Board of Directors - Open (Thursday 6 July 2023)

Thu 06 July 2023, 02:00 PM - 04:40 PM

Conference Room, Education Centre, K&C Hospital, Ethelbert Road, CT1 3NG & WebEx

Agenda

OPENING/STANDING ITEMS

02:00 PM - 02:05 PM
5 min

23/51
Welcome and Apologies for Absence

To Note *Chairman*

Verbal

02:05 PM - 02:05 PM
0 min

23/52
Confirmation of Quoracy

To Note *Chairman*

Verbal

02:05 PM - 02:05 PM
0 min

23/53
Declaration of Interests

To Note *Chairman*

23-53 - Board of Directors register of interests - July 2023.pdf (3 pages)

02:05 PM - 02:05 PM
0 min

23/54
Minutes of Previous Meeting held on 1 June 2023

Approval *Chairman*

23-54 - Unconfirmed BoD 01.06.23 Open Minutes.pdf (16 pages)

02:05 PM - 02:05 PM
0 min

23/55
Matters Arising from the Minutes on 1 June 2023

Approval *Chairman*

23-55 - Front Sheet Open BoD Action Log.pdf (6 pages)
23-55.2 - Appendix 1 CMO Diabetes update.pdf (2 pages)

Our People

02:05 PM - 02:10 PM

23/56

5 min

Staff Experience Story

To Note *Chief People Officer*

Verbal

REGULATORY AND GOVERNANCE

02:10 PM - 02:15 PM
5 min

23/57
Chairman's Report

Discussion *Chairman*

- 23-57.1 - Chairman BoD Report July 2023 06.06.23.pdf (5 pages)
- 23-57.2 - App 1 Chairman Report NEDs commitments.pdf (1 pages)

02:15 PM - 02:25 PM
10 min

23/58
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 23-58 - CEO Report to Board - July 2023.pdf (7 pages)

02:25 PM - 02:45 PM
20 min

23/59
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

Our People

23/59.1
People and Culture Committee (P&CC) - Chair Assurance Report

Assurance *Chair P&CC - Stewart Baird*

- 23-59.1 - EK PCC Board Assurance Report 060723.pdf (4 pages)

Our Patients - Our Quality and Safety

23/59.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report

Assurance *Chair Q&SC - Dr Andrew Catto*

- 23-59.2 - EK QSC Board Report 060723.pdf (6 pages)

Our Future - Our Sustainability

23/59.3
Finance and Performance Committee (FPC) - Chair Assurance Report

Assurance *Chair FPC - Richard Oirschot*

- **Pathology Collaboration Agreement**

- 23-59.3.1 - FPC Committee Assurance Report BoD final.pdf (6 pages)

Our Future - Our Sustainability

Our Patients - Our Quality and Safety

23/59.4
Charitable Funds Committee (CFC) - Chair Assurance Report

Assurance *Chair CFC - Claudia Sykes*

- 23-59.4.1 - CFC Board report 6.7.23.pdf (2 pages)
- 23-59.4.2 - Appendix 1 Expenditure Board Paper.pdf (2 pages)
- 23-59.4.3 - Appendix 2 East Kent Hospitals Charity Strategy Board paper.pdf (14 pages)

Our Patients - Our Quality and Safety

Our People

02:45 PM - 03:00 PM
15 min

23/60
Transforming our Trust: Our Response to 'Reading the Signals' - Update

Discussion *Chief Executive*

- 23-60 - Board report Reading the Signals - July.pdf (4 pages)

03:00 PM - 03:20 PM
20 min

23/61
Maternity Governance:

Interim CNMO / DoM

23/61.1
Maternity Dashboard - Maternity and Neonatal Assurance (MNAG) Report

Discussion *Interim CNMO / DoM*

- 23-61.1.1 - MNAG Dashboard Front sheet June 23.pdf (3 pages)
- 23-61.1.2 - Appendix 1 Maternity_Dashboard_May23.pdf (46 pages)

23/61.2
Perinatal Quality Surveillance Tool (PQST) Report

Assurance *Interim CNMO / DoM*

- 23-61.2 - PQST June 2023.pdf (13 pages)

23/61.3
Obstetric Workforce Update

Discussion *Chief Medical Officer / Interim CNMO / DoM*

- 23-61.3 - Obstetric workforce update June 2023.pdf (4 pages)

23/61.4
Bi-Annual Midwifery Workforce Oversight Report Covering Staffing/Safety Issues

Approval *Interim CNMO / DoM*

- 23-61.4 - Midwifery Workforce Biannual CNST SA5 Report July 2023.pdf (11 pages)

23/61.5
Clinical Negligence Scheme for Trusts (CNST) Safety Action 8 Compliance Plan

Assurance *Interim CNMO / DoM*

23-61.5 - CNST Safety Action 8 Assurance Paper PROMPT.pdf (4 pages)

03:20 PM - 03:30 PM
10 min

23/62
Infection Prevention and Control (IPC)

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

23/62.1
IPC Quarterly Update

Discussion *Deputy DIPC*

23-62.1 - IPC Quarterly Update June 2023.pdf (4 pages)

23/62.2
IPC Annual Report 2022 - 2023

Approval *Deputy DIPC*

23-62.2.1 - Front Sheet IPC_DIPC_annual_report_2022_2023.pdf (2 pages)
23-62.2.2 - Appendix 1 IPC Annual Report 2022-23_V1.pdf (19 pages)

03:30 PM - 03:40 PM
10 min

TEA/COFFEE BREAK 3:30 - 3:40 (10 MINS)

03:40 PM - 03:50 PM
10 min

23/63
Chief Medical Officer (CMO) Reports:

Chief Medical Officer (CMO)

23/63.1
Medical Revalidation Annual Report

Approval *CMO*

23-63.1 - CMO Medical Revalidation Annual Report.pdf (13 pages)

23/63.2
CMO's Report - Update on Medical Workforce

Discussion *CMO*

23-63.2 - CMO report Medical Workforce July 2023 (004).pdf (6 pages)

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

03:50 PM - 04:20 PM
30 min

23/64
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Team*

- 23-64.1 - Front Sheet May 23 IPR.pdf (4 pages)
- 23-64.2 - Appendix 1 IPR_v4.3_May23_finalv2.pdf (36 pages)

23/64.1
Integrated Improvement Plan (IIP) Update

Discussion *Chief Executive*

- 23-64.1.1 - Front Sheet Integrated Improvement Plan Report Final 06.07.23.pdf (4 pages)
- 23-64.1.2 - Appendix 1 EKHUFT IIP July Board Report FINAL Draft 20.06.23.pdf (26 pages)

23/64.2
Month 2 Finance Report

Discussion *Interim Chief Finance Officer*

- 23-64.2.1 - Front Sheet M2 Finance Report Board.pdf (4 pages)
- 23-64.2.2 - Appendix 1 M2 Finance Report short.pdf (8 pages)

23/64.3
Emergency Department (ED) Builds - Update

Information *Chief Operating Officer*

- 23-64.3.1 - Front Sheet ED Build Paper.pdf (2 pages)
- 23-64.3.2 - Appendix 1 ED Build Paper.pdf (5 pages)

CLOSING MATTERS

04:20 PM - 04:25 PM
5 min

23/65
Any Other Business

Discussion *All*

Verbal

04:25 PM - 04:40 PM
15 min

23/66
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 7 September 2023

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JULY 2023

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

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JULY 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
JONES, DYLAN	Chief Operating Officer	None	Appointed 12 April 2023
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, Audit and Governance Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director (Adult Care), Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM JULY 2023

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

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

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

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

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

Categories:

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

**UNCONFIRMED MINUTES OF THE ONE HUNDRED & THIRTIETH MEETING OF THE BOARD OF DIRECTORS (BoD)
THURSDAY 1 JUNE 2023 AT 1.05 PM
IN THE LECTURE THEATRE, EDUCATION CENTRE,
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL, RAMSGATE ROAD, MARGATE
CT9 4BG AND BY WEBEX TELECONFERENCE**

PRESENT:

Mr N Dickson	Chairman	ND
Ms A Ashman	Chief People Officer (CPO)	AA
Mr S Baird	Non-Executive Director (NED)/People and Quality Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair	SB
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair	AC
Mr S Corben	NED/2gether Support Solutions (2gether) NED In-Common	SC
Ms J Dickson	Interim Chief Nursing and Midwifery Officer (CNMO)	JD
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED	LF
Dr R Martin	Chief Medical Officer (CMO)	RM
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair (WebEx) (left meeting at 1.30 pm)	OO
Mr B Stevens	Executive Director of Strategic Development and Partnerships (EDSDP)	BS
Mrs M Stevens	Interim Chief Finance Officer (CFO)	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/*Reading the Signals* Oversight Group Chair	CS

ATTENDEES:

Ms M Cudjoe	Director of Midwifery (DoM)	MC
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Prof C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Mr P Ryder	Managing Director (MD), 2gether Support Solutions (2gether)	PR
Ms A Smith	Deputy DoM	AS
Dr N Wigglesworth	Executive Director of Infection Prevention & Control (EDIPC)	NW
Ms F Wise	Executive Maternity Services Strategic Programme Director (EMSSPD)	FW
Mr M Wood	Interim Group Company Secretary (GCS)	MW
Mrs N Yost	Executive Director of Communications and Engagement (EDoC&E)	NY

IN ATTENDANCE:

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

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr G Birkett	Client Solutions Manager, MSI Group (WebEx)
Mrs M Bonney	Governor (WebEx)
Ms V Brandon	Member of the Public (WebEx)
Ms N Edell	Member of the Public (WebEx)
Mr R Edwards	Commercial Lead South, EMS Healthcare (WebEx)
Ms C Heggie	Member of the Public (WebEx)
Ms H Jackson	Member of the Public (WebEx)
Mrs L Judd	Governor
Ms C Knight	Member of Staff (WebEx)
Ms S Mahmood	Staff Governor (WebEx)
Mrs B Mayall	Lead Governor (WebEx)
Ms A Moore	Freelance Journalist – HSJ (WebEx)
Mr M Norman	BBC South East Health Correspondent
Mr D Richford	Member of the Public (WebEx)
Mr B Rylands	Governor (WebEx)
Mr P Schofield	Governor
Ms T Sharp	Member of Staff
Mr J Sullivan	Governor
Dr J Thomas	Staff Governor (WebEx)
Mrs M Warburton	Member of the Public (WebEx)

MINUTE NO.		ACTION

23/034 **WELCOME AND APOLOGIES FOR ABSENCE**

The Chairman welcomed those in attendance, noted apologies received from Mr R Anakwe (RA), NED; and Mr D Jones (DJ), Chief Operating Officer (COO). The Chairman welcomed Ms J Dickson, Interim CNMO to her first BoD meeting.

The Chairman reported a Closed BoD meeting had been held that morning, the issues discussed included System Working, 2023/24 Cash Management; Maternity Serious Incidents (SIs); CMO's Report; Professional Bodies Update Report from the Interim CNMO; and Annual Documentation.

23/035 **CONFIRMATION OF QUORACY**

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

23/036 **DECLARATION OF INTERESTS**

There were no new interests declared.

23/037 **MINUTES OF THE PREVIOUS MEETINGS HELD ON 4 MAY 2023**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 4 May 2023 as an accurate record.

23/038 **MATTERS ARISING FROM THE MINUTES ON 4 MAY 2023**

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

23/039 **CHAIRMAN'S REPORT**
- **CARE QUALITY COMMISSION (CQC) MATERNITY REPORT**
- **CQC UNANNOUNCED INSPECTION VISIT**

The Chairman highlighted key elements:

- Board papers were being reviewed, as their length and also that of the Board Committees was unsustainable. This was around ensuring papers clearly identified assurance or not, the decision required, and the key issues that required discussion. This also included looking at other trusts and presentation of information and papers;
- Concern from the Governors about the CQC maternity report, expectation a letter would be received about their concerns. The Chairman and CE would be meeting with the Governors to discuss this report.

The CE reported an unannounced inspection visit by the CQC of the Trust's core services took place on 17 and 18 May, to the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM). The visit covered medicine, care of the elderly, urgent and emergency care (UEC), and children & young people. This was around testing how these services functioned, talking to staff and understanding the operational workings and mitigations. Informal verbal feedback had been received highlighting areas of good practice, as well as concerns identified, reassurance had been requested on specific areas that had been responded to, and further requests for information received that were in the process of being responded to against three areas. These areas included confirmation of the number of consultants appointed in UEC at QEQM, number of paediatric nurses

appointed at WHH, handover operational policies and how these worked between the Emergency Departments (EDs) and acute physicians and general medicine. The formal report would not be published for several months.

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

23/040 **CHIEF EXECUTIVE'S (CE'S) REPORT**

The CE reported key points:

- Detailed activity plans had been submitted to NHSE outlining the planned volumes of activity the Trust would deliver in 2023/24;
- Continued refurbishment works in QEQM ED over the next few weeks, current majors area size would be reduced enabling the necessary works for the resus area. These works would cause disruption and operational pressures, whilst it was recognised once completed would provide a much improved environment.

The NEDs raised the need for a clear Trust strategic direction to be developed and communicated, in respect of the management of patients from the front door and patient flow accessing the appropriate patient pathways for treatment. It was noted the great facilities provided on completion of the ED works, the importance to consider patients and their experience when very noisy works were being undertaken. It was highlighted there had been delays in completion of these works and that phase 3 be completed against the timeline. The CE acknowledged the need to ensure robust communications with primary care colleagues around referring patients, how to contact for advice and information, and where possible directing patients to the services available, and would liaise with the COO to ensure these arrangements were in place. She commented the management of UEC was for the system as a whole, noting a session covering a number of UEC elements had been held at the beginning of June. It was noted there was ongoing work within Kent & Medway Healthcare Partnership (HCP) in respect of pathway management, linking with out of hospital services to prevent unnecessary admissions and enabling patients to be discharged. The Trust was following well evidenced effective patient pathways. It was recognised the need to monitor and test that pathways were being fully utilised, as well as right sizing to ensure appropriate pathways in place for patients accessing the front door. It was noted on completion of the ED works it would be beneficial to review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy.

ACTION: 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. — COO

The NEDs asked whether there had been any synergies in what had been found from the recent CQC unannounced visit in comparison to the visit to maternity services. It was also enquired whether the environment and condition of the estate had been raised. The CE commented there hadn't been any similarities identified. The Interim CNMO stated the theme of the recent visit focussed on staffing numbers and vacancies, and how risks were being mitigated. It was noted many of the staff groups identified were nationally known challenged areas to recruit to, e.g. paediatric nursing. She commented it had been identified the significant demand on services at the front door, overcrowding in respect of the limited footprint available, and how demand and safety in respect of fire was being managed by the Trust within the limited space available.

The Chairman stated the Trust had been unsuccessful in its bid submission against

the new hospitals programme, which was really disappointing and the Trust would need to revisit the Pre-Consultation Business Case (PCBC). He emphasised the need for significant capital investment to address the Trust's poor estate, the need to upgrade the two maternity units, to review its strategy and priorities going forward and to continue to lobby for investment.

The NEDs raised the infrastructure and condition of the Trust old buildings and estate, poor conditions for treatment of patients and staff working environment. It was requested a report be presented to the Board around the short-term, medium-term, and long-term providing an update on what could be done and the mitigations for the provision of continued quality care services to patients. The CE reported work was currently being carried out to review the Trust's de-minimis bid that had been submitted as part of the new hospitals programme to ensure this reflected the current position. It was agreed on completion of the review the revised de-minimis would be presented.

ACTION: Present the revised de-minimis report following its review for Board to have a discussion about the current position of the Trust's infrastructure, the mitigations, and what could be done in the short-term, medium-term, and long-term to ensure sustained future provision of services. — EDSD&P

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

23/041 **SECTION 31 (S31) REPORTING: MATERNITY AND MIDWIFERY SERVICES – WHH AND QEQM**

The DoM reported:

- CQC had reduced the S31 submission response requirements in May as there had been effective delivery of assurance, weekly 'stop the clock' meetings would continue with collation of actions and evidence for monthly submission to CQC;
- Daily checks and monitoring as detailed in report.

The NEDs asked how assurance of these services could be provided to mothers coming to the Trust's hospitals to give birth. The Trust's communications strategy was raised, the need to be open, honest and transparent about the changes that had been made, and to consider whether external specialist communications expertise was needed to assist with its engagement approach. The DoM reported the maternity metrics would be shared and displayed in the ward areas, and the continued collation of feedback, engagement and communication with women and their families.

The NEDs recognised there had been a lot of work undertaken and enquired what had been done to support staff. The DoM confirmed sessions were held with staff on the day of publication of the CQC report, they were aware of the work that had been done, staff were positive about the improvement work and recognised there was still much more to be done. There would be a review of governance processes and how these could be streamlined, as well as reviewing and monitoring that improvement initiatives were embedded and being maintained in clinical practice. The CE commented the positive reaction from staff following the substantive DoM and Deputy DoM now in place, with a real positive focus and approach to implement the service delivery changes needed.

The Interim CNMO reported monthly Safety Champion summits would be held providing transparency and the opportunity to staff and teams to escalate any issues.

The Chairman highlighted there remained some areas that were red RAG rated. The DoM reassured that provided the Trust was aware of these areas and that it was working on making the necessary changes to move from red to green rating.

The Board of Directors **NOTED** the content of the S31 report and the CQC S31 submission reports for both WHH & QEQM with the evidence data.

23/042 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/042.1 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair highlighted key points:

- Challenges with the deployment of new nursing and Healthcare Assistant (HCA) staff, as frontline staff were struggling to train these new employees due to staff resources. This impacted temporary staffing costs that remained high, and would continue to be monitored by the Committee;
- Staff engagement and involvement remained an area of concern, the Committee requested assurance with the provision of a road map and timelines of the various cultural initiative programmes to improve the position;
- Appraisal rates remained disappointedly low with not much improvement. The Committee tasked the Executive Team to look at interventions to increase the number of appraisals completed, and whether protected time could be allocated to ensure these took place promptly;
- Assurance against staff turnover that had reduced to 9.8%;
- Assurance of vacancy rates that was lower, and a result low turnover in nursing and HCA staff;
- Retention of staff was vital and a key element was ensuring provision of adequate residential accommodation, especially supporting overseas staff. The Finance team had been asked to look at what support could be provided e.g. rent guarantors;
- Offers of employment to 30 student midwives, 16 vacancies currently for midwives;
- The Committee had asked the Risk and Executive Team to review the key risks and risk ratings.

The NEDs raised staff numbers had improved but cost pressures remained, there had not been a reduction in agency and temporary staff and what were the reasons for this. The CPO responded explaining the high costs for locum doctors, the staff resources needed to manage the escalation areas opened, and the continued significant increased demand on Trust services.

The NEDs raised concern about the low number of appraisals, the importance for staff in receiving these, what action was being taken to increase the numbers and when the target would be achieved. The CPO reported appraisals were raised with the Care Groups and Corporate Team at the Performance Review Meetings (PRMs), who were challenged to increase the numbers completed, with support from the HR Business Partners. It was noted numbers were increasing, with a backlog inputting those completed and recording these on the Electronic Staff Record (ESR) system. She commented it was expected target to be achieved by August 2023, although this might not be met due to operational pressures and maintaining safe services, and would be achieved by the end of the year.

The Board of Directors **NOTED** the 24 May 2023 P&CC Chair Assurance Report.

23/042.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- Funding provision of £300k from Integrated Care Board (ICB) supporting Trust's improvement identifying and managing deteriorating patients that was a key priority for the Interim CNMO. Noting the need for clear distinction between deteriorating patient pathway and End of Life (EoL) pathway;
- Very challenging month in April 2023 in respect of C. difficile infections with 16 cases reported, with expected performance improvement as a result of the enhanced antibiotic stewardship, noting the revised target for 2023/24 would be even more exacting. It was noted the impact of infections on patients also resulting in pro-longed stay in hospital;
- An assurance update was requested by the Committee from the Controlled Drugs Accountable Officer (CDAO) and highlighted this was an area of serious concern with limited assurance, to report back on risks and actions;
- Progress month on month had been made on the CQC actions;
- Good progress and assurance in addressing the Ophthalmology backlog noting risks remained, and there was an escalation process in place for patients who were concerned about deterioration of their eye sight.

The Interim CNMO reported she would be reviewing the CQC actions, focussing on ensuring progress of the must-dos and that these were completed and closed.

The Board of Directors **NOTED** the 23 May 2023 Q&SC Chair Assurance Report.

23/042.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted key points:

- Reported Group deficit of £0.4m in April against plan;
- Activity below plan for electives and outpatients;
- Limited assurance on savings and efficiencies with £8m identified to date against the £40m total target to be achieved;
- 411 patients reported in April as no longer fit to reside (NLFTR), paper to be presented outlining the interventions to reduce this number;
- Workforce quarterly report showing premium pay spend above target, with an increase in spend of £600k during Q4 compared to Q3.

The Chairman highlighted the need for financial control to be high on the agenda and a key focus for the Care Groups, the importance of leadership and reinforcing to staff that finances remained within budget, with regular progress updates and prediction of achievement of the Cost Improvement Programme (CIP) target. The FPC Chair reported financial control and progress against the CIP would be closely monitored. He emphasised the need for next financial year that the process start earlier in developing the annual CIP. The EDSDP highlighted the Trust's three year recovery programme to enable it to deliver a breakeven position, commenting that the majority of the currently identified CIP schemes were small efficiency savings.

The NEDs emphasised the need to engage with all staff and that they were aware of the CIP requirements, stating when undertaking joint visits some staff reported they were unaware of this, and whether the new organisational structure would support staff engagement and involvement. It was also noted the reduction in activity and whether this should result in reduced costs. The Interim CFO stated an update report would be presented to the June FPC meeting, that staff financial training would be relaunched in the Summer. The CPO commented financial expenditure control and working within the allocated budget would be part of the discussions with staff appointed to roles within the new structure. She reported

there had been additional costs incurred that were not previously sighted on in respect of changes in the Objective Structured Clinical Examination (OSCE) process for Internally Educated Nurses (IEN).

The Board of Directors **NOTED** the 23 May 2023 FPC Chair Assurance Report.

23/043 **TRANSFORMING OUR TRUST: OUR RESPONSE TO *READING THE SIGNALS* – UPDATE**

The EMSSPD reported:

- The Pillars of Change was the three year transformation programme and the report presented provided an update on progress against this;
- Report included the Oversight Group Terms of Reference (ToR) for approval, noting these did not include specified exact numbers of patient and family representation, as this allowed a flexible approach whilst ensuring involvement that was a clear key element in the *Reading the Signals* report;
- Establishment of a programme of Family Voices meetings to be held, initially two in late June/early July.

The Oversight Group Chair confirmed good engagement with patients and families, and that there needed to be better engagement within the wider community. She reported Group meetings had been scheduled up to October 2023, when a review of the Group would be undertaken, with feedback from patients and families on what they would want to happen going forward. The Chairman suggested consideration when reviewing the Group later in the year inviting some patient and family representative members to present at a future Board on their experience of this Group and progress made.

ACTION: Consider when reviewing the Oversight Group later in the year extending invitation to some patient and family representative members to present at a future Board on their experience of this Group and the progress that had been made. — EDSDP

The EDSDP emphasised issues identified in *Reading the Signals* were not just associated to maternity services but across the wider Trust as a whole, themes had been reviewed, and there had been alignment with the Integrated Improvement Plan (IIP) and We Care. He reported this would ensure a consistent approach of the Trust's improvement plans, a framework for change and improvements at pace. He highlighted good progress had been made, the updates provided in the report on each of the pillars of change, the majority of the actions were green, with a few amber rated. The Oversight Group Chair commented on the benefits of seeing what impact there had been as a result of the actions and requested an additional column be included providing a brief overview of 'the what, impact and outcomes from the actions'. The NEDs suggested looking at the use of Blue, Red, Amber and Green (BRAG) status definitions rather than RAG currently used.

ACTION: Look at including in future reports an additional column in the pillars of change update appendix providing a brief overview of the result of the actions detailing 'the what, impact and outcomes from these'. Consider and look at using Blue, Red, Amber and Green (BRAG) status definitions rather than RAG currently used. — EDSDP

The NEDs raised the report recorded the SI backlog had been resolved but in other maternity reports there were SIs overdue. The DoM stated the report referenced the original backlog, confirmed those currently overdue had been given appropriate resources for investigation and closure, and the Board would receive assurance on progress of the management of SIs in future reports.

DECISION: The Board of Directors discussed and **NOTED** the progress to date and **APPROVED** the Terms of Reference of the *Reading the Signals* Oversight Group.

23/044 **MATERNITY GOVERNANCE:**

23/044.1 **MATERNITY DASHBOARD**

The Interim CNMO reported:

- Reduction in the number of vacancies that was currently around 10%;
- Neonatal death rate (12 month rolling) remained significantly lower than the target and below the national average;
- No maternity deaths (11 consecutive months).

The Q&SC Chair reported there had been a discussion about the national maternity dashboard by the Q&SC and suggested it would be useful to include for comparison the Trust's performance against that nationally.

ACTION: Look at incorporating the national maternity dashboard within the Trust's maternity dashboard for comparison against performance. — Interim CNMO

The NEDs commented on the need for co-production of the development of services with women and provision of virtual appointments for those that wanted these and not wanting face to face appointments. The DoM referred to the clear guidance in respect of the need for face to face appointments e.g. checking size of baby and safeguarding elements. She highlighted the importance of the relationship between women and their midwives, effective communication, having open and honest discussions, as well as understanding the local demographics.

The NEDs raised the devasting impact of SIs on women and families and the importance of learning and taking action from these. The DoM stated the importance of acknowledging these incidents and what happened, that action had been taken, lessons learnt and any training needs identified for staff across the Multi-Disciplinary Team (MDT), as well as any links to complaints/claims. She reported the introduction of monthly quality boards being held with Heads of Midwifery, matrons and ward managers to monitor performance and complaint themes and actions. The Deputy DoM noted the benefits of using patient stories for staff training. The NEDs requested future reports presented include updates on the learning and training identified from SIs

ACTION: Include in future reports updates on staff learning and training identified from SIs. — Interim CNMO

The Associate NED raised concern about the midwifery turnover rate, particularly that at WHH that was significantly higher at 22.1%, and whether this was a reflection of low staff morale and the culture change programme. The DoM commented this was an area of concern for her and would be exploring in-depth feedback from staff exit interviews to understand the reasons for staff turnover and in particular the reasons for the higher rate at WHH. It was agreed a briefing would be provided in the report presented to the Board at its September 2023 meeting with an update following the review of feedback from staff exit interviews and the reasons for staff turnover, particularly the reasons for the higher turnover rate at WHH.

ACTION: Provide in the report presented to the September 2023 Board meeting an update following the review of feedback from staff exit interviews and the — Interim CNMO

reasons for staff turnover, particularly the reasons for the higher turnover rate at WHH.

The Board of Directors **NOTED** the contents of the Maternity Dashboard report and the key issues and plans to tackle and address these.

23/044.2 PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT

The Board of Directors **NOTED** the contents of the PQST report.

23/044.3 PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT Q4 2022/23

The Board of Directors **NOTED** and received assurance from the Quarterly PMRT paper received for Q4 2022/23 demonstrating full compliance in line with Clinical Negligence Scheme for Trusts (CNST) standard requirements.

23/044.4 CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) SAFETY ACTION 8 COMPLIANCE PLAN

The Board of Directors **NOTED** the CNST Safety Action 8 Compliance Plan report and the recommendations to:

- Undertake a review of the methodology of the facilitation of PRactical Obstetric Multi-Professional Training (PROMPT) across sites;
- Increase the amount of training weeks undertaken when new MDT members (Foundation Year (FY) & Trainees) which usually fall in August to ensure compliance and safety was maintained;
- Ensure the anaesthetic and obstetric teams understand the provisions needed to facilitate PROMPT.

23/044.5 CNST YEAR 4 – SAFETY ACTION 3: TRANSITIONAL CARE SERVICES TO MINIMISE SEPARATION OF MOTHERS AND THEIR BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING TERM ADMISSIONS INTO NEONATAL (ATAIN) UNITS PROGRAMME - QUARTERLY REPORT Q3 & Q4 2022/23

DECISION: The Board of Directors:

- **NOTED** the content of the CNST Year 4 Safety Action 3 Transitional Care Services quarterly report;
- Received assurance that there was an effective process established of ongoing assessment and that the evidence provided was sufficiently robust;
- **NOTED** review of the Transitional Care and ATAIN action plan;
- **SUPPORTED** the broader considerations and the development of further improvements as defined within the action plan;
- Formally **AGREED** that the Transitional Care and ATAIN reviews and action plan findings would also be shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care System (ICS) quality surveillance meeting.

23/044.6 MATERNITY IMPROVEMENT PLAN HIGHLIGHT REPORT

The Interim CNMO highlighted the need to engage and listen to the wider team and leadership, as well as Maternity Voices Partnership (MVP), to support co-production of the improvement plan. It was noted the plan would be presented to the Board at its September 2023 meeting.

The Board of Directors **NOTED** the content within the highlight update report of the Maternity Improvement plan.

23/045 **CHIEF MEDICAL OFFICER'S (CMO'S) REPORT – LEARNING FROM DEATHS (LfD) QUARTER 4 2022/23**

The CMO highlighted:

- Rise in crude mortality for deaths within the ED in December, review had indicated that while this was seen at both sites this was more pronounced in duration at the WHH site and that there was a contemporaneous increase in length of stay in the ED;
- Hospital Standardised Mortality Ratio (HSMR) at WHH remained 'as expected', with QEQM and K&C lower than expected. There was a continued divergence between the two acute sites with focus to look at key diagnostic admission data to understand what was driving the difference and to identify any areas of concern for specific patient pathways;
- Summary Hospital-level Mortality Index (SHMI) 'as expected';
- The Medical Examiners reviewed deaths, and to identify learning and the impact of patient pathways to identify any themes for changes needed.

The Board of Directors discussed and **NOTED** the Quarter 4 2022/23 Learning from Deaths report.

23/046 **PATIENT VOICE AND INVOLVEMENT REPORT**

The Interim CNMO noted:

- Update on progress ensuring that patients, families and communities had a voice, their feedback was heard and that actions were being taken;
- Good progress had been made, Trust was on a journey to further develop its Patient Voice and Involvement Strategy, with a Patient Participation and Action Group (PPAG) in place;
- Importance of continuing to monitor action on the feedback received.

The NEDs noted in the report the Patient Voice and Involvement team reviewed Friends and Family Test (FFT) responses and enquired how this was incorporated within the strategy to improve the Trust's services. It was also suggested looking at producing a deep dive report on any themes. The Interim CNMO reported she would be meeting with the team as she was new to the Trust and this was an area that she would raise and discuss in respect of how FFT feedback and complaints were triangulated in identifying any themes, and what changes and improvement action was needed to address issues raised.

ACTION: Provide an update in the next report presented following discussion with the Patient Voice and Involvement team and wider CNMO teams about the triangulation of patients, families and communities feedback across the Trust, FFT responses, as well as complaints. This was around ensuring identification of any themes, what changes and improvement action was needed to address issues raised and that action was taken on the feedback received. Consider looking at producing a deep dive report on any themes identified. — Interim CNMO

The NEDs enquired how Patient-Led Assessments of the Care Environment (PLACE) returns linked with the strategy. It was also noted it would be beneficial if identified themes from complaints was included in future reports. The Interim CNMO stated the recent PLACE audit had identified some actions around nutrition and the environment and agreed to include a section in the next report presented on feedback from PLACE audits.

ACTION: Include section in the next report presented on feedback of the PLACE audits as well as any themes identified from complaints. — Interim CNMO

The Board of Directors discussed and **NOTED** the Patient Voice and Involvement Quarterly report.

23/047 **INTEGRATED PERFORMANCE REPORT (IPR)**

Mortality (Hospital Standardised Mortality Ratio (HSMR))

It was noted mortality had already been covered under the CMO LfD report.

Reduce Incidents with Harm

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

- Tissue Viability (TV) team doing focussed work around skin damage and pressure ulcers (PUs) to reduce these incidents;
- Continued work to reduce incidents of falls;
- Good work progressing the deteriorating patient improvement plan with an education programme to take place in June/July 2023, although appeared not to be such an issue as was previously thought. This would also include identifying patients in a timely way that required EoL pathway, ensuring they received care in the right place at the right time.

The NEDs raised delays in medication arriving for patients once discharged and commented pharmacy was a potential area for a joint NED/Governor visit to understand the reasons. It was noted the rollout of electronic prescribing, its benefits and these should have addressed any delays. The Interim CNMO explained this was not necessarily a pharmacy issue and might be connected to the discharge plan and expectation of patients who had been informed they were being discharged and that it took time to put discharge plans in place.

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

The CE on behalf of the COO reported:

- Options being revisited to address and expedite treatment of longest patients waiting for otology surgery, waiting longer than 78 weeks;
- There would be additional pressure in QEQM ED over the next couple of weeks due to building works. All that could be done would be to elevate the impact on patients and staff, with provision of additional resources;
- Trust continued to work in partnership with system partners to reduce the high number of NFTR patients, developing an East Kent (HCP) UEC Plan, and provision in the community enabling patients to be discharged. As well as a focus on discharge management processes;
- Cancer 62 day performance dipped in April due to complex challenges of reduced capacity due to the industrial action and bank holidays. Trust remained in the top 3 performers nationally for 2 week wait access.

The NEDs commented on theatre utilisation and following a visit nursing staff had raised there were no scheduled theatre lists for an afternoon, and the importance of

focussed review of the metrics and theatre session opportunity to ensure these were effective as they could be.

Staff Engagement: Staff Involvement Score

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

- Continued subtly improvement of the overall staff engagement score in April to 6.20 from 6.17 the previous month, work in progress continuing to further improve this score with staff identifying their key challenges and working to 'change three things'.

Financial Position (Income and Expenditure Margin) and Month 1 Finance Report

The Interim CFO highlighted key points:

- Target to reduce premium pay spend by 10%/£8.7m in 2022/23 had not been achieved, the total spend was £104m and £26m above target. Much more detailed focussed work was needed by Care Groups with HR support on the drivers and to reduce use of bank and agency staff.

The NEDs commented the need to provide a breakdown on the planned projection to reduce premium pay, how this would be done and when, with scenarios on the actions to support this.

ACTION: Provide a breakdown on the planned projection to reduce premium pay, how this would be done and when, with scenarios on the actions to support this. — CPO/ Interim CFO

Carbon Footprint (CO2e)
Recruitment to Clinical Trials

The EDSDP highlighted key points:

- February position reported 7.40 CO2e, below the monthly trajectory of 8.17;
- 2023/24 target refreshed reflecting the switch in focus to more interventional studies.

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

- True North and Breakthrough Objectives of the Trust;
- Month 1 financial report, financial performance and actions being taken to address issues of concern.

23/047.1 **INTEGRATED IMPROVEMENT PLAN (IIP) UPDATE**

The EDSDP reported:

- Good progress with green shoots beginning to be seen on delivery of IIP;
- Future reports would show progress as a dashboard against key milestones and Key Performance Indicators (KPIs)/metrics against the six programmes;
- IPR would reflect the IIP dashboard going forward;
- Bid had been submitted to the National ISCS team for funding support, total of £1.5m, and awaiting confirmation of whether had been successful in being allocated funding;
- Strategic Improvement Committee (SIC) meetings in place, chaired by the CE, providing Executive oversight of delivery.

NHSE's Improvement Director highlighted key points:

- Important that metrics demonstrated outcomes, impact and the difference made for patients and staff;
- Encouraged by the progress achieved to date and was confident plan would be delivered;
- Next meeting with the centre was to be held the week commencing 5 June.

The Chairman commented it would be beneficial for the EDSDP to have individual discussions with the Board Committee NED Chairs on progress and dashboard reporting and whether this provided the assurance required.

The Chairman raised the organisational restructure and the risk of whether this would impact delivery of the IIP. The CE commented there was a risk, acknowledging Care Group staff anxiety for those impacted by the restructure (due for completion mid-August), emphasising the new structure was needed to take the Trust forward and ensure it achieved what it needed to. The CPO stated staff response to the restructure had been positive and encouraging that the changes needed be embraced.

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

23/048 **HEALTH AND SAFETY (H&S) AND STATUTORY COMPLIANCE UPDATE**

The MD for 2gether highlighted key points:

- Estate statutory compliance assurance level currently at c91.4%, a c3.4% improvement in quarter, with continued work to achieve c95% as soon as practicably possible and by September 2023 at the latest;
- Where there was a need for new fire doors, these were on order awaiting delivery;
- Continued focus around management of the risks to ensure safe environment and service delivery.

The NEDs commented on the specific responsibilities of 2gether in respect of fire safety and that of the Care Groups and whether there would be any impact on this with the implementation of the organisational restructure. It was noted H&S representatives within Care Groups that would remain in the new structure to monitor and raise any H&S/fire safety issues. The 2gether NED In-Common commented on the need to clearly identify and set out the responsibilities of 2gether and the Trust, in respect of the estate, H&S, fire safety and risks, noting the ideal opportunity for this to be done following implementation of the new organisational structure.

The NEDs raised concern about late reporting of some incidents noted in the report. 2gether's MD provided reassurance that there had been no breaches and the Safety team were working supporting teams to improve their reporting timescales, as well as awareness and training of the importance of prompt reporting.

The Board of Directors discuss and **NOTED** the Trust's current position in relation to H&S, statutory compliance, and in respect to the prevailing risks.

23/049 **WE CARE PROGRESS UPDATE - 2023**

The CPO reported:

- We Care had shown a positive impact on staff engagement (SE) levels, with a higher level in We Care areas (6.50) against (6.32) in non-We Care areas, maternity representing an outlier with more work needed to investigate and understand the reasons for this;
- Vital source of feedback and information on where improvements were needed, staff exit interviews would support the Trust on its continued improvement journey;
- Disappointing resulting impact on staff involvement and scores marginally lower (6.41) in We Care areas against (6.44) in non-We Care areas, the need to look at this, identify and understand the reasons and what was needed to improve the scores;
- We Care had made a difference and it was important to ensure improvements were sustained that required continued effort engaging and involving staff.

The Chairman asked the EDSDP's view and reflection of the impact of We Care being reasonably new to the organisation and having previous experience of this programme. The EDSDP stated quality improvement was one of the tools within the We Care programme and highlighted this needed to be from Board to Ward, sustained improvements, and that this programme had been framed around the Trust's IIP and Pillars of Change, pulling together all the Trust's improvement programmes to monitor progress and that there was continuous improvement.

The NEDs highlighted the Trust remained well below its targets and enquired whether the leadership were walking the floor, talking to staff, asking staff whether they felt valued, as it was important for staff to see the leadership and Executive Directors. It was noted feedback from some staff at the joint NED/Governor visits was that they had not seen Executive Directors. The CE reported visits by Executive Directors across the sites and departments had been variable, which had been discussed by the Executive Team, and whether this could be incorporated on a Wednesday when they regularly met, a revised schedule would be produced to ensure these visits were in place. The Chairman noted as part of NEDs objectives this included individuals getting out and about visiting sites and departments across the organisation. He commented on the positive feedback raised by maternity staff about the visibility of the new DoM and Deputy DoM since joining the Trust. It was highlighted that non-clinical areas needed to be included in the visits, e.g. corporate and support areas.

The Board of Directors **NOTED** the We Care progress update report and the recommendations that:

- a post-implementation review of We Care was undertaken to appraise both strengths of the programme and to identify any potential areas for improvement;
- this take place across each of the waves as the evidence appeared to indicate differences in outcome over time, using a cross-section of roles to more fully understand the impact;
- the findings of this review were provided alongside repeat analysis against staff engagement outcomes following the 2023 National Staff Survey.

23/050 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/051 **QUESTIONS FROM THE PUBLIC**

Mrs Warburton raised supernumerary had not been achieved in maternity services.

The DoM reported supernumerary had been met over the last couple of months.

Mr Rylands raised duty of candour and duty of disclosure and whether the Trust could produce a document defining the differences between these. The Interim CNMO agreed to pick this up with Mr Rylands outside the meeting to understand the reasons for the question and discuss the definitions.

Mr Rylands highlighted the vast amount of maternity services metrics measuring the services and performance, and whether these were useful and making a difference to outcomes, noting its impact in taking staff away from carrying out their day to day work. He raised the use of language at these meetings and that this be understood by the general public, and enquired about the use of triangulation and what this meant. The DoM reported there was a minimum maternity dashboard reporting requirement that reported into the Maternity and Neonatal Assurance Group (MNAG). The CE acknowledged the need to use appropriate understandable language in these meetings and explained triangulation was around reviewing different sources of information and data, and interpretation of this around whether it showed what was expected and was correct.

Mr Rylands stated he had visited WHH that week around 9.00 pm, the restaurant was not open to be able to purchase food and that the vending machines had inappropriate choices for a hospital, e.g. chocolate, high energy drinks. He raised the need for patients, visitors and staff to have more substantial and healthy food available. The CE accepted this and agreed there needed to be access and provision of healthy food and drinks across the hospital sites, and would pick this up with 2gether's MD.

ACTION: Liaise with 2gether's MD about the need for the provision of healthy food and drinks across the hospital sites for patients, visitors and staff during out of hours. — CE

Mrs Bonney raised the poor rate of appraisals, enquired how many had been completed within maternity services, highlighted these were vital engaging and empowering staff who had fantastic ideas to put forward that required minimal costs to put in place. She also emphasised the need for Executive Directors and the next tier of the leadership to undertake walkabouts, as well as the visibility of the HR Team in talking, listening and supporting staff and the leadership. The CE reported the current appraisal performance of 63.2% as detailed in the meeting papers. The Chairman highlighted the low appraisal performance rate overall across all areas and asked what action was being taken to increase theses rates. The CE acknowledged the benefits from leadership walking the floor across all the hospital sites, including Board members, wider and middle management leadership, engaging and listening to staff to understand how it felt working for the organisation, and enabling the escalation of issues. She recognised this was not working as it should currently, noting the organisational restructure that would support improved engagement and involvement. A team briefing process was in place attended by Managers who briefed their teams encouraging staff input and involvement aimed at building a stronger sense of belonging.

Mrs Bonney raised concern about the issues identified by the CQC, in respect of the estate, H&S, hygiene, misleading signage, and doors propped open, noting some of these were basic safety elements and straight forward to address, and that patient and staff safety were paramount. She highlighted it was important to develop and put plans in place to address these issues quickly. The Chairman reported immediate issues raised by the CQC had been addressed, noting the constraints with the estate, the need for significant capital investment allocation to the Trust and that it had been unsuccessful in its bid against the 8 new hospitals programme. He commented this was an opportunity to work with clinical

colleagues and staff to re-design clinical services, identify priorities, review and modernise the de-minimis, and develop the Trust's long term strategy as there was much more work to be done to ensure the future sustainability of services.

The Chairman closed the meeting at 5.00 pm.

Date of next meeting in public: Thursday 6 July 2023

Signature ______________________________

Date ______________________________

REPORT TO BOARD OF DIRECTORS

Report title: **Matters Arising from the Minutes on 1 June 2023**

Meeting date: **6 July 2023**

Board sponsor: **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 three actions recommended for closure.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	None
Link to the Corporate Risk Register (CRR):	None
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 1 JUNE 2023

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	~~Feb-23~~/ Oct-23	Integrated Audit and Governance Committee (IAGC) Chair/ Group Company Secretary	Open	Amended IAGC ToR being circulated for virtual approval, with formal ratification at its next meeting in January 2023 and presented to the February 2023 Board meeting for approval, as part of the IAGC Chair Assurance Report. The ToR will be re-reviewed as part of the annual effectiveness review of the IAGC, when the IAGC will receive the outcome of the Board Committee annual effectiveness reviews.
B/23/22	Present a progress update briefing to a future Board meeting on progress and the position of the diabetes work and the system working around this area.	~~Jun-23~~/ Jul-23	Chief Medical Officer (CMO)	To Close	CMO's Report presented to 06.07.23 Board meeting providing an update on progress and the position of diabetes work (provided as an appendix to Matters Arising Report). **Action for agreement for closure at 06.07.23 Board meeting.**
B/01/23	Present report at the June meeting on the transformation work, covering the ED phased building works, evaluating the success of the changes in ED, the impact of the building works, management of	~~Jun-23~~/ Jul-23	Chief Operating Officer (COO)	Open	Report presented to 06.07.23 Board meeting. **Action for agreement for closure at 06.07.23 Board meeting.**

	patient flow, rapid assessment areas with reduced bed numbers, patient pathway (alternative pathways) and managing demand.				
B/02/23	Check and confirm the number of women that took the decision and went elsewhere to other NHS organisations to access maternity services and not East Kent Hospitals (their local NHS Trust). Include this information in the next Board report.	~~Jun-23~~/ Jul-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 06.07.23 Board meeting.
B/03/23	Review and reassess the current BAF, its contents and the risks, assessing the risks against achievement of the strategic annual objectives and the IIP over the next 12 month period.	Sep-23	Chief Executive/ Executive Team	Open	Item for future Board meeting.
B/04/23	Present a report to the Board in November 2023 (12 months following the publication of the Kirkup report) providing a review and evaluation of the changes and improvements implemented, the impact and outcome of these on women, the service and its staff, along with feedback from staff about how they felt working in maternity services and what had changed and whether had made a real difference for them.	Nov-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.
B/05/23	Check and confirm the number of staff (percentage of	Jun-23	Chief People Officer (CPO)	Open	Currently the care group overall has a completion rate of 62.2%, which is broken down to:

	staff) in maternity services that had received appraisals.				- Gynaecology – 88.6% - Maternity – 60% o WHH – 29.1% o QEQM – 78.6% o Community – 70.7% o Midwifery Management – 55.9% - Ob's & Gynae (Admin) – 50% - Women's Health Management – 42.9% o Governance – 30.8% There are 120 Nursing and Midwifery appraisals outstanding with a plan in place to complete these which is being supported by the HR Business Partner. Specialist midwives are supporting the appraisals at the WHH with some delegation to the band 7's on the units. **Action for agreement for closure at 06.07.23 Board meeting.**
B/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.	Feb-24	Chief Operating Officer (COO)	Open	Item for future Board meeting.
B/07/23	Present the revised de-minimis report following its review for Board to have a discussion about the current position of the Trust's infrastructure, the mitigations, and what could be done in the short-term, medium-term, and long-term to ensure sustained future provision of services.	Sep-23	Chief Strategy & Partnerships Officer (CSPO)	Open	Item for future Board meeting.
B/08/23	Consider when reviewing the Oversight Group later in the year extending invitation to some patient and family representative members to present at a future Board on their experience of this	Nov-23	Chief Strategy & Partnerships Officer (CSPO)	Open	Item for future Board meeting.

	Group and the progress that had been made.				
B/09/23	Look at including in future reports an additional column in the pillars of change update appendix providing a brief overview of the result of the actions detailing 'the what, impact and outcomes from these'. Consider and look at using Blue, Red, Amber and Green (BRAG) status definitions rather than RAG currently used.	Jul-23	Chief Strategy & Partnerships Officer (CSPO)	Open	Work in progress and will report at the September 2023 Board meeting.
B/10/23	Look at incorporating the national maternity dashboard within the Trust's maternity dashboard for comparison against performance.	Jul-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 06.07.23 Board meeting.
B/11/23	Include in future reports updates on staff learning and training identified from SIs.	Jul-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 06.07.23 Board meeting.
B/12/23	Provide in the report presented to the September 2023 Board meeting an update following the review of feedback from staff exit interviews and the reasons for staff turnover, particularly the reasons for the higher turnover rate at WHH.	Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.
B/13/23	Provide an update in the next report presented following discussion with the Patient Voice and Involvement team	Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.

	and wider CNMO teams about the triangulation of patients, families and communities feedback across the Trust, FFT responses, as well as complaints. This was around ensuring identification of any themes, what changes and improvement action was needed to address issues raised and that action was taken on the feedback received. Consider looking at producing a deep dive report on any themes identified.				
B/14/23	Include section in the next report presented on feedback of the PLACE audits as well as any themes identified from complaints.	Sep-23	Interim Chief Nursing and Midwifery Officer (CNMO)	Open	Item for future Board meeting.
B/15/23	Provide a breakdown on the planned projection to reduce premium pay, how this would be done and when, with scenarios on the actions to support this.	Jul-23	Chief People Officer (CPO)/Interim Chief Finance Officer (CFO)	Open	Verbal update to be provided at 06.07.23 Board meeting.
B/16/23	Liaise with 2gether's MD about the need for the provision of healthy food and drinks across the hospital sites for patients, visitors and staff during out of hours.	Jul-23	Chief Executive	Open	Verbal update to be provided at 06.07.23 Board meeting.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising – Chief Medical Officer's Report**

Meeting date: **6 July 2023**

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

Paper Author: **CMO**

Appendices:

NONE

Executive summary:

Action required:	**Information**
Purpose of the Report:	The purpose of this report is to provide a brief update to Board on progress and the position of the diabetes work and the system working around this area.
Summary of key issues:	Diabetes was chosen as a quality priority for the East Kent Health and Care Partnership (HaCP). The East Kent HaCP team are leading the east Kent place-based diabetes work and this reports through their governance structures. There is good engagement from our East Kent Hospitals multi-professional diabetes clinical team. Outline of the key work is provided below: • The East Kent Diabetes Group also now includes voluntary sector colleagues. This is particularly important to ensure that all parties involved in patient care are aware of the range of services that patients can be signposted to. • The Community diabetes model is now live in Herne Bay, Ramsgate and The Marsh Primary Care Networks (PCNs). Work is continuing with the remaining PCNs to have the model in operation across east Kent. • Two diabetes practitioners are now working in east Kent to support practices with the management of their diabetic patients. This includes ensuring that they are engaged with the community hub programme, identifying training needs and supporting them to identify their potential diabetic ketoacidosis (DKA) admissions. • Combined retinal (for diabetic eye disease) and foot health checks are to be rolled out in Ashford. The aim is to then extend this across the rest of East Kent where possible. • An event was held in May to support Insulin Awareness week.

	• Education sessions have been taking place with mental health practitioners in the PCNs to support the input for diabetic patients. Footcare sessions are being planned to be incorporated into the education programme. • The Thanet area has the highest number of amputations and as a result, Diabetes UK are starting some work with the Thanet GP practices to identify what additional support they can offer to primary care.
Key recommendations:	The Board of Directors is asked to **NOTE** the work at place led by the HaCP to support diabetic patients across east Kent place.

Implications:

Links to 'We Care' Strategic Objectives:	• **Our patients** • **Our future** • **Our quality and safety**
Link to the Board Assurance Framework (BAF):	No
Link to the Corporate Risk Register (CRR):	No
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chairman's Report**

Meeting date: **6 July 2023**

Board sponsor: **Chairman**

Paper Author: **Chairman**

Appendices:

Appendix 1: Non-Executive Director Commitments

Executive summary:

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

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	N/A

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

Assurance route:

Previously considered by: N/A

CHAIRMAN'S REPORT

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1. Purpose of the report

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

2. Introduction

The Trust continues in these summer months to operate under considerable pressure with patients waiting too long to be treated and too many being treated in far from ideal conditions. Improving that patient experience must be a key priority in the months ahead.

Following their inspections of our maternity units, Emergency Departments, medical and children's services, the Care Quality Commission has in the week leading up to this Board, undertaken a Well Led inspection of the Trust. We had some notice of this although that has meant senior management time has been taken up in preparation. We are only too well aware that we are in transition with a relatively new set of non-executives and a still emerging executive team. Nevertheless, as with the other inspections, we must learn any lessons they identify and benefit from this external scrutiny.

Following a meeting last month with the national and regional teams at NHS England, and representatives from NHS Kent and Medway on our Integrated Improvement Plan, we are all clear that this financial year has to be one where we see tangible and measurable improvements in some key areas. These are not matters for The Trust alone, but there are a set of objectives we must commit to and deliver. The whole Board also recognises that some of the challenges we face will take longer than this financial year to solve – cultural change for example will take time, as will tackling our large underlying deficit.

However, it is now imperative that we start to demonstrate improvements to the metrics in areas with long standing performance issues. In addition to getting a grip on the financial position, the lack of appropriate patient flow through our hospitals remains a critical issue. Too many patents are having to stay too long in our care and we need to unlock this as it affects both the quality and the cost of that care.

I realise my reports often reflect the challenges we face but I also want to underline the great work that is going on in departments across the Trust. Last week I visited Buckland where the new Community Diagnostic Centre delivered tests to nearly 50,000 patients since it opened in January last year, with many coming from the most deprived communities. Patients waiting more than 6 weeks for a CT scan at the centre has gone down from more than 1000 to just 37 in the year up to March. I believe this shows what we can do with the right resources and the right approach.

In August the Board will be looking at how we take forward our longer-term strategy and how we involve everyone in shaping our vision and practical plan for our future. As with the immediate goals for this year, it will be vital that we all know what each of can contribute to deliver a successful result.

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

The East Kent Health and Care Partnership has continued to work on the delegation of key responsibilities from NHS Kent & Medway (the Integrated Care Board).

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

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

The next meeting for the Partnership will take place in early August.

4. Council of Governors (CoG)

The Council of Governors continues to build on the recent work to engage with our members, and deliver on our membership engagement strategy.

Governors have now volunteered to attend as observers to the main Board Committees and this will start to take place from September onwards. I hope this will provide additional routes for Governors to engage with the formal board governance, and effective information sharing with The Council.

I am pleased to say that Council has also ratified the Governor statement within the Quality Accounts.

Earlier this month, the Governors attended a meeting with Tracey and myself to discuss the CQC report on Maternity. Following this meeting, it was agreed that the Governors would be invited to visit the Maternity units at WHH and at QEQM. I know the staff will be pleased to welcome the Governors, and I know we will continue to build on the many site visits which the Non-Executives and Governors take as part of their regular duties.

I will report to Council this month on the end of year reviews for the Chief executive and non-executive members of the Board and the senior independent director will report on my performance. The importance of appraisals and feedback .at all levels of the organisation cannot be overstated.

The next public Council of Governors meeting will be at the Buckland Hospital Dover on 13 July.

5. Visits/Meetings/Talks

In addition to routine internal and external meetings:

- Addressed Trust welcome day for new starters in Canterbury
- Meeting with NHS Trust Chairs across Kent and Medway Integrated Care Board (ICB)
- Meeting with NHS England, and Kent and Medway ICB on the Trust's Recovery Support Programme (RSP)
- Meetings with individual Governors

- Meeting with all Governors
- Meetings with individual NEDs
- Meeting with all NEDs
- Meetings with Executive Directors
- Meetings with the Chief Executive (CEO)
- Visited clinical staff and toured facilities in:
    - X-Ray services at Royal Victoria Hospital (RVH)
    - Community Diagnostic Centre at Buckland Hospital
    - Children's Assessment Unit at Buckland Hospital
- Meeting with Kent and Medway Integrated Care Partnership (ICP)
- Meetings with staff from East Kent Health and Care Partnership (HCP)
- Meeting with East Kent Integrated Care Board (ICB) Chair
- Meeting with 2gether Support Solutions (2gether) Chair
- Meeting with Spencer Private Hospitals (SPH) Chair
- Addressed staff at the Trust Clinical Audit Symposium
- Addressed members of the public & staff from the University of Kent for ARC KSS, Research Week.
- Addressed staff & members of the public at the opening of the new Children's Emergency Department at William Harvey Hospital (WHH)

Non-Executive Directors' (NEDs) Commitments

NEDs June 2023 commitments have included:

Non-Executive Directors	Meetings with Chairman Extra-ordinary Closed Board of Directors (BoD) meeting Finance and Performance Committee (FPC) meeting Quality and Safety Committee (Q&SC) meeting People and Culture Committee (P&CC) meeting Charitable Funds Committee (CFC) meeting Extra-ordinary Integrated Audit and Governance Committee (IAGC) meeting Clinical Ethics Committee (CEC) meeting Reading the Signals Oversight Group meeting Maternity and Neonatal Assurance Group (MNAG) meeting 2gether Support Solutions (2gether) Board Meeting Meeting with 2gether's Non-Executive Director Audit Chair

REPORT TO BOARD OF DIRECTORS

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

Meeting date: **6 July 2023**

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 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.
Resource:	N

Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

CHIEF EXECUTIVE'S REPORT

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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)

Following confirmation of Commissioner funding for the Cardiac MRI service in 2023/24, the CEMG approved the Cardiac MRI Business Case to implement an expansion of the Trust's service to a two day list at the One Ashford Hospital to deliver a sustainable service, to address the current backlog of patients waiting over 6 weeks and to repatriate patients from the Brompton to receive their scans locally.

4. Operations update

4.1 Urgent & Emergency Care Performance (UEC)

The Emergency Care Delivery Group continues to focus on delivery of the clinical models that support the underpinning principle; right patients, right place, first time.

Progress continues with the planned implementation of clinical models at the front door to the Queen Elizabeth the Queen Mother Hospital (QEQM) from June, reflecting the models in place at the William Harvey Hospital (WHH) (Medical Assessment Unit (MAU), Short-stay acute medical wards). There are further developments planned across the months of June and July: The WHH team will be commencing a joint pilot for the Paediatric Direct Access Pathways with Children's Group; work continues with the development for the WHH clinical model for an Emergency Department (ED) Clinical Decision Unit (CDU); whilst ED leads are working in partnership with Integrated Care Board (ICB) clinical leads to review the Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC) pathways.

In May the percentage of patients dwelling for a total time of 12 hours in the EDs was 10.7% v 10.6% in April and remains lower than the preceding 4 months. However, the total number of reportable 12-hour Trolley Waits in the ED increased from the previous month from 989 to 1,136.

With the noted improvements to the front door pathways and the schemes of work in place, the Trust has been able to improve the time spent in ED for those patients requiring same day emergency care (note a further improvement in month of the reported 4 hour standard to 71.5% for May, the highest reported compliance across the previous year). However, the flow of

patients out of the EDs to speciality wards and the number of available beds for admitted patients remains a constraint contributing to the higher number of 12-hour Trolley Waits.

4.2 SAFER Principles

The patient flow workstream, part of the Emergency Care Delivery Group, is launching a Trust wide roll-out of the national Senior Review, Assessment, Flow, Early discharge, Regular (SAFER) Bundle review commencing in June which will focus on planned discharge processes to improve Length of Stay (LoS), timely discharge and aims to show a positive impact on timely access to beds from the front door, with the outcome of reduced waiting times in ED. The Trust has successfully employed additional resource to focus on discharge improvements with an emphasis on improving early discharges thus supporting early flow through the hospital.

4.3 Elective

Since April 2020 (the start of COVID-19 pandemic) the number of incomplete elective pathways has steadily been increasing as the Trust was unable to treat patients for a sustained period of time. From February 2023, however, the Trust reported a significant acceleration in the number of incomplete pathways, essentially meaning that the number of patients on the Trust's waiting list is increasing at a faster rate than anticipated.

Investigations have outlined that 75% of this growth is attributable to ten specialties with the main causes driven by a lower number of first outpatient appointments being completed and therefore slowing the number of clock-stops and, for some specialities, leading to an uplift in referrals greater than estimated numbers.

Each Care Group representing the ten key specialties are looking to flex their outpatient services, to extend the number of available clinics and to validate and review the source of the increased referrals to ensure patients that are referred to the services of the Trust are valid and that it is the correct pathway for the patient.

These pressures are impacting the Trust’s ability to reduce long waiting patients and additional daily oversight has been introduced to mitigate this position.

5. Finance Update

5.1 Financial performance and planning 2023/24

At the end of M2 (May) 2023 the Trust has a year to date (YTD) deficit of £19.7m against the planned year to date deficit of £17.8m. Key drivers of the YTD position include strike action (£0.4m), non-delivery of efficiency savings (£2.9m) and pay overspend including, increased levels of staffing utilisation and the associated high cost of agency premium.

Half-day sessions have been held with Care Groups and the Executive team to review their activity, workforce and income and expenditure movements from 2019/20 to date and to demonstrate the governance controls that are in place.

Significant work is on-going to develop robust efficiency plans based on five key themes for delivery in 2023/24 and beyond, which will be monitored through the monthly performance review meetings.

6. East Kent Transformation update (New Hospitals Programme)

The Trust's bid for £460 million of national NHS investment to fund vital long-term plans to transform our hospitals has not been successful.

This is very disappointing news as we bid for this much-needed funding to improve how we run our services and to invest in our buildings and new equipment.

A pre-consultation business case detailing two potential options for reconfiguring services to improve care was approved by NHS England and Improvement in 2021, however, much has changed since these options were developed and we now need to look again at how we organise our services to best meet our patients needs now and, in the future. In the meantime, we will continue to maximise every opportunity to secure funding, including investment to expand and refurbish our maternity units.

7. Antenatal Scanning

Over the last three weeks an issue has emerged relating to the obstetric scanning service which has resulted in delays for antenatal screening and anomaly scans. A significant amount of work has been undertaken to increase the available capacity in the obstetric scanning service and to understand the precise position with regards to the delays that have emerged. This work is ongoing and there is more to do to understand the totality of any delays. An update will be provided later in the agenda and again at the next Board of Directors meeting.

8. Well Led Review – 4 to 5 July 2023

The Care Quality Commission (CQC) will return to our hospitals on 4 – 5 July 2023 to complete a 'well led review', following their inspection in May of our urgent care, medical and children's services at QEQM and WHH.

An update on the immediate views on this review will be provided at the Board of Directors meeting on 6 July 2023.

9. Care Group Organisational Restructure

A Consultation process to implement a new Care Group Structure was launched on 17 April 2023 with operational, nursing and medical teams. This closed on 16 May 2023 since which time we have been working through feedback in order to confirm the final structure of six new Care Groups (two site and place-based Care Groups, one site-based Care Group and three Trust-wide Care Groups) which are roughly equitable in size.

To confirm, these Care Groups will be organised with an emphasis on pathway management predominately at either place-based care or care that operates across the Trust and for some services, the Kent & Medway sector. Each Care Group will be led by an accountable Managing

Director, supported by a senior leadership team and an appropriate leadership structure, including a Medical Director and Director of Nursing, or equivalent.

New roles within the structure have been advertised and the process of recruitment and selection has commenced. Appointments have been made to three of the Managing Director roles with the remaining three out to external recruitment. We are systematically meeting with individual staff in order to manage the process of internal redeployment and appointment to suitable roles within the new structure across all professional disciplines.

10. Industrial Action

10.1 Junior doctors' industrial action

The British Medical Association Junior Doctors' Committee (BMA JDC) has announced further dates for industrial action in the NHS. The five-day walkout will take place between 7am on Thursday 13 July and 7am on Tuesday 18 July.

The BMA JDC currently has a mandate to take industrial action which runs until 31 August and is now balloting its members in order to extend that mandate. The ballot went live on 19 June and closes on 31 August. If successful, this would provide the BMA JDC with a new mandate to continue industrial action until February 2024.

The BMA JDC continues to be resolute in its desire to see 'pay restoration' to match earnings from some years ago. The Government has been clear that this is not feasible although improvements to working conditions and terms of employment were considered prior to the last period of strike action.

10.2 Consultants' ballot outcome

The BMA has announced that 86 per cent of its consultant members that voted (a turnout of 71 per cent) have voted in favour of industrial action.

This means that the BMA plans to go ahead with the strike action and call a 48-hour strike from 7am on Thursday 20 July. The BMA has stated it will not proceed with the strike action if a 'credible' offer is received from the Government. This is the first time in ten years that the NHS has faced such action and there is likely to be a significant impact on patient care. The industrial action means consultants will provide 'Christmas Day' levels of cover. This should ensure that emergency care can continue to be provided, but will impact elective or non-emergency work.

Plans to manage our activity across the period of industrial action are being coordinated by Operational Planning, led by the Chief Operating Officer and senior colleagues across all Care Group and corporate functions in support.

10.3 Outcome of the Royal College of Nursing (RCN) ballot

The RCN also announced that it has not secured a national mandate for further industrial action in England. The RCN re-balloted its members following the decision to reject the Agenda for Change (AfC) pay offer made by the Government in March.

Of the RCN members that voted in this ballot, around 84 per cent voted in favour of further industrial action. However, the overall turnout for the ballot was 43 per cent of members eligible to vote, and it therefore did not meet the 50 per cent turnout threshold required to secure a mandate.

This re-ballot was carried out at a national level (unlike previous RCN ballots at an organisation level), and the RCN therefore does not have a mandate for further industrial action in any NHS organisation in England.

11. ED improvements at QEQM

As work to expand the EDs at the QEQM and WHH continues, I am pleased to report that as part of the latest phase, the ED team at QEQM treated their first patients in the new rapid assessment and treatment area, which includes 12 large treatment rooms, earlier this month. These new facilities alongside improvements to the models of care, will improve patients' experience and flow through the ED.

The final phase of the expansion of QEQM's ED is already underway and includes a large new resuscitation area and a new ambulance entrance which will both open later this year.

12. External Audit of Unlicensed Aseptic Preparation Service

The Trust have received the official findings of the external unlicensed preparation of medicines for the pharmacy aseptic unit at Kent and Canterbury Hospital (K&C) following a visit on 19 April 2023.

The unit's operation as a whole was assessed as posing a "MEDIUM risk" with respect to the quality of the medicines produced within it, with facilities in the 17-year-old unit in poor condition and with the design obsolete in spite of attempts to make good the fabric of the unit since 2018.

13. South East London Kent and Medway Major Trauma Network (SELKaM) Peer Review

Positive feedback has been received from the SELKaM following their peer review of the Trust's Trauma Unit at the WHH on 26 January 2023.

The initial outcome letter received on 22 June 2023, cites the professionalism and dedication of the Major Trauma Team and the Senior Management Team at the WHH, recognises the implementation of the accredited trauma nurse training programme and the Trauma Audit and Research Network (TARN) provision within the unit, as well as integration with community services, particularly in the area of rehabilitation and impressive near 100% rehab prescription complaint rates. The feedback from the panels visit in January provides no areas of concern, serious, immediate or otherwise and is a testament to the Team's commitment to delivering high-quality trauma care as part of the SELKaM network.

14. Conclusion

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

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

Committee: People and Culture Committee (P&CC)

Meeting date: 30 June 2023

Chair: Stewart Baird, Non-Executive Director

Paper Author: Interim Group Company Secretary

Quorate: Yes

Appendices:

None

Declarations of interest made:

No

Assurances received at the Committee meeting:

Agenda item	Summary
May 2023 Integrated Performance Report (IPR) 'We Care' and 'True North' Objectives	Significant key points for the Board to **note:** • **ASSURED: Sickness** The staff sickness rate is 4.3% which is stable and below the threshold. It is also the lowest point in two years. A further positive was that stress, anxiety and wider mental health instances represent a very small portion of overall sickness. • **ASSURED: Staff Turnover** Overall staff turnover stands at 9.7% which is below the threshold and falling. Generally, turnover shows an improving position (although there was a spike in May with 18 nurses leaving but HR have advised that this was not a material underlying issue). Nursing staff turnover was 8.7%. Healthcare Assistant (HCA) turnover is below the threshold and the Trust has been removed from the Healthcare Support Worker (HCSW) Support Programme in recognition of the improvement. Medical staff turnover was not reported and the Committee has requested data on this metric in future reports. • **ASSURED: Vacancy Rate** At 8.2%, the vacancy rate is below the threshold and improving. • **ASSURED: Statutory & Mandatory Training** Small improvements have been evidenced which are above the threshold.

<table>
<tr><td></td><td>The Committee did review individual Care Group performance, but will continue to monitor ‘hot spots’ across the Trust.

• NOT ASSURED: Staff Engagement and Staff Involvement – No material improvements.
Generally, the P&C Team are conducting a review of the national and local position of the Trust to ensure we are measuring performance correctly.
It was suggested that in several areas, the Trust is showing marked improvement and better than national trends. The Committee asked to review this analysis before commenting.

The Committee noted that the ‘Culture & Leadership Programme (CLP)’ will map out the full cultural improvement plan, to include measures to assess staff engagement. Outputs will be shared regularly with the Board.

• NOT ASSURED: Premium Pay
This metric is owned by the Finance & Performance Committee (FPC) but it was noted that premium pay spend increased again in May which is at odds with activity levels. It was suggested that this may be a timing or ‘cost recognition’ issue (referred to the FPC Committee).

• NOT ASSURED: Appraisals
Staff appraisals fell further to 67.4% and have consistently fallen below the threshold. A credible recovery plan is required and the issue has now been escalated as a risk (to be included on the Corporate Risk Register and referred to the Integrated Audit and Governance Committee (IAGC)). It was acknowledged that the Executive are addressing the matter as a priority and data is being reviewed as more appraisals may have been carried out but have not been properly recorded.</td></tr>
<tr><td>Vacancy and Recruitment Update – Pipeline Against Establishment – To Include Medical Vacancies Review</td><td>The Committee was ASSURED in respect of the Vacancy and Recruitment Update. Overall staff turnover and vacancies were below the threshold and improving. Particular points to note:
• 407 Internationally Educated Nurse (IEN) colleagues had been recruited in 2022, with a further 70 staff being recruited between January and March 2023;
• the Trust had received funding for an additional 150 IEN colleagues, April to December, and around 55 had already been recruited;
• the Nursing Executive Team felt they were reaching required nurse staffing levels for general wards and had requested that the recruitment effort be slowed down;
• to address nursing vacancies in speciality areas (such as Emergency Department (ED), Intensive Therapy Unit (ITU) and Paediatrics) the recruitment effort remained in full flow;
• a detailed review of Maternity staffing would be carried out, a verbal update being provided at the July Board meeting.</td></tr>
</table>

Chief Nursing and Midwifery Officer (CNMO) Quarterly Nursing and Allied Health Professions (AHP) Workforce Update	The Committee was **ASSURED** in respect of Chief Nursing and Midwifery Officer (CNMO) Quarterly Nursing and Allied Health Professions (AHP) Update. Generally, recruitment, training and workforce plans were progressing well. Key points to note: • the Pastoral Team had been awarded a Gold Award from NHS England (NHSE) for their work supporting our IENs; • 40 Matrons had been through the Matron Development Plan (which is one part of the larger cultural development programme); • residential accommodation remains a significant challenge for new nursing colleagues joining the Trust (to be discussed at the August meeting of the Committee); • some challenges highlighted in deploying new Nursing and HCA colleagues into wards – generally this is due ward staff being removed to nurse escalation areas and hence struggling to train new colleagues. The Executive Team were seeing some improvements and continue to work on a ward-by-ward basis to address these issues.
Tribunal Activity Report	The Committee was **ASSURED** by the Tribunal Activity Report, having reviewed a range of actual and potential employment tribunal activity. It was noted that the Trust was not an outlier in terms of the number of tribunal cases.
Board Assurance Framework (BAF) and Principal Mitigated People and Culture Risks (CRR)	The Committee was **ASSURED** in respect of the BAF and Corporate Risk Register (CRR) risks. Key highlights: • **BAF 40** - Risk of failure to address equality, lack of diversity and injustice - rating changed from **significant to moderate**, reflecting the work now in place with the Equality, Diversity and Inclusion (EDI) team and NHSE's 'gold' rating of our EDI Strategy. • **BAF 35** - Risk to recruit and retain high calibre staff – rating reduced from **catastrophic to significant**, reflecting the significant work undertaken to increase headcount and improve staff retention. • **CRR 118** - address poor organisational structure – rating reduced from **16 to 12** – reflecting the new structure being implemented. • **CRR 88** - risk of failing to support staff wellbeing – rating reduced from **16 to 9** - reflecting the lowering sickness and turnover. • **CRR 115** - sufficient nursing – rating reduced from **20 to 16,** reflecting the significant recruitment work undertaken. • **CRR 122** - sufficient midwifery staff – reduced from **20 to 16** (pending further review). • **New Risk** – Appraisals now escalated to the CRR as referred to above.
Statutory and Mandatory Training Report	• The Committee was **PARTIALLY ASSURED** by the Statutory and Mandatory Training Report.

Residential Accommodation	The Committee as **PARTIALLY ASSURED** in respect of Residential Accommodation challenges with a detailed report being considered at the August meeting of the Committee. It was noted that all Internationally-Educated Nurses now had an interim accommodation solution.
'Hot Items'	The Committee discussed a number of tactical challenges facing the Trust and was **ASSURED** in respect of: • **Organisational Restructure** – likely to be completed by August 2023 with several of the new senior roles recruited already; • **Industrial Action** – to understand the likely action and the Trust's response; • **National Long-term Workforce Plan** – this was issued by the Government last week and will be reviewed and reported back to the Committee at a future date • **Care Quality Commission (CQC) Well-Led inspection** - work and response in play.

Other Items of Business

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

Item	Purpose	Date
Premium Pay	FPC to monitor the position	TBC
Appraisals	IAGC consider inclusion on CRR	TBC
The Committee asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	6 July 2023

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)				
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**
Quality and Safety Committee (Q&SC)	27 June 2023	Dr Andrew Catto, Non-Executive Director (NED)	Interim Group Company Secretary	**Yes**
Appendices:	None			
Declarations of Interest made:				
No declaration of interest was made outside the current Board Register of Interest.				
In attendance: Moira Durbridge, NHS England (NHSE) Improvement Director.				
Assurances received at the Committee meeting:				
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	**Partial assurance** was received by the Committee of the True North metrics and Breakthrough Objectives for May 2023. The Committee noted the content of the report and raised the following points: – The Trust Hospital Standardised Mortality Ratio (HSMR) is below threshold target for the Kent & Canterbury Hospital (K&CH) and Queen Elizabeth the Queen Mother Hospital (QEQM) sites with William Harvey Hospital (WHH) "as expected". – The Committee sought clarity about the increase in mortality rate since November 2022 and expressed concern that if this trend continued, the Trust would be above the threshold. The Chief Medical Officer (CMO) explained that the Trust's position was not shifting significantly and the Trust was not an outlier. – There were 36 patient safety incidents of moderate and above avoidable harm in May 2023, which is a slight increase from April 2023 and remains above the threshold. The highest contributor in May 2023 were operations/procedures (11 incidents). – The Committee noted the proposed measures to address resuscitation training challenges. – The Deteriorating Patient Steering Group will be launched in July 2023. – The Committee expressed concern that the Trust did not appear to address learning from incidents and is not becoming a learning organisation but acknowledged that the implementation of Patient Safety Incident Response Framework (PSIRF) would help to achieve this. – Emergency Department (ED) 12h total time in the Department was 10.7% in May 2023 and remains lower than the preceding four months. – Cancer performance dipped again in May 2023 due to difficulties with endoscopy both for cancer and elective pathways. – The Chief Operating Officer (COO) highlighted the Urology pathway delays due to Consultant availability. – The Committee noted challenges in diagnostics vetting, booking and reporting. – Inpatient surveys show that patients still report that they have difficulty sleeping at night due to noise. The Committee sought clarity as to if this is the general or area specific picture.				

Infection Prevention and Control Report	The Committee received **partial assurance** of the current performance about nationally reportable infections noting the following: – Clostridioides difficile remains a significant challenge for the trust with the current number of cases considerably above the trajectory to achieve the external threshold. C-diff is the biggest focus area for the Antimicrobial Stewardship Group. – Currently cases of Klebsiella spp. bloodstream infections are over trajectory but this should be treated with caution at this early point in the reporting year. – Other reportable infections are within trajectory with the same caveat about the early stage of the reporting year. – The Committee requested that future reports provided more details on the patient impact of the reportable infections. – The Committee sought assurance that antimicrobial stewardship training with regards to C-diff was robust on the wards.
Care Quality Commission (CQC) Update Report	– The Committee received the assurance report on the activities of the Journey to Outstanding Care Programme Steering Group (JTOCPSG) on the 12 June 2023. – The Committee expressed significant concerns that there were outstanding CQC actions dating back to 2018. The Committee agreed that this would be questioned by the CQC during the Well Led inspection that the Trust would be undergoing on the 4 and 5 July 2023.
Corporate Principal Mitigated Quality Risks	– The Committee approved the changes and updates of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). – The Committee sought assurance that the revision of the CRR was on track and issues and risks would be separated. The Committee also queried if the assessment of acceptable risk would be made. The Interim Director of Quality Governance assured the Committee that the risks and issues were being separated and the risk appetite would be discussed at the Board Development Day on August 2023.
Patient Safety Committee (PSC) Chair's Report	The Committee noted the assurance report on the activities of the Patient Safety Committee on the 7 June 2023 with the following key points to note: – A report was presented to the PSC outlining Blood Culture Pathway Optimisation outlining actions and recommendations which will be addressed by the Deteriorating Patient workstream. Investment options must also be considered. – The Trust had no Central Alerting System (CAS) Alerts open externally. One re-opened alert remains incomplete internally related to connectivity of neuraxial devices (NRfit). The delay was caused by supply issues, as if the Trust switched to using NRfit there would be an insufficient supply to meet needs and a robust alternative was currently being explored. – A safe system for Consultants reviewing test results has been identified as a risk, as important results have been missed due to clinicians who requested tests subsequently leave the Trust. A working group was being established to agree mitigations to address the current risk to patients.

Fundamentals of Care (FoC) Chair's Report	The Committee noted the assurance report on the activities of the Fundamentals of Care Committee on the 16 May 2023. The Committee noted the following examples of good practice: – The work of Patient Voice and Involvement team – Healthwatch Kent feedback – Reduction in falls. – Launch of Dementia Strategy – Improvement in bowel care The Committee **sought assurance** that the Ward Accreditation Programme was still fit for purpose and sustainable. The Committee highlighted the need to identify if falls and other incidents happen more frequently to certain group of patients, i.e. of certain socio-economic backgrounds and protective characteristics, and include this information into future reports.
Mortality and Learning from Deaths	The CMO presented the report on the activities of the Mortality Steering and Surveillance Group on the 17 May 2023. The Committee was made aware of the concerns related to Richard Stevens Ward at WHH including the increase of incidents with harms and the number of Structure Judgement Reviews (SJRs) requested for patients who had died on Richard Stevens ward.
Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee received the assurance report on the activities of the Maternity and Neonatal Assurance Group on the 13 June 2023 and noted the following: – A safety concern in relation to Ultrasound Scan (USS) capacity was raised by the Director of Midwifery and a series of meetings to review the current process to ensure additional scan capacity ensued. Duty of Candour arranged for women who have delayed antenatal screening as a result of this. The Committee requested that a more detailed report on the USS issues for the next meeting and Board. – Six complaints were received in May 2023, which is a reduction from April 2023. – The rate of reportable neonatal and perinatal deaths remains lower than average. – There has been a significant rise in staff turnover at the WHH site. Sickness levels remain above the threshold of 5% with the rate being much higher at WHH at 10%.
Safeguarding Committee Assurance Report	The Committee noted the assurance report on the activities of the Safeguarding Assurance Committee on the 8 June 2023 and agreed that **significant assurance** was provided. The following was escalated to the Committee: – The Mental Health Governance Risk is currently on the Safeguarding Risk Register but needs to be mitigated through the Patient Safety Committee Risk Register. – Approved the RSM External Report and for this to be escalated to the Quality and Safety Committee and then the Trust Board.

	– The Safeguarding Committee noted the progress with Physical and Chemical Restraint thematic review and agreed that this should now be mitigated through the Patient Safety Committee. – Approved the Kent and Medway Safeguarding Adults Board (KMSAB) Annual Safeguarding Report was presented and would be shared with the Trust Board.
Clinical Audit and Effectiveness Committee (CAEC) – Chair's Report Theatre Utilisation Improvement Update	The Committee received and noted the content of the CAEC Chair's Report and agreed that the Audit Symposium held last week was an example of good practice.
Theatre Utilisation Improvement Update	The Committee noted that the purpose of this paper was to update on the current theatre metrics and the next steps for the Theatre Optimization Group. The Committee felt that the paper lacked insight and did not outline the improvement plan clearly. The Committee requested an update in September 2023.
Frequent Emergency Department re-attenders: Reasons and Progress Update	The COO presented the report and noted: – A manual audit of the Trust's re-attending patients found the reported numbers were being overstated. The audit has determined that this is primarily driven by inaccurate recording between IT systems but has also identified some pathways defaulting to an ED attendance. – By implementing changes to Patient Administration System (PAS), the Trust anticipates this will drive a reduction of nearly 4 percentage points to the reported numbers and bring the Trust under the national threshold target of 10%. – The development of a Trust-wide Standard Operating Procedure (SOP) outlining the required recording and management of reattenders will provide the relevant teams with the required instruction on how the Trust's reattending patients should be documented. Training materials will be developed alongside the SOP. – The various workstreams required to support the reattender improvements will be led by the Urgent and Emergency Care (UEC) Care Group with support from the COO Programme Manager.
Evaluation of clinical effectiveness and patient experience in Same Day Emergency Care (SDEC)	The Committee was made aware of the following: – Patient feedback is collected via a text link which then takes you to a patient feedback form. This forms part of the generic EKHUFT patient feedback. – Referrals to SDEC are often from primary care, and therefore the condition has been deemed to be not appropriate for primary care and are then sent to either SDEC or ED.

	– The Trust do not review the safety and outcomes of patients referred from SDEC back to primary care. However, there are methods in which patients and GPs can communicate with the Trust if they feel that they have had a poor experience and this is via the patient experience link that all patients who attend SDEC receive. – There have been no concerns raised with regards to patient experience in SDEC. – The Committee queried what data were being triangulated to ensure that the required outcomes are met.
Progress Report Against the Internal Audit of Antimicrobial Stewardship Arrangements	The Committee received and noted the content of the report and agreed to receive an update on hospital acquired infections in October 2023.
Safe Staffing Review Update	The Committee noted the **partial assurance** in the Safe Staffing Review with the following key points to note: – The additional escalation areas plus additional unfunded beds on most wards continues to put pressure on the current nursing establishment as well as the significant corridor care in our EDs has resulted in substantive nursing staff being moved to support. – A working group with the Care Groups, temporary staffing team and NHS Professionals has commenced to actively look at ways to reduce agency usage, this group is reporting into the Financial Improvement Oversight Group. – Predicted vacancy rate as of May 23 was 8.9%, this currently stands at 9.5%, 0.6% behind target. – Shift Authorisation SOP will be brought back to the Committee for authorisation as the finance team requested for a higher band of those who would be able to authorise shifts. – Business Case to expand the resuscitation team is being prepared. In the interim, funding received from Integrated Care Board (ICB) to outsource with ED and Paediatrics being a priority. This will allow resus team to focus on hospital life support. The Committee requested that more details are provided as to the risk associated with the resuscitation training capacity in the next month's report. – There were no falls with harm in May 2023.
All Age Safeguarding Sustainability Plan Update	– The Plan is used to evidence safeguarding work aligned to exit strategy from SOF4 to SOF3. – The paper provided the update on progress in the key areas such as leadership and management; safeguarding processes, multi-agency working, Mental Capacity Act, procurement and contracts.
Maternity Clinical Negligence Scheme for Trusts (CNST) Safety Actions	– The PRactical Obstetric Multi-Professional Training (PROMT) compliance is below 90% target but it is expected that the target will be met in Q3. – The Education team are currently in the process of reviewing the methodology of the facilitation of PROMPT across sites. It was noted that the model of training delivery at EKHUFT is different to

	many other Trusts in that all anaesthetists involved in Obstetrics must undertake PROMPT.
Human Tissue Authority (HTA)	– All findings from the previous HTA inspection from 2022 have been closed with the only outstanding action being roll out of the consent training for the Medical Examiners (MEs). – The next HTA inspection will be in July 2023. – Staffing challenges in mortuary are being successfully managed. – Security has been tightened as to who can gain access to mortuary. – Introduction of digital autopsy has been delayed further. – The Committee commended the report.
Any other business	– Never Events and Serious Incident (SI) reporting – Q&SC Chair and CMO to discuss offline – Committee effectiveness survey to be completed by members by 30 June 2023 for the Chair to use in his CQC Well Led interview. – Executive team to discuss and decide on the process for service closure when deemed unsafe.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

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

Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
Safeguarding training for the Board members to be held during the Board Development Day in August 2023	Assurance	6 July 2023
Risks associated with the resuscitation training capacity.	Assurance	6 July 2023
Never Events and SI reporting	Assurance	6 July 2023

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

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

Meeting date: **27 June 2023**

Chair: **Richard Oirschot, Non-Executive Director**

Paper Author: **Executive Assistant, Sarah Farrell**

Quorate: **Yes**

Appendices:

NONE

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
Cost Improvement Programme (CIP)	Significant points to note: • As at month 2, care groups have recognised £0.2m of CIP efficiencies against a plan of £3.1m. • Currently, approximately £11m of ideas has been identified (£9m in year effect), and with many of those being less than £250k, the Group will need to make some difficult decisions to make substantial progress toward the £40m target. • Care group recovery meetings are being arranged bi-weekly focusing on activity & productivity in week 1 and Finance and workforce in week 3 to drive through the efficiency ask. • In addition, the Trust has re-established its non-pay controls and is working on further controls to be implemented. The Committee discussed and **NOTED** the M2 Savings and Efficiencies Update and **LIMITED ASSURANCE** received of the Trust's progress of the programme against a £40m target.
Patients no longer fitting the criteria to reside	Significant points to note: • Recommendation for the Trust to move to report the nationally reported number for No Longer Fit To Reside (NLFTR) for those patients residing at midnight. • For business planning this would result in a revised target for the Trust's NLFTR of 119 vs the current 174 as a target number to improve flow. • The 'Improving discharge' workstream under the East Kent (EK) Health and Care Partnership Urgent and Emergency Care Plan is now several

	months into development with target dates set for all workstreams. Monitoring through the EK Urgent Care Delivery Group is in progress. • The Trust has successfully employed additional senior resource to focus on discharge improvements due to start on Monday 26 June. The Committee discussed and **APPROVED** the Patients No Longer Fitting the Criteria To Reside and agreed to the recommended revision to the reported NLFTR score.
Capital Plan	The Committee discussed and **NOTED** the Capital Plan and agreed to support the next proposed steps and any further steps to further mitigate risks, the following key points being highlighted: **Background** 1. National capital budgets ('Capital Departmental Expenditure Limit (CDEL')) are allocated to Integrated Care Boards (ICBs), who then delegate limits to Trusts. Annual allocations are not, currently, anticipated to grow significantly in future years. 2. Capital covers estates, medical equipment and digital. 3. Trusts can increase the available capital through a variety of avenues e.g. disposals or charitable donations. There are limited opportunities for EKHUFT in this area. 4. Additional capital 'pots' are allocated by Department of Health and Social Care (DHSC) and NHS England (NHSE) in year, usually ringfenced to specific schemes. 5. The core allocation to Kent and Medway ICB is low. EKHUFT's share for 2023/4 is a low £18.7m (operational capital). Additional sources (mainly ringfenced) bring the total available capital to £26.9m in 2023/24. 6. In June, the DHSC New Hospital Programme (NHP) notified the Trust that it has not been included in the latest tranche of hospital rebuilds despite poor estates condition. **Capital forecast** 1. In the coming year, the Trust will refresh its strategies. The forecast in this paper is based upon DE MINIMIS needs to keep services safe and mitigate risks. It does not allow for innovation, for example: • Revised clinical service strategy; • Revised estates strategy in light of the NHP decision; • Impacts of digital strategy refresh; • Any investment in medical equipment other than to replace current kit (e.g. to support clinical innovation); and • Reducing replacement lifecycle/ repair and renew lifespan. 2. The projected capital funding over the next five years is £130m. This represents a £140m funding gap, just to stand still, to cover today's known risks. It does not include the cost of any of the improvements or changes noted above. 3. The Trust submitted a balanced capital plan for 2023/24. This required omitting capital projects of £8.8m which are of very significant risk and

	have been escalated to the Kent and Medway ICB. In addition, further emerging pressures of £9.8m require mitigation in 2023/24. **Next steps** 1. Escalation of short-and medium-term capital shortfall via ICB to NHS England (NHSE), regional and national teams (June/July). 2. Revised management/ governance/ reporting process to better monitor and manage capital projects and risks – complete by July. 3. Refresh of capital forecast as Trust strategies agreed throughout 2023.
Month 2: • **Finance Report** • **Cash Position** • **Month 2 efficiencies**	Significant points to note: The Group has achieved £19.7m against plan of £17.8m which is a £1.9m deficit variance to plan. The Strike action in April is estimated to be c£0.4m this increase in spend is outside of the original £72m plan and will be reported monthly to the Board for any increase in costs for industrial action. The Trust submitted a third update of the financial plan on the 4 May of £72m deficit with Board approval. This has now been approved and in addition the ICB has confirmed that the 2023/24 plan is the first year of the required three-year plan to get to financial balance. Delivery of the 2023/24 financial plan looks extremely challenging and the Trust is looking at other ways to enable the financial plan to be delivered. The Committee discussed the phasing of the plan which is predicated on achieving £40m of efficiency savings over the year, there is a step change for the required delivery of c£3.9m per month (rising from £1.6m in months 1 & 2). The Committee was assured that the plan was not back loaded.
Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks	The Committee discussed and **APPROVED** the Board Assurance Framework and Corporate Risk Register. **Key Headlines**: • There are 3 BAF risks and 8 risks on the CRR relating to ‘Our Future’ and ‘Our Sustainability’. • Changes to the BAF during this reporting period: • **Reduction in risk rating (1) -** Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24. • **Changes to the CRR during this reporting period**: There are no new ‘Our Future’ and ‘Our Sustainability’ risks added. • **Other key changes**: Other changes to the risk records are included in the risk register summaries on Pages 5 - 13. • **Tracker report**: The tracker report is presented to the Committee on Pages 3-4 to enable the Committee to have oversight of risk movement over the past year.

We Care Integrated Performance Report (IPR) (M2): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee members discussed and noted the We Care Integrated Performance Report (IPR) with **partial assurance** received of the performance against key metrics for 2023/24 including the Breakthrough objectives: Improving theatre capacity, Actual utilisation, Elective Orthopaedic Centre (EOC) utilisation, Same Day Emergency Care admissions, Emergency Care Delivery Programme, Direct Access Pathways, Phase 3 William Harvey Hospital (WHH) Emergency Department (ED) build, Use of Hot Slots, Hot Clinics, Staff involvement, National Staff Survey, Team Engagement and Development (TED) pilot, We Care Rollout and Premium Pay Costs.
Contract Awards 1 - Infusion Pumps and Consumables 2 - Orthopaedic Prothesis	**1. Infusion Pumps and Consumables** The Committee discussed and **APPROVED** the **Infusion Pumps and Consumables contract award.** **2. Orthopaedic Prosthesis – Hips and Knees** The Committee discussed and **APPROVED** the **Orthopaedic Prosthesis – Hips and Knees contract award.**
Re-draft of new IPR Template for Committees – Verbal Update	The Committee discussed the re-draft of the new Integrated Performance Report (IPR) template. This will be represented to FPC in August.
Pay awards for 2gether Support Solutions	The Committee discussed at length and comments and points have been raised to the Board for onward discussion and consideration.
Back pay for Internationally Educated Nurses (IENs)	The Committee discussed and agreed that this would be taken forward to the Trust Board for further discussions before a final decision was taken understanding the potential quantum of cost pressure.
23/24 IEN Recruitment – Business case	The Committee discussed and agreed that given the revised numbers, an updated paper would be submitted to next month's FPC meeting, which would include details regarding the benefits of the recruitment, along with any cost pressures for the Trust.
Pathology Collaboration Agreement – Memorandum of Understanding (MOU)	The Committee discussed and **NOTED** the Pathology Collaboration Agreement – MOU and recommended this for approval by the Board.

Commissioning for Quality and Innovation Programme (CQUIN)	The Committee discussed and **NOTED** the Commissioning for Quality and Innovation Programme (CQUIN).
Next steps of the deep dive into Activity, Workforce and Income & Expenditure (I&E) from 2019/20 to present	The Committee discussed and **NOTED** the Next Steps of the Deep Dive into Activity, Workforce, and I&E from 2019/20 to present paper, arising out of the 8 half-day sessions Executives had with each of the clinical care groups. Corporate areas would similarly be reviewed with findings being presented to FPC. Discussions had covered increased establishments and associated cost bases, including a breakdown of approved business cases during the period. Each Care Group presented the cost pressures currently being faced and the plan for reducing or removing the cost pressure moving forward. It was acknowledged that there were three main areas which still sat outside of the Care Group baseline: increased levels of spend above 2021/22 outturn for all three elements, on escalation beds, 121 specialty nurses for mental health patients, and increased levels of supernumerary for Internationally Educated Nurses (IENs). Each care group were tasked with presenting 5 key themes for efficiency delivery which will be tracked and monitored via the care group Executive-led recovery meetings which are being established on a bi-weekly basis.
Strategic Investment Group (SIG)	The Committee received an assurance report on the activities of SIG on 20 April 2023.
Financial Improvement Oversight Group (FIOG)	The Committee received an assurance report on the activities of the FIOG on 16 May 2023.

Other items of business

Endoscopy Capital Bid – late agenda item

The Committee discussed and recommended to the Board to **APPROVE** the Endoscopy Capital Bid paper (to be submitted on 7 July), subject to clarification from the ICB concerning revenue cost support, and secondly clarification over power supply.

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 P&CC Chair Assurance Report; • **APPROVE** the Infusion Pumps and Consumables contract award**;** • **APPROVE** the Orthopaedic Prosthesis – Hips and Knees contract award**;** • **APPROVE** the Endoscopy Capital Bid. • **APPROVE** the Pathology Collaboration Agreement – MOU.	Assurance	6 July 2023

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

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

Meeting date: **20 June 2023**

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

Paper Author: **Committee Chair**

Quorate: **Yes**

Appendices:

APPENDIX 1: Charity expenditure plan proposal
APPENDIX 2: Charity strategy update

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	**Summary**
Financial controls	The Committee received ASSURANCE that there were effective controls over the Charity's financial income and expenditure. A report was presented to the Committee setting out the controls in place over the Charity's finances. The Charity adopts the same Standing Financial Instructions (SFIs) as the Trust. The recommendations highlighted by the Charity's auditors in their 2022 management letter had also been completed for the 2023 accounts preparation.
Audit tender	The Committee noted that the Charity's audit had been put out to tender, and this process was underway for the 2022/23 accounts. The Committee was assured that the process would be complete in time for the audit and filing of the Charity's March 2023 accounts.
Application for Grants	The Committee approved 2 grants: (1) £70k haemophilia counselling support Kent & Canterbury Hospital (K&C) – expanding a pilot which provides specialist counselling support to patients and families with a bleeding disorder, for a further 2 years. (2) £94k palliative care William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) – improving facilities for end of life patients and families.
Fundraising update	The Charity fundraising team have had another very busy quarter, working with individual and corporate fundraisers on marathons, climbing challenges, organising wing-walks and many fun and festive fundraising events. The Charity has just launched its website www.ekhcharity.org.uk
Expenditure plan	The Committee discussed and recommended for Board approval the expenditure plan of £1.2m (see appendix 1), with 3 main areas for Charity spend: Medical Equipment; Estates and Staff Wellbeing. Traditionally many of the larger grants have been for Medical Equipment and this was an effective and welcomed use of the Charity's funds. The Trust is still

	developing its estates and capital plans in detail, and specific expenditure items for the Charity would also be highlighted as part of this process over the next few months. There was also considerable support for spending more on staff wellbeing, but this also needed more work from the HR team to draw up specific proposals. These proposals would all come back to the CFC Committee for approval (over £25k) and to the Board (over £100k). The plan would require taking funds out of the Cazenove investment portfolio. It was noted that investments were currently highly volatile, and withdrawals could crystallise a loss. However, this was difficult to plan, given the market volatility currently, and internal timing of when funds would be needed based on proposals. The unrealised investment gain in the portfolio was £111k at the end of April, but a loss at the end of March of £129k, and expected to be a loss currently. The Committee noted that such volatility underlined the need to spend the funds, given they had been donated by individual and corporate fundraisers to be spent on charitable activities, not invested.
Strategy update	The Committee reviewed the Charity's updated 3-year strategy (see appendix 2). This sets out to achieve higher income levels each year (£1m-£1.5m), but with additional resources needed internally to achieve this. It was noted that some of the resource was funded through new grants; others partly covered from cost savings on other areas. The Committee recommended the updated strategy to the Board for approval.

Other items of business

None

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

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

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

Item	Purpose	Date
The Committee asks the BoD to **NOTE** this assurance report from the CFC and **APPROVE**: (1) The expenditure plan in Appendix 1, specifically spending £1.2m of the Charity's assets over the next 12-18 months, on the 3 main categories of Medical Equipment, Staff Wellbeing, and Estates; (2) The Charity's updated 3-year strategy in Appendix 2.	Assurance Approval Approval	To Board on 6 July 2023

Charitable Funds Committee 20 June 2023
Charitable Expenditure Plan

1. Introduction

1.1 The purpose of this report is to provide the committee with a report of potential areas where charitable grants can be made so as to provide a planned approach to charitable expenditure for 2023/24.

2. Governance

2.1 The Trust Standing Financial Instructions (SFI's) contain the detailed responsibilities of the Board of Directors and the Executive Officers including those related to the governance and administration of the funds held in the East Kent Hospitals Charity.

2.2 The Scheme of Delegation for the Charity funds is separate from those of the Trust; the scheme is encompassed within the Trusts' SFI's as the charity adopts all the policies and procedures of the Trust and does not have its own SFI's.

2.3 Overall responsibility lies with the Trust Board of Directors acting for the Corporate Trustee but is managed by the Charitable Funds Committee (CFC) under the Terms of Reference as defined by the Trust SFI's.

2.4 The procedure for all applications follows the Trust policies and procurement processes.

2.5 The Charitable Funds Committee is responsible for agreeing all grants of £25k and above in addition to the above authorisation process, with Trust Board approval required for bids of £100k or more.

3. Approach

3.1 To successfully maximise the impact of grants made by the charity the following planning approach was taken;

- For each category of spend; Estates & Facilities schemes, Medical Equipment and Well-Being & Support. A request was made to each of the key leads responsible to provide their list of high priority schemes planned for 2023/24 and suitable for charity spend.

- The Trust is currently working through its Estates and Facilities plan and a submission detailing schemes will be provided to the committee following completion of this work.

- The lists received were reviewed by the charity team and recommendation made to the charity based on the following.

Colour	Meaning
(Green)	Suitable for charity spend
(Amber)	Elements of the scheme fulfil charitable spend
(Red)	Not appropriate for charity spend

- In addition, fund balances were considered to ensure that sufficient funds held within restricted/unrestricted funds could support the bid made.

3.2 The table below summaries the total value of approved initial bids by the Committee to proceed.

Category	Sum of Proposed Funding approved at June CFC
	£
Medical Equipment	299,120
Estates & Facilities	-
Well-Being & Support	19,456
Grand Total	**318,576**

4. Recommendation

4.1 As the expenditure plan requires additional work to developed proposals and to cost those bids proposed as part of this paper. To ensure that approvals can commence at pace the Charitable Funds Committee is requested to set an initial expenditure budget of £1.2m.

4.2 The proposed budget takes account of the funds held and committed balances reported to the Charity as below;

Total Funds Held as at 30/04/2023 **£2,297k**

Less Funds Committed **£ 499k**

Total Available Funds **£ 1,797**

The budget of £1.2m ensures sufficient reserves remain to meet future obligations. The budget does not include income for 23/24 and can be flexed accordingly.

Once the expenditure budget is set and approved by the Corporate Trustee (Trust Board) the spending plan can continue to be managed at Charity Team and Charitable Funds Committee Level whilst ensuring all appropriate governance and approvals take place.

4.3 Spending will be reported on a quarterly basis to the Committee and the Committee will have opportunity to review and adjust spending plan as appropriate.

Strategy 2023

WHO ARE WE?

We are East Kent Hospitals Charity.

We are here to enhance the facilities and services delivered by East Kent Hospitals, by funding impactful and innovative projects: making a real difference to patients, visitors and staff.

WHY NOW?

Rupert Williamson stepped down from the Charity in May 2022, leaving us with 1.6 WTE in the Charity team (covering all functions of fundraising, marketing, management and administration). The finance team are 0.8 WTE.

The charity landscape has evolved rapidly since the pandemic began, and combined with external factors such as the economic pressures on individual giving, changing donor behaviour and public attitudes towards the NHS/ EKHUFT, we need to be proactive and resilient in order to maximise our income potential and therefore benefit to East Kent Hospitals.

We have been dedicated to improving our visibility, thus income opportunities in the past two years, and believe that we have significantly better brand visibility and confidence from our supporters in what we achieve.

Our Strategy was presented to the CFC in March 2022, detailing the key aims and objectives for the period between April 2022- April 2025. Given the significant changes to the Charity this year, and the challenges and opportunities that the changes bring, now is the time to refresh our strategy and outline our ambitions.

HOW WILL WE ACHIEVE THIS?

We have an ambitious and aspirational 3-year strategy: growing on our current achievements, understanding where our most likely sources of support are already rooted, and embracing opportunities that we have not previously approached, or had the resources to target.

However, in order to achieve our aspirations, we need additional resources and capacity, without which it is unlikely that we can change, grow and evolve.

Year 1- CHANGE (24/25)

AMBITION: £1M INCOME

Maximising Income	• Develop a legacy campaign • Introduce 'Make A Will' events • Engage with local solicitor firms to raise awareness of the Charity, encouraging legacy gifts. • Refocus on engaging with corporate opportunities, such as EKHUFT contractors, previous relationships and identifying new prospects. • Maximising partnership opportunities with NHSCT e.g. Starbucks partnership. • Developing and 'soft launching' major appeal, in readiness for high profile launch in 25/26.
Maximising Visibility	• Videography/ photography project completed- providing a strong bank of marketing imagery. • Increased visibility and giving opportunities for grateful patients and families across the sites, e.g. contactless giving points, improved donor journey, new webite. • Social Media Campaigns focussed on seasonal asks and events offerings. • E Marketing due to new CRM- clearly stating how we meet need: make a further ask from supporters. • Improved impact reporting and gathering mechanisms.
Maximising Resources	• Increasing Gift Aid returns. • Community Fundraising, focussed on groups, organisations and societies. • Targeting Grateful patients and families. • Increasing donor engagement, encouraging repeat support, gift aid etc. • Supporting smaller fundraising initiatives, e.g. green token schemes, funeral director project. • Maximising visibility and impact. • Continue to develop Events/ Run for Charity offering.
Maximising Grants	• Strategic approach to grant making, according to identified areas of need. • Promoting the new grant-making process, changing the perception that accessing funds is difficult. • Ensuring that patients and families are keenly aware of the immediate benefit of EKHC, through projects funded. • Apply to relevant local and national grant-making bodies, having identified key projects that are attractive to grant makers and meet areas of increased need. Focus on engaging with corporate opportunities, such as EKHUFT contractors, previous relationships, and identifying new prospects.

Year 1- **CHANGE** (24/25)

AMBITION: £1M INCOME

Resources in place:	Investment required:
• Head of Charity (1.0 WTE)- in place • Marketing and Projects Manager (0.6 WTE)- maternity cover being sought. • Admin Support Officer (1.0 WTE 12-month FTC)- recruitment in progress.	• Fundraising Officer (1.0 WTE)- Cost: £36K • Marketing Budget- cost: £20K

Year 2- GROWTH (25/26)

AMBITION: £1.25M INCOME

Major Appeal	• Additional resources needed before launch- additional fundraiser, increased marketing and admin support. • High profile launch and beginning of delivery of Appeal. • Trust staff support vital, assisting with promotion and delivery of Major Appeal.
Grants	• Continue to review EKHC grant process, addressing concerns and ensuring that the process is as efficient as possible. • Continue to grow grant income.
High Net Worth individuals	• Identify local high net-worth individuals. • Outsource this research. • Develop an attractive 'ask' and begin to make approaches.
Embedding in Trust Process	• Be at the genesis of the decision-making process for major projects, allowing our funds to be used strategically and for maximum impact.
Events	• Be the key charity at a large local event, offering potential supporters a new opportunity to engage with us, and increasing our visibility across East Kent.
	• Identify potential large fundraising opportunities, such as the 'Garden of Light' and develop relationship with businesses.
Income growth	• Continuing the excellent work achieved in 24/26, including growing the legacy campaign, marketing and visibility, reaching out to our community and corporate supporters, grateful family and patient opportunities, events offerings and grant identification. • Developing our Lottery, revitalising the promotion and increasing our return.

Year 2- GROWTH (25/26)

AMBITION 1.25M INCOME

Resources in place:	Investment required:
• Head of Charity (1.0 WTE)- in place • Marketing and Projects Manager (0.6 WTE) • Fundraising Officers (1.0 WTE)	• Marketing and Projects Officer (1.0 WTE/ £36K) • Fundraising Officers (1.0 WTE/ £36K) • Admin support officers (1.6WTE/ £43K) • Marketing budget: £25K • Outsource High Net Worth project- market cost TBC.

Year 3- EVOLUTION (26/27)

AMBITION: £1.5M INCOME

Trading/retail income	• Should a retail trading opportunity arise, be prepared to seize this and implement it as part of the key source of income for the charity.
Volunteers	• Major appeal ambassadors- maximising our capacity for community fundraising. • General Charity ambassadors- as above. • Event volunteers, supporting large, key events. • Targeting corporates with CSR days, offering a positive experience, cementing future corporate opportunities. • Lottery promotion.
Events	• Using the 'Big Tea' premise, embed a regular 'coffee morning' event locally, potentially linked to the Major Appeal.
Major Appeal	• Year 2 of delivering the Major Appeal- building on the engagement and support for the appeal from our communities, corporate supporters and high net worth donors.
Corporate Support	• Continued investigation of opportunities, linking aligning with strategic direction of the Trust. • Ongoing relationships being developed with Corporate Supporters- perhaps linked to Major Appeal of other area of core need.

Year 3- EVOLUTION (26/27)

AMBITION: £1.5M INCOME

Resources in place:	Investment required (subject to retail/ trading opportunity arising)
• Head of Charity (1.0 WTE) • Marketing and Projects Manager (0.6 WTE) • Marketing and Projects Officer (1.0 WTE) • Admin Support Officers (1.6 WTE) • Fundraising Officers (2.0 WTE)	• Volunteer manager (1.0 WTE/ £36K) • Potential trading staff- TBC. • Marketing budget: £25K

Tell me more!

Please see Appendix A for the financial projections for the coming three years, demonstrating our plan and ambition to achieve these targets.

WHAT NEXT?

We will review and update the CFC of our progress, quarterly. We will be flexible and dynamic to emerging opportunities. We will evaluate and reflect upon our aims and objectives identifying what is successful, and what we could improve upon.

Recruitment is currently taking place for the Marketing & Project Manager's maternity cover, and the Charity Admin post. This provides us with sustainability for our marketing offer, and some increased capacity for income generation, thanks to the admin role.

In order to progress with our ambitious strategy this year, we require an additional fundraising role: focussing on community fundraising, donor engagement, and other emerging opportunities that we anticipate with our strategy. This role will provide the capacity for the Head of Charity to peruse corporate relationships, grant-making opportunities, and development of campaigns.

The investment required for a 1.0 WTE Band 5 fundraising officer is £36,000.

We are asking the Charitable Funds Committee to approve this request, allowing recruitment to begin as soon as possible.

Appendix A

East Kent Hospitals Charity Plan				
	Plan submitted to March CFC	Revised Plan to Reflect 3 Year Strategy June 2023 CFC		
	Plan	Plan	Plan	Plan
Statement of Financial Activities	**2023/2024**	**2024/2025**	**2025/2026**	**2026/2027**
	£000	£000	£000	£000
Income:				
Donations Individuals	195	325	425	475
Donations Corporate	20	75	105	125
Donations Groups and Societies	10	40	65	90
NHS Charities Together Grants	35	75	90	155
Other Grants	21	65	95	135
Legacies	280	325	375	425
Investment income	67	95	95	95
Total income	**628**	**1,000**	**1,250**	**1,500**
Expenditure				
Fundraising	(162)	(208)	(285)	(294)
Audit Fee	(41)	(43)	(44)	(46)
Governance & Support Costs	(92)	(94)	(96)	(98)
Expenditure to support equipment and services EHUFT	(505)	(500)	(500)	(500)
Total expenditure	**(800)**	**(845)**	**(925)**	**(938)**
Net gains on investments	175	225	225	225
Net income/(expenditure) for period	3	380	550	787

Notes

Fundraising costs reflect transitional staff change in 23/24 and increased establishment 24/25 - 26/27 together with marketing costs as outlined within the strategy.

Year 3 trading potential does not form part of income or expenditure planned above.

Expenditure to support equipment & services EKHUFT is indicative only and will be determined by the expenditure plan agreed at the June 2023 CFC

SUPPORT US

Please show your support by following us on our social channels @ekhcharity and liking and sharing our posts and stories!

hello@ekhcharity.org.uk

(01227) 866356

www.ekhcharity.org.uk

THANK
YOU

REPORT TO BOARD OF DIRECTORS

Report title:	**Transforming our Trust: Our Response to *"Reading the Signals: Maternity and Neonatal Services in East Kent"* – Update Report**
Meeting date:	**6 July 2023**
Board sponsor:	**Chief Executive Officer (CEO)**
Paper Author:	**Chief Strategy and Partnerships Officer (CSPO)**

Appendices:

NONE

Executive summary:

Action required:	**Information**
Purpose of the Report:	To update the Board on progress on Transforming our Trust - the Trust's Interim response to *Reading the Signals*, the independent report into maternity and neonatal services in East Kent.
Summary of key issues:	This Report provides an update on the approach to responding to the Reading the Signals Report to provide safer care and improved staff engagement.
Key recommendations:	The Board of Directors are asked to **NOTE** the report for information.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 39:** There is a risk that women and their families will not have confidence in East Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	N

Subsidiary:	N

Assurance route:

Previously considered by: N/A

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

1. Background

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

2. The Pillars of Change and Assurance Framework

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

2.2. The deliverables of the pillars of change are broken down across three different time bands.

- Building the Foundations – November 2022 to May 2023
- Developing & Evaluating - May 2023 to November 2024
- Where we Want to Be - November 2024 to November 2025

The progress on the first six months was reported at the last board and the organisation now moves into the next phase of actions.

2.3. Following the review of the current improvement programmes and joining them under a single improvement framework, work is now progressing to embed the Trust's strategic and annual objectives throughout the organisation. An Improvement Plan summary has been published and shared with staff, describing the key areas of focus, why these have been chosen, what we are aiming to achieve and by when, and is available on the Trust's public website.

3. Culture and Leadership Programme (CLP)

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

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

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

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

3.5. Significant progress has been made in the identification of change champions to support the programme of cultural change. Following a recruitment campaign 120 staff have come forward to be trained as change champions.

4. The Reading the Signals Oversight Group

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

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

4.3. The third meeting of the Group was held on 20 June 2023. The Group received reports form key members including an update on progress of the first 6 months actions and review of some key metrics. The Group discussed the progress that had been made but raised concerns about what metrics are being reported and the way in which they are presented. It was agreed that further work would be undertaken in preparation for the next meeting. The Group remains committed to be flexible in its approach to family representation and if other families come forward wishing to join membership of the Group this should be facilitated.

4.4. The next meeting of the Oversight Group will be held on the 8 August 2023.

5. The Independent Case Review Process

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

5.2. We have now worked through the list of potential case reviews and having spoken to the families, confirm that the list currently stands at 14 reviews, with 12 Key Lines of Enquiry (KLOES) agreed with the families, which are awaiting review by the panel. The first completed case review has been shared with the family, who are due to meet with the Independent Review Panel to talk through the findings. Two more reports are due final sign off in the coming month.

REPORT TO BOARD OF DIRECTORS

Report title:	**Maternity Dashboard**
Meeting date:	**6 July 2023**
Board sponsor:	**Chief Nursing and Midwifery Officer (CNMO) and Maternity and Neonatal Board Safety Champion**
Paper Author:	**Heads of Midwifery and Gynaecology Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) Director and Deputy Director of Midwifery**

Appendices:

APPENDIX 1: MATERNITY DASHBOARD

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The purpose of this report is to present and give assurance on the maternity dashboard and associated actions. The maternity dashboard provides oversight on the safety and quality of the maternity services in East Kent including governance, workforce, clinical pathways and engagement with service users. The Trust's maternity dashboard is presented monthly to both the Maternity and Neonatal Assurance Group (MNAG) and Trust Board. This report covers the month of May 2023.
Summary of key issues:	• The rate of Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) reportable neonatal and perinatal deaths remains lower than the National average. • We recognise that recording issues are impacting data quality, especially associated with the recording of "fresh eyes" cardiotocograph (CTG) reviews, community equipment checking and Birthrate+ acuity data. The team are working to find a digital solution. However, until a solution is found the narrative within dashboard details the mitigations and plans. • There has been a significant rise in staff turnover at the WHH.

	• The appraisal rate has fallen over the last 3 months, the Heads and Directors of Midwifery are working with the teams to address the appraisal gaps and a trajectory for improvement is being developed. • We have noted a drop in the antenatal appointments which is aligned to the work underway by the community matrons to ensure women and birthing people are seen in accordance with National Institute for Health and Care Excellence (NICE) guidelines. • Complaints remain above the average expected.
Key recommendations:	The Board of Directors is asked to: 1. **DISCUSS** the contents of this report and; 2. **NOTE** the key risks; 3. Receive **ASSURANCE** and **NOTE** that a full maternity dashboard and safety review has been completed and continues to be monitored by the senior maternity team.

Implications:

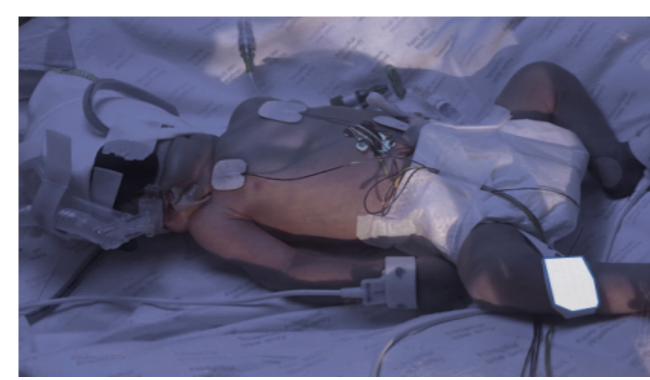
Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	Y - Additional resource will be required to implement the Final Ockenden Report Immediate and Essential Actions.
Legal and regulatory:	Y – NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST), Ockenden 1, Ockenden 2 Final and National Quality Board (NQB).
Subsidiary:	N

Assurance route:

Previously considered by: N/A

Maternity Dashboard Performance Report

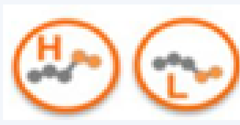
May 2023



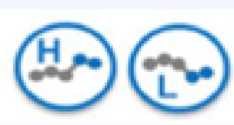
Maternity Dashboard - Revised

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

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



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



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

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

Governance, Risk & Compliance

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

Governance, Risk & Compliance: Overview

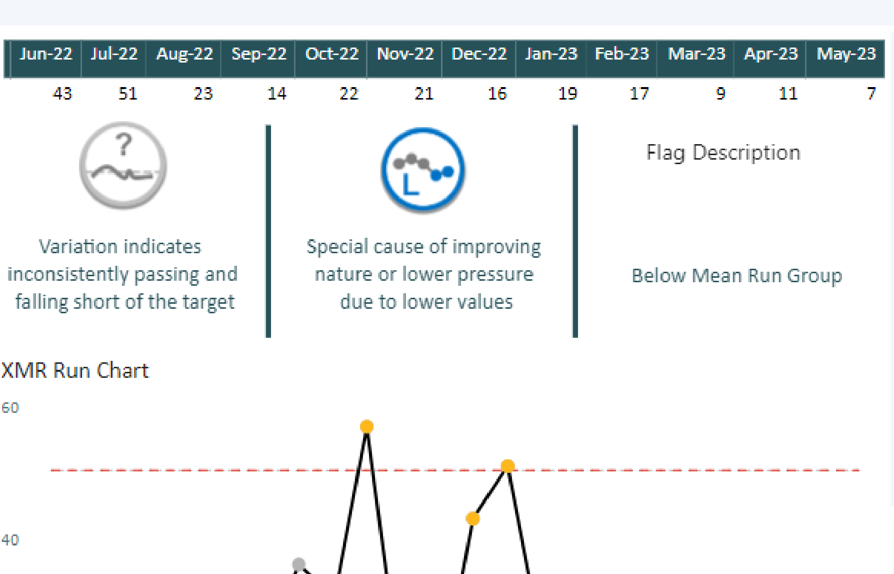
Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Incidents	Serious Incidents	3	May-23	1			3	0	9
	Total Incidents	Sigma	May-23	243			243	110	376
	Moderate+ Harm (C - E)	Sigma	May-23	3			3	0	9
	No/Low Harm (A & B)	Sigma	May-23	239			240	108	372
	HSIB Referrals	1	May-23	1			1	0	2
	Unit Divert Diff Site	1	May-23	4			2	0	6
	Unit Closure	0	May-23	0			0	0	1
	Birthrate+ Red Flags	Sigma	May-23	7			24	0	50
Morbidity & Mortality	MBRRACE Stillbirth 12m Rate	3.92	May-23	3.48			3.98	3.23	4.74
	MBRRACE Stillbirths	2	May-23	0			2	0	6
	MBRRACE NND Rate 12m	1.96	May-23	1.00			1.10	0.78	1.42
	MBRRACE Neonatal Deaths	1	May-23	0			1	0	3
	MBRRACE Ext Perinatal Rate 12m	5.87	May-23	4.47			5.08	4.24	5.92
	Maternal Deaths	0	May-23	0			0	0	1
Regulatory Compliance	Comm MW Equipment Audit	100.0%	May-23	98.3%			93.8%	87.7%	99.9%
	Fresh Eyes	90.0%	May-23	30.5%			42.6%	21.4%	63.9%

Governance, Risk & Compliance: Exception Report

Birthrate+ Red Flags

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

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
43	51	23	14	22	21	16	19	17	9	11	7

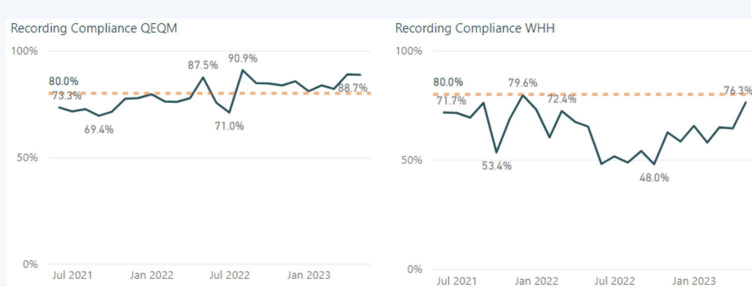


What the chart tells us

The number of reported red flags recorded on Birthrate+ has remained lower than average for 10 consecutive months

However – only QEQM is consistently achieving the 80% recording compliance which gives assurance of the accuracy of this data. WHH is improving – 76% overall in May, but is still short of the target level.

Note: Birthrate+ is currently reviewing the methodology for recording on the AN/PN wards, so data for May onward will be for Labour wards only



Intervention and Planned Impact

Reporting compliance static noted for WHH.
Further work by HOM with matron and band 7 team required to increase compliance.
Red flags include:

- Delay between admission for induction - 3 at WHH
- Delay in providing pain relief – 2 at WHH
- Co-Ordinator not able to maintain supernumerary status – 1 at WHH
- MW not able to provide 1:1 care – 1 at QEQM

It should be noted that the recording of 1:1 care is currently in 2 systems the Birth rate acuity as well as from the patient record in E3

Risks/Mitigations

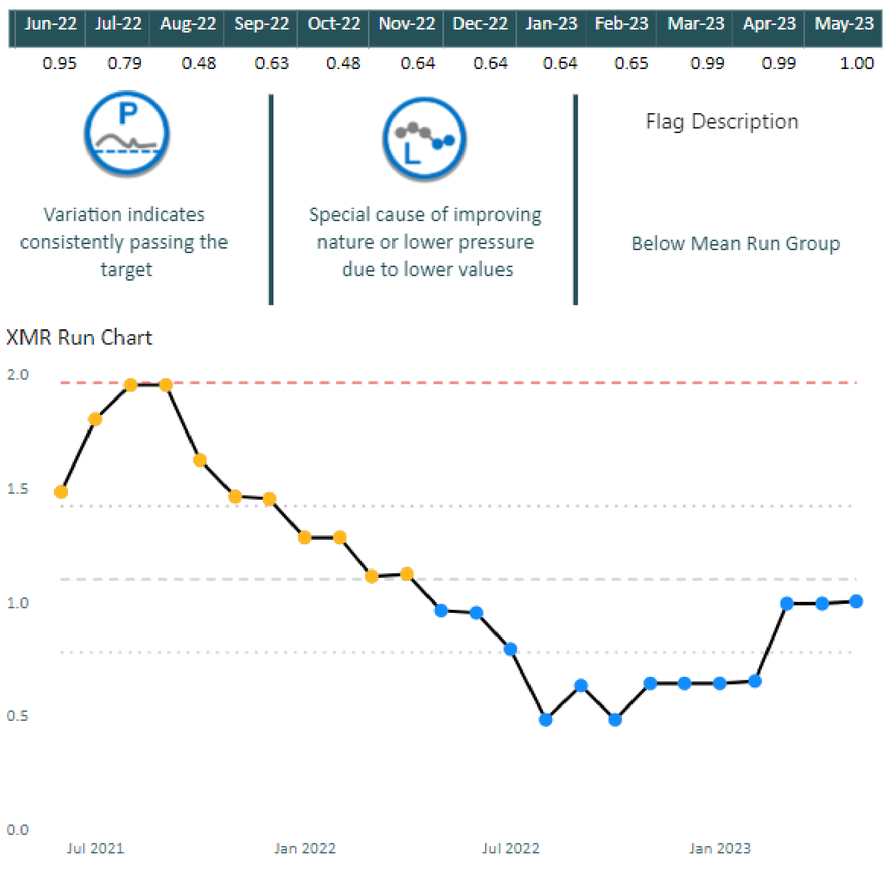
Reporting compliance is improving but further work is required to ensure the accuracy of the data particularly at WHH site. This is likely affected by staffing and acuity of the unit. Following discussion with midwifery leads there is felt to be an issue with the timings of the pm data collection as there are conflicting priorities at this time. A conversation to take place with Birthrate+ as to whether timings can be altered to support improved compliance.

Governance, Risk & Compliance: Exception Report

MBRRACE NND Rate 12m

MBRRACE methodology is used, Babies who were born at EKHUFT and died within 28 days, and which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is a rolling 12 month measure counting cases per 1000 live births

Datasource: Euroking & PAS. Threshold based on the average of the Trust's comparator group (MBRRACE 2021). Average was 1.96



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
0.95	0.79	0.48	0.63	0.48	0.64	0.64	0.64	0.65	0.99	0.99	1.00

What the chart tells us

The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 1 neonatal deaths per 1,000 livebirths, and has been so for 13 consecutive periods.

In May there were 0 neonatal deaths reportable to MBRRACE, and 4 neonatal death which are not included under the MBRRACE methodology (3 babies born before 24w, and one born at 24w but at another hospital)

In the 12 month rolling period, there have been 6 neonatal deaths reportable to MBRRACE.

The expected number of deaths based on the group average and our current birthrate would be 12

Intervention and Planned Impact

All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.

Risks/Mitigations

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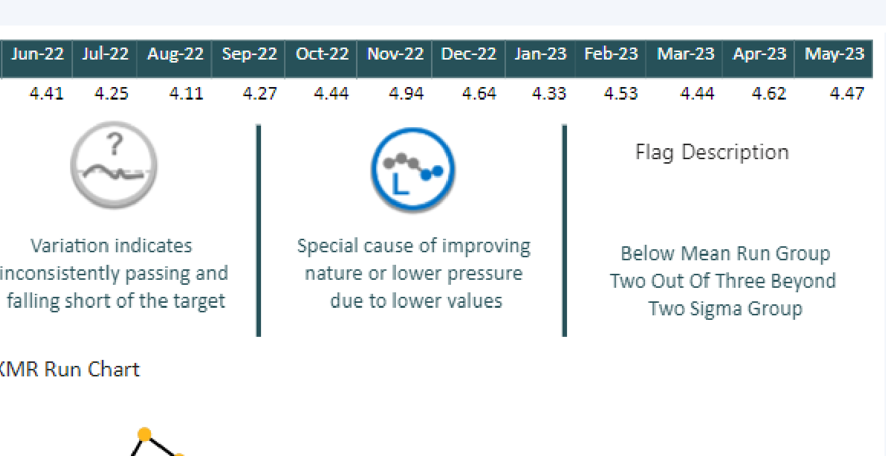
Governance, Risk & Compliance: Exception Report

MBRRACE Extended Perinatal Rate 12m

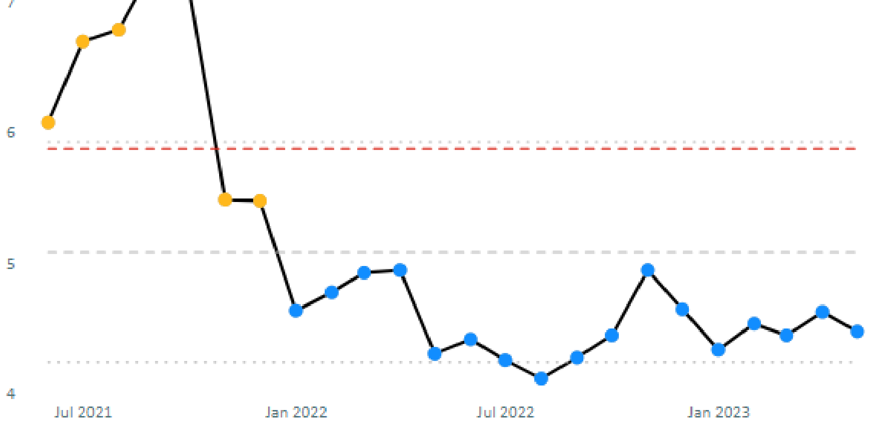
MBRRACE methodology used. Stillbirths and Neonatal deaths up to 28 days

Rolling 12 month rate. Target is set at the average of Trust's comparator group from the latest MBRRACE report (2021). The average for the group was 5.87



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
4.41	4.25	4.11	4.27	4.44	4.94	4.64	4.33	4.53	4.44	4.62	4.47

XMR Run Chart



What the chart tells us

The rolling 12 month rate for extended perinatal deaths remains lower than both the threshold and average at 4.47 neonatal deaths per 1,000 births, and has been so for 17 consecutive periods.

In May there were 0 neonatal deaths reportable to MBRRACE, and 4 neonatal death which are not included under the MBRRACE methodology (3 babies born before 24w, and one born at 24w but at another hospital)

There were 0 stillbirths in May

In the 12 month rolling period, there have been 6 neonatal deaths reportable to MBRRACE and 21 stillbirths. 27 in total.

The expected number of deaths based on the group average and our current birthrate would be 35

Intervention and Planned Impact

All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.

Risks/Mitigations

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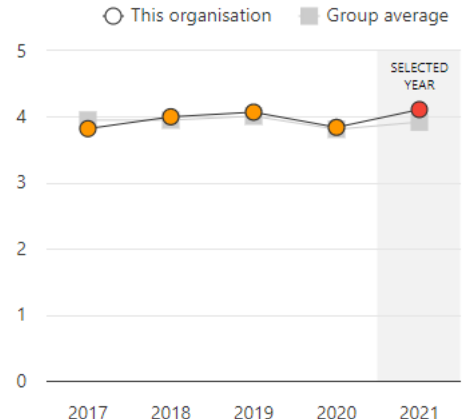
MBBRACE 2021 Results: Stillbirths

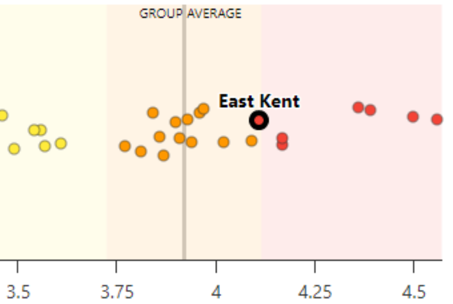
Mortality rates, by year

Stabilised & adjusted rate per 1,000 total births of the total number of stillbirths



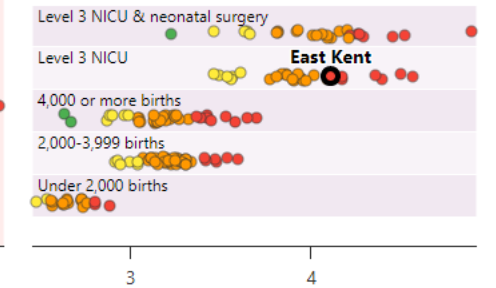
Mortality rates, Level 3 NICU, 2021

Stabilised & adjusted rate per 1,000 total births of the total number of stillbirths



Mortality rates, 2021

Stabilised & adjusted rate per 1,000 total births of the total number of stillbirths

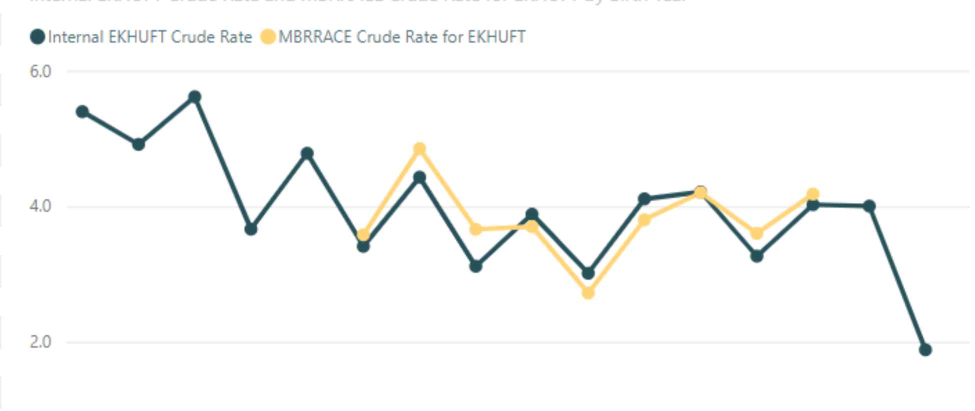


Comments

- EKHUFT have increased to red (over 5% higher) than the comparator group in the 2021 MBRRACE results, after 4 years as amber (within 5% of average)
- EKHUFTs adjusted rate was 4.11 compared to the group average of 3.92
- The group average increased in 2021, from 3.82 in 2020, however – the general trend for stillbirth rates in the group is very static overall
- Local crude data for EKHUFT suggests that a similar result is likely in the 2022 MBRRACE report, although this is highly dependent on the rates seen in other Trusts

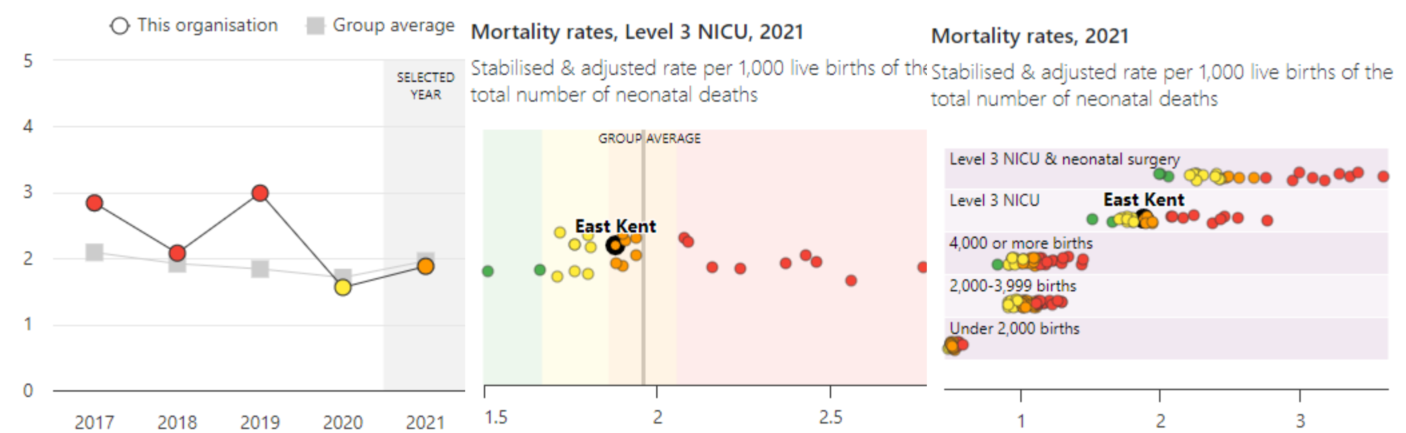
Birth Year	Stillbirths	Births	EKHUFT Crude Stillbirth Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2008	40	7,414	5.40			
2009	36	7,328	4.91			
2010	42	7,480	5.61			
2011	27	7,373	3.66			
2012	36	7,530	4.78			
2013	24	7,039	3.41	3.58	4.28	4.75
2014	31	7,000	4.43	4.85	5.01	4.98
2015	22	7,062	3.12	3.66	4.31	4.41
2016	27	6,953	3.88	3.70	4.12	4.11
2017	21	6,973	3.01	2.72	3.82	3.95
2018	27	6,571	4.11	3.80	4.00	3.95
2019	27	6,413	4.21	4.20	4.07	4.01
2020	20	6,127	3.26	3.60	3.84	3.81
2021	25	6,213	4.02	4.18	4.11	3.92
2022	25	6,246	4.00			

Internal EKHUFT Crude Rate and MBRRACE Crude Rate for EKHUFT by Birth Year



Rate compared with the group average ● Over 15% lower ● 5 to 15% lower ● Within 5% ● Over 5% higher ○ Suppressed

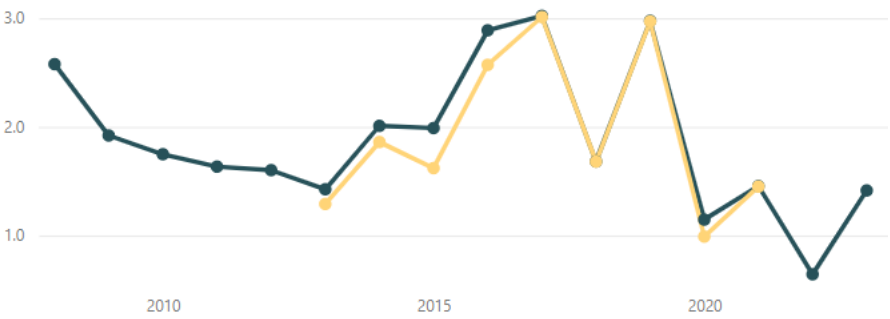
MBBRACE 2021 Results: Neonatal Deaths



Comments

- EKHUFT have increased to amber within 5% of average of than the comparator group in the 2021 MBBRACE results
- EKHUFTs adjusted rate was 1.88 compared to the group average of 1.96
- The group average increased in 2021, from 1.71 in 2020, after 3 consecutive years of reductions
- Local crude data for EKHUFT suggests that a lower rate is likely in the 2022 MBBRACE report, although this is highly dependent on the rates seen in other Trusts

Birth Year	Neonatal Deaths <28 days	Livebirths	EKHUFT Crude Neonatal Death Rate	MBRRACE Crude Rate for EKHUFT	MBRRACE Adjusted Rate for EKHUFT	MBRRACE Average for Comparator Group
2008	19	7,374	2.58			
2009	14	7,292	1.92			
2010	13	7,438	1.75			
2011	12	7,346	1.63			
2012	12	7,494	1.60			
2013	10	7,015	1.43	1.29	1.95	2.09
2014	14	6,969	2.01	1.86	1.93	1.97
2015	14	7,040	1.99	1.62	2.01	2.04
2016	20	6,926	2.89	2.57	2.53	2.10
2017	21	6,952	3.02	3.01	2.84	2.09
2018	11	6,544	1.68	1.68	2.08	1.92
2019	19	6,386	2.98	2.97	2.99	1.84
2020	7	6,107	1.15	0.99	1.56	1.71
2021	9	6,188	1.45	1.45	1.88	1.96
2022	4	6,221	0.64			



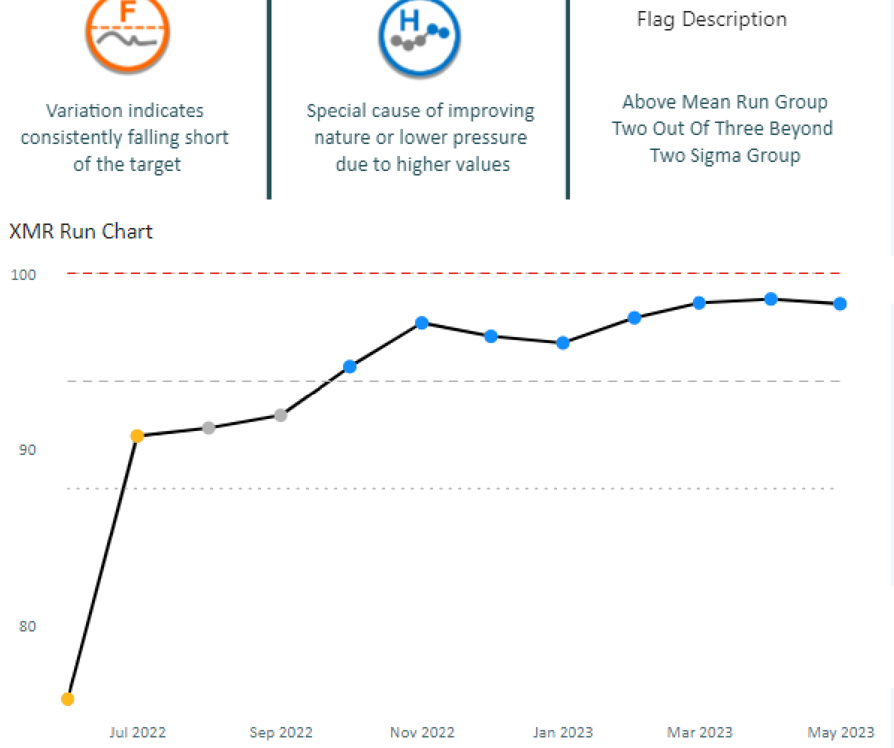
Rate compared with the group average ● Over 15% lower ● 5 to 15% lower ● Within 5% ● Over 5% higher ○ Suppressed

Governance, Risk & Compliance: Exception Report

Community Equipment

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

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



What the chart tells us

Compliance remains short of the 100% target level.

All teams and bags were 100% compliant, except:

- Coastal Homebirth (97%)
- Dover Homebirth & Day Bag (98%)
- Folkestone Homebirth & Day Bag (98%)
- Thanet Homebirth & Day Bag (96%)

Intervention and Planned Impact

Community matrons undertaking weekly spot audits and developing action plans to address shortfalls

- 1:1 with individual midwives
- Reviewing data collection methodology
- Results and performance shared with the community teams to highlight gaps

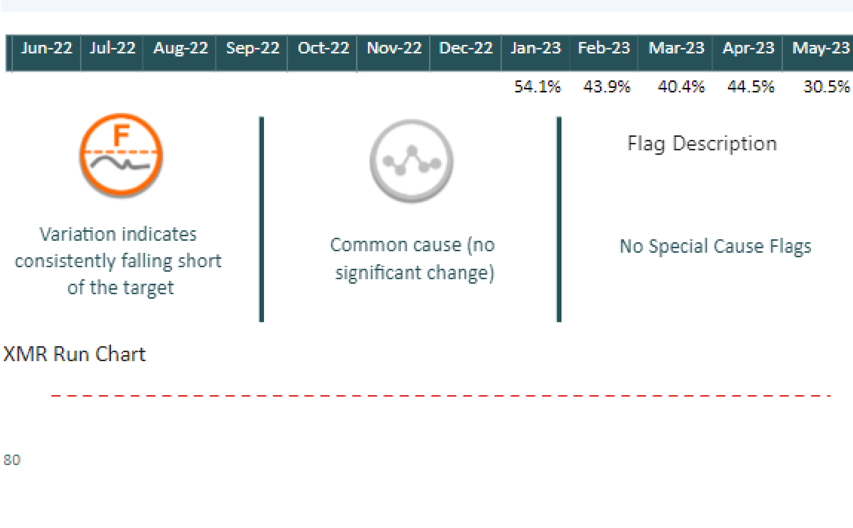
Risks/Mitigations

Data capture concerns and community matrons working with digital midwife to address. When staff are on leave or sick this is included in miss check denominator which impacts the overall compliance.

Governance, Risk & Compliance: Exception Report

Fresh Eyes

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



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
							54.1%	43.9%	40.4%	44.5%	30.5%

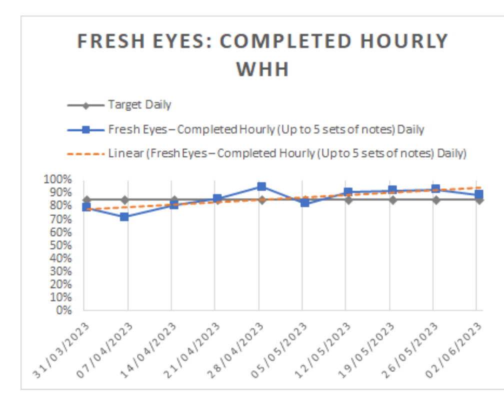
XMR Run Chart

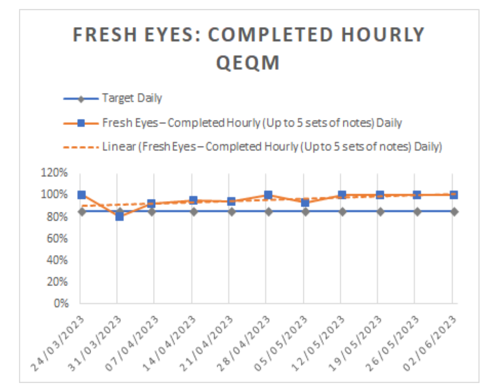
What the chart tells us

Performance is consistently under the threshold of 90%. Data is being captured manually by weekly audits and presented by the DOM and DDOM. This data has now been superseded by the manual auditing which offers assurance.

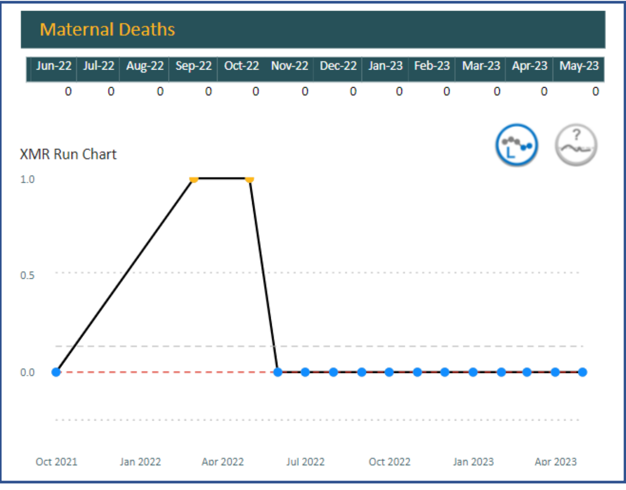
Intervention and Planned Impact

Currently, this process is only being routinely used at WHH. However, this is reliant on the midwife returning to the board and re-setting the icon. This can be used as a good aide memoire but is not a good audit tool, A more in-depth audit of patient notes is taking place across both sites, and reported to the CQC. The aim is to move this audit into this dashboard process moving forward – for better oversight and monitoring of themes. The table for these results is below and will be the way this is monitored and reported going forward





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



12 consecutive months with 0 maternal deaths

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

Governance, Risk & Compliance : Other notable

Serious Incidents

Domain	Incidents
Datapoint	01 May 2023
Num	1
Denom	
Threshold	3
Value	1
Value Type	Number
Direction	Lower is Better
Previous Val	4
Change (%)	-75%
Hyperlink	

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
6	6	1	2	6	1	0	2	4	4	4	1

Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart

Metric Definition

Any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System) - [Inc_inquiry] = 'CONFSI' (confirmed SI). We also have a clause to exclude any that later get downgraded by the CCG. Serious Incidents are reported by the date the investigation started (not the date the incident occurred or was reported)

Serious Incidents remain within confidence limits

In May, the serious incident reported was an unexpected admission to SCBU

People & Culture, Workforce Sustainability

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

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

People & Culture, Workforce Sustainability: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Staff Survey	Staff Involvement Score	6.90	Apr-23	5.60			5.00	5.40	5.00
Workforce	1 to 1 in Labour	100.0%	May-23	99.5%			99.5%	98.4%	100%
	Worked WTE: Birth Ratio	24.00	Apr-23	19.20			21.04	17.47	25.32
	Midwifery/MSW Turnover Rate	11.5%	Apr-23	10.2%			6.38%	4.81%	7.96%
	Midwifery/MSW Vacancy Rate	10.0%	Apr-23	9.1%			11.6%	0%	10.1%
	Midwifery/MSW Appraisal Rate	85.0%	Apr-23	61.7%			69.5%	62.4%	76.7%
	Sickness Rate	5.0%	Apr-23	7.3%			7.78%	5.01%	10.5%
	Total On-Call Hours	Sigma	May-23	390.8			552.0	0	1054.0
	Occurance On-Call In	Sigma	May-23	98			101	36	165
	Birthrate+ Meets Acuity	Sigma	May-23	66.1%			55.4%	34.8%	76.0%
	Supernumerary Status	100.0%	May-23	99.7%			96.3%	90.8%	100%
Maternity Training	Fetal Monitoring Training	90.0%	May-23	95.7%			88.2%	83.2%	93.2%
	PROMPT Excl ML & LTS	90.0%	May-23	96.9%			90.1%	83.5%	96.7%
	Fetal M. Excl ML & LTS	90.0%	May-23	99.0%			91.8%	87.3%	96.3%
	PROMPT	90.0%	May-23	93.5%			86.5%	79.3%	93.8%
	NLS Training	90.0%	May-23	89.1%			82.6%	75.4%	89.7%
	NLS Excl ML & LTS	90.0%	May-23	92.1%			84.7%	77.8%	91.6%

People & Culture, Workforce Sustainability: Overview

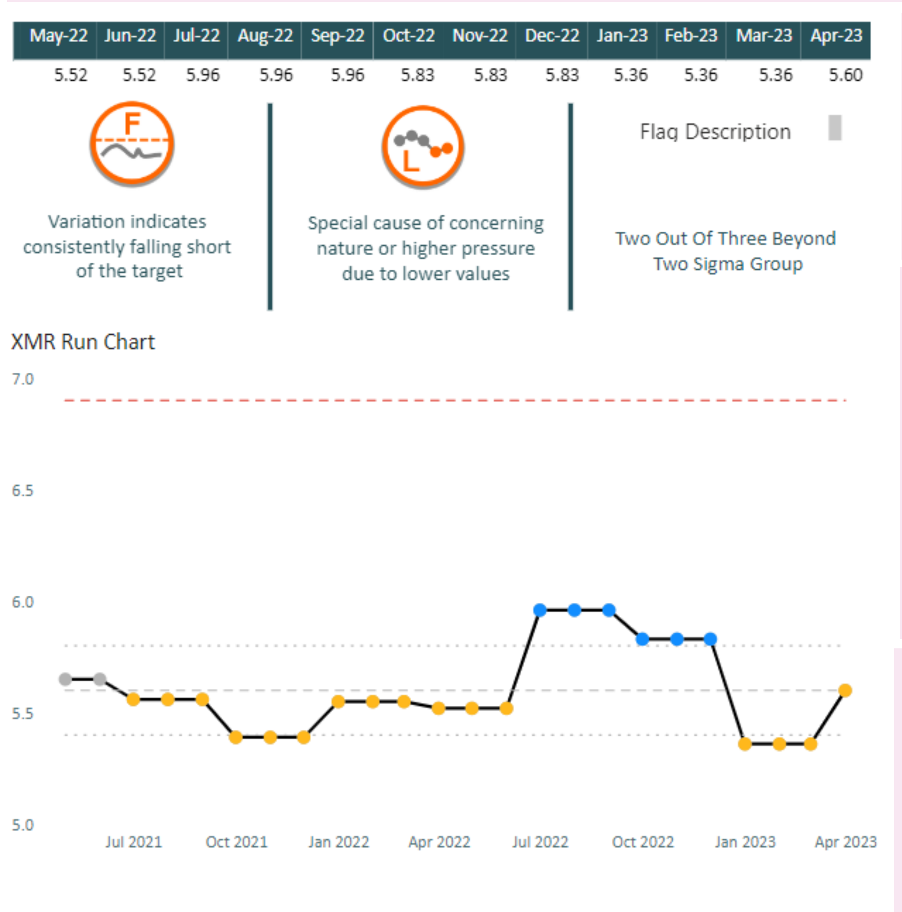
Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Mandatory Training	Safeguarding Adult Lvl 1	90.0%	Apr-23	100%			100%	100%	100%
	Safeguarding Adult Lvl 2	90.0%	Apr-23	79.6%			85.4%	81.1%	89.8%
	Safeguarding Adult Lvl 3	90.0%	Apr-23	83.3%			22.4%	0%	45.0%
	Prevent Lvl 1	85.0%	Apr-23	100%			100%	100%	100%
	Prevent Lvl 2	85.0%	Apr-23	79.6%			83.0%	65.8%	100%
	Hand Hygiene	85.0%	Apr-23	57.0%			48.4%	41.8%	55.1%
	Dementia	85.0%	Apr-23	86.0%			22.6%	0%	53.1%
	Resus Adult	85.0%	Apr-23	93.1%			67.3%	53.4%	81.1%
Statutory Training	Equality & Diversity	85.0%	Apr-23	94.7%			92.8%	91.0%	94.6%
	Child Protection Level 1	90.0%	Apr-23	100%			100%	100%	100%
	Child Protection Level 2	90.0%	Apr-23	72.7%			88.9%	82.6%	95.2%
	Child Protection Level 3	90.0%	Apr-23	74.7%			89.3%	86.4%	92.2%
	Manual Handling	85.0%	Apr-23	91.9%			88.2%	86.1%	90.2%
	Fire	85.0%	Apr-23	89.4%			87.7%	85.2%	90.3%
	Health & Safety	85.0%	Apr-23	93.4%			92.1%	90.5%	93.8%
	Infection Control	85.0%	Apr-23	96.6%			93.0%	85.6%	100%
	Information Governance	85.0%	Apr-23	85.8%			86.6%	83.1%	90.1%

People & Culture, Workforce Sustainability: Exception Report

Staff Involvement Score

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

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



May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
5.52	5.52	5.96	5.96	5.96	5.83	5.83	5.83	5.36	5.36	5.36	5.60

What the chart tells us

This data is quarterly, and as such an SPC chart is less appropriate – however, the scores for April have increased compared to the previous quarter

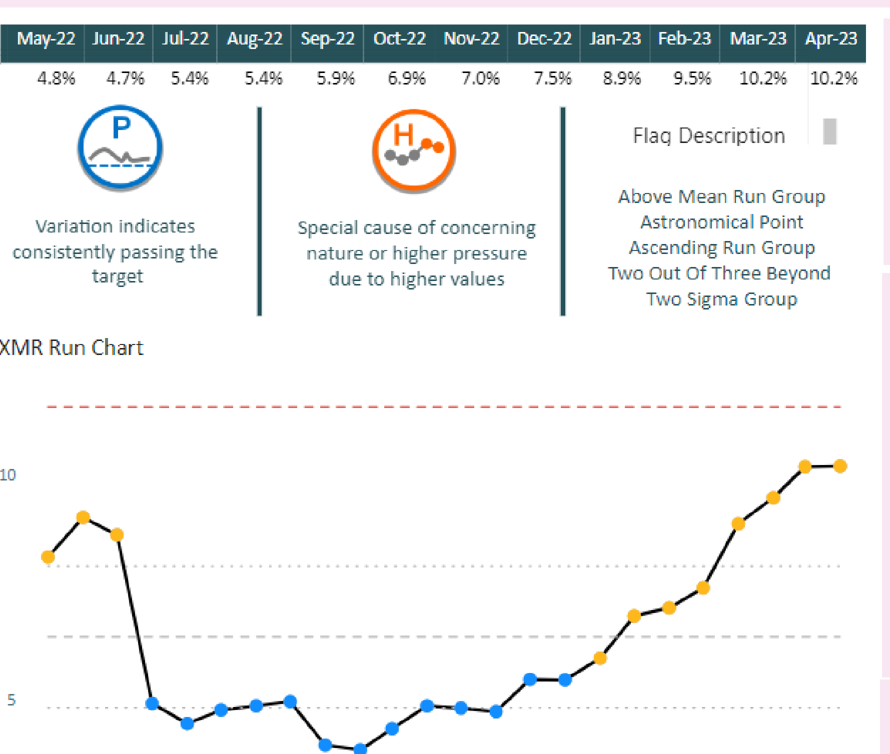
Intervention and Planned Impact

Risks/Mitigations

People & Culture, Workforce Sustainability: Exception Report

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

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



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

What the chart tells us
There has been a significant rise in turnover up to April, at 10.2% for maternity (midwives and support staff)
Within this figure, the turnover rate at WHH is the driving factor – with a significantly high rate of 22.6%, compared to the QEQM rate of 2%, and Community at 3.5%.

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

- The implementation of a flexible team that can be deployed on a shift by shift basis to areas where there is the greatest challenge in terms of staffing and acuity. The model has been developed in partnership with staff and involves the use of enhanced NHSP rates.
- The increase in the number of hours available for the discharge coordinator role
- Increase to the number of support staff including the move forward with the MSW competency framework
- Introduction of 10 midwives educated internationally at WHH commenced April and they are working through their OSCE programme – 2 have now passed the OSCE and going through a Bridging programme prior to commencing their preceptorship.

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

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

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

People & Culture, Workforce Sustainability: Exception Report

Midwifery / MSW Appraisal Rate

Appraisal rate for all staff under 560 maternity, excluding admin and clerical staff

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
74.5%	75.2%	74.2%	71.7%	74.2%	73.4%	74.2%	71.2%	68.0%	65.2%	63.2%	61.7%

What the chart tells us

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

- WHH compliance is 33% - 48 midwives and 14 support staff non-compliant
- QEQM compliance is 80% - 13 midwives and 9 support staff non-compliant
- Community compliance is 72% - 25 midwives and 1 support staff non-compliant
- Management (including governance/specialised MW) compliance is 48%

Intervention and Planned Impact

- Matrons have allocated the appraisals to all staff to complete within 8 weeks.
- Additional training given to staff in relation to uploading to ESR
- New band 7's booked on to appraisal training
- HOM's are holding staff to account and asking for weekly updates on completion and compliance.

Risks/Mitigations

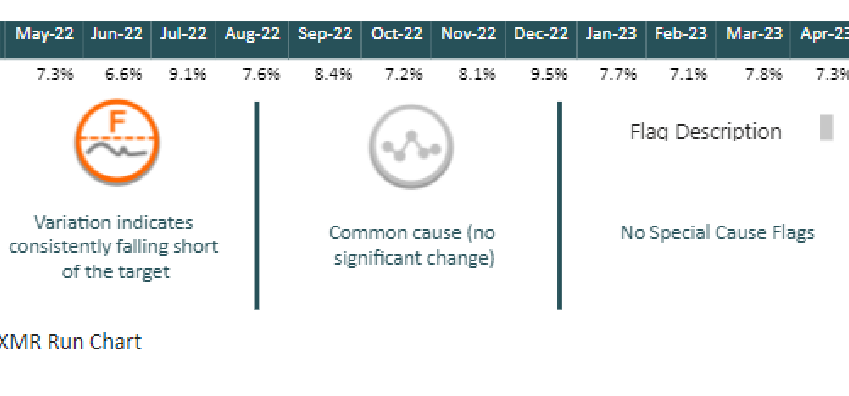
- The appraisal data will remain poor until these have been uploaded so would expect significant improvement with the June data.
- Staffing levels and sickness remain a challenge and impact on the completion of planned appraisals.

People & Culture, Workforce Sustainability: Exception Report

Sickness

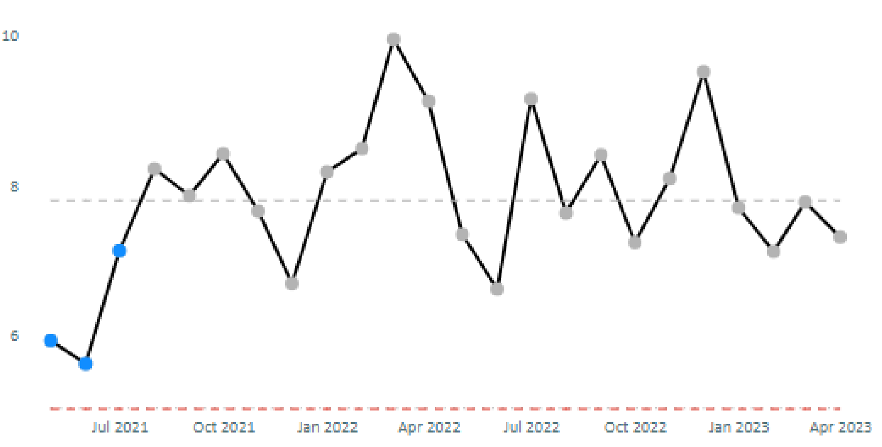
The percentage of full time equivalents (FTE) lost through absence, as a % of all FTEs

Specialty 560 – MLUs, managements, acute wards, community and liaison teams



May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
7.3%	6.6%	9.1%	7.6%	8.4%	7.2%	8.1%	9.5%	7.7%	7.1%	7.8%	7.3%

XMR Run Chart



What the chart tells us

Sickness rates remain fairly static and without any significant change, but is consistently above the threshold of 5%

- WHH = 10%
- QEQM = 7%
- Community = 6%

Intervention and Planned Impact

- 25 midwives have been written to attend first informal meeting with the matron to discuss how we can support them to attend substantive shifts.
- NHSP shifts are discouraged/suspended for staff on sickness management until individual staff are able to sustain good attendance to substantive shifts.
- To work with HR to do a thematic review of sickness to see what support could be offered to all staff to reduce short term sickness levels.

Risks/Mitigations

- Sickness management may impact the take up of NHSP shifts and overall roster fill.

People & Culture, Workforce Sustainability: Exception Report

Supernumerary Status

Supernumerary status achieved, based on documentation from Birthrate+. Of all time periods captured, how many did not record 'Co-Ordinator not able to maintain supernumerary/supervisory status'

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
96.2%	96.2%	98.2%	97.8%	98.6%	98.9%	98.9%	99.0%	98.5%	99.0%	99.3%	99.7%

What the chart tells us

Performance remains fairly static, but consistently falling short of the threshold of 100%.

1 breach in May – WHH Labour ward

Intervention and Planned Impact

- All band 7's to undertake a refresher on the definition of supernumerary status to ensure accurate data input.
- The matron and HOM to review data weekly so that conversations can take place in a timely manner and data be validated.
- Ensuring birthrate+ is embedded into the induction programme for new band 7 starters

Risks/Mitigations

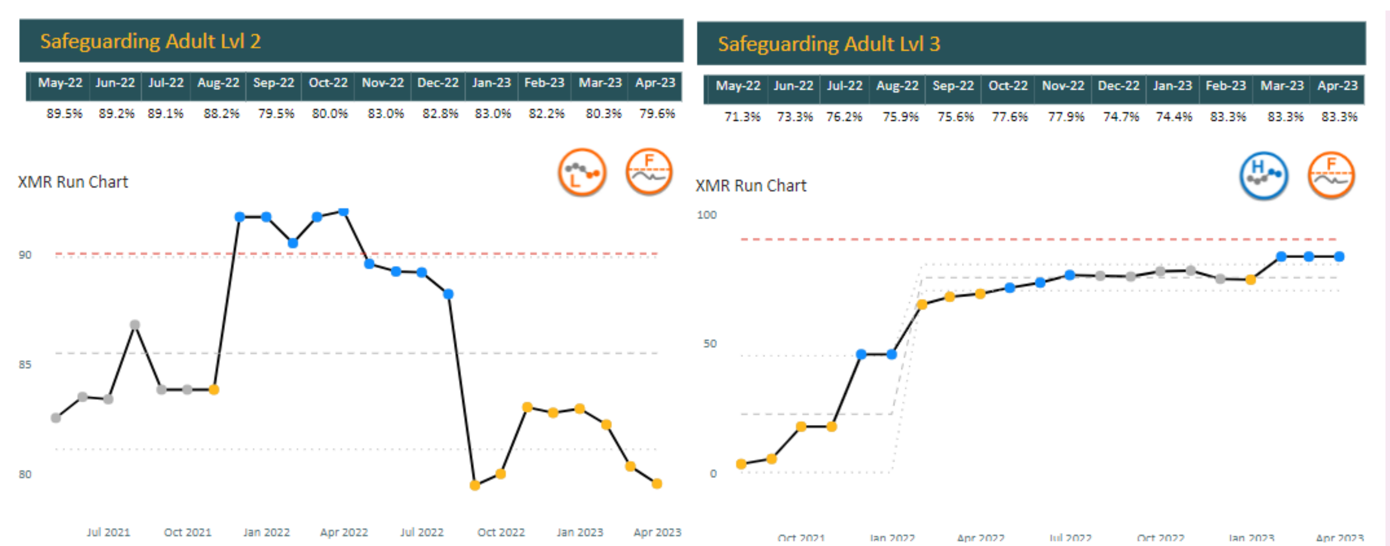
- Consistent completion of Birthrate+ data

People & Culture, Workforce Sustainability: Exception Report

Safeguarding Adults Training

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

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



Safeguarding Adult Lvl 2

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
89.5%	89.2%	89.1%	88.2%	79.5%	80.0%	83.0%	82.8%	83.0%	82.2%	80.3%	79.6%

Safeguarding Adult Lvl 3

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

What the chart tells us

Level 2

Compliance has not been achieved for 12 consecutive months, and the April figure remains below the lower confidence limit

- WHH compliance : 73% (worsened since last month)
- QEQM compliance : 82% (improved)
- KCH/Community compliance : 85% (static)

Level 3

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

Confirmed from Safeguarding team that if staff attend 8 hour level 3 training staff do not require to complete any other e learning for level 1 or 2. There will be a review of the reporting of the level 1 and 2 data going forward.

Intervention and Planned Impact

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

Risks/Mitigations

- Staffing levels remain an issue and though there is recognition of the importance of this training direct care at times takes priority.

People & Culture, Workforce Sustainability: Exception Report

Hand Hygiene, Dementia and Resus Adult Training

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

Hand Hygiene

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
46.4%	42.3%	40.4%	42.4%	40.0%	41.4%	53.8%	55.9%	57.9%	55.8%	56.3%	57.0%

XMR Run Chart

40 60 80

Jul 2021 Oct 2021 Jan 2022 Apr 2022 Jul 2022 Oct 2022 Jan 2023 Apr 2023

Dementia

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
74.5%	74.5%	75.7%	77.1%	76.9%	78.3%	79.0%	78.8%	81.6%	83.4%	84.6%	86.0%

XMR Run Chart

0 50 100

Jul 2021 Oct 2021 Jan 2022 Apr 2022 Jul 2022 Oct 2022 Jan 2023 Apr 2023

Resus Adult

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
83.8%	81.4%	77.5%	54.9%	58.0%	62.0%	72.0%	73.2%	77.1%	85.4%	82.1%	93.1%

XMR Run Chart

60 80 100

Jul 2021 Oct 2021 Jan 2022 Apr 2022 Jul 2022 Oct 2022 Jan 2023 Apr 2023

What the chart tells us

Hand Hygiene compliance remains static, above the average and upper confidence limit – however falls short of compliance (85%). WHH : 50%, QEQM : 65%, KCH/Community : 57%
Dementia compliance continues to improve month on month, just achieving compliance in April (threshold is 85%). WHH : 79%, QEQM : 93%, KCH/Community : 86%
Resus Audit compliance continues to improve, achieving compliance in April (threshold is 85%). WHH : 89%, QEQM : 95%, KCH/Community : 96%
In all cases – WHH staff have the lowest compliance levels

Intervention and Planned Impact

- Daily hand hygiene audits are now completed on Tendable which shows good compliance

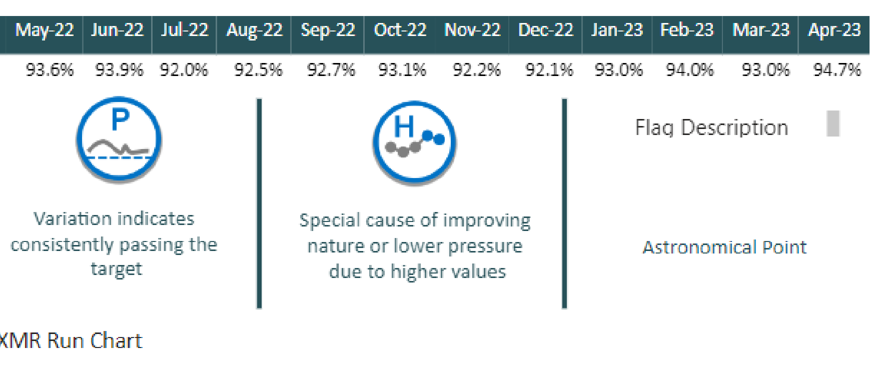
Risks/Mitigations

Issues with ESR continue for the recording of this data

People & Culture, Workforce Sustainability: Exception Report

Equality & Diversity Training

Equality and diversity training compliance for staff under 344 3212 Maternity K&C and Canterbury Coastal Community, 344 3211 Maternity QEQM and 344 3210 Maternity WHH



May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
93.6%	93.9%	92.0%	92.5%	92.7%	93.1%	92.2%	92.1%	93.0%	94.0%	93.0%	94.7%

XMR Run Chart

95
90
85
Jul 2021
Oct 2021
Jan 2022
Apr 2022
Jul 2022
Oct 2022
Jan 2023
Apr 2023

What the chart tells us

Performance has improved to 94.7%, which is outside of confidence limits

All areas are compliant, although WHH performance has been dropping below average

Intervention and Planned Impact

- To continue to encourage and support staff to attend training
- New EDI maternity network commenced in April to support a better understanding and inclusivity.

Risks/Mitigations

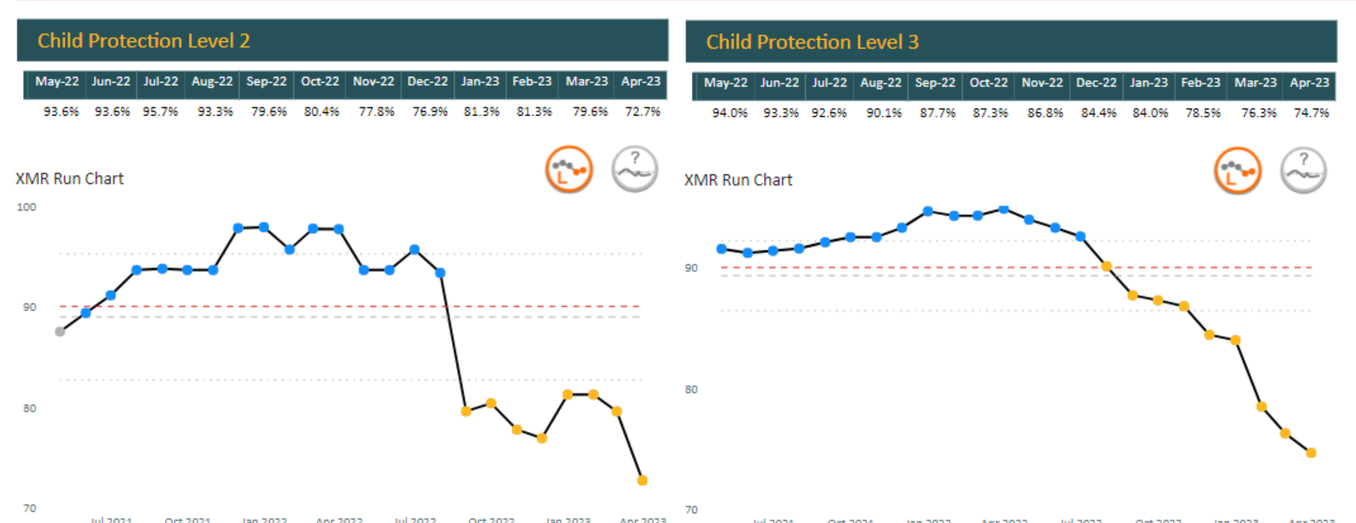
- Sickness does impact attendance

People & Culture, Workforce Sustainability: Exception Report

Child Protection Training

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

Child Protection Level 3 training compliance for staff under 344 3212 Maternity K&C and Canterbury Coastal Community, 344 3211 Maternity QEQM and 344 3210 Maternity WHH. This training is required for the majority of the staff



Child Protection Level 2

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
93.6%	93.6%	95.7%	93.3%	79.6%	80.4%	77.8%	76.9%	81.3%	81.3%	79.6%	72.7%

Child Protection Level 3

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
94.0%	93.3%	92.6%	90.1%	87.7%	87.3%	86.8%	84.4%	84.0%	78.5%	76.3%	74.7%

What the chart tells us

Level 2

Compliance has not been achieved for 8 consecutive months, with all months below the lower confidence limit and a big drop in April

- WHH compliance : 61% (reduction in performance)
- QEQM compliance : 87% (reduction)
- KCH/Community compliance : 75% (static)

Level 3

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

- WHH compliance : 71% (reduction)
- QEQM compliance : 78% (increase)
- KCH/Community compliance : 76% (reduction)

Confirmed from Safeguarding team that if staff attend 8 hour level 3 training staff do not require to complete any other e learning for level 1 or 2. There will be a review of the reporting of the level 1 and 2 data going forward.

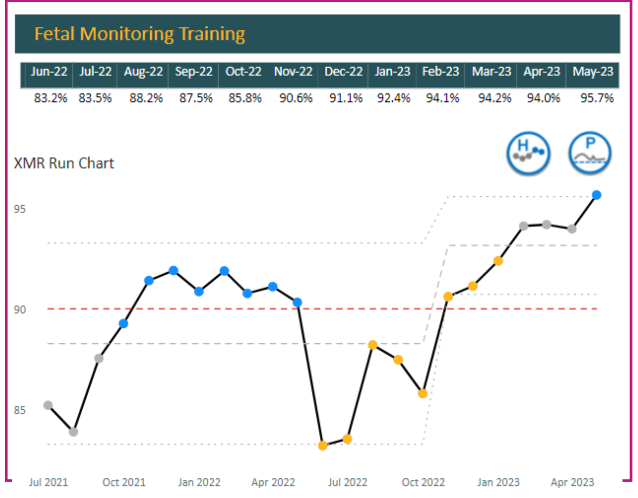
Intervention and Planned Impact

- There remain challenges in terms of capacity for safeguarding training, and dates where there remains availability have been shared with teams to ensure individuals who are non compliant are rostered to attend.
- Matrons to do targeted conversations with staff who are out of date to support their attendance.

Risks/Mitigations

- Staffing levels remain an issue and though there is recognition of the importance of this training direct care at times takes priority.

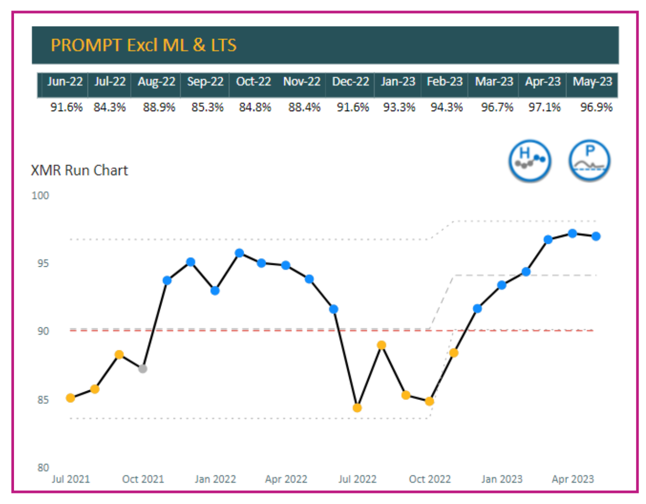
People & Culture, Workforce Sustainability: KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)



Fetal Monitoring training

All staff (includes staff on maternity and long term sick) Compliance achieved for 7 consecutive months – last month outside of the upper confidence limit.

Percentage of compliance for staff exc LTS and maternity leave is 99%

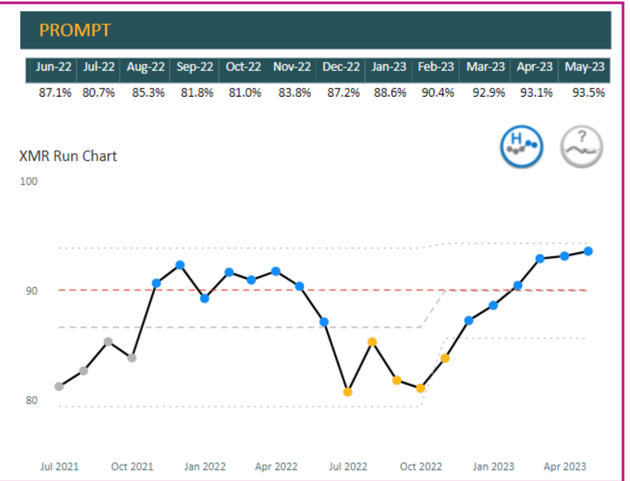


PROMPT training

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

Compliance achieved for 6 consecutive months, with an upwards trend near the upper confidence limit.

However there is an ongoing issue with the availability of obstetric faculty.

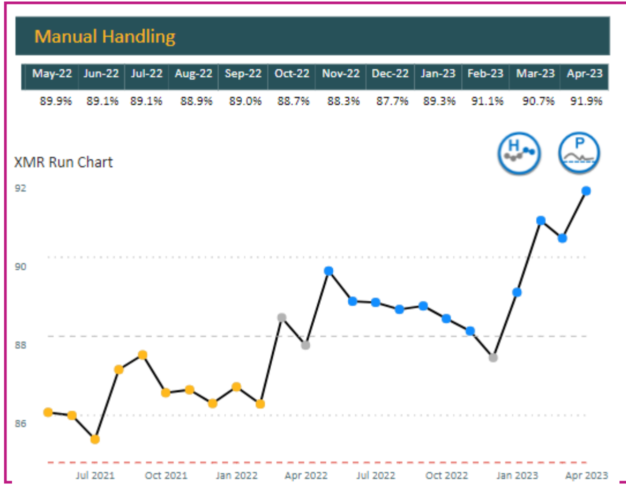


PROMPT training

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

Compliance achieved for 4 consecutive months

However there is an ongoing issue with the availability of obstetric faculty.



Manual Handling training

Compliance sits well clear of the target of 85% (April)

Clinical Pathways

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

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Antenatal	Number of Bookings	Sigma	May-23	550			572	408	737
	Bookings <13w Exceptions Excl	Sigma	May-23	94.6%			92.9%	89.6%	96.2%
	Bookings <13w	Sigma	May-23	89.6%			86.8%	83.5%	90.2%
	Bookings <10w	Sigma	May-23	51.0%			47.6%	36.7%	58.4%
	Total AN Appointments	Sigma	May-23	4,429			4,560	3,549	5,571
	Total AN Appts Virtual	Sigma	May-23	5.1%			15.6%	12.6%	10.1%
	Revised Birth Place at AN Appt	95.0%	May-23	98.1%			97.5%	97.0%	98.0%
	Revised Care Plan at AN Appt	95.0%	May-23	99.8%			99.5%	99.2%	99.9%
Triage	Telephone Triage by MW	95.0%	May-23	99.6%			82.4%	63.1%	100%
	BSOTS Total Seen	Sigma	May-23	1,945			2,235	1,601	2,869
	BSOTS Midwife Assessment	Sigma	May-23	99.5%			98.1%	94.5%	100%
	BSOTS Dr Assessment	Sigma	May-23	94.3%			92.3%	85.4%	99.3%
	BSOTS Datix Completed	Sigma	May-23	54.2%			56.9%	11.4%	100%
	BSOTS Red Rating	Sigma	May-23	15			28	0	63
	BSOTS Orange Rating	Sigma	May-23	248			314	193	435
	BSOTS Yellow Rating	Sigma	May-23	486			396	198	593
	BSOTS Green Rating	Sigma	May-23	555			457	358	555
	BSOTS Non Triage Activity	Sigma	May-23	611			785	492	1,078
	BSOTS Rating Undocumented	Sigma	May-23	22			253	38	469

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Scanning	Attended Scans	Sigma	May-23	2,829			2,893	2,504	3,282
	Cancelled by Hospital	Sigma	May-23	1,092			1,047	808	1,285
	Cancelled by Patient	Sigma	May-23	505			314	197	431
	DNA Scans	Sigma	May-23	360			351	224	478
	DNA Rate	Sigma	May-23	11.3%			10.7%	7.31%	14.2%

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Delivery	Total Babies Born	Sigma	May-23	509			514	429	600
	Term Livebirth Delivery Rate	Sigma	May-23	90.7%			91.5%	87.7%	95.4%
	Induction Rate	Sigma	May-23	33.2%			33.7%	26.4%	41.1%
	Spon Vaginal Delivery Rate	Sigma	May-23	47.0%			48.6%	42.4%	54.9%
	Instrumental Delivery Rate	Sigma	May-23	9.8%			10.9%	6.92%	14.8%
	Forcep Delivery Rate	Sigma	May-23	7.0%			7.16%	3.22%	11.1%
	Vacuum Delivery Rate	Sigma	May-23	2.8%			3.74%	1.21%	6.28%
	Total Section Rate	Sigma	May-23	43.2%			38.1%	30.7%	45.5%
	Elective Section Rate	Sigma	May-23	19.2%			16.7%	11.1%	22.2%
	Emergency Section Rate	Sigma	May-23	24.0%			21.3%	17.7%	25.0%
	Cat 1 Section <30m	Sigma	May-23	71.4%			78.8%	60.4%	97.3%
	Cat 2 Section <75m	Sigma	May-23	62.0%			67.7%	47.4%	88.1%
	Robson Group 1 C/S Rate	Sigma	May-23	20.5%			16.9%	11.5%	29.3%
	Robson Group 2 C/S Rate	Sigma	May-23	57.0%			50.9%	30.9%	66.0%
	Robson Group 5 C/S Rate	Sigma	May-23	93.0%			81.1%	69.5%	92.7%
	VBAC	Sigma	May-23	9.6%			14.9%	7.42%	20.5%
	Homebirth Rate	Sigma	May-23	2.0%			1.90%	0.35%	3.46%
	Planned Homebirth Rate	Sigma	May-23	1.6%			1.01%	0%	2.18%

Clinical Pathways: Overview

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Delivery Outcomes	3rd & 4th Degree Tears	Sigma	May-23	1.8%			3.05%	0.13%	5.97%
	MOH >1500ml	Sigma	May-23	4.2%			2.91%	0.68%	5.13%
	Shoulder Dystocia	Sigma	May-23	2.2%			1.51%	0%	3.67%
	Apgar <7 @ 5mins	Sigma	May-23	0.7%			0.86%	0%	2.56%
	Premature birth <37w	Sigma	May-23	9.2%			8.35%	4.63%	12.0%
Postnatal	Total PN Appointments	Sigma	May-23	43			389	18	149
	First PN Visit at Home	Sigma	May-23	25.0%			12.8%	0%	31.0%
	Total PN Appts Virtual	Sigma	May-23	48.8%			60.3%	34.6%	86.0%
	Maternal Readmissions	Sigma	May-23	6.4%			3.63%	0.85%	6.40%
	Neonatal Readmissions	Sigma	May-23	8.3%			8.22%	3.18%	13.2%
Anaesthetics	Anaesthetic within 30mins	80.0%	May-23	96.0%			92.6%	83.7%	100%
	Anaesthetic within 60mins	100.0%	May-23	97.0%			96.8%	91.6%	100%
	Anaesthetic Timeliness DQ	Sigma	May-23	6			5	0	14
Public Health	Skin to Skin Contact	Sigma	May-23	77.0%			77.4%	71.2%	83.7%
	Breastfeeding First Feed	Sigma	May-23	65.5%			68.1%	60.3%	75.9%
Other	ITU Admissions	Sigma	May-23	3			2	0	6

Clinical Pathways: Overview

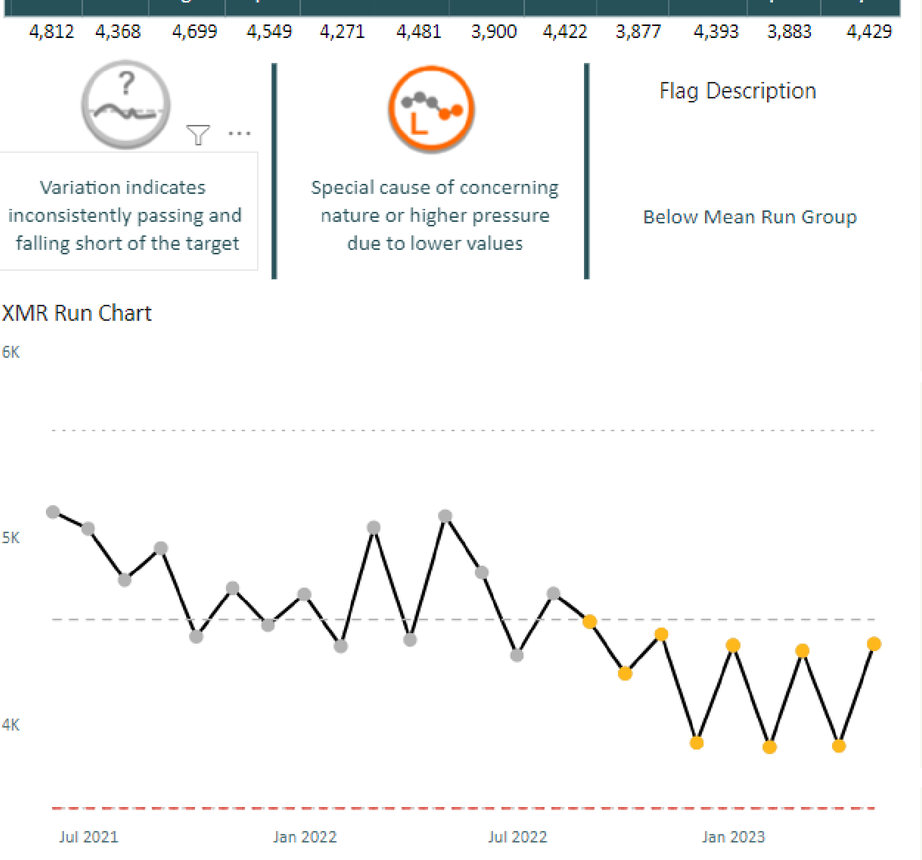
Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
SBLCB	E1 - Co Taken at Booking	80.0%	May-23	98.4%			18.6%	89.1%	98.4%
	E1 - Co >=4ppm at Booking	Sigma	May-23	11.8%			16.7%	12.1%	21.2%
	E1 - Co Reading taken at 36w	80.0%	May-23	88.5%			76.2%	62.4%	90.1%
	E1 - Co >=4ppm at 36w	Sigma	May-23	8.8%			9.55%	3.64%	15.4%
	E1 - Quit by 36w	Sigma	May-23	60.4%			52.5%	12.2%	92.8%
	E2 - SGA Detected Antenatally	Sigma	May-23	2.4%			4.06%	0.59%	7.53%
	E2 - Babies <3rd Centile 38w+	Sigma	May-23	54.5%			51.0%	18.7%	83.2%
	E2 - Babies <10th Centile 39w+	Sigma	May-23	45.9%			45.5%	25.2%	65.9%
	E2 - FGR Risks recorded	80.0%	May-23	99.5%			99.3%	98.4%	100%
	E3 - RFM Computerised CTG	80.0%	May-23	92.1%			19.1%	0%	100%
	E3 - RFM Leaflet Given by 28w	80.0%	May-23	88.0%			90.4%	86.9%	93.9%
	E4 - Fetal Monitoring Training	90.0%	May-23	95.7%			88.2%	83.2%	93.2%
	E5 - AN Steroids within 7 days	80.0%	May-23	25.0%			49.4%	6.86%	91.9%
	E5 - AN Steroids > 7 days	Sigma	May-23	8.3%			14.3%	0%	48.1%
	E5 - Mag Sulph within 24hrs	80.0%	May-23	50.0%			78.1%	0%	100%
	E5 - Appropriate Birth Setting	80.0%	May-23	99.6%			99.7%	99.0%	100%
	E5 - Singleton Born 16+0-23+6w	Sigma	May-23	0.4%			0.12%	0%	0.45%
	E5 - Singleton Born 24+0-36+6w	Sigma	May-23	7.4%			7.05%	3.54%	10.5%

Clinical Pathways: Exception Report

Antenatal Appointments

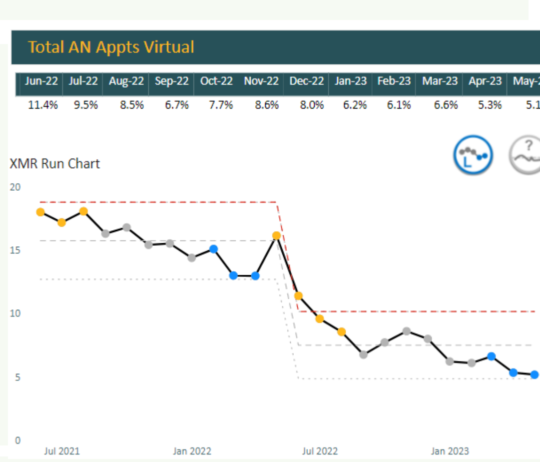
Total number of antenatal clinic appointments – midwife and obstetric, including virtual appointments

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
4,812	4,368	4,699	4,549	4,271	4,481	3,900	4,422	3,877	4,393	3,883	4,429



What the chart tells us

The number of antenatal appointments has been falling and has been below average for 9 consecutive months. This follows a reduction in virtual appointments (see chart to the right) – but a corresponding increase in face to face appointments has not been observed.



Total AN Appts Virtual

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
11.4%	9.5%	8.5%	6.7%	7.7%	8.6%	8.0%	6.2%	6.1%	6.6%	5.3%	5.1%

Interventions and Planned Impact

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

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

- Midwifery Matrons auditing care outside of NICE guidance for antenatal care and streamlining appointments to ensure not doubling up i.e. seeing midwife and consultant within a week of each other.
- To review datix to ensure that no adverse outcomes noted due to missed appointments.

Risks/Mitigations

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

Clinical Pathways: Exception Report

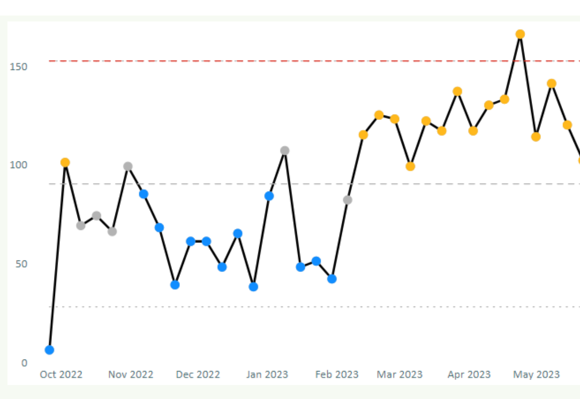
BSOTS Yellow Rating

Number of Women seen who were rated Yellow under the BSOTS system

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
				337	296	241	319	375	534	576	486

What the chart tells us

The number of patients classified as Yellow rating under the BSOTs system has increased,. Weekly data shows this increase since March 2023, and is primarily caused by an increase at WHH



Interventions and Planned Impact

- Work continues to embed the BSOTs pathways across both triage units so data will continue to fluctuate until this is fully embedded.
- More detailed auditing is underway to understand the trends and what this means.

Risks/Mitigations

- Scan plotting in both triage areas continues so during these times of high acuity this does impact the BSOTS pathway

Clinical Pathways: Exception Report

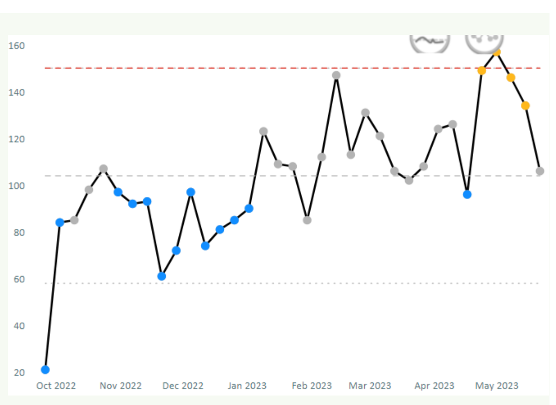
BSOTS Green Rating

Number of Women seen who were rated Green under the BSOTS system

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
				413	354	374	465	472	502	517	555

What the chart tells us

The number of patients classified as Green rating under the BSOTs system has increased,. Weekly data shows this increase since May 2023, and is primarily caused by an increase at WHH



Interventions and Planned Impact

- Work continues to embed the BSOTs pathways across both triage units so data will continue to fluctuate until this is fully embedded.
- More detailed auditing is underway to understand the trends and what this means.

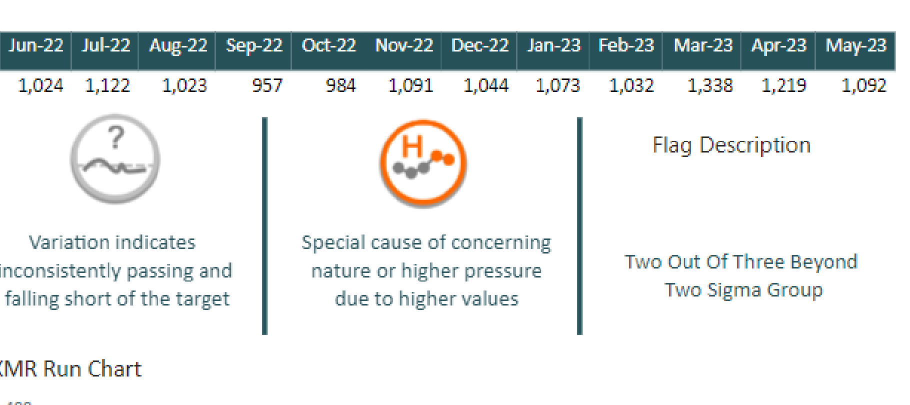
Risks/Mitigations

Scan plotting in both triage areas continues so during these times of high acuity this does impact the BSOTS pathway

Clinical Pathways: Exception Report

Scanning – Cancellations by Hospital

Number of scanning patients cancelled by hospital



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
1,024	1,122	1,023	957	984	1,091	1,044	1,073	1,032	1,338	1,219	1,092

XMR Run Chart

1,400
1,200
1,000
800
Jul 2021
Jan 2022
Jul 2022
Jan 2023

What the chart tells us

The number of patients who had a scan appointment cancelled by Hospital has increased above average for 3 months, with 2 of those 3 points close to the upper confidence limit.
This is observed across both of the main hospital sites

Interventions and Planned Impact

- **Consultation in progress to bring the obstetric ultrasound team into the women's health to enable us to have better oversight.**
- **Further education and discussions required with clinicians to ensure scans only booked within guidelines. This would reduce the number of scans required and ensure more timely appointments for those deemed urgent.**

Risks/Mitigations

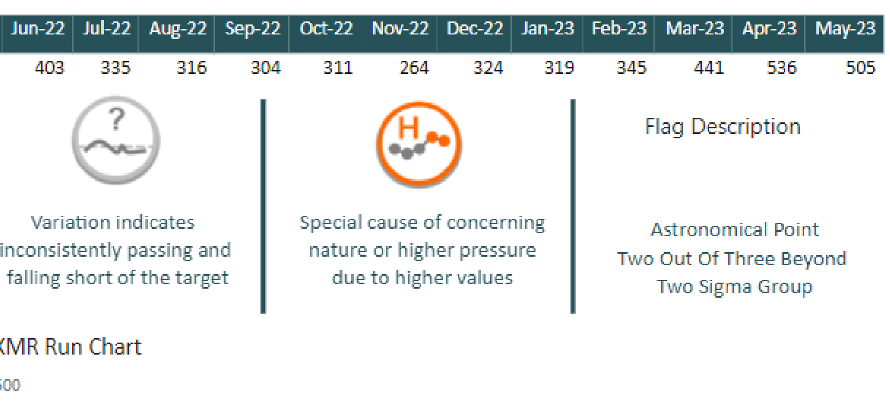
- **Radiology did not always inform public health matron in a timely manner of these cancellations resulting in serious incidents. This should be improved once the team are managed by the women's health care group.**
- **Sickness in the ultrasonography team with limited fail safe to cover this last minute sickness**
- **Poor system interface does not support early notification of issues.**

Clinical Pathways: Exception Report

Scanning – Cancellations by Patient

Number of scanning patients cancelled by the patient

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
403	335	316	304	311	264	324	319	345	441	536	505



XMR Run Chart

600
400
200
Jul 2021
Jan 2022
Jul 2022
Jan 2023

What the chart tells us

The number of patients who had a scan appointment cancelled by patient has increased above average for 3 months, with 3 points above to the upper confidence limit.

This is observed across all the main hospital sites

Interventions and Planned Impact

- **Need to review support to women to attend scans when this is not in their local area. This would be for women who match criteria for vulnerabilities.**
- **DNA is classified as cancelled by patient when being coded.**
- **More robust booking process and communication of texting through universal texting or email is required to reduce the DNA rate or last minute cancellations.**
- **Need to review antenatal pathway to avoid duplication of appointments to different clinicians within obstetrics.**

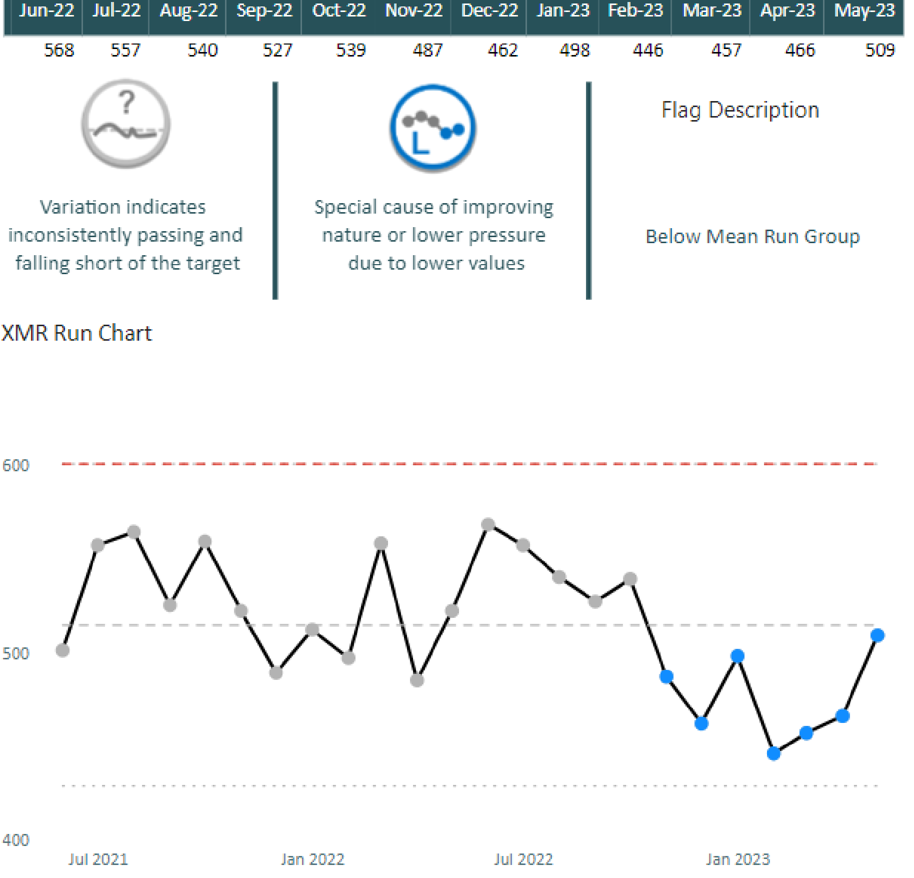
Risks/Mitigations

- **Postal service not always adequate as letter to women and birthing people at time is received after the date.**
- **Scans not always booked at the nearest site**

Clinical Pathways: Exception Report

Babies Born

Number of Babies born

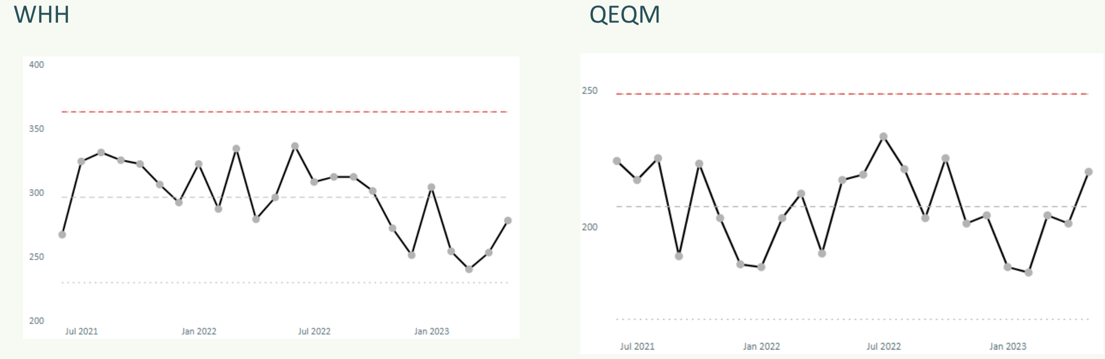


Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
568	557	540	527	539	487	462	498	446	457	466	509

What the chart tells us

There has been a reduction in birth numbers for 7 consecutive months below average – this is seen at WHH primarily, in the chart below (WHH on the left, QEQM on the right)

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



Interventions and Planned Impact

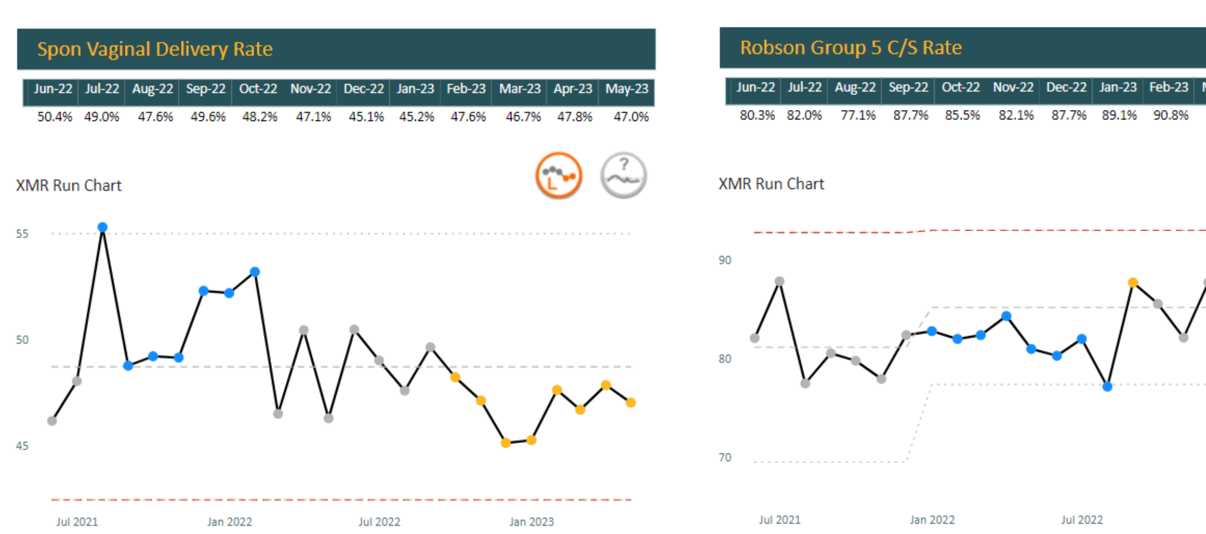
It is known nationally for birth rates o be falling throughout the UK. This does not however take into consideration n the increased complexities of women now booking for delivery.

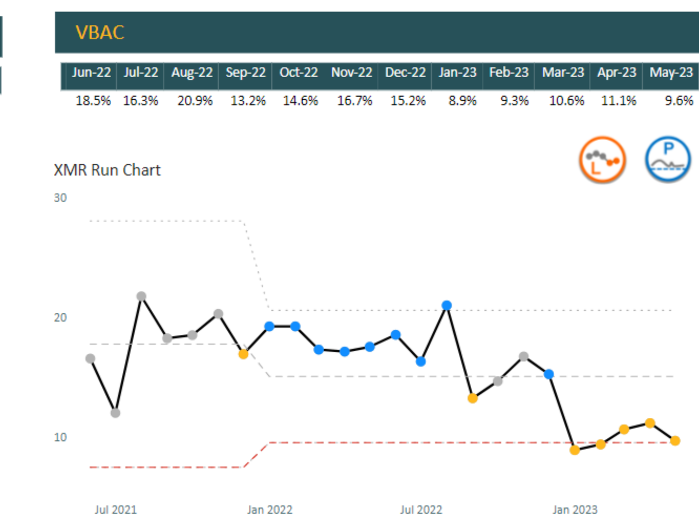
- Conversations are to take place with bordering maternity units around whether the recent publications have impacted and had an increase in out of area bookings to them.
- Full birthrate+ review due to commence in September.

Clinical Pathways: Exception Report

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

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





What the chart tells us

The section rate for Robson Group 5 women has been increasing, with the 5 most recent months close to the upper confidence limit. This is potentially impacted following the NICE guidance publication which supported women and birthing peoples choice for caesarean section.

A similar increase is seen across both sites.

In a related metric – the Vaginal Birth after Caesarean Section (VBAC) rate has decreased, with the last 5 months close to the lower confidence limit.

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

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

Interventions and Planned Impact

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

- Continual audits undertaken to review Robson Group criteria across the LMNS and it is noted when comparing data across the LMNS that East Kent is not an outlier in this field.

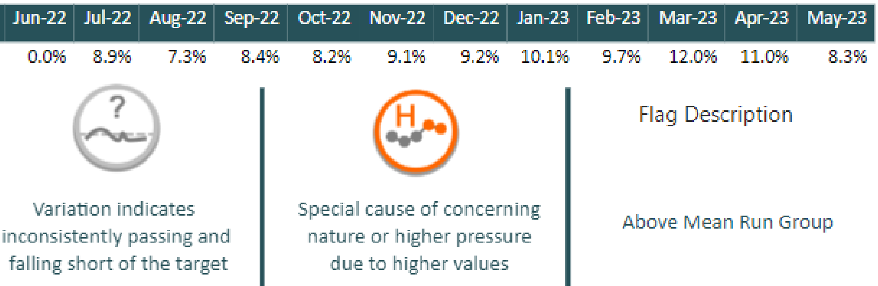
Risks/Mitigations

- MLU closure will have an impact on supporting women with low risk birth

Clinical Pathways: Exception Report

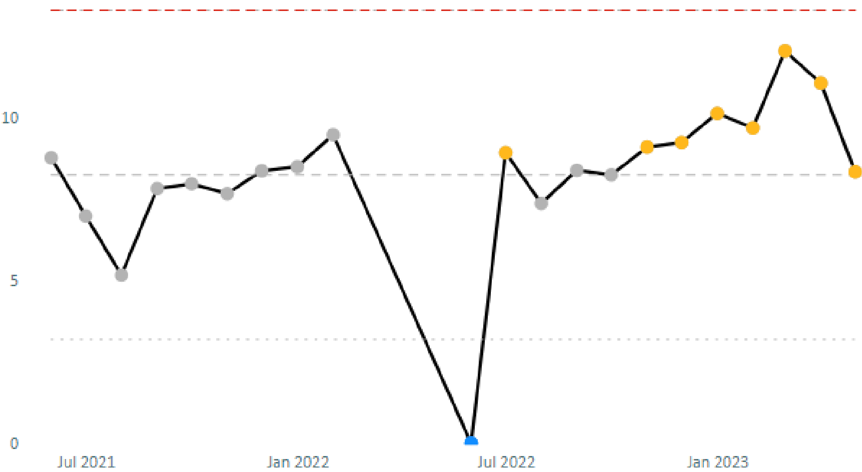
Neonatal Readmissions

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



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
0.0%	8.9%	7.3%	8.4%	8.2%	9.1%	9.2%	10.1%	9.7%	12.0%	11.0%	8.3%

XMR Run Chart



What the chart tells us

Although there has been a reduction in May, there have been 7 consecutive months above average of high neonatal readmissions – with the significant rise happening at WHH, although this has reduced to below average levels in May.

This splits by site with WHH (14 readmissions, 5%) compared to QEQM (27 readmissions, 13%)

This main reason for neonatal readmission is jaundice

The majority of babies are readmitted via the Children's Assessment Units

Interventions and Planned Impact

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

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

The audit identified that:

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

Risks/Mitigations

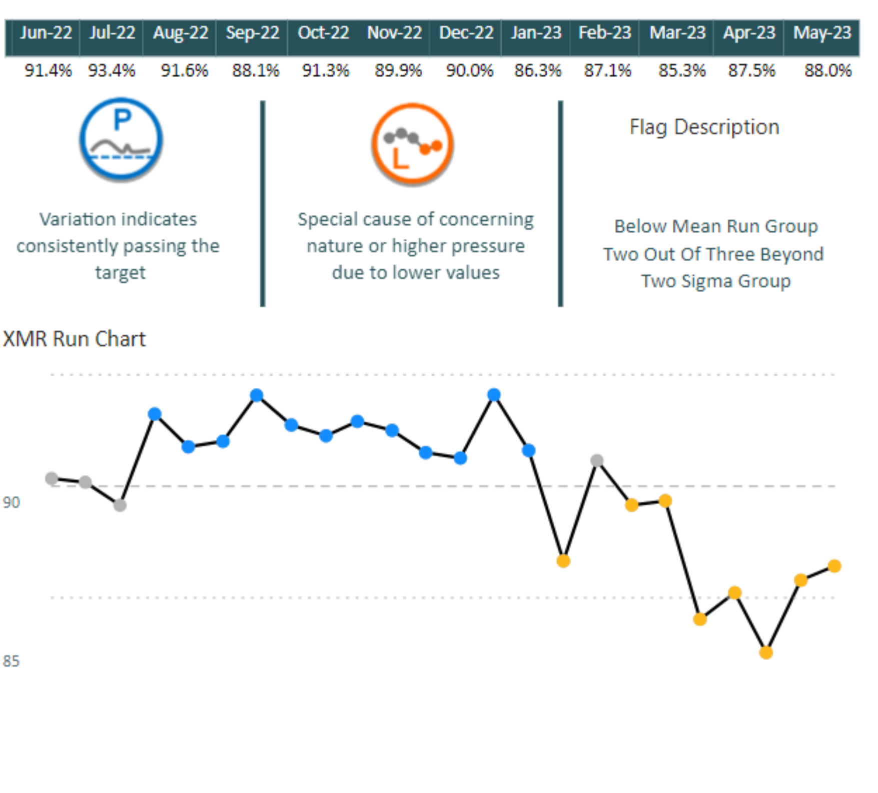
Infant team are working with ward and community based teams to increase support and education to ensure there is compliance with guidance, including assessment, communication with parents and between teams

- Through audit we are hoping to be able to identify disparity around these re-admissions between sites.

Clinical Pathways: Exception Report

Reduced Fetal Movement Leaflet given by 28 weeks

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



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
91.4%	93.4%	91.6%	88.1%	91.3%	89.9%	90.0%	86.3%	87.1%	85.3%	87.5%	88.0%

What the chart tells us

Whilst there has been a slight improvement in performance in May, the last 7 months have been below or around the lower confidence limit. However – the threshold of 80% is still being achieved consistently

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

Interventions and Planned Impact

- **Fetal monitoring and wellbeing midwives are working with the maternity triage units and community teams to support and highlight the importance of giving written information to all women and birthing people and recording on E3.**
- **Digital lead midwife working across the LMNS to ensure consistency when developing a digital solution for patient information leaflets**
- **During LMNS procurement of new digital notes it is a priority to ensure the system has the capability to support off line completion/working.**

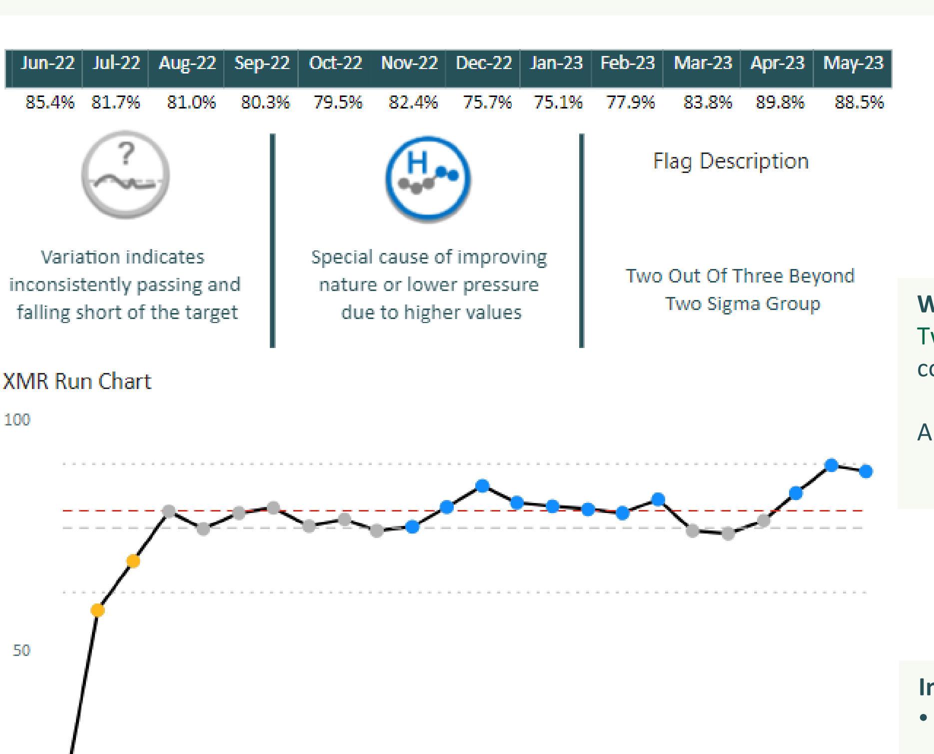
Risks/Mitigations

- **Community teams continue to have poor connectively which impacts on live data capture and increases risk of human error when documenting retrospectively.**

Clinical Pathways: Exception Report

Co Taken at 36 week appointment

Number of 36w planned appointments where the Co recording is made.



Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
85.4%	81.7%	81.0%	80.3%	79.5%	82.4%	75.7%	75.1%	77.9%	83.8%	89.8%	88.5%

What the chart tells us

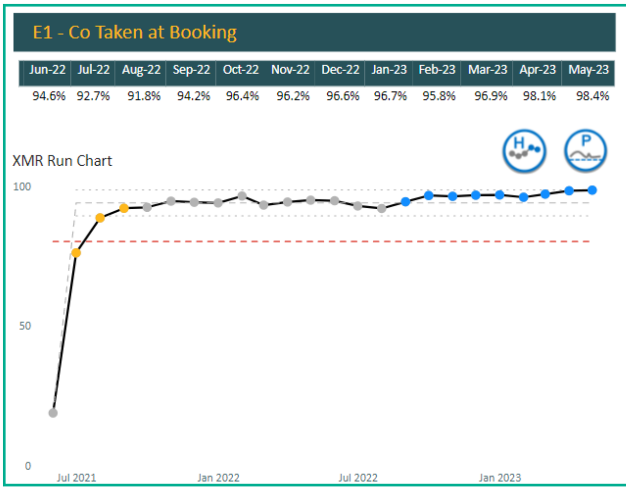
Two out of the last three periods were close to the upper confidence limit, with all teams achieving compliance of 80%

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

Interventions and Planned Impact

- Smoking cessation midwife has returned from maternity leave and re-invigorated the embedding of this practise.
- We have seen a reduction in virtual antenatal appointment which has had a positive impact on clinical practise.

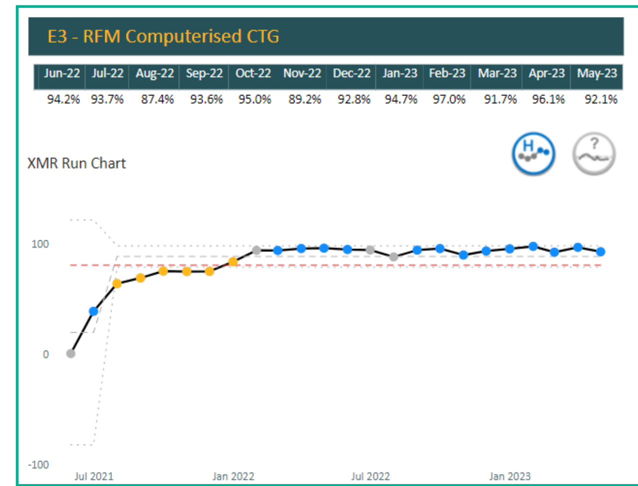
Clinical Pathways: KPIs consistently achieving threshold or sustained improvement (exception reported in previous months)



E1 - Co Taken at Booking

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
94.6%	92.7%	91.8%	94.2%	96.4%	96.2%	96.6%	96.7%	95.8%	96.9%	98.1%	98.4%

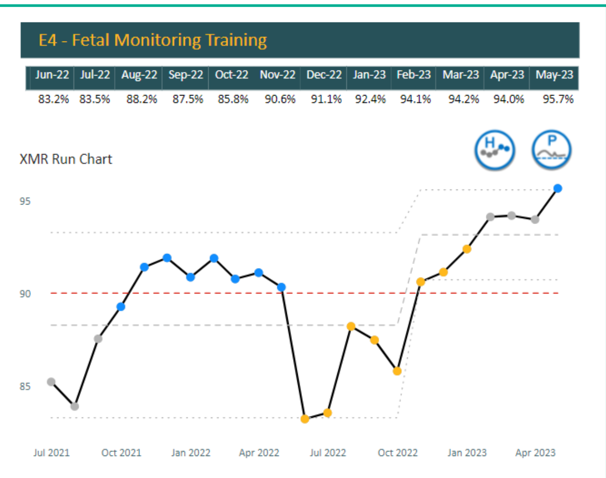
Co monitoring
Compliance remains high and achieving the threshold of 80%



E3 - RFM Computerised CTG

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
94.2%	93.7%	87.4%	93.6%	95.0%	89.2%	92.8%	94.7%	97.0%	91.7%	96.1%	92.1%

Computerised CTG recording for reduced fetal movements continues to achieve compliance



E4 - Fetal Monitoring Training

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
83.2%	83.5%	88.2%	87.5%	85.8%	90.6%	91.1%	92.4%	94.1%	94.2%	94.0%	95.7%

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

Compliance achieved for 7 consecutive months

Engagement

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

Engagement: Overview

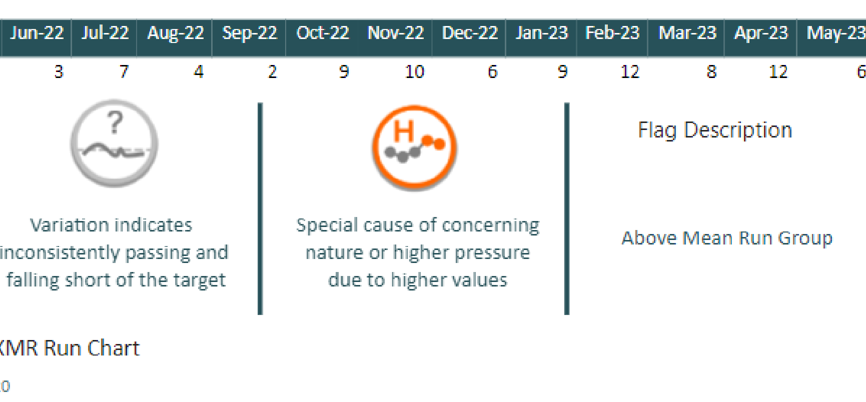
Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	Mean	LCL	UCL
Patient Experience	Complaints	Sigma	May-23	6			6	0	15
	FFT Maternity Response Rate	5.0%	May-23	10.3%			12.8%	2.63%	17.7%
	FFT Maternity (All)	90.0%	May-23	92.3%			90.6%	83.7%	97.5%
YVIH	Response Rate	70.0%	May-23	76.2%			68.1%	57.0%	79.2%
	AN Care Positive	90.0%	May-23	89.1%			90.8%	85.9%	95.6%
	Intrpartum Care Positive	90.0%	May-23	89.3%			91.7%	83.7%	99.8%
	PN Care Positive	90.0%	May-23	83.9%			85.1%	78.1%	92.0%
	Happy Returning	90.0%	May-23	86.2%			89.4%	81.2%	97.7%
	Involved in Decisions	90.0%	May-23	87.8%			87.8%	81.6%	93.9%
	Choices About Care	90.0%	May-23	84.2%			85.0%	78.9%	91.1%
	Felt Listened To	90.0%	May-23	81.3%			81.2%	74.2%	88.1%

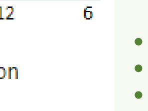
Engagement: Exception Report

Complaints

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

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
3	7	4	2	9	10	6	9	12	8	12	6





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

Flag Description

Above Mean Run Group

What the chart tells us

There have been 8 consecutive months of complaints above the average.

- 1 delay in receiving treatment (WHH Folkestone ward)
- 1 difficulty during surgical procedure (WHH labour)
- 1 doctor communication issue (QEQM)
- 1 problem with nursing care (WHH Folkestone ward)
- 1 problem with staff attitude (WHH labour)
- 1 patient unhappy with clinical management (WHH Labour)

Interventions and Planned Impact

- New complaints co-ordinator in post who is theming complaints and complements and feeding directly to the quality and safety matron to ensure complaints themes are included in education and training
- Process has been streamlined to support women and birthing people to be able to submit a complaint through YVIH rather than re telling their story through PALs.

Risk / Mitigations

- External scrutiny and publication of national reports has potentially provoked an increase in complaints to the service
- YVIH has impacted on complaint submission as women and birthing people are given opportunity to express their concerns and issues in a formalised way.

REPORT TO BOARD OF DIRECTORS

Report title: **Perinatal Surveillance Tool (PQST) Report**

Meeting date: **6 July 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO) and Maternity and Neonatal Board Safety Champion**

Paper Author: **Deputy Director of Midwifery**
Interim Head of Governance

Appendices:

NONE

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	The purpose of this report is • To update on East Kent Maternity's services, aligned to the key elements included within the perinatal and assurance framework as defined by NHS England (NHSE). • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 9, which aims to continue to support the safer maternity and Ockenden report recommendations. • Provide assurance that the service is using the tool and reporting to the required standard set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Repot December 2020, NHS resolution Clinical Negligence Scheme for trusts (CNST) Maternity Incentive Scheme year 4- Safety Action nine and Ockenden 1 Report Immediate and Essential Actions.
Summary of key issues:	• The report confirms that the service is using the tool to the required standard, as set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020. **The report includes the following key messages for the group's attention:** • CNST reporting has now begun a new period - **May to December.** • Currently the area of concern remains on standard 8 in relation to PRactical Obstetric Multi-Professional Training (PROMPT) due to anaesthetic workforce challenges. The exact criteria for year 5 have been now released. There are ongoing challenges with the availability of obstetric faculty to facilitate Multi-Disciplinary Team (MDT) PROMPT. • Anaesthetic training compliance for PROMPT remains below the national standard of 90%, but is improving. • There was one Healthcare Safety Investigation Branch (HSIB) referral for the month of May. • 3 reported moderate harm incidents of which 2 have been downgraded following rapid review. • Supernumerary status and 1:1 care compliance was not reported at 100%, however, the figures have been validated and records will be updated to confirm 100% 1:1 achieved on both units for May. • The Your Voice is Heard (YVIH) team had 170 responses which is a 10.9% response rate decrease from last month which was 11.1%. The responses show 89.4% extremely likely or likely to recommend which in the same as last month so remains stable.118 comments in total, 101 positive comments = 85.6% increase from 81.5% last month. Positive experiences and Named staff in comments - 33 members of staff named. • Friends and Family (FFT) response was 10.3 which decreased from 11.8 the previous month. 92.2% responded extremely likely of likely to recommend. • Plans to introduce **Walking the Patch** to capture live feedback from Women and Birthing people on the post-natal wards. • Introduction of **Leave your troubles at our door** as a way of addressing any issues prior to leaving the hospital. • Training compliance was met across all maternity staff groups for fetal monitoring PROMPT and Newborn Life Support (NLS). • All 3rd year student midwives were contacted with 23 indicating they wish to take up roles as newly qualified Midwives subject to completion of the course (11 William Harvey Hospital (WHH) and 12 Queen Elizabeth the Queen Mother Hospital (QEQM)). Coronary Care Unit (CCU) has lost their Midwifery Education Accreditation with solutions being explored with external faculty to support these students. • Menu of opportunities for feedback /lessons learned. • Introduction of Quality Board. • First Safety Summit at EKHFT 23/06/2023.
Key recommendations:	The Board of Directors is asked to **NOTE** the content within this PQST report.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	N

Legal and regulatory:	Y - Clinical Negligence Scheme for Trusts (CNST). NHS Long Term Plan-standard contract.
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals Perinatal Quality Surveillance April 2023

Month: March 2023	**East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting**
Care Quality Commission (CQC) Maternity Ratings WHH	Overall: Inadequate; Safe: Inadequate; Effective: Requires Improvement; Caring: Requires Improvement; Well-led: Inadequate; Responsive: Inadequate
CQC Maternity Ratings QEQM	Overall: Inadequate; Safe: Inadequate; Effective: Requires Improvement; Caring: Requires Improvement; Well-led: Inadequate; Responsive: Good
Maternity Safety Support Programme	Yes — Support Lead: Mai Buckley
Findings of review of cases eligible for referral to HSIB	During the month of May there was 1 referral to HSIB
The number of incidents logged graded as moderate or above and what actions are being taken.	There were 4 reported moderate harm incidents during May which is inclusive of one 1 serious incident declared. Below summarises the Moderate Harms and above:

CQC Maternity Ratings WHH:

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

CQC Maternity Ratings QEQM:

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

Site	Location	Category	Subcategory	Outcome
QEQM	Labour ward / delivery suite (QEQM)	Bleeding / haemorrhage	Needlestick/sharps - contact with used sharp / needle	Reviewed at MDT Rapid review and downgraded
QEQM	Labour Ward	Women's Health - unexpected problem/outcome for baby	Unanticipated admission to SCBU	Reviewed at MDT Rapid review and moderate harm agreed. However not reported as an SI.
WHH	Operating Theatre	Women's Health – Obstetric complication	PPH >1500mls	Reviewed at MDT Rapid review and downgraded

The table below summarises the serious incidents:

Site	Location	Category	Subcategory	Outcome
QEQM	Labour Ward	Women's Health - unexpected problem/outcome for baby	Unanticipated admission to SCBU	Referral to HSIB

A summary of key actions taken forward with for staff in clinical areas are:

- Compliance and Assurance Midwife commenced a rapid review of post-delivery fluid balance on cases from WHH and QEQM
- Communication regarding the sepsis screening
- Introduction of Safety Thread sharing immediate lessons learned

Themes from reviews of perinatal deaths

Themes

Women's Health Care Group
Perinatal Mortality Review Tool Upward Report
May 2023

Quoracy – 100% membership	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Chair – PMRT Lead Midwife												
Deputy Chair – PMRT Lead Consultant												
Administrator												
Obstetrician												
Midwife x 2												
Neonatologist x 2 (for NND)				N/a								
Neonatal Nurse x 2 (for NND)				n/a								
Bereavement Midwife												
Governance Midwife												
Patient Safety champion												
Managers												
External panel member												
Others as required												

What's Gone Well

- Strengthened Bereavement team
- A family commented that all staff used baby's name and this meant a lot to them.
- Continuity of care and team working for family with poor prognosis

Running Themes

- **Food and clothing provided for bereaved families being taken.**
- **No real themes contributing to the deaths**

Meeting Escalations to the WHCG Governance Group	
1	Could T21 have been identified through the anomaly USS.
2	Staff using the bereavement fridge to store lunches and collecting lunches whilst families are in the suite.
3	Swabs not taken for baby and placenta
4	Discussions with neonates once baby is at viability (Medway as lady was OOA).

Cases reported in April	
S.L	**22+6 IUD Grade A for care up to the death and A for the care following the baby's death.**
DVD	**31+1 Grading A for the care up to the baby's death and B for the care following. The B grade was due to the management of the woman's pain relief during labour.**
SD	**28+3 Grading B for care up to the baby's death and Grade C for care following the baby's death. Mum raised many points in her feedback such as the store cupboard unlocked in TS. Staff lunches in the fridge in the room. Lack of information verbal and written.**

Actions

100% of perinatal mortality reviews include an external reviewer

As shown in table above

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

Fetal Monitoring All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	214	224	95.5%
Midwife - Community	104	109	95.4%
Other Obstetric Doctor	48	49	98.0%
Obstetric Consultant	30	32	93.8%
Unknown	1	1	100.0%
Maternity Support Worker	0	0	NaN
Total	**397**	**415**	**95.7%**

Fetal Monitoring Mat Leave and LTS Removed

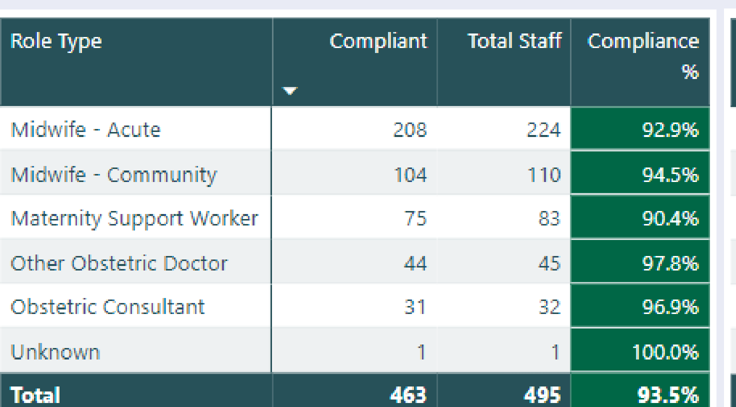
Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	204	206	99.0%
Midwife - Community	96	96	100.0%
Other Obstetric Doctor	47	48	97.9%
Obstetric Consultant	30	31	96.8%
Unknown	1	1	100.0%
Maternity Support Worker	0	0	NaN
Total	**378**	**382**	**99.0%**

Prompt All Maternity Staff

PROMPT Mat Leave and LTS Removed

Challenges:

- Availability of PROMPT obstetric faulty
- Ongoing compliance of anaesthetic attendance to training
- NLS compliance for MSWs has dropped this is due to an increase in the number of new starters at the WHH.



Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	208	224	92.9%
Midwife - Community	104	110	94.5%
Maternity Support Worker	75	83	90.4%
Other Obstetric Doctor	44	45	97.8%
Obstetric Consultant	31	32	96.9%
Unknown	1	1	100.0%
Total	**463**	**495**	**93.5%**

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	199	206	96.6%
Midwife - Community	97	97	100.0%
Maternity Support Worker	71	77	92.2%
Other Obstetric Doctor	43	44	97.7%
Obstetric Consultant	31	31	100.0%
Unknown	1	1	100.0%
Total	**442**	**456**	**96.9%**

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

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	199	224	88.8%
Midwife - Community	100	110	90.9%
Maternity Support Worker	71	84	84.5%
Other Obstetric Doctor	43	45	95.6%
Obstetric Consultant	30	33	90.9%
Unknown	0	1	0.0%
Total	**443**	**497**	**89.1%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	189	206	91.7%
Midwife - Community	94	97	96.9%
Maternity Support Worker	67	78	85.9%
Other Obstetric Doctor	42	44	95.5%
Obstetric Consultant	30	32	93.8%
Unknown	0	1	0.0%
Total	**422**	**458**	**92.1%**

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

Supernumerary Status Maintained

Month	QEQM	WHH
Dec-22	98.7%	100.0%
Jan-23	99.2%	99.6%
Feb-23	99.3%	99.5%
Mar-23	97.9%	100.0%
Apr-23	100.0%	98.9%
May-23	100.0%	99.3%
Total	99.2%	99.5%

1 to 1 care in Labour

Month	QEQM	WHH
Dec-22	100.0%	97.6%
Jan-23	100.0%	97.9%
Feb-23	99.3%	97.4%
Mar-23	100.0%	97.9%
Apr-23	100.0%	98.5%
May-23	100.0%	99.0%
Total	99.9%	98.1%

Supernumerary Status
Supernumerary Status: there was 1 incidence of supernumerary status not being met at the WHH

1:1 care in labour:
Compliance of 1:1 in Labour was reported at 99.5% Trust-wide, this related to 2 patients reported as not having received 1:1 care in labour at WHH.

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

10 Internationally educated Midwives recruited 2 passed OSCIs and in post 3 due OSCIs week commencing 5th June Remainder commenced in training

All 3rd year student midwives were contacted with 23 indicating they wish to take up roles as newly qualified Midwives subject to completion of the course (11 WHH and 12 QEQM).

The medical work force during February remains the same as the picture below-

Obstetrics-
QEQM
No incidents of nonattendance escalated.
Consultant Rota
- 2 substantive consultants not undertaking Full on call rota duties due to OH recommendations.
- 2 substantive consultants not delivering full on call due to job plan changes (leadership and post retirement)
- 2 locum agency consultants providing cover.
- 3 Offers for Consultants post

Registrar rota
- One registrar going on maternity leave at the end of April.

WHH
No incidents reported of non-attendance escalated.
Consultant rota
- 1 substantive consultant not doing full on call duties due to OH requirements.

Registrar rota
- 1 SHO GPST gap

FFT Feedback

FFT Main Themes May 2023 (collated on 5/6/23)	Actions
170 responses which is a 10.9% response rate decrease from last month which was 11.1%. The responses show 89.4% extremely likely or likely to recommend which is the same as last month so remains stable. 118 comments in total, 101 positive comments= 85.6% increase from 81.5% last month. Positive experiences and Named staff in comments- 33 members of staff named Good comments for Hearing screening -Hearing screening manager looks at these on a monthly Basis	Reported back to staff via personalised email and new posters on the wards, hard to define good care. Hearing screening manager is aware of the results
Behaviour and Attitude of Midwives	To be discussed with ward managers, Matrons and HOMs at both sites
Understaffed and not listened to on postnatal ward.	To be discussed with ward managers, Matrons and HOMs at both sites
C-section delayed and no communication about what was happening	To be discussed with ward managers, Matrons and HOMs at both sites
Inadequate care at night on the postnatal wards	To be discussed with ward managers, Matrons and HOMs at both sites. To see if essential rounding occurring at night as well in the day.
Inadequate/delayed pain relief on the postnatal wards	Essential rounding is still occurring but is not consistent at both sites. Drug rounds have now been commenced on the ward and an extra drugs trolleys order has been submitted to procurement to make the drug rounds easier for the staff. Drug rounds have commenced on the Folkestone ward now a second drug trolley has been acquired.
Food, Hydration and blankets for partners.	Refreshments for partners have been budgeted for and agreed. If partners would like some food a snack bag can be requested via help desk and these are £2 a bag. Hot drinks will be offered to partners on the ward rounds. Blankets and pillows for families to be followed up with procurement. Water coolers at the WHH site to be followed up and time frame for delivery.
Estates Room not big enough, too hot, cramped and lacks confidentiality and sound proofing. Facilities need updating.	Limitations due to the estates that PEM have put forward some suggestions from feedback receive about the estates and awaiting estate plans to be agreed and actioned.
Delays in Discharge	There has been a discharge group set up to look at the processes and what could be improved. In speeding up this process. Also, discussions around information around discharge- an information leaflet to potentially be designed in co-production with families

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – May Data	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
The service achieved a response rate of 76.4% which is an increase from April (68.5%). With a set KPI of a 70% response rate. Of the families that responded, 84.27% said that they would return to East Kent for their maternity care. This is down from April of 85.8%. 5.93% (7.6% April) (20 people) were unsure if they would return to EKHUFT, 6.23% (5.5% April) (21 people) said no they wouldn't return to EKHUFT for their care Of the 337 conversations • 268 were positive- 79.53% ↑ • 46 were neutral – 13.65%↑ • 23 were negative – 6.82%↓ (was 42! in April) Less negative conversations overall this month, both negative and neutral comments are 20.47%, which is a slight decrease from April which was 21.2% • 124 compliment emails sent to staff members	Response rate this month has been our best month to date. Even though there were fewer negative comments this month the neutral has increased. There are two meetings arranged from this months YVIH calls to patients with PEM to go through the PALS complaint services and complete the forms with them. These will both be face to face appointments which will be a first for the PEM team. Compliments have been passed on and all people emailed will be included at the end of the PEM monthly Newsletter. There have been quite a few compliments from families who have said that negative media around maternity at EKHUFT does not reflect their experience. April's data (reported in last month) has just been themed and sent to the Business Intelligence team to compare to previous data to show trends.

		Email address have been gathered from families that gave consent to be involved with a Maternity Participation group (name to be decided) and aim is to get our own Maternity participation group to commence with the MVP co-production in more areas.
	Similar themes as the previous months (ongoing theme): • More comfortable chairs for partners more at QEQM than WHH, some positive comments about the chairs at WHH • Food and drinks for partners	Two chairs have been trialled at QEQM this month with the second chair being placed in situ this week. The feedback from our families and staff will be collated to come up with a decision on which if any would be best to purchase. Refreshments for partners have been budgeted for and agreed. If partners would like some food a snack bag can be requested via help desk and these are £2 a bag. Hot drinks will be offered to partners on the ward rounds. Water coolers at the WHH site to be followed up and time frame for delivery..
	Lack of Analgesia, catheter care, bedding being changed and water offered on PN wards	Essential rounding is still occurring but is not consistent at both sites. Drug rounds have now been commenced on the ward and an extra drugs trolleys order has been submitted to procurement to make the drug rounds easier for the staff. Drug rounds have commenced on the Folkestone ward now a second drug trolley has been acquired.
	Lack of Analgesia in IOL and labour	This is being discussed and followed up with the pain management group on a monthly basis on how we can assess our birthing parents pain score. TENS machines are now at both sites and a SOP is in production, with adhoc training being requested so that these can be offered and used on the labour wards. A pain scoring system had gone out for comment via the MVP and they have agreed on one which is easier to use. The PEM team plan on going out onto the wards and getting feedback on this system from families on the units.
	Delay in the Discharge Process on the Postnatal wards	There has been a discharge group set up to look at the processes and what could be improved In speeding up this process. Also, discussions around information around discharge- an information leaflet to potentially be designed in co-production with families
	Postnatal wards lots of comments about the environment of the postnatal wards, extreme temperature fluctuation, cramped rooms, on the ward not fit for purpose toilets at the QEQM site. Lack of toilets on the ward for partners. This has been an increase in comments.	Limitations due to the estate. PEM have put forward some suggestions from the YVIH calls about the estates and awaiting estate plans to be agreed and actioned.
	Limited Birth plan appointments/Antenatal education in the community	Staff co-production events have occurred in May with the survey for staff staying open for comment until the end of June. 6 family co-production events have been organised for June with a survey also being made for them to complete and to be sent out ASAP.

MVP Feedback

Maternity Voice Partnership feedback (continued themes)	Actions
Sonography- lack of communication during appointments	PEM to feedback to sonography monthly with common themes. Awaiting sonography lead to be appointed to discuss YVIH/MVP feedback
Lack of information about whether MLUs are open/ Limited choices about place of birth	PEM in discussion with comms re MLU closures and keeping women informed. To discuss with DOM
Stressful, busy environment on labour ward	Actions taken since CQC/NHS England inspection; Resuscitaires now have an allocated room instead of corridor. Neonates have their own room instead of COW in corridor. No beds/trolleys are now in corridors. Post c/s screens used for privacy on labour ward on transfer to recovery
Inadequate pain relief in labour	This is being discussed and followed up with the pain management group on a monthly basis: - TENS machines are now at both sites and a SOP is in production, with adhoc training being requested so that these can commence to be offered and used on the labour wards - Options for analgesia in labour comms sent out via social media (8-week plan)

	- Pain score system being reviewed – PEM to send survey/poster to MVP of how best to score/assess pain in labour
Poor communication and aftercare, communication between handovers inconsistent	Essential rounding implemented at WHH, fundamentals of care at QEQM Postnatal care feedback event with MVP, Leisa Foad, Lucy Moat, services users. From this the postnatal guideline is being updated by Leisa Foad. There are a couple of leaflets in production and a new member of staff has started and will be responsible for those.
Women receiving news/results in public spaces/waiting rooms	PEM to discuss with Triage/Daycare leads at each site re availability of private spaces. Feedback to triage Lisa Wood, to arrange teams to discuss other feedback to triage leads WHH/QEQM
Replace telephone consultations with face to face appointments	Awaiting consultant leads for an update concerning this.
Lack of food/drink provision for partners	Provision of food and drinks for partners has been confirmed by HOMs, to share via comms
Staff tried to persuade woman to go home and continue IOL next day, however she refused, had to stand her ground, she stayed and gave birth 3 hours later	To D/W HOMS /matrons – what is protocol for rest for IOL is it personalised Discuss pain score use in IOL /labour at pain management To discuss at pain management, need to implement TENS/SOP – in use at WHH, ready for use in EME at QEQM equipment's clerk informed
	d/w anaesthetic leads LOCCIPS/WHO safety checklists are in place to ensure staff introduce themselves, to speak to matrons to ensure this is happening.

Number of Complaints

6 Complaints were received during May of these 5 related to care at the WHH, and 1 at QEQM

Site	Location	Category	Subcategory
WHH	FF - WHH FOLKESTONE WARD	Delays	Delays in receiving treatment
WHH	WLAB - WHH LABOUR WARD	Surgical management	Difficulties during procedure
QEQM	OTH - OTHER	Communication	Doctor communication issues
WHH	FF - WHH FOLKESTONE WARD	Nursing care	Problems with Nursing Care
WHH	WLAB - WHH LABOUR WARD	Attitude	Problems with other staff attitude
WHH	WLAB - WHH LABOUR WARD	Clinical management	Unhappy with treatment

Listening to women engagement activities and evidence of co-production	There were no events held however feedback was continually gathered through YVIH and FFT.
Staff feedback from frontline safety champions and walk-abouts	Following publication of the CQC report on the 26 May staff forums were held to support the team and be available for any questions Senior Clinicians Day planned for 6th June to discuss MTP . All staff engagement event with service users/ MIA/ICB and MatNeo representation planned for 28 June 2023 New DOM and DDOM have undertaken all engagement sessions during the month of May and continuing through June

HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	The CQC publication on the 26 May Quality rounds have now been implemented and formalised. The findings reported through the MNAG. Key metrics relate to: • Environmental and infection prevention and control (IPC) weekly rounds. These are now in place and supported by the matron or HOM on each site. These also include hand hygiene and personal protective equipment (PPE) audits. • Fresh Eyes compliance – daily audits are in place to review compliance on both sites • Equipment safety checks, including resuscitaire checks. Daily monitoring in place, 100% now being reported.
Coroner Reg 28 made directly to the Trust	N/A
Progress in achievement of CNST 10 Safety Standards	(see table below)

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

Safety action	Update	RAG
6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2	A quarterly report including all risks, mitigating actions and escalations is included in February Maternity and Neonatal Assurance Group (MNAG) Reporting.	

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		
5 Elements of SBLCBV2	**RAG**	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks - 88.5% compliance level
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 92.1% for women attending with reduced fetal movements. Requirement 8%. Fetal Movements having Computerised CTGs. 99.5% of women have FGR risks recorded at booking (requirement 80%)
ELEMENT 4: Effective fetal monitoring during labour		Compliant for all staff groups
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. National challenge- will not fail if isn't achieved. Action plan and Mat Neo Quality Improvement work in progress to support

Safety action	Update	RAG
7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services	Work continues with the MVP to coproduce plans to address concerns raised by women	
8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4	Severe Risk- Anaesthetic workforce attending multi-professional maternity emergencies training day. Attendance is improving. Working with anaesthetic leads to address gap, supported by CMO.	
9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	MatNeoSip Quality Improvement work aligned to the National Driver continue around Perinatal Optimisation bundle of care. Safety Champion Walkabouts and feedback sessions continue monthly on each site. Actioning of concerns are captured in a repository and themes are included in PQST report. Midwifery Continuity of Carer remains on hold as previously reported.	
10. Reporting 100% of qualifying 2019/20 incidents under NHS Resolution Early Notification scheme	No cases for this reporting year	

Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.
Outstanding Ockenden recommendations	Ongoing work around • Training needs analysis (TNA) - update to reflect requirements for 23/24 • LMS reports showing regular review of training data and minutes. Criteria and agreed pathways for referrals to Maternal Medicines Centre (MMC) • Personal Care and Support plans – pilot has commenced • Improving the practice & raising the profile of fetal wellbeing monitoring • Submission from MVP chair rating trust information in terms of: accessibility and quality of info available to service users • An audit of 5% of notes, on women who have specifically requested a care pathway, and also a selection of women who request a caesarean section during labour or induction. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Risk assessments required for policies not in date – fetal monitoring is completed

Glossary

CCG: Care Quality Commission

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

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

DATIX: The trusts incident reporting system

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

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

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

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

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

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

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

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

NLS: Neonatal Life Support Training

NHSR: NHR Resolution

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

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

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

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

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

REPORT TO BOARD OF DIRECTORS

Report title: **Obstetric Workforce Update**

Meeting date: **6 July 2023**

Board sponsor: **Chief Medical Officer**

Paper Author: **Interim Clinical Director Women's Services**
Acting Director of Operations

Appendices:

NONE

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The purpose of this paper is to provide an update in relation to the current obstetric workforce position within Women's services.
Summary of key issues:	The report summarises the following key areas: The team have been working with NHS England (NHSE) to review job plans mapped to service requirements. This has identified a potential shortfall, but does not take into consideration a revision of the current obstetric workforce model at William Harvey Hospital (WHH). There is a rising risk due to ongoing vacancies in the consultant workforce at Queen Elizabeth the Queen Mother Hospital (QEQM). However, recruitment is underway and the application of a recruitment incentive has attracted good candidates. The teams on both sites have had to implement additional consultant dedicated cover for triage areas. However, at WHH this has not been achieved through job planning, instead additional hours are being paid to support. Health Education England (HEE) visited the team to speak with the junior doctors across Obstetrics and Gynaecology in March, following the concerning General Medical Council (GMC) survey previously. The feedback was positive across both sites.
Key recommendations:	The Board of Directors are asked to **NOTE** the content of the report.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**CRR 76:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	N
Legal and regulatory:	Y - Maternity and neonatal safety champions report as required for Safety action 9 Clinical Negligence Scheme for Trusts (CNST)
Subsidiary:	N

Assurance route:

Previously considered by: Maternity and Neonatal Assurance Group (MNAG)

Obstetric Workforce Update

1. Purpose of the report

1.1 The purpose of this report is to provide an update in relation to the obstetric workforce across the maternity services for East Kent.

2. Background

2.1 Since the submission of the previous obstetric workforce paper, the team have been working with NHSE to review job plans aligned to current activity and ways of working.

2.2 Following further external reviews and an unannounced Care Quality Commission (CQC) inspection, additional medical cover has been put in place for triage at the WHH, which is a temporary solution to improve the obstetric senior oversight during busy periods.

2.3 There remain ongoing challenges in terms of recruitment and rota gaps for the consultant workforce, which is now beginning to add strain to the ability of the team to support compliance for mandatory training especially aligned to PRactical Obstetric Multi-Professional Training (PROMPT).

3. Consultant Establishment

3.1 The Clinical Director and Operational leads continue to work with NHSE to review the current job plans and the capacity to deliver the required clinical care.

3.2 The recent feedback from this exercise, aligned to the current obstetric workforce model, is that there may need to be additional consultant posts, at this point estimated at 8 Whole Time Equivalent (WTE).

3.3 This needs further discussion to understand how this aligns to the current way of working at WHH and QEQM, and if there is a need to revisit the overall model currently in place. Currently the 24-hour onsite presence remains in place for the WHH.

3.4 The outputs of the job planning exercise need to be shared in full within the care group and through to MNAG to inform the next steps.

3.5 At QEQM there is an increasing risk due to the number of consultant obstetric vacancies (4 WTE), combined with the added pressure of consultants who are not undertaking the full on-call commitment due to sickness/Occupational health recommendations, as well as management responsibilities.

3.6 Recruitment in in progress for the consultant posts, and a recruitment has been applied to the QEQM posts, and this has attracted a number of excellent applicants. Interviews are scheduled for the 25 May 2023.

3.7 There is 1 WTE vacancy at the WHH, which is being recruited to. There are two doctors who are not currently participating in the on-call rota.

3.8 Middle grade vacancies continue to pose a challenge in terms of recruitment sue to the inability to provide housing for overseas doctors coming to the UK

3.9 The ongoing shortages across the obstetric workforce is impacting on the compliance with PROMPT training moving forward, both in terms of delivery as well as participation.

4. Additional requirements due to clinical concerns

4.1 As previously reported there has been a need to provide dedicated senior obstetric presence to triage on both sites.

4.2 The above has been achieved at QEQM through job planning. At WHH the capacity has not been available in the existing job plans and therefore additional paid shifts have been implemented.

4.3 At the weekend additional cover has been facilitated with a registrar rostered to cover triage.

4.4 This requirement needs to be factored into a sustainable model going forward and also incorporating the assessment of the requirement to continue a resident on call model at WHH or not.

5. HEE follow up visit March 2023

5.1 On the 28 March 2023 HEE visited East Kent to meet with the junior doctors following the results of the recent GMC junior doctor survey.

5.2 The team were told by the Dean and the visiting team that the junior doctors felt very well supported by the multi-professional teams and midwives were mentioned especially as being supportive despite the pressures and workload.

5.3 The team were also told that they said they would recommend the Trust to their friends/family.

5.4 The feedback also identified that the juniors reported that they were very well supported by everyone and the midwives were very supportive

6. Summary

6.1 The consultant workforce numbers and model cannot currently meet the needs of the service to ensure senior obstetric oversight to key areas consistently, without the additional sessions outside of job planned activity.

6.2 Further discussion is required around the sustainable model for the obstetric workforce, taking the NHSE job planning exercise into consideration

6.3 The outputs of the NHSE job planning review will be presented to MNAG.

REPORT TO BOARD OF DIRECTORS

Report title: **Bi-Annual Midwifery Workforce Oversight Report covering Staffing/Safety Issues**

Meeting date: **6 July 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO) and Maternity and Neonatal Board Safety Champion**

Paper Author: **Director of Midwifery**

Appendices:

NONE

Executive summary:

Action required:	**Approval**
Purpose of the Report:	**Purpose** • This paper is presented in compliance with NHS Resolution Maternity Incentive Scheme; Clinical Negligence Scheme for Trusts (CNST) Safety Action 5 in relation to Maternity Incentive Scheme Standards for Safe Staffing in Maternity Settings. • The requirement is that a systematic review of the midwifery establishment is submitted to the Board biannually. • The last Midwifery Workforce report was received by the Board in December 2022 and covered the period of May 2022 to September 2022. • This report covers the reporting period of October 2022 to March 2023 (which precedes the CNST Year 5 period). • **Compliance is reported against CNST Safety Action 5 Standards a-e;** a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every six months, during the maternity incentive scheme year five reporting period.
Summary of key issues:	• 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, both of which are input measures linked to safer maternity staffing. • The last BirthRate Plus review was completed in April 2021 but a more detailed workforce review paper was received by this Board in May 2022 which included mitigations for the identified workforce shortfalls. An associated business case was approved for 38.24 Whole Time Equivalent (WTE) Midwife posts (and 11 WTE specialists) and included the Ockenden funding of 19.9 WTE posts. • The percentage of specialist midwives employed, including those in management positions has previously been reported as 22.7%, and was is in line with the BirthRate Plus requirements. • The previous workforce report demonstrated that a Safe Staffing investment of an additional £1.6m since 2021, combined with £1.8m Ockenden funding, resulted in an additional 38 WTE midwife and 11 specialist midwife posts being created. This investment enabled the Trust to declare that the funded maternity establishment was compliant with outcomes of the BirthRate Plus workforce review. Since the time of that declaration the birth rate declined by approximately 2% which would indicate that the current funded establishment continues to be compliant with the 2021 BirthRate Plus review. • Given that the last full BirthRate Plus review was undertaken in 2018 and a desktop exercise done in 2021 it is recommended that a full workforce review is undertaken and the findings presented to the Board in the next CNST reporting timeframe. • Evidence from the intrapartum acuity tool shows a compliance rate with the supernumerary labour ward co-ordinator of 99.5% at Queen Elizabeth the Queen Mother Hospital (QEQM) and 99.2% at William Harvey Hospital (WHH) during the six month period. On review of non-compliant shifts data recording issues were identified suggesting that the team had achieved 100% supernumerary status but occasionally there was a lack of clarity in relation to which duties a coordinator can fulfil whilst still maintaining supernumerary status. • In relation to 1:1 care in labour evidence from the maternity dashboard demonstrates 99.8% compliance at the QEQM site and 99.3% compliance at the WHH during the six month period. On reviewing the cases reported as non-compliant it was also identified that issues relating to recording and an occasional lack of understanding in relation to the definition of 1:1 care were identified and actions put in place to mitigate this.
Key recommendations:	The Board of Directors is asked to: **1.** **NOTE** the results of the CNST biannual midwifery workforce report and contents of the action plan in compliance with CNST Safety Action 5 required standard.

	2. **NOTE** and **SIGN** the inclusion of the Midwifery Workforce Action Plan.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	Y - Additional resource will be required to implement the Final Ockenden Report Immediate and Essential Actions.
Legal and regulatory:	Y – NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST), Ockenden 1, Ockenden 2 Final.
Subsidiary:	N

Assurance route:

Previously considered by: N/A

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

1. Purpose of the report

1.1 This paper is presented in compliance with NHS Resolution Maternity Incentive Scheme; CNST Safety Action 5 in relation to Maternity Incentive Scheme Standards for Safe Staffing in Maternity Settings.

1.2 The requirement is that a systematic review of the midwifery establishment is submitted to the Board biannually. The Trust Board is required to evidence midwifery staffing budget that reflects the establishment as calculated by the systematic review.

1.3 The last Midwifery Workforce report was received by this board in December 2022 and covered the period of May - September 2022.

1.4 This report therefore covers the six month reporting period of October 2022 to March 2023.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
a. A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
c. The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
d. All women in active labour receive one-to-one midwifery care
e. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every six months, during the maternity incentive scheme year four reporting period (from 8 August 2021 until 30 June 2022)

2. Standard a) A systematic, evidence-based process to calculate midwifery staffing establishment

2.1 A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.

2.1.1. Findings from the BirthRate Plus review carried out November 2020, a BirthRate Plus desk top review in April 2021 and a further full midwifery line by line staffing review conducted in August 2021, have previously been shared with Maternity Neonatal and Assurance Group (MNAG) and Board of Directors.

2.1.2. The workforce reviews undertaken prior to May 2023 indicated a shortfall of staff to deliver maternity care appropriate for the complexity of the case mix at EKHUFT. The previous report demonstrated that a Safe Staffing investment of an additional £1.6m since 2021, combined with £1.8m Ockenden funding, resulted in an additional 38 wte midwife and 11 specialist midwife posts being created. This investment enabled the Trust to declare that the funded maternity establishment was compliant with outcomes of the Birthrate plus workforce review. Since the time of that declaration the birth rate declined by approximately 2% which would indicate that the current

funded establishment continues to be compliant with the 2021 BirthRate Plus review.

2.1.3. There are discrepancies between Electronic Staff Record (ESR) and budget statements. There are also differing accounts in relation to the number of funded specialist midwifery posts in the previous workforce report, the ESR report and the budget. The previous report noted 40.7 WTE funded specialists posts, ESR shows 32.41 WTE funded specialists and the specialist budget 3208 has 44.9 WTE specialist posts.

2.1.4. Continuity of Carer continues to be suspended due to the ongoing workforce challenges which aligns with decision 3 within 'The Ockenden Final Report Letter, April 2022. It is also worthy of note that a target for continuity of carer has also been removed from the Year 5 CNST requirements.

2.2 Action Plan to address findings from workforce review table-top exercise

2.2.1 The actions to achieve the additional staff required to address the deficits identified within the BirthRate Plus and the detailed workforce review undertaken in 2022 were included in the previous midwifery workforce action plan**.** The 25% uplift has remained appropriate based on the current average of absence over the last 3 years and more recent guidance.

2.2.2 Since the time of the last BirthRate Plus review the service has experienced a slight decline in the number of births. In the April 2021 review the birth rate was recorded as 6060 births and in 2022-2023 5994 births have been recorded. In view of the decline in the number of births there is a requirement to repeat the Birthrate plus analysis to inform future workforce planning needs.

Measure	BBA/Transit	Homebirth	Other	Queen Elizabeth the Queen Mother	Queen Elizabeth the Queen Mother MLU	William Harvey	Total
Total Babies Born	21	117		2,417	68	3,465	6,088
Total Women Delivered	21	117		2,375	68	3,413	5,994

2.3 Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

2.4 The previous workforce report referenced an investment in maternity of an additional 38wte midwives and 11 WTE specialists to enable the service to be compliant with Birthrate plus.

2.4.1 The current vacancy rate across the service is 10.5% with a higher site-specific rate at WHH of 15.7% and 4.6% at QEQM.

2.5 Canterbury Christ Church University (CCCU) lost its accreditation for the midwifery education programme resulting in all local third year midwifery students being unable to complete their training in September 2023 and take up Newly Qualified Midwives (NQM) positions that have been offered. An external faculty is being sourced to provide the remaining 120 credits required for students to complete the programme. This has had an impact on the recruitment trajectory. However, the service is maintaining links with students who have all expressed an interest in taking up positions once qualifying.

2.5.1 A recruitment premium has been applied to band 6 posts, to attract experienced midwives to stabilise skills mix, as newly qualified midwives recruited.

2.5.2 International recruitment of midwives has surpassed the agreed number of 8 WTE with a total of 10 wte starting. 2 wte have successfully registered with the Nursing and Midwifery Council (NMC), 3 WTE are awaiting Objective Structured Clinical Examinations (OSCEs) and 5 WTE commencing their 4 week training prior to OSCEs.

2.5.3 Bank and agency is utilised and an on-call system implemented as a contingency for shortfalls in staffing.

2.6 Planned versus actual midwifery staffing levels

2.6.1 The Unify Report on Health Roster provides access to information on planned versus actual midwifery levels which are reviewed as part of ongoing monthly monitoring, led by the Heads of Midwifery.

2.6.2 Staff planned versus actual staffing levels are also monitored through the dashboard capture of sickness, vacancy and turnover levels. There is a daily sit rep meeting across sites to review and ensure safe staffing.

2.7 The midwife to birth ratio

2.7.1 The birth to midwife ratio is tracked and reported through the maternity dashboard, along with several other workforce performance metrics. The Trust applies a standard of 1:24 as per the most recent workforce analysis.

2.7.2 To get a reliable calculation on the number of staff on the 'shop floor' Electronic Staff Record (ESR) data is used rather than the currently used financial data. The senior midwifery team have continued to work with the HR business partner to ensure that the ESR data is accurate for all areas to aid this calculation.

2.7.3 Birth to Midwife Ratio is currently recorded as an average of 1:20 but this included specialist midwives within the budget which is contrary to the agreed methodology. Non-clinical midwifery positions will be removed to ensure an accurate reflection of the funded vs actual midwife to birth ratio.

3.

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

3.1 Supernumerary Labour Ward Co-ordinator Status

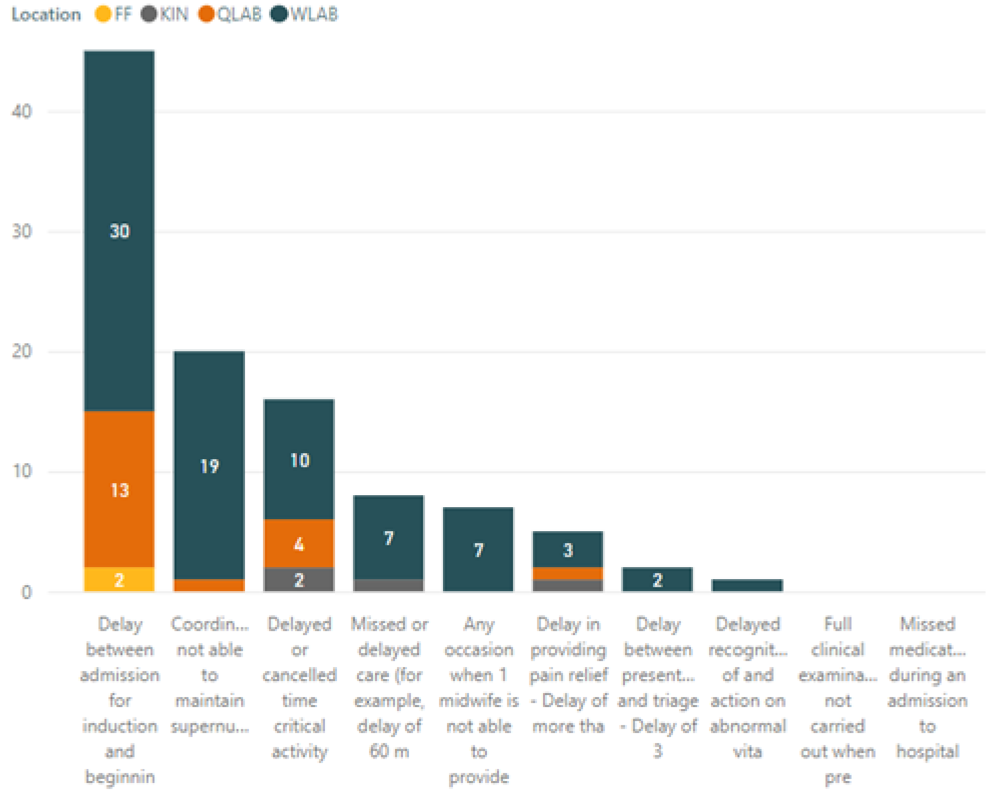
3.1.1 Supernumerary Labour Ward Status is obtained from the intrapartum acuity tool data and recorded on the maternity dashboard.

3.1.2 The table below shows the Supernumerary Status of the Labour Ward Coordinator over the past six months. Although the data recorded at QEQM in February and March 2023 was recorded on the acuity tool as below 100% further validation demonstrated that the tasks undertaken by coordinators was a part of their role and as such it was confirmed that the service was 100% compliant. Feedback from the lead at WHH also suggested some variation in the understanding around the definition of 1:1 care but as it was not possible to validate this retrospectively the rate is reflected at 99.2%. The Midwifery Workforce Action Plan includes actions being taken to ensure accurate data collection as well as mitigation to ensure 100% compliance with this metric.

Supernumerary Status Maintained			
Month	QEQM	WHH	Target
Oct	100%	96.5%	100%
Nov	100%	100%	100%
Dec	100%	100%	100%
Jan	100%	99.6%	100%
Feb	99.3%	99.5%	
March	97.9%	100%	
Total Average	99.5%	99.2%	100%

3.2 Workforce Red Flags incidents

Type	FF	KIN	QLAB	WLAB	Total
Delay between admission for induction and beginnin	2	0	13	30	45
Coordinator not able to maintain supernumerary/sup			1	19	20
Delayed or cancelled time critical activity	0	2	4	10	16
Missed or delayed care (for example, delay of 60 m	0	1	0	7	8
Any occasion when 1 midwife is not able to provide	0	0	0	7	7
Delay in providing pain relief - Delay of more tha	0	1	1	3	5
Delay between presentation and triage - Delay of 3	0	0	0	2	2
Delayed recognition of and action on abnormal vita	0	0	0	1	1
Full clinical examination not carried out when pre	0	0	0	0	0
Missed medication during an admission to hospital	0	0	0	0	0
Total	**2**	**4**	**19**	**79**	**104**



3.2.1 Data is collected around Red Flag events on the BirthRate Plus Intrapartum Acuity Tool which supports easier data entry and reporting on acuity and red flags including Supernumerary status for the Midwife coordinating Labour Ward.

3.2.2 Staff aim to input data into the acuity tool every 4-hour period. This was achieved on average at QEQM 80% and at WHH 76% of the time. This represents an improved position.

3.2.3 As previously discussed the Heads of Midwifery are working with the Labour Ward Coordinators to promote the understanding of supernumerary status, the definition being having no caseload of their own during the allocated shift.

4. Standard c) All women in active labour receive one-to-one midwifery care

4.1 1:1 care in labour is recorded on the maternity dashboard and review of each case of non-compliance takes place by the Maternity Matrons to draw out any learning or themes. The six month compliance average is 99.8% at QEQM and 99.3% at WHH. The national and CNST defined standard is 100% 1:1 care for all women in established labour. The Midwifery Workforce Action Plan shows mitigations to achieve this.

4.2 The table below shows compliance over the 6 month period with One-to-One Care in Labour. There is a need to ensure the care of the women identified as not receiving 1:1 is reviewed promptly, as initial analysis has identified that the care episodes are not always recorded completely thus impacting this result. Ongoing reporting will be taken monthly through the Maternity and Neonatal Assurance Group.

1 to 1 care in Labour			
Month	QEQM	WHH	Target
October 2022	100%	100%	100%
November 2022	100%	100%	100%
December 2022	100%	100%	100%
January 2023	100%	100%	100%
February 2023	99.3%	97.4%	100%
March 2023	100%	98.5%	
Total Average	99.8%	99.3%	100%

Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme reporting period

4.3 Bi-annual midwifery staffing oversight reports, covering staffing and staffing safety issues, as defined by the CNST Safety Action 5 standards, have been presented to Trust Board.

4.4 The last Midwifery Workforce report was received by this Board in December 2022 and covered May 2022 to September 2022.

4.5 This report covers the six month reporting period of September 2022 to March 2023.

5. Next Steps

5.1 The last BirthRate Plus review was a desktop exercise undertaken in 2021 and the last full analysis was undertaken in 2018. There is therefore a need to repeat a full BirthRate Plus review, benchmark these recommendations to the existing funding and report these findings to the Board.

5.2 Compliance with 1:1 care in labour and the supernumerary status of coordinators should be reviewed on a weekly basis to validate any inaccuracies with data collection and ensure an accurate reflection of both metrics.

5.3 The funded vs actual midwife:birth ratios need to be accurately captured excluding non-clinical posts.

Midwifery Workforce Planning Actions and status

Action Number	Overall Action Status	Action	Lead	Target Finish	Update/progress report
01		To commission a BirthRate Plus review and complete a detailed analysis of the overall midwifery workforce across the whole service	Director of Midwifery	December 2023	BirthRate Plus review funded by Local Maternity and Neonatal System (LMNS)
02		To explore alternative approaches to recruitment including open days. Embed exit interview process	Heads of Midwifery	December 2023	Explore a rolling advertisement for midwives. Facilitate local recruitment fair
03	In progress (On schedule)	Continue to support internationally educated midwives through OSCE process and pastoral care	Director of Midwifery	Ongoing	May 2023 - 2 completed OSCEs successfully, 3 awaiting OSCEs. 5 about to start four week programme
04	Complete	Continue service-wide daily SITREP meeting. Consultants to join SITREP, to replace cross-site call	Director of Midwifery	Ongoing	10 AM daily meeting established, including community. Standard Operating Procedure (SOP) in place for meeting embedded
05	In progress	Daily validation of 1:1 and supernumerary status data	Heads of Midwifery	Ongoing	Daily review and validation. Training midwifery staff in understanding both definitions
06		Exclude non-clinical staff from midwife:birth ratio to ensure adequate reflection of funded vs actual midwife:birth ration	Heads of Midwifery/Business Intelligence Lead	September 2023	

No. Actions	6	Status (%)
At risk / Not started	0	
In progress (overdue)	0	
In progress (on schedule)	5	83%
Complete	1	17%
No Status	0	
TOTAL	**6**	**100%**

Board Sign off

Name___________________ Date of Signing________________________

REPORT TO BOARD OF DIRECTORS

Report title:	**Clinical Negligence Scheme for Trusts (CNST) Safety Action 8 Compliance Plan**
Meeting date:	**6 July 2023**
Board sponsor:	**Chief Nursing and Midwifery Officer (CNMO) and Maternity and Neonatal Board Safety Champion**
Paper Author:	**Quality and Education Matron**

Appendices:

NONE

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	To offer assurance to the Board relating the ongoing plan to achieve CNST Safety action 8 by the Q3.
Summary of key issues:	• The provision of job planned faculty time to facilitated in-situ PRactical Obstetric Multi-Professional Training (PROMPT). • Not having a designated obstetric anaesthetic team which therefore requires impacts the need for the whole workforce to be trained.
Key recommendations:	The Board of Directors is asked to **NOTE** the recommendations: • Undertake a review of the methodology of the facilitation of PROMPT across sites. • Increase the amount of training weeks undertaken when new Multi-Disciplinary Team (MDT) members (Foundation Year (FY) & Trainees) which usually fall in august to ensure we maintain compliance and safety. • To ensure the anaesthetic and obstetric teams understand the provisions needed to facilitate PROMPT.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.

Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	Y - Staffing and training resource required to develop Transitional Care into a fully functioning service.
Legal and regulatory:	Y - Clinical Negligence Scheme for Trusts (CNST), BAPM standards.
Subsidiary:	N

Assurance route:

Previously considered by: N/A

PROMPT

1. Purpose of the report

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

2. Background

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

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

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

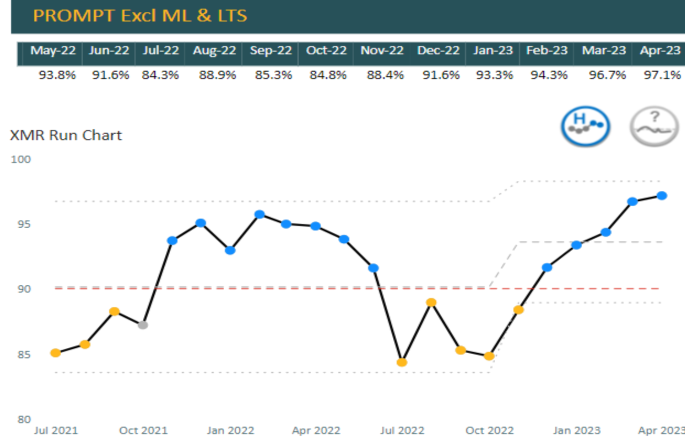
Throughout the compliance year there have been a number of occasions when the PROMPT faculty has not been quorate due to the unavailability of anaesthetic and/or obstetric faculty and therefore moved to a virtual session.

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

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

2.1 Compliance

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


PROMPT Excl ML & LTS

May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
93.8%	91.6%	84.3%	88.9%	85.3%	84.8%	88.4%	91.6%	93.3%	94.3%	96.7%	97.1%

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

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

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

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

2.2 CNST

For CNST Year 4, the trust reported non-compliance for safety action 1 & 8 (PMRT and MDT Training). Safety action 2 compliance was not met due to MDT training compliance (90%) due to anaesthetic compliance with training. Following the submission of the action plan to enable the trust to meet future CNST requirements we have been awarded £350,000 from CNST discretionary funding.

3. Next steps

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

REPORT TO BOARD OF DIRECTORS

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

Meeting date: **6 July 2023**

Board sponsor: **Director of Infection Prevention and Control (DIPC)**

Paper Author: **DIPC**

Appendices:

APPENDIX 1: IPC 2023-2024 WORK PLAN (READING ROOM FOR INFORMATION)
APPENDIX 2: KENT AND MEDWAY IPC STRATEGY 2023 TO 2026 (READING ROOM FOR INFORMATION)

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	To apprise the Board of Trust performance against external and internal Key Performance Indicators and any risks and issues arising in the previous quarter.
Summary of key issues:	• Reportable infections: New thresholds have been published for 2023-2024 and a change in the calculation methodology adds to the challenge in meeting these thresholds for the Trust. • After two months of this reporting year the Trust is considerably off trajectory to achieve the external objective for Cdiff and a range of actions have been implemented to address this issue. • An update on all reportable infections is given at month two. • The IPC work plan for 2023-2034 and the Kent and Medway IPC Strategy 2023 to 2026 are included in the reading room for information. • An update on antimicrobial stewardship activity is included.
Key recommendations:	The Board of Directors is asked to **DISCUSS** the content of the update.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our quality and safety

Link to the Board Assurance Framework (BAF):	BAF 31 – Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements, leading to harm (currently under review).
Link to the Corporate Risk Register (CRR):	New Corporate Risk in development to replace the above BAF 31, subject to committee approvals.
Resource:	N
Legal and regulatory:	Y - Supports compliance with The Code of Practice on the Prevention and Control of Infections (Health and Social Care Act).
Subsidiary:	Y - applies to 2gether Support Solutions activities.

Assurance route:

Previously considered by: N/A

Infection Control Quarterly Update to end June 2023

1. Nationally reportable infections with and without externally set thresholds.

The final year performance for the reporting year 2022/2023 is given in the accompanying IPC Annual Report for that reporting year and is not repeated here.

The thresholds which form part of the NHS standard contracts are published annually in the document "Minimising *Clostridioides difficile* and Gram-negative bloodstream infections"[1], which for 2023/2024 was published on 16 May 2023.

There is a change in the methodology for the calculation in 2023/2024 which, for EKHUFT creates, quite properly, additional challenge in achieving some of the thresholds in 2023/2024.

Previously the thresholds were based on performance to November of the previous calendar year (2022). Now there are two thresholds, one as already described and a second one with the same criterion but for the previous calendar year (2021); the lower of the two thresholds applies. (in each case the threshold is previous total with a calculated reduction which is calculated differently for *C. difficile* and the Gram-negative bloodstream infections.

1. https://www.england.nhs.uk/publication/minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections/

Based on the above, the thresholds for EKHUFT for 2023/2024 are:

Organism	Threshold 2023/2024
Clostridioides difficile	81
E. coli	115
Pseudomonas aeruginosa	32
Klebsiella species	62

Given the scale of the challenge represented by the thresholds for *C. difficile* and *E. coli*, the IPC Team have reviewed the priorities in the 2023/2024 annual plan and considered what additional actions can be identified.

For the first two months of the reporting year the trust has seen a continuation of the high numbers of cases of *C. difficile* and, in common with the acute trusts in Kent and Medway is off trajectory to meet the external threshold. Three of the four acute trusts in Kent and Medway, including EKHUFT have had circa 40% of their threshold number of cases in 2 months, with one trust over trajectory but less so. The trust is under trajectory for *E. coli* and *P. aeruginosa* and slightly over for *Klebsiella spp.* Cases of MSSA (no threshold) are at the same level as last year at this point and there has been a single healthcare associated case of MRSA.

The IPC team are focussing of Cdiff and have implemented a number of changes. Recent changes to the response to Cdiff include a revised approach to case investigation with the IPC Team completing a rapid review of all cases before convening a root cause analysis meeting with the clinical team, microbiology and the antimicrobial stewardship team. All cases will be reported to and discussed at a new Cdiff case review meeting to which the Integrated Care Board IPC Team are invited. The objective

of this new process is to speed up the investigation process and the identification of lessons to be learned and shared, both within EKHUFT and across the health economy in East Kent. In addition, this new process will reflect and anticipate the expected implementation of the NHS England 'Patient Safety Incident Response Framework' (PSIRF) in EKHUFT.

2. IPC Work Plan 2023-2024 and Kent and Medway IPC Strategy

The high level summary of the IPC work plan for 2023-2024 had been seen by the Quality and Safety Committee as part of the routine monthly reporting and is included in the reading room for information. As described above, Cdiff is a major focus of current activity. The IPC team contributed to the recently published Kent and Medway IPC Strategy 2023 to 2026 and this is included in the reading room for information.

3. Incidents and outbreaks

a. Endoscopy incident – no harm

An incident occurred where an agency member of staff used the wrong detergent brand in an automated endoscope washer-disinfector (AWD) and scopes were processed and subsequently used on patients. Investigation, including the manufacturers of both the detergent(s) and the AWD, have concluded that the product used, although incorrect, was fully compatible and no harm was caused. Endoscopy are implementing process changes to avoid recurrence.

b. Outbreak of Respiratory Syncytial Virus (RSV) on the Special Care Baby Unit (SCBU)

The re-admission of a baby recently discharged from the SCBU to the children's ward with RSV, prompted the clinical team to a higher index of suspicion of any possible symptoms of RSV on the unit. Further sampling identified a further 6 cases (7 in total). The outbreak was managed by the IPC team and the relevant clinical teams and did involve temporary closure of some capacity. The ICB and UKHSA were aware. None of the babies were adversely affected or harmed.

4. Antimicrobial Stewardship (AMS) – update

The consultant pharmacist post was filled in in February 2023, and at the same time the specialist AMS pharmacist based at William Harvey Hospital who was on maternity leave came back into post reducing her hours to 0.6wte. The other 0.5wte specialist AMS pharmacist based at QEQM is on maternity leave since January 2023. The maternity cover for AMS has not been recruited. However, this allows a better understanding of the real needs of staffing to the new consultant/lead pharmacist who is providing leadership to the AMS pharmacist. Pharmacists also need the presence of medical doctors to ensure recommendations occur appropriately. A strategy plan was presented in a driver diagram and an operational working group was established between AMS pharmacists, IPC and AMS medic consultant. Subgroups of this operational group have been established in different areas of Care Groups with a pharmacist representing this CG and AMS pharmacist. EPMA (electronic prescribing) has recently been implemented. The AMS team is working with IT to ensure reports can be done appropriately and meaningfully.

REPORT TO BOARD OF DIRECTORS

Report title: **Infection Prevention and Control (IPC) Annual Report 2022-2023**

Meeting date: **6 July 2023**

Board sponsor: **Director of Infection Prevention and Control**

Paper Author: **Director of Infection Prevention and Control**

Appendices:

APPENDIX 1: IPC ANNUAL REPORT 2022-2023

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008).
Summary of key issues:	The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes Infection Prevention and Control activity during the year, including progress made against the work plan and objectives identified in the Infection Prevention and Control Annual Programme and against any external objectives.
Key recommendations:	The Board of Directors is asked to **APPROVE** the IPC Annual Report 2022-2023.

Implications:

Links to 'We Care' Strategic Objectives:	Our quality and safety
Link to the Board Assurance Framework (BAF):	BAF 31 – Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm (currently under review).
Link to the Corporate Risk Register (CRR):	New Corporate Risk in development to replace the above BAF 31, subject to committee approvals.

Resource:	N
Legal and regulatory:	Y - Supports compliance with The Code of Practice on the Prevention and Control of Infections (Health and Social Care Act).
Subsidiary:	Y – 2gether support solutions activities are included in the reporting.

Assurance route:

Previously considered by: none

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

APRIL 2022 – MARCH 2023

EKHUFT Infection Prevention and Control Annual Report 2022 – 2023

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East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 2022 – March 2023

1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008). The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes Infection Prevention and Control activity during the year, including progress made against the work plan and objectives identified in the Infection Prevention and Control Annual Programme and against any external objectives.

2. The Year 2022 – 2023 and the Pandemic of Covid-19

This report covers the period from April 2022 to the end of March 2023. This year has been characterised by the slow progression towards business as usual in infection prevention and control. However, at the start of this reporting year we were experiencing what became the second highest rise in numbers of cases of Covid-19 in our hospitals, reaching a peak of 235 in early April 2022. This was a greater number than during the first wave in 2020 but considerably lower than the peak of the second wave in early 2021 (figures 1 and 2 below). This peak in cases and the continuing, but gradually reducing subsequent waves of peaks and troughs for the rest of the year were primarily driven by the sub-variants of the Omicron variant of SARS-CoV-2. These variants were circulating widely with the removal of all societal restrictions and, importantly, most of the cases detected in the hospitals were incidental findings, unrelated to the reason for the patient's admission to hospital, whether that reason was elective or non-elective in nature. Another welcome aspect of this changing epidemiology has been that the morbidity and mortality associated with Covid-19 is now and has been for much of this reporting year, very much lower than in earlier phases of the pandemic. The pattern of cases and the numbers of inpatients positive for SARS-CoV-2 has continued to very gradually reduce for the remainder of 2022-2023 with the number of inpatients at the end of March 2023 at circa fifty. Thankfully, in the months following this reporting year, those numbers have dwindled further into single figures. Despite these overall reductions, Covid-19 continued to present a significant operational challenge to the trust and to the IPC team throughout the year. The placing of patients both cases and contacts of Covid-19, in the context of significant operational pressures on patient flow, particularly in the emergency care pathways, remained very difficult. These challenges required daily support from the IPC team to the hospital site managers and leadership teams and continued to detract from the IPC team's ability to address the wider IPC challenges and goals. This was especially true during a very difficult and challenging winter period where the return of seasonal Influenza and, mainly but not exclusively in children, Respiratory Syncytial Virus (RSV) after being largely absent in the two previous winters, led to huge pressures on our ability to place patients in the most appropriate place for their IPC and clinical needs. Throughout this year the IPC team have continued to support the trust response to the pandemic, which is technically not over, albeit the World Health Organisation have decided in the months since this reporting period to step down the Global Health Emergency status of the pandemic. In terms of NHS and trust policy this year has seen the continuing of a gradual return to business as usual in how we manage Covid-19 from an IPC perspective. By the end of March 2023, there were almost no Covid-19 specific measures in place, with the exception of some testing requirements associated with transfers to residential care settings, all other testing being only on a clinical basis, i.e. almost no asymptomatic screening of patients or staff. Covid-19 is now managed following the guidance in the National Infection Control

Manual for England, which was published in 2022 and immediately adopted as policy in our trust. The Covid-19 specific Board Assurance Framework (BAF) was archived and replaced with a generic BAF. The Director of Infection Prevention and Control continued to report to the Quality and Safety Committee and periodically to the Trust Board on the status of the Covod-19 pandemic response throughout this reporting year. Despite the continuing impact of Covid-19 for much of the year, the IPC team were able to complete the elements of the IPC Work Plan that were within their gift and the majority of the plan was successfully achieved.

Figure 1. Cases of Covid-19 detected by EKHUFT

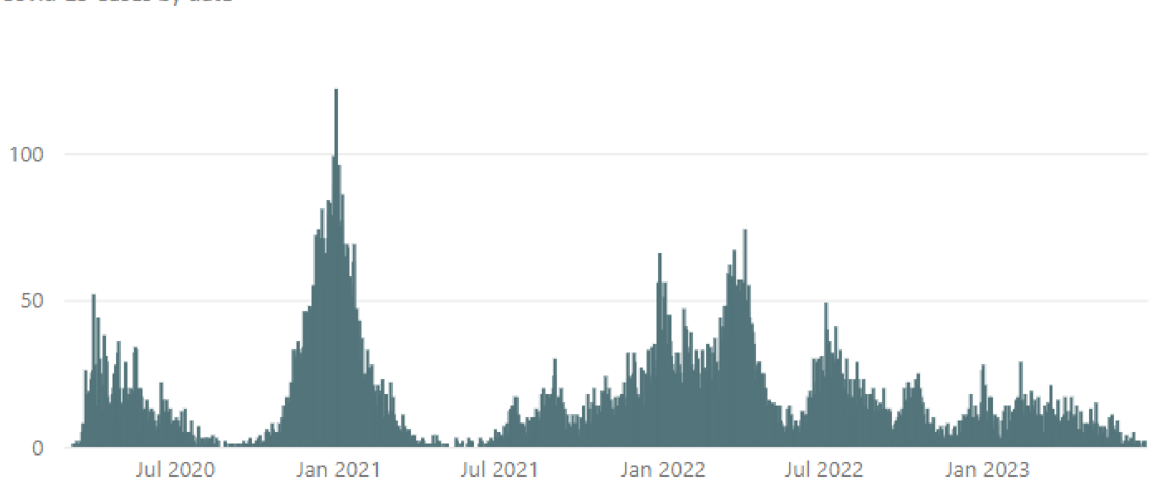
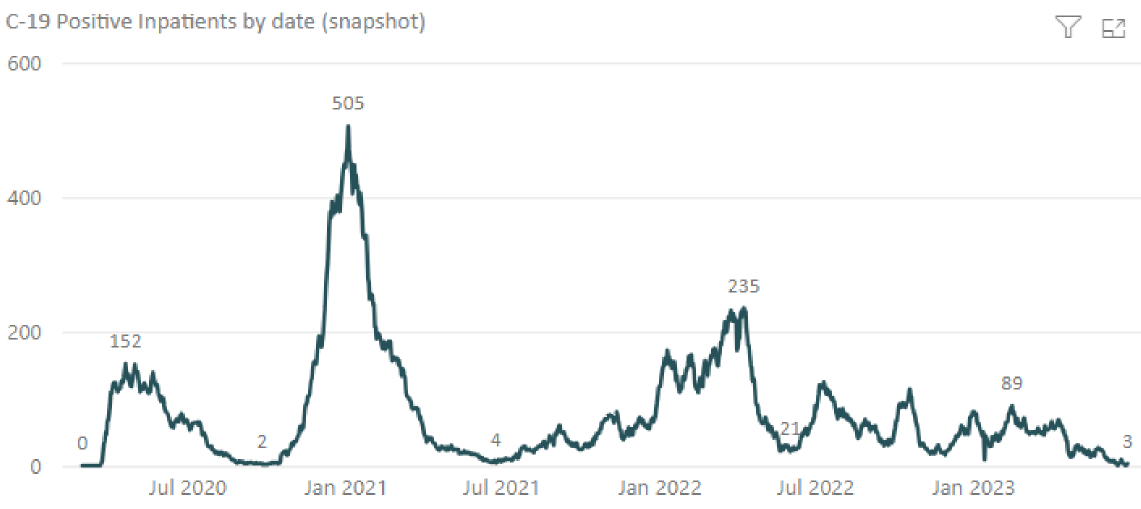


Figure 2. Covid-19 inpatients by date EKHUFT



3. The Infection Prevention and Control Team (IPCT)

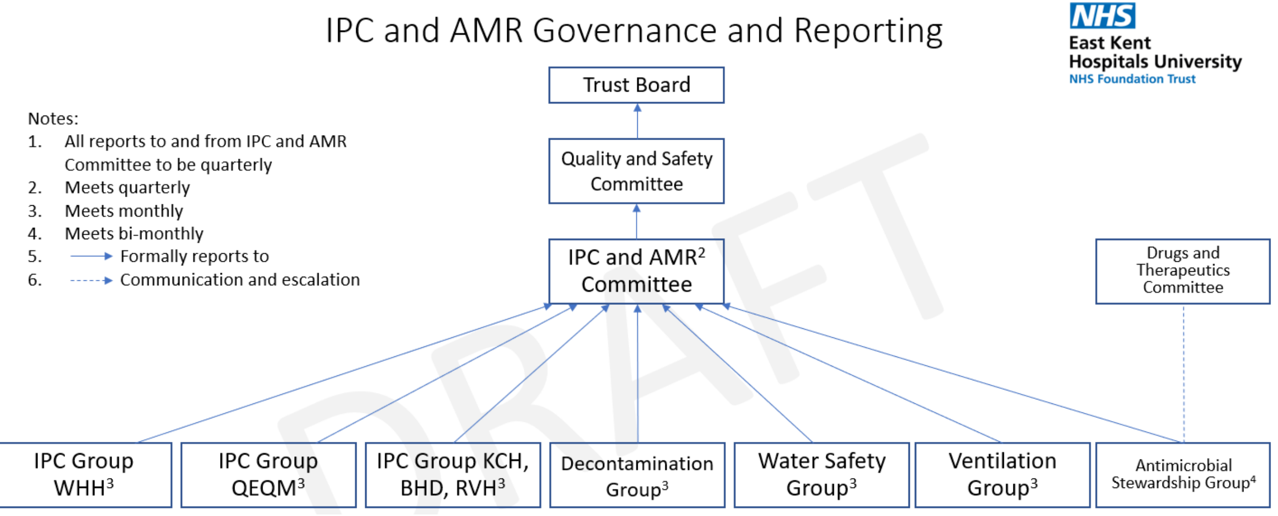
The IPCT are the medical, scientific and nursing specialists responsible for undertaking the work described, in the IPC annual programme. Information regarding the Antimicrobial Stewardship Team and resource is given further down under 'Antimicrobial Stewardship'. There has been some improvement in the IPC resource during this year, primarily through the recruitment and retention of team members to substantive roles at Agenda for Change bands 6 and 7 on all three inpatient hospital sites. Some of these colleagues are new to the specialty and are being supported to develop their specialist skills and knowledge in IPC while utilising their transferable skills from their previous clinical and other roles. In addition, a senior colleague has made a very welcome return

from period of long-term sickness and these changes mean that, on the whole, the IPC team is fully recruited to and stable at the end of March 2023. The DIPC has announced an intention to retire during 2023-2024 but succession planning has been a feature of the team since 2021 and there is no risk to the service from this change. In order to support the development of surveillance of healthcare associated infections a specific post has been developed and recruited to, that of a specialist surveillance nurse, see below under 'Surgical Site Surveillance' for more details.

4. Infection Prevention and Control Committee and Reporting Structure

As highlighted in the previous annual report for 2021-2022 a review of the IPC committee and reporting structure has been undertaken during this year and the outcome of that review has been implemented in the final quarter of 2022-2023. The objectives of this review were to strengthen the site-based IPC relationships, which anticipated the wider trust restructure which will follow, and to improve the opportunities for engagement, learning and sharing. The revised structure includes site-based Infection Control Groups on each inpatient hospital site, with links to the two smaller ambulatory facilities in Dover and Folkstone. These site groups are operationally focused and bring together clinical and non-clinical colleagues on each site to discuss challenges and successes and share the learning from investigations. Each of these groups along with groups for decontamination, water safety, ventilation safety and antimicrobial stewardship report to a new quarterly Infection Prevention and Control and Antimicrobial Stewardship Committee (IPCAS). The IPCAS Committee takes a strategic perspective and gathers themes and learning from across the trust and is a vehicle for wider sharing, including with colleagues from external bodies such as the Kent and Medway Integrated Care Board (ICB) and the United Kingdom Health Security Agency (UKHSA). The IPCAS Committee reports to the Board via the Quality and Safety Committee and directly through the DIPC as required by the Code of Practice on the Prevention and Control of Infections (Health and Social Care Act 2008). The revised structure is shown below (figure 3).

Figure 3. IPC Reporting Structure



5. The Care Quality Commission (CQC)

There have been no IPC specific themed CQC inspections during 2022-2023, these are unlikely to be repeated given the reducing impact of the Covid-19 pandemic and these not being part of routine CQC activity. An inspection of maternity services in January identified some disappointing failings in cleanliness and some aspects of basic IPC practice. The trust was issued with a Section 31 notice in relation to this inspection that covered a range of issues including, but not limited to, the cleanliness and IPC issues identified. The IPC team supported the care group in quickly and successfully correcting these failings to the satisfaction of the CQC, whose requirements for monthly reports on the mitigations has been subsequently stepped down.

6. Education and Training

The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

> 'that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection'.

The IPC team have been working to review and update the trust IPC training portfolio following the reduction in specific Covid-19 training requirements and a return towards business as usual. IPC mandatory training remains as a combination of face to face and virtual learning as well as practical hand hygiene training.
At the end of this reporting period (March 2022) compliance with IPC mandatory training requirements was 91%.

7. Audit

The audit programme has been reviewed during this year and the hand hygiene audits revised to reflect the return to pre-pandemic personal protective equipment (PPE) use. These audits have also been moved to the new trust audit platform 'Tendable'. Hand hygiene audit results at the end of March 2023 were 97% overall.

For the reporting year 2022-2023 the following audits have continued.

Audit	Completed	Achievement
Antimicrobial prescribing		Please see Antimicrobial Stewardship Report.
Infection Prevention and Control Audits of Environmental and Clinical Practice	Yearly	Regular audits (every 12 months) of the clinical environments have continued. The completed audit report is sent to the Ward/ Department Manager, who is responsible for both formulating and implementing an action plan. The results of these Audits are being reported via the Site Infection Prevention and Control Group and escalated as required.
"Saving Lives"	Monthly	Monitoring of compliance with the management of invasive devices, e.g. peripheral cannula, central vascular catheter and urinary catheter, insertion and continuing care. The results of these Audits are being reported via the Site Infection Prevention and Control Group and escalated as required.

8. Hospital Hygiene and the Healthcare Environment

The IPC Team have continued to monitor standards of cleanliness within the Trust and promote good practice in conjunction with the Hospital and Facilities Managers through participation in the following activities:

- Patient-led Assessment of the Care Environment (PLACE).
- Environmental audits of cleanliness and the healthcare environment.
- Advising contractors/contract management on cleaning and domestic issues.
- Day to day advice/intervention/escalation to facilities management as appropriate, with regard to cleaning issues.

- Advising, with engineering colleagues from 2gether Support Solutions, through the site based and trust wide Water Safety Groups on the safe management of water supplies, to prevent risks associated with Legionella and, in augmented care settings, *Pseudomonas aeruginosa*.

During 2022 and within this reporting year the trust working with 2gether Support Solutions implemented in full and by the required deadline of October 2022, the 2021 National Standards of Healthcare Cleanliness. The IPC Team continues to work with 2gether colleagues to ensure these standards are in place and to review cleanliness standards across the organisation. The trust has, with a small number of exceptions, a very old estate and a very significant backlog of maintenance and need for refurbishment of clinical environments. This creates a major challenge to effective cleanliness and does not support good IPC practice or a good patient experience. The DIPC and IPC work with the trust and 2gether to prioritise the very limited capital investment available, taking into consideration the range of patient and safety risks, not limited to IPC risks. These challenges are reflected in the trust's corporate risk register.

9. Incidents/Outbreaks of Healthcare-Associated Infection

Covid-19 'outbreak' reporting has continued through the year in line with reporting requirements which it is expected will be stood down during 2023-2024.

There have been very few confirmed outbreaks of healthcare associated infections during 2022-2023. A cluster of cases of RSV on a neonatal unit was investigated and managed, no harm was reported to the affected babies. Small outbreaks of seasonal viral infections have been managed according to existing policy and protocols. Individual contact tracing exercises for exposures to infectious diseases such as measles, Chicken Pox and Tuberculosis have been managed in collaboration with clinical teams and colleagues from Occupational Health, the ICB and UKHSA as required. The trust responded to the international outbreak of MPox (previously called Monkeypox) in 2022 with the necessary preparedness in line with national requirements.

9.1 Seasonal viral infections

As noted above the winter period in 2022-2023 saw the return for the first time in two years of seasonal winter virus activity. The impact of said activity is described above with regard to seasonal influenza and RSV. There has also been some sporadic Norovirus activity but it has not been widespread or to the extent seen in pre-pandemic winter periods.

10. Surveillance and Epidemiology

Reportable Infections

Thresholds for *Clostridioides difficile* and Gram negative bloodstream infections (see below for details) were published for the year 2022-2023 in April 2022.
Trust performance against these thresholds and data for those infections where no threshold has been set are given below.

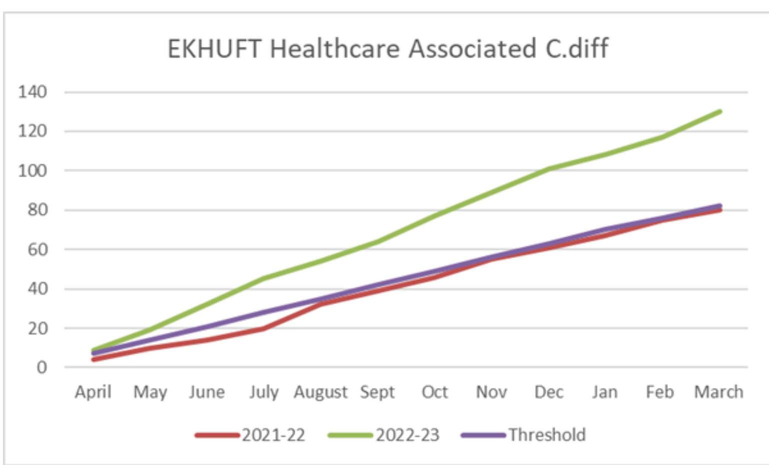
10.1 Clostridioides difficile (previously known as *Clostridium difficile*)

All cases of *C. difficile* identified from samples taken on day 2 of admission (where the day of admission is day 0) are hospital attributable.

These cases are described as Hospital Onset Healthcare Associated (HOHA). In addition, any patient discharged from hospital in the 28 days prior to a positive test for *C. difficile* are also hospital attributable. These cases are described as Community Onset Healthcare Associated

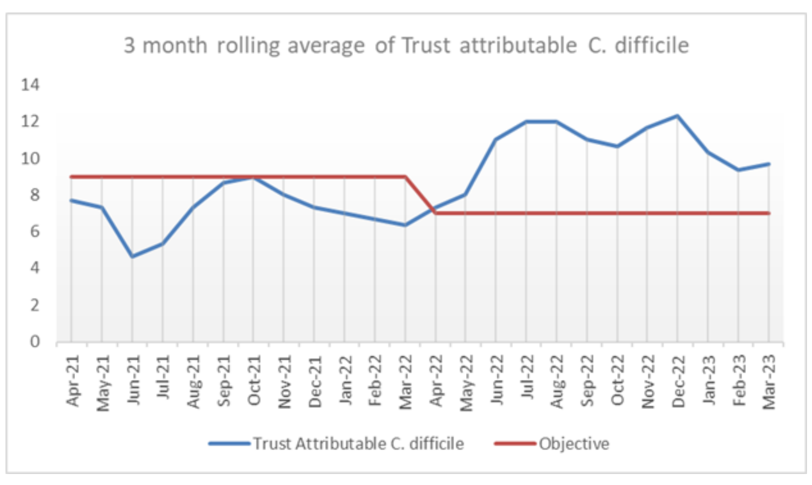
(COHA). These two categories are combined in figure 4 showing performance compared with 2021-2022 and a linear trajectory to the externally set threshold.

Figure 4:



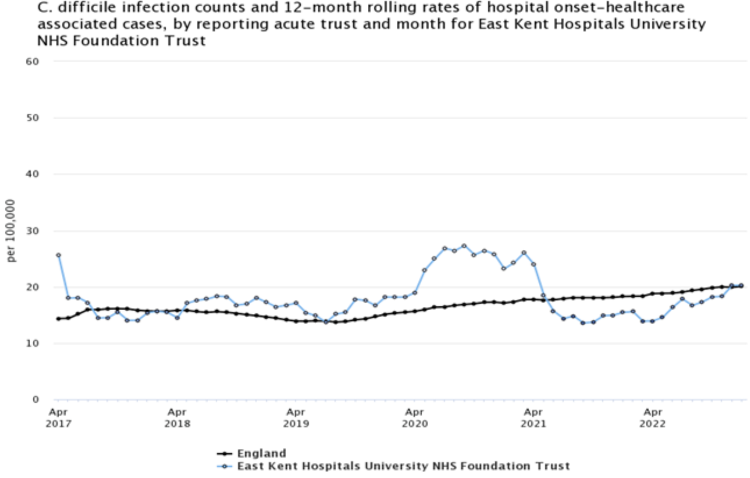
For the full year 2022-2023 the Trust was significantly above the external threshold. This reflects a local and national trend with all of the acute trusts in Kent and Medway and a large majority nationally exceeding the externally set thresholds in 2022-2023. This change in Cdiff epidemiology is not understood locally or nationally. There was no evidence of transmission of Cdiff during 2022-2023 with no cases that were connected epidemiologically having the same molecular type of Cdiff on testing. The three-month rolling average of cases has stayed persistently above the level necessary to achieve the external threshold throughout the year (figure 5).

Figure 5:



The *C. difficile* counts and 12 month rolling rates of HOHA and COHA infections published by Public Health England (PHE) to the end of January 2023 (latest data available at March 2023) show that EKHUFT remains slightly above the all England benchmark for HOHA cases than with rates of 20.2 per 100 000 bed days for HOHA (benchmark 20.1, Fig. 6) and remains higher at 12.4 (decreased) per 100,000 bed days for COHA (benchmark 7.0).

Figure 6



10.2 *Staphylococcus aureus* Infections (MRSA and MSSA) bloodstream infections

10.2.1 MRSA

MRSA bloodstream infections should be extremely rare events and avoidable healthcare onset cases should be regarded with zero tolerance. During 2021-2022 EKHUFT reported one case. An investigation is conducted for any case and any lessons shared at the IPC committees/groups.

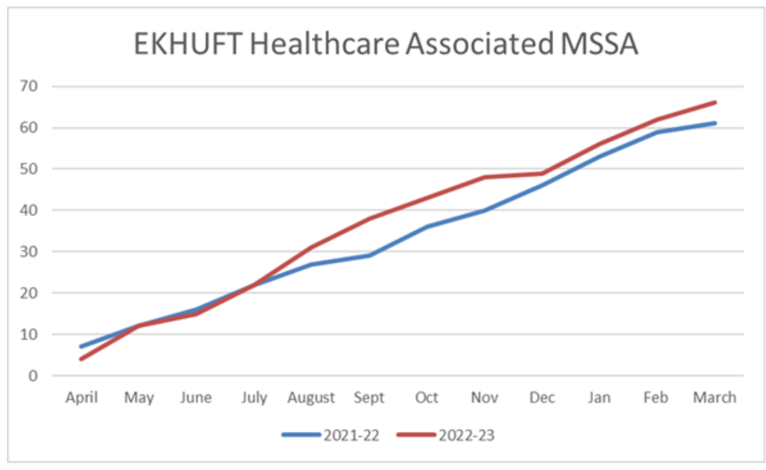
10.2.2 MSSA

Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections are common in both community and hospital settings. Healthcare associated infections are commonly related to vascular access catheters or surgical site infection. There is no externally set objective for MSSA bloodstream infections.

The number of hospital attributed bacteraemias is slightly higher for 2022-2023 compared with the previous year. Sixty six cases to the end of March 2023 compared with 61 for the previous year (figure 7). The rate of hospital onset cases is 14.6 cases per 100,000 bed days compared with the England rate of 11.2 cases per 100 000 bed days (March 2023 published data).

Hospital acquired cases are investigated by root cause analysis with an associated action plan where learning is identified.

Figure 6:



10.3 Gram Negative Bloodstream Infections

There is a national commitment to reduce the number of avoidable healthcare associated Gram-negative bloodstream infections by 25% by the end of 2021-22 and the full 50% by 2023-24 compared with 2015-2016.

The data for the three nationally reportable Gram negative bloodstream infections are given below (figures 8 -10)

Cases of *E coli* have exceeded the external trajectory. The number of cases for March was similar to the same month in 2022. Comparisons need to be made with caution due to the differential effects of the Covid-19 pandemic and the changes in patient presentation compared with the previous year (2021-2022) on which the thresholds were based. There was a major increase in cases in the summer months of 2022 which is difficult to explain but may, speculatively, have been related to the extreme heat seen at that time. There is evidence linking extreme heat conditions to increases in *E coli* infections.

Klebsiella and *Pseudomonas aeruginosa* were below the external trajectory for the year.
For *Klebsiella spp.* EKHUFT is the only acute trust in Kent and Medway to be under the external threshold for the year.

Figure 8:

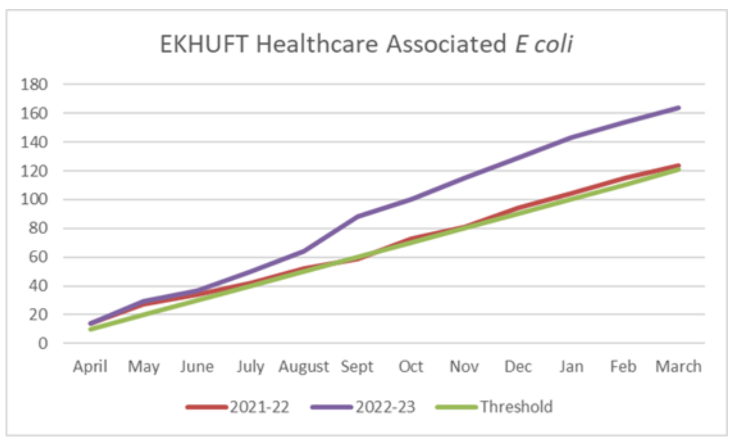


Figure 9:

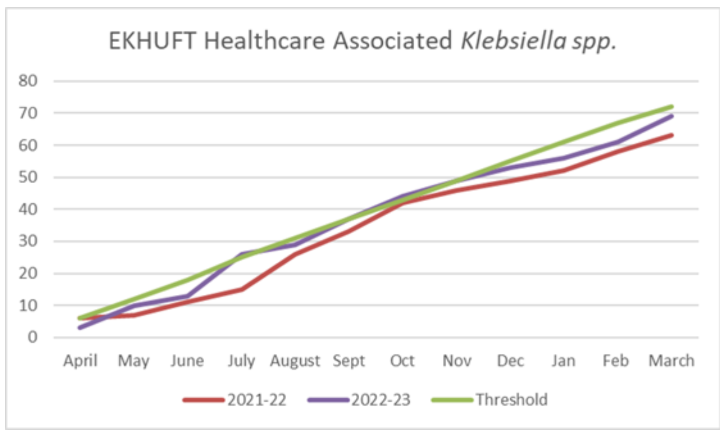
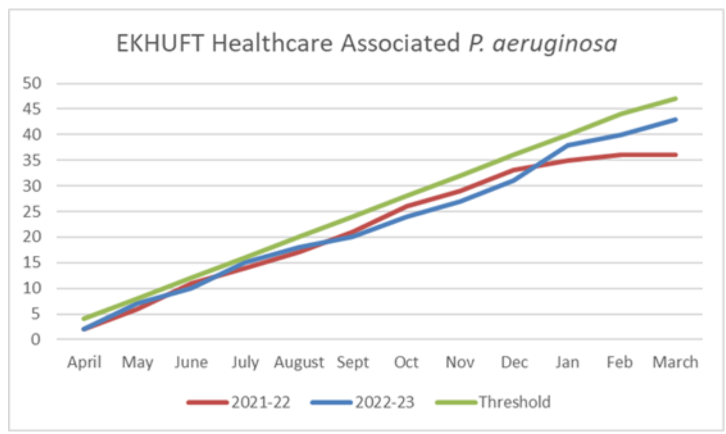


Figure 10:



10.4 Carbapenemase Producing Organisms (CPO)

CPO are of concern as organisms producing Carbapenamases (enzymes that confer antimicrobial resistance) are resistant to many of the antimicrobials of last resort. In some areas of the UK, CPO have become endemic and once established in a healthcare facility, they can be extremely difficult to eradicate. Management of CPO follows published guidance from UKHSA. For EKHUFT where CPO are not endemic this is based on targeted screening of certain patient groups. Although this screening has identified sporadic cases, no cluster or outbreaks have been identified. Vigilance remains high. New guidance on the management of CPO is still expected but has not been published.

11. Antimicrobial Stewardship

11.1 Current Antimicrobial Stewardship Team

Consultant Medical Microbiologist (Lead Consultant for AMS)
Consultant Pharmacist (AMS) – 0.6WTE – started February 2023
Advanced Pharmacist (AMS) – 0.64 WTE – returned from maternity leave February 2023
Advanced Pharmacist (AMS) – 1.0 WTE. On maternity leave September 2022-October 2023.
Other Consultant Medical Microbiologists and Clinical Fellows are available for advice/ward rounds if needed.
It should be noted that for the period April 22-September 22, there was only 1 AMS pharmacist available. From September 22-February 23, there weren't any AMS pharmacists available but

there was a rotational pharmacist available to support with directorate work e.g. guidelines where needed.
Prescribers are asked to refer any patients they are concerned about to the Consultant Microbiologists/Clinical Fellows via the Careflow app. A response can be added to the referral recommending a treatment plan and duration.
Clinical ward pharmacists are asked to review all antibiotic prescriptions and ensure that:

- there is an accurate indication and stop/review date on the Sunrise chart
- they are prescribed as per guidelines, microbiology advice or as per culture and sensitivity results. They are asked to challenge anything that does not fit these criteria and document in Sunrise notes
- prompt clinical teams to refer patients to Microbiology via Careflow if duration of treatment is at 10 days or more or if the antibiotic choice is a restricted antibiotic, not as per guidelines or microbiology advice

11.2 Aims of the AMS Team

- Reduce inappropriate antimicrobial prescribing; total consumption, broad spectrum and high *Clostridioides difficile* risk antibiotics (in particular: co-amoxiclav, piperacillin/tazobactam, fluoroquinolones, clindamycin, carbapenems and 3rd generation cephalosporins)
- Work pro-actively to prevent increasing antimicrobial resistance and healthcare associated infections e.g. *C. difficile*.
- Provide education and training to prescribers, nurses and pharmacists where needed
- Reduce allergy and other antimicrobial related incidents by 50% by 2025

11.3 Data

Unless stated otherwise, the graphs and tables presented in this report uses data collected from the RxInfo database. In order to compare data across different timeframes, the data is presented as Defined Daily Doses (DDDs/1000 admissions).
It should be noted that since April 2020, admissions for the Emergency Department (ED) is not complete. The effect this has on the data presented, is not known.
FP10s have been included in the usage data. ED use a lot of FP10 prescriptions to facilitate discharge. To not include them would potentially skew the data and not give a true representation of the prescribing patterns within ED.

11.4 Standard Contract 2022/23

The consumption of antibiotics in the Watch and Reserve categories of the AWaRe list is monitored under the NHS Standard Contract. All the 'High *C. difficile* risk antibiotics' monitored by the AMS team in the list above fall under the Watch and Reserve categories.

The data are reported as Defined Daily Dose (DDD)/1000 admissions (using the dictionary of medicines and devices nomenclature to allow benchmarking) with the original aim to reduce the Watch and Reserve category antibiotics by 4.5% for 2022/23 from the 2018 baseline use data.

Results for 2022/23 are shown below (Table 1). Final admission figures for March 2023 are not known so this figure will be subject to change, with the final figure to be reported by NHS England in June/July 2023.

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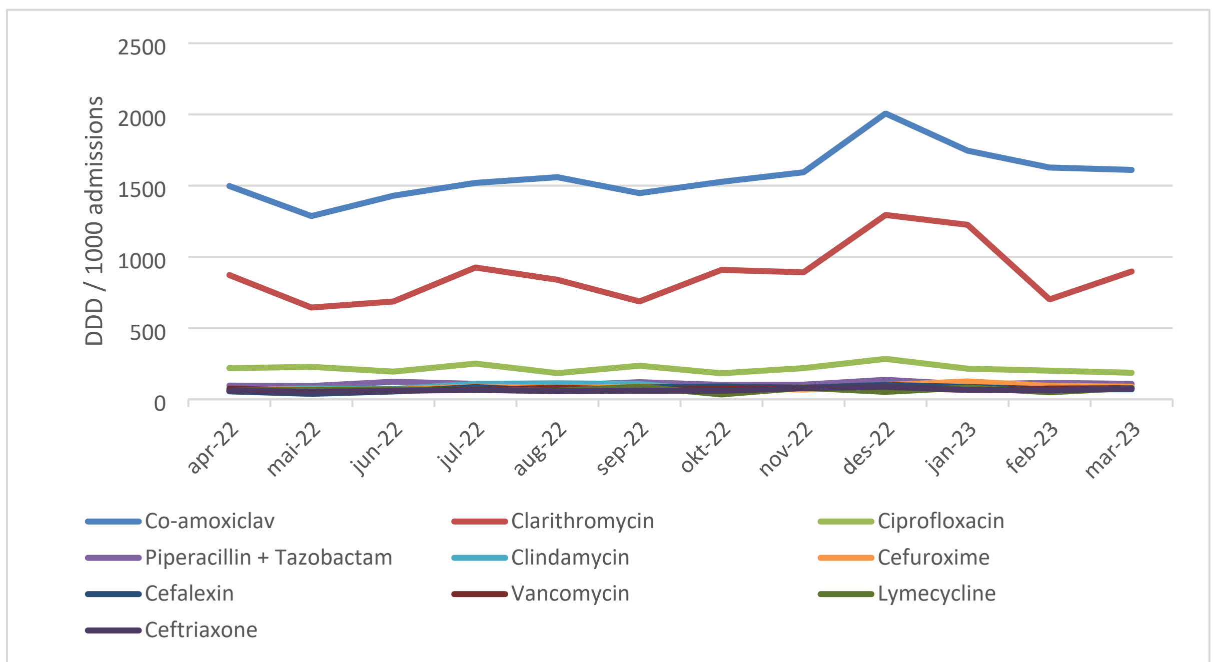
Table 1.

	Baseline 2018 data	Target Watch + Reserve DDDs per 1000 admissions for 2022/23	Actual usage of Watch+Reserve Abx for preceding 12 months up to end of March 2023
DDDs / 1000 admissions	**2580**	2464	2817
% difference in Watch + Reserve DDDs per 1000 admissions from 2018 baseline			**+14%**

Co-amoxiclav is the most used Watch and Reserve antibiotic in the trust, followed by clarithromycin, ciprofloxacin, Tazocin® (Piperacillin/Tazobactam) and clindamycin (figure 11) There has been approximately 130% increase in the use of co-amoxiclav across the trust between 2014 and 2022.

Figure 11: Consumption of Top 10 Watch and Reserve Antibiotics by drug in DDDs/1000 total admissions for FY2022-23 (including FP10s)



Emergency Medicine is the biggest user of Watch and Reserve antibiotics (figure 12). ED uses approximately three times as many antibiotics as the second highest user (Specialty Medicine) and more than the rest of the Top 5 combined.

Antibiotic usage has been steadily increasing in ED and across the trust since 2014, with co-amoxiclav and clarithromycin forming the largest portion.

Figure 12: Consumption of Watch and Reserve Antibiotics by Top 5 local directorates in DDDs/1000 total admissions for 2022-2023 (including FP10s)

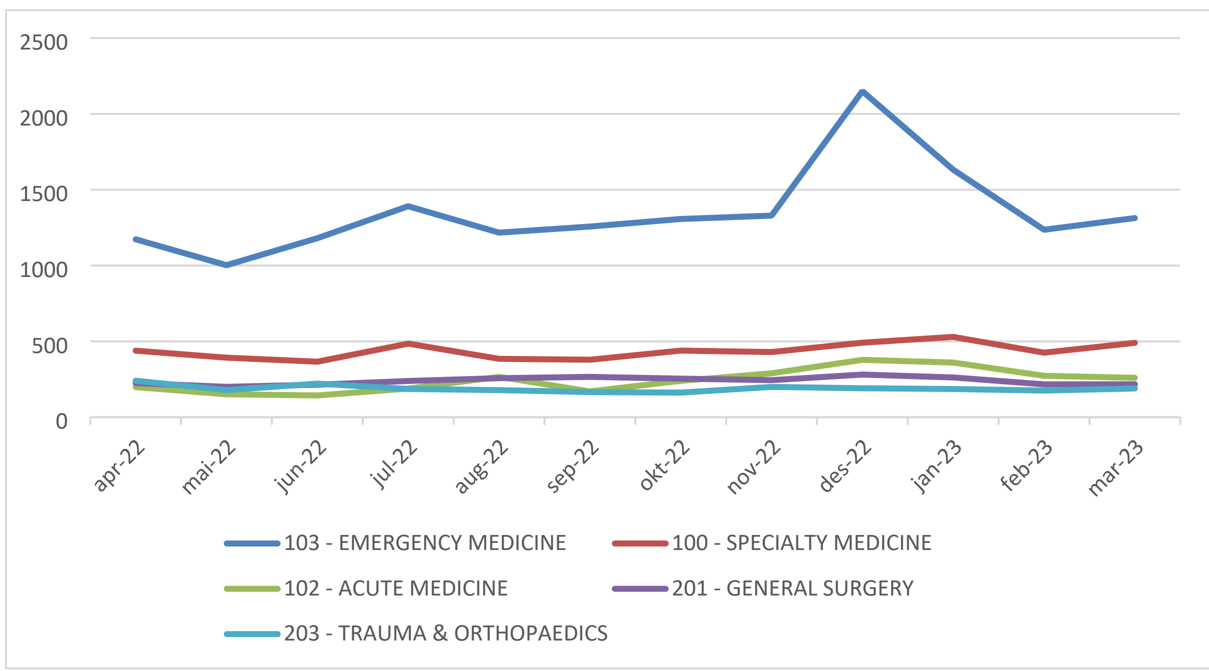
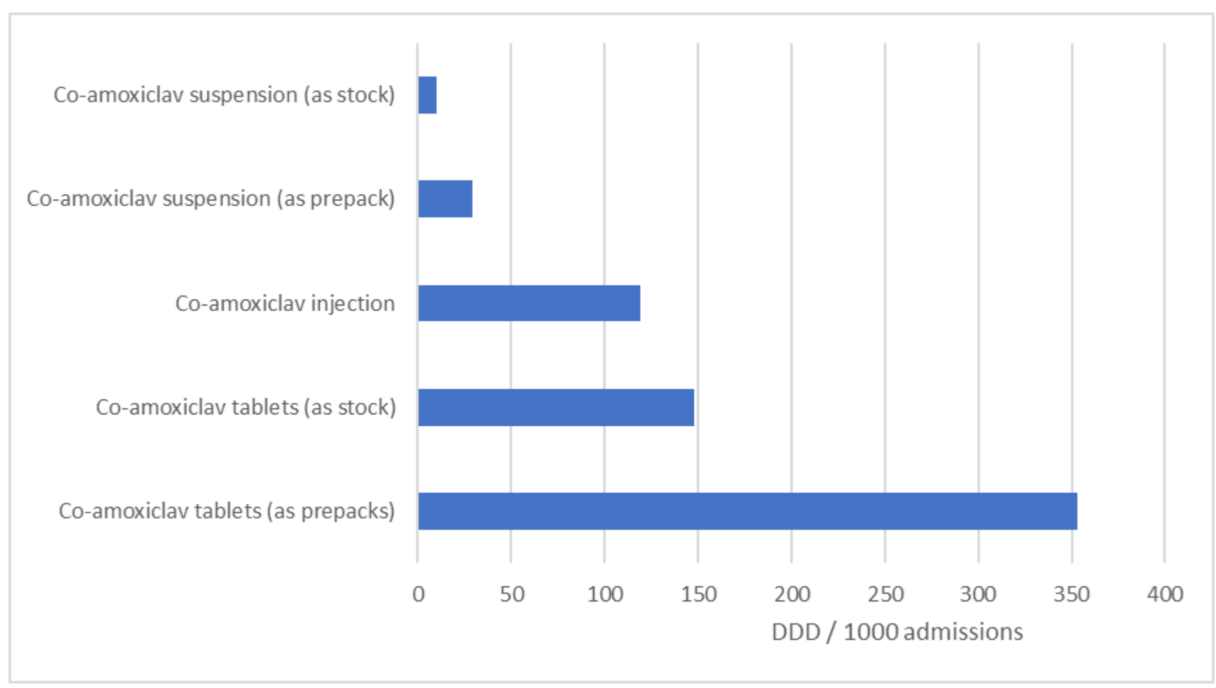


Figure 13: Co-amoxiclav use in Emergency Medicine by formulation (2022-23) in DDD / 1000 admissions including FP10s



Majority of co-amoxiclav usage in ED is in the form of TTO (to take out/home) prepacks, with usage doubling between 2014 and 2022.

11.4 AMS Team Emergency Department Project

In response to the data seen on high antibiotic usage in ED, the AMS pharmacists completed 5 visits to A&E Majors at WHH in March 2023. The TTO prepack registers were checked for co-amoxiclav 625mg tablets, amoxicillin 500mg capsules and ciprofloxacin 250mg tablets.

In addition, 3 drug charts were selected on each visit and antimicrobial prescribing reviewed. Patients were then followed up after 48 hours.

The following issues were highlighted and presented at the Emergency Medicine Clinical Governance and Patient Safety meeting in April 2023:

- There was a discrepancy in stock recorded in the prepack register vs stock in cupboard on 3/5 occasions. Co-amoxiclav was the most common and it wasn't clear from the register whether the incidents were investigated. This was handed over to the Lead Pharmacist for Acute and Emergency Medicine.
- Documentation of initial prescribing decision – 9/13 patients (69%) didn't have a clearly documented plan before pharmacist intervention
- Documented Abx plan at follow up after pharmacist intervention – 50% of patients missing duration / date of next review
- Low compliance to Microguide for prescribing of urinary infections/urosepsis and sepsis of unknown origin
- For 5 / 13 patients, we were unable to contact the Doctor

It was hoped that a formal action plan could be discussed and presented at June ASG, however the ED consultants advised that this was not an ED issue and was the responsibility of General and Specialist Medicine and Surgical care groups. Discussion on how to proceed was discussed at ASG in June 2023 and will be discussed further with the Chief Medical Officer in June 2023.

11.5 AMS Audits

AMS audits were conducted monthly with data collected by the clinical pharmacists and clinical pharmacy technicians, but were suspended a number of times due to lack of engagement or lack of staff resource. A trust wide AMS audit was last conducted in July 2022 and results distributed via Infection Prevention and Control Committee Meetings. Senior pharmacists were also asked to discuss the results at relevant care group meetings and feedback an action plan to ASG.
As ASG didn't receive any feedback on how care groups will improve prescribing quality, the audits were put on hold until February 2023 when it could be discussed by the new/returning AMS Pharmacy Team.

The trust implemented a new e-Prescribing system (Sunrise EPMA) in April 2023. It will ensure that an indication and duration is completed on every prescription as a mandatory field.
The AMS team are also working with IT and quality improvement teams to discuss how data from Sunrise EPMA can be used to guide both audits and reporting of antimicrobial usage. A meeting is planned for beginning of July 2023 to discuss an action plan. In order for trust wide audits to restart, the following conditions need to be met:

1. Data collected can be viewed by all e.g. via PTL portal (Trust IT system).
2. Engagement between ASG and the care groups is in place.

Ad hoc audits are conducted by the AMS Team when a *C. difficile* Period of Increased Incidence has occurred. Results are then fed back to the IPC team.

11.6 AMS Ward rounds/AMS PTL Portal

The AMS PTL portal build was completed in 2022. The data is taken from JAC dispensing system and updated daily to highlight patients dispensed 'restricted' antibiotics. The aim is for clinical ward pharmacists to check the portal every day and review any new patients for clinical appropriateness and whether there is a clear plan for treatment. Any patients they are concerned about or cannot

sort with the clinical team, can be referred to the AMS team for review via the portal. The clinical ward pharmacists would be asked to complete relevant information as part of the referral.
This is currently being piloted on Cambridge M2 ward. The aim of the pilot is to highlight any issues that need rectifying and determine how many patients need referral per week to the AMS team/microbiology before rolling out across more wards and eventually trust wide.
The AMS team is working with the informatics team to switch over the data feed to the trust's Sunrise e-Prescribing system. This will ensure more usable, real-time information is available. A planned date for switchover is not yet known.

Currently AMS ward rounds are not occurring but the PTL system is being used by antimicrobial stewardship pharmacists to keep track of fluoroquinolones, carbapenems and clindamycin at least twice a week. Referrals to consultant microbiologists are made when necessary and the patients reviewed by pharmacist and microbiologist. Advice is documented on Sunrise and discussed with the ward team.

12. Decontamination

12.1 Sterile Supplies (CSSD)

Instrument reprocessing is outsourced to In House Sterile Services (IHSS) The Trust Deputy DIPC undertook an informal visit following an increase in reported 'holes' in wraps in 2022 relating to a change in process. The DDIPC found that IHSS processes were robust, and that they evidenced their own independent audit compliance, as per national requirements. The contract with IHSS is managed by the service, and decontamination aspects reported through the Decontamination committee, and zero major 'failure to decontaminate' issues were reported in the reporting year.

12.2 Endoscope reprocessing

Endoscope reprocessing is undertaken and managed locally, all sites where processing is undertaken were audited by the Trust DDIPC and independently by the Trust Authorised Engineer for decontamination. The WHH service did not renew their JAG accreditation (formal external accreditation) this year, owing to the impact the COVID-19 pandemic had over the preceding years, they felt unable to prioritise the required level of documentation and evidence. All sites were deemed to be compliant with essential requirements, with some aspects of flow and training requiring some actions. No service fully met the 'best practice' standards.

12.3 Decontamination Audits

The results of decontamination audits for 2022-2023 are given below in Table 2.

Table 2 - summary of decontamination audit results

Location	Decontamination audit Results
WHH endoscopy	96%
QEQM Endoscopy	95%
KCH Endoscopy	89%
K&C Urology	90%
K&C theatres	93%
Derry Unit RVH	94%

12. Surgical Site Surveillance

Surveillance of surgical site infection (SSI) following orthopaedic surgery is included in the mandatory healthcare-associated infection surveillance system.

All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of the three orthopaedic categories:

- Total hip replacements
- Knee replacements
- Hip hemiarthroplasties

EKHUFT undertake continuous surveillance in all three categories (rather than limiting participation to the mandatory single quarter per year). This process is managed by the orthopaedic team with IPC support. All data for the year 2022-2023 have been submitted to the surveillance system. There is a time lag in receiving reports back with national comparators. Hospitals that are outliers in comparison to the national data set, based on the previous four quarters of data are notified formally by the UKHSA national surveillance team. The trust has been notified that it is an outlier for low levels of reported infection during 2022-2023. This, along with our own local intelligence suggests that the surveillance methods are not robust, i.e. that the surveillance is not identifying all of the infections that occur. As a result, the IPC team, working with the orthopaedic clinical team and the Surgery and Anaesthetics Care Group are reviewing the audit process to make sure and ensure that it is robust and sensitive. As mentioned previously in this report a surveillance nurse has been employed within the IPC team and, with the support of the IPC Site Lead Nurse for the Kent and Canterbury Hospital site, this colleague is leading this review.

13. Conclusions

The year 2022- 2023 was mixed with some positive progress and some remaining as well as emerging challenges. In summary we have:

- Completed the establishment of the Infection Prevention and Control and antimicrobial
- stewardship teams including a Consultant Pharmacist for antimicrobial stewardship and a
- specialist nurse for the surveillance of healthcare associated infections.
- Reviewed the infection control training needs and education for all staff.
- Re-established and reviewed the infection control Link Practitioner programme
- Reviewed and reinvigorated the audit programme and integrated hand hygiene audit into the new trust ‘Tendable’ audit platform.
- Contributed to and implemented the Kent and Medway *Clostridioides difficile* Root Cause Analysis tool.
- Implemented the National Infection Prevention and Control Manual
- Implemented a revised committee and governance structure including antimicrobial stewardship and decontamination.
- Revised the Business Continuity Plans.
- Reviewed the scope and quality of the surveillance of healthcare associated infections and started a programme of improvement work.
- Worked collaboratively with system partners to develop a Kent and Medway Infection Control and Prevention IPC Strategy.

We have achieved success in the following areas:

- The Trust is below the external threshold for *Pseudomonas aeruginosa* bloodstream
- infections (BSI) which was exceeded in the previous year.
- The Trust is below the external threshold for *Klebsiella species* for the second year in
- succession.
- A single case of hospital acquired Meticillin Resistant *Staphylococcus aureus* (MRSA) Blood

- Stream Infections (BSI).
- Stable numbers of Meticillin Sensitive *Staphylococcus aureus* (MSSA) BSI despite increased
- activity and acuity.

The remaining challenges and areas of focus include:

- In common with most acute trusts locally, regionally, and nationally we have seen a significant increase in *Clostridioides difficile* infections compared with the previous year. This has led to us exceeding the external trajectory.
- We have exceeded the external trajectory for *E coli* BSI and further work has started to target the root causes of these infections, including urinary tract infection prevention.
- Regulatory action in maternity services highlighted the need for further work related to cleanliness, the quality of the inanimate environment and some aspects of routine infection control practice, including handwashing between patients.
- Overall the condition of our estate and physical infrastructure remains very challenging and does not support good infection control practice.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Medical Revalidation Annual Report**

Meeting date: **6 July 2023**

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

Paper Author: **CMO**

Appendices:

NONE

Executive summary:

Action required:	**Approval**
Purpose of the Report:	All responsible officers are required to present an annual report to their Board as part of the Framework of Quality Assurance for Responsible Officers (FQA). Its purpose is to provide assurance that the doctors working in their organisations remain up to date and fit to practise and to approve the statement of compliance.
Summary of key issues:	East Kent Hospitals is a large designated body with 927 doctors directly connected and an additional 330 doctors in training as June 2023. Designated bodies have a statutory duty to provide sufficient resource to their appointed Responsible Officer (RO) to full their duties. Current shortfalls are being addressed: • Following the organisational restructure with revised roles and responsibilities across the medical leadership team, as posts are recruited to this will strengthen the management and governance of medical professional standards. • The corporate functions are also being reviewed and there is a commitment to include a senior medical workforce manager position that will address the gaps identified, provide strengthened leadership and support more strategic medical workforce planning. Processes are in place to support managing concerns about doctors' practice and the Responsible Officer works closely with the Practitioner Performance Advisory Service and General Medical Council (GMC) Employment Liaison Advisor. However, there are challenges with capacity to initiate and deliver timely outcomes when a formal process is required. There is oversight of the medical staff who are working within a governance framework, although it is recognised this can be further strengthened to deliver an effective appraisal process to support medical revalidation. To

	achieve this, we are progressing the recommendations following the NHS England Regional Revalidation Team Quality Visit in September 2022. The Revalidation Team are now working with the Patient Voice and Involvement Team to support lay representation at the Responsible Officers Advisory Group.
Key recommendations:	The Board of Directors is asked to **NOTE** the progress, **DISCUSS** the report and **APPROVE** the Report and Statement of Compliance prior to submission to NHS England Regional Revalidation Team.

Implications:

Links to 'We Care' Strategic Objectives:	• Our people • Our quality and safety
Link to the Board Assurance Framework (BAF):	**Principal Risk – BAF 33** There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.
Link to the Corporate Risk Register (CRR):	**Principal Risk – CRR 123** There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs.
Resource:	Y Designated bodies are required to support the RO in fulfilling statutory duties.
Legal and regulatory:	Y Compliance with The Medical Profession (Responsible Officers) (Amendment) Regulations 2013.
Subsidiary:	N

Assurance route:

Previously considered by: None

MEDICAL REVALIDATION ANNUAL REPORT

1. Purpose of the report

All responsible officers are asked to present an annual report to their Board as part of the Framework of Quality Assurance for Responsible Officers (FQA). Its purpose is to provide assurance that the doctors working in their organisations remain up to date and fit to practise. The Board are requested to approve the report for submission to NHS England Regional Team and approve the Statement of Compliance.

2. Background

Revalidation and appraisal are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop so care continuously improves. This report summarises East Kent Hospitals position in respect to its performance as a Designated Body. The report is structured in line with the requirements of the FQA template for Board report to demonstrate progress against actions.

3. Section 1 – General:

East Kent Hospitals Board of Directors can confirm that:

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

The Chief Medical Officer (CMO), Dr Rebecca Martin, is appointed as Responsible Officer (RO) and has appropriate training and engages in regional RO update events to support her in the role.

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

3.2.1 **Action from last year**: The Deputy CMO was appointed and started in April 2022. Due to gaps in medical leadership roles she was asked to support the Queen Elizabeth the Queen Mother Hospital medical director role so had limited time to support her role as Deputy RO, consequently the ability deliver all of the planned improvements identified in last year's report has been compromised.

3.2.2 **Comments**: Support in managing doctors with concerns remains an issue with investigations not consistently being delivered within timeframes. The internal investigation team is having a positive impact but complex investigations continue to take time. The analysis by the NHS England (NHSE) medical productivity team recommended a review to provide more senior human resource expertise and support to the medical staffing function. The experienced medical revalidation manager left her post in December 2022.

3.2.3 **Action for next year**: Following the organisational restructure with revised roles and responsibilities across the medical leadership team, as posts are recruited to, this will strengthen the management and governance of medical professional standards. The corporate functions are also being reviewed and there is a commitment to include a senior medical workforce manager position that will address the gaps identified, provide strengthened leadership and support more strategic medical workforce planning.

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

3.3.1 **Action from last year**: The Revalidation manger maintains records through General Medical Council (GMC) Connect account in close association with recruitment team to capture starters and leavers.

3.3.2 **Comments**: The appraisal e-portfolio application PReP supports this purpose.

3.3.3 **Action for next year:** We are currently in a tender process for our appraisal and revalidation system. As part of this regular updates on starters and leavers will allow accurate representation of the doctors with a prescribed connection.

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

3.4.1 **Action from last year**: The Appraisal and Revalidation Policy was reviewed and updates suggested based on the recommendations from the Higher-Level Responsible Officer (HLRO) visit in September 2022 and the actions generated from the gap analysis of the GMC Handbook 'Effective Clinical Governance for the Medical Professional'.

3.4.3 **Action for next year:** The Appraisal and Revalidation policy has been updated and is now in consultation with the Local Negotiating Committee (LNC).

3.5 A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

3.5.1 **Actions from last year:** The regional revalidation team on behalf of the Higher-Level Responsible Officer undertook a Quality Review visit on 8 September 2022. The visit highlighted many areas of good practice and made a number of recommendations to strengthen and develop appraisal and revalidation processes.

3.5.2 **Comments**: The quality assurance visit made a number of recommendations, recognising the challenges faced as a multi-site designated body with circa 800 and above connected doctors. This requires its responsible officer (RO) to have a strong core team in place to make sure the designated body itself and its appointed RO are both able to fulfil their statutory responsibilities under the Medical Professions Responsible Officer Regulations.

The recommendations included:

- Implement the planned Responsible Officer Advisory Group to provide advice and support to the RO.
- Consider opportunities for involving lay representatives to bring added benefits to the revalidation and appraisal process.
- Work with Chief People Officer to make sure People and Culture (P&C) colleagues are aware of the full breadth of the designated body and responsible officer statutory responsibilities and in particular the responsibilities for making sure the necessary checks are in place before doctors start work for the organisation and for monitoring and responding to concerns about doctors' fitness to practise.
- Review the current pool of circa. 200 medical appraisers (maintaining an appropriately sized pool of trained and well supported appraisers is fundamental to the delivery and advocacy of

medical appraisal.) Consider adopting a system for allocating doctors to their appraiser and using cross-speciality appraisers.
- Consider using a small number of the most experienced appraisers to help support the Appraisal lead to deliver appraiser refresher training, on-going appraiser support, appraiser recruitment and induction, running appraiser networks and undertaking quality assurance of appraisals.

3.5.3 **Action for next year**: The recommendations from the review will continue to be embedded with evidence of completion being gathered to assure the Board. The Responsible Officers Advisory Group (ROAG) is now established but will need embedding as the new roles in medical leadership are appointed to deliver the full ambition. In addition:

- Lay representation will be explored with the Patient Voice and Involvement Team and appointed as member of the ROAG as the group continues to develop over the next 12 months.
- Members of the P&C team have regular invites to the ROAG and at least one member of the P&C team attends.
- Following review of appraiser training strategies (see 4.5) no 'New Appraiser' training sessions are planned for 2023/2024 to allow us to focus on our existing pool of appraisers. In addition, the new policy (in consultation) has adjusted the expectations for the number of appraisals performed by each appraiser and a system of appraiser allocation has been put forward for consideration.
- As above, these changes will also facilitate the Appraisal Lead in being able to identify appraisers with consistently high-quality appraisals achieved and recruit a number of 'senior appraisers' to assist the appraisal lead in delivering appraisal support, appraisal quality assurance audits, facilitating appraiser training, and supporting the development of current appraiser pool.

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

3.6.1 **Action from last year**: Review any gaps against the GMC 'Effective Clinical Governance for the Medical Profession' handbook to ensure temporary medical workforce is supported in appraisal and revalidation needs.
3.6.2 **Comments**: Please see section 7.1 for update on action plan progress.
3.6.3 **Action for next year**: The actions from the review will continue to be progressed with barriers escalated to the RO.

4. Section 2a – Effective Appraisal

4.1 All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings.

Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

4.1.1 **Action from last year**: The Appraisal Lead is supporting doctors and appraisers that have not reached revalidation standard to complete appraisal. Appraisal Clinics are being run on the three acute hospital sites, although attendance to these sessions are steadily declining with appraisal compliance and quality improving, suggesting alternative support mechanisms have been strengthened through appraiser training and communications from the appraisal and revalidation team.

4.1.2 **Comments**: Concerns around the consistency of the quality of appraisal inputs and outputs over a number of years has been noted and the strength of revalidation recommendations. The GMC and HLRO are supportive of the measures put in place to address this during the last two years. The escalation process for those who have not completed an annual appraisal is now in place and seeing an improvement but remains resource intensive and needs continued oversight. Gaps in medical leadership roles and in the revalidation, team have compounded the achievements planned in year.

4.1.3 **Action for next year**: Continue the work of the Appraisal Lead and Revalidation team in maintaining the necessary standards and in escalating and actively managing overdue appraisals. The aim is to reach >90% compliance during appraisal year 2023/24.

4.2 Where in Question 4.1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

4.2.1 **Action from last year**: It was identified that in the PReP system the appraisal due date had been rolled forward on completion date rather than maintaining an annual due date which has made compliance difficult to monitor. The appraisal due date is now set to remain on its anniversary to improve our ability to track and respond to poor compliance.

4.2.2 **Comments**: All doctors are now closely monitored to comply with appraisal requirements but this remains labour intensive with the current e-appraisal system.

4.2.3 **Action for next year**: The e-appraisal system is being reviewed through a procurement process to reduce the manual inputs into monitoring appraisal compliance.

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

4.3.1 **Action from last year**: A full review of the policy in line with current national policy has taken place and is now in consultation with the LNC.

4.3.2 **Comments**: The current appraisal and revalidation policy was approved by the Policy Authorisation Group in June 2020.

4.3.3 **Action for next year**: The updated policy will be published later this year.

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

4.4.1 **Action from last year**: Although there is an appropriate number of appraisers more sessions will regularly be offered to meet increase in demand.

4.4.2 **Comments**: We are exploring the quality of training for appraisers.

4.4.3 **Action for next year**: As the Quality Assurance (QA) process is completed there is likely to be appraisers that will no longer continue in role, those who retire from the role and we will run appraiser training to match appraisers to number of doctors. This will be linked to job planning so demand and capacity can be matched.

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

4.5.1 **Action from last year**: The delivery of developmental sessions for appraisers is being reviewed including bringing in external support so appraisers are clear of their own responsibilities within the role but also have the opportunity to calibrate their work and discuss challenges.

4.5.2 **Comments**: Training sessions for current appraisers are being reviewed. The Appraisal Lead is acting as a second appraiser as an interim action to support individual doctors and appraisers to meet required standard.

4.5.3 **Action for next year**: To review the on-going need for external support to deliver training to existing appraisers and to consider development of Trust-delivered training through the use of senior appraisers/appraisal lead/appraisal and revalidation team.

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

4.6.1 **Action from last year**: The QA process above was reported to Board in March 2022 demonstrating a qualitative assessment of individual appraiser's appraisal output summaries. This process uses a widely recognised assessment tool called Appraisal Summary and PDP Audit Tool (ASPAT).

4.6.2 **Comments**: The revalidation manager submits a revalidation and appraisal report to the board of directors every 6 months and the ASPAT reported for the quarter after its introduction demonstrated improvements from 57% of areas rated excellent (40% satisfactory, and 3% poor) to 96% of areas rated excellent (3% satisfactory and <1% poor).

4.6.3 **Action for next year**: The focus on embedding effective medical appraisal will continue with the Appraisal Lead and Revalidation manager being supported by the Deputy RO. The ASPAT continues to be reviewed with recommendations generated at the end of each quarter.

5. Section 2b – Appraisal Data

5.1 The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: East Kent Hospitals University NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	907
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	536

Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	371
Total number of agreed exceptions	20

5.2 The Annual Organisational Audit (AOA) for 2021/2022 was completed although this has not been required for the last 2 years.

5.3 The overall appraisal rate is 76.8% overall; for consultants 81.3%; Specialty and Specialist (SAS) doctors 73.1% other locally employed doctors 70.5%.

5.4 Of note 198 appraisals have been completed for April and May 2023, reflecting the impact of the revised processes.

5.5 The Revalidation team are working with the P&C Business Partner to move to monthly medical appraisal data reporting through Electronic Staff Record (ESR) as for other staff members. This will improve visibility within the care groups to identify hot spots and particularly support locally employed doctors to participate in annual appraisal.

6.0 Section 3 – Recommendations to the GMC

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

6.1.1 **Action from last year**: All submissions were made in accordance with regulations. There was one late submission due to an administration error and this was immediately rectified.

6.1.2 **Comments**: Recommendations for revalidation from 1 April 2022 and were undertaken by the RO with support from the Revalidation manager until ROAG was established in 2023.160 recommendations have been submitted in 2022/23 and 111 were positive. A record of the rationale for the decision is maintained.

6.1.3 **Action for next year**: All recommendations will be reviewed ahead of submission date by ROAG.

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

6.2.1 **Action from last year**: Communication around revalidation recommendations has been strengthened. After a recommendation to defer is made a notification letter outlining actions needed is sent.

6.2.2 **Comments**: For doctors where a deferral recommendation is predicted, for example through having not completed their appraisal or provided an element of supporting information, they are engaged with ahead of any recommendation being submitted. Where possible they are supported either to delivery of outstanding information or agree actions to achieve. There was one recommendation of non-engagement in 2022/23 and this has been accepted by the GMC.

6.2.3 **Action for next year**: As part of the updated policy a review of the escalation processes and communications when a non-engagement recommendation is probable will be undertaken.

7.0 Section 4 – Medical governance

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

7.1.1 **Action from last year**: A gap analysis against the GMC handbook ‘Effective clinical governance for the medical profession’ has been undertaken and shared at Board. The gap analysis identified one standard was met in full and fourteen were partially met

7.1.2 **Comments**: Since April 2022, actions around the implementation of the ROAG and the completion of the Appraisal and Revalidation policy review have led to the completion of two standards relating to fifteen actions within the gap analysis. The position is now three standards met and eleven are partially met.

7.1.3 **Action for next year**: The action plan requires input from the P&C team and the Quality Governance team to meet the expected standards of the remaining eleven outcomes. The business/operations manager for the CMO will continue to progress this programme over the next twelve months and escalate any issues that a preventing progress.

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

7.2.1 **Action from last year**: The gap analysis against the ‘Effective clinical governance for the medical profession’ has identified areas where triangulation of all information about doctors can be improved and provided for annual appraisal. Work is being supported by Governance team so relevant information can be assigned and shared.

7.2.2 **Comments**: Individual doctors who have been involved receive written guidance at the conclusion of any process to include this within their appraisal. ROAG includes representatives from governance team.

7.2.3 **Action for next year:** Complete the actions identified from the gap analysis action plan to continue to strengthen processes, including ROAG.

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

7.3.1 **Action from last year**: The Maintaining High Professional Standards policy (MHPS) is in place and was last updated in July 2020. Where concerns are raised about any doctors’ performance these are dealt with under the policy.

7.3.2 **Comments**: The Trust has trained Case Investigators and Case Managers. Advice from the Practitioner Performance Advisory Service is sought where appropriate, including in supporting remediation plans.

7.3.3 **Action for next year**: The timeliness of initiation and completion of investigations and associated actions requires improvement and will be a focus of joint work with the Employee Relations team. Support has been increased as part of the handover of the RO role.

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

7.4.1 **Action from last year**: There is a bimonthly report to closed Board outlining current cases in addition to an annual report from People and Culture team which includes protected characteristics.

7.4.2 **Comments**: There is no formal QA process. The People & Culture team have developed a reporting dashboard to include open cases that will be reviewed at the People and Culture Committee.

7.4.3 **Action for next year**: Seek further guidance on QA processes used for managing concerns through RO network.

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

7.5.1 **Action from last year**: The Revalidation Manager requests and monitors the return of the Medical Practice Information Transfer (MPIT) forms and these are retained on file. The RO uses MPIT to transfer any concerns raised about a doctor who has worked in EKHUFT but is connected elsewhere. Advice is sought from GMC Employment Liaison Adviser (ELA) when a situation is not clear cut.

7.5.2 **Comments**: For joining doctors any concerns raised in the MPIT is brought to direct attention of RO. For doctors connected elsewhere there is improved visibility of concerns but the information flows are not fully embedded in Care Groups.

7.5.3 **Action for next year**: Work this year will focus on capturing through internal governance processes concerns about doctors who are connected elsewhere but work within East Kent Hospitals.

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

7.6.1 **Action from last year**: The P&C team are supporting embedding of a Just and Learning Culture approach. All GMC referrals are agreed with GMC Employment Liaison Advisor (ELA).

7.6.2 **Comments**: GMC referrals now require further checks around bias

7.6.3 **Action for next year**: Advice sought from GMC ELA around guidance as this should be employed for both internal and external action and to ask RO network for any additional guidance. This remains an important element and further refinement of our approach.

8.0 Section 5 – Employment Checks

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

8.1.1 **Action from last year**: There is a locum policy in place and this is managed through the Temporary Staffing team. Clinical leads review CVs for suitability and references and the temporary staffing team are responsible for overseeing safe recruitment checks. We have adopted the revised Royal College of Obstetrics and Gynaecologists (RCOG) 'Certificate of Eligibility' process for assessing competency of locums.

8.1.2 **Comments:** The Recruitment team are responsible for employment checks for all substantive doctors in line with NHS mandatory pre-employment checks. Any declared restrictions, warnings or convictions or anomalies with registration or Disclosure and Barring Service (DBS) reports are flagged to the RO.

8.1.3 **Action for next year**: Medical workforce is an element of the Integrated Improvement Plan with specific action to improve recruitment to our difficult to recruit areas and hence a reduction in the use of locums.

9.0 Section 6 – Summary of comments, and overall conclusion

The resource to deliver the statutory duties of the Responsible Officer this year has been compromised by departures from medical leadership roles and gaps in replacement as the Trust undertakes a necessary organisational restructure. The roles and responsibilities of the new medical leadership roles in supporting appraisal and revalidation, alongside embedding professional standards is specifically described within their updated job descriptions. This will enable the delivery of the requirements as a Designated Body to support the RO in meeting their obligations. The Revalidation Manager post has now been filled.

The review by NHS England Medical Productivity team supported the RO in their view that additional senior support to the medical workforce team is required to meet the needs of a growing and complex medical workforce, with eight different contract terms and conditions in play with differing needs and requirements. This is due to be addressed with a senior role in place in the P&C team from September 2023.

The Medical Appraisal Lead post started in Autumn 2021 and we are now looking to appoint to a senior appraiser support role as the workload remains high and growing. Their focus remains on quality assurance and he has initially met this through a QA review and acting as second sign off of appraisal outputs where any gaps can be identified and addressed by appraiser and doctor prior to completion.

The Responsible Officer Advisory Group, is now implemented with the aim to improve the governance around revalidation decisions.

The management of concerns relating to doctors' practice continues. A trained investigation team is now in place and external investigators have been used for complex cases. The open cases prior to 2020 has been addressed although unfortunately one longstanding case remains open but with progress, however new cases are completed in a timelier manner but room for improvement remains. Case Manager training will be provided to the new medical leadership team to support this element of their roles. Close relations are maintained by the RO with our GMC Employment Liaison Advisor and the Practitioner Performance Advisory Service (PPAS).

Overall progress has been made in providing greater assurance around the statutory function of the RO over the last three years, but this remains labour intensive and fragile, with the growth in numbers of doctors historically not met with an increased resource to manage. With investment in 2021/22 and the agreed structures and functions coming in

to play following the organisational restructure, when fully recruited, the position will be strengthened and should support delivery of the RO functions in the coming year. The focus on medical workforce as a workstream of the Integrated Improvement Plan is integral to future success.

10. Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

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

Name: Tracey Fletcher Signed: _ _ _ _ _ _ _ _ _ _ _

Role: Chief Executive Date: _ _ _ _ _ _ _ _ _ _ _

REPORT TO BOARD OF DIRECTORS

Report title: **Chief Medical Officer's (CMO's) Report – update on Medical Workforce**

Meeting date: **6 July 2023**

Board sponsor: **CMO**

Paper Author: **CMO**

Appendices:

'The state of medical education and practice in the UK Workplace experiences 2023' provided in reading room and at https://www.gmc-uk.org/

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The purpose of this report is to provide the Board with an update on key issues impacting on the medical workforce. This includes an update on Specialty and Specialist (SAS) and Locally Employed doctors, industrial action and medical education visits.
Summary of key issues:	The medical workforce, alongside all staff, continue to feel the long-term impacts following the Covid pandemic and the work to recover all activity to meet the constitutional standards for care that our patients should expect and our teams want to deliver. The General Medical Council (GMC) published in June 2023 'The state of medical education and practice in the UK Workplace experiences 2023'. This is stark reading and arrives at a time when healthcare in the UK faces extensive challenges. While the insights from doctors' workplace experiences are concerning there is a recognition that local action to improve the situation can be taken to improve the situation. This aligns to the primary interventions described by Professor Michael West as part of compassionate leadership and, in turn, the Culture and Leadership programme that is being launched across East Kent Hospitals. The national workforce plan for the NHS is due to be published shortly and this will provide a larger scale approach to staffing shortages, which along with unprecedented demand and waiting lists are at the root cause. However, there are interventions that can and must continue to be made at local level to improve doctors' working lives and make them feel that they belong and are valued. Improvements in areas such as fair and timely rota design, facilities for rest breaks, and provision of food and drink could make a huge difference to staff on the ground.

	The report also summarises updates from Health Education England (HEE) quality intervention visits and further planned visits. Interviews for the Director of Medical Education role are taking place in July.
Key recommendations:	The Board of Directors is asked to **NOTE** the report and how we are addressing the local interventions through the Culture and Leadership programme and the Integrated Improvement Plan (IIP). It is recognised that significant focus is needed on delivery of primary interventions to improve a sense of belonging and value.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people
Link to the Board Assurance Framework (BAF):	BAF 35 - There is a risk of failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	CRR 88 - There is a risk of failure to support staff health and wellbeing. CRR 118 - There is a risk of failure to address poor organisational culture. CRR 123 - There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs.
Resource:	Y
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

CHIEF MEDICAL OFFICERS REPORT – UPDATE ON MEDICAL WORKFORCE

1. Purpose of the report

1.1 The purpose of this report is to provide the Board with an update on key issues impacting on the medical workforce.

2. Background

The medical workforce, alongside all our staff, continue to feel the long-term impacts following the Covid pandemic and the work to recover all activity to meet the constitutional standards for care that our patients should expect and they wish to deliver. The GMC have published in June 2023 'The state of medical education and practice in the UK Workplace experiences 2023'. This is stark reading and there is a continued risk of moral injury to the work force without actions to address the situation further at local and national level. These issues are not unique to the medical profession, although this is the focus of this report.

3. Key findings of the state of medical education and practice in the UK Workplace experiences 2023 Report

The GMC has monitored doctors' workplace experiences nationally via its Barometer survey since 2019. The Barometer survey for 2022 shows a deterioration in doctors' experiences with these now being reported as the worst since the survey began. This in turn impacts on patient care with in the 2022 survey, more than two-fifths of doctors (44%) reporting they found it difficult to provide sufficient patient care at least once a week.

Key messages from the report are as follows:

3.1 Doctors' working environment is increasingly challenging

3.1.1 The report highlights the highest levels of doctor burnout and dissatisfaction recorded since starting the Barometer survey in 2019. 15% of the medical workforce have indicated that they are taking hard steps to leave UK practice.

3.1.2 The loss of benefits of the innovative ways of working during pandemic, combined with the pressure of backlogs and the re-emergence of the long-term challenges of increasing workload and intensity are at the root cause of the declining job satisfaction.

3.2 Breaking the cycle in the short term

3.2.1 The actions recommended that can and must continue to be delivered at a local level align to the work of Professor Michael West and compassionate leadership. His guiding principles of leadership support addressing the root causes through primary interventions.

3.2.2 Team working and inclusion are integral to good, safe patient care.

3.2.3 Effective induction of doctors is important, and particular challenges are associated with integrating doctors arriving from overseas and incorporating locum staff into teams.

3.2.4 Leadership development and enabling compassionate leadership is essential to ensure that leaders can support and encourage teams, building a stronger sense of belonging.

3.2.5 Improving working conditions, including by developing fair and flexible rotas and making sure that there are sufficient facilities in place for all staff for example access to water, hot meals, changing and rest facilities.

3.3 Looking ahead – reflections for the health sector to consider when looking to the future

3.3.1 The links between wellbeing of the workforce and patient safety are well recognised. While there are long term strategic workforce plans that require national action local plans must include a reduction in the intensity of workload that are impacting on wellbeing.

3.3.2 We need to support trainees to gain their competencies and skills and improve trainers' experiences to support growth in our future workforce

3.4 Local context and action

3.4.1 The report resonates with what our staff have told us, drawing on the staff survey, training surveys and local groups including the Doctors Voices Group and SAS group. There are a number of primary interventions that could improve the situation for our workforce, including improving access to hot food at night, places to rest, changing facilities and safe storage of personal belongings and effective and transparent rostering. Actions have started to address some of these.

3.4.2 The Integrated Improvement Plan has a workstream focused on medical workforce. This will include addressing some of the primary interventions including improving induction, with a focus on international medical graduates, rostering, recruitment and ability to interrogate and act on feedback including GMC survey with new reporting dashboards.

3.4.3 The Culture and Leadership Programme has commenced and doctors of all grades have been actively approached to be part of our change team. Supporting leaders to have the skills to develop their local teams and create a sense of team and belonging for a population of workforce that are seen as transitory is vital to improve wellbeing of our junior medical workforce. This is inconsistent at present although there are examples of good practise seen across specialties.

4. Update on Specialty and Associate Specialist (SAS) and Locally Employed (LE) Doctors

Since the last report recognising the growing reliance on SAS and LE doctors, their essential and diverse nature and a need to improve working conditions, a number of key updates have occurred:

4.1 A SAS tutor role has been appointed to with a focus on supporting the educational needs of the doctors.

4.2 A SAS Advocate role as outlined in the new 2022 contract has been advertised with interviews pending. This role will have a pastoral focus but

both tutor and advocate roles will collaborate to improve support to SAS and LE doctors.

4.3 A successful away day was held at Pines Calyx in May 2023 for SAS doctors and attended by the Chief Executive and Chief Medical Officer. While attendance was not as many as anticipated, the day was valued by those who attended. Sessions with a focus on Equality, Diversity and Inclusion and Well-being were well received.

4.4 The SAS task and finish group continues to work on issues raised to improve working lives of our SAS and LE doctor colleagues.

5. Industrial Action

5.1 A fourth period of Industrial action by junior doctors has been announced by the British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA). Members will be instructed not to commence work on any shift starting after 06:59 on Thursday 13 July 2023 and before 06:59 on Tuesday 18 July 2023. There are currently no derogations.

5.2 We recognise that the decision to take industrial action is not one colleagues take easily and we are working closely with representatives around plans to keep patients safe. East Kent Hospitals have a ‘tried and tested’ plan to cover junior colleagues’ absence but this will become more challenged due to fatigue and approaching holiday period. To keep essential and emergency services safe, there will inevitably be an impact on patients with further delays to those having planned care.

5.3 The BMA has balloted consultants on potential industrial action with the ballot due to close on 27 June 2023. Provisional dates of action are the 20 and 21 July if the vote is in favour of industrial action, with the plan to deliver ‘a Christmas day service’. Details are yet to be confirmed.

6. Health Education England (HEE) Visits and Medical Education Update

6.1 A HEE Quality Intervention visit took place on 28 March 2023, with a focus on specialities that contribute to maternity services: Obstetrics and Gynaecology, paediatrics, Anaesthetics and Operating Department Practitioners. The final report was published on 7 June.

The report highlighted:

6.1.1 The visiting panel were pleased to hear that all groups of doctors in training commented positively about the support received from consultants, and that Operating Department Practitioner (ODP) learners felt supported and included in theatres.

6.1.2 Most learner groups indicated they would recommend the service to a relative, although there was an awareness of the potential for factors such as space and staffing levels to impact on patient experience.

6.1.3 The panel identified a number of areas for improvement and considered that further assurance was required to ensure that HEE Quality Standards were being met. An action plan is in place and being progressed to address the mandated recommendations and evidence will be provided to HEE by 1 September.

6.2 A HEE Quality Intervention visit to meet dental core trainees is planned for July 2023, based on feedback from trainees in the department to seek further experiences of the quality for education and training in the Oral and Maxillofacial Surgery (OMFS) Department. An action plan is in place to address these issues raised by juniors in the department and the Royal College of Surgeons will be delivering the Non-Technical Skills for Surgeons (NOTSS) course on the 30 June and a Civility Saves Lives session is being planned.

6.3 A HEE Quality Intervention visit to William Harvey Hospital (WHH) Trauma and Orthopaedic Surgery is planned for the end of July 2023.

6.4 The Director of Medical Education has retired from her role after over 13 years leading medical education at East Kent Hospitals. Interviews are planned for July 2023, including external stakeholders. Interim cover to the medical education team has been provided by the Chief Medical Officer.

7. Conclusion

7.1 While the insights from doctors' workplace experiences are concerning there is a recognition that local action to improve the situation can be taken to improve the situation. This aligns to the primary interventions described by Professor Michael West as part of compassionate leadership and in turn the Culture and Leadership programme that is being launched across East Kent Hospitals. This focus on medical workforce as part of our Integrated Improvement Plan will support delivery of essential interventions at a local level, whilst national action is taken to address the workforce shortages that are impacting on doctors working lives on a daily basis.

REPORT TO BOARD OF DIRECTORS

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

Meeting date: **6 July 2023**

Board sponsor: **Interim Chief Finance Officer (CFO)**

Paper Author: **Interim CFO**

Appendices:

APPENDIX 1: MAY 2023 IPR

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The Trust has been engaged with a quality improvement programme called “We Care”. The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep). This report is updated for the key metrics that the Trust will focus on in 2023/24.
Summary of key issues:	The attached IPR is now ordered into the following: **True Norths-** These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years it may be that the targets are not met immediately and it is important to look at longer term trajectories. The areas are: • our **quality and safety.** The two metrics the Trust has chosen to measure against incidents with harm and mortality rate. • our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) 12-hour in department standard, the Referral to Treatment (RTT) 18-week standard and the Inpatient Survey score. • our **people.** The one metric chosen is for staff engagement. • our **sustainability.** The two metrics chosen to improve are the Trust’s financial position and carbon footprint. • our **future.** The two metrics chosen are the percentage of patients no longer fit to reside in hospital and Recruitment to Clinical Trials. **Breakthrough objectives-** These are objectives that we are driving over the next year and are looking for rapid improvement. The four key areas are: • **Improving theatre capacity.** By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In May the potential opportunity reduced to 37 lists, from 40 in the previous month.

- In May there was an improvement from April with booked occupancy increasing by 1% to 88.3% and actual occupancy was 79.1%. The Elective Orthopaedic Centre had a slight improvement with booked utilisation of 91.8%, an increase from April of 88.8%, and actual utilisation 85.3% an increase from 83.1% previous month.
- The number of cases per list is 2.3 cases.
- Late starts remained at 7%.
- The theatre optimisation group continues to meet monthly led by the Surgery & Anaesthetic leadership team.
- Each speciality has a detailed action plan with trajectories to improve performance.
- Elective Orthopaedic Centre have been chosen to work towards Surgical Hub accreditation.

Same Day Emergency Care (SDEC) Admissions. SDEC total activity across all services increased in May, reflecting the increase in both Surgical SDEC activity (672 v 638 April) and Medical SDEC (913 V 842 in April).

- **Direct Access Pathways (DAP) to SEAU** (Surgical Assessment Unit, WHH) in place as a pilot with review in June to Emergency Care Delivery Group (ECDP)
- The surgical DAPs will be rolled-out across the Queen Elizabeth the Queen Mother Hospital (QEQM) in June.
- **June –** William Harvey Hospital (WHH) to launch agreed Direct Access Pathways to the Children's Assessment Unit (CAU) reducing waits in Emergency Department (ED). This will be piloted in June in readiness for the newly appointed Clinical Assessment Unit (CAU) at the front door in September 2023.
- **Medical SDEC QEQM**. June will see the planned extended opening times (Mon-Fri 08:00-20:00 hours) to optimise the number of ambulatory pts requiring the service . This will be rolled-out in line with a training programme for Direct Access Pathways to the medical and surgical SDEC for QEQM for launch in June.
- QEQM Training programme for clinical staff for DAP will be rolled-out in June/July.
- QEQM implementing the Dr Initial Assessment Model at the front door (as in the WHH) to support the streaming and optimising the alternative pathways to ED.
- **There is a planned audit** with the Integrated Care Board (ICB) clinical leads and ED leads to review the utilisation of pathways to Urgent Treatment Centre (UTC) and SDECs with the intention of enhancing and optimising the utilisation of these alternative to ED services. The audit is planned to be undertaken in June/July and findings will be shared.

Staff Involvement. Staff Involvement has improved following a fall Q4 (2022/23), returning to levels seen in Q" (2022/23). Staff Involvement currently stands at 6.23, up 5 points but considerably below the desired threshold (6.7). This appears to be primarily due to staff feeling less able to make improvements happen in their area of work.

	• A Staff Engagement framework has been developed to enable colleagues to take tangible action to improve levels of involvement. • The We Care rollout has now reached Wave 6 and overall staff engagement levels are consistently higher in We Care areas than non-We Care counterparts. • Over 60 managers or team leaders have now been trained as part of the Team Engagement and Development (TED) pilot. • The 'change three things' approach is underway, with Specialties currently socialising their priorities and associated action streams. **Premium Pay costs.** Premium pay was considerably higher through 2022/23 than 2021/22. In recent months, until May 2023, the monthly numbers fluctuated slightly. Spend has increased to £10.2m in May 2023. This is likely to be down to payment timings as the underlying temporary staff usage has not increased to the same extent. Key Interventions include: • Detailed focus by care groups on drivers of premium pay. • Review of bank, agency and overtime rates across all staff groups. • Ensure improved sign off processes and governance across the Trust. • Recruitment to key clinical posts to reduce the need for temporary staffing. • Ensuring exit plans in place for high cost medical agency locums. **Watch Metrics -** these are metrics we are keeping an eye on to ensure they don't deteriorate.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated

	with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage.
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **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

May 2023

Our plan on a page

Our mission is improving health and wellbeing and our vision is to deliver Great healthcare from great people.

Our strategic themes, developed with colleagues across the Trust, are;

- **quality and safety**
- **patients**
- **people**
- **partnerships**
- **sustainability**

Our Pillars of change and strategic objectives are driven by our response to Dr Kirkup's report Reading the Signals, the importance of meeting national standards for planned, cancer and emergency care and the need to be financially sustainable by providing better care and reducing waste.

Everything we do is underpinned by our values: People feel cared for, safe, respected and confident we are making a difference.

We will discuss our progress against key performance indicators, and the difference it is making, in public at our monthly public board meetings which anyone can join, visit https://www.ekhuft.nhs.uk/

What is the Integrated Performance Report (IPR)?

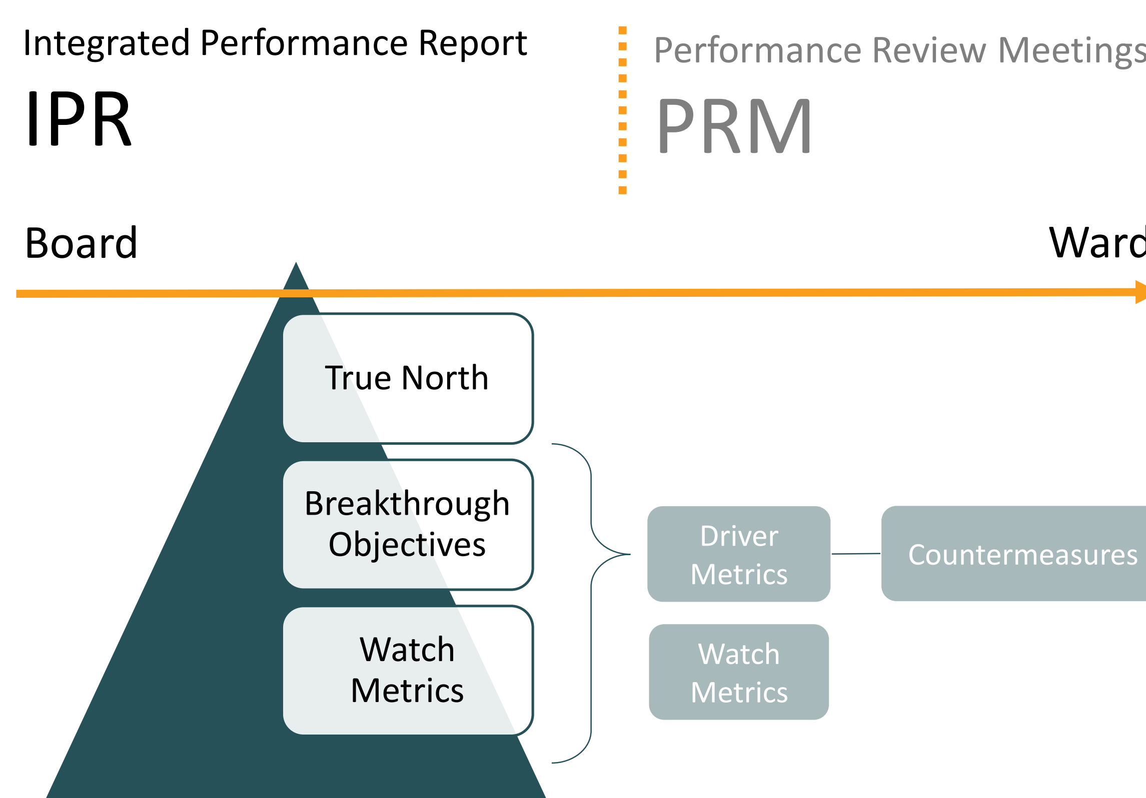
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing Patient Safety Incidents resulting in harm
- Reducing time spent in our ED Departments
- Improving theatre capacity
- Improving our Staff Involvement Score
- Reducing Premium Pay Spend

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2022/23. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

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

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

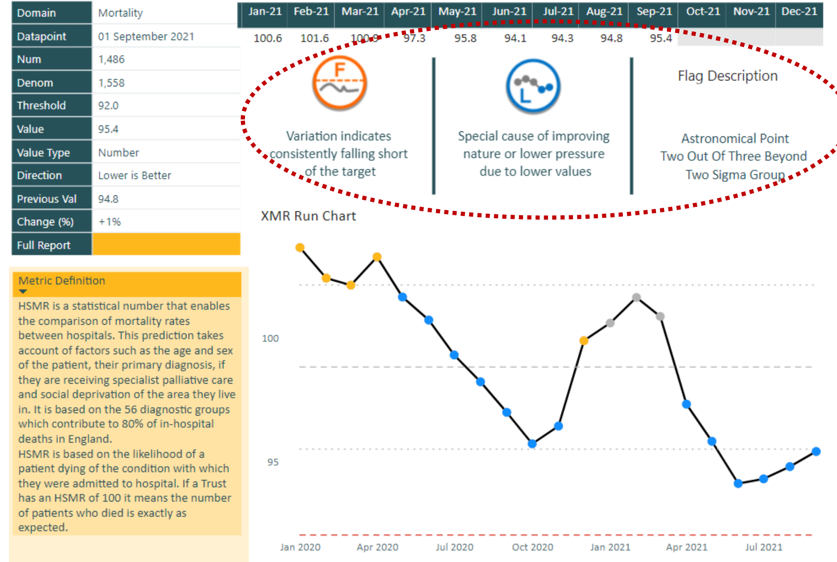
If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them



Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

What the chart tells us

The Trust HSMR is below threshold target and is now demonstrating common cause variation. The metric demonstrates a 12 month rolling position to February 2023 which is the last data release. At time of reporting this remains ‘lower then expected’ for the Trust as a whole and the K&CH site (70.4) and QEQM (92.3) with WHH (101.6) ‘as expected’. Our Palliative care rate 2.99% is above the national average (2.35%) and peer rates.

The Trust now lies 39th out of the 121 acute non-specialist Trusts on the Telstra Health platform.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. Current 12 month rolling HSMR for fractured neck of femur patients is 104.4 (to February 2023) and remains ‘as expected’ and unchanged form last reported position.

- Mortality metrics continue to be reported and discussed at monthly Mortality Surveillance Group (MSSG) and intelligence used to drive deep dives into pathways where indicated. There were no new alerts in the June 2023 Mortality report.

Risks/Mitigations

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

Our quality and safety

Jane Dickson

Incidents with Harm

The True North target is to achieve zero patient safety incidents of moderate and above avoidable harm within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. **Our target for the next 12 months is to reduce avoidable harm incidents of moderate harm and above to no more than 26 incidents per month by March 2023 (5% reduction).**

The breakthrough objective will be to reduce all patient safety harm incidents with a harm severity score of moderate and above, this will be achieved through the Fundamentals of Care and Patient Voice and Involvement workstreams.

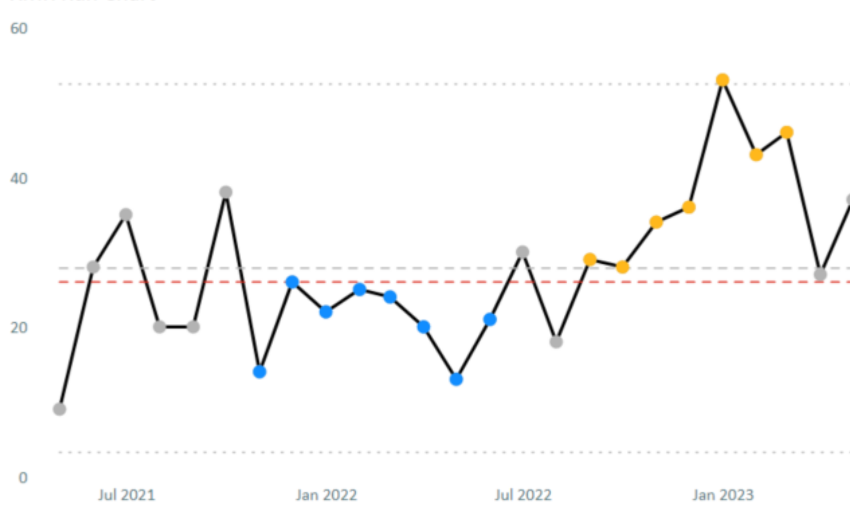
Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
21	30	18	29	28	34	36	53	43	46	27	37

Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags



What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 36 incidents in May, which still remains above threshold with a small increase from the previous month. The highest contributors to harm this month were operations/procedures with 11, which is an increase from the previous month, all of which were recognised complications from different specialities. Delay failure was the second highest with 7 incidents, which is an increase of 1 from the previous month. This was followed by care/treatment with 5 incidents which is also a decrease from the previous month. The number of severe incidents remain unchanged at 3 along with incidents associated with death also remaining unchanged at 4. Of the 36 incidents there is 1 regarding the review of a chest x-ray and subsequent pleural drain which may have caused a patients condition to deteriorate but a final decision cannot be made as the incident is still being investigated.

Intervention and Planned Impact

A pilot of a deteriorating patient educational programme will take place in June/July 2023, focussing on newly qualified Band5's and IENS. It will utilise a blended learning approach, incorporating real life examples of serious incidents so reinforcing the learning from incidents. It will be evaluated with the aspiration being to develop a 1-2 day programme that can be incorporated into the preceptorship programme. The funding from the ICB which has been identified to support the trust with the deteriorating patient improvement plan has now been released to the trust and plans for the allocation of the funding are currently being finalised. External resuscitation training for staff has been identified as one use for the money in response to the poor compliance with resuscitation training raised at the PSC by care groups.

The production of a deteriorating patient dashboard which is dependent on the development of VitalPAC functionality in Sunrise, is not envisaged to occur until the end of the year or even early 2024. Unfortunately the elements required for the development of the dashboard cannot be built until VitalPAC is transferred to Sunrise.

A deteriorating patient steering group launches in July whose aim is to act as a task & finish group to oversee the deteriorating patient improvement plan contained within the trust IIP.

Due to the continued inpatient capacity constraints it means that patients continue to remain in our emergency departments (EDs) for longer than is necessary and adds to risk of avoidable harm events. Escalation areas which are not included within the ED or ward staffing establishment continue to be utilised.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where high risk patients are cared for. An essential NEWS2 e-learning module is now live. An application for this e-learning module to be categorised as mandatory rather than essential has been submitted, the decision will be made in July.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Harm Events			Falls		Sigma	122	137	116	109
	W4		IPC: CDiff Infections		6	9	13	16	15
	W4		IPC: Audits Composite		85.0%	84.4%	84.6%	81.6%	82.1%
	W4		VTE Assessment Compliance		95.0%	92.4%	90.9%	89.0%	88.5%
			Safeguarding Incidents		Sigma	17	25	19	36
	W4		Serious Incidents Breached		0	2	6	10	13
	W4		Overdue Incidents		0	5,716	4,755	3,897	3,340

IPC: C diff Infections

This position continues to be of concern. There is no evidence of transmission (cross infection). An urgent review has identified three areas of work which are being acted on; antibiotic prescribing, timely sending of specimens and prevention of relapse/reinfection. A new Cdiff review group has been established. The 2023/2024 threshold will be very challenging to achieve.

VTE Assessment Compliance

VTE performance has deteriorated and currently the Trust Thrombosis lead is reviewing the process for VTE risk assessments in line with changes to systems and flow of patients to enable the improvements work to be appropriately focussed.

Safeguarding Incidents

There are 69 open safeguarding incidents open. 36 new safeguarding incidents were reported in May, however 9 have been identified for recategorisation taking this total to 27. None of these were declared as SI's.

Serious Incidents Breached

There were 13 breached SI's in May, 4 of which have since been submitted. 3 have been sent to Executives for final approval, 4 are being updated following SIIAP feedback and 2 are outstanding (GSM and Child Health).

Overdue Incidents

A total of 2,442 incidents reported in May 2023 and 3,529 closed.

There continues to be improvement in the number of overdue incidents which have reduced by 557, in-line with the target of 500 per month, to clear the backlog . The care group's have been supported to develop their own trajectories to ensure the back log is cleared by end of August 2023.

Currently the Corporate Care Group have 166 open with 136 overdue, however there is a plan for a substantive Patient Safety Team member of staff to clear these incidents by the end of August target.

Our patients

Our patients

Dylan Jones

Trust Access Standards: 18wk Referral to Treatment

The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the population health work with the Health Care Partnership early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
59.7%	59.5%	59.7%	58.4%	58.3%	59.0%	58.1%	56.7%	56.9%	57.7%	57.5%	55.7%

Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart

What the chart tells us

RTT performance continues to be impacted by the critical mass of patients in the non-admitted pathway, compounded by increasing breaches over 78 weeks and a notable reduction in clock stops being applied.

Intervention and Planned Impact

- Revise the Trust Access Policy and associated training to address data quality and pathway errors across priority specialities to improve the management and application of the pathway rules.
- Further analysis is underway to understand the increasing waiting list position and reduced clock stops.
- Increase validation and oversight where growth in breaches are being forecast impacting 78 week breach elimination.
- Continue to treat the longest waiting patients in the Trust ensuring patients are scheduled in chronological order of priority status and wait times.
- Focus on improving access to first outpatient appointments, reduce the waiting time as a priority and re-introduce the electronic referral service across a wider range of specialities to increase the volume of appointments patients can book directly.

Risks/Mitigations

- Weekly activity and performance meetings embedded with focus on increasing activity in both elective and diagnostic services.
- Care Groups have been asked to review their non-admitted positions to reduce first out patient waits, understanding growth in waiting list size and scope the impact out patient transformation benefits could have to aid recovery in this area.
- Recovery options within the Trust and Region to expedite the treatment of patients waiting for otology surgery continue.
- Theatre staffing recruitment and sickness levels remain an issue in our elective recovery journey. Oversight of staffing levels and scheduled activity continue to be monitored closely and solutions to address areas of risk continue to be mitigated where possible through the weekly theatre scheduling meetings.

22/23 breakthrough objective

Theatre Session Opportunity

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.
It is imperative that elective surgery deferred during the global pandemic is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
29	33	43	45	42	37	42	40	43	46	40	37

What the chart tells us

By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In May the potential opportunity reduced to 37 lists, from 40 in the previous month.

Intervention and Planned Impact

- In May there was an improvement from April with booked occupancy increasing by 1% to 88.3% and actual occupancy was 79.1%. The Elective Orthopaedic Centre had a slight improvement with booked utilisation of 91.8%, an increase from April of 88.8%, and actual utilisation 85.3% an increase from 83.1% previous month.
- The number of cases per list is 2.3 cases
- Late starts remained at 7%
- The theatre optimisation group continues to meet monthly led by the Surgery & Anaesthetic leadership team.
- Each speciality has a detailed action plan with trajectories to improve performance
- Elective Orthopaedic Centre have been chosen to work towards Surgical Hub accreditation

Risks/Mitigations

- Theatre staffing recruitment is on going
- Daily reviews of staffing across all sites are maintained to mitigate reduction of lists.
- Risks to activity due to strikes
- Continuing discussions in relation to extra contractual payment for Anaesthetist's remains risk
- The current theatre improvement plan is under review at the request of the COO to ensure the Trust has the correct approach in place for the next 6 months.

Our patients

Dylan Jones

ED 12h Total Time in Department

There is a nationally proposed new set of Emergency Department Access Standards which will focus on 12 hour Total Time in Department. This measures from arrival to either discharge, transfer or admission.

ED performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
9.5%	11.2%	12.1%	11.4%	10.5%	9.9%	12.2%	11.8%	11.5%	12.4%	10.4%	10.5%

F — Variation indicates consistently falling short of the target

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

Flag Description — Above Mean Run Group

XMR Run Chart

What the chart tells us

In May the percentage of patients with a total time of 12h in the ED departments was 10.7% v 10.6% in April and remains lower than the preceding 4 months . However the total number of reportable 12 hour DTAs in the ED increased from the previous month from 989 v 1,136 in May suggesting the flow out of the EDs to specialty wards remains a constraint . Progress continues with the planned implementation of clinical models at the front door to the QEQM from June, reflecting the models in place at the WHH (MAU, Short-stay acute medical wards) . The data does show a significant improvement in the reportable numbers for patent's > 12 hours **non admitted** in May (746 v 1,236 in December 22) and the lowest recorded in the last 11 months. There is a correlation between the 12 hour Total time and the number of reported 12 DTAs with the number of patients over 21 days . > 21days for May was 272, which is showing a month on month improvement but remains higher than June 22 (221) The correlating reported numbers of DTA in the ED at 08.00 hours continues to show a stable and improved position since Oct 22 , and is closely monitored as the new schemes , direct access pathways, clinical models are introduced over the next few months

Intervention and Planned Impact

The Emergency Care Delivery Group continues to focus on the delivery of the clinical models that support the underpinning principle; right patients, right place, first time. QEQM work is focussed on the front door models to support the Phase 3 of the ED Build (this is the majors work with the loss of 15 non-designated/non-funded spaces). The schemes include establishing a medical MAU, an ED Dedicated Observation Unit, expanding the Medical SDEC hours Mon-Fri. WHH will be commencing a joint pilot for the Paediatric Direct Access Pathways with Children's Group, commencing in June. Work continues with the development for the WHH clinical model for an ED CDU (Clinical Decision Unit). The patient flow workstream is launching a trust wide roll-out of the national SAFER Bundle, commencing in June which will focus on planned discharge processes to improve LoS, timely discharge and aims to show a positive impact on timely access to beds from the front door, reducing waiting times in ED. The SecAMB missed opportunity audit findings will be shared with the HCP/ICB for wider planning to strengthen access to community care provision and reduce conveyances to EDs. The ED leads are working in partnership with the ICB clinical leads to review the UTC and SDEC pathways this will take place in June. EKUFT are also exploring with ECIST the Alt-ED (a system wide model for alternative pathways to ED).

Risks/Mitigations.

- Leads from QEQM ED, Care Groups and the HCP are to put plans in place ahead of the June phase 3 build with a focus to mitigate the loss of care spaces. This includes reviewing the SDEC medical model to ensure full optimisation of the service with the aim to increase numbers directed to the service .
- A review of SDEC & UTC pathways is planned with the ICB to understand further opportunity to optimise services.
- A joint review of the NIFTR submissions to be completed in May and report of findings to the ECDG in June.

22/23 breakthrough objective

Same Day Emergency Care (SDEC)

Ensuring patients are seen and treated in the right setting, at the right time and in the right way are key aspects of efficient and effective patient care. A number of patients currently accessing our Emergency Departments can be safely assessed, treated and discharged via a Same Day Emergency Care pathway, such as Emergency Ambulatory Care, Gynaecology, Surgery or Frailty). Access to an SDEC service may be following a direct referral by a GP or via the Emergency Department.

It is anticipated that an average of 2,600 patients each month can be safely seen and treated via a Same Day Emergency Care pathway, this is the ambition for 2022/23.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
2,137	2,196	2,046	2,173	2,069	2,272	2,352	2,316	2,221	2,265	2,008	2,162

Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart

2,500
2,000
Jul 2021
Jan 2022
Jul 2022
Jan 2023

What the chart tells us

The chart shows the SDEC total activity across all services increased in May, reflecting the increase in both Surgical SDEC activity (672 v 638 April) and Medical SDEC (913 V 842 in April). The Surgical SDEC launched their Direct Access Pathways at WHH in May, increasing the number of patients able to be seen directly in the surgical unit, bypassing the ED. The number of arrivals in May for both type 1 and type 3 shows a marked increase compared to April, particularly Type 3 activity (**11.7 April v 12.9 in May**). It is worth noting the numbers of type 3 attendees in May is the highest number reported in the last 12 months with the WHH seeing 3,119 in month, and can be attributed to the direct access pathways to both UTC and medical SDEC launched in May at the WHH following an intensive staff training programme.

Intervention and Planned Impact

Direct Access pathways

- **Direct Access Pathways (DAP) to SEAU** (Surgical Assessment Unit, WHH) in place as a pilot with review in June to Emergency Care Delivery Group (ECDP)
- The surgical DAPs will be rolled-out across the QEQM in June
- **June –** WHH to launch agreed Direct Access Pathways to the Children's Assessment Unit (CAU) reducing waits in ED. This will be piloted in June in readiness for the newly appointed CAU at the front door in September 23 .
- **Medical SDEC QEQM**. June will see the planned extended opening times (Mon-Fri 08:00-20:00 hours) to optimise the number of ambulatory pts requiring the service . This will be rolled-out in line with a training programme for Direct Access Pathways to the medical and surgical SDEC for QEQM for launch in June
- QEQM Training programme for clinical staff for DAP will be rolled-out in June/July
- QEQM implementing the Dr Initial Assessment Model at the front door (as in the WHH) to support the streaming and optimising the alternative pathways to ED
- **There is a planned audit** with the ICB clinical leads and ED leads to review the utilisation of pathways to UTC and SDECs with the intention of enhancing and optimising the utilisation of these alternative to ED services. The audit is planned to be undertaken in June/July and findings will be shared

Risks/Mitigations

- To understand how to further optimise the number of patients directed to SDECs an audit will be undertaken with the ICB UEC clinical lead in June. This will aim to increase activity and provide a platform for scoping with SECamb and Primary Care direct access to the services, starting with medical SDEC.
- Work progresses with the WHH front door Frailty Unit (FAU) to be in place from Sept 23. QEQM are undertaking a similar exercise to widen the scope within their dedicated FAU.
- Work with the UTC Alliance is planned to enhance the service provision and reduce the number of patients directed back to ED/SDEC.

Our patients

Dylan Jones

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patients are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

What the chart tells us

Performance has dipped again in May due to the Endoscopy challenges, limited recovery possibly following the industrial action and BH's and an increase demand for the organisation with 2ww referrals. The Trust remains in the top 3 performers nationally for 2-week wait access and is still making the biggest contribution to a Cancer Alliance that has the 3rd smallest backlogs for 62 day breaches and the Kent and Medway Alliance being the best performing Alliance in the country.

Intervention and Planned Impact

- CCHH and Clinical Support Services working closely to optimise the radiology diagnostic capacity in the CDC to support faster and early diagnosis. Need to move closer to referral to report within 10days if compliance to be achieved and sustained.
- Achieving the 28-day FDS standard will support the continued reduction of patients waiting over 62 days. Straight to test (STT) for Lower GI is making significant improvements for patients and process, plans in place for full roll out.
- STT within lung pathway being supported with dedicated CT slots daily at the CDC
- Proactive management of long waiting patients continues to fully understand how we can best manage these groups through to treatment. Breach report meeting with actions and learning in place.
- All roles within CCHH Compliance team have been reviewed to support improved learning. Standardising practice for all teams, to help improve morale, support co-design and share best practice.
- Community Qfit being utilised for 80% of patients referred, new SOP and pathway to improve consistency being finalised for sign off at Network TSSG Meeting.
- From the CQUINS calculation for LGI for the patients who have gone through the STT pathway so far 75% have hit their timed pathway target, dates for a further roll out agreed but heavily dependant on Endoscopy recovery plan

Risks/Mitigations

- Urology pathway delays and challenges continue to be a significant risk, agreement for mutual aid and STT implementation is required at pace to mitigate and move to an improve position for these patients.
- Endoscopy capacity and delays remain a key contributor to the deterioration in performance and a sustainable recovery plan is urgently required
- Delays to diagnostics vetting, booking and reporting remains a significant risk but pathway mapping and changes being investigated to agree sustainable solutions.
- Histopathological reporting remains a significant contributor to the teams ability to achieving sustainable compliance, again work in progress with CSS to support improved turnaround times, understanding the significant reality of a national shortage of Histopathologists.
- Theatre capacity for Specialities within Urology, Head & Neck, Breast and Lower GI continues to be a risk.
- Tertiary capacity for OPA's, diagnostics and treatments remains challenging, working with the Alliance to support improvements.
- MDM radiology cover consistency continues to be a significant risk, need to confirm plans for future cover, part of the improvement plans with radiology.

Our patients

Jane Dickson

Patient Experience: Inpatient Survey

The National In Patient Survey published in October 22 (surveyed patients discharged in November 2021), completed responses for the trust were received from 515 patients (1,250 invited) with a response rate of 43%. The survey consists of 45 questions and the trust scored below the national trust average on all questions, and in 23 out of the 45 responses the trust scored in the bottom five trusts in the region, and in the bottom five Nationally.

The Trust has chosen ten questions from the National In-Patient survey, and our average for our focused 10 questions is 7.13 compared to 7.65 as a national average.

41 adult in-patient wards will complete 50 surveys per month (2,050) using the tendable app using the 10 questions.

Our ambition is to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	8.9	8.8	8.9	8.9	9.0	9.0	9.4	9.2	9.3	9.3	9.3

Variation indicates consistently passing the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart

9.5
9.0
8.5
8.0
7.5
Jul 2022 Sep 2022 Nov 2022 Jan 2023 Mar 2023 May 2023

What the chart tells us

In May, the trend of gaining feedback from in excess of 2,050 patients continued, providing confirmation that the process of obtaining this feedback from patients is now embedded across the organisation.

The overall trust wide score for May continued the trend of being significantly above the threshold of 7.7 (77%).

The exception continues to be patients reporting that they had difficulty sleeping at night due to noise.

Intervention and Planned Impact

The Picker results are now available for the 2022 national inpatient survey. These results are not the final comparisons that are provided by CQC later in the Autumn, but provide insight into the raw responses.

Initial analysis of the new national results concludes that areas for improvement will be:

- Patients changing wards during the night and explanation of the reasons.
- Noise at night from other patients.
- Involvement in the discharge process.
- Involvement in medication care at discharge.

Areas for celebration:

- Providing patients with their nutritional and dietary requirements.
- Assisting patients with food and drink.
- Confidence and trust in the nurses.
- Ability to discuss worries and fears with staff.
- Patients are able to take own medication when needed.

Reviews will be undertaken with regard to amending current focused questions on the internal inpatient survey and subsequent trust wide actions.

The HoNs and DoNs continue to support the wards to complete their surveys and develop actions to address poor responses. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FoC).

The Patient Involvement Team continues to review the feedback provided via targeted Friends and Family responses, feedback via Care Opinion and community engagement events.

Risks/Mitigations

If culture and behaviours do not change and the patients voice continues not to be heard, there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Cancer 62d			Cancer 31d Performance		96.0%	97.9%	98.5%	96.7%	92.4%
	W4		Cancer 28d Performance		75.0%	66.2%	65.2%	62.4%	60.4%
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	197	86	91	156
	W4		DM01 Compliance		75.0%	62.0%	60.3%	56.3%	58.6%
	W4		RTT OP Booking Breaches		14,000	28.4K			32.0K
ED Compliance	W4		ED Compliance		90.0%	67.3%	67.1%	70.7%	71.7%
	W4		Unplanned Re-attendance ED		10.0%	13.6%	13.3%	13.0%	13.0%
	W4		Super Stranded >21D		107	307	296	280	272

Cancer
The 28d faster diagnosis metric continues above 60% was impacted in month by the Industrial Action. The underlying challenge however remains the speed of diagnostic provision.

RTT 18 Weeks
78 week breaches have increased significantly in May. Significant pathway delays for an endoscopy procedure are impacting the General Surgery/Colorectal service. This coupled with patients retuning from the Independent Sector, who have not been treated, have seen a sharp increase in May contributing to the growth in breaches. Patients continue to wait longer for surgery through choice and a system solution to address the otology capacity breaches is still being considered and scoped across the region.

Out patient booked breaches remain significantly increased. Further analysis of the waiting list growth, taking into account referral patterns, activity volumes and treatment, is underway across the top ten specialities driving the position.

An improvement in month has been noted in Radiology, breaches are reducing and positive improvement has been seen in CT, DEXA and NOUS. The endoscopy service is unable to deliver the planned activity levels and this is impacting the cancer pathway targets and the routing RTT which is extended patients RTT pathways beyond 78 weeks.

ED Compliance
Compliance with the 4hr standard improved in May (71.7% all types v 70.7% in April) . This remains an improving reportable position and the best performance reported since Jan 22. Type 1 performance for both sites reported 44.9%, an improvement from April at 43.9% and shows continuous improvement since Nov 22

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
FFT	W4		FFT Maternity Response Rate		18.0%	14.0%	12.2%	11.1%	11.1%
	W4		Complaint Response		90.0%	45.8%	72.1%	47.1%	72.7%

Complaints Response

May 2023 saw 90 new formal complaints taken forward with 539 overall contacts. Most of the contacts to the team are dealt within PALS. There were 17% of contacts in May that were taken forward as new formal complaints. As a seasonal comparison to May 2022 there were 65 complaints and 592 overall contacts, which is a 38% increase in formal complaints and a 9% reduction in overall contacts.

During May our compliance with acknowledging our new complaints within three working days was 88%. This is a reduction on last month. This is owing to the number of bank holidays, combined with staff holiday, skills levels and an increase of new complaints.

The care groups are continuing their work on complaint response timescales. In May there was an increase in performance of responses within timescales to 69% from 45% in April. As a seasonal comparison, May 2022 responses within timescales was 73%.

Our people

Our people

Andrea Ashman

Staff Engagement (score)

Staff Engagement levels have remained below the national average throughout the last five years. The Staff Engagement Index itself has been on a downward trend for three years and, as an organisation, we are one of the most challenged in the country, sitting in the bottom 20% nationally. Given the negative implications of reduced staff engagement, it is imperative that levels are significantly and consistently improved.

The National NHS Staff Survey (NSS) is used to give an indication of staff engagement, providing an overall Staff Engagement Index to the Trust. In order to monitor this more regularly, we are also measuring this at quarterly intervals through the National Quarterly Pulse Survey (NQPS). Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
6.26	6.33	6.33	6.33	6.35	6.35	6.35	6.17	6.17	6.17	6.20	6.20

Variation indicates consistently falling short of the target

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

Flag Description

Astronomical Point Two Out Of Three Beyond Two Sigma Group

XMR Run Chart

6.8
6.6
6.4
6.2
Jul 2021
Jan 2022
Jul 2022
Jan 2023

What the chart tells us

Staff Engagement levels have improved subtly against each of the three domains (motivation, involvement and advocacy) as well as overall, between Q4 (22/23) and Q1 (23/24) as per below:

- Overall Staff Engagement score: 6.20 (up 3 points vs. 6.17 in Q4)
- Motivation score: 6.61 (up 3 points vs. 6.58 in Q4)
- Involvement score: 6.23 (up 5 points vs. 6.18 in Q4)
- Advocacy: 5.76 (up 1 point vs 5.75 in Q4)

The overall score is improved but remains significantly below the desired index and national average (6.8). Staff engagement is primarily being impacted by low levels of advocacy for the organisation.

Interventions and Planned Impact

The National Staff Survey results have now been socialised across the organisation and action agreed at three levels; organisational, hotspots (targeted interventions) and locally (Specialty).

At a Specialty level, colleagues are identifying their key challenges and working to 'change three things'. Progress against this work is being captured and project managed by P&C Business Partners. A P&C MDT has been initiated and, triangulating staff survey data alongside other key evidence (IIP, Clinical Adjacency work and our Pillars of Change) has identified critical hotspots for targeted intervention. Using the enhanced NSS dashboard, a new Staff Engagement Framework has been developed alongside national partners. This will offer colleagues insight into an often amorphous topic with simple, tangible actions to help drive improvement.

Risks/Mitigations

Staff Engagement levels are declining nationally, most notably with reductions in motivation levels and advocacy – two key components of staff engagement. There is a risk that national strike action perpetuates this reduction in overall motivation levels and advocacy. Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores. The Kirkup Report appears to have had an impact on staff advocacy and affected the way colleagues respond overall to engagement questions in the National Staff Survey.

22/23 breakthrough objective

Staff Involvement Score

EKHUFT's staff involvement score is lower than the national average for acute trusts (6.7). Staff involvement is one of the 3 components that contributes to staff engagement – the We Care People True North. Of the three components, staff involvement is more heavily weighted, it can be tangibly impacted and also influences the other two components - staff motivation and advocacy. Our aim is to improve staff involvement, as a core aspect of improving the overall staff engagement score.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
6.13	6.28	6.28	6.28	6.43	6.43	6.43	6.18	6.18	6.18	6.23	6.23

Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart

7.0

6.5

6.0

Jul 2021 Jan 2022 Jul 2022 Jan 2023

What the chart tells us

Staff Involvement has improved following a fall Q4 (22/23), returning to levels seen in Q" (22/23). Staff Involvement currently stands at 6.23, up 5 points but considerably below the desired threshold (6.7). This appears to be primarily due to staff feeling less able to make improvements happen in their area of work. The latest scores are provided below to confirm:

- Staff Involvement score: 6.23 (up 5 points vs. 6.18 in Q4)
- Frequent opportunities to show initiative: 6.37 (up 5 points vs. 6.32 in Q4)
- Able to make suggestions for improvement: 6.48 (up 4 points vs. 6.44 in Q4)
- Able to make improvements happen: 5.85 (up 6 points vs. 5.79 in Q4)

What the evidence establishes is that colleagues can show initiative and make suggestions, but that work is needed to help colleagues across the organisation to make improvements happen.

Intervention and Planned Impact

- A Staff Engagement framework has been developed to enable colleagues to take tangible action to improve levels of involvement
- The We Care rollout has now reached Wave 6 and overall staff engagement levels are consistently higher in We Care areas than non-We Care counterparts
- Over 60 managers or team leaders have now been trained as part of the Team Engagement and Development (TED) pilot
- The 'change three things' approach is underway, with Specialties currently socialising their priorities and associated action streams

Risks/Mitigations

- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years and there has been a pronounced fall in recent quarters
- The Kirkup Report appears to have impacted on staff morale and affected the way colleagues respond overall to engagement questions in the National Staff Survey
- Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Staff Engagement	W4		Appraisals Compliance		80.0%	70.5%	70.5%	70.1%	67.4%
			Statutory Training		91.0%	90.5%	91.0%	90.6%	91.2%
	W4		Safeguarding Adults Training		90.0%	83.1%	82.9%	84.8%	84.8%
	W4		Safeguarding Children Training		90.0%	84.8%	84.6%	85.8%	87.1%
	W4		Premature Turnover Rate		25.0%	26.1%	26.1%	26.9%	25.9%
	W4		Medical Job Planning Rate		90.0%	31.2%	38.3%	46.4%	50.4%

Appraisal Compliance

Overall appraisal compliance had been on an upward trend from June 22 to February 23. However, compliance fell slightly in April and further again in May as large numbers of appraisals are traditionally carried out in these months. Approximately 20% of all appraisals are carried out in April/May each year although so far this period has not seen as large a drop as 2022. P&CBPs are working with Care Groups to support, inform and encourage leaders to book in their appraisals and then record them via ESR Self-Service. Compliance ranges from 53.7% for Corporate areas to 76.7% for Cancer.

Statutory Training

Compliance recovered in May and is now above the Trust Level Threshold. All staff groups are compliant and above the 91% threshold, with the exception of Medical staff at 76% which is an improvement on April's compliance rate.

Safeguarding Training (Adult & Children)

Safeguarding Children Training rates improved again this month to 87.1% but are still below the 90% threshold. Safeguarding Adults Training has remained at 84.8% and is also below the required threshold. A new TNA is currently going through the approval process of the SMET Steering Group, recognising training availability challenges and enabling greater levels of occupancy at Level 3. Medical staff have the lowest compliance in both subjects at 64.3% for Adult and 68.8% for Children.

Premature Turnover Rate

Premature turnover has improved to **25.9%**, just above the target threshold (25%) – a result of falling to **17.8%** in-month. The 'New Starter Experience Survey' appears to indicate this is a result of a positive onboarding and induction experience, with East Kent Hospitals 19% ahead of the K&M average for net engagement of staff with <1 years' service. This is based on a credible 343 responses. As the method of premature turnover is acutely sensitive to improvements in total turnover, an alternative has been offered, measured as a % of total headcount of those <1years' service – the average of which is **14.8%**.

Medical Job Planning

Medical job planning rates have improved by a further 4% and stand at 50.4% surpassing the peak in January 2022 and the highest compliance rate for at least a year although still a long way from the 90% threshold.

Our sustainability

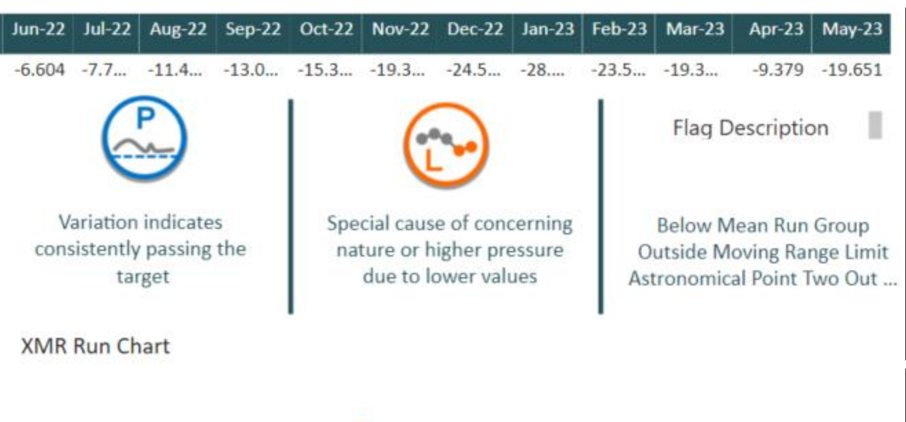
Our sustainability

Michelle Stevens

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the years up to 2019/20. During the two years over the pandemic the position was break even. In 2022/23 the Trust achieved a deficit of £19.3m which included a significant level of non recurrent items.

For 2023/24 the Trust has approval of a £72m deficit plan and confirmation that 2023/24 is the Trusts first year of the three year plan for delivery of financial balance. This plan is based upon a £40m CIP target, an increased activity target, reduces NLFTR patients, reduces escalation beds, removes 65 week breeches, no additional cost pressures arise without mitigation in year, non elective pressures are within tolerance and full controls are re-introduced.



What the chart tells us

The first two years of the graph show the monthly financial performance of the organisation which has resulted in 2021/22 at break even and 2022/23 with a deficit of £19.3m. The final graph point shows position in May as £19.7m deficit which equates to a £1.9m variance to plan. The key drivers behind the deficit are; Strike action £0.4m by the junior doctors, Non-delivery of efficiency savings £2.9m YTD of which £2m has been allocated to Pay and £0.9m to non pay, Pay overspent by £2.5m due to non delivery of CIP and increased levels of staffing utilisation mainly in nursing (c183 WTE) & Medical & Dental (c76 WTE) and high cost of agency premium & Non Pay underspend £1.7m on Drugs £1.4m and £0.6m underspend on clinical supplies & services and other smaller underspends off set against non-delivery of CIP of £0.9m

Interventions and Planned Impact

The largest interventions for the plan were:

- Delivery of the £40m CIP programme, Fortnightly meetings being held with clinical and corporate areas, use of national benchmarking data, plus detailed budget reviews underway.
- Half day sessions held with all of the care groups, corporate areas to be worked through over the coming weeks
- Increased controls on pay/ non-pay introduced.
- Full analysis of activity, workforce and expenditure for the period of 2019/20 to 2022/23 has been completed for each care group.

Risks/Mitigations

For 2023/24 the key risk and mitigations are:

- Increased usage of escalation areas, specialling and additional staffing above establishment
- Efficiency target of £40m
- Development of key Trust wide themes for CIP delivery are being developed
- WLI payments have been standardised

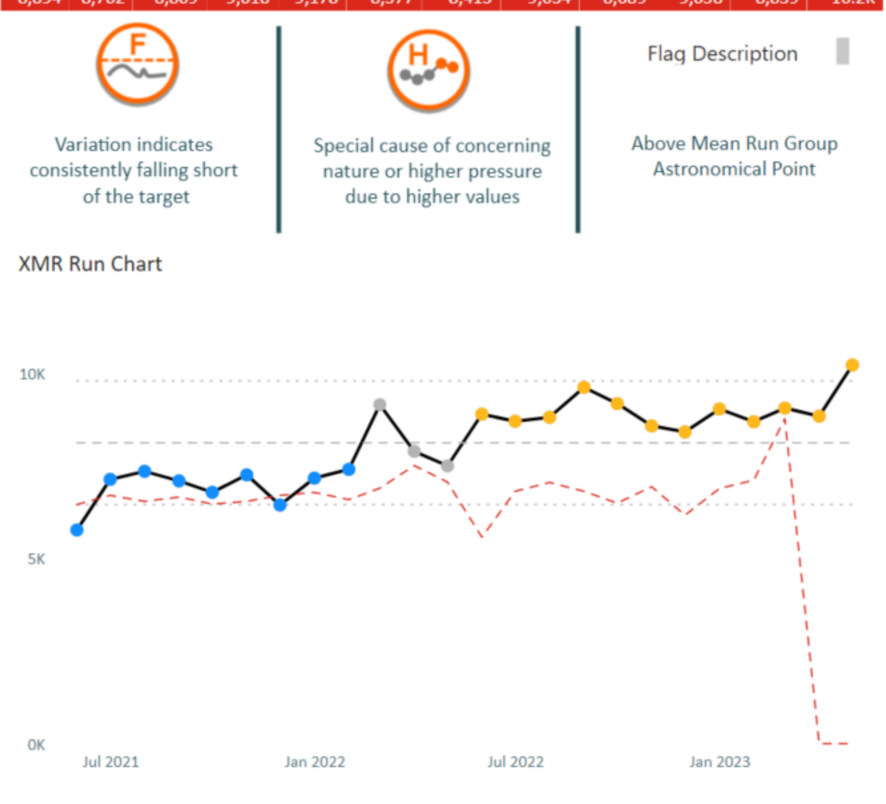
22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst the most influenceable by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective is to reduce the spend by 10% or £8.7m in 2022/23.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
8,894	8,702	8,809	9,618	9,178	8,577	8,413	9,034	8,689	9,058	8,839	10.2K



What the chart tells us

Premium pay was considerably higher through 22/23 than 21/22. In recent months, until May 23, the monthly numbers fluctuated slightly.

Spend has increased to £10.2m in May 23. This is likely to be down to payment timings as the underlying temporary staff usage has not increased to the same extent.

Intervention and Planned Impact

The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.

Key Interventions include:

- Detailed focus by care groups on drivers of premium pay.
- Review of bank, agency and overtime rates across all staff groups.
- Ensure improved sign off processes and governance across the Trust.
- Recruitment to key clinical posts to reduce the need for temporary staffing.
- Ensuring exit plans in place for high cost medical agency locums

Risks/Mitigations

- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- The remainder of spend is caused by operational demand. Work is required to control and reduce demand led spend particularly in relation to escalation areas.
- The increase in escalation beds and the increased need for specialing patients has increased the need for temporary staff

Our sustainability

Ben Stevens

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
2.95	5.29	5.12	4.75	6.31	6.29	8.66	8.15	7.40	7.95	7.86	

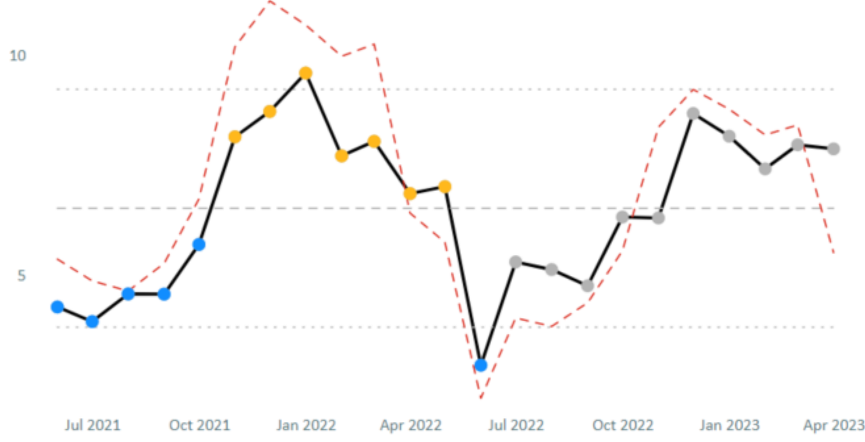
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. The position is reporting above the monthly trajectory of 5.50 at 7.86 C02e per m2 but is broadly in line with previous months and for the same period last year (which reported at 7.0). The Trust has increased its m2 during 2022/3 (ie, new Emergency Department expansions at both Queen Elizabeth The Queen Mother Hospital and William Harvey (WHH), and the ITU build at the WHH) and this, plus the installation of combined heating and power (CHP), will have an impact on the Trust's energy usage. CHP in particular will have an impact on the amount of gas used. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

Breathe Energy has been working with the Trust and 2gether to identify carbon reduction schemes that could be commissioned in the new financial year. The Trust, with 2gether, produced a business case which identifies the installation of heat pumps on the three acute sites funded via the PSDS 4 Grant. The Trust submitted its bid on 15 October 2022 and, although this successfully passed through to the second stage, we have been notified that we have been unsuccessful for this particular funding round, due to the total value of applications received. Subsequent public sector grants have recently been announced and the Trust is working with 2gether and a new submission has been made. The outcome of this is anticipated to be announced in Summer 2023.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions. Our Green Plan is in the process of being finalised and objectives relate to:

Sustainable Estate (Using energy, water, waste, travel, procurement and buildings efficiently while adapting to climate change); and Sustainable Healthcare (Delivering healthcare that reflects wider corporate, social and environmental issues, including prevention of poor health and developing more environmentally sustainable models of care). The Joint Carbon Reduction Steering Group will drive the strategic improvements required to reduce the carbon footprint, in line with our agreed trajectory.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Lack of behaviour change & culture in the organisation negates the opportunity to promote carbon reduction.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Financial Position	W4		Total Pay		0.0%	-8.2%	-11.3%	-1.9%	-2.5%
	W4		Efficiencies YTD Variance (£M)		0.0	-8.8	-10.4	-1.5	-2.9
	W4		Efficiencies Green Schemes		90.0%	65.4%	65.4%	1.2%	3.1%
	W4		I&E YTD Variance (£)		0	-22M	-19M	-426.0K	-1.9M

Efficiencies YTD Variance/ Efficiencies Green Schemes

The Trust has been slower than expected in developing its CIP programme. Significant work is underway to gain momentum on the key Trust wide themes.

I&E Monthly Variance Trust/ I&E YTD Variance

The key drivers behind the deficit are:. Strike action £0.4m by the junior doctors, Non-delivery of efficiency savings £2.9m YTD of which £2m has been allocated to Pay and £0.9m to non pay, Pay overspent by £2.5m due to non delivery of CIP and increased levels of staffing utilisation mainly in nursing (c183 WTE) & Medical & Dental (c76 WTE) and high cost of agency premium & Non Pay underspend £1.7m on Drugs £1.4m and £0.6m underspend on clinical supplies & services and other smaller underspends off set against non-delivery of CIP of £0.9m.

Our future

Our future

Dylan Jones

Not fit to reside (patients/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. This allows us to easily identify the ongoing support and care patients need to leave hospital.

Patients are delayed in hospital awaiting a supported discharge which may be a care package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works in partnership with the local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
354.9	402.6	385.9	358.3	362.2	350.4	354.1	392.3	437.1	407.5	410.7	412.4

F

Variation indicates consistently falling short of the target

H

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

Flag Description

Astronomical Point Two Out Of Three Beyond Two Sigma Group

XMR Run Chart

450
400
350
300
250

Jul 2021 Jan 2022 Jul 2022 Jan 2023

What the chart tells us

This month the Trust reports 412 patients as 'No longer fit to reside'. The May breakdown across the different discharge pathways is Pathway 0: 148, Pathway 1: 119, Pathway 2: 59, Pathway 3: 86. Patients assigned a discharge pathway of either 1, 2 or 3 equates to 70% of the patients considered 'No longer fit to reside' and all required an on-going package of care to be discharged from an acute setting.

With a high number of patients residing on the back wards of the Trust that no longer require an acute care setting, patient flow through the hospital is impacted. In May 2023, the average number of patients in our Emergency Department with a decision to admit and awaiting transfer to a ward was 73. Whilst this is an improved position against Q4 22/23 (ave. 111) this reflects changes across our ED pathways and improved flow to same day emergency care services. To improve this position further there is a need for community support and additional packages of care to increase flow across the Trust.

Intervention and Planned Impact

- Throughout Q1 23/24 the Trust has been working in partnership with ICB and HCP colleagues on the development of the East Kent Health and Care Partnership Urgent and Emergency Care Plan, and ICB lead plan aim to improve urgent and emergency care. This plan is structured with 5 priority areas of work:
  - Increasing urgent and emergency care capacity
  - Making it easier to access the right care
  - Improving discharge
  - Expanding pro-active care outside of hospital
  - Increase workforce size and flexibility
- Under the 'Improving discharge' workstream plans are outlined for increasing P1 capacity, increasing the provision of live in care schemes and additional capacity for the Trust's End of Life patients. These schemes landing at pace is key to improving the Trust's No Longer Fit to Reside position. This status of the schemes is being monitored through the ICB and HCP Urgent Care Boards and being reported to the Finance and Performance Committee.
- Within the Trust the Emergency Care Delivery Group focus workstreams include: Patient Flow, Front door, Simple discharge, SDEC and Direct access are all aimed at driving discharges within the Trust's gift, divert patients to same day emergency care where possible and focus on admission avoidance

Risks/Mitigations

- A focussed piece of work is underway to review the application of the No Longer Fit to Reside criteria which is considered for each patient and applied as the day's board rounds are undertaken. This work seeks to understand the rigour around the application of the No Longer Fit to Reside status alongside the process of determining which patients are cited as medically optimised for discharge. For those requiring an on-going package of care, this workstream is also reviewing how patients are then referred and transferred to the Trust's Rapid Transfer Service (RTS) Co-ordinators. The key objective of the work is to ensure the Trust has an accurate view of patients no longer requiring the treatment of an acute and, for those patients requiring on-going package of care, that they are identified on the RTS workflow at the earliest opportunity to support early discharge. The findings of this work will be reported to the Finance and Performance Committee in July 23.

Our future

Ben Stevens

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
430	82	161	190	120	124	116	127	128	117	168	259

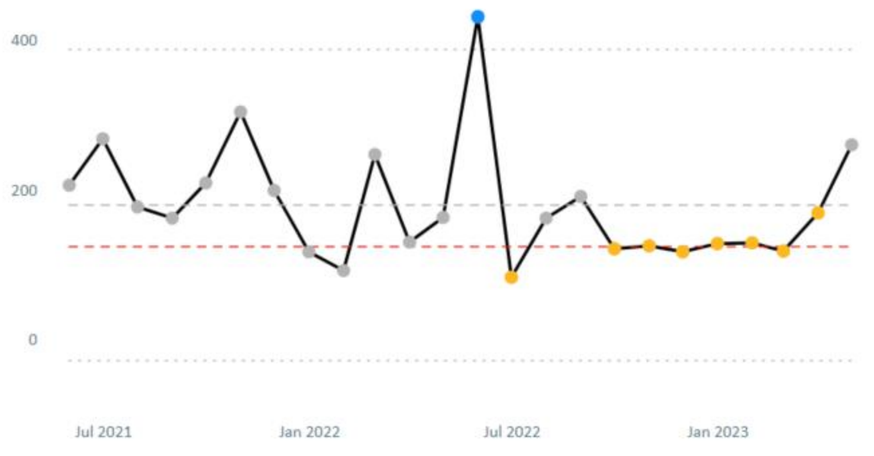
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The May position of 259 participants is above the monthly threshold (positive), largely due to the continuation of the *ACS: ED study* (Acute Coronary Syndrome rule-out strategies in the ED). This study has now completed recruitment at the Trust and recruited a total of 207 participants over two months. Another highlight for May was the *Open Door* study, recruiting maternity staff for their experience of accessing psychological support for perinatal obsessive-compulsive disorder. The study was open for one month and recruited 39 participants from East Kent Hospitals.

The Trust Stroke team are also the first site in the UK to set up the Bayer OCEANIC study, a commercial stroke study, and recruited the first UK patient to the trial. The study investigates the effect of a particular drug dosage on the body and its efficacy in preventing acute non-cardioembolic ischemic stroke or TIA in people who have experienced these events.

Intervention and Planned Impact

- A refreshed target for 2023/24 is being finalised to reflect the switch in focus to more interventional studies.
- 5 key areas for Clinical Fellows have been identified and supported by CEMG: Anaesthesia and Perioperative Medicine (already appointed); Cardiovascular disease; Neurological disease; Surgery; and Trauma and Emergency care.
- The Trust continues to design its first real-world data project using the Trinetx platform (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators) with access to 114 million patient records globally.

Risks/Mitigations

- The IT delays to the Trinetx integration project are now impacting on the revenue opportunities into the Trust. In 2022, the team received 30% fewer collaboration requests than other similar secondary acute care Trusts that are fully integrated. This has been escalated to the Director of IT for support.
- Urgent care pressures within the Trust have impacted on clinician time in the acute settings, making it hard for the delivery teams to coordinate study activity.
- Space at K&C has been identified as a constraint to the Trust’s ability to continue to provide a number of cancer trials. The Oncology/Haem-Oncology research delivery teams are merging to mitigate the risk of having to close cancer studies to recruitment and work is underway to facilitate the space to enable the merged team to co-locate.

Appendix 1
Non-Alerting Watch Metrics

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Harm Events	W		IPC: EColi Infections		10	6	8	4	9
	W		IPC: Klebsiella Infections		6	4	7	4	2
	W		IPC: Pseudomonas Infections		3	2	1	3	1
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	224	204	229	230
	W		Medication Errors; Severity C+		1	1	7	1	2
	W		Nutrition Incidents		Sigma	44	60	37	53
	W		Pressure Ulcers: Cat 2		Sigma	34	41	47	42
	W		Pressure Ulcers: Cat 3 & 4		Sigma	0	2	0	0
	W		Pressure Ulcers: DTI		Sigma	7	7	4	8
	W		Pressure Ulcers: Unstageable		Sigma	13	8	7	15
	W		Clinical Incidents		Sigma	1,962	2,285	2,165	2,442
	W		IP Spells with 3+ Ward Moves		Sigma	386	428	409	408
	W		Serious Incidents		Sigma	16	35	10	5
	W		Never Events		0	0	1	0	1
	W		Maternity Serious Incidents		2	4	4	5	1
Mortality	W		Extended Perinatal Mortality		5.87	4.53	4.44	4.62	4.47

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Cancer 62d	W		Cancer 2ww Performance		93.0%	96.6%	94.8%	95.7%	97.0%
	W		Radiology Diags vs Plan		Traj.	17.1K	19.0K	17.5K	18.9K
	W		Endoscopy vs Plan		Traj.	1,286	1,488	1,000	1,173
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,239	1,104	1,176	1,488
	W		RTT 52w Breaches		Traj.	3,187	2,997	3,027	3,608
	W		OPA vs Plan		Traj.	66.0K	75.2K	61.4K	68.4K
	W		Elective Admissions vs Plan		Traj.	8,573	9,663	7,093	8,221
ED Compliance	W		Clinician First Seen within 1h		50.0%	50.8%	51.3%	56.4%	55.1%
	W		A&E Atts vs Plan		Traj.	21.7K	24.4K	22.4K	24.6K
	W		Discharges by Midday		15.0%	13.8%	15.1%	14.0%	14.1%
	W		Pathway 0 Patients >7 Days		Sigma	152	146	136	154
	W		NEL Admissions vs Plan		Traj.	6,249	6,736	6,713	7,259
	W		NEL Readmissions		15.0%	9.9%	8.7%	10.7%	10.5%
	W		Stroke Ward within 4 Hours		50.0%	65.9%	76.5%	60.8%	74.3%

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
Staff Engagement	W		Sickness		5.0%	4.9%	5.1%	4.3%	4.3%
	W		Staff Turnover Rate		11.5%	9.9%	10.0%	9.8%	9.7%
	W		Vacancy Rate		10.0%	8.7%	8.4%	8.2%	8.2%
	W		Staff Turnover: HCA		13.5%	13.1%	13.0%	12.7%	12.4%
	W		Staff Turnover: Nursing		10.0%	9.0%	8.8%	8.6%	8.7%
Financial Position	W		Non Pay		0.0%	-3.6%	-10.5%	4.5%	2.7%
	W		Efficiencies FOT Variance (£M)		0.0	-9.1	-10.4	0.0	0.0
	W		I&E Monthly Variance Trust (£)		0	4.2M	3.3M	-426.1K	-1.5M
	W		I&E FOT Variance (£)		0	-19M	-19M	0	0

True North Domain	BR	Flag	KPI	SPC	Thres.	Feb-23	Mar-23	Apr-23	May-23
FFT	W		FFT IP Response Rate		15.0%	20.5%	19.8%	20.4%	19.1%
	W		FFT DC Response Rate		27.0%	30.3%	31.7%	28.6%	29.6%
	W		FFT ED Response Rate		12.0%	13.8%	14.3%	14.8%	14.8%
	W		FFT OP Response Rate		17.0%	19.4%	19.6%	19.8%	19.5%
	W		Complaints Number		Sigma	78	85	65	89
	W		Mixed Sex Breaches		Sigma	113	46	112	121
	W		Duty of Candour - Verbal		100.0%	100%	98.1%	100%	94.1%
	W		Duty of Candour - Written 15wd		100.0%	97.4%	100%	100%	95.0%
	W		Duty of Candour - Findings		100.0%	100%	100%	100%	88.9%

Appendix 2
Trust Priority Improvement Projects

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Jane Dickson	To have a central repository for all clinical guidelines	Jan 2022 1st phase complete 2nd phase April 23	• Continued to review and revise current MicroGuide content to ensure current, fit for purpose and accessible. • Contacted acute medicine to assess their needs for transfer to MicroGuide.	• Arrange meeting with and consider requirements of clinical support services (Pharmacy, Pathology, etc.) • Support SDEC in their new Clinical Guide pathways • Support maternity in using new templates ready for uploading • Support therapies for altered airway management Clinical G
Improving End of Life Care	Jane Dickson	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	April 23 Revised Jul 23	**Process / System Workstream** • The beds on Sandwich Bay are up and running work continues for WHH • ReSPECT – led by Judith Banks. Updates to Sunrise / KMCR functionality prevent full electronic go live. Plan for phased approach with paper ReSPECT first. **Education workstream** • PEoLC education framework live on StaffZone. • Focusing on film development and launch. **Culture workstream** • Focusing on film development and launch.	**Process / System Workstream** • Further discussion required to agree medical solution for Sandwich Bay. • Recruitment to palliative care medical staff required to progress WHH beds – option being explored. • Hold care group triumvirate workshop to engage and agree improvement plan refresh with care group held improvement plans **Culture workstream** • Mandatory Training Film 'Caring with Compassion' launched during Dying Matters week, alongside other engagement activities and workshop event,
Fractured Neck of Femur	Rebecca Martin	To agree, develop and implement a Trust wide Fractured Neck of Femur pathway that will address and improve the eight Key Performance Indicators on the National Hip Fracture database	April 23 Revised Jul 23	• The fast track patient pathway for NOF's has been developed at the QE and out for comments from WHH. • Ring fenced beds have been agreed for both sites • The fractured flower project (all confused patients are seen by the dementia team on admission) continues at the QE and will be adopted at the WHH	• When operational pressures allow, the ring fenced beds and fast track patient pathway will be piloted on Seabathing and Kings C1 • Continue to monitor The National Hip Fracture database for improvements.

Appendix 2
Completed Trust Priority Improvement Projects

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Nicky Bentley	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Nicky Bentley	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Nicky Bentley	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Sarah Shingler	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Moved to BAU Oct 22
Trust wide Job Planning	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	Moved to BAU Oct 22
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	Moved to BAU Oct 22
Safe & Effective Discharge	Rebecca Martin	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Project to become more targeted within the Trust Emergency Care Delivery Group Nov 22
Maternity Ultrasound Booking	Rebecca Martin	All patients will have an Ultrasonography appointment that is linked to their pathway and consultant. To ensure the capacity and staffing is available to meet the demand of the service.	Moved to BAU Nov 22

Appendix 3: Glossary of Terms

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

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

REPORT TO BOARD OF DIRECTORS

Report title: **Integrated Improvement Plan (IIP) Report including Metrics**

Meeting date: **6 July 2023**

Board sponsor: **Chief Executive Officer (CEO)**

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

Appendices:

APPENDIX 1: PROGRESS UPDATE ON DELIVERY OF THE IIP SINCE LAST MONTH AND AGREED METRIC REPORTING

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	To update the Board on progress of delivery of the Integrated Improvement Plan, performance against the agreed metrics and to provide oversight of key risks to delivery.
Summary of key issues:	All programmes of work have made progress with some beginning to demonstrate signs of early improvement. The challenge however remains sizeable and there is a need to continue to increase the pace of delivery. It is important to recognise that the report highlights achievement of actions and not the impact that they have made. Metrics have been developed aligned to each of the programmes and performance against these is included in the board. All of the workstreams have had a review and reset with significant changes within Maternity and Quality and Safety so there is greater confidence of the programme milestones and measures of success and a clearer understanding of the resources required to deliver the plan. The plan and delivery approach has been aligned to the Pillars of Change work and the 'We Care Quality Improvement Programme'.
Key recommendations:	Trust Board members are invited to **DISCUSS** the report and progress of delivery of the Integrated Improvement Plan to date.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Board Assurance Framework (BAF):	BAF 32 – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. BAF 34 – There is a risk that our constitutional standards are not met. BAF 38 – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	N/A
Resource:	Y - discussions with National team regarding the use of available resources.
Legal and regulatory:	Y – regulatory impact.
Subsidiary:	Y – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by: From June onwards, this report will be considered by the Strategic Improvement Committee ahead of the Trust Board. The Strategic Improvement Committee is being established to oversee delivery of the Integrated Improvement Plan.

Recovery Support Programme (RSP) Integrated Improvement Plan (IIP) Report

1. Purpose of the report

1.1 The purpose of this report is to update the Board on progress of delivery of the Integrated Improvement Plan (IIP). It is also intended to give the Board oversight of key risks to delivery.

1.2 As previously agreed the report will now include the performance against the agreed metrics for each programme of work.

2. Background

2.1 The IIP sets out the Trust objectives over the next 12-18 months to deliver sufficient sustained improvement to support an exit from the National Recovery Support Programme in March 2024.

2.2 The report set out in Appendix 1 provides an update on delivery of the Integrated Improvement Plan to date. Progress against the 'priority areas of focus in the first six months' are set out in a high-level summary, followed by a progress update for each of the six key programme areas within the plan. A progress update on the Communications and Engagement Plan which supports delivery of the IIP, covering June 2023 is also included in the report.

2.3 The Strategic Improvement Committee oversees the delivery of the IIP and is chaired by the Chief Executive, Tracey Fletcher. The Strategic Improvement Committee is due to meet fortnightly with a rolling review of three of the six programmes of work at each meeting.

3. What progress has been made over the last month?

3.1 There has been further progress across all six programme areas evidenced through the milestones that have been delivered to date. Whilst there has been some progress towards the agreed metrics this is not at the pace required in some areas.

3.2 Detailed updates and delivery of milestones in each programme area are provided in the attached report.

3.3 Funding for the programme from the ISCS (RSP) budget was presented at a meeting with the National Director of Intensive Support on the 12 May 2023. Subsequent to this meeting conformation has been given of approval of £1.25 million of the original bid. This is in the process of being deployed across the agreed programme areas.

3.4 Ben Stevens, the Senior Responsible Officer (SRO) for the programme, has continued to work with Programme SROs to align the Integrated Improvement Plan with the Pillars of Change work and 'We Care Quality Improvement

Plan'. This draft single framework has been summarised in a document for all staff and has been published on the Trust intranet and public website. In addition, this has featured as a key topic on both the leaders and all staff briefing.

4. What are the risks to delivery of the plan and how are they being considered?

4.1 Through the process of developing the IIP a number of key risks have been highlighted. Initial risks have included: delays in cancer pathways, delays in Patient Safety Incident Response Framework (PSIRF) implementation and capacity to scale up the delivery of the leadership development programmes. These are in addition to the Trust risks of deficits in planned workforce; estates and equipment; industrial action and resource to deliver the programme. Mitigations have been developed to minimise the risks.

4.2 Additional workstream level risks have been captured in work programmes and have undergone a check and challenge at the Strategic Improvement Committee.

5. How is progress and delivery going to be tracked and monitored effectively?

5.1 Progress and delivery is tracked via the Strategic Improvement Committee. Programme SROs submit a monthly highlight report to this Committee which includes key progress updates, risks and issues for escalation, and key performance indicators (KPIs)/metrics and trajectories to measure improvements being made.

5.2 Wider supportive programme management arrangements are also in development.

5.3 The Programme SRO along with the RSP team and the programme SROs developed a set of KPIs that are reported in the progress report at Appendix 1.

6. Conclusion

6.1 Board members are invited to note the progress and the risks in delivery of the Integrated Improvement Plan and recommend any further actions.

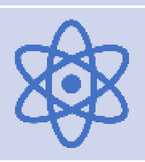
6 July 2023

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

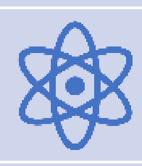
Journey to Exit NHS Oversight Framework (NOF4)
1 July 2023

Final Draft

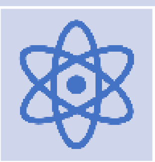
Purpose of Report



This report has been established to update the Board on progress of delivery of the Integrated Improvement Plan. It is also intended to give the Board oversight of key risks to delivery; and to update on key evidence that has been added to the evidence repository to support exit from the Recovery Support Programme (RSP).



Delivery of the Integrated Improvement Plan is overseen by the EKHUFT Strategic Improvement Committee which is chaired by the Chief Executive, Tracey Fletcher.



The Board will receive an update on the IIP on a monthly basis focusing on successes, challenges and actions to mitigate any key risks to delivery. We will also provide a quarterly deep dive to demonstrate impact and progress against the overall programme objectives.

High-level Summary on Programme Delivery

	Priority area of focus in IIP	Summary update
Leadership & Governance	Leadership Development	Good progress made with three substantive appointments made and two interims in place. A start date for the new Chief Nurse has been conformed for September 23. The advertisement for the Chief Medical Officer (CMO) role has been placed. The organisational restructure consultation has concluded and a number of key appointments have been made with the full care group structure planed to be implemented by the middle of August at the latest. The supporting corporate functions have begun the process of aligning to the new care group structure. The Leadership Programme for the Care Groups and Service Group triumvirates started in June and will support key leaders across the Trust to develop and utilise relevant skills and approaches to deliver the Trusts aims in a manner that reflects its values.
	Governance Framework	Progress is being made with the governance model review and the workstream is on track to report back in July 23. The next step will be to implement and embed the clear framework for governance oversight within and throughout the Care Groups, ensuring that all staff are clear on their responsibilities for the management and learning from risks, incidents and complaints.
Maternity	Maternity Transformation	The new Director of Midwifery and Deputy Director of Midwifery are making good progress with understanding the issues and challenges in the service and have begun to implement actions for improvement. The maternity transformation plan development is on track to be finalised in July 2023 and has included an engagement event with Trust staff, external partners and service users at the end of June. Progress has been made in the reduction of open Serious incident actions and datix incidents.
Operational Performance	Urgent and Emergency Care (UEC) Patient Pathways	There is continued progress in emergency care type 1 and all type performance. 4-hr performance at William Harvey Hospital (WHH) continues to improve following the interventions that have been introduced at the front door over recent months. the Trust secured the services of a discharge improvement expert during May and he commenced on-site at WWH on 26 June funded by RSP resource. The Trust, as part of the Tier 1 UEC process, is also in discussions with regard to securing corresponding support for Queen Elizabeth the Queen Mother Hospital (QEQM).
Quality & Safety	The Deteriorating Patient	Progress has been made with training by the Head of Nursing for the Deteriorating Patient. The monitoring data for this programme indicates a positive improvement in the programme. In a addition There is collaborative work with critical care outreach and the PDN team.
	Ward Accreditation	Progress made with a full review and reset of the Fundamentals of Care work streams/Ward Accreditation programme with a new set of refreshed milestones as set out under the Quality & Safety programme.
People & Culture	Culture & Leadership	Good progress has been made with Culture & Leadership Development with programme milestones realised as set out in the programme slide. The culture and leadership programme change team recruitment is live with a positive response across the organisation.
Finance	Workforce Plan	Care group deep dive sessions have been completed with all care groups to assist with the improved understanding of service areas with high vacancy rates coupled with high premium payments with specific plans being developed.

High Level IIP Programme Risk Summary

Key Risks:

15 key areas of delivery risk have been recognised within the individual programmes (see appendix A). The risk log is now in place and utilises the trusts scoring matrix for consistency. Risks with a score of 16 or greater are summarised below including mitigating actions:

- **Diagnostic delays in cancer pathways** – **Risk score 20** - Mitigating actions include – Weekly Radiology improvement meetings with specific focus on Endoscopy and Urology pathways and capacity; prioritisation and clearance of reports waiting longer than 15 days post diagnostic; for all diagnostics to be booked within 5-10 days; heavy sedation capacity for endoscopy to be agreed; agreement of Mutual Aid plan for urology.
- **Delay to Patient Safety Incident Response Framework (PSIRF) Implementation** – **Risk score 20** - The workstream in relation to Datix and Learn from Patient Safety Events (LFPSE), which supports the PSIRF transition, and which replaces STEIS & NRLS in September 2023, is delayed owing to issues within the Datix company. In particular, not upgrading our system to the most up to date version (as with all Trusts using Datix). A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts.
- **Capacity in Ward Accreditation Team** – **Risk score 20** - Ward Accreditation Team are small in number and have long term sickness. This may impact the plan to achieve the first accreditation for all inpatient wards by end of November 2023, as planned. Alternative solutions are being explored, including the potential of utilising additional internal staff and reviewing the current accreditation timetable.
- **Capacity to scale up delivery – Score 16** - Capacity to scale up delivery of the Leadership Development Programmes at each of the levels (Leading Others, First Line Leader, Mid-level Leader). Currently each of these 5-day programmes are scheduled to run 3x per annum. In order to increase scale more faciliatory resource is required. Escalating current vacancies to Vacancy Review Panel (VRP) to progress. Assessment of possible increase to be taken to VRP June 2023.
- **No overdue (breached) Serious Incidents (SIs) / Healthcare Safety Investigation Branch (HSIB) investigations - Score 16** - Whilst pending development and approval of the new Quality & Safety Framework, the service is working to the published V2 of the QSF. Structures for maintaining oversight, and managing, of overdue governance related activities require further work (update from Head of Governance 28.06 - Maternity currently has 25 open SIs with 0 breaches). The service is working to published V2 QSF. There are trackers being used to monitor progress of all governance related activities, including backlogs. In addition Maternity have a dedicated patient safety team.

Funding to support Delivery of programme

- A Business Case for £1.5M was submitted to the National ISCS team to support the programme. £1.2m of this has been approved as an urgent requirement. The remaining portion is awaiting approval.
- Key urgent areas for the bid include:
  - Maternity Transformation Programme Support
  - Culture and Leadership Programme
  - Operational Performance (UEC and Elective Improvement)
  - Learning from Patient Safety Incidents

Integrated Improvement Plan

June 2023 Programme Summaries
May 2023 Performance Data

Leadership & Governance Programme

SRO: CEO

NHS
East Kent
Hospitals University
NHS Foundation Trust

Progress over last month:

- Interim Chief Nurse in Post to cover the period before the substantive Chief Nurse Commences in post
- Substantive Chief Nurse start date confirmed for September 2023
- Advert published for Chief Medical Officer recruitment
- Organisation restructure consultation has concluded and a range of appointments made
- Corporates function are aligning form and function to deliver appropriate services to the new clinical care groups
- Remaining posts will be advertised externally
- Governance model review on track to report in July 2023
- Board strategy day scheduled for the 1 August
- Work has commenced to scope the options for the development of a revised organisational strategy.

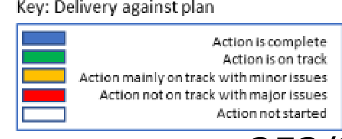
Key risks and issues:

- Unable to appoint Chief Finance Officer (CFO) substantively
- Loss of focus on operational delivery due to the ongoing effect of the restructure

Plan for next month:

- Conclude and report on the Governance model review
- Full commencement of the revised organisational structure
- Finalise the strategy development scoping piece of work in preparation for reporting back mid September 23

Leadership & Governance Programme - Product Milestones to end July	Due	RAG
1.1 Executive Leadership Team		
1.103: Review and refresh Executive Leadership Development Plan	Jun-23	Green
1.104: Current vacant Executive Director posts successfully recruited to	Jun-23	Green
1.2 Governance		
1.201: Review and refresh Governance Model to ensure it is aligned with the organisation restructure	Jul-23	Green
1.3 Communications & Engagement		
1.303 Detailed Communications and Engagement Plan developed, based on feedback received, and rolled out across Trust	Jul-23	Green
1.4 Transformation Programme		
1.404: Develop the Leadership Behavioural Framework	Jun-23	Green
1.405: Develop and adopt the Behavioural Code in Maternity	Jun-23	Green
1.406: Pilot "Civility Saves Lives" in Maternity	Jun-23	Green
1.407: Introduce a simple tool to assist staff to challenge poor behaviours	Jun-23	Green
1408: Start the leadership programme for team leader, first line, middle manager	Jul-23	Blue
1.409: Undertake recruitment to new organisational structure	Aug-23	Green



Maternity

Maternity Programme

SRO: Chief Nurse and Midwifery Officer

Progress over last month:

- Patient Information (Quality & Safety (Q&S) Boards) hardware installed at WHH pending chrome boxes, and pending installation at QEQM. Walkarounds with IT and Estates complete to identify immediate works required to activate the screens
- Multi-Disciplinary Team (MDT) Consultation session around rectification approach for sonography services
- Your Voice Is Heard post-implementation review held 19 June 2023; comment from Maternity and Neonatal Voices Partnership (MNVP) Chair "this is one of the best pieces of coproduced work that I've been involved with so far, literally from a blank page, and it continues to be coproduced"
- Maternity Transformation Plan (MTP) Engagement Away Day booked for Weds 28 June 2023
- Antenatal & Newborn Screening (ANNBS)/Fetal Medicine Unit (FMU)/Ultrasound Scans (USS) Project Plan re-shared with Public Health Matron and Consultant Midwife for reference re: NHS England (NHSE) scrutiny relating to compliance with national screening standards and work underway to improve local efficiencies / monitoring (request placed with IT for a Newborn Screening Patient Tracking List (PTL)). Project Plan also recirculated with project group for feedback / input / progress
- Obstetric consultant lead for Midwifery-Led Discharge at WHH has published a Standard Operating Procedure (SOP) and a pilot of midwifery-led discharge will go live for two months (Jun-Aug 2023) at WHH following an elective c-section - the circulation email contains clear roles and responsibilities for medical staff
- Joint review with Trust Clinical Audit team of existing clinical audit management processes in Maternity. Improved workforce involvement in audit activity
- Situation-Background-Assessment-Recommendation (SBAR) process mapping / improvement to action setting
- Scheduling of culture-related training sessions
- Identification of the current position within the Maternity Governance team (specifically the Patient Safety Workstream)
- Refinement of information slides for Quality & Safety Boards

Plan for next month:

- Internal and external stakeholder MTP consultation away day booked for 28 June 2023
- First draft of Birmingham Symptom Specific Obstetric Triage System (BSOTS) training video that highlights roles and responsibilities
- Installation and activation of TV screens for Triage PTL / MOSOS / Patient Information
- Approval and publication of Venous thromboembolism (VTE) Guideline
- Senior-level discussion regarding future approach of clinical audit / management processes
- [Linked to Project 2.1] Multidisciplinary review of clinical priorities within the Maternity Improvement Plan (MIP) v2 scheduled for 28 June 2023 to facilitate involvement of sonography and neonatal teams in the development of the transformation programme. Following this work, the MTP Clinical Pathways Project Group will commence from July 2023
- Installation and activation of MOSOS screens in Triage offices
- Activation of Modified Early Warning Score (MEWS) assessment in Sunrise for pregnant women presenting in Emergency Department (ED), including an alert system for notifying Maternity via the Maternity PTL
- Activation of Quality & Safety Boards in Triage and Postnatal wards at QEQM/WHH

Key risks:

- Non-compliance with Project 4 - Governance trajectory / plan
- Risks associated with postnatal / discharge processes e.g. EDN
- Management of pace and priority of RSP/IIP and MTP whilst managing a challenged maternity service
- Success monitored and identified through Your Voice is Heard (YVIH) metrics (listened to, trends and themes)

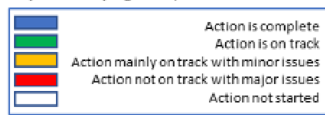
Maternity Programme

Maternity Programme - Product Milestones to end July	Due	RAG
2.1 Team Working		
2.101: Ensure obstetric oversight of triage services is undertaken by an obstetric registrar in line with best practice	Jul-23	
2.2 Clinical Escalation and Handover		
2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE	Ongoing	
2.3 Clinical Assessment & Care Pathways		
2.301: Centralisation of telephone triage	Jul-23	
2.302: Agree model and implementation plan for improved discharge pathway	May-23	
2.304: Implementation of discharge pathway	Jul-23	
2.4 Governance		
2.401: No overdue (breached) SIs / HSIB investigations	May-23	
2.5 Engagement		
2.504: Demonstrable improvement that staff feel listened to (quarterly survey)	Ongoing	

Milestones off track:

- **2.302** – There was an original local plan to have this delivered by 31 July 2023 and therefore the supporting postnatal guideline was scheduled to be presented for approval at the Women's Health Guideline Group on 23 June 2023, which takes this work beyond the milestone of the IIP. The original project plan remains on track to deliver by 31 July 2023, as per IIP milestone ref. 2.304
- **2.401** - Backlogs have increased over recent months; plans are in development to clear the backlogs and sustain service provision within mandated timeframes. Further information on numbers detailed within the Maternity performance slide.

Key: Delivery against plan



Maternity Programme

SRO: Chief Nurse and Midwifery Officer

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Maternity	Serious Incidents Maternity	Sigma	May-23	1			-3	3	9	Common cause (no significant change)
	Maternity Incidents Moderate / Sev...	Sigma	May-23	3			-3	2	8	Common cause (no significant change)
	Maternity Complaints	Sigma	May-23	8			-2	6	14	Special cause of concerning nature or higher pressure due to higher values
	Maternity Complaint Response	90.0%	May-23	20.0%			-28	46	121	Common cause (no significant change)
	Extended Perinatal Mortality	5.87	May-23	4.47			4	5	6	Special cause of improving nature or lower pressure due to lower values
	FFT Maternity Response Rate	5.0%	May-23	10.3%			4	9	15	Special cause of improving nature or lower pressure due to higher values
	FFT Maternity Recommended	90.0%	May-23	92.3%			83	91	99	Common cause (no significant change)
	FFT Maternity (IP) Recommended	90.0%	May-23	92.4%			82	92	103	Common cause (no significant change)
	Maternity Engagement Score	6.90	May-23	5.87			6	6	6	Common cause (no significant change)

May Performance Summary

Incidents: Maternity currently have 25 open SI's, no breaches – 11 have been submitted to the Integrated Care Board (ICB) (4 of these have been closed at the ICB panel 28 June). At 19/06/2023 Women's Health had 345 overdue SI actions, this reduced to 305 on 26/06/2023. Working to eliminate this backlog by end of July. At 01/06/2023 Women's' Health had 762 open datix, this backlog had reduced to 569 on 26/06/2023. Working to eliminate this backlog by end of August. Additional resource has been identified for the Governance team to address an existing backlog of unreviewed datixes and SI actions. The team have been given a trajectory for reducing the backlog within the next month. The backlog of unreviewed datixes has reduced from 868 to 569. Open SI actions reduced from originally 750 to 305. A deep dive into SI actions is planned for 27th June with the MIA during which time SI actions will be themed. One new SI was declared which met the criteria for review by HSIB

Complaints: 8 new complaints were opened in May . There currently 49 opened complaints some of which date back to many months ago. A process of reviewing historical complaints as well as the current complaints review process needs to be discussed and agreed with the Chief Nursing and Midwifery Officer (CNMO). Some key themes include attitudes and behaviours, communication and failure to provide support with personal hygiene have been identified. These issues are being progressed within the care group – actions include reiteration of Trust values and how these translate into expected behaviours. Patient stories are being developed for staff to reflect on and learn from.

Patient Involvement: The 'Walking the patch initiative' was launched in May 2023 this includes the Director of Midwifery (DOM)/Deputy DOM (DDOM) obtaining information about experience. The 'leave your troubles at our door' initiative was also introduced to enable proactive involvement with families. Service users have been invited to the co design of the MTP on 28 June 2023. An MNVP chair has been recruited and a 15 steps review is planned.

Staff Engagement: The 'we hear you' initiative has been introduced which includes a specific email address to provide staff with direct access to the Quad team. An engagement session for the team to be involved with the Maternity Transformation programme has been arranged for the 28 June 2023. Daily GEMBA walks by DOM/DDOM enables visibility which promotes engagement. A monthly Safety Champion forum was launched to provide floor to board reporting. Freedom to Speak Up Guardian (FTSUG) asked to complete a report for discussion within the Care group.

Patients

Operational Performance Programme

SRO: COO

Progress over last month

Urgent and Emergency Care (UEC)

- Continued good progress in performance in Emergency Care (ED) Type 1: 45.1% (above trajectory), all types 71.68% (above trajectory)
- Established Clinical Forum WHH bed reconfiguration, transforming services strategy
- The DAP pathways introduced and reviewed. The QEQM commenced the roll out there mid-June
- Missed Opportunity Audit Ambulance conveyances completed
- The WHH lounge is in place 24/7. It is a 10 bedded unit for pts with a planned discharge 24/48 that fit a criteria to ensure patient safety
- Agreement with ICB to run the Getting it Right First Time (GIRFT) Alt-ED tool

Elective Recovery

- Commenced weekly activity and performance monitoring/oversight meetings with each care group and established daily PTL meetings where breaches are increasing
- Refreshed monthly planned care meeting to focus on improvement and transformational actions in the next 4 months
- DM01 breaches reducing in radiology modalities: NOUS, DEXA and CT
- 65-week breaches below trajectory position for month 1 and 2 (growth noted in month 3)

Cancer

- Straight to Test (STT) for Lower Gastrointestinal (GI) has shown a significant improvement
- Review potential further Endoscopy improvement options

Key risks and issues:

- Reduction in No Longer Fit to Reside (NLFTR) position to support emergency flow and 12 hour breach reduction
- Compliance with 2023/24 activity plan at Trust level in order to stabilise waiting list and reduce long waiters
- Diagnostic delays in cancer pathways

Plan for next month:

- QEQM ED Build plan to be completed to include the provision of;
  1. Extending hours of Same Day Emergency Care (SDEC) Medical
  2. Established Medical Assessment Unit (MAU) - pilot
  3. Established ED Clinical Decisions Unit (CDU)
  4. Implementing DIA model at front door
  5. DAP pathway training commences to support direct access to SDEC / Urgent Treatment Centre (UTC)
  6. Surgical DAP to commence
  7. Trauma & Orthopaedics (T&O) pathways to Kent & Canterbury Hospital (K&C)
  8. System support for P3 and front door P1 to support flow
- Medical Decisions Unit (MDU) K&C - plans continue to support access for selected pt cohort from QEQM/WHH
- CDU WHH development plans continue
- Continue the implementation of Direct Access Pathways (WHH) Medical Assessment Unit (MAU) and optimisation of the Surgical Assessment Unit (WHH)
- Continue work on the re-design and roll-out of clinical model to QEQM (MAU, Direct Access pathways to SDEC and optimising SDEC opportunities)
- Cohort EoL plans for WHH continue
- Finalise the theatre improvement programme including inputting of additional resource and capacity
- Finalise the out patient transformation actions in line with Kent and Medway OP Transformation re-launch agreed at ICB Board meeting 27 June2023
- Agree a system approach for ENT services which includes a short term plan to recover otology 78 week breaches
- Agree further roll out for STT in Lower GI
- Agree interventions to reduce Endoscopy waiting times and therefore prolonged colorectal pathways
- Urgently review the Urology pathway to mitigate capacity and efficiency risks

Operational Performance Programme

SRO: COO

Operational Performance Programme - Product Milestones to end July	Due	RAG
3.1 Urgent and Emergency Care (UEC) and Whole System Interface Flow		
3.111: Established pathways to the MDU at KCH (nurse led)	Jun-23	Amber
3.112: QEQM Emergency Department Build Phase 3 started	Jun-23	Green
3.113: WHH End of Life Model implemented	Jun-23	Amber
3.2 Elective Recovery (including diagnostics)		
3.204: Outpatient transformation plan re-launched with key milestones and stretch targets for transformation including activity increases (1st OP) and decreases (follow-up)	Jun-23	Amber
3.205: Validation plan agreed and implemented for all diagnostic modalities utilising digital transformation available within the Trust	Jul-23	Amber
3.114: Patient Flow SAFER principles in place across Trust with metrics focussed on discharges by 10.00, golden patients, reduction in 12-hour ED waits	Aug-23	Amber

Milestones off track:

- **3.111** - The pathways have been established. The funding to support the staffing has been declared by the ICB supported by. Work in progress to determine finances and recruitment as a next step. The pathways element of the action is complete but the service is yet to start, hence the amber RAG.
- **3.113** - Medical cover arrangements have protracted this process. The medica model has been reviewed in light of the cover arrangements and End of life will be cohorted and will share a space with Frailty. This is on the agenda at the clinical forum taking place on 29th June. Unlikely to hit the June deadline but anticipate completion by mid-July.
- 3.204 - The finalised outpatient transformation actions are aligned with the Kent and Medway outpatient transformation re-launch to be agreed at the ICB planned care board meeting on 27 June. This will complete the action on 27 June and tip the milestone to green.
- **3.205** - The process of finalise the technical logic for patients to receive text message communication to support validation in diagnostics is near completion. This will be completed by end of July 2023.

Key: Delivery against plan

Colour	Meaning
Blue	Action is complete
Green	Action is on track
Amber	Action mainly on track with minor issues
Red	Action not on track with major issues
White	Action not started

Operational Performance Programme

SRO: COO

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Operational Perfomance	ED Compliance	90.0%	May-23	71.7%			67	73	79	Special cause of concerning nature or higher pressure due to lower values
	Type 1 Compliance 4hrs	75.0%	May-23	44.2%			44	52	61	Special cause of concerning nature or higher pressure due to lower values
	Ambulance Handovers within 30m	95.0%	May-23	86.5%			78	86	93	Common cause (no significant change)
	12Hr Trolley Waits (MTD unvalidated)	0	May-23	1136			212	418	624	Special cause of concerning nature or higher pressure due to higher values
	Super Stranded >21D	107	May-23	272			145	177	209	Special cause of concerning nature or higher pressure due to higher values
	Not Fit to Reside (pats/day)	300.0	May-23	412.4			214	272	329	Special cause of concerning nature or higher pressure due to higher values
	Cancer 28d Performance	75.0%	May-23	60.4%			59	70	80	Special cause of concerning nature or higher pressure due to lower values
	Cancer Over 62d on PTL	67	May-23	371			98	176	255	Special cause of concerning nature or higher pressure due to higher values
	Cancer Over 104d on PTL	0	May-23	77			9	24	39	Special cause of concerning nature or higher pressure due to higher values
	DM01 Compliance	75.0%	May-23	58.6%			61	69	76	Special cause of concerning nature or higher pressure due to lower values
	RTT 52w Breaches	Traj.	May-23	3,608			2,872	3,526	4,179	Special cause of concerning nature or higher pressure due to higher values
	RTT 65w Breaches	0	May-23	984			989	1,479	1,968	Special cause of improving nature or lower pressure due to lower values

May Performance Summary

Emergency Department: 4-hr performance at WHH continues to progress following the interventions that have been introduced at the front door over recent months. Type 1 performance has moved from 40.4% in March to 49.8% May. Similar interventions are been introduced at QEQM during June. The overall Trust position has moved on Type 1 to 44.9% in May from 38.9% March and on All Types to 71.5% May from 66.9% March.

Hospital Discharges: Whilst the front part of the emergency care pathway is improving less progress is being achieved in terms of discharge numbers. In response, the Trust secured the services of a discharge improvement expert during May and he commenced on-site at WWH on 26 June funded by RSP resource. The Trust, as part of the Tier 1 UEC process, is also in discussions with regard to securing corresponding support for QEQM.

Cancer: Cancer performance is being hampered by challenges within two specific pathways. Lower GI pathways are being elongated by the constraints detailed below regarding endoscopy. Urology pathways are being delayed by consultant capacity constraints for surgical treatment and the Trust is seeking mutual aid from partner providers in response. Both pathways would benefit from the utilisation of straight to test pathways. This is partly in place for Lower GI and funding has been secured from the Cancer Alliance to progress this solution in Urology.

Diagnostics: DM01 performance has improved in month (April 56.3%), key improvements are due to a reduction in breaches across both CT and Non-Obstetric Ultrasound (NOUS). The scale of recovery required within the endoscopy service is significant; which is a key constraint for the Trust to reduce breaches at pace and improve performance. Demand from emergency/cancer pathways is further hindering the Trust's ability to deploy funded capacity to our longest waiting routine patients. A procurement exercise is underway in order to source additional capacity to address this issue.

Referral to Treatment Waiting Times: A consistent reduction in 65 and 52wk breaches has been observed monthly until April 2023 where breaches have started to increase in both categories. The volume of 78wk otology breaches remain with no immediate Trust or system solution and gen surg/colorectal have seen a sharp rise in 78wk breaches since April due to a significantly reduced capacity plan within the endoscopy service.

Quality & Safety

Quality & Safety Programme

Progress over last month:

- The Quality and Safety Programme has been fully reviewed and milestones reset supported by a new SRO
- Progress has been made against multiple milestones with the exception of the launch of the NEWSs-2 e-learning module which was planned to be completed by the end of May
- Revised terms of reference for the SI Declaration Panel function and membership was approved at the May Patient Safety Committee.
- The revised complaints process is now in place and a self-assessment against the Dec 2022 PHSO Complaints Standards is underway to identify further actions to aid increased compliance
- Training has commenced for the Corporate and Care Group staff that manage the complaints process
- A review of the quality of the application of the DoC process has started and is due to be completed by end of July 2023.

Plan for next month:

- Ensure that up to date safeguarding policies are in place consistent with national guidance
- Review current fundamentals of care work streams
- Confirm the Deteriorating Patient Safety Improvement Project building on the current Trust improvement capacity

Key risks and issues:

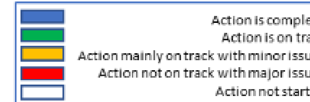
- Delay to PSIRF Implementation
- Capacity in Ward Accreditation Team
- Kent and Medway Medical School (KMMS) unable to support deteriorating patient training as proposed funded by Health Education England (HEE)
- Capacity in Business Intelligence (BI) team to support deteriorating patient dashboard

Quality & Safety Programme

SRO: Chief Nursing and Midwifery Officer / Chief Medical Officer

Quality & Safety Programme - Product Milestones to end July	Due	RAG
4.1 Quality Governance		
Define and describe a quality governance structure and framework for senior leaders to work within to support the delivery of safe, effective and compassionate care	Jul-23	
4.104: Commence transitioning across to the new PSIRF	Aug-23	
4.2 Safeguarding		
4.202: Demonstrate up to date safeguarding polices that are consistent with statutory guidance and NHSE SAAF requirements relating to both children and adults.	Jun-23	
4.204: Demonstrate effective process for safe working practices that is consistent with statutory guidance and responds and manages allegations against staff timely.	Aug-23	
4.205: Demonstrate an effective safeguarding process for responding and investigating safeguarding working practices that is consistent with statutory guidance.	Aug-23	
4.206: Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements and monitor the effectiveness and sustainability of these.	Aug-23	
4.208: Demonstrate an effective system for responding and managing restrictive and restraint practices that is in line with statutory duties and best practice guidance.	Aug-23	
4.3 Fundamentals of Care (FOC)		
4.303: Review current FOC workstreams	Jun-23	
4.304: Review FoC delivery plans	Jul-23	
4.305: Publish FOC framework and KPIs	Jul-23	
4.306: Develop trajectory for further reduction in FoC incidents resulting in moderate harm and above.	Jul-23	
4.4 The Deteriorating Patient		
4.402:Confirm The Deteriorating Patient Safety Improvement Project building on current Trust improvement capacity	Jun-23	
4.407: Commence roll out of deteriorating patient education programme	Jun-23	

Key: Delivery against plan



Quality & Safety Programme

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Quality	Serious Incidents	Sigma	May-23	5			-1	20	40	Special cause of improving nature or lower pressure due to lower values
	Overdue Incidents	0	May-23	3,340			4,677	5,732	6,787	Special cause of improving nature or lower pressure due to lower values
	Incidents - Moderate / Severe	Sigma	May-23	39			8	33	59	Common cause (no significant change)
	HSMR	96.0	Feb-23	93.0			90	95	99	Special cause of improving nature or lower pressure due to lower values
	Pressure Ulcers	Sigma	May-23	127			69	100	132	Special cause of concerning nature or higher pressure due to higher values

May Performance Summary

Incident Reporting:
There is a continuing reduction in the number of overdue incidents, with approximately 500 being closed month on month, the majority of Care Groups are on track to achieve their trajectory by end of August. The two areas at risk of not achieving their trajectory are Maternity and General Specialist Medicine, both of whom are receiving additional support.

Mortality:
Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. Mortality data should be seen as a possible signal on quality of care but considered following triangulation of other quality metrics.
The Trust 12 month rolling position to February 2023 HSMR is below threshold target based on a 3 year timeframe and is demonstrating improvement in this context. At time of reporting this remains 'lower then expected' for the Trust when benchmarked nationally on the Telstra Health platform as a whole and the K&C site (70.4) and QEQM (92.3) with WHH (101.6) 'as expected'.
There are no new mortality alerts.

Harm Events:
There were five serious incidents (SI) reported in both April and May, which is an improvement on previous months. One of the incidents reported in May was a never event relating to a retained swab, in gynaecology, which is currently being investigated. The other incidents relate to a delay in recognising sepsis; development of a pressure ulcer; incorrect placement of a pacemaker and one incident in which a patient suffered a fractured femur following a fall.

A deep dive is currently underway to benchmark all Trust reported harm events (by level of harm) against similar size organisations and across Kent and Medway for the period April 2022 – September 2022. (This is the latest available data from the National Reporting and Learning System (NRLS))

People

People & Culture Programme

SRO: CPO

Progress over last month:

- Development of pastoral care award in preparation for sign off
- Continued monitoring and actions related to absence
- Continued tracking of Healthcare Support Worker (HCSW) and Internationally Educated Nurse (IEN) recruitment and vacancy rates
- Ongoing engagement with Clinical Executive Management Group (CEMG) and other channels. Two sessions with Chief Executive Officer (CEO) and Programme Director to encourage people at all levels to be involved continues.
- Delivery of sessions with CEO via Staff Briefing / team brief.
- Culture and Leadership Programme (CLP) change team recruitment campaign is live - closing date for applications for Discovery Phase is 16 June.
- Leadership Development programmes (3 levels) launched and good uptake for current and future cohorts.
- Behavioural Framework created and currently developing a user friendly format with Comms
- Connectors training progressing (40 trained) 20 Resolution Facilitators trained
- Detailed social media and digital campaigns outlines by role along with development of hard to recruit actions fed from clinical adjacencies
- Completion of remainder of speciality workforce plans
- Completion of workforce and recruitment strategy
- Detailed hard to recruit plan signed off
- Social media plan signed off and active
- Launch CLP campaign for change team recruitment
- Continue with engagement activities for CLP

Plan for next month:

- Initial scoping and start development of appraisal dashboard
- Submit pastoral care award
- Close campaign for change team and inform applicants. Planning delivery of change team launch days in early July.
- Reviewing capacity to provide more cohorts of Leadership Development Programme, to double provision
- Developing an online learning space for LD participants
- Planning for an Exec to attend first day of all LD programmes
- Reviewing Resolution training to ensure a more comprehensive offering
- Provide proposal for developing new LTs as per of restructure

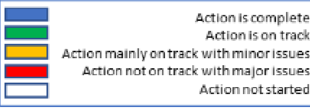
Key risks and issues:

- Awaiting information re funding for CLP to go ahead with additional resourcing to support CLP trust wide. At moment remains as 1 programme director and 1 seconded Programme Manager.
- Need to clarify alignment for CLP with wider programmes in this space, eg we care and potentially other People and Culture work
- Capacity to scale up delivery of the Leadership Development Programmes at each of the levels (Leading Others, First Line Leader, Mid-level Leader

People & Culture Programme

SRO: CPO

People & Culture Programme - Product Milestones to end July	Due	RAG
5.1 Attract & Retain		
5.102: Workforce specialty developed plans linked to clinical adjacencies	Jun-23	Green
5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23	Green
5.104: Absence audit completed with analysis of outcomes	Jun-23	Green
5.105: Pastoral Care award	Jun-23	Green
5.106: Nursing pipeline plan developed 3-5 years	Jul-23	Green
5.107: NHSE absence tool	Jul-23	Green
5.108: Appraisal quality reviews	Jul-23	Green
5.2 Culture & Leadership Development		
5.208: Behavioural framework created	Jun-23	Green
5.209: Culture & Leadership Development rolled out Trust wide	Jul-23	Green
5.210: Define EDI Strategy & Plan	Jul-23	Green
5.211: Effective succession planning and cycle established	Jul-23 - Dec-23	Green
5.3 Medical Workforce		
5.301: Medical attraction programme plan developed for fragile clinical services	Jun-23	Green
5.302: Digital and social media targeted recruitment	Jun-23	Green
5.303: Dashboard for medical attraction and trends built	Jun-23	Red



Milestones off track:

- **5.301 –** Milestone off track due to the vacancy in the information team. This has now been recruited too but will not commence until August 23. A training plan will be implemented for the new post holder to initiate this workstream.

People & Culture Programme

SRO: CPO

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
People	Sickness	5.0%	May-23	4.3%			3	5	7	Common cause (no significant change)
	Vacancy Rate	10.0%	May-23	8.2%			7	9	11	Common cause (no significant change)
	Staff Turnover Rate	10.0%	May-23	9.7%			10	10	11	Common cause (no significant change)
	Premature Turnover Rate	25.0%	May-23	25.9%			22	23	25	Special cause of concerning nature or higher pressure due to higher values
	Staff Engagement Score	6.80	May-23	6.20			6	6	7	Special cause of concerning nature or higher pressure due to lower values
	Statutory Training	91.0%	May-23	91.2%			90	91	92	Common cause (no significant change)
	Medical Job Planning Rate	90.0%	May-23	50.4%			24	35	45	Special cause of improving nature or lower pressure due to higher values
Leadership & Culture	Staff Advocacy Score	6.70	May-23	5.76			6	6	6	Special cause of concerning nature or higher pressure due to lower values

May Performance Summary

People Metrics: Sickness absence remained stable at 4.3%, which is the lowest level recorded since June 2021. This was mostly due to a drop in the levels of short-term absence related to coughs and colds. Stress and anxiety related sickness absence increased, with 16 more episodes, representing 11% of all absence – and appears a direct consequence of the withdrawal of *talking wellness* services by NHSE. The vacancy rate remained stable at 8.2%, below the desired threshold. Staff turnover has reduced further to 9.7% and continues to sit below the national standard (10%). The overall picture is a consistently improvement one, with turnover on a positive, downward trend. Premature turnover has improved to 25.9% and is approaching the target threshold. The value is acutely sensitive to improvements in total turnover so an alternative means of calculating has been proposed. Statutory training improved slightly to 91.2%, however compliance in the medical staff group remains an issue.

Engagement Metrics: Staff Engagement (6.20) is up 3 points against Q4 and is in the second quartile nationally, against a revised (and reduced) national average (of 6.5). It is recommended the threshold is reduced to 6.50 to reflect the latest national, system-level (ICB), peer and size (clinical output) averages. Staff Survey results have been well socialised across the organisation and action agreed at three levels; organisational, hotspots and locality (Specialty). At a specialty level, colleagues are identifying their key challenges and working to 'change 3 things'. A People and Culture MDT has been initiated and, triangulating data alongside other key evidence, has identified critical hotspots for targeted intervention.

Leadership Metrics: Staff Advocacy (5.76) is up 1 point against Q4 but remains low, in the lowest 25% nationally. This is the primary contributor to reduced staff engagement levels across the organisation. Recent evidence has demonstrated advocacy levels are considerably (45 points) higher in We Care areas. Given this represents one of the areas the Trust is furthest from the national average (6.4) against, and where closing this gap has been placed as an urgent organisational priority, consideration ought to be given to how We Care can be used as a tool to enhance this alongside wider reputational improvements.

Financially Sustainable

Financially Sustainable Programme

SRO: CFO

Progress over last month:

- Care group sessions completed reviewing financial position from 19/20 to 22/23, focusing on activity, workforce and finance.
- Work has now completed on invigorating budget holder training, ensuring that it is fit for purpose. Rolling out early July 23.
- Forecasting from M4 and roll out of new style reporting from M3
- Interim Deputy CFO appointed, starting 17 July
- Tighter controls established on non-pay
- Further Cost Improvement Programmes (CIPs) identified by Care Groups
- Care group oversight approach finalised and in place. Governance presented
- Model Years 1 & 2 of Financial Recovery Plan (FRP) updating the overall FR to be presented at July Trust Board

Key risks and issues:

- Currently no project leads within the IIP workstream
- Updating of the FRP in the absence of the additional RSP resources
- Identify and prioritise development of "harder to achieve" improvements
- Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT

Plan for next month:

- Implement strengthened oversight and governance for financial recovery with the care groups.
- Implement revised business case process.
- Continuous Ongoing work to re-establish financial controls across the Trust.
- Identify additional resource to support financial recovery including accelerating the cost improvement programme.

Financial Sustainable Programme - Product Milestones to end July	Due	RAG
6.1 Financial Governance		
6.102: Effective Care Group oversight approach in place	Jun-23	
6.103: Embed monthly finance reviews with Care Groups	Jun-23	
6.104: SFIs definition & refresh	Jul-23	
6.105: Meeting structure and review of TOR	Jul-23	
6.106: Review, relaunch and embed Strategic Investment Group (SIG)	Aug-23	
6.2 Financial Improvement		
6.203: Model years one and two of FRP	Jun-23	
6.204: Update FRP document	Jun-23	
6.205: Fully develop FY24 efficiencies	Jul-23	
6.206: Identify and prioritize development of "harder to achieve" improvements	Jul-23	
6.207: Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT	Jul-23	
6.3 Financial Consciousness		
6.303: Regular communications on finance and efficiency	Ongoing	
6.304: Regular updates to and oversight by FPC & FIOG	Ongoing	

Key: Delivery against plan
- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Financially Sustainable Programme

SRO: CFO

Domain	KPI	Thres.	Latest Date	Value	Variation	Assurance	LCL	Mean	UCL	Understanding the Latest Position
Finance	Efficiencies Green Schemes (£M)	40	May-23	1			2	11	21	Special cause of concerning nature or higher pressure due to lower values
	Efficiencies YTD Variance (£M)	0.0	May-23	-2.9			-8	-3	1	Common cause (no significant change)
	Premium Pay	Traj.	May-23	10.2K			6,050	7,821	9,591	Special cause of concerning nature or higher pressure due to higher values

May Performance Summary

Financial Position:
Premium pay spend is off track against the trajectory despite the focus applied to date.
Spend has increased to £10.2m in May 23. This is likely to be down to payment timings as the underlying temporary staff usage has not increased to the same extent. However, the number remains high in spite of a significant reduction in nursing vacancies and 2-weekly focus on spend at efficiency meetings.

A strengthened exec led financial governance and oversight framework will commence in August 2023. This will include oversight of finance, efficiency, activity and productivity as well as a strengthened vacancy control process.

Efficiencies:
Size of the challenge: The overall improvement challenge facing the Trust in Financial Year (FY24) is a c.£30m run rate reduction, and a c.£40m CIP target.

Approach to date: The care group focused ideas generation approach supported by the Programme Management Office (PMO) has only identified approximately £10m of improvements to date. While there are more schemes to value, the majority to date have been less than £50k benefit.

Change of approach: We are aligning the core improvement resource (PMO, strategy team, and We Care team) and switching to focus on 5 Cross Cutting themes with Executive Director leadership (key areas: Agency spend, Escalation beds, No Longer Fit to Reside, Theatres, and Outpatients alongside a renewed focus on cost control).

Financial consciousness: We have rolled out an efficiency communications strategy to improve the efficiencies culture across the Trust. This includes articles in staff news letters, an efficiency ideas generation button on the staff intranet site (68 ideas received to date), a 'hands up if you hate waste' campaign, and regular efficiency screen saver updates.

Integrated Improvement Plan Communications and Engagement Update - June

SRO: CFO

Progress over last month:

- Culture and Leadership Programme change team recruitment campaign completed, with the change team fully recruited to within the required timeframe
- 2023-25 Improvement Plan Summary published on our intranet and public website, along with detailed Integrated Improvement Plan, to show links between Strategic Objectives/Pillars of Change, 1 and 3 year aims and measures.
- The above shared and discussed at June's Team Brief and all staff forum (21 June)
- Dedicated 'Our improvement journey' section on Staff Zone (intranet) bringing together the different elements, drivers and enablers of the IIP
- Freedom to Speak Up training communications campaign begun
- Dementia strategy launch and Clinical Audit Awareness Week
- Celebrating success: First Healthcare Support Worker Awards event held
- Internal and external communications staff and patient stories
- Antenatal education classes user events
- Maternity We Hear You engagement maternity and neonatal event
- MP engagement included visit to new Children's Emergency Department at WHH

Key risks and issues:

- Number and pace of initiatives for staff to be aware of/engaged in. Mitigation: 'joining the dots' in the narrative to describe how each supports our improvement journey; a monthly focus on one key theme
- Capacity to engage staff and cascade information to the front line. Mitigation: Resources to streamline information and support managers

Plan for next month:

- With Maternity Voices Partnership, outreach to families in community to listen to maternity care experiences
- Developing next phase of Culture and Leadership Programme communications
- Continue the Freedom to Speak Up and caring with compassion communications campaigns, both elements are now mandatory training
- Feedback to all staff on savings ideas submitted so far through the financial consciousness campaign, and their progress
- Visual displays in hospital sites showing Integrated Improvement Plan in action
- 'Our people' staff magazine distributed, focussing on 'care and compassion' pillar of change and positive culture work
- Continue to link patient and staff stories to improvement plan and use campaign approach to engage all staff in individual projects
- Finalise detailed communications and engagement plan to support all key priorities in Integrated Improvement Plan by deadline of July 2023

Evidence of reach and outcomes:

- Change team fully recruited to within the required timeframe (120 people)
- The Improvement Plan page on staff zone has had 805 views and the plan summary was sent to 270 Trust leaders to use in team meetings
- Financial consciousness campaign ongoing, 428 staff have now visited the savings ideas portal on staff zone and more than 70 ideas have been submitted

REPORT TO BOARD OF DIRECTORS

Report title: **Month 2 Finance Report**

Meeting date: **6 July 2023**

Board sponsor: **Interim Chief Finance Officer (CFO)**

Paper Author: **Interim CFO**

Appendices:

APPENDIX 1: M2 FINANCE REPORT

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	The report is to update the Board of Directors on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	The group has achieved variance against plan of £1.9m deficit Year to Date (YTD) on a planned deficit of £17.8m. The Trust submitted a third update of the financial plan on the 4 May of £72m deficit with Board approval. This has now been approved and in addition the Integrated Care Board (ICB) has confirmed that the 2023/24 plan is the first year of the required three-year plan to get to financial balance. Delivery of the 2023/24 financial plan looks extremely challenging as it requires that the Trust: 1) Delivers £40m of efficiency savings on a cash releasing efficiency basis. 2) Delivers a stretch activity target. 3) Reduces not medically fit to reside patients. 4) Eliminates 65-week breeches. 5) No additional unknown cost pressures are presented without mitigation in year. 6) Non-elective pressures are within planning tolerances. 7) Full control measures are reintroduced.

Group Position

£'000	This Month Plan	Actual	Variance	Year to Date Plan	Actual	Variance
EKHUFT Income	71,733	72,066	334	139,846	139,202	(643)
EKHUFT Employee Expenses	(50,264)	(51,874)	(1,611)	(97,832)	(100,327)	(2,494)
EKHUFT Non-Employee Expenses	(30,451)	(30,131)	319	(60,118)	(58,434)	1,683
EKHUFT Financial Position	**(8,982)**	**(9,939)**	**(957)**	**(18,104)**	**(19,559)**	**(1,455)**
Spencer Performance After Tax	50	1	(50)	96	(11)	(108)
2gether Performance After Tax	59	103	44	118	232	114
Rephasing/Consolidation Adjustments	13	(84)	(97)	26	(500)	(526)
Consolidated I&E Position (pre Technical adjs)	**(8,859)**	**(9,919)**	**(1,060)**	**(17,864)**	**(19,838)**	**(1,974)**
Technical Adjustments	51	94	43	104	187	83
Consolidated I&E Position (incl adjs)	**(8,808)**	**(9,826)**	**(1,018)**	**(17,760)**	**(19,651)**	**(1,891)**

The planned phasing will form part of the main body of the report from month 3, however, the table below shows how the £72m deficit plan has been phased. From month 4 the efficiency plan increases to c£3.8m. In months 1 & 2 the planned achievement was c£1.6m per month.

Month	1	2	3	4	5	6	7	8	9	10	11	12	YTD
Deficit	-8,954	-8,806	-7,436	-5,398	-5,316	-5,049	-4,579	-4,600	-6,211	-5,614	-4,494	-5,472	-71,929

The key drivers to the Trusts YTD deficit are:

- Strike action £0.4m,
- Non-delivery of efficiency savings £2.9m YTD of which £2m has been allocated to Pay and £0.9m to non-pay,
- Pay overspent by £2.5m due to non-delivery of Cost Improvement Programme (CIP), increased levels of staffing utilisation, mainly in nursing (c183 Whole Time Equivalent (WTE)) & Medical & Dental (c76 WTE) and high cost of agency premium.
- Non-Pay underspend £1.7m on Drugs £1.4m and £0.6m underspend on clinical supplies & services and other smaller underspends off set against non-delivery of CIP of £0.9m

The increased pay award to be funded from month 3 has been accounted for in month 2 as per national guidance and held centrally.

All NHS systems have access to funding in 2022/23 through the Elective Recovery Fund (ERF), subject to meeting the required threshold of 104% of 2019/20 activity levels. We have assumed to receive full ERF funding in April and May as per national guidance. The Trust has submitted a plan to achieve 106% of 2019/20 baseline.

The Group cash balance (including subsidiaries) at the end of May was £29.2m. The Trust did not draw revenue Public Dividend Capital (PDC) as working capital to support its in-month deficit but plan to draw PDC in June to support the Year to date deficit.

Total capital expenditure at the end of May was broadly on plan with a £3.1m spend against a plan of £2.9m plan.

The Trust has achieved very little efficiency savings so far this year against the £3m plan. This has contributed to the Trust not meeting its planned year to date deficit of £18.1m in May.

The Trust is continuing to experience the difficulties with the flow of Non-Elective patients which began in 2022/23. This has been caused by significant delays to the discharging of medically fit patients and the Trust planned for the issue to be resolved, allowing activity to return to normal levels. The combination of this and an evolution in the use of observation bays has resulted in a greater proportion of patients seen and treated in Accident & Emergency (A&E) with stays >12hrs, resulting in the number of Non-Elective admissions being lower. The underlying reason is a lack of capacity for patients in the community, resulting in pressure on Non-Elective beds, caused by increasing average patient length of stays due to the high number of delayed discharges.

The level of A&E attendances were 6% lower than plan in month resulting in a YTD underperformance of 9%. The financial variance is under by 6% in month.

Elective Inpatient spells activity has overperformed by 1% against plan in month, and is now showing a 2% underperformance against plan YTD. Trauma & Orthopaedic (T&O) are £0.4m below plan YTD and Gastro/Endoscopy are £0.4m below plan YTD, both of which would be drivers for ERF under-performance against baseline, should this be required to be provided for currently.

Other operating income is adverse to plan in May by £0.2m and by £0.3m YTD. The main drivers for the variance in month are lower than planned income for Spencer Wing Age-related macular degeneration (AMD) drugs (£0.1m), offset by reduced drug expenditure, and below planned income for GP trainee salaries (0.1m), offset by lower than planned GP trainee salary costs.

Employee expenses performance is adverse to plan in May by £1.6m and by £2.5m YTD (2.6%). CIP schemes relating to all pay headings are adverse to plan in May by £1.0m and by £2.0m YTD (substantive schemes £0.7m in month and £1.4m YTD and agency schemes £0.3m in month and £0.7m YTD). This also reflects the impact of cover during strike action by Junior Doctors in April, which is estimated at £0.4m.

Other operating expenditure is favourable to plan by £0.3m in May and by £1.7m YTD (2.7%). CIP schemes relating to all other operating expenditure headings are adverse to plan by £0.4m in May and by £0.9m YTD.

Half day sessions have been undertaken with each of the Care Groups, Corporate areas are being booked. The sessions looked at the activity, workforce & financial changes from the 2019/20 year and to the full year of 2022/23. Each Care Group presented a detail pack covering all of these areas. In addition, the Care Groups were asked to demonstrate all governance controls within each Care Group and a forward look at activity levels for 2023/24.

In addition, the Care Groups were tasked with presenting to the group their 5 key themes that they wished to have as key efficiency plans for

	2023/24 and beyond. Significant work is on-going to develop these into robust plans for in year and beyond delivery.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern. To **NOTE** the reforecasting of the financial position to a £19.3m deficit.

Implications:

Links to 'We Care' Strategic Objectives:	• Our sustainability
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2023/24 efficiencies target equating to £40m. **CRR 136**: Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: None

Finance Performance Report 2023/24

May 2023

Interim Chief Finance Officer
Michelle Stevens

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Executive Summary
Month 02 (May) 2023/24

Executive Summary

The group achieved a £1.9m deficit YTD against plan. From the 1st of April electives and outpatients (apart from follow ups) have been reinstated to payment by results, however current guidance states that Trusts need to report on full delivery of the activity plan due to timings of data collection.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2023/24 at the beginning of May. The plan is a deficit position of £72m post a small inflationary allocation. The rest of the ICB need to deliver a breakeven position to achieve the ICB target of £72m deficit. The Trust has now had approval for the £72m deficit position and conformation that 2023/24 is the first year of the three year trajectory to achieve financial balance.

Delivery of this deficit plan for 2023/24 is a stretch for the Trust as it's based on a higher level of activity than 2022/23 and requires £40m of efficiency savings on a CRES basis and full adherence to cost control measures.

At present there is an outstanding consolidating adjustment between the Trust and 2gether which will be resolved in June. The position below shows this as outstanding but is included within the month end position.

Group Position

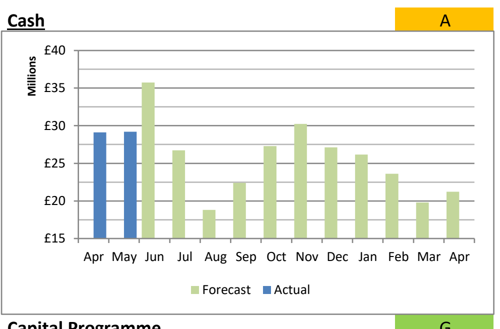
	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income	71,733	72,066	334	139,846	139,202	(643)
EKHUFT Employee Expenses	(50,264)	(51,874)	(1,611)	(97,832)	(100,327)	(2,494)
EKHUFT Non-Employee Expenses	(30,451)	(30,131)	319	(60,118)	(58,434)	1,683
EKHUFT Financial Position	**(8,982)**	**(9,939)**	**(957)**	**(18,104)**	**(19,559)**	**(1,455)**
Spencer Performance After Tax	50	1	(50)	96	(11)	(108)
2gether Performance After Tax	59	103	44	118	232	114
Rephasing/Consolidation Adjustments	13	(84)	(97)	26	(500)	(526)
Consolidated I&E Position (pre Technical adjs)	**(8,859)**	**(9,919)**	**(1,060)**	**(17,864)**	**(19,838)**	**(1,974)**
Technical Adjustments	51	94	43	104	187	83
Consolidated I&E Position (incl adjs)	**(8,808)**	**(9,826)**	**(1,018)**	**(17,760)**	**(19,651)**	**(1,891)**

All NHS systems have access to funding in 2023/24 through the Elective Recovery Fund (ERF). The Trust has received funding to meet a threshold of 104% of 2019/20 activity levels, the Trust has submitted a plan that delivers 106% of the 2019/20 baseline. YTD the Trust is behind its activity plan by c£0.5m. the guidance for ERF for month 2 is to report as per plan due to the timings of the freeze and flex activity reporting.

Income and Expenditure

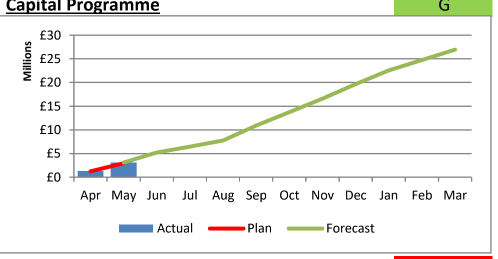
The key drivers behind the deficit are: Strike action £0.4m by the junior doctors, Non-delivery of efficiency savings £2.9m YTD of which £2m has been allocated to Pay and £0.9m to non pay, Pay overspent by £2.5m due to non delivery of CIP and increased levels of staffing utilisation mainly in nursing (c183 WTE) & Medical & Dental (c76 WTE) and high cost of agency premium & Non Pay underspend £1.7m on Drugs £1.4m and £0.6m underspend on clinical supplies & services and other smaller underspends off set against non-delivery of CIP of £0.9m

Cash A



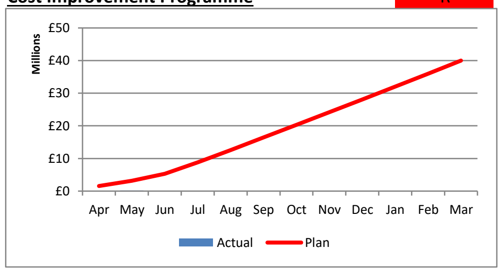
The Group cash balance (including subsidiaries) at the end of May was £29.2m.
The Trust did not draw revenue PDC as working capital to support its in-month deficit but plan to draw PDC in June to support the Year to date deficit.

Capital Programme G



Total capital expenditure at the end of May was broadly on plan with a £3.1m spend against a plan of £2.9m plan.

Cost Improvement Programme R



The Trust has achieved very little efficiency savings so far this year against the £3m plan.

This has contributed to the trust not meeting it's planned year to date deficit of 18.1m in May.

Income and Expenditure Summary

Month 02 (May) 2023/24

Unconsolidated

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.
Income						
Electives	8,262	8,368	106	15,468	15,053	(416)
Non-Electives	21,896	19,097	(2,798)	43,901	35,680	(8,221)
Accident and Emergency	4,268	3,984	(283)	8,327	7,729	(598)
Outpatients	9,306	9,667	362	17,518	18,196	677
High Cost Drugs	4,070	3,853	(217)	8,140	7,944	(196)
Private Patients	14	27	12	29	70	42
Other NHS Clinical Income	19,408	22,741	3,333	37,444	45,887	8,443
Other Clinical Income	133	150	16	266	213	(53)
Total Income from Patient Care Activities	**67,357**	**67,887**	**530**	**131,094**	**130,771**	**(323)**
Other Operating Income	4,376	4,179	(197)	8,752	8,431	(321)
Total Income	**71,733**	**72,066**	**334**	**139,846**	**139,202**	**(643)**
Expenditure						
Substantive Staff	(43,322)	(43,673)	(350)	(84,352)	(85,234)	(882)
Bank	(3,605)	(3,904)	(299)	(6,927)	(7,370)	(444)
Agency	(3,336)	(4,297)	(961)	(6,553)	(7,722)	(1,169)
Total Employee Expenses	**(50,264)**	**(51,874)**	**(1,611)**	**(97,832)**	**(100,327)**	**(2,494)**
Other Operating Expenses	(29,586)	(29,320)	266	(58,386)	(56,833)	1,554
Total Operating Expenditure	**(79,849)**	**(81,194)**	**(1,345)**	**(156,219)**	**(157,159)**	**(941)**
Non Operating Expenses	(865)	(811)	54	(1,731)	(1,602)	129
Income and Expenditure Surplus/(Deficit)	**(8,982)**	**(9,939)**	**(957)**	**(18,104)**	**(19,559)**	**(1,455)**

Consolidated

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.
Income						
Income from Patient Care Activities	66,849	66,660	(189)	132,166	133,320	1,154
Other Operating Income	4,501	4,691	190	9,002	9,381	379
Total Income	**71,350**	**71,351**	**1**	**141,168**	**142,701**	**1,533**
Expenditure						-
Employee Expenses	(52,879)	(54,130)	(1,251)	(104,861)	(108,260)	(3,399)
Other Operating Expenses	(26,399)	(26,323)	77	(52,309)	(52,645)	(336)
Total Expenditure	**(79,278)**	**(80,453)**	**(1,175)**	**(157,170)**	**(160,905)**	**(3,735)**
Non-Operating Expenses	(931)	(817)	114	(1,862)	(1,634)	228
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**(8,859)**	**(9,919)**	**(1,060)**	**(17,864)**	**(19,838)**	**(1,974)**
Technical Adjustments	51	94	43	104	187	83
Consolidated I&E Position (incl adjs)	**(8,808)**	**(9,826)**	**(1,018)**	**(17,760)**	**(19,651)**	**(1,891)**

Income from Patient Care Activities

In month the Trust saw an overperformance against plan of £0.5m (under performance £0.3m YTD).

The largest change from M1 relates to the backdated pay award of 1.6% of contract income which has been included at £2.1m YTD. This is not generating an overperformance, as national guidance allowed for a corresponding adjustment to the M2 plan. There is no bottom line variance as the income accrued was matched to the expected cost accrued as pay expenditure.
The 1.6% pay award changes to the National Tariff has not been published yet, so there has been no change to the rates used for planned or actual activity.

Following national guidance, no variance has been accrued against ERF performance at Month 2, but any emerging risk will be evaluated and included in future months' positions if required.

The Trust is showing a YTD underperformance, this is largely due to high cost drugs which has an underperformance of £0.2m YTD and is a pass through cost mirrored in expenditure.

Low Value Activity (Out of Area patients) are now directly funded and set nationally, paid in direct block payments from ICBs.
It should be noted that Non-Elective patients are not paid at cost per case in23/24. That is the reason that the larger underperformance is offset by Other NHSE clinical income.

Other Operating Income and Expenditure

Other operating income is adverse to plan in May by £0.2m and by £0.3m YTD. Income for Spencer Wing AMD drugs and GP trainee salaries are below plan in month and YTD by a total of £0.2m. In addition to these variances YTD, income for staff accommodation, donated assets and research and innovation are adverse to plan by a total of £0.3m, offset by above plan income for education and training income of £0.2m.

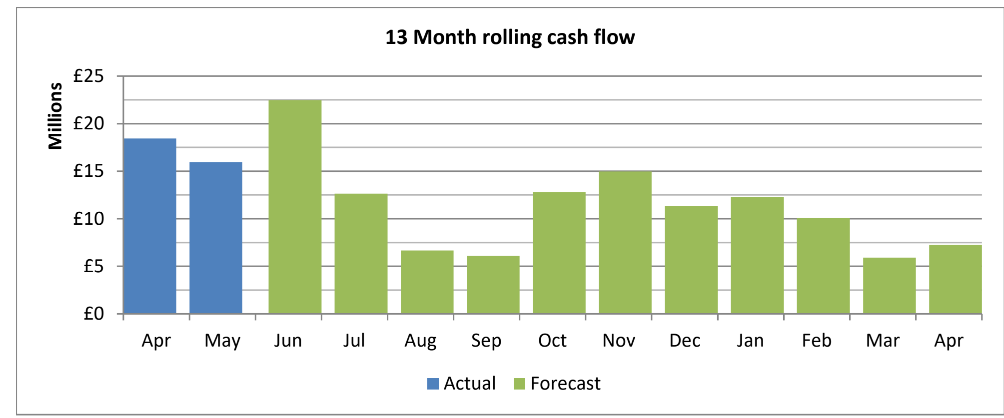
Total operating expenditure is adverse to plan in May by £1.3m and by £0.9m YTD, including CIPs which are adverse in month £1.4m and £2.9m YTD.

Employee expenses performance is adverse to plan in May by £1.6m and by £2.5m YTD, with unachieved CIPs accounting for £1.0m in month and £2.0m YTD of the variance. This also includes the impact of cover during junior doctor strike action in April of £0.4m. Indicative direct costs for escalation beds are £2.3m in May and £3.8m ytd, and 1:1 specialing for May is £1.0m and £1.8m ytd

Total expenditure on pay in May was £51.9m, an increase of £3.4m when compared to April, mainly relating to provisions for the 23-24 pay award for all AfC staff which were increased in May to cover the additional 3% above plan, backdated to April, and estimated at £2.1m. This is offset by an increase in patient care income. Excluding the pay pay award, expenditure on permanent staff grew by £0.2m and bank staff increased by £0.2m, mainly relating to nurses and HCAs. Expenditure on agency staff increased by £0.9m, with increases in most staffing groups but predominantly relating to medical consultants.

Other operating expenditure is favourable to plan by £0.3m in May and by £1.6m YTD. CIP schemes are adverse to plan by £0.4m in May and by £0.9m YTD. In month, underspends on drugs, clinical supplies and education and training totalling £1.1m are offset by adverse performances on non clinical supplies, purchase of healthcare and premises costs totalling £0.7m.

Other operating expenditure was £29.3m in May, an increase of £1.8m when compared to April. The main driver for the increased spend in month is the OHF and EMS contracts with 2gether which grew by £1.0m inclusive of consumables and pay award estimate. Premises costs increased by £0.4m, mainly in business rates and computer



Unconsolidated Cash balance was £16m at the end of May 23, £4.5m above plan.

Cash receipts in month totalled £72.6m (£1.8m below plan)
K&M ICB paid £53.1m in May. £3.9m below plan.
Other non NHS receipts totalled £2.2m (£2.7m below plan due to no VAT reclaim being received in month)
Revenue Support is £4.7m above plan in month.

Cash payments in month totalled £75.1m (£6.1m below plan)
Creditor payment runs including Capital payments were £34.0m (£5.6m above plan)
Payroll was £0.5m above plan

YTD cash receipts total £151.4m (£1.6m below plan - largely driven by receipts from K&M ICB under plan (£3.9m), VAT reclaims under plan (£2.8m), revenue support above plan by £4.7m)

YTD cash payments total £154.0m (£3.0m below the plan - mainly driven by creditor payments (£2.5m) and Payroll (£0.5m))

2023/24 Plan

The revised plan submitted to NHSE/I in May 2023 shows a technically adjusted deficit position at the end of 2023/24 of £71.9m. Revenue support for the full deficit amount is forecast in the year.

Forecast

Monthly payments on account are being made to 2gether Support Solutions in lieu of invoices being paid whilst charges are being reviewed. As a result, VAT reclaims are significantly reduced from plan. This will continue to be the case until charges are confirmed. Invoices are forecast to be cleared in October with the relating VAT reclaim being received in November.

Creditor Management

The Trust moved to 37 day creditor terms in Month 02. Payments to one key supplier are being held and invoices cleared if the funds are available. As at 31st May 23, £3.7m was overdue for payment to them.

The Trust received £13.7m revenue support in June and a further £3m has been requested in July.

At the end of May 2023, the Trust was recording 62 creditor days (Calculated as invoiced creditors at 31st May/ Forecast non-pay expenditure x 365).

Cost Improvement Summary
Month 02 (May) 2023/24

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Outturn	Forecast Variance
Agency	422	-	(422)	844	-	(844)	10,005	711
Bank	-	-	-	-	-	-	8	8
Workforce	207	13	(194)	414	25	(389)	3,368	284
Outpatients	15	-	(15)	30	-	(30)	275	(69)
Procurement	92	95	3	176	141	(35)	2,477	849
Medicines Value	42	19	(23)	84	19	(65)	1,042	42
Theatres	72	-	(72)	144	-	(144)	2,609	(391)
Care Group Schemes *	396	23	(374)	782	23	(760)	12,833	(1,636)
Sub-total	**1,246**	**149**	**(1,097)**	**2,474**	**207**	**(2,267)**	**32,616**	**(203)**
Central	335	-	(335)	670	-	(670)	7,384	203
Grand Total	**1,581**	**149**	**(1,432)**	**3,144**	**207**	**(2,937)**	**40,000**	**-**

* Smaller divisional schemes not allocated to a work stream

Delivered £000

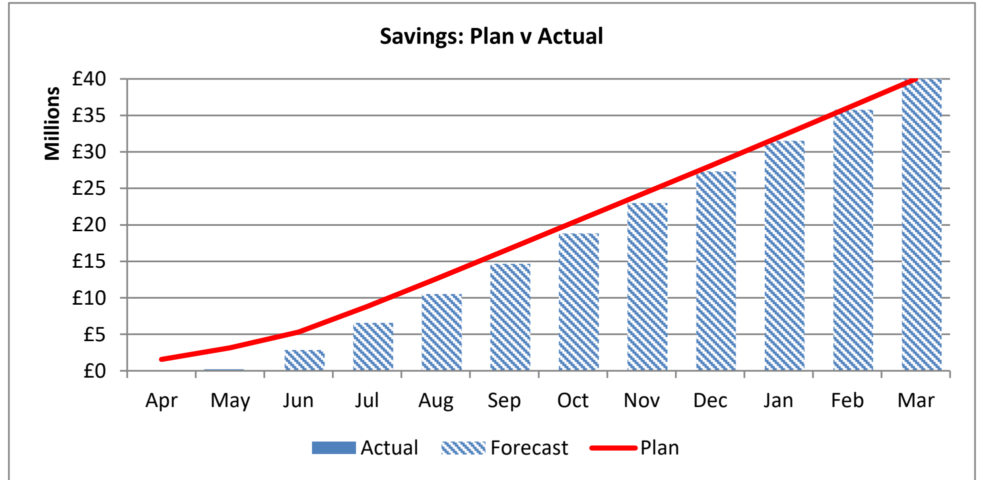
Month	Target	Actual
April	1,563	58
May	1,581	149
June	2,149	
July	3,514	
August	3,749	
September	3,890	
October	3,873	
November	3,874	
December	3,874	
January	3,929	
February	3,989	
March	4,015	
	40,000	**207**

Efficiencies

The submitted Efficiencies plan for 2023-24 is £40m. The Trust achieved savings of £0.15m in May, which is below Plan. The in month performance relates to shortfalls across all areas except Procurement.

YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed.
Recurrent savings in May amounted to £0.14m, with £0.01m being on a non-recurrent basis.

Recurrent savings YTD amount to £0.19m with £0.02m on a non-recurrent basis.
Fortnightly Care Group meetings continue with an increased focus on determining values for 2023/24 ideas, and seeking further opportunities to develop savings plans.



Capital Expenditure
Month 02 (May) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Emergency Department Expansions	4,271	4,271	1,603	1,295	308
Community Diagnostics Centre	2,845	2,845	0	0	0
Mechanical Thrombectomy	2,608	2,608	0	0	0
Diagnostics Clinical Equipment	2,550	2,550	0	0	0
Information Development Group	2,000	2,000	690	619	71
Medical Devices Group	1,666	1,666	276	245	31
Electronic Medical Records	1,545	1,545	205	297	(92)
Stroke HASU	1,463	1,463	67	49	18
Diagnostics Imaging Capacity	1,433	1,433	0	()	
Patient Environment Investment Committee	3,771	3,771	0	16	(16)
Charity Donations	900	900	80	70	10
Other Build	736	736	0	0	0
Subsidiaries	519	519	0	0	0
Other IT	375	375	0	375	(375)
Other Medical Equipment	259	259	20	20	
All Other	0	5	0	111	(111)
	26,941	**26,946**	**2,941**	**3,095**	**(154)**

Funded By:		
Operational Cash	21,515	21,515
System Set Underutilisation	(2,850)	(2,850)
Donations	900	900
Disposals	250	250
System Capital PDC	1,463	1,463
PDC	5,663	5,663
New Lease Loans	0	8
New Lease Repayments	0	(3)
	26,941	**26,946**
Under/(Over) Commitment		**0**

2023/24 Capital Programme - as at M2 (May 2023)

The Trust submitted the final 5-year Capital Plan to NHSE/I on 4th May 2023, the programme totalling £26.9m in 2023/24. This included a target System Control Total of £20.1m (made up of the available internally generated funding and the System Capital Support PDC allocated) and £6.8m of other national funding streams.

A subsequent formal submission to NHSE/I of the Trust's 5-year Operational Plans took place on the 26th May 2023, although this included no Capital changes from the previous iteration.

Capital Spend Position - as at M2

The group's gross capital year-to-date spend to the end of Month 2 was £3.1m, against a YTD plan of £2.9m. This represents a £0.2m net overspend, as a result of:

- Underspends totalling £0.4m (including £0.3m on ED Expansion WHH & QEQM and £0.1m other smaller underspends)
- Overspends totalling £0.6m (including £0.4m on Digital Diagnostics IT Schemes and £0.2m due to unexpected costs relating to prior year schemes and other smaller overspends)

The costs pressures of circa £0.1m related to prior year schemes are expected to be fully offset by a corresponding level of VAT recovery in year.

The reported position is not expected to result in a risk exposure for the Trust against the available funding envelope at the end of the financial year.

Statement of Financial Position

Month 02 (May) 2023/24

£000	Opening	To Date	Movement	
Non-Current Assets	**402,107**	**401,161**	**(946)**	▼
Current Assets				
Inventories	6,749	7,089	340	▲
Trade Receivables	11,677	9,902	(1,775)	▼
Accrued Income and Other Receivables	29,981	35,895	5,914	▲
Assets Held For Sale				-
Cash and Cash Equivalents	18,618	15,970	(2,648)	▼
Total Current Assets	**67,025**	**68,856**	**1,832**	▲
Current Liabilities				
Payables	(41,537)	(54,107)	(12,569)	▲
Accruals and Deferred Income	(46,653)	(51,646)	(4,992)	▲
Provisions	(2,887)	(2,796)	91	▼
Borrowing	(4,838)	(3,531)	1,308	▼
Net Current Assets	**(28,892)**	**(43,222)**	**(14,331)**	▼
Non Current Liabilities				
Provisions	(3,405)	(3,405)		-
Long Term Debt	(77,371)	(76,897)	474	▼
Total Assets Employed	**292,439**	**277,636**	**(14,803)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	454,994	459,750	4,756	▲
Retained Earnings	(217,590)	(237,149)	(19,559)	▼
Revaluation Reserve	55,035	55,035		-
Total Taxpayers' Equity	**292,439**	**277,636**	**(14,803)**	▼

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

Trust closing cash balance was £16m (£18.4m in April) £4.5m above plan. See cash report for further details. Cash has been supported in year by £4.8m of PDC working capital which was drawn in May - no revenue support was drawn in April. An application for £13.7m of revenue support has been approved and will be received by the Trust in June - that will bring the total revenue support in Q1 to the same level as the planned deficit for that period.

Trade and other receivables have reduced from the 2023/24 opening position by £1.8m (£3.0m reduction in April). Key drivers are detailed on the Cash report

Payables have increased by £12.5m (£9m increase in April) See Working Capital sheet for more detail on debtors and creditors. As no cash support was drawn in April the Group cash position resulted in fewer creditor payments - driving the increase in payables.

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

PDC increased in month by Working Capital (£4.8m).

The movement in Retained earnings reflects the year-to-date unadjusted deficit.

REPORT TO BOARD OF DIRECTORS

Report title: **Emergency Department (ED) Builds – Update**

Meeting date: **6 July 2023**

Board sponsor: **Chief Operating Officer**

Paper Author: **Interim Hospital Director William Harvey Hospital (WHH)**

Appendices:

APPENDIX 1: EMERGENCY DEPARTMENT BUILDS – UPDATE REPORT

Executive summary:

Action required:	**Information**
Purpose of the Report:	At a previous Board of Directors meeting the following was requested: Present report on the transformation work, covering the ED phased building works, evaluating the success of the changes in ED, the impact of the building works, management of patient flow, rapid assessment areas with reduced bed numbers, patient pathway (alternative pathways) and managing demand.
Summary of key issues:	The building works at WHH and Queen Elizabeth the Queen Mother Hospital (QEQM) have placed significant and prolonged constraints on clinical activity in both Emergency Departments. In response the Trust starting at WHH, and now at QEQM, has remodelled front door pathways to mitigate the risks created by the building works.
Key recommendations:	The Board of Directors is asked to **NOTE** the report and the associated progress with front door performance.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our quality and safety
Link to the Board Assurance Framework (BAF):	N/A

Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	Yes – regulatory impact in terms of 4-hr performance
Subsidiary:	N

Assurance route:

Previously considered by: N/A

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Emergency Department (ED) Builds – Update

Introduction
This paper aims to respond to the Board's request for a detailed status update on the ED build work within the Trust and the impact of the works on the services provided.

The William Harvey Hospital (WHH) build commenced in June 2021 and is due for completion in September 2023.

The Queen Elizabeth the Queen Mother Hospital (QEQM) build commenced in June 2021 and due for completion in December 2023.

William Harvey Hospital
The phasing of the WHH build has been as follows:

Phase 1 saw development of the new rapid assessment and treatment are and resuscitation area and ambulance offloading bays.

Phase 2 consisted of the closure of half the old majors area and the development of the newly appointed front door area/reception and clinical rooms plus the development of the new Paediatric Emergency Unit.

Phase 3 commenced in April 2023 and consists of the second half of the old majors, the move of the old Paediatric ED to the new area and the development of the old Paediatric ED into a co-located Children's Assessment Unit.

The new build also provides an enhanced number of clinical rooms and patient waiting areas, mental health adult and children's dedicated space, provision for trauma and orthopaedics, a seminar room for teaching, offices and a rest area for staff with fully kitted changing rooms and showers.

The ultimate benefit of the build will be as follows:

Capacity	Old	New
RAT (rapid Assessment and Treatment	10	**12**
Resuscitation	6	**9**
Paediatrics	3	**6**
Majors – Adults	14	**19**
Mental Health Rooms	1	**2**
Total	34	**48**

As one of the key parts of the build required access to the old majors area it was essential that clinical pathways were developed to mitigate the risk associated with this.

Consequently, a clinical forum was established in October 2022 with the purpose of reviewing existing pathways and processes and to agree how these could be enhanced. At this time, EKUFT was a national outlier for how patients accessed urgent and emergency care with the Emergency Departments being a single point of access to care provision. The clinical forum therefore adopted the guiding principle: ***right patients, right place, first time***. This principle was kept at the centre of the planning when developing the changes required for the future.

This work led to a review of all existing emergency care action plans and the creation of the Emergency Care Delivery Group (ECDG) to focus on four key workstreams – Front Door, Patient Flow, Simple Discharge and Direct Access pathways. It was intended that these workstreams would support both sites with the ability to allow for local variation as required. Each workstream had a senior accountable officer appointed who held a senior clinical leadership role within EKUFT.

The primary initial aim was to establish alternative pathways to reduce the footfall through the EDs given the immediate pressure of the build works. This was to be achieved by enhancing the services for patients accessing urgent care by developing dedicated and resourced assessment units, optimising same day emergency care services whilst improving flow through the department through schemes to enhance and improve timely discharge.

Given the phasing of the William Harvey build, relevant new and agreed models were piloted with the plan being to share the learning across to QEQM.

The key interventions agreed by the clinical teams were:

- Reinforcing alternative pathways to ED by enhancing Urgent Treatment Centre (UTC) co-located utilisation.
- Delivering nurse initial assessment at the front-door in order to achieve effective streaming to appropriate care pathways.
- Introducing a doctor initial assessment role to improve the time to be seen by a senior clinical decision maker and optimising alternative pathways.
- Achieving same day emergency care (SDEC) provision for medicine, surgery and children.
- Setting up SDEC booked hot slots for patients to be discharged outside of normal working hours and return the next day.
- Implementing virtual SDEC clinics, to increase capacity and reduce the need for patients to reattend.
- Delivering front door frailty provision via a roaming model in advance of being located in a new physical space.
- Implementation of direct access pathways, underpinned by robust training, to provide direct access to more appropriate care locations such as SDEC and UTC from the point of initial assessment.
- Establishing medical and surgical assessment units with dedicated short stay wards for up to 48 hours to move appropriate patients out of ED more efficiently.
- Co-horting pathway 1 and 3 cases to optimise patients' therapy and future care needs.

As can be seen, the programme was front-loaded to address the front-door challenge with the Emergency Care Delivery Group (ECDG) acting as the core governance throughout.

In terms of impact, there are growing signs that the model changes outlined above are having an effect and place the WHH site in a position to sustainably improve its emergency care position going forward. At the point of writing, the following comparisons between June 2023 and June 2022 are noteworthy for instance:

- Type 1 4-hr performance at 51% vs 40%
- All type 4-hr performance at 65% vs 53%
- Time to initial assessment at 52% vs 28%
- Number of patients not admitted seen within 4 hours at 61% v 51%

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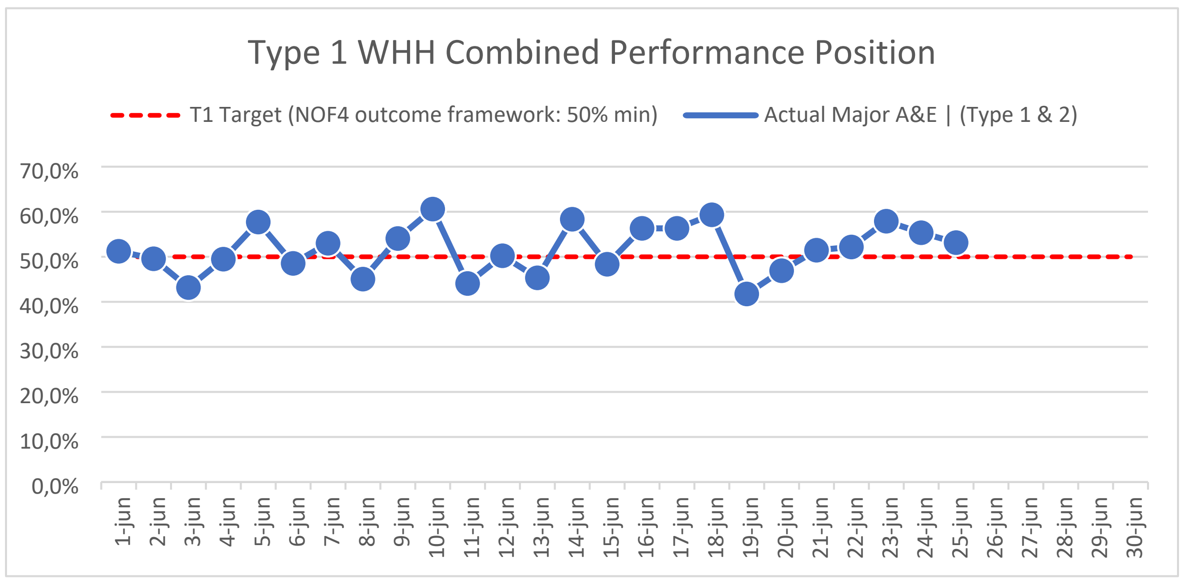
The chart below, furthermore, shows daily Type 1 performance for June (until the point of writing):



To reinforce this progress further actions are now occurring as follows:

- Review of ambulance conveyances to ED to identify opportunities for future avoidance.
- Utilisation of the Alt-ED tool on a system basis to map the extent of alternative available pathways in East Kent and the extent to which these are sufficient.
- A review of the Trust's urgent care provision by the national Getting it Right First Time (GIFT) team to confirm key further opportunities and to peer-review current practice.
- Scoping of the need for a Clinical Decisions Unit on-site in order to offer provision for patients needing input for c12 hours.
- Formation of a clinical forum to decide on the optimal way to configure the on-site bed base.

Whilst this should be viewed positively it is important to note that the metrics associated with waiting times for admission, particularly patients waiting above 12 hours, remain challenged. It can reasonably be concluded therefore that the innovation shown at the front-door at WHH (and the demonstrable impact this is now having) needs to be mirrored at the back-door in order to deliver improved flow through the site.

QEQM
The phasing of the QEQM build has been as follows:

Phase 1 included development of the UTC, paediatric area and majors development.

Phase 2 consisted of the rapid assessment and treatment unit.

Phase 3 commenced in June 2023 and consists of the development of the resus spaces and a corresponding impact on the old majors space.

The new build also provides an enhanced number of clinical rooms and patient waiting areas, mental health adult and children's dedicated space, seminar room for teaching, offices and a rest area for staff with fully kitted changing rooms and showers.

The ultimate benefit of the build will be as follows:

Capacity	Old	New
RAT (rapid Assessment and Treatment	4	**14**
Resuscitation	4	**7**
Paediatrics	7	**7**
Majors – Adults	15	**12**
Mental Health Rooms	2	**2**
Total	35	**42**

Phase 3 of the build necessitated the loss of 15 undefined care spaces across the majors footprint thereby compromising the volume of patients that the department could hold at a given time. This change is permanent. To mitigate this risk, it was decided that implementation of revised clinical models, mirroring those in place at WHH, was essential.

The main alterations have been as follows:

- Establishing a dedicated medical assessment unit and short stay medical ward in order to flow patients out of ED more effectively.
- Expanding medical SDEC provision Monday-Friday from 08.00-17.00 hours to 08.00-20.00 hours with weekend 08.00-17.00 hours.
- Implementing a dedicated ED Observation Unit for patients requiring between 4 hours and 12 hours of care (for instance, to receive IV antibiotics or fluids).
- Implementing direct access pathways from the front door.
- Introducing a doctor initial assessment role to improve the time to be seen by a senior clinical decision maker and optimising alternative pathways.
- Evolving the front door frailty service to enhance the capacity and increase the numbers of patients managed through this service including co-location within the ED.
- Creating dedicated space for a front door therapist to support early discharge back to the community with access to in-reach community services.

In addition, system partners within East Kent have also contributed by committing to:

  - Increasing pathway 3 discharges for a period of 2-3 months.
  - Increasing front door in-reach from community teams with access to increased pathway 1 capacity.
  - Enhancing on-site mental health liaison to reduce the times for assessment for referred patients.

The interventions were introduced in the run up to the commencement of Phase 3 in mid-June and the chart below shows daily Type 1 performance at QEQM for June (up to the point of writing). As can be seen there are early signs of improvement following the actions outlined above and certainly the immediate risk of the Phase 3 works has been addressed. Needless to say, however, this progress needs to be embedded and taken further:

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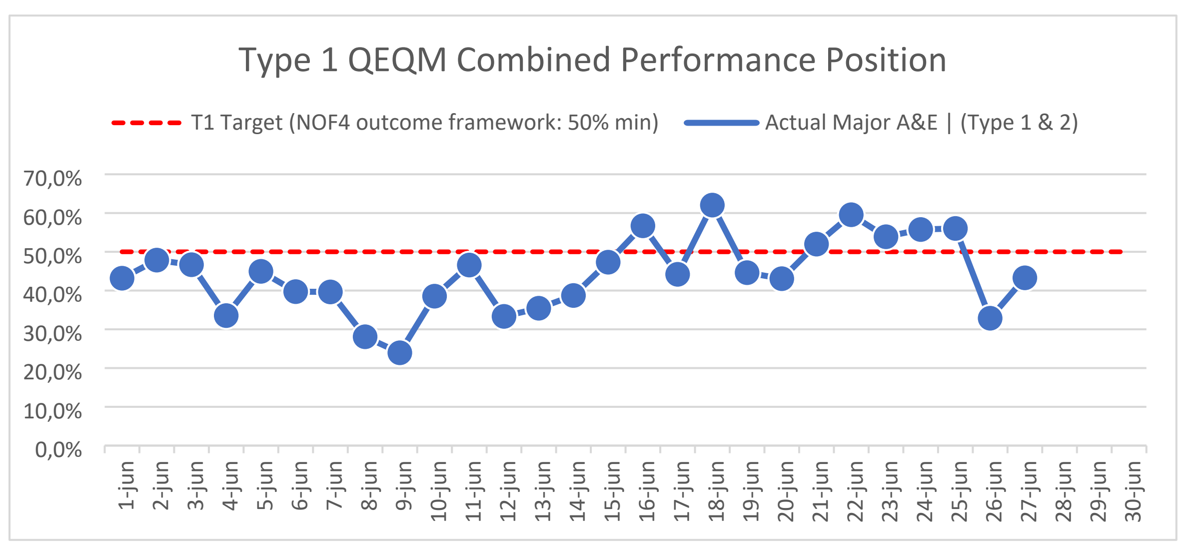

Conclusion

As this paper aims to demonstrate, significant clinically-led change has been enacted within the organisation to address the challenges on both sites resulting from the ED build work. Not only have these changes offered short-term mitigation, they have also provided the Trust with updated clinical models focused on diversifying the flow of patients at the front-door of William Harvey and QEQM. Once the totality of the building work is completed and the new departments are functioning a fuller review will be undertaken to guide decision making as to the best permanent future arrangements.

Interim Hospital Director WHH

Chief Operating Officer

June 2023