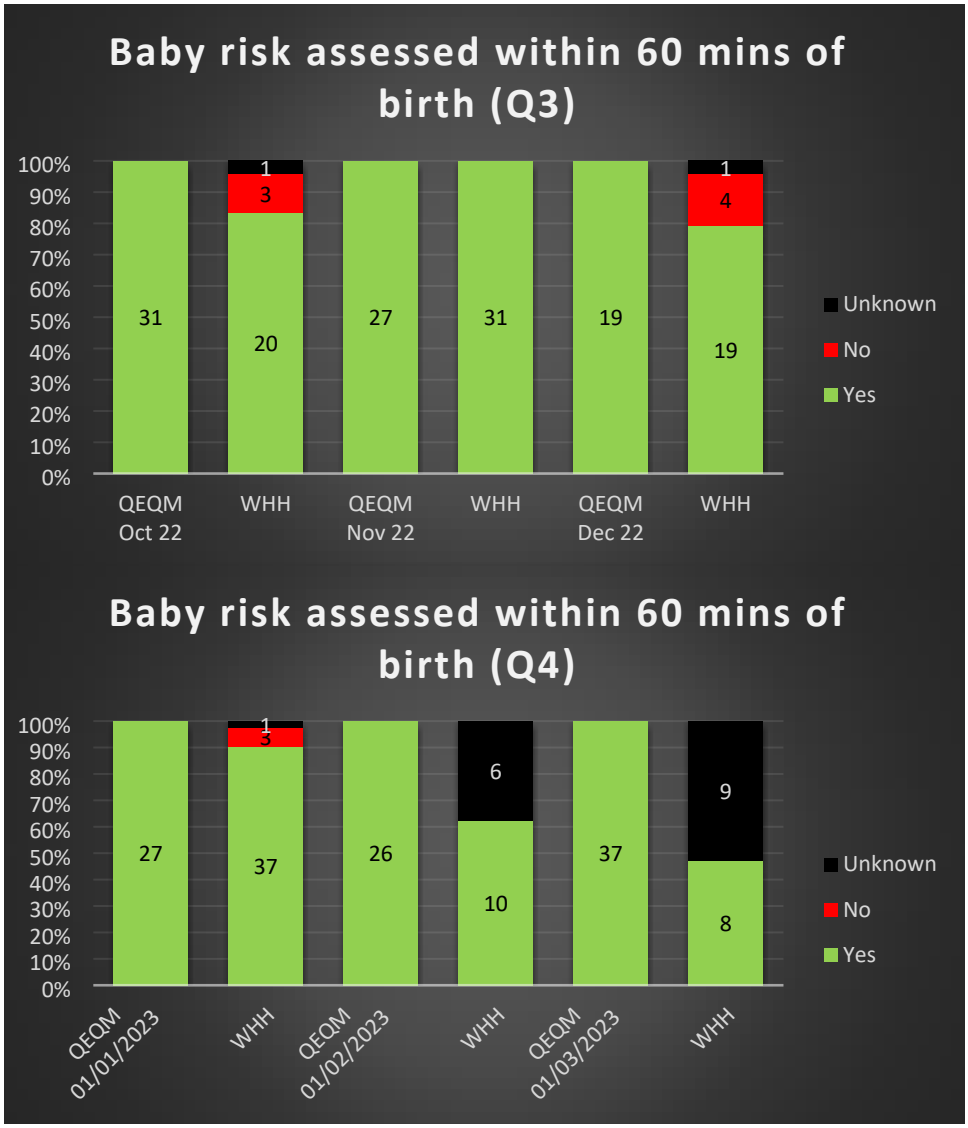
Graph 3: Primary Transitional Care Criteria Reason for Admission



QEQM	The primary criteria for admission to Transitional Care during quarter three were; IVABX (48%), compared with 43% in quarter 4, Weight<2kg/<10th centile saw 18% of admissions in quarter 3 compared to 28% in quarter 4 , NAS and Significant SGA saw zero babies in both quarters.
WHH	The primary criteria for admission to Transitional Care during quarter 3 were; Phototherapy (46%), compared with 39% in quarter 4, IVAB was the reason for admission in quarter 3 for 38% of babies compared with 46% in quarter 4. 34-35+6 weeks (10%) in quarter 3 and 15% in quarter 4, Weight<2kg/<10th centile 4% in quarter 3 and none in quarter 4, NAS (1%) in quarter 3 and Significant SGA (1%) in quarter 3 alone.

East Kent Hospitals University NHS Foundation Trust

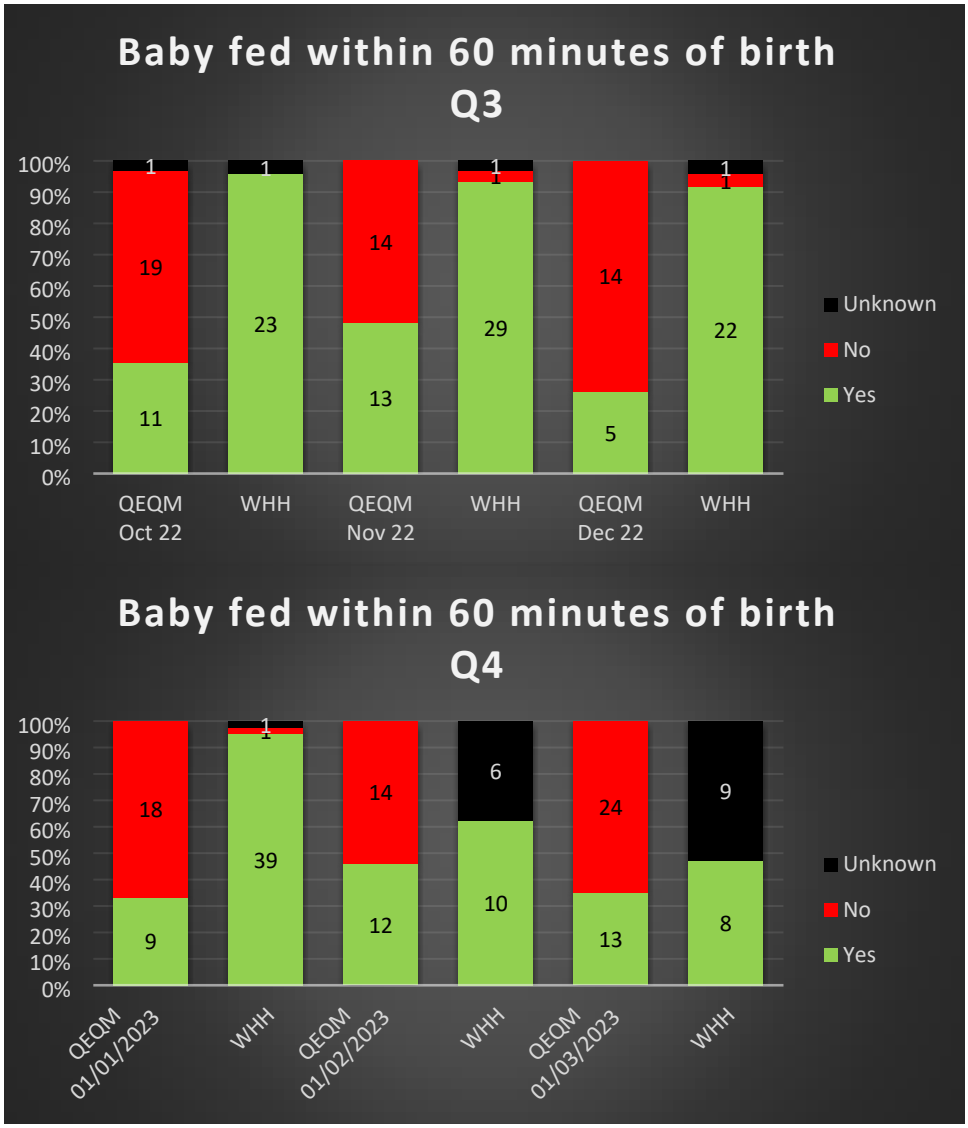
Graph 4: TC Babies risk assessed within first hour of birth



QEQM	**100%** of babies were risk assessed within 60 minutes of birth in quarter 3 100% of babies were risk assessed within 6 minutes of birth in quarter 4
WHH	**89%** of babies were risk assessed within 60 minutes of birth in quarter 3 74% of babies were risk assessed within 60 minutes of birth in quarter 4

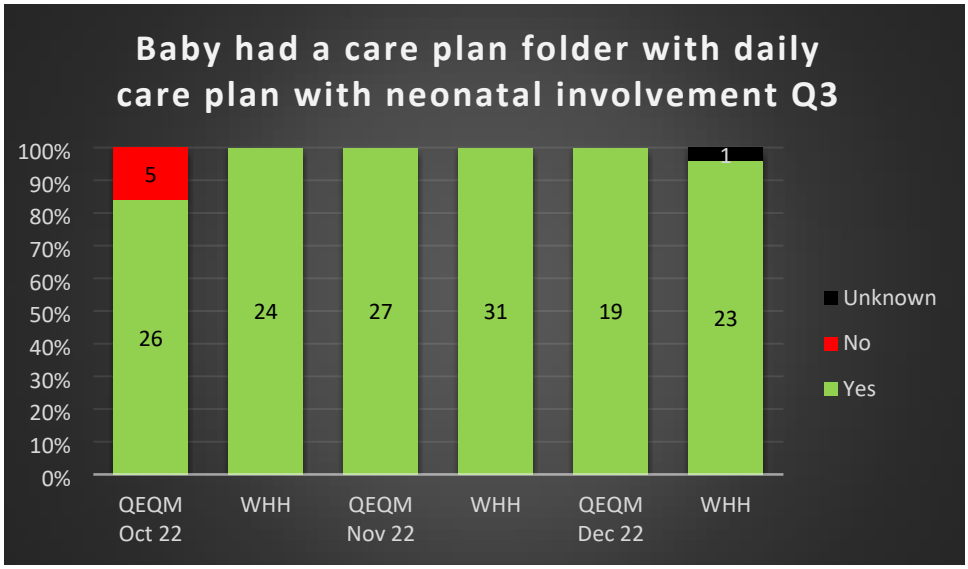
East Kent Hospitals University NHS Foundation Trust

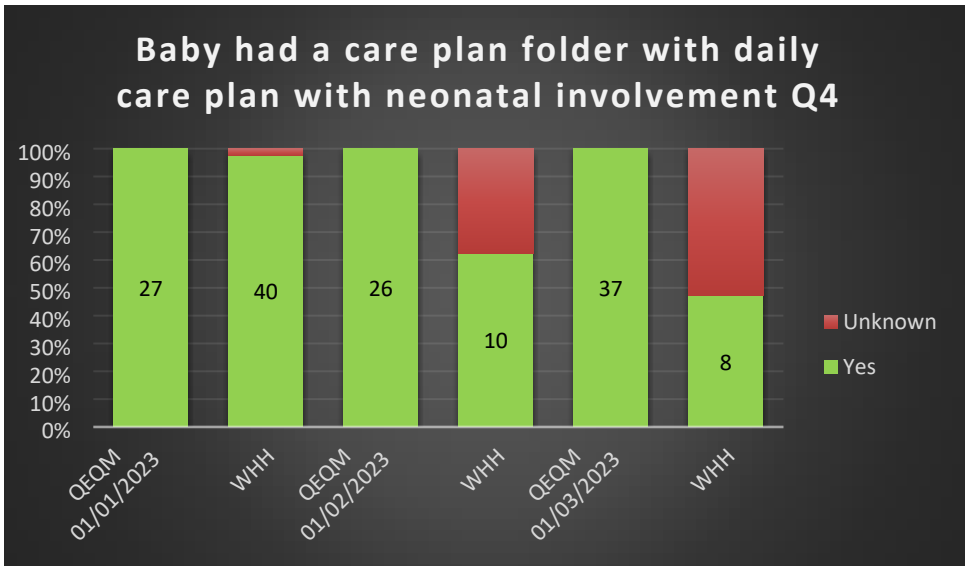
Graph 5: Number of TC babies that were fed within first hour of birth



QEQM	38% of babies were fed within the first 60 minutes of birth in quarter 3 38% of babies were fed within the first 60 minutes of birth in quarter 4
WHH	**98%** of babies were fed within 60 minutes of birth in quarter 3. 77% of babies are documented to have been fed within the first 60 minutes of birth in quarter 4. No babies were documented as not being fed and 22% were documented as unknown – this could potentially be a documentation issue.

Graph 6: Number of babies with a care plan folder showing a daily care plan completion with neonatal involvement

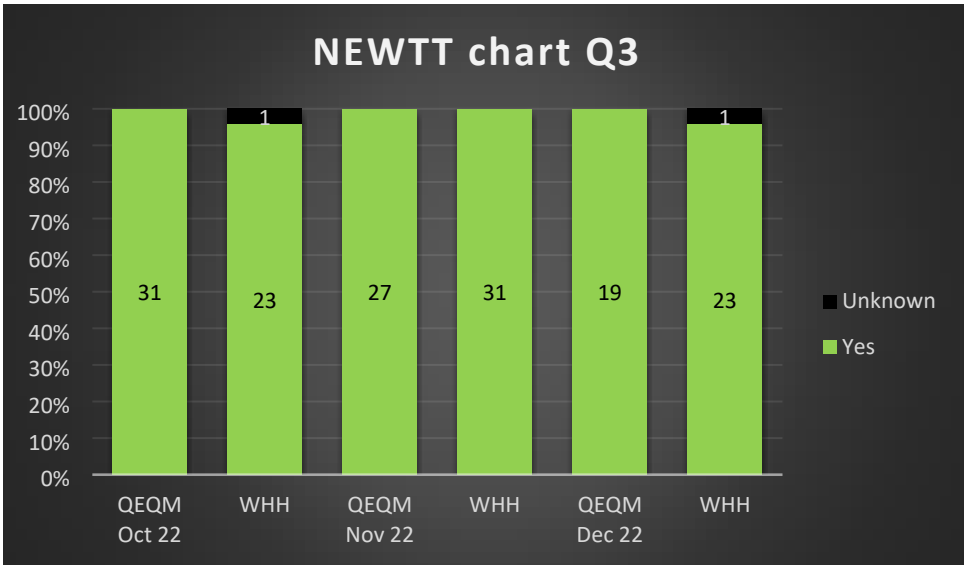


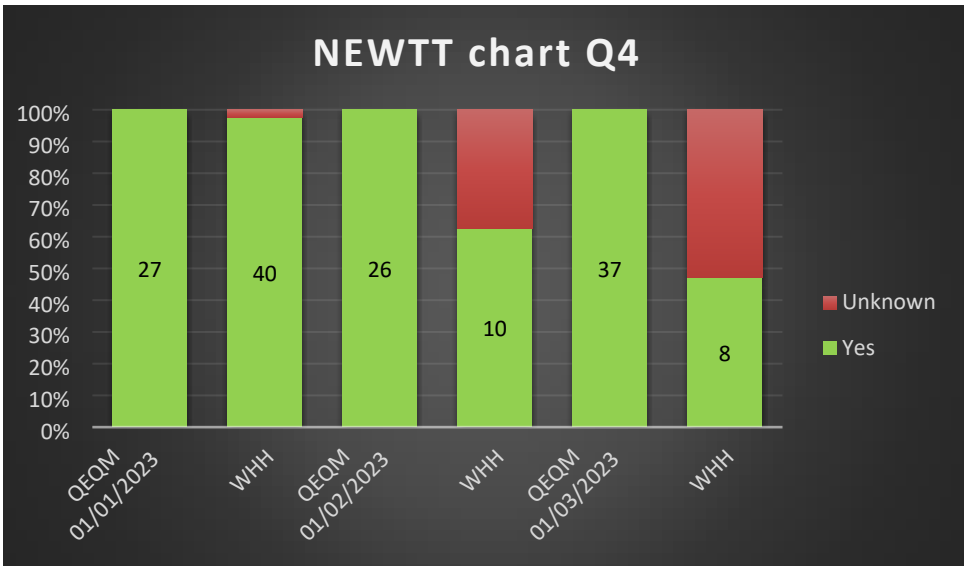


QEQM	In Q3 there was an improvement in care plans in the folders with neonatal involvement from **69%** in Q2 to 34% in Q3 and **100%** in Q4
WHH	**100%** of babies had a care plan folder containing a completed daily care plan with neonatal involvement in Q3 compared to **78%** in Q4. No babies were recorded as having none – 22% were recorded as unknown for this metric.

East Kent Hospitals University NHS Foundation Trust

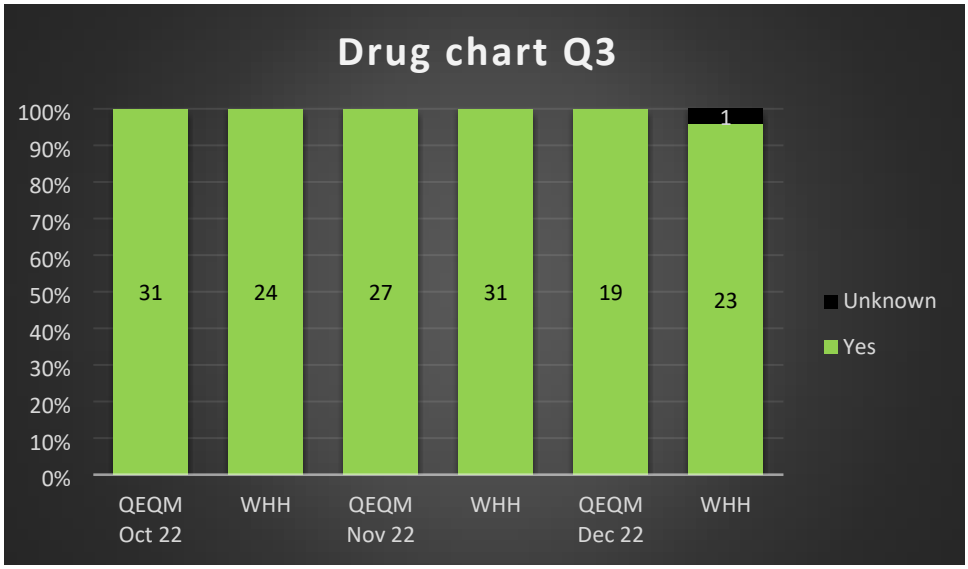
Graph 7: Number of babies that had a NEWTT Charts

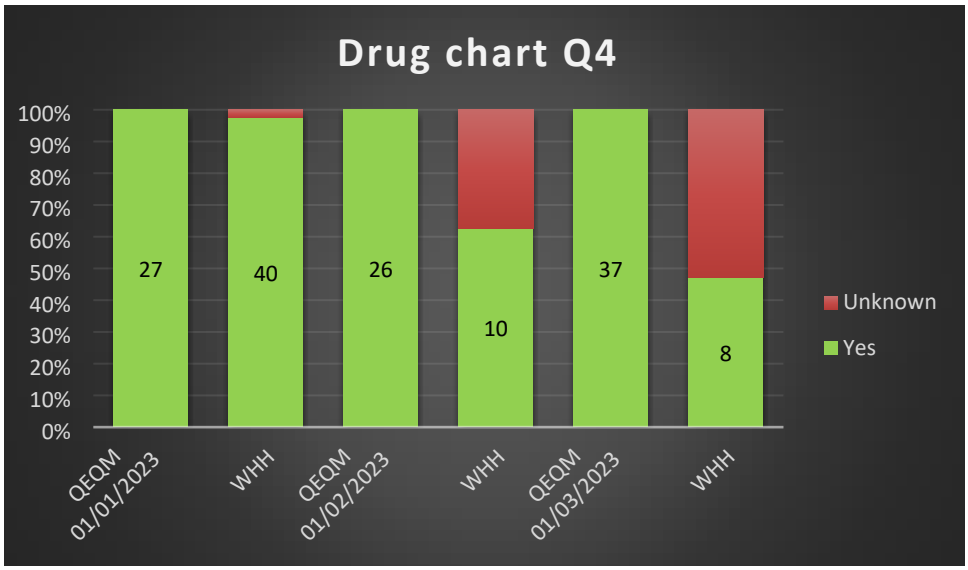




QEQM	**100%** of babies had a NEWTT chart completed in Q3 and Q4
WHH	**97%** of babies had a NEWTT chart completed Q3 and 78% in Q4 – these findings correlate with the care plan being available within the notes

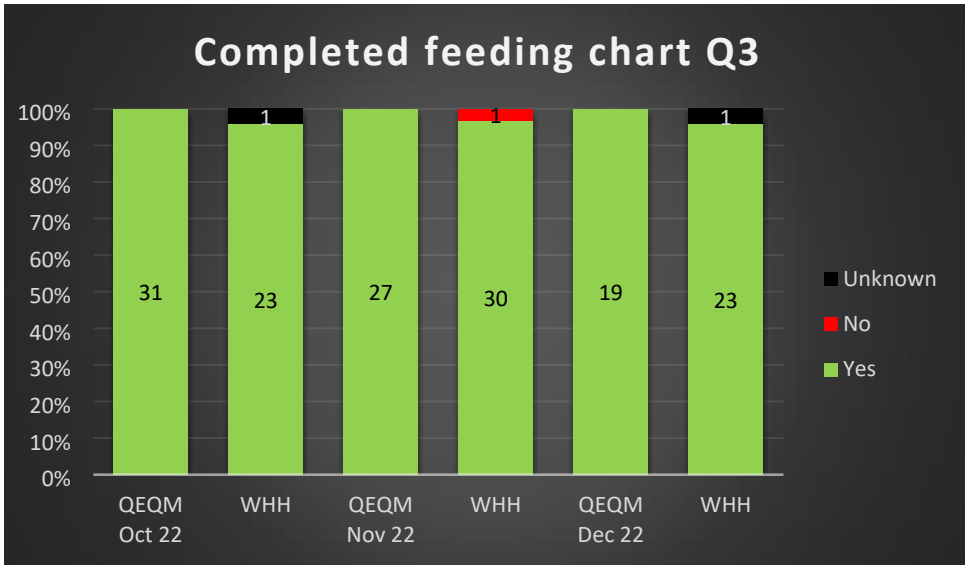
Graph 8: Number of babies that had a Drug Chart

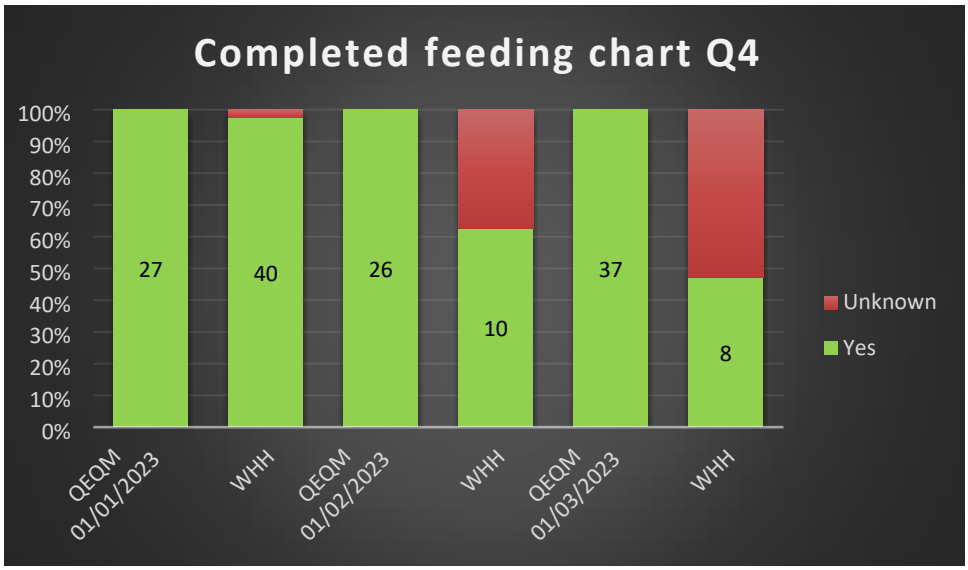




QEQM	**100%** of babies had a drug chart completed for Q3 and Q4
WHH	**100%** of babies had a drug chart completed for Q3 and 78% for Q4 – again this data aligns to previous findings above.

Graph 9: Number of babies that had a feeding Chart completed

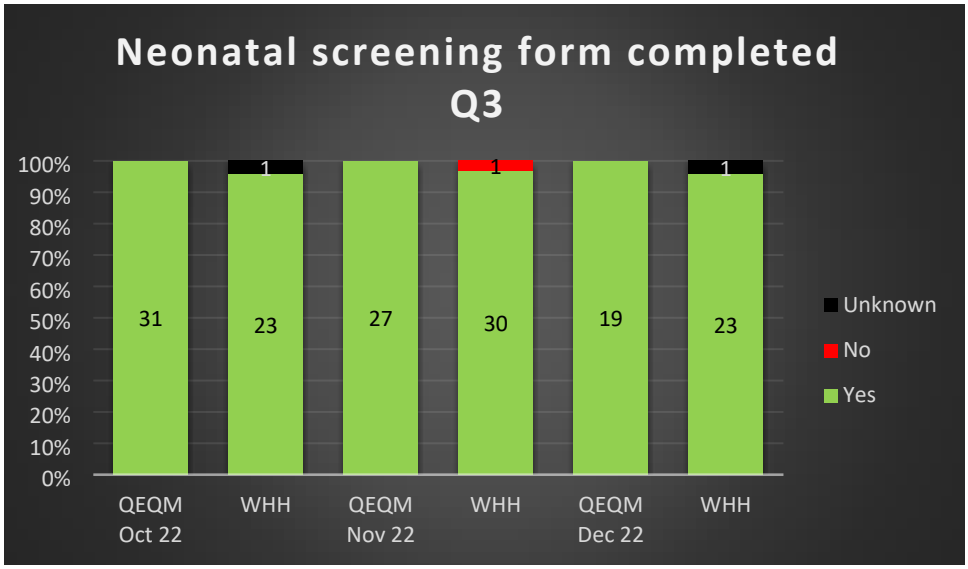


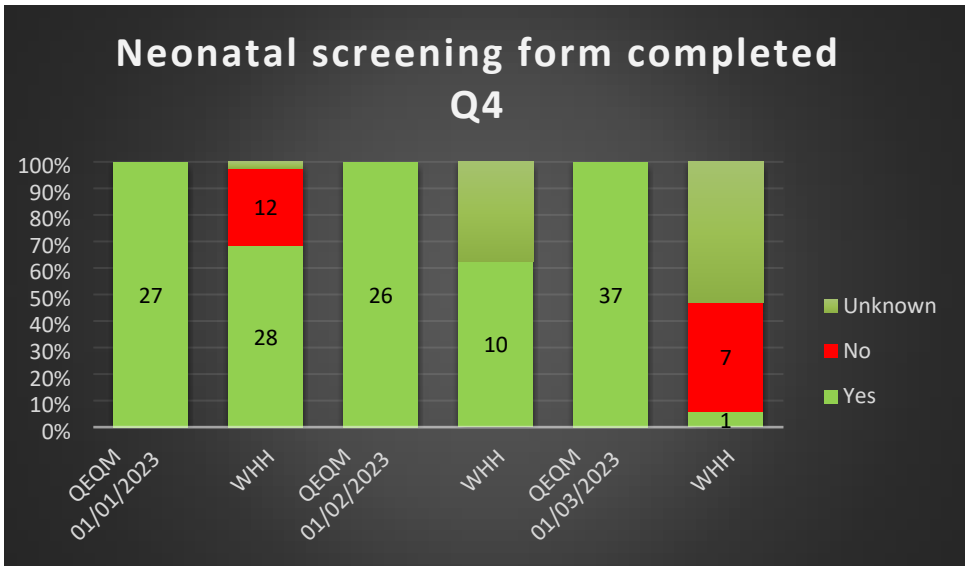


QEQM	**100%** of babies had a feeding chart completed for Q3 and Q 4
WHH	**96%** of babies had a feeding chart completed or Q3 and 78% for Q4

East Kent Hospitals University NHS Foundation Trust

Graph 10: Number of babies that had a Neonatal Screening Form completed

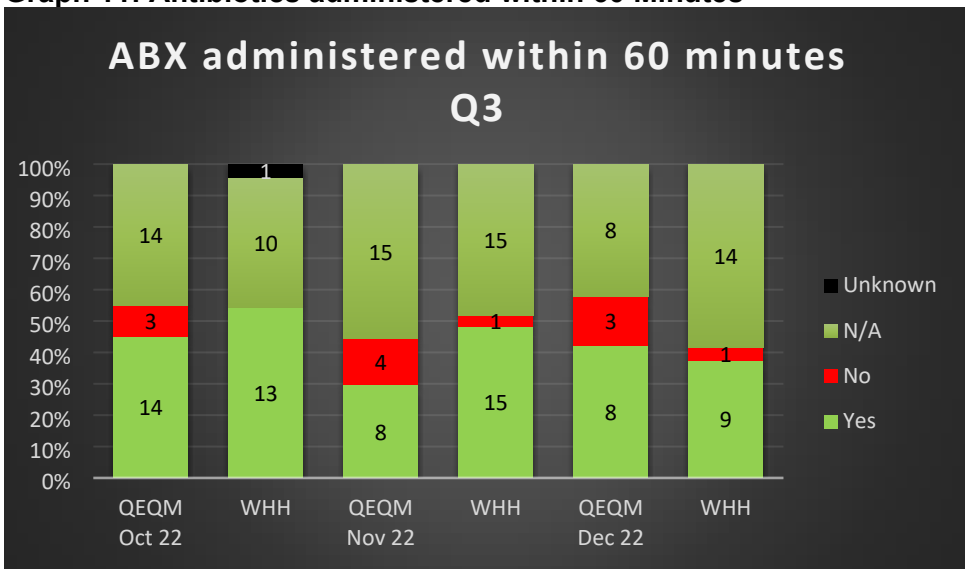


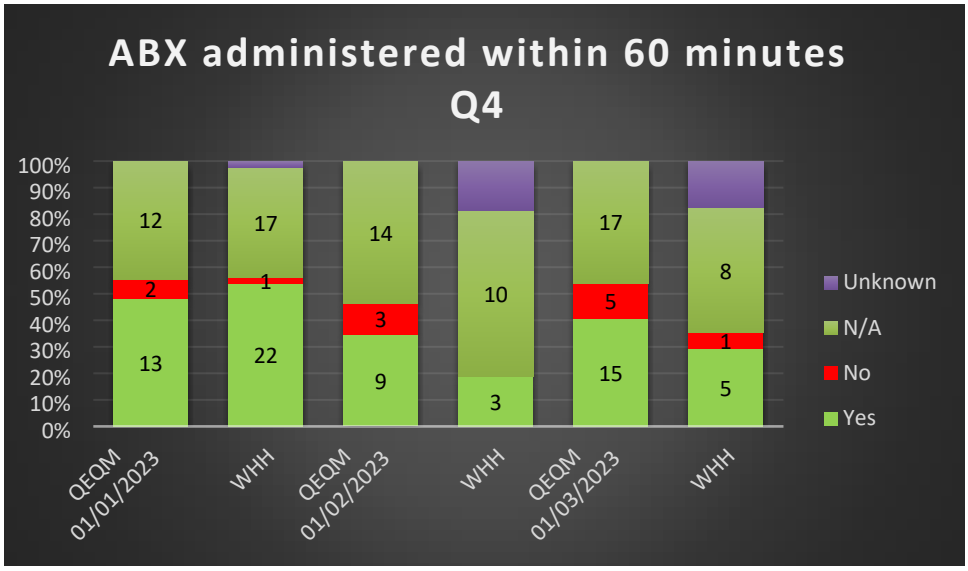


QEQM	**100%** of babies had a screening form completed for Q3 and Q4
WHH	**96%** of babies had a screening form completed for Q3 and 78% for Q4

East Kent Hospitals University NHS Foundation Trust

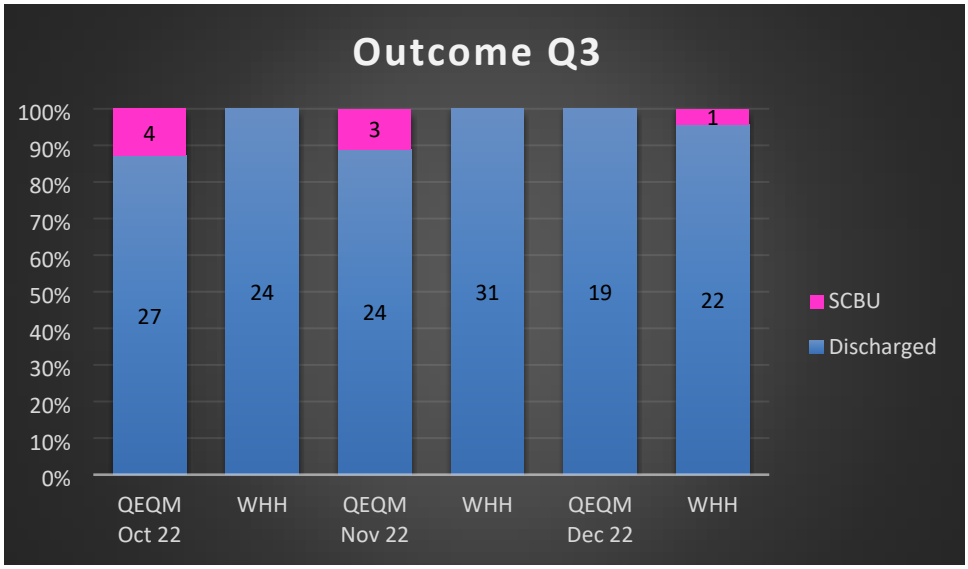
Graph 11: Antibiotics administered within 60 Minutes

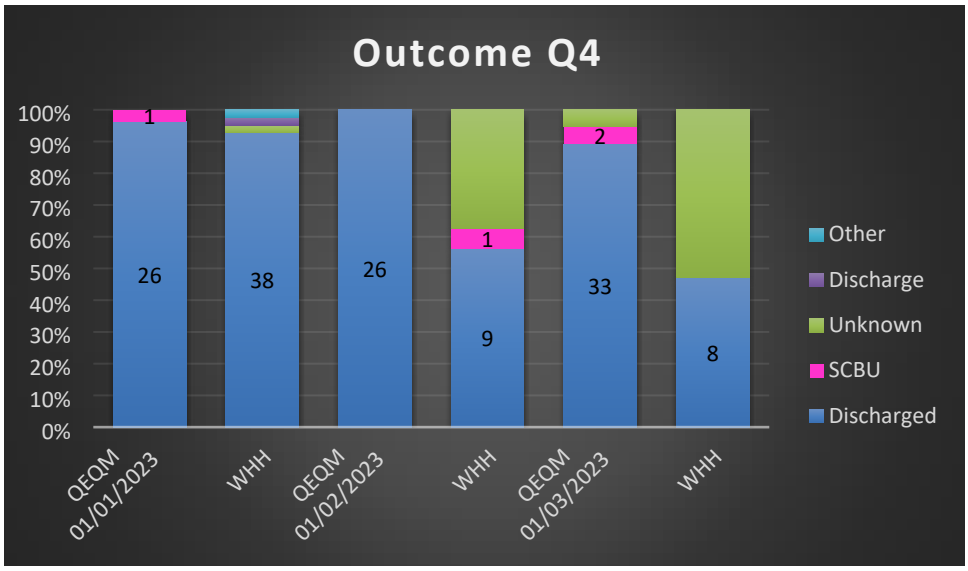




QEQM	Unfortunately, due to the lack of data collected for these measures, a reliable result cannot be generated
WHH	Unfortunately, due the lack of data collected for this measure, a reliable result cannot be generated.

Graph 12: Outcome of admission





QEQM	**90%** of babies were discharged home, **3%** to SCBU and **7%** to DOTS.
WHH	**98%** of babies were discharged home in Q3, 2**%** to SCBU. **74%** of babies were discharged home in Q4 with around 14% documented as unknown

Overall Summary

5.2. Data completion has significantly improved since quarter 2 which has evidenced the effectiveness of the interventions made at WHH, although there are still some metrics documented as ‘unknown' Any measures that are not 100% compliant with guidelines will be reviewed by ward managers.

5.3. Audit findings are shared with the Neonatal Safety Champion monthly and quarterly with the Board Safety Champion through the Maternity and Neonatal Assurance Group.

5.4. Barriers to achieving full implementation of the policy are captured on an action plan and shared with the neonatal safety champion and appended to the quarterly reports.

5.5. A process for sharing with the LMNS, Commissioners and integrated care system is now in place.

6. **Standard c)**

A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.

6.1. An electronic data recording process is established for all term admissions to the Neonatal Units and this is captured and reported on the Maternity Dashboard.

6.2. A paper-based process was in place by Monday 18 July 2022 for the capturing of all term babies transferred to the neonatal unit, regardless of the length of stay.

7. **Standard d)**

A data recording process for capturing existing transitional care activity, (regardless of place which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 and 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

7.1. Transitional Care was developed in partnership with BAPM to enable the safe management of babies with medical conditions, whilst allowing baby to remain with mother.

7.2. Babies suitable for management on a fully equipped TC unit;

- Of at Least 34weeks gestation and at least 1600g birth weight who do not fur fill criteria for HDC/NICU admission
- Well babies with Suspected Sepsis requiring IV Antibiotics
- Congenital Anomalies requiring NG assisted feeding
- Jaundiced babies requiring phototherapy (Single or Enhanced)
- Babies requiring feeding support with NG assisted feeding
- Babies under observation or treatment for Neonatal Abstinence Syndrome
- Babies who require assistance with thermoregulation

7.3. Transitional Care has been provided on the Postnatal Wards on each acute site since 2018

7.4. The Neonatal Transitional Care Guideline was jointly developed with Maternity and Neonatal Leads in 2018 and reviewed in 2021.

7.5. Criteria for admission is aligned to BAPM and defined within the 'Bobble Hat' Risk Assessment Tool.

7.6. Data on Transitional Care activity is captured on the Maternity Dashboard and is shown on the table below both by bed days and number of babies

Transitional Care Activity						
	Oct		Nov		Dec	
KPI	WHH	QEQM	WHH	QEQM	WHH	QEQM
Transitional Care Location/Care Days	38	57	44	53	45	36
Transitional Care Location/ Care Babies	13	18	15	20	16	14

Transitional Care Activity						
	Jan		Feb		Mar	
KPI	WHH	QEQM	WHH	QEQM	WHH	QEQM
Transitional Care Location/Care Days	91	57	15	56	16	74
Transitional Care Location/ Care Babies	26	17	6	16	8	24

7.7. The Neonatal Outreach service was implemented in 2021 and further supports the principles of Transitional Care by keeping mothers and babies together and facilitating earlier discharge from hospital.

7.8. A Secondary Data Recording Process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting.

7.9. The following table shows Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special or normal care days where supplemental oxygen was not delivered

7.10. This provides information on late preterm babies who are currently cared for in the Neonatal Unit, who could be cared for in a fully functioning TC setting, to inform future capacity planning/management.

7.11.

Secondary Data Recording to inform future capacity management for late preterm babies who could be cared for in a TC setting.						
	Oct		Nov		Dec	
KPI	WHH	QEQM	WHH	QEQM	WHH	QEQM
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 total	47	56	50	91	87	11
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 cared for on Neonatal Unit	22	43	14	51	58	3
Secondary Data Recording to inform future capacity management for late preterm babies who could be cared for in a TC setting.						
	Jan		Feb		Mar	
KPI	WHH	QEQM	WHH	QEQM	WHH	QEQM
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 total	85	82	12	63	9	90
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 cared for on Neonatal Unit	28	52	4	51	0	57

8. **Standard e)**

Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

8.1. The Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 is captured and recorded locally on the

Badgernet Neonatal Information System and may be used for the purposes of direct care, clinical audit, Reference Costs, and other local uses.

8.2. There is not a requirement for the Trust to regularly submit this data but the fact that we are able to download it from Badgernet, if requested, means we meet the CNST criteria.

8.3. The National Target set for ATAIN is under 5%, both QEQM and WHH have consistently remained well below this level. Data is recorded on the Neonatal section of the Maternity Dashboard

8.4. The following table shows the Kent Surrey Sussex ATAIN Unit Summary 2022/23. Quarterly ATAIN summary reports that are provided by the Neonatal Operational Delivery Network (ODN).

8.5. Term admission rates were 2.9/100 live births at WHH which is lowest among all level 3 NICUs at KSS and Thames Valley and Wessex network.

8.6. Corresponding rates for QEQM were 3.7/100 live births which is well below the recommended admission rate for term infants.

8.7. The highest reason for admission is of babies with respiratory problems and of note, we had only 5 admissions for observation across EKHUFT.

NHS
East Kent Hospitals University
NHS Foundation Trust

ATAIN Unit Summary Q3 2022-23 (Apr-Dec 2022)

Return to Front Page

SCU | LNU | NICU

Network	Unit	Live births (all)	Term admissions		Respiratory			Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 only			
			n	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	NNU 1 Day	% term ads	NNU>1 Day	% term ads
Thames Valley & Wessex	Milton Keynes	2604	147	5.6%	83	56%	31.9	7	5%	2.7	2	1%	0.8	12	8%	4.6	14	10%	5.4	24	16%	38	26%
	Royal Berkshire, Reading	3685	200	5.4%	136	68%	36.9	8	4%	2.2	6	3%	1.6	13	7%	3.5	8	4%	2.2	27	14%	62	31%
	Stoke Mandeville	3433	148	4.3%	65	44%	18.9	10	7%	2.9	4	3%	1.2	15	10%	4.4	8	5%	2.3	15	10%	58	39%
	Wexham Park Hospital	3088	92	3.0%	41	45%	13.3	8	9%	2.6	3	3%	1.0	10	11%	3.2	5	5%	1.6	22	24%	52	57%
	John Radcliffe, Oxford	5683	270	4.8%	139	51%	24.5	8	3%	1.4	11	4%	1.9	18	7%	3.2	15	6%	2.6	25	9%	70	26%
	Dorset County Hospital FT	1158	70	6.0%	28	40%	24.2	14	20%	12.1	14	20%	12.1	4	6%	3.5	2	3%	1.7	16	23%	19	27%
	St Marys Isle of Wight	753	29	3.9%	18	62%	23.9	2	7%	2.7	0	0%	0.0	1	3%	1.3	3	10%	4.0	8	28%	5	17%
	HHFT - Basingstoke	1862	93	5.0%	34	37%	18.3	3	3%	1.6	7	8%	3.8	3	3%	1.6	20	22%	10.7	16	17%	34	37%
	HHFT - Winchester	1731	78	4.5%	36	46%	20.8	4	5%	2.3	9	12%	5.2	9	12%	5.2	4	5%	2.3	21	27%	23	29%
	Poole Hospital FT	3113	134	4.3%	73	54%	23.5	4	3%	1.3	3	2%	1.0	3	2%	1.0	14	10%	4.5	11	8%	43	32%
	Salisbury NHS FT	1676	106	6.3%	48	45%	28.6	2	2%	1.2	6	6%	3.6	13	12%	7.8	8	8%	4.8	3	3%	55	52%
	St Richard's Hospital	1717	56	3.3%	34	61%	19.8	6	11%	3.5	4	7%	2.3	2	4%	1.2	0	0%	0.0	3	5%	19	34%
	Queen Alexandra Hospital	3621	143	3.9%	59	41%	16.3	4	3%	1.1	13	9%	3.6	0	0%	0.0	22	15%	6.1	16	11%	43	30%
	University Hospital Southampton FT	3916	200	5.1%	53	27%	13.5	11	6%	2.8	22	11%	5.6	8	4%	2.0	7	4%	1.8	27	14%	57	29%
	TV & W Network Total	**38040**	**1766**	**4.6%**	**847**	**48%**	**22.3**	**91**	**5%**	**2.4**	**104**	**6%**	**2.7**	**111**	**6%**	**2.9**	**130**	**7%**	**3.4**	**234**	**13%**	**578**	**33%**
Kent Surrey Sussex	Conquest Hospital	2116	93	4.4%	29	31%	13.7	36	39%	17.0	5	5%	2.4	1	1%	0.5	4	4%	1.9	26	28%	37	40%
	Darent Valley Hospital	3640	185	5.1%	79	43%	21.7	27	15%	7.4	12	6%	3.3	24	13%	6.6	6	3%	1.6	40	22%	90	49%
	Princess Royal Hospital	1589	77	4.8%	47	61%	29.6	0	0%	0.0	5	6%	3.1	2	3%	1.3	2	3%	1.3	13	17%	17	22%
	Queen Elizabeth the Queen Mother Hos	1935	72	3.7%	37	51%	19.1	12	17%	6.2	1	1%	0.5	8	11%	4.1	2	3%	1.0	8	11%	32	44%
	Royal Surrey County Hospital	2180	73	3.3%	39	53%	17.9	8	11%	3.7	3	4%	1.4	7	10%	3.2	5	7%	2.3	11	15%	25	34%
	Worthing Hospital	1626	51	3.1%	20	39%	12.3	1	2%	0.6	4	8%	2.5	7	14%	4.3	0	0%	0.0	5	10%	21	41%
	East Surrey Hospital	3393	171	5.0%	77	45%	22.7	27	16%	8.0	9	5%	2.7	14	8%	4.1	8	5%	2.4	28	16%	64	37%
	Frimley Park Hospital	3779	68	1.8%	21	31%	5.6	17	25%	4.5	5	7%	1.3	3	4%	0.8	4	6%	1.1	19	28%	18	26%
	Tunbridge Wells Hospital	4423	162	3.7%	103	64%	23.3	17	10%	3.8	6	4%	1.4	2	1%	0.5	6	4%	1.4	7	4%	30	19%
	Medway Maritime Hospital	3440	164	4.8%	69	42%	20.1	17	10%	4.9	3	2%	0.9	10	6%	2.9	0	0%	0.0	17	10%	50	30%
	Royal Sussex County Hospital	1800	74	4.1%	38	51%	21.1	1	1%	0.6	9	12%	5.0	2	3%	1.1	0	0%	0.0	1	1%	20	27%
	St Peter's Hospital	2440	123	5.0%	55	45%	22.5	17	14%	7.0	5	4%	2.0	12	10%	4.9	3	2%	1.2	21	17%	41	33%
	William Harvey Hospital	2684	77	2.9%	41	53%	15.3	7	9%	2.6	1	1%	0.4	2	3%	0.7	3	4%	1.1	7	9%	23	30%
	KSS Network Total	**35045**	**1390**	**4.0%**	**655**	**47%**	**18.7**	**187**	**13%**	**5.3**	**68**	**5%**	**1.9**	**94**	**7%**	**2.7**	**43**	**3%**	**1.2**	**203**	**15%**	**468**	**34%**

NHS
East Kent
Hospitals University
NHS Foundation Trust

WHH and QEQM Data for all Quarters

Kent Surrey Sussex SELECT UNIT: Queen Elizabeth the QM Margate

Queen Elizabeth the QM Margate	Live births	Term Admissions		Respiratory Symptoms			Suspected Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 Only NNU 1 day only		HRG 3-5 Only NNU >1 day	
		N	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	n	% term ads
Q1 - Apr-June	628	22	3.5%	14	64%	22.3	2	9%	3.2	1	5%	1.6	2	9%	3.2	0	0%	0.0	1	5%	8	36%
Q2 - July-Sept	666	25	3.8%	13	52%	19.5	5	20%	7.5	0	0%	0.0	2	8%	3.0	1	4%	1.5	2	8%	13	52%
Q3 - Oct-Dec	641	25	3.9%	10	40%	15.6	5	20%	7.8	0	0%	0.0	4	16%	6.2	1	4%	1.6	5	20%	11	44%
Q4 - Jan-Mar	0	0	0.0%	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0	0%
Year to Date	**1935**	**72**	**3.7%**	**37**	**51%**	**19.1**	**12**	**17%**	**6.2**	**1**	**1%**	**0.5**	**8**	**11%**	**4.1**	**2**	**3%**	**1.0**	**8**	**11%**	**32**	**44%**

Kent Surrey Sussex SELECT UNIT: William Harvey Ashford

William Harvey Ashford	Live births	Term Admissions		Respiratory Symptoms			Suspected Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 Only NNU 1 day only		HRG 3-5 Only NNU >1 day	
		N	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	n	% term ads
Q1 - Apr-June	901	32	3.6%	15	47%	16.6	4	13%	4.4	1	3%	1.1	0	0%	0.0	1	3%	1.1	4	13%	7	22%
Q2 - July-Sept	945	24	2.5%	14	58%	14.8	2	8%	2.1	0	0%	0.0	0	0%	0.0	1	4%	1.1	2	8%	8	33%
Q3 - Oct-Dec	838	21	2.5%	12	57%	14.3	1	5%	1.2	0	0%	0.0	2	10%	2.4	1	5%	1.2	1	5%	8	38%
Q4 - Jan-Mar	0	0	0.0%	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0	0%
Year to Date	**2684**	**77**	**2.9%**	**41**	**53%**	**15.3**	**7**	**9%**	**2.6**	**1**	**1%**	**0.4**	**2**	**3%**	**0.7**	**3**	**4%**	**1.1**	**7**	**9%**	**23**	**30%**

9. **Standard f)**

Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been 27 cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

9.1. Weekly cross site Multidisciplinary Maternity and Neonatal Review meetings take place to discuss in detail all term admissions into the Neonatal Unit and critically assess whether the admission could possibly have been avoided if risk had been identified and/or care had been provided differently.

9.2. Learning theme posters are generated to communicate opportunities to improve with the wider team.

9.3. An audit tool template has been formalised to support improved capture of themes and tracking of learning from cases.

9.4. From Monday 18 July 2022 reviews have also included all term babies transferred to the neonatal unit, regardless of the length of stay

9.5. The ATAIN and TC Action Plan (Appendix 1) shows areas of focused improvement.

9.6. The following Table shows the data collected on the neonatal section of the Maternity Dashboard Term Admissions to Special Care Baby Unit (SCBU)/Neonatal Unit (NNU).

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Neonatal Unit	Therapeutic Hypothermia	2	Mar-23	0			1	0	3
	ATAIN %	4.2%	Mar-23	4.0%			3.34%	0.79%	5.89%
	PO: All Criteria Met	85.0%	Mar-23	20.0%			26.8%	0%	56.8%
	PO: Optimised Cord Clamping	85.0%	Mar-23	50.0%			63.5%	22.7%	100%
	PO: AN Steroids <7d	85.0%	Mar-23	50.0%			45.5%	3.51%	87.5%
	PO: Mag Sulph <24h	85.0%	Mar-23	100%			78.1%	8.06%	100%
	PO: Normal Temp	90.0%	Mar-23	87.5%			71.5%	0%	100%
	Pneumothorax	0	Mar-23	0			1	0	2
	Transfers for Surgical Opinion	2	Mar-23	1			2	0	6
	IVH Grade 3 & 4	1	Mar-23	1			1	0	4
	Antibiotics within 60 mins	80.0%	Mar-23	76.2%			80.2%	57.2%	100%
	Antibiotics timing complete	90.0%	Mar-23	100%			88.5%	70.0%	100%
	Total Cot Days	Sigma	Mar-23	691			798	285	1,312
	SC & NC Days w/o O2	Sigma	Mar-23	109			99	6	192
	SC & NC Days w/o O2 on NNU	Sigma	Mar-23	59			52	0	104
	TC Location/Care Days	Sigma	Mar-23	90			92	24	159
	TC Location/Care Babies	Sigma	Mar-23	32			31	10	52

Domain	KPI	Thres.	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Neonatal Unit	Therapeutic Hypothermia	2	2	2	1	1				1			
	ATAIN %	4.2%	4.4%	3.6%	2.3%	2.3%	2.9%	1.7%	2.9%	3.2%	3.9%	0.8%	4.2%
	PO: All Criteria Met	85.0%	25.0%	50.0%	22.2%	42.9%	33.3%	42.9%	57.1%	16.7%	14.3%	10.0%	28.6%
	PO: Optimised Cord Clamping	85.0%	75.0%	66.7%	44.4%	71.4%	44.4%	85.7%	57.1%	66.7%	57.1%	30.0%	71.4%
	PO: AN Steroids <7d	85.0%	42.9%	66.7%	33.3%	71.4%	66.7%	85.7%	85.7%	60.0%	42.9%	40.0%	71.4%
	PO: Mag Sulph <24h	85.0%	100%		100%	75.0%	60.0%	100%	100%	75.0%	100%	80.0%	100%
	PO: Normal Temp	90.0%	57.1%	100%	57.1%	100%	66.7%	25.0%	83.3%	50.0%	0.0%	50.0%	85.7%
	Pneumothorax	0	0	0	0	1	2	2	0	1	1	0	0
	Transfers for Surgical Opinion	2	1	4	2	3	1	2	1	1		2	1
	IVH Grade 3 & 4	1	2		1				2	2		1	1
	Antibiotics within 60 mins	80.0%	65.5%	87.5%	63.6%	75.0%	72.2%	64.7%	86.7%	76.7%	72.2%	84.2%	71.4%
	Antibiotics timing complete	90.0%	96.7%	80.0%	91.7%	87.0%	78.3%	85.0%	88.2%	90.9%	72.0%	90.5%	100%
	Total Cot Days	Sigma	506	748	698	492	430	670	462	519	527	330	488
	SC & NC Days w/o O2	Sigma	54	83	117	79	53	47	50	87	85	12	9
	SC & NC Days w/o O2 on NNU	Sigma	39	44	72	28	24	22	14	58	28	4	0
	TC Location/Care Days	Sigma	50	87	66	76	35	38	44	45	91	15	16
	TC Location/Care Babies	Sigma	16	26	19	20	13	13	15	16	26	6	8

9.7. Learning recommendations from ATAIN reviews

Month	Site	Learning Recommendations:
July	WHH	Ensure all resuscitation equipment available and working
		No sepsis form
		Parent communication must be fully recorded
		Nnap data to be completed in all relevant cases
Aug	WHH	Remember to check that the team has screened for diabetes
		Sats to be completed and recorded
		neonatal - badger paperwork for admission or discharge-transfer to PN Ward must be completed
		Documentation on why baby was cooled to be completed
		Baby Not admitted correctly on badger. Parent communication recorded before admission
	QEQM	Neonatal - lack of Kaiser permante scoring. Maternity - consider offering EBM as alternative to formula
		Maternity - No admission SBAR/no latent phase proforma/synto at 6ml/hr is not within guideline/no gases taken at del for resuscitation
		Maternity - When AFI >95th centile – should be referred to neonatal team at delivery for NG tube/care of temp during resuscitation
		Neonatal - Not all SCBU entries documented/dated/timed
		Neonatal - if following the respiratory care pathway, the pre/post ductal saturations should be recorded
		Neonatal learning - No admission summary on Badger
		Maternity - no resus proforma found in notes
		Maternity - Proper documentation of apgars should be in blue neonatal notes. Just apgars at 1 and 5 minutes recorded non for 10 mins although documented elsewhere
		Neonatal - SCBU staff should provide more accurate documentation

Sept	QEQM	If there is difficulty in getting adequate chest rise consider two person manoeuvres or using an igel
		Proper parent communication
		Use of propes in 3 cm dilated women (obs) the use of double dose antibiotics in an otherwise well baby (neonatal)
		No Sepsis form complete
	WHH	Start phototherapy prior to SBR result if symptomatic. Complete Newt chart
		No Sepsis form complete X2
		To complete history and information
Oct	QEQM	Maternity - No baby sats performed when baby demonstrating respiratory difficulties. In episodes of baby having raised resps then always perform baby sats. - Good observation and escalation to paediatric team of raised resps, if review delayed escalate to registrar or consultant. - Do not wait to escalate raised resps in baby over 4 hours old as indicative of sepsis. When baby declared TC and having active treatment baby should be cared for by RM, not MSW (or NQM acting as MSW)
		Neonatal learning – poor review time response in baby >4hrs when resps raised. Poor documentation
		Neonatal - SBR taken as part of sepsis screen, results not reviewed, potentially if raised SBR has been noted earlier would not have required SCBU admission. Neonates to investigate where TC babies can be viewed in badger
		Neonatal learning - No follow up arranged for rpt bloods- to be arranged by Pead team
		Joint learning - Poor documentation surrounding chosen method of feeding or support provided. Cannot rv maternity PN notes as with mother so unavailable at time of review but consider supporting mother could have been supported to EBM. EBM kits are available for use on labour ward
		Neonatal - May be a manpower/resource context of limitations at QEQM but with more team members available might have had more planning for reviews and observation on ward. Documentation could have been improved as Badger updates were not created
		Neonatal - Unless there are clinical signs, consider if you need to double dose of IV abx
		Neonatal - If you are worried about sepsis consider giving a dose of abx IM to reduce risk of delay and give within hour
		Neonatal - No HC plotted – HC should be plotted, documentation of optiflow, nursing respiratory support documentation was incorrect
		Neonatal - No HC plotted – HC should be plotted, documentation of optiflow, nursing respiratory support documentation was incorrect
		Neonatal - Following assessment on LW ensure adequate documentation is completed

	WHH	Still an inpatient
		Better documentation
Nov	QEQM	Neonatal - Clinical review was only on admission date – no follow up review – no documentation of decision – to involve surgeon
		3x Neonatal- poor information recording on badger net
		Neonatal- intubation given before ventilation breaths, no sepsis tool, discharged whilst on antibiotics- to be discussed at perinatal
		Congratulations from WHH neonatal team regarding swift action taken by QEQM teams
		Improve communication regarding baby alerts - not related to admission but point seen
		Maternity - To be discussed at rapid review - as possible inadequate treatment of intrapartum sepsis
		Neonatal - Clinical review was only on admission date – no follow up review – no documentation of decision – to involve surgeon
	WHH	2 x No Sepsis form.
		Follow the hypoglycaemia guideline.
		For rapid review with Clare Redfern
		To be included in MDT meeting. No information given to WHH
Dec	QEQM	Paeds learning - haemolysis.
		Neonatal - no badger upload but system down
		Maternity learning - Cord gases to be taken at each EMCS. Complete MEWS in its entirety to accurately calculate scores
	WHH	4x Sepsis form not complete
		No Growth chart
		Consultant review prior to admission
		Parent communication not recorded.
		Discharges/Transfers to PNW need to have a badger letter before leaving NICU
		Chase Culture results
Jan	QEQM	Neonates - team to communicate specific clinical observations to nursing team with regards to particular conditions
		2x Neonates – to improve communications with parents & to record this on Badger
		2x Maternity to improve record keeping of baby CBG on NEWT charts
		Neonatal – to consider vapotherm rather than NCPAP for term babies
	WHH	Well managed by midwifery and neonates
		Chasing and recording sepsis form
		Could have observed for longer on labour ward.

		Baby could have stayed with mum and reviewed on the ward with Pulse Oximetry
		Ivabs not recorded on badger, Badger admission incorrect date as not discharged from TC
		Complete head circumference
Feb	QEQM	Obs - Cord should not be C&C before delivery - CR to f/up with reg at del
		Neonatal - Careful calculation of Kaiser scoring – review reason for admission – is it absolutely necessary – can anything additional be provided for baby in SCBU that cannot be provided on the TC space of the PNW
		Transfer tool would be beneficial between SCBU/PNW
		Any baby with bilious asp should be assessed and admitted – there was a delay in admission from PNW – even if xray show normal should still be considered and investigated
		For AAR by PH/CR. babies with low pH, abnormal bloods should have clinical evaluation of neurology. No result for blood culture in sepsis form, no mention of chlorhexidine for cleaning. Would have infused baby based on low HB high lactate send Kleihaur
	WHH	No learning recorded
Mar	QEQM	Neonatal - discussion with seniors may have avoided admission but acknowledge that high acuity made this difficult
		Feedback- Really good pick up, good use of saturation monitoring on the NEWTT chart
		No parental consultation
	WHH	No sepsis form

9.10 The following table shows babies that could have been cared for in the existing Transitional Care (TC) and those that could have been cared for if there was a fully functioning TC.

	Could Care have been provided in existing TC	Could care have been provided in fully functioning TC (i.e. babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there)
July	No	1 X NG Tube feeding
August	No	1 X NG Tube feeding and IV ABX
	No	1 x NG Tube Feeding
	Yes	1 x Neuro obs can occur enhanced TC input
September	Yes	1 x phototherapy could have been given on PN ward
October	Yes No	1 x Double phototherapy (QEQM – were equipment issues that are ow resolved) 2x NG Tube feeding 1 x enhanced observations
Nov	No	1x enhanced observations 1x NG Tube feeding
Dec	No	2x NG Tube feeding

	Yes	1x enhanced observations 1x PO and feeding support
Jan	Yes No	1x Could have been left with mum for a bit longer. 1x Enhanced observations 2x NG feeding 2x PO & enhanced observations
Feb	Yes No	1x no reason recorded. 1x PO obs 2x NG feeding
Mar	No	1x NG feeding 2x PO obs

10. **Standard g)**

An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.

10.1. The Transitional Care and ATAIN action plans have been developed and approved by the Clinical and Midwifery Leads and Neonatal Safety Champion and are shared with the Maternity and Board Safety Champions through the Bi Monthly meetings and MNAG and Board reporting arrangements.
10.2. Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter is through the agreed Trust Board reporting structure.
10.3. See Appendix 1 for the Transitional Care and ATAIN action plan
10.4. In addition, ATAIN Learning Posters are developed and shared with staff

11. **Standard g)**

Progress with the revised ATAIN action plan has been shared with the maternity neonatal and Board level safety champions LMNS and ICS quality surveillance meeting.

11.1. An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point e).
11.2. Presentations have been provided by leads at Care Group Audit Days, an audit tool has been developed with support from the Trust Audit Team to formalise the process and reporting structures have been agreed with Trust Board.
11.3. Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter is through the agreed Trust Board reporting structure.
11.4. See Appendix 1 for the Transitional Care and ATAIN action plan

12. **Next steps**

12.1. Transitional Care and ATAIN working party group continue to review cases and explore opportunities to expand Transitional care services. Nursery Nurses have been appointed on the WHH site and have completed competencies to allow them to

support NG Tube feeding in the TC setting. Rotation is in place to maintain these competencies

12.2. Quarter 3 and 4 Transitional Care and ATAIN audits, data reviews and action plan findings will also be shared with the LMNS and ICS quality surveillance meeting

East Kent Hospitals University NHS Foundation Trust

Appendix 1:
ATAIN Action Plan

Item No	Link to ATAIN admission criteria (i.e.Respiratory, Jaundice, Hypoglycaemia, HIE, Observation, Poor feeding)	Recommendation identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Date for completion	RAG rating	Progress/comments	Date completed
1.	Respiratory	1.1. Reduce the number of babies admitted with respiratory issues there needs to be a reduction in the number of elective CS performed under 39 weeks unless there is a clear contraindication	• Not arranging elective LSCS before 39 weeks unless clinically indicated. • If needed, ensuring mother is given antenatal steroids as per RCOG guideline	Obstetric leads	September 2023	In Progress within time line	Weekly review meeting and feedback of any cases and learning. Understand route cause against individual cases Working with operations team to centralise and better coordinate elective caesarean sections.	Ongoing
2.	Hypoglycaemia	Reduce admission of babies at risk of hypoglycaemia	Educate and share awareness of importance of feeding within 60 minutes of delivery and feeding support during postnatal period. Audit compliance within auditable standards of Transitional Care Guideline and ongoing audit	Labour ward managers	October 2023	In Progress within time line	Audit template agreed for Transitional Care. Monthly audits in progress. **03.10.22** 35% of babies on the QEQ site and 99% on the WHH were fed within 60 minutes. Further work is to be done to improve this on the QEQM site	Ongoing
3.	ATAIN review process	To ensure that all admissions to the Neonatal Unit are reviewed using an agreed audit template to identify areas of improvement	To agree NEW Audit Review Template and begin using within review meeting/as part of monthly audits	Amit Gupta Leisa Foad Lucy Moat	Sept-22	Complete	Audit template has been developed that aligns to weekly case review template but will generate data trend information to support learning. Data to be populated on new template from May 2022	Ongoing
4.	Reduction in repeat themes and improved learning	Identifying themes/trends in term admissions on action plan template	• An audit tool and Action plan for ATAIN and Transitional Care admissions has been created. • Reviewing how data is presented in clinical areas and as part of monthly reporting to align with the quarterly reporting coming from the ODN based on Badgernet data. • Neonatal and Maternity leads to attend weekly review meeting to review antenatal and intrapartum care elements and support shared learning that comes out of the meetings.	Amit Gupta Leisa Foad Lucy Moat	Sept-22	Complete	Monthly local data collection via Badgernet and Maternity Dashboard data reporting to Care Group Governance, Maternity and Neonatal Assurance Group and into Trust Board. Action plan reviewed in the weekly meetings, the Safety Champion/MNAG meetings and from July 2022 will be shared quarterly at the LMS Quality Assurance Group meetings.	Ongoing
5.	To monitor opportunities for future development of Transitional Care service to reduce Neonatal Admissions and keep mums and babies together	• Monitor babies that could have been looked after in Transitional Care if Nasogastric tube feeding was offered • Secondary Data Recording Process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. • Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were	• To increase cot capacity at LCH by 8 Recruitment of staff to comply with Neonatal staffing template to ensure appropriate cover and skill mix Implementation of outreach service to increase cot capacity • Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of normal care days and special care days is now recorded on the Maternity Dashboard	Amit Gupta Leisa Foad Lucy Moat	October-21	Complete	Data is recorded on the Maternity Dashboard and included within Quarterly reporting	Ongoing

East Kent Hospitals University NHS Foundation Trust

		transferred during any admission, to monitor the number						
6.	Develop the Transitional Care Service to include full care criteria and expand opportunities to keep mums and babies together	• Scope opportunities/requirements to support transformation of the TC service	• Current position • Required standard • What expansion opportunities are there within existing estates footprint • What additional capacity requirements are required • What are the additional staffing requirements to support this expansion • What are the training needs and who/how can these be met • What additional equipment/resource requirements	TC working party group	March 2024	In Progress within time line	Working party group to scope requirements and present paper to leadership team, as part of the Maternity Improvement Plan	S

Transitional Care Action Plan from Audit Findings

Date action entered	Action number	Recommendation	Action (SMART)	Evidence of assurance	Lead (for action)	Completion date	Evidence received	Date achieved	Comments
27/10/2022	1	Ensure that local guidelines instructing staff are aligned to National guidance.	Update Trust Post Natal care (women and babies) and publish on Policy centre (current review date Feb 2021).	Screen shot of updated policy on Policy Centre	Sarah Jevons	31/03/2023			Guideline update delayed but now progressing
			Update Trust Infant Feeding published Apr 2019 (current review date Apr 2022).	Screen shot of updated policy on Policy Centre	Infant feeding co-ordinators - Phillipa Parrett & Kate Lynch	31/03/2023			Guideline update delayed but now progressing
	2	Provide robust data to be able to draw reliable conclusions of the care given and therefore be able to implement improvements where required.	Ensure that all data is captured for the audit by ensuring all paperwork is available i.e. scanning drug charts.	1. Scanned drug chart. 2. Fully completed Q2 report.	1. Clare Walford 2. Amanda Goodman	Completed	1. E mail confirmation from CW with example attached. 2. Q2 report.	1. 27/10/2022 2. 7/11/2022	
	3	Increase the number of babies being fed during the first hour to reduce hypoglycaemia.	Display a poster in the delivery rooms and theatre recovery rooms (obstetrics and main).	Poster & pic of them in situ.	Amanda Goodman to create poster and e mail to labour ward managers.	14/11/2022			Improvements have been noted at WHH, but still require poster.
	4	Increase awareness of this workstream by sharing the results of this audit.	1. Create and display/ distribute a summary poster.	Poster & pic of them in situ.	Amanda Goodman to create poster and e mail to labour ward managers.	Completed	E mail circulated to all	01/11/2022	
			2. Present findings at audit day in December.	Presentation and agenda.	Leisa Foad & Lucy Moat	Completed			Presented by Audit lead on behalf of team

East Kent Hospitals University NHS Foundation Trust

	5	Further investigate any compliance issues, including when measures are recorded as 'unknown' to identify where improvements can be made.	1. Add an 'exceptions' tab on the quarterly transitional care audit report. 2. Data collectors to notify ward managers to investigate any 'fail' cases as they are identified who will complete the exceptions tab and either make amendments to the data collected and/or add any actions to this action plan.	1. Report template with new tab. 2. Completed exception tab for Quarter 3.	1. Amanda Goodman 2. Leisa Foad & Lucy Moat	1. Completed 2. 31/01/2023	1. Q3 spread sheet	1. 7/11/2022	QEQM Q1 antibiotics administration exceptions e mailed to Leisa Foad 27/10/2022

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MATERNITY IMPROVEMENT PLAN HIGHLIGHT REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF NURSING AND MIDWIFERY OFFICER: EXECUTIVE MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**				
PAPER AUTHOR:	**DIRECTOR OF MIDWIFERY**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	**Assurance**	Discussion
Purpose of the Report:	The purpose of this report is: • To update the Board on key highlights of the East Kent Maternity's services Improvement Plan. • Provide assurance that the service is using the metrics and reporting to the required standard to illustrate the improvement plans and key millstones.				
Summary of Key Issues:	The report includes the following key messages for the Board's attention on areas not in track and requiring improvement: • **Team Working: Review to Assess**: consultant arrangements; roles and responsibilities of senior staff; triage oversight and shift handovers including safety huddles. This action is at Amber status with improvement for a more structured approach to ensure the sharing and delivery of key patient safety information using the Situation, Background, Assessment, Recommendation (SBAR) model. In addition, SBAR processes were recently process mapped and recommendations agreed for implementation for a more effective system. • **Governance & Patient Safety:** Agree Quality and Safety Framework aligned to Trust and national ambitions. This action is at a Red status with the following issues: o Quality & Safety Framework yet to be developed, this was being looked at by a former external consultant but has yet to be received so may need to be delivered using existing resources i.e. Head of Governance with support from the corporate Quality Governance team. o There are currently 11 overdue and open Serious Incidents (SIs), 45 overdue responses to complaints, 31 expired guidelines, and 868 overdue datix incidents indicating that systems of control require further work. o Antenatal and Newborn Screening (ANNBS) processes require a review to respond to recommendations made by the Trust's assigned NHS England (NHSE) Maternity Improvement Advisor, and these form part of the Maternity Transformation Programme (MTP) Workstream 3 - Clinical Pathways with a completion date of March 2024. The following areas are Green on track: • **Clinical Assessment & Care Pathways:** o A current concern impacting the timeliness of discharges home is EDN. Maternity continues to be monitored and has started to be shared across management teams, and the training that was circulated prior to the change-over of EDNs to Sunrise will be recirculated so that any members of the workforce who have not yet completed this can continue to familiarise themselves with the new system. o SBAR and Venous thromboembolism (VTE) process mapping was recently completed, as were observations of handover processes - refer to project 2.3 for details. o Annual staff survey metrics measure staff confidence to escalate concerns and there are internal metrics within the MTP to measure this; the aim is to achieve a 0.5 increase compared to 2022 results. • **Clinical Escalation & Handover:** o Process mapping sessions undertaken to review SBAR and VTE systems and processes; sepsis assessment tool pending review. Embedded Fresh Eyes process as part of senior 'Stop the Clock' weekly compliance checks and audits; notification from Care Quality Commission (CQC) that due to assurance around this process the level of scrutiny will be stepped-down however, this is based on sustained monitoring of effectiveness and review therefore Stop the Clock will be continuous process. o Comprehensive audit tool obtained from another Trust for consideration to encompass all areas of clinical assessment and discussion in progress with corporate clinical audit team about management of future Maternity audits. o A review of emergency pathways are yet to be recommenced; initial scoping work was completed pre-2020, however, this will need to be revisited and refreshed based on current service needs with service user input to shape improved ways of working. This is a sub-workstream within the MTP with a delivery date of March 2024, aligned to the milestone within this plan. • **Engagement, Listening & Leadership:** o Supporting MTP Communications (Comms) Plan to be developed to share key messages with staff and service users about progress of service improvements. o There is a Maternity Patient Information Group within the care group's governance structure that develops communication tools, aids, and methods for sharing key information. o Quality and Safety boards pending 'go live'; there are two screens in situ at William Harvey Hospital (WHH) and two screens pending installation at Queen Elizabeth the Queen Mother Hospital (QEQM) that will display key information for women and families. o Engagement Framework to be developed based on Trust Patient Involvement Strategy and linked to existing Maternity Patient Voices Model, and revised Maternity Strategy. o Oversight of education within Maternity was recently adjusted and Professional Development falls into the new Governance team framework under the Quality & Education Matron; there is a formal education forum called Maternity Faculty for Multi-professional Education (MFME) for management and oversight of the portfolio that reports into the Women's Health Care Group Governance Group, and is underpinned by a Maternity Training Guideline and supporting Training Needs Analysis.				

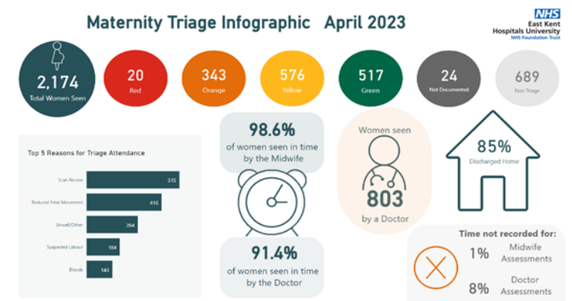
	○ Maternity Patient Experience Midwives are currently working with Community Matrons on the development of an antenatal education programme with input from service users and representatives of service user groups. Key Target for next period are: • Delivery of Postnatal and Discharge Processes Model. • Development of Maternity Engagement Framework. • Further planning to support full implementation of Birmingham Symptom Specific Obstetric Triage System (BSOTS) (plans for removal on non-Triage activity). • Review of methods / framework for sharing lessons learned, including links to inform the Training Needs Analysis (TNA).
Key Recommendation(s):	The Board of Directors are asked to **NOTE** the content within the highlight update of the Maternity Improvement plan.

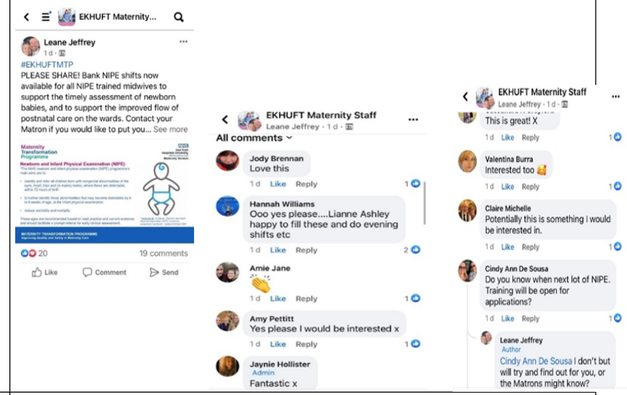
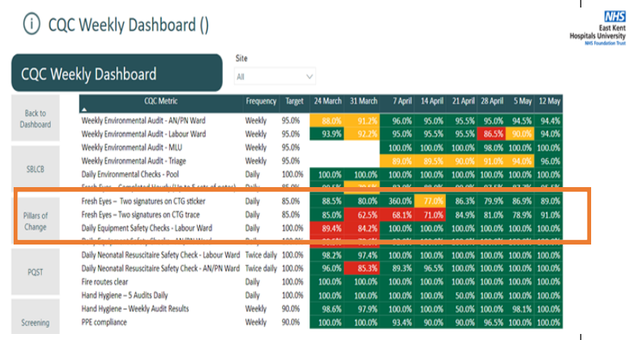
Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients (women and Families)	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards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

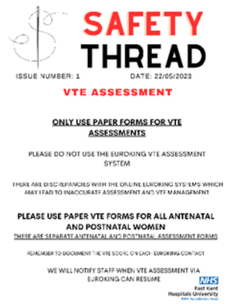
NHS East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Maternity Improvement Plan May 2023

Programme of work:	Maternity	Produced Date:	23.05.2023	Owner:	Director of Midwifery	SRO:	Interim Chief Nursing and Midwifery Officer (CNMO)
Progress Rating:		Start date:	Mar-23	Planned End:	Mar-24	Revised End:	

Delivery Status		Delivery Status Summary	Key achievements this period	Examples of monitoring
2.1 - Team Working: Review to Assess: **consultant arrangements**; roles and responsibilities of senior staff; triage oversight and shift handovers including safety huddles. Review and strengthen existing plans to support **safe challenge** around behaviours and to build teams that value, support and trust each other	Amber - action mainly on track with minor issues	NHSE Demand and Capacity review was used to inform the development of an overarching obstetric model, which identified the need for 8 additional consultant posts to continue with current service provision based on current ways of working. However, a full review of, and change to, these current ways of working could avoid significant associated and unfunded costs with this proposal. 'To review and assess' could be completed by the July 2023 milestone but to agree and implement will take longer (with consultants for review and decision on appropriate timeframe) The Triage Guideline was published Jan 2023 that includes details of obstetric oversight (aligned to the above overarching job planning requirements). Any doctor breaches within the Triage service are documented and reported through the Triage dashboard with reasons identified; refer to Key Performance Indicators (KPIs) below. Regular oversight in-line with requirements at QEQM, pending status for WHH from CD (ZW) - due July 2023 Director of Midwifery (DoM)/DDoM conducted an observation of handover processes (recording template to be developed) and identified areas of improvement for a more structured approach to ensure the sharing and delivery of key patient safety information using the SBAR model. In addition, SBAR processes were recently process mapped and recommendations agreed for implementation for a more effective system. 2 x Civility Saves Lives training sessions are scheduled for 26 May 2023; triumvirate booked to attend additional Perinatal Culture and leadership pProgramme, including a SCORE survey (Mat/Neo culture assessment). There is a dedicated Maternity Freedom to Speak Up Guardian (FTSUG) whose role is promoted across the service. More focus required on 'in the moment' challenge to maintain patient safety and support staff safety	Obstetric workforce demand and capacity review Good monitoring of doctor attendance / oversight in Triage (refer to Triage Dashboard) DoM/DDoM Observation of handover processes SBAR process mapping / improvement action setting Scheduling of culture-related training sessions	

2.2 - Clinical Assessment & Care Pathways: Development of **care pathways**: high dependency care, Triage / centralised Telephone Triage, ANNBS / Sonography, Discharge, and VTE. Focus on **SBAR Handover process** and escalation processes. Undertake **staff surveys** to identify barriers and levels of staff confidence to **escalate concerns**	Green - action on track	Clinical Pathways is a standalone workstream within the MTP and encompasses all elements required of this project e.g. HDU, Triage, ANNBS/Sonography, Discharge processes, VTE/SBAR. A current concern impacting the timeliness of discharges home is EDN functionality and staffing constraints to complete the EDNs; this concern has been escalated to IT colleagues in the T3 team and is a known Trust-wide concern that has been escalated by other care groups too. In the meantime, completion of EDNs within Maternity continues to be monitored and has started to be shared across management teams, and the training that was circulated prior to the change-over of EDNs to Sunrise will be recirculated so that any members of the workforce who have not yet completed this can continue to familiarise themselves with the new system. SBAR and VTE process mapping was recently completed, as were observations of handover processes - refer to project 2.3 for details Annual staff survey metrics measure staff confidence to escalate concerns and there are an internal metrics within the MTP to measure this; the aim is to achieve a 0.5 increase compared to 2022 results.	ANNBS/FMU/USS Project Plan developed with multidisciplinary project group with measures, outcomes and outputs and shared for comment; will also be shared for service user input Centralised Telephone Triage model to be finalised and implemented via Project Lead Postnatal Care and Discharge Processes project plan being delivered; Newborn and Infant Physical Examination (NIPE) bank shifts introduced to support timeliness of non-complex baby assessments / Neonatal Senior House Officer (SHO) oversight increased and improved at WHH; similar to be replicated at QEQM further to discussion with Neonatal consultant lead VTE and SBAR process mapping completed and improvement action log developed (refer to 2.3) DoM/DDoM observation of handover processes with recommendations for improvement	
2.3 - Clinical Escalation & Handover: Development of systems and processes to allow staff to **recognise deteriorating patients** including sepsis management assessment and CTG tools. This will include a review and audit of **emergency pathways** to ensure these are appropriate and informed by woman's experience.	Green - action on track	Process mapping sessions undertaken to review SBAR and VTE systems and processes; sepsis assessment tool pending review. Embedded Fresh Eyes process as part of senior 'Stop the Clock' weekly compliance checks and audits; notification from CQC that due to assurance around this process the level of scrutiny will be stepped-down however, this is based on sustained monitoring of effectiveness and review therefore Stop the Clock will be continuous process. Comprehensive audit tool obtained from another Trust for consideration to encompass all areas of clinical assessment and discussion in progress with corporate clinical audit team about management of future Maternity audits. A review of emergency pathways are yet to be recommenced; initial scoping work was completed pre-2020 however, this will need to be revisited and refreshed based on current service needs with service user input to shape improved ways of working. This is a sub-workstream within the Maternity Transformation Programme (MTP) with a delivery date of Mar 2024, aligned to the milestone within this plan.	VTE / SBAR process mapping with supporting improvement action logs Monitoring of, and compliance with, Fresh Eyes as part of 'Stop the Clock' process Clinical audit plan as ongoing review of use and effectiveness of clinical escalation tools with recommendations based on outcomes Inclusion of development of emergency / enhanced maternal care in MTP	

2.4 - Governance & Patient Safety: Agree **Quality and Safety Framework** aligned to Trust and national ambitions Ensure there are **no backlogs** in Patient Safety activities. Learning to be identified and communicated through regular **incident learning events** and monthly sharing of learning from incidents	Red - Milestones not met	Quality & Safety Framework yet to be developed, as this is with a former external Governance consultant and the work has yet to be received so this may need to start again using existing resources i.e. Head of Governance with support from the corporate Quality Governance team. There are currently 11 overdue and open Serious Incidents, 45 overdue responses to complaints, 31 expired guidelines, and 868 overdue incidents indicating that systems of control require further work. ANNBS processes require a review to respond to recommendations made by the Trust's assigned NHSI Maternity Improvement Advisor, and these form part of the MTP Workstream 3 - Clinical Pathways with a completion date of March 2024.	Identification of the current position within the Maternity Governance team (specifically the Pt. Safety workstream) Launch of 'Lunch and Learn' events Launch of Safety Thread communications for sharing urgent safety messages	 
2.5 - Engagement, Listening & Leadership: Coproduced **communication plan** to ensure staff feel listened to, and staff receive relevant and timely information. Maternity User **Engagement Framework** aligning to Trust Patient Involvement Strategy. Service will work with partners to develop high quality supported **training experiences**.	Green - action on track	Supporting MTP Communications (Comms) Plan to be developed to share key messages with staff and service users about progress of service improvements; Your Voice is Heard (YVIH) also has a comms plan that is already in place for sharing 'you said, we did' changes internally and externally and to set out a timed structure for sharing general updates about service user feedback through the YVIH service. There is a Maternity Patient Information Group within the care group's governance structure that develops communication tools, aids, and methods for sharing key information to service users with representation from Maternity, Communications Team, Patient Information Coordinator, perinatal mental health team; invitations are now being sent to DA Languages and service user groups for their attendance and involvement in development of the service's patient information provision. Quality and Safety boards pending 'go live'; there are two screens in situ at WHH and two screens pending installation at QEQM that will display information for women and families based on content such as infant feeding, bobble hat initiative, DadPad, antenatal education classes, domestic abuse helpline, when to attend Triage - this will be in addition to key maternity statistics such as number of babies born, number of vaginal / c-section deliveries, multiple (twin) births, number of Inductions of Labour, number of women giving birth for the first time. Engagement Framework to be developed based on Trust Patient Involvement Strategy and linked to existing Maternity Patient Voices Model, and revised Maternity Strategy. Oversight of education within Maternity was recently adjusted and Professional Development falls into the new Governance team framework under the Quality & Education Matron; there is a formal education forum called Maternity Faculty for Multi-professional Education (MFME) for management and oversight of the portfolio that reports into the Women's Health Care Group Governance Group, and is underpinned by a Maternity Training Guideline and supporting Training	YVIH Communications Plan Relaunch of Women's Health Patient Information Group (following appointment of new Patient Information Midwife) Refinement of information slides for Quality & Safety Boards (TV screens on a loop system) - examples of information slides provided Development of PD team model Commencement of development of antenatal education programme	   

	Needs Analysis. Maternity Patient Experience Midwives are currently working with Community Matrons on the development of an antenatal education programme with input from service users and representatives of service user groups.	

Escalation to Strategic Improvement Committee	Key Targets Next Period
Non-compliance with Project 4 - Governance trajectory / plan **Risks associated with postnatal / discharge processes e.g. EDN** **Management of pace and priority of Recovery Support Programme (RSP)/Integrated Improvement Plan (IIP) and MTP whilst managing a challenged maternity service** **Success monitored and identified through YVIH metrics (listened to, trends and themes)** **Plans for away days and engagement events to enable staff involvement in the Trust response to Reading the Signals, and January's CQC inspection outcomes**	*** Delivery of Postnatal and Discharge Processes Model** *** Development of Maternity Engagement Framework** *** Further planning to support full implementation of BSOTS (plans for removal on non-Triage activity)** *** Review of methods / framework for sharing lessons learned, including links to inform the TNA**

Top 3 Open Delivery Issues		Top 3 Open Delivery Risks		
Owner	Summary	Owner	Summary	Risk rating

KPIs

Project	KPI	Description	Baseline Measure (Jan 2023)	Ambition (Jan 2024)	Target this month (May 2023)	Current performance (Apr 2023)	Trend from last month (Mar 2023)	Comments
Team Working	Triage consultant oversight	*From Triage Guideline:* **At QEQM:** • Monday to Friday – AM nominated middle grade or consultant, PM nominated consultant • Saturday and Sunday – additional middle grade 0800 – 1700 who covers gynaecology and triage **At WHH:** • Monday to Friday – on-call consultant / LW consultant NB this will change to a dedicated triage consultant in the afternoons following job plan changes • Saturday and Sunday – additional	Compliance of timeliness of doctor assessment: Overall 92.4% QEQM 95.7% WHH 82.6%	Sustained compliance with BSOTS time to treatment performance indicators: Maintaining high levels (TBC%) of doctor oversight of Triage service, aligned to EKHUFT Triage Guideline and BSOTS compliance requirements	Minimum 90% doctor assessment compliance (by site, and overall)	Compliance of timeliness of doctor assessment, April 2023: Overall 91.4% QEQM 94.7% WHH 87.7%	Overall is down from 93.8% in March 2023 QEQM is **up** from 94.3% in March 2023 WHH is down from 92.9% in March 2023	

BSOTS category	Maximum time until treatment	Performance indicator (%)
Red	Immediate	100
Orange	15 minutes	75
Yellow	1 hour	75
Green	4 hours	75

		middle grade 1000 – 1700 who covers gynaecology and triage						
Team Working	Attendance on Perinatal Culture and Leadership Programme	TBA	0%	Women's Health senior leadership team to reach 100% attendance and completion of the programme (delegate list to be defined)	TBA	0%	N/a	The perinatal culture and leadership programme is a Trust-led programme; schedules set at Trust level
Clinical Assessment and Care Pathways	SBAR Audit outcomes	The previous audit (May – July 2022) showed that SBARs were used in 51% of handovers at EKHUFT. Further analysis showed that even when SBARs were utilised, they were not always fully completed. In total, there were only 12% of fully completed SBARs present in women's notes. BSOTS was introduced mid September 2022 and other SBARs were updated around the same time. This audit is to determine the effectiveness of the new documentation	Completion rates for the reporting period (14/11/2022 – 12/12/2022): Antental Admissions: QEQM - 0% / WHH - 0% Antenatal Handover: QEQM - 40% / WHH - 0% Admission for delivery: QEQM - 0% / WHH - 0% Intrapartum care: QEQM - 15% / WHH - 11% Escalation: QEQM - 0% / WHH - 0% Postnatal: QEQM - 6% / WHH - 0% Postnatal shift handover: QEQM - 9% / WHH - 0% Summary - SBARs used 49% of required occasions but only fully completed for 12% of required cases from the audit sample dataset	75% completion rate	TBA	TBA	TBA	SBAR has historically been a periodic audit. However, recommendations from the process mapping work are pending implementation after which completion rates will be re-assessed and after testing, there are plans for this to become an ongoing audit to measure continuous improvement
Clinical Assessment and Care Pathways	VTE Audit outcomes	TBA	TBA	TBA	TBA	TBA	TBA	Last audit completed in Nov 2022 but support from corporate Clinical Audit team withdrawn to produce analysis - discussing options through Governance management team, and liaising with Business Intelligence team to draw outcomes - once available - into a dashboard
Clinical Assessment and Care Pathways	Staff survey metric: would feel secure raising concerns about unsafe clinical practice	NHS Annual Staff Survey 2022 Results - Maternity This is a measure within People Promise 3 - We each have a voice that counts	Overall People Promise 3 Maternity score - 5.6 (59.7% for the specific question)	Overall People Promise 3 Maternity score - 6.1 (TBA% for the specific question)	N/a	N/a	N/a	This is an annual survey so await 2023 results; other local initiatives could be potentially developed with People & Culture Business Partner to sense-check progress

23/43.6.1

Clinical Escalation and Handover of Care	Sepsis escalation assessment tool audit outcomes	Last completed in June 2022 under supervision and oversight of the Clinical Audit team. Questions within this audit were: Was the maternal sepsis screening tool used? Was sepsis six completed in the golden hour? Ensure a senior clinician attends Obtain IV access and take blood Commence IV broad spectrum within 1 hour of diagnosis of sepsis Monitor urine output Neonatal involvement Placenta swabbed / sent for histology	From June 2022 presentation: 49% 77% 80% 14% no lactate / 43% no clotting screening / 48% no MSU sent 87% 65% 73% 38%	TBA	N/a	N/a	N/a	Pending discussion regarding clinical audit resource, management and oversight with Governance management team, and liaising with Business Intelligence team to draw outcomes - once available - into a dashboard
Clinical Escalation and Handover of Care	CTG escalation assessment tool audit outcomes	Fresh eyes completed hourly (up to 5 sets of notes) Two signatures on CTG sticker Two signatures on CTG trace	The weekly audit / compliance cycle commenced in February with Maternity dashboard reporting from 24 Mar 2023; the overall starting compliance rates were: 90.5% 88.5% 85.0%	85% 85% 85%	85%	w/e 12 May 2023: 95.5% 89.0% 91.0%	w/e 31 Mar 2023: Overall improvements 79.5% 80.0% 62.5%	The CQC stepped-down it's level of scrutiny of CTG compliance based on evidence submitted as part of the service's S31 reporting however, the process of monitoring continues through the continued weekly midwifery management 'Stop the Clock' process
Clinical Escalation and Handover of Care	MEWS escalation assessment tool audit outcomes	MEWS Documentation audit for the reporting period: Aug-Dec 2022 with outcomes identified from the 'Recognition of the unwell or deteriorating woman, management and escalation'	Patient ID measures: QEQM - 69% / WHH - 76% Completion of observations: QEQM - 64% / WHH - 61% Overall completion: QEQM - 90% / WHH - 85%	TBA	TBA	N/a	N/a	Alignment to the national MEWS chart; the Maternity Audit & Research Midwife is a member of the national pilot group and has made plans in readiness for the launch of the new MEWS chart and the roll-out of a NHSE elearning training package

		Guideline and the requirement that "Appropriate physiological parameters are monitored, correctly recorded and accurately scored on the MEOWS chart"						
Governance and Patient Safety	No. SIs overdue (breached)	Level 1 & 2 Investigations: internal investigations, whether concise or comprehensive must be completed within 60 working days of the incident being reported to the relevant commissioner Level 3 investigations: 6 months from the date the investigation is commissioned	0	0	TBA	5	Up from 3 in Mar 2023	Breached SIs have been steadily increasing since Jan 2023; a management plan to complete and close these reports is being developed with the Head of Governance, and Patient Safety Matron
Governance and Patient Safety	No. Incidents open (overdue)	From corporate Risk Team, the overdue incidents number is: 1045	TBA	0	TBA	1045	TBA	The corporate Risk team has requested a management plan to close this backlog by Sept 2023
Governance and Patient Safety	No. Complaints overdue	From Datix: 83 overdue acknowledgement 43 overdue investigations	9	TBA	TBA	11	Up from 8 in Mar 2023	The number of complaints has been steadily increasing since Jan 2023; there is a new Complaints coordinator within the Governance team to support management of the caseload
Governance and Patient Safety	No. expired Guidelines	From Guideline Midwife: 25 expired guidelines	0	0	4	TBA	TBA	The Guideline Midwife has been working on updating and publishing the Maternity guidelines since coming into post and has reduced the number of expired guidelines down from 41 and continues to progress this with the MDT
Engagement, Listening and Leadership	YVIH metric: felt listened to	Target of 90%	72.40%	90%	90%	68.20%	Down from 71.1% in Mar 2023	YVIH calls are made 6wks postnatally, therefore reflect a woman's experience 6wks prior to the time the data is captured
Engagement, Listening and Leadership	FFT metric: would recommend	Summary of FFT responses which indicated that the woman would recommend the Trust's Maternity Services	93.70%	90%	90%	92.70%	Up from 91.9% in Mar 2023	With the exception of Feb 2023, FFT responses that would recommend Maternity Services has been consistently above the 90% threshold since May 2022 (11mths out of 12)

Engagement, Listening and Leadership	NHS Staff Survey, People Promise 3 - we have a voice that counts	NHS Annual Staff Survey 2022 Results - Maternity This is a measure within People Promise 3 - We each have a voice that counts	Overall People Promise 3 Maternity score - 5.6	Overall People Promise 3 Maternity score - 6.1	N/a	N/a	N/a	This is an annual survey so await 2023 results; other local initiatives could be potentially developed with People & Culture Business Partner to sense-check progress
Holistic measures of safe care	Number of stillbirths	MBRRACE methodology: stillborn babies born 24+0wks gestation by birth month. Threshold 24 per year based on the range of the Trust's comparator groupin the latest MBRRACE report (2021)	0	0>24	0	2	Up from 0 in Mar 2023	12mths: May 2022 to April 2023 = 21 Reported stillbirths
Holistic measures of safe care	Number of neonatal deaths	MBRRACE methodology: live born babies 0>24wks gestation who died within 28 days regardless of place of death, by birth month. Threshold 12 per year based on the range of the Trust's comparator group in the latest MBRRACE report (2021)	0	0>12	0	0	Down from 2 in Mar 2023	12mths: May 2022 to April 2023 = 6 Reported neonatal deaths
Holistic measures of safe care	Number of maternal deaths	Women who have died either during pregnancy, or within 6wks of delivery (may include deaths completely unrelated to obstetric health or care)	0	0	0	0	No change	Sustained level of 0 maternal deaths reported since June 2022 (11mth period) there was 1 reported maternal death in May 2022

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**LEARNING FROM DEATHS – QUARTER 4 2022/23**
MEETING DATE:	**1 JUNE 2023**
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER**
PAPER AUTHOR:	**CHIEF MEDICAL OFFICER**
APPENDICES:	**NONE**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report provides the Board with Quarter 4 (Q4) 2022/23 updates on how we are Learning from Deaths (LfD) in line with the National Quality Board recommendations.				
Summary of Key Issues:	The Trust's mortality position continues to report a 'statistically low' Hospital Standardised Mortality Ratio (HSMR) as reported in the monthly Integrated Performance Report (IPR) and 'as expected' Summary Hospital-level Mortality Index (SHMI). Mortality data is reviewed monthly at the Mortality Surveillance and Steering Group (MSSG) and deep dives undertaken dependent on data and coding reviews. The themes from LfD highlighted in Q4 are recognised, especially the impact of the current pressures in our emergency departments (EDs) leading to overcrowding and corridor care. Safety huddles and rounding are in place to support safe care and improvement workstreams to divert patients to most appropriate pathways away from ED are underway. There was a rise noted in crude mortality for deaths within the ED in December. Preliminary review has indicated that while this was seen at both sites this was more pronounced in duration at the William Harvey Hospital (WHH) site and there was a contemporaneous increase in length of stay in the ED. The crude rate was elevated nationally in December. Although the HSMR at WHH remains 'as expected' there is a continued divergence between the two most acute sites. The focus is now on understanding the observed difference. The LfD team continue to promote the use of the Structured Judgement Review (SJR) programme to identify where we can learn from excellent care as well as where 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.				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** this Quarter 4 2022/23 Learning from Deaths report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people		Our future	Our sustainability	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**Principal Risk – BAF 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):	**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 Venous thromboembolism (VTE) assessment in inpatients using VitalPAC assessment tool (12).				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	In part by Quality and Safety Committee (updated data).				

East Kent Hospitals University NHS Foundation Trust

Mortality & Learning from Deaths – Q4 2022/23

1. Introduction

This report highlights the activity undertaken in Q4 for Learning from Deaths.

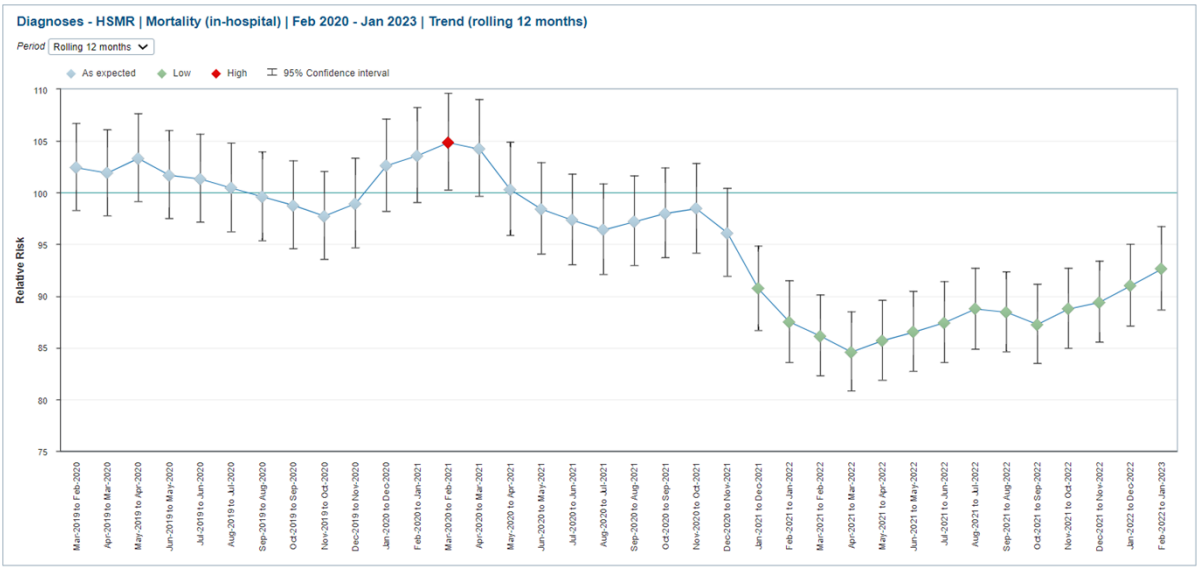
1.1 Overview of mortality data

Mortality summary reports from the Telstra Health platform are received and reviewed in depth at the monthly Mortality Surveillance Steering Group. 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. It was developed to enable a more meaningful comparison of mortality rates between hospitals. The HSMR 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.

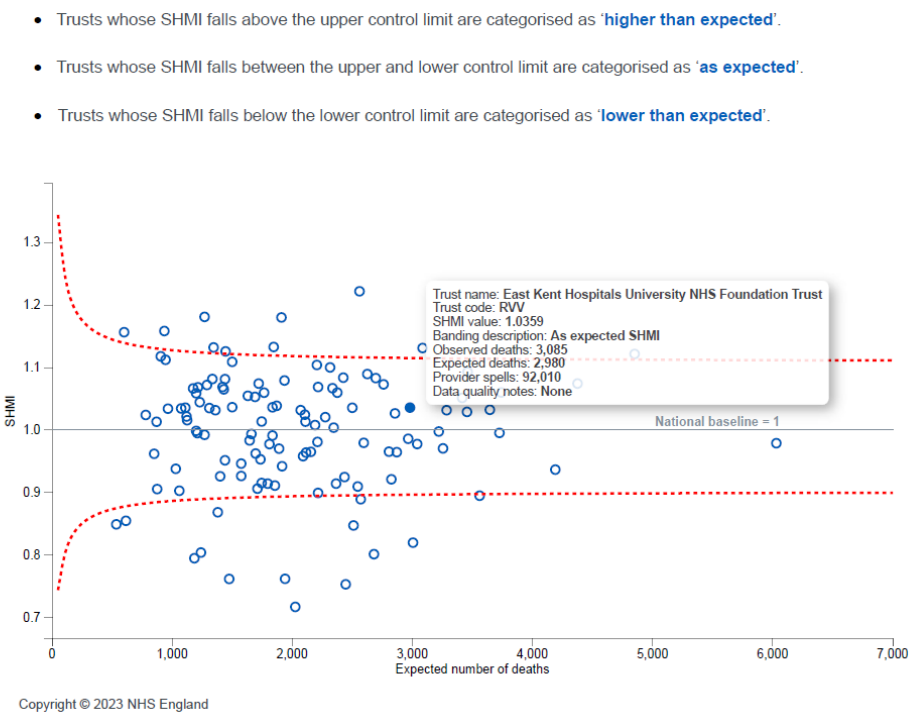
Current HSMR performance is reported within the Integrated Performance Report (IPR) as a True North metric for reduction in mortality. Our last reported position demonstrates a rolling 12 month to January 2023 HSMR is 92.6, statistically 'lower than expected'. Our Palliative care rate 2.99% is above the national average and peer rates. Key alerts and current position are now reported to Quality and Safety Committee in the assurance report from MSSG.

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.

Figure 2. SHMI



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.

There was a rise noted in crude mortality for deaths within the ED in December. Preliminary review has indicated that while this was seen at both sites this was more pronounced in duration at the WHH site and there was a contemporaneous increase in length of stay in the ED. The crude rate was elevated nationally in December. Although the HSMR at WHH remains 'as expected' there is a continued divergence between the two most acute sites. The focus is now on understanding the observed difference.

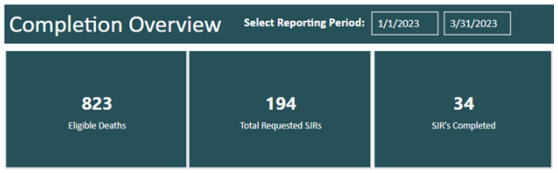
2. Learning from Deaths

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, for child deaths and for deaths in patients with learning disabilities.

The Learning from Deaths 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 4 (Q4) 34 cases were reviewed through SJRs 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 process.

Figure 3: Overall Completion Q4 2022/23



The SJR reviews care across five phases of care as relevant to each patient and overall care. Phase of care scores for Q4 are illustrated in Figure 4.

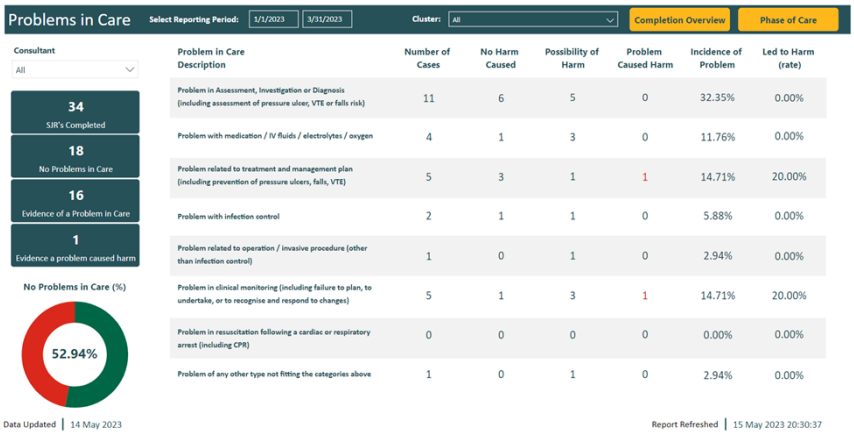
Figure 4. Phase of Care Scores Q4

Overall the majority of care is judged to fall within the good category. Poor overall care was identified in 8 cases in Q4 in any phase of care. Drilling into the reviewers' comments to identify causes of poor care the following can be identified:

- Delay in being assessed within the ED or being admitted to a ward.
- Documented senior review and oversight of clinical care with clear plan including ceilings of care.

In Quarter 4 (figure 5), there were sixteen cases where a problem in care was identified and for one patient the problem caused harm (there were two problems identified for one patient). The concern related to a delay in responding to specialist advice and in initiation of critical care.

Figure 5: Problems in Care Q4



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)	11	6	5	0	32.35%	0.00%
Problem with medication / IV fluids / electrolytes / oxygen	4	1	3	0	11.76%	0.00%
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	5	3	1	1	14.71%	20.00%
Problem with infection control	2	1	1	0	5.88%	0.00%
Problem related to operation / invasive procedure (other than infection control)	1	0	1	0	2.94%	0.00%
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	5	1	3	1	14.71%	20.00%
Problem in resuscitation following a cardiac or respiratory arrest (including CPR)	0	0	0	0	0.00%	0.00%
Problem of any other type not fitting the categories above	1	0	1	0	2.94%	0.00%

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 Learning from Deaths facilitators, although there remain 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 Learning from Deaths facilitators and to chair the Learning from Deaths review panels.

The themes highlighted in Q4 are recognised, especially the impact of the current pressures in our emergency departments with overcrowding and corridor care. Safety huddles and rounding are in place to support safe care and improvement workstreams to divert patients to most appropriate pathways away from ED are underway.

Data from the medical examiners' 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 roll out of the medical examiner function to scrutinise the majority of deaths in hospital and in the community across east Kent is providing greater intelligence on provision of health care pathways in and out of hospital and will support a greater understanding of the drivers behind the proportion of deaths that occur in the 30-day post discharge portion of the SHMI. The feedback of the additional intelligence from the medical examiners work is being reviewed to agree the pathways to feed into the east Kent place-based governance structures to inform place level agreed 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. This dashboard will be live and reported from the next quarterly report.

3. Conclusion

The Learning from Deaths 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:	**PATIENT VOICE AND INVOLVEMENT QUARTERLY REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**INTERIM CHIEF NURSING AND MIDWIFERY OFFICER (CNMO)**				
PAPER AUTHOR:	**HEAD OF PATIENT VOICE AND INVOLVEMENT**				
APPENDICES:	**APPENDIX 1: PATIENT VOICE AND INVOLVEMENT QUARTERLY REPORT**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The report provides the Board with an update on how we are implementing the Patient Voice and Involvement Strategy.				
Summary of Key Issues:	A key element of the strategy is to ensure that patients, families and communities have a voice, and this includes being part of groups and committees where decisions are made and progress on implementing the strategy is reviewed. We have recruited 13 Participation Partners up to the end of March. They all are members of our Patient Participation and Action Group (PPAG). Two have now joined the End of Life Care Committee and one will be joining the Nutrition and Hydration Group (to be renamed the Food and Drink Committee) once established. We involved some of our Participation Partners in the recruitment of one of our Patient Involvement Officers during April, holding online stakeholder panels involving three Participation Partners and then one Participation Partner on the interview panel. We have continued to establish links with people who are part of the voluntary, community and social enterprise (VCSE) sector. We have representatives on the Patient Participation and Action Group (PPAG) from Hi-Kent and from Carers Support East Kent and also a Healthwatch Kent representative. We also have a VCSE representative on the Fundamentals of Care Committee from the Kent MS Therapy Centre. The Patient Participation and Action Group (PPAG) has now met three times up to the end of March. This group holds us to account for implementing the Patient Voice and Involvement Strategy. The group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director attends as the Board Champion for Patient Voice. Each PPAG meeting has a focus on a particular service or area of work. The January meeting focused on our Maternity Services including their work on 'Your Voice is Heard'. The March meeting focused on Safeguarding, the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS). From March we've delivered sessions as part of the Matron's Development Programme, and the monthly sessions for Health Care Support Workers. During February and March, the team has had contact with a range of community groups and attended both online and face to face events. This has included meeting with people who have used our services (e.g. Stroke groups) or who experience barriers				

	to accessing healthcare (e.g. Deaf people who use British Sign Language (BSL) at Deaf Together Groups and Migrant women). We are working with clinical colleagues to improve patient experience. We worked with the Lead Rheumatology Nurse to establish a Rheumatology Patient Action Group that held its first meeting in March and will now meet every two months. We have worked with colleagues from Stroke services and with local Stoke groups to co-design a patient experience feedback survey to use in follow-up phone calls to patients who received care at EKHUFT and were then discharged to the community. The report provides a summary of the feedback we've had so far. The team review Friends and Family Test (FFT) responses, including all comments, from a specific service each month, focussing on out-patients and day cases/surgery. In the last quarter this included Gynaecology, Stroke medicine and Transient Ischaemic Attack (TIA) services and Oral and Maxillofacial Surgery. Whilst feedback is overwhelmingly positive, there is some useful insight into what can be improved related to all aspects of communication. Triangulating this insight with other feedback via Care Opinion, Patient Advice and Liaison Service (PALS) and feedback shared directly with the team, ensures we are picking up the themes accurately and we are able to support services to respond and make improvements, however small, that improve patient experience.
Key Recommendation(s):	The Board of Directors is asked to note the report.
Implications:	
Links to 'We Care' Strategic Objectives:	

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

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

East Kent Hospitals University NHS Foundation Trust

Patient Voice and Involvement Report January to March 2023

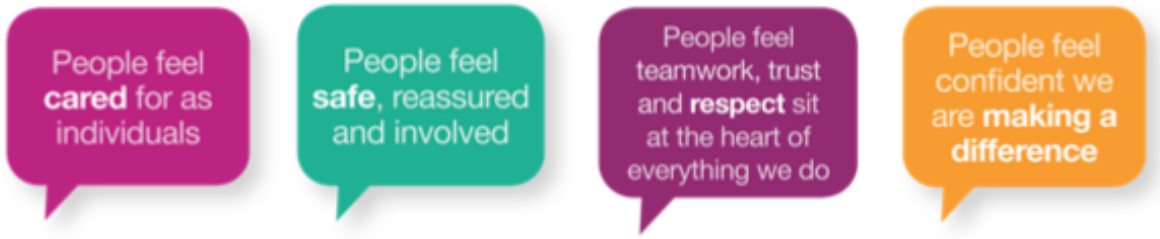
1. Introduction

1.1 The Patient Voice and Involvement strategy was agreed by the Trust Board in March 2022. This included establishing a Patient Voice and Involvement Team. The first team members started in August 2022.

1.2 Listening to patients and their families, acting on their feedback and sharing the changes and improvements made are all part of patient experience.

1.3 Patient involvement builds on this to engage with and involve people who use our services and the local communities that we serve. The ultimate goal is co-designed services and co-design service improvements.

1.4 East Kent Hospitals' values directly relate to patient experience and patient involvement:



1.5 The report provides an update on implementing the trust's Patient Voice and Involvement Strategy.

2. Participation Partners

2.1 A key element of the strategy is to ensure that patients, families and communities have a voice, and this includes being part of groups and committees where decisions are made and progress on implementing the strategy is reviewed.

2.2 We have recruited 13 Participation Partners to date, with two others waiting for reference checks. These are people who use our services, their families and people from the wider community. They all are members of our Patient Participation and Action Group (PPAG) (see below). Two have now joined the End of Life Care Committee and one will be joining the Nutrition and Hydration Group (to be renamed the Food and Drink Committee) once established.

2.3 We involved some of our Participation Partners in the recruitment of one of our Patient Involvement Officers during April, holding online stakeholder panels involving three Participation Partners and then one Participation Partner on the interview panel.

2.4 We have continued to establish links with people who are part of the voluntary, community and social enterprise (VCSE) sector. We have two representatives on

the Patient Participation and Action Group (PPAG) from Hi-Kent and from Carers Support East Kent and also a Healthwatch Kent representative. We also have a VCSE representative on the Fundamentals of Care Committee from the Kent MS Therapy Centre.

3. Patient Participation and Action Group (PPAG)

3.1 The **Patient Participation and Action Group (PPAG)** has now met three times up to the end of March. This group holds us to account for implementing the Patient Voice and Involvement Strategy.

3.2 The January meeting focused on our Maternity Services including their work on 'Your Voice is Heard', where Patient Experience Midwives contact mothers / parents six weeks after they've had a baby to get feedback on their experience whilst in our care. The March meeting focused on Safeguarding, the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) and the importance of patients and families being aware of how the trust supports patients who are at risk or vulnerable as defined by the Safeguarding legislation.

3.3 The group is co-chaired by a Participation Partner and the Head of Patient Voice and Involvement, and a Non-Executive Director attends as the Board Champion for Patient Voice. Membership of the group is 50% people who use our services or are carers or family members (up to 12 people), 30% voluntary community and social enterprise (VCSE) sector representatives (up to 8 people) and 20% EKHUFT staff.

4. Involvement Champions

4.1 Involvement Champions are staff who participate in a bespoke training session on patient involvement and agree to get involved in making changes based on patient feedback.

4.2 From March we've delivered sessions as part of the Matron's Development Programme, and the monthly sessions for Health Care Support Workers (HCSWs), where we deliver a 'Seeing the Person' session. Approximately 24 Matrons and 12 HCSWs have participated to date.

4.3 During the next three months we will be co-designing a patient involvement toolkit for staff to support this work.

5. Community Engagement

5.1 During February and March, the team has had contact with a range of community groups and attended both online and face to face events.

- Deaf Together Group Ashford
- Ethnic Minorities in Canterbury (EMIC) meeting
- Ageing Without Children East Kent (AWOC)
- Pop Up stand at Westwood Cross
- Place older Storytelling Festival (online)
- Deal Stroke Association meeting
- Story Telling Cancer Alliance (online)
- Scope Hospital Maps meeting
- Somali Elders and Dementia care – story telling conference (online)
- Start With People Spring Event (online)

5.2 We have a programme of outreach and engagement for April onwards and will provide an update on this in our next quarterly report. We have agreed a schedule of visits by Healthwatch Kent to our three main sites to gather feedback direct from patients and carers. These visits will start in May.

6. Patient Experience

6.1 Rheumatology:
We worked with the Lead Rheumatology Nurse to establish a Rheumatology Patient Action Group, which included developing the terms of reference, a promotional flyer and contacting people who had expressed an interest in joining the group. The group held its first meeting in March and will now meet every two months. Feedback includes issues with making follow-up appointments at Queen Elizabeth the Queen Mother Hospital (QEQM) and poor signage at hospital sites. Being sent an appointment with two week's notice is not helpful particularly for patients who work, or rely on family for transport to hospital.

6.2 Stroke services:
We have worked with colleagues from Stroke services and with local Stoke groups to co-design a patient experience feedback survey to use in follow-up phone calls to patients who received care at EKHUFT and were then discharged to the community. They are called approximately four weeks after discharge by one of the Patient Involvement Officers.

6.3 We have feedback from six patients who have had a stroke to date. Feedback has highlighted the excellent care received whilst on the ward, including being treated with dignity and respect and generally being listened to. There was concern that a patient with hearing loss was unable to hear much of what staff said and the patient's spouse was not updated, despite them asking to be kept in the loop.

6.4 Feedback highlighted that many people weren't offered the Stroke Passport, and many people are waiting for follow up support in the community. The responses also highlight the additional support provided by family and friends after someone has had a stroke. Several people mentioned their worries about the impact this has on their family. As a result of this feedback the team are visiting Stoke groups to share the Passport. They are ensuring people are aware of local Stroke groups and Carers Support.

7. Friends and Family Test (FFT)

7.1 The Trust received 53,000 responses to the Friends and Family Test (FFT) from January to March 2023. Of these responses nearly a third relate to services at Kent and Canterbury Hospital, a third to services at William Harvey, with slightly lower figures for QEQM, and smaller numbers for Buckland and Royal Victoria hospitals. Response rates (surveys sent versus surveys completed) is around 19% Trust-wide, with a satisfaction level of between 93% and 94% overall from January to March 2023.

7.2 Each month the team reviews FFT surveys and comments from a specific out-patient service across all sites. The results are shared in a report to Fundamentals of Care Committee.

7.3 Gynaecology FFT:

In January we looked at FFT data for Gynaecology gathered in December 2022. There were 307 responses to the FFT survey, with an overall positive score of 94%. There were a wide range of comments, mostly positive regarding the care received, compassion shown by staff and people feeling listened to. The negative comments related to the length of time to get an appointment, having a phone appointment when the patient felt a physical examination was needed, and a few comments about doctor's lacking a good bedside manner.

7.4 There were a few negative comments related to patients who'd had a colposcopy or who were seen in relation to an uro-gynae issue. Colposcopy can be an uncomfortable procedure and whilst staff carrying it out are used to carrying it out, for the patient it can be a difficult, and sometimes painful experience. In a number of comments patients thanked the nurses present for helping them to feel more at ease whilst having the colposcopy.

7.5 Stroke Medicine and TIA service:

In February we focused on Stroke Medicine and TIA's FFT survey results, collected in January 2023. Stroke Medicine and the TIA service received 38 responses in January. Comments made were overwhelmingly positive, with people expressing that the speed of diagnostic tests following a TIA were fast and that staff were kind and helpful.

7.6 There were several comments that those presenting with a TIA then received a follow-up phone call from a consultant once home. Several were not expecting this. We need to ensure that when patients leave hospital after having a TIA, they are clear on next steps.

7.7 For patients who had been treated by the Stroke Medicine team, comments were generally positive relating to the care received and compassion of staff. There were a few negative comments made about patients not understanding the doctor, including the medical terms used by the doctor, and the lack of contact with a doctor or nurse face to face after their stroke and discharge.

7.8 Oral and Maxillofacial Surgery:

In March we focused on Oral and Maxillofacial Surgery across the four sites, based on FFT survey data from February 2023. Although the smallest amount of feedback comes from patients seen at Buckland, this feedback along with the three main sites provides useful insight into patient experience.

7.9 The feedback was overwhelmingly positive, with patients consistently highlighting the care and compassion of both doctors and nurses, and how they take time to explain procedures clearly, answer questions and put patients at ease when they are feeling anxious. **The team deserve to be recognised for this, as it highlights what can be achieved when teams work well together, listen to patients, and show care and compassion**.

7.10 Where there were a few negative comments, these relate to delays whilst waiting to see the doctor or nurse (clinics running late), occasionally no-one updating people who are waiting in the clinic and poor signage in some of the hospitals.

8. Communication

8.1 Since January two of the team have been working with Care Group leads on updating appointment letter templates used. This has proved to be a much larger piece of work than originally anticipated and has involved over a dozen meetings with Care Group leads. We are looking to create two or three appointment letter templates for outpatients with a view to creating standardised wording. Within the standardised wording we want to include: access needs (BSL, mobility support, transport etc), a department contact number (should patients require any information regarding their appointment), PALS contact number, clear instructions regarding their appointment time/date, which clinician they will be seeing at their appointment, where their appointment will be taking place and where in the hospital they need to travel to.

8.2 We are pulling all the feedback together and will then discuss with all the care group leads what we propose to include in the outpatient appointment letters and how we plan to go about it. We will then work with the Patient Administration System (PAS) Team, IT, and the Communications team on next steps and putting the changes in place.

8.3 Poor communication, including difficulties in getting through to services by telephone, inaccurate appointment letters and unclear information are recurrent themes of patient feedback. The lack of service email addresses has also been raised. We are hoping that this work will resolve some of these long-standing issues.

8.4 The Communication team and IT have worked on the new public website, with a focus on what patients want to know, rather than what we think they need to know. The Patient Voice Feedback Co-ordinator is a member of the steering group for this work. The new website launched at the end of March. We are keen to get feedback from people who use the new website, in particular people with communication needs related to a disability. We will be setting up a small patient group to support this work.

9. Accessible Information Standard (AIS)

9.1 During January to March the team has been gathering feedback related to the communication and information needs of patients related to a disability. This could be a visual or hearing loss, being Deaf and using British Sign Language, being neurodiverse or having a learning disability or cognition issues.

9.2 Feedback has highlighted that many patients or parents or carers are not having their communication needs identified, recorded or met. During 2023/24 the team will have improving AIS compliance as one of our key objectives. We will start by reviewing the current AIS action plan and begin to focus on areas that need to be better implemented. Our ultimate goal is that AIS compliance becomes everyone's business who works at EKHUFT. This is a big piece of work and we will be involving Participation Partners who are experts by experience, voluntary organisations and other partners in this work.

10. Conclusion

10.1 The Patient Voice and Involvement team continue to make good progress on implementing the strategy.

10.2 There were some changes to the team during the quarter, with the Lead for Patient Voice and Involvement starting in January, one Patient Involvement Officer going on

Maternity Leave and another leaving the trust in March. The new Patient Involvement Officer has been recruited and will start in early June.

10.3 We have agreed the team's priorities for 2023/24, which are in line with the strategy. In addition, our work will include supporting the Community and Family Voices work related to our response to the Reading the Signals report on Maternity Services.

May 2023

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INTEGRATED PERFORMANCE REVIEW (IPR)**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF FINANCE OFFICER**				
PAPER AUTHOR:	**CHIEF FINANCE OFFICER**				
APPENDICES:	**APPENDIX 1: APRIL 2023 IPR**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Trust has been engaged with a quality improvement programme called "We Care". The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep). This report is updated for the key metrics that the Trust will focus on in 2023/24.				
Summary of Key Issues:	The attached IPR is now ordered into the following: **True Norths-** These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years it may be that the targets are not met immediately and it is important to look at longer term trajectories. The areas are: • our **quality and safety.** The two metrics the Trust has chosen to measure against incidents with harm and mortality rate. • our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) 12-hour in department standard, the Referral to Treatment (RTT) 18-week standard and the Inpatient Survey score. • our **people.** The one metric chosen is for staff engagement. • our **sustainability.** The two metrics chosen to improve are the Trust's financial position and carbon footprint. • our **future.** The two metrics chosen are the percentage of patients no longer fit to reside in hospital and Recruitment to Clinical Trials. **Breakthrough objectives-** These are objectives that we are driving over the next year and are looking for rapid improvement. The four key areas are: • **Improving theatre capacity.** By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In April the potential opportunity reduced to 40 lists, from 46 in the previous month. • In April there was a deterioration from March with booked occupancy reducing by 1.6% to 87.3% and actual occupancy remaining the same at 79%. This was further impacted due to the industrial action which took place over four days from the 11 April. Elective Orthopaedic Centre				

	(EOC) had a booked utilisation of 88.8% and saw a decrease in actual utilisation by 2% from 85.1% to 83.1%. • The number of cases per list in the most recent week has increased by 0.1% from 2.3 cases to 2.4. • Late starts saw a reduction in April reducing from 8% to 7%. General Surgery continue to reduce delays due to Intensive Therapy Unit (ITU) beds through putting a small case first on the list this has provided a solution for ITU capacity enabling additional time to source capacity. • The theatre optimisation group continues to meet monthly led by the Surgery & Anaesthetic leadership team. This group continues to focus on theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. • EOC have a dedicated transformation group meeting monthly to review metrics with aims to increase utilisation at our dedicated EOC in Canterbury. • We continued to successfully appoint theatre staffing across the sites and increase skill mix. **Same Day Emergency Care (SDEC) Admissions.** The chart shows the SDEC total activity across all services reduced in April. There is a correlation with SDEC activity and the reduction in total attendances which also reduced in month. Both Emergency Departments (EDs) reported lower walk-in patients, who are the highest users of SDEC pathways from the front door. The Industrial actions that took place during the month may have been a cause for the reduced footfall. • April saw the introduction of Medical SDEC virtual clinics for the William Harvey Hospital (WHH). The aim was to manage more patients in the community and reduce the numbers of patients returning to release capacity in the acute setting. This will be monitored to understand the impact. • Direct Access pathways to Surgical Emergency Assessment Unit (SEAU), WHH have been agreed with a plan to roll-out in May directing more patients to the unit and reducing waiting in ED to see a specialist. • Work is in place with Child Health to agree Direct Access Pathways to the Children's Assessment Unit (CAU) reducing waits in ED. The aim is to commence the pilot of the pathways in June in readiness for the newly appointed CAU at the front door in September 2023 . • Medical SDEC Queen Elizabeth the Queen Mother Hospital (QEQM). Work commencing in May to review activity and opportunity to increase the numbers accessing the service with the aim to put in the changes to opening /closing times in early June. • Meeting with the Integrated Care Board (ICB) lead was set up in April to increase the awareness of the service with primary care, enhancing the direct access pathways for GPs to the service . This needs to be monitored with a follow–up meeting planned June to understand progress.

East Kent Hospitals University NHS Foundation Trust

	• Work continues with specialty medical services to provide 'hot clinics' within SDEC to enable patients to be seen by a specialist through a rapid booking process. The plan is to roll this out with gastro/respiratory **Staff Involvement.** Staff Involvement has improved following a fall Q4 (2022/23), returning to levels seen in Q" (2022/23). Staff Involvement currently stands at 6.23, up 5 points but considerably below the desired threshold (6.7). This appears to be primarily due to staff feeling less able to make improvements happen in their area of work. The approach to the National Staff Survey is for each Specialty to 'change 3 things' – involving staff across every area in the identification of key objectives and action. • A Staff Engagement framework has been developed to enable colleagues to take tangible action to improve levels of involvement. • The We Care rollout has now reached Wave 6 and overall staff engagement levels are consistently higher in We Care areas than non-We Care counterparts. • 58 managers or team leaders have now been trained as part of the Team Engagement and Development (TED) pilot. • The 'change three things' approach is underway, with Specialties currently socialising their priorities and associated action streams. **Watch Metrics -** these are metrics we are keeping an eye on to ensure they don't deteriorate.
Key Recommendation(s):	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

Implications:

Links to 'We Care' Strategic Objectives:

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

Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of 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.

East Kent Hospitals University NHS Foundation Trust

	CRR 78: There is a risk that patients do not receive timely access to emergency care within the ED.	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	Y	Working through with the subsidiaries their involvement and impact on We Care.
Assurance Route:		
Previously Considered by:		

NHS
East Kent
Hospitals University
NHS Foundation Trust

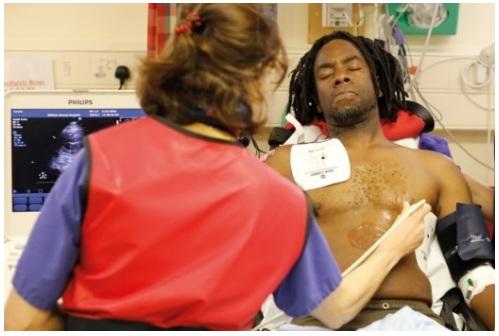
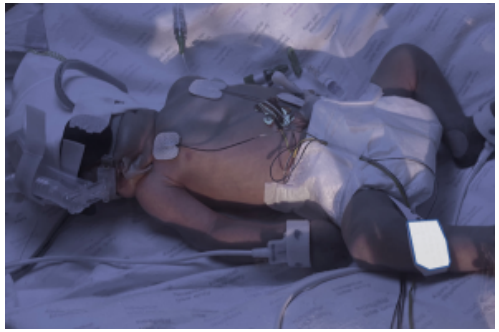
Integrated Performance Report

April 2023







We care

Our vision, mission and values

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

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

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

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

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

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

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

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

What is the Integrated Performance Report (IPR)?

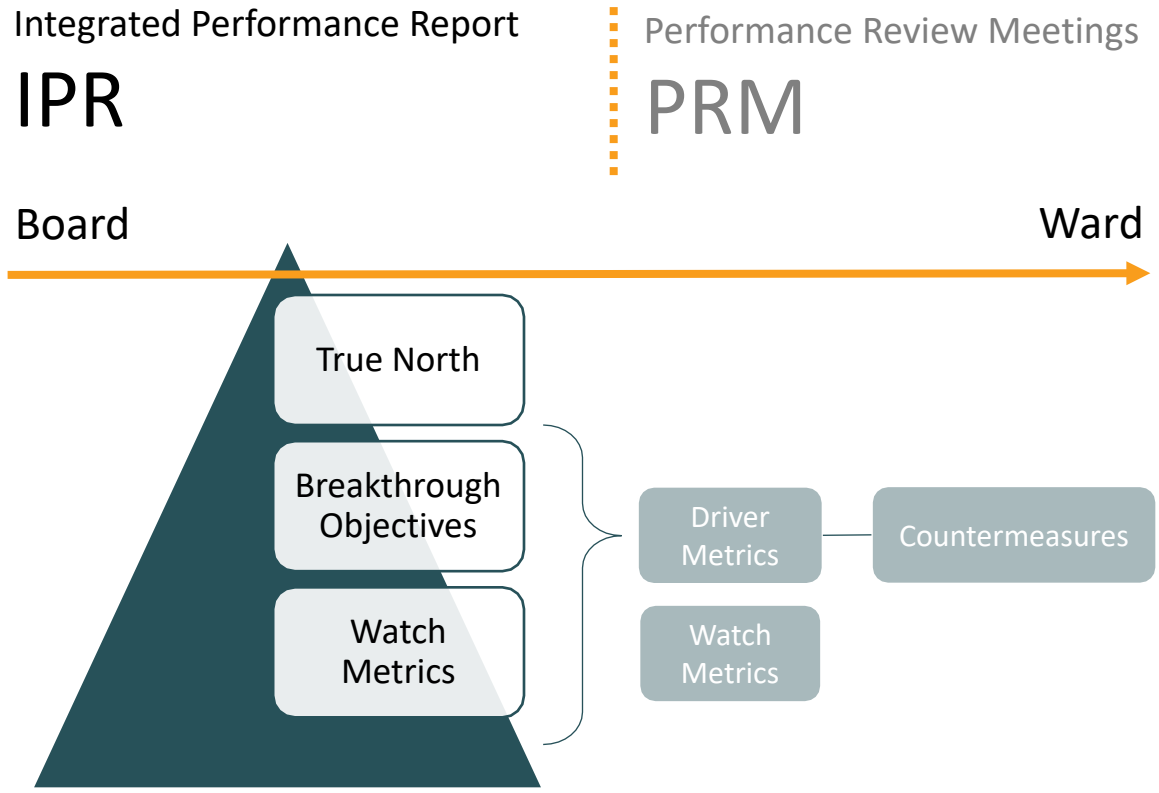
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

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

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

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

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



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

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

NHS Improvement SPC icons

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

Where to find them

What are the Business Rules?

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

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

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

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

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

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

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
86.5	87.4	88.7	88.4	87.3	88.8	89.4	91.0	92.7			

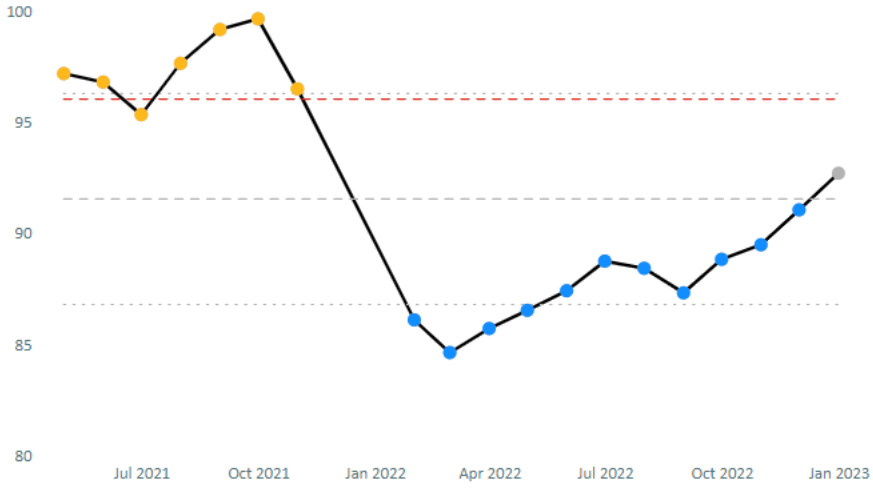
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust HSMR is above the lower control limit, overall showing 'special cause variation of improving nature'. The metric demonstrates a 12 month rolling position to January 2023 which is the last data release. At time of reporting this remains 'lower then expected' for the Trust as a whole and the K&CH site (72.7) and QEQM (89.8) with WHH (101.6) 'as expected'. Our Palliative care rate 2.99% is above the national average and peer rates.

The Trust now lies 28th out of the 121 acute non-specialist Trusts on the Telstra Health platform.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. Current 12 month rolling HSMR for fractured neck of femur patients is 100.1 (to January 20223) and remains 'as expected' and unchanged form last reported position.
- Mortality metrics continue to be reported and discussed at monthly Mortality Surveillance Group (MSSG) and intelligence used to drive deep dives into pathways where indicated. There were no new alerts in May 2023 Mortality report.

Risks/Mitigations

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

Our quality and safety

Incidents with Harm

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

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

Jane Dickson

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
13	21	30	19	29	31	36	35	55	43	49	30

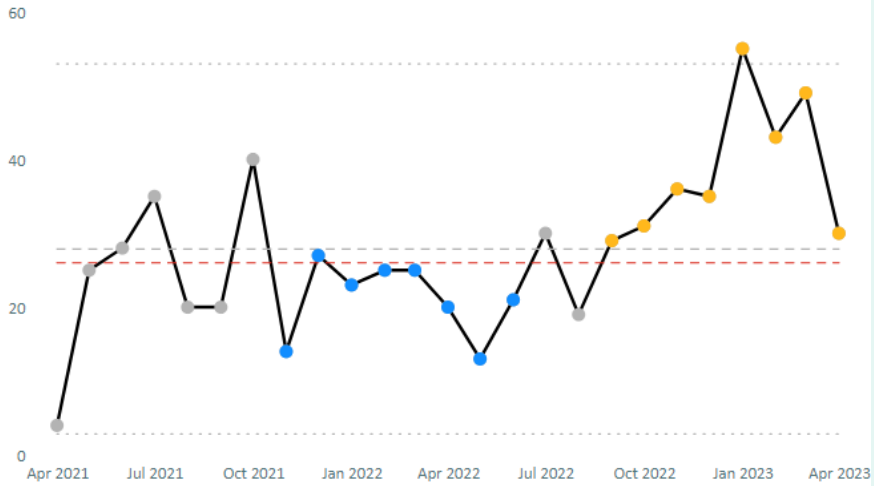
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 30 incidents in April, whilst this remains above threshold it is a significant reduction from the previous month. The highest contributors to harm this month were care/treatment with 9, which is an decrease from the previous month, operations/procedures was the second highest with 7 incidents, with either unplanned return to theatre or recognised complication again a decrease from the previous month. This was followed by delay/failure with 6 incidents which was also a decrease from the previous month. In fourth place was falls with 5 incidents, all of which are discussed at the pressure Ulcer and Falls Panels meeting. The number of severe incidents was 3, down from 10 and incidents associated with death also decreasing from 4 to 3 compared to the previous month.

Intervention and Planned Impact

A pilot of a deteriorating patient educational programme will take place in June/July 2023, focussing on newly qualified Band5's and IENS. It will utilise a blended learning approach, incorporating real life examples of serious incidents so reinforcing the learning from incidents. It will be evaluated with the aspiration being to develop a 1-2 day programme that can be incorporated into the preceptorship programme. The funding from the ICB which has been identified to support the trust with the deteriorating patient improvement plan is still being discussed and as yet not been finalised.

The development of a deteriorating patient dashboard remains challenging due to the complexity of data retrieval required. There has been a positive development after meeting with another trust which has developed a dashboard using Sunrise. Whilst there is still much work to do, the move to Vitals on Sunrise provides an opportunity to build the appropriate platform to develop the dashboards. The sepsis form is now live on Sunrise.

Due to the continued inpatient capacity constraints it means that patients continue to remain in our emergency departments (EDs) for longer than is necessary and adds to risk of avoidable harm events. Escalation areas which are not included within the ED or ward staffing establishment continue to be utilised.

It has been suggested to the PSC that a deteriorating patient task and finish group be formed in light of the site medical directors for QEQM and WHH leaving the Trust as they used to provide a deteriorating patient paper for the PSC. This will be discussed with the CMO as it will also provide oversight of the improvement plan which was presented to the last QSC meeting.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where high risk patients are cared for. The risk register for the deteriorating patient has been updated. An essential NEWS2 e-learning module is now live. The data gathering and collation for the 'Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions CQUIN 23/24', which now includes patients from ED is agreed. Compliance with the 22/23 CQUIN was achieved.

NHS
East Kent Hospitals University
NHS Foundation Trust

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
Harm Events	W4		IPC: CDiff Infections		6	7	9	13	16
			IPC: Audits Composite		85.0%	86.1%	84.4%	84.6%	81.6%
	W4		VTE Assessment Compliance		95.0%	92.8%	92.4%	91.0%	89.0%
	W4		Overdue Incidents		0	6,635	5,716	4,755	3,897
	W4		Maternity Serious Incidents		2	4	4	5	5

IPC: C diff Infections

This position reflects that, in common with most acute trusts we have exceeded out external threshold for Cdiff cases in 2022/2023. All existing processes, as previously described, remain and the 2023/2024 plan will describe additional approaches to antimicrobial stewardship and the processes for investigation of, and learning from cases.

VTE Assessment Compliance

The Trust thrombosis group is working with Care Groups on key risk areas. VTE risk assessment will move to Sunrise to collocate with prescribing on to a single system but currently this will not be until after the completion of Electronic Prescribing and Administration roll out which is now live at WHH and K&CH, with QEQM anticipated in June.

Overdue Incidents

A total of 2331 incidents reported in May 2023. There continues to be improvements in the number of overdue incidents which have reduced by more than the expected 500 in the last month.
There are currently 96 open serious incidents 8 of which have breached, 4 of these are awaiting downgrade requests to be completed and 3 are with the execs to approve. There are currently 10 open non-closure requests. Owing to the increased number of SI's due to the ICB in May, additional SIIAP panels have been scheduled to address this.

Maternity SIs

Maternity has 25 open Serious incidents. There were 4 new serious incidents reported for Maternity in April. No never events. There are currently 5 breached SI's, of which 3 are awaiting downgrade forms to be completed by care group. The remaining 2 reports are with SIIAP for approval. There are 2 non closure requests open, of which 1 has breached the submission date.

Our patients

Our patients

Dylan Jones

Trust Access Standards: 18wk Referral to Treatment

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
60.2%	59.7%	59.5%	59.7%	58.4%	58.3%	59.0%	58.1%	56.7%	56.9%	57.7%	57.5%

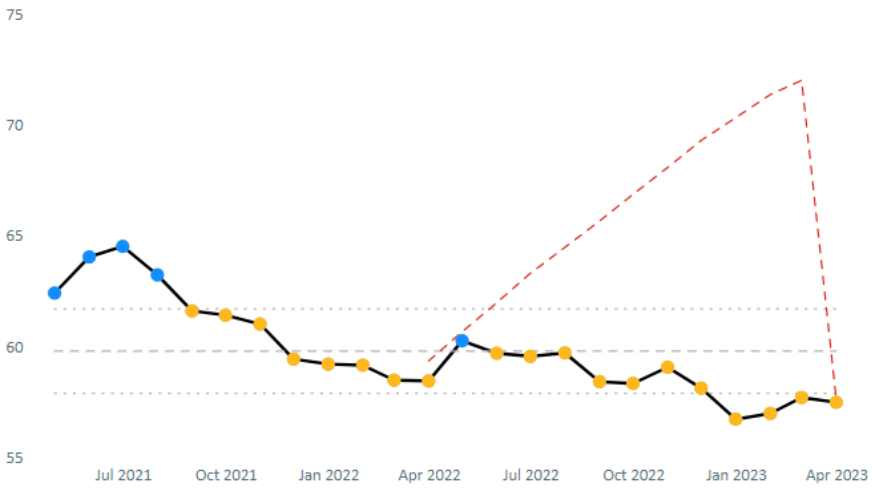
Variation indicates consistently passing the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

RTT performance continues to be impacted by the critical mass of patients waiting longer than 18 weeks for their first out patient appointment. Scheduled outpatient and elective activity levels were impacted due to the Industrial Action in April which has contributed to a reduced volume of patients being treated in month.

Intervention and Planned Impact

- Continue to validate pathways to ensure patients are fit, ready and able to proceed with planned care and treatment.
- Reschedule activity in month to ensure patients affected by the Industrial Action are treated as a priority.
- Continue to treat the longest waiting patients who require otology surgery whom are currently waiting longer than 78 weeks.
- Focus on improving access to first outpatient appointments and reducing the waiting time is a priority for all specialities where waiting times are longer than we would prefer for our patients.
- Increase access via the electronic referral service to enable patients to schedule appointments directly.
- New structures have been implemented for managing elective performance within the Trust with weekly meetings held between the COO and each Care Group to review activity and waiting time levels.

Risks/Mitigations

- Revisit options within the Trust and Region to expedite the treatment of patients waiting for otology surgery.
- Theatre staffing recruitment and sickness levels remain an issue in our elective recovery journey. Oversight of staffing levels and scheduled activity continue to be monitored closely and solutions to address areas of risk continue to be mitigated where possible through the weekly theatre scheduling meetings.
- Outpatient waiting times continue to be elongated and specialities are reviewing how they could make further improvements aligned to the national out patient transformation schemes to improve access to non-admitted care and ultimately support a reduction in waiting times.

22/23 breakthrough objective

Theatre Session Opportunity

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
31	29	33	43	45	42	37	42	40	43	46	40

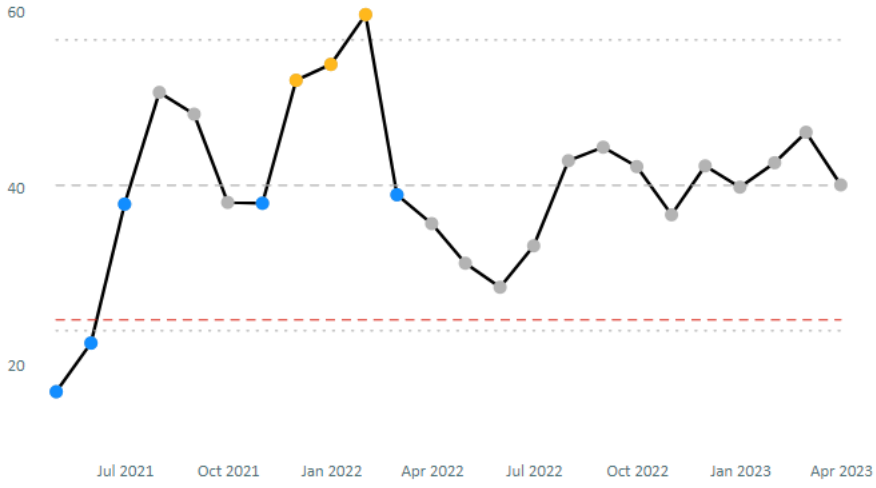
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In April the potential opportunity reduced to 40 lists, from 46 in the previous month.

Intervention and Planned Impact

- In April there was a deterioration from March with booked occupancy reducing by 1.6% to 87.3% and actual occupancy remaining the same at 79%. This was further impacted due to the industrial action which took place over four days from the 11th April. EOC had a booked utilisation of 88.8% and saw a decrease in actual utilisation by 2% from 85.1% to 83.1%.
- The number of cases per list in the most recent week has increased by 0.1% from 2.3 cases to 2.4
- Late starts saw a reduction in April reducing from 8% to 7%. General Surgery continue to reduce delays due to ITU beds through putting a small case first on the list this has provided a solution for ITU capacity enabling additional time to source capacity.
- The theatre optimisation group continues to meet monthly led by the Surgery & Anaesthetic leadership team. This group continues to focus on theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance.
- Elective Orthopaedic Centre have a dedicated transformation group meeting monthly to review metrics with aims to increase utilisation at our dedicated Elective Orthopaedic Centre in Canterbury.
- We continued to successfully appoint theatre staffing across the sites and increase skill mix

Risks/Mitigations

- Theatre staffing recruitment is ongoing with a trajectory to fully recruit by July 24 subject to business case approval.
- Daily reviews of staffing across all sites are maintained to mitigate reduction of lists.
- The current theatre improvement plan is under review at the request of the COO to ensure the Trust has the correct approach in place for the next 6 months.

Our patients

Dylan Jones

ED 12h Total Time in Department

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

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
8.7%	9.5%	11.2%	12.1%	11.4%	10.5%	9.9%	12.2%	11.8%	11.5%	12.4%	10.4%

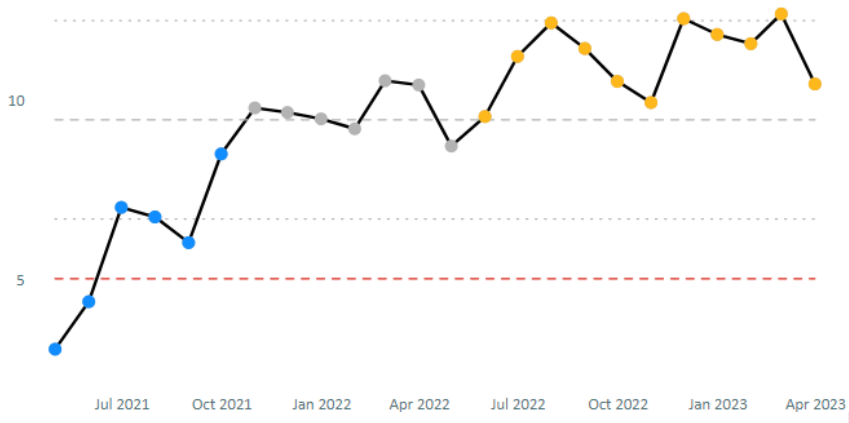
F — Variation indicates consistently falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

In April the percentage of patients dwelling for a total time of 12h in the ED departments was 10.4% v 12.8% in March. This was mirrored across both type 1 & 3 attendances and could be associated with the Industrial Action during the month. The WHH implemented the Medical Assessment Pilot which is a service set up to take the medically accepted patients from the front door and direct from GPs. Whilst its early in its inception, it is expected to have a positive impact on total times in the ED through the early senior medical decision making. This is reflected in the monthly performance with WHH reporting the best position since May 22 .The correlating reported numbers of DTA in the ED at 08.00 hours also showed an improving position and is the lowest since Oct 22.

Intervention and Planned Impact

Work continues in line with the Emergency Care Improvement Plan alongside the delivery of the ED builds. WHH commenced a number of key initiatives in April to mitigate the loss of clinical capacity with the implementation of the Medical Assessment Unit and short stay unit- Acute Physician led department, taking 65% of the medical take away from ED. The impact on the 4 hour performance for all types 70.6% is the best reported position in the last 12 months with an improving position for type 1 attendances.

The impact of the changes to the clinical model at WHH (DIA/MAU and established Short stay) is demonstrated in the reported performance – 62.0% all types, 47.8% Type 1 is the best reported position since Jan 22.

Direct Access pathways (DAP) are now established for Medical Same Day Emergency Care (SDEC) with training completed for the streaming nurse. Further DAP pathways are in development in collaboration with speciality leads, working towards supporting the right place first time for patients, for launch in May.

QEQM are establishing a programme of work in readiness for their Phase 3 build in June, which sees the reduction in majors space for launch in May. These plans aim to mirror the changes to the clinical model and pathways at the WHH.

A missed opportunity audit to review the number of ambulance being conveyed to understand the use/access alternative community pathways to reduce attendance to ED is planned in May with system partners

Risks/Mitigations.

- Leads from QEQM ED, Care Groups and the HCP are to put plans in place ahead of the June phase 3 build with a focus to mitigate the loss of care spaces. This includes reviewing the SDEC medical model to ensure full optimisation of the service with the aim to increase numbers directed to the service .
- A review of SDEC & UTC pathways is planned with the ICB to understand further opportunity to optimise services.
- A joint review of the NIFTR submissions to be completed in May and report of findings to the ECDG

22/23 breakthrough objective

Same Day Emergency Care (SDEC)

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
2,258	2,137	2,196	1,970	2,041	1,989	2,182	2,264	2,263	2,218	2,266	2,008

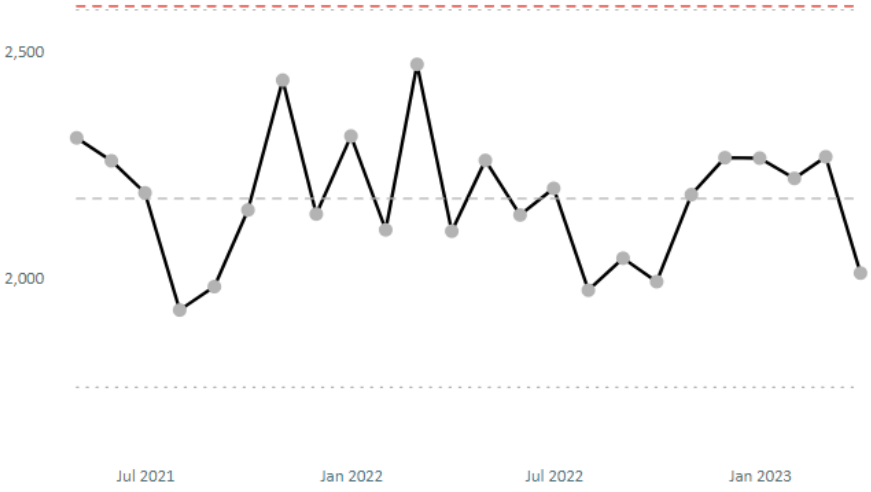
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The chart shows the SDEC total activity across all services reduced in April. There is a correlation with SDEC activity and the reduction in total attendances which also reduced in month. Both EDs reported lower walk-in patients, who are the highest users of SDEC pathways from the front door. The Industrial actions that took place during the month may have been a cause for the reduced footfall.

Breaking the activity down by speciality the reduction was seen across medical, paediatric and women's health SDEC. There is a continuation of the decrease in patients accessing the frailty front door service partly, as previously documented, due to the change in the front door model at the WHH.

Intervention and Planned Impact

- April saw the introduction of Medical SDEC virtual clinics for the WHH. The aim was to manage more patients in the community and reduce the numbers of patients returning to release capacity in the acute setting. This will be monitored to understand the impact.
- Direct Access pathways to SEAU (Surgical Assessment Unit, WHH) have been agreed with a plan to roll-out in May directing more patients to the unit and reducing waiting in ED to see a specialist.
- Work is in place with Child Health to agree Direct Access Pathways to the Children's Assessment Unit (CAU) reducing waits in ED. The aim is to commence the pilot of the pathways in June in readiness for the newly appointed CAU at the front door in September 23 .
- Medical SDEC QEQM. Work commencing in May to review activity and opportunity to increase the numbers accessing the service with the aim to put in the changes to opening /closing times in early June.
- Meeting with the ICB lead was set up in April to increase the awareness of the service with primary care, enhancing the direct access pathways for GPs to the service . This needs to be monitored with a follow –up meeting planned June to understand progress.
- Work continues with specialty medical services to provide 'hot clinics' within SDEC to enable patients to be seen by a specialist through a rapid booking process . The plan is to roll this out with gastro/respiratory

Risks/Mitigations

- Clinical forums have been set up at WHH in May to work with strategy and clinical leads to pull together the ambition to build dedicated SDEC/Assessment units in support of the vision of right place, first time. Work to understand the capacity/resource requirements will be carried out in these sessions and the outputs taken through the ECDG June.
- To understand how to further optimise the number of patients directed to SDECs an audit will be undertaken with the ICB UEC clinical lead in June. This will aim to increase activity and provide a platform for scoping with SECamb and Primary Care direct access to the services, starting with medical SDEC.
- Work progresses with the WHH front door Frailty Unit (FAU) to be in place from Sept 23. QEQM are undertaking a similar exercise to widen the scope within their dedicated FAU.
- Work with the UTC Alliance is planned to enhance the service provision and reduce the number of patients directed back to ED/SDEC.

Our patients

Dylan Jones

Trust Access Standards: Cancer 62day

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
61.7%	73.2%	78.0%	71.7%	65.8%	65.3%	71.5%	73.3%	63.0%	64.6%	76.0%	67.7%

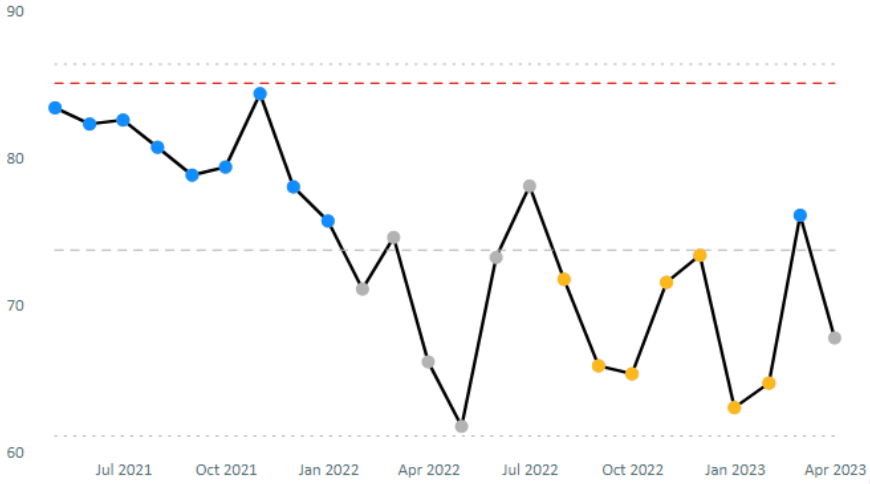
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Performance has dipped in April due to the complex challenges of reduced capacity due to the industrial action and Bank holidays. The Trust remains in the top 3 performers nationally for 2-week wait access and is still making the biggest contribution to a Cancer Alliance that has the 3rd smallest backlogs for 62 day breaches and the Kent and Medway Alliance being the best performing Alliance in the country

Intervention and Planned Impact

- Enhanced escalation process put in place for Consultant reviews, Tertiary referrals, surgical dates and diagnostics.
- CCHH and Clinical Support Services working closely to optimise the radiology diagnostic capacity in the CDC to support faster and early diagnosis. Need to move closer to referral to report within 10days compliance is to be achieved and sustained.
- Achieving the 28-day FDS standard will support the continued reduction of patients waiting over 62 days. STT for Lower making significant improvement for patients and process, plans in place for full roll out.
- PGD now in place, minimising delays and repeat colonoscopies.
- Proactive management of long waiting patients continues to fully understand how we can best manage these groups through to treatment. Breach report meeting with actions and learning in place.
- All roles within CCHH Compliance team have been reviewed to support improved learning. Standardising practice for all teams, to help improve morale, support co-design and share best practice.
- Community Qfit being utilised for 80% of patients referred, new SOP and pathway to improve consistency being finalised for sign off at Network TSSG Meeting.
- From the CQUINS calculation for LGI for the patients who have gone through the STT pathway so far 75% have hit their timed pathway target.

Risks/Mitigations

- Delays to diagnostics vetting, booking and reporting remains a significant risk but pathway mapping and changes being investigated to agree sustainable solutions.
- Histopathological reporting remains a significant contributor to the teams ability to achieving sustainable compliance, again work in progress with CSS to support improved turnaround times, understanding the significant reality of a national shortage of Histopathologists.
- Theatre capacity for Specialities within Urology, Head & Neck, Breast and Lower continues to be a risk.
- Tertiary capacity for OPA's, diagnostics and treatments remains challenging, working with the Alliance to support improvements.
- MDM radiology cover consistency continues to be a significant risk, need to confirm plans for future cover, part of the improvement plans with radiology.

Our patients

Patient Experience: Inpatient Survey

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

The Trust has chosen ten questions from the National In-Patient survey, and our average for our focused 10 questions is 7.13 compared to 7.65 as a national average.

41 adult in-patient wards will complete 50 surveys per month (2,050) using the tendable app using the 10 questions.

Jane Dickson

Our ambition is to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
		8.9	8.8	8.9	8.9	9.0	9.0	9.4	9.2	9.3	9.3

P

Variation indicates consistently passing the target

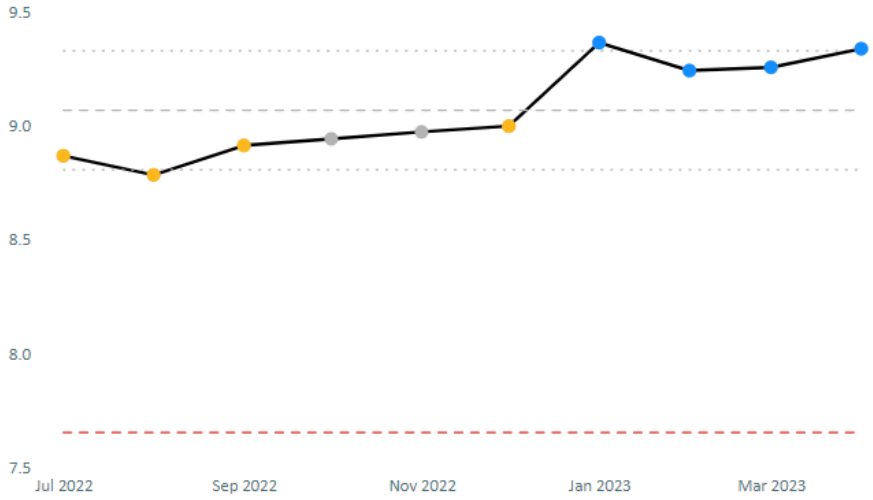
H

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

In April, 2238 Patient Experience Surveys were completed via the Tendable platform. Continuing the trend of gaining feedback from in excess of 2050 patients.

The overall Trustwide score for April was 9.4 (94%), continuing the trend to be above the threshold of 7.7 (77%).

The exception continues to be patients reporting that they had difficulty sleeping at night due to noise. The 'No' response for this specific question is a positive, therefore the April score is that 31% of patients responded that they were disturbed by noise at night – a slight improvement from the March score of 34%.

Intervention and Planned Impact

Measures to counteract the noise disturbances at night continue to be raised with the frontline teams, including the provision of earplugs and eye masks for patients and sharing of guidelines for night duty staff across all wards and our escalation areas. The Procurement Team are leading on ways to safely reduce the noise from equipment. There has been a delay in providing patients with the newly developed information booklet, which includes information on night time processes and the night time packs available for patients. The Communications Team have now designed this and a printing date is to be confirmed. Design of a patient information poster and comparisons with other Trusts is being undertaken.

The results indicate room for improvement on patients being given adequate notice when leaving hospital and the commentary from patients indicates room for improvement relating to communication from Drs. Further analysis will be undertaken in May.

The HoNs and DoNs continue to support the wards to complete their surveys and develop actions to address poor responses, reporting monthly to the Nursing, Midwifery and AHP Board. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FoC). The Patient Involvement Team continues to review the feedback provided via targeted Friends and Family responses, via Care Opinion and via community engagement events. This has led to specific workstreams related to implementation of the Accessible Information Standard and provision of translation and interpreting services.

The national inpatient 2022 survey results are available in May and will be presented in June.

Risks/Mitigations

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

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
Cancer 62d	W4		Cancer 28d Performance		75.0%	53.0%	66.3%	65.1%	61.6%
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	314	197	86	91
	W4		DM01 Compliance		75.0%	57.6%	62.0%	60.3%	56.3%
	W4		RTT OP Booking Breaches		14,000	27.6K	28.4K		30.6K
			Elective Admissions vs Plan		Traj.	8,565	8,573	9,659	6,937
ED Compliance	W4		ED Compliance		90.0%	68.4%	67.3%	67.1%	70.7%
	W4		Unplanned Re-attendance ED		10.0%	13.0%	13.6%	13.3%	13.0%
	W4		Super Stranded >21D		107	310	307	296	280
			NEL Admissions vs Plan		Traj.	6,672	6,249	6,742	6,708

Cancer
The 28d faster diagnosis metric continues above 60% was impacted in month by the Industrial Action. The underlying challenge however remains the speed of diagnostic provision.

RTT 18 Weeks
A small increase in 78 week breaches is noted in month due to patient choice and covid preventing surgery proceeding. Capacity breaches in ENT continue to drive the greatest proportion of breaches reported due to the impact of unplanned sickness absence in the service.

Out patient booked breaches remain significantly increased above the threshold, opportunities to improve this position through the annual business planning cycle and transformation actions are being scoped and modelled.

Improvement work across Radiology, Endoscopy and Cardiology continues, with focus on reducing the request to reporting times for patients on our urgent and cancer pathways, ensuring diagnostic requests can be scheduled at point of referral without delay.

ED Compliance
Compliance with the 4hr standard improved in April (70.6% all types v 67.1% in March) . This was the best performance reported since Jan 22. Type 1 performance for both sites reported 43.9%, an improvement from March at 38.9% and overall improvement since Nov 22
Total times in ED improved from the previous month (March 12.8% v 10.6% for April) there was a correlating improvement in both the numbers of DTAs at 08.00 hours from 110.8 in March to 72.5 in April.
There remains a correlation with the numbers of complex pathway patients reported ; April reported the highest number ever recorded with month on month increases seen April 460, March 426,February 450, January 430 compared to circa 210 in the first 6 months of 2021

The mean time for ED waits for admitted patients was 20.1hours in April – best reported position since June 22 and non-admitted at 3.5 hours v 4.2 in March. The performance of the type 1 admitted for April was 22.9% from 15.9% in March (best reported performance since July 21) and non-admitted type 1 from 46.2% in March to 51.9% in April

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
FFT	W4		FFT Maternity Response Rate		18.0%	15.6%	14.0%	12.2%	11.1%
	W4		Complaint Response		90.0%	58.8%	44.6%	71.7%	45.1%

Complaints Response

Complaints Response

April 2023 saw 64 formal complaints taken forward and 483 overall contacts. We had 10% of contacts in April 2023 that were taken forward as formal complaints. As a seasonal comparison to April 2022 there were 52 complaints and 708 overall contacts – a 23% increase in formal complaints and a 32% reduction in overall contacts. The drop in overall contacts to the department in April 2023 could be contributed to the closure, due to funding, on 19.04.2023 of the Waiting Patients Service (patient support - updates on waiting times for surgery).

We achieved a 100% compliance rate of acknowledging our new complaints within three working days. This has been maintained for the previous five months.

The care groups are continuing their work on complaint response timescales. April 2023 saw a reduction in performance of responses within timescales to 45%. As a seasonal comparison, April 2022 responses within timescales performance was 7%. The drop in performance of our response rates in April 2023 can be contributed to the increased number of complaints received in December and January, combined with business pressures. As reported in March 2023, the complaints and PALS teams are now fully resourced and new team members are continuing their training and induction.

Our people


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

Our people

Andrea Ashman

Staff Engagement (score)

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

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
6.26	6.26	6.33	6.33	6.33	6.35	6.35	6.35	6.17	6.17	6.17	6.20

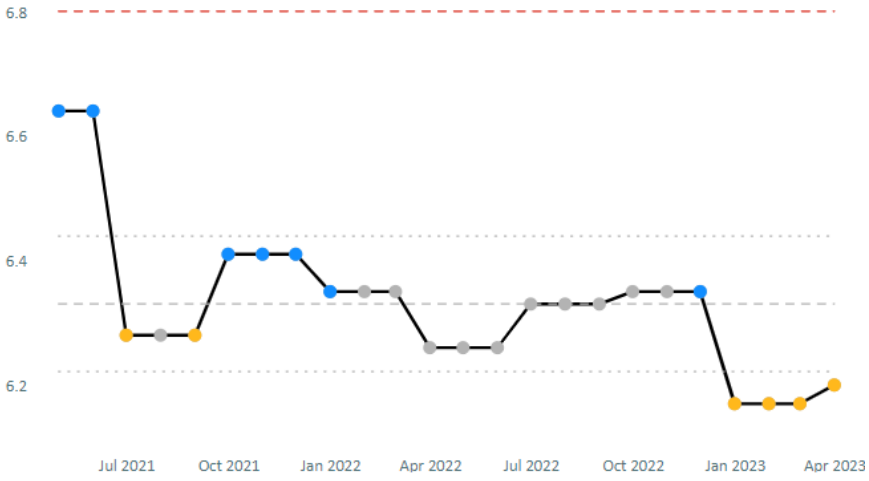
F — Variation indicates consistently falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Staff Engagement levels have improved subtly against each of the three domains (motivation, involvement and advocacy) as well as overall, between Q4 (22/23) and Q1 (23/24) as per below:

- Overall Staff Engagement score: 6.20 (up 3 points vs. 6.17 in Q4)
- Motivation score: 6.61 (up 3 points vs. 6.58 in Q4)
- Involvement score: 6.23 (up 5 points vs. 6.18 in Q4)
- Advocacy: 5.76 (up 1 point vs 5.75 in Q4)

The overall score is improved but remains significantly below the desired index and national average (6.8). Staff engagement is primarily being impacted by low levels of advocacy for the organisation.

Interventions and Planned Impact

The National Staff Survey results have now been socialised across the organisation and action agreed at three levels; organisational, hotspots (targeted interventions) and locally (Specialty).

At a Specialty level, colleagues are identifying their key challenges and working to 'change three things'. Progress against this work is being captured and project managed by P&C Business Partners. A P&C MDT has been initiated and, triangulating staff survey data alongside other key evidence (IIP, Clinical Adjacency work, our Pillars of Change and CLP) has identified critical hotspots for targeted intervention. Using the enhanced NSS dashboard, a new Staff Engagement Framework has been developed alongside national partners. This will offer colleagues insight into an often amorphous topic with simple, tangible actions to help drive improvement.

Risks/Mitigations

Staff Engagement levels are declining nationally, most notably with reductions in motivation levels and advocacy – two key components of staff engagement. There is a risk that national strike action perpetuates this reduction in overall motivation levels and advocacy. Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores. The Kirkup Report appears to have had an impact on staff advocacy and affected the way colleagues respond overall to engagement questions in the National Staff Survey.

22/23 breakthrough objective

Staff Involvement Score

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

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
6.13	6.13	6.28	6.28	6.28	6.43	6.43	6.43	6.18	6.18	6.18	6.23

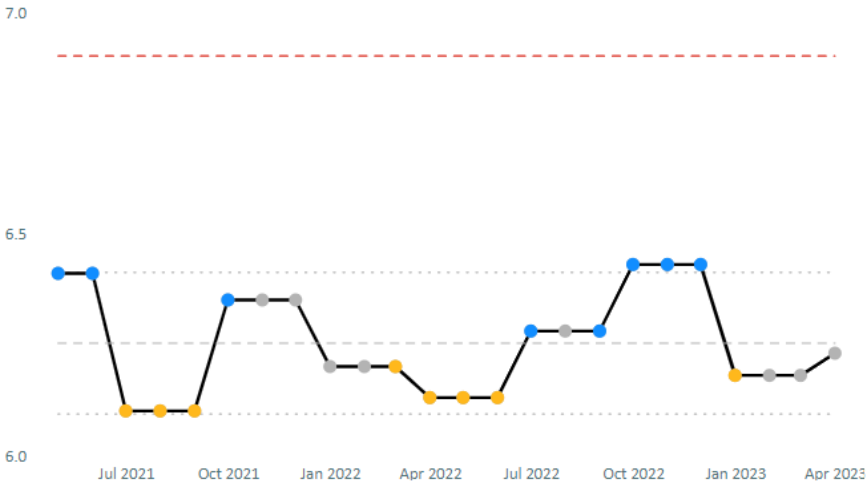
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Staff Involvement has improved following a fall Q4 (22/23), returning to levels seen in Q" (22/23). Staff Involvement currently stands at 6.23, up 5 points but considerably below the desired threshold (6.7). This appears to be primarily due to staff feeling less able to make improvements happen in their area of work. The latest scores are provided below to confirm:

- Staff Involvement score: 6.23 (up 5 points vs. 6.18 in Q4)
- Frequent opportunities to show initiative: 6.37 (up 5 points vs. 6.32 in Q4)
- Able to make suggestions for improvement: 6.48 (up 4 points vs. 6.44 in Q4)
- Able to make improvements happen: 5.85 (up 6 points vs. 5.79 in Q4)

What the evidence establishes is that colleagues can show initiative and make suggestions, but that work is needed to help colleagues across the organisation to make improvements happen.

Intervention and Planned Impact

- A Staff Engagement framework has been developed to enable colleagues to take tangible action to improve levels of involvement
- The We Care rollout has now reached Wave 6 and overall staff engagement levels are consistently higher in We Care areas than non-We Care counterparts
- 58 managers or team leaders have now been trained as part of the Team Engagement and Development (TED) pilot
- The 'change three things' approach is underway, with Specialties currently socialising their priorities and associated action streams

Risks/Mitigations

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

Alerting watch metrics

Supporting metrics that have either;

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

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
Staff Engagement	W4		Appraisals Compliance		80.0%	69.9%	70.5%	70.5%	70.1%
			Statutory Training		91.0%	90.2%	90.5%	91.0%	90.6%
	W4		Safeguarding Adults Training		90.0%	84.1%	83.1%	82.9%	84.8%
	W4		Safeguarding Children Training		90.0%	85.5%	84.8%	84.6%	85.8%
	W4		Premature Turnover Rate		25.0%	25.8%	26.1%	26.1%	26.9%
	W4		Medical Job Planning Rate		90.0%	50.1%	31.2%	38.3%	46.4%

Appraisal Compliance

Overall appraisal compliance had been on an upward trend from June 22 to February 23. However, compliance fell slightly in April as a large number of appraisals are carried out in April and May each year, and these have now become non-compliant from last year. Approximately 20% of all appraisals are carried out in April/May each year. P&CBPs are working with Care Groups to support, inform and encourage leaders to book in their appraisals and then record them via ESR Self-Service. Compliance ranges from 54.2% for Corporate areas to 83.0% for Surgery, Head, Neck, Breast & Dermatology.

Statutory Training

Compliance fell slightly, but remains above 90%. All staff groups are compliant and above the 91% threshold, with the exception of Medical staff at 74.4%.

Safeguarding Training (Adult & Children)

Safeguarding Children Training rates improved to 85.8% but are below the 90% threshold. Safeguarding Adults Training improved to 84.8% and is also below the required threshold. A new TNA is currently going through the approval process of the SMET Steering Group, recognising training availability challenges and enabling greater levels of occupancy at Level 3. Medical staff have the lowest compliance in both subjects at 67%.

Premature Turnover Rate

Premature turnover stands at 26.9%. This is above the target threshold (25%) and has now been for the last six months. Some of this is a consequence of improved overall turnover, with this falling as low as 7.5% in April whilst the number of premature leavers has remained relatively stable (15-20 pcm). The 'New Starter Experience Survey' is beginning to give intelligence across the first of five time-points to enable targeted action. 264 staff have already responded, and early insights indicate that East Kent is performing significantly better than the Kent and Medway regional average against all of the respective new starter experience measures. The net engagement score for EKHUFT colleagues with <1years' service (77%), for example, is 19% higher than the K&M average (58%).

Medical Job Planning

Medical job planning rates have improved by a further 8% and stand at 46.4%. The Job planning policy is receiving renewed focus with Executive meetings with Care Groups about improving operational activity.

Our sustainability

22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst the most influenceable by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective was to reduce the spend by 10% or £8.7m in 2022/23. The total spend for premium pay in was £104m for the full year which was £26m above target.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
-212.7K	-2.5M	-31...	-3.1M	-1.4M	-2.4M	-4.1M	-5.8M	-5.4M	4.2M	3.3M	-497.1K

F

Variation indicates consistently falling short of the target

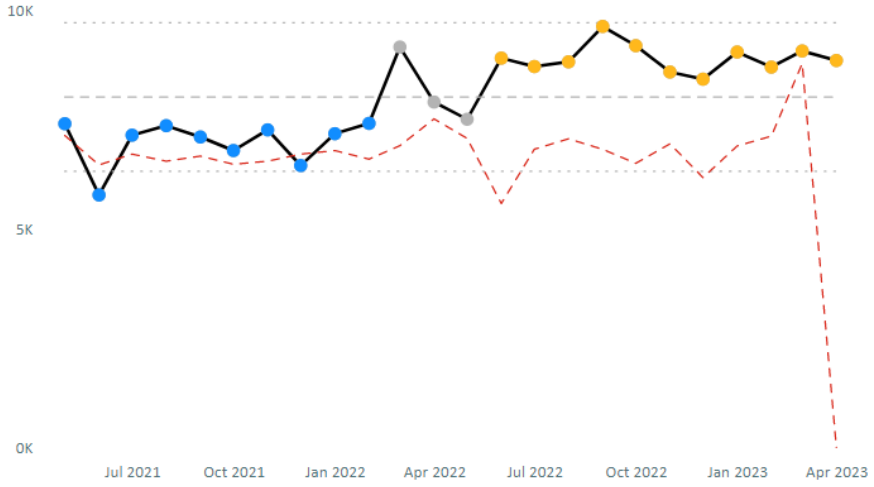
H

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

Flag Description

Above Mean Run Group

XMR Run Chart



What the chart tells us

The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits. This is caused by the Trust ensuring all costs in that financial year are captured and include unpaid claims due in year.

This information is the baseline for which we will measure improvement over 2023/24.

Intervention and Planned Impact

The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.

Key Interventions include:

- Detailed focus by care groups on drivers of premium pay.
- Review of bank, agency and overtime rates across all staff groups.
- Ensure improved sign off processes and governance across the Trust.
- Recruitment to key clinical posts to reduce the need for temporary staffing.
- Ensuring exit plans in place for high cost medical agency locums

Risks/Mitigations

- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- The remainder of spend is caused by sickness and operational demand. The former should reduce but work is required to control and reduce the latter.
- The increase in escalation beds and the increased need for specialing patients has increased the need for temporary staff

Our sustainability

Ben Stevens

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
6.84	7.00	2.95	5.29	5.12	4.75	6.31	6.29	8.66	8.15	7.40	

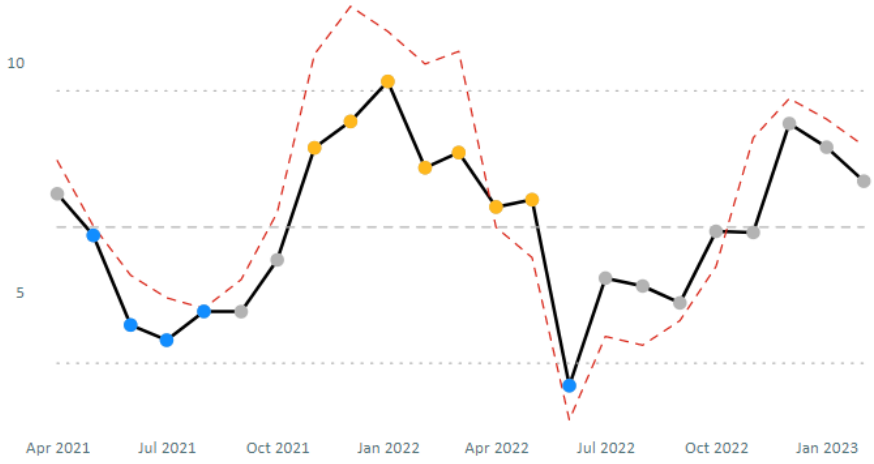
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. The position is reporting below the monthly trajectory of 8.17 at 7.40 C02e per m2 and is slightly lower than the same period last year (which reported at 7.7). The Trust has increased its m2 during 2022/3 (i.e. new Emergency Department expansions at both Queen Elizabeth The Queen Mother Hospital and William Harvey (WHH), and the ITU build at the WHH) and this, plus the installation of combined heating and power (CHP), will have an impact on the Trust's energy usage. CHP in particular will have an impact on the amount of gas used. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

Breathe Energy has been working with the Trust and 2gether to identify carbon reduction schemes that could be commissioned in the new financial year. The Trust, with 2gether, produced a business case which identifies the installation of heat pumps on the three acute sites funded via the PSDS 4 Grant. The Trust submitted its bid on 15 October 2022 and, although this successfully passed through to the second stage, we have been notified that we have been unsuccessful for this particular funding round, due to the total value of applications received. Subsequent public sector grants have recently been announced and the Trust is working with 2gether and a new submission has been made. The outcome of this is anticipated to be announced in Summer 2023.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions. Our Green Plan is in the process of being finalised and objectives relate to:

Sustainable Estate (Using energy, water, waste, travel, procurement and buildings efficiently while adapting to climate change); and Sustainable Healthcare (Delivering healthcare that reflects wider corporate, social and environmental issues, including prevention of poor health and developing more environmentally sustainable models of care). The Joint Carbon Reduction Steering Group will drive the strategic improvements required to reduce the carbon footprint, in line with our agreed trajectory.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Lack of behaviour change & culture in the organisation negates the opportunity to promote carbon reduction.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Our future


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

Our future

Dylan Jones

Not fit to reside (patients/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. This allows us to easily identify the ongoing support and care patients need to leave hospital.

Patients are delayed in hospital awaiting a supported discharge which may be a care package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works in partnership with the local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
352.9	354.9	402.6	385.9	358.3	362.2	350.4	354.1	392.3	437.1	407.5	410.7

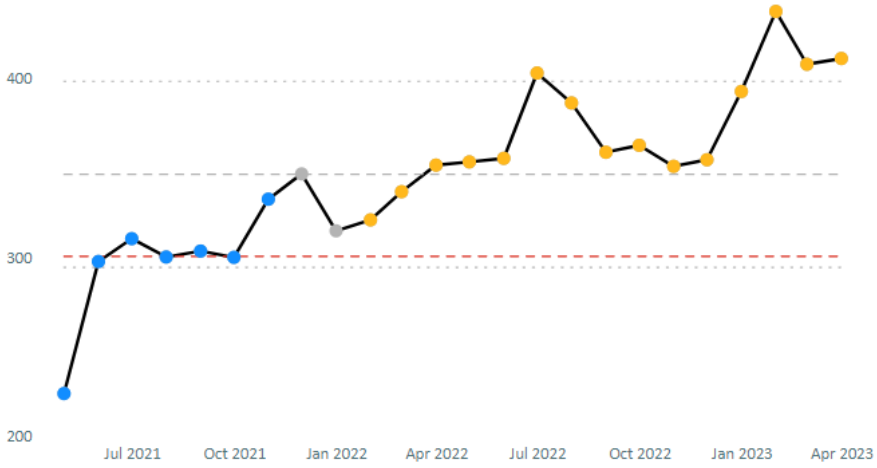
Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart



What the chart tells us

This month the Trust reports 411 patients as 'No longer fit to reside'. The April breakdown across the different discharge pathways is Pathway 0: 121, Pathway 1: 135, Pathway 1: 59, Pathway 3: 96. Patients assigned a discharge pathway of either 1, 2 or 3 equates to 70% of the patients considered 'No longer fit to reside' and all required an on-going package of care to be discharged from an acute setting.

With a high number of patients residing on the back wards of the Trust that no longer require an acute care setting, patient flow through the hospital is impacted. In April 2023, the average number of patients in our Emergency Department with a decision to admit and awaiting transfer to a ward was 73. Whilst this is an improved position on the previous month, the need for community support and additional packages of care remains a key factor to increase flow across the Trust.

Intervention and Planned Impact

- In the last two months the Trust has been working in partnership with ICB and HCP colleagues on the development of the East Kent Health and Care Partnership Urgent and Emergency Care Plan, and ICB lead plan aim to improve urgent and emergency care. This plan 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
- Under the 'Improving discharge' workstream plans are outlined for increasing P1 capacity, increasing the provision of live in care schemes and additional capacity for the Trust's End of Life patients. These schemes landing at pace is key to improving the Trust's No Longer Fit to Reside position. This work is being monitored through the ICB and HCP Urgent Care Boards.
- Within the Trust the Emergency Care Delivery Group focus workstreams include: Patient Flow, Front door, Simple discharge, SDEC and Direct access are all aimed at driving discharges within the Trust's gift, divert patients to same day emergency care where possible and focus on admission avoidance

Risks/Mitigations

- A focussed piece of work is underway to review the application of the No Longer Fit to Reside criteria which is considered for each patient and applied as the day's board rounds are undertaken. This work seeks to understand the rigour around the application of the No Longer Fit to Reside status alongside the process of determining which patients are cited as medically optimised for discharge. For those requiring an on-going package of care, this workstream is also reviewing how patients are then referred and transferred to the Trust's Rapid Transfer Service (RTS) Co-ordinators. The key objective of the work is to ensure the Trust has an accurate view of patients no longer requiring the treatment of an acute and, for those patients requiring on-going package of care, that they are identified on the RTS workflow at the earliest opportunity to support early discharge.

Our future

Ben Stevens

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
129	162	430	82	161	190	120	124	116	127	128	99

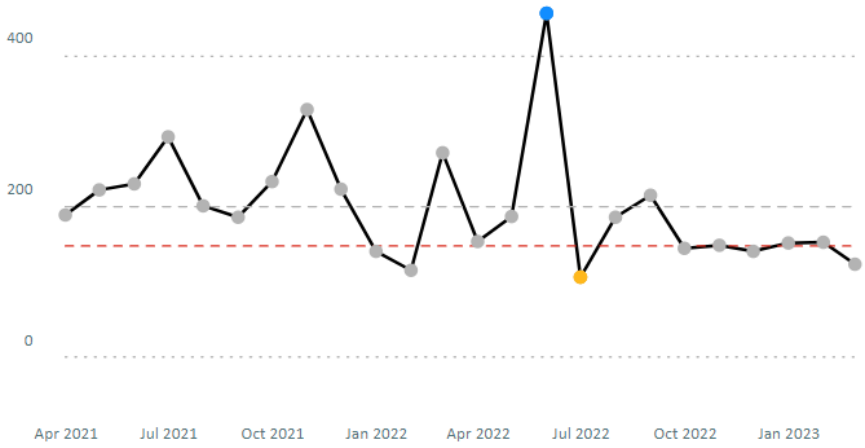
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The March position of 99 participants is below the monthly threshold of 123 (negative). Validation of the final position indicates that the March position is likely to increase slightly from 99 to 110.

The March position reflects the transition to more interventional and commercial studies, which tend to be more complex to set up and run, have a slower recruitment pace and lower targets to match.

However, the 2022/23 full year position shows that the annual target has exceeded with 1,879 participants recruited - 27% above the full year plan (positive).

Intervention and Planned Impact

- A refreshed target for 2023/24 is in place to reflect the switch in focus to more interventional studies.
- 5 key areas for Clinical Fellows have been identified and supported by CEMG: Anaesthesia and Perioperative Medicine (already appointed); Cardiovascular disease; Neurological disease; Surgery; and Trauma and Emergency care.
- The Trust continues to design its first real-world data project using the Trinetx platform (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators) with access to 114 million patient records globally.

Risks/Mitigations

- The IT delays to the Trinetx integration project are now impacting on the revenue opportunities into the Trust. In 2022, the team received 30% fewer collaboration requests than other similar secondary acute care Trusts that are fully integrated. This has been escalated to the Director of IT for support.
- Urgent care pressures within the Trust have impacted on clinician time in the acute settings, making it hard for the delivery teams to coordinate study activity.
- Space at K&C has been identified as a constraint to the Trust's ability to continue to provide a number of cancer trials. The Oncology/Haem-Oncology research delivery teams are merging to mitigate the risk of having to close cancer studies to recruitment and work is underway to facilitate the space to enable the merged team to co-locate.

Appendix 1
Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
Harm Events	W		Falls		Sigma	192	122	137	116
	W		IPC: EColi Infections		10	13	6	8	4
	W		IPC: Klebsiella Infections		6	1	4	7	4
	W		IPC: Pseudomonas Infections		3	5	2	1	3
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	205	224	204	229
	W		Medication Errors; Severity C+		1	6	1	7	2
	W		Nutrition Incidents		Sigma	34	44	60	37
	W		Pressure Ulcers: Cat 2		Sigma	40	34	41	47
	W		Pressure Ulcers: Cat 3 & 4		Sigma	3	0	2	0
	W		Pressure Ulcers: DTI		Sigma	6	7	7	5
	W		Pressure Ulcers: Unstageable		Sigma	10	13	8	6
	W		Safeguarding Incidents		Sigma	32	17	25	19
	W		Clinical Incidents		Sigma	2,436	1,962	2,286	2,165
	W		IP Spells with 3+ Ward Moves		Sigma	344	386	427	408
	W		Serious Incidents		Sigma	16	16	36	10
	W		Serious Incidents Breached		0	0	2	6	10
	W		Never Events		0	1	0	1	0
Mortality	W		Extended Perinatal Mortality		5.87	4.33	4.53	4.44	4.62

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
Staff Engagement	W		Sickness		5.0%	5.1%	4.9%	5.1%	4.1%
	W		Staff Turnover Rate		11.5%	10.0%	9.9%	10.0%	9.8%
	W		Vacancy Rate		10.0%	9.1%	8.7%	8.4%	8.2%
	W		Staff Turnover: HCA		13.5%	13.5%	13.1%	13.0%	12.7%
	W		Staff Turnover: Nursing		10.0%	9.2%	9.0%	8.8%	8.6%
Financial Position	W		Efficiencies FOT Variance (£M)		0.0	-8.0	-9.1	-10.4	0.0
	W		I&E Monthly Variance Trust (£)		0	-5.4M	4.2M	3.3M	

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
Cancer 62d	W		Cancer 31d Performance		96.0%	96.2%	97.9%	98.5%	96.0%
	W		Cancer 2ww Performance		93.0%	96.9%	96.6%	94.8%	95.4%
	W		Radiology Diags vs Plan		Traj.	18.6K	17.1K	19.0K	17.5K
	W		Endoscopy vs Plan		Traj.	1,247	1,286	1,489	1,000
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,443	1,239	1,104	1,176
	W		RTT 52w Breaches		Traj.	3,317	3,187	2,997	3,027
	W		OPA vs Plan		Traj.	70.5K	66.0K	75.0K	59.4K
ED Compliance	W		Clinician First Seen within 1h		50.0%	53.4%	50.8%	51.3%	56.5%
	W		A&E Atts vs Plan		Traj.	22.6K	21.7K	24.4K	22.4K
	W		Discharges by Midday		15.0%	14.5%	13.8%	15.1%	13.9%
	W		Pathway 0 Patients >7 Days		Sigma	128	152	146	136
	W		NEL Readmissions		15.0%	8.9%	9.9%	8.7%	10.6%
	W		Stroke Ward within 4 Hours		50.0%	74.4%	65.9%	77.1%	62.7%

True North Domain	BR	Flag	KPI	SPC	Thres.	Jan-23	Feb-23	Mar-23	Apr-23
FFT	W		FFT IP Response Rate		15.0%	18.8%	20.6%	19.8%	20.4%
	W		FFT DC Response Rate		27.0%	30.6%	30.3%	31.7%	28.6%
	W		FFT ED Response Rate		12.0%	14.8%	13.8%	14.3%	14.8%
	W		FFT OP Response Rate		17.0%	19.6%	19.4%	19.6%	19.8%
	W		Complaints Number		Sigma	94	79	88	64
	W		Mixed Sex Breaches		Sigma	71	113	46	112
	W		Duty of Candour - Verbal		100.0%	100%	97.9%	98.0%	100%
	W		Duty of Candour - Written 15wd		100.0%	82.8%	97.4%	100%	100%
	W		Duty of Candour - Findings		100.0%	66.7%	100%	100%	100%

Appendix 2
Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Jane Dickson	To have a central repository of for all clinical guidelines	Jan 2022 1st phase complete 2nd phase April 23	• CGAG meeting arranged for the end of April. • Revision of clinical guidelines governance continues with several being transferred to the new approved template. • Removal of outdated guidance from MicroGuide has commenced.	• Continue to review and revise current MicroGuide content to ensure current, fit for purpose and accessible. • Arrange meeting with acute medicine to assess their needs for transfer to MicroGuide. • Consider requirements of clinical support services (Pharmacy, Pathology, etc.) who frequently have to update guidance to ensure alignment with national guides.
Improving End of Life Care	Jane Dickson	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	April 23	**Process / System Workstream** • The beds on Sandwich Bay are up and running work continues for WHH • ReSPECT – led by Judith Banks. Updates to Sunrise / KMCR functionality prevent full electronic go live. Plan for phased approach with paper ReSPECT first. **Education workstream** • PEoLC education framework live on StaffZone. • Focusing on film development and launch. **Culture workstream** • Focusing on film development and launch.	**Process / System Workstream** • Further discussion required to agree medical solution for Sandwich Bay. • Recruitment to palliative care medical staff required to progress WHH beds – option being explored. • Hold care group triumvirate workshop to engage and agree improvement plan refresh with care group held improvement plans **Culture workstream** • Aim to launch Mandatory Training Film 'Caring with Compassion' during Dying Matters week, alongside other engagement activities and workshop event,
Fractured Neck of Femur	Rebecca Martin	To agree, develop and implement a Trust wide Fractured Neck of Femur pathway that will address and improve the eight Key Performance Indicators on the National Hip Fracture database	April 23	• Continued good figures, over 90% compliance at WHH to get patients to theatre in timely manner • Prompt mobilisation training starting this month with trauma cos and ward staff • QEQM ward staff and therapists are submitting requests for rehab beds directly to rehab facilities rather than through discharge to see if more timely access	• Training is progressing at the QE • Theatre sister developing Draft SOP when identifying the golden patient. • Interviews taking place for new Hip fracture practitioner. • All confused patients to be seen by the dementia team on admission to improve their care.

Appendix 2
Completed Trust Priority Improvement Projects

East Kent Hospitals University NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Nicky Bentley	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Nicky Bentley	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Nicky Bentley	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Jane Dickson	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
Sepsis Audit tool	Jane Dickson	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Jane Dickson	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete
Accommodation Strategy	Michelle Stevens	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Moved to BAU Oct 22
Trust wide Job Planning	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	Moved to BAU Oct 22
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	Moved to BAU Oct 22
Safe & Effective Discharge	Rebecca Martin	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Project to become more targeted within the Trust Emergency Care Delivery Group Nov 22
Maternity Ultrasound Booking	Rebecca Martin	All patients will have an Ultrasonography appointment that is linked to their pathway and consultant. To ensure the capacity and staffing is available to meet the demand of the service.	Moved to BAU Nov 22

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

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

Appendix 3: Glossary of Terms

NHS
East Kent
Hospitals University
NHS Foundation Trust

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INTEGRATED IMPROVEMENT PLAN (IIP) REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF EXECUTIVE**				
PAPER AUTHOR:	**IMPROVEMENT DIRECTOR AND DEPUTY IMPROVEMENT DIRECTORS**				
APPENDICES:	**APPENDIX 1: SLIDE DECK PROVIDING PROGRESS UPDATE ON DELIVERY OF THE IIP SINCE LAST MONTH**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To update the Board on progress of delivery of the IIP and provide oversight of key risks to delivery.				
Summary of Key Issues:	The IIP has continued to be developed with the introduction of a number of new Senior Responsible Officers (SROs) which has required some refreshing and refreshing of programme and project goals. All programmes of work have made progress with some beginning to demonstrate signs of early improvement. The challenge, however, remains sizeable and there is a need to continue to increase the pace of delivery. It is important to recognise that the report highlights achievement of actions and not the impact that they have made. Metrics have been developed aligned to each of the programmes with a dashboard due to be presented at the July Board. These metrics will look to demonstrate an impact on patient or staff outcomes. All of the workstreams have had a review and reset with significant changes within Maternity and Quality and Safety so there is greater confidence of the programme milestones and measures of success and a clearer understanding of the resources required to deliver the plan. The plan and delivery approach has been aligned to the Pillars of Change work and the 'We Care Quality Improvement Programme'.				
Key recommendation(s)	Trust Board members are invited to **DISCUSS** the report and progress of delivery of the Integrated Improvement Plan to date.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**	
Link to the Board Assurance Framework (BAF):	BAF 32 – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. BAF 34 – There is a risk that our constitutional standards are not				

East Kent Hospitals University NHS Foundation Trust

	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:	Y/N	Y - discussions with National team regarding the use of available resources.
Legal and regulatory:	Y/N	Y – regulatory impact.
Subsidiary:	Y/N	Y – in the overall provision of services within the resources available to the Trust.
Assurance Route:		
Previously Considered by:	From June onwards, this report will be considered by the Strategic Improvement Committee ahead of the Trust Board. The Strategic Improvement Committee is being established to oversee delivery of the Integrated Improvement Plan.	

East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP) Report

1. Purpose of the report

1.1 The purpose of this report is to update the Board on progress of delivery of the IIP. It is also intended to give the Board oversight of key risks to delivery.

1.2 From June, the report will update on key evidence that has been added to the evidence repository to support exit from the Recovery Support Programme (RSP).

1.3 On a quarterly basis the report will also demonstrate in detail the impact that delivery of the plan is having against the overall programme objectives.

2. Background

2.1 The IIP sets out the Trust objectives over the next 12-18 months to deliver sufficient sustained improvement to support an exit from the National RSP in March 2024.

2.2 The report set out in Appendix 1 provides an update on delivery of the IIP to date. Progress against the 'priority areas of focus in the first six months' are set out in a high-level summary, followed by a progress update for each of the six key programme areas within the plan. A progress update on the Communications and Engagement Plan which supports delivery of the IIP, from May 2023 is also included in the report.

2.3 The Strategic Improvement Committee oversees the delivery of the IIP and is chaired by the Chief Executive, Tracey Fletcher. Its inaugural meeting on the 26 May signed off the Terms of Reference for the Strategic Improvement Committee. The Strategic Improvement Committee is due to meet fortnightly with a rolling review of three of the six programmes of work at each meeting.

3. What progress has been made over the last month?

3.1 There has been progress across all six programme areas evidenced through the milestones that have been delivered to date, although this has not yet, in many instances, demonstrated impact in terms of agreed trajectories starting to be delivered.

3.2 Detailed updates and delivery of milestones in each programme area are provided in the attached report.

3.3 Funding for the programme from the ISCS (RSP) budget has been presented at a meeting with the National Director of Intensive Support on the 12 May 2023. Further detail was requested on the proposed bids which was subsequently supplied. The National team is waiting for confirmation of budget before allocation of funds to Trusts.

3.4 Ben Stevens, the SRO for the programme, has continued to work with Programme SROs to align the IIP with the Pillars of Change work and 'We

Care Quality Improvement Plan'. This draft single framework will be communicated across the organisation once complete.

4. What are the risks to delivery of the plan and how are they being considered?

4.1 Through the process of developing the IIP a number of key risks have been highlighted. Initial risks highlighted have included: deficits in planned workforce; estates and equipment; industrial action and resource to deliver the programme. Mitigations are being developed minimise the risks described including a financial bid to the national RSP team for additional support for the maternity, operational performance and finance, and culture and leadership programmes.

4.2 The Strategic Improvement Committee will create a risk register aligned to the programme of work and develop appropriate mitigations. These will be regularly reviewed as part of the agenda for the committee. Significant risks to delivery will mirrored in the corporate risk register.

4.3 Additional workstream level risks have been captured in work programmes and have undergone a check and challenge at the Strategic Improvement Committee.

5. How is progress and delivery going to be tracked and monitored effectively?

5.1 Progress and delivery will be tracked via the Strategic Improvement Committee. Programme SROs submit a monthly highlight report to this Committee which includes key progress updates, risks and issues for escalation, and key Key Performance Indicators (KPIs)/metrics and trajectories to measure improvements being made.

5.2 Wider supportive programme management arrangements are also in development.

5.3 The Programme SRO along with the RSP team along with the SROs developed a set of KPIs and evidence that will be provided to the Board, in order to give assurance that delivery of the plan is having the expected impact.

6. Conclusion

6.1 Board members are invited to discuss the progress and the risks in delivery of the Integrated Improvement Plan and recommend any further actions.

26 May 2023

East Kent Hospitals University Foundation Trust
Report on Integrated Improvement Plan (IIP)

Journey to Exit NOF4

1 June 2023

Final

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. It is also intended to give the Board oversight of key risks to delivery; and to update on key evidence that has been added to the evidence repository to support exit from the Recovery Support Programme (RSP).

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Strategic Improvement Committee which is chaired by the Chief Executive Officer (CEO), Tracey Fletcher.

The Board will receive an update on the IIP on a monthly basis focusing on successes, challenges and actions to mitigate any key risks to delivery. We will also provide a quarterly deep dive to demonstrate impact and progress against the overall programme objectives.

High Level Summary on IIP Programme

NHS
East Kent Hospitals University
NHS Foundation Trust

Progress over last month:

- The draft exit criteria which the IIP aims to address have now been approved with the addition of two elements under operational performance and finance
- The associated additional evidence for the exit criteria have been confirmed and built into the two relevant programmes within the IIP
- The Strategic Improvement Committee met for the first time on 26 May chaired by the CEO with agreed terms of reference and a clear governance framework including a fortnightly "drum beat" to support an increased pace of delivery
- All six programmes, with a number of new Senior Responsible Officers (SROs), reported progress against their planned milestones alongside initial assessments of impact and issues and risks
- Key metrics for IIP reporting have been agreed and a IIP dashboard has been developed to support accurate and timely reporting across the IIP
- Planned milestones have been delivered across the majority of the programmes with some early indications of positive impact although there is still much to do
- Two programmes have undergone reviews and resets with the appointment of new SROs, these are Maternity and Quality and Safety which have been reviewed in detail with both SRO and individual project leads and are now reset

Update on Improvement Framework

- Since last month the single framework which encompasses the IIP, We Care and Strategy Pillars, has been finalised with further details set out in this report

Key Risks:

- A number of key risks have been highlighted. Some of these risks are already recognised within the individual programmes
- The Strategic Improvement Committee will review the overall risks highlighted by programmes in June when all have formally reported and consider whether there are any further risks and whether all appropriate mitigations had been put in place
- Key risks highlighted to date include:
  1. Deficits in planned critical workforce
  2. Estates and equipment constraints
  3. Impact of Industrial Action
  4. Resource to deliver the IIP
  5. Capacity of Business Intelligence to support all programmes on a timely basis

Funding to support Delivery of programme

- Business Cases for the funding to support the Programmes have been submitted to the National ISCS team. The team are awaiting confirmation of final budgets before allocation to Trusts.
- Key areas for the bid include:
  - Maternity Transformation Programme Support
  - Culture and Leadership Programme
  - Operational Performance (Urgent and Emergency Care (UEC) and Elective Improvement)
  - Financial Sustainability
  - Board Development
  - Learning from Patient Safety Incidents

High-level Summary on Programme Delivery

NHS East Kent Hospitals University NHS Foundation Trust

	Priority area of focus in IIP	Summary update
Leadership & Governance	Leadership Development	Good progress made including early achievement of 50% appointment to substantive executive posts. The organisational restructure consultation concluded at the end of May 2023 with plans in place to rapidly recruit to all key posts. The Leadership Programme for the Care Groups and Service Group triumvirates is planned to start in June to support key leaders across the Trust to develop and utilise relevant skills and approaches to deliver the Trusts aims in a manner that reflects its values.
	Governance Framework	Progress has been delayed as the allocated new clinical lead has had to prioritise other Chief Nurse responsibilities. The appointment of a new interim Chief Nurse has now released the planned clinical lead to commence the process of reviewing and refresh the governance model. The next step will be to implement and embed the clear framework for governance oversight within and throughout the Care Groups, ensuring that all staff are clear on their responsibilities for the management and learning from risks, incidents and complaints.
Maternity	Maternity Transformation	Progress has been made with the substantive appointments of both Head of Midwifery (HOM) and Dep HOM alongside a new Chief Nursing and Midwifery Officer (CNMO) as SRO. The IIP Maternity programme has been fully reviewed and refreshed. Work is ongoing to develop and confirm the updated Maternity Transformation Plan which has now been agreed to be finalised by July 2023.
Operational Performance	UEC Patient Pathways	Good progress made against planned UEC milestones and, despite Emergency Department (ED) phased handovers at both William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) and acute on chronic ED workforce issues at QEQM, UEC type 1 performance has continued to exceed the planned Type 1 trajectory on occasions. However, this improvement is still variable and not sustained. A system UEC working plan has been developed with weekly meetings in place to drive UEC system pace and delivery.
Quality & Safety	The Deteriorating Patient	Progress has been made with training by the Head of Nursing for the Deteriorating Patient. The monitoring data for this programme indicates a positive improvement in the programme. In a addition There is collaborative work with critical care outreach and the Practice Development Nurse (PDN) team. The Integrated Care Board (ICB) have previously agreed that the appointment of a specific clinical lead and a front-line coach would be supported however in light of good internal progress with training there is a verbal agreement with the ICB to direct the available funding towards resuscitation training, which will be confirmed in the next two weeks along with a trajectory for compliance.
	Ward Accreditation	Progress made with a full review and reset of the Fundamentals of Care work streams/Ward Accreditation programme with a new set of refreshed milestones as set out under the Quality & Safety programme.
People & Culture	Culture & Leadership	Good progress has been made with Culture & Leadership Development with programme milestones realised as set out in the programme slide.
Finance	Workforce Plan	Progress has continued to be made on the process of improving the understanding of service areas with high vacancy rates coupled with high premium payments with specific plans being developed, however impact continues to be limited.

Improvement Framework

East Kent Hospitals University NHS Foundation Trust

Progress update

- A review has been undertaken of the IIP, Pillars of Change and the We Care programme.
- The draft single framework that will encompass the IIP, Pillars of Change and We Care has been presented and approved at Clinical Executive Management Group (CEMG).
- The key metrics for the exit criteria have been agreed.
- An IIP dashboard has been developed incorporating the agreed key metrics. (draft shown below)
- Trust wide communication of the framework is being finalised and will be shared across the organisation once complete

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
People	Sickness	5.0%	Apr-23	4.1%			3	5	7	Common cause (no significant change)
	Vacancy Rate	10.0%	Apr-23	8.2%			7	9	11	Common cause (no significant change)
	Staff Turnover Rate	10.0%	Apr-23	9.8%			10	10	11	Common cause (no significant change)
	Premature Turnover Rate	25.0%	Apr-23	26.9%			22	23	25	Special cause of concerning nature or higher pressure due to higher values
	Staff Engagement Score	6.80	Apr-23	6.20			6	6	7	Special cause of concerning nature or higher pressure due to lower values
	Statutory Training	91.0%	Apr-23	90.6%			90	91	92	Special cause of concerning nature or higher pressure due to lower values
	Medical Job Planning Rate	90.0%	Apr-23	46.4%			23	34	45	Special cause of improving nature or lower pressure due to higher values
Operational Perfomance	ED Compliance	90.0%	Apr-23	70.7%			68	74	79	Special cause of concerning nature or higher pressure due to lower values
	Type 1 Compliance 4hrs	75.0%	Apr-23	42.9%			45	54	63	Special cause of concerning nature or higher pressure due to lower values
	Ambulance Handovers within 30m	95.0%	Apr-23	86.0%			78	86	93	Common cause (no significant change)
	12Hr Trolley Waits (MTD unvalidated)	0	Apr-23	989			192	387	581	Special cause of concerning nature or higher pressure due to higher values
	Super Stranded >21D	107	Apr-23	280			139	171	204	Special cause of concerning nature or higher pressure due to higher values
	Not Fit to Reside (pats/day)	300.0	Apr-23	410.7			203	260	318	Special cause of concerning nature or higher pressure due to higher values
	Cancer 28d Performance	75.0%	Apr-23	61.9%			59	70	81	Common cause (no significant change)
	Cancer Over 62d on PTL	67	Apr-23	379			77	174	271	Special cause of concerning nature or higher pressure due to higher values
	Cancer Over 104d on PTL	0	Apr-23	49			8	22	36	Special cause of concerning nature or higher pressure due to higher values
	DM01 Compliance	75.0%	Apr-23	56.3%			60	69	77	Special cause of concerning nature or higher pressure due to lower values
	RTT 52w Breaches	Traj.	Apr-23	3,027			2,800	3,437	4,074	Special cause of improving nature or lower pressure due to lower values
	RTT 65w Breaches	0	Apr-23	766			977	1,452	1,927	Special cause of improving nature or lower pressure due to lower values

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Leadership & Culture	Staff Advocacy Score	6.70	Apr-23	5.76			6	6	6	Special cause of concerning nature or higher pressure due to lower values
Quality	Serious Incidents	Sigma	Apr-23	10			-1	20	41	Common cause (no significant change)
	Overdue Incidents	0	Apr-23	3,897			4,996	5,998	7,000	Special cause of improving nature or lower pressure due to lower values
	Incidents - Moderate / Severe	Sigma	Apr-23	33			7	33	60	Common cause (no significant change)
	HSMR	96.0	Jan-23	92.7			90	95	100	Special cause of improving nature or lower pressure due to lower values
	Pressure Ulcers	Sigma	Apr-23	127			67	99	130	Special cause of concerning nature or higher pressure due to higher values
Maternity	Serious Incidents Maternity	Sigma	Apr-23	4			-3	3	9	Common cause (no significant change)
	Maternity Incidents Moderate / Sev...	Sigma	Apr-23	0			-3	2	8	Special cause of improving nature or lower pressure due to lower values
	Maternity Complaints	Sigma	Apr-23	12			-2	6	13	Special cause of concerning nature or higher pressure due to higher values
	Maternity Complaint Response	90.0%	Apr-23	25.0%			-31	47	125	Common cause (no significant change)
	Extended Perinatal Mortality	5.87	Apr-23	4.62			4	5	6	Special cause of improving nature or lower pressure due to lower values
	FFT Maternity Response Rate	5.0%	Apr-23	10.3%			3	9	14	Special cause of improving nature or lower pressure due to higher values
	FFT Maternity Recommended	90.0%	Apr-23	92.7%			83	91	100	Common cause (no significant change)
	FFT Maternity (IP) Recommended	90.0%	Apr-23	94.9%			82	92	103	Common cause (no significant change)
	Maternity Engagement Score	6.90	Apr-23	5.87			6	6	6	Special cause of concerning nature or higher pressure due to lower values
Finance	Efficiencies Green Schemes (£M)	40	Apr-23	0			2	12	22	Special cause of concerning nature or higher pressure due to lower values
	Efficiencies YTD Variance (£M)	0.0	Apr-23	-1.5			-8	-3	1	Special cause of improving nature or lower pressure due to higher values
	Premium Pay	Traj.	Apr-23	8,839			5,997	7,702	9,407	Special cause of concerning nature or higher pressure due to higher values

Programme Summaries

Leadership & Governance Programme

SRO: CEO

East Kent Hospitals University NHS Foundation Trust

Progress over last month:

- Achieved milestone of 50% substantive executives in post ahead of schedule with Chief Operating Officer (COO) and Director of Strategic Development and Partnerships (DSDP) appointments and recruitment to Chief Medical Officer (CMO) to commence shortly
- Substantive CNMO starting September 2023 with experienced interim in place
- Deputy Chief Finance Officer (CFO) acting up as CFO supported by Director of Financial Improvement
- First event held for the senior leadership Culture and Leadership Programme
- Extended Clinical Executive Management Team away day undertaken
- Over 100 leaders at team brief engaged in discussions on Culture and Leadership
- Consultation completed for the new clinical operating model restructure
- The planned start of the review and refresh of the governance model was delayed due to other key priorities but is still on track to be delivered as agreed
- Extended Clinical Executive Management Team away day undertaken
- Key stakeholders engaged in Maternity Round Table and second Reading the Signals Oversight Group meeting
- Caring with Compassion video created to be included in mandatory training for all
- Financial sustainability campaign led to 48 staff submitting financial savings ideas
- Single framework agreed to manage oversight and delivery of Pillars for Change and IIP through the We Care programme
- PMO has moved into the portfolio of the Executive Director for Strategy and Partnerships to give greater alignment with the improvement team

Key risks and issues:

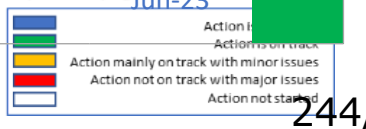
- Loss of focus on operational delivery due to the ongoing effect of the restructure
- Unsuccessful recruitment to the CFO Post - currently mitigated with the acting arrangement and additional support through the DFO and recruitment to deputy.

Plan for next month:

- Formal one to one consultations and planning of recruitment into posts
- Advertise CMO post
- Recruit cohorts to next leadership programmes and continue engagement

Leadership & Governance **Programme - - Product Milestones to end June**	Due	RAG
1. 1 Executive Leadership Team		
1.103: Review and refresh Executive Leadership Development Plan	Jun-23	
1.104: Current vacant or upcoming vacant Executive Director posts successfully recruited to	Jun-23	
1.2 Governance		
1.201: Review and refresh Governance Model to ensure it is aligned with the organisation restructure	Jul-23	
1.3 Communications and Engagement		
1.301: Outline Communications and Engagement Plan published	May-23	
1.302: Weekly roll out of key messages, feedback, quick wins and success stories	May-23	
1.4 Transformation Programme		
1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23	
1.404: Develop the Leadership Behavioural Framework	Jun-23	
1.405 Develop and adopt the Behavioural Code in Maternity	Jun-23	
1.406: Pilot "Civility Saves Lives" in Maternity	Jun-23	
1.407: Introduce a simple tool to assist staff to challenge poor behaviours	Jun-23	

Key: Delivery against plan



Maternity Programme

SRO: Chief Nurse and Midwifery Officer

NHS East Kent Hospitals University NHS Foundation Trust

Progress over last month:

- The Maternity Programme has been fully reviewed and milestones reset supported by a new SRO and new project leads with progress against milestones as set out below
- Governance and Patient Safety “No overdue Serious Incidents (SIs)/Healthcare Safety Investigation Branch (HSIB) investigations” is RAG rated Red with work ongoing to deliver this key milestone on a sustained basis
- Obstetric workforce demand and capacity review undertaken
- Good monitoring of doctor attendance / oversight in Triage
- Antenatal and Newborn Screening (ANNBS)/Fetal Medicine Unit (FMU)/USS Project Plan developed with multidisciplinary project group
- Postnatal Care and Discharge Processes project plan being delivered; Newborn and Infant Physical Examination (NIPE) bank shifts introduced to support timeliness of non-complex baby assessments / Neonatal Senior House Officer (SHO) oversight increased and improved at WHH; similar plan to be replicated at QEQM
- Venous thromboembolism (VTE) and Situation, Background, Assessment, Recommendation (SBAR) process mapping completed and improvement action log developed
- DoM/DDoM observation of handover processes with recommendations for improvement
- VTE / SBAR process mapping with supporting improvement action logs
- Monitoring of, and compliance with, Fresh Eyes as part of 'Stop the Clock' process
- Ongoing review of clinical escalation tools with recommendations based on outcomes
- Inclusion of development of emergency / enhanced maternal care in the MTP
- Launch of 'Lunch and Learn' events
- Launch of Safety Thread communications for sharing urgent safety messages
- YVIH Communications Plan in place
- Relaunch of Women's Health Patient Information Group
- Development of PD team model

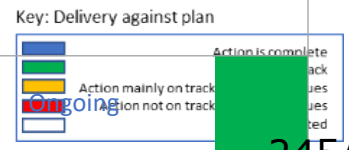
Key risks and issues:

- The vacancies in Midwifery are higher at the WHH site with the potential to impede progress
- Effective management of clinical escalation and Serious Incidents
- Ongoing reputational damage impacting staff recruitment and patient choice
- The suspension of Midwifery pre registration training impacting on the pipeline for recruitment

Plan for next month:

- Delivery of Postnatal and Discharge Processes Model
- Development of Maternity Engagement Framework
- Further planning to support full implementation of Birmingham Symptom Specific Obstetric Triage System (BSOTS)
- Review of methods / framework for sharing lessons learned

Maternity Programme - - Product Milestones to end June	Due	RAG
2.1 Team Working		
2.101: Ensure obstetric oversight of triage services is undertaken by an obstetric registrar in line with best practice	Jul-23	
2.2 Clinical Escalation and Handover		
2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE	ongoing	
2.3 Clinical Assessment & Care Pathways		
2.301: Agree model and implementation plan for improved discharge pathway	May-23	
2.302: Centralisation of telephone triage	Jul-23	
2.303: Implementation of discharge pathway	Jul-23	
2.4 Governance and Patient Safety		
2.401: 2.401: No overdue (breached) Sis / HSIB investigations	May-23	
2.5 Engagement, Listening & Leadership		
2.504: Demonstrable improvement that staff feel listened to (quarterly survey)	Ongoing	



Operational Performance Programme

SRO: COO

East Kent Hospitals University NHS Foundation Trust

Progress over last month

Urgent and Emergency Care (UEC)

- Good progress with continued signs of improved performance in Emergency Department (ED) Type 1 and all Types for April although this is variable and not yet sustained. Type 1: QEQM 39.7% , WHH 47.8% , All types 70.6%
- Roll out of Direct Access pathways for Medical SDEC /Surgery completed at WHH
- Medical Assessment Unit (MAU) and short stay acute medical ward pilot established at WHH with 65% of the medical take going directly to this area which is a significant step forward
- Virtual clinics Same Day Emergency Care (SDEC) with extended hours at WHH and Medical SDEC 7 days a week
- Direct Access Pathways and training for Medical SDEC/Surgical SDEC rolled-out at WHH with work in progress for Children's DAP to Clinical Assessment Unit (CAU)

Elective Recovery

- Some progress however Industrial Action has continued to adversely impact on planned elective position
- Ahead of trajectory for 52-week breaches however performance in April deteriorated compared to the March position
- Patient portal launched in April providing an opportunity to develop future patient communication and scheduling
- Two-way text messaging trial for admitted patients launched to ensure patients are fit, ready and able for planned treatment

Cancer

- Good progress April performance not yet validated but indicates ahead of trajectory
- Ongoing challenges associated with access to diagnostics and timely reporting
- Two-week referrals continue to be very high. Work is ongoing to better understand this drivers and to work to address this demand on an appropriate basis.

Plan for next month:

- Implementation of Direct Access Pathways (WHH) Medical Assessment Unit (MAU) and optimisation of the Surgical Assessment Unit (WHH)
- Re-design and roll-out of clinical model to QEQM (MAU, Direct Access pathways to SDEC and optimising SDEC opportunities)
- Revise and embed Planned Care Improvement Meeting
- Refine Theatre productivity and Outpatient transformation plans
- Agree Otology position with the ICB
- Review potential further Endoscopy improvement options

Key risks and issues:

- Kent and Medway system placed in Tier 1 for UEC performance
- Reduction in No Longer Fit to Reside (NLFTR) position to support emergency flow – ongoing work with Director of Integration to mitigate
- Compliance with 2023/24 activity plan at Trust level
- Diagnostic delays in cancer pathways
- Differential in Type 1 performance between WHH and QEQM associated with significant shortfall in staffing e.g. deficits ED & AMU consultant cover
- 78-week trajectory - capacity breaches due to ENT unplanned sickness absence (surgical impact from Jan 23 to Autumn 23)
- Further78 week breach risks in General Surgery/Colorectal/Gastroenterology due to scale of Endoscopy waiting list and limited capacity
- 62-day cancer performance risk due to continued diagnostic and reporting delays

Operational Performance Programme

SRO: COO

East Kent Hospitals University NHS Foundation Trust

Operational Performance Programme - - Product Milestones to end June	Due	RAG
3.1 Urgent and Emergency Care (UEC) and Whole System Interface Flow		
3.110: Direct Access Pathways launched in Respiratory, Gastroenterology and Cardiology with hot clinics established in SDEC	May-23	
3.111: Established pathways to the MDU at KCH (nurse led)	May-23	
3.112: QEQM Emergency Department Build Phase 3 started	Jun-23	
3.113: WHH End of Life Model Implemented	Jun -23	
3.2 Elective Recovery (including diagnostics)		
3.202: Business planning assumptions agreed by EMT and detailed speciality stretch targets articulated	May-23	
3.203: Trust Access Policy revised to incorporate clinical review policy and the new Kent and Medway Access Policy	May-23	
3.204: Out-patient transformation plan re-launched with key milestones and stretch targets for transformation including activity increases (1st OP) and decreases (follow-up)	Jun-23	

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Quality & Safety Programme

SRO: Chief Nursing and Midwifery Officer / Chief Medical Officer

East Kent Hospitals University NHS Foundation Trust

Progress over last month:

- The Quality and Safety Programme has been fully reviewed and milestones reset supported by a new SRO
- Progress has been made against multiple milestones with the exception of the launch of the NEWSs-2 e-learning module which was planned to be completed by the end of May
- Revised terms of reference for the SI Declaration Panel function and membership was approved at the May Patient Safety Committee.
- The revised complaints process is now in place and a self-assessment against the Dec 2022 Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards is underway to identify further actions to aid increased compliance
- Training has commenced for the Corporate and Care Group staff that manage the complaints process
- A review of the quality of the application of the DoC process has started and is due to be completed by end of July 2023.

Plan for next month:

- Ensure that up to date safeguarding policies are in place consistent with national guidance
- Review current fundamentals of care work streams
- Confirm the Deteriorating Patient Safety Improvement Project building on the current Trust improvement capacity

Key risks and issues:

- Backlog of SI's for closure and impact on learning
- Volume of incidents for review
- Business Intelligence capacity to support the programme
- Potential non compliance with intercollegiate document for the provision of safeguarding

Quality & Safety Programme -- Product Milestones to end June	Due	RAG
4.1 Quality Governance		
4.101: Define and describe a quality governance structure and framework for senior leaders to work within to support the delivery of safe, effective and compassionate care	Jul-23	
4.2 Quality Safeguarding		
4.201: Demonstrate sustainable safeguarding team workforce that is consistent with the requirements as outlined in the NHSE SAAF and statutory guidance.	tbc	
4.202: Demonstrate up to date safeguarding polices that are consistent with statutory guidance and NHSE SAAF requirements relating to both children and adults.	Jun-23	
4.3 Fundamentals of Care (FoC)		
4.301: Develop and Launch Dementia Strategy.	May-23	
4.302: Gap analysis of compliance with Accessible Information Standards.	May-23	
4.303: Review current FOC workstreams	Jun-23	
4.304: Review FoC delivery plans	Jul-23	
4.305: Publish FOC framework and KPIs	Jul-23	
4.306: Develop trajectory for further reduction in FoC incidents resulting in moderate harm and above	Jul-23	
4.4 The Deteriorating Patient		
4.401:Confirm The Deteriorating Patient Safety Improvement Project building on current Trust improvement capacity	Jun-23	
4.402: Launch NEWs-2 e-learning module	May-23	
4.403: Commence roll out of deteriorating patient education programme	Jul-23	
4.404: Deteriorating Patient Dashboard developed and shared with care groups	Jul-23	

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

People & Culture Programme

SRO: CPO

East Kent Hospitals University NHS Foundation Trust

Progress over last month:

- Progress continues to be made against planned milestones
- Across the Trust staff within specialties and teams were asked to review their local results and "Change three things" to make local improvements
- Draft recruitment strategy developed for review
- Recruitment trajectories developed
- Culture and Leadership Steering Group established and terms of reference signed off to support the implementation of the Culture & Leadership Plan (CLP) actions
- Trust has been released from the National support scheme for Healthcare Support Workers as a result of good progress being made
- Targeted work has been undertaken on hot spots for sickness absence with an aim to improve current performance of 4.3%
- Work in development for attraction campaigns for medical recruitment
- Specialist induction in place for all international recruits

Key risks and issues:

- Vacancy in information team may impact planned delivery of workforce dashboards
- Continued significant staffing deficits across the organisation in key clinical areas
- Impact of ongoing National Strikes
- Organisational restructure consultation

Plan for next month:

- Completion of remainder of speciality workforce plans
- Completion of workforce and recruitment strategy
- Detailed hard to recruit plan signed off
- Social media plan signed off and active
- Launch CLP campaign for change team recruitment
- Continue with engagement activities for CLP

People & Culture Programme -- Product Milestones to end June	Due	RAG
5.1 Attract and Retain		
5.101: Recruitment trajectories produced and progress monitored for IENs and HCSWs	May-23	
5.102: Workforce specialty developed plans linked to clinical adjacencies	Jun-23	
5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23	
5.104: Absence audit completed with analysis of outcomes	Jun-23	
5.105: Pastoral Care award	Jun-23	
5.2 Culture & Leadership Development		
5.208: Behavioural framework created	Jun-23	
5.3 Medical Workforce		
5.301: Medical attraction programme plan developed	Jun-23	
5.302: Digital and social media targeted recruitment	Jun-23	
5.303: Dashboard for medical attraction and trends built	Jun-23	

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Finance Programme

SRO: CFO

East Kent Hospitals University NHS Foundation Trust

Progress over last month:

- Progress has continued to be made against the planned milestones
- Financial and Efficiency Communications are ongoing with early signs of improved staff engagement. 48 staff have submitted ideas for financial savings
- Work has continued to agree Care Group plans, including agreeing the baseline budgets and efficiency targets
- Half day challenge sessions will have been undertaken with Executives and all care groups by the end of May to review current activity, workforce and finance against the pre-Covid position and to develop finance and Cost Improvement Programme (CIP) plans
- Ongoing joint ICB and Trust work to update the Financial Recovery Programme (FRP)
- Work started to reinvigorate budget holder training so that this is both robust and fit for purpose.
- Review of reporting for FY23/24 has commenced. Plan shortfall in M1 of £0.4m entirely driven by impacts of industrial action
- The 2023/24 CIP plan is not yet robust, significant work needed to meet July deadline

Key risks and issues:

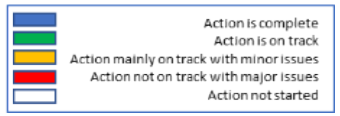
- Lack of embedded financial controls across the Trust
- Organisational restructure – potential loss of focus on finance
- Capacity constraints impacting the ability to deliver and drive the improvements and FRP modelling e.g. the Deputy FD post is vacant, interviews planned May 2023.
- Impact of ongoing Industrial action
- Estate and Kit constraints – access to necessary capital

Plan for next month:

- Ongoing work to re-establish financial controls across the Trust
- Development of CIP programme
- Care group oversight approach finalised and in place
- Model Years 1 & 2 of FRP whilst updating the overall FR

Finance Programme -- Product Milestones to end June	Due	RAG
6.1 Financial Governance		
6.102: Effective Care Group oversight approach in place	Jun-23	
6.103: Embed monthly finance reviews with Care Groups	Jun-23	
6.109: Joint Trust and ICB action plan re. Financial Recovery Plan (FRP) Development	Ongoing	
6.2 Financial Improvement		
6.202: Update deficit drivers analysis	May-23	
6.203: Model years one and two of FRP	Jun-23	
6.204: Update FRP document	Jun-23	
6.205: Fully develop FY24 efficiencies	Jul-23	
6.210: Input to Kent and Medway System Finance Work	Ongoing	
6.3 Financial Consciousness		
6.303: Regular communications on finance and efficiency	Ongoing	
6.304: Regular updates to and oversight by FPC & FIOG	Ongoing	

Key: Delivery against plan



Integrated Improvement Plan Communications and Engagement update - May

Progress update May 2023: Themes included maternity improvements and culture change

Engagement:

- Board development session on culture and leadership programme led by Michael West.
- Extended Clinical Executive Management Team engaged in development of the culture and leadership programme and integrated improvement plan at half day away day.
- Culture and Leadership and role of culture change champions, led by CEO and culture change director, featured at Team Brief in May and all staff forum (27 May).
- KCC's Health Overview & Scrutiny Committee updated on maternity improvement work by CEO, CNMO, CMO and DoM and East Kent MPs updated in regular engagement meeting.
- Caring with compassion video launched, will be included in mandatory training for staff.
- Reading the signals oversight group held 2nd meeting and discussed areas of focus.

Communications:

- Monthly rhythm of regular, clear and consistent communications for staff, public and stakeholders in place.
- Stakeholder newsletter provided update on maternity improvements.
- Internal comms celebrating staff achievements linked to improvements in IIP.
- Draft summary and narrative of Improvement Plan for staff and public in production.
- Diagnostic of care group comms and engagement started and survey under development.

Next steps (June)

- ➢ Reading the signals outreach to families in community.
- ➢ Publish summary of IIP and narrative to describe 3yr and 1yr aims.
- ➢ Launch Culture Change champion recruitment campaign and roll out engagement plan in line with culture change programme
- ➢ Continue to link patient and staff stories to improvement plan and use campaign approach to engage all staff in individual projects
- ➢ Continue to develop dashboard to report on reach and evidence of outcomes from engagement

Evidence of reach and outcomes

- ❖ Financial consciousness campaign throughout April resulted in 245 staff visiting submit your savings ideas portal on staff zone, translating into 48 ideas submitted and being explored by PMO.
- ❖ >100 leaders attended team brief in person, followed up by written brief sent to 270 Trust leaders to use in team meetings.
- ❖ Expressions of interest to become culture change champions already coming in from staff who want to be involved.
- ❖ Recently launched staff facebook getting average of 5k views per story

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**MONTH 1 FINANCE REPORT**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**INTERIM CHIEF FINANCE OFFICER (CFO)**				
PAPER AUTHOR:	**INTERIM CHIEF FINANCE OFFICER**				
APPENDICES:	**APPENDIX 1: M1 FINANCE REPORT**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The report is to update the Trust Board on the current financial performance.				
Summary of Key Issues:	The Group achieved a £0.4m deficit in April against plan. Activity was below plan for electives and outpatients. From the 1 April electives and outpatients (apart from follow ups) have been reinstated to payment by results. Efficiency achievement is still being reviewed and will be reported from month 2.				
Key Recommendation(s):	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.				
Implications:					
Links to 'We Care' Strategic Objectives: **Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further.					
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety	
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).				
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2022/23 efficiencies target equating to £30m. **CRR 136**: Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline.				
Resource:	N	Key financial decisions and actions may be taken on the basis of this report.			
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	None				

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

April 2023

Interim Chief Finance Officer
Michelle Stevens

Executive Summary
Month 12 (March) 2022/23

Executive Summary

The group achieved a £0.4m deficit in April against plan. Activity was below plan for electives and outpatients. From the 1st of April electives and outpatients (apart from follow ups) have been reinstated to payment by results.

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 post a small inflationary allocation. The rest of the ICB need to deliver a breakeven position to achieve the ICB target of £72m deficit. .

Delivery of this deficit plan for 2023/24 is a stretch for the Trust as it's 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.

Group Position

£'000	This Month Plan	This Month Actual	This Month Variance
EKHUFT Financial Position	**(9,127)**	**(9,619)**	**(492)**
Spencer Performance After Tax	0	(12)	(12)
2gether Performance After Tax	122	124	2
Rephasing/Sub IFRS16 Adjustment	0	0	0
Consolidated I&E Position (pre Technical adjs)	**(9,005)**	**(9,507)**	**(502)**
Technical Adjustments	51	128	77
Consolidated I&E Position (incl adjs)	**(8,954)**	**(9,379)**	**(425)**

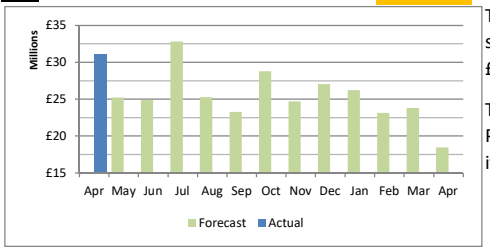
All NHS systems have access to funding in 2023/24 through the Elective Recovery Fund (ERF). The Trust has received funding to meet a threshold of 104% of 2019/20 activity levels, the Trust has submitted a plan that delivers 106% of the 2019/20 baseline. In April, the Trust underperformed against plan by £0.5m for eligible ERF elective and outpatient activity. The Trust has recognised the full financial risk of this position in April. However full guidance is expected in month 2 for ERF allocation.

Income and Expenditure R

Month 1 reporting shows a small deficit of £0.4m. Activity for month 1 is lower than plan likely due to the strike action. Further analysis is underway to understand the full impact of the activity which was stood down.

CIP delivery for month 1 is still being clarified in line with the care group sessions to approve the budget for 2023/24 in full

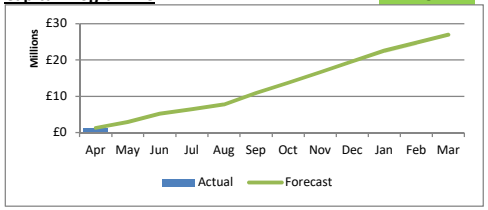
Cash A



The Group cash balance (including subsidiaries) at the end of April was £31.1m.

The Trust did not draw revenue PDC as working capital to support its in-month deficit

Capital Programme G



Total capital expenditure at the end of April was broadly on plan with a £1.3m spend against a plan of £1.2m plan.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BOD)**
REPORT TITLE:	**HEALTH & SAFETY (H&S) AND STATUTORY COMPLIANCE UPDATE**
MEETING DATE:	**1 JUNE 2023**
BOARD SPONSOR:	**INTERIM EXECUTIVE DIRECTOR OF STRATEGIC DEVELOPMENT AND PARTNERSHIPS**
PAPER AUTHOR:	**2GETHER SUPPORT SOLUTIONS (2GETHER) - MANAGING DIRECTOR** **2GETHER - ASSOCIATE DIRECTOR OF SAFETY** **2GETHER - ASSOCIATE DIRECTOR OF ESTATES**
APPENDICES:	**NONE**

Executive Summary:

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

Purpose of the Report:	This report provides an update to the Trust Board of Directors on the Trust's position in relation to the status and management of H&S, and estates statutory compliance.
Summary of Key Issues:	• The current cumulative Health and Safety Toolkit Audit (HASTA) score was 90% as of end March 2023. • Audits completed within 2022/23 for all Care Group and Corporate areas. Support being provided to Care Groups to enable improved outcomes for this financial and future years. • Redress of issues raised by the Care Quality Commission (CQC) with Kent Fire and Rescue around deficiencies in Queen Elizabeth the Queen Mother Hospital (QEQM) Maternity services. Progression being monitored at the Fire Safety Group. • Estate statutory compliance assurance level currently sits at c91.4%, a c3.4% improvement in quarter. Still working to achieve c95% as soon as practicably possible.
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the Trust's current position in relation to H&S, and statutory compliance, especially in respect to the prevailing risks.

Implications:

Links to 'We Care' Strategic Objectives:

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

Link to the Board Assurance Framework (BAF):	**Strategic Goal 4: Objective:** Develop a clinical strategy for the Trust that addresses key risks faced in terms of service delivery, workforce and estate condition (backlog and statutory compliance).

Link to the Corporate Risk Register (CRR):	**CRR 34**: Continuing to embed H&S systems within the Care Groups.	
Resource:	Y	The Trust allocated c£4.05m capital for 2022/23, most of which has all been assigned against urgent priority risk items. It should be noted that the funding made available in the budget period is lower than the level required to redress the historic under investment into the critical infrastructure as identified within the ARUP report in 2021. Any additional capital and future funding will be allocated based on output of ARUP Critical Infrastructure Risk Survey and joint risk workshops.
Legal and regulatory:	Y	• Health and Safety Legislation. • Estates legislative Statutory Compliance.
Subsidiary:	Y	2gether provides health and safety advice and guidance in line with the Service Level Agreement. 2gether also provides the Trust's hard facilities management services.
Assurance Route:		
Previously Considered by:	Strategic Health and Safety Committee has received the HASTA information table and other elements summarised in a report that is consistent with this report. The Strategic Capital Planning and Performance Committee, and Clinical Executive Management Group (CEMG) has received briefings and updates relating to Health and Safety and Statutory Compliance, backlog maintenance status.	

East Kent Hospitals University NHS Foundation Trust

HEALTH AND SAFETY & ESTATES STATUTORY COMPLIANCE UPDATE

1. Background and Executive Summary

1.1. This report updates the Trust Board of Directors on the Trust's position in relation to the ongoing management of Health & Safety, and the estates statutory compliance.

2. Health & Safety (H&S)

2.1 **HASTA:** Audits are scheduled throughout the year in all clinical and non-clinical wards and departments. Good audit results have been evident across most areas. Our overall Year-End (YE) score mirrored that of the previous year at c90%.

Overall, four Care Groups saw improvement in their in-year scores. Five Care Groups experienced reductions in their in-year scores:

- Women's Health experienced a significant drop from 91% - 79% (red rating). This reduction was in the main attributable to local leadership changes.
- QEQM particularly struggled due to staff turnover. Day surgery midwifery dropped from 100% – 55%, medical secretaries for Women's Health slipped from 72% - 63%, and Birchington dropped from 99%-45%.

Work is ongoing locally to help improve the current situation.

HASTA Score-Card	2020/21 Year end	2021/22* Year end	2022/23*
Cancer Services	90%	96%	91% ↓
Children's Health	99%	97%	98% ↑
Corporate Services	92%	91%	88% ↓
Clinical Support Services	96%	97%	95% ↓
General Specialist Medicine	87%	87%	90% ↑
Surgical & Anaesthetic	87%	84%	87% ↑
Surgery Head & Neck, Breast and Dermatology	93%	88%	98% ↑
Urgent and Emergency Care (UEC)	83%	80%	84% ↓
Women's Health	93%	91%	79% ↓
Trust Wide Totals	**91%**	**90%**	**90% --**

**Scores adjusted slightly due to new questions added regarding ligature and Covid Risk Assessment for the new financial year. This has affected previous scores due to the system administration adding the question sets to the previous year's scores also. There is a variance of 1-2% drop on scores previously reported.*

2.2 **Training**: In Q4 2022/23 the partnership has remained focused on delivering link worker training, via a combination of face to face and WebEx sessions. Other training that has taken place during this quarter includes:

a. First Aid at Work;
b. Institution of Occupational Safety and Health (IOSH) (managing safely);
c. IOSH (working safely);
d. Control of Substances Hazardous to Health (COSHH);
e. Fire Safety;
f. Risk Assessment Awareness.

2.3 In addition, a small number of ad-hoc training sessions have also been undertaken in regard to the risk assessment process and HASTA folder Support. These were within the link workers working environment and were in the form of a walkthrough / talk through of an actual risk assessment the link worker needs to undertake. These have proved to be popular and well regarded and the H&S team are looking at ways of expanding this work in the future.

The safety team are looking at how COSHH training is being delivered and how it can be improved. Additional suppliers are being sought via the Learning and Development department.

2.4 **H&S Team Support:** The Safety Team has been engaged in numerous areas of support across the Trust, in general this has involved accident investigations, assistance and support for risk assessments in areas such as Nitrous Oxide use and Emergency Department (ED) corridor bed usage, as well as involvement in the numerous building projects across the whole of the estate. Additional Support has included supporting external areas affected by new EDs, locations of mobile scanners, and patients in corridors.

There has also been a drive from the safety team supporting Personal Emergency Evacuation Plan (PEEP) assessments across the various sites, disability access, Display Screen Equipment (DSE) support with special attention supporting home working and ligature meetings.

2.5 **Trust H&S Leads:** It should be noted that the Trust H&S Leads continue to work well to embed H&S standards in their Care Groups. There are currently two gaps in the H&S Leads, Cancer and UEC for Kent & Canterbury Hospital (K&C) and Buckland.

2.6 **Working Together:** Both the 2gether and Trust H&S teams continue to work together to ensure continued compliance against the HASTA framework. HASTA outcomes will be monitored via monthly H&S meetings chaired by the Intelligent Client function. Formal quarterly compliance reports are presented to the Strategic Health and Safety Committee.

3. RIDDOR reports 2023

3.1 During Qtr 4 2023/24 budget period, the Trust raised 8 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) events with the Health and Safety Executive (HSE).

3.1.1 January – 4 events: two slips, one trip over cable and one as a result of patient pushing the staff member over.

3.1.2 February – 3 events; all falls, one snow related, one fall in an office - possibly over a chair leg, and a third due to a staff member tripping whilst running.

3.1.3 March – 1 event; member of staff absent from work for more than seven consecutive days.

The HSE have recently intervened in regards to some late reporting of incidents. An investigation identified that late reporting with the HSE is generally caused by late reporting of incidents in the first instance or lack of information and responses to investigations. The Safety team are working to support teams with their reporting and to try and improve these timescales with awareness and training.

4. Fire Safety Update

4.1 **Fire Safety Governance:** The Joint EKHUFT and 2gether Fire Safety Group (FSG) continues to meet on a monthly basis. The Group monitors and tracks topics including fire safety compliance, the fire safety plan and fire training.

4.2 **Fire Safety Plan:** The joint Fire Safety Plan has seen generally good progress across the 4 quarters, with some areas not achieving most notably an annual Authorising Engineers Audit, completing sufficient fire evacuation drills, and the review of the fire policy which will need to reflect the revised organisational structure. Emergency Fire Procedures have been reviewed at Buckland Hospital Dover (BHD) and Royal Victoria Hospital (RVH) but require the Trust to designate suitable nominated persons to take charge.

4.3 **Fire Risk Assessments and support:** There has been very good compliance with fire risk assessment this quarter, with 100% of all risk assessments completed by 2gether in time. There is active tracking and reporting of risk-based actions that arise from the fire risk assessments. There continues to be professional support and advice for fire safety provided to EKHUFT in areas such as corridor usage, fire safety management and regulatory body findings - currently the lack of storage in parts of the estate is leading to a level of risk being applied to the safe management of evacuation corridors and fire street. 2gether are also currently carrying out a survey of all fire doors across the estate post the recent Care Quality Commission (CQC) visits.

4.4 **Fire Training:** There have been good levels of e-learning fire training in the quarter with levels across the Trust standing at 88.4%. However, recent engagement has identified inconsistencies across clinical groups in respect to the day to day application of this learning. To comply with National guidance, we would strongly recommend that the existing on-line training course be complimented with a level of face to face engagement through 2023/24.

4.5 **Fire inspections:** There was one formal audit under the Fire Safety Order for the QEQM maternity unit by Kent Fire and Rescue on the 9 March 2023; following concerns being raised by CQC. A number of minor deficiencies were identified, they were not subject to any enforcement action. Kent Fire and Rescue update the CQC directly of their inspection finding. There is joint action plan set up to address the issues raised with 2gether monitored on a monthly basis at the FSG.

Kent Fire and Rescue Service (KFRS) has advised on the siting of scanners and other mobile units. Due to the possible risk of fire the revised location guidance has been set to 10m away from buildings where practicably possible.

5 Risk & Mitigation

The following table provides an overview of the current risk, mitigation, and planned activity.

Risk Identified	Current Mitigation	Planned/Scheduled Activity
Patient care in corridors particularly in EDs at William Harvey Hospital (WHH) and QEQM.	Revised escalation plan distributed to EKHUFT managers. Revised procedures produced and communicated. Daily checks by safety team at WHH and QEQM. Risk Assessments undertaken.	Plan to reduce corridor care to an absolute minimum. Monitoring of situation within EKHUFT continues at gold calls (three times a week at present).
Lack of fire drills over the last few years (significantly affected by staffing levels and Covid).	Fire training and procedures.	Table top and actual fire drills will be scheduled in the forthcoming year. New Fire Advisors to support with delivery.
Lack of Annual Audit by Authorising Engineer (fire).	Fire Safety Group monitoring issues on a monthly basis.	Authorising Engineer should be appointed by June and an audit / gap analysis to be instructed and carried out in quarter 3.
Gaps in assurance and support to face to face training (e-learning monitored and completed at present).	Some ad-hoc face to face training has been arranged and delivered, especially where clinical staff need support around understanding of fire safety obligations.	Fire training programme for 2023/24 includes plans for face to face training. Two new Fire Safety Advisors recruited to support team to deliver training by quarter 3.
Proximity of scanners to existing building less than revised KFRS guidance.	Review of all sites underway and revised positions being reviewed.	Once the final positions agreed with all parties on each site, risk assessments and consultations with KFRS to commence lead by Fire Safety Manager.

6. Estates Statutory Compliance

6.1 Work continues in respect to improving the overall statutory compliance levels within the estate. The review of the existing compliance reporting platform remains ongoing. At this point we are working to establish a plan to develop the existing infrastructure to meet industry best practice. All statutory compliance figures captured within this report cover inspection and test only, not remediation status.

6.2 The overarching statutory compliance assurance level currently sits at 91.4%, an increase of c3.4% on the figure reporting in March. We continue to face challenges in respect to the time taken to complete Pressure Systems Safety Regulations (PSSR) insurance inspections, 5 year fixed wire testing, underground oil line pressure testing

and 11Kv lightening protection earthing. 6-monthly fire door inspections are near completion. We are working to achieve c95% compliance by September 2023.

6.3 The priority for statutory compliance inspections remains in line with previous reported items, these being; water safety, electrical improvements and fire safety maintenance activities.

6.4 We continue to manage the risk associated with the areas of shortfall; at this juncture we are expecting to hit the c95% level sometime between June and September, dependent on specialist works completion and possible ancillary funding requirements.

6.5 We have recently completed a tender process to assign new Authorising Engineers (AE's) across the service. We are aiming to appoint AE's for Water, Power, Pressure systems, Fire, Medical Gasses, Lifts in June 2023.

7.0 Critical Infrastructure/Backlog Maintenance

7.1 Post the publication of the ARUP Critical Infrastructure Report in 2021 work has continued to try and redress various technical systems shortfall that remain prevalent within the estate. Our technical leadership continue to review backlog maintenance priorities for each site; all items have been risk scored in conjunction with the support of the Hospital Leadership Teams, the Director of Infection Prevention and Control (DIPC), and Deputy to prioritise patient safety. A combination of these processes gives a final risk allocation for use by the Patient Environment and Investment Committee (PEIC).

7.2 To date the Trust has allocated an average of c£3.5m annually toward this area of risk; c50% of the level required to manage the prevailing risk at this point in time. Whilst discussions remain ongoing, it is our understanding that c£1.3 is planned to be allocated in the 2023/24 budget period. An additional c£3.3m+/- is scheduled to be spent on key part of the infrastructure required to ensure new clinical areas such as the EDs at both the WHH & QEQM may operate safely.

8.0 Risk Management & Mitigation

8.1 The current compliance reporting model remains under development as part of a wider piece of work designed to improve the technical assurance levels within the estate. At this point the existing statutory compliance management process remains inconsistent, mainly due to the fact that the current Planet CAFM system is not fully utilised. Work remains ongoing to redress the current management process shortfall. An interim compliance reporting model will be utilised until a suitable resolution can be achieved.

Action Requested

The Board of Directors is asked to discuss and **NOTE** the Trust's current position in relation to H&S, and statutory compliance, especially in respect to the prevailing risks.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**WE CARE PROGRESS UPDATE - 2023**				
MEETING DATE:	**1 JUNE 2023**				
BOARD SPONSOR:	**CHIEF PEOPLE OFFICER**				
PAPER AUTHOR:	**HEAD OF STAFF EXPERIENCE**				
APPENDICES:	**NONE**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report gives a progress update on the impact of We Care on Staff Engagement levels as measured through the 2022 National Staff Survey (NSS). It provides an overview of the impact of We Care across six 'waves' as well as benchmarking against areas where We Care has yet to be implemented.				
Summary of Key Issues:	This report follows an initial paper brought to Board in October 2022, which provided early insights into the effectiveness of We Care as a programme to drive staff engagement levels. It is based on the latest data from the NSS which took place between September and October 2022 – and crucially on a credible 4023 responses. The roll-out of We Care to front-line teams has been conducted in 'waves' and the continued rollout means that six waves can now be analysed – a total of 602 respondents from We Care areas. The below is a summary of the key findings: ▪ Staff engagement (SE) levels are higher in We Care areas (6.50) than their non-We Care counterparts (6.32). ▪ Staff engagement levels in We Care areas are also, on average, 15 points higher than the Trust average (6.35). ▪ When a known outlier (wave 3) is removed, this gap widens to 35 points, with SE for We Care growing to 6.67 (vs. 6.32). ▪ Of the six We Care waves, four (67%) score significantly better for staff engagement than the Trust average. ▪ Data no longer supports the assertion that SE improves in a stepwise manner over time as was previously hypothesised. ▪ Instead, SE levels have remained largely the same in waves 1-4 and are, in fact, higher in waves 5 & 6. ▪ This appears to suggest the programme initiates a 'bounce' in SE that needs continued efforts to sustain. ▪ Wave 3 (maternity) continues to represent an outlier – the evidence of which can continue to be seen in the report. ▪ Overall, levels of motivation and advocacy are 15 and 43 points higher respectively in We Care areas than their non-We Care counterparts. ▪ Curiously, this is not the case for involvement, which scores marginally (3 points) lower (6.41 vs 6.44) in We Care areas than those not involved. ▪ This is primarily driven by low levels of involvement in maternity, but also by low scores against 'I am able to make				

	improvements happen in my area of work' and warrants further investigation to be fully understood. ▪ The ability to make improvements happen in your area of work is marginally higher in We Care areas (48.8%) than non-We Care areas (48.4%), but this is driven by wave 5 (60.8%) and 6 (56.3%) as the remaining four We Care areas actually score lower than the Trust average against this. ▪ All We Care areas (minus maternity) score at or above the Trust average for recommending the organisation as a place to work. ▪ In fact, overall advocacy is 62 points higher in We Care areas (when wave 3 is omitted) than non-We Care. ▪ Five of the six We Care areas also score significantly ahead of the Trust average for care representing our top priority. ▪ Overall, SE levels are higher in We Care areas than their non-We Care counterparts. These findings give greater clarity to the impact of We Care on SE, with a sample of 602 colleagues in We Care areas against 3421 in non-We Care areas. The gives more credence to the findings that earlier reports. The headlines are that overall staff engagement is higher in We Care areas, as are the domains of motivation and advocacy. There is a concern that levels of involvement (a central tenet of We Care) don't follow this trend, and that colleagues in We Care areas feel somewhat less able to make improvements happen in their area of work. This will require further exploration to be fully understood. The hypothesis that SE improves in a stepwise manner over time appears to have been disproven – with it instead more likely the approach initiates a 'bounce' in SE that requires continued effort and attention to sustain.
Key Recommendation(s):	It is recommended to the Board of Directors that: • a post-implementation review of We Care is undertaken to appraise both strengths of the programme and to identify any potential areas for improvement. • this take place across each of the waves as the evidence appears to indicate differences in outcome over time, using a cross-section of roles to more fully understand the impact. • the findings of this review are provided alongside repeat analysis against staff engagement outcomes following the 2023 National Staff Survey.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 35** – There is a risk of failure to recruit and retain high calibre staff.			
Link to the Corporate Risk Register (CRR):	**CRR 118** -There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. 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	

East Kent Hospitals University NHS Foundation Trust

WE CARE PROGRESS UPDATE - 2023

1. Purpose of the report

1.1 This report gives a progress update on the impact of We Care on Staff Engagement levels as measured through the 2022 National Staff Survey (NSS).

1.2 It provides an overview of the impact We Care has had in the 34 front-line areas it has been implemented within, across six time-points, as well as benchmarking against areas where We Care has not yet been implemented.

2. Background

2.1 We Care is the Trust's long-term approach to transforming hospital services for the better. It is a process of continuous improvement and is ultimately about empowering front-line staff to make improvements themselves – by providing the training, tools, skills, support and freedom to make change happen.

2.2 It is based on proven improvement methodologies, most notably the principles of continuous improvement and the Lean approach to management. It was adapted successfully for use in healthcare by organisations such as Thedacare and the Virginia Mason Medical Center.

2.3 The methodology has been successfully implemented in a number of organisations in the NHS including Western Sussex Hospitals, where it is known as 'Patient First'.

2.4 The reason for implementation at East Kent Hospitals is because there is overwhelming evidence that patients receive better care in organisations where staff are engaged and feel able to make a difference. This report intends to determine whether We Care is helping us to achieve this.

3. Context & Limitations

3.1 In 2022, work was conducted to transform locality levels at which the National Quarterly Pulse Survey (NQPS) could be reported. This meant that staff engagement could be explored at a Ward or 'unit' level for the very first time. This was reported at Board in October 2022.

3.2 The Trust has since been able to explore staff engagement levels via the NSS at this more granular (Ward or Departmental) level.

3.3 It must be acknowledged however that comparative analysis between We Care and non-We Care areas be undertaken with a degree of care as we are comparing 602 respondents against 3421 respectively, with each of those in We Care at different stages of the programme.

3.4 The updated report is able to compare We Care against non-We Care areas, to review the hypothesis around a stepwise improvement over time (by wave) and whether there are specific facets (i.e. motivation, involvement or advocacy) which appear to see more pronounced change.

4. Findings

4.1 The first and most significant finding was that staff engagement levels appear to be significantly higher in We Care areas (6.50) than their non-We Care counterparts (6.32).

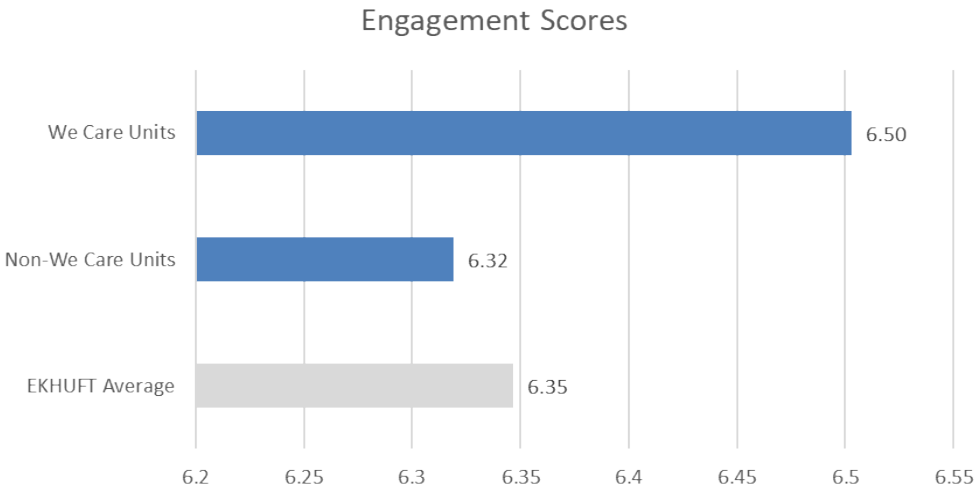


Figure 1: Average Staff Engagement Levels; We Care vs. non-We Care units

4.2 Staff engagement levels are also 15 points higher in We Care areas than the Trust average (6.35). This can be seen in **Figure 1**.

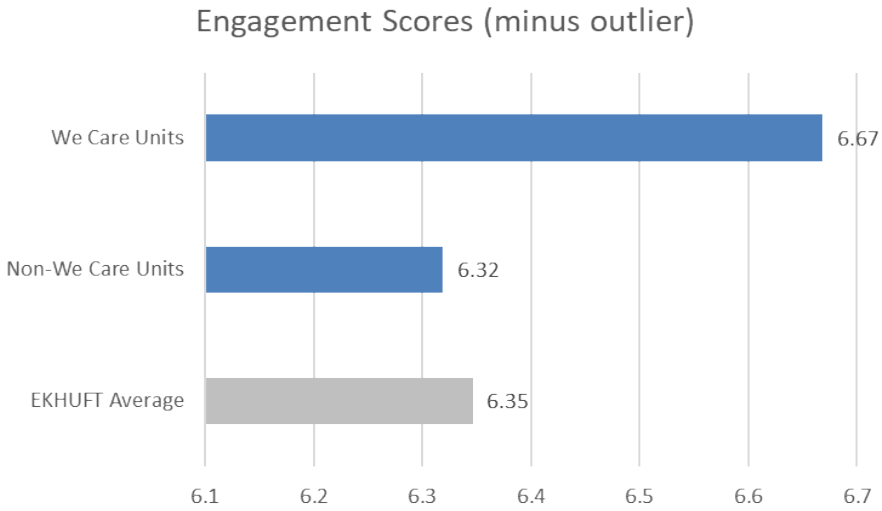


Figure 2: Staff Engagement Levels; We Care vs. non-We Care units (minus wave 3)

4.3 As can be seen in Figure 2, the average staff engagement score for We Care areas grows considerably to 6.67 – and the gap to non-We Care areas widens to 35 points when a known outlier (wave 3) that is somewhat skewing the data is removed.

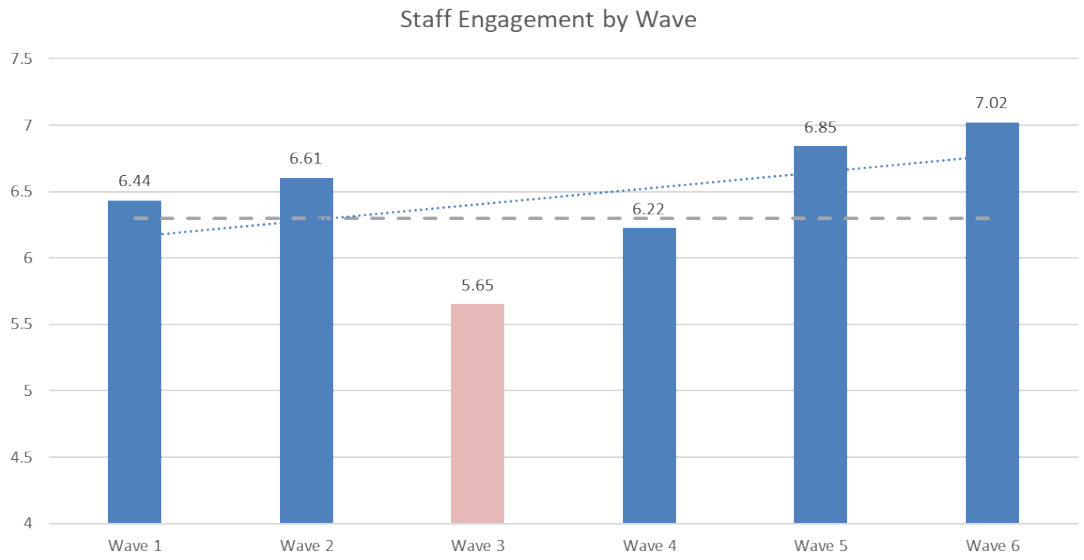


Figure 3: Staff Engagement Levels by We Care wave

4.4 Of the six We Care waves, four (67%) score significantly better for staff engagement than the Trust average (6.35) – as can be seen in **Figure 3**.

4.5 However, it was previously asserted that staff engagement improved in a stepwise manner over time based on the early We Care data. This hypothesis appears to have been refuted, with the latest body of evidence indicating this is not the case. The trendline, in fact, shows the opposite. Instead, it appears that We Care initiates a 'bounce' in staff engagement that needs continued effort and attention to be sustained.

4.6 **Figure 3** illustrates that staff engagement levels have remained largely the same in waves 1-4, and are, in fact, higher in the newer waves 5 & 6. The We Care Awards form part of a continued support and recognition offer to teams that have had the initial training in the We Care methodology – and encourages them to continue with their We Care practice. The evidence appears to indicate that further support or encouragement is necessary in order to sustain continuous improvements.

4.7 Maternity is a known outlier, both locally and nationally. The results continue to indicate that wave 3 (Maternity services in red) remains a prominent outlier, with engagement levels largely unchanged since the last report. For this reason, wave 3 has been omitted from one of the above averages as it negatively skews the data in a comparatively small sample.

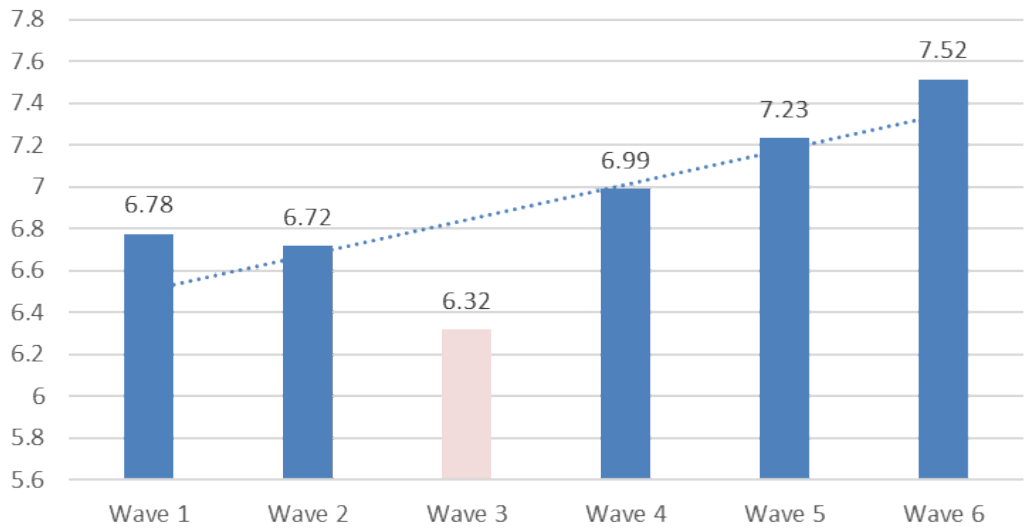


Figure 4: Staff Motivation Levels by We Care wave

4.8 Motivation forms one of the three domains of staff engagement. Staff motivation levels appear to be the domain most positively impacted by the We Care programme. Figure 4 illustrates that this is most pronounced in the early phases or more immediately following the training, with motivation levels then declining over time. Consideration needs to be given to how teams continue to receive support and encouragement to maintain this early motivation.

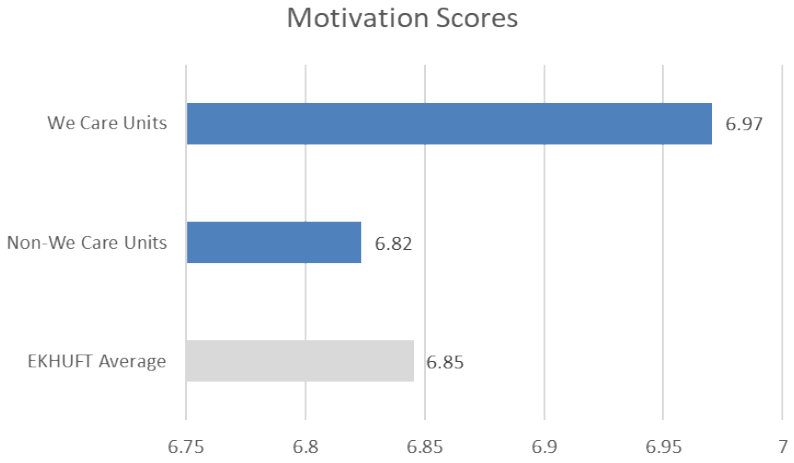


Figure 5: Staff Motivation Levels; We Care vs. non-We Care units

4.9 When measured as an overall average, staff motivation levels are 15 points higher in We Care areas (6.97) than their non-We Care counterparts (6.82).

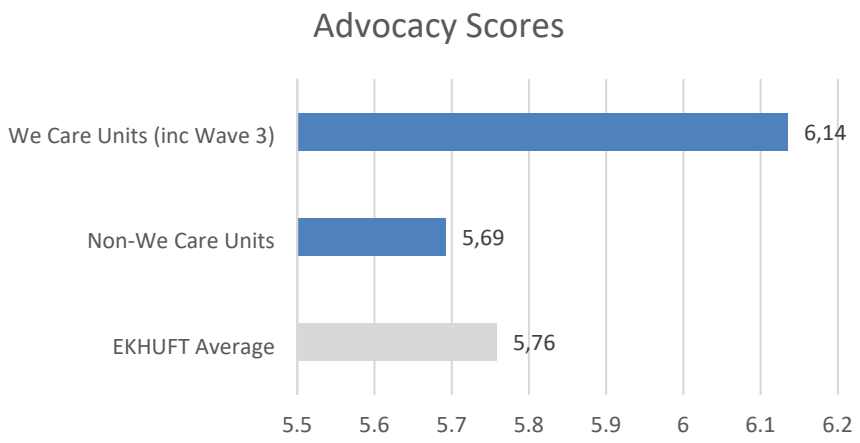


Figure 6: Staff Motivation Levels; We Care vs. non-We Care units

4.10 When measured as an overall average, advocacy levels are 45 points higher in We Care areas (6.14) than their non-We Care counterparts (5.69). Given that improving advocacy represents an organisational level priority, the scale of impact We Care appears to have in this space ought not to be underestimated. In addition, advocacy does not appear to deteriorate over time in the same way as motivation levels – suggesting that this programme may be an integral part of a solution to the challenge of building advocacy.

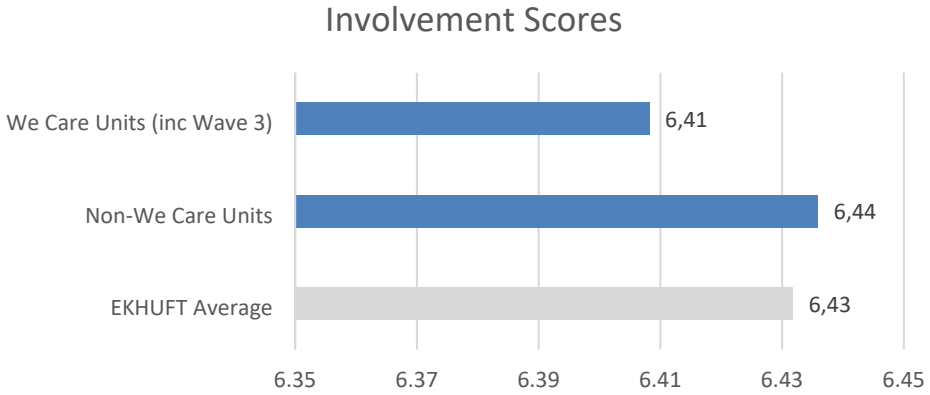


Figure 7: Staff Involvement Levels; We Care vs. non-We Care units

4.11 Somewhat concerning is that involvement does not follow this same trend. It forms part of the central tenet of We Care – asking staff to identify opportunities for positive, sustainable change, and giving them the skills and support to make that change happen. However, the latest data (**Figure 7**) indicates that staff involvement was actually lower in We Care areas (6.41) than their non-We Care counterparts (6.44). It is recommended that this is explored further in order to be better understood.

4.12 That involvement does not appear higher in We Care areas is somewhat driven by low levels of involvement in maternity (wave 3), but also by low scores against 'I am able to make improvements happen in my area of work' in four of the six waves (1, 2, 3 and 4) and warrants further investigation to be fully understood.

4.13 The ability to make improvements happen in your area of work is marginally higher in We Care areas (48.8%) than non-We Care areas (48.4%). It is higher (52.6%) when wave 3 is omitted, but this is driven by wave 5 (60.8%) and 6 (56.3%) - with the remaining four We Care areas actually scoring lower

than the Trust average. This represents a cause for concern in a programme centred around driving continuous improvement.

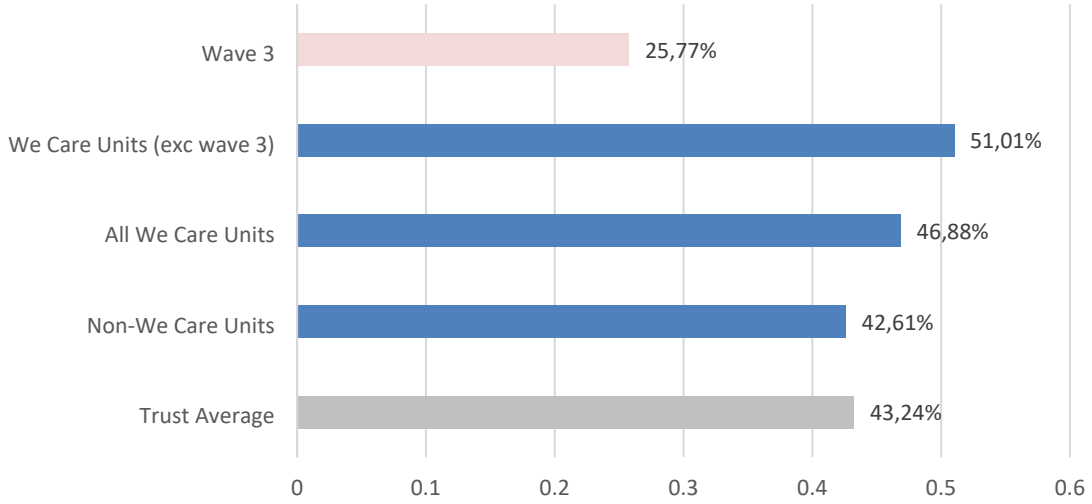


Figure 8: Would recommend the organisation as a place to work

4.14 **Figure 8** gives insight to the percentage of colleagues who would recommend the organisation as a place to work. This is highest in We Care units (specifically when wave 3 is omitted) and lowest in wave 3 and non-We Care areas. Since these areas form the majority of the organisation, this drives down the Trust average. A key finding from this report is the impact We Care has on advocacy overall – and specifically on the extent to which people would recommend East Kent Hospitals as a place to work.

5. Conclusion

5.1 The main finding of this report is that staff engagement levels are considerably higher in We Care areas than their non-We Care counterparts.

5.2 Previous assertions around engagement improving in a stepwise manner over time depending on duration of involvement with We Care have been refuted

5.3 Instead, We Care appears to have a more immediate impact on staff engagement (specifically motivation levels), which deteriorates over time. Consideration needs to be given to how this can be maintained.

5.4 Advocacy levels are considerably higher in We Care areas. Given this represents one of the areas the Trust is furthest from the national average on and where closing this gap has been placed as an urgent organisational priority, consideration ought to be given to how We Care can enhance this.

5.5 Staff involvement levels are marginally lower in We Care areas than their non-We Care counterparts. Given this represents a central tenet of We Care, it is recommended that this be further explored to better understand.

5.6 It is suggested that when this analysis takes place, there is a focus on tracked *change*, rather than overall score, with the working hypothesis that 'areas involved in We Care should demonstrate more pronounced change or improvement' as a result of the associated work.

5.7 It is recommended that a post-implementation review of We Care is now undertaken to appraise strengths of the programme (motivation and advocacy) and to identify any potential areas for improvement (involvement).

5.8 It is recommended that this take place across each of the six waves using a cross-section of roles to more fully understand the impact.

5.9 Finally, it is suggested that the findings of this post-implementation review are provided alongside a repeat analysis against staff engagement outcomes following the 2023 National Staff Survey.