Board of Directors - Open Meeting (Thursday 25 July 2024)

Thu 25 July 2024, 01:00 PM - 04:40 PM

Webinar teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:10 PM
10 min

24/36
Welcome and Apologies for Absence

To Note *Acting Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

24/37
Confirmation of Quoracy

To Note *Acting Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

24/38
Declaration of Interests

To Note *Acting Chairman*

24-38 - Board of Directors register of interests - June 2024.pdf (3 pages)

01:10 PM - 01:10 PM
0 min

24/39
Minutes of Previous Meeting held on 6 June 2024

Approval *Acting Chairman*

24-39 - Unconfirmed BoD 06.06.24 Open Minutes.pdf (14 pages)

01:10 PM - 01:10 PM
0 min

24/40
Matters Arising from the Minutes on 6 June 2024

Approval *Acting Chairman*

24-40 - Front Sheet Open BoD Action Log.pdf (4 pages)

People

01:10 PM - 01:40 PM
30 min

24/41
Staff Experience Story

Discussion *Chief People Officer (CPO)*

- 24-41.1 - Front Sheet Staff Story Board EDI July 24.pdf (2 pages)
- 24-41.2 - App 1 Staff Story Board EDI July 24.pdf (4 pages)

REGULATORY AND GOVERNANCE

01:40 PM - 01:45 PM
5 min

24/42
Acting Chairman's Report

Information *Acting Chairman*

- 24-42 - Acting Chairman BoD Report July 2024.pdf (2 pages)

01:45 PM - 01:55 PM
10 min

24/43
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 24-43 - CEO Report Board July 2024.pdf (3 pages)

01:55 PM - 02:25 PM
30 min

24/44
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 24-44.1 - Front Sheet June IPR.pdf (4 pages)
- 24-44.2 - App 1 Board IPR_v6.0_Jun 24.pdf (47 pages)

24/44.1
Month 3 Finance Report

Information *Director of Finance*

- 24-44.1.1 - Finance Report M3 202425 front sheet Board.pdf (2 pages)
- 24-44.1.2 - App 1 Finance Report M3 202503 Board SHORT.pdf (6 pages)

02:25 PM - 02:35 PM
10 min

24/45
Report on Journey to Exit NHS Oversight Framework (NOF4) and Integrated Improvement Plan (IIP)

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

- 24-45.1 - Front Sheet IIP Progress Report 12.07.24.pdf (2 pages)
- 24-45.2 - App 1 Board IIP Report FINAL 15.07.24.pdf (8 pages)

02:35 PM - 02:45 PM
10 min

24/46
NHS Kent and Medway (K&M) Integrated Care Board (ICB) Strategy

Discussion *Chief Executive / CSPO*

Verbal

02:45 PM - 02:55 PM

24/47

10 min

Risk Register Report

Assurance *Chief Nursing and Midwifery Officer (CNMO)*

- 24-47.1 - Risk Report Board of Directors Public July 24 V4 160724.pdf (29 pages)
- 24-47.2 - App 1 Risk Management 8.23.24 FINAL EKHUFT.pdf (26 pages)

02:55 PM - 03:05 PM
10 min

TEA/COFFEE BREAK 2:55 - 3:05 (10 MINS)

Patients - Quality and Safety - Partnerships - Sustainability - People

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03:05 PM - 03:40 PM
35 min

24/48
Board Committee - Chair Assurance Reports:

Board Committee Chairs

24/48.1
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3.05 pm to 3.15 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

- 24-48.1 - QSC Chair's Report May June.pdf (7 pages)

24/48.2
Finance and Performance Committee (FPC) - Chair Assurance Report (3.15 pm to 3.25 pm)

Assurance *On behalf of Chair FPC - Claudia Sykes*

- 24-48.2.1 - FPC Board Report 31 May 2024.pdf (4 pages)
- 24-48.2.2 - FPC Board Report 25 June 2024.pdf (4 pages)

24/48.3
People and Culture Committee (P&CC) - Chair Assurance Report (3.25 pm to 3.35 pm)

Assurance *Chair P&CC - Claudia Sykes*

- Equality, Diversity and Inclusion (EDI) (EDI is now a standing item on this committee/board meeting as part of NHSE Equality Delivery System and so EDI can be considered in all meetings and key decisions. Please discuss and consider how this meeting/decision may impact EDI and record this e.g. have an adverse or positive impact on staff or patients with protected characteristics e.g. race, age, disability etc.)

- 24-48.3 - PCC Board report 25.7.24.pdf (2 pages)

24/48.4
Charitable Funds Committee (CFC) - Chair Assurance Report (3.35 pm to 3.40 pm)

Assurance *Chair CFC - Claudia Sykes*

- 24-48.4 - CFC Board report 25.7.24.pdf (1 pages)

Patients - Quality and Safety

03:40 PM - 03:50 PM
10 min

24/49
Care Quality Commission (CQC) Update Report

Discussion *CNMO*

24-49 - Board CQC Report July 2024 v2 Final.pdf (15 pages)

People

03:50 PM - 04:10 PM
20 min

24/50
Culture and Leadership Programme (CLP) Update

Information *CSPO*

24-50.1 - CLP update Board July 24.pdf (4 pages)
24-50.2 - App 1 CLP Immediate actions delivery plan.pdf (1 pages)

04:10 PM - 04:20 PM
10 min

24/51
Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report

Assurance *CNMO / Director of Midwifery (DoM) / Managing Director - Women's and Children's Health*

24-51.1 - BoD Overarching MNAG report - July 2024.pdf (7 pages)

04:20 PM - 04:20 PM
0 min

FOR INFORMATION

04:20 PM - 04:20 PM
0 min

Patients - Quality and Safety

04:20 PM - 04:20 PM
0 min

24/52
Patient Safety Incident Response Framework (PSIRF) for 2024/2025

Information *CNMO*

24-52.1 - Board Front Sheet PSIRF 16.07.2024.pdf (2 pages)

CLOSING MATTERS

04:20 PM - 04:25 PM
5 min

24/53
Any Other Business

Discussion *All*

Verbal

04:25 PM - 04:40 PM
15 min

24/54
Questions from the Public

Discussion *All*

Verbal

- **Questions from the public - questions to be submitted in advance of meeting by 12.00 noon the day before meeting is held**

Date of Next Meeting: Thursday 3 October 2024

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JUNE 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ASHMAN, ANDREA	Chief People Officer	None	Appointed 1 September 2019
BAIRD, STEWART	Acting Chairman	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)** 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	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)** School Governor, Twyford School (Winchester) **(4)**	1 October 2022 (First term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
GLENN, TIM	Interim Chief Finance Officer	Chief Finance Officer and Deputy Chief Executive, Royal Papworth Hospital NHS Foundation Trust (substantive role – on secondment to East Kent Hospitals) **(1)**	6 November 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JUNE 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HODGKISS, ROB	Interim Chief Operating Officer	None	2 January 2024
HOLDEN, DES	Chief Medical Officer	International Advisor, Public Intelligence (Denmark) **(5)** (2018) Advisor/Non-Executive Director, South East Health Technology Alliance **(4)** (2017) Visiting Professor, Clinical and Experimental Medicine, University of Surrey **(5)** (2023 to 2026)	2 January 2024
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Executive Chairman, TL First Group (started 9 May 2020) **(3)** Chairman, Governance and Leadership Academy UK (started 11 September 2018) **(1)** Non-Executive Director, Priory Care Group (started 1 June 2022) **(1)** Independent Chair of Audit and Governance, London Borough of Croydon (started 1 October 2021) **(4)**	1 April 2021 (Second term)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JUNE 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)
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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY EIGHTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 6 JUNE 2024 12.45 PM HELD IN THE CONFERENCE ROOM, EDUCATION CENTRE, KENT AND CANTERBURY HOSPITAL & WEBINAR TELECONFERENCE

PRESENT:

Mr S Baird	Acting Chairman (meeting Chair)	SB
Ms A Ashman	Chief People Officer (CPO)	AA
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair/Nominations and Remuneration Committee (NRC) Chair	AC
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common (left at 3.15 pm)	SC
Ms T Fletcher	Chief Executive (CE)	TF
Mr T Glenn	Interim Chief Finance Officer (CFO)	TG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Mr R Hodgkiss	Chief Operating Officer (COO)	RH
Dr D Holden	Chief Medical Officer (CMO)	DH
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/ Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair	OO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals Oversight Group* Chair/People & Culture Committee (P&CC) Chair	CS

ATTENDEES:

Mr M Blakeman	Improvement Director, NHS England (NHSE)	MB
Mr K Desai	Director of Corporate Governance (DCG)	KD
Ms C Doran	Quality Lead, East Kent Health & Care Partnership (HCP)	CD
Ms K Edmunds	Associate Director of Patient Experience (minute number 24/023)	KE
Professor C Holland	Associate NED	CH
Ms C Maynard	Head of Nursing (Cancer, Clinical Haematology and Haemophila) (minute number 24/023)	CM
Ms A Smith	Deputy Director of Midwifery (DoM) (minute number 24/030) (joined by Webinar)	AS
Mrs S Turle	Patient Story (minute number 24/023)	ST
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING (BY WEBINAR):

Ms M Bonney	Governor
Mr N Child	Member of the Public
Mr N Daw	Member of Staff
Ms C Heggie	Member of the Public
Ms R Hulbert	Member of Staff
Ms L Judd	Governor
Ms H Marriage	Member of Staff
Mrs B Mayall	Governor
Ms E Moore	Member of Staff
Ms R Oliver	Member of the Public
Mr N Potter	Member of the Public
Ms W-L Relph	Member of Staff
Ms M Warburton	Member of the Public
Mrs L Williams	Member of Staff

MINUTE NO.		ACTION
24/017	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Acting Chairman opened the meeting, welcomed everyone present, and noted no apologies for absence received.	
24/018	**CONFIRMATION OF QUORACY** The Acting Chairman **NOTED** and confirmed the meeting was quorate.	
24/019	**DECLARATION OF INTERESTS** There were no new interests declared.	
24/020	**MINUTES OF THE PREVIOUS MEETING HELD ON 4 APRIL 2024** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 4 April 2024 as an accurate record.	
24/021	**MATTERS ARISING FROM THE MINUTES ON 4 APRIL 2024** **B/22/23 and B/03/24 – Patient Advice and Liaison Service (PALS) Annual Report** The CNMO stated the Annual PALS report was being reported through the Trust's governance structure process and would be presented to the next BoD meeting. The BoD **APPROVED** the closure of action B/22/23 and that action B/03/24 would remain open. **ACTION:** Present the Annual PALS report to the July 2024 BoD meeting.	CNMO
	B/33/23 – Update on gap analysis and actions implementing the ten Sexual Safety in Healthcare: Charter commitments The CPO confirmed initial principles had been implemented with training sessions provided, information available for staff on Trust's staff intranet, and liaising with other Trusts in respect of training and best practice. Development of a specific policy around sexual safety, speaking up, and accessing support. It was noted a paper would be presented to the next BoD meeting. **B/40/23 – Carer Experience Story** The CNMO confirmed the Carer continued to be involved and provide feedback on progress of the Task and Finish Group, close liaison with the Patient Experience team, and the opportunity extended to meet with the Acting Chairman. The BoD **APPROVED** the closure of this action. **B/01/24 - Staff Survey/Culture and Leadership Programme (CLP)** The CPO highlighted the work being progressed around the Culture and Leadership Programme (CLP), people plans developed to address the actions and issues raised in the staff survey monitored through the Performance Management Review (PRMs) and updates reported to the P&CC. **ACTION:** Present an update report to the July 2024 Closed BoD meeting on the development of a strategy, next steps and actions to address the issues raised in the 2023 NHS Staff Survey results, and increase the response rate in the 2024 survey.	CPO

B/02/24 – Lessons learnt review on Emergency Departments (EDs) expansion builds at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM)
The CSPO confirmed the review had not yet been concluded and a report would be presented to the BoD once completed.

B/04/24 – Care Quality Commission (CQC) Maternity Must Do and Should Do actions
The BoD **APPROVED** the closure of this action, noting the update provided at the meeting in the report from the Women's Care Group Maternity and Neonatal Assurance Group Chair.

The Board of Directors **NOTED** the action log, **NOTED** the updates on the actions, **NOTED** the actions for future Board meetings, and **APPROVED** the three actions above for closure.

24/022 **2024/25 ANNUAL PLANNING AND CASH DRAWDOWN**

The Interim CFO highlighted the following key points:

- 2024/25 plan report summarised the annual financial position for the Trust for the current financial year (FY), setting out the performance standards within NHSE national guidance required to be delivered for key areas. The draft plan had been discussed previously by the BoD at its closed meetings;
- 2024/25 plan enabled the Trust to meet the set performance standards, with the exception of two areas noted below:
  - Waits of over 65 weeks for elective care to be eliminated by September 2024, Trust's plan to achieve this by March 2025, and was working hard towards bringing this forward and achieving this target date earlier;
  - Systems should breakeven, Trust's plan of £85.8m deficit (£31m improvement from the 2023/24 FY) had been negotiated and agreed with the Integrated Care System (ICS).
- Thanks to national, regional and local (ICS) leadership for continued support around the Trust's financial sustainability. The Trust continued to work with system partners to reduce numbers of patients no longer meeting the criteria to reside and discharging these patients as quickly as possible (to secondary/community/social care). It was recognised the level of the Trust's expenditure exceeded its funding allocation that required continued robust management and identifying a resolution;
- 2024/25 plan included delivery of an internal Cost Improvement Programme (CIP) of £49m, driving forward cost efficiencies and enabling continual improved performance to be able to treat more patients and reduce waiting lists. Extensive planning work had been undertaken with robust plans developed, the Trust was in a much better position at the beginning of this FY than previous years. Highlighted CIP delivery remained a risk.

The NEDs enquired whether there was any slippage or projects within the £49m CIP from the previous FY's programme. The Interim CFO reported there was a small slippage of just under £2m where projects had not been sufficiently progressed by the end of the previous FY.

The Acting Chairman thanked the Interim CFO, Executive Directors and all Trust staff for their hard work in identifying and driving forward efficiency savings.

DECISION: The Board of Directors **APPROVED** the final plan for 2024/25.

24/023 **PATIENT STORY**

The Patient explained their experience and story relating to cancer services noting the following key points:

- Real impact of people, processes and partnership, for patients accessing NHS services, and that healthcare was around how staff made people feel that they were caring for. It was important that staff introduced themselves, how they interacted with patients, they were friendly and welcoming that had a positive impact. To always think about the person behind the patient being treated, the impact of a terminal illness on patients and their families. The need for staff to work in partnership with patients in respect of their health and treatment around personalised care;
- Important that patients received appointments, scans, and treatment promptly, and also the importance of research;
- Important patients felt listened to and that their voice had been heard, managing patient expectations, keeping patients updated and minimising where possible delays with discharge, ensuring prompt provision of medication required before patients could be discharged;
- Working collaboratively with patients, families and carers around the provision of services and listening and acing upon their feedback to make improvements, ensure patients had a positive experience and outcome;
- Thanks to all the Trust staff for their care and treatment, and the great job they were doing under significant pressure.

The CPO commented on the importance highlighted in report in respect of the first 15 steps when entering a site/building/department. The Patient highlighted the negatives around the hospital building main entrances and individuals smoking in these areas (where there were signs noting non-smoking). It was recognised the trauma and stress individuals might have experienced, and that some other NHS organisations had re-introduced smoking shelters.

The CMO enquired what more could have been done to support the Patient and her husband when he had been admitted and allowing him to have been discharged earlier. The Patient commented having support, provision of the required medication, necessary equipment and also staff seeing how patients were coping, and provision of appropriate care in the community for ongoing care and treatment to enable prompt discharge.

The EDC&E enquired about the processes for patients to provide feedback and how accessible these were. The Patient commented the prompt text messages received from QEQM requesting patient feedback, and the disparity between the hospitals as this had not been received following visiting the WHH. She highlighted she contacted the Trust to provide feedback to WHH and the vital information that patients provided. The Associate Director of Patient Experience commented the Friends and Family Test (FFT) continued to be reviewed to make improvements for patients to provide feedback, and that patients were able to contact the Patient Experience team direct.

The NEDs highlighted the need for provision of services during weekends (e.g. physiotherapy) to support patients to be discharged.

The COO asked whether staff had informed the Patient about being moved to the Discharge Lounge, to wait to be discharged. The Patient reiterated staff were unable to keep them updated and informed of when they would be discharged.

The CE emphasised the need for the Trust to ensure its processes were right, that these were streamlined and efficient across all the hospital sites to ensure positive patient experience, weekend therapy support, and an alternative solution was being explored to address smoking on hospital sites.

The Board of Directors discussed and **NOTED** Sara's story and **SUPPORTED** actions being taken to improve the involvement of patients, carers and families in cancer services to provide equity of access, excellent patient experience and optimal outcomes.

24/024 **CHAIRMAN'S REPORT**

The Acting Chairman highlighted the following key elements:

- Recovery Support Programme (RSP) meeting recently held, good and challenging discussions about the Trust's performance, recognition of the improvements whilst there was still more to be done;
- Confident Trust was moving in right direction to achieve the NHS Oversight Framework (NOF4) exit criteria by the end of the financial year (FY);
- Improvement target to clear all patients waiting more than 78 weeks by the end of June;
- Achieving cancer targets, recognising improvements needed to be sustained;
- Seeing more patients within 4 hours in the EDs and the need for more work to further reduce the number of patients waiting more than 12 hours.

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

24/025 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported on the following key points:

- Trust engaging in co-production of the NHS Kent & Medway (K&M) Strategy 2024/25 – 2029/30, led by K&M Integrated Care Board (ICB), expected to be presented to the BoD in the next few months;
- Progress of the work of the K&M Provider Collaborative around a unified approach and efficient support services, improving access to care, delivering treatments closer to home, and promoting sustainable practices;
- Good progress implementing the CLP that would make a real difference for Trust staff and their experience working within the organisation;
- Celebrating Theatre Appreciation Day event, recognising the work of theatre staff and Operating Department Practitioners (ODPs) with presentation of awards. The importance of these celebration events and acknowledging the hard work and support of Trust staff.

ACTION: Present to the July 2024 BoD meeting the NHS Kent & Medway (K&M) Integrated Care Board (ICB) Strategy 2024/25 – 2029/30. CE

ACTION: Present an update on progress of the Provider Board Collaborative in the CE's Report to the next BoD meeting in July 2024. CE

ACTION: Present the action plan and progress update on the CLP to the next BoD meeting in July 2024. CSPO

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

24/026 **INTEGRATED PERFORMANCE REPORT (IPR)**

The COO highlighted the following key elements in respect of operational performance metrics:

- Type 1 ED compliance patients being seen within 4 hours reduced in April to 47.4%, now green against red in March, during May delivered 53%, as of that day 55% (ahead of trajectory), highest performance over last two years;
- Good position in relation to cancer performance;
- Diagnostics performance continued to improve, DMO1 at 62.5% in April with further improvement in May;
- 104 weeks wait eliminated in May, commitment to clear 78 weeks wait by end of June, and 65 weeks wait by end of September;
- Thanks to all staff for their hard work in achieving the improved performance, recognising there was still much more work to be done;
- Continued reduction in length of stay;
- Improvement event being held the following week, identified areas for focussed improvement work, and working closely with the CNMO;
- Endoscopy backlog continued to be significantly reduced from 14,000 in January to currently approximately 9,000.

The CNMO highlighted the following key elements in respect of Quality & Safety and Maternity metrics:

- Number of harm events related to pressure ulcers (PUs) had reduced over the last two months, there had been an increase in number of falls and work would continue following Falls Summit with focussed actions to reduce these;
- Deterioration in complaint response times in month, with a focus on the quality of responses that had impacted on delayed responses, with increased activity in number of complaints received;
- Previous drop in incidents of mixed sex accommodation (MSA), with April showing an increase as at that day of 24.

The NEDs enquired about PUs and whether these related to the patient waits in the EDs. The CNMO reported some were attributable to ED waits and that new patient trolley beds and mattresses had been ordered, with a review to be undertaken to identify the impact of this new equipment.

The CMO highlighted the following key elements in respect of mortality metrics:

- Mortality rates as expected, future change in how Hospital Standardised Mortality Ratio (HSMR) was to be calculated;
- Review of 47 mortality cases at WHH being undertaken to identify any reasons for the higher mortality rate at WHH.

The CPO highlighted the following key elements in respect of people metrics:

- Reduction in sickness absence at 4.7%, below the 5% threshold;
- Vacancy rate at 10.1%, above the 10% threshold;
- Staff turnover remained in line with previous month at 9.3%, with improvement in premature turnover to 14.6%;
- Appraisal rates had increased by 3% to 76%, had been subject to a deep dive with areas of low completion rate challenged through the Performance Review Meetings (PRMs);
- Improving the staff engagement score was a real area of challenge and concern, with ongoing work around the CLP. It was hoped over the next quarter to see an improved score and increased staff response rate to the quarterly pulse survey.

The Acting Chairman asked about the actions to increase the staff engagement score, noting an update on progress of actions would be provided at the next BoD Strategy Development Session at the end of July. The CPO reported actions included allowing staff protected time to complete the survey, accessibility to IT equipment to undertake the survey, and that managers regularly spoke to staff encouraging them to complete the survey. The CE commented on the need to look at innovative ways of engaging with staff and support to improve uptake of completion of the staff survey. The CSPO encouraged Board members when interacting with staff, asking them how they were, showing that they cared, encouraging them to complete the survey and asking what could be done to enable them to do this, noting it was important to celebrate significant events within the NHS recognising and acknowledging the work of key staff areas. The EDC&E stated the Trust was looking at what other trusts did and best practice that could be adopted, and any incentivising ideas.

The Board of Directors discussed and **NOTED** the metrics reported in the IPR.

24/026.1 **MONTH 1 FINANCE REPORT**

The Interim CFO reported on the following key points:

- Trust achieved its plan at Month 1 of £8,768k deficit, lowest deficit of the Trust since March 2023;
- Recognising the challenges and further work required to meet the planned deficit of £85.8m at Year End (YE), robust actions within the annual plan that required continued focus to ensure efficiencies and sustained performance within the plan.

The NEDs raised it was important to receive assurance that the Trust remained on target to achieve its YE plan. The Interim CFO stated future finance reports would include updates on the quarterly projections and Trust's position in alignment with these and achievement of the identified phases.

The Board of Directors reviewed and **NOTED** the financial performance of Month 1.

24/027 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

- **2023/24 IIP CLOSEDOWN**
- **2024/25 RESET IIP**

The CSPO highlighted the following key points:

- Recognition of the progress made during 2023/24 and its closure position of the six programmes (28 exit criteria, of which 14 were met enabling exit from NOF4 to NOF3 that included Maternity) following review of evidence. People element of People & Culture transition to NOF3 and further work needed on culture within 2024/25 IIP;
- Work to continue within the reset 2024/25 IIP against four programmes (11 exit criteria) noted below:
  - Leadership, Governance & Culture;
  - Operational Performance – Planned Care;
  - Operational Performance - Urgent & Emergency Care (UEC);
  - Financial Recovery.
- Majority of breakthrough objectives were aligned with the IIP, including reducing harm, achieving FFT overall score, to be in the top 25% of NHS organisations for staff engagement score and staff survey response rate greater than 50%;
- Correlation of the annual objectives against the IIP;
- Aspiration continuing improvement journey to achieve NOF1.

NHSE's Improvement Director reported on the good progress achieved, with appropriate processes and governance framework in place, highlighting the key risk in relation to the staff survey response rate.

The Board of Directors discussed and **NOTED** the report on Journey to Exit NOF4 and IIP.

24/028 **BOARD ASSURANCE FRAMEWORK (BAF)**

The DCG highlighted the following key points:

- Importance of utilising and implementing the BAF to driving forward the Board Committee and Board assurance;
- BAF required to be closely aligned with the Significant Risk Register (SRR);
- BAF consisted 13 principle risks against the strategic objectives with progress to be regularly reported to Board Committees for detailed discussion, and reports to the Board on how risks were being managed.

The NED IAGC Chair highlighted the need for the DCG to work with colleagues to ensure the BAF was fully populated and included all content required to provide the assurance needed the BAF was being robustly managed. This included narrative around gaps in controls and assurance, risk scores, and that an updated version be presented to the next scheduled Board Committee meetings. The DCG reported the BAF would be further reviewed in alignment with the review of Board Committees.

The NED FPC Chair stated FPC meeting agenda items were linked to the BAF risk reference supporting proactive discussions around risks, driving forward mitigations and improvements.

The Board of Directors **NOTED** the April 2024 version of the BAF.

24/029 **RISK REGISTER REPORT**

The CNMO highlighted the following key elements:

- SRR report presented to each Board Committee meeting;
- Following review process of all risks, some risks removed, and additional and new risks added to register;
- Risk score for exposure of staff to level of nitrous oxide from the use of Entonox in the maternity unit (risk ref: 2999) increased from moderate to high. This was due to findings of recent external review commissioned with immediate mitigations put in place and regular monitoring;
- Action plan to address the Aseptic unit risk, progress overseen by the CMO;
- Trust working with 2gether Support Solutions (2gether) to ensure oversight of their risk register;
- Risk Review Group would test the risk management processes, identification of risks, escalation of risks, and that these were fully embedded and working effectively.

The Acting Chairman raised concern about the Aseptic unit extreme risk and assurance that all was being done to address this risk. The CMO reported the Trust had agreed all the recommendations, with work and support in place to progress the action plan, reduce the risk of failure, and robust management to comply with regulation, with continued external monitoring.

The NEDs raised concern about the standard of accommodation provision for staff. The NED P&CC Chair stated reports would be presented to P&CC in future, with updates provided to the BoD within the P&CC Chair Assurance Report.

The NEDs raised it was important to test the controls and mitigations in place around the management of risks, and that Internal Audit would support to review the risk management processes.

The Board of Directors:

- **SUPPORTED** the recommendations made within the Risk Register report;
- **RECEIVED** and **NOTED** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

24/030 **WOMEN'S CARE GROUP MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) CHAIR'S REPORT**

- **PERINATAL QUALITY SURVEILLANCE TOOL (PQST)**
- **PERINATAL MORTALITY REVIEW TOOL (PMRT)**
- **AVOIDING TERM ADMISSIONS INTO NEONATAL UNITS (ATAIN)**
- **SAVING BABIES LIVES CARE BUNDLE (SBLCB)**
- **TRAINING**
- **CARE QUALITY COMMISSION (CQC) MUST AND SHOULD DO REQUIREMENT**
- **OBSTETRIC MEDICAL WORKFORCE**
- **NEONATAL WORKFORCE**

The Deputy DoM reported on the following key issues:

- Year 6 for Clinical Negligence Scheme for Trusts (CNST);
- PQST and maternity dashboard, team was now exploring disparities that might exist within these outcomes. An Equality, Diversity and Inclusion (EDI) task and finish group had been set up that had met twice since the last Board meeting;

- No Serious incidents (SIs) or Maternity and Newborn Safety Investigation (MNSI) referrals in March;
- Safeguarding training compliance was just below 90% and 20 staff who had not attended in the last year had now been booked to attend;
- Continuing to work with the Local Maternity and Neonatal System (LMNS) working towards achieving full compliance with the Year 6 requirements;
- Actions to progress the Maternity and Neonatal Improvement Programme (MNIP), each of the workstreams reviewed and discussed at the monthly MNAG meetings;
- Approval of funding provision from the East Kent Hospitals Charity for the WHH Bereavement Facility works;
- Obstetric workforce, continued challenges with recruitment and rota gaps for the consultant workforce, impacting the ability of the team to support compliance for mandatory training especially aligned to PRactical Obstetric Multi-Professional Training (PROMPT). Following review of the sustainable model for obstetric workforce resulted in a number of actions, including ongoing work on business case for four additional middle grades (trainees), and changing a traditional consultant post that had not been recruited to into a specialist grade post;
- Neonatal workforce: junior doctor workforce fully compliant, gaps in registrar rota, consultant rota non-compliant, and vacancies in WHH Neonatal Intensive Care Unit (NICU) and QEQM Special Care Baby Unit (SCBU). Action plan with mitigations in place, including increasing number of trainees, and appointing a locum to fill gap in rota until September;
- Generally positive feedback from staff at Midwifery events and discussions with Safety Champion, although issues remained around staff resources at WHH and estates work.

The CNMO stated all current student midwives had been written to confirming the Trust's commitment offering midwifery positions.

The Chairman raised the minor estate works and when these would be completed.

ACTION: Provide the Acting Chairman and DoM and Deputy DoM with an update on the timeframe of a date when the minor estate works would be completed by. CSPO

The CNMO stated in response to the *Reading the Signals* recommendations, restorative work would be offered to families recognising not all would wish to take up this offer.

The Board of Directors discussed and **NOTED** the MNAG Chair Assurance Report.

Mr S Corben, NED, left meeting at this point.

24/031 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

24/031.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair reported on the following key issues:

- Confirmed compliance and submission of the annual NHS Fit and Proper Person Test (FPPT);

- Limited assurance around bonus pay arrangements within the Group Subsidiaries, the ongoing governance review and awaiting the outcome report with further discussions by the Committee once received;
- Review and discussion of the 2023/24 annual appraisal and 2024/25 objectives for the CE and Executive Directors.

The Board of Directors **NOTED** the 21 May 2024 NRC Chair Assurance Report.

24/031.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**
- **CERVICAL SCREENING ANNUAL REPORT**

The Q&SC Chair reported on the following key issues:

- Q&SC meeting was not quorate due to impact of the NED vacancy, which had been addressed with the Acting Chairman attending future meetings;
- Focussed review and discussions on mortality rates and learning from deaths triangulating this with other sources of information;
- Compliance with National Institute for Health and Care Excellence (NICE) had been an area of concern, with assurance received of a plan targeted to achieve 90% compliance over the next 12 months;
- Good and challenging discussions about harm, the harm review process, and ED waiting times impacting the number of patient harms, with assurance of the focussed work to address this;
- Ambitious Dementia Strategy with good progress already made, and more work was needed.

The Board of Directors **NOTED** the 23 April 2024 Q&SC Chair Assurance Report.

24/031.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- Written report presented from April FPC meeting, further meeting held previous week and written report to be presented to the next BoD meeting;
- Review and approval of the Annual Plan;
- Noted the ongoing work regarding PRISM and KPMG supporting Trust to reduce length of stay and that recommendations would be acted upon where relevant;
- Cost Improvement Programme (CIP) for 2024/25 was in a much better position this year than at the same time the previous year, with a committed target of £49m;
- Continued improvements in performance;
- Cancer: Increase in the number of patients waiting over 62 days.

The Board of Directors **NOTED** the 30 April 2024 FPC Chair Assurance Report.

24/031.4 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**
- **STANDING FINANCIAL INSTRUCTIONS (SFIs) AND SCHEME OF DELEGATION (SoD)**
- **GIFTS, HOSPITALITY AND CONFLICTS OF INTERESTS POLICY**

The IAGC Chair reported on the following key points:

- Two documents recommended for approval by the BoD, the SFIs and SoD, and Gifts, Hospitality and Conflicts of Interests Policy;
- Good progress being made around risk management control and the processes in place;
- Lessons learned report on the 2022/23 accounts process and not meeting the submission deadline the last couple of years, confident the 2023/24 annual accounts would be delivered and submitted on time this year;
- Evidence that the Group remained a 'going concern';
- Draft annual documents were reviewed with feedback provided and the final versions to be presented at a meeting at the end of June for approval for submission.

DECISION: The Board of Directors:

- **NOTED** the 26 April 2024 IAGC Chair Assurance Report;
- **APPROVED** the SFIs and SoD;
- **APPROVED** the Gifts, Hospitality and Conflicts of Interests Policy.

24/031.5 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair reported on the following key points:

- Presentation on EDI Strategy from Head of EDI, lot of good work being undertaken, recognising there was still much more to be done, ensuring these were embedded throughout the organisation and the responsibility of all staff;
- Deep dive report on appraisals, current completion rate of 76% against target of 80% and commitment to target areas needed to increase and achieve the target;
- Training compliance was above the 91% target of 92.2%, and areas for targeting in respect of hand hygiene and resus training;
- Staff turnover remained low, with hot spot areas identified where further work was required. Positive feedback and assurance from the CMO about the experience of new staff recruited and working at the Trust;
- Guardian of Safe Working report and the need to ensure appropriate reporting in all areas, with areas identified for actions, further update would be provided to the Committee in four months;
- Accommodation Strategy and the provision of accommodation was a concern in respect of the poor facilities, what could be done in the short term around mitigations, the legal position, and longer term over next five to ten years around a sustainable strategy, funding and affordability, to attract recruitment of staff to work at the Trust.

The CSPO stated an external review of the Trust's accommodation would be undertaken in conjunction with 2gether in respect of the opportunities of its long term management, as well as options to meet the requirements of the KMMS.

The Board of Directors **NOTED** the 23 May 2024 P&CC Chair Assurance Report.

24/032 **CHIEF NURSING AND MIDWIFERY OFFICER'S (CNMO) REPORT:**

24/032.1 **PATIENT VOICE AND INVOLVEMENT (PV&I) ANNUAL REPORT 2023-24**

The CNMO highlighted the following key points:

- Significant progress made around patient, community and outreach involvement and engagement to gather feedback;
- Good discussions at the Q&SC.

The Acting Chairman enquired what the top themes were that the Trust needed to focus on. The CNMO stated the key areas of focus included FFT feedback, outreach, and health inequalities. It was noted it was important to review themes from complaints and PALS with the feedback from patients, and incorporating this with the work with staff around the CLP.

The NEDs suggested it would be beneficial to show as a pie chart the statistics and data on how feedback from patients was being provided.

ACTION: Next PV&I Annual Report for 2024-25 to include statistics and data on how feedback from patients was being provided shown as a pie chart. CNMO

The NEDs acknowledged and commended the work progressed by the PV&I team and particularly co-production with patients.

The Board of Directors **NOTED** progress in delivering the Patient Voice and Involvement Strategy.

24/033 **CHIEF MEDICAL OFFICER'S (CMO's) REPORTS:**

24/033.1 **ANNUAL ORGANISATIONAL AUDIT (AOA)**

The CMO highlighted the following key elements:

- Provision of support to enable the annual medical appraisal standards to be met, with progress being made, external evaluation to be undertaken and the outcome of this would not be known until this time the next year;
- Valid reasons required for any late appraisals.

The Board of Directors **NOTED** the content of the AOA report and its information provided in addition to the Annual Revalidation report.

24/033.2 **PAEDIATRIC AUDIOLOGY SERVICES**

The CMO highlighted the following key elements:

- Services required to be accredited through Improving Quality in Physiological Services (IQIPS) programme, and working towards achieving this accreditation;
- In general cases from referral to be seen 14 week wait, and for more complex cases a 22 week wait;
- Further progress report to be presented to a future BoD meeting.

The Board of Directors **NOTED** the assurance report on the Paediatric Audiology Services, about the safety, quality, and accessibility of EKHUFT children's hearing services/paediatric audiology, and a report would be submitted to CQC addressing the key issues in point 3.1 CQC Request in the main body of the report.

24/034 **SAFETY, FIRE AND STATUTORY COMPLIANCE UPDATE**

The CSPO highlighted from 1 April, the Safety team had moved to EKHUFT, this included Health and Safety (H&S), fire safety and Security Management Specialist.

The Acting Chairman requested an update on the action and what was being done to address incidents of assaults on staff ensuring staff were protected and supported.

ACTION: Provide an update on the action and what was being done to address incidents of assaults on staff ensuring staff were protected and supported. — CSPO

The CNMO commented on the work with staff around violence and aggression and that the inaugural meeting of a working group had been held the previous day.

The Associate NED enquired about staff fire safety training and whether this covered corridor care for the treatment of patients in respect of fire compartmentation arrangements and fire evacuation procedures.

ACTION: Check and confirm whether the Trust's staff fire safety training covers the evacuation procedures for patients being provided corridor care treatment. — CSPO

The CNMO stated risk assessments were undertaken. The COO commented ongoing discussions were held with teams in respect of corridor care and minimising this wherever possible.

The Board of Directors discussed and **NOTED** the Trust's current position in relation to Health & Safety, and statutory compliance, especially in respect to the prevailing risks.

24/035 **ANY OTHER BUSINESS**

There were no other items of business raised.

24/036 **QUESTIONS FROM THE PUBLIC**

The Chairman reported no questions had been received in advance of the meeting.

The Chair closed the meeting at 4.00 pm.

Date of next meeting: Thursday 25 July 2024.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 6 June 2024**

Meeting date: **25 July 2024**

Board sponsor: **Acting Chairman**

Paper Author: **Board Support Secretary**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: None

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MATTERS ARISING FROM THE MINUTES ON 6 JUNE 2024

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. The ToR will be re-reviewed following completion of the Good Governance Institute (GGI) Governance Review.	~~Oct-23~~/ ~~Jun-24~~/ Jul-24	Integrated Audit and Governance Committee (IAGC) Chair/ Director of Corporate Governance (DCG)	Open	Board Committee ToR will be reviewed by the DCG following the recommendations of the GGI Governance Review. **Item for future Board meeting.**
B/06/23	01.06.23 - On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy. 05.10.23 - Provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.	~~Dec-23~~/ ~~Feb-24~~/ ~~Jun-24~~/ Jul-24	Chief Operating Officer (COO)	Open	**01.02.24 -** Trust would be looking at and reviewing the front door services to redesign patient pathways through ED, ensuring these were simplified and less complicated to benefit the care and experience of patients, as well as supporting staff to manage demand. A further update would be provided at a future Board meeting. **04.04.24 –** The Trust is reviewing and resetting patient pathways across the Trust. An update will come to Board in June 2024.
B/33/23	Present an update to the Board on progress monitoring the gap	~~Jun-24~~/ ~~Jul-24~~/ Oct-24	Chief People Officer (CPO)	Open	**06.06.24 -** Initial principles implemented with training sessions provided, information available for staff on the Trust's

	analysis, action plan, work needed and any additional support to enable implementation of the ten Sexual Safety in Healthcare - Organisational Charter commitments.				staff intranet, liaising with other Trusts in respect of training best practice. Development of a specific policy around sexual safety and speaking up, and accessing support. Lead Freedom to Speak Up Guardian working on a paper to be presented to the July 2024 Board meeting. **July 2024 -** Update on Sexual Safety will be included in the regular six monthly Freedom to Speak Up report to be presented to the October 2024 Board meeting.
B/01/24	Provide an update at the ~~June~~/July 2024 Closed Board meeting on progress to formulate a plan and develop a strategy on the next steps and actions to address the issues raised in the 2023 NHS Staff Survey results.	~~Jun-24~~/ Jul-24	CPO	To Close	Report presented to the Closed Board meeting on 25.07.24. **Action for agreement for closure at 25.07.24 Board meeting.**
B/02/24	Share lessons learnt review on the WHH and QEQM EDs expansion builds for information.	~~Jun-24~~/ Jul-24	Chief Strategy and Partnerships Officer (CSPO)	Open	06.06.24 - Review not yet concluded and report to be presented once completed.
B/03/24	Present the Annual PALS report to the ~~June~~/July 2024 Board of Directors meeting.	~~Jun-24~~/ ~~Jul-24~~/ Oct-24	Chief Nursing & Midwifery Officer (CNMO)	Open	**July 2024 -** Report being presented through internal governance process to the Patient Experience Committee, Quality & Safety Committee, then to the BoD.
B/05/24	Present to the July 2024 BoD meeting the NHS Kent & Medway (K&M) Integrated Care Board (ICB) Strategy 2024/25 – 2029/30.	Jul-24	Chief Executive (CE)	Open	**July 2024 -** Verbal update to be provided at 25.07.24 Board meeting.
B/06/24	Present an update on progress of the Provider Board Collaborative in the CE's Report to the next BoD meeting in July 2024.	Jul-24	Chief Executive (CE)	Open	**July 2024 -** Verbal update to be provided at 25.07.24 Board meeting.
B/07/24	Present the action plan and progress update on the CLP to the next BoD meeting in July 2024.	Jul-24	CSPO	To Close	Report presented to Board meeting on 25.07.24. **Action for agreement for closure at 25.07.24 Board meeting.**

B/08/24	Provide the Acting Chairman and DoM and Deputy DoM with an update on the timeframe date when the minor estate works would be completed by.	Jul-24	CSPO	Open	**July 2024 -** Verbal update to be provided at 25.07.24 Board meeting.
B/09/24	Next PV&I Annual Report for 2024-25 to include statistics and data on how feedback from patients was being provided shown as a pie chart.	Jun-25	CNMO	Open	Item for future Board meeting.
B/10/24	Provide an update on the action and what was being done to address incidents of assaults on staff ensuring staff were protected and supported.	Jul-24	CSPO	Open	**July 2024 -** Verbal update to be provided at 25.07.24 Board meeting.
B/11/24	Check and confirm whether the Trust's staff fire safety training covers the evacuation procedures for patients being provided corridor care treatment.	Jul-24	CSPO	Open	**July 2024 -** Verbal update to be provided at 25.07.24 Board meeting.

East Kent Hospitals University NHS Foundation Trust

Report to: Board of Directors (BoD)

Report title: Staff Story

Meeting date: 25 July 2024

Board sponsor: Chief People Officer (CPO)

Paper Author: Head of Equality, Diversity and Inclusion (EDI)

Appendices:

Appendix 1: Staff Story at Board form

Executive summary:

Action required:	Discussion
Purpose of the Report:	Staff member, Tracy Stewart, works as a Theatres Administrator at Queen Elizabeth the Queen Mother Hospital (QEQM). Tracy wishes to share her story of a personal example of the importance of Staff Networks, in this case the Neurodiversity Network.
Summary of key issues:	In 2022 Tracy was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), dyspraxia and autistic traits at the age of 49. She wishes to share her experience of processing this and the impact on her mental health, work and relationships. Tracy also wishes to highlight the importance of the staff networks and how she felt supported and accepted by the Neurodiversity Staff Network. This story aims to provide a personal narrative to Tracy's experience and the value and of the staff networks, in being a place of support and guidance for staff with any type of neurodiversity (ND), or who have a family member with a diagnosis or suspected diagnosis, but also to be a platform from which misunderstanding can be replaced with knowledge, information and a much better insight into neurodiversity for everyone across the Trust.
Key recommendations:	Ongoing Trust wide support from the Board is key to helping that realisation be achieved.

Implications:

Links to Strategic Theme:	• Patients • People • Partnerships

East Kent Hospitals University NHS Foundation Trust

	• Sustainability • Quality and Safety
Link to the Trust Risk Register:	**CRR 118:** There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	Y - Trust needs to comply with the Equality Act 2010.
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Staff Story Checklist for Board Meeting

Section A
To be completed by the story sponsor and supplied to the relevant team along with any additional contextual information.

Name of person sharing the story: Tracy Stewart

(contact details to be shared via email to the team: ekhuft.edi@nhs.net)

Senior sponsor name and email: Parveen Kumi; Head of Equality, Diversity & Inclusion (EDI)

parveen.kumi@nhs.net

Board Sponsor name: Andrea Ashman; Chief People Officer, People & Culture.

Preparation	Prompt	Comments
Why are we hearing this story?	What sort of story is it?	A personal example of the importance of Staff Support Networks, in this case the Neurodiversity Network within the Trust in the absence of easily accessible National Support.
	Will the story show the organisation or staff negatively?	No.
	What actions has the service taken to address the issues raised?	The Neurodiversity Network is the most recent of the five EDI Trust Networks. It is hoped that this will become not only a place of support and guidance for staff with any type of neurodiversity (ND), or who have a family member with a diagnosis or suspected diagnosis, but also to be a platform from which misunderstanding can be replaced with knowledge, information and a much better insight into neurodiversity for everyone across the Trust. Ongoing Trust wide support from the Board is key to helping that realisation be achieved.
How is this item going to be managed?	Who from the service is going to lead this item and attend the Board meeting? What preparation or information will Board members need to ensure their questioning is appropriate?	Parveen Kumi, Head of Equality, Diversity & Inclusion, will be attending with and supporting Tracy.
What does this story add to our understanding of the quality of our services?	How does this story relate to information in our quality and/or performance reports?	Many neurodiverse staff will have faced a lifetime of misunderstanding and, sadly, bullying because of their differences in how they process the information around them. This leads to depression, anxiety, isolation and often the inability to hold a job due to

		poor misunderstanding from a managerial perspective. The ND Network can not only provide direct support to staff, but can help to give managers and teams a basic insight into how someone with a neurodiversity can be supported at work. This will not only greatly improve the wellbeing of the staff member involved, but will support the Trust aim of being a fully inclusive EDI employer and improve recruitment and retention of employees who truly do have some wonderful talents to offer.
	What additional information does the Board require to help put the story in context?	**The following was written by Tracy;** **<u>Support for Neurodiversity by Tracy Stewart</u>** I was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in January 2022 at the age of 49. The assessments I underwent for that diagnosis also revealed I have dyspraxia and clinically-significant Autistic traits. While this was a huge relief for me, as I was starting to fear I had early-onset dementia, there was no further advice, support or aftercare from the psychiatrist or my GP. Essentially, it was left up to me to find out about ADHD and dyspraxia; what they are, how they affect me – which lead to me saying out loud, "So *that's* why I do that!" so many times! Not long after my diagnosis I came across an article on the Trust Staff Zone about the newly formed Neurodiversity Network, and joined immediately. Here, at last, were people who could fully understand and support me; who knew the challenges I face each day and could totally empathise with me. Network meetings are an absolute pleasure, and I always look forward to them. I use online sources such as the ADHD Foundation, ADDitude, ADHD UK and the Dyspraxia Foundation for my research. While information about ADHD is very readily available, with books, TED talks and all sorts, there is relatively little about dyspraxia, and the focus – quite understandably – is on supporting children with this neurodiversity, which used to be called the "Clumsy Child Syndrome". It was through the Dyspraxia Foundation that I found out that I'm not the only grown person who has trouble tying shoelaces, or can't straighten my hair or put make-up on. I'm not

		the only one who failed the National Cycling Proficiency at the age of 11, and who has never – and will never – learn to drive a car. Such an incredible source of reassurance and information - until I tried to do a little more research at the beginning of May. The website directed me to a page which explained that the Dyspraxia Foundation, a charity which had been supporting people with dyspraxia as well as their families for over 40 years had to close their website and charity down due to lack of funds. I was appalled at the fact that a charity had to close due to a lack of funding, but dismayed at the fact that so many people would not be able to access the information I had been able to. I am, however, incredibly lucky that I have the Neurodiversity Network at work who are fantastic in their support and understanding of all the challenges that neurodivergent people meet every day. For example, I have to think very carefully about the shoes I get, not only because of the laces, but dyspraxic people tend to have poor muscle tone (and I most certainly do), so shoes cannot be too flat, too high or too pointed. I have to set the alarm on my phone for several things – even when I'm cooking dinner and have to get the vegetables cooking or stir the bolognese – or it will be forgotten because my ADHD brain is looking for something far more interesting to do! In talking to others in these meetings, I have learned so much about neurodiversity, and every time I think how lucky I am to work with such clever, funny and insightful people. I love the way that Autistic people have this incredible ability to see the answer to a problem so quickly and so clearly, as though it's staring us all in the face! People with ADHD have enormous empathy; my mum has always called me the family peacemaker. Dyslexic people have incredible visual creativity and are excellent problem solvers. Everyone in the Network, by the time they reached adulthood, had spent years finding and perfecting coping mechanisms – some of us, like myself, without even realising we were neurodiverse! The Neurodiversity Network, in continuing and developing its resources and support to Trust staff, made a huge difference to me and I have no doubt it has provided the same support and reassurance to many

		other ND staff across the Trust. This can only serve to be a positive measure for the Trust, with a great impact on the wellbeing of ND staff, thereby reducing sickness levels and helping to retain staff who, although challenged every day of our lives, bring some wonderful assets to the Trust workforce.

Please return completed form to the EDI Team:
ekhuft.edi@nhs.net

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT JULY 2024

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 Council of Governors (CoG) and to bring any other significant items of note to the Board's attention.

My report should be read alongside Tracey's Chief Executive Officer (CEO) report providing an overall assessment of the Trust's operational performance and the Committee Chairs' report providing assurance.

Introduction

On 6 July I took the opportunity to spend time in William Harvey Hospital, with colleagues and patients in maternity as their Safety Champion; the Emergency Department (ED); and Kennington ward. I also saw how colleagues in the control room oversaw fast-paced, constantly changing circumstances, was very impressive to witness.

My visits are always extremely rewarding and revealing. It was clear our colleagues in William Harvey are under immense pressure and activity levels were very high – unsurprisingly in the Emergency Department - even for a July afternoon. However, the calmness and consideration all the staff I witnessed were showing towards patients was clear. I visited triage, majors, Rapid Assessment and Treatment (RAT) and Resus. All the managers/nurses in charge were aware of their longest waits and planning for new arrivals. Conversations with staff and patients focused on the unavailability of primary care and that being a continuing challenge and cause of recourse to the ED.

It was clearly evident to me (yet again) that working in an acute hospital can feel like permanently paddling furiously under the water while retaining calm above it but I was so impressed with everyone I met today and the empathy and calmness they showed towards their patients. It reinforced my privilege of being the Chairman of the Trust and being able to represent such dedicated colleagues within our services.

Board changes

We will be saying 'goodbye' to East Kent's Chief People Officer, Andrea Ashman, in September. Andrea is leaving after seven years at the Trust to take up a post at a Trust closer to home. I want thank Andrea for all she has done for East Kent and we all wish her well for the future. Debbie Viner, Interim Deputy Chief People Officer, will be stepping up into the Chief People Officer role while Andrea's successor is recruited to.

We are also progressing recruitment to our vacant non-executive director (NED) position on the Board. We hope to move to interviews in August and be in a position to appoint someone shortly thereafter.

Council of Governors

I chaired the quarterly Council of Governors meeting earlier this month. It was great to have our CEO, the NEDs and our Governors in the same room at a well-attended and energetic meeting. We heard

important contributions from Governors representing the patients in their communities as well as staff governors.

Board Governance

The Board's move to alternating Board meetings with Board Development Days is proving successful. Board scrutiny and approvals are being effectively managed within the bi-monthly cycle. More importantly, the time the Board now has to come together and deep-dive into key areas of focus is proving very valuable. The Board has benefitted from external input as well as the time to really hone in on areas such as strategy and our ongoing Governance improvement journey. Board Committees are evolving and our NED Chairs are working hard to ensure they are another forum to drill down into detail and secure appropriate assurance within their areas of focus.

As we go into summer we are not complacent. We continue our focus on improving our performance in key areas of Finances, ED Performance, Elective Waiting Lists and Cancer Treatment. We are also focused on our culture improvement programme and we will start our winter preparedness. Please do examine the information shared in the Board pack by Tracey and my Executive colleagues who will report on our operational and financial performance, save to say I am encouraged by both the improvements we are seeing across the Trust and the pace in which we are achieving these.

I would like to extend my thanks to all staff who are delivering these excellent improvements despite being under a huge amount of operational pressure. The Board is acutely aware of the pressures of the forthcoming winter and as such we will be reviewing both our own plans and those of the wider system by September to ensure we are ready for whatever the winter period throws at us.

Acting Chairman
Stewart Baird

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **25 July 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, 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)

At meetings of the CEMG in June and July, the group approved an updated version of the Access Policy to provide clear guidelines to staff for the management of patient appointments within the Trust.

4. Operational update

The length of time patients are waiting to be seen is continuing to reduce. As previously reported, we still, however, have a long way to go.

At the end of June 2024, the Trust had 233 patients awaiting cancer treatment over 62 days. In addition the number of patients waiting over 104 days has remained static at 38.

The focus on reducing the number of patients waiting for an endoscopy across our surveillance, urgent and routine waiting lists continues. We continue to see the backlog reduce from 13,350 at the start of January to 8,200 at the end of June. We have further improved our management of the demand for endoscopy with a new internal triage service introduced in June and also a wider system initiative has been ratified to ensure referrals can be better managed in Primary Care with Quantitative Faecal Immunochemical Test (qFIT) testing now a mandated part of the referral process.

Efforts to mitigate long waiting times for planned treatments have also seen marked improvements. In January 2024, over 2,000 patients were at risk of exceeding the 78-week wait threshold; however, this number has now reduced to 87 at the end of June. Whilst recognising the progress that has been made, the Trust acknowledges that these long waits for planned treatment fall below the standard of care expected by our patients. Projections were to half this number by the end of July.

5. Culture and Leadership Programme (CLP)

A senior leaders away session was held on Wednesday 3 July, at which the findings and the proposed next steps were discussed with over 150 attendees. A discussion on the CLP was also held at the Staff Forum in July which included discussion with two of the change ambassadors.

As previously reported the next steps of this work will be broken down into two clear areas and will form part of our overall transformation work:

- Commencement of the design phase of the culture work where we will start to share and seek wider organisational engagement on the findings, sense checking the recommendations and priorities.

- Create a plan with aligned actions to start work on now using the CLP work as the main driver but also include feedback from recent executive led listening events, new staff forums and open comments from the national staff survey. This plan is broken down into immediate actions as well as projects for the next three, six and 12 months. In order to start this process and assign relevant owners a new culture delivery board has been established to ensure pace and delivery.

Progress made over the past two months has included recruitment of more change ambassadors, development and implementation of leadership skills reset, introduction of staff led administrative forums for each site plus a virtual forum, development of the approach to the creation of a Staff Council and launch of the search for nominations for the Trust Celebratory Awards.

6. NHS Kent and Medway Strategy 2024/25 – 2029/30

Work has been ongoing across the sector to develop an NHS Kent and Medway Strategy and has involved representatives from all provider Trusts. The strategy will focus on the following themes; patient access, outcomes & experience, people, sustainable services and finance and resources over the next five years. This will be a strategy that not only has engagement from all providers but is intended to be 'owned' by all providers alongside NHS Kent and Medway Integrated Care Board (ICB).

It is intended that the draft strategy will be presented at each provider Board for discussion, comment and endorsement.

7. Chief People Officer – Andrea Ashman

Following successfully securing a new post as Chief People Officer for Dartford & Gravesham NHS Trust, Andrea will be leaving the Trust at the end of the summer. We will start the search process for a new Chief People Officer immediately.

I would like to take this opportunity to thank Andrea for all the commitment and hard work she has given to the Trust since 2017 and for the support that she has given me personally since my arrival in the Trust.

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: **Integrated Performance Report (IPR)**

Meeting date: **25 July 2024**

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

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

Appendices:

Appendix 1: June 2024 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the Integrated Improvement Plan, Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. The Trust Integrated Improvement Plan 2. Other Statutory reporting 3. Other agreed key metrics.
Summary of key issues:	The Integrated Performance Report has been subject to a review and refresh and a revised format is being presented from May 2024 onwards. The reported metrics have been grouped to give a detailed view of progress against the quarterly milestones for the Integrated improvement plan alongside a summary view of metrics falling within each strategic theme. The attached IPR is now ordered into the following strategic themes: • **Integrated Improvement Plan (IIP).** • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics. • **People,** incorporating people, leadership & culture metrics. • **Sustainability.** Incorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. Key performance points (June Reported Month): **Integrated Improvement Plan**

	• The Organisation is demonstrating consistent reductions in the number of patients with an in-hospital stay of more than 14 days. • The Endoscopy backlog is showing variation of an improving nature with its continued reductions since January 2024. From an assurance perspective it has achieved the target performance for the last two months. • The financial efficiency programme, number of patients waiting more than two years for elective treatment and Type 1 four hour Emergency Department (ED) Compliance are all demonstrating improving performance but continue to inconsistently pass the thresholds set. • The majority of IIP metrics are demonstrating no significant change on a monthly basis and will not consistently pass or fail the assurance targets if nothing changes. • Referral to Treatment (RTT) 65 week Breaches metric is flagging as variation of a concerning nature however performance has achieved target for the first month of the year. • Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds. **Patients** • The Organisation is demonstrating consistent reductions in the number of patients with an in-hospital stay of more than 14 days & is currently meeting the trajectory for improvement. • Overall a consistent reduction in 104 & 78 week breaches is in place with remaining challenges to demand seen in Gastroenterology & Otology. • Type 1 Compliance has exceeded the tier 1 target in each month of Q1. **Quality & Safety** • Three Serious Incidents (SIs) declared in the month. • One never event reported in June. • FFT Satisfaction levels for Outpatients and ED are demonstrating a statistical improvement. **People** • Sickness absence remains below the alerting threshold for the 5th month, with William Harvey Hospital (WHH) care group being the lowest clinical area at 3.79%. • Vacancy rate has risen to 9.2%, just below the threshold. • Statutory training compliance continues on a positive trajectory and is at 92.5%. **Finance** • The Group delivered the Year to Date (YTD) plan of £23,128k in Quarter 1. • Pay expenditure has reduced and is below plan from Month 2, and is currently under plan by £0.6m YTD for the Trust. Income is remaining stable, with increased levels of activity

	especially within outpatients. Non pay has remained stable as compared to Month 2, with Month 2 being an improved position to Month 1. • There are emerging risks to the submitted 2024/25 financial plan relating to the Consultant pay award and Strike action. These have been offset by non-recurrent benefits YTD, however if additional funding is not agreed, could be a risk to our year-end position. • The Trust has delivered £9.2m of efficiencies in Quarter 1 in line with the YTD plan, consisting of recurrent savings of £5.7m and non-recurrent savings of £3.5m. There was, however, an increase to non-recurrent Cost Improvement Programme (CIP) achievement of £1.5m YTD to plan, due to slight delays in the commencement of recurrent schemes. **Maternity** • The extended perinatal rate remains consistently below the threshold of 5.87 per 1,000 births, with the June 12 month rolling rate at 3.47 per 1,000 births. • The FFT maternity response rate (based on the national methodology of delivery episodes only) remains below average for six consecutive months and below the threshold of 15%. • The quarterly staff engagement score remains below the threshold and was below the lower threshold at 6.07 in April - June.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

Implications:

Links to Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the Emergency Department (ED).
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Working through with the subsidiaries their involvement and impact on We Care.

Assurance route:

Previously considered by: N/A

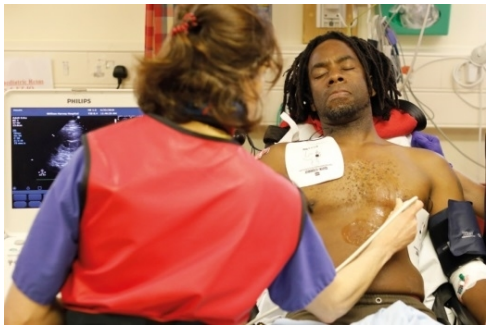
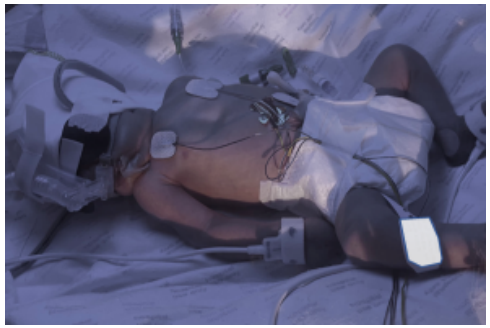
Integrated Performance Report

June 2024







Integrated Performance Report

Statistical Process Control

The Trust's IPR forms the summary view of Performance against the organisations five strategic themes; Patients, Quality & Safety, People, Partnerships and Sustainability. It also collocates the metrics which are intrinsic to our Integrated Improvement Plan and monitors progress against the quarterly milestones which will enable the organisations exit from National Oversight Framework 4 and Tier 1 monitoring. To do this is uses Statistical Process Control to assess performance.

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.

Our Trust Integrated Performance Report incorporates the use of SPC Charts 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.

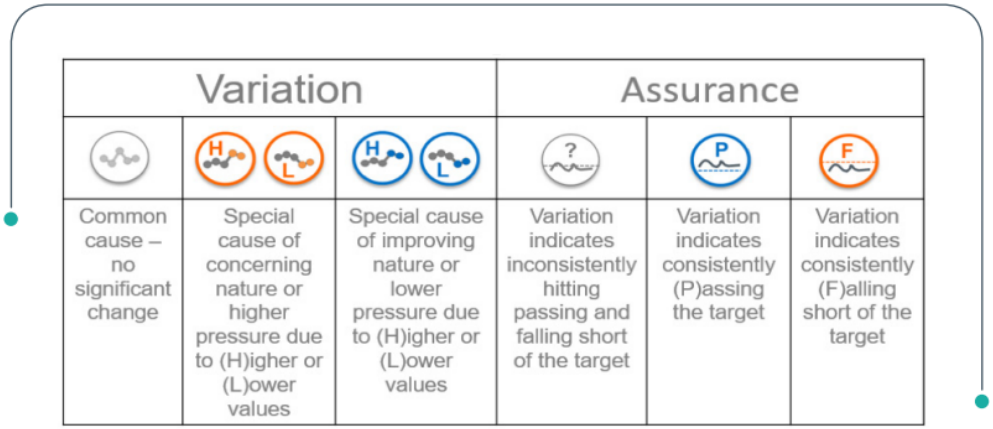
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

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.



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

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

The colours used for data points in the dashboard (tabular view) represent the position of each KPI from an SPC (Variation) perspective. The colours are based on statistically significant movement. The key is as follows:

Statistically significant improving variation	Statistically significant variation of concern	No significant change

Integrated Improvement Plan (IIP)

Summary Highlights

June Highlights:

The Organisation is demonstrating consistent reductions in the number of patients with an in-hospital stay of more than 14 days. The metric will however continue to fall short of the target without further intervention.

The Endoscopy backlog is showing variation of an improving nature with its continued reductions since January 2024. From an assurance perspective it has achieved the target performance for the last two months.

The financial efficiency programme, number of patients waiting more than two years for elective treatment and Type 1 four hour Emergency Department Compliance are all demonstrating improving performance but continue to inconsistently pass the thresholds set.

The majority of IIP metrics are demonstrating no significant change on a monthly basis and will not consistently pass or fail the assurance targets if nothing changes.

RTT 65w Breaches metric is flagging as variation of a concerning nature however performance has achieved target for the first month of the year.

Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds.

Integrated Improvement Plan (IIP)

Exit Criteria Metrics: Dashboard

Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
People	IIP		Staff Engagement Score			6.27	6.27	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70
Operational Perfo...	IIP		Type 1 Compliance 4hrs			51.6%	46.5%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%
	IIP		12 Hr Total Time in Department			8.7%	9.7%	10.2%	10.7%	10.4%	11.4%	11.1%	10.2%	9.5%	10.1%	9.6%	9.6%
	IIP		Cancer 28d Combined Performance			62.0%	60.5%	59.3%	63.2%	61.7%	68.1%	56.2%	65.3%	67.2%	63.4%	70.2%	70.6%
	IIP		Cancer 62d Combined Performance			74.1%	67.2%	59.5%	64.1%	62.4%	63.3%	56.6%	55.7%	68.9%	66.8%	64.1%	63.4%
	IIP		Cancer Over 62d on PTL			313	327	405	367	308	407	419	244	188	236	237	233
	IIP		RTT 65w Breaches			1,148	1,292	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656
	IIP		RTT 78w Breaches			127	145	233	325	435	643	752	653	485	465	272	82
	IIP		RTT 104w Breaches			4	9	9	8	12	12	6	13	24	15	1	1
	IIP		Endoscopy Backlog			8,376	8,771	9,067	9,218	9,254	9,397	8,941	7,831	7,055	5,969	4,986	3,921
	IIP		DM01 Compliance			55.9%	53.6%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%
Quality	IIP		Falls with Harm			2	2	8	6	2	3	2	10	4	8	3	4
	IIP		Pressure Ulcers			78	76	62	103	82	84	113	91	76	84	84	84
Finance	IIP		I&E Monthly Variance Group (£M)			-10.0...	-11.314	-9.030	-8.929	-6.461	-9.326	-10.995	-10.215	-12.1...	-8.768	-7.310	-7.078
	IIP		Efficiencies YTD Variance (£M)			-8.0	-6.3	-9.5	-11.8	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0

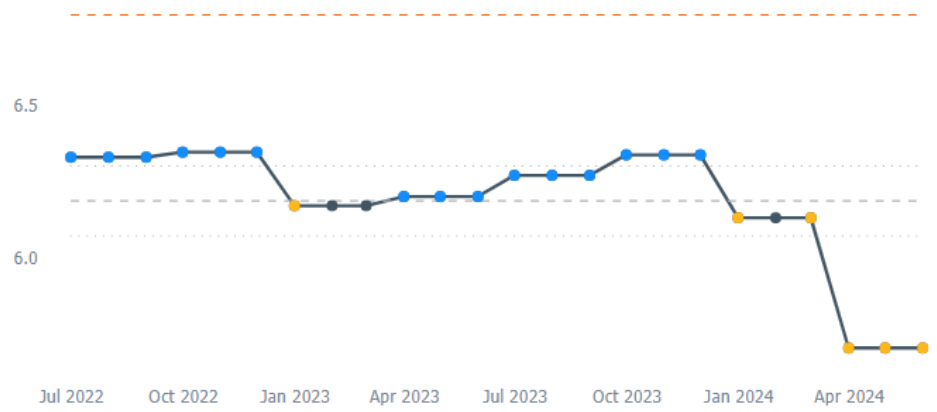
Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
Jul-23	6.27	
Aug-23	6.27	
Sep-23	6.27	
Oct-23	6.34	
Nov-23	6.34	
Dec-23	6.34	
Jan-24	6.13	
Feb-24	6.13	
Mar-24	6.13	
Apr-24	5.70	
May-24	5.70	
Jun-24	5.70	

XMR Run Chart



Understanding the most recent data point

Performance

5.70

Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point; Two Out Of Three Beyond Two Sigma Group

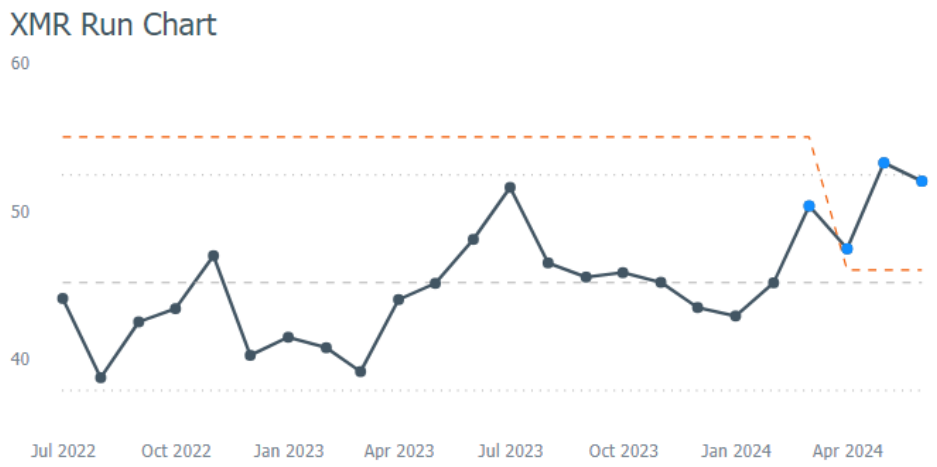
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• End Mar 25	• Staff engagement (5.70) is at a historic low and has fallen for a second successive quarter. July data indicates that this trend continues and that advocacy (the extent to which colleagues would recommend the Trust) remains the primary driver.
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• End Jul 24	• Actions to improve staff engagement are articulated through the Culture & Leadership Programme (CLP) and governed through the associated delivery group. Care Group People Plans have also been developed, with performance against these actions monitored monthly at PRM's through 12 key performance indicators.
National Staff Survey 2024	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• End Nov 24	• The 2024 NHS Delivery Plan has been shared with Board, EMT and CLP and relates specifically to actions taken to drive greater response rates. The NQPS response rate for Q1 (24%) was 5% higher than the national average (19%) and the Q2 NQPS response rate is currently 5% above the national average.

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
Jul-23	51.6%	
Aug-23	46.5%	
Sep-23	45.5%	
Oct-23	45.8%	
Nov-23	45.2%	
Dec-23	43.5%	
Jan-24	42.9%	
Feb-24	45.1%	
Mar-24	50.3%	
Apr-24	47.4%	
May-24	53.2%	
Jun-24	52.0%	



Understanding the most recent data point

Performance

52.0%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2024/5 to incorporate functions of an 'emergency portal' – advice and guidance, same day emergency care access – primary and secondary care; acute GP referral management; ambulance 'stack reviews'; frailty response, care home support and update of DOS. • Development of direct access pathways and extending use of the virtual wards, same day emergency care services	• COO • Dep COO UEC • CN/CL ED	• Quarter 2 • Quarter 2	• Performance 52% which is ahead of trajectory for Q1 • SPOA model evaluation 23/4 completed end May 24 • Working group: revisit ToR and model of care for development – clear on areas of focus based on attendance data • Workshop to review system wide SPOA and virtual ward 20/6 • Frailty model: task and finish group established to review model
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites	• CL ED • Dep COO UEC • Site MDs	• Quarter 2 • Quarter 1	• ED Internal professional standards drafted; awaiting LNC sign off following clarity on monitoring and escalation mechanisms • Safe & Effective ED workstream established; w/shop held 12/6 and workplan developed for internal ED actions • Heatmap for demand profiles requested to ensure workforce alignment – due end Q1
Admission avoidance	• Front door alternatives to ED: • Review and development of AMU model and SDEC at WHH with direct access pathways • Review of effectiveness of AMU model and SDEC at QEQM	• WHH/QE Tri • Dep COO UEC	• Quarter 3	• AMU workstream established for WHH – direct access, workforce, pathways and data for demand and capacity to be completed Q1. • AMU model at QEQM under review – operational policies to be drafted for both sites to ensure standardisation – Q1

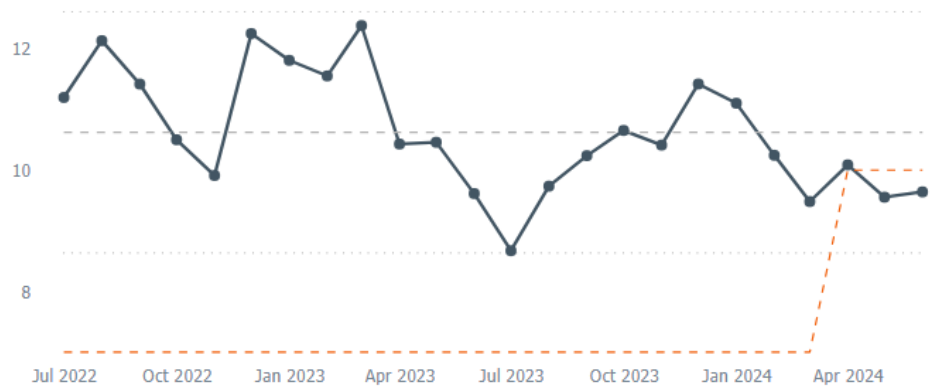
Integrated Improvement Plan (IIP)

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
Jul-23	8.7%	
Aug-23	9.7%	
Sep-23	10.2%	
Oct-23	10.7%	
Nov-23	10.4%	
Dec-23	11.4%	
Jan-24	11.1%	
Feb-24	10.2%	
Mar-24	9.5%	
Apr-24	10.1%	
May-24	9.6%	
Jun-24	9.6%	

XMR Run Chart



Understanding the most recent data point

Performance

9.6%

Variation indicates inconsistently passing and falling short of the target

Variation

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

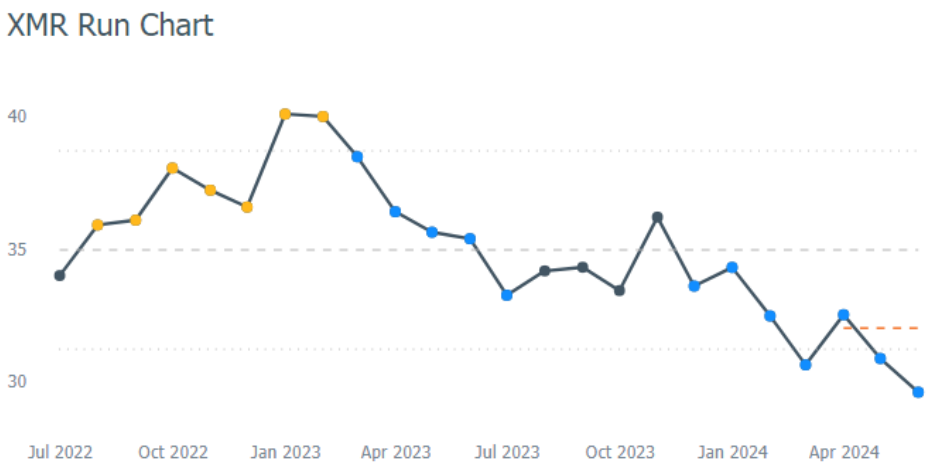
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity (admitted patients)	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment units; aligned to demand • Improve flow into downstream wards – internal flow workstream from RLoS and proactive site management • Reducing Length of Stay Programme – reduce delays in patient pathways and robust and proactive management of flow	• Tri MD Tri DoN	Quarter 3	• Medical workforce review underway supported by Deputy MD • RLoS programme roll out – Internal flow and SAFER bundle core improvement programme to site Triumverates • Daily site management 'test of change' for remote site management • Workstream established to review direct admission pathways • Cross site ED task and finish group in place – development of 12 hour recovery plan – including establishment of effective CDUs on both sites • RLoS – 0.74 day reduction in NEL in June against baseline to support more patients being managed through the core beds
Weekend profiles	• Improve discharge profile at weekends to match demand • Implement criteria led discharge • Review support functions at weekends to support discharges • Improve w/e planning & proactive transfer processes across sites	• CG Tri	Quarter 3	• Diagnostics for key reasons for delays at weekend finalised • Workstream to be established for criteria led discharge • Escalation and discharge policies under review; to be finalised quarter 1 & to include expectations to support 7d services; w/shop held 12/6
High number of Mental Health (MH) patients in ED with long waits	• Daily external escalation processes to be approved by the HCP to support oversight and planning • ICB support to EKMHT to manage OOA access • SAFEHAVEN roll out underway across both sites	• CG Tri WHH/Q EQM	Quarter 2	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4 • Focus for 24/25 on escalation and capacity to manage long stayers- SOP for escalation being developed by MD for WHH and QEQM

Integrated Improvement Plan (IIP)

In-Hospital Spells with a Length of Stay over 14 Days

% Beds Occupied 14+

Timescale	Value	SPC
Jul-23	33.2%	
Aug-23	34.2%	
Sep-23	34.3%	
Oct-23	33.4%	
Nov-23	36.2%	
Dec-23	33.6%	
Jan-24	34.3%	
Feb-24	32.5%	
Mar-24	30.6%	
Apr-24	32.5%	
May-24	30.8%	
Jun-24	29.6%	



Understanding the most recent data point

Performance

29.6%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation	Special cause of improving nature or lower pressure due to lower values
Flags	Below Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

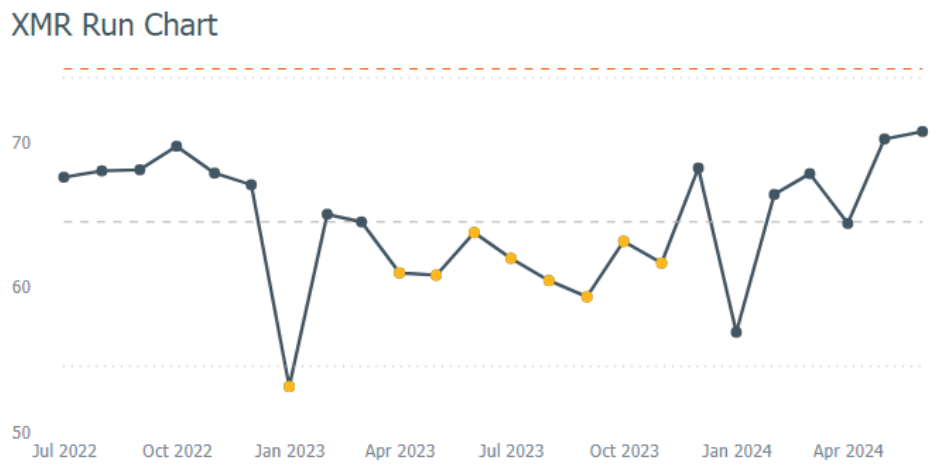
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Dep COO UEC/CG DoN • COO/Dep COO UEC • Deputy COO/MD DCB	• Q2 • Q2 • Q2	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for C2R • MADE event/ care audit to be considered with regards to understanding reasons for residing and scoping opportunities for alternative models • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities • Therapy review underway
Patients not meeting the criteria to reside >14 days	• Demand and capacity for D2A pathways – working with HCP partners to review demand and capacity to mitigate delays for patients waiting to access D2A capacity • Review of internal codes – therapy reviews required for discharge – develop D2A approach	• COO/Deputy COO-UEC • System Partners	• Q2 • Q2	• Test and change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – programme overview for completion quarter 2.
Grip and control: all LOS	• Implement weekly stranded reviews on all sites; SAFER bundle • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Q2	• Discharge and escalation policy review in progress – Sept 24 • SAFER bundle – revisit and standardise process for consistent implementation Q1 complete by care groups • Stranded review and escalation process drafted for consideration.

Integrated Improvement Plan (IIP)

Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance

Timescale	Value	SPC
Jul-23	62.0%	
Aug-23	60.5%	
Sep-23	59.3%	
Oct-23	63.2%	
Nov-23	61.7%	
Dec-23	68.2%	
Jan-24	56.9%	
Feb-24	66.4%	
Mar-24	67.8%	
Apr-24	64.4%	
May-24	70.2%	
Jun-24	70.7%	



Understanding the most recent data point

Performance

70.7% — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Guided Biopsy, US. • Endoscopy booking turnaround times • Breast US booking turnaround times	• Radiology • Endoscopy	• Funding – July 24 • Working groups – Q3	• Amended escalation process with weekly radiology touchpoint • Funding to support insourcing CT and US guided biopsy – likely implementation from September 24 • Further increased in Endoscopy capacity to support Cancer pathways due to mobilise from early September • US capacity for Breast increasing with locum support from mid-July onwards – Cancer patients priority access to increased capacity
Timely diagnostic reporting	• Reduced reporting times for radiology • Reduced reporting times for histopathology	• Radiology • Endoscopy	• Ongoing	• Amended escalation process with weekly radiology touchpoint • Thresholds for escalation now reduced and set at: Histopathology reporting – 10 days for <50s and 7 days for 50+days. Radiology – 50+days in pathway is 48 hours. <50 days in pathway is 7 days. Reduced from two weeks. • Tiered funding in place to support 35 additional outsourced radiology reports per week • Histopathology consultant in post supported by tiered funding
Letter backlog	• Timely consultant dictation of cancer outcome letters to patients • Timely administrative support to process dictated letters	• Cancer compliance • Admin • Consultants	• Ongoing	• Weekly updates provided to specialties on backlog position • Request out to operational and clinical teams for cover for 28 day letters over the summer annual leave period.

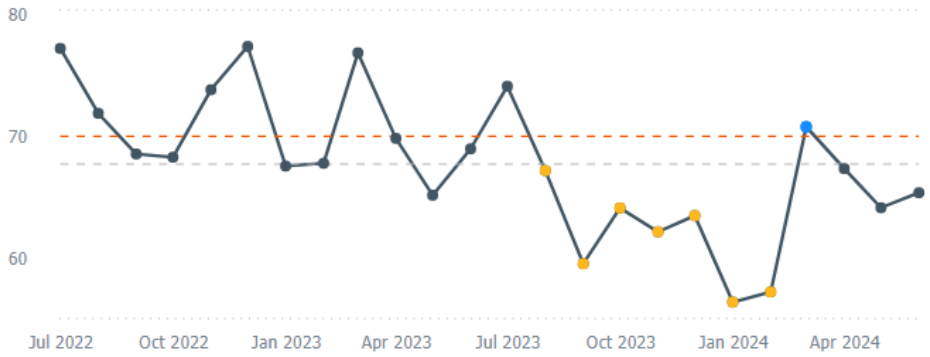
Integrated Improvement Plan (IIP)

Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Jul-23	74.1%	
Aug-23	67.2%	
Sep-23	59.5%	
Oct-23	64.1%	
Nov-23	62.2%	
Dec-23	63.5%	
Jan-24	56.4%	
Feb-24	57.2%	
Mar-24	70.8%	
Apr-24	67.3%	
May-24	64.1%	
Jun-24	65.4%	

XMR Run Chart



Understanding the most recent data point

Performance

65.4%

Variation indicates inconsistently passing and falling short of the target

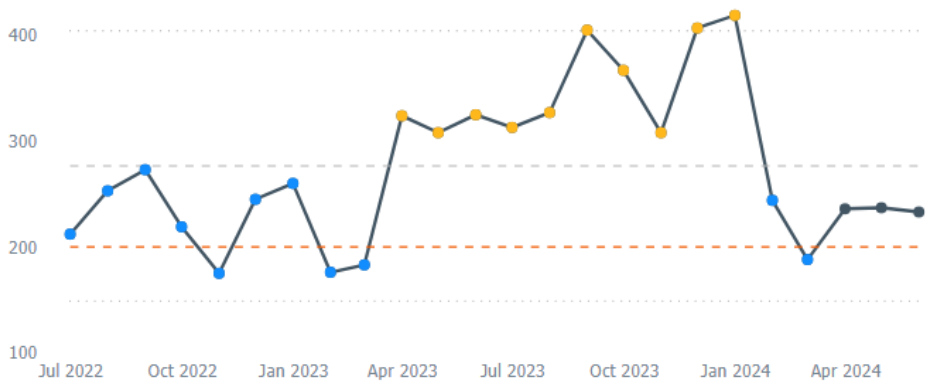
Variation

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

Cancer Over 62d on PTL

Timescale	Value	SPC
Jul-23	313	
Aug-23	327	
Sep-23	405	
Oct-23	367	
Nov-23	308	
Dec-23	407	
Jan-24	419	
Feb-24	244	
Mar-24	188	
Apr-24	236	
May-24	237	
Jun-24	233	

XMR Run Chart



Understanding the most recent data point

Performance

233

Variation indicates inconsistently passing and falling short of the target

Variation

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

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern • Patient level review of those 50+ day on the PTL	• Cancer Operational lead/ compliance team	• Ongoing	• Cancer weekly access meeting in place to discuss key challenged areas to review cause, effect and mitigations • PTL process review in progress • Improved BI dashboard allowing teams to identify patients at risk of breach • Targeted escalation for patients against agreed thresholds for Histopathology and Radiology • Breach reviews for all patients
Capacity for radiology diagnostics	• Staff vacancies contributing to reduced radiological diagnostics	• Radiology	• Q3	• Tiering funding provided to support insourcing for US, Guided CT and US biopsy, endoscopy, skin biopsy • Review via FDS working groups of diagnostic request practice
Urology surgical capacity	• Limited consultant robotic capacity	• Urology	• Q3	• Mat leave return in September for consultant to support RALP • Funding support for kidney robotic consultant locum – job out to ad and engagement with insourcing providers to source locum • In discussion with MTW re surgical capacity support
Patient engagement	• Reduce the numbers of DNAs and refer back to GP where appropriate	• Cancer compliance	• Q2	• Cancer access policy ratified at June Cancer Delivery Group • All patient contact points now being evidenced on the PTL to escalate to consultant following 2 x DNA • Increased patient contact ahead of diagnostic appointments
Surgical booking out times	• Elongated time between MDM and surgical treatment	• All surgical specialties	• Q3	• Close monitoring of booking out times for all surgical treatments across all specialties • Feedback from PTLs being monitored through cancer access. • Engagement with CCASS care group for additional theatre capacity • Insourcing provision being allocated from tiering funding
Effective implementation of Tiered Funding	• Ensuring all funding streams are implemented to maximise impact on FDS and 62 compliance	• All specialties	• Q3	• Operational implementation being monitored through Cancer Weekly Access • Financial controls in place • Trajectory of impact of funding being developed for NHSE

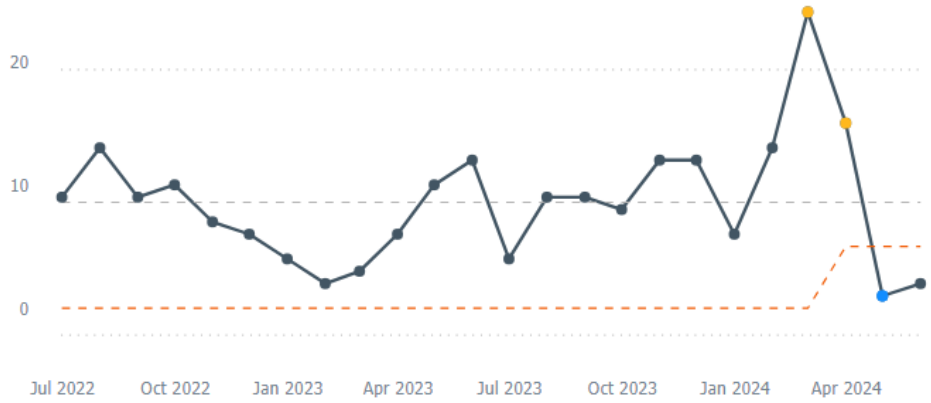
Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

Timescale	Value	SPC
Jul-23	4	
Aug-23	9	
Sep-23	9	
Oct-23	8	
Nov-23	12	
Dec-23	12	
Jan-24	6	
Feb-24	13	
Mar-24	24	
Apr-24	15	
May-24	1	
Jun-24	2	

XMR Run Chart



Understanding the most recent data point

Performance

2

Variation indicates inconsistently passing and falling short of the target

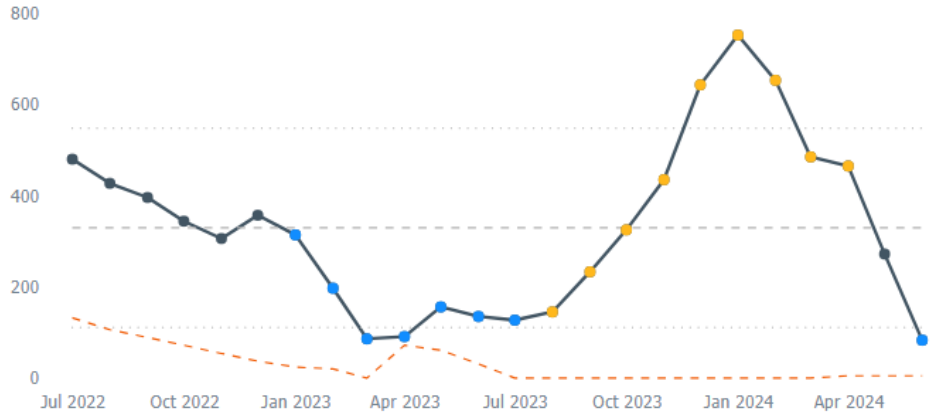
Variation

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

RTT 78w Breaches

Timescale	Value	SPC
Jul-23	127	
Aug-23	145	
Sep-23	233	
Oct-23	325	
Nov-23	435	
Dec-23	643	
Jan-24	752	
Feb-24	653	
Mar-24	485	
Apr-24	465	
May-24	272	
Jun-24	83	

XMR Run Chart



Understanding the most recent data point

Performance

83

Variation indicates consistently falling short of the target

Variation

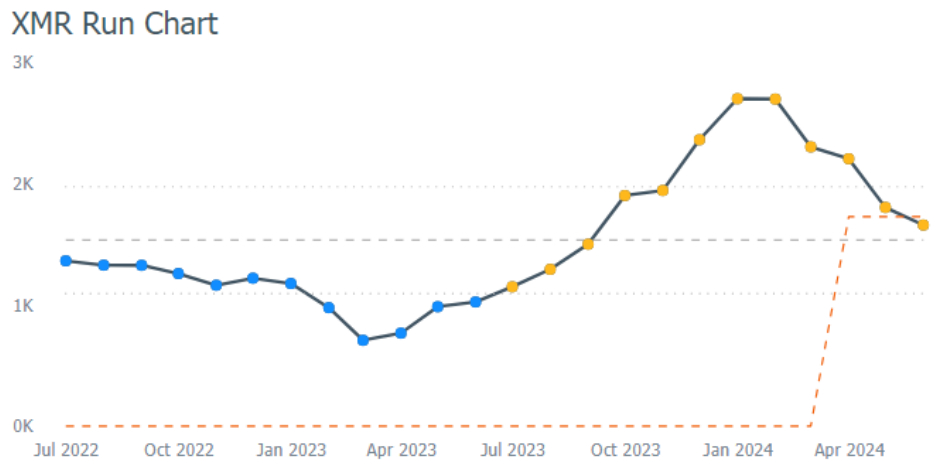
Variation	Special cause of improving nature or lower pressure due to lower values
Flags	Astronomical Point

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches

Timescale	Value	SPC
Jul-23	1,148	
Aug-23	1,292	
Sep-23	1,499	
Oct-23	1,900	
Nov-23	1,942	
Dec-23	2,360	
Jan-24	2,698	
Feb-24	2,695	
Mar-24	2,301	
Apr-24	2,203	
May-24	1,802	
Jun-24	1,657	



Understanding the most recent data point

Performance

1,657

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Pro-active management of 104 risk's to prevent future breaches.	• All 104 risks reviewed 8 weeks ahead and oversight through Access meeting with COO escalations of any risks. • Non-RTT validation findings to be managed through weekly review and escalated through Care Groups and into Access to ensure late findings are treated at pace	COO Dep COO	• In place • In place	• 1 remaining breach for July – re-dated for 18th July. Patient Choice.
Drive to clear all 78 week risks by end of July.	• GiRFT team secured 20 pts for Otology Capacity from BHR. • Development of Choice Application SOP to manage non-admitted choice in line with revised Access Policy • Additional 1st OPA's Commissioned to support current backlog via Insourcing • MTW support for ENT and Gastro patients • Paediatric ENT reviewing additional WLI's	COO Dep COO COO COO CCAS/WYCP	• ASAP • July • July • Ongoing • July	• UCLH identified with capacity. Working through plans. • Draft SOP ready for July Access meeting. • Approved by Dep COO on 19th June and to mobilise 512 appts from August. • Regular weekly transfer process in place

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; Long Waiter Actions

RTT Long Waiter Actions

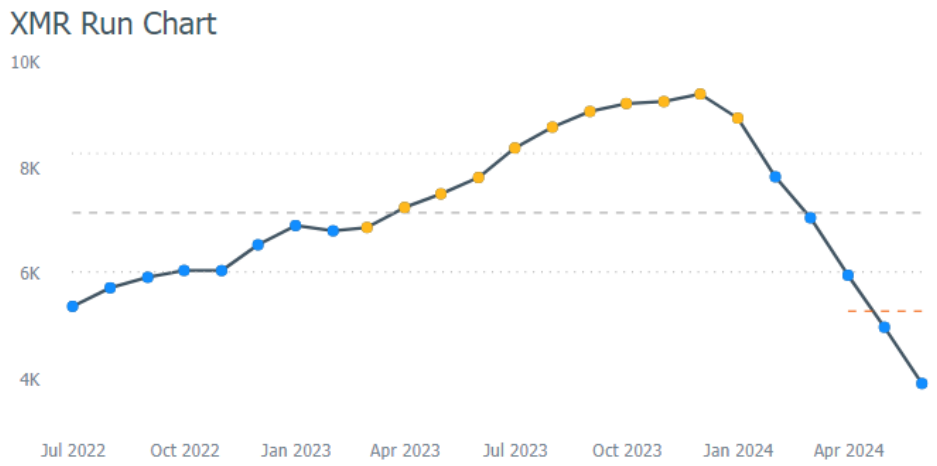
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to eradicate 65 weeks by end of March 2025	• Detailed Care Group recovery plans to be completed. • 12 week contact validation programme commenced to support clearance plan. • Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting. • Theatre programme to improve utilisation to 85% and drive clearance of backlog. • Two additional Ophthalmic Consultants to commence. • Validation programme to commence in Cardiology.	• Dep COO • Dep COO • COO • MD – CCAS • MD – CCAS • GM - Cardiology	• Completed • June • Ongoing • Jul-Sep • Aug-Oct • July	• Plans drafted and agreed by COO through Access and shared with Tier 1 team in June • Commenced 11th June with small pilot and 2,000 patients contacted in July. • In place • Commenced • Appointed and progressing to start • Appointed and commenced in July

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Jul-23	8,376	
Aug-23	8,771	
Sep-23	9,067	
Oct-23	9,218	
Nov-23	9,254	
Dec-23	9,397	
Jan-24	8,941	
Feb-24	7,831	
Mar-24	7,055	
Apr-24	5,969	
May-24	4,986	
Jun-24	3,921	



Understanding the most recent data point

Performance

3,921

Variation indicates consistently falling short of the target

Variation

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

Flags: Astronomical Point
Descending Run Group
Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Ensure that booking team were not performing no booking tasks including reception. • Recruit reception staff. • Train other members of the team to book for Endoscopy patients.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• Weekly activity now consistently at around 530 elective patients week up 25%. In the last month we have reduced insourcing by 20% and maintained activity with improved utilisation. • Ongoing training of the wider team to contribute to the booking process in underway to support the service target of 600 per week in September.
Demand management	• New Triage system for Endoscopy internal referrals now live. • Demand Analysis & Sustainable Waiting List Calculation	• Endoscopy recovery lead • Clinical lead	• Commenced 18/6	• Triage of internal referrals evaluation on going • Consideration for a triage process for routine GP referrals underway. • Demand analysis complete future capacity planning underway. • Alternative pathway working group established.
Waiting list accuracy	• Validation of the current waiting list. • Review of the referral process and waiting list configuration. • Consolidation and simplification of waiting list.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• The validation of the Endoscopy WL will be completed this month. • Process mapping of referral pathway underway. • Triage of internal referrals now in place, impact being evaluated.

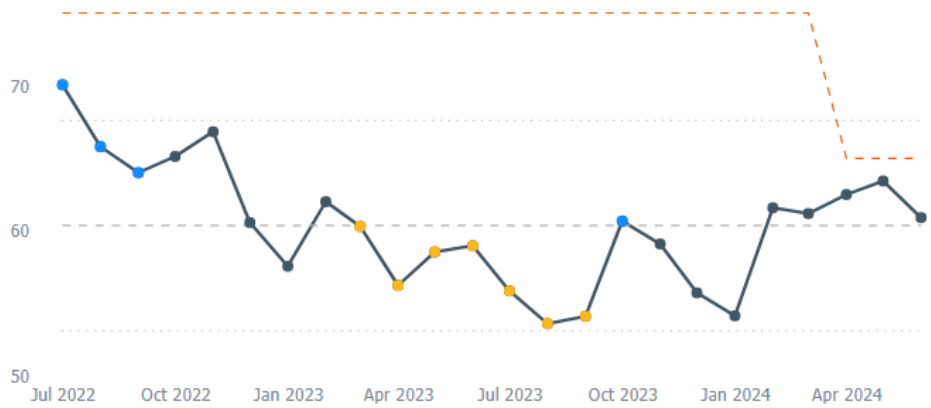
Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Jul-23	55.9%	
Aug-23	53.6%	
Sep-23	54.1%	
Oct-23	60.7%	
Nov-23	59.1%	
Dec-23	55.8%	
Jan-24	54.2%	
Feb-24	61.6%	
Mar-24	61.2%	
Apr-24	62.5%	
May-24	63.4%	
Jun-24	60.9%	

XMR Run Chart



Understanding the most recent data point

Performance

60.9%

Variation indicates inconsistently passing and falling short of the target

Variation

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

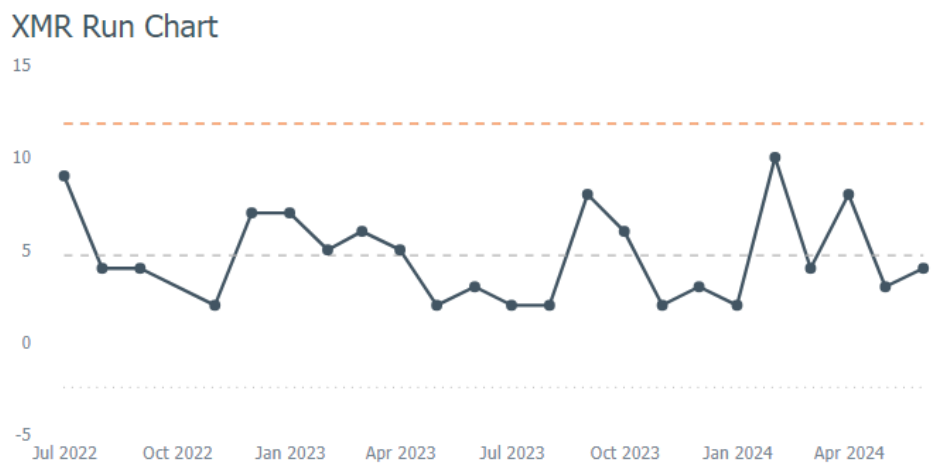
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Endoscopy backlog clearance plan	• Clear targeted recovery plan in place for Colonoscopy, Gastroscopy & Flexi.	• Endo Lead	• Ongoing	• Fully detailed recovery plan in place covering a multitude of actions but key elements relate to increased booking capacity, validation of OGD backlog and drive towards full compliance by October 2024.
Breast Backlog Clearance and Recovery Plan	• To clear long waiters and backlog of Breast US • To improve 2ww TAT and DM01 position	• Head of Service	• Ongoing	• Funding secured from the Cancer Alliance to support additional US and biopsy capacity • Locum secured for 7 days for July to commence 20.07.24 • Tender process underway for longer term insourced support via approved Cancer Alliance funding
MRI Backlog clearance and recovery plan	• To clear long waiters and backlog • To support improvements in 2ww TAT and DM01 compliance	• Head of Service	• Ongoing	• Secured funding for additional MRI scanner capacity • Review of outsourced efficiencies/productivity • Working up CDC Thanet Spoke site from October 2024 for an additional 210 patients a week

Integrated Improvement Plan (IIP)

Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Jul-23	2	
Aug-23	2	
Sep-23	8	
Oct-23	6	
Nov-23	2	
Dec-23	3	
Jan-24	2	
Feb-24	10	
Mar-24	4	
Apr-24	8	
May-24	3	
Jun-24	4	



Understanding the most recent data point

Performance

4 — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Harm from falls increasing since January 2024	• Escalation sighting care group ownership, Falls Steering Group • Trust Wide Improvement Plan (TWIP) in place • Falls Summit held in May • Identification of a consultant Falls lead • Linking with FOC specialist teams and therapies	Falls Lead ADON FOC	• July 31st 2024	• Falls summit held good attendance supported by Chief Nursing and Midwifery Officer and Chief Medical Officer • Work streams identified falls team linking with patient safety to develop quality improvement through PSIFR linking with the TWIP • Consultant Lead identified. • Collaborative working on going
Lack of access to falls training.	• Mandatory training package developed inline with national RCP standard • Package to be available to access on ESR processes followed to achieve this	Falls Lead People and Culture Systems Team	• July 31st 2024	• DCN working with Integrated Education Group to move through process for approval. • Position report for staff mapping completed and returned to Lead for People and Culture Systems Team awaiting delayed response.
Unwitnessed falls remain high In the most vulnerable patients. Enhanced observational care need identified not always able to put in place.	• Enhanced observation tool to go on to Sunrise trust wide • Falls team are part of a EKHUFT working group for Enhanced Care.	Associate Director of Nursing FOC	• September 2024	• The EKHUFT Enhanced Care Tool is now on Sunrise at the QEQMH. This is to be reviewed. • Planned roll out to be agreed and ownership. • EKHUFT working group with other Trusts and the community ICB led by Associate Director of the Fundamentals of Care.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

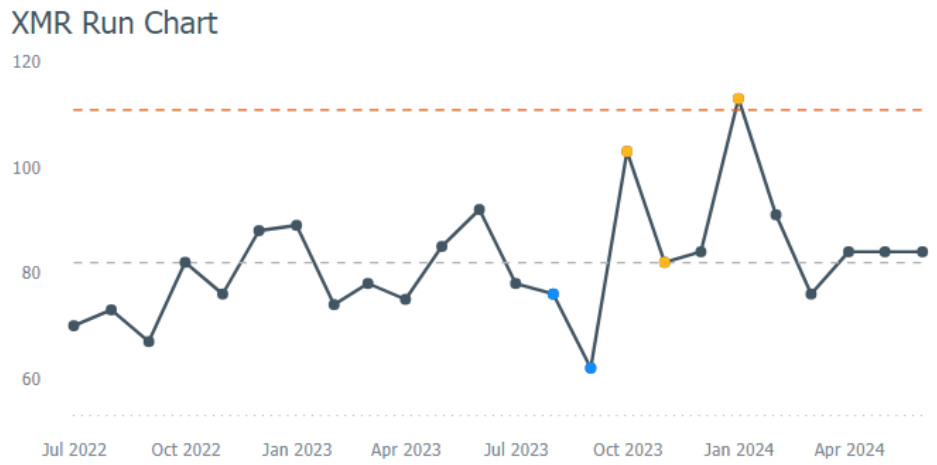
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient risk assessments not always completed timely and comprehensively by registered staff member. Findings not always acted upon correctly.	• Information shared at Falls Steering Group to Care Groups. • Moodle training developed to be added to ESR to support 1 yearly mandatory training for Multifactorial Risk Assessment Care Plan completion.	Falls Lead Work Force Planning Lead.	• September 2024	• Discussed in KPI meetings barriers to completion of assessments, project being undertaken with CNIO to review and streamline processes for all assessments. • Dash board to be created to include MFRACP completion including time reports and clinician status completing • Work Force Planning team linking with falls team to support moodle training package

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Jul-23	78	
Aug-23	76	
Sep-23	62	
Oct-23	103	
Nov-23	82	
Dec-23	84	
Jan-24	113	
Feb-24	91	
Mar-24	76	
Apr-24	84	
May-24	84	
Jun-24	84	



Understanding the most recent data point

Performance

84

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Recent audits have demonstrated that risk assessments are often incomplete or inaccurate leading to delayed pressure ulcer prevention strategies.	• Information shared at Tissue Viability Steering Group to CG's and escalated to the Fundamentals of Care committee. • Working with IT training team to develop training on PURPOSE T on ESR with case studies • Presenting to Statutory Mandatory and Essential Training Steering Group to develop a mandatory training module. • Liaising with Sunrise regarding simplifying the risk assessment process. • Working with the Quality improvement team to audit identified areas of concern. These areas to present improvements to TVSG.	• ADoN for FOC • TV Lead	• October 2024	• Discussed in KPI meetings barriers to completion of assessments, project being undertaken with CNIO to review processes for all assessments. • Case studies have been developed- Cambridge L ward have been approached to trial. • Several training sessions held this month on medical floor by TVNs to educate on PURPOSE-T & SKINS bundle completion on Sunrise. • Sunrise team looking at ways to simplify and avoid repetition on Sunrise.
Increased pressure damage noted due to long gaps in repositioning.	• Working with high reporting areas to improve repositioning techniques • Working with manual handling to improve repositioning and positioning of patients in bed. • Continue to work with other FOC specialities, conducting multi-disciplinary visits for complex cases. • To develop guidance on the repositioning of patients with unstable spinal issues.	• TV Lead	• October 2024	• SKINS and repositioning regimes have been separated on Sunrise for ease of completion. • Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas. • Liaising with Stanmore TVN and spinal specialist regarding the guidance

Integrated Improvement Plan (IIP)

Pressure Ulcers; Action Table

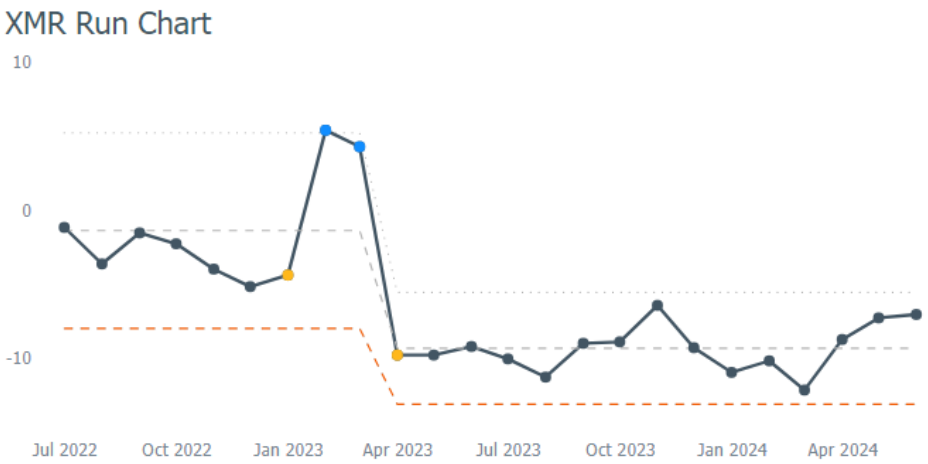
Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increase in Patients developing Category 2 medical device related pressure ulcers. Specifically related to Naso-Gastric Tubes (NGT), Thrombo-Embolic Devices (TED) urinary catheters.	• To trial two new NGT fixation dressings. • Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas. • Liaising with VTE lead for TED related damage. • Medical device SOP to be included in policy and to be available on Tissue Viability Intranet page. • To promote the use of Stat Locks for urinary catheter positioning. • To continue to separately monitor trends of Medical device related damage.	• TV Lead	• **October** 2024	• Trial of dressings to start in ITU at WHH in August • Policy is under review and to be presented to the Tissue Viability Steering Group in September 2024. • Medical Devices SOP presented to steering group and approved to be added to the Tissue Viability Page on the Intranet

Integrated Improvement Plan (IIP)

Income & Expenditure Monthly Deficit (Group)

Timescale	Value	SPC
Jul-23	-10.081	
Aug-23	-11.314	
Sep-23	-9.030	
Oct-23	-8.929	
Nov-23	-6.461	
Dec-23	-9.326	
Jan-24	-10.995	
Feb-24	-10.215	
Mar-24	-12.190	
Apr-24	-8.768	
May-24	-7.310	
Jun-24	-7.078	



Understanding the most recent data point

Performance

-7.078

Variation indicates consistently passing the target

Variation

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

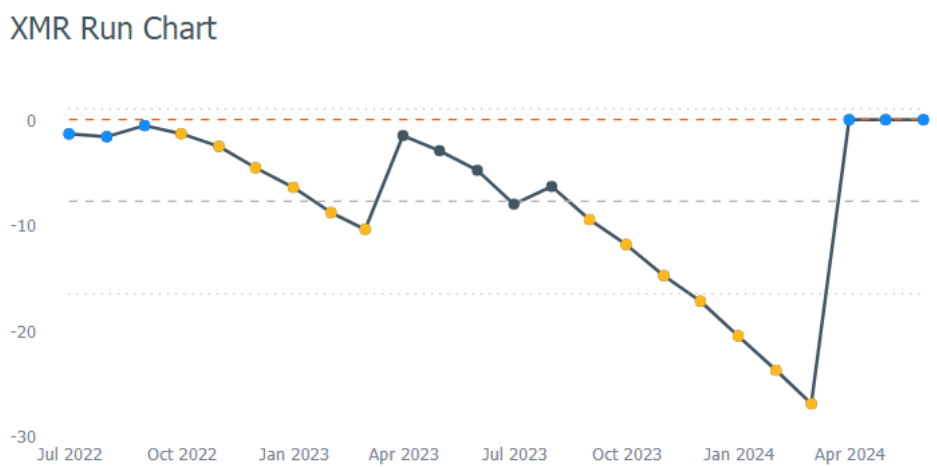
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining achievement of financial plan through Quarters two to four	• Increase level of CIP plan being developed to mitigate any potential slippage against efficiency schemes • Embedded bi-weekly FIPB with full Care Group representation and Theme lead presentations on a rotation basis	• Theme leads • PMO	• July 2024	• £54.4m risk-adjusted schemes as at 17/7/24, of which £52.9m are green schemes. • Half day development session (June 2024) to review progress to date following the launch event in January 2024. Full review of the long list of CIP schemes was undertaken with clear actions of the forward direction.
Currently 2 additional cost pressures are being mitigated on a non-recurrent basis	• Reporting into the ICB the value of the Strike Impact and also the shortfall in the Consultant pay award funding	• CFO	• Q2	• On-going escalation and demonstration of both the financial impact of the strike as well as the activity impact • On-going monitoring of the financial impact of the Consultant pay award

Integrated Improvement Plan (IIP)

Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Jul-23	-8.0	
Aug-23	-6.3	
Sep-23	-9.5	
Oct-23	-11.8	
Nov-23	-14.8	
Dec-23	-17.2	
Jan-24	-20.5	
Feb-24	-23.7	
Mar-24	-26.9	
Apr-24	0.0	
May-24	0.0	
Jun-24	0.0	



Understanding the most recent data point

Performance

0.0	Variation indicates inconsistently passing and falling short of the target

Variation

Variation	Special cause of improving nature or lower pressure due to higher values
Flags	Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £49m Recurrent CIP target for 2024/25	• PWC support to PMO function • Financial Recovery Director in post	Financial Recovery Director	• July 2024	• The trust is on plan with CIP delivery at Q1 £9.2m, however £3.5m is non-recurrent. • £54.4m risk-adjusted recurrent schemes (in-year effect) identified as at 17/7/24, of which £52.9m are green schemes.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director DOF	• July 2024	• CIP Methodology defined for each scheme • Financial Recovery Director working with Director of Finance to redefine the ways of working to streamline the reporting process.
Insufficient PMO Resource to support the development and execution of the CIP Programme	• PWC support to PMO function in place • Formulate a new PMO structure and resourcing profile	Financial Recovery Director	• September 2024	• New PMO Structure in development, pending approval. Following approval, the Trust will proceed with securing the necessary resources to bolster the PMO and support the CIP programme effectively.

Patients

June Highlights:

Unplanned Care
Attendances were above contract for NEL in June 2024, although admissions were below plan – linked predominantly to internal medicine and the lack of effective flow through the AMUs. The trajectories for improvements in key UEC targets were achieved in June.

An internal UEC Board has been established to oversee and build on these improvements and will link in with the HCP UEC system improvement plan to support the collective reduction required for A&E attendances, admissions and delays in discharging from the hospital.

A reduced length of stay for NEL patients has been achieved in June 24 and is ahead of trajectory, and is supporting a reduction in patients delayed discharges from the ICU as well as reduced corridor care and additional patients on wards.

The Organisation is demonstrating consistent reductions in the number of patients with an in-hospital stay of more than 14d & is currently meeting the trajectory for improvement despite the increase in the number of patients on the RTS caseload >7d increasing since the start of the year.

Planned Care
Successful 12 week contact validation programme pilot in June with full roll-out to commence in July to address RTT incomplete performance.

One remaining 104 week risk with clear plans to treat in July & a consistent reduction in 78 week breaches is in place with remaining challenges to demand seen in Gastroenterology & Otology. Mitigation plans through Insourcing, MTW support and GiRFT input to Otology capacity.

Variation	Assurance: P — Will consistently pass the target if nothing changes	Assurance: ? — Will not consistently pass or fail the target if nothing changes	Assurance: F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)		DNA Rate OP New ED Compliance Type 1 Compliance 4hrs	14D+ LOS Endoscopy Backlog Not Fit to Reside (pats/day) RTT 78w Breaches Super Stranded >21D
No Significant Change		12 Hr Total Time in Department Cancer 2ww Performance Cancer 31d Combined Performance Cancer 62d Combined Performance Cancer Over 62d on PTL DM01 Compliance RTT 104w Breaches	Ambulance Handovers within 30m Cancer 28d Combined Performance Cancer Over 104d on PTL Theatre Session Opp. Theatre Uncapped Utilisation
Concerning Variation (High or Low)	RTT Incomplete Performance	RTT 52w Breaches RTT 65w Breaches RTT Total Incomplete Pathways	12Hr Trolley Waits

Patients

June Highlights:

Theatre utilisation improvement plan developed and agreed to commence focussed around reduction of day 1-7 cancellations.

Endoscopy backlogs down by 967 in month to 8,064 at the end of June. 50% reduction to be celebrated in August with sustainable position to be achieved by October.

DM01 issues with MRI and NOUS with recovery plans in place targeted to booking efficiency, clinician capacity and insourcing to support.

Mobilisation of £1.9m funding underway to ensure significant improvements in FDS performance, 62 day combined and backlogs are delivered.

Patients

Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
Operational Perfo...	NAT		ED Compliance			74.3%	71.9%	70.7%	70.6%	70.3%	69.0%	68.8%	70.8%	73.1%	71.8%	76.0%	75.2%
	IIP		Type 1 Compliance 4hrs			51.6%	46.5%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%
	IIP		12 Hr Total Time in Department			8.7%	9.7%	10.2%	10.7%	10.4%	11.4%	11.1%	10.2%	9.5%	10.1%	9.6%	9.6%
	NAT		12Hr Trolley Waits			769	908	867	1,079	1,168	1,260	1,368	1,111	1,131	1,207	1,227	1,189
	NAT		Ambulance Handovers within 30m			91.8%	89.7%	90.0%	90.3%	88.7%	89.4%	89.4%	88.0%	87.9%	88.3%	92.6%	88.1%
			% Beds Occupied 14+			33.2%	34.2%	34.3%	33.4%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%
	KEY		Super Stranded >21D			246	241	245	235	260	244	243	229	208	224	213	205
	NAT		Not Fit to Reside (pats/day)			192.3	193.0	199.8	193.5	207.0	176.7	184.6	166.5	168.9	172.2	174.4	192.0
	IIP		Cancer 28d Combined Performance			62.0%	60.5%	59.3%	63.2%	61.7%	68.1%	56.2%	65.3%	67.2%	63.4%	70.2%	70.6%
	NAT		Cancer 31d Combined Performance			95.2%	92.5%	91.6%	91.5%	91.8%	93.2%	91.6%	94.7%	90.4%	92.8%	95.7%	94.3%
	IIP		Cancer 62d Combined Performance			74.1%	67.2%	59.5%	64.1%	62.4%	63.3%	56.6%	55.7%	68.9%	66.8%	64.1%	63.4%
	IIP		Cancer Over 62d on PTL			313	327	405	367	308	407	419	244	188	236	237	233
	KEY		Cancer Over 104d on PTL			63	67	77	83	67	65	84	62	43	38	36	42
	KEY		Cancer 2ww Performance			94.0%	95.7%	97.0%	96.2%	96.4%	95.4%	93.6%	97.2%	96.2%	94.8%	94.9%	96.1%
	NAT		RTT Incomplete Performance			51.6%	51.7%	51.5%	49.2%	49.1%	48.7%	49.0%	50.1%	50.8%	51.9%	52.0%	51.0%
	NAT		RTT Total Incomplete Pathways			84.8K	86.8K	88.9K	89.9K	89.2K	90.0K	90.0K	87.2K	85.4K	86.9K	87.5K	85.8K
	NAT		RTT 52w Breaches			4,575	4,767	5,113	5,966	6,194	6,459	6,912	6,691	6,613	6,356	5,700	5,186
	IIP		RTT 65w Breaches			1,148	1,292	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656
	IIP		RTT 78w Breaches			127	145	233	325	435	643	752	653	485	465	272	82
	IIP		RTT 104w Breaches			4	9	9	8	12	12	6	13	24	15	1	1

Patients

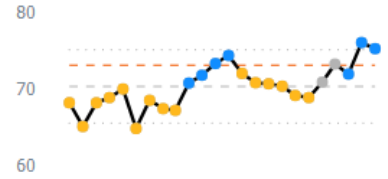
Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
	IIP		Endoscopy Backlog			8,376	8,771	9,067	9,218	9,254	9,397	8,941	7,831	7,055	5,969	4,986	3,921
	IIP		DM01 Compliance			55.9%	53.6%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%
	KEY		Theatre Session Opp.			46	61	54	52	41	46	45	42	33	40	40	33
	NAT		DNA Rate OP New			6.8%	7.4%	7.3%	7.6%	7.6%	8.2%	7.8%	7.0%	6.7%	6.8%	6.9%	6.9%
	NAT		Theatre Uncapped Utilisation			77.5%	79.5%	79.1%	79.9%	79.4%	77.2%	76.7%	78.1%	79.4%	80.7%	78.5%	79.9%

Patients

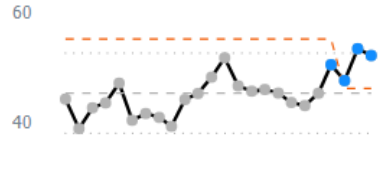
KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Development of Clear Governance Oversight on Planned Care	• Creation of governance structure to also include management oversight of service.	• Dep COO	• Complete • August	• Draft governance structure approved at Planned Care board on 21st May. • Review of longer term sustainable management structure underway.
Improvement programme for Theatre Utilisation	• Robust programme in place to ensure clear deliverables in utilisation supported by Prism.	• MD - CCAS	• Ongoing	• 8-6-4-2 process commenced in June. • Ophthalmic utilisation review underway. • WLI approval process now in place to ensure effective use of additional capacity.
Criteria to reside and Reasons for Delayed Discharge (RfDD)	• Task and finish group established with partners to develop and implement SOP for effective daily management and escalation of patients who are delayed in their pathway – either for those who are meeting the criteria to reside and RfDD	• Deputy COO UEC • Care Group Tri	• Q2	• Task and finish group established • Implementation of new codes and initial analysis of reasons to reside with MADE event planned mid June • Draft SOP developed – draft standards developed for review
Ambulance handover delays	• Validation of breaches for those >30 mins to understand opportunities to address delays and development of handover delay action plan – co-owned with SeCAMB	• Deputy COO UEC	• July 24	• Workshop held to understand key areas of focus to address delays • K&C MD reviewing system and process to address any delays

Patients

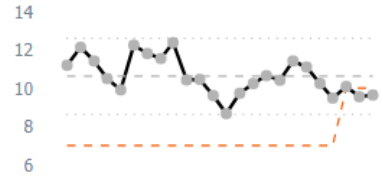
ED Compliance



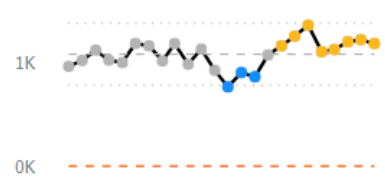
Type 1 Compliance 4hrs



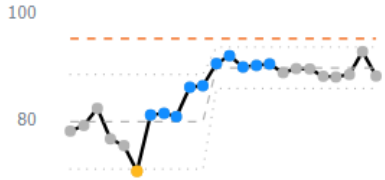
12 Hr Total Time in Department



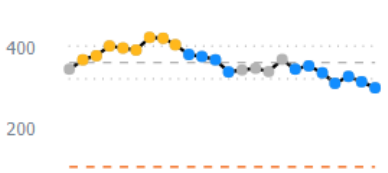
12Hr Trolley Waits



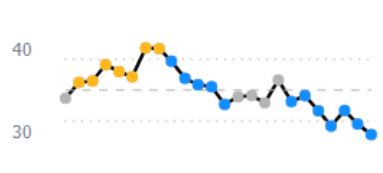
Ambulance Handovers within 30m



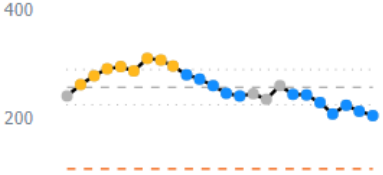
14D+ LOS



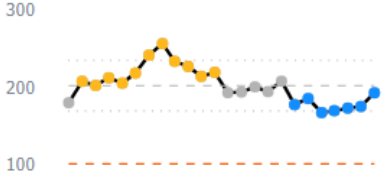
% Beds Occupied 14+



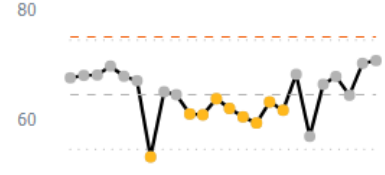
Super Stranded >21D



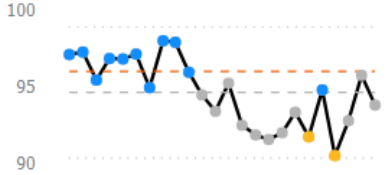
Not Fit to Reside (pats/day)



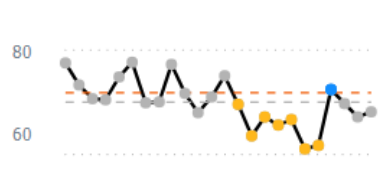
Cancer 28d Combined Performance



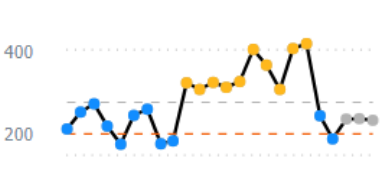
Cancer 31d Combined Performance



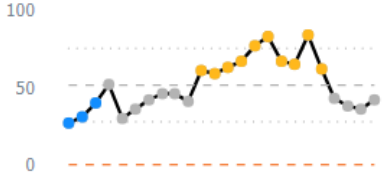
Cancer 62d Combined Performance



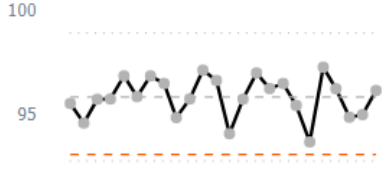
Cancer Over 62d on PTL



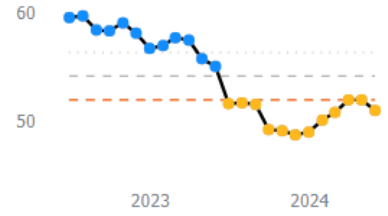
Cancer Over 104d on PTL



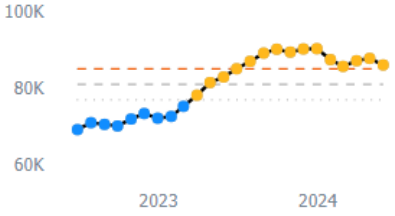
Cancer 2ww Performance



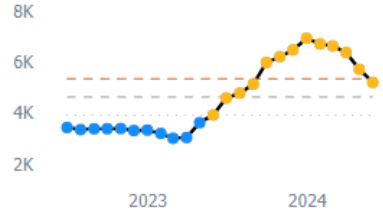
RTT Incomplete Performance



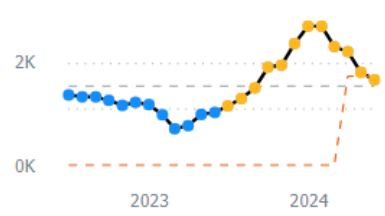
RTT Total Incomplete Pathways



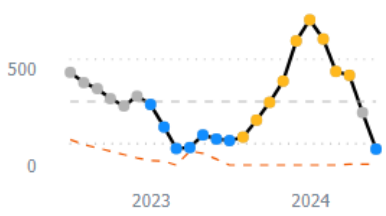
RTT 52w Breaches



RTT 65w Breaches

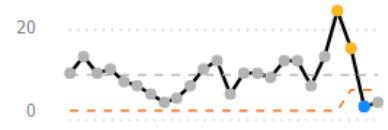


RTT 78w Breaches

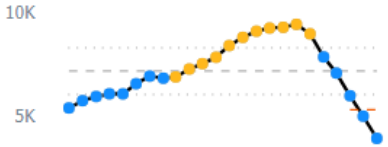


Patients

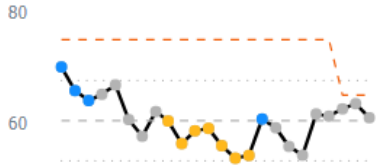
RTT 104w Breaches



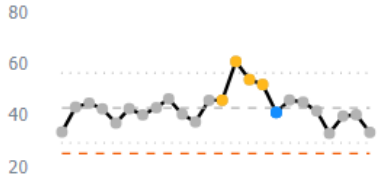
Endoscopy Backlog



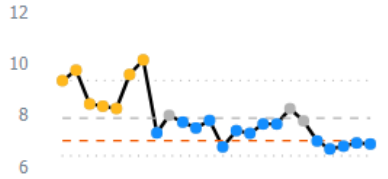
DM01 Compliance



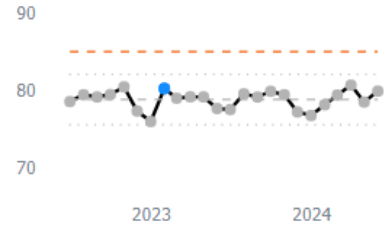
Theatre Session Opp.



DNA Rate OP New



Theatre Uncapped Utilisation



Quality and safety

June Highlights:

Safeguarding Incidents:
The safeguarding team continues to spend significant time with the care groups to ensure they recognise safeguarding when reviewing an incident and are undertaking quality assurance of the reports being undertaken. The number reflects safeguarding referrals and is a positive position.

Safeguarding supervision has been commenced to support reflection upon the incident within the ward and departments based teams.

Duty of Candour:
Duty of Candour data is temporarily unavailable. The compliance data continues to be collected via the Datix system. On extraction for the scorecards, discrepancies have been identified. This is due to changes made to the Datix system on implementation of LfPSE which require the sequence of coding for extraction to the scorecards to be updated. The patient safety and BI teams are working together to resolve this.

Complaint Response:
June 2024 has seen an increase in performance of response times 4.5% to 7.6% Changes to the complaints process, with trust wide ownership of complaints, is showing signs of performance improvement. June 2024 has seen a fall in complaints received, which is outside of the trend experienced.

Variation	Assurance: Will consistently pass the target if nothing changes	Assurance: Will not consistently pass or fail the target if nothing changes	Assurance: Will consistently fail the target if nothing changes
Improving Variation (High or Low)	FFT Satisfaction Level - Outpatient	Clinical Incidents IPC: CDiff Infections Safeguarding Children Training Serious Incidents Serious Incidents Breached exceed 60-day deadline	FFT Satisfaction Level - ED Overdue Incidents Safeguarding Adults Training VTE Assessment Compliance
No Significant Change		Falls with Harm FFT Satisfaction Level - Inpatient Incidents - Moderate / Severe IPC: Klebsiella Infections IPC: MRSA Infections IPC: MSSA Infections IPC: Pseudomonas Infections Mixed Sex Breaches Never Events Patient Incidents Patient Incidents - Moderate / Severe Pressure Ulcers	
Concerning Variation (High or Low)		Complaints Number HSMR IPC: EColi Infections Safeguarding Incidents	Complaint Response

Quality and safety

June Highlights:

Overdue Incidents:
The responsibility for reviewing and closing incidents sits with the Care Groups and the identified handlers. The patient safety team are working with the Triumvirates to enable them to identify how improvements can be made.

The Patient Safety Team will continue to support incident closures by having Weekly workload meetings with the care group governance teams to discuss barriers to closures coupled with providing monthly data with care group and specialty breakdowns so there is opportunity for continuous review as part of the governance meetings.

Trajectories for closure of overdue incidents for the care groups by October 2024 have been provided but since January we have closed over 3500 incidents so progress is being made, this needs to be a care group focus and part of business as usual governance.

The Patient Safety Team will continue to support incident closures by having Weekly workload meetings with the care group governance teams to discuss barriers to closures coupled with providing monthly data with care group and specialty breakdowns so there is opportunity for continuous review as part of the governance meetings.

We are working to get a trajectory for closure from the care groups of October 2024 but since January we have closed over 3500 incidents so progress is being made, this needs to be a care group focus and part of business as usual governance.

Never Events:
A Never Event occurred in June 2024 as a result of a misplaced NG tube. An immediate review of the Never Event was completed by the ED Head of Nursing, Lead Nurse for Nutrition and Hydration and Radiology governance lead. The incident was reported as an SI under SI Framework as the incident occurred prior to the Trusts transition to PSIRF.

The investigation is being led by the Quality Business Partner for WHH and an initial scoping meeting has been held and the terms of reference for the investigation has been agreed. The investigation is due for completion 29/08/2024. Additional information can be found on slide 33.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
Quality	NAT		Clinical Incidents			2,192	2,336	2,286	2,519	2,134	2,061	2,377	1,147				
	NAT		Patient Incidents										762	1,950	1,938	1,980	1,854
	NAT		Never Events			1	0	0	1	0	0	1	0	1	0	0	1
	NAT		Serious Incidents			11	12	13	13	14	6	15	10	7	6	4	3
	KEY		Incidents - Moderate / Severe			33	23	33	41	27	29	40	24				
	NAT		Patient Incidents - Moderate / Severe										13	41	43	32	51
	KEY		Overdue Incidents			2,395	2,669	2,980	3,353	3,293	3,614	2,986	1,663	1,358	822	1,406	1,557
	NAT		Serious Incidents Breached exceed 60...			6	2	3	1	2	3	4	1	0	1	1	0
	IIP		Falls with Harm			2	2	8	6	2	3	2	10	4	8	3	4
	NAT		Safeguarding Incidents			22	26	40	36	48	34	42	34	53	33	52	32
	NAT		Safeguarding Children Training			88.3%	89.5%	90.0%	90.1%	91.2%	91.4%	91.9%	93.6%	93.5%	94.3%	93.6%	93.3%
	NAT		Safeguarding Adults Training			83.7%	85.6%	86.5%	87.2%	88.6%	89.1%	89.8%	91.7%	92.1%	93.2%	93.5%	93.6%
	NAT		IPC: EColi Infections			8	7	7	11	5	15	13	14	17	10	11	16
	NAT		IPC: CDiff Infections			12	13	11	9	13	11	11	8	14	4	4	6
	NAT		IPC: Klebsiella Infections			3	5	7	4	9	9	5	4	5	10	7	7
	NAT		IPC: Pseudomonas Infections			0	0	1	3	1	2	3	4	3	2	2	4
	NAT		IPC: MRSA Infections			0	0	0	1	1	2	1	0	1	0	0	0
	NAT		IPC: MSSA Infections			10	5	3	6	7	6	8	7	2	6	7	5
	KEY		HSMR			98.0	99.1	100.0	100.7	102.2	106.0	109.3	112.4	112.0			

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
	IIP		Pressure Ulcers			78	76	62	103	82	84	113	91	76	84	84	84
	NAT		Mixed Sex Breaches			20	49	62	26	49	63	132	134	132	120	24	38
	KEY		Complaint Response			62.1%	42.6%	32.8%	7.1%	5.0%	5.9%	10.4%	15.5%	17.2%	0.0%	3.1%	7.6%
	KEY		Complaints Number			87	80	84	80	85	60	100	84	84	110	107	83
	NAT		FFT Satisfaction Level - ED			84.1%	83.0%	81.3%	81.3%	81.5%	81.7%	80.9%	83.9%	82.9%	83.1%	83.7%	84.0%
	NAT		FFT Satisfaction Level - Outpatient			95.2%	95.1%	95.2%	95.0%	95.1%	95.5%	95.5%	95.4%	95.2%	95.9%	95.8%	95.7%
	NAT		FFT Satisfaction Level - Inpatient			89.8%	90.0%	88.8%	89.7%	87.7%	89.6%	90.1%	92.0%	90.0%	89.4%	91.0%	90.6%
	NAT		VTE Assessment Compliance			88.1%	90.9%	91.2%	92.0%	92.1%	90.4%	91.6%	92.4%	92.4%	92.2%	93.2%	93.4%

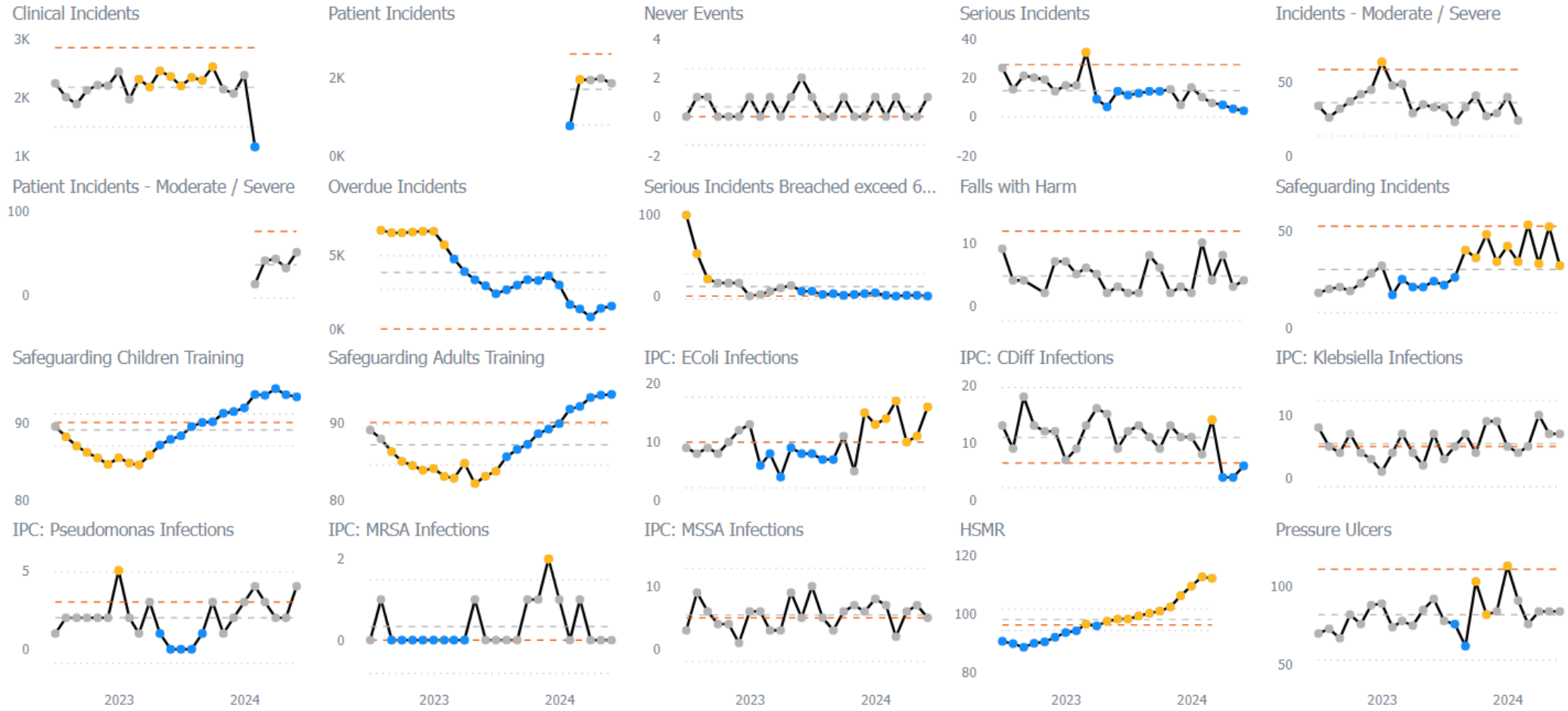
Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Reporting of Serious incidents (SI's) ceased on 8th June 2024 due to transition to PSIRF	• A trajectory and plan has been agreed with ICB to close all existing open SI's by the end of August 2024. • Serious Incident Investigation Approval Panels (SIIAP) will continue until all existing SI's have been approved through SI process. • Incidents of concern now follow the PSIRF plan and get discussed at Pre-Incident Response panel prior to escalation to executive led Incident Response Panel (IRP)	Head of Patient safety and Improvement	31/08/2024	• ICB closure panels scheduled to review and approve existing SI's • There are currently 24 open SI's , of which 9 have already been submitted to ICB. • Pre-IRP meetings and IRP meetings are established and run weekly.
One Never Event reported in June 2024	• Patient fed through misplaced NG tube • Evidence of good practice, checklist completed, nurse who inserted was NHSP who normally works on surgical ward - skilled with NG insertion. PH check was within safe levels. • LocSSIP not used. • Patient had complex history with a recent diagnosis of oesophageal cancer. • No clear confirmation on the radiology report as to whether the NG was safe to use or not	Quality Governance Business Partner for WHH	29/08/2024	• Immediate review of the Never Event (NE) by the ED Head of Nursing, Lead Nurse for Nutrition and Hydration and Radiology governance lead completed • Reported as an SI under SI Framework • Safety Pin (Trust wide safety message) published to emphasise the mandatory use of the NG tube insertion LocSSIP • Plan to add all LocSSIPs to Sunrise, ongoing, further information to be sourced regarding barriers to progression and planned timeframes.
Reduction in Clinical Incident's being reported	• The reduction in clinical incident reporting is attributed to the implementation of LFPSE. Incidents are now 4 categories for reporting incidents (patient, staff, visitor, organisation). Incidents previous reported as clinical incidents are now being reported under other categories like organisation. The total number of incidents in unchanged from the normal variation (2326 incidents in total in June 2024)	Head of Patient safety and Improvement	ongoing	• All reported incidents are reviewed by the Patient safety Team to ensure correct categorisation.
Increase in overdue incidents	• Care groups have been provided with trajectories for the closure of overdue incidents by October 2024. • Weekly reports are sent to Triumvirates with data broken down into specialty and handler to enable prioritisation of where support is needed with closures • Weekly meetings between Patient safety Team and care group governance teams to discuss progress and issues.	Head of Patient safety and Improvement	ongoing	• Care group governance meetings set up weekly to discuss progress with trajectories

Quality and safety

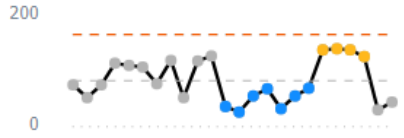
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
IPC Measures: Blood stream infections are currently over the threshold, and without intervention will breach	• Targeted training focus on Lines – Urinary catheter, peripheral and central line care as part of CLEAN campaign, AND hydration drive collaboratively with MDT	IPR Team	Aug 2024	• Targeted training on all sites completed in relation to line care, whole Trust 'line forum' completed, local QI projects commenced
FFT ED: satisfaction levels remain significantly below the Trust target of 90% satisfaction.	• Improve communication about waiting times whilst patients are waiting to be treated. • Improve patient comfort in waiting areas, including improved seating, offering pressure relieving cushions, ensuring patients are offered water (if not nil by mouth), and regular checks on those assessed at triage as vulnerable. • Identify, record and flag patients with communication needs when booking in. • Provide clear written information on who to contact if the patient / family have worries / new symptoms after returning home.	• Associate Directors of Nursing at each ED • Operational Manager at each ED • With support from Volunteering Services and the Patient Voice and Involvement team	• By early October 2024	• WHH ED creating an action plan to improve how they identify, record, flag, share and meet patient's communication needs. • Volunteer service looking to recruit volunteers for ED to support patient wellbeing whilst waiting. • QEQM ED working on a patient booklet.
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity) and patient experience once on a ward (e.g. being moved several times, lack of handover of key information)	• Improve communication with and involvement of carers / families of patients. • Supporting patients living with dementia by having fewer moves around wards • Supporting the wellbeing of parents / carers whose child / children are receiving inpatient care (Sophie's Legacy) (providing food and drinks when parents/carers stay on the ward with their child). • Supporting patients to get up and dressed; not stay in bed.	• Matron and ward managers • With support from the Dementia team, Patient Voice and Involvement team and Lead for Moving and Handling	• By early October 2024	• Carers policy published 14.6.24 and on Staff Zone and public website. • Updated carers page on Staff Zone • Expanded use of Carers Passports • John's Campaign is on-going • Patient boards behind the bed being developed to be used on all adult wards. Once launched a version for children's wards to be developed. • Audit of chairs on wards and plans to improve bedside seating.
Complaint Performance is below the standard we would expect	• Centralisation of the complaints team • Enhanced training for new team • Changes to system and process of complainants handling to include early calls to complainants to establish issues from the outset of the complaint being received	• Sue Holland CBPS Manager	• Ongoing in line with agreed trajectory for clearing the complaint breaches	

Quality and safety

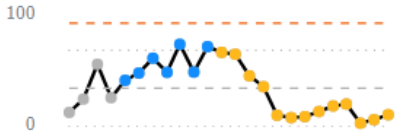


Quality and safety

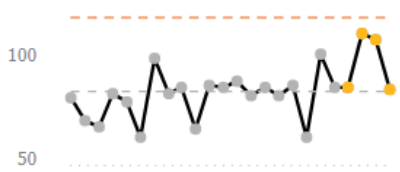
Mixed Sex Breaches



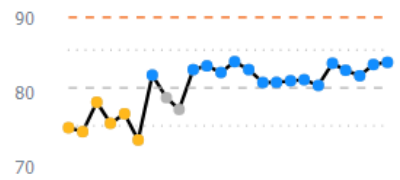
Complaint Response



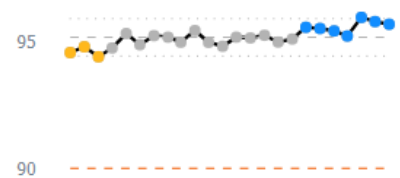
Complaints Number



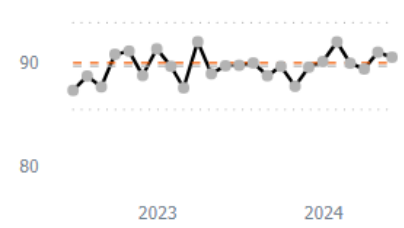
FFT Satisfaction Level - ED



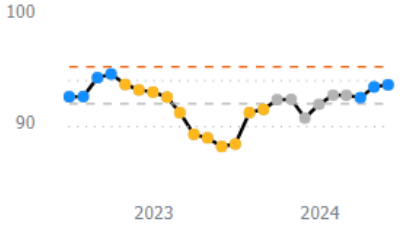
FFT Satisfaction Level - Outpatient



FFT Satisfaction Level - Inpatient



VTE Assessment Compliance



People

June Highlights:

Sickness absence remains below the alerting threshold for the 5th month, with WHH care group being the lowest clinical area at 3.79%.

Episodes of stress and anxiety related absence have continued to improve with targeted support by the P&C Care Group teams and following the re-introduction of on-site clinical psychology. In addition, Employee Relations are supporting Care Groups with contacting all members of staff who have had more than 4 occasions off sick in a rolling 12 month period.

Vacancy rate has risen to 9.2%, just below the alerting threshold. This increase has been partly due to a deliberate holding of vacancies as part of the review of Admin & Clerical establishments and vacancy rates over 10% within Diagnostics and WCYP (predominantly Maternity). Staff turnover remains stable (9.1%) and continues to achieve the desired industry 'gold' standard (≤10%). Premature turnover is 14.9% and remains within the desired parameters (≤15%).

Statutory training compliance continues on a positive trajectory and is at 92.5%. Compliance for medical staff is below the expected threshold, but is on an upward trajectory (at 79.8%). Medical compliance remains highest in WCYP at 89.9%.

Variation	Assurance: Will consistently pass the target if nothing changes	Assurance: Will not consistently pass or fail the target if nothing changes	Assurance: Will consistently fail the target if nothing changes
Improving Variation (High or Low)	Infection Control Training	Staff Turnover Rate Statutory Training	Appraisals Compliance Hand Hygiene Training
No Significant Change	Premature Turnover Rate	Sickness Vacancy Rate	Medical Job Planning Rate
Concerning Variation (High or Low)			Staff Engagement Score

People

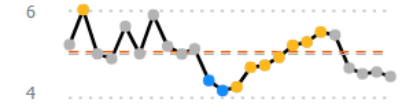
Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
People	NAT		Sickness			4.6%	4.7%	4.9%	5.2%	5.2%	5.5%	5.4%	4.6%	4.5%	4.5%	4.3%	4.4%
	NAT		Vacancy Rate			7.2%	7.9%	7.4%	6.7%	7.5%	7.7%	7.9%	8.4%	8.7%	8.2%	8.7%	9.2%
	NAT		Staff Turnover Rate			9.5%	9.2%	9.0%	9.1%	9.1%	9.3%	9.2%	9.2%	9.2%	9.3%	9.2%	9.1%
	NAT		Premature Turnover Rate			13.8%	13.7%	13.3%	13.6%	13.9%	14.7%	14.1%	14.5%	14.9%	14.6%	15.0%	14.9%
	KEY		Appraisals Compliance			72.4%	73.0%	73.3%	72.6%	72.9%	72.4%	73.9%	73.6%	73.8%	76.6%	74.7%	74.1%
	IIP		Staff Engagement Score			6.27	6.27	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70
	NAT		Statutory Training			91.7%	92.1%	91.9%	90.1%	90.6%	90.8%	91.4%	91.9%	92.0%	92.2%	92.4%	92.5%
	KEY		Infection Control Training			92.9%	93.0%	92.6%	92.4%	92.4%	92.8%	92.9%	93.1%	92.9%	92.9%	93.2%	93.7%
	KEY		Hand Hygiene Training			73.0%	75.1%	74.7%	73.1%	73.6%	72.4%	72.7%	74.2%	74.9%	75.8%	76.3%	76.8%
	KEY		Medical Job Planning Rate			58.7%	52.3%	58.1%	60.3%	58.3%	58.8%	61.1%	70.5%	45.3%	45.3%	44.1%	37.0%

People

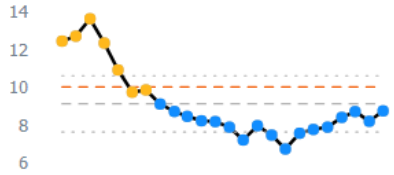
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working. • Vacancies in maternity will fall significantly with the recruitment of student midwives, due to be in post later this year.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• Pro-Active Sickness Absence Working Group set up, improved support through EAP for anxiety and reintroduction of Clinical Psychology from February 24. Advertising and promoting the service
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Staff Experience	• Ongoing	• Staff Turnover drops to **9.1%** and has achieved the gold standard (10%) for over a year. It appears to be stabilising at and around 9%.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Staff Experience	• Complete	• Premature turnover (**14.9%**) has reduced back and remains within the desired parameters (≤15%).
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2024 staff survey, with the launch linked to the Culture & Leadership programme implementation.	Head of Staff Experience	• End Mar 25	• Staff engagement (5.70) is at a historic low and continues to fall. July data indicates this trend continues and that advocacy (the extent to which colleagues would recommend the Trust) remains the primary driver.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Sept 24	• All Care Groups to target improvement within medical staff compliance. Compliance at 79.8%, and has increased for eight months running.

People

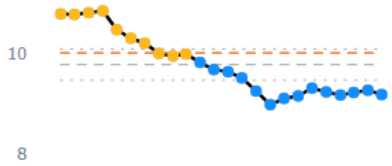
Sickness



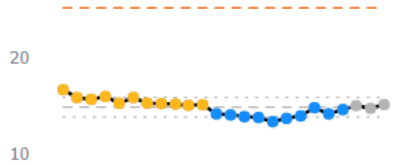
Vacancy Rate



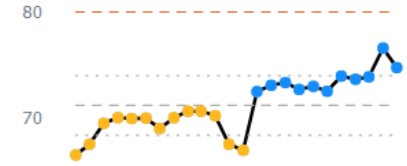
Staff Turnover Rate



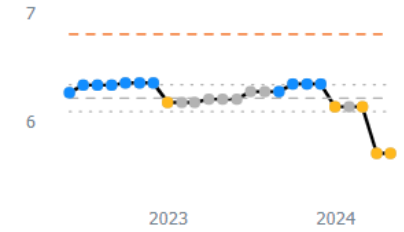
Premature Turnover Rate



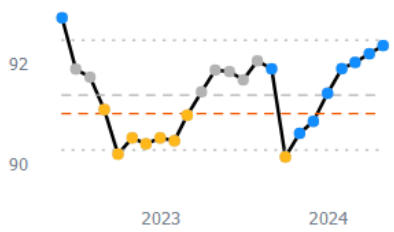
Appraisals Compliance



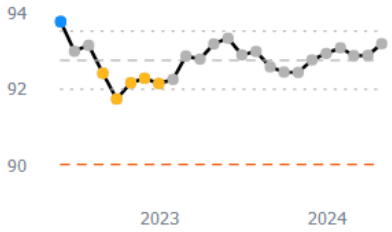
Staff Engagement Score



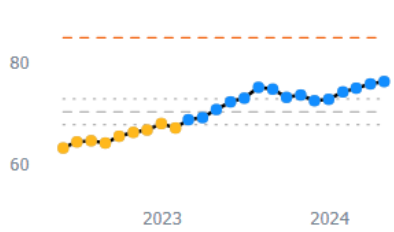
Statutory Training



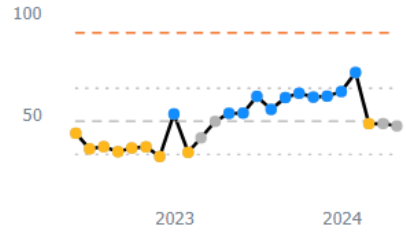
Infection Control Training



Hand Hygiene Training



Medical Job Planning Rate



Sustainability

Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
Finance	IIP		I&E Monthly Variance Group (£M)			-10.0...	-11.314	-9.030	-8.929	-6.461	-9.326	-10.995	-10.215	-12.1...	-8.768	-7.310	-7.078
	KEY		Efficiencies Green Schemes (£M)			3	10	9	9	11	11	13	13	13	3	5	4
	IIP		Efficiencies YTD Variance (£M)			-8.0	-6.3	-9.5	-11.8	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0
	KEY		Premium Pay			9,687	10.7K	8,847	8,179	8,404	8,258	8,671	8,391	10.0K	8,069	8,369	7,858

June Highlights:

The Group delivered the YTD plan of £23,128k in Quarter 1.

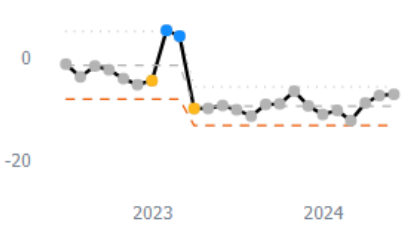
Pay expenditure has reduced and is below plan from Month 2, and is currently under plan by £0.6m YTD for the Trust. Income is remaining stable, with increased levels of activity especially within outpatients. Non pay has remained stable as compared to Month 2, with Month 2 being an improved position to Month 1.

There are emerging risks to the submitted 24/25 financial plan relating to the Consultant pay award and Strike action. These have been offset by non-recurrent benefits YTD, however if additional funding is not agreed, could be a risk to our year-end position.

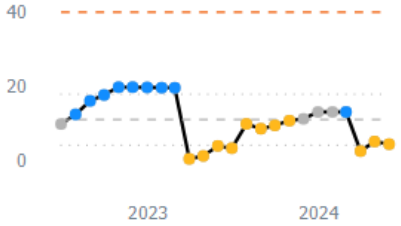
The Trust has delivered £9.2m of efficiencies in Quarter 1 in line with the YTD plan, consisting of recurrent savings of £5.7m and non-recurrent savings of £3.5m. There was, however, an increase to non-recurrent CIP achievement of £1.5m YTD to plan, due to slight delays in the commencement of recurrent schemes.

Sustainability

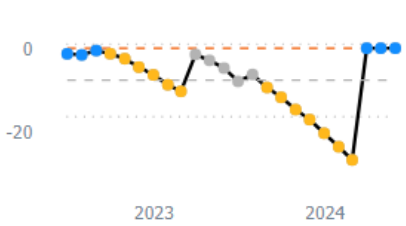
I&E Monthly Variance Group (£M)



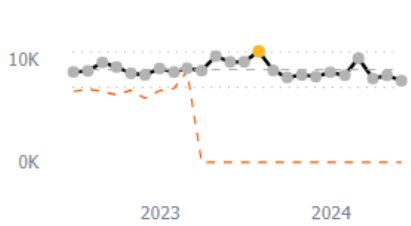
Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



Premium Pay



2023 2024

Maternity

June Highlights:

The extended perinatal rate remains consistently below the threshold of 5.87 per 1,000 births, with the June 12 month rolling rate at 3.47 per 1,000 births. This rate includes stillbirths and neonatal deaths, and whilst the stillbirth rate remains significantly low (1.39 per 1,000 against a threshold of 3.92 per 1,000), the neonatal death rate has recently risen to 2.09 per 1,000 against a threshold of 1.96 per 1,000. 50% of the neonatal deaths were extremely premature (<28 weeks gestation) All deaths are included in PMRT.

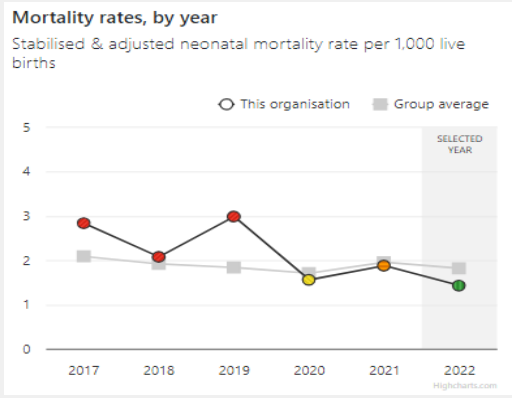
The FFT maternity response rate (based on the national methodology of delivery episodes only) remains below average for 6 consecutive months and below the threshold of 15%. The rates are similar across both acute sites (12%) which is an increase from previous months.

The quarterly staff engagement score remains below the threshold and was below the lower threshold at 6.07 in Apr-Jun. The Trust overall saw a similar reduction, reducing to 5.70, and the Women's and Children's score is the highest in the Trust.

Maternity: Metric Dashboard

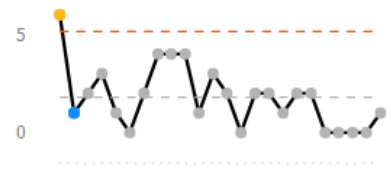
Domain	Nat	Flag	KPI	SPC	Ass...	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-...	May-24	Jun-24
Maternity	NAT		Serious Incidents Maternity			2	0	2	2	1	2	2	0	0	0	0	1
	KEY		Maternity Incidents Moderate / Severe			0	1	1	4	0	2	1	2				
	KEY		Maternity Patient Incidents Moderate ...										0	6	1	1	3
	KEY		Maternity Complaints			6	2	15	5	8	6	11	5	1	9	8	6
	KEY		Maternity Complaint Response			50.0%	60.0%	60.0%	0.0%		33.3%	50.0%	17.6%	80.0%	0.0%	0.0%	0.0%
	KEY		Extended Perinatal Mortality			3.40	3.58	3.11	2.62	2.29	2.81	2.99	2.45	2.61	2.77	3.46	3.47
	NAT		FFT Maternity Response Rate			15.5%	13.7%	11.7%	13.6%	16.0%	15.0%	14.1%	12.8%	11.5%	9.2%	9.1%	12.1%
	NAT		FFT Maternity Recommended			91.6%	88.3%	90.7%	96.3%	93.0%	88.9%	93.5%	93.2%	88.1%	88.5%	94.7%	96.3%
	NAT		FFT Maternity (IP) Recommended			94.3%	88.8%	90.6%	96.8%	93.8%	90.4%	94.1%	92.9%	90.9%	92.7%	94.8%	95.3%
	KEY		WH Engagement Score						6.38	6.38	6.38	6.35	6.35	6.35	6.07	6.07	6.07

Maternity: Actions

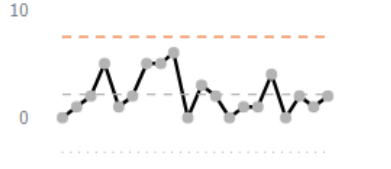
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		• QR codes being introduced • Promotion of the FFT as well as the YVIH initiative • Exploration of text reminders
Overdue Incidents	• Email and communication with individual action owners with expected completion date	• Denise Newman • Head of Governance		• Downward trajectory • Agreed number of incidents to be closed by teams on a daily basis
External Review Neonatal Deaths	• Aggregate review of all NNDs from 1st April 2023 to 31st March 2024 	• Adaline Smith Dep Director of Midwifery		• Contracts being organised to onboard external team • Plan for report to be available to the Trust by September 2024 The total NND rate for the fiscal year 2023/24 was 1.22 deaths per 1,000 livebirths, amounting to a total of 7 deaths. In comparison, the MBRRACE average for the Trust's comparator group, based on the most recent 2022 data, was 1.82 deaths per 1,000 livebirths. This indicates that the Trust experienced 3 fewer neonatal deaths than would be expected if its rate matched the comparator average. The NND rate for minority ethnicities and/or patients from the most deprived areas (IMD groups 1 & 2) was 0.47 per 1,000 livebirths, with a total of 1 death. This was a white British/Irish patient from a deprived area. • The graph embedded shows the recently published MBRACCE Data. Since 2018, the MBRRACE NND rate for EKHUFT has decreased from 3 years over 5% higher than the comparator average, to over 15% lower than average in 2022. It is not possible to disaggregate the MBRRACE data by ethnicity deprivation areas for comparison purposes.
Engagement Score 6.07	• Board Level meetings with staff and actions taken to close the loop on feedback • Several platforms for escalating concerns • Focus on RCS facilitated by PMA team	• Care Group Quadrumvirate		• Survey Monkey undertaken in month and actions taken • Senior team all trained on the use of TED to be able to obtain real time information from teams • The WCYP score remains the highest in the Trust

Maternity: Metric Run Charts

Serious Incidents Maternity

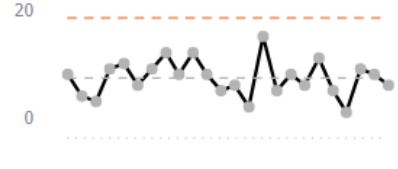


Maternity Incidents Moderate / Severe

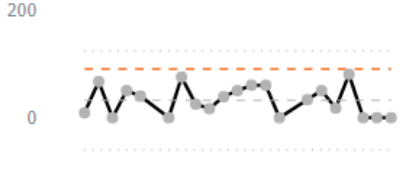


Maternity Patient Incidents Moderate ...

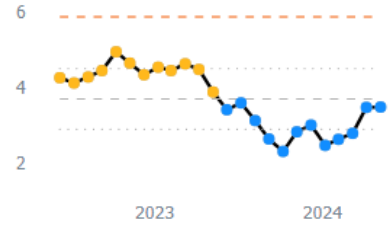
Maternity Complaints



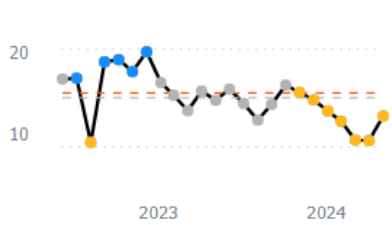
Maternity Complaint Response



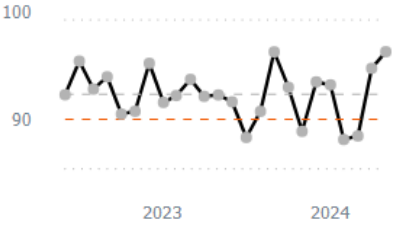
Extended Perinatal Mortality



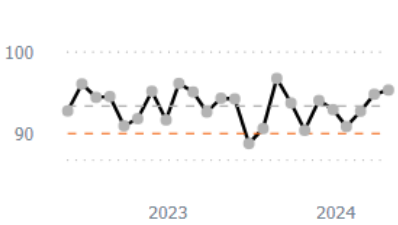
FFT Maternity Response Rate



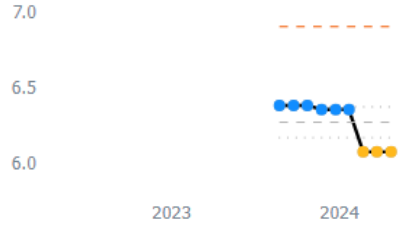
FFT Maternity Recommended



FFT Maternity (IP) Recommended



WH Engagement Score



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: MONTH 3 (M3) FINANCE REPORT

Meeting date: 25 JULY 2024

Board sponsor: INTERIM CHIEF FINANCE OFFICER (CFO)

Paper Author: INTERIM DEPUTY CHIEF FINANCE OFFICER

APPENDIX 1: M3 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the financial performance to June (Month three).
Summary of key issues:	In June (Month 3), the Group delivered a deficit position of £7,078k, against a deficit plan of £7,050k, an in-month adverse variance of £28k. The year to date (YTD) position is therefore an actual of deficit plan to Month 3 (£23,128k) was achieved by the Group, as detailed below.

£000	YTD Plan	YTD Actual	YTD Variance
Patient care income	£221,203	£222,072	£869
Other income	£16,893	£15,253	(£1,640)
Employee expenses	(£167,280)	(£166,226)	£1,054
Other operating expenses	(£91,734)	(£92,476)	(£742)
Non-operating expenses	(£2,337)	(£2,132)	£205
Technical adjustments	£127	£353	£226
TECHNICALLY ADJUSTED SURPLUS / (DEFICIT)	**(£23,128)**	**(£23,156)**	**(£28)**

Patient care income has overperformed YTD due to an increase in rechargeable drugs and devices and an income accrual relating to the consultant pay award, together with Elective Recovery Funding (ERF) activity being higher than planned. These increases are all offset by additional expenditure.

Other income is underachieving by £1.6m YTD, predominantly within 2gether Support Solutions (2gether) where income underperformance is offset by non-pay underspends.

Within employee expenses the consultant pay award has been paid and is £1m YTD. This is partly offset in income (£0.6m), however, a shortfall in funding remains and although currently offset by non-recurrent benefits in the

East Kent Hospitals University NHS Foundation Trust

	YTD position, if additional funding is not agreed, it could be a risk to our year end position (£1.2m). A £49m in-year cost improvement programme (CIP) target has been set for 2024/25, as part of the £85.8m deficit plan. CIP delivery is on plan YTD to Month 3. The Trust has recognised recurrent savings of £2.1m in June, and £5.7m on a YTD basis, and non-recurrent savings of £1.3m in June and £3.4m YTD. There was an increase to non-recurrent CIP achievement of £1.5m YTD, due to slight delays in the commencement of recurrent schemes. The Group cash balance (including subsidiaries) at the end of June was £28.0m. The Trust drew £3.7m of working capital (Public Dividend Capital (PDC)) in the month (£21.5m YTD). Total capital expenditure at the end of June was £1.8m spend against a plan of £2.5m. The underspends against standing committee plans totals £0.35m. All standing committees now have detailed prioritised plans in place, with delivery underway and which are monitored each month by the Capital Investment Group (CIG). The residual YTD underspend of £0.29m is spread broadly evenly across all the major capital schemes, with minor slippage in each. The planned capital spend in 2024/25 is £26.7m.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of Month 3.

Implications:

Links to Strategic Theme:	• Partnerships • Sustainability Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Trust Risk Register:	**SRR 3664**: Failure to deliver the Trust financial plan for 2024/25
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: N/A

We care

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2024/25

June 2024

Chief Finance Officer
Tim Glenn

Group Summary
Month 03 (June) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	201.773	200.478	(1.295)	0.000	0.000	0.000	5.330	4.380	(0.950)	(2.379)	(0.724)	1.655	204.724	204.135	(0.589)
NHS Income From Commissioners - Drugs	13.437	14.812	1.375	0.000	0.000	0.000	0.942	0.785	(0.157)	0.000	0.000	0.000	14.379	15.597	1.218
NHS Income From Commissioners - Devices	2.100	2.340	0.240	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	2.100	2.340	0.240
Other Income	16.437	15.815	(0.622)	39.867	36.414	(3.453)	0.004	0.010	0.006	(39.415)	(36.986)	2.429	16.893	15.253	(1.640)
Total Income	**233.747**	**233.445**	**(0.302)**	**39.867**	**36.414**	**(3.453)**	**6.276**	**5.175**	**(1.101)**	**(41.794)**	**(37.709)**	**4.085**	**238.096**	**237.325**	**(0.771)**
Substantive Staff (inc. Apprenticeship Levy)	(134.122)	(134.370)	(0.248)	(10.283)	(10.168)	0.115	(2.146)	(1.892)	0.254	(0.399)	0.157	0.556	(146.950)	(146.273)	0.677
Bank Staff	(11.288)	(11.585)	(0.297)	0.000	0.000	0.000	0.000	0.000	0.000	0.069	0.000	(0.069)	(11.219)	(11.585)	(0.366)
Agency/Contract	(8.749)	(7.566)	1.183	(0.641)	(0.573)	0.068	(0.183)	(0.220)	(0.037)	0.462	(0.009)	(0.471)	(9.111)	(8.368)	0.743
Total Employee Expenses	**(154.159)**	**(153.521)**	**0.638**	**(10.924)**	**(10.741)**	**0.183**	**(2.329)**	**(2.112)**	**0.217**	**0.132**	**0.148**	**0.016**	**(167.280)**	**(166.226)**	**1.054**
Drugs	(11.324)	(11.089)	0.235	0.000	(0.004)	(0.004)	(0.989)	(0.785)	0.204	0.837	0.631	(0.206)	(11.476)	(11.247)	0.229
Rechargeable Drugs	(12.065)	(13.576)	(1.511)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(12.065)	(13.576)	(1.511)
Rechargeable Devices	(2.100)	(2.340)	(0.240)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(2.100)	(2.340)	(0.240)
Supplies and Services - Clinical	(11.429)	(11.316)	0.113	(10.518)	(13.947)	(3.429)	(0.443)	(0.563)	(0.120)	1.391	0.302	(1.089)	(20.999)	(25.525)	(4.525)
Supplies and Services - General	(36.117)	(36.525)	(0.408)	(7.443)	(4.557)	2.886	(0.079)	(0.057)	0.022	36.227	33.466	(2.761)	(7.412)	(7.673)	(0.261)
Clinical negligence	(8.764)	(8.765)	(0.000)	0.000	0.000	0.000	0.000	0.000	0.000	0.005	(0.000)	(0.005)	(8.759)	(8.765)	(0.006)
Depreciation and Amortisation	(6.545)	(5.814)	0.731	0.000	(0.077)	(0.077)	(0.051)	(0.053)	(0.002)	0.000	0.000	0.000	(6.596)	(5.944)	0.652
Other non pay	(12.832)	(12.228)	0.604	(10.481)	(6.765)	3.716	(2.192)	(1.575)	0.617	3.178	3.162	(0.016)	(22.327)	(17.406)	4.921
Total Other Operating Expenses	**(101.176)**	**(101.653)**	**(0.477)**	**(28.442)**	**(25.350)**	**3.092**	**(3.754)**	**(3.033)**	**0.721**	**41.638**	**37.560**	**(4.078)**	**(91.734)**	**(92.476)**	**(0.742)**
Non Operating Expenses	(2.398)	(2.277)	0.121	0.064	0.157	0.093	(0.055)	(0.012)	0.043	0.052	(0.000)	(0.052)	(2.337)	(2.132)	0.205
Profit/Loss	**(23.986)**	**(24.005)**	**(0.019)**	**0.565**	**0.480**	**(0.085)**	**0.138**	**0.018**	**(0.120)**	**0.028**	**(0.002)**	**(0.030)**	**(23.255)**	**(23.509)**	**(0.254)**
Less Technical Adjustments	0.127	0.353	0.226	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.127	0.353	0.226
Technically Adjusted Profit/Loss	**(23.859)**	**(23.652)**	**0.207** 1	**0.565**	**0.480**	**(0.085)** 2	**0.138**	**0.018**	**(0.120)** 3	**0.028**	**(0.002)**	**(0.030)** 4	**(23.128)**	**(23.156)**	**(0.028)** 5

1. Trust:
The Trust year-to-date deficit is £23.7m against a plan deficit of £23.9m; a £0.2m favourable variance YTD. The key drivers include:

- Income from patient care activity is favourable to plan by £0.3m YTD. The key factors are drugs and devices over performance £1.6m and £0.6m income accrual for the Consultant pay award (both offset by additional expenditure) together with £1m CIP shortfall against a plan of £2.7m and £1.2m underperformance against ICB discharge funding due to the lower than planned number of not fit to reside patients in our beds.
- Other operating income is adverse to plan by £0.6m YTD, mainly driven by cash donations £0.2m (but this is removed as a technical adjustment in the overall net performance of the Group), charitable contributions are behind plan by £0.1m and lower non patient care services (mainly inter-company services income) £0.1m.
- Employee expenses is favourable to plan YTD by £0.6m. The use of temporary staff is favourable to plan by £0.9m YTD, mainly in agency qualified Nursing and Midwifery. Substantive staff are £0.2m adverse to plan YTD mainly driven by the Consultant pay award (This is partly offset in income, however a shortfall in funding remains).
- Other operating expenses is adverse to plan YTD by £0.5m, predominantly due to rechargeable drugs spend (which is offset by additional rechargeable drugs income).

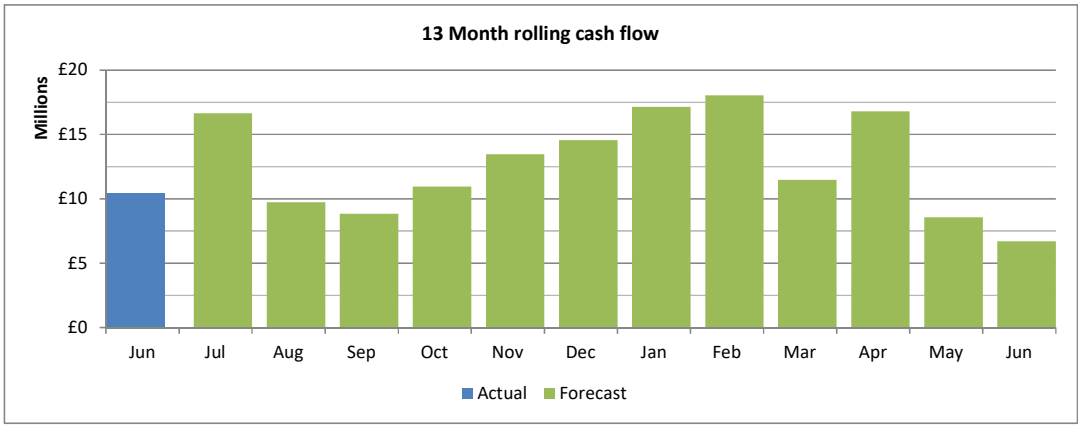
2. 2gether Support Solutions
2gether Support Solutions reported a YTD surplus of £0.5m; £0.09m adverse to plan. Income underperformance is offset by non pay underspends.

3. Spencer Private Hospitals
Spencer Private Hospitals Operating Profit and Profit after Tax level is a YTD surplus of £0.018m; adverse to plan by £0.1m YTD, mainly due to lower level of Surgical activity below budgeted levels which was offset by Budget underspends on indirect costs and administration staffing.

4. Consolidation Adjustments
Consolidation adjustments remove all inter-company transactions for income and expenditure.

5. Group
The Group reported a year to date position of £23.1m against plan to date of £23.1m .

Cash Flow
Month 03 (June) 2024/25



Unconsolidated Cash balance was £10.5m at the end of June 2024, £0.1m above plan.

Cash receipts in month totalled £88.4m (£4.0m above plan):

- K&M ICB paid £59.2m in June (£1.8m above plan)
- NHS England paid £12.7m in June (on plan)
- VAT reclaim was £3.0m above plan as May and June were both received in month (total £6.5m received)
- Other Receipts totalled £6.3m (£3.3m above plan largely due to £1.6m CNST rebate from NHS Litigation Authority)
- Revenue Support received in month was £3.7m (£4.2m below plan)

Cash payments in month totalled £93.1m (£11.7m above plan)

- Creditor payment runs including Capital payments were £34.7m (£15.1m above plan).
- £13.0m payments to 2gether were £2.0m below plan.
- Total payroll was £45.4m, £1.4m below plan (inc PAYE, NI and Pensions)

2024/25 Cash Plan

The revised plan submitted to NHSE/I in June 2024 shows a Trust deficit position at the end of 2024/25 of £88.5m.Revenue support PDC for the full deficit amount is forecast in the year.

Revenue Support

The Trust submitted a request to draw £28.8m in PDC revenue support in Quarter 1. The deadline for submission was before the draft plan had been finalised and so only April was initially agreed. May and June support requests were subsequently based upon the draft plan.

£9.5m support was received in April, £8.3m in May with a further £3.7m received in June. A total of £21.5m for the Quarter 1 period. (£7.3m below the initial request)

The Trust has submitted a PDC revenue support request for Q2 of £25.0m. This has yet to be agreed by NHSE/I.

Creditor Management

The Trust stayed at 30 day creditor terms for Non NHS suppliers in Month 3. But moved away to 34 day terms in early July. This is in response to the uncertainty of whether Revenue Support will be granted as requested.

At the end of June 2024, the Trust was recording 42 creditor days (Calculated as invoiced creditors at 30th June/ Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 03 (June) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**379.770**	**375.241**	**(4.529)**	**67.469**	**66.857**	**(0.612)**	**4.408**	**4.141**	**(0.267)**	**(145.701)**	**(145.693)**	**0.008**	**305.946**	**300.546**	**(5.400)**
Inventories	7.878	8.304	0.426	5.245	5.245	0.000	0.047	0.053	0.006	0.000	0.000	0.000	13.170	13.602	0.432
Trade Receivables	37.592	36.664	(0.928)	25.520	14.252	(11.268)	5.397	5.744	0.347	(31.706)	(22.456)	9.250	36.803	34.204	(2.599)
Accrued Income and Other Receivables	(3.504)	(3.459)	0.045	(0.127)	(0.153)	(0.026)	(0.134)	(0.069)	0.065	0.000	0.000	0.000	(3.765)	(3.681)	0.084
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	17.955	10.480	(7.475)	12.413	15.369	2.956	2.049	2.262	0.213	0.000	0.000	0.000	32.417	28.111	(4.306)
Current Assets	**59.921**	**51.989**	**(7.932)**	**43.051**	**34.713**	**(8.338)**	**7.359**	**7.990**	**0.631**	**(31.706)**	**(22.456)**	**9.250**	**78.625**	**72.236**	**(6.389)**
Payables and Accruals	94.290	86.822	(7.468)	23.247	14.426	(8.821)	5.103	5.663	0.560	(27.854)	(18.718)	9.136	94.786	88.193	(6.593)
Deferred Income and Other Liabilities	8.100	6.629	(1.471)	0.000	0.000	0.000	0.000	0.000	0.000	(0.006)	(0.045)	(0.039)	8.094	6.584	(1.510)
Provisions	10.035	10.395	0.360	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.035	10.395	0.360
Borrowing	4.270	3.676	(0.594)	2.524	1.919	(0.605)	0.105	(0.001)	(0.106)	(4.334)	(4.371)	(0.037)	2.565	1.223	(1.342)
Current Liabilities	**116.695**	**107.522**	**(9.173)**	**25.771**	**16.345**	**(9.426)**	**5.208**	**5.662**	**0.454**	**(32.194)**	**(23.134)**	**9.060**	**115.480**	**106.395**	**(9.085)**
Provisions	3.423	3.378	(0.045)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.423	3.378	(0.045)
Borrowing	71.611	70.925	(0.686)	50.475	49.579	(0.896)	1.964	1.852	(0.112)	(115.804)	(114.698)	1.106	8.246	7.658	(0.588)
Non Current Liabilities	**75.034**	**74.303**	**(0.731)**	**50.475**	**49.579**	**(0.896)**	**1.964**	**1.852**	**(0.112)**	**(115.804)**	**(114.698)**	**1.106**	**11.669**	**11.036**	**(0.633)**
Net Assets	**247.962**	**245.405**	**(2.557)**	**34.274**	**35.646**	**1.372**	**4.595**	**4.617**	**0.022**	**(29.409)**	**(30.317)**	**(0.908)**	**257.422**	**255.351**	**(2.071)**
Public Dividend Capital	559.544	580.995	21.451	30.267	30.267	0.000	0.048	0.048	0.000	(30.315)	(30.315)	0.000	559.544	580.995	21.451
Retained Earnings	(373.566)	(397.575)	(24.009)	5.085	5.376	0.291	1.736	1.754	0.018	0.363	0.538	0.175	(366.382)	(389.907)	(23.525)
Revaluation Reserve	61.983	61.981	(0.002)	0.000	0.000	0.000	2.812	2.812	0.000	(0.535)	(0.535)	0.000	64.260	64.258	(0.002)
Taxpayers Equity	**247.961**	**245.401**	**(2.560) 1**	**35.352**	**35.643**	**0.291 2**	**4.596**	**4.614**	**0.018 3**	**(30.487)**	**(30.312)**	**0.175 4**	**257.422**	**255.346**	**(2.076)**

1. Trust:

Non-Current Assets - values reflect in-year additions less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Current Assets - Accrued Income and receivables have decreased from the 2023/24 opening position by £0.8m See Working Capital page for additional detail.

Current Liabilities - Payables and other - invoiced creditors has increased (See Working Capital sheet for more detail) offset by decrease in accruals.

Non current liabilities - The long-term debt entry relates to the long-term finance lease debtor with 2gether.

Public Dividend Capital - Increased to date by £21.5m reflecting PDC revenue support received as at June 2024.

2. 2gether Support Solutions:

Non-current assets - reflects movement in depreciation to date.

Cash balance - has increased from opening position due to decrease in receivables.

3. Spencer Private Hospitals:

Current Assets - increased mainly due to invoiced receivable.

Current Liabilities - increased due to slow payment of creditors.

4. Consolidation Adjustments - Removal of inter-company transactions and loans.

Capital Expenditure
Month 03 (June) 2024/25

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
Critical Priorities (PEIC)	4,000	4,000	335	177	158
MDG - Medical Devices Replacement	2,249	2,249	255	90	165
Diagnostics Clinical Equipment Replacement Progr	3,618	3,618	255	250	5
IDG - IT Systems Replacement	700	700	23	3	20
Electronic Medical Records (EMR)	800	800	53	41	12
Subsidiaries - 2Gether Suport Solutions (2SS)	618	618	49	31	18
Subsidiaries - Spencer Private Hospitals (SPH)	150	150	15	0	15
Mechanical Thrombectomy	2,028	2,028	738	708	30
Renal – Expansion of dialysis services (Phase 2)	964	0	20	0	20
Stroke HASU	1,118	1,118	32	5	27
Pathology S8 - GP and Community Order Comms (	140	140	140	140	0
Maternity Estates Review	1,594	0	30	0	30
Diagnostics Imaging (QEQM MRI)	2,100	2,100	0	0	0
Community Diagnostics Centre (CDC) - Buckland (E	1,033	1,033	128	167	(39)
Fire Compartmentation Strategy	4,000	4,000	0	3	(3)
Digital Histhopathology - 2024/25 (Year 2)	407	407	317	307	10
QEQM MRI Power Upgrade	45	45	0	0	0
Donated Assets	900	900	90	14	76
Trust IFRS16 Acquisitions	242	242	0	0	0
All Other	0	(14)	0	(91)	91
	26,706	**24,134**	**2,480**	**1,844**	**636**

Funded By:	**Plan**	**Forecast**	**Change**
Operational Capital	21,887	21,887	0
Donations	900	900	0
PDC	1,347	1,347	0
	24,134	**24,134**	**0**
Under/(Over) Commitment	**(2,572)**	**0**	

The Group's gross capital spend to the end of Month 3 was £1.84m, resulting in a £0.64m underspend in Q1 2024/25 against the YTD Plan of £2.48m.

The Q1 2024/25 YTD £0.64m underspend is the net effect of:

1) Underspend against standing committee plans totalling £0.35m, primarily £0.16m PEIC slippage (backlog maintenance/ critical infrastructure works) and £0.17m slippage on the MDG/ ERP programmes (BAU/ major equipment replacement). All standing committees now have detailed prioritised plans in place, with delivery underway and which are monitored each month by the Capital Investment Group (CIG).

2) The residual YTD underspend of £0.29m is spread broadly evenly across all the major capital schemes, with minor slippage in each, except the Buckland CDC MRI scheme. The YTD slippage is currently not expected to have an impact on the delivery against the overall agreed annual capital allocations and no risks have been reported by scheme leads.

3) The only major capital scheme reporting a programme delay is the BHD MRI Community Diagnostics Centre (CDC) scheme which has reported a 2-week programme delay at Month 3 (with a minor overspend of £0.04m). Despite this, the project is expected to remain within the allocated budget. Both the Renal Dialysis and Maternity Estates Review major capital schemes are yet to commence, with the final business case for the Renal expected over the next few months. The Maternity Estates Review scheme has an approved business case in place, but a reassessment of the scope and scale of works is needed in light of the potential success of the £25m Maternity capital bid for external funding submitted by the Trust earlier this year.

Other key areas to highlight:

• £2.572m over-planning and revised externally published forecast 2024/25 capital expenditure:
As per the capital plan approved by the Trust Board, the 12th June 2024 plan re-submission included an over-planning element of £2.572m. As of Month 3, the Trust is required by NHSE to publish forecast capital expenditure within the quantum of available funding. This is due to the fact that whilst systems are allowed to over-plan within a 5% tolerance of their overall CDEL (capital expenditure limit), they are not allowed to commit the expenditure until such time when additional funding is confirmed.

The £2.572m forecast reduction has been reflected in external reporting by reducing forecast spend on the Maternity and Renal schemes as these are yet to have an agreed way forward and are currently either going through the governance process (Renal Haemodialysis) or are under review (Maternity Estates) to assess the preferred strategic direction and explore potential funding avenues.

Cost Improvement Summary
Month 03 (June) 2024/25

Delivery Summary	This Month		Year to Date	
Programme Themes £000	Plan	Actual	Plan	Actual
0.01 Estate Utilisation & Rationalisation	26	6	39	6
0.02 Procurement	505	329	1,358	864
0.03 Digital Utilisation & Rationalisation	6	-	12	5
0.04 Income – Capture, Coding and Pricing	100	300	300	300
0.05 Financial Control & Governance	676	1,284	2,030	3,436
0.06 Low Value Interventions	-	-	-	-
0.07 Drugs & Devices	124	201	377	499
0.08 Length of Stay	223	203	668	599
0.09 Medically Optimised for Discharge Pathway	-	-	-	-
0.10 Theatre Utilisation	389	(330)	1,048	353
0.11 Admission Avoidance	-	-	-	-
0.12 Outpatients	284	1,003	852	1,571
0.13 Diagnostics	180	129	525	427
0.14 Medical Staffing	431	(256)	835	221
0.15 Nursing and Midwifery	150	4	312	12
0.16 Allied Health Professionals	80	65	153	117
0.17 Other Workforce	162	436	405	524
Care group Led Schemes **	107	66	270	249
Grand Total	**3,440**	**3,440**	**9,184**	**9,184**

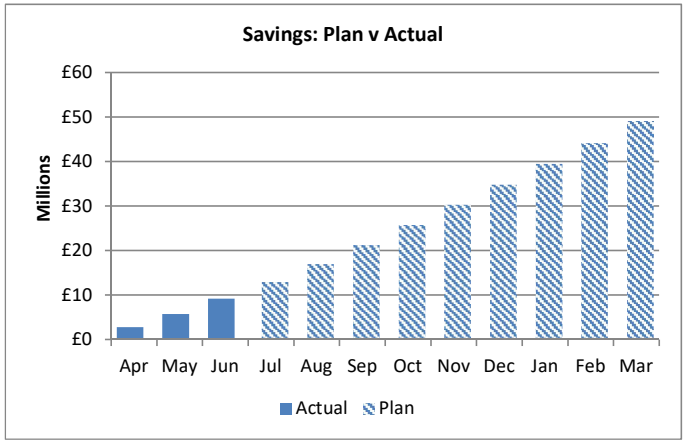
Delivered £000		
Month	Target	Actual
April	2,786	2,786
May	2,957	2,957
June	3,440	3,440
July	3,715	
August	4,057	
September	4,247	
October	4,501	
November	4,597	
December	4,517	
January	4,630	
February	4,636	
March	4,915	
	49,000	**9,184**
		18.7%

Efficiencies
The agreed Efficiencies plan for 2024/25 is £49.0m. CIP delivery is on plan to Month 3. The Trust has recognised
- recurrent savings of £2.1m in June, and £5.7m on a YTD basis
- non-recurrent savings of £1.3m in month, and £3.5m YTD.

There was an increase to non-recurrent CIP achievement of £1.5m YTD, due to slight delays in the commencement of recurrent schemes.

PwC support to the PMO and Theme Leads continues. The PMO is working closely with Finance Business Partners and Theme Leads, focussing on delivery of CIPs for the current financial year.

The PMO is collaborating effectively with the Financial Recovery Director, concentrating efforts on advancing projects at various stages - Amber, Red, and Pipeline - towards Green status. This will put the trust in a strong position for action and ensure delivery in FY24/25.



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Report on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)**

Meeting date: **25 July 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Strategy and Partnerships Officer (CSPO)**

Appendices:

Appendix 1: IIP Closing Report – July 2024

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the IIP during June 2024 and offers assurance based on evidence gathered for how this is influencing the exit criteria set within the NHS England Recovery Support Programme (RSP) National Oversight Framework Segment 4 (NOF4) as at Q1. The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.
Summary of key issues:	The report includes an update by programme and project. The Finance Programme has been rated as green this month, achieving the Q1 metrics. The Leadership, Governance & Culture, Urgent & Emergency Care (UEC) and Planned Care programmes have been rated as amber, working towards the achievement of the Q1 metrics. The Programme Management Office (PMO) continue to work to align IIP associated risks with the Trust significant risk register, which will be identified and discussed during the next highlight reporting period. 80 pieces of evidence were received in Q1, compared to six pieces of evidence received in Q1 2023/24 IIP. Q1 internal review took place on 9 July to confirm both the performance and evidence positions against the Q1 metrics. These are reflected within this report.
Key recommendations:	The Board of Directors is invited to **DISCUSS** the report.

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Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	No
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: N/A

East Kent Hospitals University Foundation Trust
Report on Integrated Improvement Plan (IIP)

Journey to Exit NOF4 – IIP Closing Report
July 2024

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the Integrated Improvement Plan and offers assurance based on evidence gathered for how this is influencing the exit criteria set within the NHS England Recovery Support Programme National Oversight Framework Segment 4 (NOF4). The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.

Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Clinical Executive Management Group (CEMG) which is chaired by the Chief Executive. Programmes continue to ensure the level of evidence meets EKHUFT and other stakeholder requirements i.e., system partners and region.

The Board of Directors receive a monthly update on delivery of the Integrated Improvement Plan focusing on successes, challenges and actions to mitigate any key risks to delivery which may affect NOF4 exit criteria with a programme RAG self-assessment. Impact and demonstrable progress against the overall programme objectives set by the National Team are provided on a quarterly basis through a deep dive presentation.

High-level Programme Summary

Agreed Q4 Programme RAG	Summary
Leadership, Governance & Culture	• A proposal has been received from NHS Providers to undertake board development. The plan was confirmed at the board development session on the 4 July. • A bespoke programme for Exec development is currently being scoped with an external partner. • The Culture and Leadership Programme (CLP) delivery plan to May 25 is now completed and being monitored to ensure delivery and pace through the new CLP steering Board. . The design phase of the CLP programme is also underway with recruitment of additional change team members with a target of an additional 150 to join. This campaign went live on 26 June 2024. • The 'We Care' refresh is progressing, with the agreement on the initial phase of projects supporting cancer and urgent and emergency care. A final decision on funding the workforce plan is pending and will allow for the agreed plan to move to delivery. Leader standards have been drafted and will be delivered through a robust training programme, this will be complemented by the addition of the CIC Leadership behaviours being developed. • Following the board development session on 4 July, the Director of Corporate Governance is now a series of changes to the way in which committee operate. • The development of the Organisational Strategy has been underway throughout Q1. 40 speciality level packs are currently under production and 30 of these specialties are now in the dairy to initiate discussions.
Finance	• A follow up audit of financial controls was conducted by the Recovery Support Programme (RSP) appointed Director of Financial Recovery Keith Pringle. Significant progress has been made, with some further work to do, particularly with respect to subsidiaries. This will form part of final tranche of PricewaterhouseCoopers (PWC) support - to be commissioned in September. • Cost Improvement Programme (CIP) delivery on plan Year to Date (YTD). Delivery to Month 3 is £9,183k. The YTD delivery includes £5,795k recurrent CIP achievement and £3,424k non-recurrent CIP achievement (There was an increase to non-recurrent achievement of £1,424k due to slight delays in the commencement of recurrent schemes). • The forecast remains the delivery of £49m recurrent savings in year. • YTD deficit plan to Month 3 (£23,128k) achieved by the Group. • Emerging risks relate to the recent junior doctor industrial action at the end of June, and shortfall in funding to cover the consultant pay award. The trust is working both internally and with Integrated Care Board (ICB), regional and national partners to mitigate these risks. • Initial scope has been agreed with external support - Trust Board approved 4/7/24. • Initial work already completed by the Trust. • Interdependence with ICB recovery plan is both a key risk and opportunity. The trust is actively engaged in the system process, supporting the leadership of a system wide workshop with Miles Scott (Chief Executive Officer (CEO) at Maidstone and Tunbridge Wells NHS Trust (MTW)) who is CEO Senior Responsible Officer (SRO) at a system level for the plan production.

High-level Summary of Programme Closing Position

Programme	Summary
Planned Care	**Referral to Treatment (RTT)** • As at the end of June, the trust had one 104 week risk (dated for 17 July) & 84 78 week breaches. The trust had also completed a detailed review around their 65 week clearance plan which has been reviewed at Access on 6 June, ratified by the • Chief Operating Officer (COO) and presented at Tier 1 on the 12 June. This plan currently forecasts 574 65 week risks at the end of September (ahead of 1,125 IIP plan) with continued work to full eradication by the end of March 2025. • Key successes in month - RTT training programme for all staff now has trained over 200 admin staff with targeted speciality clinician trained booked for July, 12 week contact validation programme pilot commenced on 4 June with 56% response rate with full launch in July, revised Access policy approved by CEMG with minor edits to launch in July. • Key current challenges relate to Otology demand (Getting it Right First Time (GiRFT) team engaged with support agreed from Barking, Havering & Redbridge Trust), Paediatric bed capacity improvements required and focussed efforts needed in Ophthalmology utilisation to both improve theatre utilisation and focus on backlog clearance ahead of new recruits commencing in August and September. **Cancer:** • Initiatives supported by the confirmation of the tiered funding for £2m will start to play into the cancer position from Q2. • The-28 day letter backlog was the lowest recorded in June 24 following a concentrated effort to clear the backlog. • Further initiatives likely to be established towards the end of Q2 include the addition of a robotic urology consultant, capacity for US/CT guided biopsy, punch biopsies supporting the skin pathway. • There has been some deterioration in the 31-day standard impacting 62-day compliance. • There have been surgical capacity issues for Head & Neck (H&N) driven by a higher number of complex out-of-area referrals and lung patients impacted by the cyber-attack. **Diagnostics:** • As of the end of June, the trust Endoscopy backlog was at 8,064 ahead of trajectory (8,459) with a clear plan to achieve 4,918 by the end of September. Additional funding support to deliver this improvement has been bid for as part of Tiering and National Cancer monies (£2m in total). £900K has been approved with expectations of remaining funds to be approved in July. • Lower GI triage service commenced from 10 June with ID medical and ICB supporting with regional support for ERCP backlog clearance plan (89 patients to clear). • Entire surveillance backlog now fully validated with team commenced validation of DM01 routine OGD backlog (700 of 2,200 patients completed to date). • Key current challenges relate to MRI compliance at 60.5% & Ultrasound at 63.8% (primarily due to Breast capacity). Echo's and Cardiac MRI both looking to insourcing solutions as temporary measures. • The overall trust DM01 position at the end of June was 60.5% i.e. 39.5% against 35% target for Q1. Key actions revolve around additional MRI, Did Not Attend (DNA) reduction, utilisation improvements and insourcing support for Breast Ultrasound.
Urgent Care	• At Month 3, Length of Stay (LOS) >14 days was at 29.6% which was ahead of trajectory for 32% at the end of quarter 1. • Type 1 performance was 52% and 12hrs 9.6% at the end of Month 3 - both ahead of trajectory. A workstream focused on Safe and Effective Emergency Department (ED) as part of the Reducing Length of Stay (RLoS) programme has been established and a workshop held in June between the 2 ED teams to finalise the ED improvement plan and areas of focus for the year. System work continues to target attendance reductions and development of direct access pathways, with internal focus also on alternatives to ED through appropriate streaming and signposting. A review of the function of Same Day Emergency Care (SDEC) and Acute Medical Unit (AMU) on both sites is also in progress to ensure these respond to demand and are appropriately resourced to support an increase in patients being managed in less than 48 hours. • A full review has been undertaken and the overarching Harms policy is being worked on, with independent Standard Operating Procedures (SOPs) as appendices. Due to the number of specialties, the process is complex and the SOP for UEC patients has been prioritised

Impact to NOF4 Exit Criteria – Leadership, Governance & Culture - Q1

Transition Criteria RAG agreed at Q1 Review meeting 9 July 2024

NHS East Kent Hospitals University NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2	Transition Criteria 3
A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme.	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	Development of organisation strategy for clinical pathways.

Suggested Evidence

- All Board and sub-board leadership and development programmes in place
- Evidence of Board oversight of regulatory actions with clear improvement plans, and use of BAF
- Evidence of progress against action plan for Well Led domains and GGI recommendations and delivery of CQC must dos (within capital restrictions)

- No significant deterioration in quality
- Evidence of learning from statutory reviews
- Evidence of improved and effective engagement of staff, patients and wider stakeholders
- Evidence of ongoing delivery of maternity & neonatal improvement plan

- Trust organisation strategy for clinical pathways or equivalent developed with effective clinical and stakeholder engagement and plan for implementation developed

Impact to NOF4 Exit Criteria – Finance - Q1

Transition Criteria RAG agreed at Q1 Review meeting 9 July 2024

NHS East Kent Hospitals University NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2	Transition Criteria 3
Delivery of 2024/25 plan inclusive of the CIP, income and expenditure plans.	Robust financial oversight, governance, and a strong financial control environment in place.	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable progress towards delivery.

Suggested Evidence

- Financial position actuals submitted in monthly NHS England (NHSE) returns in line with plan.
- 2024/25 outturn position in line with plan.
- Improved levels of agency usage; at or towards national agency ceiling target.
- Delivery CIP programme agreed as part of 2024/25 annual plan.
- Recurrent % of the 2024/25 CIP programme being greater than 67%.

- 6 monthly review of PWC Grip and Control Actions
- Evidence that recommendations from PWC report have been adhered to
- Independent review of financial governance
- Appropriate attendance at finance & investment committees
- Evidence of staff engagement (e.g. Finance training attended by non-finance staff)
- Equality and Quality impact assessments developed for each cost improvement plan (CIP) linked to financial savings.
- Clear governance process for assessing and approving CIPs including clinical sign off
- Evidence of financial governance processes working in practice

- Development of Medium-Term Financial Recovery Plan (FRP) with financial trajectories agreed with ICB & NHSE.
- Evidence FRP addresses key drivers of deficit as identified in PWC reports including workforce realignment/resizing.
- Evidence of alignment with the Integrated Care System (ICS) financial plans and of engagement and support from stakeholders (e.g finance committee papers/ minutes, documents used to engage Trust staff).
- Evidence Trust has internal capacity and capability in place to deliver FRP (e.g substantive internal finance leadership & resource).
- Evidence timely progress is being made on 2025/26 efficiency plan.

Impact to NOF4 Exit Criteria – Urgent & Emergency Care - Q1

Transition Criteria RAG agreed at Q1 Review meeting 9 July 2024

NHS
East Kent Hospitals University
NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2
Consistent improvement in performance to deliver UEC type 1 to >50% and 12 hour waits to below 8%.	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.

Suggested Evidence

- Type 1 to exceed 50% sustainably
- 12 hours from arrival to be below 8%
- Sustainable removal of corridor care
- Compliance with NHSE Tiering requirements and governance

- Evidence of reduction of Length of Stay through improvements in simple and timely discharge
- Patients requiring emergency care or experiencing a deterioration in their condition receive timely, appropriate escalation and treatment
- Evidence of effective safety prioritisation and harm avoidance processes across UEC pathways that incorporates sustained learning from incidents

Impact to NOF4 Exit Criteria – Planned Care - Q1

Transition Criteria RAG agreed at Q1 Review meeting 9 July 2024

NHS East Kent Hospitals University NHS Foundation Trust

Transition Criteria 1	Transition Criteria 2	Transition Criteria 3
To deliver Zero 104 and 78 week waits with consistent reduction in overall Patient Tracking List (PTL) and 65 week waits in order to deliver zero by March 2025.	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog.	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered.

Suggested Evidence

- Evidence of sustainable improvement in elective performance and waiting list management with reduction in overall PTL 65w consistently reducing against % of PTL
- Reduction in incidents of harm relating to diagnostics and/or treatment delays for patients waiting longer than standard waiting times or a result of being lost to follow up
- Compliance with NHSE Tiering requirements and governance

- Evidence of sustainable improvement in cancer performance with effective multidisciplinary team (MDT) arrangements and improved validation position of surveillance waiting list
- Embedded streamline pathway, aligning diagnostic and MDT capacity
- Reduction in total diagnostic PTL
- Tiering process monitoring, feedback and delivery

- Endoscopy recovery delivery plan with agreed trajectories and milestones delivered against
- Reduction in total diagnostic PTL and >6ww
- Reduction in incidents of harm relating to diagnostics and/or treatment delays for patients waiting longer than standard waiting times or a result of being lost to follow up
- At least 90% of Community Diagnostic Centre (CDC) activity plans delivered.
- Trust delivering their portion of the Kent and Medway Integrated Care Board endoscopy plan

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Risk Register Report**

Meeting date: **25 July 2024**

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

Paper Author: **Associate Director Quality Governance (on behalf of Director of Quality Governance)**

Appendices:

Appendix 1: **Internal Risk Audit Report (RSM LLP), 22 May 2024**

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through the Clinical Executive Management Group (CEMG) and the appropriate Board Sub Committees to Board. This paper show movement in month, details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place and new risks. Escalations from the last Risk Review Group on 24 June 2024 are provided for information. This report also provides the outputs of the recent internal audit into risk management conducted on behalf of the Trust by RSM LLP. A broad overview of the findings was provided in the last Board paper as the final report was pending at the time of writing. The final report was received on 22 May 2024. The results have been shared at CEMG and are for consideration at the next Integrated Audit and Governance Committee (IAGC) meeting. The report is at Appendix 1.
Summary of key issues:	The majority of the risks contained in the significant risk report have had a 'review' within the last four weeks. As of the 12 July 2024 when the Significant Risk Register was extracted there 14 risks with associated overdue actions. These have been escalated with care group leadership teams and corporate leads. There have been significant improvements in ensuring records are reviewed and updates provided but it is essential that this process becomes embedded within strengthened business as usual governance arrangements.

East Kent Hospitals University NHS Foundation Trust

	The Risk Review Group on 24 June 2024 received deep dive presentations from the Critical Care, Anaesthetics and Specialist Surgery (CCAS) Care Group and Kent and Canterbury and Royal Victoria (KCHRV) Care Group. Monthly meetings with each accountable executive and the Associate Director of Quality Governance (in the absence of a Risk Manager) commenced in May to review the Significant Risk Report and any additional risks within the Corporate sections of the risk register. The following escalations were made from the Risk Review Group on 24 June 2024 to CEMG: • The Care Group deep dive presentations revealed ongoing work needed in relation to outstanding actions and review of open historical risks (in particular for KCHRV Care Group) in line with agreed risk tolerances. Many of the Care Groups are now having Risk Groups to support this work and challenge but this work needs to continue at pace. • There are a large number of actions on Care Group level risk registers relating to the estates and equipment and it is not clear what the oversight arrangements are for this at Trust level. Where medical devices risks are identified these risks are reviewed at the Medical Devices Group but clarity is needed on estates issues that require investment, visibility of these risks, prioritisation and ownership. • Care Groups and Corporate Leads to be aware of the actions required of them following on from the internal risk audit. • It has been identified that the digital risks on the Risk Register need to be reviewed and enhanced. Meeting to be held with Director of IT and senior team to progress. On 22 May 2024 the final report was received following the internal risk audit undertaken on behalf of the Trust by RSM UK Risk Assurance Services LLP as part of the internal audit plan 2023/24. The report indicates the Board can take 'reasonable assurance' that the controls upon which the organisation relies to manage risk are suitably designed, consistently designed and effective, and examples of good practice are noted. There are four 'medium priority' management actions within the report. An action plan has been agreed at the June Risk Review Group with escalations to CEMG. The overall findings of the report and management actions required are summarised within this report. The full report is included as Appendix 1.
Key recommendations:	The Board of Directors is asked to **SUPPORT** the recommendations above made within the paper. The Board is asked to **RECEIVE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

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Implications:

Links to Strategic Theme:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the Corporate Risk Register (CRR).
Resource:	**Yes**. Additional resource will be required to mitigate some of the significant risks identified. There is one Risk Manager for the whole organisation who works within the Quality Governance directorate. This post is vacant as of the end of April 2024. The first round of recruitment was unsuccessful and as such the job description has been reviewed and subsequently the grading amended to ensure parity with other multi-site acute hospitals. The job is currently out to advert with a closing date of 26 July 2024. Essential support is being provided by the Associate Director of Quality Governance.
Legal and regulatory:	**Yes.** The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer

Assurance route:

Previously considered by: Risk Review Group 24 June 2024 and CEMG 3 July 2024.

It should be noted that as the Risk Register is a live document the supporting information was extracted on 12 July 2024. Whilst the Risk Register will contain updates since presentation at CEMG it will not include additional new risks as these require approval at the Risk Review Group ahead of CEMG.

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

1.1 This report is provided to ensure the Board are aware of all risks rated high (15) and above on the Trust risk register.

1.2 This paper presents movement in month and details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place.

1.3 Escalations are presented as discussed and agreed at the Risk Review Group on 24 June 2024. These have previously been escalated to CEMG on 3 July 24 but are contained for completeness.

1.4 On 22 May 2024 the final report was received following the internal risk audit undertaken on behalf of the Trust by RSM UK Risk Assurance Services LLP as part of the internal audit plan 2023/24. The overall findings of the report and management actions required are summarised. The full report is included as Appendix 1.

2. Background

2.1 A comprehensive review and refresh of the Corporate, Care Group and Specialty level risk registers was launched in November 2023. This followed an initial review and recommendations made by an External Consultant on behalf of the Trust in October 2023. Phase 1 of this work was concluded at the end of March 2024. Phase 2 will involve embedding the processes and governance improvements introduced and continuing to develop the risk culture in the organisation.

2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is below and summarised with priority actions noted.

2.3 The Risk Review Group was established in early February 2024. The sixth meeting was held on 24 June 2024 where there was a deep dive presentation received by Critical Care, Anaesthetics and Specialist Surgery (CCAS) Care Group and Kent and Canterbury and Royal Victoria (KCHRV) Care Group.

3. Current Significant Risk Register

3.1 There are currently 34 risks in total on the Significant Risk Report (down from 40 in the June report to the Board and 82 at the start of the review).

3.2 There are no changes to the residual risk scores of the risks which were also reported last month.

3.3 There are overdue actions associated with 14 of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Care Group Triumvirate leadership teams.

3.4 The Significant Risk Register is summarised below:

East Kent Hospitals University NHS Foundation Trust

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to last month	Target Risk Score	Actions summary
1891	Corporate Operations	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	⟺	Low (6)	**Expand trial of Single Point of Access (SPoA) to Queen Elizabeth the Queen Mother Hospital (QEQM)** **Person Responsible: Sandra Cotter** **Due: 28 Jun 2024** **Further enhance collaboration with community healthcare providers to alleviate Emergency Department (ED) burden with measure attendance avoidance** **Person Responsible: Sandra Cotter** **Due: 30 Jun 2024** **Conduct comprehensive review of current ED processes and identify areas for improvement - focus initially on opportunity to reduce the number of patients spending 12+ hour in ED** **Person Responsible: Sandra Cotter** **Due: 30 Jun 2024** Trust wide Length of Stay (LOS) programme in place

						which will support the implementation and monitoring of the SAFER bundle Person Responsible: Kate Hannam Due: 27 Sep 2024 Utilise investment from the NHS England (NHSE) Bed Capacity Management System to invest in technology solutions, to more accurately manage the placement of admitted patients resource allocation Person Responsible: Kate Hannam Due: 29 Sep 2024
3386	Care Group - Women's Health	Potential risk of inaccurate records due to Euroking back copying	Extreme (20)	⟺	Low (4)	IT to provide weekly updates to Maternity teams on progress actions from the queries review with Magentus following the daily meetings. Person Responsible: Sharon Gough Due: 06 Dec 2024
2406	Care Group - Diagnostics, Cancer and Buckland	Delay to patient diagnosis from potential loss of Nuclear Medicine service at William Harvey Hospital (WHH)	High (16)	⟺	Low (4)	Camera to be installed / work to be completed. Person Responsible: Colin Fell Due: 30 Aug 2024
2934	Care Group - Women's Health	Inadequate theatre capacity at QEQM for	High (16)	⟺	Low (4)	Additional section list to be explored at QEQM to have

		maternity services				sections every day (Monday to Friday) to meet demand. Person Responsible: Zena Jacobs Due: 1 Aug 2024. Progress plans with strategic development with potential NHSE funding to support the needed maternity estate expansion (including obstetrics theatre) at QEQM Person Responsible: Karen Costelloe Due: 30 Sept 2024
2808	Queen Elizabeth Queen Mother Care Group	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity	High (16)	⟺	Low (6)	Participation in relevant audits relating to deteriorating patients and development and implementation or robust actions to address gaps and identified areas where improvement needed. Person Responsible: Joanna Williams Due: 19 Jul 2024 System work being undertaken to improve flow Person Responsible: Susan Brassington Due: 30 Sep 2024
3354	Queen Elizabeth Queen Mother Care Group	Clinical environment not fit for purpose in many areas	High (16)	⟺	Low (4)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing

						programme of maintenance and repair. List of estates issues from closed ward risks attached Person Responsible: Susan Brassington Due: 30 Nov 2024
2682	Care Group - Diagnostics, Cancer and Buckland	Increased likelihood of potential radiation incidents and regulatory breaches leading to patient, staff and public harm, due to repeated postponement of TRAC meetings	High (16)	⟺	Low (4)	Radiation safety to be agenda item for all care group governance meetings and quarterly report to be submitted to TRAC. Person Responsible: Samantha Gradwell Due: 31 July 2024 Schedule quarterly meetings and ensure required staff are invited. Person Responsible: Desmond Holden Due: 28 Jun 2024 **Attendance at TRAC meetings to be ensured and supported by care groups.** **Person Responsible: Desmond Holden** **Due: 28 Jun 2024**
3553	William Harvey Hospital Care Group	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	High (16)	⟺	Low (6)	**New UPS batteries to be ordered for each lab** **Person Responsible: Bob Gadd** **Due: 28 Jun 2024**

						Exploration of running of weekend lists. Paper for enhanced rate for physiologists still to be drafted. Wider conversation around weekend NSTEMI and elective lists ongoing. **Person Responsible: Alexandra Mcvey** **Due: 28 Jun 2024** **Engineering assessment of lab equipment in labs 1. Lab 3 & lab 2 assessment complete - high priority for replacement.** **Lab 1 remains for assessment** **Person Responsible: Andrew Barrow** **Due: 30 Jun 2024** Business Continuity Plan (BCP) to be updated following Sept 2023 failure of both Percutaneous Coronary Intervention (PCI) labs at WHH and agreed with region. On-going along with other discussions around Primary Percutaneous Coronary Intervention (pPCI) with the region. New BCP template circulated and

						discussed with emergency planning. Person Responsible: Alexandra Mcvey Due: 31 Jul 2024 Development of COPEL levels to manage specialty response to pressures similar to MOPEL and POPEL Person Responsible: Alexandra Mcvey Due: 31 Jul 2024
2158	Care Group - Diagnostics, Cancer and Buckland	Risk of Patient harm and treatment due to unreported A&E chest xrays	High (16)	⟺	Low (4)	**Paper being drafted about whether Radiology should report ED Chest X-rays.** **Person Responsible: Gemma Matthews** **Due: 30 Jun 2024** External review by Regional Adviser commissioned. Person Responsible: Desmond Holden Due: 29 Jul 2024
3210	Corporate Nursing	Failure to comply with the NHS standard contract for infection prevention and control	High (15)	⟺	Low (6)	Deliver antimicrobial stewardship strategy Person Responsible: Veronica Chorro-Mari Due: 31 Mar 2025 Collaborative working with the system on C. difficile Person Responsible: Lisa White

						Due: 31 Mar 2025 Develop and implement 2426 Infection Prevention and Control (IPC) Improvement Plan as per Patient Safety Incident Response Framework (PSIRF) methodology Person Responsible: Lisa White Due: 31 Mar 2025
678	Care Group - Diagnostics, Cancer and Buckland	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Recruit to establishment for clinical pharmacy before starting Care Quality Commission (CQC) Business Case (BC) recruitment by considering innovative recruitment options. Person Responsible: Rebecca Morgan Due: 31 Jul 2024 Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments. Person Responsible: Rebecca Morgan Due: 29 Aug 2024 Confirm remit and timeframes of external pharmacy review. This is planned by Chief Medical Officer (CMO).

						Person Responsible: Rebecca Morgan Due: 02 Sep 2024 Recruit following BC approval for medical wards. Person Responsible: Kamaldeep Sahota Due: 30 Nov 2024 Consider Full 7-day service from Pharmacy following action from CQC Must do Person Responsible: Will Willson Due: 31 Dec 2024
2796	Kent & Canterbury and Royal Victoria Care Group	There is a risk of delay in dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old	High (15)	⟺	Low (6)	No open actions. Escalated with Care Group for attention.
1831	Queen Elizabeth Queen Mother Care Group	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)	⟺	Low (6)	Monitoring of use of corridor areas as patient areas using DATIX reports and harm reviews as necessary as an ongoing process Person Responsible: Joanna Williams Due: 31 Jul 2024
3556	William Harvey Hospital Care Group	Delays in delivery and personal care are resulting in an increased	High (15)	⟺	Low (6)	**Regular audits of the ED care plan to ensure that the actions that are**

		risk of pressure ulcers and falls occurring				**prompted by this are delivered** **Person Responsible: Tomislav Canzek** **Due: 30 Jun 2024** Continued Implementation of the Emergency Floor Improvement plan which includes direct pathways such as right sizing Same Day Emergency Care (SDEC), Surgical Emergency Admissions Unit (SEAU) and Urgent Treatment Centre (UTC) Person Responsible: Rachel Perry Due: 01 Jul 2024
3367	Corporate Medical	Lack of timely review of diagnostic test results	High (15)	⟺	Low (6)	**To understand the issues and Trust processes across the specialties to identify the causes of this risk** **Person Responsible: Samantha Gradwell** **Due: 28 Jun 2024** Developing a page on Sunrise for consultants to review all results that are allocated to them Person Responsible: Michael Bedford Due: 31 Jul 2024

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2999	Care Group - Women's Health	Exposure of staff to level of nitrous oxide from the use of Entonox in the Maternity unit.	High (16)	⟺	Moderate (9)	Annual report on compliance to the medical gases committee Person Responsible: Cherrie Knight To be implemented by: 01 Nov 2024 **Explore if continuous gas monitoring systems can be installed in maternity areas using Equanox to provide assurance for the controls in place.** **Person Responsible: Colin Comper** **Due: 30 Jun 2024** Ventilation system alert alarm to be installed within midwifery office at QEQM to alert team if system fails. Person Responsible: Andrew Wakefield. Due: 30 Sept 2024. **Purair systems to be procured and installed in QEQM Midwifery Led Unit (MLU) rooms** **Person Responsible: Andrew Wakefield** **Due: 30 Jun 2024** With support from Occupational Health plan for at risk staff to return to full clinical duties.

						Person Responsible: Cherrie Knight Due: 31 August 2024 Low level extract air ventilation system controls have been misused changing the ventilation from pull to push or turned off. Action to progress minor works to have a guard over the controls. Person Responsible: Cherrie Knight Due: 31 Jul 2024 Re-test Entonox levels at QEQM MLU following initial findings from the initial external visit on 17 May 2024. Person Responsible: Cherrie Knight Due: 31 Jul 2024 WHH MLU - to remove the string pulls to turn the Pur-air devices on and off with light to visibly see the power is on. Person Responsible: Bob Mitchell Due: 31 Jul 2024
679	Care Group – Diagnostics, Cancer and Buckland	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)	⟺	Moderate (10)	**Options regarding future plan for Admissions & Pre Assessment Unit (APU) presented at Capital Investment Group (CIG). Presentation will be**

						by Strategic Development (SD) but support for options provided by APU staff. Actions will be generated following outcome of CIG **Person Responsible: Rebecca Morgan** **Due: 28 Jun 2024** Replacement of the unit with off site licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Person Responsible: Will Willson Due: 30 Sep 2029
3566	Care Group – Queen Elizabeth, The Queen Mother	Delayed diagnoses for patients awaiting endoscopy	High (16)	⟺	Moderate (8)	Endoval process to be revisited to check whether patients on waiting lists still wish to proceed with the procedure they are awaiting. All overdue surveillance validated and scopes booked for patients who breached over 2023 and those breached 31/10/2023 to 1/3/2024 to be clinically validated and actioned. Person Responsible: Sarah Hyett Due: 30 Sep 2024 Ensure full utilisation of capacity

						Person Responsible: David Bogard Due: 30 Sep 2024 Review of insourcing opportunities through framework of Consultant only provision completed. This is linked to agreement of standardised rates for Consultants. Ongoing review of insourcing requirements required. Person Responsible: Sarah Hyett Due: 30 Sep 2024 Clinical performance manager to track untracked cancers and lead on Duty of Candour (DoC) for any delayed diagnosis. This is ongoing Person Responsible: Bridget Creighton Due: 30 Sep 2024
2696	Care Group – Critical Care, Anaesthetics and Specialist Surgery	There is a risk that staff will not be sufficiently trained in resuscitation due to the size of the resuscitation team	High (16)	⟺	Moderate (8)	All HLS and pHLS have 'walk in' availability Person Responsible: Peter Samworth Due: 16 Aug 2024 The resus team have agreed to increase their number of Responsible Officer (RO) - candidates ratio from 1- 6, to 1-8

						to accommodate more staff to receive training and as of now there are 3 new RO's who can all facilitate HLS at present Person Responsible: Peter Samworth Due: 16 Aug 2024 Training dates released to be booked to until December 2024 Person Responsible: Peter Samworth To be implemented Due: 16 Aug 2024 Bespoke training for areas who request this to increase compliance Person Responsible: Peter Samworth Due: 16 Aug 2024
3264	Care Group – Critical Care, Anaesthetics and Specialist Surgery	There is a risk that patients will breach the 52 week wait standard for a maxillofacial first outpatient appointment due to an inability to recruit specialty doctors	High (16)	⟺	Moderate (8)	Recruitment into vacancies and reduce outpatient first appointment wait time. Person Responsible: Juliet Apps Due: 31 Aug 2024 Proposed risk be de-escalated – awaiting outcome of governance meeting discussion.
3557	Care Group – William Harvey	Increased length of stay for mental	High (16)	⟺	Moderate (9)	**The UEAM team are working to identify and provide**

		health patients awaiting inpatient community beds				**assessment facilities for patients awaiting inpatient beds. This is still under review due date amended** **Person Responsible: Benjamin Hearnden** **Due: 30 Jun 2024** Recruit mental health nurses. This is still in progress due date amended. Person Responsible: Tomislav Canzek Due: 31 Jul 2024 Work with external partners/commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with Kent and Medway NHS and Social Care Partnership Trust (KMPT) Ongoing consultation and recent Integrated Care Board (ICB) visit and actions unidentified. This is still in progress - date amended Person Responsible: Benjamin Hearnden Due: by: 21 Aug 2024 Ensure safeguarding vulnerable adults and paediatric training compliance. Compliance is

						monitored on an ongoing basis and also reinforced at Team Days. Person Responsible: Benjamin Hearnden To be implemented Due: 31 Aug 2024
3642	Care Group – Queen Elizabeth, The Queen Mother	There is a demand and capacity gap in respiratory sleep and diagnostic services which risks patients breaching Referral to Treatment (RTT), DMO1 and Cancer targets	High (16)	⟺	Moderate (9)	**New procurement award for devices across 2 companies to mitigate lone company FSNs** **Person Responsible: David Boyson** **Due: 30 Jun 2024** **Establish fully remote CPAP monitoring service to achieve discharge profile of 50% current WL. Funding for modems for home monitoring being explored.** **Person Responsible: David Boyson** **Due: 30 Jun 2024** Programme Management Office (PMO) support for business case completion through efficiencies programme. It is primarily focused on the Respiratory Diagnostic services; Sleep Disordered Breathing- 'sleep service/ CPAP service', and Respiratory

						Physiology testing - 'lung function'. It also encompasses the domiciliary Non-Invasive Ventilation (NIV) service- 'NIV', which is not a diagnostic service but a large (separate) outpatient service that runs alongside the sleep service as there is much overlap of work, equipment and staffing. Person Responsible: David Boyson Due: 31 Jul 2024 Review options for localised LFT service at WHH with associated income and financial/performance trajectory-- staff, equipment and Consultant support Person Responsible: David Boyson Due: 31 Aug 2024 Establish revised training programme for existing and new staff including tertiary colleague support to improve recruitment and retention. Apprenticeships have started Person Responsible: David Boyson Due: 31 Oct 2024

1895	Care Group – Diagnostics, Cancer and Buckland	Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment	High (16)	⟺	Moderate (9)	External review to be undertaken by Regional Advisor (Tony Newman-Saunders). Person Responsible: Desmond Holden Due: 31 Jul 2024 4 additional posts to be recruited to as part of vacancy factor Person Responsible: Beverley Saunders Due: 30 Aug 2024 Waiting for 4 Radiologist to come into post following successful recruitment Community Diagnostic Centre (CDC) business case. Person Responsible: Beverley Saunders Due: 31 Oct 2024
2979	Care Group – Critical Care, Anaesthetics and Specialist Surgery	Delays to patient care and poor patient experience due fragile YAG Laser machine at QEQM Eye Clinic	High (15)	⟺	Very Low (3)	Replacement YAG Laser to be funded and purchased Person Responsible: Howard Ford Due: 31 Aug 2024
3625	Care Group – William Harvey	Capacity and demand for ED care resulting in corridor care	High (15)	⟺	High (15)	**Send CQC action plan - must and should do's.** **Person Responsible: Rachel Perry** **Due: 28 Jun 2024** **WHH Triumvirate team requested to**

						review risk. Suggestion action above to be removed and to reflect ongoing work. Chief Operating Officer (COO) to be involved as exec lead.
2766	Care Group – Critical Care, Anaesthetics and Specialist Surgery	There is a risk that patients are cancelled and theatres starts are delayed due to a lack of surgical admissions lounge at WHH, this impacts on patient's experience and dignity	High (15)	⟺	Moderate (9)	**Return of surgical admissions unit at WHH.** **Awaiting site lead update for estate allocation of Surgical Admissions Lounge (SAL).** **Meetings to take place week commencing 10 June.** **Person Responsible: Anthony Adams** **Due: 28 Jun 2024** Work with Prism around theatre utilisation to improve productivity Establish task and finish group for theatre right sizing Right sizing task and finish group established. Person Responsible: Anthony Adams Due: 30 Jul 2024
1628	Care Group – William Harvey	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric	High (16)	⟺	Low (4)	**Advertise and recruit into Matron post. Use internal and external networks to promote role. Interim in place in meantime.**

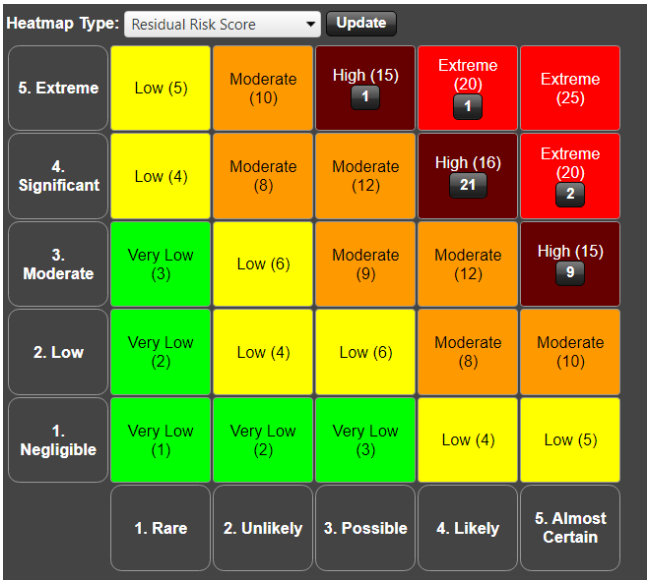
		patients in line with the Royal College of Paediatrics and Child Health (RCPH) standards				**Person Responsible: Benjamin Hearnden Due: 28 June 2024**
2195	Care Group – Queen Elizabeth, The Queen Mother	Due to large volumes of recruitment, risk of poor skill mix, junior nursing workforce	High (16)	⟺	Low (6)	Staffing levels to be reviewed and active recruitment, in line with the Care Group Recruitment Strategy Person Responsible: Susan Brassington Due: 31 Aug 2024
2565	Care Group – Women's Health	There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and their families	High (16)	⟺	Moderate (8)	Explore further the use on non-Midwife roles (Registered Nurses/Nursery Nurses/MSW's) to release Midwifery time Person Responsible: Adaline Smith Due: 30 September 2024.
2234	Care Group – Diagnostics, Cancer and Buckland	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)	⟺	Moderate (8)	Recruit Band 2x additional Band 3 admin to support increased audio typing and outsourcing to LDPath (c. 80 cases per day) Person Responsible: Stuart Turner Due: 30 Aug 2024
3309	Care Group – Queen Elizabeth, The Queen Mother	Inability to recruit Emergency Department Consultants and Acute Consultants at QEQM	High (16)	⟺	Low (4)	*Active recruitment with dedicated HR support to the Care Group *Digital and social media campaign

						*Awaiting commencement of recruited Consultant Trajectory is for 10 Consultants to be in post by September 2024. Person Responsible: Wayne Kissoon Due: 01 Nov 2024
2899	Care Group – Women's Health	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service	High (16)	⟺	Moderate (9)	Readvertise for the 3 vacancies at QEQM. Post held off until after April so that the cohort who get their Certificate of Completion of Training (CCT) in October could apply Person Responsible: Zoe Woodward Due: 31 July 2024
3384	Corporate – Strategic Development & Capital Planning	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement	High (16)	⟺	Moderate (12)	**Prioritised and signed off capital expenditure plan for 2024/25** **Person Responsible: Benjamin Stevens** **Due: 31 May 2024**
2599	Corporate – Medical	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)	⟺	Low (6)	Deliver a fit for purpose medical appraisal platform Person Responsible: Jason Watson Due: 30 Aug 2024

East Kent Hospitals University NHS Foundation Trust

3.4 The below table shows the risk register entries by clinical or corporate care group and residual risk score. All Significant Risks have been allocated an Accountable Executive.

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG	2	2			4
DCB CG	1	5	1		7
K&C CG	1				1
QEQM CG	1	6			7
WHH CG	2	3			5
WCYP CG		4	1		5
Corporate Medical	2				2
Corporate Nursing	1				1
Corporate Operations			1		1
Corporate Strategic Development & Capital Planning		1			1
TOTAL	**10**	**21**	**3**	**0**	**34**
CHANGE SINCE JUNE BOARD REPORT	**0**	**-7**	**0**	**0**	**-6**



3.5 The 5 risks that have been de-escalated on the Significant Risk Report (SRR) are:

- Patients are at risk of breaching the national cancer standards. This could result in patients waiting longer for treatment with associated poor patient outcomes and patient experience (ref: 3528). Corporate Operations. Previous residual risk rating 16 (high) to 12 (moderate).
- Misalignment between demand and capacity across Trust's RTT, non-RTT and Cancer pathways (ref: 2038). Corporate Operations. Previous residual risk rating 16 (high) to 12 (moderate).
- Reduced Consultant Microbiology (CMM) workforce (ref: 2620). DCB Care Group. Previous residual risk rating 16 (high) to 12 (moderate).
- Risk to service delivery as a result of difficulty recruiting to Patient Service Centre (ref: 2850). DCB Care Group. Previous residual rating 16 (high) to 12 (moderate).
- Insufficient tympanometers – risk to service delivery (ref: 3617). DCB Care Group. Previous residual rating 16 (high) to 12 (moderate).

3.6 The below risk has been closed since the last report:

- Data quality issues created by administrative staff (ref: 2419). Corporate Operations. Agreed to merge controls and actions with open risk 2038.

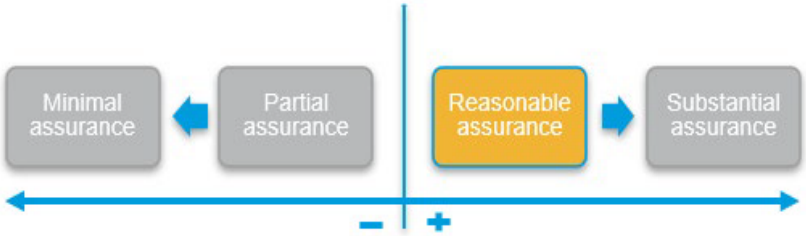
4. Risk Audit 23/24

4.1 On 22 May 2024 the final report was received following the internal risk audit undertaken on behalf of the Trust by RSM UK Risk Assurance Services LLP as part of the internal audit plan 2023/24. The review aimed to determine whether the Trust has continued to develop its risk management framework to assist with managing its strategic risks.

4.2 The auditors found some controls in place relating to Risk Management at the Trust to be designed and operating effectively. The auditors confirmed there was a suitable Risk Management Policy and Strategy in place to guide staff with the management of risk and the design of the new Trust risk register is sufficiently detailed around the description of risks, controls and actions in place.

4.3 Specific examples of good design were noted including the process for adding new risks to the Trust Risk Register, governance around the flow of risks between the Significant Risk Register and the Board Assurance Framework (BAF), the creation of the Risk Review Group and the associated deep dives and strengthened governance via CEMG, Board Sub Committees and the Board.

4.4 The auditors have suggested the Board can take **reasonable assurance** that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.



4.5 In addition to a thorough review of a sample of risk records (both retrospectively and 'live' on the 4Risk system), the auditors also distributed a survey to Executive Directors, Non-Executive Directors and senior leaders at care group level with regards to the risk culture in place at the Trust. 38 responses were received. Overall, respondents confirmed that the Trust is on a journey and the need for continued effort to strengthen the risk management culture within the Trust. This was supported by the fact most respondents were aware of the risk management policy and associated procedure but felt risks are not being well covered and reviewed in team meetings at overall Trust and Care Group level, risks are not being suitably de-escalated when mitigating controls are applied (30% agreed with this statement), there is not sufficient risk information sharing across the organisation including at Care Group level if appropriate (30% agreed with this statement) and risk management is not well embedded within the Trust and there is no clear ownership of risks (32% agreed with this statement).

4.6 There are four Management Actions contained within the report. These are detailed below. Progress with completion of the actions will be managed via the Risk Review Group with escalations to CEMG.

	Action	Responsible Owner	Due date	Priority
Management Action 1	On a monthly basis, the appropriate specialty service or Care Group governance meetings must include an agenda item for Risk Management where risk changes or changes in ratings that are about to happen are discussed and agreed.	Care Group Triumvirates & corporate service leads	31 August 24	Medium
Management Action 2	Implementation dates will be monitored monthly against progress of actions. If deadlines are no longer appropriate, these will be amended on 4risk and the risk register with supporting narrative.	Care Group Triumvirates and corporate service leads. Associate Director of Quality Governance (reporting)	30 June 24	Medium
Management Action 3	The SRR will be updated with the following: a) All risk owners or delegated owners will allocate an assurance level for all risks. b) When providing assurance levels to risks, risk owners will also add a note into 4risk of some narrative for how the assurance levels were assessed and agreed. c) Progress update column will be completed for all risks after the next risk review group. This will be done through running a report showing significant risks that are missing any of the information listed above on a monthly basis so this can be flagged for action to the risk owners.	Care Group Triumvirates & corporate service leads Executive leads Risk Manager and Associate Director of Quality Governance	31 July 24	Medium

Management Action 4	The Trust will review the outcomes of the questionnaire and either link them to already existing actions within the Risk Management Strategy or add additional actions to support continued improvement to embed a positive risk management culture.	Risk Manager and Associate Director of Quality Governance	31 July 24	Medium

5. Escalations from Risk Review Group (24 June 2024)

5.1 The following escalations were made from the Risk Review Group on 24 June 2024 to CEMG on 3 July 2024. These are noted here for completeness.

5.2 The Care Group deep dive presentations revealed ongoing work needed in relation to outstanding actions and review of open historical risks (in particular for KCHRV Care Group) in line with agreed risk tolerances. Many of the Care Groups are now having Risk Groups to support this work and challenge but this work needs to continue at pace.

5.3 There are a large number of actions on Care Group level risk registers relating to the estates and equipment and it is not clear what the oversight arrangements are for this at Trust level. Where medical devices risks are identified these risks are reviewed at the Medical Devices Group but clarity is needed on estates issues that require investment, visibility of these risks, prioritisation and ownership.

5.4 Care Groups and Corporate Leads to be aware of the actions required of them following on from the internal risk audit.

5.5 It has been identified that the digital risks on the Risk Register need to be reviewed and enhanced. Meeting to be held with Director of IT and senior team to progress.

6. Conclusion

6.1 The Board of Directors is asked to receive the Significant Risk Report for assurance purposes and for visibility of the key risks facing the organisation.

6.2 Board members are asked to receive the findings of the internal audit and assurance regarding the management actions identified.

EAST KENT HOSPITALS UNIVERSITY NHS FT

Risk Management

Internal audit report 8.23/24

Final

22 May 2024

1. EXECUTIVE SUMMARY

Why we completed this audit.

An audit of revised Risk Management processes was undertaken at the Trust as part of the agreed internal audit plan for 2023/24. The review aimed to determine whether the Trust has continue to develop its risk management framework to assist with managing its Strategic risks.

The Risk Management function within East Kent Hospitals University NHS Foundation Trust is led by the Director of Quality Governance who has the overall responsibility for ensuring that risk management process within the Trust is appropriately reported. Risk Management is supported by the Risk Manager who has the responsibilities for facilitating risk management processes within the organisation.

The BAF sits under the portfolio of the Director of Corporate Governance. This post was vacant at the time of the review and an interim in place but the substantive post holder has since started in the organisation.

The Trust has the following Clinical Care Groups:

1. Women's Health and Children and Young People
2. Diagnostics, Cancer and Buckland
3. Queen Elizabeth, The Queen Mother
4. Critical Care, Anaesthetics and Specialist Surgery
5. William Harvey
6. Kent and Canterbury and Royal Victoria

Previously, a Care Group Risk Register was available for each group which captured the highest and cross-speciality operational risks. However, the Trust implemented a new process where a central cleanse of the Corporate, Care Group and specialty level risks took place between December to January 2024 to create one single trust-wide risk register. We reviewed the Trust risk register (TRR), where all risks are visible. At the time of our review, we confirmed there are 494 risks in total on the register. For Board committees and Clinical Executive Management Group (CEMG) the Trust used a Significant Risk Report (SRR), showing all risks scoring 15+ which currently has 46 risks. We also reviewed the latest iteration of the BAF as part of this review.

The Trust uses a risk management software system called 4risk to record and manage its exposure to risk. The system is used across the organisation to record strategic as well as operational risks. It records the organisation's risks, the controls in place to mitigate these risks; assurance levels and the action plans. The risk registers and reports are run from the system, which has the functionality to filter the risks according to the committee, to which the register will be presented.

There is a review of the Risk registers by the Risk Manager and the Executive Leads with reports being received by the Clinical Executive Management Group (CEMG); Risk Review Group (RRG) and the relevant Board sub-Committees, such as the Integrated Audit and Governance Committee (IAGC); Quality and Safety Committee (QSC); Finance and Performance Committee (FPC); and People and Culture Committee (PCC).

In addition, we have completed a staff survey distributed to the Executive Directors, non-Executive Directors and senior staff at Divisional level with regards to the risk culture in place at the Trust. The survey received 38 responses and the results can be seen summarised in the Questionnaire Overview section below.

We would like to thank the staff at East Kent Hospitals NHS Foundation Trust for their assistance during this review.

Conclusion

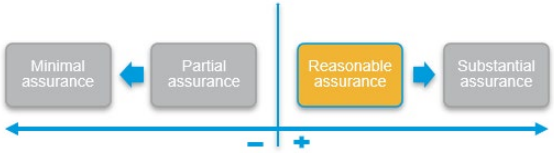
Overall, we found some controls in place relating to Risk Management at the Trust to be designed and operating effectively. We confirmed there is a suitable Risk Management Policy and Strategy in place to guide staff with the management of risk and the design of the new Trust risk register is sufficiently detailed around the description of risks, controls and actions in place.

Weaknesses have been identified in relation to the timeliness of actions being completed, a lack of progress updates to support the tracking of actions and assurance levels not provided for all controls. We have also identified areas for improvement from the outcomes of staff feedback received from the Risk Management culture questionnaire completed at the Trust. Although the BAF is currently undergoing redevelopment, the change in format of the updated BAF reviewed at the time of this audit found that the board did not have sufficient oversight of the Trust's key risks contained within the BAF as there was a lack of detail around controls and assurances in place. However, we appreciate this is to be addressed at the Board Development Day to be held on the 30th April 2024 where a further updated Board Assurance Framework and Significant Risk Report will be presented and reviewed in detail to ensure it is fit for purpose for 2024/2025. The Board receive a monthly report on the Significant Risk Report.

Internal audit opinion:

Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).

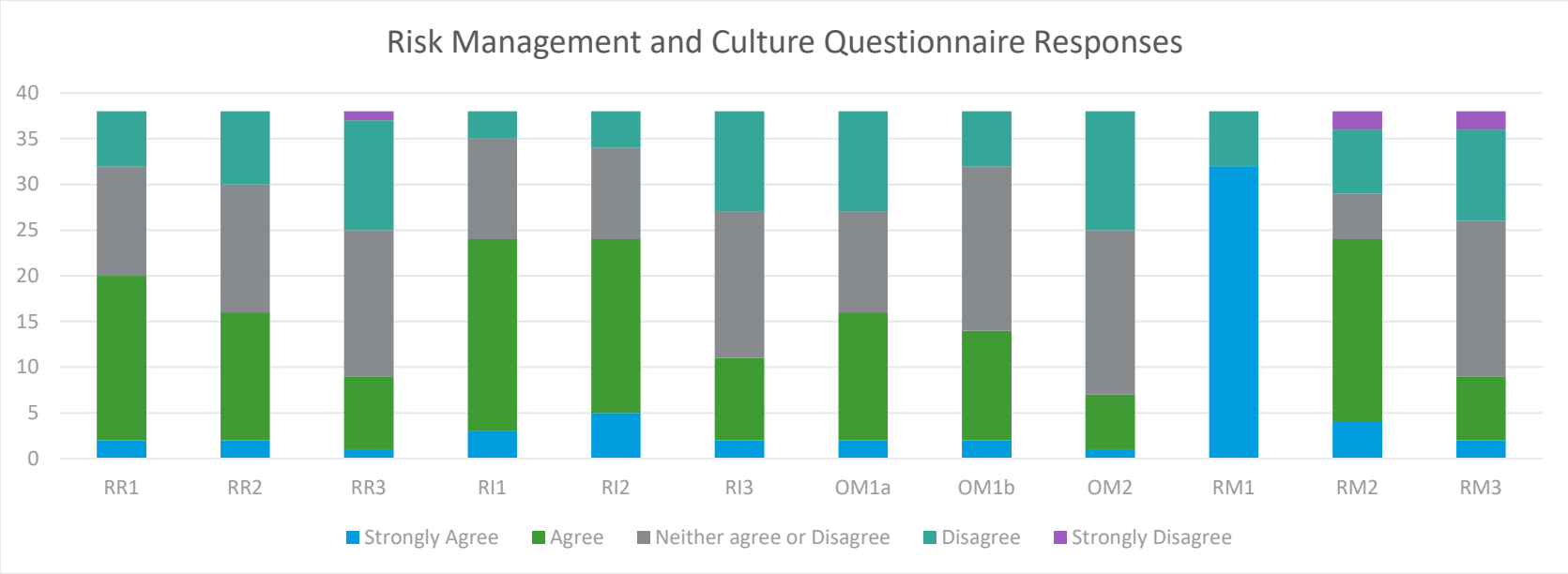


Questionnaire Overview

We have completed a staff survey using RSM's 4Questionnaire which was distributed to Executive Directors, non-Executive Directors, and senior staff at Divisional level at the Trust with regards to the risk culture at the Trust.

Respondents chose from 'Strongly Agree,' 'Agree,' 'Neither agree nor disagree', 'Disagree', 'Strongly Disagree' for all questions apart from Q10 relating to whether staff were aware of the risk management policy and associated procedural guide ('Yes' or 'No') and Q13 which asked staff opinion on the maturity of risk management at the Trust, which was scored by respondents choosing 'Mature', 'Requires Improvement', 'In its infancy', 'non-existent'.

The survey received 38 responses and a summary of the results is as follows:



The questions were split into five categories the following five categories, which were as follows:

- **RR:** Roles & Responsibilities
- **RI:** Risk Identification & Assessment
- **OM:** Ongoing Monitoring Arrangements
- **RM:** Risk Management Awareness

Overall, respondents confirmed that the Trust is on a journey and the need for continued efforts to strengthen the risk management culture within the Trust. This was supported by the fact most respondents were aware of the risk management policy and associated procedure but felt risks are not being well covered and reviewed in team meetings at overall Trust and Care Group level, risks are not being suitably de-escalated when mitigating controls are applied (30% agreed with this statement), there is not sufficient risk information sharing across the organisation including at Care Group level if appropriate (30% agreed with this statement) and risk management is not well embedded within the Trust and there is no clear ownership of risks (32% agreed with this statement)

Management should consider the results of this questionnaire to identify potential weaknesses and emerging challenges within the risk management culture at the Trust so that rectifying actions can be taken. **Management Action 4 – Medium**

Detailed breakdown of the responses can be found in Appendix A of this report.

Key findings

As part of our audit, we have raised four '**Medium**' priority actions for management. The actions relate to the following matters:

Revised Board Assurance Framework

We confirmed through discussion with management, the previous BAF format contained the old strategic objectives and had not been aligned to the Integrated Improvement Plan (IIP). The IIP is the Trust's plan, created in collaboration with ICB and NHS England, and is the agreed plan and criteria to exit the National Oversight Framework 4 (NOF4). Due to the significant changes made to the BAF, we were only able to track the risk scores from December 2023 to February 2024. We did note, however, at this moment in time the Target Risk score and Target Date had not yet been populated.

In the course of our testing, we have drawn comparisons between the old Board Assurance Framework (BAF) and the new one to ensure that the risk registers are comprehensive. The new BAF has brought about a more structured approach by aligning risks with specific strategic goals, thereby offering clarity on priorities and alignment with organisational objectives. This has led to an enhanced focus on strategic goals, with risks and opportunities being explicitly identified for each goal. Furthermore, risk ratings and assurance levels are now presented in a more systematic manner, facilitating a more effective assessment of risk severity and the efficacy of mitigation measures. The planned actions in the new BAF have also seen a significant improvement, with greater detail and specificity reflecting a proactive approach towards risk management and continuous improvement. Overall, the new BAF represents an improvement over the previous version of the BAF in terms of clarity, alignment with strategic goals, and specificity of planned actions to address identified risks and opportunities.

Following the agreement at the Board Development session of the new format for the Trust BAF, the paper from the January 2024 IAGC meeting set out the latest version of the BAF for the sub-committee to review their relevant section. The BAF has been discussed with Executive leads and the Chief Executive ahead of presentation to the sub-committee.

Alongside this work on the BAF, the Director of Corporate Governance and the Director of Quality Governance are overseeing work on updating and reviewing the Significant Risk Report (SRR) to ensure they both align.

We reviewed the most recent iteration of the Board Assurance Framework from February 2024, and confirmed that Principal Risks have been identified and appropriately linked to strategic goals of the Trust. For each Principal Risk, the following considerations have been made:

- Executive Owner of the Risk
- Responsible Committee
- Last review date, next review scheduled date, date risk identified.
- Risk appetite.
- Risk Tolerance
- Current Risk Score
- Informed by Current SRR Entries
- Measures
- Controls in place
- Assurances by Level (Level 1 - Team/Ward, Level 2 - Trust, Level 3 - Third Party/Independent)
- Gaps in controls and assurance
- Planned actions to be taken, does not include action owner and implementation date
- Progress comments

However, review of the new BAF found that all actions detailed did not have any deadlines or responsible owners. Without deadlines in place or assigned owners, there is a risk of delay or oversight in addressing risks which leads to increased exposure to those risks. It will also be difficult to track the actions as there will be no one accountable for implementing the action and providing regular progress updates.

For the new iteration of the BAF, whilst controls and assurances have been recorded, they need expanding to inform the reader of the actual purpose. Out of the 15 risks on the BAF, we found that two risks had gaps in controls identified but these did not have any actions in place to address the gaps. If actions are not in place for gaps in controls or assurances, this could hinder the Trusts achievement of strategic objectives.

The Deputy Group Company Secretary confirmed that alongside the overall risk work being undertaken, the Trust are underway with the continuation of refreshing the BAF. Once further updates have been made this will be presented to the Board Development Day at the end of April 2024, this update will include action owners and timelines, and assurance metrics/deliverables. Therefore, we have not raised an action regarding the further development of the Board Assurance Framework as these will be put in place by the end of 30th April 2024. We also note the version reviewed at the time of this audit was the draft new framework that was requested for IAGC + Board to approve, which they are happy with. We were able to review a more complete version from April which is now being taken forward to the Board for approval and confirmed that this included more detail, including the action dates.

Changes in Risk Scores
We selected a sample of ten risks from the Trust's SRR. In all ten instances, we noted changes in the risk scores over the past 12 months. However, for four instances we were not able to review supporting evidence such as minutes or updates within 4risk to provide rationale behind the changes in scores. **(MA1, Medium)**

SRR Action Deadlines
We reviewed the latest iteration of the SRR at February 2024 and noted that there were 46 significant risks with a total of 216 actions. Out of the 216 actions we found that 95 actions were overdue. We have broken down these actions below by how much they were overdue and whether any progress updates were provided within the last three months which is when the risk registers were being consolidated:

Date actions were due	Total number of actions	Progress Updates since December 2023
2019	1	0
2021	1	0
2022	6	0
2023 - Over 12 months	1	0
2023 - 7 to 12 months	18	5
2023 - 4 to 6 months	30	3
2023 - 1 to 3 months	38	13

We found that out of the 95 actions, 50 actions had no progress updates noted within the Significant Risk Report (53%). We also found that 26 actions had progress updates ranging from 2021 to November 2023 which implies that some actions may not have been followed up in over two years. If actions are not regularly tracked and completed on time, the Trust remain exposed to the identified risks for a longer period which could result in negative impacts such as financial losses or operational disruptions.**(MA2, Medium).**

We note from our review that there is greater focus on the significant risk register from the recently formed Risk Review Group. This group maintains an action and decision log which includes actions around undertaking further review of risks over two years, raising delays to risks and moving significant risks to the top of the deep dive template. Therefore, we can confirm the identified risk is being partially mitigated through the Risk Review Group**.** However, further steps may be necessary to fully address the risk

SRR Assurances and Progress Updates

We tested ten risks from the Trust's SRR and found in five cases, assurances were not provided for all controls. If assurances are not provided for all controls, there is a risk of incomplete coverage of potential risks which can result in critical issues not being assessed. Via a walkthrough the 4risk system, we further confirmed there was no additional narrative provided to support the decision for assigned assurance levels provided.

We selected a sample of six of risks with overdue actions from the SRR. Review of the progress reports and walkthrough of the 4risk system found that all six did not have any progress updates or notes supporting the action. Without regular updates noted in the progress column of the SRR, it is difficult to track the status of risk mitigation efforts and identify emerging risks. It could also be difficult to assess the effectiveness of existing controls which could result in overlooking critical risks or opportunities for improvement **(MA3, Medium)**.

Risk Management Perception and Culture

Overall, respondents confirmed that the Trust is on a journey and the need for continued efforts to strengthen the risk management culture within the Trust. This was supported by the fact most respondents were aware of the risk management policy and associated procedure but felt risks are not being well covered and reviewed in team meetings at overall Trust and Care Group level, risks are not being suitably de-escalated when mitigating controls are applied (30% agreed with this statement), there is not sufficient risk information sharing across the organisation including at Care Group level if appropriate (30% agreed with this statement) and risk management is not well embedded within the Trust and there is no clear ownership of risks (32% agreed with this statement)

Management should consider the results of this questionnaire to identify potential weaknesses and emerging challenges within the risk management culture at the Trust so that rectifying actions can be taken. **(MA4, Medium).**

Notwithstanding the above, we also identified the following examples of good design of and compliance with the control framework:

Risk Management Policy

The policy effectively outlines the Trust's systematic approach to risk identification, management, and escalation. It provides comprehensive definitions, delineates staff duties, and details the steps for managing risks, including both strategic and operational. Training requirements are also specified within the policy. The policy's monitoring arrangements are clearly defined, mandating monthly reviews of risk registers by Care Groups and Corporate Quality groups, and annual reviews of reporting arrangements into the Board. Appendices A, B, and C offer detailed guidance on the committees responsible for risk management, risk assessment/scoring criteria, and risk domain scoring, ensuring a thorough and consistent risk management process across the Trust.

Risk Management Strategy and Appetite

The policy articulates the level of risk the organisation is willing to accept, providing examples and outlining tolerances for various risk types. The Risk Management Strategy for 2023/2024, presented in a slide deck, aligns with the Risk Management Policy's statements on risk appetite and tolerance. The strategy's objectives are part of the 2023/2024 plan for embedding and improvement.

The Trust utilises a risk management maturity framework derived from the HM Treasury Risk Management Assessment Framework and the Alarm National Performance Model for Risk Management in Public Services.

Trust Risk Register (TRR)
We reviewed the Trust Risk Register as at February 2024 which incorporates all Care Group Risk registers and the Corporate Risk Register. We confirmed that the design of the new risk register is sufficiently detailed. We also identified a strength in governance around the scoring processes.

As part of our testing, we selected a sample of 10 risks from the Trust's Significant Risk Report (SRR). Our findings are as follows:

- In all 10 instances, we noted that the risks were well-defined, documenting both the cause and effect of the risk.
- In all 10 instances, we observed that the risk score is based on likelihood and impact.
- In all 10 instances, we confirmed that the controls were clearly defined, related to the core risk identified and demonstrated how the risks were being managed.
- In all 10 instances, we observed that the actions were clearly detailed with deadlines and responsible owners.

Addition of risks to TRR
There is a new process for adding risks which has not be fully embedded at the time of this review. February 2024 was the first full month of the new system. The addition of new risks requires the following steps:

- Risk is identified
- Risk application must be completed,
- Risk is presented for approval at care group governance meeting
- Risk is put as an emerging risk by risk manager
- If the new risk has a proposed residual score of 15 or above then it is submitted to the Risk Manager to be approved at the Risk Review Group.

Due to this process being implemented at the time of our review, we were unable to test a sample of new risks against the process in place. We further confirmed through discussion with management that there have not been any risks added yet that have gone through this process.

Flow of Risk
The Trust has recently established a new procedure to consolidate all risks into a single, trust-wide risk register. This process involved a comprehensive review and cleanse of risks at the Corporate, Care Group, and specialty levels from December 2023 to January 2024. Review of the BAF confirmed there is a column that shows how the BAF risk has been informed by current significant risk report entries to show the flow of risks from the SRR to the BAF.

We reviewed a sample of 6 risks from the BAF which were informed by the current significant risk report entries. We confirmed that this column details the risk reference, the risk title and the risk scores of the SRR risks which link to the strategic theme from the BAF.

Risk Review Group

The Risk Review Group replaced the Executive Risk Assurance Group (ERAG) from December 2023. These meetings are chaired by the Chief Nursing and Midwifery Officer. The first meeting was held on the 2 February 2024 where an initial deep dive of the Significant Risk Report was undertaken with actions to review risks relating to renal services, chemotherapy, efficiencies, and the emergency departments.

This group focuses on deep dives into significant risks and actions. Monthly progress reports are provided to the Board and sub-committees. We reviewed the February 2024 deep dive slide deck, noting discussions were held on significant risks, new risks, closed risks and overdue actions. Going forward this group will meet monthly to do an in-depth review of the significant risk report and progress on actions from the previous meetings. We also confirmed the Risk Review Group keep track of their actions through an action log which details the area, description, progress update, start date, due date, owners and status.

Governance

We reviewed Risk Management Assurance reports for July, September, and December 2023, covering progress, updates, and next steps regarding risk and the risk management process. Clinical Executive Management Group (CEMG) receives monthly reports outlining extreme risks and emerging areas, reflecting efforts to implement a new risk management system and foster a robust risk culture.

We also reviewed the three latest sets of meeting minutes, agendas and papers for the Board, Integrated Audit and Governance Committee (IAGC), the Finance and Performance Committee (FPC), People and Culture Committee (PCC), Clinical Executive Management Group (CEMG) and the Quality and Safety Committee (QSC). We confirmed that these included discussions on BAF, SRR and the new governance framework as well as the redevelopment of the BAF and risk register structure. CEMG meetings underscore the organisation's commitment to robust risk management practices and new governance processes. Standardising governance processes and initiatives to address risks are priorities within this meeting.

Overall, efforts to enhance risk management practices and governance structures are evident across committees and groups.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

Risk or Area: Management of risks (Testing)			
Control	Risks are being managed at the appropriate level with regular updates and appropriate level of detail on controls and assurances in place to help manage the risks	**Assessment:**	
		Design	✓
		Compliance	×

Findings / Implications

Changes in scores

As part of our testing, we selected a sample of 10 risks from the Trust's significant risk report. Our aim was to ensure that each risk is well-defined, the risk score is based on likelihood and impact, the risk score aligns with the objectives, if the risk score has changed over the past 12 months, and there is a clear rationale for any changes. Additionally, we examined whether the controls were clearly defined, the assurances for controls were clearly stated, and the actions were detailed. Our findings are as follows:

- In all 10 instances, we noted changes in the risk scores over the past 12 months.
- In six out of the 10 instances, the Trust provided us with relevant evidence, such as meeting minutes, board minutes, and screenshots from 4risk (the risk management software used at the Trust), to support the changes in the risk scores.

The Risk Management Consultant confirmed that for the remaining four instances they have not been able to source evidence for changes or closure. Discussion with management confirmed that changes cannot be made onto the system without approval at the Risk Review Group for significant risks and Care Groups for lower scored risks. We understand that if changes always had to be agreed before being made in the system, this would slow down the process. However, without clear supporting documentation of discussions and rationale behind changes in scores, there is a lack of accountability in the risk management process which could result in misinterpretation of risk levels or inadequate decision making. We have therefore, raised a recommendation around implementing an agenda item specifically for discussion around changes to scores prior to them being amended in the system within the relevant governance groups on a monthly basis.

Assurance

We have conducted a review of 10 risks from the Trust's significant risk report. This review was to ensure that for each risk with an assigned assurance level, the following criteria are met: the assurance has indeed been provided, the assurance levels are clearly aligned with the identified core risk, the assurance levels correspond with the controls, and the Trust has provided evidence for this. Our findings are summarised below:

- In five out of the 10 cases, we observed that an assurance level has been assigned to all controls for each risk.
- For three cases, some assurance was given for some controls, but the assurances for some of the controls were missing.
- In the remaining two cases, we noted that the Trust has not provided assurance for any of the controls.

Risk or Area: Management of risks (Testing)

If assurances are not provided for all controls, there is a risk of incomplete coverage of potential risks which can result in critical issues not being assessed. The lack of assurance could also compromise the Trust's ability to effectively manage risks and meet its objectives.

Through a walkthrough with management of the 4risk system, we further confirmed that there was no additional narrative provided to support the decision for the assigned assurance level and how the assurance has been assessed. Without any clear explanations, it is challenging to assess the effectiveness of controls which could potentially lead to oversight of critical risks or increase operational risks.

Overdue Actions

We confirmed through discussion with management that 4risk sends out automatic emails to risk owners and delegated risk owners regarding actions that are due. Regular meetings also now take place with the risk manager and risk leads looking at risks overall. However through review of the updated SRR we found a significant amount of actions overdue.

We reviewed the latest iteration of the SRR at February 2024 and noted that there were 46 significant risks with a total of 216 actions. Out of the 216 actions we found that 95 actions were overdue. Upon review of the progress update column within the SRR we identified that 50 actions had no commentary on the actions and seven actions had progress updates from 2021 to 2022, implying that those actions have not been followed up for nearly two years. We also conducted a walkthrough with management of a sample of six of these risks which further confirmed there were no notes provided within the action section on 4risk for those risks to explain why these actions were not completed by the implementation date.

We note that out of the 95 actions, 68 of those are overdue by up to six months. Therefore, only a small percentage of the overdue actions are overdue by a significant period of time. However there is still the risk that if actions are not completed on time, the Trust remain exposed to the identified risks for a longer period which could result in negative impacts such as financial losses or operational disruptions.

We also note that with the new care group structure, which went into place around September 2023, there have been changes to the risk register so some risk owners and delegated owners are fairly new to their risks. This has resulted in some delays in completing the actions in a timely manner. However, at the time this structure was developed, the previous risk owners should have provided an update or commentary noting that this will be delegated to another risk owner or the status of the action at that point.
Without regular updates noted in the progress column of the SRR, it is difficult to track the status of risk mitigation efforts and identify emerging risks. It could also be difficult to assess the effectiveness of existing controls which could result in overlooking critical risks or opportunities for improvement.

Additional Information

The system is currently undergoing improvements, as some users consistently add comments while others do not.
The trust faces challenges due to organisational changes, impacting their ability to make risk-related adjustments with risk owners.

Risk or Area: Management of risks (Testing)				
Management Action 1	On a monthly basis, the appropriate specialty service or Care Group governance meetings must include an agenda item for Risk Management where risk changes or changes in ratings that are about to happen are discussed and agreed..	**Responsible Owner:** Care Group Triumvirates and corporate service leads	**Date:** 31 August 2024	**Priority:** Medium
Management Action 2	Implementation dates will be monitored monthly against progress of actions. If deadlines are no longer appropriate, these will be amended on 4risk and the risk register with supporting narrative.	**Responsible Owner:** Hannah Smith, Director of Quality Governance	**Date:** 30 June 2024	**Priority:** Medium
Management Action 3	The SRR will be updated with the following: a) All risk owners or delegated owners will allocate an assurance level for all risks. b) When providing assurance levels to risks, risk owners will also add a note into 4risk of some narrative for how the assurance levels were assessed and agreed. c) Progress update column will be completed for all risks after the next risk review group. This will be done through running a report showing significant risks that are missing any of the information listed above on a monthly basis so this can be flagged for action to the risk owners.	**Responsible Owner:** Risk Manager and Emma Kelly, Associate Director of Quality Governance	**Date:** 31 July 2024	**Priority:** Medium

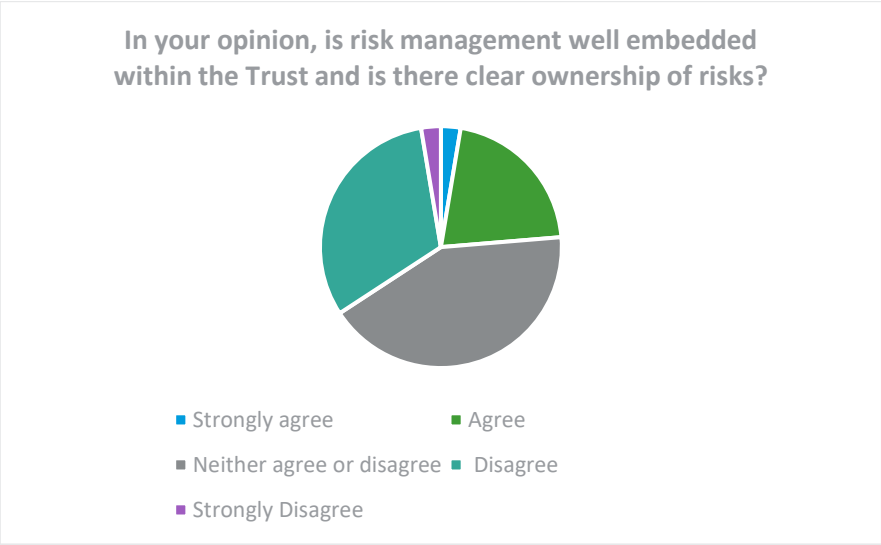
Risk or Area: Questionnaire (Testing)				
Control	As part of our review, we undertook a questionnaire to find staff opinions on the risk management processes and culture within the Trust.		**Assessment:** **Design** ✓ **Compliance** ×	
Findings / Implications	We issued a questionnaire on Risk Management to Executive Directors, non-Executive Directors and senior staff at Divisional level at the Trust. The results of the questionnaire are displayed below. Respondents chose from 'Strongly Agree,' 'Agree,' 'Neither agree nor disagree', 'Disagree', 'Strongly Disagree' for all questions apart from Q10 relating to whether staff were aware of the risk management policy and associated procedural guide ('Yes' or 'No') and Q13 which asked staff opinion on the maturity of risk management at the Trust, which was scored by respondents choosing 'Mature', 'Requires Improvement', 'In its infancy', 'non-existent'. We received 38 responses in total. Overall, respondents had a balanced perception of Risk Management. It is perceived that there is a clear leadership in terms of risk management with significant risks being able to be brought to the attention of Senior Management and the Board, with 24 out of the 38 respondents choosing strongly agree and agree. 9 out of 38 respondents agreed that risk management is well embedded within the Trust with clear ownership of risks and 20 out of 38 respondents believing that roles and responsibilities are well defined. For Q10 in the survey, 32 out of 38 respondents answered 'Yes' to being aware of the risk management policy and associated procedure. Overall, the respondents have varying views on the Risk Management Culture at the Trust. We found that 25 respondents (66%) rated the risk management culture in the top two ratings available.. While 32% believe that the culture is in its infancy stage which indicates the need for continued efforts to strengthen the risk management culture within the Trust.			
Management Action 4	The Trust will review the outcomes of the questionnaire and either link them to already existing actions within the Risk Management Strategy or add additional actions to support continued improvement to embed a positive risk management culture.	**Responsible Owner:** Risk Manager and Emma Kelly, Associate Director of Quality Governance	**Date:** 31 July 2024	**Priority:** Medium

APPENDIX A: QUESTIONNAIRE

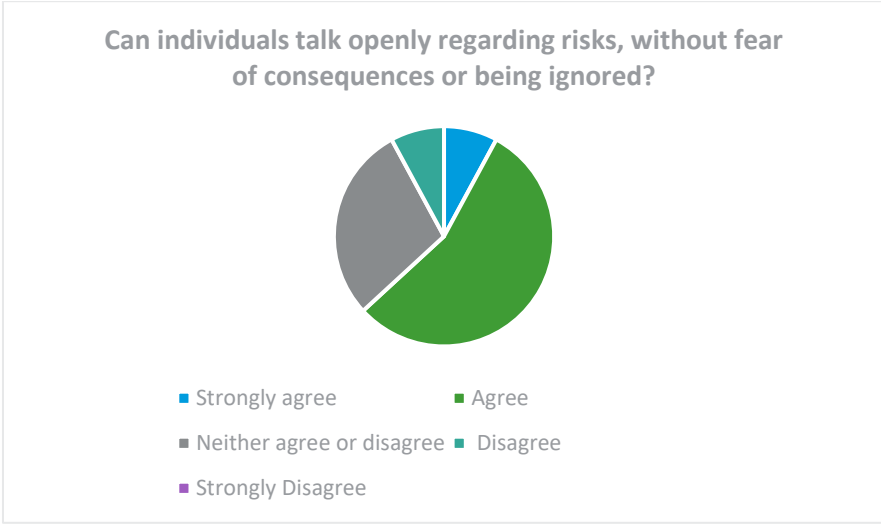
Below is a summary of the results of the questionnaire that was sent to Executive Directors, non-Executive Directors, and senior staff at Divisional level at the Trust. The questionnaire comprised of 13 questions, of which five had a further follow up section to add detail. The results are as below:

5% of respondents stated that they strongly agree that roles and responsibilities regarding managing risks are well managed whilst the 47% agreed. 32% neither agreed or disagreed and 16% disagreed that roles and responsibilities are well defined.

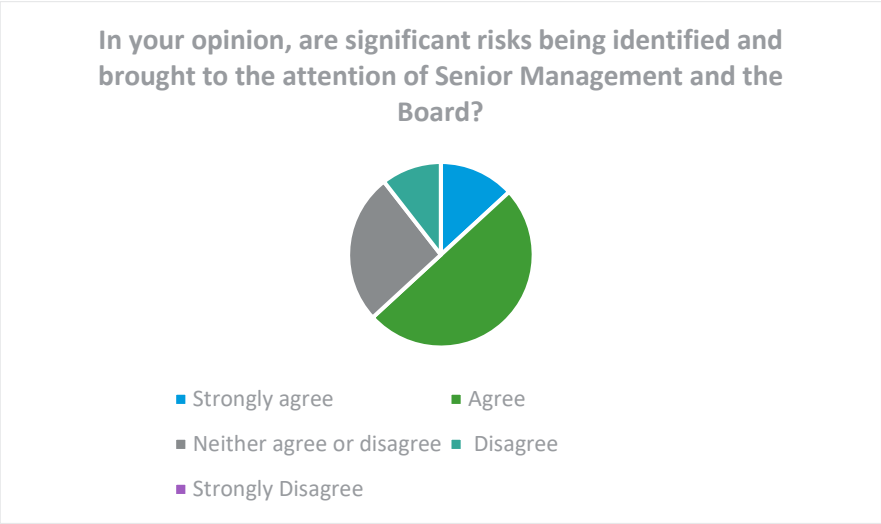
37% agreed that the Trust have clear leadership regarding risk management. 37% also neither agreed or disagreed with this statement. Some of the reasons for this are the redevelopments in place and changes in the governance structures which has made it unclear. We found that 21% disagreed and the remaining strongly agreed.



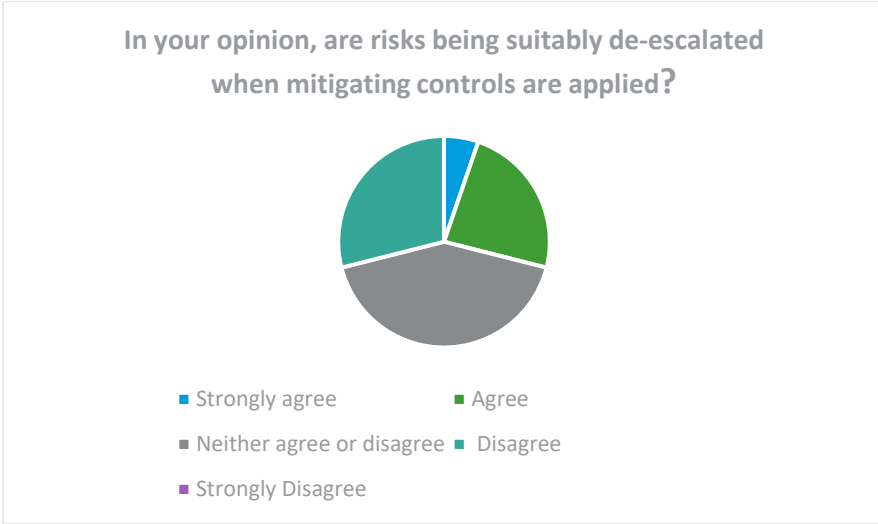
42% of respondents neither agreed or disagreed with this statement whilst 32% disagreed that risk management is well embedded within the Trust. We noted that reasons for this are that there is currently work in progress with the Trust on an improving journey but at this point in time risks are not clearly owned.



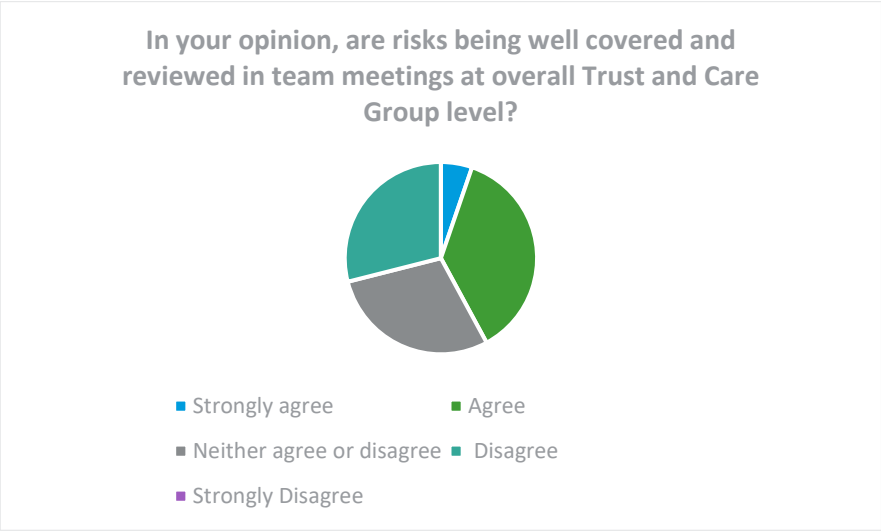
The majority of respondents (55%) agreed that individuals can talk openly about the risk without the presence of consequence or being disregarded. 29% neither agreed or disagreed with this statement. One reason for this being due to the lack of embeddedness within the Trust and a risk to whistleblowers in the NHS.



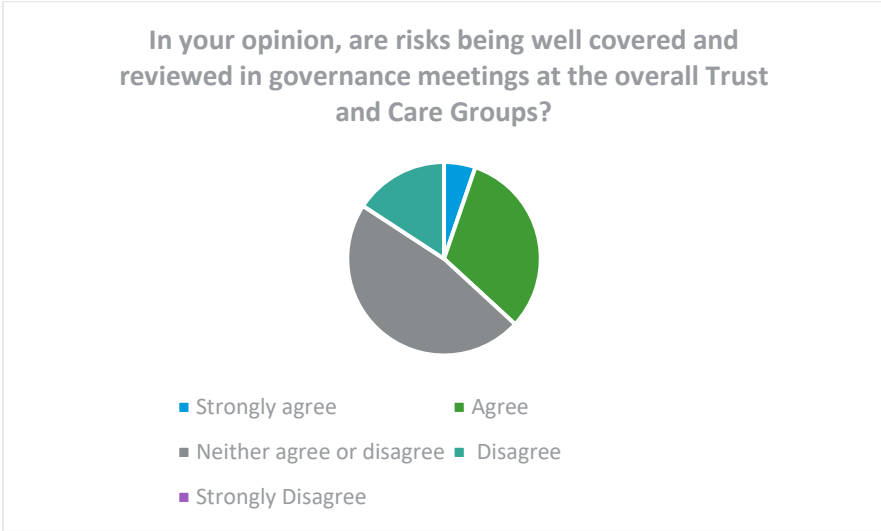
50% of the respondents agreed and 13% strongly agreed that significant risks are identified and brought to the attention of Senior Management and the Board.



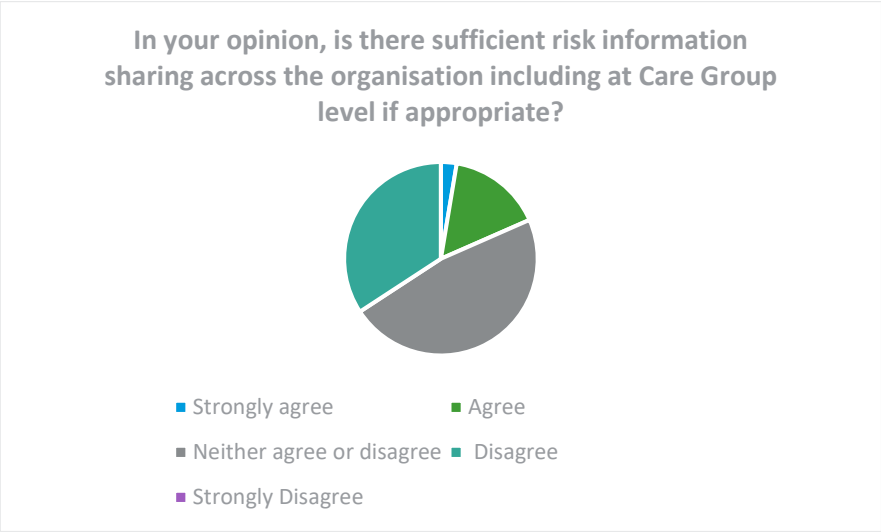
42% of respondents neither agreed nor disagreed that risks are suitably de-escalated. Reasons for this include that this happens inconsistently, with more focus on complete solution more than risk reduction, and sometimes a reduction in score without solid evidence. 29% agreed and strongly agreed with this statement.



42% agreed or strongly agreed that risks are well covered at team meetings. While the remaining percentage was equally split between neither agreeing nor disagreeing and disagreeing.

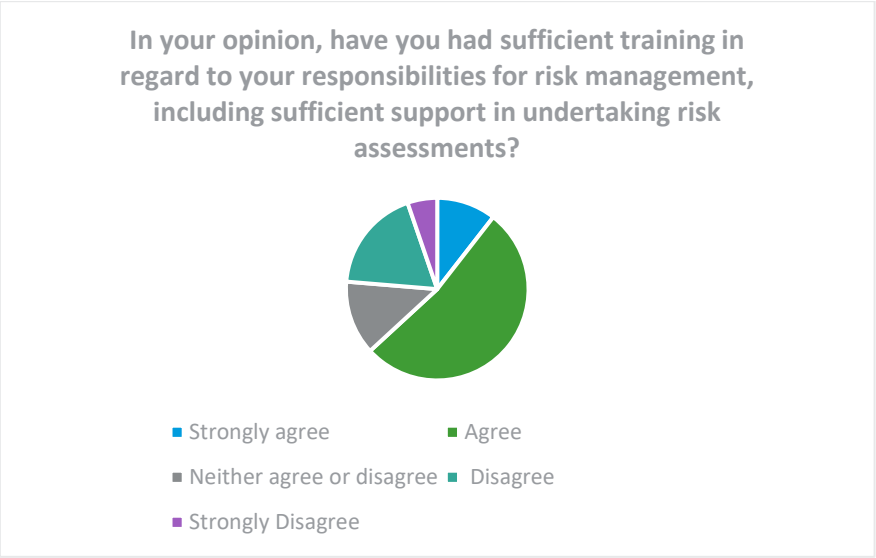


Nearly half the respondents neither agreed nor disagreed that risks are well covered and reviewed in governance meetings (47%). This is due to some respondents not being involved or attending those meetings. Whilst 32% agreed that they are well covered in governance meetings.

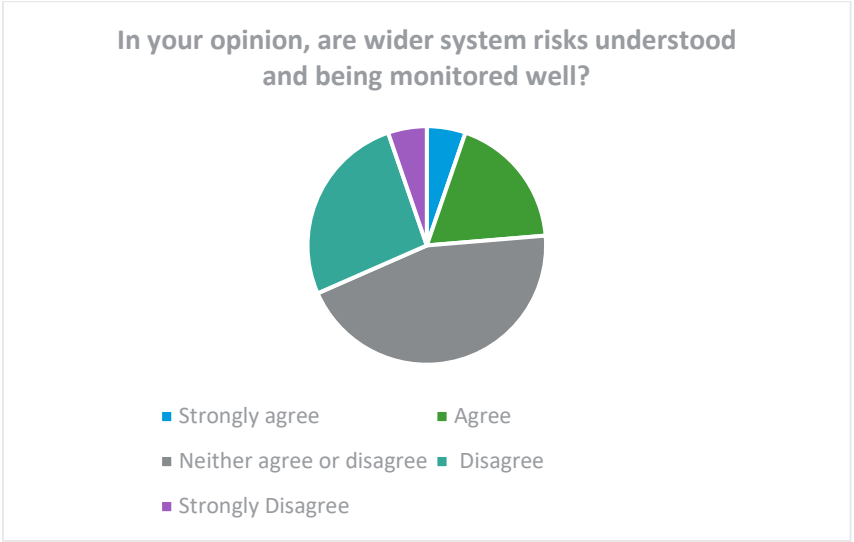


Nearly half the respondents (47%) neither agreed nor disagreed that there is sufficient risk information sharing across the Trust. 34% disagreed with this statement with comments around the lack of clarity of the risk register and varying information according to staff levels.

Majority of respondents stated that they are aware of the risk management policy and associated procedural guidance (84%).



52% of respondents agreed that they have had sufficient training with a further 11% strongly agreeing with this statement. We noted comments around training being undertaken outside of this Trust and a lack of refresher training.



Around 45% of respondents neither agreed nor disagreed that wider system risks are understood and monitored well.

66% of respondents rated the risk management culture in the top two ratings available, while 32% believe that the culture is in its infancy stage. One responded stated that the Trust need to raise the profile and train more staff. While other respondents say there has been considerable improvement but there is more to go.

APPENDIX B: CATEGORISATION OF FINDINGS

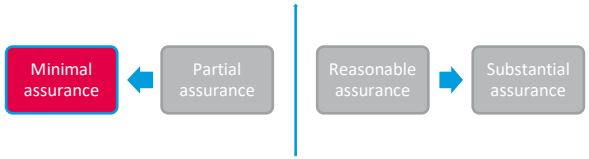
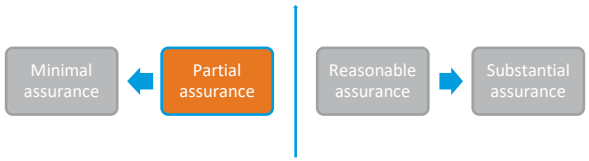
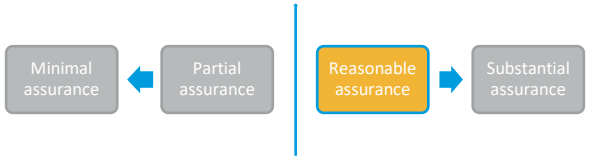
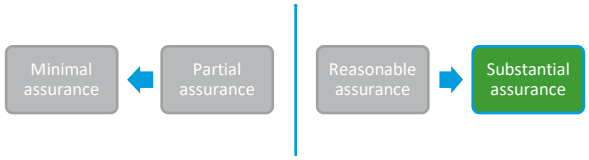
Categorisation of internal audit findings	
Priority	**Definition**
Low	There is scope for enhancing control or improving efficiency and quality.
Medium	Timely management attention is necessary. This is an internal control risk management issue that could lead to: Financial losses which could affect the effective function of a department, loss of controls or process being audited or possible reputational damage, negative publicity in local or regional media.
High	Immediate management attention is necessary. This is a serious internal control or risk management issue that may lead to: Substantial losses, violation of corporate strategies, policies or values, reputational damage, negative publicity in national or international media or adverse regulatory impact, such as loss of operating licences or material fines.

The following table highlights the number and categories of management actions made as a result of this audit.

Risk	Control design not effective*	Non Compliance with controls*	Agreed actions		
			Low	Medium	High
Failure to deliver the full benefits of the We Care Improvement system.	0	4	0	4	0
Total			**0**	**4**	**0**

* Shows the number of controls not adequately designed or not complied with. The number in brackets represents the total number of controls reviewed in this area.

APPENDIX C: INTERNAL AUDIT OPINIONS

Graphic	Opinion
	Taking account of the issues identified, the board can take minimal assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

APPENDIX D: SCOPE

The scope below is a copy of the original document issued.

Scope of the review

The scope was planned to provide assurance on the controls and mitigations in place relating to the following risk:

Objective of the risk under review	Risks relevant to the scope of the review	Risk source
This audit will be conducted to consider the Trust's risk management framework and processes and how risks flow through the organisation and are managed effectively. As part of the review, we will undertake a questionnaire to gauge the perception of risk management processes and culture. across the Trust. We will agree the questionnaire in advance with Management and this will be sent to a range of Executive and non-Executive Directors and senior staff at Care Group level.	Failure to deliver the full benefits of the We Care Improvement system.	Board Assurance framework

When planning the audit, the following areas for consideration and limitations were agreed:

The audit will consider the following.

- Review of the relevant policies and procedures on risk management.
- Assessment of how risks flow throughout the organisation to ensure these are being managed effectively. As part of this we will consider the flow of risks from the Care Groups through to the Corporate risk register and the BAF and vice versa. We will test a sample of risks in this area.
- Extent to which risks are being managed at the appropriate level with regular updates and appropriate level of detail on controls and assurances in place to help manage the risks. We will test a sample of risks ensure these are being subjected to an appropriate level of management and monitoring.
- Adequacy of the reporting arrangements in place around risk management.
- We will undertake a questionnaire to gauge the perception of risk management processes and extent to which risk management is embedded across the Trust. We will agree the questionnaire in advance with Management and this will be sent to a range of Executive and non-Executive Directors and senior staff across the organisation who are involved in the risk management process.

Limitations to the scope of the audit assignment:

- Testing undertaken as part of this audit will be on a sample basis for the financial year 2023/24 only.
- This review will not comment on whether individual risks are appropriately managed, or whether the organisation has identified all risks and opportunities facing it.
- It remains the responsibility of the Trust Board and senior management to agree and manage information needs and to determine what works most effectively for the organisation.
- Our work does not provide absolute assurance that material errors, loss or fraud does not exist.

Our work does not provide assurance that material error, loss or fraud do not exist.

Please note that the full scope of the assignment can only be completed within the agreed budget if all the requested information is made available at the start of our fieldwork, and the necessary key staff are available to assist the internal audit team. If the requested information and staff are not available, we may have to reduce the scope of our work and/or increase the assignment budget. If this is necessary, we will agree this with the client sponsor during the assignment.

To minimise the risk of data loss and to ensure data security of the information provided, we remind you that we only require the specific information requested. In instances where excess information is provided, this will be deleted, and the client sponsor will be informed.

Debrief held	25 April 2024	**Internal audit Contacts**	Nick.Atkinson@rsmuk.com / +44 2032 018028
Draft report issued	7 May 2024		
Responses received	22 May 2024		David.May@rsmuk.com / +44 7972004131
Final report issued	22 May 2024	**Client sponsor**	Sarah Hayes / Chief Nursing and Midwifery Officer
		Distribution	Sarah Hayes / Chief Nursing and Midwifery Officer

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rsmuk.com

The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Actions for improvements should be assessed by you for their full impact. This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

Our report is prepared solely for the confidential use of East Kent Hospitals University NHS FT, and solely for the purposes set out herein. This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM UK Risk Assurance Services LLP for any purpose or in any context. Any third party which obtains access to this report or a copy and chooses to rely on it (or any part of it) will do so at its own risk. To the fullest extent permitted by law, RSM UK Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

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East Kent Hospitals University NHS Foundation Trust

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

Committee: Quality and Safety Committee (Q&SC)

Meeting dates: 28 May 2024 and 25 June 2024

Chair: Dr Andrew Catto, Non-Executive Director (NED)

Paper Author: Executive Assistant

Quorate: 28 May 2024 – yes / 25 June 2024 - no

Appendices:

None

Declarations of interest made:

No declaration of interest was made outside the current Board Register of Interest.

Assurances received at the Committee meeting - focus on learning and improvement:

Agenda item	Summary
INTEGRATED PERFORMANCE REPORT (IPR)- VENOUS THROMBOEMBOLISM (VTE) UPDATE (May)	The Committee received the report and **NOTED** the following key updates; • Work continued on making VTE assessment compulsory within Sunrise. In addition, there was focused work in a number of specialties, to improve performance. • A VTE deep dive was in progress, the outcomes of which would be presented to the Quality and Safety Committee.
INTEGRATED PERFORMANCE REPORT (IPR) – Focused Review of Complaints (June)	The Committee received the report and **NOTED** the following key updates; • The complaints team had been restructured and a new complaints process had been rolled out. The Care Groups now had greater oversight of the complaints related to their services. • The majority of the complaints backlog had been cleared, however, there remained some further work to do. • There had been an increase in the number of complaints over the last three to four months, and work was planned to investigate the causes. • The key themes of our complaints mirrored those of neighbouring Trusts. • Work remained ongoing to comply with the Parliamentary and Health Service Ombudsman (PHO) standards. • It was agreed that the Trust should triage concerns and contact patients directly to prevent issues leading to a complaint, as it was important that we listened to our patients and their relatives.

East Kent Hospitals University NHS Foundation Trust

PROGRESS AGAINST RECOMMENDATIONS FROM ASSOCIATION FOR PERIOPERATIVE PRACTICE (AFPP) REPORT - CRITICAL CARE, ANAESTHETICS AND SPECIALITY SURGERY CARE GROUP (May)	The Committee received the report and **NOTED** the following key updates; • Following the identification of an increased incidence of Surgical Site Infections (SSI) within Orthopaedics Services, two AfPP consultants undertook peer reviews spending two days reviewing practice on each of the three sites. • Following the inspection there had been a reduction SSIs, which were monitored through the Infection Prevention Control Committee. • All the actions within the action plan were on track and were being effectively monitored. The aim was for our theatres to obtain AFPP accreditation following their return visit in September 2024. • The cultural issues within some of our theatre teams was also being actively addressed. • It was felt that the SSIs were not linked to holes in the equipment wraps, but the more basic issue of hand hygiene standards.
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS, CENTRAL ALERTING SYSTEM (CAS) AND PATIENT INCIDENT RESPONSE FRAMEWORK (PSIRF) UPDATE) (May and June)	The Committee received the report and **NOTED** the following key updates; • Overdue incidents improvements had been made but there remained further work to do. There was a target of seeing a significant reduction in complaints by October 2024. • Work remained ongoing to improve compliance with National Institute for Health and Care Excellence (NICE) Guidance. • Patient Incident Response Framework (PSIRF) had been implemented and the process was embedding well, and all the relevant staff in the process of being trained. • A table-top independent review was taking place looking at four paediatric cases and work continued on a number of maternity legal cases. • It was agreed that it was important that the work of legal services was triangulated with the Serious Incident (SI), complaints and Structure Judgement Review (SJR) processes. • Two Patient Safety Alerts were overdue: NatPSA/2023/010/MHRA: MHRA National Patient Safety Alert - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls and NatPSA/2023/013/MHRA: Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. • Clinical Audit: We had been identified as an outlier for the National Paediatric Diabetes Audit (NPDA) 2022-23 data but this had been anticipated following outlier status the previous year. Actions for improvement have already been presented to the Clinical Audit and Effectiveness Committee (CAEC).
CARE QUALITY COMMISSION (CQC) UPDATE REPORT (May)	The Committee received the report and **NOTED** the following key updates; • The Trust had started the CQC self-assessment process, each care group would review their performance against the CQC key lines of inquiry, which enabled them to focus on the relevant key areas.

	• The monthly submission of the Section 31 return for maternity was sent on 1 May 2024, and an engagement meeting with the CQC was planned to discuss the improvements made and the arrangements for CQC re-assessment.
PATIENT SAFETY COMMITTEE (PSC) CHAIR'S REPORT (May)	The Committee received the report and **NOTED** the following key updates; • It was confirmed that the number of clinical guidelines which required review was being addressed • The Aseptic Audit was noted to be a risk on the significant risk register, there were mitigations in place to support the ongoing delivery of the service.
SAFE STAFFING REVIEW (May)	The Committee received the report and **NOTED** that the nursing establishment review had now completed. The wards with the most notable staffing concerns were Stroke at Kent & Canterbury Hospital (K&C) and Acute Medical Unit (AMU) at the William Harvey Hospital (WHH), and additional staff were allocated to these wards when required. The Trust was in the upper quartile for the number of care hours per patient, which was indicative of some wards being over established, which had been addressed as part of the review.
MATERNITY & NEONATAL ASSURANCE GROUP (MNAG) (May)	The Committee received the report and N**OTED** the following key updates; • The Trust was fully compliant with Clinical Negligence Scheme for Trusts (CNST). • Stewart Baird, Acting Chairman was now the Trust's Non-Executive Safety Champion for maternity. • Listening events for maternity staff had been arranged throughout the year.
CORPORATE PRINCIPAL MITIGATED QUALITY RISKS (May and June)	The Committee received the report and **NOTED** the following key updates; • There was now a clear process in place regarding downgrade of risks. • The Team were working with 2gether Support Solutions and Spencer Private Hospital to review their risk registers so they could be triangulated with Trust risks and presented in the same format. • The new risk structure focused on care groups owning their risks and being challenged on how they were addressed. • There were 37 risks detailed within the risk register, 29 of which were categorised as quality risks, and there were no changes to the residual scores. • Going forward risks would be monitored by the new Inphase system.
SAFEGUARDING COMMITTEE	The Committee received the report and **NOTED** the following key updates;

ASSURANCE REPORT (May)	• Conversions had taken place with the Integrated Care Board (ICB) regarding their oversight of safeguarding and they were going to step down their additional scrutiny committee. • Further work was required to address the safe guarding training compliance of medical colleagues. • The safeguarding policies were now complete and up to date. • The next focused piece of work would be on learning disabilities as the Trust was not currently meeting the national benchmark, and were working with the ICB in relation to resources for this piece of work. • It was confirmed that Kent Police implemented 'Right Care Right Person' on the 1 April 2024 and the process was being embedded.
REGULATORY OVERSIGHT GROUP (ROG) CHAIR'S REPORT (May)	The Committee received and **NOTED** the report and ratified the Groups Terms of Reference.
MIDWIFERY WORKFORCE PAPER (May)	The Committee received the report and **NOTED** the following key updates; • There continued to be a high midwife vacancy rate at the WHH, which was a challenge. Currently the gaps were filled by using regular agency midwives to maintain safety. • It was confirmed that there were no concerns in relation to Queen Elizabeth the Queen Mother Hospital (QEQM) midwifery staffing.
HUMAN TISSUE AUTHORITY (HTA) REPORT (May)	The Committee received the report and **NOTED** the following key updates; • An unannounced HTA inspection took place in January 2024, due to lack of assurance that the shortfalls raised in August. There has been significant progress since January 2024 and the teams were working together to improve the service and HTA compliance. • It was agreed that the Committee needed to have greater oversight of the HTA report and Fuller Inquiry.
QUALITY ACCOUNT (May)	The Committee received the report and **NOTED** that the Quality Accounts had been updated and covered everything that was required.
EFFECTIVENESS OF CERVICAL PROGRAMME ANNUAL REPORT (May)	The Committee received the report and **NOTED** the following key updates • The Trust were visited by the Screening and Quality Assurance Service (SQAS) in January 2024. • All the conditions had been met or were due to be met shortly. There was one outstanding action from the previous visit in May 2019, which was that Kent and Canterbury Hospital (K&C) did not have an appropriate recovery area, should it be required post procedure. This was currently being mitigated by delaying the clinic on the rare occasion that this was required and work had been carried out to identify an alternative location for the clinic.

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PATIENT EXPERIENCE COMMITTEE (PEC) ANNUAL REPORT (May)	The Committee received the report and **NOTED** the following key updates
	• There had been a strong Friends and Family Test (FFT) response rate however their remained scope for further improvement. The key CQC surveys were children, inpatient and the Emergency Department and work would be taking place over the coming year to triangulate the data from the FFT, the CQC survey results and the complaints and Patient Advice and Liaison Service (PALS) themes.
	• The key themes that have been identified and continued work was taking place to address these;
	  • Timely access to services.
	  • Attitude of staff.
	  • Kindness and compassion.
	  • Appropriate use of our estates.

PATIENT VOICE AND INVOLVEMENT ANNUAL REPORT (May)	The Committee received the report and **NOTED** that a lot of good work and community engagement had taken place and It was agreed that it would be useful for the relevant Council of Governor member to be involved in patient voice and involvement work.
BOARD ASSURANCE FRAMEWORK (BAF) (May)	The Committee received the report and **NOTED** the following key updates; • It was advised that coordinated committee review was about to start. • Going forward there would be much greater synergy between the BAF and the Corporate Risk Register.
FUNDAMENTALS OF CARE (FoC) CHAIR'S REPORT (May)	The Committee received the report and **NOTED** the FoC Chairs report.
ENDOSCOPY UPDATE (May)	The Committee received the report and **NOTED** the following key updates; • The endoscopy task and finish group making good progress. • There had been clinical validation of our patient backlog, to priorities and risk stratify patients, and the relevant patients were moved to a 2week wait pathway. • Work had been done on our booking process and to utilize our endoscopy suites. • The Trust was on track to meet the trajectory to get the waiting list down to 5k by September 2024, to achieve this we were seeking additional external capacity. • There remained an issue with capacity and demand which needed to be addressed further, with more effective triaging.
PROGRESS ON IMPROVEMENT OF	The Committee received the report and **NOTED** the following key updates;

RENAL SERVICES - KENT & CANTERBURY AND ROYAL VICTORIA CARE GROUP (June)	• Kent Renal Dialysis Service Quality Review Meeting was held on 17 April 2024. An Initial service action plan was developed to respond to initial feedback and the team were currently awaiting the formal report. • Some patients were receiving dialysis which was below national average. However, this was not associated with a worse outcome for our patients and was preferred by many patients. • The team had moved towards providing more person centred and individualised care, and agreeing with our patients in shared decision making a dialysis time appropriate for them. • Our aging dialysis equipment and estate needed replacement, resulting in increased breakdowns and repairs being required. • Stretched haemodialysis capacity there was increased need in Medway as currently over 70 patients were dialysing at other dialysis units within the service, awaiting a dialysis slot at Medway. This resulted in increased travel times and an impact on quality of life. • There had been a significant increase in the prevalent dialysis population due to increased co-morbidity (particularly diabetes and hypertension) in an aging population.
CLINICAL AUDIT AND EFFECTIVENESS COMMITTEE (CAEC) CHAIR'S REPORT (June)	The Committee received the report and **NOTED** the CAEC Chairs report.
COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) QUARTERLY REPORT (June)	The Committee received the report and **NOTED** that the focus of all CQUINs was quality improvement.
COST IMPROVEMENT SCHEME QUALITY IMPACT ASSESSMENTS (QIA) (June)	The Committee received the report and **NOTED** that it would receive annual QIA progress updates, and it was confirmed that the current scoring process was being reviewed.
UPDATE ON IMPROVING ENGAGEMENT WITH TRAC (June)	The Committee **NOTED** that the first relaunched TRAC meeting was taking place in July 2024.

Referrals from other Board Committees

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

East Kent Hospitals University NHS Foundation Trust

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	25 July 2024 BoD meeting

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **31 May 2024**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Paper Author: **Executive Assistant**

Quorate: **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:

Agenda item	Summary
Board Assurance Framework (BAF) And Principal Mitigated Financial and Performance Risks	The Committee noted the ongoing work being done on the BAF and received assurance that the Committee reporting would continue to improve as to reflect this. The Director of Corporate Governance (DCG) agreed that the first stage of this process is to align the significant risks which relate to each FPC BAF risks being identified and presented. This will be delivered in subsequent meetings.
Significant Risk Register	The Committee received assurance the document would be keep up to date and make sure corrective actions are being implemented. The report at today's meeting was taken up to the 21 May for which a considerable amount of work had been completed, but further work is still required to ensure the register is complete. The FPC Chair invited the team to make the Committee paper more analytical of changes to key FPC risks and for those to eb the subject of the committees focus. This was agreed and would be presented at the next committee.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received an update on the Trust's performance in respect of the We Care Integrated Performance metrics. The Committee **NOTED** the Trust will be going into June with only one patient exceeding the 104 week wait and that could be explained by patient choice. The Trust is also on track to deliver the 78 weeks waits for June and as of 31 May the number is 251 for the end of May. It was noted the overall aggregate for length of stay (LOS) reduced by 0.6 days which is helpful in context for the Cost Improvement

	Programme (CIP): had the Trust not reduced this in April it would have needed an extra 52 beds to deliver the level of activity delivered in April.
Patients No Longer Fitting the Criteria to Reside (RTS Post 7 Days) Length of Stay (LoS) and Bed Plan Update (Including Internal and NFC2R) – BAFFPC002	The Committee received an update and **NOTED** the report. The Chief Operating Officer (COO) advised this was briefly discussed earlier in the meeting. The COO informed the Committee that Pauline Butterworth, Deputy Chief Executive Officer (CEO)/COO at Kent Community Health NHS Foundation Trust (KCHFT), is leading on a project looking at better use of beds across the region. The Committee heard the challenges in social care is being picked up and looked at in an emergency summit with the Community Trust and the local authorities as to how social and health care need to be integrated much better around care packages.
BAFFPC003 Update on the 2024/25 Capital Programme Including Fire Strategy	It was agreed to defer this to next month's meeting due to the Chief Strategy & Partnerships Officer's (CSPO's) absence
BAFFPC005 Partnerships and Strategy Update	It was agreed to defer this to next month's meeting due to CSPO's absence.
Month 1 Finance Report	The Interim Chief Finance Officer (CFO) updated the committee on the Month 1 Finance Report, confirming it is consistent with what was forecast in the previous month and the position is in line with the budgeted plan, amounting to £8.7million deficit in the month. The Interim CFO also explained that £8.7million is the second lowest deficit over the last 12 months, which is indicative of real progress and evidence that the Trust is on track to deliver the annual plan. The Committee received **ASSURANCE** on the Month 1 Finance Report.
Cost Improvement Programme (CIP)	The Committee received an update on the CIP and noted the ongoing work being done in this area. The Committee received a new, refreshed report and were promised further insight and intelligence particularly on the risk adjusted plans as progress is made through Q1. This will ensure the Committee has real site of areas, risks and delivery. The CIP lead is meeting with Care Groups over the next few weeks to discuss their schemes which will be regular discussions. The Committee received an update and **NOTED** the status of the CIP.

East Kent Hospitals University NHS Foundation Trust

BAFFPC006 Review of Progress Against PricewaterhouseCoopers (PWC) Recommendations for Cost Control	The Interim CFO flagged a number of the red ragged items, and explained they are linked to 2gether Support Solutions (2gether) and Spencer Private Hospitals (Spencer) and are linked to the reviews discussed elsewhere in the Committee.
Business Cases: Over £1.75M Requiring Investment £2.5M For Self-Funding. Capital Business Cases Over £1M	No papers to be presented as no business cases over £1.75m.
Capital Investment Group (CIG) Assurance Report	The Committee **NOTED** the CIG report.
Business Case Scrutiny Group (BCSG) Assurance Report	There were no Business Cases to report.
Financial Improvement Oversight Group (FIOG) Assurance Report	The Report was **NOTED** and the Committee received confirmation there is no intention to remove the £500 limit for the non-pay panel. The Interim CFO explained, gradual reduction due to the implementation has shown a significant improvement at the level of rejection, but not at a level for this to remove this.
Workforce Quarterly Report to Include Substantive, Bank and Agency Usage, Spend, Recruitment Challenges, Action Plan.	The Chief People Officer (CPO) gave an update to the Committee on Workforce costs. In general, the workforce is heading in a positive direction. The current position on nursing recruitment has been largely successful due to recruitment around bank positions. The Committee **NOTED** the report and asked that any significant changes be reported to the Committee.
Internationally Educated Nurses (IENs) Recruitment and Objective Structured Clinical Examination (OSCE) Support	The numbers and costs associated with the international recruitment exercise were discussed and made clear together with the changes in overall numbers as a result. The CPO confirmed the overseas recruitment has now ceased.
Annual Self-Assessment of Committee's Effectiveness – Terms of Reference (TOR)	**To note:** Deferred to October.

We care

East Kent Hospitals University NHS Foundation Trust

Referrals from other Board Committees

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

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from FPC.	Assurance	To Board on 25 July 2024.

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **25 June 2024**

Chair: **Richard Oirschot, Non-Executive Director (NED)**

Paper Author: **Executive Assistant**

Quorate: **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:

Agenda item	Summary
Significant Risk Register	The Committee received assurance the document would be keep up to date and make sure corrective actions are being implemented. The Chief Nursing & Midwifery Officer (CNMO) presented the risk register to the committee and pointed out there are no outstanding actions. The last page of the report shows closed actions.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received an update and **NOTED** the Trust will be going into June with only one patient would be going into June figure on the 104 weeks. The Trust is hoping to end June with 67 patients on the 78-week list which is a significant improvement for the Trust. This has been possible with support received from Maidstone and Tunbridge Wells NHS Trust (MTW) in relation to certain 65-week patients. It was confirmed the Trust has been successful in submitting two separate bids to the Cancer Alliance: one for £900k, which has been approved in full and one for £1.1million which was to support Tier 1 trusts and £1million of the £1.1milion has been approved.

East Kent Hospitals University NHS Foundation Trust

Patients No Longer Fitting the Criteria to Reside (RTS Post 7 Days) Length of Stay (LoS) and Bed Plan Update (Including Internal and NFC2R) – BAFFPC002	The Committee received an update and **NOTED** the report. The Committee received confirmation that May ended with 153 patients no longer fit to reside, in the context of reducing LoS down to 11.1 days, the number of patients not fit to reside has increased. The structural challenges with lack of social care is being picked up by the Trust, the Community Trust and Local Authorities to consider collectively how Social and Health care can be integrated and come together to ensure appropriate discharge and availability of care packages. The Chief Operating Officer (COO) is meeting with the community teams and a system wide event started at Queen Elizabeth the Queen Mother Hospital (QEQM), which will move to William Harvey Hospital (WHH) on Wednesday 26 June and Kent & Canterbury Hospital (K&C) on Thursday 27 June, reflecting the increasing number of patients not within our control to discharge, due to unavailability of community support related to social care and housing issues and we continue to work with Kent County Council (KCC) on how to tackle these issues.
BAFFPC003 Update on the 2024/25 Capital Programme Including Fire Strategy	The Committee received an update and **NOTED** the report. Following the finalisation of the 2023/24 M12 year-end capital position, better than anticipated expenditure levels were achieved in both the Community Diagnostics Centre (CDC) and the Mechanical Thrombectomy schemes in terms of brought forward spend, marginally reducing the 2024/25 over-commitment against EKHUFT's share of the Kent & Medway (K&M) Integrated Care Board (ICB) Capital Departmental Expenditure Limits (CDEL) down to £7.52m.
BAFFPC005 Partnerships and Strategy Update	The Committee received an update and **NOTED** the report.
Month 2 Finance Report	At the end of Month 2 the Trust remains on plan financially. The Trust has delivered our Year to Date (YTD) target on Cost Improvement Programme (CIP) (£5.7m), and consequently the financial plan. The Group cash balance (including subsidiaries) at the end of May was £29.4m. The Trust drew £8.3m of working capital (Public Dividend Capital (PDC)) in the month (£17.8m YTD). The Committee confirmed we are in Month 2, on track to achieve our deficit plan of £80.1million. **The Committee APPROVED the paper.** The Committee received **ASSURANCE** on the Month 2 Finance Report.

Annual Accounts	The Committee received confirmation that the Annual Accounts to be presented at the Integrated Audit and Governance Committee (IAGC) and Board reflect the position reported to the Committee on previous occasions. The Committee **NOTED** the report and approved the submission of the Annual Accounts for sign-off.
Transition from PricewaterhouseCoopers (PwC)	The Committee received details of the on-going work of PwC supporting the CIP and the arrangements for PwC to continue to support until transitioned in-house to the Trust. The committee approved the proposal to extend via a new award the continuation of external resources to support the Trusts financial improvement programme from PwC. The Committee **AGREED** to recommend this to the Board for approval
Workforce	It was agreed to defer this paper to August due to annual leave.
Cost Improvement Programme (CIP)	An update report on the CIP was presented to the committee in a refreshed format. It summarised the position as follows: • the current pipeline of CIPs for 2024/25 was risk adjusted to some £48.8m against a target of £49m; • work is ongoing to increase this pipeline to £60m; • CIP target of £1.382m was achieved in Month 1; • that this is a refreshed report and as progress is made through Q1 the report will be enhanced with further insight and intelligence particularly on the risk adjusted forecast to ensure the committee has real site of areas, risks and delivery; • meetings with Care Groups over the next few weeks have been arranged to discuss their schemes which will become regular discussions. The Committee received an update and **NOTED** the update of the CIP programme.
BAFFPC006 Review of Progress Against PWC Recommendations for Cost Control	The Committee discussed the report and noted progress had been made in clearing the action points, however, it was noted that a number of the red items are linked to 2gether Support Solutions (2gether) and Spencer Private Hospitals (SPH) and are subject to further action.
Business Cases: Over £1.75M Requiring Investment £2.5M For Self-Funding. Capital Business Cases Over £1M	No papers to be presented as no business cases over £1.75m.

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Capital Investment Group (CIG) Assurance Report	Paper was taken as read. The Committee received an update and **NOTED** the update of the CIG report
Business Case Scrutiny Group (BCSG) Assurance Report	There were no Business Cases to report.
SPH Review	It was agreed to defer this paper to August due to the Interim CFO's absence.
Financial Improvement Oversight Group (FIOG) Assurance Report	The Interim CFO confirmed there is no intention to remove the £500 limit for the non-pay panel. A gradual reduction due to the implementation has shown a significant improvement at the level of rejection, but not at a level for this to remove this. There are certain issues for a number of care groups that still need to be resolved.
Board Assurance Framework (BAF) And Principal Mitigated Financial and Performance Risks	The Committee reviewed the FPC BAF risks following the conclusion of the substantive items and agreed they represented the correct risks and focus of the Committee. The Committee invited consideration of the BAFFPC Risk 001 (Covid) for review by the Executive.

Referrals from other Board Committees

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

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from FPC.	Assurance	To Board on 25 July 2024.

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

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

Meeting date: **26 June 2024 - A verbal update on the meeting held on 24 July 2024 will be given at the 25 July 2024 BoD meeting**

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

Paper Author: **Claudia Sykes, NED**

Quorate: No

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting:

Agenda item	Summary
Vacancy and recruitment update	The Committee was **ASSURED** of the progress on recruitment. • There was a slight increase in Band 5 Registered Nurses vacancies but this is not concerning currently and should decrease. • Consultant recruitment – during the last round of Consultant recruitment 15 posts were filled, 11 of which are in hard to recruit areas. The very focused approach to recruitment is beginning to produce the desired outcome. The Committee discussed that the Consultant recruitment was not only about filling Consultant posts but also about bringing leadership, and in some areas advertising roles which include both clinical and management aspects would be beneficial. • The Integrated Care Board (ICB) have renewed their focus on how to make recruitment to the Kent and Medway system more attractive and it is important for the Trust to be involved in these discussions. • The Trust had secured a number of newly qualified Nurses to commence in summer 2024 and the Committee discussed potential challenges around their training and retention. This will be one of the priorities for the new Deputy Chief Nurse who will commence with the Trust on 1 July 2024.
Doctor's Voice Group (DVG) update	The Committee received an update from the DVG. The Group was receiving excellent support from the Chief Executive Officer (CEO) and Chief Medical Officer (CMO) and this was helping to resolve some of the issues the Group had identified in previous reports, for example ensuring doctors had line management support to attend the DVG meetings. Working groups were looking at specific improvement areas, for example rest areas and access to computers as well as staffing cover. There was a discussion around improving support for staff relocating from other countries.

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Equality, Diversity and Inclusion (EDI) update	The Committee received a verbal update on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions from the Head of EDI. The Trust's WRES and WDES data was submitted to NHS England in May 2024. The annual report will be presented to the Committee in October 2024.
Significant Risk Report	The Committee reviewed the Significant Risk report. There were no overdue actions associated with the risks noted. There were no escalations from the Risk Review Group in relation to People risks. The most significant People risks were recruitment and poor skill mix in the Care Groups, and the paper on recruitment earlier in the agenda highlighted mitigations around this. The Chief People Officer (CPO) emphasised that the level of this risk had not increased. The Committee was **ASSURED** over the Significant Risk report.
Strategic Workforce Plan	The Committee received an update on the work underway on workforce planning. High-level workforce plans for 2024/25 had been submitted to the ICB. More detailed work was underway on workforce planning with the Nursing and Medical teams for the next three years.

Items to come back to the Committee outside its routine business cycle: None

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

Items referred to the BoD or another Committee for approval, decision or action: None

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from P&CC.	Assurance	To Board on 25 July 2024.

We care

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

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

Meeting date: **11 July 2024**

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

Paper Author: **Claudia Sykes, NED**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made: None

Assurances received at the Committee meeting: see below

Agenda item	Summary
Update on East Kent Hospitals Charity Strategy	The Committee received an update on the Charity's progress against its three-year strategy and was **ASSURED** of the progress being made. The Charity was on track against plan to achieve its £1m income target this year. The Committee thanked the Charity team for their excellent work given their limited resources. A new Fundraiser has now been recruited (as per the strategy) which will support further income diversification.

Other items of business: None

Actions taken by the Committee within its Terms of Reference:

The Committee **APPROVED** the following funding applications:

- Queen Elizabeth the Queen Mother Hospital (QEQM) Refurbishment of St Peter's Road Entrance £31k
- Trust Celebration Awards £9k
- Dialysis Machines £90k

Items to come back to the Committee outside its routine business cycle: None

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

Items referred to the BoD or another Committee for approval, decision or action: None

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from CFC.	Assurance	To Board on 25 July 2024.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Care Quality Commission (CQC) Update Report

Meeting date: 25 July 2024

Board sponsor: Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Compliance and Assurance Lead
Associate Director of Quality Governance

Appendices:

None

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-mid-May to early July 2024 and includes: • update on CQC Oversight and Assurance Group terms of reference review; • summary of the CQC self-assessment and check and challenge meeting programmes; • feedback following the programme of quality visits to surgical services across the Trust; • update on performance against the most recent CQC inspection reports (May and July 2023) published in December 2023; • update on performance against 'historical' open CQC action plans (2018, 2020 and 2021); • update on Maternity Section 31 Enforcement Notice; • summary of CQC queries; • recent CQC publications.
Summary of key issues:	The terms of reference for the CQC Oversight and Assurance Group have been reviewed and updated. The CQC self-assessment programme has commenced with the first two Check and Challenge meetings taking place in May and July for Critical Care, Anaesthetics, Specialist Surgery (CCASS) and Women's, Children's and Young People (WCYP) Care Groups. The forward programme has been confirmed. Quality visits to surgery at Kent & Canterbury Hospital (K&C), Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) have been completed and reports of findings provided to the Care

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	Groups who have been asked to produce action plans addressing the areas requiring improvement. Closure of actions for the 2023 inspection action plans has slowed and there are a number of overdue actions. Several of these relate to mandatory and statutory training compliance which has not been achieved by its target date of 31 March 2024; for nursing there are a small number of courses that are non-compliant, for medical a significant number. The Chief Medical Officer (CMO) has agreed a target of 30 September 2024 to achieve full compliance. There remain some historical must and should do requirements from inspections in 2018, 2020 and 2021, and their current status is included. The monthly submission of the Section 31 return for Maternity was sent on 3 June and 1 July 2024, and an engagement meeting with the CQC took place on 20 May 2024 where maternity improvements were discussed. Continued progress has been made, with only two Must Do requirements remaining open. An increased number of CQC queries have been received over this reporting period. There have been some delays in responding to the CQC due to the availability of leads to collate and approve the responses and the deadlines set by the CQC. We continue to ensure the CQC are aware of any delays and seek extensions accordingly, as agreed with the CQC.
Key recommendations:	The Board of Directors is asked to receive the attached report and the assurance provided in relation to progress with inspection action plans, query management, surgery quality visits, and the self-assessment and Check and Challenge meeting programme.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	There is a risk of noncompliance with CQC regulations which would have an impact on registration and may lead to repeat enforcement action, improvement notices and a critical report (ref 3636). Residual Risk 12 (moderate).
Resource:	N
Legal and regulatory:	Y. Inability to provide assurance to our regulators impacting on the quality and safety of care provided to our patients and service users.
Subsidiary:	N

Assurance route:

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Previously considered by: CQC Oversight and Assurance Group (June and July 2024), Regulatory Oversight Group (June 2024), Quality and Safety Committee (July 2024).

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Care Quality Commission (CQC) Update Report

1. Purpose of the report

1.1 This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-May to early July 2024 and includes:

- update on CQC Oversight and Assurance Group terms of reference review;
- summary of the CQC self-assessment and check and challenge meeting programmes;
- feedback following the programme of quality visits to surgical services across the Trust;
- update on performance against the most recent CQC inspection reports (May and July 2023) published in December 2023;
- update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
- update on maternity Section 31 Enforcement Notice;
- summary of CQC queries;
- recent CQC publications.

2. Background

2.1 The CQC rated our Trust as 'requires improvement' following inspections in May and July 2023. Improving our CQC rating is a Trust Strategic Initiative, a key part of our Quality Strategy and is referenced in the Integrated Improvement Plan (IIP) in particular in relation to improvements in maternity, quality and safety and leadership and governance.

3. CQC Oversight and Assurance Group

3.1 Draft revised terms of reference were shared at the meetings in June and July, and the group discussed the purpose of the meeting. Attendees shared that they find value in the meeting, particularly in relation to oversight of other Care Groups' and specialities' CQC activity, but that frequency could be reduced. Meetings will therefore change to bi-monthly rather than monthly – and there will be an emphasis on shared learning and problem solving. Membership was discussed at the July meeting and this will be finalised before the next meeting in September.

3.2 CQC Oversight and Assurance Group reports to the Regulatory Oversight Group. The approved Terms of Reference will be submitted to the next meeting in August 2024.

4. CQC Self-Assessment Programme and Check and Challenge Meetings

4.1 The refreshed CQC self-assessment tool and guidance, developed by the Compliance and Assurance Lead and based on the CQC's new Single Assessment Framework, was approved at the CQC Oversight and Assurance Group in April. Care Group and

speciality leads were provided with these documents and requested to present to a Check and Challenge meeting twice-yearly. This work has commenced within the Care Groups, supported by their allocated Facilitator.

4.2 The Check and Challenge meetings, chaired by the CNMO, and attended by the CMO, Director of Quality Governance, Associate Director of Quality Governance and members of each Care Group's leadership team, commenced in May:

- CCASS presented at the first meeting on 23 May. They assessed their trustwide services and QEQM, William Harvey Hospital (WHH) and K&C sites separately, resulting in a total of 14 self-assessments undertaken.
- WCYP (WH) also presented at the meeting on 23 May. They undertook two self-assessments (maternity and gynaecology).
- WCYP (CYP) presented at the next Check and Challenge meeting on 9 July. They undertook three self-assessments (acute, neonatology and community).

The percentage of Quality Statements rated as fully met within their self-assessments is shown in the table below.

Percentage of Quality Statements rated as fully met					
	Safe	**Effective**	**Caring**	**Responsive**	**Well Led**
CYP	13%	17%	67%	48%	50%
Women's Health	81%	75%	90%	71%	75%
CCASS	43%	77%	73%	73%	84%

4.3 Care Group leadership teams identified their top five areas for improvement and celebration and shared these at the meetings.

4.4 The schedule for Check and Challenge meetings for the forthcoming year was received at the O&AG meeting in July and there will be one Care Group presenting each month, twice yearly.

5. Feedback from Surgery Quality Visit Programme

5.1. Surgical Services have not been inspected by the CQC since 2018. Prompted by a series of never events within theatres and surgical site infections, and to complement the improvement work following the Association for Perioperative Practitioners (AfPP) review in January 2024, a quality visit was arranged on each sit (QEQM, WHH and K&C). The visits took place between December 2023 and May 2024. The aim was to identify areas of good practice and areas for improvement, to share findings across the different sites and Care Groups, and to provide assurance internally and externally. The visits were all unannounced and took place at QEQM, WHH and K&C between December 2023 and May 2024.

5.2. A Routine Quality Review (RQR) tool for the surgery core service was used, this was designed using the CQC's single assessment framework. It contained questions for staff, questions for patients, what to observe and what documentation to look and aligned to the CQC's new evidence categories.

5.3. The Care Group triumvirates have been provided with reports detailing areas of good practice and areas for improvement and are required to produce action plans addressing the areas for improvement. These will be managed via the Care Groups' governance structures and by the Compliance and Assurance Team, and reported into CQC Oversight and Assurance Group.

5.4. Areas of good practice included: patients stating that they felt well-cared for across all sites, being treated with kindness and having privacy and dignity respected; examples of staff being well-supported by their ward manager; examples of staff feeling positive and proud to work for the area and the Trust; some good use of display boards with patient feedback displayed; kind and attentive conversations between staff and patients and relatives were observed.

5.5. Areas of improvement included: patient notes not stored securely and computer terminals left unlocked; Infection, Prevention and Control (IPC) issues including lack of adherence to uniform policy, hand hygiene and glove use; medicines issues including trolleys not tethered and medicines not stored securely, inconsistent use of allergy wristbands; incomplete or inaccurate patient documentation; lack of knowledge of safeguarding processes; lack of equipment storage; Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and associated Mental Capacity Act (MCA) assessments not completed.

6. Update on performance against the most recent 2023 CQC Inspection Reports

6.1. The inspection reports from the core service inspection in May 2023 and well led inspection in July 2023 were published on 20 December 2023. Speciality leads developed action plans to address the must and should do requirements, signed off by the Care Group triumvirates. There are nine action plans listed below. A new action plan was produced this month containing four actions transferred from speciality action plans, where ownership is by Corporate Nursing, Medicine and Operations rather than care group.

- 2gether Support Solutions (2gether) action plan
- CYP action plan
- DCB action plan
- QEQM General Medicine (GM) action plan
- QEQM Urgent and Emergency Care (UEC) action plan
- WHH GM action plan
- WHH UEC action plan
- Well Led action plan
- Corporate Nursing/Medical/Operations action plan

6.2. In addition, there is an action plan associated with the Maternity inspection of

January 2023.

6.3. Maternity have closed two Should Do requirements since mid-March 2024 and all Should Dos are now closed. Two Must Do requirements have been closed since mid-March 2024 with two remaining open. One is not expected to be closed until April 2025 (actions relating to estate / environment including a second obstetrics theatre). The other Must Do relates to midwifery staffing. The cessation of the midwifery programme of education at Canterbury Christ Church University last year means that the current students will not qualify until December 2024. All of the students have expressed an interest in staying at the Trust and have been offered positions. This Must Do will therefore remain overdue until then.

6.4. A number of actions have been undertaken to preserve safe midwifery staffing. These include:

- Working with a range of universities to future proof the local midwifery pipeline
- Working with the Trust in relation to the development of nursing and midwifery ambitions and strategy
- Continued Restorative Clinical Supervision (RCS) sessions to support the workforce, and targeted sessions for colleagues working in high pressure services / environments e.g. students, maternity governance team. These will expand to bereavement and community teams looking after 'out of guidance' women
- Trauma Risk Management (TRiM) sessions offered and delivered
- Collaborative planning of a schedule of new career cafes
- Development of a recruitment video with the Local Maternity and Neonatal System (LMNS).

6.5. Inspection Action Plan Review Meetings continue to be held monthly with each speciality to review progress against their inspection action plans.

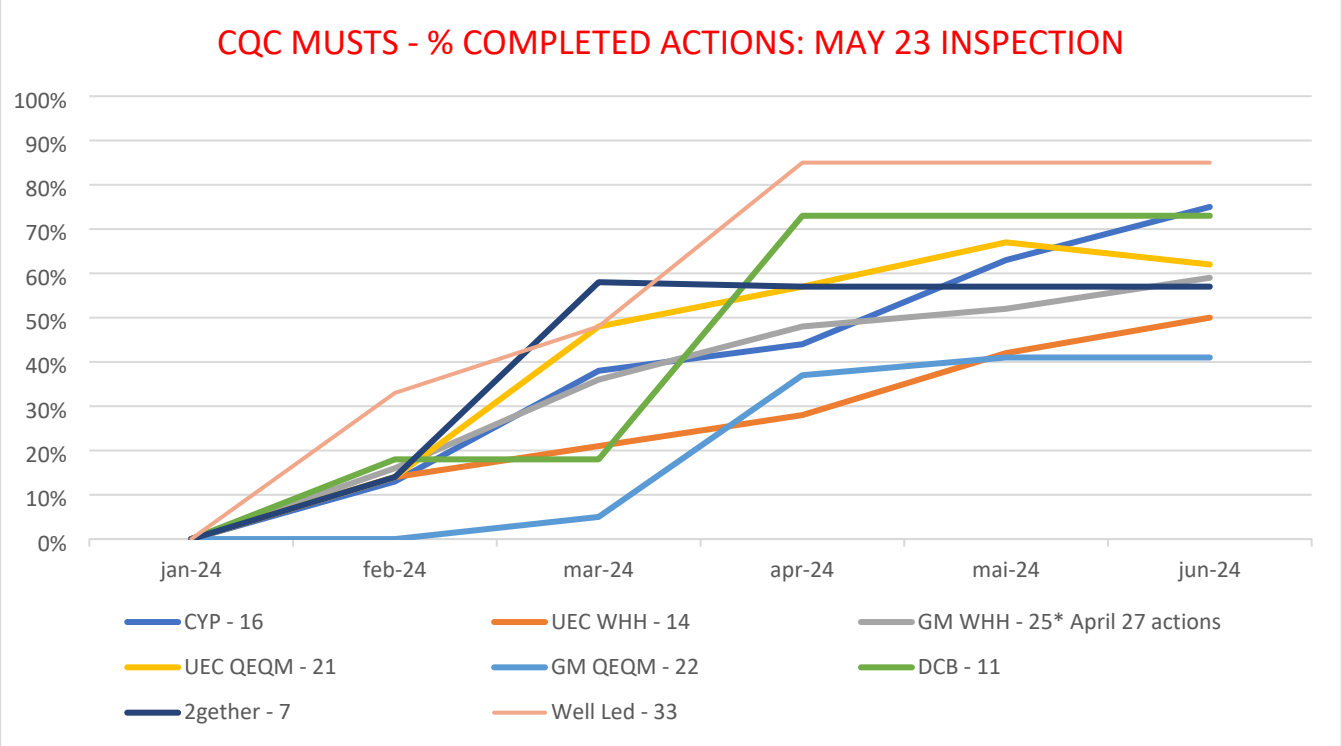
6.6. All specialities continue to make progress with action closures. The graphs below show the percentage of actions complete each month. The first graph shows all actions relating to Must Do requirements, the second shows all actions relating to Should Do requirements. The percentages include fully completed actions and those actions marked as complete pending evidence review. The latter will move to fully complete by next month, provided evidence and care group triumvirate approval is received. If not, they will move to overdue. For that reason, QEQM UEAM show a slight decline in percentage of completed actions between May and June 2024 due to a proposed closed action in May being deemed incomplete after the evidence was reviewed by the Compliance and Assurance Lead.

6.7. The tables below each graph show the percentage of actions that are overdue with mitigation in place (amber). All specialities now have a number of overdue actions. These are discussed every month at the Inspection Action Plan Review meetings with each speciality, and extensions agreed where appropriate. The care group triumvirate are informed of all overdue actions and asked to approve extensions. Extensions and overdue actions are also reported to CQC Oversight and Assurance Group.

6.8. There are a number of CQC requirements relating to statutory and mandatory training compliance in the recent inspection action plans, and in the historic plans, as referenced

in Section 6 of this report. There has been significant improvement in nursing compliance although there are still some courses where Trust target has not yet been achieved. Most courses for medical staff remain below Trust target. The CMO has set an expectation that compliance is achieved by 30 September 2024. This means that actions relating to these requirements will remain open until then.

6.9. Progress to complete actions has slowed over the past two months. This is due to the remaining actions in general being the more challenging to achieve. On the QEQM GM and WHH GM plans, a number of actions are reliant on assurance being provided by the daily electronic quality and safety checklist. It has become apparent that this checklist is not embedded into daily practice in all areas. Work has commenced to embed the tool. A full month of 100% compliance with the checklist is required to close the relevant actions, with a further two months' monitoring.



CQC MUSTS % ACTIONS: OVERDUE			
Speciality/CG - total no of actions	Jan 24	April 24	June 24
CYP - 15	0%	50%	25%
UEC WHH - 14	0%	43%	7%
GM WHH - 27	0%	33%	15%
UEC QEQM - 21	0%	19%	24%
GM QEQM - 22	0%	55%	50%
DCB - 1	0%	18%	18%

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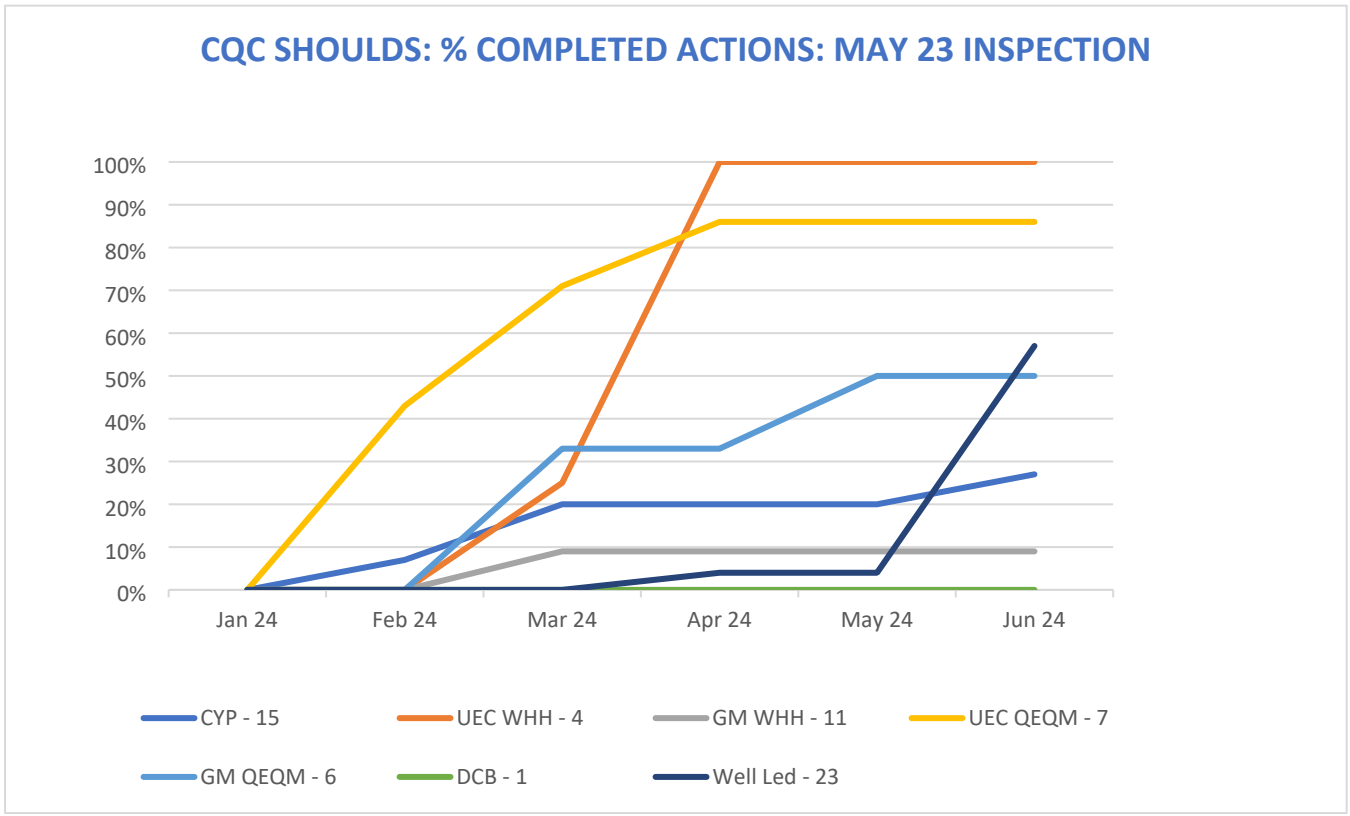
2GETHER - 7	0%	43%	43%
Well Led - 33	0%	9%	12%



CQC SHOULDS % ACTIONS: OVERDUE			
Speciality/CG - total no of actions	Jan 24	April 24	June 2024
CYP - 15	0%	40%	33%
UEC WHH - 4	0%	0%	0%
GM WHH - 11	0%	36%	73%
UEC QEQM - 7	0%	14%	14%
GM QEQM - 6	0%	50%	33%
DCB - 1	0%	0%	100%
Well Led - 23	0%	0%	43%

6. Update on performance against 'historical' open action plans (2018, 2020 and 2021)

6.1. There are four open inspection action plans relating to CQC inspections that took place between 2018 and January 2023. These action plans are also subject to regular review and update by the specialities, supported by the Compliance & Assurance Team (C&AT).

6.2. The following requirements remain open. These will be closed once agreed trajectories and plans are in place as detailed below.

CG and Speciality	Requirement	Status
WHH UEC 2020	MD01.UEC.WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. (Also on May 2023 action plan) MD28.UEC.QEQM&WHH.2023 The service must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.	Current status based on Learning & Development (L&D) data 31.05.24: **Nursing**: Statutory compliance 89% (target 91%) 3 of 10 courses are below the Trust target. Mandatory compliance 90% (target 85%) 3 of 12 courses are below the Trust target. **Medical:** Statutory compliance 72% (target 91%) 8 of 9 courses below Trust target. Mandatory compliance 65% (target 85%) 8 of 10 courses below Trust target. A trajectory for medical staff has been agreed by the CMO to reach compliance by 30.09.24 and an action plan is in place to improve medical training compliance across the Trust.
WHH UEC 2020	SD05.UEC.WHH The Trust should ensure all staff have access to the training needed for their role including advanced life support.	L&D have advised that the Resus figures may look different from last month, due to only actual staff requiring the lower level resus being counted in the figures. L&D will be reporting on all levels of resus shortly now the Training Needs Analysis (TNA) details have been provided by the subject matter experts.
WHH GM 2021	SD02.MED.KCH & WHH.2021 The Trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Current status based on data from IT portal as at 31.05.24: WHH General Medicine **Nursing** Statutory compliance 96% (target 91%) 2 of 10 courses below Trust target Mandatory compliance 92% (target 85%) 2 of 11 courses below Trust target **Medical** Statutory compliance – 60% (target 91%) 8 of 9 courses below Trust target Mandatory compliance – 50% (target 85%) 9 of 9 courses below Trust target.
KCH GM 2021	SD02.MED.K&C & WHH.2021 The Trust should ensure that all staff complete their mandatory training. (Also on May 2023 action plan)	Current status based on data from 31.05.24: **Nursing** Statutory compliance 96% (target 91%) 0 of 10 courses below Trust target

CG and Speciality	Requirement	Status
		Mandatory compliance 90% (target 85%) 3 of 11 courses below Trust target **Medical** Statutory compliance – 73% (target 91%) 9 of 9 courses below Trust target Mandatory compliance – 59% (target 85%) 9 of 9 courses below Trust target.
WHH UEC 2020	MD16.UEC. WHH The Trust must ensure critical fluids and medicines are administered and recorded in a timely manner.	There have been delays in the Sunrise team creating a 'missed dose' dashboard to provide assurance in this area. The CMO, Associate Director of Nursing for DCB and Managing Director for DCB held a summit to discuss key risks, strategic challenges and intent and identify remaining actions to progress. An external review was requested by the CMO and CNMO. In July 2024 the Director of Pharmacy advised actions should be transferred back to Emergency Department (ED) nursing and prescribing teams.
QEQM UEC 2020	MD01.UEC.WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. Also on 2023 action plan MD28.UEC.QEQM & WHH.2023 The service must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.	Current status based on L&D data 31.05.24 **Nursing**: Statutory compliance 94% (Target 91%) 2 of 10 courses are below the Trust target. Mandatory compliance 86% (Target 85%) 4 of 12 courses are below the Trust target. Local records for HH hold compliance at 85.6%- delay in assessments being uploaded onto Electronic Staff Record (ESR) following team days **Medical:** Statutory compliance 79% (Target 91%) 8 of 9 courses below Trust target. Mandatory compliance 77% (Target 85%) 4 of 10 courses below Trust target. ED clinical lead has been provided with details of all staff who are non-compliant with training and what training is outstanding.
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH The Trust should ensure medicines reconciliation is undertaken in a timely manner	7-day pharmacy service in Acute Medical Unit (AMU) but large % of patients in ED for 24-hours (the time period when med rec must happen). Data now available but needs further work. The CMO, Associate Director of Nursing for DCB and Managing Director for DCB held a summit to discuss key risks, strategic

CG and Speciality	Requirement	Status
		challenges and intent. An external review was requested by the CMO and CNMO.
QEQM UEC 2020 S29a	SD01.UEC.QEQM & WHH (2020) The Trust should consider how to recruit a full establishment of emergency department consultants and SD02.UEC.QEQM (2021) The Trust SHOULD meet the Royal College of Emergency Medicine requirements for the number of consultants employed within the department.	Recruitment campaign on going and led by ED Clinical Network Lead. Total of 5 vacancies appointed to with 1 in post. Trajectory for 10 Whole Time Equivalent (WTE) by September 2024 is still expected.
EOLC 2018	MD37 Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).	Deputy CMO is now co-chairing a task and finish group with the Trust MCA Lead to address the issues identified. The first meeting was on 24 May 2024.
EOLC 2018	SD27 Make sure that staff responsible for training other staff have the skills, knowledge and experience to do so and that all ward staff receive training in the delivery of effective care, support and treatment for patients at the end of life.	CNMO met with Deputy CNMO, Consultant Nurse Supportive and Palliative Care and Director of Quality Governance in June 2024 to discuss action plan. Further meeting held between Deputy CNMO and Consultant Nurse; plans to ensure these actions are addressed and linked to other actions arising from self-assessments are to be finalised and will then be monitored as part of End of Life (EoL) Committee.
EOLC 2018	SD29 Make sure there is a framework and focus for identifying patients with an uncertain recovery who were at risk of dying, together with a framework for advance care planning. Trust-wide:	As above.
EOLC 2018	SD31 Ensure that discussions about preferred place of care are consistently held in advance of the last days of life and that the achievement of discharge to the preferred place of care is monitored.	As above.
EOLC 2018	SD36 Take action to make sure that records for patients on the 'care of the dying patient and their family plan' are consistently completed.	As above.

7. Emergency Care Quality Summit- 10 June 2024

7.1 On 10 June 24 the leadership teams from both EDs and Care Groups leads came together to discuss intelligence from the recent Medway inspection of Emergency Care and proposed regulatory action.

7.2 Several areas of concern were raised that were highlighted in the Section 29A Warning Notice of June 2023 that remain of concern. The Trust responded to the Warning Notice in September 2023. These are listed below

- *'The ED service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment'.*

  This related specifically to paediatric competencies and is of specific concern at the QEQM site where there is currently no PEM in place. Mitigations are in place (temporary cover) and longer-term plans are being agreed overseen by the Medical Director for the QEQM Care Group.

- *The ED service did not have an effective handover process of patients who had been in ED for more than 24 hours which led to a delay in treatment and a lack of continuity of care in some cases.*

  A number of workstreams ongoing but there has been a delay to developing a Board Round Standard Operating Procedure (SOP) for +24 hour and speciality patients and the corridor care SOP (and full capacity protocol). Interprofessional Standards are being written, with oversight from CMO, which once agreed will need to be monitored.

7.3 It was suggested that, alongside urgent escalation of the above actions, that the UEC specialities should consider using the self-assessment tool to identify any other risks and issues that do not already feature in their open action plans.

8. Update on Maternity Section 31 Enforcement

8.1. The Trust submitted the monthly Section 31 notice requirement for Maternity on 3 June and 1 July 2024. The improvements made since the S31 was imposed in January 2023, were discussed at the engagement meeting between the CNMO and CQC on 20 May 2024. As summarised in sections 6.2 to 6.4 above, there are now only 2 must do requirements that remain open. At that meeting it was agreed that more time was required to complete those outstanding Must Do requirements whilst the CQC consider their assessment approach.

9. CQC Queries Update

9.1. There were 31 queries received from the CQC during May and June 2024, which is almost double that of the previous two months (16). During that period, 17 were fully responded to, the others remained ongoing. The CQC are kept fully updated in terms of progress with each live query and are informed if deadlines cannot be met. This process

has been agreed with the CQC Manager for the Trust, who has advised the Trust to request extensions when needed.

9.2. Of the 14 queries received in May, five had due dates set. Of these five, one was returned within the specified time. Four extension requests were sent to the CQC, of these one was requested for seven days but only approved by the CQC for four days.

9.3. Of the 17 queries received in June, two queries were for information only and required no response. 8 had due dates set by the CQC. Two were returned within the deadline set, with five extension requests sent to the CQC. Two responses were not returned in time for the second extension request. At the end of June, 15 query responses remained open from 2024 and two remain from 2023.

9.4. An engagement meeting was held between the CQC, CNMO, Director of Quality Governance and Associate Director of Quality Governance on 20 May 2024. This was the first meeting since November 2023 due to changes in the CQC's structures. At that meeting, maternity (staffing, student pipeline, maternity triage, neonatal death data, S31), surgery (never events, serious incidents, surgical site infections), the Association for Perioperative Practice (AfPP) review, endoscopy backlog and action plans from the May 2023 inspections were discussed. The CNMO also gave an update on the status of our CQC enquiries and the outstanding historical CQC requirements from inspections prior to 2023.

10. CQC publications

10.1. The CQC have shared the following publications between May and June:

1. CQC's programme of Independent Care (Education) and Treatment Reviews (ICETRs) Published: 18 April CQC's programme of Independent Care (Education) and Treatment Reviews (ICETRs) - Care Quality Commission
2. Assessing services we do not rate Published: 24 April 2024 Assessing services we do not rate - Care Quality Commission (cqc.org.uk)
3. First local authority assessment reports published Published: 17 May 2024 First local authority assessment reports published - Care Quality Commission (cqc.org.uk)
4. What does a general election mean for CQC? Published: 28 May 2024 What does a general election mean for CQC? - Care Quality Commission
5. Integrated care system assessments: update May 2024 Published: 24 May 2024 Integrated care system assessments: update May 2024 - Care Quality Commission (cqc.org.uk)
6. Ian Trenholm to step down as CQC's Chief Executive Published: 25 June 2024 Ian Trenholm to step down as CQC's Chief Executive - Care Quality Commission

11. Conclusion

11.1. Trust Board members are asked to receive this report and the assurance provided by the closures from CQC action plans in month, noting the slowing down of closures as the more challenging issues remain on the plans.

11.2. The Board has been provided with information about the embedding of the new CQC self-assessment programme and commencement of the Check and Challenge meetings, which provide assurance in a proactive manner around compliance with CQC regulations.

11.3. The Board should note the increased numbers of queries received from the CQC over the past two months and the assurance provided regarding the query management process.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Culture and Leadership Programme (CLP) Update**

Meeting date: **25 July 2024**

Board sponsor: **Chief Executive**

Paper Author: **Culture and Leadership Programme Director**

Appendices:

Appendix 1: Action Plan

Executive summary:

Action required:	Information
Purpose of the Report:	This paper provides the Board with an update on the CLP.
Summary of key issues:	The paper describes progress to date as well as highlighting key immediate areas of focus. Summarise key messages from the paper and bullet points of key issues (positives and negatives) for the Board to consider.
Key recommendations:	The Board of Directors is asked to **NOTE** progress to date and continue to support the programme.

Implications:

Links to Strategic Theme:	• People • Patients
Link to the Trust Risk Register:	There is a risk of failure to address poor organisational culture as part of Integrated Improvement Plan (IIP) requirements for 2024/25.
Resource:	No
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: Brief update shared with Board on 4 July 2024 Development session.

East Kent Hospitals University NHS Foundation Trust

Culture and Leadership (CLP) Programme Update

1. Purpose of the report

1.1 This paper provides an update on the CLP following the Discovery presentation to the Board in April 2024.

2. Background

2.1 Since the Board presentation on the 4 April there has been considerable work behind the scenes to agree how to proceed with both the design phase of the programme and how to act on the areas of Voice, Vision and Value from the discovery work. The CLP team has adopted a programme support process to support accountability and action utilising current teams within the People and Culture function. This paper shares the detail of this large programme of work focussing on immediate actions, and subsequent actions over the next three, six and 12 months.

3. Translating the Discovery findings

3.1 The task of prioritising the areas of focus post the discovery feedback has been comprehensive. The delivery plan for the first time in the organisation aligns the Culture programme findings with feedback from the National staff survey, the Executive led listening events and admin forum feedback. This will ensure that there are a clear set of aligned actions as well as clear messaging to the organisation that we have heard and we are now taking these steps to change. It is also recognised that an improvement in culture and leadership is critical this year and linked to our IIP work and exit from NHS Oversight Framework 4 (NOF4) criteria.

4. Delivery Plan

4.1 The delivery plan details the areas for action using the themes of Voice, Vision and Value from the discovery findings.

4.2 The detailed plan shares all of the priorities and they have assigned leads who will be responsible and accountable for progress via the newly set up Culture and Leadership Steering Group.

4.3 This newly established group is Chaired by Tracey Fletcher, Chief Executive Officer (CEO) and Senior Responsible Officer (SRO) for the programme and co-chaired by Ben Stevens, Chief Strategy and Partnerships Officer (CSPO). The CLP work now resides under the CSPO's portfolio.

4.4 The aims of the new group are to ensure pace of delivery.

4.5 Appendix 1 shares the detailed CLP workplan for the next 12 months.

5. Immediate actions

5.1 There are a number of priorities that are being actioned now to keep momentum and focus on the CLP work throughout the organisation.

5.1.1 The design and implementation of a new ***Leadership Essentials*** programme. This is aimed at managers at all levels and will be rolled out in all care groups starting in August. The aim of this work is to "reset and remind" all managers on

basics areas such as taking prompt action, for example, on authorising annual leave requests for their teams and seeking their teams' ideas on areas for improvement.

5.1.2 The formation of a new staff council is a direct response to the findings of the CLP discovery phase. The council will aim to amplify and act upon the diverse voices of staff across the Trust and will be one of many interventions rolled out over the next three years to amplify and act on the staff voice in EKHUFT.

5.1.3 The council will represent the entire workforce using a constituent model, dividing the workforce using staffing groups (professions) and other staff-led groups such as staff networks and governors into 14 constituencies (essentially 14 groups). Then, 29 representatives will be proportionally elected to collect and represent the views of their constituents. The council's primary goals will be to raise the staff voice, collectively act or recommend actions to the Board based on staff feedback, and share progress with their constituencies.

5.1.4 The council meeting will be held bi-monthly and attended by the CEO and Board Chair. It will be pivotal in addressing staff concerns and driving cultural improvements across the Trust. This will promote a more inclusive and responsive organisational culture, and ensure that all voices, including those not always heard or considered (junior staff, specific sites and people from minority backgrounds and groups) are integrated into the Trust's change decision-making process.

5.1.5 On the 3 July, 144 senior leaders were brought together to share the CLP findings and to start the new messaging about the importance leadership has on developing and improving culture within organisations. One of the other immediate actions is to develop a simple model of behaviour for everyone at East Kent using the themes of Compassionate, Inclusive and Collective behaviours.

5.1.6 The process for further engagement on this new model has already started using our own change ambassadors and other groups during July 2024.

5.1.7 A new annual staff awards event for the autumn has been organised to recognise great work across the trust through a range of categories. At the time of writing over 100 nominations have been received with a further two weeks to close for nominations.

5.1.8 Work is underway to develop a management induction programme for all leaders with particular focus on new leaders joining EKHFT. A pilot programme for the out patients' team took place on the 4 July with further work now underway to build and develop the remaining elements. An important component of this programme will be to ensure managers understand which systems they need to use as well as how to use them.

5.1.9 Food and water provision are another area of focus to both connect the areas where work has already started such as seeking feedback on good options in restaurants for our people. This was brought up on several occasions in the staff survey feedback.

6. Design Phase - Culture and Leadership Programme

6.1 To continue the success of the change ambassadors from the discovery phase and to really strengthen continuing staff voice the recruitment for an additional cohort is now underway.

6.2 The application process went live on 26 June and closes on 26 July. To date 65 applications have been received.

6.3 Our current change ambassadors will support this recruitment to ensure we have a wide representation across roles, bands and sites.

6.4 A launch day for the new cohort will take place in September 2024.

6.5 Our current team of change ambassadors continue to support the CLP programme as we move into the next phase.

6.6 Over the coming weeks change ambassadors will provide support work on ongoing-messaging / communication about the culture and leadership work, provide feedback on the proposed new East Kent behaviours and support the development of a new culture and leadership strategy for the Trust which is a key part of the design phase work. Two of the team have also been asked to be part of the panel for the new trust awards.

7. Conclusion

7.1 The Board is asked to note the progress of the Culture and Leadership programme to date.

CULTURE & LEADERSHIP PROGRAMME							WE CARE					
Pillar	**Exec Lead**	**Senior Responsible Officer (SRO)**	**Now**	**3 Months**	**6 Months**	**12 Months**	**SRO**	**Lead**	**3 Months**	**6 Month**	**12 Months**	
Compassionate, Inclusive & Collective (CIC) Leaders	D.V/N.Y/T.F	C.S &K.W	Rapid back to basic interventions	Programme of continuous engagement work at exec and care group level	Review key people policy with a CIC lens		B.S	S.H2	Relaunch of we care - coaching for improvement approach and behaviour using CIC			
	B.S/D.V/T.F	C.E/D.F/R.L	Management Induction - essentials training		CIC masterclass sessions (bitesized)	Launch East Kent Way programme	A.A	CLP team		On-going monitoring/ impact of OD programmes in line with IIP.		
	T.F	R.L	Leadership Event content (for 3rd July): design	Leadership Event 3rd July - CIC Launch								
Voice	K.D	S.U	Staff Council Phase 1: Formulation	Staff Council Phase 2: Implementation		Staff Council meets Board annually						
	A.A	C.T		FTSU Provision Review								
	B.S	R.L/D.V	Listen & act on staff feedback gathered through events, staff survey & CLP	Develop robust plan to increase NSS response rate to 50% & engagement scores to 6.8								
	R.H/A.A	Staff admin group - SRO?	Admin & clerical listening actions		Review appraisal process in light of CIC and NSS themes							
	A.A	S.B	New local induction implementation		Introduce more feedback mechanisms in clinical areas							
Vision	D.V/A.A	R.L & S.U	Assess current OD interventions against CLP discovery		Introduce measurable diversity metrics		B.S	A. S	Launch the clinical Strategy Development (including values).	Senior leaders have a culture change or improvement performance objective		
	B.S	D.F	Design CIC behavioural model	Rebrand/relaunch of we care and CIC	Performance objectives linked to org vision - all staff							
	B.S/N.Y	R.L/S.U/G.S	Set up culture delivery steering group	Start Culture and Leadership Stratgey Development	Develop a workforce chart to enhance leadership visibility.	Launch Culture and Leadership Strategy			Define how we change/ improve services through a CIC/ ONS lens.			
Value	D.V	S.U/C.H			Roll out value driven recruitment practices	Inclusive Talent Management phase 1: talent conversations & toolkits				How we change/ improve services through a CiC/ONS		
	K.D/A.A	S.U/G.S/T.M	Cultivate a org commitment for adequate protected time	Appraisal monitoring via care groups for quality	Scope options to reward and recognise staff locally	Roll out value driven recruitment practices						
	A.A/N.Y	T.M/P.K		Pilot value driven recruitment	Review and embed positive action programmes.	Annual programme of celebration events/ awards.						
	S.H/A.A	W.L.R/H.S/M.L	Review and implement other basics for staff e.g. food quality	Interventions to enhance civility, respect and a zero tolerance for bullying and poor behaviours								

Full Leads/SRO List:		
Abbreviation	**Full Name**	**Role**
T.F	Tracey Fletcher	Executive
A.A	Andrea Ashman	Executive
B.S	Ben Stevens	Executive
N.Y	Natalie Yost	Executive
R.H	Rob Hodgkiss	Executive
K.D	Khaleel Desai	Executive
S.H	Sarah Hayes	Executive
D.V	Deborah Viner	Executive
R.L	Rita Lawrence	SRO
K.W	Karl Woods	SRO
C.B	Casey Byrne	SRO
R.F	Rob Fordham	SRO
C.T	Celina Todd	SRO
D.F	David Fisher	SRO
S.H2	Simon Hayward	SRO
G.S	Gemma Shilito	SRO
C.E	Claire Everley	SRO
S.B	Sam Bessant	SRO
M.L	Martin Luff	SRO
H.S	Heather Skelton	SRO
W.L.R	Wendy Ling-Relph	SRO
P.K	Parveen Kumi	SRO
C.H	Claire Hinson	SRO
S.U	Samantha Uwadiae	SRO
T.M	Twyla Mart	SRO

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

Committee: **Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report**

Meeting dates: **11 June 2024 and 9 July 2024**

Chair: **Chief Nursing and Midwifery Officer (CNMO)**

Paper Author: **Director of Midwifery (DoM)**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Maternity and Neonatal Improvement Programme (MNIP) Update	A detailed report was presented for each workstream highlighting progress made in month and any milestones that were off track against the year 1 trajectory. It is worthy of note that some milestones were superseded by other actions or deferred as additional milestones became priority. For this reason, some milestones originally added to year 2 of the programme have been completed in year 1. The progress reports and exceptions were approved by MNAG. **Workstream1: Developing a positive culture.** There are five high level milestones with two, due to be completed in Year 1. These two milestones have been achieved and there were no matters for escalation. **Workstream 2: Developing and sustaining a culture of safety learning and support.** There are ten high level milestones within this workstream with seven due to be completed in year 1. Six have been completed and one off track with a revised trajectory. **Workstream 3: Clinical Pathways that underpin safe care.** There are six high level milestones with 20 sub-milestones. Three of these are off track with revised trajectories. **Workstream 4: Listening to and working with women and families with compassion.** There are seven high level milestones within workstream 4 all of these are due to be completed in Year 1. Two milestones have been superseded by other work and two revised to be brought in line with Trust or regional timescales.

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	Workstream 5: Growing retaining and supporting our workforce. There are seven high level milestones in this workstream with four of these due to be completed in Year 1. Two milestones were superseded by other actions that were implemented, two were moved to year two as linked to work which can only be undertaken once local students qualify. One action was off track in relation to requirements within an Health Education England (HEE) action plan which is centrally managed by the Medical Education Team. Some of these link to estates work such as dedicated training spaces. **Workstream 6: Infrastructure and Digital.** There are four high level milestones within this workstream with one of these due to be completed in year 1. This milestone has been achieved – no escalations required.
Clinical Negligence Scheme for Trusts (CNST) Compliance	The Maternity Incentive Scheme (MIS) Year 6 data collection period commenced on 2 April 2024. The service continues to work towards achieving full compliance with the Year 6 requirements. At the July 2024 MNAG the following papers were discussed in compliance with CNST reporting: **Q1 PMRT Report – Safety Action 1 (SA1)** • The report confirms that during the Quarter 1 reporting period the service has used the tool to the required standard as set out in NHS Resolution, CNST Maternity Incentive Scheme Year 6. • During Quarter 1, there have been a total of 14 cases reported. Of these 14 cases, four of the cases were not supported; three were medical terminations of pregnancy (MTOP), and one was a NND at 21 weeks, and not supported for a full PMRT review. Of the ten supported cases, eight were neonatal deaths and two were still births/Intrauterine deaths (IUD'S). • Compliance for Newborn Life Support (NLS) has fallen below 90% overall, it can be seen **Maternity Workforce Review - SA5** The report evidences compliance against the CNST Safety Action 5 Standard. This compliance is based on previous workforce reviews, approved business cases and investment. • The report includes information regarding the supernumerary status of midwifery coordinators and the provision of 1:1 care in labour. These are input measures linked to safer maternity staffing that have both been compliant in the timeframe of this review. • A review of the current funded establishment demonstrates compliance with the 2021 BirthRate Plus staffing requirements. Since the time of the last review there has been a 5% decline in the birth rate suggesting that the funded establishment remains compliant with the birth rate plus recommendations. • A full Birthrate plus workforce review is currently being undertaken. It is anticipated that the findings of this review will be received by July 2024 and this will inform the next staffing report submitted to the Board within the MIS Year 6 timeframe.

Q1 Training Report - SA8

- PRactical Obstetric Multi-Professional Training (PROMPT) compliance within this report is at 97.5% for all staff groups, with the anaesthetic doctors currently at 100%. The practice development team are reviewing training date availability for Q2 as this quarter compliance data is often impacted by the rotation of trainees in both obstetrics and anaesthetics.
- Compliance for fetal monitoring continues to remain above the stretch target of ≥95% set by Saving Babies Lives Care Bundle version.
- Compliance for NLS has fallen below 90% overall, it can be seen from the current data that Maternity Support Workers, Midwives and Obstetric Consultants are above 90%. Obstetric doctors are currently at 78.8% with a current trajectory of 91% by the end of July 2024. The standard has changed in Year 6 meaning inclusion of staff groups not previously included.
- The current Newborn and Infant Physical Examination (NIPE) register may not be contemporaneous and that many NIPE practitioners have not attended or received an annual update. To ensure that this is rectified several actions have been developed to mitigate potential risk to babies born in EKHUFT.

Maternity Claims Report - SA9

The paper provided triangulation between maternity claims, complaints and incidents and demonstrated how this links in the with Maternity Patient Safety Incident Response Framework (PSIRF) plan.

- Psychiatric injury featured in 50% of claim settlements. The maternity service has benchmarked practice against the recently published 'Birth Trauma – Listen to Mums'. Areas identified for improvement are integral in the MNIP.
- There is a need for an additional focus on safety outcomes / birth experience of women, birthing people and families with ethnic and socio-economic inequalities to greater inform our safety profile and inform focussed improvement.
- The requirement for regular and ongoing review of the maternity and Neonatal PSIRP was identified to ensure it is responsive to the themes and trends identified within the maternity and neonatal safety profiles, complaints, legal claims and stakeholder feedback.

Q1 Serious Incident (SI)/Duty of Candour (DOC)/Early Notification Scheme (ENS) Report - SA10

The purpose of this paper is to assure the MNAG that all qualifying cases are referred to the Maternity and Newborn Safety Investigations programme (MNSI/Care Quality Commission (CQC)) and to NHS Resolution's ENS. 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 (Safety Action 10). It also briefs the Board on Maternity SIs

Quarter 1 summary 1 April – 30 June (2024 / 2025)
During Q1 there were four maternity serious patient safety incidents.

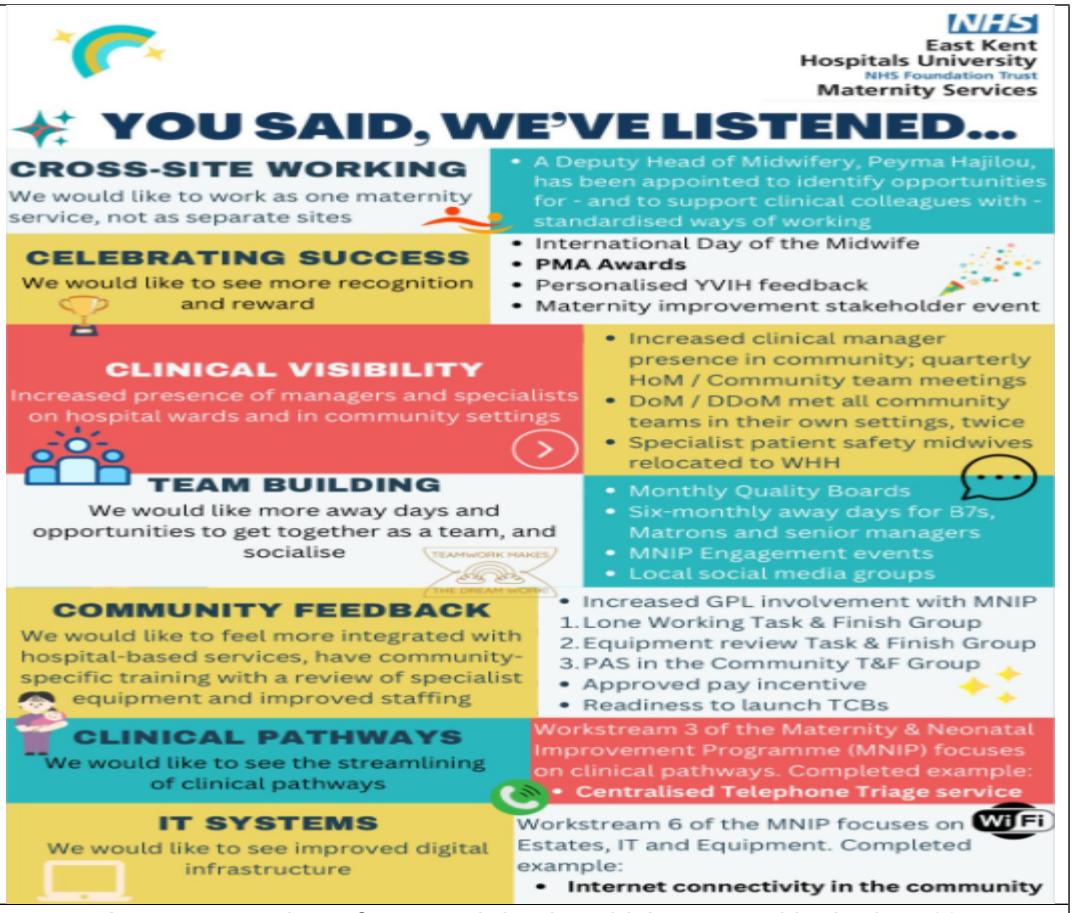
	William Harvey Hospital (WHH) 1 Queen Elizabeth the Queen Mother Hospital (QEQM) 2 Home Environment 1 Some key learning themes have been highlighted relating to: • Comprehensive documentation to give a complete picture of assessment and care given; impact of use of multiple platforms for documentation of clinical care and management. • Timely activation of emergency call bells to summons senior neonatal / obstetric clinical support • Early recognition and escalation of the deteriorating patient to an appropriate healthcare professional/team. These themes identified are included within both the Maternity and Neonatal Improvement Plan (MNIP) and the Maternity Patient Safety Incident Response Plan (PSIRP) and have specific actions assigned with Key Performance Indicators (KPIs) to drive improvement. • The report confirms that during the Quarter 1 reporting period the service has reported 100% of qualifying cases to MNSI and to NHS Resolution's ENS as set out in NHS Resolution, CNST Maternity Incentive Scheme Year 6, from 1 April 2024 – 30 June 2024.
Neonatal Death Review	The paper was presented to MNAG in June 2024 and summarised the current review being undertaken in relation to Neonatal Deaths at EKHUFT. The external review will include neonatal deaths (of all gestations) that occurred within the time frame of 1 April 2023 to 31 March 2024. This specific timeframe was chosen given that a five-year review of all neonatal deaths identified an increase in the last 12 months. Despite the local increase, it is worthy of note that the Trust's Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACCE) reportable neonatal death rate (deaths that occur at or over 24 weeks gestation) at this time remained at 1.39 per 1000 births against a comparator group of 1.96 per 1000 births. The review will be undertaken by an external team comprising of a regional lead neonatologist, a senior midwife and a neonatal nurse and is expected to be completed in 12-weeks' time. A report detailing the findings of the review including any recommendations made will be shared with the Board.
CQC Update: Estates and minor work Maternity Staffing	A request was made by the Executive team for the list of outstanding work to be shared as a matter of urgency to maintain pace. It was confirmed that many of the minor works have since been approved.
PQST report	This report covered the minimum dataset required for Trust Board review as recommended by the Ockenden review. The report relates to the month of May 2024. During this month 512 babies were born at EKHUFT.

- The Stillbirth rate is 1.38 and continues to remain lower than average, with the Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) comparator average threshold being 3.92 stillbirths per 1000.
- The neonatal death rate in the month of May was 2.08 (this includes NNDs from June 2023 to May 2024) which is now slightly higher than the MBRRACE comparator average threshold of 1.96 NNDs per 1000.
- During the month of May there were four reported Neonatal Deaths, three which will be reviewed in PMRT with external Multi-Disciplinary Team (MDT).

25+6/40
24+3/40
25+3/40
21/40 MTOP

- There were two moderate incidents.
- Zero Serious incident reported.
- Supernumerary status compliance reported at 100% at William Harvey Hospital (WHH), 100% at Queen Elizabeth the Queen Mother Hospital (QEQM).
- Compliance of 1:1 in Labour was reported as 100% QEQM, 100% at WHH.
- Level 3 Safeguarding compliance as of the end of May has improved to 93.5%.
- Child protection level 3 compliance as of the end of May is 95.5%.
- Maternity logged 12 formal Stage 1 complaints, themes identified:
  - Communication
  - Postnatal care on the ward
  - Delay in discharge
- Maternity specific PSIRF plan developed and aligned to Trust overarching plan.
- Friends and Family (FFT) received 141 responses, which is an overall 8.17% response rate.

East Kent Hospitals University NHS Foundation Trust

Feedback from Board Level Safety Champions	
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	• Aggregate review of neonatal deaths which occurred in the last 12 months being undertaken. • Midwifery Staffing and current mitigation – Key matter of feedback from executive walkabouts in Maternity. • Gap in Freedom to Speak Up Guardian (FTSUG) cover in last month but other independent opportunities for escalation shared in interim. • NLS training compliance flagged as a risk to CNST – standard have changed. Trajectory to be monitored to ensure CNST compliance. • Stop the line put in place in relation to NIPE examinations whilst action plan being implement. • Business case for anaesthetic cover agreed. • Regional processes around notification of Maternal Deaths to be explored. • Maternity claims review demonstrate high volume low value claims linked to psychiatric injury (in 50% of cases).

Other items of business

Actions taken by the Committee within its Terms of Reference.

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Items to come back to the Committee outside its routine business cycle: None

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

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

Item	Purpose	Date
MNAG asks the BoD to discuss and **NOTE** this MNAG Chair Assurance Report.	Assurance	25 July 2024

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Safety Incident Response Framework (PSIRF) for 2024/2025**

Meeting date: **25 July 2024**

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

Paper Author: **Deputy Director of Quality Governance (DQG)**

Appendices:

Appendices Provided in Reading Room (Documents for Information)
Appendix 1: **Patient Safety Incident Response Policy – June 2024**
Appendix 2: **Patient Safety Incident Response Plan for 2024/2025**

Executive summary:

Action required:	**Information**
Purpose of the Report:	The aim of this report is: • The BoD to note the updated PSIRF Policy and Plan which has been approved by the Kent and Medway Integrated Care Board (ICB). • These documents have been ratified through the Policy Authorisation Group (PAG).
Summary of key issues:	1. The Plan and the Policy should be read together. They will be updated after the first six months and then every year thereafter. 2. The Policy explains how we will respond to incidents and the Plan details what we will be responding to over the next year. 3. We are in a trial phase of the Plan and Policy which commenced in June 2024 following ICB approval. 4. There are significant changes in relation to how the Trust will respond to our incidents in particular serious incidents SIs). 5. SIs will no longer be a part of our response, instead the Trust will be required to undertake Patient Safety Incident Investigations (PSIIs) using a different methodology. 6. The Trust experienced 240 SIs last year. There will be an expectation that we will try and keep our PSII figures to less than 20 over the coming year. The aim is to use the time to focus on improvement rather than repeat investigations. 7. The Trust is in a fortuitous position as we are also in the process of transferring the Care Group Governance teams to the Corporate Governance team. This has provided the Trust with an opportunity to rethink how we will deliver PSIRF by creating one team, aligned to be able to deliver on PSIRF over the coming year.
Key recommendations:	It is recommended that the Board of Directors **NOTE** the updated PSIRF Policy and Plan.

We care

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	Risk Ref 3669: Failure to (i) meet quality standards for clinical care; (ii) continuously improve care quality and safety; and/or (iii) engage patients and carers in that care, could result in patient harm, impaired outcomes, and poor experience for both. Risk Ref 3670: Failure to identify harm and involve patients and their families in their care and investigations, and use opportunities to embed a culture of safety and learn from when things don't go well and share best practice across the organisation.
Resource:	Yes • The Trust is required to have an independent investigation team that is highly trained. This has been created within the transfer of the Care Group Governance Teams to the corporate team. • There is a significant level of training and development required for the Governance Teams across the Trust in order to adopt the new approaches to patient safety. A training plan is now in place. Much of this training is on line and free. • We have now created a deputy role for the Head of Clinical Safety and Improvement which will release the Head of Clinical Safety and Improvement to lead on PSIRF over the coming year.
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: N/A