Board of Directors - Open Meeting (Thursday 7 December 2023)

Thu 07 December 2023, 01:20 PM - 05:00 PM

WebEx teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:20 PM - 01:25 PM
5 min

23/122
Welcome and Apologies for Absence

To Note *Chairman*

Verbal

01:25 PM - 01:25 PM
0 min

23/123
Confirmation of Quoracy

To Note *Chairman*

Verbal

01:25 PM - 01:25 PM
0 min

23/124
Declaration of Interests

To Note *Chairman*

23-124 - Board of Directors register of interests - November 2023.pdf (4 pages)

01:25 PM - 01:25 PM
0 min

23/125
Minutes of Previous Meeting held on 2 November 2023

Approval *Chairman*

23-125 - Unconfirmed BoD 02.11.23 Open Minutes.pdf (17 pages)

01:25 PM - 01:25 PM
0 min

23/126
Matters Arising from the Minutes on 2 November 2023

Approval *Chairman*

23-126 - Front Sheet Open BoD Action Log.pdf (5 pages)

People

01:25 PM - 01:30 PM
5 min

23/127
Staff Experience Story

Discussion *Chief People Officer*

Verbal

REGULATORY AND GOVERNANCE

01:30 PM - 01:35 PM
5 min

23/128
Chairman's Report

Information *Chairman*

- 23-128 - Chairman BoD Report Dec 2023 07.12.23.pdf (4 pages)

01:35 PM - 01:45 PM
10 min

23/129
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 23-129 - CEO Report Board Dec 2023.pdf (6 pages)

01:45 PM - 02:15 PM
30 min

23/130
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 23-130.1 - Front Sheet Dec 23 IPR.pdf (3 pages)
- 23-130.2 - App 1 Board IPR_v5.0_Oct23_FINAL.pdf (61 pages)

23/130.1
Month 7 Finance Report

Information *Interim Chief Finance Officer (CFO)*

- 23-130.1.1 - M7 Finance Report Trust Board 071223.pdf (4 pages)
- 23-130.1.2 - Appendix 1 M7 Finance Report Short.pdf (8 pages)

02:15 PM - 02:25 PM
10 min

23/131
Report on Journey to Exit NHS Oversight Framework (NOF4) and Integrated Improvement Plan (IIP)

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

- 23-131.1 - Board Front Sheet IIP Progress Report 27.11.23.pdf (2 pages)
- 23-131.2 - App 1 Trust Board IIP Report FINAL 27.11.23.pdf (16 pages)
- 23-131.3 - IIP Risk Register FINAL 30.11.23.pdf (3 pages)

02:25 PM - 03:05 PM
40 min

23/132
Board Committee - Chair Assurance Reports:

Assurance *Board Committee Chairs*

People

23/132.1

People and Culture Committee (P&CC) - Chair Assurance Report (2.25 pm to 2.35 pm)

Assurance *Acting Chair P&CC - Claudia Sykes*

- 23-132.1 - PCC Board Assurance Report 07.11.23.pdf (4 pages)

Patients - Quality and Safety

23/132.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report (2.35 pm to 2.45 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

- 23-132.2.1 - EK Q&SC Chair's Report 281123.pdf (4 pages)
- 23-132.2.2 - App 1 Quality and Safety Committee ToR.pdf (6 pages)

Partnerships - Sustainability

23/132.3
Finance and Performance Committee (FPC) - Chair Assurance Report (2.45 pm to 2.55 pm)

Approval *Chair FPC - Richard Oirschot*

- **Terms of Reference (ToR)**

- 23-132.3 - FPC Committee Assurance Report 311023.pdf (4 pages)
- 23-132.3.1 - FPC Committee Assurance Report 281123 Final.pdf (6 pages)
- 23-132.3.2 - App 1 FPC Terms of Reference.pdf (7 pages)

23/132.4
Integrated Audit & Governance Committee (IAGC) - Chair Assurance Report (2.55 pm to 3.05)

Approval *Chair IAGC - Dr Olu Olasode*

- 23-132.4.1 - IAGC Chair Assurance Report to Dec BoD 07.11.23 DRAFT V1.pdf (6 pages)
- 23-132.4.2 - App 1 EPRR Report Nov 23.pdf (11 pages)
- 23-132.4.3 - App 2 Risk Management Policy v2.2.pdf (32 pages)
- 23-132.4.4 - App 3 Risk Management Strategy 2023-2025.pdf (12 pages)
- 23-132.4.2.1 - IAGC Board report 28.11.23.pdf (1 pages)

23/132.5
Charitable Funds Committee (CFC) - Chair Assurance Report (3.05 pm to 3.10 pm)

Approval *Chair CFC - Claudia Sykes*

- **East Kent Hospitals Charity Annual Accounts and Report 2022/23**

- 23-132.5.1 - CFC Board report 07.12.23.pdf (2 pages)
- 23-132.5.2 - App 1 Charity Annual Accounts Report 2022-23.pdf (51 pages)
- 23-132.5.3- App 2 Letter of representation 2022-23.pdf (4 pages)
- 23-132.5.4 - App 3 Audit findings report 2022-23.pdf (12 pages)

03:05 PM - 03:15 PM
10 min

TEA/COFFEE BREAK 3:05 - 3:15

Patients - Quality and Safety - People

03:15 PM - 03:20 PM
5 min

23/133
Chief Nursing and Midwifery Officer's (CNMO) Report

To Note *CNMO*

Verbal

03:20 PM - 03:35 PM
15 min

23/134
Maternity Incentive Scheme Year 5 Submissions

Approval *CNMO / Deputy Director of Midwifery (DDoM)*

- Maternity Dashboard
- Perinatal Quality Surveillance Tool (PQST)
- Midwifery Workforce
- Obstetric Workforce
- Care Quality Commission (CQC) Update
- Maternity and Neonatal Improvement Programme (MNIP)
- Clinical Negligence Scheme for Trusts (CNST)
- Training Update
- Avoiding Term Admissions into Neonatal Units (ATAIN) Report

23-134.1 - BoD Maternity Overarching Report November 23 (003).pdf (5 pages)

03:35 PM - 03:45 PM
10 min

23/135
Serious Incidents and Safe Nursing Staffing:

CNMO

23/135.1
Serious Incident (SI) Report

Assurance *CNMO*

23-135.1.1 - Serious Incidents Report BoD 07.12.23.pdf (2 pages)
23-135.1.2 - Appendix 1 Serious Incidents Report.pdf (12 pages)

23/135.2
Safer Nursing Staffing

Assurance *CNMO*

23-135.2.1 - Board Safer Staffing Front sheet Oct 2023.pdf (5 pages)
23-135.2.2 - App 1 Safer Staffing Report October 2023 final.pdf (13 pages)

03:45 PM - 03:55 PM
10 min

23/136
Chief Medical Officer's (CMO's) Report:

23/136.1
Research and Innovation (R&I) Update

Information *Interim Chief Medical Officer (CMO) / Director of R&I*

23-136.1 - Board Dec 23 Research Innovation.pdf (7 pages)

Partnerships - Sustainability

03:55 PM - 04:05 PM
10 min

23/137
Winter Plan 2023/24

Assurance *Interim Chief Operating Officer (COO) (Urgent and Emergency Care (UEC))*

23-137.1 - Winter Plan Board 301123.pdf (4 pages)
23-137.2 - App 1 Tier 1 Winter update Board 301123.pdf (11 pages)

CLOSING MATTERS

04:05 PM - 04:10 PM
5 min

23/138
Any Other Business

Discussion *All*

Verbal

04:10 PM - 04:25 PM
15 min

23/139
Questions from the Public

Discussion *All*

Verbal

Date of Next Meeting: Thursday 1 February 2024

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM NOVEMBER 2023

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

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM NOVEMBER 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)
GLENN, TIM	Interim Chief Finance Officer	To be confirmed	6 November 2023
GOODGER, NIC	Interim Chief Medical Officer	Surgeon, Chaucer Hospital **(5)**	7 August 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM NOVEMBER 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
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)
STEVENS, BEN	Chief Strategy and Partnerships Officer	None	1 June 2023 (substantive) (20 March 2023 interim)
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

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM NOVEMBER 2023

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY FOURTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 2 NOVEMBER 2023 AT 1.00 PM HELD AS A WEBEX TELECONFERENCE

PRESENT:

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

ATTENDEES:

Ms S Cotter	Deputy COO (Unplanned Care) (UC)) (minute number 23/116)	SC
Ms M Cudjoe	Director of Midwifery (DoM) (minute number 23/112)	MC
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Professor C Holland	Associate NED/Dean, Kent & Medway Medical School (KMMS)	CH
Mr A Littlefield	Lead for Patient Voice and Involvement (PV&I) (minute number 23/108)	AL
Ms T Phillips	Patient Story (minute number 23/108)	TP
Ms A Smith	Deputy DoM (minute number 23/112)	AS
Mr M Wood	Interim Group Company Secretary (GCS)	MW
Ms Z Woodward	Associate Medical Director (MD) for Women's Health (WH) (minute number 23/112)	ZW
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Mr T Cook	Special Adviser to the Chairman and Deputy GCS	TC
Miss S Robson	Board Support Secretary (Minutes)	SR
Ms J Smith	Good Governance Institute (GGI)	JS

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mr D Esson	Kent Online
Ms C Heggie	Member of the Public
Mr C Holmes	Member of the Public
Ms M Hope	Member of the Public
Dr Kaushika	Member of the Public
Ms A Moore	Health Service Journal
Mr D Richford	Member of the Public
Mr M Taylor	Member of the Public
Mr T Vellender	Member of the Public
Mrs M Warburton	Member of the Public

MINUTE NO.		ACTION
23/103	**VICE-CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE** The Vice-Chairman opened the meeting, welcomed everyone present, and noted the intention for Board members to meet in person in future, notwithstanding storm weather conditions which had necessitated holding the meeting virtually. Apologies for absence received from Mr N Dickson (ND), Chairman; Mr S Corben (SC), NED/2gether Support Solutions (2gether) NED In-Common; and Ms J Dickson (JD), Interim Chief Operating Officer (COO) (Urgent and Emergency Care (UEC)). The Vice-Chairman thanked all Trust staff for their continued hard work and support overnight and that morning in managing the impact of the storm and ensuring continued provision of safe healthcare services to the East Kent population. The Vice-Chairman stated at the end of the meeting when inviting questions from the public, he would take written questions via the Question and Answer function. The Vice-Chairman reported Closed Board meetings had been held to discuss the Trust's financial position, financial challenges, financial performance and how improvements could be achieved.	
23/104	**CONFIRMATION OF QUORACY** The Vice-Chairman **NOTED** and confirmed the meeting was quorate.	
23/105	**DECLARATION OF INTERESTS** There were no new interests declared.	
23/106	**MINUTES OF THE PREVIOUS MEETING HELD ON 5 OCTOBER 2023** **DECISION:** The Board of Directors **APPROVED** the minutes of the previous meeting held on 5 October 2023 as an accurate record.	
23/107	**MATTERS ARISING FROM THE MINUTES ON 5 OCTOBER 2023** **B/17/23 – Patient pathways** The Vice-Chairman noted this action was covered within the 2023/24 Winter Plan presented at this meeting. It was **AGREED** to close this action. **B/23/23 – Lone working** The CNMO confirmed discussions taken place with Kent Community Health NHS Foundation Trust (KCHFT), this had generated wider conversations in respect of lone staff working, to be monitored at meetings of the appropriate groups. It was **AGREED** to close this action. **B/26/23 – Safeguarding Training Compliance** The CNMO reported Trust's target of 85% compliance, adults safeguarding training for level 3 at 70%, level 2 at 84%, and children safeguarding training at 83% for level 2 and 87% for level 3, 32 members of staff had received training the previous week commencing 30 October 2023. Training compliance would continue to be monitored by the Safeguarding Committee. It was **AGREED** to close this action.	

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

23/108 **PATIENT STORY**

The Lead for PV&I introduced the patient story about communication between staff and patients. The importance of providing medication and pain relief in a timely fashion was highlighted as part of compassionate care. The negative and positive experiences of a patient with pre-existing mental health and long-term conditions (LTC) were duly noted as points of learning.

The Vice-Chairman thanked the Patient for sharing their experience and apologised for shortcomings experienced in their care, which was reinforced by the CE.

NEDs requested assurance that the Trust would learn from this patient experience, requesting a review of the clinical skills and competence of staff, recognising the demand and pressure on staff and services and the upcoming busy winter period. The Interim CMO reported that an in-depth review of this case would be conducted in liaison with the Lead for PV&I, and the CNMO.

ACTION: Update to be provided to the Board following a review of the Patient Story. — Interim CMO/ CNMO

The Board of Directors **NOTED** the Patient Story, and commitment from Board to ward to:

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

23/109 **VICE-CHAIRMAN'S REPORT**

The Vice-Chairman highlighted the following key elements:

- the Trust's considerable financial challenges and the agreed plan to address the situation. It was commented that the Trust was unlikely to achieve its plan by year-end. An Interim CFO would be joining the Trust from 6 November 2023, to focus on Trust's long-term financial sustainability plan;
- there had been evidence of some positive impact of financial controls being in place, with the September run rate being at its lowest for current financial year. It was important that this position continued to be maintained during the winter period;
- continued unprecedented demand of patients accessing EDs and ambulances. Patient flow through the hospitals was a major area of focus and needed to be improved;
- significant progress continued to be maintained in respect of maternity service improvements around safety metrics, although it was recognised that much more work was still required, including regaining the confidence of patients and families. Learning was a key element of daily staff huddles and bi-monthly staff Safety Summits.

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

23/110 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported the following developments:

- PRISM was working with the Trust, currently focused at QEQM looking at how inpatient flow could be improved, management of patient pathways and reducing delays;
- KPMG were supporting Trust at WHH around the implementation and integration of the SAFER principles, reducing number of long stay patients and increasing number of complex discharges;
- local Kent & Medway (K&M) Provider Collaboratives were being developed which would bring together all K&M providers working collaboratively on design, delivery of care and services, and driving forward improvements to benefit the local population (e.g. K&M Pathology ensuring efficient use of provision of these services);
- the Health Care Partnership (HCP) Provider Collaborative was working closely with KCHFT, Kent County Council (KCC) Social Care Services in managing urgent and emergency pathways as a system supporting patients in hospital and the community, and how best to provide services to meet their needs;
- Dr Des Holden had been appointed as substantive CMO, anticipated to join the Trust at the end of the year.

The NEDs highlighted the importance of relationship building to address operational pressures and working together to make improvements. The CE stated the HCP Provider Collaborative would continue to build upon system relationships and commitment developed in East Kent HCP, working collectively and holding each other to account on the delivery of identified improvements.

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

23/111 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/111.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair highlighted the following key points:

- Approval of appointments of CMO and Director of Corporate Governance;
- Approval of interim COO arrangements;
- Approval of recruitment process to appoint a substantive COO before the end of the Financial Year (FY).

The Board of Directors **NOTED** the 10 October 2023 NRC Chair Assurance Report.

23/111.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted the following key points:

- 13 serious incidents (SIs) declared in September 2023 with deep dives carried out into themes. Positive feedback received from Integrated Care

Board (ICB) on the Trust's management of SIs following changes implemented;
- Continued focus and assurance in respect of Infection Prevention and Control (IPC) management and reducing infections. Clostridioides difficile (C-diff) remained a challenge, above threshold, a local and national challenge for trusts to meet due to high trajectory set. Reasonable assurance of mitigating steps in place, that included antibiotic stewardship;
- Stable mortality position, robust focus reviewing mortality, a gap in engagement with Structured Judgement Review (SJR) process in some specialties that the Interim CMO would be addressing;
- Disappointing compliance position against PRactical Obstetric Multi-Professional Training (PROMPT) anaesthetic staff, dropped to 80% for Consultants. With continued focus ensuring working towards achieving Clinical Negligence Scheme for Trusts (CNST) 90% threshold;
- Assurance of wide range of mitigating actions to address endoscopy capacity, recognising there remained significant waiting list challenges, and progress would continue to be monitored;
- Theatre utilisation key to improving patient outcomes and experience. The Committee recognised work already progressed with additional PRISM support, but more was still needed to ensure improved and sustained productivity.

The Board of Directors **NOTED** the 24 October Q&SC Chair Assurance Report.

23/111.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair made a verbal report on the meeting held on 31 October 2023 (written to be presented to the next BoD meeting), highlighting the following key points:

- Cost Improvement Programme (CIP) for month 6 (M6) achieved £200k savings against the planned £3.9m, further savings schemes being worked up. It was unlikely that the Trust would achieve its forecast £40m CIP target by Year-End (YE);
- Patients no longer fit to reside, 199 in September, marginal increase from previous month at 193. Increased number of patients with 21 days stay, 245 in September, from 241 previous month. Actions in place to address, reduce and improve these numbers, further supported by PRISM inpatient flow improvement work;
- M6 financial position Group deficit of £9m against planned £5m deficit, year to date (YTD) Group deficit £59.3m, with adverse variance of £18.4m, against the planned position of £40.9m. Due to financial challenges, CIP underperformance, the planned YE deficit of £72m would not be achieved. The Trust was currently in the process of producing a revised forecast position. Additional working capital funding secured of £15m;
- Business case presented following approval through the appropriate governance structure, Outsource of Managed Agency Provision to a Managed Service Supplier. This would increase efficiency, streamline supply and rates, and release financial savings;
- Concern about performance and increased number of patients waiting for cancer services longer than 62 days and 104 days, along with increased breaches in Referral to Treatment (RTT) waiting times of 52 weeks and 65

weeks. Action plans to improve performance were discussed that were expected to have an impact to reduce the numbers.

The Board of Directors **NOTED** the 31 October 2023 verbal FPC Chair Assurance Report.

23/111.4 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair highlighted the following key points:

- Good work of Trust's staff wellbeing team, presentation for consideration of application for grants, due to technical areas that needed further work this were not approved. CFC committed to working with the team to support staff wellbeing initiatives;
- Following review to streamline CFC membership, Terms of Reference had been amended, proposed only include two NEDs, and two Executive Directors (CFO and CSPO), revised version presented for BoD approval.

DECISION: The Board of Directors:

- **NOTED** the 3 October 2023 CFC Chair Assurance Report;
- **APPROVED** the CFC revised ToR.

23/112 **MATERNITY INCENTIVE SCHEME YEAR 5 SUBMISSIONS**

The DoM reported on the following key matters:

- Seven Clinical Negligence Scheme for Trusts (CNST) reports, discussed in detail at Maternity and Neonatal Assurance Group (MNAG) and Q&SC;
- Perinatal Mortality Review Tool (PMRT): Quality assurance of reviews, independent external practitioner review, identification of appropriate care and outcome would not have been different, learning shared with teams;
- Avoiding Term Admissions into Neonatal Unit (ATAIN): Multi-disciplinary team (MDT) reviews of neonatal unit term baby admissions, development of an action plan. Both units performing in line/above national average, WHH 3.4% and QEQM 4.5%, national average of 4.4%. Performance also reviewed by the Local Maternity and Neonatal System (LMNS);
- Obstetric Medical Workforce review including management of locums, induction programme, and attendance of Consultants for specific situations;
- Saving Babies Lives Care Bundle (SBLCB): on track to fully implement all elements of tool by March 2024 with key milestones ahead of this. Compliance locally reviewed and also by ICB, expectation to be able to provide full assurance in December 2023;
- Perinatal Quality Surveillance Tool (PQST): the Trust continued to be an outlier of non-compliance for PROMPT anaesthetic staff training, impacted by industrial action, standards had been amended to 80%. Now being achieved for Consultants, needed to improve compliance for trainees, meetings with team to discuss gaps and action to be taken to achieve compliance;
- Friends and Family Test (FFT): decline in uptake due to a coding issue that had been resolved, more than 90% of women using the service were happy with their care, continued work with Maternity and Neonatal Voices Partnership (MNVP) in respect of listening to women and families and utilising feedback received to take forward quality improvements;

- SIs: Four SIs in Quarter 2, one met criteria and referral to the Healthcare Safety Branch (HSIB);
- Trust compliant with Duty of Candour (DoC) and Root Cause Analysis;
- Care Quality Commission (CQC) update on must and should do recommendations: Two recommendations currently off track, revised trajectory and actions to achieve the 90% compliance by the end of November 2023 in respect of safeguarding training, 86% at end of October. Weekly meetings held with CNMO, DoM and Estates team to discuss and prioritise estate and minor works, to ensure traction to progress these works. Recognition these were not at the required pace and would continue to be raised and discussed with Estates about expediating these promptly. WHH Midwifery Led Unit (MLU) due to be completed by end of November.

ACTION: Provide a progress update on implementation of the estate and minor work elements of the CQC must and should do recommendations, and any additional support required to ensure these works were expediated at pace. CNMO

The Vice-Chairman asked about any current key areas of concern. The DoM reported staffing remained key issue and challenge particularly at WHH, contingency in place utilising agency staff, and continuing to support the team during the current resource gap whilst awaiting the student midwives to qualify, noting internationally educated midwives (IEM) in place.

The Vice-Chairman commented that the quality metrics were moving in the right direction, seeing improvements, although there had been an increase in complaints received. The DoM stated October's complaint peak related to capacity in respect of delays with ultrasound scans, which had now been addressed. A behavioural charter had been launched around role models of good behaviour and challenging poor behaviour. Themes from complaints and patient stories were informing lessons learnt training for staff.

The NEDs enquired about forward forecast activity and toolkit availability to predict future demand and staffing resources required. Assurance was also sought in relation to any potential issue that would impact PQST compliance not being met for the reporting year. The DoM reported on training for the period December 2022 to December 2023, and the potential challenge area around 1:1 care in labour, supernumery status of co-ordinators and staffing issues, due to high standard to be met. Maternity data to be reviewed for forecasting, looking at number of births and bookings to identify peaks in activity and staff resourcing needs, aligning with management of annual leave and training. Review also of Birthrate Plus, midwifery workforce methodology prediction tool, to analyse staffing requirements looking at numbers, acuity of patients, increased women over the age of 40 with co-morbidity and complex conditions, demographics, deprivation and ethnicity. To identify any areas requiring targeted care, expected to be available by the end of the year. The CSPO commented the Trust had access to longer term forecasting of birth rate projections to plan the provision of services for longer term planning.

The *Reading the Signals* Oversight Group Chair noted an update from the Group and families, one year on from Dr Kirkup Report, commenting on feedback on progress of the Group and evidence provided at meetings. There was recognition of the significant progress made in maternity services and from the leadership of the DoM and Deputy DoM, and the hard work from the teams. More work still needed to be done, including providing evidence showing impact from MDT working, and having consistent compassionate care and positive behaviours across

sites. Meetings would continue to be held over the next 12 months, thanks being extended to families who remained involved and engaged with the Group.

The *Reading the Signals* Oversight Group Chair highlighted a recent Houses of Parliament debate on birth trauma in maternity services, with very powerful and moving speeches, and encouraged Board members to review this. It was noted that an average of 5% (30,000) women experienced birth trauma annually. The DoM agreed to provide a future update for the Board on actions to support women who experienced birth trauma, including work being done around provision of trauma informed care, recognising women with mental health conditions and specific support and needs for them.

ACTION: Provide an update on the actions to support women who experienced birth trauma, provision of trauma informed care, and specific support requirements in maternity care for women with mental health conditions. — CNMO

The CE enquired about MDT work progress and whether this was working well. The WH Associate MD confirmed a great deal of MDT working, which was critical to progressing improvement work, but that this was not always visible, and it had been discussed with the Interim CMO about how this could be better communicated. Workforce continued to remain a challenge, recruitment to consultant vacancies impacted due to the geography and Dr Kirkup Report, particularly difficult to recruit at QEQM.

The Board of Directors:

- **NOTED** the Maternity Incentive Scheme Year 5 Submissions - Summary of Maternity Papers report;
- **NOTED** Safety Action 1: PMRT Q2 2023/24 report, received assurance demonstrating compliance with CNST for four areas of evidential requirement;
- **NOTED** Safety Action 3: ATAIN Q2 2023/24 report, received assurance on the admission rate and reasons for admission, mainly due to respiratory causes, team would be undertaking a deep dive into these cases;
- **NOTED** Safety Action 4: Obstetric Medical Workforce report, received assurance;
- **NOTED** Safety Action 6: SBLCB report, received assurance and the ongoing work to achieve implementation of all elements;
- **NOTED** Safety Action 9: PQST report and decline in PROMPT anaesthetic training compliance;
- **NOTED** update on SI cases;
- **NOTED** CQC update on must and should do recommendations.

23/113 **SAFE NURSING STAFFING**

The CNMO highlighted the following key matters:

- Assurance to the Board of Trust's safe staffing position, report would be further developed to include data around red flags (any concerns raised about staffing levels in specific areas and triangulation against harm);
- Showed appropriate fill rates of staffing, where this was above 100% staff moved to cover escalation areas that were not funded against an established budget, and also enhanced or 1:1 care. A review of the ward

establishment was currently being undertaken along with enhanced care bringing this care within the Trust's overall establishment;
- Neonatal unit staffing remained a challenge, as with other trusts, where there was difficulty in recruiting Qualified in Specialty (QIS) neonatal nurses. The Trust was looking at a plan to address this position in close working with the system.

The Vice-Chairman asked how the Trust measured and ensured it had the right staff (appropriately qualified and skilled) in the right place when needed, and how it managed overall staffing needs. The CNMO provided assurance around a complex ratio tool managing numbers of registered and unregistered nurses In respect of acuity and dependency needs of patients. The Trust also utilised a Safe Care tool that staff inputted at midnight, reviewed and professional judgement taken on the staffing requirements to meet the needs patients in real time. National set nursing to patient ratios were being adhered to. There was a focus on incidents of harm and pressure ulcers (PUs) which were included in the Integrated Performance Report, to which falls data would be added. It was noted that incidents of harm were relatively low and these were reported to Q&SC along with the Fundamentals of Care work.

The NEDs enquired about the process for authorisation of agency staff requests by the Heads of Nursing, its management and whether this was working robustly to ensure no unauthorised agency shifts. The CNMO stated that she (or her deputy) chaired a Key Performance Indicator (KPI) meeting with each Care Group, looking at staffing data in detail.

The Board of Directors received assurance and **NOTED** the content of the Safer Nursing Staffing report, including mitigations that were in place, and progress being made in relation to the recruitment pipeline.

23/114 **CHIEF MEDICAL OFFICER'S (CMO's) REPORT:**

23/114.1 **LEARNING FROM DEATHS (LfD)**

The Interim CMO reported on the following matters:

- Continued fall in Hospital Standardised Mortality Ratio (HSMR), remained lower than expected which had been the case for the whole of the current FY;
- Summary Hospital-level Mortality Index (SHMI) ratio remained as expected, a review to be undertaken later in the year;
- Assurance of mortality investigation process: all hospital deaths and currently approximately 70% of community deaths were scrutinised by the Medical Examiner service. If there were any concerns about care or death these were reported for review by the Serious Incident (SI) Declaration Panel, appropriate SI investigation undertaken, and Structured Judgement Review (SJR) if required, to ensure any themes or lessons learnt and the implementation of any necessary actions. It was noted that the Trust's Mortality Lead Clinician liaised with Care Group Mortality and Morbidity (M&M) Speciality Leads to ensure these processes were fully embedded.

The NEDs enquired whether HSMR was reviewed in detail in respect of sub-speciality diagnostic groupings to identify whether anything had been missed. The Interim CMO confirmed the M&M Steering Group undertook detailed reviews around themes and variances to identify any deep dives required to be carried out.

The Board of Directors reviewed and **NOTED** the contents of the LfD report.

23/114.2 **STATEMENT OF COMPLIANCE (SoC)**

The Interim CMO highlighted the following developments:

- Actions and progress delivering recommendations from Higher Level Responsible Officer (HLRO) visit in 2022, and annual requirement of Framework of Quality Assurance for Responsible Officers (ROs) and Revalidation;
- RO Assurance Group introduced to ensure review and implementation of all revalidation recommendations; robust appraisal process followed to ensure that all Trust doctors were up to date with GMC requirements;
- Appraisal and Revalidation Policy updated to be presented for discussion and approval by the Local Negotiating Committee;
- More senior appraisers being identified to support the Trust's Appraisal Lead, in overseeing appraisals to ensure these were of an appropriate and quality level, it was anticipated an update would be available towards the end of the financial year.

ACTION: Provide an update on progress to identify additional senior appraisers, to ensure the Trust's Appraisal Lead was sufficiently supported and that assurance was provided in overseeing appraisals. — Interim CMO

NHSE's Improvement Director enquired about the processes for sharing any concerns with private providers. The Interim CMO confirmed a Private Provider Group was in place with engagement from the Trust and private providers for the sharing of any concerns.

DECISION: The Board of Directors reviewed and **APPROVED** the Statement of Compliance report and for this to be returned to the HLRO.

23/115 **INFECTION PREVENTION AND CONTROL (IPC) QUARTERLY REPORT**

The Deputy DIPC highlighted the following points:

- C-diff cases were above threshold with focus on antimicrobial stewardship to address this. The Trust was not an outlier as this was a challenging target and nationally was difficult for all organisations to achieve;
- Good progress had been achieved in reducing the number of avoidable healthcare associated Gram-negative bloodstream infections and maintaining these below the threshold;
- Good surveillance in place for surgical site infections, operating theatres deep cleaned, weekly meetings in place along with audits, gap analysis undertaken against the National Institute for Health and Care Excellence (NICE) to further reduce these;
- IPC Board Assurance Framework (BAF) providing assurance on progress of compliance, currently at 60% compliance (high level) with ongoing work and actions to achieve the remaining 40% (at local level).

The Vice-Chairman sought assurance that the Trust was getting the basics right in respect of cleanliness and maintenance against IPC guidelines. The Deputy DIPC commented on the Trust's current 'back to basics' campaign to remind staff of IPC protocols and ensuring that processes were in place around risk assessments,

cleaning audit standards, and estates condition considerations. It was reported that the CNMO was working closely with 2gether Support Solutions Managing Director and the Deputy DIPC in respect of estate works, cleaning standards, and decluttering. It was noted this review was expected to be completed within two months, an assurance report on the outcome and feedback would be presented to the IPC Committee who reported into the Q&SC.

The Board of Directors discussed and **NOTED** the IPC quarterly report.

23/116 **WINTER PLAN 2023/24**

The Deputy COO for Unplanned Care (UC) highlighted the following key points:

- The Plan provided a position statement on collaborative working with ICB, HCP and system partners, in order to deliver the plan against the current unmitigated gap of -185 beds (risk to the Trust that would reduce provision of corridor care). Last year's bed gap was around -39 with corridor care of around 80 patients at height of demand. Capacity and demand modelling within plan, how the winter funding had been utilised, uplift from base level bed position of 1040 core open beds to a projected uplift of 1283;
- Plan to be presented for discussion at East Kent UEC Board meeting week commencing 6 November;
- A great deal of stress testing carried out with much more work to be done to reduce the bed gap and corridor care risks;
- Schemes supporting patient safety in urgent care pathways across all services and supporting EDs to be implemented.

The CSPO provided assurance of focus to ensure limited impact from the Plan on the Trust's planned elective activity.

The NEDs enquired about the timeframe to eliminate corridor care. The Deputy COO for UC stated more work was still needed, in addition to that already done to support patients at the front door, in assessment areas and Clinical Decision Units (CDUs) to be moved to beds and onward transfer to wards as quickly as possible. The work with PRISM and KPMG on the SAFER initiative would improve patient flow through the hospitals, more efficient management of bed capacity, as well as working with the community on the provision of more domiciliary care. The trajectory work on the schemes would provide assurance around timelines to reduce corridor care.

The CE emphasised that the Trust would continue to be challenged and pressured to meet demand due to the current bed gap, noting the good progress and work around out of hospital care, community services, care home beds and domiciliary support, and system working with KCC and KCHFT.

The NEDs highlighted the plan presented did not provide assurance, and requested a short update report on the specific work to address the additional requirements over the winter period to meet demand; including the cost impact and timelines for when the various schemes would be implemented.

The NEDs stated the FPC had discussed the financial implications associated with the plan, and a report with costings had been agreed to be presented at the next meeting. It was highlighted that the Trust needed to know its own position outside that of the system, in respect of having its own contingency plan and protecting its elective activity. The Deputy COO for UC reiterated the utilisation of winter funding

as detailed in the plan, and this was required to be aligned against discharge. Current Trust local winter and escalation plans were being reviewed and refreshed to align with the revised Operational Pressures Escalation Levels (OPEL) framework, that would provide performance comparison with other local trusts. The CE commented that winter funding was portioned to the EK system as a whole and disseminated where needed, and that winter schemes were required to have a discharge element within them.

ACTION: Provide a short update report by the December Board meeting, to include a focused summary detailing the specific work and actions of the winter support schemes with a timeline when these would be implemented, to include a breakdown of how the winter funding had been utilised, and a summary of the refreshed Trust's winter and escalation plans (aligned to the revised Operational Pressures Escalation Levels (OPEL) framework). Liaise outside the Board meeting, discuss and identify the content of a weekly short Winter Plan briefing to be circulated to Board members.

CE/ Interim COO (UEC)/ Deputy COO for Unplanned Care

The Vice-Chairman reported it was important for patient safety, care and experience to significantly reduce the hours patients were waiting on trolleys, before being promptly transferred to beds. It was proposed that a short weekly briefing be circulated to Board members with key bullet points around the current position (corridor patient care numbers, mitigating risks of demand, progress and position in protecting elective care activity, and whether the winter plan was on track).

The Vice-Chairman raised staff wellbeing and the need to support staff during the winter period in managing demand. He enquired about local and national public communications advising patients about accessing the right care to meet their needs during the busy winter period. The CPO confirmed wellbeing and mental health support was in place for staff, including access to the Health and Wellbeing team, staff rest rooms, and other support mechanisms (including external support). It was important that staff rosters were robustly managed ensuring staff received appropriate breaks and rest periods.

The CNMO reported on a review that was currently being undertaken of the ED ward establishment to ensure appropriate staff resources were in place. It was noted the commitment of the Executive Directors to do all they could to support front line staff in managing demand and pressures during the winter period. The EDC&E commented working with system partners to align local and national public communications on how and where to access care to meet individual patient needs (e.g. pharmacy services, NHS 111) to reduce demand on EDs, recognising patients sometimes unable to access GP services attend EDs.

The Board of Directors **NOTED** the 2023/24 Winter Plan, the work in progress, risks and proposed schemes.

23/117 **INTEGRATED PERFORMANCE REPORT (IPR)**

The CSPO reported on the following matters:

Operational Performance

- Trust remained challenged against operational performance metrics for elective and emergency care;

- Performance in EDs had deteriorated in last two months for type 1 and all types, in line with increased demand levels nationally. Last two weeks of September had seen an increase in type 1 walk-in attendance numbers as well as ambulance conveyances. Slight improvement in ambulance handovers standard performance for 15 and 30 minutes;
- Elective activity for cancer, diagnostics and Referral to Treatment (RTT) pathways were also challenged. Specific area of concern remained in endoscopy, actions in place to increase capacity and reduce waiting times, with provision of a temporary unit on a Trust site currently being progressed;
- Work to refresh and reforecast the elective YE activity position, currently being finalised with Care Group action plans to achieve activity improvements and an update would be reported to a future Board meeting;
- Planning for 2024/25 in progress with initial draft demand and capacity modelling activity plans for each specialty. Executive Director and Care Group challenge sessions would be commencing 6 November.

The Vice-Chairman raised concern about the increase in patients waiting longer for cancer diagnostics and treatment, the impact of this for patient outcomes and experience. The CSPO stated that current backlog patients waiting longer than 62 days in September was 519, due to diagnostic and tertiary cancer pathway delays as well as patient choice. There had been a change in cancer standard from 2 week wait to a focus on cancer 28 day faster diagnosis for patients to receive a diagnosis of cancer or not. Trust currently behind 75% target with improvement actions including the diagnostic pathway, to achieve by end of March 2024 no more than 224 patients waiting longer than 62 days, current position 58% with a projected monthly 5% increase. It was recognised the patient impact due to these delays and complaints received about elective delays, recognising breast and skin specialities were achieving above the 75% target and lessons learnt to be disseminated across the other specialities. Support from ICB and providers in accessing local capacity that were not as challenged as the Trust.

It was noted that provision of additional funding from the Cancer Alliance to support cancer pathway improvements had been forthcoming. The Vice-Chairman emphasised it was important to accelerate improvements in cancer performance and to consider what more could be done and prioritised to support this.

The NEDs commented on the Culture and Leadership Programme (CLP) work and the initial feedback which had been raised highlighting issues with the theatre opportunity work and progress. In respect of IPR metrics and assurance, no areas were showing as a significant outliers. The CSPO stated the improvement work with PRISM would focus on reviewing theatre productivity and the efficient use of the estate, which included looking at CLP and improving the surgical pathway. The CPO commented staff feedback with concerns about CLP in theatres was being addressed with the theatre leadership to support changes and improvements.

The NEDs highlighted areas of good performance and achievement of target standards throughout the Trust that the Board needed to acknowledge and include within future reports.

ACTION: Consider including in future IPR reports a brief summary highlighting areas of good performance and areas achieving target standards. CSPO

Quality and Safety

The CNMO highlighted the following points:

- Continued good performance in SI response times and Duty of Candour (DoC) compliance. Review of SI process as not achieving timely closure of SIs, ongoing work with Care Groups to ensure prompter closure;
- Good performance against safeguarding metrics, following review of the number of open and overdue section 42s a trajectory set to close these within the next month;
- Reduction in the number of PUs.

The NEDs commented on a gap in the report not providing a general update on complaints received, themes, and actions taken following patient feedback about how they were spoken to, treated, and compassionate care. The CNMO confirmed this had already been raised and discussed, and such information would be included in future reports. It was noted that an annual complaints report would be presented to Q&SC, and that the Patient Advice and Liaison Service (PALS) report would be presented at the December 2023 Board meeting It was important Care Groups monitored complaints and reviewed and understood emerging themes.

People

The CPO reported as follows:

- There had been a steady increase in appraisal rates, but not at the level required, HR Business Partners were working with Care Groups to further improve at a faster pace, as well as undertake quality spot checks of appraisals;
- Increased sickness absence was of concern at 5.1%, The P&C Team, Occupational Health and leadership teams were working together to ensure earlier interventions in supporting staff to return to work and ensuring return to work interviews were held;
- National Staff Survey (NSS) would close on 24 November with ongoing communications encouraging staff to engage and complete this.

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

23/117.1 **MONTH 6 FINANCE REPORT**

The Interim CFO reported as follows:

- Slowed run rate in M6 by the value of controls put in place at M4 and M5, slowing to a £9m deficit and that this needed to be a breakeven position, significantly more work was needed with further controls to improve this. Noting whilst ensuring continued quality and safety of patient care;
- Current position £59.3m against £40.9m plan, deficit £18.4m of which £2.6m due to underfunding of pay awards for medical and Agenda for Change (A4C) staff with ongoing discussions with ICB about the provision of funding, £1.5m cost impact from junior doctors and consultants strike action;
- Cost Improvement Programme (CIP) pipeline currently £14.9m against the £40m target, delivery of less than £1m monthly recurrent basis. The additional finance resources would focus on achieving efficiencies in current FY and forward looking to achieve breakeven position in future years;
- Controls continued to be embedded, significant reduction in staff utilisation of 167 in month, as well as a reduction in non-pay costs;

- Elective Recovery Funding (ERF), due to under delivery against elective activity risk of circa £3.9m income not being received;
- £18.2m cash received in Q3 to support the Trust's deficit with a further additional cash of £15.3m in Q4.

The Board of Directors **NOTED** the Month 6 Finance Report, financial performance and actions being taken to address issues of concern.

23/118 **JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) - INTEGRATED IMPROVEMENT PLAN (IIP) UPDATE**

The CSPO reported:

- Key red rated areas of risk to delivery remained within Finance and Operational Performance programmes;
- Leadership and Governance (L&G) rated green, three programme areas remained rated amber, and good progress in Quality & Safety (Q&S), Maternity, and People & Culture.

NHSE's Improvement Director reported on progress to move out of Phase 1 (setting a sustainable improvement programme) and into Phase 2, that would show impact and outcome of improvements and evidence to meet the exit criteria requirements. This would identify areas on track, those that needed more focus, and if any additional external support required to move from NOF4 to NOF3.

NEDs emphasised the need to keep the summary and assurance update at a strategic level, noting progress against achieving the objectives. NHSE's Improvement Director noted IIP Phase 2 would be around monitoring progress to achieve the exit criteria. It was noted that the Improvement Director would be working with the Senior Responsible Officers (SROs) (Executive Director leads) to ensure the right areas were being focussed on. The CSPO stated the report would be reviewed to ensure it included the appropriate level of content providing the necessary assurance to the Board.

NEDs raised the limited period until the end of the FY, enquiring as to the feasibility of achieving exit criteria within the remaining short timeframe, and what this meant to the Trust if not met. The CE acknowledged the challenges in progressing improvements in Finance and Operational Performance, whilst recognising the successful improvements in Maternity, Q&S, and L&G. It was commented that discussions would be held at RSP meetings in respect of red area improvements, and the need for greater focus and support to progress these. NHSE's Improvement Director stated that quarterly review meetings were being held with the National team to discuss progress and trajectory dates.

The Vice-Chairman emphasised the current gaps in substantive organisational leadership, and thanked staff who stepped up to cover roles in the interim.

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

23/119 **SEXUAL SAFETY IN HEALTHCARE – ORGANISATIONAL CHARTER**

The CPO reported that NHSE had launched its first ever sexual safety charter which the Trust had signed up to pledging to implement the ten Charter commitments by July 2024. It was reported that the Lead Freedom to Speak Up

(FTSU) Guardian would continue to hold staff webinars about each of the commitments, undertake gap analysis, identify work required and provide an action plan to progress implementation of these, expected to conclude in the next couple of weeks. The Trust was engaging at a national level and the CPO would be leading a National Group looking at domestic abuse and sexual violence. The Trust had in place a Domestic Abuse Policy, along with Safeguarding policies.

NEDs requested a further update be presented to the Board following completion of the gap analysis, production of the action plan, and the work needed to implement the ten commitments. This would enable the Board to monitor progress and provide any necessary support to ensure implementation.

ACTION: Present an update to the Board on progress monitoring the gap analysis, action plan, work needed and any additional support to enable implementation of the ten Charter commitments. — CPO

The Board of Directors **NOTED** the contents of the Sexual Safety in Healthcare – Organisational Charter paper and **SUPPORTED** the Trust in executing the ten commitments by July 2024.

23/120 **ANY OTHER BUSINESS**

There were no other items of business raised.

23/121 **QUESTIONS FROM THE PUBLIC**

Q1: A question was raised in respect of workforce resources for nursing, Allied Health Professionals (AHPs) and midwives had been an issue for the Trust, impacting various services and finances, and whether the Trust would be continuing international recruitment for the next year?

In response, the CNMO stated that the Trust over the last two years had substantially recruited staff growing its nursing and AHP workforce. Internationally-educated Midwives had been recruited who were now commencing with the Trust. Staff vacancies would continue to be monitored and reviewed. It was noted in line with other trusts, East Kent Hospitals had not signed up to a wider international recruitment over the next year, and applications from international applicants would be considered as part of the Trust's recruitment process to vacancies. The Vice-Chairman noted the high nursing staff levels currently in the Trust.

Q2: A question was raised in respect of the Vice-Chairman's comment that all ideas including left of field should be reviewed in respect of improving capacity to meet demand. It was asked if the Trust was reviewing the 'Getting it Right First Time'(GIRFT) digital pathway options that could deliver results, together with reducing Patient Tracking List (PTL), increasing outpatient capacity and managing activity.

In response, the CSPO confirmed engagement with GIRFT on various speciality elective and non-elective pathways, and that the Trust was currently reviewing opportunities for improvement, particularly in respect of outpatient waiting lists that would include digital options.

The Chair closed the meeting at 4.35 pm.

Date of next meeting: Thursday 7 December 2023.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 2 November 2023**

Meeting date: **7 December 2023**

Board sponsor: **Vice-Chairman**

Paper Author: **Board Support Secretary**

Appendices:

NONE

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 2 NOVEMBER 2023

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. Circulate for virtual IAGC approval and once approved to be presented to the Board for approval.	~~Oct-23~~/ May-24	Integrated Audit and Governance Committee (IAGC) Chair/ Group Company Secretary (GCS)	Open	Amended IAGC ToR being circulated for virtual approval, with formal ratification at its next meeting in January 2023 and presented to the February 2023 Board meeting for approval, as part of the IAGC Chair Assurance Report. The ToR will be re-reviewed as part of the annual effectiveness review of the IAGC, when the IAGC will receive the outcome of the Board Committee annual effectiveness reviews. Following completion of the Governance Review. Item for future Board meeting.
B/06/23	01.06.23 - On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy. 05.10.23 - Provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.	Dec-23/ Feb-24	Interim Chief Operating Officer (COO)	Open	Verbal update to be provided at 07.12.23 Board meeting.

B/21/23	Consider for a future Board of Directors meeting for the families engaged with the Reading the Signals Oversight Group being invited to present, as part of the Patient Experience Story, their feedback and comments about the Group, discussions, achievements, and whether they felt progress and improvements had been made.	Feb-24	Chief Strategy & Partnerships Officer (CSPO)	Open	Item for future Board meeting.
B/22/23	Present annually a Patient Advice and Liaison Service (PALS) report (December 2023), providing details about themes of complaints, timeline of responding to complaints, numbers of complaints and compliments received, lessons learnt, and any actions as a result of feedback received.	Dec-23	Chief Nursing and Midwifery Officer (CNMO)	Open	Verbal update to be provided at 07.12.23 Board meeting.
B/27/23	Update to be provided to the Board following a review of the Patient Story.	Mar-24	Interim CMO/CNMO	Open	Item for future Board meeting.
B/28/23	Provide a progress update on implementation of the estate and minor work elements of the Care Quality Commission (CQC) must and should do recommendations, and any additional support required to ensure these works were expediated at pace.	Dec-23	CNMO	Open	Verbal update to be provided at 07.12.23 Board meeting.

B/29/23	Provide an update on the actions to support women who experienced birth trauma, provision of trauma informed care, and specific support requirements in maternity care for women with mental health conditions.	Feb-24	CNMO	Open	Item for future Board meeting.
B/30/23	Provide an update on progress to identify additional senior appraisers, to ensure the Trust's Appraisal Lead was sufficiently supported and that assurance was provided in overseeing appraisals.	Feb-24	CNMO	Open	Item for future Board meeting.
B/31/23	Provide a short update report by the December Board meeting, focussed summary detailing the specific work and actions of the winter support schemes with a timeline when these would be implemented, breakdown of how the winter funding had been utilised, and summary of the refreshed Trust's winter and escalation plans when completed aligning these with the revised Operational Pressures Escalation Levels (OPEL) framework.	Dec-23	CE/Interim COO (UEC)/Deputy COO for Unplanned Care	Open	Verbal update to be provided at 07.12.23 Board meeting.
B/32/23	Consider including in future IPR reports a brief summary highlighting areas of good performance and areas achieving target standards.	Dec-23	CSPO	Open	Verbal update to be provided at 07.12.23 Board meeting.

B/33/23	Present an update to the Board on progress monitoring the gap analysis, action plan, work needed and any additional support to enable implementation of the ten Sexual Safety in Healthcare - Organisational Charter commitments.	Mar-24	CPO	Open	Item for future Board meeting.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chairman's Report**

Meeting date: **7 December 2023**

Board sponsor: **Chairman**

Paper Author: **Chairman**

Appendices:

Appendix 1: Non-Executive Director (NED) Commitments

Executive summary:

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

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	No
Legal and regulatory:	No
Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

First, I would like to extend my thanks to Stewart Baird, Vice-Chairman, for his role in supporting the Trust during my leave of absence. I am pleased to be back to Chair this Board of Directors meeting.

The Trust's winter planning has continued, with the primary focus to support our patients, and ensure their safety as we move into a difficult and intensive period across the region. Our front door and Emergency Departments (EDs) continue to receive unprecedented demand. The total time a patient spends in our EDs has increased for the fourth month in a row, with this month representing the largest increase in admitted patients. In order to tackle this, we have begun to roll out many new initiatives, this includes additional operational taskforces at each site to support patients to leave hospital, as well as supporting patient-centred care at the heart of decision making. Furthermore, the Trust continues to make use of external opportunities, including bidding for regional and national money to support our systems.

As we continue to tackle our significant operational pressures, our staff must remain a priority, and we can see that sickness absence across the Trust's workforce has increased for the fifth consecutive month, with the primary sickness relating to stress, anxiety, depression and other psychiatric illnesses. I understand the immense pressure our staff are under, and the Trust's priority must be to support our staff during this difficult time. The Trust has implemented additional measures to pro-actively tackle sickness, before it triggers any formal stage, and we have seen an increase in support received through our Occupational Health teams. The Trust has also formally reviewed its staff sickness policy, in collaboration with the Staff Committee, this will hopefully provide a more streamlined, and effective, management process.

Alongside the considerable operational strain on our services, there continues to also be pressure on our financial position. As reported previously, the increased levels of staffing due to escalation areas and staff sickness, which comes with high associated agency costs, alongside non-delivery of cost savings (£13.8m) has resulted with the Trust having a deficit position of £68.2m against a planned year-to-date deficit of £45.5m. The Trust continues to make significant measures to implement financial controls, and stabilise our financial position as we move into the most difficult period for our health services.

3. Council of Governors (CoG)

The Council of Governors continues to work and support the Trust's substantial pressures and build on the work across the sites. The Council has a number of vacancies which we hope to fill by election in the new year.

Although the Council previously suspended all joint site visits until early next year as it understands the current pressures that the Trust is experiencing, the planning for next year is

underway, and I know all Governors are keen to restart engagement across the Trust, across our patients, staff and members. The Council will aim to host membership engagement sessions at each of our acute sites in the new year, and we hope this will provide an opportunity for our patients to understand more about the work of the Trust's Governors.

East Kent Hospitals University NHS Foundation Trust

Appendix 1 – Non-Executive Director (NED) Commitments

NEDs November 2023 commitments have included:

Non-Executive Directors	NEDs meeting Meetings with NEDs Meetings with Executive Directors Extra-Ordinary Charitable Funds Committee (CFC) meeting Extra-Ordinary Closed CoG meeting Finance and Performance Committee (FPC) meeting Integrated Audit and Governance Committee (IAGC) meeting Closed IAGC meeting Extra-Ordinary IAGC meeting People and Culture Committee (P&CC) meetings Quality and Safety Committee (Q&SC) meeting 2gether Support Solutions (2gether) Board meeting Spencer Private Hospitals (SPH) Board Strategy Day Meeting with Kent and Medway (K&M) NHS Integrated Care Board (ICB) Chair Meeting with K&M NHS ICB Chair and Chief Executive Meeting with NHS England Improvement Director Meeting with 2gether's Chairman Meeting with SPH Chairman Meeting with 2gether's Audit Chair Meeting with Freedom to Speak Up (FTSU) Guardians Culture and Leadership Programme (CLP) Interviews Good Governance Institute (GGI) Governance Review Interviews

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **7 December 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 Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

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

2. Background

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

3. Clinical Executive Management Group (CEMG)

There were no Business Cases approved or recommended for approval at the meetings of the CEMG on 1 or 15 November 2023.

4. Operations update

4.1 Winter planning

As we approach the winter months, the Trust's primary focus remains on patient safety. The Trust has been diligently planning to cope with the anticipated increase in demand for healthcare services over the winter period. To address the challenge of increased patient numbers, we have taken a comprehensive approach to maximise and optimise available capacity. This includes an assessment of staffing levels, resource allocation, bed provision in patient-facing and non-patient facing areas, alongside the utilisation of improved technology.

The Trust has been invited to bid for NHSE investment funding to enhance Electronic Bed Capacity Management Systems; the first tranche of investment would be provided in this financial year. This funding would be used to bolster the staffing for the site teams and improve technology used to manage the bed allocations, supported by enhanced hardware and software, enabling our site teams to access live information more easily from board rounds to the Operational Control Centre (OCC)/Care Coordination Centre (CCC). This will facilitate improved flow and enhance data-driven decision making within the clinical site management team. This real-time bed state and digital site reporting will enable the Integrated Care Board (ICB) to assess whole system risks and support mitigating actions where appropriate. Accurate data will also support early escalation and de-escalation to mitigate risks.

The Trust continues to work with colleagues across the Healthcare Partnership (HCP) to ensure additional capacity is available for patients in need of continued care beyond their stay in the acute setting. HCP colleagues are also signposting patients to alternative services, community Urgent Treatment Centres (UTCs), and other direct access facilities, to alleviate the strain on the Trust's Emergency Departments (EDs) and streamline patient pathways.

The recently established a Discharge Taskforce at each site has a particular emphasis on Criteria Led Discharge and addressing barriers to efficient patient flow. Criteria Led Discharge ensures that patients are discharged based on predefined clinical criteria which is patient-centred and clinically appropriate. The taskforce will also be monitoring and managing patients with Long Length of Stays (21+ days) by ward and specialty with specific Executive Team focus on patients with very high lengths of stay (50+ days). This taskforce is supported by PRISM at the Queen Elizabeth the Queen Mother Hospital (QEQM) and KPMG at William Harvey Hospital (WHH).

By reducing patient Length of Stay, and ensuring patients are cared for in the most appropriate care setting, beds can be released supporting flow through our EDs for all patients that need to be admitted.

4.2 Maintaining Planned Care

A core part of the Trust's strategy, in particular over winter, is to preserve elective activity, protect our cancer patient pathways, and continue to improve access to our core diagnostic services to enable us to provide timely and necessary care for our patients. Our strategy for this winter involves a structured escalation plan to balance the demands of emergency care and protect elective procedures.

In October, the Trust has seen an improvement in our Cancer Faster Diagnosis Standard from 60% to 63.9%. Notable improvements were observed across all tumour sites. Furthermore, there was an improvement of 6.6 percentage points in-month in our DM01 (Diagnostics Standard) position, rising from 54.1% to 60.7%, the first improvement in the position since June 2023 and attributed to a reduction in our CT vetting backlog and an improvement programme within MRI.

Despite this, our elective recovery position continues to deteriorate; this aligns to our revised trajectories for planned care factoring in capacity and demand. The Trust currently has seven patient breaches at 104 weeks, 305 at 78 weeks, and 1,831 at 65 weeks. The primary driver for this relates to our ongoing Endoscopy backlog (12,894 scopes), capacity challenges within Otology, alongside an unvalidated Referral to Treatment (RTT) of 24,538 greater than 12 weeks which places the organisation at 50.5% RTT performance. Additionally, our patients are experiencing long wait times for first outpatient appointments within Gastrointestinal (GI), Max-Fax and Cardiology.

Some key workstreams to address these challenges have commenced and include:

- A Task and Finish Group for Endoscopy Recovery supported by the ICB has been in place since 09 October 2023 looking at wider system capacity and the option for Quantitative Faecal Immunochemical Test (QFIT) testing of the existing backlog.

- £345K of cancer funding to bring in a locum Radiologist to improve reporting turnaround times and associated administrative support around benign letter completion.

- Prism are now in the implementation support phase of their theatre improvement programme, re-launching the Trust 6-4-2 processes and the set-up of the Theatre Improvement Group.

- An ICB led Acute Provider Collaborative has commenced to review ENT demand and capacity with deliverables expected in February 2024.

- An identified need to deliver some short-term support for validation and also a medium-term plan to provide RTT training support across challenged areas to help improve performance.

As we navigate the challenges associated with winter pressures, our commitment to patient safety and quality care remains unwavering. The collaborative efforts of our teams, coupled with the strategic initiatives outlined in this report, position us to proactively address and manage the demands of the upcoming winter season. The Discharge Taskforce, in particular, will play a pivotal role in enhancing our discharge processes and contributing to the overall efficiency of our healthcare services.

5. Financial performance and NHSE control measures

At the end of M7 (October) 2023 the Trust has a year to date (YTD) deficit of £68.2m against a planned YTD deficit of £45.5m.

Key drivers of the YTD position continue to be the non-delivery of recurrent cost savings (£13.8m) and pay overspend including increased levels of staff use due to escalation areas, one to one care and the associated high cost of agency premium.

Financial controls to reduce the run-rate, which have been adopted in line with the national level 4 (NHS Oversight Framework (NOF4)) requirements, are in place. In October the Trust maintained the improvements seen in September in relation to temporary staffing costs, however, there is much more we need to do to improve the financial controls and the pace of delivery across the Trust. To that end the Trust is in the process of increasing capacity within its core cost control and improvement teams to increase the grip and pace at which savings can be made.

6. National Staff Survey

The NHS Staff Survey launched in September and is now into its final week. All 9,814 staff were invited to take part in the survey with 3,987 respondents completing to-date, a response rate of 41% two days before the survey closes on 24 November 2023.

A comprehensive range of outreach-related fieldwork has taken place across the ten-week period to ensure response rates are as high as possible, and to give a clear mandate from the results. In addition, all six reminders have been timed to coincide with peak staff attendance (pausing at half-terms, for example) in order to maximise the return.

A weekly response rate temperature gauge was introduced to drive healthy competition across Care Groups and this has been published Trust-wide at the end of each week, with the winning Care Group celebrated. An innovative and interactive dashboard was also developed which has allowed for a transparent overview of responses across the Trust; rates which range from 12% to 94% across sub-specialties. This enabled the identification of hotspot and bright spot areas – and crucially, targeted intervention.

The staff experience team has been deployed across the organisation to target low response areas and provide timely support. Much of their work has been to showcase ‘you said, we did’, the activity that has taken place since last year, whilst dispelling common myths and answering frequently asked questions.

This year the organisation has also been supported by NHS England who have focussed their efforts on engaging with Care Group Leadership Teams and encouraging permission giving so that a wider body of staff share their feedback. At this stage, it would appear that the overall response rate will close behind last years’ position and the national average (both 44%).

Ultimately, the NHS Staff Survey represents an annual barometer of the way staff experience the organisation. Response rates themselves act as an early indicator of staff engagement, as a proxy of overall staff sentiment.

The Board is encouraged to reflect on what has led to the lower response rate achieved this year as this will inevitably influence overall results. More fieldwork activity has taken place than ever before, although apathy has been regularly encountered, related to dissatisfaction with the extent to which local changes have taken place that affect their daily experience.

The manner with which we respond to these early findings long before the embargo is lifted in March 2024 will determine engagement with this critical indicator in future.

7. Fire Safety Audit – Kent and Canterbury Hospital (K&C)

Initial findings of a recent planned Fire Safety Audit carried out by Kent Fire & Rescue Service at the K&C (Brabourne and Clarke Wards) have been received.

The audit which was focused on all fire safety measures in accordance with the 2005 Fire Safety Order has identified four key areas of focus which include ward compartmentation, change of use, fire safety training for clinical staff and risk assessments.

Work is ongoing to redress the issues that have been identified in advance of the final report, including remediation requirements, being issued.

8. Health Education England Education Quality Reports

The following Health Education England education quality reports have been published this week, following reviews carried out in July this year:

- Training in Trauma and Orthopaedic (T&O) Surgery
- Dental Core Training in Oral and Maxillofacial Surgery

Doctors in training in Trauma and Orthopaedics felt generally well supported by consultants, able to raise concerns and the Elective Orthopaedic Centre in Canterbury provided good training opportunities.

However, there were a number of areas for improvement where we have made changes, including to the responsibilities of doctors in training, amending rotas and reducing the amount of travelling between sites. We have introduced the Royal College of Surgeons Non-Technical Skills for Surgeons (NOTSS) course designed to improve situation awareness, decision making, communication and teamwork and increased team engagement, to support improved teamworking and culture across the sites.

The results of the General Medical Council's (GMC's) survey of T&O trainees shows significant improvement in East Kent between 2022 and 2023 which we are determined to build on.

The Core dental trainees in Oral and Maxillofacial Surgery reported positive feedback about their learning and training, including support for those wishing to pursue specialty training. However, there was still a need to improve the culture within the department.

All consultants have undertaken the Royal College of Surgeons Non-Technical Skills for Surgeons (NOTSS) course and the nationally recognised 'Civility Saves Lives' programme and all staff groups have taken part in "open door" sessions with consultants.

We have introduced an appropriate middle-tier on-call rota which will be fully recruited to in January 2024 and training has been overhauled with a very structured timetable of teaching during the week with all Consultants involved in the teaching sessions.

The postgraduate training doctor post and six dental core trainee posts are currently being covered by locally employed doctors and locums known to the department while discussions continue about the return of dental trainees to the Trust, following the suspension of the training posts earlier this year.

9. Executive Team update

I am pleased to announce that Tim Glenn has joined the Trust as Interim Chief Finance Officer on a 12-month secondment from the Royal Papworth Hospital NHS Foundation Trust, where he was the Deputy Chief Executive and Chief Finance Officer. Tim will work with Michelle Stevens, who has provided cover for this role over the past six months, and to whom I am very grateful for her leadership throughout.

10. Good News Stories

I am pleased to note below good news stories that have happened in November.

11. Conclusion

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **7 December 2023**

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

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

Appendices:

APPENDIX 1: October 2023 IPR

Executive summary:

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

	Key performance points (October Reported Month): **Patients** • All type Emergency Department (ED) performance is now behind plan at 70.6%; • Type 1 ED performance is under plan at 45.8%; • Cancer 28 Faster Diagnosis Standard (FDS) has improved in month to 63.9%; • Diagnostics performance has improved to 60.7% with key issues remaining in endoscopy. **Quality & Safety** • 13 Serious Incidents (SIs) declared in the month; • One never event reported in October; • The number of overdue incidents increased in month by 373; • Hospital Standardised Mortality Ratios (HSMR) remains below 100 and appears to have plateaued at an index figure of around 93. **People** • Sickness absence has tipped over the 5% threshold in month to 5.4%; • Vacancy rate remains below the desired threshold, with improvements appearing to plateau; • Staff turnover remains in line with the previous month at 9.1% and has now sat below the national standard (10%) for ten consecutive months; • Staff engagement score is not reported on during the National Staff Survey window; • Completed medical job plans remains below the target at 60.3% but is showing some improvement; • Appraisal rates remain around 73%. **Sustainability** • The financial position is adverse to plan by £8.9 million in month 7; • Cost Improvement Programme (CIP) delivery is significantly below the plan for month 7; • The current value of the pipeline is £16.3m, a (£1.4m, 9%) increase in value vs. the prior month; • Premium pay remains high with drivers that include escalation beds, and additional 1:1 care needs. **Maternity** • Two SIs declared in the month of October for women's health in Maternity; • Complaint response times are below the target threshold; • Perinatal mortality remains low and in line with the prior month; • FFT recommend rate is 96.2% for the month.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

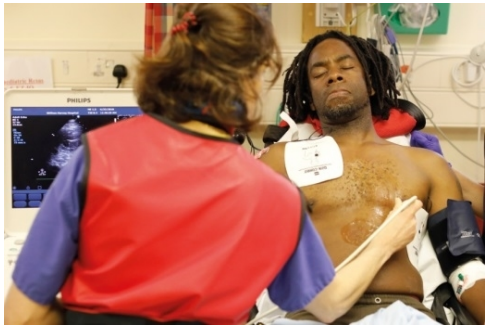
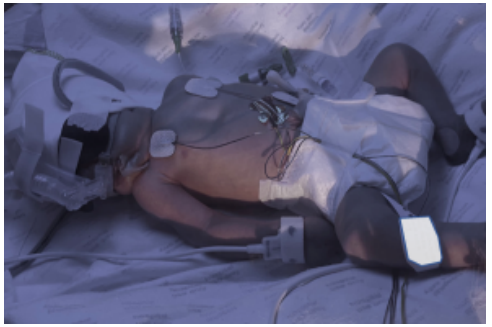
Integrated Performance Report

October 2023







Patients

Operational Performance

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Operational Performance	IIP		ED Compliance		73.0%	69.9%	64.7%	68.4%	67.3%	67.1%	70.7%	71.7%	73.2%	74.3%	71.9%	70.7%	70.6%
	IIP		Type 1 Compliance 4hrs		55.0%	47.0%	40.2%	41.5%	40.7%	39.1%	44.0%	45.1%	48.1%	51.6%	46.5%	45.5%	45.8%
	IIP		12 Hr Total Time in Department		7.0%	9.9%	12.2%	11.8%	11.5%	12.4%	10.4%	10.5%	9.6%	8.7%	9.7%	10.2%	10.7%
	IIP		12Hr Trolley Waits (MTD unvalidated)		0	1005	1190	1168	1021	1189	989	1136	929	769	908	867	1079
	IIP		Ambulance Handovers within 30m		95.0%	75.1%	70.4%	80.8%	81.1%	80.5%	86.0%	86.2%	90.4%	91.8%	89.7%	90.0%	90.3%
	IIP		Super Stranded >21D		107	295	287	310	307	296	280	272	260	246	241	245	235
	IIP		Not Fit to Reside (pats/day)		300.0	204.5	217.6	240.7	255.7	232.8	226.1	213.4	218.5	192.3	193.0	199.8	193.5
	IIP		Cancer Over 62d on PTL		67	232	321	342	233	230	379	371	371	386	431	519	506
	IIP		Cancer Over 104d on PTL		0	40	48	64	57	54	49	77	66	73	84	98	107
	IIP		Cancer 28d Combined Performance		75.0%	69.0%	68.5%	53.6%	66.3%	65.6%	62.3%	61.8%	64.6%	63.2%	60.5%	59.5%	63.9%
	IIP		RTT 52w Breaches		Traj.	3,379	3,299	3,317	3,187	2,997	3,027	3,608	3,907	4,575	4,767	5,113	5,966
	IIP		RTT 65w Breaches		0	1,161	1,219	1,175	976	707	766	984	1,023	1,148	1,292	1,499	1,900
	IIP		DM01 Compliance		75.0%	66.8%	60.6%	57.6%	62.0%	60.3%	56.3%	58.6%	59.0%	55.9%	53.6%	54.1%	60.7%

October Performance Summary

Emergency Department: Performance deteriorated in October for all types (70.6% v 70.7% in September) with a slight improvement reported in type 1 performance. Overall the trust remains below the trajectories as set out in the TIER 1 plan. The total time in the department increased for the 4th month in a row, with the largest increase in the admitted patients waiting in the EDs . This correlates to the number of patients with DTAs reported at 08.00 hours (64.6 August, 132 September v 145 October) together with both sites reporting an increase in both the number of type 1 arrivals in October (12.5 v 12.4 Sept) and Ambulance conveyances (5212 V 5044 September) which is the highest number reported since December 22

Cancer: Increased number of patients waiting longer than 62 or 104 days. Highest contributing factors are within the Lower GI and Urology Cancer Pathway, with the endoscopy delays being the highest contributing factor, followed by radiology delays and biopsy delays. New weekly focused Cancer feeder pack for each team linked to Performance meetings and weekly PTL's will focus on agreed actions to clear back log. Specific funding provided to support locum radiologist in Lower GI and admin support to clear benign letter backlog (commenced in mid November.

Diagnostics: October has seen the first uptick in performance since June 2023. This primarily relates to a reduction in breaches within MRI of 700 patients due to improvements made within internal booking procedures and a continued improvement in NOUS and CT with a further reduction in the CT vetting backlog. The trust however continues to see Endoscopy demand far outweigh capacity at 30% DM01 with 5,234 breaches at the end of October.

Referral to Treatment Waiting Times: The impact of referral growth, waiting longer for first out patient appointments (70 weeks within Gastro, 60 in Max Fax and Cardiology at 68 weeks), diagnostic delays, reduced elective (inpatient and day case) activity and the accumulative impact of Industrial Action since April 2023 are hindering our ability to improve the position. Particular challenges beyond 78 weeks relate to Endoscopy, ENT (Otology), T&O and Cardiology. T&O improvements expected from Prism overnight, Otology from internal WLI's and Cardiology requires a strong remedial action plan to be developed.

Type 1 Emergency Department 4h Compliance

Integrated Improvement Plan

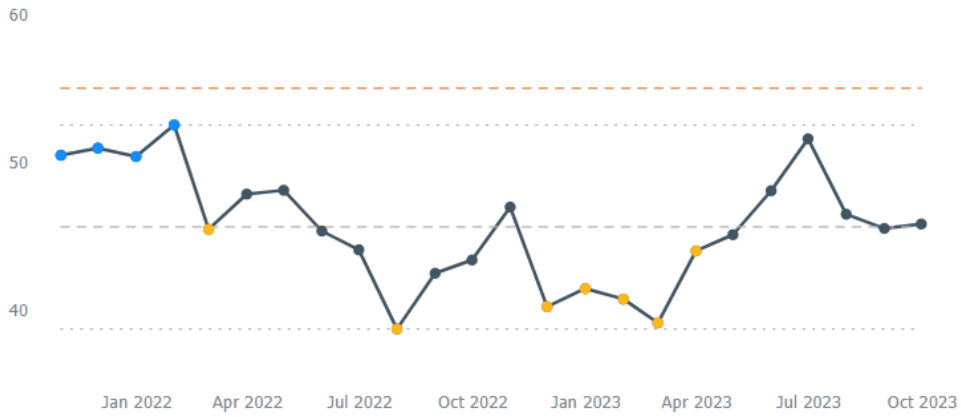
NHS
East Kent Hospitals University
NHS Foundation Trust

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

Type 1 Compliance 4hrs

Timescale	Value	SPC
Nov-22	47.0%	
Dec-22	40.2%	
Jan-23	41.5%	
Feb-23	40.7%	
Mar-23	39.1%	
Apr-23	44.0%	
May-23	45.1%	
Jun-23	48.1%	
Jul-23	51.6%	
Aug-23	46.5%	
Sep-23	45.5%	
Oct-23	45.8%	

XMR Run Chart



Understanding the most recent data point

Performance

45.8% — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ED Single point of access for all patients requiring urgent and emergency care	• Further work to undertake to increase the number of DAP and include the Medical Assessment Units on both sites • Training completed for the Medical staff at QEQM • SPOA – Pilot commenced WHH November. Working with ICB/HCP to expand to QEQM from December with winter monies proposed to cover resource costs	• SC/DS/HT/ RL • Clinical lead/Frailty leads/SECA MB	• On going monitoring • Weekly meetings in place	• Work to progress the DAPs ahead of the opening of the CAU end Sept- completed • Support from ICB requested to extend the project for winter . ICB support to fund required resources post the Nov pilot . Impact on unmitigated bed gap for EKUFT to be analysed via weekly hubs
Internal processes not fully aligned to operational delivery	• Implementation of internal escalation processes • External support to review internal escalation processes: daily rhythm: OPEL actions; Site team structure and review the Full Capacity protocol commences in Oct-Nov • Updated FCP with review of bed capacity – conversion of areas to increase bed base	• COO • MDs	• Nov 2023 • Nov/Dec 2023	• Internal plans for UEC both sites completed – QEQM/WHH to provide training for the whole hospital in line with OPEL actions -in place • Review of escalation/surge/super surge capacity across the 3 sites – to align to the FCP /winter plan . • Share with CNO/2gether to support build costs plans
Whole Hospital Response Establishing CDUs at WHH/QEQM	• Trust wide development of IPS. GIRFT recommendation • CDU Models agreed for QEQM and in place sept. Next phase to widen criteria post review to increase utilisation. • CDU Model being explored at WHH to go live Nov 23. Requires phase 3b of the build to be completed	• CMO /MeD • CL/MDs DoN	• Dec 2023 • Nov 2023 • Nov 23	• Work the GIRFT team to support IPS implementation (forms part of the wider action plan) • Further work to reduce the number of speciality patients in the proposed CDU | a focussed working group established with actions to achieve

Emergency Department 4h Compliance (all types)

Integrated Improvement Plan

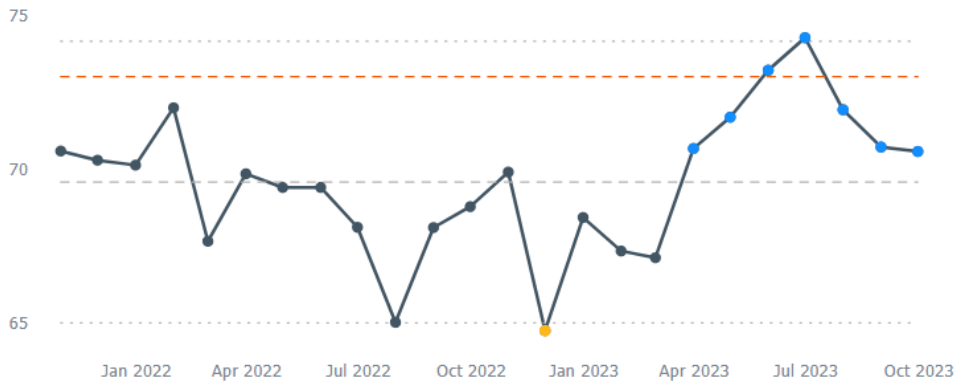
East Kent Hospitals University NHS Foundation Trust

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

ED Compliance

Timescale	Value	SPC
Nov-22	69.9%	
Dec-22	64.7%	
Jan-23	68.4%	
Feb-23	67.3%	
Mar-23	67.1%	
Apr-23	70.7%	
May-23	71.7%	
Jun-23	73.2%	
Jul-23	74.3%	
Aug-23	71.9%	
Sep-23	70.7%	
Oct-23	70.6%	

XMR Run Chart



Understanding the most recent data point

Performance

70.6%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Above Mean Run Group

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

Ambulance Handovers within 30m

Integrated Improvement Plan

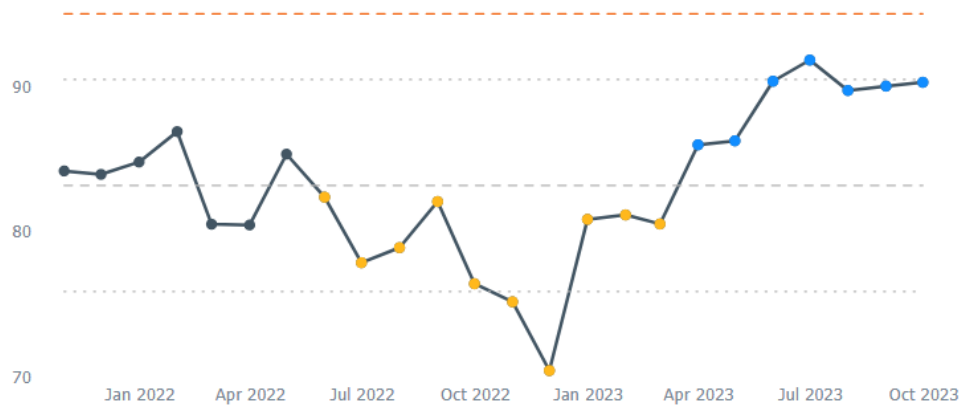
East Kent Hospitals University NHS Foundation Trust

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

Ambulance Handovers ...

Timescale	Value	SPC
Nov-22	75.1%	
Dec-22	70.4%	
Jan-23	80.8%	
Feb-23	81.1%	
Mar-23	80.5%	
Apr-23	86.0%	
May-23	86.2%	
Jun-23	90.4%	
Jul-23	91.8%	
Aug-23	89.7%	
Sep-23	90.0%	
Oct-23	90.3%	

XMR Run Chart



Understanding the most recent data point

Performance

90.3%

Variation indicates consistently falling short of the target

Variation

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

Flags: Above Mean Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
High numbers of ambulance conveyances to the Emergency Departments at QEQM/WHH (national outlier)	• Working with the HCP and SECAMB partners . Implementation the Alt-ED model • Support from GIRFT – one of the key recommendations following the review in July	• HCP/Hospital Site teams /Secamb	• Sep 2023; 3 month plan	• Establishing the HCP action plan to support the Alt-ED roll-out and the GIRFT action plan to support UCR pathways
ED used as a single point of access increasing the risk of overcapacity and reduce the ability to manage handover Patients waiting outside the department due to process and space concerns at the WHH site	• Introduction of front door streaming and RAT to support early handover of patients. Early ED triggers in place to reduce risk for off-loading . • Streaming in place to support direct access to SDEC//SAEU/CAU/UTCs against patient criteria • Review of the process . To review environment and reception /streaming process and review the direct access for paediatrics to the Paeds ED	• Clinical lead ED and Head of Ops • MDs • DCOO /MDS/DoNS	• In place • October 23	• ED reviewing their internal plans to ensure early triggers resolve potential issues with off loads /Over capacity EDs • Plans to be developed for improving waiting environment / direct to paeds pathways / reception cover to reduce waits. Number of ambulance conveyances triaged to Waiting Room | review as part of GIRFT recommendations
Wait times to be seen by a senior clinician were over the standard 1 hour – with potential risks associated with waits	• Introduction of the Dr Initial Assessment(WHH) to support timely reviews and assessment of pts arriving on ambulances • Model in place at QEQM from September	• Clinical lead ED and Head of Ops	• In place and on-going	• Metrics in place

>12h Total Time In Emergency Department

Integrated Improvement Plan

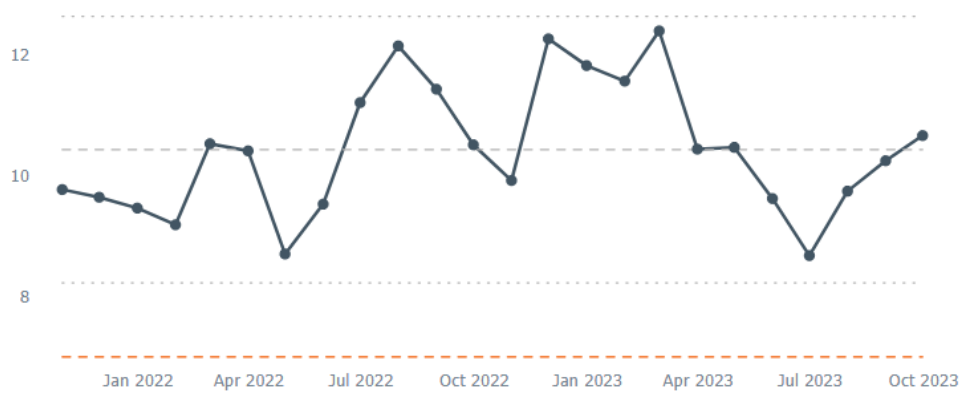
East Kent Hospitals University NHS Foundation Trust

This measure counts the proportion of patients whose total time in the emergency department exceeded 12 hours.

12 Hr Total Time in Dep...

Timescale	Value	SPC
Nov-22	9.9%	
Dec-22	12.2%	
Jan-23	11.8%	
Feb-23	11.5%	
Mar-23	12.4%	
Apr-23	10.4%	
May-23	10.5%	
Jun-23	9.6%	
Jul-23	8.7%	
Aug-23	9.7%	
Sep-23	10.2%	
Oct-23	10.7%	

XMR Run Chart



Understanding the most recent data point

Performance

10.7%

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Number of patients waiting for a bed (admitted cohort)	Implementation of; • Daily pathway zero meeting • Specialty in-reach to the front door • Frailty units established –both site • Clinical forums to right size bed base and ensure appropriate configuration WHH in place QEQM November	• Clinical leads /MDs /Head of Ops	• October for 3 months	• Creation of integrated hubs at the front door with access to domiciliary care to reduce P1 admissions • SAFER Bundle roll-out | Commenced WHH July – reviewed September with a plan to utilise KPMG to follow the work through at WHH – start Oct • Focussed work to improve patient flow at QEQM | External support PRISM starting October
Use of corridor to manage high numbers of pts in ED	• Implement SAFER Bundles • Protection of the DAP pathways and assessment units • Increase UTC/SDEC activity • Increase capacity – bed head service review • Review of internal triggers aligned to the new OPEL Framework (live from Oct 23) and work with HCP to align system wide response requirements	• Clinical leads /MDs /Head of Ops • HCP/MDs	• On going • Nov 23 • Sep 2023 for 3 months	• Internal triggers and access and use of escalation areas completed WHH pending approval. QEQM – in development • MDs and DoNs reviewing their sites – proposal for increasing capacity to the CNO • OPEL framework goes live Dec 23
High number of Mental Health (MH) patients in ED. Long waits due to lack of inpatient MH facilities	• Daily external escalation processes to be approved by the HCP to support oversight and planning • External ICB support to EKMHT to manage capacity access OOA	• DoNs/MDs/ MDs/COO/C NO/HCP leads	• On-going • Oct/Nov 2023	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4

Super Stranded Patients (>21d LoS)

Integrated Improvement Plan

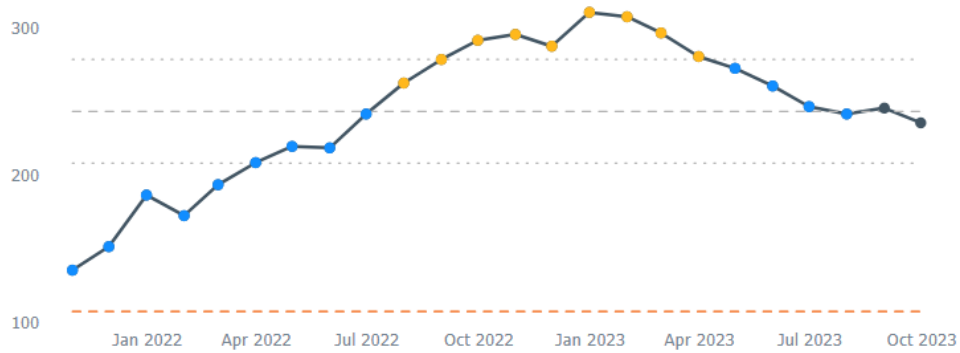
East Kent Hospitals University NHS Foundation Trust

The NHS defines a super stranded patient as someone who has spent 21 days or more in hospital.
This metric counts the number of Super Stranded patients at the time snapshot was taken, in this case the last day of the month.

Super Stranded >21D

Timescale	Value	SPC
Nov-22	295	
Dec-22	287	
Jan-23	310	
Feb-23	307	
Mar-23	296	
Apr-23	280	
May-23	272	
Jun-23	260	
Jul-23	246	
Aug-23	241	
Sep-23	245	
Oct-23	235	

XMR Run Chart



Understanding the most recent data point

Performance

235 — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Further support from KMPG will come online from early November. • Revised practice to include >14 day patients in the MFFD weekly RTS huddle. Roaming LoS management commenced at WHH where all patients >14d discussed with action workbook and accountable owners • QEQM PRISM Inpatient Flow Improvement Project commenced on 2nd October and is in the initial 4-week evaluation phase.
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) | 7 of the 25 are due to start on the 18th October, another seven posts have been offered this week. Introduction of this service will increase pathway 1 capacity. • Proposed capacity supporting P2, P3 discharges across KCHFT, Broadmeadow, Westview and Westbrooke facilities. Included as part of the EK HCP Winter Plans providing up to an additional 48 beds spaces. The Trust are working on close partnership will HCP to determine start dates and phased opening plans.

Patients No Longer Fit to Reside in Hospital

Integrated Improvement Plan

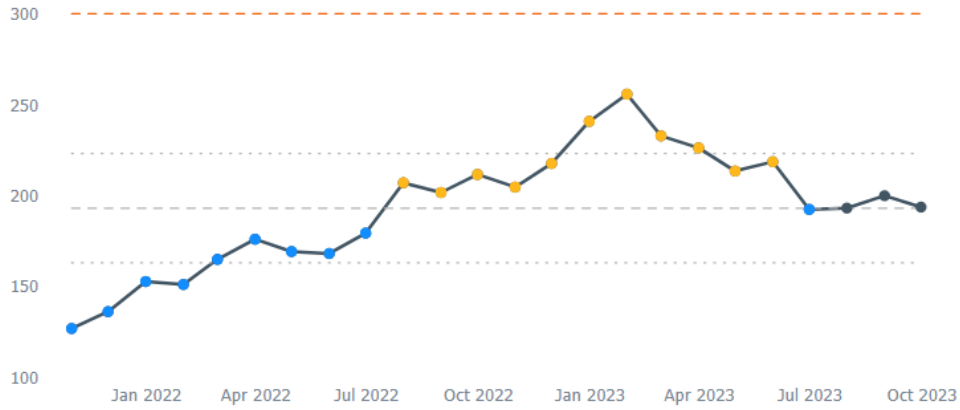
East Kent Hospitals University NHS Foundation Trust

The status of a patient is captured and recorded by clinical teams on a daily basis. Where a patient is deemed 'no longer fit to reside' (nlftr) this means that their care could be safely given in a setting outside of the acute hospital.
This metric measures the number of patients classified as nlftr each day in the month and expresses this as an average over the month.

Not Fit to Reside (pats/...

Timescale	Value	SPC
Nov-22	204.5	
Dec-22	217.6	
Jan-23	240.7	
Feb-23	255.7	
Mar-23	232.8	
Apr-23	226.1	
May-23	213.4	
Jun-23	218.5	
Jul-23	192.3	
Aug-23	193.0	
Sep-23	199.8	
Oct-23	193.5	

XMR Run Chart



Understanding the most recent data point

Performance

193.5 — Variation indicates consistently passing the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to community capacity	• East Kent Health and Care Partnership Urgent and Emergency Care Plan for 23/24 is structured with 5 priority areas of work: Increasing urgent and emergency care capacity, Making it easier to access the right care, Improving discharge, Expanding pro-active care outside of hospital, Increase workforce size and flexibility.	• HCP/ COO	• 23/24 Year End	• Development of generic Health and Social Care (Home First Support Worker) – 7 of the 25 are due to start on the 18th October, another seven posts have been offered this week. Introduction of this service will increase pathway 1 capacity. • Proposed capacity supporting P2, P3 discharges across KCHFT, Broadmeadow, Westview and Westbrook facilities. Included as part of the EK HCP Winter Plans providing up to an additional 48 beds spaces. The Trust are working in close partnership will HCP to determine start dates and phased opening plans.
Long Stay Patients	• Roll out of SAFER bundle. Under the 'R' – 'Regular Review' principle patients with a LoS of more than 14 days will be reviewed at a weekly Super Stranded MDT	• Site MDs	• End Oct	• SAFER Board Round Bundle launched at WHH w/c 21st August. The programme will run from August to October 2023. Further support from KMPG will come online from early November. • QEQM PRISM Inpatient Flow Improvement Project commenced on 2nd October and is in the initial 4-week evaluation phase.
Ward/RTS comms.	• PTL improvements provide the ward and RTS with a traffic light system highlighting the patient status on the RTS caseload. Alert system rolled out to provide two-way communication between ward and RTS for patient reviews.	• GS and Gastro DHoN	• End Oct	• PTL updates complete for RTS discharge PTL which now feeds into the main discharge planning PTL. • A single referral form is in development for enhanced discharge pathway planning. The Trust are seeking to attain the position where all enhanced discharge pathways are determine by RTS and Integrated Hubs.

Cancer 28d Faster Diagnosis

Integrated Improvement Plan

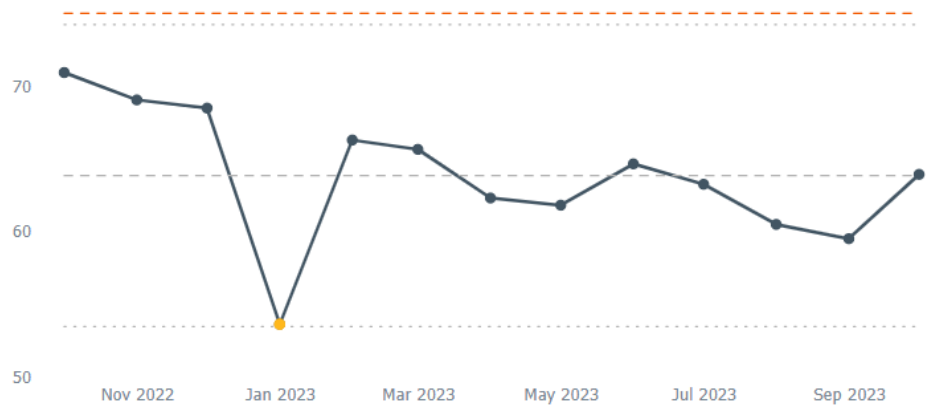
East Kent Hospitals University NHS Foundation Trust

There is a national requirement to diagnose or rule out cancer for patients referred on a cancer pathway within 28 days of receipt of referral.
This metric measures the % pf patients discharged or given a diagnosis in each month within 28 days of their referral.

Cancer 28d Combined P...

Timescale	Value	SPC
Nov-22	69.0%	
Dec-22	68.5%	
Jan-23	53.6%	
Feb-23	66.3%	
Mar-23	65.6%	
Apr-23	62.3%	
May-23	61.8%	
Jun-23	64.6%	
Jul-23	63.2%	
Aug-23	60.5%	
Sep-23	59.5%	
Oct-23	63.9%	

XMR Run Chart



Understanding the most recent data point

Performance

63.9% — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic reporting for CT's & MRI's (current reporting time is 2 weeks for CT's and 6 weeks for MRI's) Ref to exam - CT- 2-3 days if bloods done, if not 14 days. MRI 11 days.	Reduce referral to reporting to 10 days for CT and MRI	• Radiology • Cancer Trackers • Phlebotomy	• End Nov 2023	• Improved escalation process being piloted for bloods, vetting, booking and reporting • Awaiting confirmation of 2 locum staff starting to support CT biopsy, NOUS biopsy and reporting
Qfit process not consistently applied and current waiting time for endoscopy booking is 4 weeks.	Qfit process to be consistently applied and sustained. To reduce waiting time to Scope to 10 days for 2ww and screening patients	• Endoscopy • Qfit Facilitator • AMD Surgery	• Dec 2023	• Task and finish group established that includes actions for Endoscopy and Qfit • STT implemented for Lower GI SOP being revised to extend criteria with learning from other organisations. • The endoscopy request form is being updated to include Qfit result as is the 2ww referral form within the community • Lead GP is contacting practices who are showing zero utilisation of Qfit to encourage them to utilise Qfit current utilisation 70% by GP's
Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging 8-12 weeks.	Typing of letters for those tumour sites to be completed within 7 days.	• Care Group Lead Medical Secs	• End Nov 2023	• Updates on progress circulated to teams 3 times a week to support improvement • Additional funding to support improvement secured from NHSE (345K which includes admin funding)

Cancer Patients >62d on PTL

Integrated Improvement Plan

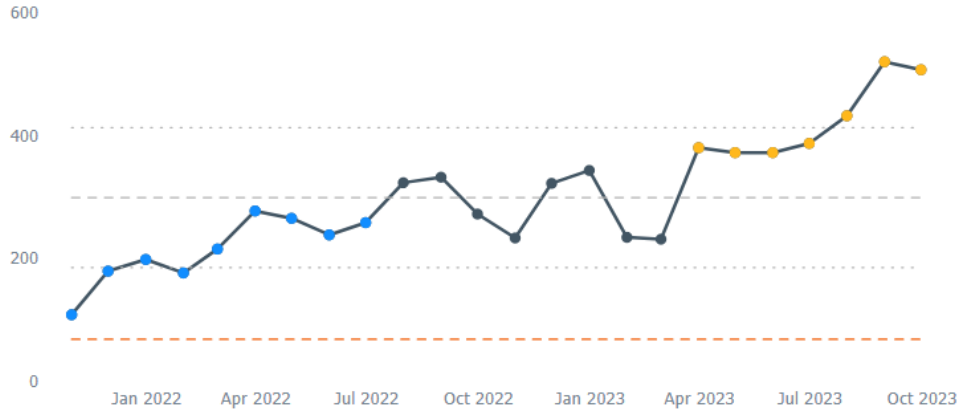
East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 62d or more from point of referral and have not yet received treatment. This metric is a snapshot count of patients as at month end.

Cancer Over 62d on PTL

Timescale	Value	SPC
Nov-22	232	
Dec-22	321	
Jan-23	342	
Feb-23	233	
Mar-23	230	
Apr-23	379	
May-23	371	
Jun-23	371	
Jul-23	386	
Aug-23	431	
Sep-23	519	
Oct-23	506	

XMR Run Chart



Understanding the most recent data point

Performance

506	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Above Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic waiting time for U/S Guided Biopsies. Average wait time 4-5 weeks	• Reduce wait time to diagnostic to 7-10 days.	• Radiology • Cancer	• Jan 2024	• Radiology Improvement plan in place awaiting new interventionalists to start • Ultrasound guided biopsy waiting times decreased slightly • Options for dedicated lists on the K&C site being explored
Delays with radiology vetting, booking and reporting adding weeks to suspected cancer patient pathway	• 140 back log (300 last month)of reporting needs to be cleared asap and timeline of what can be delivered for suspected cancer patients agreed	• Radiology • Cancer	• Nov 2023	• Backlog included in weekly feeder pack, for update and discussion at Performance meetings and PTL's to ensure weekly improvement • Additional improvement funding of 345K secured from NHSE to support improvement
Inadequate capacity within out-patients for F2F appointments post MDM to discuss treatment options post MDM	• Increase Outpatient capacity for decision to treat (DTT) OPA's. OPA to be available within 5 days following the MDM. • Provide Increased straight to test (STT) capacity to release medical time for F2F OPA's etc	• FDS Lead Clinician • Out-patient Lead	• Oct 2023	• 2ww Transformation and longer waiter Working Group established • STT for lower expanding capacity • STT prostate funding agreed posts shortlisted and being interviewed in Dec • STT Lung and Upper in place, under review for additional learning/improvement following patients feedback

Cancer Patients >104d on PTL

Integrated Improvement Plan

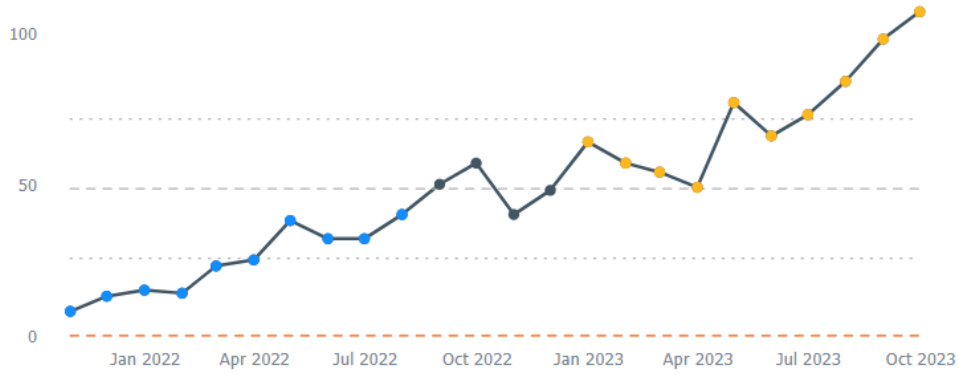
East Kent Hospitals University NHS Foundation Trust

The number of patients on a Cancer Pathway who have been waiting 104d or more from point of referral and have not yet received treatment. This metric is a snapshot count of patients as at month end.

Cancer Over 104d on PTL

Timescale	Value	SPC
Nov-22	40	
Dec-22	48	
Jan-23	64	
Feb-23	57	
Mar-23	54	
Apr-23	49	
May-23	77	
Jun-23	66	
Jul-23	73	
Aug-23	84	
Sep-23	98	
Oct-23	107	

XMR Run Chart



Understanding the most recent data point

Performance

107	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Above Mean Run Group Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Urology Surgical capacity and high levels of breaches for patients needing active surveillance	Increase surgical capacity by exploring mutual aid options with MFT for RALP and Cystectomy. Team asked to find alternative plans before STT team appointed	• MD • AMD and MD K&C • MDT Lead for Urology	• Nov 2023	• Pathway agreed with MFT and local team. • K&M Cancer Alliance meeting being arranged. So far patients not engaging in having surgery elsewhere, but this is being reviewed to maximise offer • Clinical team reviewing potential additional actions needed to reduce delays for active surveillance
Tertiary referral – delays with receiving communication back from tertiary centres.	Improved collaboration between EKHUFT and tertiary centres.	• Senior Service Managers EKHUFT • Tertiary Centres • EKHUFT Compliance Managers	• Nov 2023	• Established weekly PTL meetings for UGI with our London colleagues. • Meetings with Kings taking place regularly to review IPT transfers, and correct completion of documents. • Joint Kent & Medway Escalation PTL to be set up with GSTT as issues across all Trusts.
Patient engagement throughout pathways, multiple cancellations/DNA's	Ensure GP's are informing the patients they are being referred on a cancer pathway and not all investigations will be at the hospital nearest to them.	• Care Group Leads/ CNS's • GP's/Support Workers/Patient Engagement Officer K&M Cancer Alliance	• Nov 2023	• 2ww Transformation Working Group. • Working with our GP Cancer Lead to ensure patients are being told they are on a cancer pathway at referral • STT implementation • Early escalation to Cancer CNS's to support patients • Development of 2ww information of Trust web page to support patients and their relatives/carers on a cancer pathway, being designed

Diagnostic Waiting Times: DM01

Integrated Improvement Plan

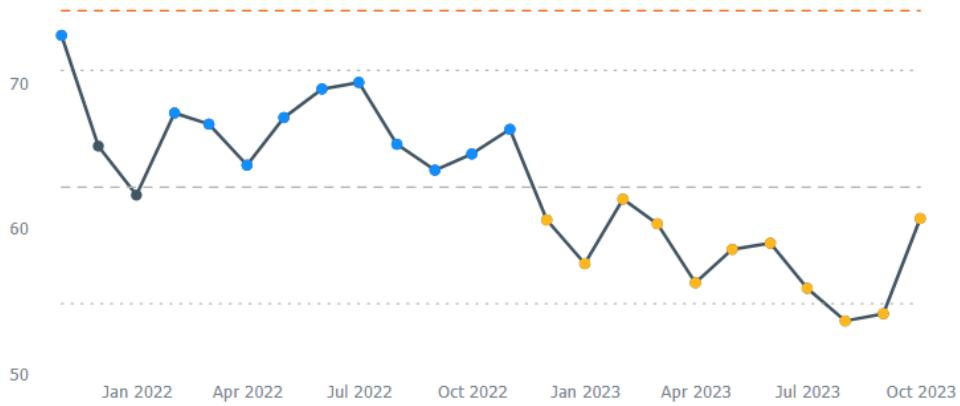
East Kent Hospitals University NHS Foundation Trust

Diagnostic tests/procedures are used to identify and monitor a person's disease or condition and which allows a medical diagnosis to be made. The national waiting time standard states that no more than 1% of patients should wait more than 6 week for their diagnostic test. The Trust currently has a stretch target to hit 75% by March 2024.

DM01 Compliance

Timescale	Value	SPC
Nov-22	66.8%	
Dec-22	60.6%	
Jan-23	57.6%	
Feb-23	62.0%	
Mar-23	60.3%	
Apr-23	56.3%	
May-23	58.6%	
Jun-23	59.0%	
Jul-23	55.9%	
Aug-23	53.6%	
Sep-23	54.1%	
Oct-23	60.7%	

XMR Run Chart



Understanding the most recent data point

Performance

60.7% — Variation indicates consistently falling short of the target

Variation

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

Flags: Below Mean Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT issues; • CT Cardiac • CT Vetting • Ranzac protocol	• Cardiac | awaiting review of external funding	• DCOO	• Awaiting approval	• CT Cardiac beaches reduced from 555 in Sept to 483 in Oct due to support from Chaucer. Awaiting grey list funding from CDC.
	• Vetting | Clearance of backlog	• Head of Imaging	• Completed	• Vetting numbers improved to 1,192 from 3,258 and stabilising.
	• Ranzac | agree protocol	• Head of Imaging	• Start mid Sep 24	• Guidance approved on 17/11. Sunrise update planned for 11/12 to go live.
MRI scanning capacity	Review of internal booking procedures within MRI	• Head of Imaging	• Completed – Sept 24	• Reduced MRI breaches from 2,800 to 2,100 in Sept and now at 75% compliance.
Endoscopy Capacity	WLI & ID Medical to provide 700 scopes per month for 12 months, additional mobile unit to support backlog from CDC underspend.	• DCOO	• Immediate	• Consultant engagement undertaken in November. • Business case being prepared for mobile unit.

Referral to Treatment Waiting Times: 65w Waits

Integrated Improvement Plan

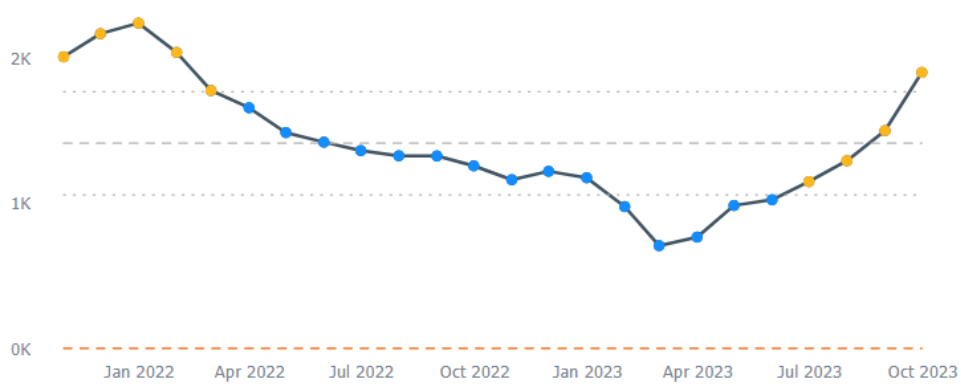
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 65 weeks to start treatment.
The Trust has a stretch target to eliminate 65w waits by the end of March 2024.

RTT 65w Breaches

Timescale	Value	SPC
Nov-22	1,161	
Dec-22	1,219	
Jan-23	1,175	
Feb-23	976	
Mar-23	707	
Apr-23	766	
May-23	984	
Jun-23	1,023	
Jul-23	1,148	
Aug-23	1,292	
Sep-23	1,499	
Oct-23	1,900	

XMR Run Chart



Understanding the most recent data point

Performance

1,900 — Variation indicates consistently falling short of the target

Variation

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

Flags — Astronomical Point; Ascending Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Non-admitted pathway delays impacting ability to reduce breaches	• Weekly recovery meetings re-set with MD's focussed on recovery actions (65 week risk cohort)	• DCOO • Interim MD	• Oct 2023 • End Nov	• Recovery meetings commenced in November. • Out patient transformation group to be refreshed aligned to national transformation requirements with first draft programme due at end of November.
Diagnostic delays – impacting ability to scan/scope routine (longer waiting RTT patients) creating significant increase in 78 week breaches	• Endoscopy Insourcing provision to be increased following conclusion of procurement process • Internal Diagnostic Group to be established in line with Planned Care governance refresh	• DCOO • DCOO • DCOO • DCOO	• Oct 2023 • Nov 2023 • Nov 2023 • Dec 2023	• Trajectories refreshed for each modality in October. • ICB support for Endoscopy requested to review full pathway transfers to less challenged sites. • MD for Cancer and Diagnostic Care Group appointed • Interim MD in post since 6th November. • Risk stratification of endoscopy waiting lists (surveillance, cancer and routine) completed and T&F group established. • QFIT of routine backlog to commence in December.
Admitted pathway delays – volume of 65 and 78 week breaches increasing (104 weeks breaches have not been eliminated)	• Delays driven by Endoscopy capacity. • Otology backlog to be reduced through recruitment and additional capacity. • Focus on Orthopaedic delays through Prism productivity review.	• DCOO • DCOO • MD SS	• Dec 2023	• Forecasting suggested increasing volumes of 65 and 78 week breaches monthly (trajectories completed) • Otology internal clearance plan to be agreed in December revolved around consultant new starter and additional WLI's • Prism diagnostic completed, Implementation phase to commence in Dec

Referral to Treatment Waiting Times: 52w Waits

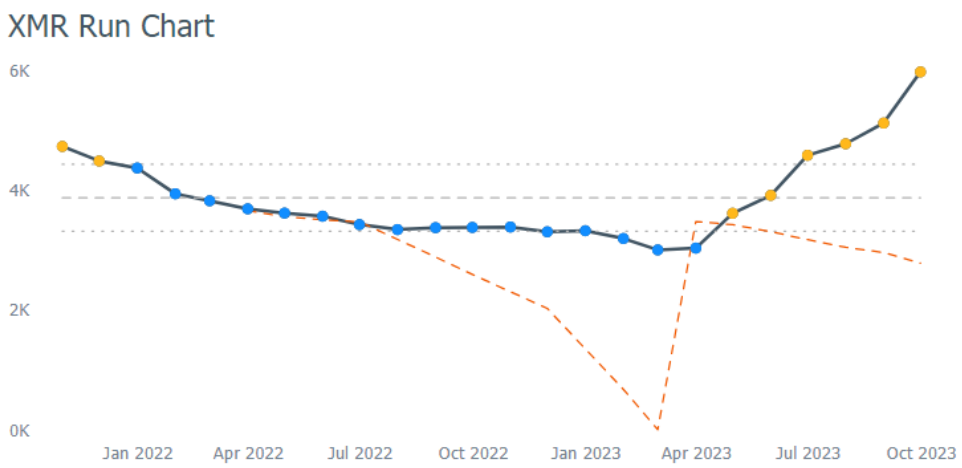
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 52 weeks to start treatment.

RTT 52w Breaches

Timescale	Value	SPC
Nov-22	3,379	
Dec-22	3,299	
Jan-23	3,317	
Feb-23	3,187	
Mar-23	2,997	
Apr-23	3,027	
May-23	3,608	
Jun-23	3,907	
Jul-23	4,575	
Aug-23	4,767	
Sep-23	5,113	
Oct-23	5,966	



Understanding the most recent data point

Performance

5,966

Variation indicates consistently falling short of the target

Variation

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

Flags: Outside Moving Range Limit; Astronomical Point; Ascending Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Business Plan 23/4 Elective activity (IP and DC) below plan – delivering circa 92% of plan and OP FU above 75% threshold	• PRISM to commence programme of work to improve theatre productivity • Specialities to quantify plans to deliver elective activity business plan • Specialities to quantify plans to deliver 5% PIFU and 75% OP FU (national out patient transformation requirement)	• PRISM • MD's • MD's	• Dec 2023 • Nov 2023 • Nov23 - Jan24	• PRISM completed diagnostic phase (4 week process) and Theatre Improvement Board to commence in Dec • Revised trajectories completed. • GiRFT Further Faster Programme commenced in November to inform PIFU and 75% FU reduction plan. Clinically led.
Validation - inability to deliver 90% target to clinically/administratively validate every patient over 12 weeks/every 12 weeks	• Implement two way text messaging for all patients to support requirement to validate requirement • Additional funding secured from NHSE to support initial validation requirement - £100K. • Require significant investment to develop a sustainable validation and training programme across the Trust	• Elective Recovery Director • DD of Info • DCOO/NHSEI	• Oct 2023 • Nov 2023 • Dec 2023	• PIDMA's commenced in November and held by NHSEI to review in Feb24. • Agreed to recruit 3 FTE's to support validation from £100K • Report provided on 7th November recognising requirement for training programme. Support to be agreed on 23rd November.

Cancer Performance

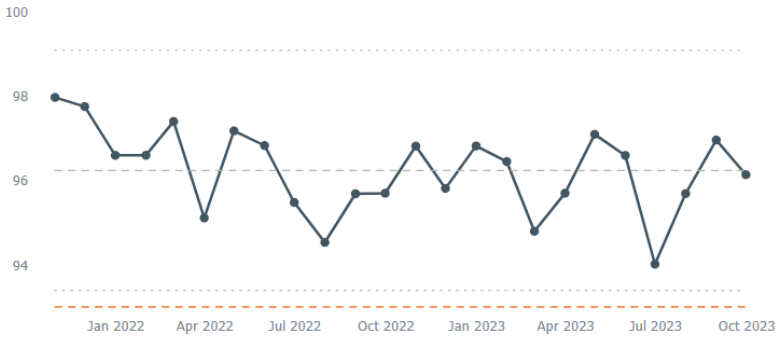
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Cancer 2ww Performance

Timescale	Value	SPC
Nov-22	96.8%	
Dec-22	95.8%	
Jan-23	96.8%	
Feb-23	96.4%	
Mar-23	94.8%	
Apr-23	95.7%	
May-23	97.1%	
Jun-23	96.6%	
Jul-23	94.0%	
Aug-23	95.7%	
Sep-23	97.0%	
Oct-23	96.1%	

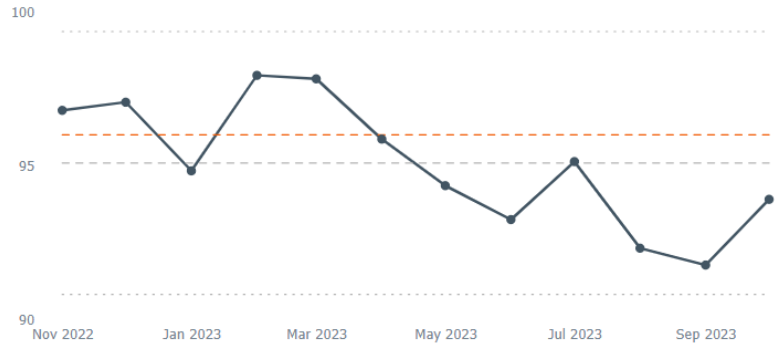
XMR Run Chart



Cancer 31d Combined P...

Timescale	Value	SPC
Nov-22	96.8%	
Dec-22	97.1%	
Jan-23	94.8%	
Feb-23	97.9%	
Mar-23	97.8%	
Apr-23	95.9%	
May-23	94.3%	
Jun-23	93.2%	
Jul-23	95.1%	
Aug-23	92.3%	
Sep-23	91.8%	
Oct-23	93.9%	

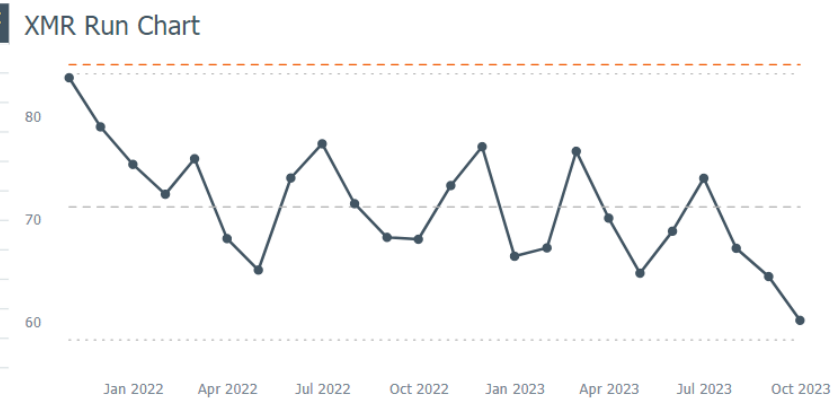
XMR Run Chart



Cancer 62d Combined P...

Timescale	Value	SPC
Nov-22	73.3%	
Dec-22	77.0%	
Jan-23	66.4%	
Feb-23	67.2%	
Mar-23	76.6%	
Apr-23	70.1%	
May-23	64.7%	
Jun-23	68.8%	
Jul-23	74.0%	
Aug-23	67.2%	
Sep-23	64.4%	
Oct-23	60.2%	

XMR Run Chart



PERFORMANCE UPDATE

2ww performance has dipped slightly in month but remains compliant with the national standard. 2WW working group and weekly capacity meetings in place

31 Day Performance improved within month and is highlighted weekly within Cancer Performance Feeder pack and daily escalation to influence continued improvement

62d performance deteriorated further, due largely to backlog and delays within endoscopy, radiology and urology.
Improvement actions are;

- Additional escalation for radiology now include Clinical lead to help support prioritisation
- Endoscopy backlog reducing beginning to see an improvement within Lower GI, but the backlog still significant and being addressed within the weekly performance meeting
- Straight to Test (STT) pathways for Lung, Lower GI, Upper GI and Haematuria being reviewed to share learning and improve further
- Enhanced escalation process in place for Consultant reviews, tertiary referrals, surgical dates and diagnostics to reduce the number of days on the pathway
- Engagement with Care Groups to support booking of patients through weekly feeder pack and PTL meetings to support teams juggling multiple demands
- Improving access to blood tests for cancer patients so that diagnostics can be booked earlier, this has made a huge improvement and will continue to take days out of the pathway.
- Educational event organised with GP Colleagues in Nov to support learning and earlier diagnostics

RTT Performance

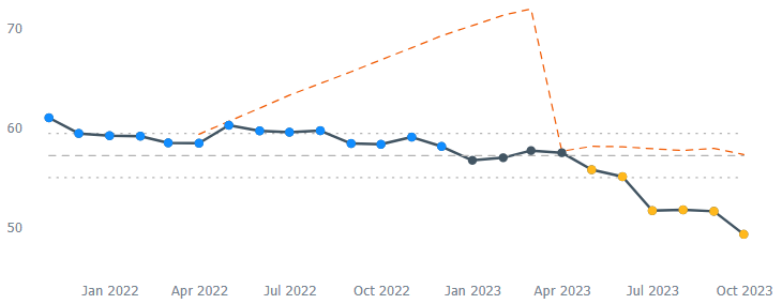
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

RTT Incomplete Performance

Timescale	Value	SPC
Nov-22	59.0%	
Dec-22	58.1%	
Jan-23	56.7%	
Feb-23	56.9%	
Mar-23	57.7%	
Apr-23	57.5%	
May-23	55.7%	
Jun-23	55.0%	
Jul-23	51.6%	
Aug-23	51.7%	
Sep-23	51.5%	
Oct-23	49.2%	

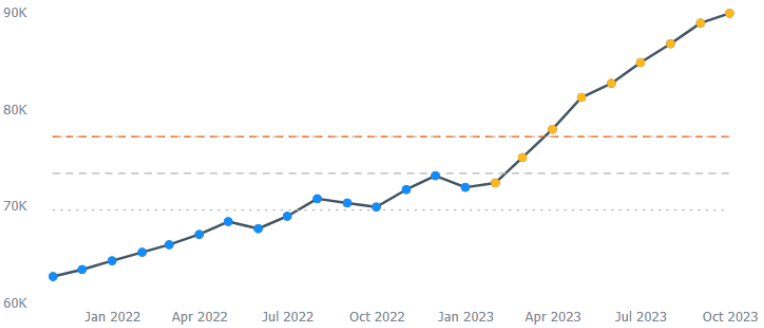
XMR Run Chart



RTT Total Incomplete P...

Timescale	Value	SPC
Nov-22	71.7K	
Dec-22	73.1K	
Jan-23	71.9K	
Feb-23	72.4K	
Mar-23	75.0K	
Apr-23	77.9K	
May-23	81.2K	
Jun-23	82.7K	
Jul-23	84.8K	
Aug-23	86.8K	
Sep-23	88.9K	
Oct-23	89.9K	

XMR Run Chart



PERFORMANCE UPDATE

Performance continues to deteriorate monthly due to our inability to increase capacity significantly beyond plan for patients waiting beyond 18 weeks for first definitive treatment.

The volume of total incomplete pathways is growing rapidly each week – a proportion of the referrals can be attributed to referral growth from primary care but a growing volume of out of area patients are being referred via non-primary care pathways to our clinicians.

Weekly more patient RTT pathways are being started (clock start) compared to those being ended (clock stop) by around 500 per week.

Elongated pathway waits in first, follow up and diagnostics are contributing to our ability to treat and end pathways before 78 weeks. The volume of 52, 65 and 78 week breaches are increasing weekly and are forecast to continue growing due to demand for cancer and lack of capacity to treat routine patients.
Particular concerns around Gastroenterology waits for 1st outpatient appts and Max-Fax. Max-Fax has targeted plan with new reg and trial of telephone consultations.

Validation has been a key focus for speciality teams since last year, approximately 50% of the total RTT PTL is validated. The plan to roll out a digital solution, to support teams validating, is progressing but needs significant investment to support validation/training in the short/medium/long term. Furthermore the option to utilise the patient portal to support this programme of work is being reviewed and considered but requires further investment and support to develop the system to its full potential.

DM01 performance is impacting waiting times – a radiology improvement plan to support recovery in the most challenged diagnostic modalities is in place, performance in month has seen an improvement to 60.7% from 54.1% in Sept due to reductions in breaches within CT and MRI.

Efficiency Metrics

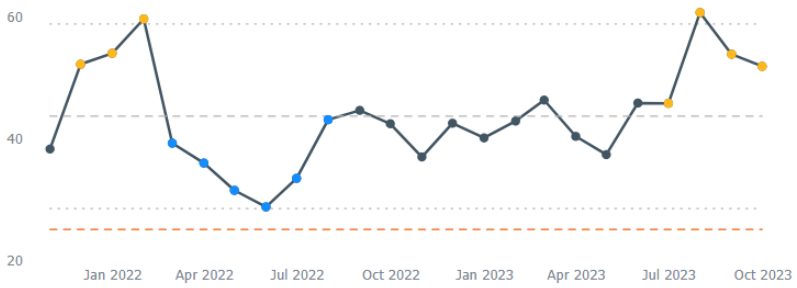
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

Timescale	Value	SPC
Nov-22	37	
Dec-22	42	
Jan-23	40	
Feb-23	43	
Mar-23	46	
Apr-23	40	
May-23	37	
Jun-23	46	
Jul-23	46	
Aug-23	61	
Sep-23	54	
Oct-23	52	

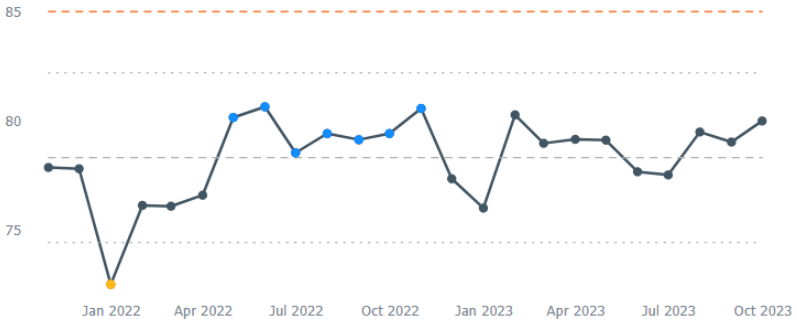
XMR Run Chart



Theatre Actual Utilisation

Timescale	Value	SPC
Nov-22	80.6%	
Dec-22	77.4%	
Jan-23	76.0%	
Feb-23	80.3%	
Mar-23	79.0%	
Apr-23	79.2%	
May-23	79.1%	
Jun-23	77.7%	
Jul-23	77.5%	
Aug-23	79.5%	
Sep-23	79.0%	
Oct-23	80.0%	

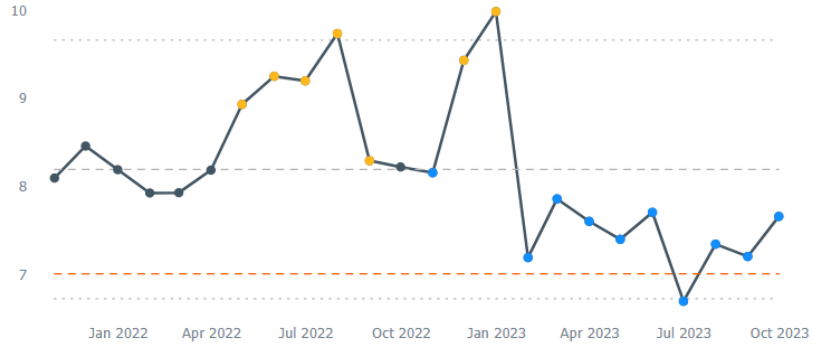
XMR Run Chart



DNA Rate OP New

Timescale	Value	SPC
Nov-22	8.1%	
Dec-22	9.4%	
Jan-23	10.0%	
Feb-23	7.2%	
Mar-23	7.9%	
Apr-23	7.6%	
May-23	7.4%	
Jun-23	7.7%	
Jul-23	6.7%	
Aug-23	7.3%	
Sep-23	7.2%	
Oct-23	7.7%	

XMR Run Chart



PERFORMANCE UPDATE

Doctor strike action continues to be a contributing factor to the high session opportunity and is likely to continue into Q3 with more strike action planned.

Theatre actual utilisation remains within normal variation around 78-79% utilised. Teams are being asked to book up to a minimum of 90% utilised in order to meet the aim of 85% actual utilisation moving forward. The Elective Orthopaedic Centre is aiming for an actual utilisation of 90%.

The theatre efficiency programme will be reviewed in line with new operational changes and specialty plans to improve theatre performance will be evaluated to ensure they are quantified and deliverable in line with theatre capacity and workforce.

DNA rates are improving but remain above the 7% threshold at 7.37 in October. Increasing numbers of patients now have the ability to choose their appointment date as specialties are moving back to the electronic referral service which appears to be having a positive impact and decreasing capacity lost due to DNA.

Quality & Safety

Quality & Safety

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Quality	IIP		Serious Incidents		Sigma	19	13	16	16	34	10	5	14	11	12	13	13
	IIP		Incidents - Moderate / Severe		Sigma	42	45	65	48	54	29	34	32	36	23	38	51
	IIP		Overdue Incidents		0	6,579	6,637	6,635	5,716	4,755	3,897	3,340	2,938	2,395	2,669	2,980	3,353
	IIP		Serious Incidents Breached exceed 60...		0	16	16	0	2	6	10	13	6	6	2	3	1
	IIP		HSMR		96.0	90.1	91.3	92.5	92.5	94.2	93.0	93.3	93.1	91.7			
	IIP		Pressure Ulcers		Sigma	116	135	137	104	115	127	127	122	104	113	94	148

October Performance Summary

Incident Reporting: There were 2,520 patient incidents reported in October, of which 13 were declared as serious incidents at the Serious Incident Declaration Panel, which is chaired by the Chief Nursing and Midwifery Officer, the Chief Medical Officer or the Director of Quality Governance. The number of incidents compares with 2,279 in September; 2,339 in August and 2,194 in July. A detailed report on these will be presented to CEMG on 6 December and Trust Board on 7 December, however a summary of each is presented on the next two slides.

Mortality: Following an upward trend in HSMR between October 2022 and March 2023, HSMR continues to improve and remains below expected. Analysis by the Mortality Surveillance Steering Group did not identify any specific reason for the upward trend seen prior to March 2023.

Harm Events: The number of harm events continues to show a plateauing trend this financial year with a subsequent increase in cases taken to the Serious Incident Declaration Panel, although not all cases presented resulted in an SI being declared. There was a significant spike in numbers during 4th quarter of 2022/2023 which was followed by a levelling up period in the first and second quarters of 2023/2024. This appears to be returning to a similar baseline. On initial review, the Patient Safety Team has not identified any specific themes and will be reviewing the figures for moderate harm during the past 12 months to establish any problems requiring additional investigation and support.

Serious Incidents

Integrated Improvement Plan

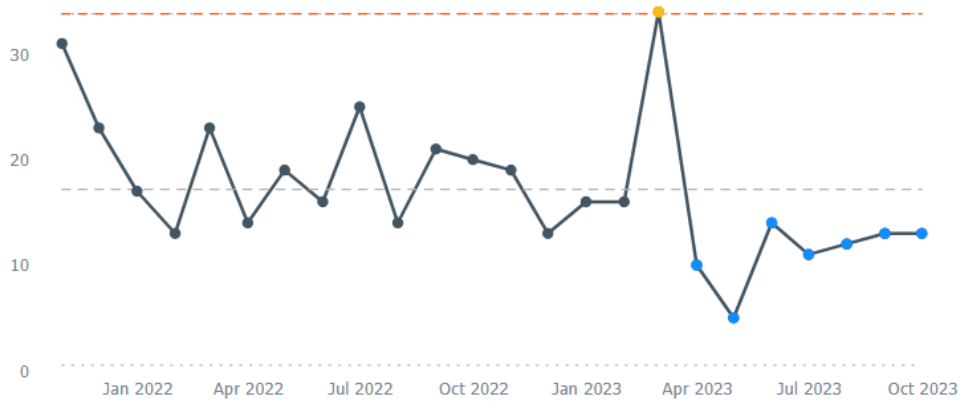
East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents

Timescale	Value	SPC
Nov-22	19	
Dec-22	13	
Jan-23	16	
Feb-23	16	
Mar-23	34	
Apr-23	10	
May-23	5	
Jun-23	14	
Jul-23	11	
Aug-23	12	
Sep-23	13	
Oct-23	13	

XMR Run Chart



Understanding the most recent data point

Performance

13

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Below Mean Run Group

As described on the previous slide, there were 12 SIs reported in August and which are currently being investigated.
In summary these were:

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
• Three diagnostic delay cases	It is nationally recognised that there is a risk of discrepancies occurring within radiology reporting which occur for a number of different reasons including satisfaction of search, image quality, perception and incomplete clinical information. Case to be discussed at the Robust Radiology Events and Learning Meeting (REALM) forum to assist with recognising further learning points and to reduce further incidents One case relates to failure to follow up on diagnostic scan from 12 months earlier.	• Care Group leadership teams.	• Within 60 days of each incident being reported on StEIS.	• The investigations are in progress.
Please see next slide				→

Serious Incidents

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
• One baby was born at full term in unexpectedly poor condition and required transferring to the Neonatal Intensive Care Unit (NICU).	• The baby underwent therapeutic hyperthermia (cooling) to treat hypoxic-ischemic injury. The case was referred to MNSI to investigate as it met their criteria for reporting.	• Care Group Leadership Team	• MNSI (previously HSIB) will provide timescales and appropriate extensions will be sought via ICB accordingly.	• This investigation is in progress.
• Never Event	• Retained guidewire retrieved and no harm sustained to the patient.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• This investigation is in progress.
• One falls-related incident	• Omissions in care as Falls risk assessment not adhered to.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• This investigation is in progress.
• Medication incidents	• Permanent staining from a Monofer iron infusion due to extravasation. • Prescribing error combining Oromorph and Zomorph rectified.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• The investigations are in progress.
• Four incidents involving delay in appropriate treatment and recognising deteriorating patient/escalating condition	• In each case (which have very different circumstance) Immediate learning around transfer of patient and escalation.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• The investigations are in progress.

Overdue Incidents

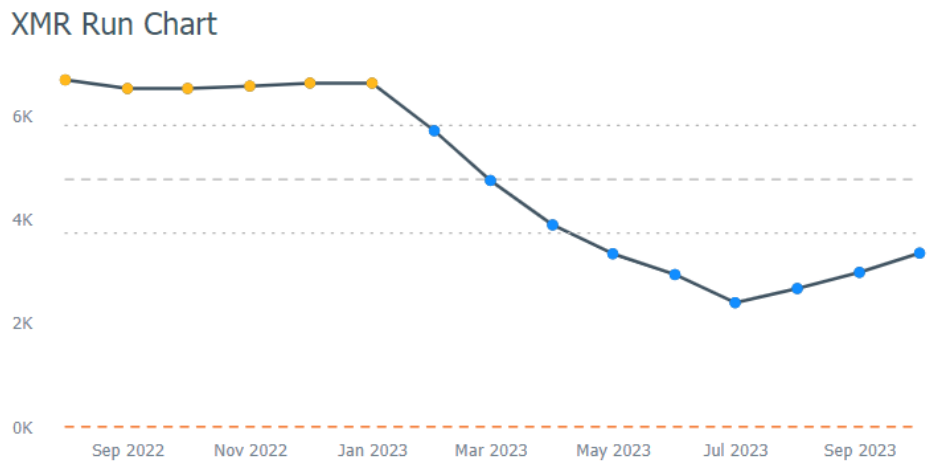
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of incidents which are overdue their agreed timescale for closure (all types) both overall and at each key stage of the investigation process: Awaiting review (AWAREV), In Review (INREV) and Awaiting Final Approval (AWAFA)

Overdue Incidents

Timescale	Value	SPC
Nov-22	6,579	
Dec-22	6,637	
Jan-23	6,635	
Feb-23	5,716	
Mar-23	4,755	
Apr-23	3,897	
May-23	3,340	
Jun-23	2,938	
Jul-23	2,395	
Aug-23	2,669	
Sep-23	2,980	
Oct-23	3,353	



Understanding the most recent data point

Performance

3,353

Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
It has been identified that the number of overdue incidents has been inaccurately counted. The method for calculating overdue incidents has included open incidents breaching at each stage rather than the overall deadline being breached. This was discovered as part of our new approach providing intensive support to the care groups. Work is underway to address the discrepancies this week.	• A recount and quality checks of overdue incidents is now taking place and will be reported on next month, with the figures adjusted.	• Director of Quality Governance	20 December 2023	

Incidents Causing Harm

Integrated Improvement Plan

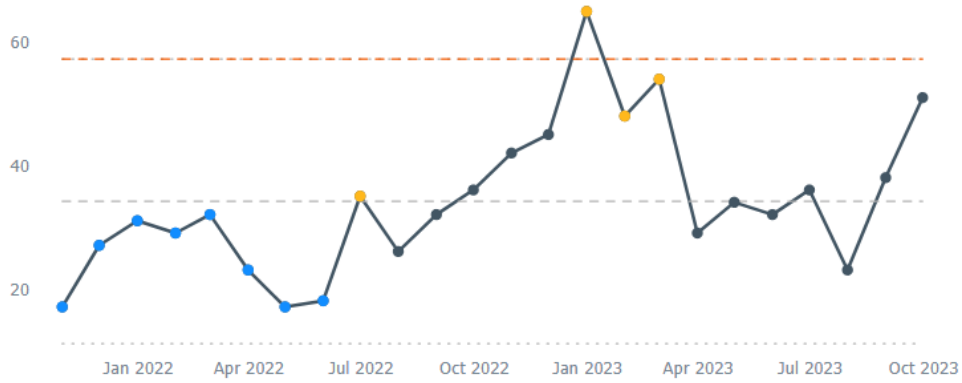
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of clinical incidents where the harm status was moderate or above.

Incidents - Moderate / ...

Timescale	Value	SPC
Nov-22	42	
Dec-22	45	
Jan-23	65	
Feb-23	48	
Mar-23	54	
Apr-23	29	
May-23	34	
Jun-23	32	
Jul-23	36	
Aug-23	23	
Sep-23	38	
Oct-23	51	

XMR Run Chart



Understanding the most recent data point

Performance

51

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Four moderate harm incidents relating to patients returning to theatre following bowel surgery due to anastomosis leaks. The procedures were undertaken by different surgeons. On initial review, the Patient Safety Team has not identified any other specific themes for moderate harms other than those identified above and on slides 21 & 22 however they will be reviewing the figures for moderate harm during the past 12 months to establish any problems requiring additional investigation and support.	The patient's care were reviewed: • No acts or omissions in care identified • Anastomic leak is a known complication of bowel surgery • Confirmed that risk was included in the consent for surgeries • DoC still applies and completed with patients face to face post operatively	• Colorectal surgeon	• 30/11/2023	Incidents relating to this type of complication reviewed. There have been a total of 11 reported since April 2023 (including these 4 incidents) and therefore reporting in October is slightly above the usual reporting rate for this type of complication. Colorectal surgeon SM asked to review to identify any themes as to why increased incident type in October.

Hospital Standardised Mortality Ratio (HSMR)

Integrated Improvement Plan

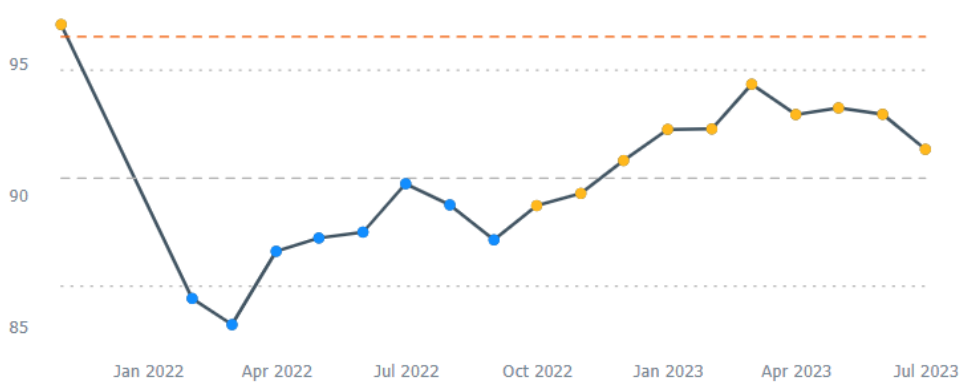
East Kent Hospitals University NHS Foundation Trust

HSMR is a statistical number that enables the comparison of mortality rates between hospitals. This prediction takes account of factors such as the age and sex of the patient, their primary diagnosis, specialist palliative care and social deprivation of the area they live in. It is based on the 56 diagnostic groups which contribute to 80% of in-hospital deaths in England. HSMR is based on the likelihood of a patient dying of the condition with which they were admitted to hospital. If a Trust has an HSMR of 100 it means the number of patients who died is exactly as expected.

HSMR

Timescale	Value	SPC
Aug-22	89.6	
Sep-22	88.3	
Oct-22	89.6	
Nov-22	90.1	
Dec-22	91.3	
Jan-23	92.5	
Feb-23	92.5	
Mar-23	94.2	
Apr-23	93.0	
May-23	93.3	
Jun-23	93.1	
Jul-23	91.7	

XMR Run Chart



Understanding the most recent data point

Performance

91.7

Variation indicates consistently passing the target

Variation

Variation	Special cause of concerning nature or higher pressure due to higher values
Flags	Above Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
To agree, develop and implement a Trust-wide Fractured Neck of Femur Pathway that will address and improve the eight Key Performance Indicators on the National Hip fracture database	• Analyse the recent increase to relative risk reported on Telstra Health UK via MSSG • Confirm comments from WHH regarding fast track process • Launch ring fencing/fast track pilot on Seabathing & Kings C1	• KCVH CG	• Ongoing	• Ongoing work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection.
HSMR by site of discharge: • K & C statistically, statistically lower than expected: 49.4 • QEQM 'as expected': 101.7 • WHH 'as expected': 79.4	• Compare data through Telstra and integrate with the fractured NoF improvement plan noting WHH fractured NoF mortality is low • Review impact of higher than avg patient complexity (Charlson Comorbidity) score.	• CMO	• Ongoing	• Identified at previous MSSG meeting for further investigation analysis.
WHH Relative Risk is statistically higher than expected for emergency weekday admissions for Acute MI and Pleurisy, pneumothorax, pulmonary collapse. It is also statistically higher than expected for emergency weekend admissions for Skin and subcutaneous tissue infections	• Continue to review and analyse data in MSSG • Identify any areas of concern and develop countermeasures for this to address relative risk above 100.	• CMO	• Ongoing	• Analysis ongoing • Progress noted at November MSSG but not able to finalise analysis at present.

Pressure Ulcers

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.
This measure counts the number of hospital acquired pressure ulcers graded 1 to 4.
Datasource: DATIX

Pressure Ulcers

Timescale	Value	SPC
Nov-22	116	
Dec-22	135	
Jan-23	137	
Feb-23	104	
Mar-23	115	
Apr-23	127	
May-23	127	
Jun-23	122	
Jul-23	104	
Aug-23	113	
Sep-23	94	
Oct-23	148	

XMR Run Chart

Understanding the most recent data point

Performance

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

Variation

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

Flags — Outside Moving Range Limit

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inaccurate Risk assessment resulting in delays or inappropriate pressure ulcer (PU) prevention interventions	• To rollout PURPOSE T risk assessment to replace Waterlow trust wide.	• Lead TVN Specialist.	• Trust wide Rollout Jan 2024	• Training has been completed in both EDs • Maternity: to commence use in November. • Rollout to general wards will commence in December/January teaching to start in AMUs on both sites
Increased pressure damage noted to the feet due to positioning in the bed.	• PURPOSE T risk assessment, will provide prompts to examine all areas susceptible to damage. • Highlight at the Nov Stop the Pressure campaign & study days • Campaign with Manual and Handling team to raise awareness of applying bed bolsters to the head of the bed. Including on the spot checks from both teams	• TVN/ Manual Handling	• Dec 2023	• Discussed at Bi annual tissue Viability Study day. • Trust wide Stop the Pressure awareness campaign in November. • Discussed at Pressure Ulcer Steering group both teams are raising awareness when on the wards.
Key issue in documentation due to gaps in repositioning appears patient been in the same position for long periods	• Ward audits for areas with ward based teaching as targeted approach. • SKINS Document simplified following staff feedback • PURPOSE T documentation will have a bespoke care plan including a prompt on repositioning.	• Lead TVN Specialist.	• Mar 2024	• New document has bee uploaded to Allscripts. • Discussion at latest Bi annual Tissue Viability Study Day • As per the progress of PURPOSE T rollout.

Falls

Integrated Improvement Plan

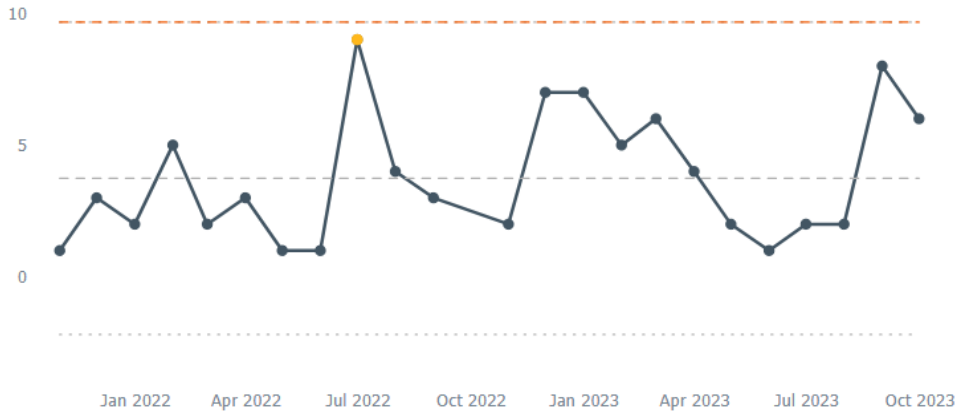
East Kent Hospitals University NHS Foundation Trust

Falls in hospital are the most commonly reported patient safety incidents, with more than 280,000 safety incidents reported in inpatient settings in England every year. Falls in older people are more likely to result in harm and when harm occurs it is three times more likely to be severe.
This metric measures the number of reported incidents classified as falls where a harm level of moderate or above was identified.
Datasource: Datix

Falls

Timescale	Value	SPC
Nov-22	2	
Dec-22	7	
Jan-23	7	
Feb-23	5	
Mar-23	6	
Apr-23	4	
May-23	2	
Jun-23	1	
Jul-23	2	
Aug-23	2	
Sep-23	8	
Oct-23	6	

XMR Run Chart



Understanding the most recent data point

Performance

6

Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Three severe harm falls resulting in fractured neck of femur. Three moderate harm falls resulting in • Fractured scapula and ribs • Fractured patella • Fractured humerus. Lack of MCA & Enhanced observations.	• Embed cohort culture across EKHUFT • Embed yellow tabards • Embed door bell help system • Collaboration with safe guarding to deliver targeted training	• Lead Nurse for Falls • CNS	• April 2024 • Ongoing	• Discussions with care group leads to identify areas to begin roll out of tabard and door bell system • Meeting planned with safe guarding lead to discuss targeted training collaboration.
Increase in unwitnessed falls, repeat unwitnessed patient falls in our most vulnerable patients.	• Embed cohort culture across EKHUFT • Collaborative working of specialist teams including dementia and safe guarding team.	• Lead Nurse for Falls • CNS	• April 2024	• Discussions with care group leads to identify areas to begin roll out of tabard and door bell system • Discussions with collaborative specialist teams
Inability to embed consistent change through learning from incidents. Limitations to deliver targeted training.	• Identify high risk areas with repeat harm events and deliver consistent support. • CNS presence to support clinical areas trust wide	• Lead Nurse for Falls • CNS	• July 2024 • July 2024	• Roll out of training trust wide, one clinical area at one time. Limitations due to priority of work load. • Lead nurse and CNS cross site support where able.

Incident Reporting

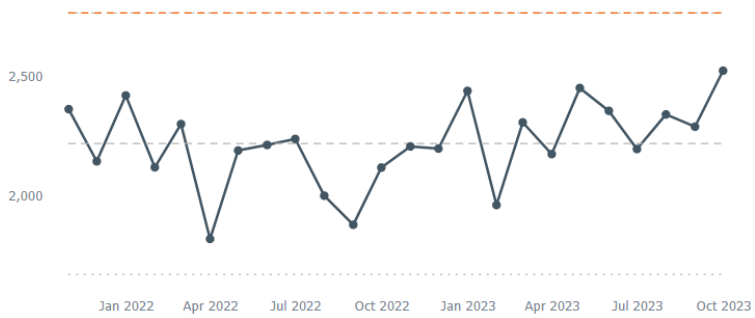
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Clinical Incidents

Timescale	Value	SPC
Nov-22	2,205	
Dec-22	2,196	
Jan-23	2,436	
Feb-23	1,961	
Mar-23	2,305	
Apr-23	2,173	
May-23	2,448	
Jun-23	2,353	
Jul-23	2,194	
Aug-23	2,338	
Sep-23	2,287	
Oct-23	2,520	

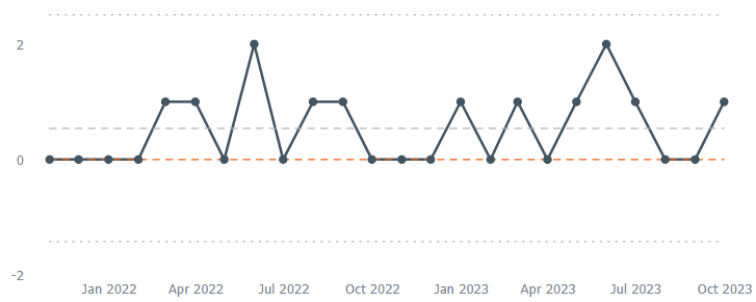
XMR Run Chart



Never Events

Timescale	Value	SPC
Nov-22	0	
Dec-22	0	
Jan-23	1	
Feb-23	0	
Mar-23	1	
Apr-23	0	
May-23	1	
Jun-23	2	
Jul-23	1	
Aug-23	0	
Sep-23	0	
Oct-23	1	

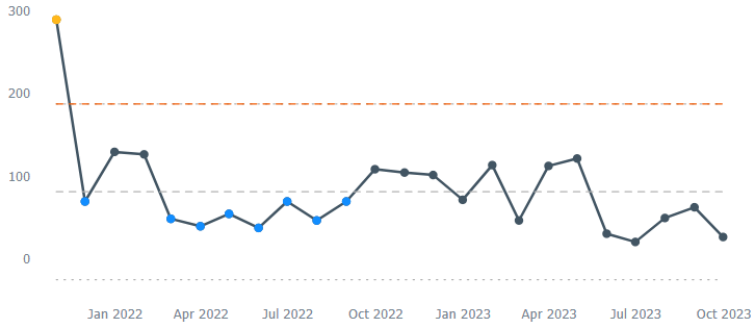
XMR Run Chart



Mixed Sex Breaches

Timescale	Value	SPC
Nov-22	104	
Dec-22	101	
Jan-23	71	
Feb-23	113	
Mar-23	46	
Apr-23	112	
May-23	121	
Jun-23	30	
Jul-23	20	
Aug-23	49	
Sep-23	62	
Oct-23	26	

XMR Run Chart



PERFORMANCE UPDATE

Clinical Incident reporting continues to show common cause variation and no significant change. It remains below the upper threshold set for clinical incidents. Ensuring that no-harm events are scrutinised gives assurance that all of these events are captured.

There was 1 Never Event in October 23, relating to retained guidewire post surgery.

- A number of actions have been implemented including a cold de-brief to ensure staff were supported and maximum learning drawn out of the incident.
- A review of current practice was undertaken to check the integrity of guidewires being used and mitigate future cases with pre/peri/post operative checks on the guidewire.
- A look-back review was completed to establish any other patients who may have had the same issue with retained guidewire-none were identified.
- MHRA Yellow card was completed.

Mixed sex breaches: The graph shows us incidences of unjustifiable Mixed Sex Accommodation breaches due to non clinical reasons. The key objective is to achieve zero Mixed sex accommodation breaches. In March 23 it was agreed with the ICB that SEAU would change to Surgical SDEC and therefore out of scope for national reporting, resulting in consistency across Kent and Medway. In July 23 a further agreement was reached with the ICB that MAU breaches are those sharing mixed sex accommodation for greater than 4 hours, with a decision to admit, but that the breach declared will be for the individual patient and not the unit as a whole.
No complaints have been received about mixed sex accommodation from patients during the last 3 months.

Duty of Candour

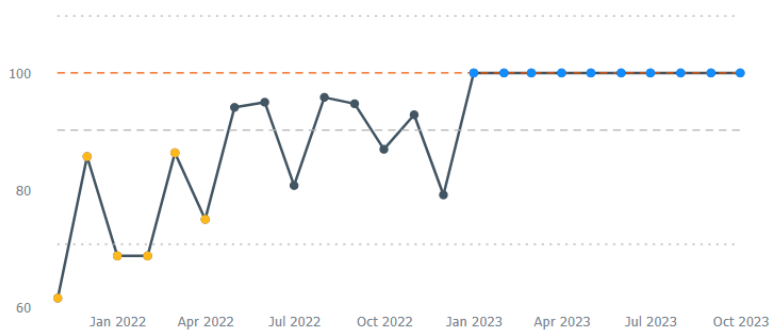
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Duty of Candour - Verbal

Timescale	Value	SPC
Nov-22	92.9%	
Dec-22	79.2%	
Jan-23	100%	
Feb-23	100%	
Mar-23	100%	
Apr-23	100%	
May-23	100%	
Jun-23	100%	
Jul-23	100%	
Aug-23	100%	
Sep-23	100%	
Oct-23	100%	

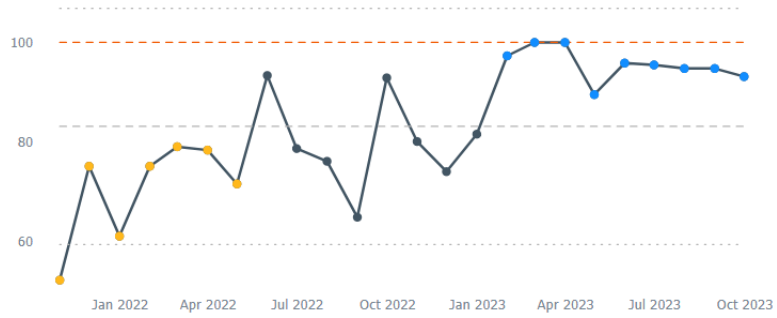
XMR Run Chart



Duty of Candour - Writt...

Timescale	Value	SPC
Nov-22	80.0%	
Dec-22	73.9%	
Jan-23	81.5%	
Feb-23	97.3%	
Mar-23	100%	
Apr-23	100%	
May-23	89.5%	
Jun-23	95.8%	
Jul-23	95.5%	
Aug-23	94.7%	
Sep-23	94.7%	
Oct-23	93.1%	

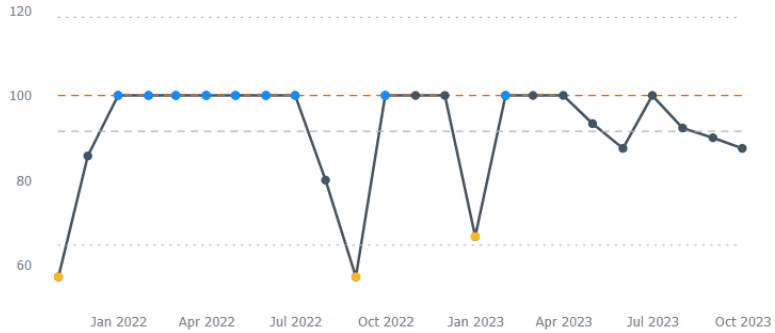
XMR Run Chart



Duty of Candour - Findi...

Timescale	Value	SPC
Nov-22	100%	
Dec-22	100%	
Jan-23	66.7%	
Feb-23	100%	
Mar-23	100%	
Apr-23	100%	
May-23	93.3%	
Jun-23	87.5%	
Jul-23	100%	
Aug-23	92.3%	
Sep-23	90.0%	
Oct-23	87.5%	

XMR Run Chart



PERFORMANCE UPDATE

Duty of Candour (DoC) metrics have been upheld since January 2023. The data for July had a discrepancy which has been resolved. Verbal DoC 100% compliant.

Written DoC within 15 working days non-compliance in 2 cases, but both were completed within 20 days.

The final DoC letter which accompanies the completion of the investigation report was compliant in all but 1 case, where by the report findings were not sent until November, but is now compliant.

Twice weekly meetings between Governance leads and DDQG continue to address non-compliance and barriers to completion.

Complaints

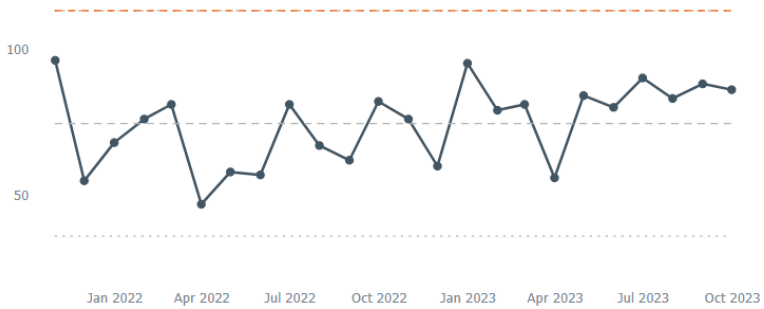
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Complaints Number

Timescale	Value	SPC
Nov-22	76	
Dec-22	60	
Jan-23	95	
Feb-23	79	
Mar-23	81	
Apr-23	56	
May-23	84	
Jun-23	80	
Jul-23	90	
Aug-23	83	
Sep-23	88	
Oct-23	86	

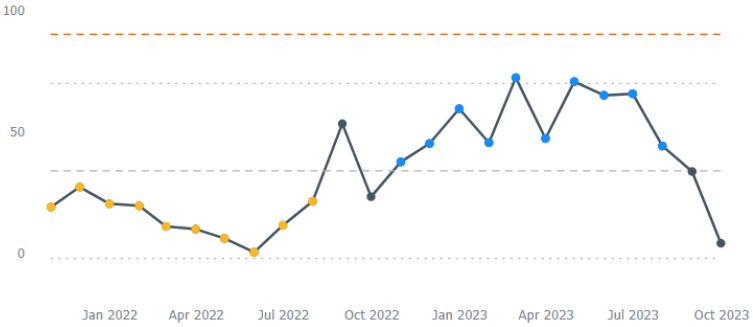
XMR Run Chart



Complaint Response

Timescale	Value	SPC
Nov-22	37.3%	
Dec-22	44.9%	
Jan-23	59.3%	
Feb-23	45.2%	
Mar-23	72.1%	
Apr-23	46.9%	
May-23	70.5%	
Jun-23	64.8%	
Jul-23	65.5%	
Aug-23	43.9%	
Sep-23	33.3%	
Oct-23	3.7%	

XMR Run Chart



PERFORMANCE UPDATE

October 2023 saw 1006 contacts to the department resulting in 86 new formal complaints and 444 new PALS contacts being taken forward. 8.5% of contacts in October 2023 were taken forward as new formal complaints. 93% of the new complaints were acknowledged within three working days, this is above the target of 90%.

As a seasonal comparison, in October 2022 there was 76 complaints and 647 PALS; a 13% increase in complaints. This equates to a 31% decrease in new PALS cases. October 2022 to April 2023 the PALS team set up the Waiting Patient Service with temporary staff. The service dealt with enquiries about delays to surgery and waiting times, part of the work coming out of the pandemic. The Waiting Patient contacts were recorded as PALS during this time and reflects the increased number of PALS recorded during the above period. In April 2023 this service was closed and the resource withdrawn from PALS which accounts for the drop in contacts.

October 2023 saw a decrease in performance of responses within timescales to 4%, from 35% in September 2023. The reason for the drop in compliance is owing to a sustained increased number of new complaints which is impacting on complaint response performance as well as the implementation of strict sign off standards within the Care Groups to drive up the quality.

A project to reduce the backlog of complaints, along with breaching complaints has started. An interim is in post (13.11.2023) to support the care groups and central complaints team to drive quality complaint responses within timescales. 30.09.2023 there was an identified backlog of 26 complaints, with a further 83 complaints breaching as at 31.11.2023. This project is supported with review meetings with the care groups governance leads to monitor the trajectory and review progress.

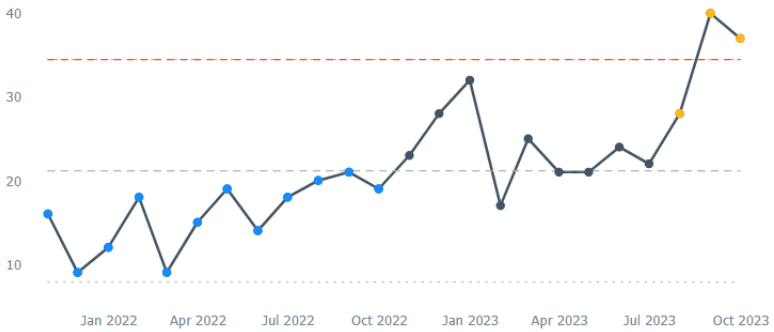
Safeguarding
Statutory Metrics

NHS
East Kent Hospitals University
NHS Foundation Trust

Safeguarding Incidents

Timescale	Value	SPC
Nov-22	23	
Dec-22	28	
Jan-23	32	
Feb-23	17	
Mar-23	25	
Apr-23	21	
May-23	21	
Jun-23	24	
Jul-23	22	
Aug-23	28	
Sep-23	40	
Oct-23	37	

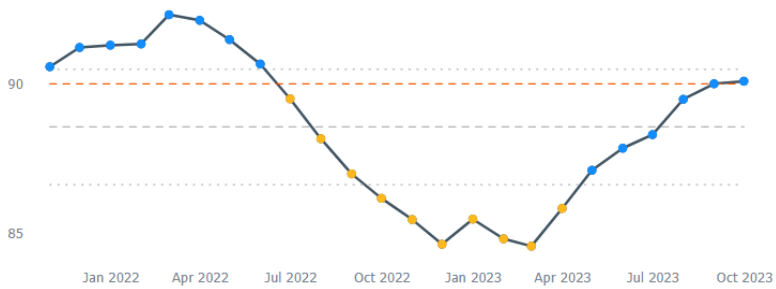
XMR Run Chart



Safeguarding Children T...

Timescale	Value	SPC
Nov-22	85.5%	
Dec-22	84.6%	
Jan-23	85.5%	
Feb-23	84.8%	
Mar-23	84.6%	
Apr-23	85.8%	
May-23	87.1%	
Jun-23	87.8%	
Jul-23	88.3%	
Aug-23	89.5%	
Sep-23	90.0%	
Oct-23	90.1%	

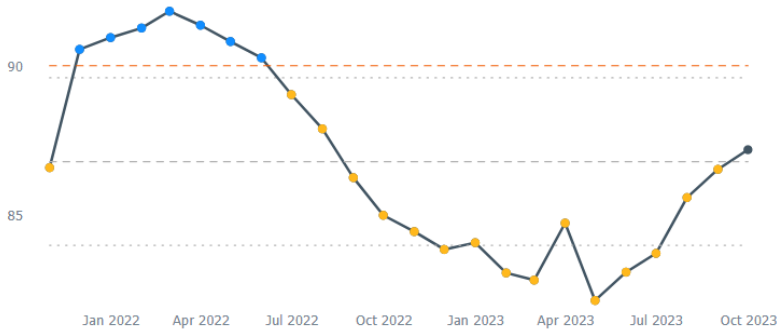
XMR Run Chart



Safeguarding Adults Tra...

Timescale	Value	SPC
Nov-22	84.5%	
Dec-22	83.9%	
Jan-23	84.1%	
Feb-23	83.1%	
Mar-23	82.9%	
Apr-23	84.8%	
May-23	82.2%	
Jun-23	83.1%	
Jul-23	83.7%	
Aug-23	85.6%	
Sep-23	86.5%	
Oct-23	87.2%	

XMR Run Chart



PERFORMANCE UPDATE

The reporting of all safeguarding metrics is outlined in the Business report and safeguarding dashboard with KPIs. This report goes to the Safeguarding Operational Group with exception to the Safeguarding Assurance Committee. Safeguarding metrics were also reported in the last Schedule 4 to the ICB.

The number of safeguarding concerns raised has remained consistent across the Trust in September. There was a higher than average amount for patients who left before full assessment and treatment.

The review of the number of open section 42s and overdue was undertaken and a paper presented to the closed section of the Safeguarding Assurance Committee in October 2023, which indicated that as of October 2023. The mitigation for the backlog is that additional resources have been sourced to clear the backlog, which has started. Currently there are **36** cases awaiting completion and **66** awaiting further actions from the LA.

With regards to training - there remains a very small shortfall in training compliance at level 2 (children 83% and adults 84%) and a shortfall at level 3 (adults 70%) across the Care Groups at the agreed local level of **85% in line with national level** (end of September compliance).

There has been some improvements by Care Group, however, the compliance by December 2023 trajectories may not be achievable, therefore, the Safeguarding team will continue to explore options with the care groups to support with this.

The safeguarding team continue to provide more sessions and support, however, the DNA fluctuates (16% in Sep) This is being addressed by the Deputy Chief Nurse and the Care Groups Governance.

This is also being addressed through the NHSE and ICB Safeguarding Oversight Meetings, ICB PQM through schedule 4 requirements and the CQC must do requirements relating to safeguarding training.

Infection Prevention Control

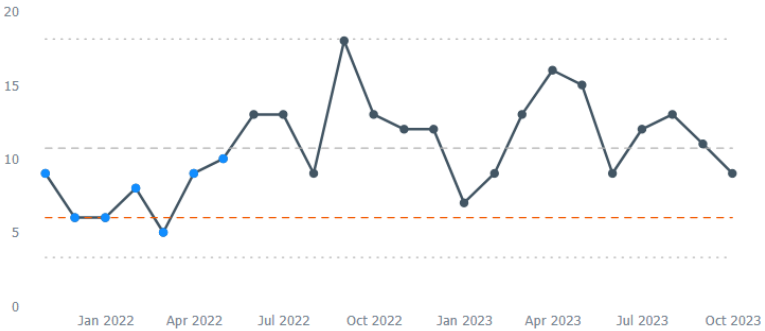
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

IPC: CDiff Infections

Timescale	Value	SPC
Nov-22	12	
Dec-22	12	
Jan-23	7	
Feb-23	9	
Mar-23	13	
Apr-23	16	
May-23	15	
Jun-23	9	
Jul-23	12	
Aug-23	13	
Sep-23	11	
Oct-23	9	

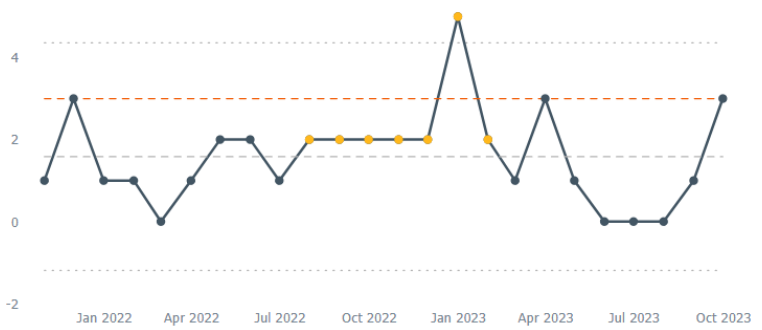
XMR Run Chart



IPC: Pseudomonas Infe...

Timescale	Value	SPC
Nov-22	2	
Dec-22	2	
Jan-23	5	
Feb-23	2	
Mar-23	1	
Apr-23	3	
May-23	1	
Jun-23	0	
Jul-23	0	
Aug-23	0	
Sep-23	1	
Oct-23	3	

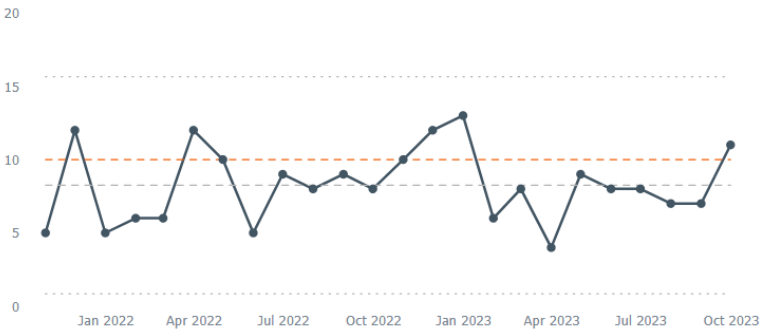
XMR Run Chart



IPC: EColi Infections

Timescale	Value	SPC
Nov-22	10	
Dec-22	12	
Jan-23	13	
Feb-23	6	
Mar-23	8	
Apr-23	4	
May-23	9	
Jun-23	8	
Jul-23	8	
Aug-23	7	
Sep-23	7	
Oct-23	11	

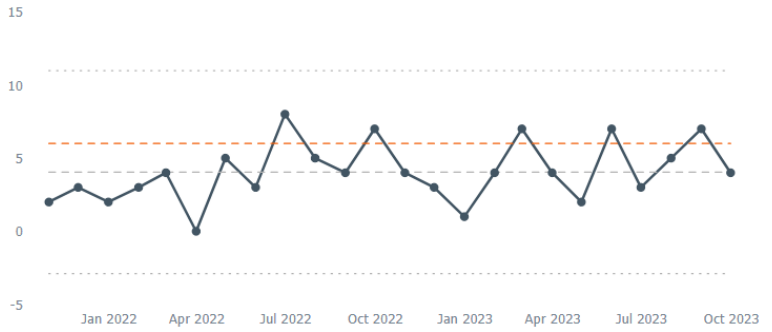
XMR Run Chart



IPC: Klebsiella Infections

Timescale	Value	SPC
Nov-22	4	
Dec-22	3	
Jan-23	1	
Feb-23	4	
Mar-23	7	
Apr-23	4	
May-23	2	
Jun-23	7	
Jul-23	3	
Aug-23	5	
Sep-23	7	
Oct-23	4	

XMR Run Chart



PERFORMANCE UPDATE

Performance against trajectories for the gram negative bacteraemias remains just above target, with ongoing monitoring and local actions underway where incidences occur.

The C-dif trajectory remains one of concern, and the Trust has already breached the threshold for this year by 4 cases. All cases are reviewed for learning, and the main focus remains antimicrobial stewardship and environment and equipment cleaning. C-dif rates remain a regional concern, with other local Trusts reporting higher rates of c-dif than us, and we are active participants in the regional c-dif reduction group, lead by the ICB.

Friends & Family Test

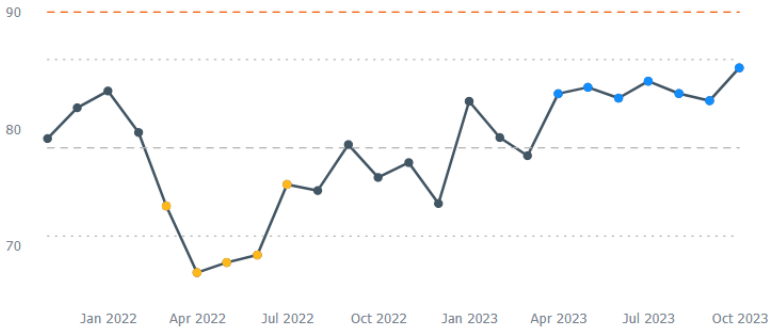
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

FFT_Satisfaction_ED

Timescale	Value	SPC
Nov-22	77.1%	
Dec-22	73.6%	
Jan-23	82.4%	
Feb-23	79.3%	
Mar-23	77.7%	
Apr-23	83.0%	
May-23	83.6%	
Jun-23	82.6%	
Jul-23	84.1%	
Aug-23	83.0%	
Sep-23	82.4%	
Oct-23	85.2%	

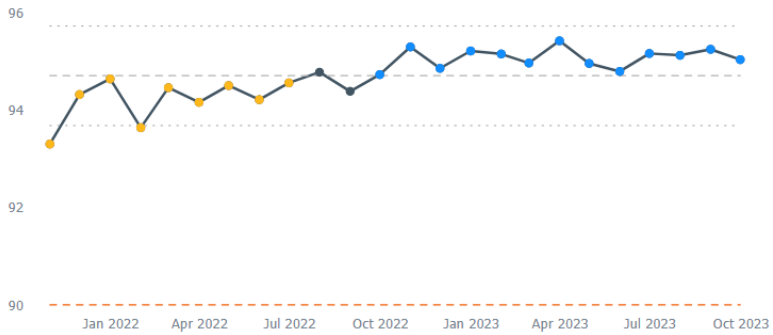
XMR Run Chart



FFT_Satisfaction_OP

Timescale	Value	SPC
Nov-22	95.3%	
Dec-22	94.9%	
Jan-23	95.2%	
Feb-23	95.2%	
Mar-23	95.0%	
Apr-23	95.4%	
May-23	95.0%	
Jun-23	94.8%	
Jul-23	95.2%	
Aug-23	95.1%	
Sep-23	95.2%	
Oct-23	95.0%	

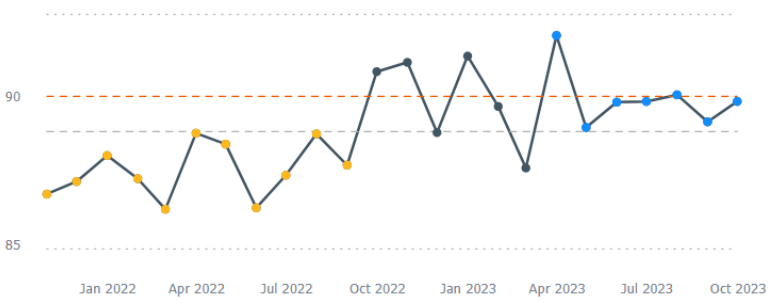
XMR Run Chart



FFT_Satisfaction_IP

Timescale	Value	SPC
Nov-22	91.1%	
Dec-22	88.8%	
Jan-23	91.4%	
Feb-23	89.7%	
Mar-23	87.6%	
Apr-23	92.1%	
May-23	88.9%	
Jun-23	89.8%	
Jul-23	89.8%	
Aug-23	90.0%	
Sep-23	89.1%	
Oct-23	89.8%	

XMR Run Chart



PERFORMANCE UPDATE

The trust's overall satisfaction level has remained over our target level of 90% for the past two years. **In October 2023 it was 93.7%.** The response rate was 19.4% overall. Looking at overall satisfaction by site Care Groups it varied from 90% for WHH Care Group (1% higher than in September) to 91.7% at QEQM Care Group and 93.&% for K&CH/RVH Care Group.

For out-patients the satisfaction level was 95% overall, a reduction of 1%. This is based on 12,858 responses - 20% of people sent the FFT survey. The highest satisfaction level was at Buckland Hospital – 96.8% and lowest at Kent and Canterbury at 94.5%. QEQM was 94.9%, William Harvey was 94.1% and Royal Victoria was 95.5%.

For in-patients the overall satisfaction score across the three sites was 90.1%. This is based on 1,132 responses, which is 17% of those sent the FFT survey. The highest satisfaction level for in-patients was 95.6% at Kent and Canterbury, followed by 89.1% at QEQM and 89% at William Harvey. **Triangulation of theming from FFT, the national in-patient survey and our Trust in-patient survey shows that patients are dissatisfied with the discharge process and information given when leaving hospital**. Our carers survey feedback indicates high levels of dissatisfaction with not being listened to, not being involved and seeing their loved one's additional needs related to a disability not being met.

For Urgent and Emergency Care our FFT satisfaction level in October was 85.1% overall, which is an increase of 1%. When breaking this down by site, QEQM ED scored 84.5%, William Harvey ED scored 80.3% (an increase of nearly 10%) and KCH Urgent Treatment Centre scored 89.9%, a reduction of 2% and Buckland UTC scored 97.1%.

How we compare with national data:
The most recent national data available is for September 2023. **For Emergency Departments the overall satisfaction level is 79%.**
For in-patient care, the **national** satisfaction level is **94%** and for outpatient care it is **94%.** Therefore, our satisfaction level for in-patients in October of **90.1% overall** is significantly lower and for outpatients at **95% overall** is slightly higher.

Friends and Family Test free text comments: the qualitative data (patient's comments) is a rich source of insight that satisfaction levels alone do not give. A new Theming Tracker enables our services to theme free text comments as positive or negative and by subject. In October 2023, the top positive themes were care given by staff, staff attitude, quality of treatment and communication. The top negative themes were waiting time to be seen on site, poor communication and information, quality of treatment and ensuring comfort / alleviating pain.

People

People, Leadership & Culture

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
People	IIP		Sickness		5.0%	5.0%	5.9%	5.1%	4.9%	5.1%	4.3%	4.0%	4.2%	4.6%	4.7%	4.9%	5.4%
	IIP		Vacancy Rate		10.0%	9.7%	9.8%	9.1%	8.7%	8.4%	8.2%	8.2%	7.9%	7.2%	7.9%	7.4%	6.7%
	IIP		Staff Turnover Rate		10.0%	10.3%	10.2%	10.0%	9.9%	10.0%	9.8%	9.7%	9.6%	9.5%	9.2%	9.0%	9.1%
	IIP		Premature Turnover Rate		25.0%	15.8%	15.2%	15.1%	15.1%	15.0%	15.0%	14.1%	14.0%	13.8%	13.7%	13.3%	13.6%
	IIP		Staff Engagement Score		6.80	6.35	6.35	6.17	6.17	6.17	6.20	6.20	6.20	6.27	6.27	6.27	
	IIP		Statutory Training		91.0%	90.5%	90.4%	90.5%	90.5%	91.0%	91.4%	91.9%	91.9%	91.7%	92.1%	91.9%	90.1%
	IIP		Medical Job Planning Rate		90.0%	33.9%	29.1%	50.1%	31.2%	38.3%	46.4%	50.4%	50.5%	58.7%	52.3%	58.1%	60.3%

October Performance Summary

People Metrics: Sickness absence increased for the fifth month in succession and has now breached the alerting threshold at 5.4%. Stress, anxiety, depression & other psychiatric illness is the chief contributor to this and has been rising steadily since the withdrawal of the *Talking Wellness* by NHSE. Final steps are being taken to return clinical psychology to the Trust in December. This is subject to financial approval, although it is noted that sickness absence is currently costing the Trust c.£16.5m annually. Vacancy rate continues to improve and, at 6.7% is the lowest it has been in over a year. Staff turnover (9.1%) continues to consistently achieve and exceed the nationally accepted gold standard (10%) and has done for 10 consecutive months. Premature turnover is also consistently achieving the new performance standard (15%), and remains at/ around 13%. Statutory training rates have fallen by c.2%. This is partially due to the introduction of new training courses (Oliver McGowan) and a handful of low-completion areas. Acute Medical Staffing, for example, accounts for 642 outstanding courses alone. Compliance for medical staff, whilst a focal area, continues to fall and is now almost >18% off-target.

Engagement Metrics: The National Staff Survey launched on Monday 18th September, with 10 weeks of fieldwork and a closing date of Friday 24th November. The current response rate is 39.6% (3,908 respondents) which is on par with the national average although behind previous years. Response rates vary considerably; from 12% (Emergency Medicine Medical Staffing) to 94% (Audiology). These represent a proxy measure of staff engagement. Further engagement results will not be available until 2024 due to the national embargo. A comprehensive range of outreach-related fieldwork continues to take place, although some apathy towards completing has been experienced. This relates to perceived inactivity, at a local level, against previous findings.

Leadership Metrics: Advocacy continues to represent the domain of engagement which is furthest (0.6 away) from the national standard (6.4) and is the primary contributor to reduced staff engagement levels across the organisation. Staff Advocacy (5.83) improved subtly in Q2 but remains in the lowest quartile nationally. As advocacy metrics fall within the national staff survey embargo, the next update on this will be in 2024. Recent evidence has demonstrated advocacy levels are considerably higher (up to 62 points) in We Care areas, and work is ongoing to roll this out further across more areas of the organisation through waves 7 and 8, with 337 further colleagues trained since Sept 22.

Staff Sickness

Integrated Improvement Plan

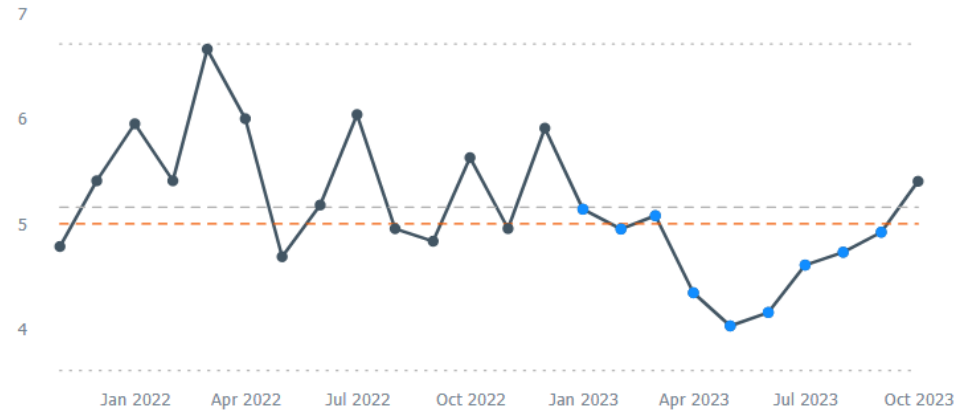
East Kent Hospitals University NHS Foundation Trust

The percentage of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs).
Data Source: Healthroster, eRostering for the current month (unvalidated) with previous months using the validated position from ESR.

Sickness

Timescale	Value	SPC
Nov-22	5.0%	
Dec-22	5.9%	
Jan-23	5.1%	
Feb-23	4.9%	
Mar-23	5.1%	
Apr-23	4.3%	
May-23	4.0%	
Jun-23	4.2%	
Jul-23	4.6%	
Aug-23	4.7%	
Sep-23	4.9%	
Oct-23	5.4%	

XMR Run Chart



Understanding the most recent data point

Performance

5.4%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **sickness absence** below 5%, and improved against our fellow Trusts in the ICB	• Working with NHSEI on the Absence Tool Kit to review current sickness management processes and develop actions for improvement.	• Heads of P&C, P&CBPs	• End Dec 23	• New Sickness Absence Policy agreed in principle by Staff Committee in Oct 23, but final sign off in Dec staff committee. Agreed removal of loop holes to support more effective and timely absence management.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	• Head of Staff Experience, Heads of P&C, P&CBPs, OH	• Ongoing	• Pro-Active Sickness Absence Working Group set up between P&C, ER and OH teams, including improved support through EAP for anxiety and adding in support for H&W through training Connectors.
Improved pro-active absence management	• New P&C Care Group Teams to focus on absences through a Care Group deep dive, and P&C support.	• P&C Care Group Teams	• Ongoing	• Additional resource added in for 12 month focus on Sickness Absence with each Care Group identifying the target areas.

Staff Vacancy Rate

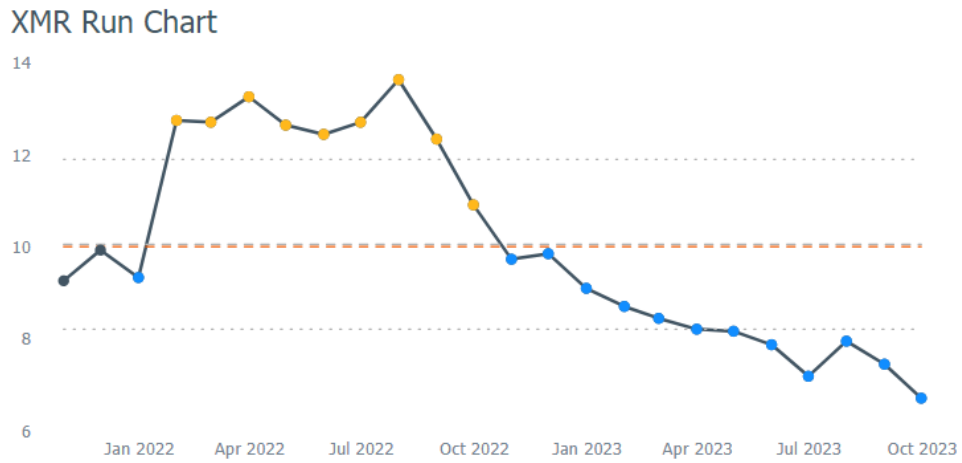
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The proportion of vacant positions against the number of Whole Time Equivalent (WTE) funded establishment.
Datasource: ESR

Vacancy Rate

Timescale	Value	SPC
Nov-22	9.7%	
Dec-22	9.8%	
Jan-23	9.1%	
Feb-23	8.7%	
Mar-23	8.4%	
Apr-23	8.2%	
May-23	8.2%	
Jun-23	7.9%	
Jul-23	7.2%	
Aug-23	7.9%	
Sep-23	7.4%	
Oct-23	6.7%	



Understanding the most recent data point

Performance

6.7% — Variation indicates inconsistently passing and falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place.	• Heads of P&C • P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead • Heads of P&C • P&CBPs	• End Dec 23	• Hard to recruit roles out to advert with social media campaigns. Support from ID Medical
Minimising risk of turnover by improving retention and reducing time to hire.	• Focus on time to hire, with Dashboard set up to monitor.	• Head of Resourcing	• Ongoing	• Time to hire reduced to 8 weeks. • Band 5 Nursing vacancy rate down to 8.1% - lowest level in 5 years • HCSW vacancy rate down

Staff Turnover Rate

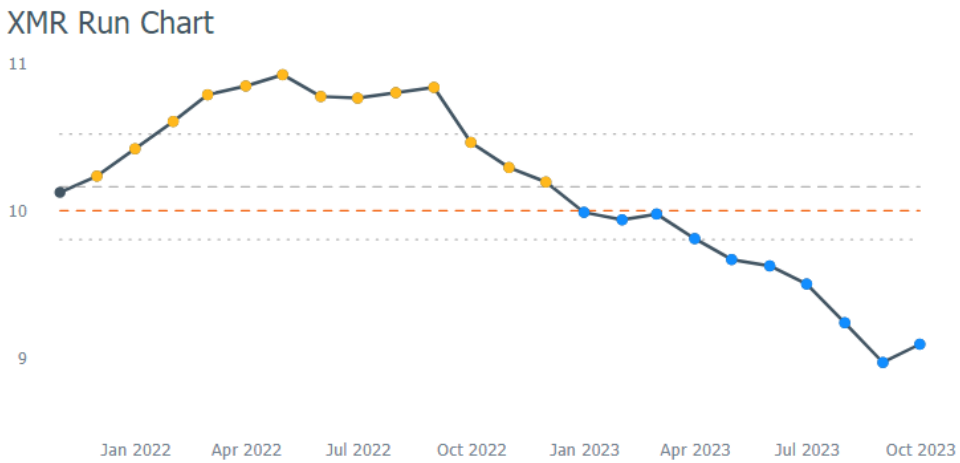
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of staff leaving & joining the Trust against Whole Time Equivalent (WTE).
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Staff Turnover Rate

Timescale	Value	SPC
Nov-22	10.3%	
Dec-22	10.2%	
Jan-23	10.0%	
Feb-23	9.9%	
Mar-23	10.0%	
Apr-23	9.8%	
May-23	9.7%	
Jun-23	9.6%	
Jul-23	9.5%	
Aug-23	9.2%	
Sep-23	9.0%	
Oct-23	9.1%	



Understanding the most recent data point

Performance

9.1%

Variation indicates inconsistently passing and falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	• Head of Staff Experience	• Ongoing	• Staff Turnover is consistently achieving the gold standard (10%) and has been for 10 consecutive months. It currently stands at **9.1%**
Maintaining **Nurse Turnover** against a gold standard of 10%	• Implementation of actions against the Nursing Workforce Retention Action plan	• Associate Director of Nursing	• Ongoing	• Nurse Turnover continues to improve and has been outperforming the target (10%) for >18 consecutive months. It currently stands at **8.3%**
Reducing **Healthcare Support Worker** Turnover below 13.5%	• Introduction of the HCSW Voice Programme and continued delivery of the Ready to Care programme	• Matron for Recruitment & Career Dev.	• Ongoing	• HCSW Turnover has inflected upward over the last 2 months but continues to achieve and exceed performance expectations at **11.6%**

Premature Staff Turnover Rate

Integrated Improvement Plan

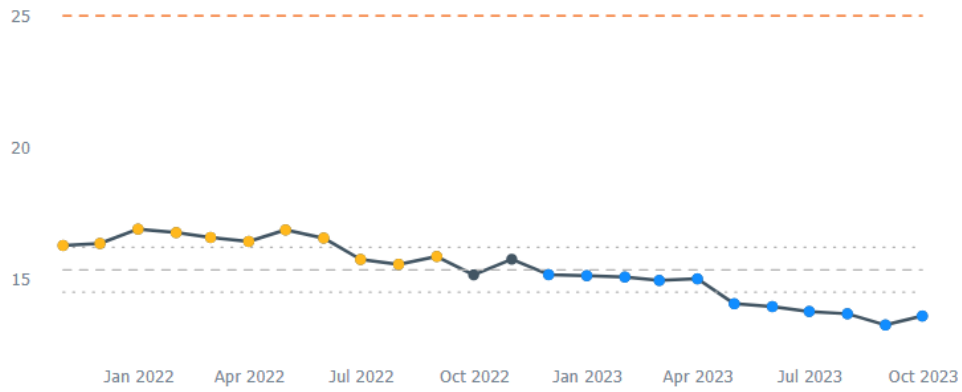
East Kent Hospitals University NHS Foundation Trust

The number of staff leaving the Trust within their first year of employment as a proportion of the total number of staff in the organisation with less than 12 months' service.
Metric excludes; Doctors in training, fixed term and bank staff and the following leaving reasons, Death in Service, Employee Transfer, Dismissal, Flexi Retirement, Pregnancy & Redundancy.

Premature Turnover Rate

Timescale	Value	SPC
Nov-22	15.8%	
Dec-22	15.2%	
Jan-23	15.1%	
Feb-23	15.1%	
Mar-23	15.0%	
Apr-23	15.0%	
May-23	14.1%	
Jun-23	14.0%	
Jul-23	13.8%	
Aug-23	13.7%	
Sep-23	13.3%	
Oct-23	13.6%	

XMR Run Chart



Understanding the most recent data point

Performance

13.6% — Variation indicates consistently passing the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	• Head of Staff Experience	• Complete	• Premature turnover (**13.6%**) has consistently been achieving the new performance standard (15%) across the last 6 months
Reduction in **Premature Turnover** below desired threshold of 15%	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• Ongoing	• Evidence (NSES) that initial experience is strong but needs bolstering from 30-100 days. EKHUFT leading on development of system-level line manager guide
Improvement in the **New Starter Experience** (as denoted by the Kent & Medway NSES)	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Jan 24	• Overall net engagement score for new starters (71%) 14% ahead of the K&M average (57%) as at 16/11/23

Staff Engagement Score

Integrated Improvement Plan

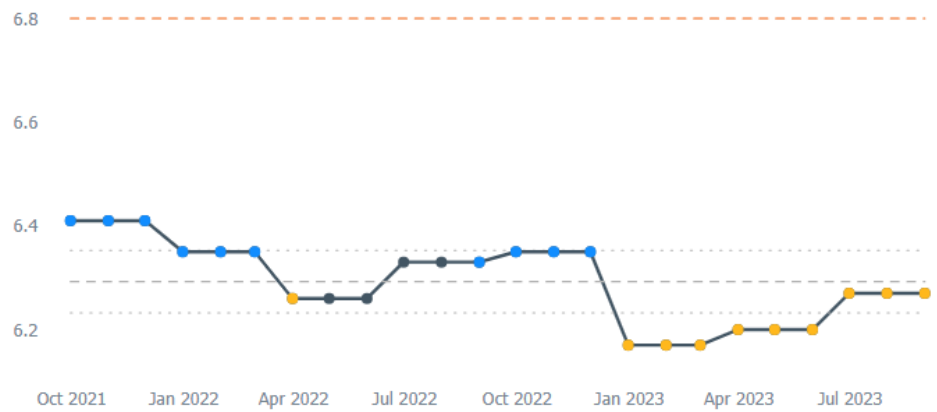
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide overall engagement score.

Staff Engagement Score

Timescale	Value	SPC
Oct-22	6.35	
Nov-22	6.35	
Dec-22	6.35	
Jan-23	6.17	
Feb-23	6.17	
Mar-23	6.17	
Apr-23	6.20	
May-23	6.20	
Jun-23	6.20	
Jul-23	6.27	
Aug-23	6.27	
Sep-23	6.27	

XMR Run Chart



Understanding the most recent data point

Performance

6.27 — Variation indicates consistently falling short of the target

Variation

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

Flags — Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• Next results available Jan/ Feb 24 (post-NSS)	• Updated staff engagement metrics will not be available until Jan '24 due to the NSS embargo. There have been successive quarterly improvements
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• Ongoing	• A new staff engagement framework has been developed, giving leaders and managers practical guidance around how to improve staff engagement
National Staff Survey 2023	• Driving response rates across the 2023 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• End Nov 23	• The NSS is into its final week. To-date, there have been c.4000 respondents (40% RR), although this represents a fall against 2021 and 2022

Statutory Training

Integrated Improvement Plan

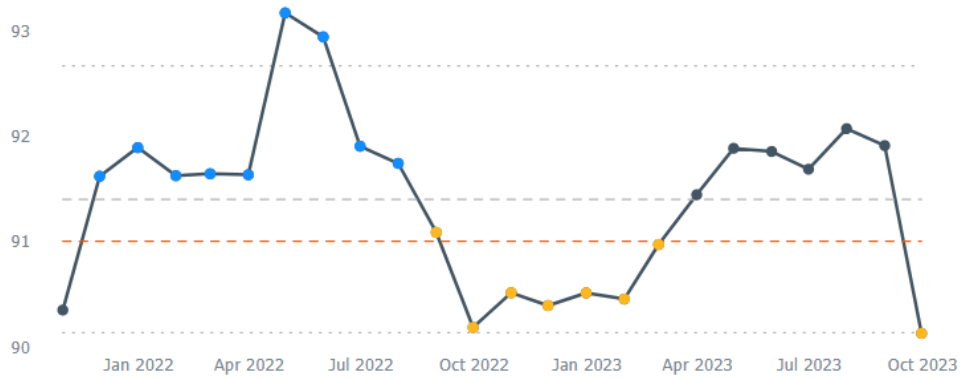
East Kent Hospitals University NHS Foundation Trust

The proportion of staff who have successfully completed Mandatory training in;
Child Protection, Equality and Diversity, Fire Safety Awareness, Health and Safety Awareness, Infection Control, Information Governance and Manual Handling Awareness.
Data source: ESR

Statutory Training

Timescale	Value	SPC
Nov-22	90.5%	
Dec-22	90.4%	
Jan-23	90.5%	
Feb-23	90.5%	
Mar-23	91.0%	
Apr-23	91.4%	
May-23	91.9%	
Jun-23	91.9%	
Jul-23	91.7%	
Aug-23	92.1%	
Sep-23	91.9%	
Oct-23	90.1%	

XMR Run Chart



Understanding the most recent data point

Performance

90.1%	Variation indicates inconsistently passing and falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to lower values
Flags	Outside Moving Range Limit Astronomical Point

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Medical staff levels of compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance.	• Head of L&D • Heads of P&C • P&CBPs • CMO	• End Dec 23	• Policy to be updated to allow withholding of study leave if statutory training not complete.
Capacity within face to face statutory learning, particularly Resus.	• Resus team currently at 50% capacity due to vacancies and sickness absence. Being addressed through the Corporate Team	• Deputy Chief Nurse • Resus Team	• End Dec 23	• Care Groups ensuring that the most essential, non-compliant staff are booked on Resus training first.
Low compliance with Trainee Drs, as they do not complete this on arrival, and no agreement to who chases this especially after rotation.	• P&C Leads to work with Med Ed on supporting improvements with this, particularly focusing on induction and rotation.	• DME • Head of L&D • P&C Senior Team	• End Dec 23	• Head of P&C to work with Care Groups to seek support from Med Ed management team.

Medical Job Planning Rate

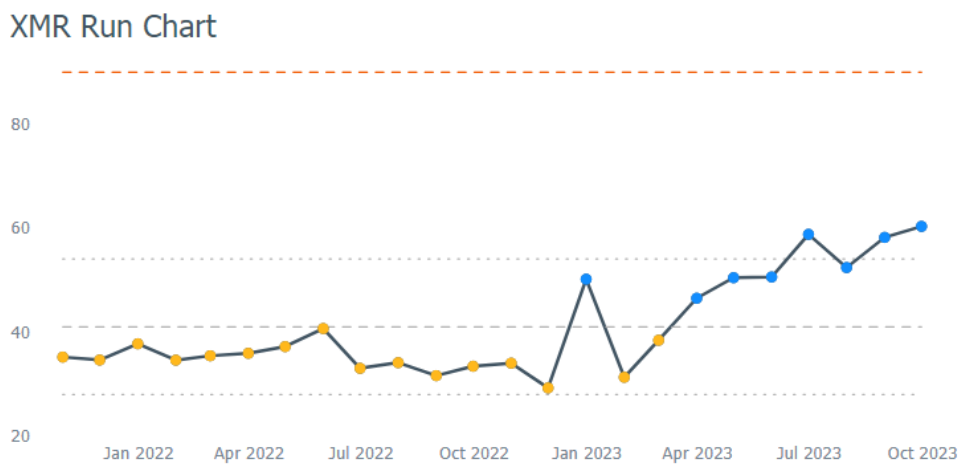
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Number of staff who have a fully signed off job plan in the current job planning cycle (1 April - 31 March), as a proportion of the total number of staff. A signed off job plan requires approval from the local Specialty Lead, the Care Group Clinical Director, and the Hospital Medical Director. Exclusions: This job planning data refers to non-training consultant and SAS grade doctors only and is not required by other doctor grades.

Medical Job Planning Ra...

Timescale	Value	SPC
Nov-22	33.9%	
Dec-22	29.1%	
Jan-23	50.1%	
Feb-23	31.2%	
Mar-23	38.3%	
Apr-23	46.4%	
May-23	50.4%	
Jun-23	50.5%	
Jul-23	58.7%	
Aug-23	52.3%	
Sep-23	58.1%	
Oct-23	60.3%	



Understanding the most recent data point

Performance

60.3%

Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Job planning compliance continues to improve across specialities, there are approximately 180 doctors (19%) that remain in discussion and 23% in the sign-off stages.	• Initial reminders sent to clinicians in September • Follow up reminders for those not engaging sent in October • Sign-off managers/leads contacted to chase decisions in October and again in November.	• CMO	• End Dec 23	• Obstetrics and Gynaecology have now achieved 100% compliance • Gynae Oncology have achieved 93% compliance • 5 other specialities are currently at 100% compliance with 2 over 90% and another 3 over 80%
The new structure hierarchies for specialities have been created on e-JobPlan however they have not yet been migrated	• Wait until next cycle in April 2024 to move all into discussion and back to their correct hierarchy	• CMO	• Apr 24	• Migration plan complete • Sign-off and compliance issues noted by Allocate. Mitigations to occur in April due to issues in transferring DCC element.
The previous process for managing LCEA's did not effectively encourage uptake of job planning	• LCEA applications to only be accepted if suitable engagement with the job planning process is evident, establishing a baseline with which to judge excellence. • LCEA competitive round has been launched and we are awaiting applications	• CMO	• Jan 24	• Decision made by Trust to progress with a competitive CEA round • Application forms and guidance have been distributed in October 2023 and deadline for application is 19th January 2024

Staff Advocacy Score

Integrated Improvement Plan

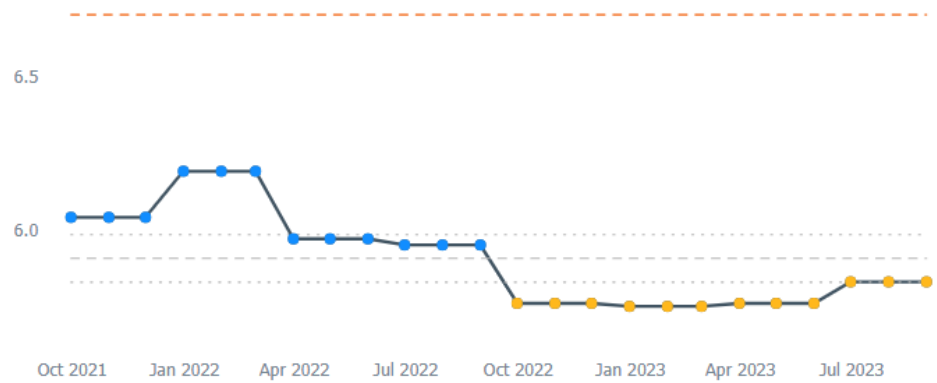
NHS
East Kent Hospitals University
NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff advocacy questions added to Staff Friends and Family quarterly surveys commencing March 2021.
3 advocacy questions in staff survey and replicated in quarterly staff FFT, these are a subset of the staff engagement score.

Staff Advocacy Score

Timescale	Value	SPC
Oct-22	5.76	
Nov-22	5.76	
Dec-22	5.76	
Jan-23	5.75	
Feb-23	5.75	
Mar-23	5.75	
Apr-23	5.76	
May-23	5.76	
Jun-23	5.76	
Jul-23	5.83	
Aug-23	5.83	
Sep-23	5.83	

XMR Run Chart



Understanding the most recent data point

Performance

5.83

Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Advocacy levels (5.8) are significantly below the national standard (6.4)	• Continued action is required to repair the reputation of the organisation & the extent to which staff would recommend as a place to work and be treated	• Executive Team	• End Jan 24	• Staff Advocacy levels will be updated following the release of the NSS embargo in 2024. It continues to represent the most concerning domain of staff engagement
Staff Advocacy levels remain in Quartile 1 when benchmarked nationally	• Increased rollout of We Care as a programme to drive staff engagement levels	• Head of Transformation	• Ongoing	• Staff Advocacy levels are 62 points higher in We Care areas than non-We Care counterparts. Increased roll-out to 337 more staff and 1114 overall
The extent to which staff would recommend the Trust as a place to work or be treated	• Majority completion of the National Staff Survey which acts as a measure of engagement and advocacy in it's own right	• Head of Staff Experience	• End Nov 23	• Comprehensive activity taking place to drive responses and a 'live' dashboard in-place to track hotspots. Some apathy experienced in areas relating to perceived inactivity

Appraisal Rates

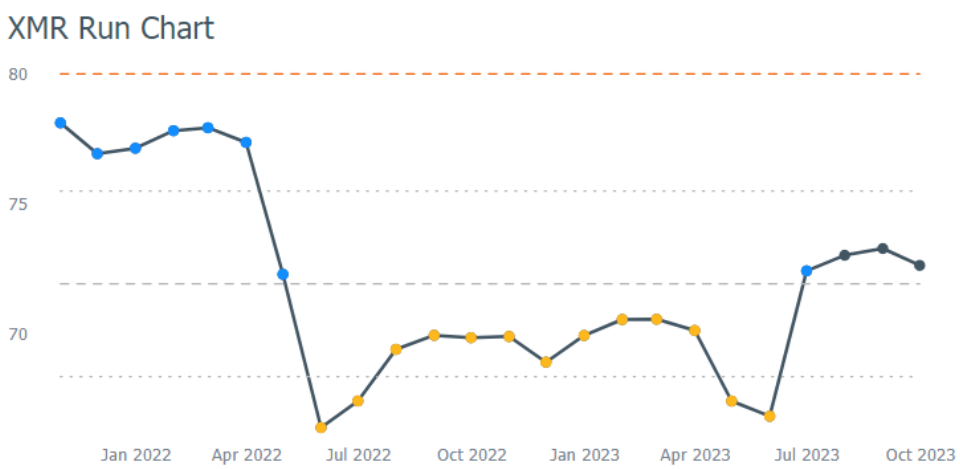
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Number of staff who have completed an appraisal and objective setting meeting in the preceding 12 months, as a proportion of the total number of staff.
Exclusions: Doctors, Secondary Assignments, Career Break, Maternity & Adoption, External Secondment and Unpaid Suspensions. Staff who have worked at the Trust for less than 12 months.
Datasource: ESR

Appraisals Compliance

Timescale	Value	SPC
Nov-22	69.9%	
Dec-22	68.9%	
Jan-23	69.9%	
Feb-23	70.5%	
Mar-23	70.5%	
Apr-23	70.1%	
May-23	67.4%	
Jun-23	66.8%	
Jul-23	72.4%	
Aug-23	73.0%	
Sep-23	73.3%	
Oct-23	72.6%	



Understanding the most recent data point

Performance

72.6% — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Managers not uploading completion dates to ESR	• Each Care Group identifying the areas where no or few uploads to ESR have been identified. Supporting those managers with ESR self service training.	• Heads of P&C • PCBPs	• End Nov 23	• 350 names added to ESR that had previously not been updated • Identifying areas where support needed for updated ESR training
Admin & Clerical appraisal rates remain below threshold, with 600 outstanding appraisals.	• Focus within the new Care Groups on improving A&C appraisal rates, and ensuring they are uploaded to ESR.	• Care Group MDs • Heads of P&C • PCBPs	• End Dec 23	• New P&C Care Group teams to work locally with targeting areas of low A&C appraisal compliance.
Quality of appraisal remains low, according to staff survey	• F2F meetings with line managers re: appraisal and Slido sent out to 600 staff asking for feedback on individual appraisals to identify reasons for low quality.	• P&CPs • Heads of P&C	• End Dec 23	• Approximately 70 responses to requests for suggested improvements to appraisal. These have been fed back to the OD team. HoP&C/OD to meet.

Sustainability

Financial Sustainability

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Finance	IIP		I&E Monthly Variance Group (£M)		Traj.	-4.010	-5.197	-4.415	5.380	4.264	-9.826	-9.826	-9.244	-10.081	-11.314	-9.030	-8.929
	IIP		Efficiencies Green Schemes (£M)		40	20	20	20	20	20	0	1	4	3	10	9	9
	IIP		Efficiencies YTD Variance (£M)		0.0	-2.5	-4.6	-6.4	-8.8	-10.4	-1.5	-2.9	-4.8	-8.0	-6.3	-15.0	-11.8
	IIP		Premium Pay		Traj.	8,577	8,413	9,034	8,689	9,058	8,839	10.2K	9,666	9,687	10.7K	8,847	8,179

October Performance Summary

Financial Position: The financial position YTD is £22.7m away from a plan of £45.5m, with a total deficit YTD of £68.2m. The key drivers behind the deficit variance are direct cost impact of the Strike action £2m by the Junior doctors and Consultants (excluding the impact of April industrial action, which has now been funded through the new ERF guidance), shortfall in funding for AfC pay award of £0.7m & Medical and Dental pay award £2.3m, non-delivery of efficiency savings £11.8m YTD. The agency spend YTD is £28.5m which is £12.3m away from the agency cap.

Efficiencies: The Care Groups recognised recurrent savings of £0.1m in October, and £1.0m on a YTD basis, which is significantly below Plan. As well as the £40m CIP requirement, the run rate is required to improve significantly in order to deliver the 23/24 Plan.
Additional non-recurrent efficiencies of £7.5m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 care.
The current value of the efficiencies pipeline is £16.3m, a (£1.4m, 9%) increase in value vs. the prior month.
The majority of ideas currently identified through the care group process are less than £50k (48%) or less than £250k (29%), but working across the cross-cutting themes of Workforce, Elective and Non-Elective productivity, Theatres, we are predominantly scoping larger group-wide to significantly increase the value of CIP schemes.

I&E YTD Actual Group (£m)

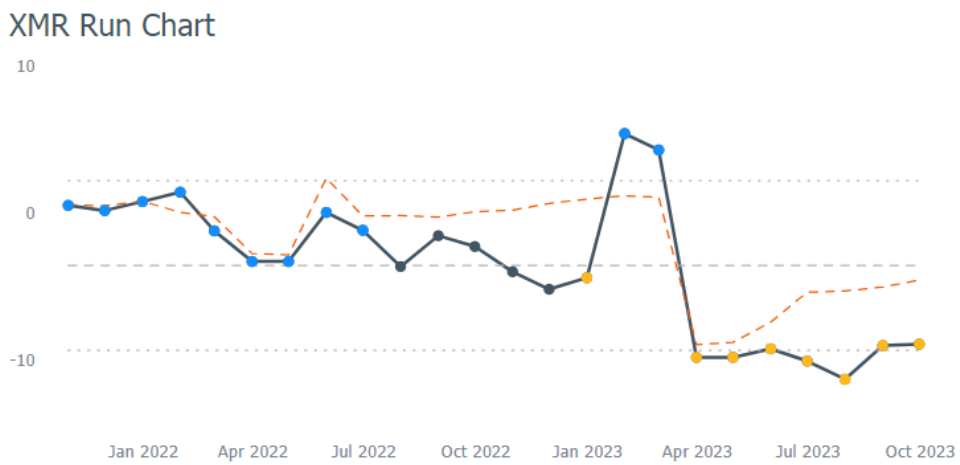
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The I&E Margin (£M) is the Group's technically adjusted profit or loss shown as a percentage of its technically adjusted Income result for each month. If the number is positive the Group is making a surplus

I&E Monthly Variance G...

Timescale	Value	SPC
Nov-22	-4.010	
Dec-22	-5.197	
Jan-23	-4.415	
Feb-23	5.380	
Mar-23	4.264	
Apr-23	-9.826	
May-23	-9.826	
Jun-23	-9.244	
Jul-23	-10.081	
Aug-23	-11.314	
Sep-23	-9.030	
Oct-23	-8.929	



Understanding the most recent data point

Performance

-8.929

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Below Mean Run Group; Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure national grip and control level 4's are embededd into the Trust for pay & non pay areas	• All level 4 grip and controls are being rolled out to the wider Trust for both pay and non pay.	• CFO	• On-Going	• Vacancy panel for embedded led by CPO. Nursing workforce review embedding led by CNMO. • Investment panel implemented led by CFO • Finance Improvement Programme Board Embedding (FIPB)
Run rate continues to be above plan due to utilisation in excess of establishment and non delivery of CIP	• Nursing deep dives continue. Golden key has been implemented • CMO has reviewing high cost agency for Medical & Dental	• CNMO & CMO	• On-Going	• Launch of non pay controls agreed at FIPB • Launch of increased workforce controls at FIPB
Non delivery of CIP to date and non achievement of a robust in year CIP plan.	• Workforce & Financial Sustainability Recovery meetings commenced. • Further work is needed on the corporate areas to ensure CIP delivery • PMO working closely with Financial Recovery Director on forecast CIP	• Care group MD's • PMO • Exec Team	• On-Going	• External support to be commission to help and support the Trust in the delivery of a robust CIP plan

Financial Efficiencies: Green Rated Schemes

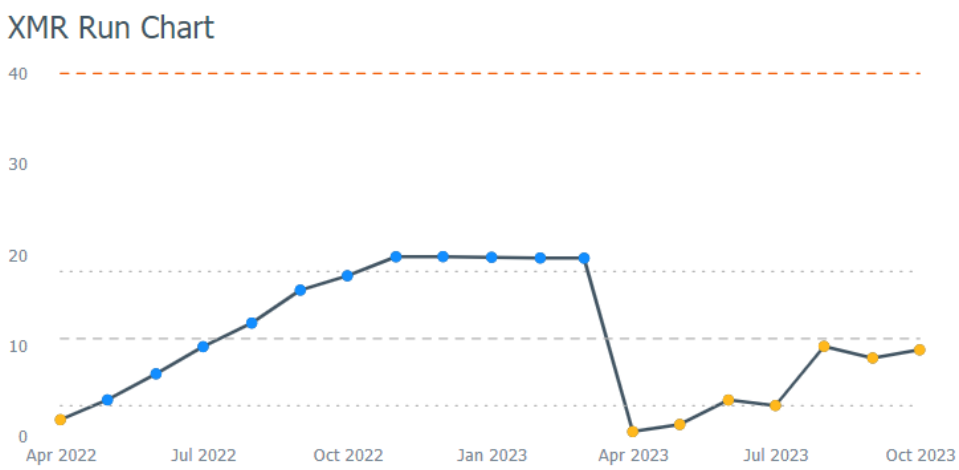
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Efficiencies Green Schemes is the sum of delivered schemes YTD plus the sum of forecast of green rated schemes as a percentage of the annual efficiencies target. If the percentage rated Green is < 90% then overall rating is RED.

Efficiencies Green Sche...

Timescale	Value	SPC
Nov-22	20	
Dec-22	20	
Jan-23	20	
Feb-23	20	
Mar-23	20	
Apr-23	0	
May-23	1	
Jun-23	4	
Jul-23	3	
Aug-23	10	
Sep-23	9	
Oct-23	9	



Understanding the most recent data point

Performance

9	Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to lower values
Flags	Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining organisational focus during restructure	• Continue CEO and CFO messaging to organisation on finance and efficiency; • PMO re-aligned to new care group structure, and to attend finance and workforce recovery meetings • CIP targets for new care groups have been re-calculated based on re-structured budgets	Finance/PMO	Underway	• CFO released enhanced controls 08/08. • CIP targets for new care groups have been re-calculated and issued. Schemes identified/in the pipeline realigned to new care groups. • Additional and greater controls in place for pay and non pay spend
Pace of scheme development	• Engagement with PWC to work with the Trust to delivery CIP's • Target of 80% achievement of CIP identification for 24/25 by 31st of March 24	CFO	Underway	• PWC commenced on site November 23 for drivers of the deficit & forecast review
Identification of opportunities sufficient to reach the required £40m	• EMT agreed 5 cross cutting themes for focus with Exec leads; • New Turnaround Director appointed, meeting with PMO • New Interim CFO appointed • PWC Commissioned with clear agenda	EMT/ADFI TD/PMO	Ongoing 25/09/23	• Theme values being developed. • FRD/ADFI met 21/09, PMO meeting 06/11. Meeting weekly.

Financial Efficiencies YTD Variance

Integrated Improvement Plan

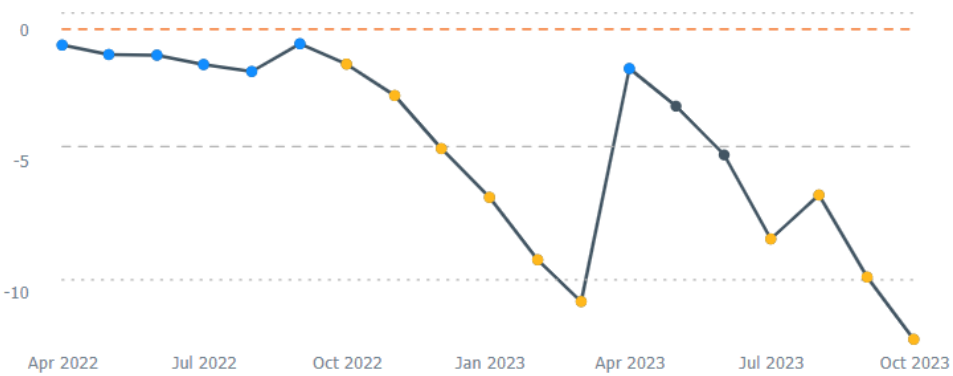
East Kent Hospitals University NHS Foundation Trust

Efficiencies YTD Variance (£M) is the difference between the YTD delivered efficiencies and YTD efficiencies target. If that number is zero or positive, the Trust is delivering the expected efficiencies.

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Nov-22	-2.5	
Dec-22	-4.6	
Jan-23	-6.4	
Feb-23	-8.8	
Mar-23	-10.4	
Apr-23	-1.5	
May-23	-2.9	
Jun-23	-4.8	
Jul-23	-8.0	
Aug-23	-6.3	
Sep-23	-9.5	
Oct-23	-11.8	

XMR Run Chart



Understanding the most recent data point

Performance

-11.8

Variation indicates inconsistently passing and falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring finance and CIP transparency while reflecting underlying organisational improvement	• Additional non-recurrent efficiencies of £7.5m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 specialling). Work is underway to understand if these non-recurrent efficiencies are able to be turned into recurrent efficiencies.	CFO/PMO PMO	Oct-23 On-going	• Methodology and calculation agreed at FPC, used for Mth5 reporting onwards - Completed • PMO continue to work with care groups to establish whether there are any recurrent savings inherent in the underspends
Agency usage and cost at a similar level to this time last year	Nursing agency costs remain high • Action: Greater controls through authorisation and "golden key" process • Action: Super-numery period reduced to two weeks for IENs • Context: High cost medical agency (HCMA) use remains high, ongoing issue. • Action: CPO/FRD/PMO working with care groups to review HCMA value add.	• CNMO • CNMO • FID/PMO	• Ongoing • 22/09 • Sept/Oct 23	• Golden Key went live 18/09/23 • Reduced supernumerary period implemented in inpatient areas • To combine deep dives to include medical and nursing, and to feed into Workforce and Financial Sustainability recovery meetings.

Premium Pay

Integrated Improvement Plan

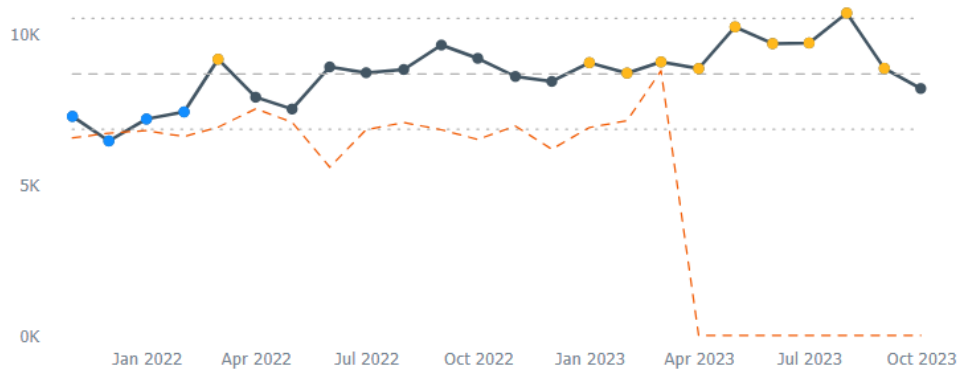
East Kent Hospitals University NHS Foundation Trust

Summary metric of Trust premium pay items Agency (NHSP and direct engagement), Bank, WLI payments, Locally Agreed Group, Medical Short Sessions, Other Medical Locum costs and Overtime (excl additional basic) in £.

Premium Pay

Timescale	Value	SPC
Nov-22	8,577	
Dec-22	8,413	
Jan-23	9,034	
Feb-23	8,689	
Mar-23	9,058	
Apr-23	8,839	
May-23	10.2K	
Jun-23	9,666	
Jul-23	9,687	
Aug-23	10.7K	
Sep-23	8,847	
Oct-23	8,179	

XMR Run Chart



Understanding the most recent data point

Performance

8,179

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Timely information that can be used to target areas of high premium pay usage.	• Premium Pay Dashboard now live, and updated regularly.	• Information Lead • Strategic Workforce Lead • Heads of P&C	• End Sept 23	• CMO, Heads of P&C and P&CBPs to use this Dashboard and information to support Care Group Exec Efficiency meetings.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead, Heads of P&C, P&CBPs	• End Sept 23	• First draft Workforce Strategies in place, to be reviewed regularly with Care Groups and Resourcing • QEQM & WHH currently being reviewed on a monthly basis.
Appointment of managed service provider to reduce agency spend as above the Trust agency spend cap.	• Seek Board approval for procurement. • Onboard provider.	• CPO/ Procurement • Deputy CPO	• End Nov 23	• Obtained Trust approval • Implementation of ID Medical Managed service due to launch 03/12/23 with full handover over and use of system from 29/01/24

East Kent Hospitals University NHS Foundation Trust

Maternity

Maternity

Integrated Improvement Plan

NHS
East Kent
Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Maternity	IIP		Serious Incidents Maternity		Sigma	1		2	4	4	4	1	3	2		2	2
	IIP		Maternity Incidents Moderate / Severe		Sigma	1	2	6	5	6		3	2		1	2	5
	IIP		Maternity Complaints		Sigma	10	6	9	12	8	10	8	5	6	2	17	5
	IIP		Maternity Complaint Response		90.0%	50.0%	40.0%		0.0%	75.0%	25.0%	16.7%	35.3%	50.0%	66.7%	60.0%	0.0%
	IIP		Extended Perinatal Mortality		5.87	4.94	4.64	4.33	4.53	4.44	4.62	4.47	3.87	3.40	3.58	3.11	2.62
	IIP		FFT Maternity Response Rate		15.0%	17.0%	14.9%	16.2%	14.0%	12.2%	11.6%	11.7%	12.8%	13.0%	11.1%	9.3%	11.9%
	IIP		FFT Maternity Recommended		90.0%	90.5%	90.7%	95.2%	91.6%	92.2%	93.7%	92.1%	92.3%	91.6%	88.8%	90.8%	96.2%
	IIP		FFT Maternity (IP) Recommended		90.0%	90.9%	91.8%	95.2%	91.7%	96.2%	95.1%	92.6%	94.3%	94.3%	89.3%	90.7%	96.7%
	IIP		WH Engagement Score		6.90	5.89	5.89	5.45	5.45	5.45	5.87	5.87	5.87	6.15	6.15	6.15	

October Performance Summary

Incidents: There were 2 serious incidents reported in October in Women's Health for Maternity, and 5 moderate harm incidents.

Complaints: 5 Stage 1 complaints were received in October for Maternity. This is a decrease on the previous month. At 07/11/2023 there were 26 open first complaints of which 5 had breached (4 submitted on time by care group).

Patient Involvement: FFT Response rate increased to 11.9% - 96.2% extremely likely or likely to recommend

Staff Engagement: Score 6.15

Maternity Serious Incidents

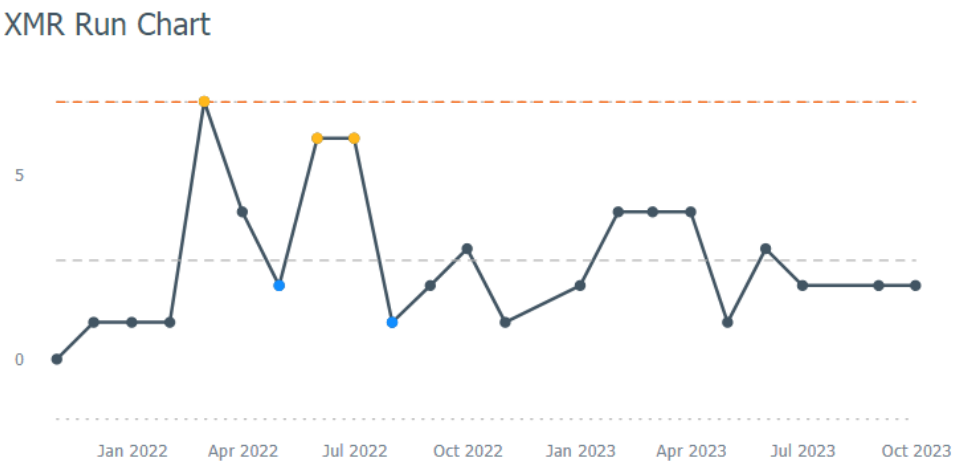
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures any maternity incident recorded on Datix that has subsequently been reported to STEIS (Strategic Executive Information System). Any maternity incidents that are subsequently downgraded are removed retrospectively therefore this number is subject to change. Serious Incidents are reported by the date the investigation started and not the date the incident occurred or was reported.

Serious Incidents Mater...

Timescale	Value	SPC
Sep-22	2	
Oct-22	3	
Nov-22	1	
Jan-23	2	
Feb-23	4	
Mar-23	4	
Apr-23	4	
May-23	1	
Jun-23	3	
Jul-23	2	
Sep-23	2	
Oct-23	2	



Understanding the most recent data point

Performance

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

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were 2 serious incidents reported in October for Maternity.	1. Monofer skin staining 2. Baby therapeutic cooling - MNSI Investigation	• Interim Head of Gov.	• 05/01/23 • 17/01/23	Investigation commenced. Immediate actions implemented: • Safety Thread to all maternity staff of the risk of Monofer infusion and staining • Patient Information Leaflet being developed and SOP reviewed • Monofer infusions stopped from 27/10/2023 while further mitigations explored. Training and education issue – exploring scheduled appointments at Maternity Day Care and KCH Ambulatory with targeted training and education for team.
There are currently 13 open SI's in Maternity. (A further 2 Neonatology and 1 Gynae).	For all SI investigations to be completed within agreed timeframes.	• Interim Head of Gov.	• Monthly – ongoing	• All open SI's under investigation are within agreed timeframes. However, there are 2 open Si's with NCR breaches that have now been submitted to the ICB.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of original June backlog and current position	• Interim Head of Gov.	• 30/11/23	• The number of overdue actions from the original backlog (June) has reduced from 345 to 180 at 13/12/23. The overall current overdue actions has increased to 302 due to action plans being added to the module and further actions breaching. The Patient Safety Team continue to supporting clinical staffing at 20% after half-term when required. There is additional agency resource focussing on open actions from October and further sprint day with NHSE Maternity Improvement Advisor on 20/11/23. Patient Safety Matron vacancy is backout to advert.

Maternity Incidents Causing Harm

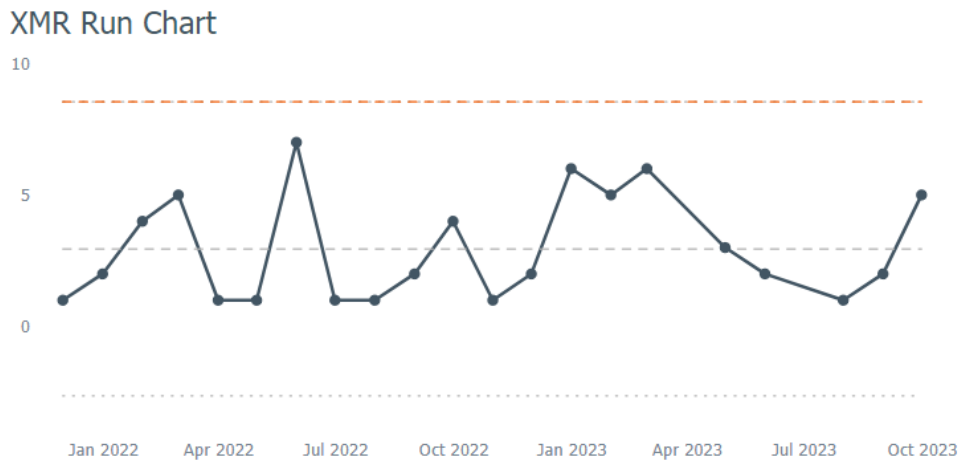
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of maternity incidents where the harm status was moderate or above.

Maternity Incidents Mo...

Timescale	Value	SPC
Sep-22	2	
Oct-22	4	
Nov-22	1	
Dec-22	2	
Jan-23	6	
Feb-23	5	
Mar-23	6	
May-23	3	
Jun-23	2	
Aug-23	1	
Sep-23	2	
Oct-23	5	



Understanding the most recent data point

Performance

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

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	• Interim Head of Governance	• Monthly - ongoing	• Themes and learning identified from rapid reviews disseminated via Message of the Week and Safety Threads. • Three of the moderate harms have been escalated as SI's (2 Monofer cases and 1 therapeutic cooling MNSI case)
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	• Interim Head of Governance	• 30/11/2023	• The number of open datix from the original June backlog for Maternity has reduced from 686 to 47 at 13.11.23. The overall current overdue datix has reduced in month to 354. This is a priority for the Patient Safety Team to close these open datix, all of which have had an initial review at the time of reporting.

Maternity Complaints

Integrated Improvement Plan

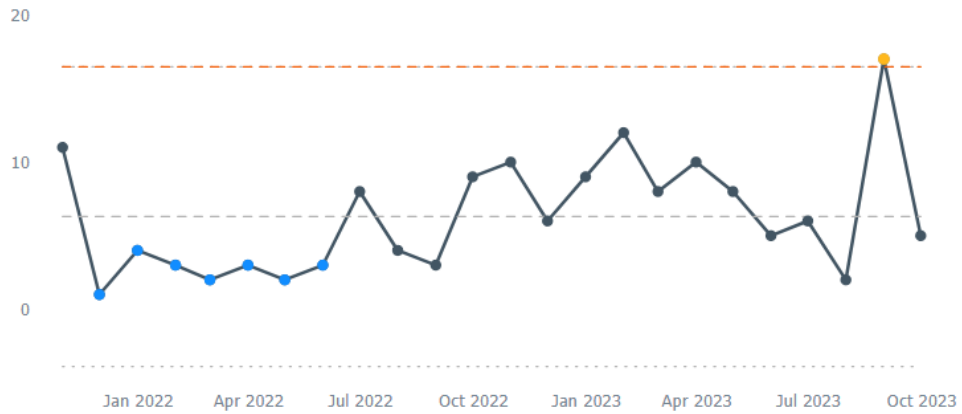
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of complaints made to Obstetrics, Midwifery or New-born Hearing Screening Services.

Maternity Complaints

Timescale	Value	SPC
Nov-22	10	
Dec-22	6	
Jan-23	9	
Feb-23	12	
Mar-23	8	
Apr-23	10	
May-23	8	
Jun-23	5	
Jul-23	6	
Aug-23	2	
Sep-23	17	
Oct-23	5	

XMR Run Chart



Understanding the most recent data point

Performance

5

Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
5 Stage 1 complaints received in October 2023 for Maternity	Significant decrease from the number of complaints received in previous month.	Patient Experience and Complaints Coordinator	Monthly reporting	Complaint "sprint day" held on 26/10/2023 to respond to increased complaint workload received in previous month in a timely manner.
Recurrent themes	The main themes are • Communication • Busy post-natal wards causing people to feel uncared for in a timely way	Adaline Smith DDOM	Monthly	We have commenced leave your troubles at the door initiative and posters can be seen at every entry point to support immediate response and action of any concerns.

Maternity Complaints Response Rate

Integrated Improvement Plan

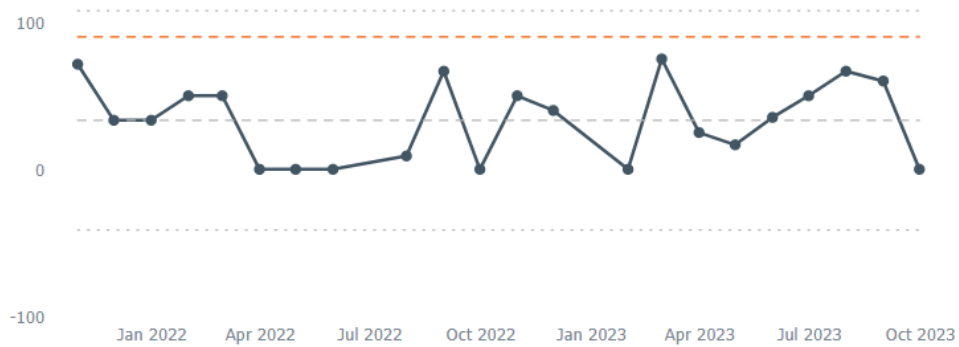
East Kent Hospitals University NHS Foundation Trust

This metric measures the proportion of complaints which were responded to within the agreed timescale of the complaint being received. This includes both 30 and 45 working day timescale targets.
Complaint Types included are Formal, External and MP Formal that have not been rejected.
Complaint Stages included are extensions 1,2,3 and extensions agreed by Chief Nurse, Local Resolution, On Hold and Withdrawn.

Maternity Complaint Re...

Timescale	Value	SPC
Oct-22	0.0%	
Nov-22	50.0%	
Dec-22	40.0%	
Feb-23	0.0%	
Mar-23	75.0%	
Apr-23	25.0%	
May-23	16.7%	
Jun-23	35.3%	
Jul-23	50.0%	
Aug-23	66.7%	
Sep-23	60.0%	
Oct-23	0.0%	

XMR Run Chart



Understanding the most recent data point

Performance

0.0% — Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	• Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	• Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• There has been a significant improvement in the number of open/breached complaints in recent months. Positive feedback has been received on the quality of the complaint responses. • Successful sprint day held 26/10/2023. • At 07/11/2023 there were 26 open first complaints of which 5 had breached (4 submitted on time by care group).

Extended Perinatal Mortality

Integrated Improvement Plan

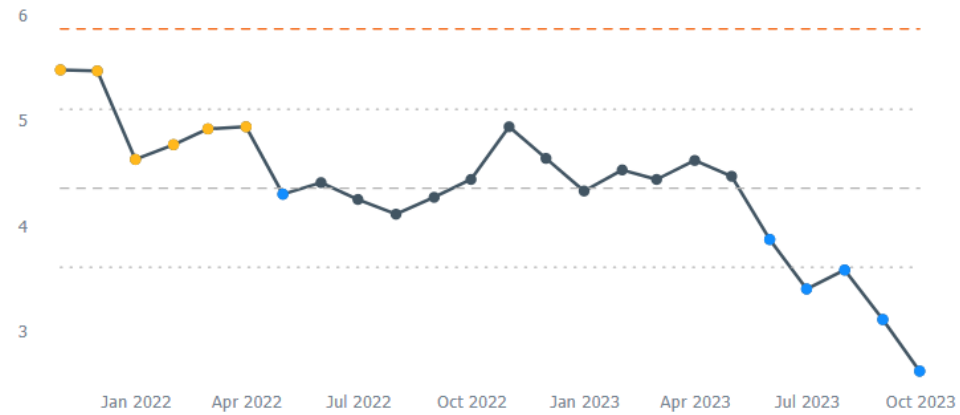
East Kent Hospitals University NHS Foundation Trust

Extended perinatal mortality refers to all stillbirths and neonatal deaths, MBRRACE methodology is used, which excludes births <24+0 weeks gestation and terminations (even if over 24+0w). The rate is per 1000 total births.
Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (Trust with level 3 NICU) from the 2021 MBRRACE report.

Extended Perinatal Mort...

Timescale	Value	SPC
Nov-22	4.94	
Dec-22	4.64	
Jan-23	4.33	
Feb-23	4.53	
Mar-23	4.44	
Apr-23	4.62	
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	
Oct-23	2.62	

XMR Run Chart



Understanding the most recent data point

Performance

2.62	Variation indicates consistently passing the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In October there was 1 maternal death. This sad case was a woman who died who had had been pregnant in the last year.	Trust wide learning for ensuring communication of maternal death with maternity services when women die outside of maternity wards.	DDoM		This case has been reported to MBRRACE and MNSI for investigation.
In October there was 1 neonatal death reportable to MBRRACE and no stillbirths.	The rolling 12 month rate for neonatal deaths remains lower than both the threshold and average at 1.05 neonatal deaths per 1,000 livebirths, and has been so for 18 consecutive periods.	PMRT Lead Midwife	Monthly	Discussed at rapid review 03/11/23. PMRT in December.
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees.	PMRT Lead Midwife	Monthly	100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

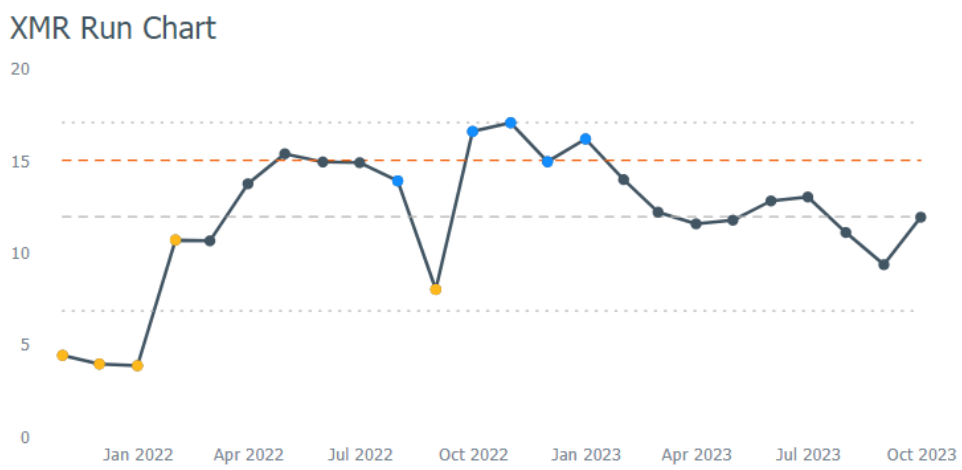
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

This metric measures the number of responses to the maternity friends and family questionnaires and displays as a % of the total questionnaires sent.

FFT Maternity Response...

Timescale	Value	SPC
Nov-22	17.0%	
Dec-22	14.9%	
Jan-23	16.2%	
Feb-23	14.0%	
Mar-23	12.2%	
Apr-23	11.6%	
May-23	11.7%	
Jun-23	12.8%	
Jul-23	13.0%	
Aug-23	11.1%	
Sep-23	9.3%	
Oct-23	11.9%	



Understanding the most recent data point

Performance

11.9%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	• Patient Experience Midwives	• March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023 • The care group welcomed the new MNVP chair for EKHUFT who we will continue to work collaboratively with. The 2023/2024 work plan has now been finalised with next steps including walking the patch and 15 steps. • Feedback is being continually gathered through YVIH and FFT.

Maternity Friends & Family Test: Recommended

Integrated Improvement Plan

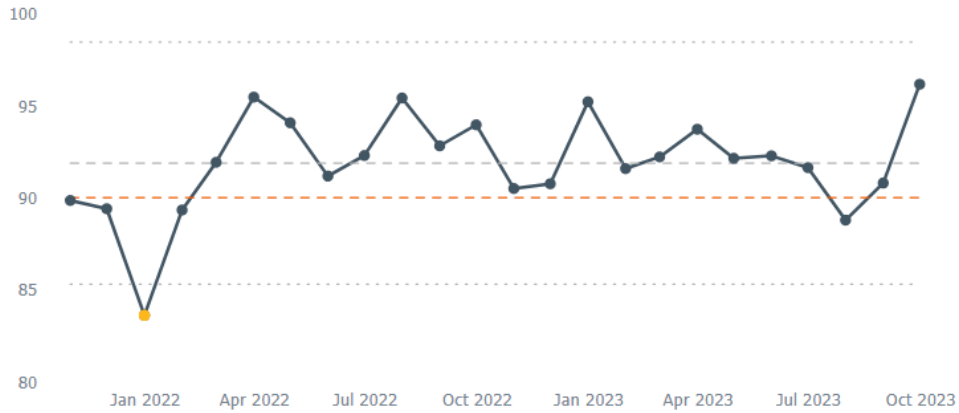
East Kent Hospitals University NHS Foundation Trust

This metric is a summary of all Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity Recomme...

Timescale	Value	SPC
Nov-22	90.5%	
Dec-22	90.7%	
Jan-23	95.2%	
Feb-23	91.6%	
Mar-23	92.2%	
Apr-23	93.7%	
May-23	92.1%	
Jun-23	92.3%	
Jul-23	91.6%	
Aug-23	88.8%	
Sep-23	90.8%	
Oct-23	96.2%	

XMR Run Chart



Understanding the most recent data point

Performance

96.2% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 96.2% extremely likely or likely to recommend which is an increase in month and highest value in year.	• PEM feedback to staff on a regular basis via personalised email and update posters on the units/community offices and in the monthly newsletter.	• PEM	• Monthly	

Maternity Friends & Family Test: Inpatient Recommended

Integrated Improvement Plan

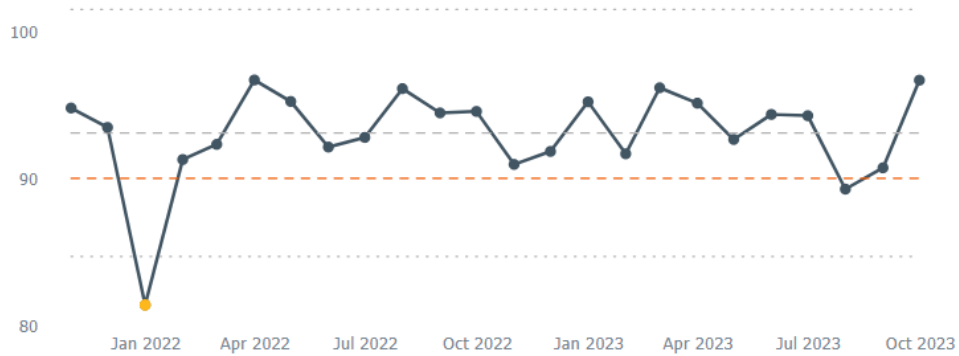
East Kent Hospitals University NHS Foundation Trust

This metric is a summary of Inpatient Maternity Friends & Family responses which indicated that the woman would recommend the Trust's Maternity Services.

FFT Maternity (IP) Reco...

Timescale	Value	SPC
Nov-22	90.9%	
Dec-22	91.8%	
Jan-23	95.2%	
Feb-23	91.7%	
Mar-23	96.2%	
Apr-23	95.1%	
May-23	92.6%	
Jun-23	94.3%	
Jul-23	94.3%	
Aug-23	89.3%	
Sep-23	90.7%	
Oct-23	96.7%	

XMR Run Chart



Understanding the most recent data point

Performance

96.7%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code • Matron working clinically for 2 weeks to embed good practice.	• Liane Ashley	• December 23	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval in September 2023

Women's Health Staff Engagement Score

Integrated Improvement Plan

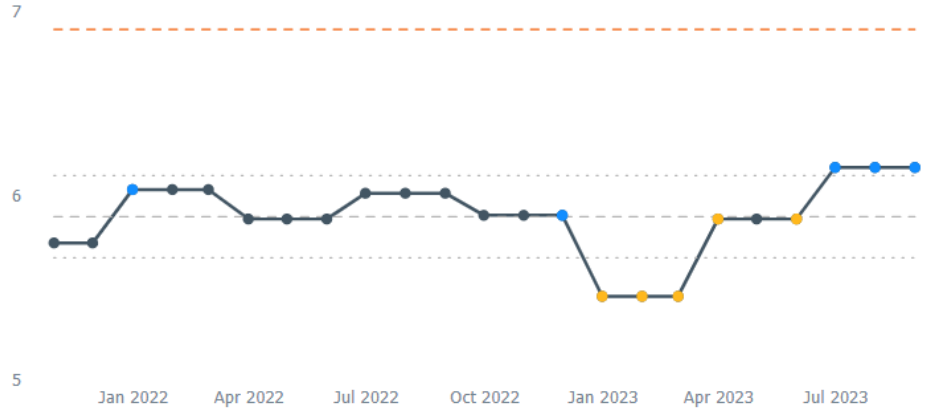
East Kent Hospitals University NHS Foundation Trust

National annual staff survey results provided by Picker March each year.
Staff engagement questions added to Staff Friends and Family quarterly surveys commencing March 2021.
9 questions in staff survey and replicated in quarterly staff FFT (3 x motivation, 3 x involvement and 3 x advocacy) which provide the overall engagement score.

WH Engagement Score

Timescale	Value	SPC
Oct-22	5.89	
Nov-22	5.89	
Dec-22	5.89	
Jan-23	5.45	
Feb-23	5.45	
Mar-23	5.45	
Apr-23	5.87	
May-23	5.87	
Jun-23	5.87	
Jul-23	6.15	
Aug-23	6.15	
Sep-23	6.15	

XMR Run Chart



Understanding the most recent data point

Performance

6.15

Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Opportunities for Staff Engagement	• Introduction of " We Hear You " providing platform for feedback • Embedding Safety Champions Forum • Band specific Meetings /away days • Increase Appraisal rates and SMART objectives • Promoting Freedom to Speak Up Guardians and arrange dedicated walkarounds • Embedding retention conversations • Compassionate attendance at work conversations following absences	• Adaline Smith DDOM	• December 23	Score survey in progress.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: M7 FINANCE REPORT

Meeting date: 7 DECEMBER 2023

Board sponsor: INTERIM CHIEF FINANCE OFFICER (CFO)

Paper Author: DEPUTY CHIEF FINANCE OFFICER (DCFO)

Appendices:

APPENDIX 1: M7 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Trust Board on the current financial performance and actions being taken to address issues of concern.
Summary of key issues:	The Group reported an in-month position of £8.9m against a plan of £4.6m, resulting in a deficit variance of £4.4m. The Year to Date (YTD) position is £68.2m against a plan of £45.5m, giving a YTD variance to plan of £22.7m. The agreed financial plan for 2023/24 is a £72m deficit. Delivery of the 2023/24 financial plan is based upon some extremely challenging assumptions as it requires that the Trust: 1) Delivers £40m of efficiency savings on a cash releasing efficiency basis. 2) Delivers a stretch activity target. 3) Reduces not medically fit to reside patients. 4) Eliminates 65-week breaches. 5) No additional unknown cost pressures are presented without mitigation in year. 6) Non-elective pressures are within planning tolerances. 7) Full control measures are reintroduced.

Group Position

£'000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
EKHUFT Income	72,799	73,965	1,165	501,391	510,151	8,760
EKHUFT Employee Expenses	(48,125)	(50,376)	(2,251)	(340,562)	(358,855)	(18,293)
EKHUFT Non-Employee Expenses	(29,457)	(33,268)	(3,811)	(207,723)	(221,154)	(13,431)
EKHUFT Financial Position	**(4,783)**	**(9,680)**	**(4,897)**	**(46,894)**	**(69,857)**	**(22,964)**
Spencer Performance After Tax	72	57	(15)	291	156	(135)
2gether Performance After Tax	100	90	(10)	699	735	36
Rephasing/Consolidation Adjustments	(33)	519	552	(48)	4	52
Consolidated I&E Position (pre Technical	**(4,643)**	**(9,014)**	**(4,370)**	**(45,952)**	**(68,962)**	**(23,010)**
Technical Adjustments	65	85	20	414	713	299
Consolidated I&E Position (incl adjs)	**(4,578)**	**(8,929)**	**(4,350)**	**(45,538)**	**(68,249)**	**(22,711)**

Run-rate has reduced in Month 7 by £0.1m compared to Month 6.

The key drivers to the Group's YTD deficit are:

Key Drivers	**£000**
Non-delivery of recurrent efficiency savings, against recurrent Cost Improvement Programme (CIP) plan	(£17,821)
Nursing drivers (Escalation Beds £523k / 1:1 care £2,810k / Supernumery Nurses £1,496k)	(£4,829)
Unfunded Pay Award (Medical and Dental, Agenda for Change (AfC) and AfC Bonus)	(£3,122)
Strike Action impact unfunded (Excludes April as now funded through new Elective Recovery Fund (ERF) guidance)	(£1,650)
Strike Action Consultants (7 days YTD)	(£350)
Internationally Educated Nurses (IEN) Backpay 2022/23 above plan	(£925)
Non-recurrent savings, above non-recurrent CIP plan	£5,986
Group YTD Deficit	**(£22,711)**

Trust Pay is overspent by £18.3m YTD due to

- Non-delivery of Pay CIPs.
- Shortfall in funding for pay awards.
- High cost of agency premium to cover escalation areas still open above plan £0.5m.
- Increased levels of 121 nursing care £2.8m.
- IEN supernumery cover above plan £1.5m (of which £1.3m relates to the 6-month supernumery period for 2022/23 Q3/4 cohorts).
- IEN backpay relating to 2022/23, paid in September and October, £0.9m above plan.
- Increased levels of staffing utilisation/high cost agency in Medical & Dental.

Whole Time Equivalent (WTE) over-utilisation fell by a further 78 WTE in October from 167 WTE to 89 WTE, which is a good indication that the pay controls in place are working.

Trust Non-Pay is overspent by £13.4m primarily driven by:

- Non-delivery of Non-Pay CIPs.
- Rechargeable drugs costs (offset by corresponding increase in income).
- IT systems contracts relating to Laboratory Information Management System (LIMS) (again, offset by an increase in income).

Trust Income is above plan YTD by £8.8m mainly due to:

- funded service developments not in plan, including Cancer Alliance income (Targeted lung checks) £0.9m, additional allocation from the

	Integrated Care Board (ICB) for Healthcare Partnership projects for virtual ward and schemes targeted at discharges £1.1m, vascular reconfiguration and Continuous Glucose Monitoring funding £0.9m and Pathology LIMS £0.5m. These are all offset by an increase in expenditure. • overperformance in high cost drugs and devices £3.7m (matched by a corresponding increase in expenditure). • favourable prior year income benefit/non-recurrent CIP of £0.6m. In line with the previous ERF guidance, Trusts are now required to report the actual income performance against their plan. As at Month 7, the Trust is behind its activity plan by £4.2m, predominantly due to cancelled elective activity as a result of the Doctor's strikes. However, to compensate Trusts for the Doctors strike in April, annual targets have been reduced by 2% and the value has been converted into fixed funding (£3.2m) and allocated to April. This funding is to cover the expenditure consequence of the April strike (£0.4m) as well as the estimated activity loss in April. The net underperformance to M7 is therefore £1.0m. The Group cash balance (including subsidiaries) at the end of October was £40.2m. The Trust drew £7.8m of working capital (Public Dividend Capital (PDC)) in the month, making a YTD total of £48.6m. Total capital expenditure at the end of October was £11.1m spend against a plan of £13.7m; this represents a £2.6m net underspend due to slippage on a major scheme. The Trust has achieved very little efficiency savings so far this year, with £2m achievement against the £20.4m YTD plan, of which £1m is recurrent. Additional non-recurrent efficiencies of £6.5m have been achieved YTD when taking into consideration the reported financial position adjusted for the known overspends (such as pay award funding shortfall, impact of strike action, increased levels of utilisation for nursing & medical staffing above plan and 1-2-1 care).
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.

Implications:

Links to Strategic Theme:	• **Partnerships** • **Sustainability** **Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).

East Kent Hospitals University NHS Foundation Trust

Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 23/24 efficiencies target equating to £40m.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee - 28 November 2023

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2023/24

October 2023

Chief Finance Officer
Tim Glenn

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Month 07 (October) 2023/24

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Executive Summary
Month 07 (October) 2023/24

Executive Summary

The Group reported an in-month position of £8.9m against a plan of £4.6m, resulting in a deficit variance of £4.4m. The Groups YTD position is £68.2m against a plan of £45.5m, giving a YTD variance to plan of £22.7m.

From the 1st of April electives and outpatients (apart from follow ups) have been reinstated to payment by results, however current guidance states that Trusts need to report on full delivery of the activity plan due to timings of data collection.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2023/24 at the beginning of May. The plan is a deficit position of £72m. The rest of the ICB need to deliver a breakeven position to achieve the ICB target of £48m deficit. Delivery of this deficit plan for 2023/24 is a stretch for the Trust as it is based on a higher level of activity than 2022/23 and requires £40m of efficiency savings on a CRES basis and full adherence to cost control measures. 2023/24 is the first year of the three year trajectory to achieve financial balance.

In line with recent ERF guidance, Trusts are now required to report the actual income performance against their plans. £4.2m Income underperformance has been reported to M7, predominantly due to cancelled elective activity as a result of the Doctor's strikes. However, to compensate Trusts for the Doctors strike in April, annual targets have been reduced by 2% and the value has been converted into fixed funding (£3.2m) and allocated to April. This funding is to cover the expenditure consequence of the April strike (£0.4m) as well as the estimated activity loss in April. The net is an underperformance at M7 of £1.0m.

Group Position

£'000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
EKHUFT Income	72,799	73,965	1,165	501,391	510,151	8,760
EKHUFT Employee Expenses	(48,125)	(50,376)	(2,251)	(340,562)	(358,855)	(18,293)
EKHUFT Non-Employee Expenses	(29,457)	(33,268)	(3,811)	(207,723)	(221,154)	(13,431)
EKHUFT Financial Position	**(4,783)**	**(9,680)**	**(4,897)**	**(46,894)**	**(69,857)**	**(22,964)**
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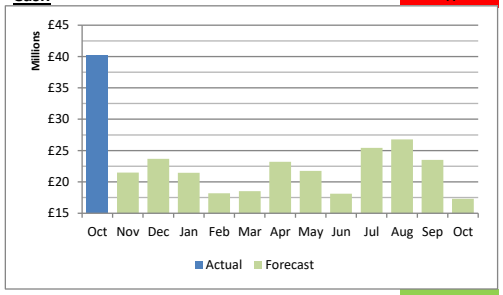
Technical Adjustments	65	85	20	414	713	299
Consolidated I&E Position (incl adjs)	**(4,578)**	**(8,929)**	**(4,350)**	**(45,538)**	**(68,249)**	**(22,711)**

Income and Expenditure R

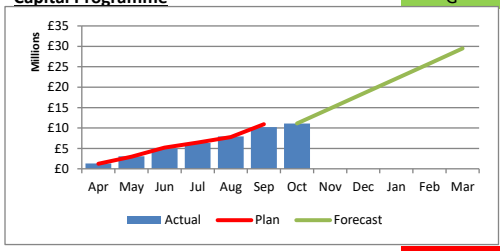
The key drivers behind the deficit variance are Strike action by the Junior doctors and Consultants £2m (excluding the impact of April industrial action, which has now been funded through the new ERF guidance), non-delivery of efficiency savings £11.8m YTD (net of £1.8m delivery of income CIP) of which £9.7m has been allocated to Pay and £4.1m to non pay. Pay is overspent by £18.3m YTD, however Wte over-utilisation fell by 78 wte in October from 167 wte to 89 wte, mainly relating to bank and agency usage. Total non-Pay overspend of £13.4m, predominantly driven by non-delivery of efficiency saving and rechargeable drugs costs (offset by corresponding increase in income).

Cash R



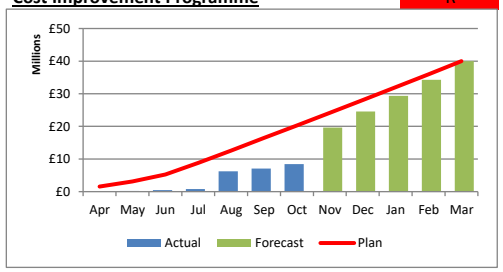
The Group cash balance (including subsidiaries) at the end of October was £40.2m.
The Trust drew £7.8m of working capital (PDC) in the month, making a YTD total of £48.6m.

Capital Programme G



Total capital expenditure at the end of October was under plan by £2.6m, due to slippage on a major scheme. The Trust is forecasting a £2.3m cost pressure, but the ICS have confirmed additional funding to fully alleviate this risk.

Cost Improvement Programme R



The Trust has achieved £8.5m efficiency savings so far this year against a £20.4m plan.
Work is under way on Nursing Agency cost deep-dives, and on a review of Admin and Clerical vacancies.

Income and Expenditure Summary
Month 07 (October) 2023/24

Unconsolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	9,567	8,726	(842)	62,068	57,066	(5,003)
Non-Electives	22,709	18,549	(4,159)	158,762	133,336	(25,426)
Accident and Emergency	4,342	3,758	(584)	30,177	26,989	(3,188)
Outpatients	10,549	11,869	1,319	68,920	71,859	2,940
High Cost Drugs	4,070	4,201	131	28,489	31,540	3,052
Private Patients	14	23	8	100	184	84
Other NHS Clinical Income	17,023	21,379	4,356	121,248	155,160	33,912
Other Clinical Income	133	128	(5)	932	854	(77)
Total Income from Patient Care Activities	**68,408**	**68,632**	**224**	**470,697**	**476,990**	**6,293**
Other Operating Income	4,392	5,332	941	30,695	33,162	2,467
Total Income	**72,799**	**73,965**	**1,165**	**501,391**	**510,151**	**8,760**
Expenditure						
Substantive Staff	(41,604)	(43,475)	(1,871)	(294,748)	(306,880)	(12,132)
Bank	(3,534)	(3,719)	(184)	(24,409)	(25,814)	(1,405)
Agency	(2,987)	(3,183)	(196)	(21,405)	(26,161)	(4,755)
Total Employee Expenses	**(48,125)**	**(50,376)**	**(2,251)**	**(340,562)**	**(358,855)**	**(18,293)**
Other Operating Expenses	(28,598)	(32,495)	(3,897)	(201,682)	(215,650)	(13,968)
Total Operating Expenditure	**(76,723)**	**(82,871)**	**(6,148)**	**(542,244)**	**(574,505)**	**(32,261)**
Non Operating Expenses	(859)	(773)	86	(6,041)	(5,504)	537
Income and Expenditure Surplus/(Deficit)	**(4,783)**	**(9,680)**	**(4,897)**	**(46,894)**	**(69,857)**	**(22,964)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	68,610	70,117	1,507	481,781	487,058	5,277
Other Operating Income	4,517	5,400	883	31,570	31,994	424
Total Income	**73,127**	**75,517**	**2,390**	**513,351**	**519,052**	**5,701**
Expenditure						
Employee Expenses	(50,520)	(54,083)	(3,563)	(369,121)	(387,371)	(18,249)
Other Operating Expenses	(26,319)	(29,630)	(3,311)	(183,667)	(194,985)	(11,318)
Total Expenditure	**(76,839)**	**(83,713)**	**(6,874)**	**(552,788)**	**(582,356)**	**(29,567)**
Non-Operating Expenses	(931)	(818)	113	(6,515)	(5,658)	857
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**(4,643)**	**(9,014)**	**(4,371)**	**(45,952)**	**(68,962)**	**(23,010)**
Technical Adjustments	65	85	20	414	713	299
Consolidated I&E Position (incl adjs)	**(4,578)**	**(8,929)**	**(4,351)**	**(45,538)**	**(68,249)**	**(22,711)**

Income from Patient Care Activities

The £6.3m overperformance YTD on clinical income is primarily due to funded service developments not included in the plan in the following areas:

- Additional Cancer Alliance (Targeted Lung Checks) new income stream confirmed (£0.9m)
- One-off funding for Pathology LIMS from the ICB to cover expenditure on digital Pathology system (£0.5m)
- K&M Healthcare Partnership funding for Virtual Wards and schemes targeted at discharges (£1.1m)
- Vascular reconfiguration and Continuous Glucose Monitoring funding not included in plan (£0.9m)
- Overperformances in High cost drugs (£3.0m) and Devices (£0.7m) - matched by a corresponding increase in expenditure
- Prior year income benefit (£0.6m)

The majority of commissioner income is paid on a block basis with the exception of the Elective Recovery Fund Activity and NHS England high cost drugs and devices.

The full year Elective Recovery target has been reduced by 2% as a result of national guidance to compensate Trusts for the impact of the doctor's strike in April, and converted into fixed funding (£3.2m) allocated to April. This funding is to cover the expenditure consequence of the April strike as well as the estimated activity loss in April. Trusts are now required to report the actual income performance against their plan. Net of the £3.2m fixed funding, the underperformance on ERF is £1.0m YTD.

Other Operating Income and Expenditure

Other operating income is favourable to plan in October by £0.9m and by £2.5m YTD. The in month variance is driven mainly by above plan education and training income of £0.8m, following rebase of the Education Contract with NHSE for pay awards in P3 (October - January), backdated to April.

Total operating expenditure is adverse to plan in October by £6.1m and by £32.3m YTD, including CIPs which are reported as £3.3m adverse in month and £18.8m adverse YTD.

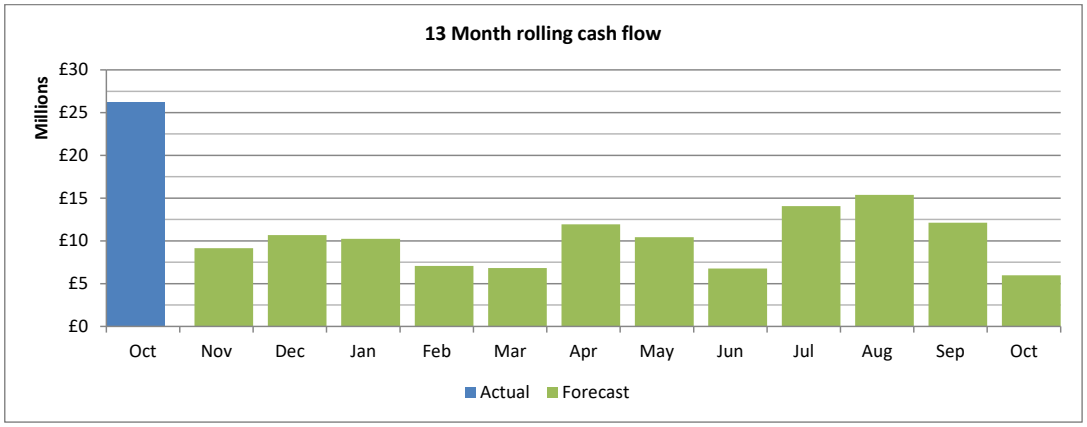
Employee expenses performance is adverse to plan in October by £2.3m and by £18.3m YTD. Pay CIP schemes are adverse to plan in month by £1.5m and by £10.8m YTD. The adverse variance due to the AfC and medical staff pay awards was £0.4m and £3.1m YTD. Further arrears payments to IENs were processed in October costing £0.7m, which caused an adverse variance in mth of £0.5m and £0.9m YTD. The adverse position also reflects the impact of cover during strike action by Junior Doctors and Consultants, which is estimated at £0.5m and £2.0m YTD. Wte over-utilisation fell by a further 78 wte from 167 wte to 89 wte, mainly relating to nurses and HCAs. Over-utilisation reflects the indicative variance to plan for escalation beds of £0.5m YTD, and 1:1 care of £0.2m and £2.8m YTD.

Total expenditure on employee expenses in October was £50.4m, a reduction of £1.2m when compared to September. Expenditure on substantive staff fell by £0.6m, relating to qualified nurses where there was a reduction in the cost of current year IEN arrears month on month.

Other operating expenditure is adverse to plan by £3.9m in October and by £14.0m YTD. CIP schemes relating to other operating expenditure are adverse to plan by £1.7m in October and by £7.9m YTD. The other main driver for the overspend in month is the Operating Healthcare Facility (OHF) contract (with 2gether Support Solutions) which is adverse to plan by £2.1m, reflecting the identified risks for catering, supplies and EME.

Other operating expenditure increased month on month by £1.2m, mainly relating to the OHF contract where spend grew by £1.9m due to the recognition of the catering supplier contract risk £0.5m, increased costs relating to medical equipment maintenance and damages, and growth in consumables. This growth is offset by reductions in spend on drugs and supplies and services clinical totalling £0.5m, and education and training of £0.2m.

Cash Flow
Month 07 (October) 2023/24



Unconsolidated Cash balance was £6.4m at the end of October 23, £26.3m above plan.

Cash receipts in month totalled £107.4m (£20.8m above plan):

- HMRC VAT reclaims totalled £17.4m (£13.9 above plan)
- K&M ICB paid £55.8m in October (£1.2m below plan)
- NHS England paid £22.7m in October (£5.1m above plan)
- Other NHS receipts totalled £0.7m (£0.5m below plan)
- Non NHS Receipts totalled £3.1m (£1.8m above plan)
- Revenue Support received in month was £7.8m (1.8m above plan)

Cash payments in month totalled £87.6m (£4.9m above plan)
Creditor payment runs including Capital payments were £21m (£0.6m below plan) Payments to 2gether were £0.3m below plan. Payroll was £5.7m above plan primarily due to an increase in PAYE and NI Contributions.

YTD cash receipts total £614.5m (£41.0m above plan) largely driven by receipts from NHS England above plan (£27.1m, of which £17.2m was unconsolidated pay award in June), VAT reclaims (£2.8m above plan), revenue support above plan by £8.9m).

YTD cash payments total £606.8m (£30.4m above the plan) driven by payments to 2gether below plan (£12.0m), Payroll over plan (£33.0m, predominantly due to the unconsolidated pay award) and creditor payments over plan (£10.2m, due to increase in bank and agency spend)).

2023/24 Plan

The revised plan submitted to NHSE in May 2023 shows a technically adjusted deficit position at the end of 2023/24 of £72.8m. Revenue support for the full deficit amount is forecast in the year.

Forecast

The majority of the monthly OHF invoices from 2gether Support Solutions were authorised for payment in Month 5. The VAT reclaimed against these, £11.5m, was received on the 9th October. 2 further invoices were authorised in Month 6. The VAT reclaim will be received in October/November and will enable a further significant payment to creditors.

The Trust has submitted a request for £18.2m Q3 revenue support. £7.8m was received in October, £4.3m in November and £6.1m in December, in line with the original planned £72m deficit.

The Trust submitted a request for exceptional working capital for £25.7m to NHSE in October, which was the value required to clear relevant outstanding creditor balances. The Trust has received approval for additional working capital of £15.4m of the requested £25.7m (£13m in November, £2.4m in December) to cover creditors overdue by more than 90 days only.

Creditor Management

The Trust moved to 81 day creditor terms in Month 7.

In prior months, payments to one key supplier were being held and invoices cleared only if the funds were available. To avoid late payment charges being levied, it was agreed to clear their balance by the end of October at a rate of £2m per week. As at 31st October 23, £2.2m was overdue for payment with a further £3.2m falling due next month.

At the end of October 2023, the Trust was recording 78 creditor days (Calculated as invoiced creditors at 31st October/ Forecast non-pay expenditure x 365).

Cost Improvement Summary

Month 07 (October) 2023/24

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Agency	699	415	(284)	4,013	415	(3,598)	7,851	517
Bank	-	-	-	-	-	-	5	5
Workforce	1,353	40	(1,312)	7,630	231	(7,400)	7,006	(7,240)
Outpatients	-	-	-	-	-	-	110	110
Procurement	94	29	(65)	231	356	125	2,332	1,624
Medicines Value	95	39	(56)	469	355	(114)	771	(229)
Theatres	220	-	(220)	1,208	-	(1,208)	2,111	(389)
Care Group Schemes *	1,392	53	(1,338)	6,815	608	(6,208)	13,328	(884)
Sub-total	**3,852**	**577**	**(3,275)**	**20,367**	**1,965**	**(18,402)**	**33,513**	**(6,487)**
Central	-	802	802	-	6,487	6,487	6,487	6,487
Grand Total	**3,852**	**1,379**	**(2,473)**	**20,367**	**8,452**	**(11,915)**	**40,000**	**-**

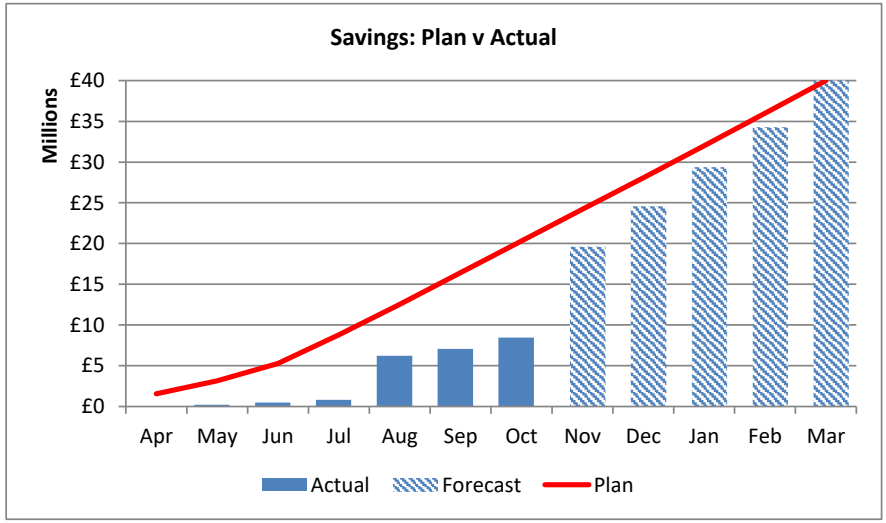
* Smaller divisional schemes not allocated to a work stream

Delivered £000		
Month	**Target**	**Actual**
April	1,532	58
May	1,550	149
June	2,100	290
July	3,474	311
August	3,684	5,422
September	4,174	842
October	3,852	1,379
November	3,865	
December	3,923	
January	3,931	
February	3,879	
March	4,036	
	40,000	**8,452**

The submitted Efficiencies plan for 2023/24 is £40m. The Trust recognised recurrent savings of £0.1m in October, and £1m on a YTD basis, which is significantly below Plan. YTD underperformance is primarily due to timing of schemes in Agency, Workforce, Theatres, and Care Groups currently being developed.

The current value of the pipeline is £12.9m, similar in value vs. the prior month, and this also includes efficiencies being confirmed as reduction to run-rate overspends from FY23, rather than CIPs.

The majority of ideas currently identified through the care group process are less than £50k (60%) or less than £250k (20%), but working across the cross-cutting themes of Workforce, Elective and Non-Elective productivity, Theatres, we are predominantly scoping larger group-wide to significantly increase the value of CIP schemes next month. This work includes linking in with the Nursing Agency cost deep-dives, and a review of Admin and Clerical vacancies.



Capital Expenditure
Month 07 (October) 2023/24

Capital Programme	Annual	Annual	Year to Date		
£000	**Plan**	**Forecast**	**Plan**	**Actual**	**Variance**
Emergency Department Expansions	4,271	6,270	3,611	5,559	(1,948)
Community Diagnostics Centre	2,845	2,845	812	18	794
Mechanical Thrombectomy	2,608	1,191	408	54	354
Diagnostics Clinical Equipment	2,550	2,550	425	0	425
Information Development Group	2,000	2,000	1,595	1,069	526
Medical Devices Group	1,666	1,666	966	488	478
Electronic Medical Records	1,545	1,526	1,035	1,180	(145)
Stroke HASU	1,463	1,463	146	683	(537)
Diagnostics Imaging Capacity	1,433	1,383	1,433	(0)	1,433
Patient Environment Investment Committee	3,771	4,034	1,640	229	1,411
Charity Donations	900	700	490	188	302
Other Build	736	2,247	686	717	(31)
Subsidiaries	519	839	208	120	88
Other IT	375	375	0	375	(375)
Other Medical Equipment	259	244	259	244	15
Trust IFRS16 Acquisitions	0	110	0	110	(110)
Lease Cars	0	47	0	30	(30)
All Other	0	2	0	44	(44)
	26,941	**29,492**	**13,714**	**11,109**	**2,605**

Funded By:	**Plan**	**Forecast**	**Change**
Operational Cash	21,515	21,515	0
System Set Underutilisation	(2,850)	(2,843)	7
Donations	900	700	(200)
Disposals	250	250	0
System Capital PDC	1,463	3,806	2,343
PDC	5,663	5,613	(50)
Carried Forward PDC	0	131	131
New Lease Loans	0	458	458
New Lease Repayments	0	(138)	(138)
	26,941	**29,492**	**2,551**

Under/(Over) Commitment	**0**	**0**

The Trust submitted the final 5-year Capital Plan to NHSE on 4th May 2023, the programme totalling £26.94m in 2023/24.

The latest forecast for the year, as at M7, is £29.49m, representing a £2.55m net increase from the original plan; this represents the net impact of:

• increases totalling £2.8m, of which £2.34m was additional CDEL approved by the K&M ICB following a corresponding bid submitted by the Trust in October 2023 and £0.46m due to New Lease Loans taking in-year;

• reductions totalling £0.25m, of which £0.05m was due to a reduction in the Diagnostic Imaging Capacity PDC funding assumed (and associated spend plans) to align it to the final funding figure provided in the MOU and £0.2m forecast reduction in the assumed Charity Donations expenditure.

YTD Capital Spend

The Group's gross capital year-to-date spend to the end of Month 7 was £11.1m, against a YTD plan of £13.7m. This represents a £2.6m net underspend, as a result of:

Underspends totalling £5.8m (including £2.35m on Diagnostics Imaging Capacity, MDG and other Medical Equipment, £2.55m on PEIC, CDC and Mechanical Thrombectomy and £0.9m on IDG, Charity Donations and Subsidiaries;

Overspends totalling £3.2m (including £1.95m on the ED Expansion programme, £0.54m on Stroke HASU, £0.52m on Electronic Medical Records (EMR) and Other IT schemes and £0.2m on IFRS16 items other small overspend items);

Risks and Mitigations

The Trust has now fully mitigated the previously reported £6.6m gross cost pressures, of which mitigations totalling £4.3m were identified internally and a further £2.3m externally, following the K&M ICB approval of a corresponding bid the Trust submitted in October 2023. Further risks remain on:

• the Community Diagnostics Centre (CDC), where an underspend of circa £1.25m is estimated, as at M7; the Trust is actively engaged in external conversations on how to best mitigate this risk, including an option to broker the slippage internally amongst other schemes in 23/24 and fund the remaining balance internally, in 24/25;

• Maternity Entonox scheme, where scheme slippage of £0.5m will be available for re-distribution if no further intervention is required following the installation this year of the Pure-air system in the delivery suites at WHH and QEQM. An air quality testing process is currently underway and is expected to complete in the coming weeks. If it is determined that further intervention is required, the scheme is expected to incur a £0.2m cost pressure overall, although given the expected completion times, it will likely slip into the next financial year.

Statement of Financial Position
Month 07 (October) 2023/24

£000	Opening	To Date	Movement	
Non-Current Assets	**402,107**	**398,537**	**(3,570)**	▼
Current Assets				
Inventories	6,749	7,732	983	▲
Trade Receivables	11,677	12,627	950	▲
Accrued Income and Other Receivables	29,981	15,938	(14,043)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	18,618	26,264	7,646	▲
Total Current Assets	**67,025**	**62,561**	**(4,463)**	▼
Current Liabilities				
Payables	(41,537)	(68,532)	(26,995)	▲
Accruals and Deferred Income	(46,653)	(38,215)	8,439	▼
Provisions	(2,887)	(2,715)	172	▼
Borrowing	(4,838)	(1,567)	3,271	▼
Net Current Assets	**(28,892)**	**(48,467)**	**(19,576)**	▼
Non Current Liabilities				
Provisions	(3,405)	(3,323)	82	▼
Long Term Debt	(77,371)	(75,527)	1,844	▼
Total Assets Employed	**292,439**	**271,220**	**(21,219)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	454,994	503,632	48,638	▲
Retained Earnings	(217,590)	(287,448)	(69,857)	▼
Revaluation Reserve	55,035	55,035	-	
Total Taxpayers' Equity	**292,439**	**271,220**	**(21,219)**	▼

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

Trust closing cash balance was £6.4m (6.4m in September) £5.4m below plan. See cash report for further details. Increase in balance driven by increased VAT receipts following the resolution of invoicing issues with 2gether Support Solutions. Cash has been supported in year by £48.6m of PDC working capital.

The current I&E adverse variance to plan is having an impact on cash - and the Trust's ability to pay creditors to terms - this impact is clearly seen in the Better Payment Practice Code figures.

Trade and other receivables have increased from the 2023/24 opening position by £1m (£0.1m reduction in September). Key drivers are detailed on the Cash report.

The Trust and Spencer Priovate Hospitals cleared £1.2m of inter-company debt in October.

Payables have increased by £27m (£24.7m increase in September), another clear indicator of the impact of a shortage of cash. See Working Capital sheet for more detail on debtors and creditors.

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

PDC increased in month by Working Capital (£7.8m).

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **7 December 2023**

Board sponsor: **Chief Executive**

Paper Author: **NHS England (NHSE) Improvement Director**

Appendices:

Appendix 1: IIP Report
Appendix 2: IIP Risk Register

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the IIP and offers assurance based on evidence gathered for how this is influencing the exit criteria set within the NHS England Recovery Support Programme National Oversight Framework Segment 4 (NOF4). The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.
Summary of key issues:	The report includes an update by programme and project. Four programmes are rated as amber with significant progress being made in Quality & Safety, Maternity and People & Culture programmes. Two programmes continuing to be rated as red in this period which are the biggest risk to delivery and exit from NOF4. Robust evidence continues to be gathered against the IIP and the Strategic Improvement Committee have implemented a robust self-assessment process to offer assurance in meeting the NOF4 exit criteria which is shared in the IIP Board report based on current evidence gathered. An 'Evidence Review and Assurance Panel' (accountable to the Strategic Improvement Committee) will be implemented from January 2024 to ensure there is a thorough assessment, confirm and challenge of evidence to ensure the organisation is assured of its progress. Last month the Board of Directors was introduced to the phase two framework of the IIP. All programmes are now reviewing milestones for phase two purposes which is due to be finalised in December 2023 to ensure key areas of work are progressed to address meeting exit criteria and improve metrics.

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East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is invited to **DISCUSS** the report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Board Assurance Framework (BAF):	**BAF 32** – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. **BAF 34** – There is a risk that our constitutional standards are not met. **BAF 38** – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).
Link to the Corporate Risk Register (CRR):	N/A
Resource:	No
Legal and regulatory:	Yes – regulatory impact.
Subsidiary:	Yes – in the overall provision of services within the resources available to the Trust.

Assurance route:

Previously considered by:

Oversight and Assurance is provided through the Strategic Improvement Committee (SIC).

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

Journey to Exit NOF4 – IIP Update
November 2023 Summary

Purpose of Report

NHS
East Kent Hospitals University
NHS Foundation Trust

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

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

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

High-level Assurance on Programme/Project Delivery

Programme	Project	Summary
Leadership & Governance	Executive Leadership	• Progress continues with recruitment of the Executive Leadership Team with start dates being agreed for both the Chief Medical Officer and Deputy Chief Medical Officer. An Interim Chief Finance Officer on a 12-month secondment commenced in the Trust on 6th November 23. Interim Chief Operating Officer arrangements for Unplanned Care continue whilst a plan to recruit substantively is in discussion. • The CQC well led inspection took place on 4th and 5th July 2023 with the factual accuracy report now shared with the Trust as Requires Improvement however, some areas noted evidenced improvement. This workstream RAG remains amber on this basis.
	Governance	• This month has seen the start of the Good Governance Institute (GGI) review into Board effectiveness. Interviews will conclude 24th November with initial feedback expected before January 24. • The Trust Board have undertaken a development session on the BAF and were provided with an update on risk management progress and the pending risk register review. A Board development session on PSIRF is to be provided in December 23. • Current RAG status remains red as it is recognised there is further work to do in order to embed governance across the organisation which will be progressed and monitored by this programme and milestones to improve the governance position are being developed to form the IIP phase 2.
	Comms & Engagement	• This project remains rated green as the milestones have been met to develop and roll out a communications and engagement strategy including a monthly rolling programme of activity now BAU. • Included in the last period; shared improvements in maternity, winter planning progress and the current financial position. Quality improvements and success stories have also been shared, along with the promotion of the staff survey and staff health and wellbeing initiatives. • Plans are being developed to communicate and engage staff on the next phase of financial control measures and benefits of quality improvements for patients linked to savings. For the IIP Phase 2, an engagement grid to promote the visibility of the Executive team and to promote the golden thread between the Board, staff and patient experience is being developed which supports the NOF4 exit criteria.
	Transformation Programme	• This workstream remains amber as whilst good progress has been made there are three milestones remaining off track. • Shortlisting is underway for the Medical Director post at QEQM, with interim arrangements continuing for the Managing Director post. • Work has progressed significantly with the development of the behavioural code in Maternity and production of a behaviours leaflet now circulated across maternity services to reach managers over multiple platforms for them to share with their teams and reference during 1:1 and appraisal discussions/meetings. The Inclusion and Respect Charter/Behavioural code is included as priority for Year 1 of Maternity Neonatal Improvement plan.
People and Culture	Attract and Retain	• The project remains rated as green as the fundamentals are now in place to enable robust monitoring and interactions with our staff and teams. The next steps will be to deep dive further into appraisal management to understand future interventions required with an aim to improve the appraisal trajectory and organisational efficiency by ensuring that individuals perform to the best of their ability and develop their potential. • Unfortunately, sickness has continued to increase therefore within the review of the IIP for Phase 2 the team will be reviewing and implementing specific milestones to support improvements in this area. The vacancy position remains in an improved position from the baseline but is continuously static. • The Workforce Recruitment Strategy was ratified at the People & Culture Committee early November 23, next steps will be to communicate this across the organisation aligning to the EKHUFT communication plan and providing further improvements to support People and Culture exit criteria 4.
	Culture Leadership & Development	• The project remains rated at green as there have been significant developments to launch new starter surveys, responding to feedback by utilising the NSS dashboard and communications aligned to the People & Culture programme continuing as BAU. • Positively, the Culture and Leadership Behavioural Programme (including culture focus groups, patient experience and leadership workforce analysis) remains on track. The survey was shared at the Board development session in November and Board member interviews are reaching towards completion which will allow focus of interventions required thereafter. This project is significantly supportive of the People & Culture exit criteria 1 with further improvements expected to be seen in exit criteria 2 over the next 12-18 months. • The staff survey response as at 27th November is at 40.8% with actions such as; targeted outreach, floor walks with leaders and Exec videos aimed to support increasing the response rate.
	Medical Workforce	• There has been a significant improvement in leadership and engagement from the Medical Office to drive forward the diagnostic for the People and Culture milestones for the medical workforce. However, the risk remains to meet target date for majority of milestones due to complexity of the work which impacts on pace to deliver such as medical rostering or the creation of electronic dashboards. • While a there is the intention to establish a number of dashboards to enable the ability to monitor metrics instantaneously from one source, mitigations remain in place which allows the People & Culture team to obtain data from a range of sources and is therefore not causing delays to interventions required.

High-level Assurance on Programme/Project Delivery

Programme	Project	Summary
Quality & Safety	Quality Governance	• The project RAG rating this month has improved from red to amber as significant evidence has now been shared to all stakeholders supportive of improvements in the management of Sis including; consistent performance for reaching the 60-day deadline, SI decision making, SI processes being embedded and shared learning across the organisation. • Delays remain for the transition to PSIRF (this was out of the Trust's control due to IT technical issues), although the milestone to implement PSIRF remains on target to be achieved by March 24 with the business case for procurement of a new quality governance system being progressed now through relevant committees. • Risk Management is a significant focus to be further developed and a timeline has now been produced and shared with the Board to progress actions at pace to support improvements to be made. Actions include; developing robust policies and procedures for risk management, risk escalation process arrangements and dedicated resource for 2 days per week to undertake a deep dive review and refresh of the risk register. This piece of work will support moving towards exit from NOF4 as the organisation will have clearer monitoring arrangements of risk and mitigation.
	Safeguarding	• The Safeguarding project remains on track with overall good progress made. The team attended an oversight meeting with regional and ICB colleagues in October 23 to review evidence and it was agreed to remain at amber status. There remains an open action at the oversight meeting for a current EKHUFT safeguarding risk register, given this and due to the changes in leadership of safeguarding most recently, it was agreed to continue the oversight meetings but reduce to monthly due to the good progress made to date. • Due to the care groups restructure this has impacted on the collation of accurate data for training, once clarified it will be reviewed and a recovery plan will be developed. • Work with the agency staff supplier and supporting the agency to develop a policy and review the actions taken to support and train staff.
	Fundamentals of Care	• This month has seen good progress with the completion and evidencing of a number of milestones, turning the RAG rating from amber to green. • Following on from the organisational governance review, workstreams for all FoC meetings have now been reviewed and agendas amended to reflect the changes. Some workstreams have been realigned with patient safety and others have realigned with FoC. • KPIs and trajectories for applicable workstreams have now been agreed and published, although there has been a delay to agreeing the FoC framework as this is dependent on the wider corporate nursing functions review which is currently in discussion. • Only a small number of wards remain to be completed in the first ward accreditation programme which has made substantial progress in getting back on track. • All corporate actions have been undertaken to ensure that the organisation is compliant with the Accessible Information Standard (AIS). Further work to be completed at Care Group level to ensure that the organisation meets the standards that will be detailed within updated NHSE guidance on AIS which is due imminently.
	Deteriorating Patient	• The IIP has started to clearly articulate the progress made across various workstreams which are contributing to improvements with the deteriorating patient pathway and in doing so preventing unnecessary harm or delays in patients' journey. This has allowed the project RAG rating this month to improve from amber to green as significant evidence has now been shared with all stakeholders supportive of these improvements. • While consistent contributors for moderate and above harm to our patients remain care/treatment and delay/failure, the number of harm events directly related to the deteriorating patient remain small. • Recognising there is a need for training on the escalation of the deteriorating patient and better awareness of policies such as NEWS2 and improved documentation, these will be further progressed through Phase 2 of the IIP to ensure we implement robust training and monitor compliance, targeting areas with specific needs. • There are mitigations remain in place to include questions on the identification and management of the deteriorating patient on Tendable (while the dashboard is being built). The questions went live in August 2023 with the aim for Care Groups to monitor their own departments compliance and overseen by the deteriorating patient lead.
Operational Performance	UEC and Whole System Interface	• The overall position for UEC deteriorated by 0.1% for all types in October with type 1 reporting slight improvement (45.6% October v 45.5% September) the high numbers of type 1 attendances continued in month (12.5k October v 12.4k in September) with ambulances conveyances at the highest reported numbers since November 22 (5,212 October v 5,044 September). • The pilot of the single point of contact - care coordination hubs (SPOA) to reduce ambulance conveyances and support patients to remain at home using the community pathways commenced November 23. This will be supported by the roll-out of the Alt-ED system and aims to stress test the ability to access timely alternative pathways including Virtual Ward capacity, with the aim to roll-out to QEQM post the 4- week pilot period. • The focus for EKUFT,HCP & ICB is the unmitigated bed gap for winter (currently reported at minus 129) with schemes to address and mitigate the bed gap being forensically reviewed for their validity and ability to address the gap.

High-level Assurance on Programme/Project Delivery

Programme	Project	
Operational Performance Continued…	**Elective Recovery (including Diagnostics)**	• The Elective position remains red as the organisation continues to see a deterioration in 65-week performance driven by Endoscopy backlog (12,894 scopes) and a unvalidated RTT of 24,538 greater than 12 weeks. An Endoscopy T&F Group has been set-up since 9th October to ensure oversight on Endoscopy recovery and an NHSI visit reviewing Elective Care was carried out on 25th October with report received into the COO office in early November. • However, for the first time this financial year we have seen the following key improvements/deliverables: 6.6% improvement in DM01 performance since September, previously seeing monthly deterioration from June and completion of revised trajectories and improvement plans for all Planned Care constitutional standards with ICB input included. • Key risks remain in relation to the resources available to complete the administrative validation and the resources required to address the Endoscopy backlog at pace. Current month plans continue to engage with Prism whom have completed their diagnostic phase and presented their first report to CEMG. • The interim MD for DCB commenced in November with a key action to produce a first draft Outpatient transformation plan by the end of November and a targeted focus through the recovery meetings in reducing first outpatient backlogs within Cardiology, Max-Fax and Gastroenterology.
	Cancer	• Revised trajectories to improve compliance with FDS and decrease the backlog for 62 days have been submitted with October's position demonstrating above trajectory improvement. A successful bid for improvement funding from NHSE (£345K) will significantly support our improvement. • Weekly transformation groups established for 2ww in collaboration with our GP lead, Lower GI, Lung and negotiated support from K&M cancer Alliance to improve our H&N pathway with MTW . • Weekly Performance meetings supported by update for teams on current performance including key priorities, learning from harm reviews and actions for the next 7 day.
Maternity	**Team Working**	• Patient safety remains consistent in triage, with 826 women seen by a Dr, of which 91.5% were seen on time in line with the BSOTs RAG system. 99.1% of women were seen by a midwife on time in line with the BSOTS RAG system therefore this project remains green.
	Clinical Escalation & Handover	• On the back of a process mapping event held in September 23, with support from NHSI MIAs, there has been multi-professional development of the Enhanced Maternal Care (EMC, deteriorating patient) pathway, with training started in November 23 and planned through to March 24. Identification of dedicated space and equipment is complete on both acute sites, with Estates works requested and equipment ordered. To support this development the MEWS2 assessment tool was launched across Maternity on 13th November 23 with ongoing education to support teams with implementation.
	Clinical Assessment & Care Pathways	• Antenatal New-Born Screening (ANNBS) pathway was processed mapped in February 23, NHS MIA proposed two priority recommendations. These are behind schedule and will be revisited before the end of November with the NHS MIAs and the multi-disciplinary teams. Workstream remains Amber, however all four priority pathways for year 1 of 3 year MNIP are underway.
	Governance & Patient Safety	• QUAD are reviewing the QSF and the new organisational governance structures to align local reporting systems and processes to the corporate framework. • Work continues on the patient safety related backlogs, with consideration of future ways of working to sustain timely completions of e.g. incident investigations and complaints. Programme of sharing lessons learned is effective and includes 'lunch and learn' alongside newsletters and message of the week, with escalation to WH Care group Governance Committee. RAG remains amber due to timeliness of clearing of backlogs and the development of the revised care group governance structure.
	Engagement, Listening & Leadership	• Co-produced MNIP Comms plan out for consultation to share structured messages internally and externally with clear pathways for two-way messaging. At the same time there is a programme of scheduled visits for the MNVP through to June 24, with a supporting workplan and feedback log that are monitored with the support of the patient experience midwives. • Engagement framework has been superseded by Maternity Patient Voices Model and the Comms plan that is currently out for consultation. Formal engagement forum to be established alongside the Trust patient involvement team, for service user input - project remains green.

High-level Assurance on Programme/Project Delivery

Programme	Project	
Finance	**Financial Governance**	• Revised financial governance processes are now in the embedding stage with regular comms in place with the care group triumvirates. There is regular review of the Trusts financial performance by the Board of Directors and the Finance and Performance sub-committees. • Enhanced controls of pay and non-pay was approved by the Executives on 15 November of which will be implemented by 4 December. A financial control review has been commissioned from PWC to compare current processes with best practice. Initial views indicate that there are likely areas where more robust control is required. Report will be published by mid-December.
	Financial Improvement	• Improvements in run rate have been noted with a number of benefits due online in next coming months however, whilst an FRP has been drafted, the trust has significantly diverged from the trajectory within. Drivers of the deficit review commissioned from PWC which will provide a clear picture of the deficit at the trust i.e. what is structural, what is operational efficiency. Report will be published mid-December. • Immediate priority is to continue with grip and control to stabilise the position and then developing the detailed cost improvement plans to improve financial and operational performance with PWC support to drive forward. • The trust is £18.4m worse than plan at the end of month 6.
	Financial Consciousness	• Continued engagement & comms aligned to the comms strategy is now BAU. Development of sessions take place with the clinical workforce & leaders regularly. • Independent review of the trust's forecast for year end is in the process of being produced and will be published for discussion with ICB and other stakeholders by mid-December.

Transition to Phase 2 of our Integrated Improvement Programme to exit NOF4

East Kent Hospitals University NHS Foundation Trust

Phase 2 – Analyse, improve and deliver

Analyse, improve and deliver

- Review and learn from phase 1
- Evaluate project impact and effectiveness by using robust data
- Review evidence to determine whether completed milestones have generated desired outcomes toward exit criteria
- Identify further opportunities for improvements
- Establish if new milestones are required or existing milestones should be enhanced
- Are there key areas of work that will address meeting exit criteria and improve metrics
- Assess plans to ensure they are beneficial for our stakeholders
- Self-assess levels of confidence against exit criteria monthly (RAG)
- Deliver on our commitments and compliance requirements
- Ensure our approach to improvement is sustainable and embedded for long-term

- All programmes and projects are now reviewing milestones for phase 2 purposes to ensure key areas of work will address meeting the exit criteria and improve metrics.
- SROs and Project Leads continue to share robust evidence to demonstrate compliance with exit criteria.
- This has enabled all programmes to self-assess against exit criteria using NOF4 RAG definition;

Exit Criteria RAG Definitions		Exit Criteria achieved and embedded
		On track, and with clear evidence, to meet the exit criteria by the planned exit date
		Emerging risk of inability, or no clear evidence of ability to meet exit criteria by the planned exit date.
		Off track with high risk of inability to meet exit criteria by planned date.

Impact to NOF4 Exit Criteria – Leadership and Governance

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5	Exit Criteria 6
Executive leadership team posts filled.	Executive leadership development plan in place.	Trust board sighted on key risks and actions taken via appropriate escalation routes.	Evidence of effective comms and engagement channels between the frontline and the Board and outwards to ICB/NHSE/system partners, inclusive of routes of escalation for risks and concerns.	In response to the 2022 Independent Investigation into Maternity Services, evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology to address culture, psychological safety and teamworking within the maternity service.	The Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the ICS.

Suggested Evidence

• Executive leadership team posts filled.	• Board development programme in place and evidenced, which places equal importance on the internal leadership of the Trust as the external leadership within the East Kent HCP, and the Kent and Medway ICS. • Evidence of clear focus and internal traction on key priorities against transparent improvement methodology.	• Evidence of robust governance processes in place with clear Board ownership of risks and mitigating actions. • Evidence of 5 months of BAF and corporate risk register being actively used at sub-committee and Trust Board with appropriate and timely response. • Evidence of governance review recommendations implemented.	• Evidence of improved communication processes. • Evidence of timely communication between key stakeholders and specifically ICB and NHSE colleagues. • Evidence of a 'golden thread' running through the organisation from Board to ward, where executives are fully sighted on what it feels like to be a patient and be a member of staff receiving and delivering services.	• Evidence of improvement measured by workforce, FTSU, leadership and cultural measures across maternity and wider services and ability to demonstrate learning across the Trust where applicable.	• Evidence that the Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the ICS.

Impact to NOF4 Exit Criteria – Quality and Safety

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1

Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process.

Exit Criteria 2

Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity, with continuous cycle of review, assessment and implementation of best practice and learning.

Suggested Evidence

Governance

- Evidence of improved transparency and timeliness of communication, reporting and information sharing with ICB partners.
- Evidence of SI ownership, improvement methodology, learning and training programme with a focus on detecting and responding to 'missed opportunities' promptly, with no delay in the immediate actions arising out of 72 hour reports.
- Evidence of a Clinical Harm Review process that supports future learning, improved risk assessment and process improvements so that patients at risk of ongoing/future harm can be identified in advance and care prioritised in order to prevent harm occurring.
- Timely identification, effective investigation and closure of SIs within national guidelines.
- Clear documented up to date process/policy for reporting serious incidents and never events (SIs and NEs) which includes the governance of SIs from front line to Board and demonstrating how the Board oversees the management of Serious Incident and Never Event framework including how learning is implemented for all services.
- Evidence of training on SI and NE delivered in induction for all new staff.
- Focus on recognising, responding and escalating the deteriorating patient, diagnostic delays in reporting, safer medicines administration.

Reporting and Investigation of SIs

- Reduced number of SIs over the 60 day deadline for completion of investigation. The only overdue SIs are those held up by external investigations or waiting for ICB to close.
- Significant reduction in SI investigations returned following request for closure for more information.

Learning from SIs and Never Events

- Clear evidence of the identification of learning from serious incidents influencing change in practice.
- Evidence from the trust of the process of training and identifying an investigator, reinforcing ownership of the issues and improvements to the front line there needs to be alignment of the SI process so that maternity and general SI's are not managed in silos.
- Evidence of how trust wide action plans for falls and pressure ulcers are resulting in improvements to patient safety.
- Evidence that the Board assures themselves of improvements in practice as a result of learning from SIs relating to patient deterioration.
- Evidence of an audit programme presented to the Board demonstrating improvements in patient safety as a result of serious incident management.

Safeguarding

- Workforce: Evidence that Substantiative leadership for the safeguarding team has been recruited to, and workforce plan.
- Annual reports: Evidence of 'Looked after Children' in annual reporting, and continued evidence of annual reports for safeguarding adults and children. Evidence of a safeguarding audit plan aligned to safeguarding SIs and statutory reviews.
- Policy: Evidence that enables the rag rating of the requisite policies to underpin safeguarding can move from red on the plan and risk register.
- Supervision: Evidence of increased uptake.
- Training: Evidence of safeguarding and mental capacity training needs analysis with compliance trajectory.
- Evidence to show sustainability of improvements made in the last 6 months.
- Provide a copy of the most recent safeguarding improvement plan showing compliance against the NHS Safeguarding Accountability and Assurance Framework

Impact to NOF4 Exit Criteria – People and Culture

NHS
East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5
Evidence of staff and user involvement in improvements and changes made through methods of capturing feedback e.g., use of template proformas asking staff how they have been involved in specific improvements.	Staff survey demonstrating an improvement in staff engagement and Trust leadership in line with National/ peer/ICS.	Staff sickness and vacancy trajectories tracked and responded to in line with regional and national position with no evidence of being a significant outlier across the ICS.	Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit specialties.	International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024.

Suggested Evidence

• Evidence of improved FTSU processes and reduction in whistle-blowing • Increasing inclusion and diversity awareness and response • Staff/User Involvement improvement e.g. use of template proformas asking staff how they have been involved in specific improvements, Pulse surveys.	• Staff surveys showing improvement in response rate (41.9% in 2020, national average was 45.4%) and outcomes for engagement, morale, safe environment: bullying and harassment, safety culture (outliers nationally).	• Reduction in sickness rate and plans in place for staff wellbeing.	• HCSW - pipeline/progress and tracking retention of these staff at 3/6/12 months. • RN recruitment and tracking retention of these staff at 3/6/12 months. • Evidence of medical workforce job planning and demonstration of compliance against the levels of attainment with trajectory to achieve level 4. • Evidence of a Trust recruitment and retention strategy to support all areas. • Evidence of workforce plans • Sustained reduction in use of agency staff trajectory.	• Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit to specialties. • Reduction in overspend for work permits.

Impact to NOF4 Exit Criteria – Operational Performance

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3
Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024	Sustained improvement in cancer 62-day performance by March 2024	Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024.

Suggested Evidence

- Evidence of sustained improvement in delivery trajectories, process, leadership and grip across UEC, elective and cancer.
- Implement a patient flow model, that gives the trust consistent capacity to meet demand.
- Comprehensive UEC plan which aims to deliver 76% by end of year for all types, with type 1 at 50% or above and consistent reduction in 12 hour in department.

- Evidence that the Trust is delivering against the operational plan trajectories (RTT, Cancer, Diagnostics).

- Evidence the Trust understands what is driving performance and what they are trying to address with clear plans for consistent improvement and path to sustainability.
- Evidence the Trust embeds the basics of operational management; rota management, job planning, waiting list oversight, and theatre scheduling.
- Improvement delivery towards zero 65 week waits, and a drop in waiting list size.

Impact to NOF4 Exit Criteria - Maternity

East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3
Evidence of improved and sustained maternity governance process in place.	Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024.	Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff.

Suggested Evidence

- Robust policies in place with internal audit undertaken to show their effectiveness and compliance.

- Feedback from service users and staff to provide evidence of impact of improvements.
- Evidence that the Trust has complied with all the actions from the HEE & NMC report into Canterbury Christ Church Midwifery BSC programme in improving the learning environment.
- Evidence of delivery against the revised maternity transformation programme (MTP) which has been developed through engagement and co-production with clinical staff.
- Benchmark and evidence against all national standards - CQC, NHSEI (Ockenden), NICE etc.
- Compliance with Ockenden and Clinical Negligence Scheme for Trusts (CNST).
- Evidence of sustained improvement as demonstrated by feedback, assurance visits and monthly reports from Maternity Safety Support Programme.

- Evidence that the culture and working relationship between midwives and obstetric staff has improved, as measured by staff Pulse services.
- Evidence that there are effective freedom to speak up guardians in place and staff trust that they can escalate to them and that their concerns will be listened to and acted on.
- Evidence of the approach being taken to improve the culture within the Trust, accepting the findings of 'Reading the Signals' and demonstrating the beginning of a restorative process.

Impact to NOF4 Exit Criteria - Finance

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5	Exit Criteria 6	Exit Criteria 7	Exit Criteria 8
Agreed financial recovery plan in place supported by a clear evidence base, approved off by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.	Delivery of the 23/24 planned deficit or better.	Evidence of improved delivery against agreed financial plans, trajectories, and envelopes.	The Trust fulfils its statutory duties with regard to financial management.	Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.	That the Trust benchmarks well against the model hospital financial efficiencies, or where this is not the case has a trajectory which brings alignment as soon as possible.	The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place.	Control of the costs of overseas recruitment against plan.

Suggested Evidence

• Financial Recovery plan (FRP) and any supporting documentation • Evidence that the FRP has been approved by the ICB and NHSE.	• Delivery of the 23/24 planned deficit or better.	• Evidence of delivery of financial trajectories set out in the FRP.	• Evidence that there is regular oversight by the Board and sub-committees on the progress against delivery against the FRP.	• Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.	• Clear view on the drivers of deficit- what is structural, what is operational efficiency etc. and a plan for what is in the Trust's gift to change.	• System wide alignment of risks to the financial plan and shared view of mitigations, by both Trust and ICB.	• Evidence of a cash management plan in place.

High Level IIP Risk Summary

Definitions

Movement in month – Key:

★	New Risk	↓	A decrease in risk score
↔	The score remains the same	↑	A rise in risk score

East Kent Hospitals University NHS Foundation Trust

Key risks to delivery in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
3.4.01	23.08.23	Operational Performance	Ben Stevens	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	15	a) No immediate mitigation to reduce 78 week breaches before January 2024.	27.11.23	15	↔
2.102	22.09.23	Maternity	Sarah Hayes	Unfilled vacancies, combined with high levels of maternity leave and short-term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed b) Line bookings of NHSP and agency, framework and off framework with applied incentive c) Specialist midwives redeployed to fill gaps d) Suspension of continuity of carer e) Utilisation of managers on call and community midwives	27.11.23	12	↔
2.402	22.09.23	Maternity	Sarah Hayes	Inadequate Estates in Maternity. Delivery rooms are too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity b) Introduction of quality rounds on both units that includes estate elements against CQC compliance c) Neonatal service attend postnatal ward daily to facilitate discharges d) Portable suction unit available in each labour room e) Pure air scavenging unit and ventilation in labour rooms on both sites f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size	27.11.23	12	↔
3.2.01	14.06.23	Operational Performance	Ben Stevens	Inability to comply with 2023/24 activity plan at Trust level in order to stabilise waiting list and reduce long waiters due to increased theatre activity (cases per session), staffing issues, competency impacting on ability to deliver head & neck activity, consultant sickness in ENT, volume of paediatric patients due to limited access to paeds provision at K&CH and no elective provision at QEQM and WHH.	12	a) Refreshed activity plan in Q2/3/4 for each speciality where activity needs to be increased to sustain waiting list position and eliminate breaches over 65 weeks by March 2024. Rate limiting steps identified (Theatre workforce and equipment, paediatric provision and ENT otology capacity) require quantifiable and measurable actions to support elective activity and reduction in waiting list and waiting times. b) Specialities to articulate robust recovery actions through weekly activity/performance meetings and agree transformational actions to improve planned care across the trust through the monthly Planned Care Improvement Meeting.	27.11.23	12	↔
3.3.01	14.06.23	Operational Performance	Ben Stevens	Diagnostic delays in cancer pathways due to increase in activity.	20	a) Radiology improvement meeting weekly now embedded & Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. b) Specific focus on Endoscopy and Urology pathways with heavy sedation capacity for Endoscopy to be agreed. Pending confirmation of Endoscopy insourcing funding and ICB bid to secure underspend via CDC budget. Endo improvement meetings now in place. c) Mutual Aid plan for urology to be agreed.	27.11.23	12	↓

High Level IIP Risk Summary

Definitions

Movement in month – Key:

★	New Risk	⬇	A decrease in risk score
⬌	The score remains the same	⬆	A rise in risk score

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Key risks to delivery in this period continued:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Mitigating Actions	Date of Last Review	Residual Risk Score	Risk Trend
4.1.01	14.06.23	Quality & Safety	Sarah Hayes	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	20	a) This has been escalated to a Director at Datix for their intervention. b) Full cost of overspend being costed for the agency Datix Project Lead. c) A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts. d) A roadmap for delivery has been presented to relevant governance committees. e) Updated datix fields.	27.11.23	12	⬌
4.4.02	14.06.23	Quality & Safety	Sarah Hayes	The build of the deteriorating dashboard is dependent on the current integration of VitalPAC functionality within Sunrise which is a very complex process. The predicted timeline for rolling out this functionality is later this year or early next year with dates yet to be confirmed. This links with milestone 4.408 with a target date to achieve by March 24 and also CQC action on Sepsis screening. In the meantime, questions relating to deteriorating patient compliance have been included in Tenable and will be ready for reporting from July 23.	12	a) Continue to discuss at Sunrise Vitals Integration Steering Group. b) Deteriorating patient is now available on the Tenable Ward platform (from August 23) as an interim measure posing additional challenging questions. Care Groups will be able to produce their own reports on deteriorating patients. Although this will not be as robust as Sunrise it will provide assurances against Trust Policy i.e. escalation. c) Risk owner member of Sunrise Vitals Integration Steering group – any changes to predicted timeline will be included in PSC deteriorating patient report, along with Tenable deteriorating patient reports.	27.11.23	12	⬌
6.1.03	07.08.23	Finance	Tim Glenn	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	20	a) Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation.	27.11.23	12	⬌
6.1.04	07.08.23	Finance	Tim Glenn	Risk of identifying and prioritising the development of “harder to achieve” improvements from Care Groups.	16	a) Conversations are ongoing with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions.	27.11.23	12	⬌

High Level IIP Programme Risk Summary

East Kent Hospitals University NHS Foundation Trust

Opened risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
6.1.05	22.11.23	Financially Sustainable	Tim Glenn	Delivery of 23/24 reforecast or better	12	• Support from PWC now online & additional resource aligned to finance programme to drive plans.	27.11.23	6	N/A
4.1.02	09.11.23	Quality & Safety	Sarah Hayes	There are a significant number of risks at Care Group and Specialty level currently scored at 15 or above which, due to the current risk management processes and reporting arrangements, had not escalated from Specialty level or Care Group risk registers or to the Corporate Risk Register meaning that the Executives, and consequently the Board and its' sub-committees have not previously been sighted on.	12	• Review and refresh of all risk registers taking place with dedicated resource aligned to progress 2 days per week • Executive oversight meetings established to continue for at least 2 months • TOR for operational risk register group being drafted for approval at CEMG in Dec 23 • Board and subcommittees to receive monthly update"	27.11.23	12	N/A

Closed risks in this period:

Risk Ref	Date Raised	Workstream	Risk Owner	Risk Description	Inherent Risk Score	Update	Date of Last Review	Residual Risk Score	Risk Trend
4.3.02	09.08.23	Quality & Safety	Sarah Hayes/Nic Goodyear	Head of Nursing for FoC & Quality (who is also clinical Lead for Nutrition) is currently recruited on an interim arrangement until end December 23 as a secondment. Post holder is chair of key quality strategic meetings, project lead for IIP FoC, line manager of specialist nurses, coach & mentor to nursing teams. Risk of instability to lead on FoC workstreams if future of post is not agreed promptly.	16	• Review of the post currently underway however, Care Group is ensuring work continues as a priority. No impact to delivery of IIP and therefore agreed to close at SIC.	10.11.23	4	↓
6.1.02	14.06.2023	Financially Sustainable	Tim Glenn	In order to support updating Financial Recovery Programme additional support is being explored. Current post holder leaving end of July 23, organisation off plan and further grip required.	16	• Resource now aligned to the financial programme to drive plans. Agreed to close at SIC.	22.11.23	8	↓

Summary

- At the beginning of the reporting period 22 risks were recorded on the IIP risk register.
- 2 new risks has been added during this reporting period relating to the delivery of the financial reforecast 23/24 and significant risks at care group level, please see above.
- In total 24 key areas of risk were discussed in this period relating to delivery against the IIP with 2 risks closed relating to the Head of Nursing post within FoC and the extra resources required to assist with the FRP.
- 2 risks during this period have decreased their inherent score.
- 22 risks remain open on the IIP risk register, summary per programme is as follows; 3 Finance (1 opened and 1 closed this period), 3 Leadership & Governance, 4 Maternity, 6 Operational Performance, 3 People & Culture, 2 Quality & Safety risks (increase of 1 and reduction of 1). There is strengthened risk monitoring within the IIP with particular focus on 'confirm & challenge'.
- Please see Appendix A for a full detailed IIP Risk Register.

IIP Open Risk Register (as at 29th November 2023)

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
Risk reference number	Date identified	BAF or Corporate risk	IIP Workstream	Risk raised by	Risk responsibility of	What is the risk to delivery? This is a risk that "something happens" due to the "cause" leading to "consequence/impact".	(1-5) & category	(1-5) & category	Severity of risk before controls implemented	What are the mitigating actions (ensure clear dates are provided)	Progress notes including date of update	(1-5) & category	(1-5) & category	Severity of risk after controls implemented	Date risk was last reviewed at SiC	Date risk was closed at SiC
1.101	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	Unable to appoint CFO substantively posing potential instability to executive team and financial workstreams / improvements required.	4 - likely	4 - likely	16	a) Working with NHSE and SE Regional team to support the appointment of the longer term CFO	**14.09.2023** - Financial Recovery Director funded by RSP starts in October 2023 to support financial delivery **08.11.23** - Interim CFO joined Trust on 06.11.23 for seconded for a 12 month period with the support of NHSE SE Region. Residual score reduced to 6 due to experience of postholder	3 - possible	2 - low	6	09.11.23	
1.102	14.06.2023	IIP	Leadership & Governance	Ben Stevens	Tracey Fletcher	The current restructure has the potential to detract from the BAU operations of the Trust and impact on progress against the IIP.	3 - possible	3 - moderate	9	a) Ensure restructure is concluded by 16th August 2023 and appointment to leadership posts to progress IIP programmes at pace.	**22.08.23** - new organisational structure went live on 14th August 23. **25.09.23** - Some vacant positions are await recruitment. Residual score to remain the same at this time. **08.11.23** - Adverts are now closed and shortlisting is underway for Medical Director at QE. Managing Director post at QE continuing on an interim basis. Residual score to remain the same at this time.	3 - possible	2 - low	6	08.11.23	
1.103	25.09.2023	IIP	Leadership & Governance	Andrea Ashman	Tracey Fletcher	No substantive COO following the resignation from the current postholder.	4 - likely	4 - likely	16	a) Interim COO in place for unplanned care who has experience, knowledge and understanding of the organisation	**25.09.2023** - Trust have engaged with an agency to start the recruitment process for the COO **08.11.23** - Trust progressing with advert over the coming months	3 - possible	3 - moderate	9	09.11.23	
2.101	29.06.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	Work commissioned to external adviser whose contract expired April/May 2023. Work incomplete, draft document still not received mid June 2023. This framework sets out Governance structures throughout the service, without which there are insufficient systems of control.	4 - likely	2 - low	8	a) The service is currently working towards V2.0 of the Maternity Quality & Safety Framework (Risk Management Strategy) until the refreshed version is available to ensure there continues to be structures for maintaining oversight, and managing of overdue governance related activities. b) Work progresses internally with an MDT to produce the final QSF. This will be ratified at the Women's Health Guidelines Group in Aug and assurance/ratification at MNAG in September. c) New QSF will be published by end August 2023.	Next MNIP governance group meeting 17th August (postponed from 10th) **15.09.23** Governance Review is complete at Trust level. Work to be undertaken with the Care Group to embed the process. **20.09.23** - residual score reduced.	2 - unlikely	1 - negligible	2	20.11.23	
2.301	29.06.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	The original model for this service has been revised by the incoming substantive DoM meaning that systems which underpin this service need to be reconsidered and revised. Until agreed and implemented, the current triage system remains in place.	3 - moderate	3 - moderate	9	a) Existing telephone triage system remains operational with supporting guideline in place. b) A planning meeting was held 06/07 to redefine the scope of work to be completed to enable centralisation. c) Weekly meetings to be reformed to facilitate revised model with much of the work completed through delivery of the original plan and other elements are underway i.e. triage PTL boards. d) This will appear as an agenda item on the next Women's Health Care Group Governance meeting on 28th July for agreement of way forward with a revised date for completion.	**15.09.23** DoM/DDoM to discuss way forward with Matrons and HoMs **20.09.23** - residual score reduced.	3 - moderate	1 - negligible	3	20.11.23	
2.102	22.09.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	Unfilled vacancies, combined with high levels of maternity leave and short term sickness will have an effect on patient outcomes and quality and safety. Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour.	5 - almost certain	4 - likely	20	a) Daily site-wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed b) Line bookings of NHSP and agency, framework and off framework with applied incentive c) Specialist midwives redeployed to fill gaps d) Suspension of continuity of carer e) Utilisation of managers on call and community midwives	This is also on the Corporate Risk Register -CRR122.	3 - possible	4 - significant	12	20.11.23	
2.402	22.09.2023	IIP	Maternity	Michelle Cudjoe	Sarah Hayes	Inadequate Estates in Maternity There are numerous issues with estates. A few examples are delivery rooms being too small to accommodate essential equipment, ventilation is poor, triage is cramped. Overall capacity does not support delivery. Poor estate means that maternity are unable to provide appropriate care, privacy and dignity and staff are not able to work effectively.	4 - likely	4 - significant	20	a) Induction rates standardised across sites - Daily SitReps for induction demand and capacity b) Introduction of quality rounds on both units that includes estate elements against CQC compliance c) Neonatal service attend postnatal ward daily to facilitate discharges d) Portable suction unit available in each labour room e) Pure air scavenging unit and ventilation in labour rooms on both sites f) Risk assessments for the resuscitaires are undertaken to ensure maximum safety within constraints of the room size	This is also on the Corporate Risk Register -CRR144.	4 - likely	3 - moderate	12	20.11.23	
3.1.01	14.06.2023	IIP	Operational Performance	Sandra Cotter	Jane Dickson	The current process for accounting for the NLFTR has been reviewed in partnership with HCP in which there are a number of recommendations to be considered and taken forward. This will impact reducing the NLFTR position to support emergency flow and 12 hour breach reduction.	3 - possible	4 - significant	12	a) The recommendations will be monitored via the ECDG/HCP delivery groups. b) SAFER across QEQM /WHH c) Additional resource secured to support enhanced discharging. d) Future of the integrated hubs to determine pathways for patients will continue to be evolved over the next 6 months. E) Admission avoidance schemes to include front door Virtual ward pathways and Pilot of the Single Point of Access to reduce ambulance conveyances	**18.10.23** Safer commenced WHH Aug- QEQM rollout Oct VW pathways being developed for pilot in Nov A-TED completion Nov Expansion MAU WHH -Nov SPOA -Nov pilot Winter plan schemes developed with HCP	3 - possible	3 - moderate	9	15.11.23	
3.2.01	14.06.2023	IIP	Operational Performance	Sunny Chada	Ben Stevens	Inability to comply with 2023/24 activity plan at Trust level in order to stabilise waiting list and reduce long waiters due to increased theatre activity (cases per session), staffing issues, competency impacting on ability to deliver head & neck activity, consultant sickness in ENT, volume of paediatric patients due to limited access to paeds provision at K&CH and no elective provision at QEQM and WHH.	3 - possible	4 - significant	12	a) ENT system meeting 22 June 2023 chaired by Planned Care Lead (CEO Medway) to consider hub/spoke model and short term recovery actions to reduced breaches before January 2024. b) Increase frequency of PTL meetings in surgery agreeing daily tasks and actions to support breach reduction at pace. c) Analysis of cases per session completed for each speciality to review reason for reduced activity per session (based on slight increase in theatre time compared to pre covid) and quantify theatre actions to increase activity levels. d) Refreshed activity plan in Q2/3/4 for each speciality where activity needs to be increased to sustain waiting list position and eliminate breaches over 65 weeks by March 2024. Rate limiting steps identified (Theatre workforce and equipment, paediatric provision and ENT otology c capacity) require quantifiable and measurable actions to support elective activity and reduction in waiting list and waiting times. e) Specialities to articulate robust recovery actions through weekly activity/performance meetings and agree transformational actions to improve planned care across the trust through the monthly Planned Care Improvement Meeting.	**26.06.23** - Out patient activity is above plan in Q1 (year to date position). Elective and diagnostic activity is approximately 94% of plan. Referrals are not above plan and are in line with predicted levels based on the previous years(2019- 2022) referral pattern and growth.	4 - likely	3 - moderate	12	15.11.23	
3.3.01	14.06.2023	IIP	Operational Performance	Sarah Collins	Ben Stevens	Diagnostic delays in cancer pathways due to increase in activity.	5 - almost certain	4 - significant	20	a) Radiology improvement meeting weekly b) Radiology reports waiting longer than 15 days post diagnostic are prioritised and cleared. c) All diagnostics are aimed to be booked within 5-10 days of receiving referral. d) Specific focus required on Endoscopy and Urology pathways and capacity e) Heavy sedation capacity for Endoscopy to be agreed. Pending confirmation of Endoscopy insourcing funding and ICB bid to secure underspend via CDC budget. f) Mutual Aid plan for urology to be agreed	**26.06.23** - Updates and progress to be recorded at weekly performance meetings **21.11.23** - Residual risk score reduced from 16 as radiology improvement meetings are embedded, Endoscopy T&F group focusing on capacity and Interim MD for Diagnostics are now in post, focusing on reporting times.	4 - likely	3 - moderate	12	21.11.23	
3.4.01	23.08.23	IIP	Operational Performance	Sunny Chada	Ben Stevens	Delays to eliminate 78 week waits due to inability to secure additional endoscopy and otology capacity immediately before January 2024.	5 - almost certain	3 - moderate	15	a) No immediate mitigation to reduce 78 week breaches before January 2024.	**14.09.23** - No system capacity available to support EKHUFT otology recovery. **19.10.23** - due to impact of IA/theatre equipment/increasing volume of more urgent p2 patients the trajectory has been refreshed and projects otology 78 week breaches will not be eliminated at the end of March 2024	5 - almost certain	3 - moderate	15	15.11.23	
3.5.01	23.08.23	IIP	Operational Performance	Sunny Chada	Ben Stevens	Inability to fully validate all patients from 12 weeks wait as per Board Assurance letter received 4 August due to lack of capacity.	4 - likely	3 - moderate	12	a) System wide challenge acknowledged at Planned Care Board 22nd August 23. b) Proceed with two way text message roll out. Increased spend to be approved before roll out can commence c) Review of EKHUFT Access Governance/Validation workforce compared to MFT/MTW/DGH d) Progress patient portal opportunities with IT to consider role in validation. e) Funding notification received 23.10.2023. £300k from national CDC underspend to be utilised on diagnostic validation only. £100k received from Regional team to be allocated to elective validation.	**14.09.23** - Elective Leads across K&M unable to deliver/achieve national requirement. System review of Access Governance support in place confirms EKHUFT, based on size of Trust/PTL, have a significantly reduced team compared to neighbouring Trusts. **24.10.23** - Increased risk score from 8 to 12 as the completion of the validation exercise may not be completed within the due timeframe.	3 - possible	2 - low	6	15.11.23	
3.6.01	24.10.2023	IIP	Operational Performance	Sunny Chada	Ben Stevens	Inability to ensure that all endoscopy surveillance patients which have been identified beyond a breach date will be treated within target 6 weeks post clinical validation	4 - likely	4 - significant	16	a) Weekly task and finish group has been set up and first meeting held 9th October. Aim to ensure all overdue surveillance patients (3527) are clinically validated and clear treatment plan in place b) Weekly meeting with ICB to provide assurance and support to EKHUFT with the recovery plan. Particularly clinical support has been requested due to lack of resources in EKHUFT. c) ID Medical additional capacity has been secured, commencing November 23 to assist with the backlog d) Surveillance project being considered by other departments to ensure this is not a wider problem	**24.10.23** - Identified admin validation team. Agreed clinical validation criteria. Assessment underway for resource required for clinical validation.	3 - possible	2 - low	6	15.11.23	

4.1.01	14.06.2023	IIP	Quality & Safety	Katy White	Sarah Hayes/ Nic Goodyear	Not upgrading our system to the most up to date version (as with all Trusts using Datix) will delay the PSIRF transition. The Trust has been supported in this work with an agency Datix Project Lead. This post was initially funded by NHSE for 6 months until March 23. As there is not the specialist capability within the Trust to continue managing the Datix upgrade without this support. This specialist remains in post supporting the Trust, however in doing so is incurring a financial overspend.	5 - almost certain	4 - significant	20	a) This has been escalated to a Director at Datix for their intervention. It is unlikely that we will meet the deadline for September 23 (as with all Trusts using Datix). b) Full cost of overspend being costed for the agency Datix Project Lead. c) A business case is being developed to secure an alternative system, which will be aligned to other Kent and Medway Trusts. d) A roadmap for delivery is to be presented to relevant governance committees in September 23. e) updated datix fields	**20.09.23** - roadmap produced inline to deliver plan to implement. Residual score reduced at SIC.	4 - likely	3 - moderate	12	27.11.23	
4.4.02	14.06.2023	IIP	Quality & Safety	Ian Setchfield	Sarah Hayes/ Nic Goodyear	The build of the deteriorating dashboard is dependent on the current integration of VitalPAC functionality within Sunrise which is a very complex process. The predicted timeline for rolling out this functionality is later this year or early next year with dates yet to be confirmed. This links with milestone 4.408 with a target date to achieve by March 24 and also CQC action on Sepsis screening. In the meantime, questions relating to deteriorating patient compliance have been included in Tenable and will be ready for reporting from July 23.	4 - likely	3 - moderate	12	a) Continue to discuss at Sunrise Vitals Integration Steering Group. b) Deteriorating patient is now available on the Tenable Ward platform (from August 23) as an interim measure posing additional challenging questions. Care Groups will be able to produce their own reports on deteriorating patients. Although this will not be as robust as Sunrise it will provide assurances against Trust Policy i.e. escalation. c) Risk owner member of Sunrise Vitals Integration Steering group – any changes to predicted timeline will be included in PSC deteriorating patient report, along with Tenable deteriorating patient reports.	**05.09.23** - discussions at SIC at length, Deteriorating Patient programme to discuss with ICB to ensure this action is appropriate and will be suffice as this is a quarterly RSP requirement.	4 - likely	3 - moderate	12	27.11.23	
5.2.03	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Culture and Leadership Programme currently not fully aligned with wider IIP programmes (including 'we care' programmes). This means there could be two separate culture pieces of work taking place causing conflicts for the organisation.	3 - possible	3 - moderate	9	a) Discussions continue regularly with IIP SRO & Programme SRO re: new strategy to align CLP with existing programmes and to reduce duplication.	**20.06.23** - Venue and budget code now booked to hold launch days in July 2023. **05.09.23** - residual score reduced.	3 - possible	2 - low	6	27.11.23	
5.2.04	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Capacity is limited (only 3.6wte available) in order to scale up delivery of the Leadership Development Programmes at each of the levels required (Leading Others, First Line Leader, Mid-level Leader) as planned. Each of these 5-day programmes are scheduled to run 3x per annum and to do so will require more facilitators. The team are also holding a vacancy due to the required financial efficiencies.	4 - likely	4 - significant	16	a) Consultation now complete with appointments made however some vacancies still remain which are to be advertised in September 23. b) Post recruitment the OD team will prioritise delivering the Leadership Development Programme fully as capacity will be available.	**05.09.23** - residual score reduced.	3 - possible	3 - moderate	9	27.11.23	
5.02.05	09.08.23	IIP	People & Culture	Louise Goldup	Andrea Ashman	Lack of leadership and engagement from Medical Office to drive forward pace of People and Culture milestones for medical workforce and ensure this is consistently applied.	4 - likely	4 - significant	16	a) New interim CMO fully engaged in P&C workstreams and regular meetings in place to review milestones. b) Appointment of medical workforce lead in August 23, regular meetings in place to increase engagement and review milestones. c) Detailed plans currently being produced by medical office to support milestones with clear timescales and leads being identified. d) Medical workforce dashboard being progressed. e) Medical Office have implemented regular meetings with Care Group Medical Directors to drive pace. □	**05.09.23** - residual score added. **27.09.23** - Nature of risk updated	2 - unlikely	4 - significant	8	27.11.23	
6.1.03	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Tim Glenn	Risk to the delivery of the Trusts 2023/24 Efficiency Plan.	4 - Likely	4 - Significant	20	a)Enhanced Controls measures have been issued to all care groups to ensure adherence to the national controls required for a level 4 organisation	**03.10.23** - Inherent Risk Score increased to 20 as per the CRR	4 - Likely	3 - moderate	12	22.11.23	
6.1.04	07.08.23	IIP	Financially Sustainable	Michelle Stevens	Tim Glenn	Risk of identifying and prioritising the development of "harder to achieve" improvements from Care Groups.	4 - Likely	4 - Significant	16	a)Conversations are on going with care groups to fully understand areas which could be explored to reduce spend but with a clear understanding of the clinical impact on the decisions	**05.09.23** - discussion at SIC, residual score reduced.	4 - Likely	3 - moderate	12	22.11.23	
6.105	22.11.23	IIP	Financially Sustainable	Michelle Stevens	Tim Glenn	Delivery of 23/24 reforecast or better	3 - possible	4 - significant	12	a) Support from PWC now online & additional resource aligned to finance programme to drive plans		3 - possible	2 - low	6	27.11.23	
4.1.02	09.11.23	IIP	Quality & Safety	Katy White	Sarah Hayes	There are a significant number of risks at Care Group and Specialty level currently scored at 15 or above which, due to the current risk management processes and reporting arrangements, had not escalated from Specialty level or Care Group risk registers or to the Corporate Risk Register meaning that the Executives, and consequently the Board and its' sub-committees have not previously been sighted on.	4 - likely	4 - significant	16	a) Review and refresh of all risk registers taking place with dedicated resource aligned to progress 2 days per week b) Executive oversight meetings established to continue for at least 2 months c) TOR for operational risk register group being drafted for approval at CEMG in Dec 23 d) Board and subcommittees to receive monthly update		4 - likely	3 - moderate	12	27.11.23	

RISK MATRIX

Impact						
	5. Extreme	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3 V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	2. Unlikely	3. Possible	4. Likely	5. Almost certain
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

IIP Closed Risks

Risk Ref	Date Raised	Risk Register	Workstream	Risk Author	Risk Owner	Risk Description	Likelihood	Impact	Inherent Risk Score	Mitigating Actions	Progress Notes	Likelihood	Impact	Residual Risk Score	Date of Last Review	Date Risk Closed
2.303	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline supporting implementation of improved discharge pathways was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone target date of July 23 and until approved the service will continue to operate the current discharge model.			12	a) Postnatal Ward Manager (QEQM) to work with Guideline Midwife to circulate the postnatal guideline for review and approval. b)The postnatal guideline will be circulated via email, by exception for chairs action to agree the new model for implementation by end of July 23.	**18.07.23 -** Discussed with programme manager, obtain approval at SiC on 26.07.23 that this risk is a duplicate and is now merged with risk 2.302 to enable closure. 26.07.23 - risk agreed to be closed at SiC as a duplication.				26.07.23	26.07.23
2.401	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Whist pending development and approval of the new maternity Quality & Safety framework, the service is working to the draft V2 of the QSF. Structures for maintaining oversight, and managing of overdue governance related activities require further work particularly to ensure there are no overdue/breached governance related activities including SIs/HSIB investigations.			16	a) To ensure there is some strengthened governance in the interim the maternity service is working to V2 of the QSF until the final version is published in August 2023. b) There are trackers being used to monitor progress of all governance related activities, including backlogs. c) In addition there is now a dedicated patient safety team progressing with overdue governance to ensure focus.	**18.07.23 -** Discussed with programme manager, obtain approved at SiC on 26.07.23 that this risk is a duplicate and is now merged with 2.302 to enable closure. 26.07.23 - Risk agreed to be closed at SiC as now a duplication.				26.07.23	26.07.23
4.4.01	14.06.2023	IIP	Quality & Sa	Ian Setchfield	Jane Dickson/ Rebecca Martin	Unable to support deteriorating patient training across the organisations as proposed due to funding provided by HEE not available.	3 - possible	3 - moderate	9	a) Plan is to utilise money for additional resuscitation training provided by an external supplier, which improves the deteriorating patient pathway. b) Full resuscitation training needs and costings to be finalised & submitted to HEE. c) Funding since received in June 23 to enable rollout of training across the organisation (funding supports both training and posts). Allocation of remaining funding to support additional deteriorating patient workstreams need to be agreed with CNMO.	**19.06.23 -** Funding agreed for £300k one off via HEE (which supports both training and posts). Money has been transferred to the Trust from the ICB - risk can therefore now be closed. **18.07.23 -** Project Lead to requested for closure to be submitted to the SiC on 26.07.23. **26.07.23** - Risk agreed to be closed at SiC now funding is received risk is removed.	2 - unlikely	3 - moderate	6	26.07.23	26.07.23
2.302	29.06.2023	IIP	Maternity	Michelle Cudjoe	Jane Dickson	Postnatal guideline was not reviewed as planned by the WH guideline group on 16 June 2023. This poses a threat to the milestone date of July and until the service will continue to operate the current discharge model.	3 - possible	5 - extreme	15	a) Corresponding postnatal guideline has been updated which sets out the improved model for the discharge pathway. However, the guideline was not reviewed as planned by the Women's Health Guideline Group on 16 June 2023 due to insufficient time on the agenda to consider and approve. b) The postnatal guideline was planned to be circulated via email, by exception for chairs action however it has since been agreed for wider discussion at the Women's Health Audit Group on 18/07 for ratification.	**16.08.23 -** guidance published on 4th August. Request to SiC to close risk.	3 - possible	3 - moderate	9	16.08.23	24.08.23
5.2.01	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	In order to support Culture and Leadership Programme trust wide, additional funding for 1 Programme Director and 1 seconded Programme Manager was requested from NHSE (RSP funding). Currently funding has not been approved and received however, NHSE confirmed to 'go at risk' to ensure the project is not delayed. If funding is not received this will be an overspend for the organisation.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up and regular updates received from RSP team. b) Posts are recruited to and programme has commenced, moving forward to diagnostics.	**20.06.23 -** still awaiting if funding has been allocated and amount. **07.09.23** - funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23** - risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23
5.2.02	14.06.2023	IIP	People & Culture	Andrea Ashman	Andrea Ashman	Due to insufficient funding within Culture and Leadership Programme unable to undertake practical arrangements for launch of Culture and Leadership Programme trust wide including events / booking venues.	3 - possible	3 - moderate	9	a) NHSE confirmed to go 'at risk' with budget codes so not to hold project up for posts to progress with programme. Internally also 'gone at risk' to account for additional revenue required to support events. b) Launch days and conference centre now booked to enable diagnostics to be commenced. b) Working with SRO to realign budgets to support future funding.	**07.09.23 -** funding now agreed from RSP, residual risk score reduced. Request to SiC on 20th Sep to close. **20.09.23 -** risk agreed to be closed.	2 - unlikely	2 - low	4	05.09.23	20.09.23
4.3.01	20.6.23	IIP	Quality & Sa	Wendy-Ling Relph	Jane Dickson/ Rebecca Martin	Ward Accreditation Team are currently small in number with a team member having long term sickness. They may not be able to complete a first accreditation for all inpatient wards by end of November 2023 as the original trajectory anticipated.	5 - almost certain	4 - significant	20	a) Alternative solutions are being explored, including the potential of utilising additional internal staff and reviewing the current accreditation timetable. b) One staff member now returned from long term sick and progressing with plans.	**15.09.23 -** Sickness within the team has now resolved. Working practices and priorities have been reviewed. The first accreditation for all wards is now planned to be completed before the end of December, meaning that completion of this action will be delayed, but by only 3 weeks. The risk of lack of completion of the whole section of Quality & Safety is therefore greatly reduced. Residual score now reduced.	4 - likely	4 - significant	2	10.10.23	10.10.23
6.1.01	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	Due to vacancies within the Finance team there are currently no project leads within the IIP finance workstream. This is a risk to ensuring there is pace and delivery of the programme and could cause delays to ensuring financial savings and improvements are achieved in the organisation.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover has been undertaken with clear objectives. b) The CFO is currently both SRO and project lead for the finance programme within the IIP. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23 in order to bring pace to financial programme.	**05.09.23 -** discussion at SiC, RSP support available from October 23. **03.10.23 -** Additional resources have commenced in this period to support the delivery of the IIP (Turnaround Director, ADOF Financial Planning). Request SiC to close.	2 - unlikely	3 - moderate	6	10.10.23	10.10.23
6.1.02	14.06.2023	IIP	Financially Sustainable	Michelle Stevens	Michelle Stevens	In order to support updating Financial Recovery Programme additional support is being explored. Current post holder leaving end of July 23, organisation off plan and further grip required.	3 - possible	3 - moderate	9	a) Deputy CFO commenced in post 17th July of which a full handover was undertaken with clear objectives. b) A draft version of the FRP was presented to the Trust Board in July 23, it was agreed further work with key stakeholders is required to finalise draft aimed at presenting again in October to achieve target date of Jan 24. c) RSP team offered urgent financial recovery support which has been approved and will be available from October 23. d) Comms to support with staff engagement to support financial consciousness.	**05.09.23 -** discussion at SiC, RSP support available from October 23. **22.11.23 -** resource now aligned to the financial programme to drive plans. Request closure at SIC on 27th Nov.	2 - unlikely	4 - significant	8	10.10.23	22.11.23
4.3.02	09.08.23	IIP	Quality & Safety	Wendy-Ling Relph	Jane Dickson	Head of Nursing for FoC & Quality (who is also clinical Lead for Nutrition) is currently recruited on an interim arrangement until end December 23 as a secondment. Post holder is chair of key quality strategic meetings, project lead for IIP FoC, line manager of specialist nurses, coach & mentor to nursing teams. Risk of instability to lead on FoC workstreams if future of post is not agreed promptly. ::	4 - Likely	4 - significant	16	a) Corporate team restructure is currently being reviewed. :: b) There is a plan to substantively recruit and submit to vacancy panel prior to December 23 to ensure work continues.	**10.11.23 -** Request to close risk from CNMO. Review of the post currently underway, however, if there were no post holder, Gare Group would ensure the work would continue.	4 - likely	3 -moderate	6	10.11.23	10.11.23

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **7 November 2023**

In-the-Chair: **Claudia Sykes, 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
October 2023 Integrated Performance Report (IPR) 'We Care' and 'True North' Objectives	Significant key points for the Board to **note:** • **ASSURED: Sickness** Sickness absence increased above 5% which was a particular point of focus for the new Heads of People & Culture. It was noted that anxiety, stress and depression were significant reasons for absence. An in-house psychological support service was planned to be in place by January 2024. • **ASSURED: Staff Turnover** Staff turnover remained below the nationally desired standard at 9%, including Healthcare Support Worker (HCSW) and nurse turnover. • **ASSURED: Statutory & Mandatory Training** Statutory training compliance remained stable and was above the threshold of 91% at 92%. • **ASSURED**: **Staff Engagement and Staff Involvement** Staff Engagement levels had continued to improve. • **PARTIALLY ASSURED: Premium Pay** The Committee was partially assured on the issue of premium pay and requested a more detailed report for the next meeting. • **ASSURED: Appraisals**

	Overall appraisal compliance had improved with the medical appraisal rate increasing to 76%.
Vacancy and Recruitment Update – Pipeline Against Establishment to Include Medical Vacancies Review	• **ASSURED: Vacancy Rate** The Committee was assured in respect of the overall vacancy rate which stood at 7.4%.
Cultural Development & HR Programme	The Committee was **ASSURED** in respect of the Cultural Development & HR Programme. The Committee received a 'discovery phase' report and noted that 891 staff had engaged with a staff survey. The Change Team continued to facilitate culture conversations within teams.
'Hot Items'	**HOT ITEMS** The Committee noted the following developments: • there had been significant changes within the Integrated Care Board (ICB); • concerns had been raised in respect of the Staff Survey response rate due to the current financial challenges, and significant effort was being made to address the staff concerns raised as a priority.
Industrial Action	There was no further update on this matter.
Strategic Workforce Plan	The Committee was **ASSURED** with regard to the 5-10 year Workforce Plan, which it was noted was still subject to detailed discussion with Business Partners, Care Groups, and other senior colleagues within the Corporate Teams and Medical Workforce. The Committee highlighted the importance of aligning the Plan with the Trust's clinical strategy and the need for this to be sufficiently transformative, including rotations across primary and secondary care, and remote consultation.
Recruitment Strategy	The Committee **approved** the Trust's Recruitment Strategy.
Experiences of Black, Asian and Minority Ethnic (BAME) Doctors	The Committee was **ASSURED** in relation to the Experiences of BAME Doctors' Report which was focused on the differential attainment gap based on ethnicity throughout the NHS, using surveys and interviews to gather data on the experiences of Doctors from minority ethnic backgrounds.
Accommodation Strategy	The Committee was **NOT ASSURED** in relation to the Accommodation Strategy and requested a full review of the current strategy to be considered by the Committee in February 2024.

Chief Nursing and Midwifery Officer (CNMO) Report: Safer Nursing Staffing	The Committee was **ASSURED** in relation to the report on Safer Nursing Staffing.
Tribunal Strategy	The Committee was **ASSURED** in relation to the Tribunal Activity Report.
Risk Register Update	The Committee was **ASSURED** in relation to the Risk Register Review update, it being noted that additional senior resource would be dedicated to developing the Risk Register further in respect of mitigations.
General Medical Council (GMC) Review	The Committee was **PARTIALLY ASSURED** in relation to the GMC report which highlighted improvements against last year's results, and identified areas for further improvement, particularly in relation to satisfaction, clinical supervision, out of hours supervision, induction, and educational supervision.
Guardian of Safe Working (GoSW)	The Committee was **ASSURED** in relation to the GoSW Report, it being noted that Guardians plan to work with Care Groups to ensure that new doctors receive the necessary support as part of the implementation of a flexible rostering system.
Committee Annual Workplan	The Committee **NOTED** the People and Culture Committee Annual Work Programme, 2023/24.
Feedback from Local Negotiating Committee (LNC)	The Committee **NOTED** the Feedback from the LNC.
Feedback from Staff Committee	This item was deferred until the next meeting.
Feedback from Integrated Education, Training and Leadership Development Group (IETLDG)	The Committee **NOTED** the Feedback from IETLDG.
Feedback from Equality, Diversity & Inclusion (EDI) Steering Group	The Committee **NOTED** Feedback from the EDI Steering Group.

East Kent Hospitals University NHS Foundation Trust

Other Items of Business

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

There were no items referred to the BoD or another Committee for approval, decision or action.		
The Committee asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	7 December 2023

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **28 November 2023**

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

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

Quorate: **Yes**

Appendices:

APPENDIX 1: Q&SC Terms of Reference (ToR)

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:

Agenda item	Summary
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	**Partial assurance** was received by the Committee in considering the IPR. The following key points were noted: – deterioration in response to complaints rate in October 2023 due to sustained increased number of new complaints and implementation of strict sign-off process within the Care Groups to improve quality of responses; – a spike in pressure ulcers cases in October 2023: the Chief Nursing and Midwifery Officer (CNMO) is leading on the pressure ulcers project to improve performance; – review of the 12-hours in the Emergency Department (ED) breaches re-commenced as performance in October 2023 was 70.6%, below the 73% target; – the Committee expressed concerns with regard to deteriorating cancer performance and noted that TIER 1 support would be available to the Trust; – Hospital Standardised Mortality Rate (HSMR) continues to fall and is below the expected threshold.
Infection Prevention and Control (IPC) Report	The Committee received **partial assurance** of the current performance about nationally-reportable infections noting the following: – Clostridioides difficile (C-diff) remains a concern and the Trust has already breached the threshold for this year by four cases;

	– cases of Klebsiella and E-coli infections were over trajectory; other reportable infections are significantly below trajectory; – improved surveillance of mandatory surgical site infections (SSI) continues effectively to identify cases and a Steering Group is in place to manage and monitor actions. The Committee was made aware that the number of SSI cases had reduced; – the issue of "holes in wraps" was identified as a potential issue which may have contributed to infection rates.
Care Quality Commission (CQC) Update Report	– The Committee **received** the latest assurance report on progress with open CQC actions and **noted** that the final CQC report following the inspection of the core services for Urgent and Emergency Care (UEC), Medical care and Children and Young People Care in May 2023 and Well Led inspection in July 2023 was expected to be published soon.
Commissioning for Quality and Innovation (CQUIN) Q2 Report	– The Committee was presented with the first CQUIN report and **noted** that in Quarter 2 the Trust was compliant with the majority of the national CQUINs, with the exception of compliance with timed cancer diagnostics pathways, pressure ulcer risk assessment and documentation, and treatment of non-small cell lung cancer, in line with the national pathway.
Progress Report on the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) Review and Associated Governance Arrangements	The Committee **received** the progress report around transformation of the current Corporate, Care Group and Speciality level risks registers and **noted** the following: – a number of risks were emerging as significant. These centred around the Endoscopy backlog, renal dialysis provision, estates risks, interventional Radiology backlog and governance and risk management; – the Executive team to take immediate actions to ensure that all identified significant risks were recorded and adequately mitigated to a manageable level.
Patient Safety Committee (PSC) Chair's Report	– The Committee **considered** the assurance report on the activities of the PSC, with discussion around poor attendance of the Trust Radiation Advisory Committee (TRAC) meetings. The Chief Medical Officer (CMO) and the CNMO agreed to identify responsible Executive Directors to address poor engagement with TRAC.
Fundamentals of Care (FoC) Chair's Report	– The Committee **received** the assurance report on the activities of the FoC Committee and noted that discussions led by the CNMO were underway to develop a Patient Experience Committee distinct from the FoC Committee.
Mortality Steering and Surveillance Group (MSSG) Chair's Report	The Committee **considered** an assurance report on the activities of the MSSG noting the following: – the recent Aspiration Pneumonia project had produced recommendations that nurses should complete a risk assessment to support identifying

	patients at risk of dysphagia, and that this risk assessment was due to be piloted in the EDs; – there continued to be a lack of engagement with the Structured Judgement Review (SJR) process within some specialties; – the Medical Examiner team noted concerns regarding frequency of medical reviews, weekend reviews and Consultant reviews, which may be attributable to recent industrial action.
Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee **received** an assurance report on the activities of the MNAG and noted the following key matters: – the rate of reportable neonatal and perinatal deaths remained lower than comparable peers; – one incidental maternal death was recorded in October 2023: the woman was not pregnant at the time and not linked to maternity care; – a number of workforce metrics remained below the required threshold due to staffing challenges; – Safeguarding training compliance had increased to 86% in October 2023.
Clinical Ethics Committee (CEC) Chair's Report (Q2)	– The Committee **received** the CEC Chair's Report and noted that the CEC continued to discuss dummy cases due to the absence of active cases.
Serious Incidents (SIs) Report	– The Committee **received** the SIs Report representing September 2023 data and noted the efficacy of the overall incident management and Duty of Candour compliance processes in place within the Trust.
Antimicrobial Stewardship Progress Report	– The Committee **considered** the Antimicrobial Stewardship Progress Report and had a robust discussion around clinical ownership of antimicrobial prescribing.
Safe Staffing Review	– The Committee **received** the Safe Staffing Report and noted that the Trust continued to monitor Nursing and Midwifery numbers and skill mix in response to clinical needs on a daily basis.
Data Quality and Accountability Assurance Update	– The Committee **received** a verbal update on arrangements in place to ensure data quality and lines of accountability within the Trust.
Quality and Safety Committee Terms of Reference (ToR)	– The Committee **reviewed** its updated ToR and agreed to submit them to the Trust Board for approval.

Referrals from other Board Committees

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

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The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	**Assurance**	7 December 2023
The Committee asks the BoD to discuss and **APPROVE** the Q&SC ToR.	**Approval**	7 December 2023

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QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors has established a committee of the Board known as the Quality and Safety Committee (the Committee). It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2. PURPOSE

2.1. The Committee is responsible for seeking and obtaining assurance on all aspects of quality and safety of care across the Trust (including the statutory and mandatory requirements relating to quality and safety of care). If not assured, the Committee will oversee the appropriate actions for improvement or escalation of relevant issues to the Board for consideration.

2.2. The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

3. OBJECTIVES

Quality Strategy and Performance

3.1. Oversee the development implementation and communication of a Quality Strategy with a clear focus on improvement, which draws on and benchmarks against ideas and best practice from external organisations.

3.2. Ensure that the Trust's Quality Strategy and performance are consistent with mandatory requirements and national guidance.

3.3. Oversee and seek assurance of an effective system for delivering a high-quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement.

3.4. Oversee the effectiveness of the clinical systems to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards of quality and safety.

3.5. Ensure effective systems and processes are in place in order to be assured that there is systematic oversight of regulatory compliance with external bodies e.g. including but not limited to, the Human Tissue Authority (HTA), Royal Colleges and the Medicines & Healthcare products Regulatory Agency (MHRA).

3.6. Review Reports from Committees and Subject Matter Experts (SMEs) as per the Committee workplan

3.7. Review nursing and midwifery staff establishments and provide assurance to the Board that ward nursing and midwifery staff establishments provide an appropriate and safe staff level and skill mix to support the delivery of safe and effective patient care to patients.

3.8. Review the quality impact assessments for financial improvement, staff safety and wider health and safety requirements.

3.9. Receive reports on 'deep dives' from Care Groups once per annum on a rotating basis as appropriate.

3.10. Oversee an effective system for safety within the Trust, aligning with the National Patient Safety Strategy reporting principles of:

- Openness and transparency
- Just culture
- Learning and continuous improvement

Clinical Effectiveness, Outcomes and Improvement

3.8 Oversee an effective system for monitoring clinical outcomes and clinical effectiveness with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.

3.9 Obtain assurance from individual Care Groups that the Trust is compliant with guidance from NICE and other related bodies.

3.10 Obtaining assurance that the Trust is learning from deaths.

3.11 Receive the outcomes of participation in and learning from the national clinical audit programme and provide assurance to the Board that clinical audit supports the Care Groups to provide safe and clinically effective patient care.

3.12 To receive the draft annual Quality Report and Account and recommend the final version to the Trust Board.

Governance

3.13 Monitor the progress against actions to mitigate the quality risks on the significant risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

3.14 Review the controls and assurance against relevant quality risks on the Board Assurance Framework, provide assurance to the Board that risks to the annual objectives are being managed and facilitate the completion of the Annual Governance Statement at year end.

3.15 Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHS England, the Care Quality Commission, the Health and Safety Executive and other external assessors.

4. MEMBERSHIP AND ATTENDANCE

4.1 The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Chief Nursing and Midwifery Officer (Joint Executive Lead)
- Chief Medical Officer (Joint Executive Lead)
- Chief Operating Officer

4.2 Required Attendees:

- Director of Quality Governance

4.3 Attendees:

- A representative from the Kent and Medway Integrated Care Board
- A Patient Partner
- A Governor

Quorum

4.4 The committee will be quorate with four members, including at least two Non-Executive Directors, and one Executive Director. If the Trust Chair is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items

requiring approval may be approved virtually by members and ratified at the subsequent meeting of the Committee.

Attendance

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

Others Invited to Attend

4.7 The Committee will be open to the Trust Chair, Chief Executive and Company Secretary to attend.

4.8 Other staff may be invited to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

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

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly, alternating quality assurance and quality improvement and last no more than two hours. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

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

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee has decision making powers with regard to the approval of clinical procedural documents.

6.4 The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the Committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair at least five days in advance of the meeting.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work programme that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair in collaboration with the Chief Nursing and Midwifery Officer and the Chief Medical Director.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive exception reports for scrutiny from the following meetings (minutes to be available to Committee members):

- Patient Safety Committee
- Fundamentals of Care
- Clinical Audit and Effectiveness Committee
- Infection Prevention and Control Committee
- Mortality Surveillance Steering Group
- Clinical Ethics Committee

9.2 The Committee shall refer (and have referred to it) from the other Board Assurance Committees (the Integrated Audit and Governance Committee, the People and Culture Committee and the Finance and Performance Committee) matters considered by the Committee deemed relevant to their attention. The Committee, in turn, will consider matters referred to it by those three Assurance Committees.

9.3 The annual work programme of the Committee may be reviewed by the Integrated Audit and Governance Committee at any given time.

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report to the Board outlining the activities it has undertaken throughout the year to be included in the Annual Report.

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

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

APPROVED BY BOARD OF DIRECTORS: Date TBC

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: 31 October 2023

Chair: Richard Oirschot, Non-Executive Director

Paper Author: Interim Deputy Chief Finance Officer (CFO)

Quorate: Yes

Declarations of interest made:

None

Appendices:

None

Agenda item	Summary
Cost Improvement Programme (CIP)	In Month 6, the Trust recognised £0.2m of recurrent savings; £0.9m Year to Date (YTD), with non-recurrent savings of £6.2m YTD. The current value of the pipeline CIP savings is £14.9m Financial Year End (FYE); £12.9m Part Year Effect (PYE). The Committee noted the following: • care groups have been issued their new CIP targets, following the restructure; • the format of the CIP report will be re-modelled next month, with content to include run-rate reductions; • the CIP approach has been bottom-up with care groups, however, in light of having limited developed schemes, the approach needs to be top-down with larger saving opportunities identified and the more difficult decisions being proposed with supporting Quality Impact Assessments (QIAs); • resource requirements to assist in savings delivery are being worked up, to support 2023/24 delivery and 2024/25 plans. The Committee discussed and **NOTED** the M6 Savings and Efficiencies Update and **LIMITED ASSURANCE** was received in respect of the Trust's progress with regard to the CIP.

Patients no longer fitting the criteria to reside	The Committee discussed and **NOTED** the Patients No Longer Fitting the Criteria to Reside (NLFTR) report which centred on the following key areas: • the reported NLFTR position – position stable in month; • super stranded patients – a very slight increase in month, driven by increases at Queen Elizabeth the Queen Mother Hospital (QEQM) and Kent & Canterbury Hospital (K&C), but a marked decline at William Harvey Hospital (WHH) due to the impact of the SAFER workstream; • SAFER at WHH – Programme commenced July. From November, KPMG will take over implementation and integration; • Prism at QEQM – Work commenced 2 October. Four weeks discovery phase. Implementation Plan in progress. Targets to come to next meeting; • Winter planning – unmitigated bed gap highlighted. Options appraisal by site submitted and to be worked into a 5-tier trigger plan. Conversations taking place with system partners. Winter plan to be costed.
Month 6: Finance Report Forecast Update	**Month 6 Finance Report** The Committee discussed and **NOTED** the Trust's financial performance and actions being taken to address issues of concern; the following key points being noted: • the Group reported an in-month position for month 6 of £9.0m against a plan of £5.0m, resulting in a deficit variance of £4m; • run-rate slowed in month, as a result of the controls and interventions in place. Temporary staffing usage reduced by £0.9m in month; • the YTD position is £59.3m against a plan of £40.9m, giving a YTD variance to plan of £18.4m; • Key drivers of the deficit continue to be non-delivery of recurrent efficiency savings, nursing drivers (including escalation beds and 121 care), unfunded pay award and impact of the strike action. • At the end of September, capital expenditure was £10.2m against a plan of £10.9m; • The Group cash balance (including subsidiaries) at the end of September was £18.4m. The Trust drew £8.2m of working capital (public dividend capital (PDC)) in the month, making a YTD total of £40.9m. **Forecast Update** The Committee discussed and **NOTED** the Month 6 Group Forecast report which included an update on actions being undertaken to improve the financial position. In-month forecast for Month 6 achieved, but Month 7 forecast includes a further run-rate reduction. Reforecasting protocol discussed.

Q2 Cash Management Update	The Committee discussed and **NOTED** the Q2 Cash Management Update report. An update on the additional working capital borrowing request was provided.
Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks	The Committee noted the following matters in relation to the BAF: **Headlines**: There were three BAF risks and eight risks on the Corporate Risk Register (CRR) relating to 'Partnerships' and 'Sustainability'. **Changes to the BAF**: BAF 41 increased from high (16) to extreme (20). **Changes to the CRR**: There were no changes to the CRR during this reporting period. Scores continued to be requested to be re-reviewed for the following Risks: 145, 148 and 149. New governance process for risk review and risk management in development. The Committee discussed and did **NOT APPROVE** the BAF and CRR.
Business cases	The Business case for the appointment of agency provision of a managed service supplier has been approved by Business Case Scrutiny Group (BCSG) and Clinical Executive Management Group (CEMG) and was presented to the Committee for information. The Committee discussed and **NOTED** the business case.
PRISM Programmes Overview	The Committee discussed and **NOTED** the Prism Theatre Improvement overview paper, the key points being: - 28-week programme of work. - Initial diagnostic stage reaching completion. - Proposed strategy and implementation structure to be agreed once Insight and Delivery report finalised. - Targets, including financial impact, to come to the next meeting.
We Care Integrated Performance Report (IPR) (M6): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee discussed and **NOTED** the 'We Care IPR' with **PARTIAL ASSURANCE** being received with regard to performance against key metrics for 2023/24. The Committee **NOTED** the Cancer and Endoscopy funding approvals. Deep dive report being finalised and to come to the next meeting.
Green Plan / Carbon Footprint Report	The Committee **NOTED** the Green Plan Monthly Progress Report.

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Update on external engagement of the 5-year capital plan	The Committee discussed and **NOTED** the Capital Investment engagement report, which outlined actions being taken to raise awareness of the need for further capital investment at the highest levels of the NHS and Government.
HealthEx Update	The Committee discussed and **NOTED** the HealthEx Update report.
Business Planning Update	The Committee discussed and **NOTED** the monthly Business Planning 2024-2026 Update report. Progress on-track.
Capital risks – as at Month 6	The Committee discussed and **ENDORSED** the 2023/24 Capital Risks as at Month 6 report. The forecast capital cost pressures and the internal mitigations were discussed, together with the knock-on impact into 2024/25. Formal capital bid to Kent & Medway (K&M) Integrated Care Board (ICB) for the unmitigated cost pressure to be submitted.
Enhanced Care Update	The Committee discussed and **NOTED** the Enhanced Care update report and the steps being taken to improve the governance process and reduce the reliance on agency workers to care for these vulnerable patients.
National Costs Collection (NCC) – Pre-submission paper	The Committee discussed and **APPROVED** the NCC Pre-Submission report, which provided assurance that: - the Trust is following the correct process for the submission. - that the changes in guidance for this year will be implemented in the submission. - the Trust will have a fully compliant submission, which will be uploaded in line with the national timetable.
Business Case Scrutiny Group (BCSG)	The Committee **RECEIVED** an assurance report and minutes of the BCSG on 14 September 2023.
Financial Improvement Oversight Group (FIOG)	The Committee **RECEIVED** an assurance report and minutes of the FIOG meeting on 19 September 2023.
Terms of Reference (ToR)	Committee members were asked to review the ToR, and provide comments to the Interim CFO by 10/11/23, for these to be presented at the 28/11/23 FPC meeting for consideration and approval.
Any Other Business	None

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

Item	Purpose	Date
The BoD is asked to receive and **NOTE** this FPC Assurance Report.	Assurance	7 December 2023

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: 28 November 2023

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

Paper Author: Director of Finance

Quorate: Yes

Appendices:

Appendix 1: FPC Terms of Reference (ToR)

Declarations of interest made:

None

Agenda item	Summary
Cost Improvement Programme (CIP)	The Committee received a report covering the initial views, findings and forward plan from the Trust's Interim Chief Finance Officer (CFO) and the Financial Recovery Director (FRD). Some reassurance was provided by the report that the Executive were working to understand the Trust's likely forecast outturn, the drivers of that position and how improvements could be made to the Trust's financial control environment. The Committee noted that an independent review of these areas had been commissioned and would report in December. The paper also set out the steps being taken to change the pace at which the Trust's CIP is scoped and delivered. Whilst it is too early in the tenure of either interim CFO or FRD to provide a fully scoped plan, the Committee received some reassurance from the themes laid out and the changes being made to supporting infrastructure that a path to a more comprehensive plan was becoming clearer. In relation to CIP delivery to date, the Committee was disappointed to learn in a verbal report that: • Very little progress had been made in achieving savings on a recurrent basis (£1.0m year to date); and • Some additional non-recurrent savings had been identified (£6.5m year to date); • These total £7.5m year to date which is someway short of the £20.2m target.

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	The Committee **NOTED** the M7 Savings and Efficiencies as reported verbally.
Patients no longer fitting the criteria to reside	The Committee discussed and **NOTED** the Patients No Longer Fitting the Criteria to Reside report which focused on measures the Trust was taking to improve length of stay (LoS). This considered the following key areas: **No Longer Fit to Reside Patients**: The Trust position for those no longer fit to reside is stable in month. In October the reported number was 193, and marginal improvement against the September position. **Super Stranded Patients (>21d LoS)**: The October position is 235, the best reported position since June 2022. The number of super stranded patients has declined across all sites. **Length of Stay Interventions at William Harvey Hospital (WHH) - SAFER/KPMG** • Re-launch planned for 27 November – KPMG supported by Trust transformation team; • Follow up from the SAFER work started in August 2023; • Focusing on embedding changes in discharge planning, improved board rounds, educating staff on the use of digital Patient Tracking List (PTL), identifying ward roles and responsibilities for supporting patient discharge; • Medical wards prioritised due to higher LoS. **LoS Interventions at Queen Elizabeth the Queen Mother Hospital (QEQM) - Prism** • New programme is now in week eight; • Discovery phase completed and recommendations for key projects completed; • Key projects identified outlining areas of high-impact outcomes: • Improve daily rhythm - match site management rhythm with ward rhythm; • Review site policies - review and embed site management policies; • Improve patient movement/flow - timely ward updates to PTLs; • Defining site management team - clearly define roles and responsibilities for the site team.
Month 7: Finance Report Forecast Update	**Month 7 Finance Report** The Committee discussed and **NOTED** the Trust's financial performance and actions being taken to address issues of concern; the following key points being noted: • The Group reported an in-month position of £8.9m against a plan of £4.6m, resulting in a deficit variance of £4.4m;

	• Run-rate has reduced in Month 7 by £0.1m compared to Month 6; • The Year to Date (YTD) position is £68.2m against a plan of £45.5m, giving a YTD variance to plan of £22.7m; • Key drivers of the deficit continue to be non-delivery of recurrent efficiency savings, nursing drivers (including escalation beds and 121 care), unfunded pay award and impact of the strike action; • Total capital expenditure at the end of October was £11.1m spend against a plan of £13.7m; this represents a £2.6m net underspend due to slippage on a major scheme; • The Group cash balance (including subsidiaries) at the end of October was £40.2m. The Trust drew £7.8m of working capital (public dividend capital (PDC)) in the month, making a YTD total of £48.6m; • PricewaterhouseCoopers (PwC) are carrying out a full reforecasting exercise through to the end of the financial year and this was expected to be completed by mid-December. The Committee discussed and **NOTED** the Month 7 Group Finance Report.
Board Assurance Framework (BAF) and Principal Mitigated Financial and Performance Risks Progress Report	The Committee noted the following matters in relation to the BAF: Work is underway to review and update the current BAF, this work is being review by the board in December.
Business Planning Update	The update focuses on key points of progress made in November 2023 on the development of the Trust's 2024/25 business plan and the focussed actions that will be undertaken during December 2023.
Business cases	The Business case for the Digital Pathology Short Form Business Case. The Committee discussed and **APPROVED** the business case.
We Care Integrated Performance Report (IPR) (M7): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	**Cancer waiting times/RTT/Diagnostics** Increased number of patients waiting longer than 62 or 104 days. Highest contributing factors are within the Lower Gastrointestinal (GI) and Urology Cancer Pathway, with the endoscopy delays being the highest contributing factor, followed by radiology delays and biopsy delays. New weekly focused Cancer feeder pack for each team linked to Performance meetings and weekly PTLs will focus on agreed actions to clear back log. Specific funding provided to support locum radiologist in Lower GI and admin support to clear benign letter backlog (commenced in mid-November.

	Diagnostic reporting for CTs & MRIs (current reporting time is two weeks for CTs and six weeks for MRIs) Ref to exam - CT- two-three days if bloods done, if not 14 days. MRI 11 days. Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging eight-12 weeks. Diagnostic waiting time for ultrasound (U/S) Guided Biopsies. Average wait time four-five weeks. Delays with radiology vetting, booking and reporting adding to length of suspected cancer patient pathway. The Committee discussed and **NOTED** the 'We Care IPR' with **PARTIAL ASSURANCE** being received with regard to performance against key metrics for 2023/24.
Winter Plan	• Progress had been made in relation to implementing schemes both inside the hospital and in the community to improve capacity to manage winter. However, even after these schemes have been fully implemented there is currently a mismatch between the forecast number of beds the Trust needs, to manage demand over winter, and those it has available. Further work is being progressed to close this gap. • The Committee noted that there was some risk against some of the out of hospital schemes due to the difficulties being experienced by social care and system partners from both a financial and human resource perspective. • Review to be undertaken of which schemes are working and where the biggest risks are and implications for the Trust and what we can do to mitigate these. The Committee discussed and **NOTED** the Winter Plan verbal update.
Quarterly Workforce Report	• Vacancy rate for band 5 nurses and Healthcare Support Workers (HCSWs) are at the lowest within the financial year with band 5 nurses being 5.2% and HCSWs at 8.2%. • The top hard to recruit Consultant positions remain with a consistent vacancy rate of 22.2%, however, are covered with locums. • Bank & Agency spend currently over predicted levels, however, there has been reduction in agency spend for both nursing and Medical staff, with a slight increase in medical bank costs. The start of nursing approval control measures, September 2023 has

	seen a reduction of £908,000 compared to the previous month of August 2023. • Implementation of an agency managed service, and changes to nursing agency authorisation requests are expected to see reduction on monthly and quarterly agency spend. • There are a number of projects being implemented, to create workforce savings for the Trust from the Nursing Safer Staffing review, admin and clerical review, vacancy control panel and workforce realignment. The Committee discussed and **NOTED** the Quarterly Workforce Report.
National Costs Collection (NCC)	To: • Provide the Board with further detail related to the proposed NCC submission by the Trust; • Outline those assurance processes that have occurred; and • Highlight any residual risk areas. The Committee discussed and **NOTED** the National Costs Collection.
Capital Investment Group	The Committee received assurance reports and minutes of the Capital Investment Group on 17 August and 21 September 2023.
Business Case Scrutiny Group	The Committee **received** an assurance report and minutes of the Business Case Scrutiny Group on 12 October 2023.
Financial Improvement Oversight Group (FIOG)	The Committee **received** an assurance report and minutes of the FIOG meeting on 17 October 2023.
Interim Governance Process	It is in place as an interim process whilst the Full Business Case Investment Policy is being revised and formally ratified by the Policy Advisory Group (PAG). The document also contains all up-to-date relevant templates and proformas that are needed to complete a Business Case, with guidance on how to do so. The Committee discussed and **APPROVED** the Interim Governance Process.

East Kent Hospitals University NHS Foundation Trust

Terms of Reference (ToR)	The Committee discussed and **APPROVED** the FPC ToR for onward submission to Trust Board.

Other items of business

None

Actions taken by the Committee within its Terms of Reference:

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 BoD is asked to receive and **NOTE** this FPC Assurance Report.	Assurance	To Board on 7 December 2023
The BoD is asked to **APPROVE** the FPC ToR.	Approval	To Board on 7 December 2023

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

1 CONSTITUTION

1.1 The Board of Directors has established a Committee of the Board known as the Finance and Performance Committee. It is a Non-Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2 PURPOSE

2.1 The purpose of the Committee is to maintain an overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. As well as maintaining an overview of the Trust's operational performance and activity. This will include:-

- Overseeing the development and maintenance of the Trust's financial and performance plans and medium and long term financial strategy;
- Overseeing the development of specific financial plans as may from time to time be required by NHSE/I including financial recovery plans, and other financial undertakings;
- To consider the impact of the Integrated Care System plans on the Trust;
- reviewing and monitoring financial plans and their link to operational performance;
- ensuring that there is good triangulation between financial, performance, quality and safety and workforce plans;
- overseeing financial risk evaluation, measurement and management;
- scrutiny and approval of business cases and oversight of the capital programme;
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise;
- maintaining oversight of the Trust's performance against the contract activity plan;
- maintaining oversight of the Trust's performance against the national standard and recovery trajectories.

3 OBJECTIVES

3.1 Financial Strategy

3.1.1 To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.

3.1.2 To review long term financial models and strategies including the impact of the Integrated Care System.

3.1.3 To review annual operational plans including efficiency targets and savings projects.

3.1.4 To review key medium term planning assumptions.

3.1.5 To review NHSE/I/LAT /CCG, etc publications around financial andoperating environment and their link to planning assumptions and models.

3.2 Monitoring Performance

3.2.1 Monitor the achievement of the financial strategy, and financial targets (including agency spend), associated activity targets and how these relate to the performance of the Trust in non-financial domains such as patient safety and effectiveness.

3.2.2 Monitor the trajectories for activity performance and financial performance.

3.2.3 Monitor productivity, cost improvement and savings targets.

3.2.4 Scrutinise financial and non-financial performance, trends, projections and underlyingdata on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.

To oversee the development of financial and non-financial performance reporting, to include:

3.2.5 Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.

3.2.6 Structuring monitoring reports around the key performance statements.

3.2.7 Developing high level metrics to focus the Committee on areas where corrective action may need to be developed.

3.2.8 Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions.

3.2.9 Monitoring agreed actions.

3.2.10 To consider the annual reference costs and review profitability analyses.

3.2.11 To review the annual accounts prior to IAGC and Board approval.

3.3 Financial Risk Management

To review financial risk and advise the IAGC and Board accordingly:

3.3.1 Review and evaluate key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity.

3.3.2 Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Executive Risk Assurance Group).

3.4 Business Case consideration and Capital Programme management

3.4.1 To perform a preliminary review of proposed major investments.

To establish the overall controls which govern business case investments, using NHSE/I's guidance on Capital regime, investment and property business case approvalguidance for NHS Trusts and Foundation Trusts, and to approve the Trust's Business Case Procedure. In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases.

3.4.3 To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.

3.4.4 To ensure testing of all relevant options for larger business cases prior to detailed workup.

3.4.5 To focus on financial metrics within cases e.g. payback periods, rate of return etc.

3.4.6 Review the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

3.5 Commercial Income

3.5.1 Ensure new income generating opportunities from non-clinical activities are identified, appropriately vetted and safely implemented.

3.5.2 Ensure mechanisms are in place to provide assurance that all income generating projects are implemented timely and safely.

3.5.3 Review current income streams from all non-clinically related activities.

3.5.4 Ensure a database of all contracts and service agreements are in place and updated regularly.

3.5.5 Benchmark the Trust's commercial income against other NHS providers.

3.5.6 Receives assurance that commercial opportunities are being identified and acted upon.

3.5.7 Ensure that robust processes are followed, to evaluate, scrutinise and monitor implementation of income generating opportunities so that benefits realisation can be confirmed.

3.5.8 Commission internally supported market opportunity reviews.

3.6 Other Matters

3.6.1 To provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge.

3.6.2 To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.).

3.6.3 To develop the Trust’s Treasury and cash management policies in line with NHSE/I guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.

3.6.4 To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the NHSE/I regime and thewider statutory/regulatory framework.

3.6.5 To oversee arrangements for outsourced financial functions and shared financial services.

3.6.6 To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The membership of the Committee shall consist of at least three Non-Executive Directors, together with the Chief Operating Officer, Chief Finance Officer and Director of Strategic Development and Capital Planning. The Committee meetings shall be open to all the members of the Board of Directors.

Quorum

4.4 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chairman is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved virtually by members and ratified at the subsequent meeting of the Committee. .

Attendance by Members

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

Attendance by Officers

4.7 The Committee will be open to the Trust Chairman, Chief Executive and Group Company Secretary toattend.

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

4.9 The Chief Finance Officer will act as lead Executive Director for the Committee.

Voting

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

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

6. AUTHORITY

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

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the Committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work programme that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

10 MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

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

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

Approved by the Board of Directors:

East Kent Hospitals University NHS Foundation Trust

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

Committee:	**Integrated Audit and Governance Committee (IAGC)**
Meeting date:	**7 November 2023**
Chair:	**Dr Olu Olasode, Non-Executive Director**
Paper Author:	**Board Support Secretary**
Quorate:	**Yes**

Appendices:

Appendix 1: Emergency Preparedness, Resilience and Response (EPRR) Assurance Outcome and EPPR Report
Appendix 2: Risk Management Policy
Appendix 3: Risk Management Strategy

Declarations of interest made:

No additional declarations of interest made

Assurances received at the Committee meeting:

Agenda item	Summary

Internal Audit Progress Report	• The Committee received **Assurance** from the Internal Audit progress report:
	  • One audit report finalised since last meeting:
	  • Overseas Recruitment and Retention – **Reasonable Assurance**. This was in respect of safe onboarding, meeting legislation, operating effectively and sufficiently around counter fraud. It was noted it was important to have continued regular check-ins with overseas staff, and obtain feedback on what was working well, any concerns, learning, and making any required improvements to support retention;
	  • Three draft audit reports to be finalised and presented at next meeting, which included Locum Recruitment, Staff Wellbeing, and Legal Services.
	  • The agreed audit plan is being progressed to achieve delivery. It was agreed the annual audit plan will be reviewed in alignment with completion of the governance reviews and PRISM and KPMG patient pathway improvement work to ensure no duplication of work and achievement against the planned goals;
	  • Good progress on follow up of actions, these being resolved and promptly closed, and to reduce those overdue with only three remaining outstanding.

Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – Progress Report	• The Committee received **Assurance** and noted the LCFS progress report and the detailed activity. • The Committee noted following a review of overseas patients and systems in place, the identification of management actions and agreed mitigations against fraud risks. Three actions have been implemented,

	with one remaining in respect of staff training around counter fraud prevention. • The Committee raised the significant increase in overseas debt written off compared to the previous year, an action was agreed to undertake a review of these costs over a longer timeframe to provide a comparison, and identify any necessary actions to reduce these costs.
External Audit Grant Thornton (GT): External Audit Progress Report and Sector Update	• The Committee received **Assurance** from the External Audit progress report, the indicative timeline for the 2023/24 annual audit, and the sector update.
Review and Lessons Learnt – Annual Audit 2022/23	• The Committee received **Partial Assurance** from a verbal report about the delay in undertaking the lessons learnt review, the identification of an auditor member of staff to undertake and complete this review work. • It was agreed the reviewed Terms of Reference (ToR) will be circulated to Committee members for information, following agreement of these with the Committee Chair.
Clinical Executive Management Group (CEMG) Chair Reports – Board Assurance Framework (BAF) Risk Registers BAF and Corporate Risk Registers (CRR)	• The Committee received **Assurance** from a verbal report on progress of the BAF further refresh following discussion at a Board Development Strategy session in November. It was noted the revised BAF will be presented to the December Closed Board meeting. • The Committee along with the Board Committees will have deep dive discussions on their associated specific risks in January 2024, in respect of the format and information presented, level of assurance provided, and mitigating actions to reduce risk score. There will then be a further discussion in February 2024 at the Closed Board, for the final agreed version to be presented at the March 2024 Open Board.
Risk Management and Governance: The New Governance Framework	• The Committee received **Partial Assurance** from the Quality Governance and Accountability Framework presented. Progress to implement the framework aimed at improving the Care Groups governance structure, due to be finalised with a review in January 2024. • The Committee highlighted the governance review being undertaken by the Good Governance Institute (GGI), as well as the Care Quality Commission (CQC) well-led review, and the BAF review that needed to be considered and included within this framework. There was also more to be done in respect of working with local and external partners. It was noted the framework will be reviewed and amended in alignment with any recommendations following the outcome of the reviews.
Good Governance Institute (GGI) External Governance Review Programme	• The Committee received **Assurance** from the programme of work in progress by GGI to review the Trust's governance, due to be finished by December 2023. This will support the wider governance framework review. • The Committee noted a report will be presented to the Board on the outcome of the review and the effectiveness of the Board and Board Committees. • The Committee noted the review also included looking at the links and governance documentation of the Trust's subsidiaries.

Appraisal Compliance Update	• The Committee received **Partial Assurance** from update report presented. • Low appraisal compliance remained a concern, continues to be monitored by the People and Culture Committee (P&CC). It was noted the current compliance of 73% against the 80% threshold, with a steady improved increase. • HR Business Partners providing targeted focussed work supporting Care Groups, Strategic Development and Corporate teams to continue improvements to meet the threshold. Particular area for improvement is the admin and clerical staff group currently at 65.4% compliance. • The Committee noted some appraisals have been completed but not yet inputted on the Electronic Staff Record (ESR) system, with discussions at CEMG to ensure cascading communications that these be appropriately recorded, and the importance of appraisals being held. The Committee recognised the value and importance of staff appraisals in supporting to improve the Trust's culture and leadership (C&L) and holding leaders to account for non-compliance.
Emergency Preparedness, Resilience and Response (EPRR) Assurance Outcome and EPPR Report	• The Committee received **Assurance** and approved the EPRR Assurance Outcome and EPRR Report, recommending this for Board approval (Appendix 1). • Trust rated fully compliant against all 62 EPRR core standards and ten deep dive standards for training. Assurance evidence reviewed by the Interim Chief Operating Officer, and reviewed and approved by the Integrated Care Board. • Work undertaken since the previous year strengthening communications, resilience around fire, emergency planning and risk training, and also a review and revision of EPRR risk register and risk plans. • The Committee noted a debrief to be undertaken in respect of learning and any required actions and amendments to the plan following the recent storm.
Data Security and Protection Toolkit (DSPT) Submission 2022/23 – Progress Report	• The Committee received **Assurance** from the DSPT progress report, noting the 2022/23 DSPT submission in June 2023 and the achievement of 'standards exceeded' status for the third consecutive year. • Uptake of annual Information Governance (IG) mandatory training continued to be a challenge, noting the requirement for the Trust to demonstrate 95% compliance. The IG team are reminding non-compliant staff to complete this training, by pop up reminders and personal e-mails. • The Committee thanked the IG team for their continued hard work and support in maintaining the Trust's compliance.
Losses and Special Payments Report	• The Committee received **Limited Assurance** from the report for the period 1 April 2023 to 30 September 2023. • The Committee noted the total losses and special payments of £163k (139 cases), compared to £71k (118 cases) the previous year, equating to an increase of £92k in year. It was noted the main area related to overseas visitor debt of £111k (40 cases) written off in 2023/24 compared to £14k (six cases) the previous year. Staff debt totalling £18k (25 cases) compared to £19k (23 cases) in the same period the previous year. Accommodation debt write off in 2023/24, £3k (six cases) compared to £3k (13 cases) in the same period the previous year. It was noted the process for booking accommodation has been changed, and

	for the majority of cases online prepayment required reducing risk of cases of bad debt arising.
	• Significant losses and special payments:
	  • Bad debt write-offs £135k (81 cases);
	  • Loss of personal effects £26k (33 cases): includes - dentures (£15k – eight cases); Hearing Aids (£8k – five cases); other personal property including clothing, glasses, jewellery etc. (£3k - 20 cases); and other (£2k - 25 cases).

Single Tender Waiver (STW) Report	• The Committee received **Partial Assurance** from the STW report for the quarter one 2023/24.
	• The Committee noted:
	  • Trust approved 47 STWs with a total value of £4.23m;
	  • 12 STWs with a combined value of £427k were rejected during Financial Year (FY) 2023/24 Year to Date (YTD);
	  • No Declarations of Interest;
	  • No Retrospective Approvals of STWs;
	  • STW numbers comparative to the previous year, with an increase in value.
	• The Director of Finance (DoF) will be working with 2gether Support Solutions (2gether's) Associate Director of Procurement and Managed Equipment Services to review the reasons for the number of STWs. This is to ensure these are reduced, working with the Care Groups and Corporate teams. It was agreed a progress update will be presented at the next Committee meeting providing assurance of the work and actions to manage, address and reduce the number of STWs raised.
	• It was agreed for a further internal audit review to be undertaken later in the year looking at STWs and what more could be done to reduce the numbers and values raised.

Freedom of Information (FoI) Act Annual Report 2022/23	• The Committee received **Partial Assurance** from the FoI Act Annual Report noting:
	  • Activity up by 8.2% from the previous year. Thanked the FoI team, who are a small busy team in continuing to actively manage the increased caseload;
	  • Compliance increased by 4.7%, although compliance remains below the 95% target;
	  • Delays in signing off responses resulting in breaches.

Risk Management Policy and Risk Management Strategy	• The Committee received **Assurance** and approved the Risk Management Policy and Risk Management Strategy recommending these for approval by the Board (Appendices 2 and 3).
	• The Committee noted:
	  • The Risk Management Policy reviewed and revised reflecting changes in Care Group and Corporate governance structures, along with detailed description of risk management and escalation process;
	  • Risk Management Strategy updated reflecting revised risk appetite statements and risk tolerance levels agreed by the Board at its 7 September meeting;
	• The Committee noted the Interim CFO raised the Cautious risk appetite for financial risks considering the Trust's current financial position and challenges, noting this should be Minimal. It was agreed a further review

	and assessment of the Trust's risk appetite against the Trust's pressures will be undertaken in alignment with completion of the BAF review work.
Proposed Addendum to Spencer Private Hospitals (SPH) Reserved Matters	• The Committee received **Assurance** and approved the proposed amendment to the current SPH Reserved matters regarding approval of new posts. The agreed new benchmark of equivalent to NHS Band 8D must be approved by the Trust's Nominations and Remuneration Committee (NRC).

Draft East Kent Hospitals Charity (EKHC) Annual Report and Accounts	• The Committee received **Assurance** from the verbal report noting:
	  • Annual Audit progressing well;
	  • Extra-Ordinary meetings of CFC and IAGC to be held on 28 November to consider the 2022/23 Annual Report and Accounts for approval and recommendation to Board for approval;
	  • Central submission date of 31 January 2024.

Review of Senior Managers' Risk Management Training Compliance	• The Committee received **Limited Assurance** from the report, noting compliance deteriorated against that in 2022/23. It was emphasised it was important to undertake a focussed push reminding staff they were required to complete and be compliant with this training. • It was agreed the Chief Executive will liaise with the Care Group leadership teams and Senior Managers to ensure non-compliant staff completed this required training as soon as possible.
SPH Audited Accounts 2022/23	• The Committee received **Assurance** and noted the 2022/23 SPH's Audited Annual Accounts and Report, signed off by SPH's Audit Committee and uploaded to Companies House. • Successful Unqualified audit report.
Better Payment Practice Code (BPPC) Improvement Plan 2023/24	• The Committee received **Assurance** from the 2023/24 BPPC Improvement Plan, which had been approved by the IAGC Chair and submitted nationally by the required deadline of 12 October. • The Committee noted the improvement actions, and the controls in place to reduce deficit and payment of invoices.
Standing Financial Instructions (SFIs)	• The Committee received **Assurance** from the verbal report about the ongoing review and refresh of the SFIs, including a review of approval limits, revised version to be presented to the next IAGC meeting in January 2024.

Annual Report on Accessed Study Leave for 2022/23	• The Committee received **Partial Assurance** from the 2022/23 Study Leave Annual Report.
	• The Committee noted:
	  • Report included data on all eligible Consultants; Speciality and Specialist (SAS) Doctors and Locally Employed Doctors (LEDs);
	  • Doctors entitled to ten days study leave per annum, with a total budget of £1,000;
	  • Breakdown on spend per site: William Harvey Hospital (WHH) of £130,068.67, Queen Elizabeth the Queen Mother Hospital (QEQM) of £91,239.06, and Kent & Canterbury Hospital (K&C) of £35,366.18;
	  • Showed variation for LEDs with access lower at QEQM and WHH than at K&C;

	• Over half of Consultants, SAS Doctors and LEDs accessed this available study leave; • Reasonably similar percentage of female and male doctors accessing study leave, although a variation at K&C with 37% female and 63% male; • Total spend in the year of £256,673.91; • The Committee emphasised the benefits of providing ethnicity data and assurance around Equality, Diversity and Inclusion, and accessing this study leave equitably. • The Committee raised concern that only over 50% of doctors were accessing this study leave and what could be done to encourage more uptake. It was noted a potential impact with service and work commitments and pressures. The Interim Chief Medical Officer (CMO) provided assurance this was an area of focus for him to push and encourage uptake of this available funding and its importance in respect of doctors revalidation.
Closed IAGC meeting – External Audit Appointment 2023/24	• The Committee received **Assurance** and approved the direct award to the current Trust's External Auditors to provide External Audit services for a one plus one year contract, with an optional one year extension. • This will ensure the Trust was covered for its current 2023/24 annual audit, and up to its 2024/25 annual audit.

Other items of business
The Committee noted the 2023/24 IAGC Annual Work Programme, and following completion of the governance reviews, there will be a review of annual work programmes and assurances presented at the Board and Board Committee meetings.

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 7 December 2023.
The Committee asks the BoD to **APPROVE** the:		
• Emergency Preparedness, Resilience and Response (EPRR) Assurance Outcome and EPPR Report;	Approval	To Board on 7 December 2023.
• Risk Management Policy;	Approval	To Board on 7 December 2023.
• Risk Management Strategy.	Approval	To Board on 7 December 2023.

East Kent Hospitals University NHS Foundation Trust

Report title: **Emergency Preparedness, Resilience & Response (EPRR) Assurance Outcome and EPRR Report**

Board sponsor: **Interim Chief Operating Officer (COO) – Urgent and Emergency Care (UEC)**

Paper Author: **Head of Emergency Planning & Resilience**

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The Trust is required to submit a report to the Trust Board summarising the NHS England Core Standards for EPRR annual assurance outcome and EPRR update. This report is submitted in line with the EPRR governance process.
Summary of key issues:	East Kent Hospitals University NHS Foundation Trust has rated as fully compliant against all 62 EPRR core standards and ten deep dive standards regarding training. The report outlines the EPPR activity since the beginning of the calendar year to date including: • Risks • Plans • Incidents • Exercises • Training
Key recommendations:	The Board is asked to **APPROVE** the EPRR Assurance Outcome and EPRR Report.

Implications:

Links to Strategic Theme:	• 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:

To be presented at November 2023 Clinical Executive Management Group (CEMG) and presented at November 2023 Integrated Audit and Governance Committee.

East Kent Hospitals University NHS Foundation Trust

NHS England Core Standards Emergency Preparedness, Resilience and Response (EPRR) Annual Self-Assessment Outcome Report 2023

1. Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

In addition to the set of core standards is a deep dive on a nominated, relevant topic each year.

The table below outlines the RAG rating scoring system.

The deep dive outcome is not counted towards the final overall rating of the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

East Kent Hospitals University NHS Foundation Trust

2. 2022 Outcomes

The Trust rated as 'fully compliant' in 2022 against 64 Core Standards for EPRR and partially complaint against 13 deep dive standards. Hospital evacuation is part of a wider NHS workstream, in which EKHUFT is engaging. EKHUFT was represented at Exercise Hiertan, the regional hospital evacuation exercise, and the Head of EPRR is chairing the planning group for a Kent & Medway multiagency exercise in November. This will be followed by an internal table top exercise in 2024.

Areas for Improvement within the Evacuation Deep Dive			RAG Rating	Action Plan	RAG Rating 2023/24	Actions taken
DD8	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	This has not been considered	Non-Compliant	Evacuation arrangements are to be reviewed as part of the 2023 Work Plan. This will involve a detailed review of each site and work with the Local Health Resilience Partnership to address support to other organisations and communities.	Partially Compliant	EKHUFT took part in Exercise Hiertan June 2023 and planning for Kent & Medway (K&M) evacuation exercise Winter 2023
DD9	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	There has not been considered	Non-Compliant	Evacuation arrangements are to be reviewed as part of the 2023 Work Plan. This will involve a detailed review of each site and work with the Local Health Resilience Partnership to address support to other organisations and communities.	Partially Compliant	EKHUFT took part in Exercise Hiertan June 2023 and planning for K&M evacuation exercise Winter 2023
DD10	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	This has not been considered	Non-Compliant	Evacuation arrangements are to be reviewed as part of the 2023 Work Plan. This will involve a detailed review of each site and work with the Local Health Resilience Partnership to address support to other organisations and communities.	Partially Compliant	EKHUFT took part in Exercise Hiertan June 2023 and planning for K&M evacuation exercise Winter 2023

DD13	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year.	Evacuation has not been exercised in 3 years. It is not currently on the 2023 exercise plan because the review of the plan needs to be completed first.	Non-Compliant	Evacuation arrangements are to be reviewed as part of the 2023 Work Plan. This will involve a detailed review of each site and work with the Local Health Resilience Partnership to address support to other organisations and communities. Exercise will be accommodated if time available.	Non Compliant	To be carried out in 2024 following completion of workshops and plan review

3. 2023/24 Outcomes

East Kent Hospitals University Foundation NHS Trust has been self-assessed against the 2023 core standards and has rated Fully Compliant against all 62 core standards.

The deep dive on EPRR Training was also self-assessed and the Trust is fully compliant against all ten standards.

Areas of good practice identified within the core standards are:

	Core Standard	Example of Good Practice
Areas of Strength (1)	35. Warning & Informing: communicating with partners & stakeholders	• The EPRR team have a regular social media presence, with new accounts on Instagram and TikTok, sharing activities and exercises. • The weekly Emergency Resilience Communication Dashboard has proved a great way to communicate with staff across a multisite provider sharing urgent information related to emergency resilience • There are monthly communications exercises to ensure alerting methods are working and contacts are correct.

		• Engagement work with Switchboard to ensure they are fully involved in planning and delivering communications methods and improving contact with 999 operators.
Areas of Strength (2)	23. Training & Exercising; EPRR exercising and testing programme	• A large range of exercises have been carried and participated in with multiagency partners. • There is a robust lesson learnt process in place which ensures recommendations from incidents and exercises are recorded, monitored and actioned. • EKHUFT were involved in the KRF Exercise Lemur planning group and are currently involved in KRF Exercise Friesian and chairing the Local Health Resilience Partnership (LHRP) Exercise Melville planning groups. • Loggist Training programme has been improved on feedback from staff which has resulted in better engagement and involvement of Loggists in training and exercises.
Areas of Strength (3)	Domain 10. CBRN	• EKHUFT have set up and chair the Kent Surrey Sussex (KSS) Chemical, Biological, Radiological and Nuclear (CBRN) Forum • Training numbers and improvements to CBRN training have resulted in better engagement with members of staff outside of the Emergency Department (ED). • Exercise Calico and Exercise Big Top with Kent Fire and Rescue Service (KFRS) have been carried out. • Use of amputee volunteers to explore Initial Operational Response (IOR) delivery to vulnerable victims

All Core Standards are compliant so there are no areas for improvement.

Areas of good practice in the EPRR Training Deep Dive are:

'Deep dive'	Core Standard	Example of Good Practice
Areas of Strength (1)	DD6 The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	• The EPRR team keep strict records of training and compliance for health commanders.
Areas of Strength (2)	DD8 The Organisations delivered / commissioned EPRR training is aligned to Joint Emergency Service Interoperability Programme (JESIP) joint doctrine	• JESIP is delivered in all training sessions and embedded in exercises, portfolios and aide memoires
Areas of Strength (3)	DD10 The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	• Learning from Loggist feedback the course has been reviewed and developed offering monthly refreshers sessions and access to exercises. This has visible improvement in engagement from staff.

East Kent Hospitals University NHS Foundation Trust

EPRR 2023 REPORT (October 2023)

The section provides an update on the key Emergency Preparedness activity since the beginning of the calendar year.

1. Risks

This year the EPRR team have reviewed and revised the EPRR Risk Register aligning the risks to the repository of incident response plans. Risks have been split into organisational risk which underpin the response plans and operational risks which are temporary, predominantly site specific and can be closed when the risk has been resolved or has stopped.

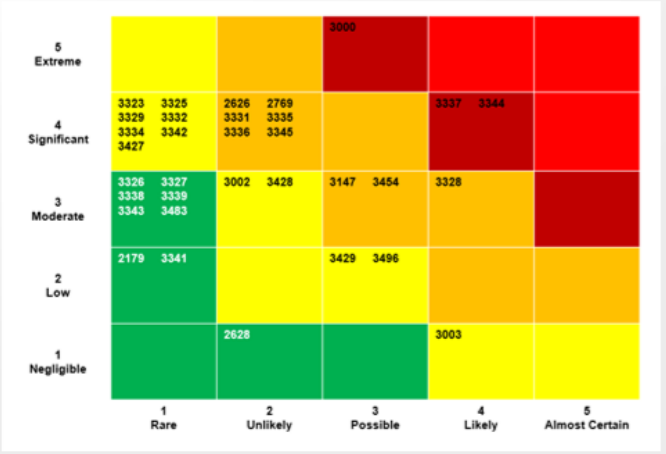
Organisational Risks

Risk Ref	Risk Title	Residual Risk Score
3337	Severe Weather	16 - High (S)
3344	Missing Vulnerable Person	16 - High
3000	Failure of the Electricity Network	15 - High
3328	Heatwave and prolonged hot weather	12 - Moderate (S)
2626	Mass Casualty Incident	8 - Moderate
3331	IT Failure	8 - Moderate
3335	Power Failure - Local	8 - Moderate
3336	Emerging Infectious Diseases (Including Pandemic)	8 - Moderate
3345	NHSE EPRR Assurance Compliance	8 - Moderate
3002	National Planned Power Outages	6 – Low
3428	Helicopter Take Off and Landing	6 – Low
3429	Strategic and Local Transport Infrastructure Interruption	6 – Low
3323	Improvised Explosive Device on Trust Site	4 – Low
3325	Cyber Attack	4 – Low
3329	Fire	4 – Low
3332	Infant Abduction	4 – Low
3334	Piped Oxygen Failure	4 – Low
3342	Mass Fatalities Incident	4 – Low
3427	Hazards Rendering Trust Estate Unsafe	4 – Low
3326	CBRNe	3 - Very Low
3327	Fuel Shortage	3 – Very Low
3338	Telecommunications Failure	3 – Very Low
3339	Water Supply Failure	3 – Very Low
3343	Increase in National Threat Level	3 – Very Low
3341	VIP Attendance at a Trust Site	2 – Very Low

★ New Risk ▲ Risk Score Increase (s) Seasonal Risk

Operational Risks

	Risk Ref	Risk Title	Residual Risk Score
	3147	Inability to access CCTV in a timely manner 24/7 on all sites	9 – Moderate
★	3454	Failed or dangerous helicopter landing or take-off	9 – Moderate
	2769	Inability to effectively carry out a Lockdown of the 3 main hospital sites	8 - Moderate
★	3496	Procurement of new or replacement PRPS Suits for decontamination (CBRN)	6 – Low
	3003	Increase in hospital attendances from Manston Immigration Centre	4 - Low
★	3483	Uncoordinated Fire Response - Buckland Hospital	3 - Very Low
	2628	Building works at the WHH that impact on K&M mass fatality arrangements	2 – Very Low
	2179	Loggist provision	2 – Very Low



2. Plans

Since the beginning of 2023 the following new plans have been written based on current risks, national and local guidance, in collaboration with EKHUFT and 2gether Support Solutions stakeholders.

- Cyber Resilience Incident Response Plan
- ICT Business Continuity Plan
- Incident Helpline Standard Operating Procedure (SOP)
- Industrial Action Framework
- Piped Oxygen Failure Response Plan

- Power Failure Incident Response Plan
- National Power Outage Response Plan
- Rolling Power Outage Response Plan
- Unplanned Generator Failure SOP
- Water Supply Failure Response Plan

Four of the new plans are power failure response plans. In Winter 2022/23 the government announced the potential for planned power disruption in response to an imbalance in gas supply and demand. Similarly, national power outages were tested in national exercises Lemur and Mighty Oak in which EKHUFT took part and these plans are based on the learning and local resilience forum work.
The following plans have been reviewed and revised.

- Heatwave and Prolonged Hot Weather Plan
- Interim Mass Casualty Plan
- Mass Fatalities Plan
- VIP and Protected Persons Plan

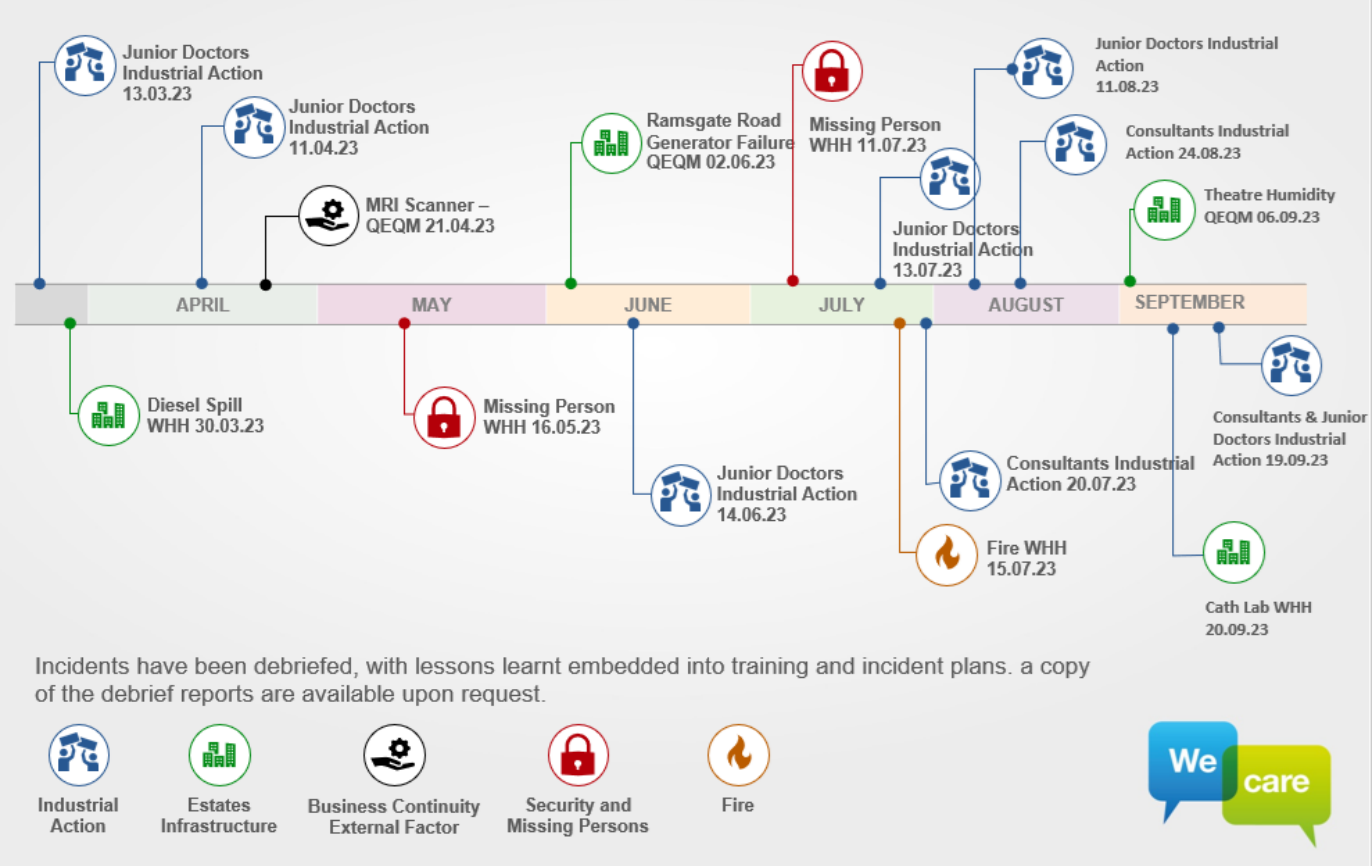
The following plans will be reviewed by the end of the year

- Decontamination Plan
- Severe Weather Plan
- Critical Incident Plan

The review of the Hospitals lockdown plans has been unnecessarily protracted due to delays in minor works. The final publishing deadline is now the beginning of November 2023. However, whilst this plan addresses the immediate lockdown of the external doors, there remains security weaknesses across the hospitals due to a multitude of factors including poorly locking doors, doors not locking at all, access control that cannot be overridden, public footpaths and general security culture.

3. **Incidents**

The info-gram below displays the incidents that have occurred in 2023 which have impacted or occurred in EKHUFT. Incidents are debriefed and reported and the lessons identified are tracked through the Tactical Steering Response Group and the Strategic Resilience and Capabilities Group.



4. Training and Exercises

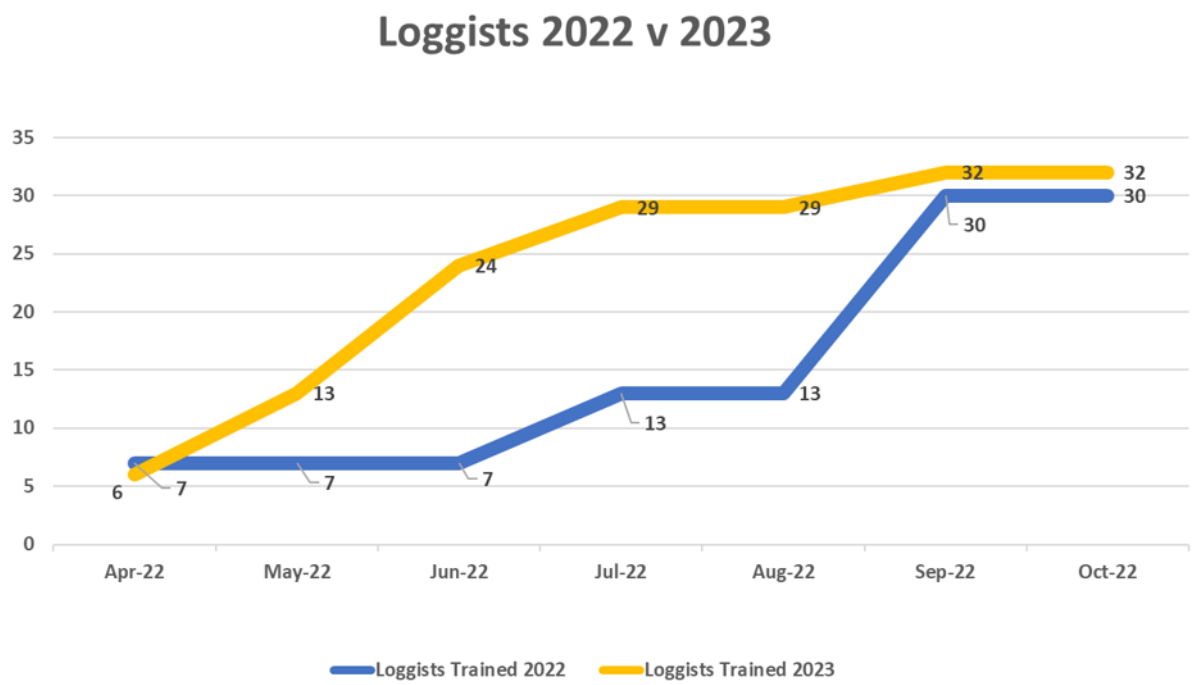
4.1 Training

The 2023 training programme has almost concluded for the year, delivering the highest number of training sessions in a year to date.

Working with Medical Illustration and Learning Development emergency planning are in the process of producing an eLearning package for all staff.
The Training Needs Analysis has also been reviewed and aligned with the Minimal Occupational Standards for EPRR (2022).

To date 223 staff have been trained in Chemical Biological, Radiological and Nuclear (CBRN) compared to 137 in 2022. 92% of William Harvey Hospital (WHH) Emergency Department (ED) and 83 % of Queen Elizabeth the Queen Mother Hospital (QEQM) ED substantive staff now have a current permit to work. Staff from other areas have also been asked to join training to alleviate the demand on the EDs. There has only been small take up on this but we will continue to promote this in 2024.
There have been a number of changes to the on-call rota staffing this year but command training compliance has been maintained and if all staff attend booked courses all staff on the rota will be trained.

There has been a concerted effort to improve the loggist training sessions in order to engage staff, encouraging them and retaining them on training (Risk 2179). Despite the success in the recruitment, staff leavers and role changes have kept loggist trained numbers still low at 46.



4.2 Exercises

This year the EPRR team have continued the fire incident response workstream and carried out Exercise Ignis II at Kent & Canterbury Hospital with KFRS. A live fire was simulated in main theatres testing the fire team response and theatre evacuation plans in line with the revised KFRS response plans. This exercise was repeated at WHH in October 2023.

Exercise Dyson was run at QEQM and WHH testing the new Piped Oxygen Supply Failure Plan within the incident command centres. Learning has been used to revise the new plan.
Exercise Calico tested the live response to a contaminated casualties self presenting to QEQM and the subsequent response.

A business continuity exercise was planned with the WHH Heart Centre team in November 2023 but the Cath lab failure incident in September 2023 has surpassed the need to test this as it has occurred. At the time of this report the system debrief, led by the Integrated Care Board (ICB), is outstanding. EKHUFT has also taken part in external exercises run by the Small Boats Operational Command, the Kent Resilience Forum and NHS England South East.

Monthly communications tests have continued testing incident response communications methods with switchboard and incident commanders and responders.

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University

NHS Foundation Trust

TRUST POLICY

Risk Management Policy

Version:	2.2
Author (Title and Care Group):	Risk Manager, Quality Governance
Approving committee:	Board of Directors
Date approved:	December 2023
Date ratified by Policy Authorisation Group:	19 October 2023
Date issued:	
Next scheduled review date:	December 2026

Applies to (include subsidiary companies):	
Trust staff (specify groups e.g. clinical/non-clinical):	All EKHUFT staff
Subsidiaries	No
2gether Support Solutions Ltd. as a service provider (hard and soft facilities services)	No
Includes references to children/young people	No
Included references to medicines	No

We care

Version Control Schedule

Version	Date	Author	Status	Comment
1.0	Mar 20	Risk Manager	Final	
2.0	Dec 21	Risk Manager	Final	
2.1	Aug 23	Risk Manager	Draft	Incorporation of risk appetite statements and changes in Care Group and governance structure
2.2	Oct 23	Risk Manager	Draft	Detailed description of risk management process and practical application included

Policy Reviewers

Title and Care Group of Individual	Date Consulted
Director of Quality Governance	Sep 2023
Governance Consultant	Sep 2023
Company Secretary	Sep 2023

Name of Committee	Date Reviewed
Clinical Executive Management Group	Oct 2023
Integrated Audit and Governance Committee	Nov 2023
Board of Directors	Dec 2023

Summary of Key Changes from Last Approved Version

Incorporation of risk appetite statements and changes in Care Group and Corporate governance structures.

Detailed description of risk management process and practical application included

Associated Documentation

Risk Management Handbook

Summary Guide to Managing Risks at EKHUFT

Risk Management Strategy

Contents

1. Policy Description

1.1. The aim of this policy is to ensure that East Kent Hospitals University NHS Foundation Trust (EKHUFT) has a proactive and consistent approach to the management of risk.

1.2. It describes in detail the process for identifying, managing and escalating risk.

1.3. This policy replaces version 2.0 of the Risk Management Policy.

2. Introduction

2.1. The Risk Management Policy outlines the Trust's commitment to managing risks in an effective and appropriate manner to enable the provision of the highest quality of care to our patients. Of equal relevance is the legal duty of the Trust to control any potential risk to staff and the public, as well as safeguarding the Trust's assets. The policy should be used in conjunction with the Risk Management Strategy and Risk Management Handbook for the implementation of risk management across the Trust.

3. Definitions

3.1. **Board Assurance Framework (BAF)** – A tool for the Board corporately to assure itself about successful delivery of the organisation's strategic objectives.

3.2. **Inherent Risk** – The risk that an activity would pose if no controls or other mitigating factors were in place.

3.3. **Internal Audit** – Our internal auditors primarily provide an independent and objective opinion to the Trust on the degree to which risk management, control and governance processes support the achievement of the Trust's objectives.

3.4. **Issue** – An issue is a risk that has happened. In other words, risks are potential future problems and issues are current problems.

3.5. **Risk** – Risk is the combination of the probability of an event and its consequence. Consequences can range from positive to negative.

3.6. **Residual Risk** – The risk that remains after controls are taken into account.

3.7. **Risk Appetite** – The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

3.8. **Risk Assessment** – Consists of a combination of the likelihood of a perceived threat and the magnitude of its impact upon objectives.

3.9. **Risk Management** – The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

3.10. **Risk Tolerance** – Reflects the boundaries within which the executive management are willing to allow the day-to-day risk profile of the Trust to fluctuate.

3.11. **Target Risk** – The desired risk level over a period of time after risk actions have been implemented.

4. Purpose and Scope

4.1. This policy aims to ensure that the Trust actively manages all types of risk inherent within the organisation.

4.2. This policy applies to all members of Trust staff.

4.3. Risk Management is the identification, assessment and control of the impact of events to which the Trust is exposed. This process is carried out in order to minimise the likelihood and impact of adverse events and take advantage of opportunities. It covers the full range of risk exposure and therefore includes financial, regulatory, reputational, operational, cyber, clinical and non-clinical risk as well as any risk that threatens the achievement of the Trust's annual and strategic objectives.

5. Duties

5.1. **Board of Directors**: The Trust Board is accountable to NHS England for ensuring that sound governance systems and processes are in place and that risks associated with any of its functions are managed within a robust compliance framework.

5.1.1. They delegate to managers the responsibility to design, implement and monitor the strategy and policy.

5.1.2. They receive assurance regarding the effectiveness of the risk management process.

5.1.3. They ensure there are processes in place to enable complete, timely, relevant, accurate and accessible risk disclosure to stakeholders.

5.1.4. They set the risk appetite and risk tolerance of the Trust and the system for enabling risk control and contingency decisions.

5.2. **Chief Executive**: The Chief Executive has overall responsibility for risk management at EKHUFT as the Accountable Officer.

5.2.1. The Chief Executive is responsible for ensuring that a risk management system is established, implemented and maintained in accordance with this policy.

5.2.2. The Chief Executive is responsible for ensuring that full support and commitment is provided and maintained in every activity relating to risk management.

5.3. **Chief Nursing and Midwifery Officer**: Provides Executive sponsorship of risk management activities across the Trust, ensuring that the Trust's key risk management objectives are met.

5.3.1. Executive responsibility for ensuring that risk management processes are reviewed, updated and driven forward by the Trust.

5.3.2. Accountable to the Chief Executive and the Board for ensuring that the risk management strategy and policy are implemented effectively and evaluated consistently.

5.4. **Executive Directors**: Executive Directors have overall responsibility for the implementation of the strategy and policy.

5.4.1. They are responsible for the oversight of the processes for identifying and assessing risk, and for advising the Chief Executive as required.

5.4.2. They must ensure that, so far as it is reasonably practical, resources are available in order to manage risk.

5.4.3. They are responsible for ensuring that risks that threaten the achievement of the Trust's strategic objectives within their sphere of responsibility are actively identified and managed.

5.5. **Director of Corporate Governance**: Ensures an appropriate Board Assurance Framework (BAF) is prepared and regularly updated, and that it receives appropriate consideration at relevant committees and the Trust Board.

5.5.1. Co-ordinates the production of the Annual Governance Statement and ensures it adequately reflects the risk management processes within the Trust.

5.6. **Director of Quality Governance**: Operational management responsibility for the implementation of the Risk Management agenda through the management of the Risk Management and Patient Safety functions.

5.6.1. Responsible for the management of the Corporate Risk Team.

5.7. **Risk Manager**: The development of strategy, policies and process documents with regard to risk management.

5.7.1. Responsible for the implementation of all aspects of risk management including embedding risk management across the Trust.

5.7.2. Supporting the Care Groups with ensuring their Care Group Risk Registers are fit-for-purpose.

5.7.3. Undertaking an audit of local risk registers on a quarterly basis.

5.7.4. Provision of training, information and support for Trust staff in relation to risk management.

5.7.5. Continuing development of a proactive risk management culture and practice throughout the Trust; actively promoting and ensuring good risk management practices.

5.8. **Managing Directors**: Responsible for ensuring maintenance of a live and relevant risk register and establish and maintain clear mechanisms within the care group to ensure that this is reviewed regularly.

5.8.1. Escalate risks in quality and compliance to Chief Operating Officer, Chief Medical Officer, Chief Nursing and Midwifery Officer as appropriate.

5.8.2. Identify and, where possible, pre-empt significant financial issues and lead the development of strategies to mitigate the risk. Escalate issues to the Chief Finance Officer and Chief Operating Officer, as appropriate, and seek further assistance as necessary.

5.8.3. Ensure systems are in place for delivery of plans identified through risks, Serious Incident reports and other intelligence in a timely manner and that appropriate interventions are made to improve the safety and quality of service delivery and care.

5.9. **Heads of Operations:** Lead site meetings ensuring quality, risk, and safety are key component parts and ensure plans are in place to mitigate any risk to the Trust and our patients.

5.10. **General Managers:** Work with the Heads of Operations to ensure the implementation of Trust policies across the service and to ensure that staff are aware of their responsibilities and have appropriate training. This includes health and safety, risk management and assurance framework compliance.

5.10.1. Support the triumvirate leadership team with the delivery of risk management and governance processes working closely with the Governance Lead and senior members of the team. This includes maintenance and oversight of the service Risk Register.

5.11. **Medical Director/Associate Medical Director:** Work in partnership with the Managing Director and Director of Nursing and fellow Medical Directors/Associate Medical Directors to ensure operational and clinical continuity within the site whilst supporting the Trust wide response to risk, quality and operational pressures.

5.11.1. Take a strategic approach which anticipates the future demands for doctors and the impact on patient care in order to identify potential options and risks.

5.11.2. Supports the Managing Director and Director/Associate Director of Nursing in the delivery of the constitutional standards to the highest standards of clinical safety, quality and experience balancing risk across their Care Group and Trust wide.

5.11.3. Oversee, with the Care Group triumvirate team the governance, assurance and effective risk management of the Care Group.

5.11.4. Demonstrate high levels of personal and professional judgment in determining the acceptable level and mitigation/treatment of risk.

5.12. **Director/Associate Director of Nursing:** Work in partnership with the Care Groups Medical Director and Managing Director to ensure operational and clinical continuity within the Care Group whilst supporting the Trust wide response to risk, quality, and operational pressures.

5.12.1. Oversee, with the hospital triumvirate team the governance, assurance and effective risk management of the Care Group.

5.12.2. Demonstrate high levels of personal and professional judgment in determining the acceptable level and mitigation/treatment of risk.

5.12.3. Takes a strategic approach which anticipates the future demands for nurses, midwives and allied health professionals and the impact on patient care in order to identify potential options and risks.

5.12.4. Support the Care Groups Managing Director, and Medical Director in the delivery of the constitutional standards to the highest standards of clinical safety, quality and experience balancing risk across the Care Group.

5.13. **Heads of Nursing:** The Care Group Head(s) of Nursing act as the delegated leads for safety, quality and patient experience, responsible for development and application of systems, control processes and risk management arrangements that ensure full compliance with internal and external governance procedures and to benchmark against best practice requirements.

5.13.1. Ensure clinical governance of service aligns with Trust requirements and provides assurance on clinical quality and safety, considers risks and their mitigation thoroughly, to learn from adverse incidents and takes actions as a result monitoring and reporting progress up to the Care Groups Board.

5.13.2. Lead trend analysis of all complaints, adverse incidents, concerns, compliments and comments and ensure the development, implementation, and monitoring of action plans to reduce risk and improve quality, safety and patient experience.

5.13.3. Ensure compliance with Trust Risk Management Policies and Procedures, and that these are understood by staff within the specialty.

5.13.4. To ensure embedding of a risk and safety culture across the service so that staff working in the wards and departments function with risk and safety at the heart of their practice.

5.14. **Deputy Heads of Nursing:** Responsible for development and application of systems, control processes and risk management arrangements that ensure full compliance with internal and external governance procedures and to benchmark against best practice requirements.

5.14.1. Ensure the highest standards of clinical and corporate governance, ensuring that the speciality and care group operate within Trust governance, risk and patient safety frameworks.

5.15. **All Managers**: Ensure that there is a regular multidisciplinary governance meeting at which the departmental risk register is reviewed.

5.15.1. Aligning the clinical audit programmes with actual and emerging clinical risks.

5.15.2. Implementing and monitoring any identified risk management control or assurance measures within their designated area/and scope of responsibility. Departmental managers are expected to address low-level risks as they arise.

5.15.3. Where significant risks have been identified and where local control measures are considered to be potentially inadequate and where local resolution has not been satisfactorily achieved, managers are responsible for and have the authority to:

5.15.3.1. Arrange for the addition of the new/emerging risks to their relevant risk area on the risk management system.

5.15.3.2. Bring these risks to the attention of their Care Group Triumvirate.

5.15.3.3. Develop and submit business cases where appropriate to support mitigation and improvements.

5.16. **All staff**: Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks.

5.16.1. Resolve risks or bring immediate risk issues to the attention of their line manager.

5.16.2. Undertake training and any other risk training deemed necessary for their role as described in the Trust Risk Management Training Needs Analysis.

5.16.3. All staff have individual responsibility for engaging in risk management activities. Staff are made aware of this policy by publication on the Trust's policy management system and through the performance management structure. Using this mechanism staff are supported and committed to the identification and minimisation of risk.

6. Risk Appetite and Tolerance

6.1. Risk appetite is the level of risk that an organisation is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

6.1.1. We have a **CAUTIOUS** appetite for **FINANCIAL** risks. We are prepared to accept the possibility of limited financial risk. However, value for money is our primary concern.

6.1.2. We have a **MINIMAL** appetite for **REGULATORY** risks. We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

6.1.3. We have a **CAUTIOUS** appetite for **QUALITY** risks. Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.

6.1.4. We have an **OPEN** appetite for **REPUTATIONAL** risks. We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

6.1.5. We have an **OPEN** appetite for **PEOPLE** risks. We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.

6.2. Risk tolerances risk the predetermined upper level of risk that can be assigned to an objective. It is the level of residual risk below which the Board expects sub-Committees to operate and management to manage. Breaching the tolerance requires escalation to the Board for consideration of the impact on other objectives, competing resources and timescales.

6.2.1. The tolerance for **financial** risks is a moderate (10).

6.2.2. The tolerance for **regulatory** risks is a low (5).

6.2.3. The tolerance for **quality** risks is a low (6).

6.2.4. The tolerance for **reputational** risks is a high (16).

6.2.5. The tolerance for **people** risks is a moderate (12).

7. Risk Management Process

7.1. **Establishing objective and context** – Effective risk management requires a thorough understanding of the context in which the Trust and its Care Groups/Departments operate. The analysis of this operating environment enables managers to define the parameters within which the risks to their outputs need to be managed.

7.1.1. The context sets the scope for the risk management process. The context includes strategic, organisational and risk management considerations. Strategic context defines the relationship between the organisation and its environment. Factors that influence the relationship include financial, operational, competitive, political (public perceptions / image), social, cultural and legal. The definition of the relationships is usually communicated through analysis frameworks such as the SWOT (Organisational Strengths, Weaknesses, Opportunities and Threats) and PESTLE (Political, Economic, Social, Technological, Environmental and Legal). Other tools can also be used.

7.1.2. Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk it must first be understood what the objectives/outcomes to be achieved are.

7.1.3. Strategic or corporate objectives; to identify and clarify which Trust strategic or corporate objective is relevant to the Care Group, department or specialty. Look at the Trust business plan and the latest Care Group, or local business plan. If this step is missed or omitted then the risk register will be neither relevant nor effective.

7.1.4. Local objectives should also be considered. By clarifying the objectives, it can be identified whether there is a risk to manage.

7.1.5. All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

7.1.6. Board members have the responsibility of horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

7.2. **Identifying risks to objectives** – Risk identification involves examining all sources of potential risk that the Trust may be exposed to from the perspective of all stakeholders throughout the organisation. When identifying potential risk, there are two key approaches: top down and bottom up approach.

7.2.1. **Top down (identifying strategic risk)** – Strategic risk management is undertaken through Executive Management and Committee structures and enables the identification, assessment and recording of strategic risks which threaten the achievement of EKHUFT objectives.

7.2.2. The Board Assurance Framework (BAF) provides clarity over the risks that may impact on the Trust's ability to deliver its strategic objectives. This simplifies Board reporting and prioritisation, which in turn allows more effective performance management. The BAF, which is reported to the Trust Board at least four times a year, also facilities the preparation of the Board agenda and the reporting of key information to the Board. At the same time, it records structured positive assurances about where risks are being managed effectively and objectives are being delivered.

7.2.3. Any new strategic risks will be considered and approved by the board before being accepted as such and added to the BAF. The Board will also consider for approval any recommendation to remove strategic risks from the BAF.

7.2.4. The populated BAF articulates clearly the key strategic controls in place to ensure that strategic risks are being managed and the sources of evidence, or assurance, that the controls are operating effectively to secure delivery of the Trust's strategic objectives.

7.2.5. Individual Executive Directors review their BAF entries monthly to monitor progress against actions and to identify changes that need to be reported in the next BAF update.

7.2.6. The Board sub-Committees receive the BAF on a monthly basis and provide the Trust Board with assurance that the correct risks are identified on the BAF within their scope of responsibility; that they are assured the risk is being appropriately managed and that the controls and actions are appropriate to mitigate the risk to a tolerable level within a specified timeframe.

7.2.7. **Bottom up (Identifying operational risk)** – Operational risk management activity is supported by staff working in adherence to organisation's policies and procedures. Operational risk may present themselves, via incidents, complaints, claims, patient feedback, safety inspections, external review, ad hoc assessments etc. which may impact on the organisation's ability.

7.2.8. The Trust has segmented its risk register into two levels: Board Assurance Framework (BAF) and operational (4risk). This enables the Board to take a holistic view of the Trust's risk profile through assessment of risk across the Trust as well as taking a 'bottom up' perspective from local operational areas. Through the scoring matrix identified at Appendix B the Board is able to prioritise its attention on those risks that have the greatest potential to impact the Trust's strategic direction.

7.3. **Analyse the risk** – Identify the controls (currently in place) that deal with the identified risks and assess their effectiveness. Based on this assessment, analyse the risks in terms of likelihood and consequence. Refer to the risk scoring matrix at Appendix B to assist you in determining the level of likelihood and consequence, and the current risk level (combination of likelihood and consequence).

7.4. **Evaluate the risk** – This stage of the risk assessment process determines whether the risks are acceptable or unacceptable. This decision is made by the person with the appropriate authority. A risk that is determined as acceptable should be monitored and periodically reviewed to ensure it remains acceptable.

7.4.1. A risk deemed unacceptable should be treated. In all cases the reasons for the assessment should be documented within 4risk to provide a record of the thinking that led to the decisions. Such documentation will provide a useful context for future risk assessment.

7.5. **Treat the risk** – The range of risk treatment options or combination of risk treatments will vary dependent upon each risk and the costs and benefits applied to each option.

7.5.1. The 5T's provide an easy list of treatment options available to anyone considering how to manage (control) risk:

7.5.1.1. **Tolerate** – the likelihood and consequence of a particular risk happening is accepted

7.5.1.2. **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action)

7.5.1.3. **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against of subcontracted to another party

7.5.1.4. **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.

7.5.1.5. **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

7.5.2. Potential mitigation options are developed according to the selected treatment strategy. The selection of the preferred mitigation options takes into account factors such as the costs and effectiveness. The determination of the preferred treatments also includes the documentation of implementation details (e.g. responsibilities, a timetable for implementation and monitoring requirements). The intention of these risk treatments is to reduce the risk level of unacceptable risks to an acceptable level (i.e. the target risk level).

7.5.3. There will be risks where the target has been attained with all current mitigating actions completed but a level of risk remains and there is little or no scope for further mitigation in the immediate future. These risks are considered to be tolerated risks and should be closed. Closed risks remain available on the 4risk system, guidance on how to access closed risks can be found in the Risk Management Handbook.

7.6. **Monitor and review** – Managers are required to monitor the effectiveness of risk treatment and have the responsibility to identify new risks as they arise and treat them accordingly. Managers are required to report on the progress of risk mitigation at regular intervals. The person who has the responsibility for risk mitigation is expected to provide feedback to the risk owner on progress being made. Monitoring should take into account the potential effect of the implementation of mitigation and any potential cause and effect obstacles.

7.7. **Communicate and consult** – Involving key individuals/groups that may be affected by the risk can help with gaining and understanding of their perspective and ensure commitment and buy-in to changes that may be required for treatment. Communication may occur at any phase of the process and particularly when authority for decisions is required.

8. Risk escalation

8.1. To ensure monitoring and review of risks and their management, the following processes should be applied:

8.1.1. Services or departments should complete a pro-forma for submitting a risk to the risk register. This should be submitted to the Care Group/Department Quality Governance Meeting for approval.

8.1.2. The Care Group Quality Governance Meeting should approve the risk description, impact, likelihood, risk score, risk owner, controls and actions. The agreed completed pro-forma should then be emailed to the Risk Manager for entry on to the risk management system.

8.1.3. If the risk has an agreed residual risk rating of 15 or higher this will be presented to the Risk Review Group by the Care Group triumvirate for approval prior to escalation to the Clinical Executive Management Group.

8.1.4. It is the responsibility of the risk owner to ensure the risk is updated on a monthly basis. The 4risk system will send reminders to the risk owner and delegated risk owner on the first of the month.

8.1.5. For each risk, the controls and actions will be allocated a responsible owner to ensure risk management actions are delivered as planned.

8.1.6. Where risks are cross-cutting, assigning a risk control or action to another control owner (in another department) must only be done by mutual agreement and only to those who are capable of controlling the risk. In the event here is no clear agreement, the matter should be escalated to the Risk Manager for a decision on where the risk control or action should sit. No changes in this regard can be made on the 4risk system until clarity on the assignment is agreed.

8.1.7. A risk where 2gether Support Solutions Ltd (as the service provider) or EKHUFT (as the customer) has a dependency on the other organisation e.g. to make a decision, take action or provide funding, to be able to mitigate the cause and/or effect of a risk that presents a threat to the successful delivery of the service provision should be added to the Subsidiary Shared Risk Register. This is through the Risk Manager and reported monthly to the Contract Management Performance Meeting.

8.1.8. Monthly reviews of Care Group risk registers will take place at the Care Group Quality meetings before being presented to the relevant Executive-Led meetings e.g. Performance Review Meetings, Patient Safety Committee which includes progress of control measures, assurances and action plans.

8.1.9. The relevant Executive-Led meetings will provide assurance to the Clinical Executive Management Group that key risks are being appropriately managed and escalate any risks that they consider to be significant, either through their scoring or affect on multiple Care Groups.

8.1.10. Risks that have a high score (15+) after controls are identified or have a moderate score (12) that affect multiple Care Groups will be escalated through the Significant Risk Register to the Board sub-Committees on a monthly basis. The Board sub-Committees will escalate any risks outside of the risk appetite through a monthly Chair's assurance report to the Board of Directors. Risk management responsibilities of the Board sub-Committees can be found at Appendix A.

8.1.11. The Significant Risk Register and the Board Assurance Framework will be reported to the Board of Directors quarterly.

8.1.12. The Integrated Audit and Governance Committee provide assurance to the Board of Directors that the risk management processes are working effectively. They receive the Board Assurance Framework, Significant Risk Register and an overview of Board sub-Committee risk activity on a quarterly basis.

9. Training

9.1. The Trust has a responsibility to ensure that its employees are safe and competent with the appropriate knowledge and skills to deliver high quality care to its service users. Risk Management training, for all staff groups, is described in the Trust's Training Needs Analysis (which can be found on the Learning pages on Staff Zone) and the expectation is that all staff will comply and undertake the appropriate training programme.

9.2. Training will be appropriate to the staff groups receiving it and commensurate with their risk management responsibilities. The Trust will identify, how, where and when risk training will take place.

10. Policy Development, Approval and Authorisation

10.1. This policy will be approved by the Board of Directors.

10.2. This policy will be ratified by the Policy Authorisation Group.

11. Review and Revision Arrangements

11.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.

11.2. It will be ratified by the Policy Authorisation Group every three years, or when there are significant changes and/or changes to underpinning legislation in accordance with the policy for the Development and Management of Trust Policies.

12. Policy Implementation

12.1. Refer to Appendix E.

13. Document Control including Archiving Arrangements

13.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.

13.2. This policy will be uploaded to the Trust's policy management system.

13.3. Version 2.0 of this policy, which this document supersedes, will be retained within the Trust's policy management system for future reference.

14. Monitoring Compliance

14.1. The process for managing risks locally will be through the Performance Review meetings. Care Group and Corporate Quality Groups should review their Risk Registers regularly (at least monthly).

14.2. Reporting arrangements into the Board will be reviewed annually when reviewing the Terms of Reference of the Board of Directors.

14.3. Ensuring that strategic risks are assessed, reviewed and aligned with the annual objectives will be assessed by an audit of process by the Trust's internal auditors annually.

14.4. Risk management training for Board members and very senior managers Group leadership teams will be reported annually with a report of compliance to the Integrated Audit and Governance Committee.

14.5. A formal review of the Trust's risk management maturity will be conducted annually reported to the Integrated Audit and Governance Committee.

14.6. A review of tolerated risks should be undertaken on an annual basis by the Care Group or Corporate Department as part of business planning to ensure these continue to be monitored.

15. References

15.1. BS31100 Code of Practice for Risk Management

15.2. HM Treasury – The Orange Book Management of Risk – Principles and Concepts

15.3. HM Treasury – Risk Management assessment framework

15.4. The Alarm National Performance Model for Risk Management in the Public Services

15.5. Fundamentals of Risk Management 5th Edition, Paul Hopkin

16. Appendices

Appendix A – Relevant Committees with Responsibilities for Risk Management

The following describes how responsibilities of different Trust committees for risk management are executed.

Board of Directors

The Board of Directors is ultimately accountable for ensuring that the Trust is complying with its Terms of Authorisation, which includes its arrangements for integrated governance and effective risk management. The Board of Directors and the Chief Executive are also responsible for ensuring that an open and just culture is developed and sustained throughout the Trust; this is an essential foundation for effective risk management. The Board of Directors receive the BAF in full quarterly.

The Group Company Secretary ensures that papers received to be discussed at Clinical Executive Management Group and Board of Directors address the issue of risk in line with this policy.

Integrated Audit and Governance Committee

Reporting to the Board, the Integrated Audit and Governance Committee has responsibility for monitoring and review of the risk, control and governance processes which have been established in the organisation, and the associated assurance processes. This is in order to help the Board of Directors be fully assured that the most efficient, effective and economic risk, control and governance processes are in place and the associated assurance processes are optimal. The Integrated Audit and Governance Committee receive the BAF and Significant Risk Register at each meeting.

Finance and Performance Committee

Reporting to the Board, the Finance and Performance Committee has responsibility for reviewing the financial strategy and for monitoring and review of the risk, control and governance processes associated with financial management of the Trust. The outcomes of discussion on any additions to or changes in the evaluation of financial risks are noted by the Finance and Performance Committee and incorporated into the Board Assurance Framework or Significant Risk Register.

People and Culture Committee

Reporting to the Board, the People and Culture Committee has responsibility for raising concerns to the Board on any workforce risks that are significant or for escalating. They also consider the control and mitigation of workforce-related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

Quality and Safety Committee

This Committee reports to the Board of Directors and is responsible for ensuring the risks associated with quality and the achievement of the Quality Strategy are met. It provides control, governance and assurance to the Board on quality related risks. The risks relating to quality and patient safety on the Significant Risk Register are reviewed by the Quality and Safety Committee monthly.

Clinical Executive Management Group

This committee reports to the Chief Executive Officer. It provides the IAGC and the Quality and Safety Committee with regular reports and will work with both committees to strengthen the systems of control, governance and assurance. The Clinical Executive Management Group (CEMG) receives new risks for proposed inclusion on the Significant Risk Register monthly and identifies any emerging risks or any changes required to the assessment of existing risks. The Group will receive on a monthly basis any risks identified by the Care Groups or Corporate Departments that fall outside of the Trust's agreed risk appetite.

Performance Review Meetings

The Care Groups are responsible for ensuring systematic and effective risk management takes place (including recording of risks on 4Risk) across the areas within their sphere of responsibility; ensuring that risks are brought to the attention of the Performance Review Meeting and either managed within their resources or escalated where appropriate to the Clinical Executive Management Group.

Strategic Health and Safety Committee

This committee meets the requirements of section 2 (7) of the Health and Safety at Work Act 1974 and reports to the Clinical Executive Management Group. The Strategic Health and Safety Committee acts as the operational committee for supporting the management of health and safety risks.

Appendix B – Risk Assessment/Scoring

LEVEL	**IMPACT** OF RISK (SEE APPENDIX C FOR OTHER APPLICABLE MULTIPLE IMPACT DOMAINS)
1	Negligible - no obvious harm, disruption to service delivery or financial impact. Reputation is unaffected.
2	Low - The Trust will face some issues but which will not lower its ability to deliver quality services. Minimal harm to a person/people; local adverse publicity unlikely; minimal impact on service delivery.
3	Moderate – The Trust will face some difficulties which may have a small impact on its ability to deliver quality services and require some elements of its long-term strategy to be revised. Level of harm caused to a person/people requires medical intervention resulting in an increased length of stay. Local adverse publicity possible.
4	Significant – The Trust will face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long-term strategy. Major injuries / harm to a person/people resulting in prolonged length of stay. External reporting of consequences required. Local adverse publicity certain, national adverse publicity expected. Likelihood of litigation action. Temporary service closure.
5	Extreme – The Trust will face serious difficulties and will be unable to deliver services on a daily basis. Its long-term strategy will be in jeopardy. Serious harm may be caused to a person/people resulting in death or significant multiple injuries. Extended service closure inevitable. Protracted national adverse publicity
LEVEL	**LIKELIHOOD - F**REQUENCY/**P**ROBABILITY OF RISK CRYSTALLISING\RECURRENCE
1	Rare – Not expected to occur for years/ This will probably never happen/recur / Will only occur in exceptional circumstances or <20%
2	Unlikely – Expected to occur annually/ Do not expect it to happen/recur but it is possible it may do so / Unlikely to occur or 20% - 40%
3	Possible – Expected to occur monthly/ Might happen or recur occasionally / Reasonable chance of occurring or 40% - 60%
4	Likely – Expected to occur at least weekly/ Will probably happen/recur, but it is not a persisting issue/circumstances / Likely to occur or 60% - 80%
5	Almost Certain – Expected to occur at least daily/ Will undoubtedly happen/recur, possibly frequently / More likely to occur than not or > 80%

RISK MATRIX						
Impact	5. Extreme	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3.V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	2. Unlikely	3. Possible	4. Likely	5. Almost certain
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

Appendix C – Detailed risk domain scoring guidance

Domain	Negligible	Low	Moderate	Significant	Extreme
Injury (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment. ►No time off required.	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi-permanent harm ►Affects 1-2 people ►Requiring time off work for <3days	►Moderate injury or illness requiring professional intervention ►No staff attending mandatory / key training ►RIDDOR / Agency reportable incident (4-14 days lost) ►Adverse event which impacts on a small number of patients ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. loss of limb) ►>14 days off work ►Affects 16 – 50 people	►Fatalities ►Multiple permanent injuries or irreversible health effects ►An event affecting >50 people
Patient Experience	►Reduced level of patient experience which is not due to delivery of clinical care	►Unsatisfactory patient experience directly due to clinical care – readily resolvable ►Increase in length of hospital stay by 1-3 days	►Unsatisfactory management of patient care – local resolution (with potential to go to independent review) ►Increased length of hospital stay by 4 – 15	►Unsatisfactory management of patient care with long term effects ►increased length of hospital stay >15 days ►Misdiagnosis	►Incident leading to death ►Totally unsatisfactory level or quality of treatment / Service

Domain	Negligible	Low	Moderate	Significant	Extreme
			days		
Environmental Impact	►Onsite release of substance averted	►Onsite release of substance contained ►Minor damage to Trust property – easily remedied <£10K	►On site release no detrimental effect ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K – £50K	►Offsite release with no detrimental effect / on-site release with potential for detrimental effect ►Major damage to Trust property – external organisations required to remedy - associated costs >£50K	►Onsite /offsite release with realised detrimental / catastrophic effects ►Loss of building / major piece of equipment vital to the Trusts business continuity
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day ►Low staff morale affecting one person	►On-going low staffing level – minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality ►75% - 95% staff	►Late delivery of key objective / service due to lack of staff ►50% - 75% staff attendance at mandatory / key training ►Unsafe staffing level ►Error due to	►Uncertain delivery of key objective / service due to lack of staff ►25%-50% staff attendance at mandatory / key training ►Unsafe staffing level >5days ►Serious error due to	►Non-delivery of key objective / service due to lack of staff ►Ongoing unsafe staffing levels ►Loss of several key staff ►Critical error due to lack of staff or insufficient training

Domain	Negligible	Low	Moderate	Significant	Extreme
		attendance at mandatory / key training ►Low staff morale (1% - 25% of staff)	ineffective training / competency we removed ►Low staff morale (25% - 50% of staff)	ineffective training and / or competency ►Very low staff morale (50% – 75% of staff)	and / or competency ►Less than 25% attendance at mandatory / key training on an ongoing basis ►Very low staff morale (>75%)
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint (Stage 1) ►Minor implications for patient safety if unresolved ►Claim <£10K	►Justified complaint (Stage 2) involving lack of appropriate care ►Claim(s) between £10K - £100K ►Major implications for patient safety if unresolved	►Multiple justified complaints ►Independent review ►Claim(s) between £100K - £1M ►Non-compliance with national standards with significant risk to patients if unresolved	►Multiple justified complaints ►Single major claim ►Inquest / ombudsman inquiry ►Claims >£1M
Financial	►No obvious harm, disruption to service delivery or financial impact.	►Financial impact up to £1 million non recurrent/one off or up to £2 million over 3 years.	►Financial impact between £1 million and £3 million non recurrent/one off, or between £2million and £ 6million over 3 years.	►Financial impact between £3million and £5million non recurrent/one off or between £6 million and £1 0million over 3 years.	►Financial impact at least £5 million non recurrent/one off, or at least £10 million over 3 years.

Domain	Negligible	Low	Moderate	Significant	Extreme
Objectives/ Projects	►Interruption does not impact on delivery of patient care / ability to provide service ►Insignificant cost increase / schedule slippage	►<5% over project budget / schedule slippage	►5 – 10% over project budget / schedule slippage	►10 – 25% over project budget / schedule slippage	►>25% over project budget / schedule slippage ►Key objectives not met
Business/ Service Interruption	►Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	►Short term disruption, of >8 hours, with minor impact	►Loss / interruption of >1 day ►Disruption causes unacceptable impact on patient care ►Non-permanent loss of ability to provide service	►Loss / interruption of > 1 week. ►Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ►Temporary service closure	►Permanent loss of core service / facility ►Disruption to facility leading to significant 'knock-on' effect across local health economy ►Extended service closure
Inspection/ Statutory Duty	►Small number of recommendations	►Minor recommendations which can be	►Challenging Recommendations which can be addressed with	►Enforcement action ►Multiple breaches of statutory duty	►Multiple breaches of statutory duty ►Prosecution

Domain	Negligible	Low	Moderate	Significant	Extreme
	which focus on minor quality improvement issues ►No or minimal impact or breach of guidance / statutory duty ►Minor non-compliance with standards	implemented by low level of management action ►Breach of Statutory legislation ►No audit trail to demonstrate that objectives are being met	appropriate action plans ►Single breach of statutory duty ►Non-compliance with core standards <50% of objectives within standards met	►Improvement Notice ►Critical Report ►Low performance rating ►Major non-compliance with core standards	►Severely critical report ►Zero performance rating ►Complete systems change required ►No objectives / standards being met
Adverse Publicity / Reputation	►Rumours ►Potential for public concern	►Local Media – short term – minor effect on public attitudes / staff morale ►Elements of public expectation not being met	►Local media – long term – moderate effect – impact on public perception of Trust & staff morale	►National media <3 days – public confidence in organisation undermined – use of services affected	►National / International adverse publicity >3 days. ►MP concerned (questions in the House) ►Total loss of public confidence
Fire Safety/ General	►Minor short term (<1day) shortfall in fire safety system.	►Temporary (<1 month) shortfall in fire safety system /	►Fire code non-compliance / lack of	►Significant failure of	►Failure of multiple critical components of fire safety system

Domain	Negligible	Low	Moderate	Significant	Extreme
Security	►Security incident with no adverse outcome	single detector etc (non-patient area) ►Security incident managed locally ►Controlled drug discrepancy – accounted for	single detector – patient area etc. ►Security incident leading to compromised staff / patient safety. ►Controlled drug discrepancy – not accounted for	critical component of fire safety system (patient area) ►Serious compromise of staff / patient safety	(high risk patient area) ►Infant / young person abduction
Information Governance/ IT	►Breach of confidentiality – no adverse outcome. ►Unplanned loss of IT facilities < half a day ►Health records / documentation incident – no adverse outcome	►Minor breach of confidentiality – readily resolvable ►Unplanned loss of IT facilities < 1 day ►Health records incident / documentation incident – readily resolvable	►Moderate breach of confidentiality – complaint initiated ►Health records documentation incident – patient care affected with short term consequence	►Serious breach of confidentiality – more than one person ►Unplanned loss of IT facilities >1 day but less than one week ►Health records / documentation incident – patient care affected with major consequence	►Serious breach of confidentiality – large numbers ►Unplanned loss of IT facilities >1 week ►Health records / documentation incident – catastrophic consequence

Appendix D – Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	**Rhiannon Adey**	
Job title	Risk Manager	
Care Group / Department	Quality Governance	
Date completed	September 2023	
Who will be impacted by this policy?	☒ Staff (EKHUFT) ☐ Staff (Other) ☐ Service Users	☐ Carers ☐ Patients ☐ Relatives

Assess the impact of the policy on people with different protected characteristics. When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.		
Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	**None**	**Neutral**
Disability (please see additional information below)	**None**	**Neutral**
Gender reassignment	**None**	**Neutral**
Marriage and civil partnership	**None**	**Neutral**
Pregnancy and maternity	**None**	**Neutral**
Race	**None**	**Neutral**
Religion or belief	**None**	**Neutral**

Sex	**None**	**Neutral**
Sexual orientation	**None**	**Neutral**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	No
Did the consultation analysis reveal any difference in views across the protected characteristics?	N/A
Disability Protected Characteristic	
We need to ensure that we meet the Accessible Information Standard (AIS) which aims to support people with a disability, sensory loss or impairment to receive information they can understand and any communication support they need. For more information: https://www.ekhuft.nhs.uk/staff/clinical/accessible-information-standard-ais/ https://www.england.nhs.uk/ourwork/patients/accessibleinfo/	

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	N/A

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	N/A

Appendix E – Policy Implementation Plan

To be completed for each version of policy submitted for approval.

Policy Title:	Risk Management Policy
Version Number:	3.0
Implementation Lead:	Risk Manager

Staff Groups affected by policy:	All EKHUFT staff
Subsidiary Companies affected by policy:	None
Detail changes to current processes or practice:	Removal of Corporate Risk Register, introduction of Significant Risk Register
Specify any training requirements:	Risk Management Training as identified in section 11
How will policy changes be communicated to staff groups/ subsidiary companies?	Through Staff Zone and via risk management reports to the Board of Directors, Board sub-Committees and Clinical Executive Management Group

NHS
East Kent Hospitals University
NHS Foundation Trust

Risk Management Strategy
2023/2025

We care

Executive Summary

East Kent Hospitals University NHS Foundation Trust

- East Kent Hospital University NHS Foundation Trust is committed to proactive management of risk and on-going development of robust systems of governance and assurance.
- The Risk Management Strategy outlines our commitment to managing risks in an effective and appropriate manner to enable the provision of the highest quality of care to our patients.
- Our approach to risk management aims to be forward looking, innovative and comprehensive; to make the effective management of risk an integral part of every practice. The overall vision of the strategy is to ensure our strategic objectives are not jeopardised by risks that have not been identified and/or managed and continually improve the maturity of the risk management framework.
- We recognise that healthcare provision and the activities associated with caring for patients, employing staff and managing finances are all, by their very nature, risk activities and will therefore carry an inherent degree of risk. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust.
- The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, non-clinical, organisational or financial.
- Risk management is outlined within the Trust's overall performance management framework and informs business planning and investment decisions.

We care

Risk Statement

East Kent Hospitals University NHS Foundation Trust

- Our approach to risk management aims to be forward looking, innovative and comprehensive; to make the effective management of risk an integral part of everyday practice. The overall vision of the strategy is to continually improve the maturity of the risk management framework and ensure the Trust's strategic objectives are not jeopardised by risks that have not been identified and/or managed.

- The Trust is committed to ensuring the health and safety of patients, staff and the public through the integrated management of all aspects of governance and risk. Good governance is at the heart of controlling risk in any organisation. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, non-clinical, organisational or financial. Risk management is embedded within the Trust's overall performance management framework and informs business planning and investment decisions.

- The Trust's organisational arrangements for addressing risk management are in keeping with best practice guidance and it is recognised that a systematic approach to assessing and managing risk is essential in order to deliver high quality patient care and the health and safety of staff and the public.

- Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk. Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits.

- Senior leaders will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed. Staff will not be blamed or seen as being unduly negative for identifying risks.

- All staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks. Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally.

We care

Objectives

East Kent Hospitals University NHS Foundation Trust

- The objectives of the Risk Management Strategy are
    - to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may threaten the achievement of the Trust's objectives;
    - to improve the process of continual evaluation of risk maturity to support the Trust to become leaders in healthcare risk management;
    - ensuring that risks between partners, subsidiaries and associated companies are managed appropriately
    - to set the risk appetite for the Trust and identify a process for escalation where risks fall outside of this
    - to separate risks and issues to enable effective identification and management of risks
- These objectives will be delivered through the 2023/2025 embedding and improving plan

We care

NHS
East Kent Hospitals University
NHS Foundation Trust

Risk Appetite Statement 2023/24

Risk appetite is the level of risk that an organisation is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

- We have a **CAUTIOUS** appetite for **FINANCIAL** risks. We are prepared to accept the possibility of limited financial risk. However value for money is our primary concern.
- We have a **MINIMAL** appetite for **REGULATORY** risks. We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
- We have a **CAUTIOUS** appetite for **QUALITY** risks. Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
- We have an **OPEN** appetite for **REPUTATIONAL** risks. We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.
- We have an **OPEN** appetite for **PEOPLE** risks. We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long term gains.

We care

Risk Tolerance Levels

Risk tolerance is the predetermined upper level of risk that can be assigned to an objective. It is the level of residual risk within which the board expects sub-committees to operate and management to manage. Breaching the tolerance required escalation to the board for consideration of the impact on other objectives, competing resources, and timescales.

Financial	• The tolerance for financial risks is a moderate (10)
Regulatory	• The tolerance for regulatory risks is a low (5)
Quality	• The tolerance for quality risks is a low (6)
Reputational	• The tolerance for reputational risks is a high (16)
People	• The tolerance for people risks is a moderate (12)

Risk Maturity Assessment

East Kent Hospitals University NHS Foundation Trust

- The Trust has adopted a risk management maturity framework based on the HM Treasury Risk Management Assessment Framework and the Alarm National Performance Model for Risk Management in Public Services.

- This assessment is undertaken annually by the Board of Directors and the Care Group Leadership Team. It asks the participants to rate the Trust against seven core areas which are then aggregated to provide an overall score for the Trust. The Risk Maturity rating for 2022/23 was level 3, risk management applied consistently and thoroughly across the organisation

Levels	Description
1	Awareness and understanding (Engaging)
2	Implementation Planned and in progress (Happening)
3	Implementation in all key areas (Working)
4	Embedding and Improving (Embedded & Working)
5	Excellent capacity established (Driving)

We care

Embedding and improving in 2023/2024

East Kent Hospitals University NHS Foundation Trust

Core Risk Area	Embedding and Improving
Risk Leadership and Management	Executive Directors and Care Group Leaders are proactive in driving and maintaining the embedding and integration of risk management; in setting criteria and arrangements for risk management and in providing top down commitment to well managed risk taking to support and encourage innovation and the seizing of opportunities

Action to support	Delivery date
Revised Board Assurance Framework approved at Board of Directors	November 2023
Risk Management escalation through revised governance structure	December 2023
Risk Management training delivered to new Care Group leadership teams	January 2024

Core Risk Area	Embedding and Improving
Risk Strategy and Policy	Risk strategy and policies are communicated effectively and are an inherent feature of department policies and processes

Action to support	Delivery date
Revised Risk Management Policy and Strategy approved at Board of Directors	November 2023
Significant risk register developed and report to Board sub-Committees	December 2023
Develop a more systematic focus on progressing static risks	February 2024

Embedding and improving in 2023/24

NHS East Kent Hospitals University NHS Foundation Trust

Core Risk Area	Embedding and Improving
People	People are encouraged and supported to be innovative and are generally empowered to take well-managed risks. Most people have relevant skills and knowledge to manage risks effectively and regular training etc. is available for people to enhance their risk skills and fill any 'gaps'

Action to support	Delivery date
Risk identification workshops to take place with Care Group leadership teams	October 2023
Risk management training levels to be developed for staff depending on their roles – risk assurance, risk management, risk introduction	January 2024
Update of supporting risk management materials – user guides, handbook and summary guide	October 2023

Core Risk Area	Embedding and Improving
Partnership, Shared Risks and Resources Processes	Risk with partners and suppliers is managed consistently for key areas and across organisational boundaries

Action to support	Delivery date
Revise the risk management processes with subsidiaries to ensure effectiveness	February 2024
Work with Kent and Medway ICB to ensure system risks are adequately captured	March 2024

Embedding and improving in 2023/24

NHS East Kent Hospitals University NHS Foundation Trust

Core Risk Area	Embedding and Improving
Risk Management Processes	Management of risk and uncertainty is an integrated part of all key business processes and shown to be a key driver in the Trust's success. Best practice approaches are used and developed

Action to support	Delivery date
Revise the current risk management system to align with revised risk appetite	November 2023
Develop key risk indicators in line with risk appetite	December 2023

Core Risk Area	Embedding and Improving
Risk Handling and Assurance	Clear evidence that risks are being handled very effectively in all areas and useful for the Trust and producing clear benefits

Action to support	Delivery date
Ensure risk management is an agenda item at all key meetings as part of the governance review	January 2024
Undertake audit of risk registers across the Trust to ensure appropriate actions are in place to address the risk	February 2024

We care

Embedding and improving in 2023/24

East Kent Hospitals University NHS Foundation Trust

Core Risk Area	Embedding and Improving
Outcomes and Delivery	Very clear evidence of very significantly improved delivery of all relevant outcomes and showing positive and sustained improvement

Action to support	Delivery date
Ensure risk management is embedded as part of the business planning process	March 2024
Risk Management Internal Audit provides reasonable assurance	March 2024

The risk maturity self-assessment will be undertaken with senior leaders in December 2023, reporting to the Integrated Audit and Governance Committee in January 2024 to determine whether there are additional workstreams that can be undertaken to improve risk management further within the revised structures.

We care

Excellent capability established in 2024/25

East Kent Hospitals University NHS Foundation Trust

Core Risk Area	Excellent capability established
Risk Leadership and Management	Executive Directors and Care Group Leaders re-enforce and sustain risk capability, organisational and business resilience and commitment to excellence. They are regarded as exemplars
Risk Strategy and Policy	Risk management aspects of strategy and policymaking help to drive the risk agenda and are reviewed and improved, role model status
People	All staff are empowered to be responsible for risk management and see it as an inherent part of the Care Groups business. They have a good record of innovation and well managed risk-taking
Partnership, Shared Risks and Resources Processes	Clear evidence of improved partnership delivery through risk management and that key risks are being effectively managed. The Trust is regarded as a role model.
Risk Management Processes	Management of risk and uncertainty is an integrated part of all key business processes and shown to be a key driver in the Trust's success. Best practice approaches are used and developed
Risk Handling and Assurance	Very clear evidence that risks are being effectively managed throughout the Trust
Outcomes and Delivery	Risk management arrangements clearly acting as a driver for change and linked to plans and planning cycles

We care

East Kent Hospitals University NHS Foundation Trust

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

Committee: Extra-ordinary Integrated Audit and Governance Committee (IAGC)

Meeting date: 28 November 2023

Chair: Olu Olasode, Non-Executive Director (NED)

Paper Author: Board Support Secretary

Quorate: Yes

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
East Kent Hospitals Charity (EKHC) Annual Report and Accounts 2022/23	• The Committee reviewed the EKHC 2022/23 Annual Report and Accounts, and recommend these for approval, signing and filing by the Board. The accompanying Audit Management Representation Letter from Azets, a requirement for all audits, was also reviewed and recommended to the Board for approval and signing. • The Committee reviewed and noted the Audit Findings Report, that included two immaterial adjustments, and two recommendations, that have been accepted and action is being progressed. • The Committee commended and thanked the Charity team, for their hard work and commitment to the Charity and producing the accounts in a tight turnaround. • The Committee noted the Annual Report and Accounts had also been reviewed and approved by the Charitable Funds Committee (CFC), who recommend to the Board for approval (documents presented with the CFC Chair Assurance Report at the 7 December Board meeting.

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

Item	Purpose	Date
The Board is asked to **NOTE** this IAGC Chair Assurance Report.	Assurance	7 December 2023

We care

East Kent Hospitals University NHS Foundation Trust

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

Committee: Extra-ordinary Charitable Funds Committee (CFC)

Meeting date: 28 November 2023

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

Paper Author: Claudia Sykes, NED

Quorate: Yes

Appendices:

Appendix 1: East Kent Hospitals Charity – statutory accounts for the year ended 31 March 2023
Appendix 2: Audit representation letter
Appendix 3: Audit findings report

Declarations of interest made:

None

Assurances received at the Committee meeting:

Agenda item	Summary
East Kent Hospitals Charity (EKHC)	• The CFC reviewed the annual accounts for East Kent Hospitals Charity, and recommended these for approval, signing and filing by the Board. The Committee also reviewed the accompanying Audit representation letter from Azets, a requirement for all audits. • The Committee reviewed and noted the Audit findings report, which included two immaterial adjustments, and two recommendations, which have been accepted and will be acted upon. • I would like to thank Azets, the new auditors, for their efficient audit, having only been appointed by the Board on 5 October 2023. • I would also like to thank the Charity team, Jenny Still and Danielle Neligan, for their excellent work on the Charity accounts and a very swift turnaround. • The accounts have also been reviewed by the IAGC.

East Kent Hospitals University NHS Foundation Trust

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

Item	Purpose	Date
The Board is asked to **APPROVE** the annual Charity accounts for signing and filing.	Approval	7 December 2023
The Board is asked to **APPROVE** the audit representation letter for signing.	Approval	7 December 2023
The Board is asked to **NOTE** the contents of the Azets Audit Findings report.	For information	7 December 2023

East Kent Hospitals Charity
Registered Charity Number: 1076555

East Kent Hospitals Charity
Level 3 Trust Offices,
Kent & Canterbury Hospital,
Ethelbert Road, Canterbury,
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Tel: (01227) 868748

Email: ekh-tr.fundraising@nhs.net

ANNUAL REPORT 2022/2023

Contents

01

Foreword

It remains a challenging time for many charities, but we have continued to have amazing support from our donors, Trust staff and the local community.

Claudia Sykes, Chair of Charitable Funds Committee

Introduction from Claudia Sykes, Chair of the Charitable Funds Committee

On behalf of the Trustees, I am delighted to present the accounts for the East Kent Hospitals Charity for the financial year ended 31 March 2023.

Since joining the Trust as a Non-Executive Director in March, I have been overwhelmed by the energy, dedication, and enthusiasm of the Charity team, in raising funds and supporting activities to benefit patients and staff at the Trust. It remains a challenging time for many charities, but we have continued to have amazing support from our donors, Trust staff and the local community. Many of the amazing activities undertaken by staff and volunteers to raise funds for the Charity can be seen in the next few pages.

This year has also seen some changes at the Charity, as we enter an exciting new period. I would like to record a huge vote of thanks to Rupert Williamson, who stepped down as the Head of the Charity in 2023 – Rupert has been core to the development of the Charity over the last few years and is widely respected for his professionalism, commitment, and sense of humour. It has been a delight to work with Danielle Nelligan, who has so ably taken on the job of Charity Manager this year and is fulfilling the role with huge energy and drive. The finance team, led by Jenny Still, have continued to provide professional and flexible support. The Charity team is set to expand, to look for further fundraising opportunities and increase the Charity's income in future years.

We know that the NHS is going through a very difficult time. Funding is challenging and we face a crumbing hospital estate, and yet the need for high quality patient care is higher than ever before. Our hospitals and staff play a vital role in maintaining the health and wellbeing of the East Kent community. The extra funds raised by the Charity team are therefore vital in supporting many aspects of patient and staff wellbeing and care. We all know that a patient's experience in our hospitals is not just about the clinical outcome, but how they felt supported and cared for – and it can be the smallest things which mean a lot to a patient at their most vulnerable time. Some of those examples can be seen in the Charity's report.

None of this would be possible without the ongoing support from our donors and fundraisers – thank you all so much.

Claudia Sykes
Chair of the Charitable Funds Comittee

02

Fundraising Introduction

"We give a massive and heartfelt thank you, most particularly in the current climate, to all of those who have supported us."

We are East Kent Hospitals Charity. We are here to help your hospitals. We at East Kent Hospitals Charity are humbled by the ongoing support from our communities who give so much time and effort into raising funds for us, ensuring that we can continue to have a huge and positive impact across East Kent Hospitals.

We give a massive and heartfelt thank you, most particularly in the current climate, to all of those who have supported us.

As we continue to emerge from the pandemic we have aimed to revitalise the charity offering and visibility, allowing our supporters to make a strong brand link to the work we do, and the cause that they donate towards.

In this annual report, we celebrate our achievements during 2022-2023- from funding projects worth £810,000 to engaging with community groups across East Kent; launching innovative initiatives to support EKHUFT patients, visitos and staff, to brightening the hospital environment across the Trust.

We are delighted to showcase this account, detailing how we have put charitable funds to good use.

Many thanks to all our supporters!

From the Fundraising Team

The Role of the Charity

The core mission of the Charity is to enhance the care and treatment of patients and visitors accessing NHS services provided by East Kent Hospitals University NHS Foundation Trust, by raising funds to support the purchase of equipment and facilities which are beyond the scope of government funding.

We achieve this by involving NHS Clinicians and staff to identify and deliver projects that make a vital difference to patients, visitors and staff by:

- Enhancing the quality of patient care
- Improving the environment for patients and visitors
- Supporting NHS staff development to enable them to provide excellent clinical and patient centred care
- Providing financial support for pioneering research that has the potential to impact on the treatment and well-being of patients

The Trustees confirm that they have referred to the guidance provided by the Charity Commission with regard to the need for public benefit. They are confident that the activities which contribute to the above mission have a clear public benefit.

The Trust provides clinical services within the scope of their NHS requirements and the Charity works hard to enhance these services to benefit the patients and visitors (and therefore the public).

The Trustees are aware when making grants, of the distinction between the requirements of the NHS to provide their services and those grants made by the Charity to extend the scope of the service, either through new equipment, advanced technology and improving patient experience through the environment and/or additional activities and facilities which are not the responsibility of the NHS.

Section 13 of the Charities (Protection and Social Investment) Act 2016 does not require charities with an income of below £1 million to report on fundraising reporting. However, we are pleased to include these statements and promote openness and transparency.

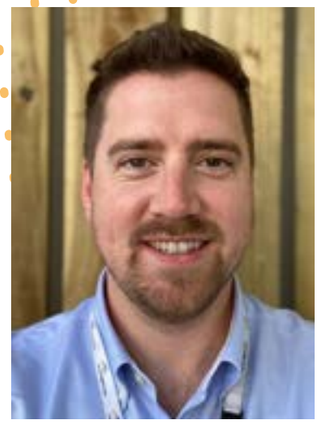
The following areas are included:

- Fundraising – the Charity does not use professional fundraisers or door-to-door fundraising. All fundraising is carried out by our fundraising team or by supporters of the charity.
- Regulation – the charity is registered with the Fundraising regulator and complies with the standards which apply to all fundraising.
- Monitoring fundraisers – The Charity has not worked with any 'On behalf of' fundraisers (including third-party fundraisers, commercial participators and volunteers).
- No fundraising complaints have been received
- All staff members must comply with the NHS Trust policies and mandatory training which includes Safeguarding, customer services and Information governance training. The Charity is fully aware of the requirements to make sure vulnerable people are protected from unreasonable intrusions on their privacy.

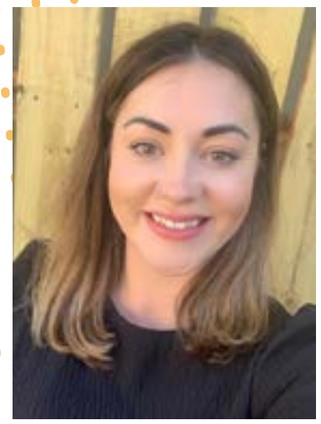
Rupert Williamson
CHARITY MANAGER

Danielle Neligan
SENIOR CHARITY OFFICER

Jenny Still
CHARITY ACCOUNTANT



Richard Stevens
ASSISTANT FINANCIAL ACCOUNTANT



Lizzie Warner
MARKETING AND PROJECTS MANAGER

03

Fantastic Fundraisers

Half Marathon Mum

Anna Slark took on a half marathon and raised £553 for the hospital teams who helped save her daughter's life. The money will go to the neonatal intensive care unit (NICU) at the William Harvey Hospital in Ashford, where her daughter Amber spent the first three months of her life.

Anna, 35, who works as a physiotherapist at the hospital, said:
"It was a healthy and low-risk pregnancy until suddenly everything changed and Amber was born by emergency caesarean section at 28 weeks, weighing just 1lb 13 ounces. When she was born I heard her cry and it was the smallest rasping noise I have ever heard, but it meant she was alive so it was such a relief.

It was one of the most stressful situations I have ever been in. I didn't know anything about the NICU – even though I work in the hospital I'd never been there or had any involvement with it, and it was a whole other world. But the staff were amazing and even though it was such a traumatic time we felt we were in really good hands and they looked after us as much as Amber. The memories from that time will always stay with us and we will forever be grateful for their care."

200 May Miles

A family raised £4,868 walking 200 miles in May to benefit the critical care unit at Kent and Canterbury Hospital who were looking after their Dad.

Nigel Avery was left paralysed and unable to breathe after being struck down by a rare illness after he contracted Covid-19. He developed Guillain-Barre Syndrome – a condition where the body's immune system attacks itself after an infection, damaging the nerves. It can disrupt signals to the brain, causing paralysis – including of the muscles needed to breathe.

His family vowed to raise money for the unit where he is being treated as a thank you to staff for nursing him back to health.

Daughter Kayleigh said: "The staff have been absolutely amazing. He is making incredible progress but it is going to take a really long time to get back to where he was."

Nigel had been planning a 100-mile sponsored walk with his beloved dog Martha before he fell ill, and his family decided to walk for him in May instead, raising money for East Kent Hospitals Charity.

Kayleigh said: "We all felt pretty useless so we thought the walk was one thing we could do for him, and we could raise money for the unit at the same time. Martha is his best friend, and they have been really missing each other. The staff realised this and managed to get him on a portable ventilator so they could bring him outside to see her. The second time they did it he had regained some movement and he was able to smile and it was the most fantastic moment.

My brother and I, and the whole family, are so grateful for the support and help the team have provided to my dad and us all. No question is too silly, no worry too small, and they have handled it all with kindness, compassion and honesty. We're overwhelmed with the amount of people who have donated and so thankful for their support in helping us say thank you to the fantastic hospital staff."

Swinging into Action

Golfers swung into action and raised a total of £6,653.53 for the breast screening unit at the Kent and Canterbury Hospital.

Lesley Johnson, 2022 Lady Captain at Canterbury Golf Club, organised a host of events for members and friends. She chose the unit after being diagnosed with breast cancer after a routine mammogram at the unit 14 years ago – and during her year of fundraising another two members were told they had cancer following appointments there.

Lesley said: "It really demonstrates why it is so important that we have this facility locally. It is something that touches everyone – whether you are someone who has a routine screening appointment there, or whether it's your partner, mother, daughter or granddaughter who does".

Lesley had the lumps removed surgically, as well as chemotherapy and radiotherapy treatment and has been well since her treatment finished in 2009. She said: "I had fantastic support from members, including those who run local businesses, who provided sponsorship and raffle prizes as well as attending the events I organised or making donations. My neighbour is the chief executive of a firm in Dover and he very generously donated £2,000 which helped us boost our total".

Members of Canterbury Golf Club will continue supporting East Kent Hospitals Charity this year, with the Lady Captain and Senior Captain choosing us as their Charity of the Year, with any money raised to go towards the dementia appeal.

Saffery Farm

Saffery Farm continued to fundraise for Padua Ward in 2022, following the treatment that the farm owner's daughter has received there. To date they have raised an amazing £5,408 from their annual pumpkin patch sales!

East Kent Hospitals Charity
Dementia Fund

Sue Supports Dementia Fund

Sue Threadingham has been a committed and passionate supporter of the Dementia Fund, and has thrown all of her energies into raising funds since 2016, mainly by selling her delicious jams, chutneys and crafted items outside her home and at various vintage fairs and shows across the county. To date, she has raised an incredible £8,585, helping East Kent Hospitals Charity to make a significant difference for patients living with dementia across EKHUFT.

Union of Catholic Mothers

We were welcomed by the Union of Catholic Mothers to their September meeting, held at Our Lady and St Benedict church, in Birchington. The UCM had selected our Dementia Fund amongst several other charities to support during 2022 and we were delighted to receive a donation of £500.

24 hour Pool Challenege

Four players chalked up an incredible 24 hours of pool in a fundraising challenge in February 2022. Matt Champ, Callum Tydeman, Sean Kirby and Kirk Knight played through the night, racking up more than £2,400 for Rainbow Ward at the Queen Elizabeth The Queen Mother Hospital.

Matt, 33, a partner at Boys and Maughan Solicitors, qualified for the World Championships in 2016 and has played on the UK Pool Tour, but said playing non-stop was gruelling: "It may not sound particularly demanding, but when you consider being on your feet for 24 hours, and then walking round the table and bending over to take a shot, as well as the mental challenges of the game, it really was a lot. I think it took about three days to really recover from the experience. But it was definitely worth it to raise so much money for such a good cause."

Matt and Callum played most of the matches, joined by Sean and Kirk as well. Matt emerged victorious, winning more than 300 games over the 24-hour period.

The money will help fund items for the children's ward to benefit young patients and their families.

Sponsored Silence for Rainbow Ward

Youngsters held a sponsored silence to raise money for poorly children at the Queen Elizabeth The Queen Mother Hospital in Margate.

Pupils in Year 3 at Monkton Primary School completed the challenge as part of their Young Leaders Award, and raised a total of £225.20 for East Kent Hospitals Charity.

The class chose to support Rainbow Ward as a way of giving something back to their community, and also wrote stories of their own experiences at the hospital to reassure other children.

These funds will ensure that we can continue to enhance the hospital experience for poorly children at Rainbow Ward, by providing toys, games, arts and crafts and other distraction items to make the hospital experience a bit less scary.

Rugby Shirt Comp

A specially designed rugby shirt was donated to the QEQM hospital during a lunch organised by Thanet Wanderers Rugby Club to say thank you to NHS staff.

The club came up with the idea during the Covid lockdown and held virtual fundraising events to gather the funds. They asked junior members to submit entries for a design competition, and young creator Tomas Hamil and his family joined the lunch to hand over the finished shirt.

More than 40 staff attended, together with members of the rugby club and Doug Hursey, Kent RFU president. A raffle was held during the lunch, raising £1,000 for local NHS charities including our own East Kent Hospitals Charity.

Christmas Day Swim

Nicola Oakley has raised an impressive £2,250 to benefit Cathedral Day Unit at Kent & Canterbury Hospital, where she works as a chemotherapy nurse educator. The donations flooded in after she took the plunge in a Christmas Day swim.

The money will be used to benefit patients and staff on the ward, and could fund items such as specialist cooling caps for those undergoing cancer treatment. The caps are worn during chemotherapy infusions and stop the drug reaching the hair follicles, helping to prevent hair loss.

Nicola said: "The caps are fantastic and help people keep their dignity and sense of self during their treatment. They aren't for everyone – some people find them too uncomfortable – but for those who can tolerate them it really does seem to work."

Team Swap Scrubs for Mud in Charity Challenge

A team from the emergency department at QEQM joined fitness instructors Darren and Julie Vilton-Tebbutt, from Body Architects, to take on the Tough Mudder challenge – a 15km course with 30 tough obstacles and plenty of mud!

They were raising money to fund improvements to their department, including a mobile phone charging unit for patients to use. The team raised more than £1800.

Joanna Williams, head of nursing for urgent and emergency care at the QEQM, said: "Everyone puts 100 per cent into their work and had the same attitude to the Tough Mudder obstacle course – and although we were tired and aching by the end we were delighted to have completed it."

Rotarians' Gift Inspired by Cancer Treatment

Rotarians have raised £2,500 for the Viking Day Unit at the QEQM, inspired by the wife of their president who had treatment there. Hazel Hedges is now clear of cancer, but husband Chris, who is president of the Rotary Club of Westgate and Birchington, chose the unit as the club's charity for the past two years.

Chris said: "Rotary and its sister organisation Inner Wheel, which Hazel is part of, is all about helping people so raising money is what we like to do. We held a race night, where wooden hobby horses, raced up the middle of a hall, with the assistance of two children, and my wife and I completed an 88-mile sponsored walk, inspired by the 88th anniversary of Inner Wheel in Kent. But most of the money was raised via door-to-door collections with Santa and his sleigh around the streets of Westgate and Birchington, so our thanks to everyone who supported that."

04

Corporate Support

ANNUAL REPORT 2022/2023

Bauvill

> This hospital means a lot to us as a company and we are delighted to be able to give something back for the benefit of staff and patients.'

Bauvill and 3 Wishes

Kent-based construction firm Bauvill, chose us as their charity of the year in 2022 and so far, have raised more than £30,700 for the charity's 3 Wishes Project.

East Kent Hospitals was the first UK trust to pilot the 3 Wishes Project, which aims to grant 'wishes' to those approaching the end of their life. These simple, personalised requests reflect the patients' interests and passions and it aims to bring comfort to them and their families.

Bauvill held their annual winter ball, which alone raised £13,000 towards funding the initiative. Director, Matt Gurr, said: 'This hospital means a lot to us as a company and we are delighted to be able to give something back for the benefit of staff and patients.'

Critical care consultant, Ruth Tighe, said: "We are totally overwhelmed with the support from Bauvill, which has enabled the project to grow and help even more families. Already more than 50 patients have benefited from the 3 Wishes Project and it is helping us practice medicine and nursing in a different way, with truly personalised care."

wwmartin
Quality Construction Since 1877

WW Martin are the contractors for the new Emergency Department Expansion at the Queen Elizabeth The Queen Mother hospital and they opted to support us as their Charity of the Year 2022.

They raised more than £5,300 for East Kent Hospitals Charity when they welcomed guests from a raft of local businesses to compete in a pro-am tournament held in association with the Kent Professional Golfers' Association at Canterbury Golf Club.

Local housebuilder, Barratt Homes, is helping to support those in critical care, thanks to a donation of £4,000 to the 3 Wishes Project at The Queen Elizabeth The Queen Mother Hospital.The housebuilder, who is building at nearby development Spitfire Green in Ramsgate, will be donating £1,000 every three months over the course of a year.

Natalie Perry, Sales and Marketing Director for Barratt Homes Kent, commented: "The 3 Wishes Project is a fundamental part of the critical care unit at The Queen Elizabeth The Queen Mother Hospital, and it is important we do what we can to provide ongoing support our local hospital and seriously ill people at this time. We know that staff at The Queen Elizabeth The Queen Mother Hospital work tirelessly to support their patients and we want to support them in the incredible work they do every day. We look forward to seeing the fantastic wishes the project can grant though out the course of the year to make a real difference to people's lives at this difficult time."

KENT CONSTRUCTION CONSULTANTS

Margate based Kent Construction Consultants took part in the Finsbury Park Tough Mudder in April 2022, raising over £4,600 for Rainbow Ward at the QEQM Hospital!

Our Helping Your Hospitals Appeal was selected as one of the causes for Co-Op's Local Community Fund, and thanks to the support of customers from the Sturry Road Funeral Care and Sturry stores, we have received £1,717 in total!

We have been supported by Kreston Reeves (Canterbury Branch) since 2020, after they donated shower gels, snacks and hand creams for staff during the pandemic. We have since been selected to be their Charity of the Year and were delighted to receive £4,098 thanks to their fundraising efforts!

05

Events


Find us on socials
@ekhcharity
East Kent
Hospitals Charity
www.ekhcharity.org.uk
Helping your local
NHS Hospitals go
further

In order to maximise the offering for our potential fundraisers, we have joined Run For Charity, who offer numerous spaces on popular local, regional and international fundraising events. As a result, we have been able to engage more fundraisers than in previous years to sign up to events such as Brighton Marathon, Colour Obstacle Rushes and London Landmarks Marathons. We hope to be able to continue to offer a rich selection of challenges to our fundraisers, using the Run For Charity platform: increasing donations and future donor engagement.

Brighton Marathon

We had three entrants into the 2022 Brighton Marathon, raising £3,973! Thank you so much, Mel, Dan, Dave and Alex!

Pride 2022

We were delighted to be able to fund Pride Packs in June, which were given to wards and departments across EKHUFT, as organised by the EDI team. We also represented the Trust and the Charity at Canterbury Pride, by marching with other NHS colleagues.

We also funded a 'trolley dash' at the Maternity Unit at the William Harvey Hospital, to raise awareness of gender-neutral language and the importance of respecting people's pronouns. It was so successful that Matron Jo Olagboyega plans to make this a regular event, and hopes to deliver sessions on disability awareness and BAME issues in the future.

Jo said: "It was prompted by the ITEMS report – Improving Trans and Non-binary Experiences of Maternity Services – by the LGBT Foundation, which found that people tend to freebirth in the community rather than access midwifery services because they feel they will be judged.

Historically, we haven't been geared up for gender-neutral care but we know that we need to change and raising awareness is key to that. I put together a folder that can be a resource for the team to help them start conversations with people using our services and make sure we are truly inclusive.

I was so impressed with the way everyone reacted; there was huge engagement and people said it was something that was much needed. Some of our students reflected that the curriculum didn't fully cover these issues so they welcomed the chance to talk about it and improve their practice.

It is just one of the ways we are working to promote positive practice and to change the culture within the department and I am so proud of the team for how they responded."

NHS Big Tea 2022

We celebrated the NHS' 74th birthday on the 5th July 2022, by hosting The Big Tea.

Reaching across all EKHUFT sites, we had the support of the Executive, Volunteering and Wellbeing teams to deliver this staff engagement initiative.

Our key message was to 'come sip with us'- encouraging staff to celebrate the NHS' birthday by having a cup of tea, courtesy of East Kent Hospitals Charity.

Our uniquely branded teabags cost £2,475.60, meaning the event cost 4.1 pence per staff member that we engaged with.

East Kent Hospitals Charity

We gave 6000 cups of tea to staff as well as numerous other branded merchandise, promoting the charity across the Trust.

47	50	15
William Harvey	QEQM	K&C

We engaged with a total of 112 departments across the acute sites.... as well as delivering goodies to Buckland Hospital and the Royal Victoria Hospital!

Our social media impact

We spent £131.21 on paid social media ads, to ensure that our communities and staff were aware of The Big Tea event.

During this campaign, an additional 3267 people viewed our social media platforms, and we had a 23% increase in visitors to our website.

NHS BIG TEA

Bollywood Bonanza

Bollywood music fans helped raise more than £5,600 for East Kent Hospitals Charity. Hundreds packed the Malthouse Theatre in Canterbury for a fundraising concert featuring Dr Rema Iyer, a consultant gynaecological oncologist for East Kent Hospitals.

They were treated to a celebration of old and contemporary Indian music, performed by her band Muzic India Ltd.

Proceeds from ticket sales, a raffle, and collection buckets raised a total of £5,601.40, which will go towards projects benefiting people with gynaecological cancer across east Kent.

Rema, who works at the Queen Elizabeth The Queen Mother Hospital in Margate, said: "I love to perform and share my passion for music, and it is even more special when we can raise money for such an important cause at the same time. I am very grateful to everyone who bought tickets and came to support us at the event, and delighted we were able to raise such a significant amount."

Festive Cheer 2022

Marketing Campaign

During the festive period we relied heavily on our social media campaign in order to raise awareness of the charity, and the giving opportunities that were available, particularly focussing on our amazon wishlists, which were very popular.

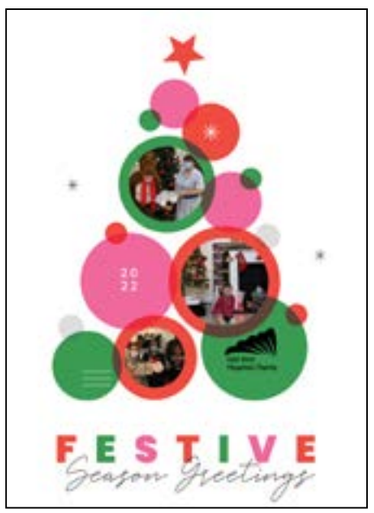
Using a festive themed video, promoted via paid ads on Instagram and Facebook, as well as regular posts and updates during the period, we got a total reach of nearly 300k!

You can find the full video here.

Cards and Baubles

We sent our Christmas Cards to over 220 of our donors and supporters of 2022.

We included a newsletter detailing our fabulous fundraisers and the projects that they enabled us to fund, as well as a sustainable Christmas decoration, which we encouraged people to take photos of, and tag us on their social media accounts- in order to increase our visibility!



Impact

We are pleased to say that we had a total of 53 donors who made festive specific donations or conducted fundraisers. (2021- 49 donors). Of these 53 donors, 29 were new to the Charity.

The physical donations of toys, games, chocolates etc totalled approximately £16,229 (2021- £3,513.83)

We had eleven financial donations from organisations, companies and individuals who had fundraised during the festive period. These donations totalled £6,662.02 (2021- £3,874.04)

The Festive Fund

As we do every year, we offered the Festive Fund to all wards, services and departments across EKHUFT and 2gether, in order that staff could decorate patient facing areas, or bring other festive cheer to patients during December.

A total of 33 wards applied for this fund, and the total cost was £2,261.56, averaging approx. £68.53 per ward. We noticed that less wards applied this year, as opposed to last, when 44 wards participated.

Stagecoach Trees

This year, we were lucky enough to be gifted three Christmas trees for our main entrances of the larger Acute sites at QEQM, WHH and KCH. Thanks so much to Stagecoach bus for our trees and decorations.

The Big Festive Walkaround

300 tubs of Cadbury Heroes

This year, we went a little bigger with our chocolate order and purchased 280 tubs, 20 were given free of charge from the lovely Charity Champions at Morrisons in Dover and Margate. The total cost to us was £1,435.98.

Alongside with the Exec Team and our Wellbeing colleagues, we visited approximately 170 wards and departments in December, across all sites, delivering a box of chocolates, and a message of thanks and gratitude from our supporters.

This was really well received by staff, and gave us an opportunity to have lots of face to face engagement, and to share the charity's aims and achievements.

Phred, Charity Champion from Morrisons Dover

Left: Lizzie with KCH Nuclear Medicine Team and Right: Chairman, Niall Dickson with medical secretary

Betsy helps Father Christmas deliver gifts to poorly children at QEQM

A schoolgirl who faced Christmas in hospital last year has raised hundreds of pounds to buy presents for youngsters in the same position. Betsy Boardman, 11, was worried Father Christmas wouldn't visit the children on Rainbow Ward at the Queen Elizabeth The Queen Mother Hospital in Margate, so decided to give him a helping hand.

With a little help from mum Sarah, the Palm Bay Primary School pupil delivered a car-full of toys to the hospital after collecting more than £1,300. Another £400-worth of gifts were ordered from a wishlist she set up for the ward.

Despite being diagnosed with mixed connective tissue disease, a collection of auto-immune disorders that includes arthritis and lupus, Betsy set herself the challenge of walking 10 miles in October 2022 to raise funds.

In the end, she completed more than double her target, clocking up 22 miles during the month – including a walk along the Thanet coastline with some of her friends and classmates.

Sarah said: "When she said she wanted to do 10 miles I was a bit worried it would be too much for her but she did fantastically well. It was a massive achievement for her and our friends and family started spreading the word and soon we had lots of people wanting to donate, so I set up a fundraising page. I was amazed to see the donations coming in, and the presents arriving from the wishlist. It started as a little pile and it just grew and grew. She was over the moon and we are so proud of her. We know how awful it is to be in hospital at Christmas, so it means a lot to be able to help other families in the same situation this year."

Betsy and her parents, together with her brother, visited the ward on her birthday to hand over the gifts to staff.

Tree Donation from NFU

NFU Mutual Ashford Tenterden and Whitfield donated two beautiful Christmas trees to the Cathedral Day Unit, at Kent and Canterbury Hospital.

Kent Fire and Rescue Service

The Crew from Margate Fire Station have fundraised during December for East Kent Hospitals Charity for a number of years, and we were thrilled to celebrate their donation of £200 for Padua Ward in January 2022. To date, they have raised £1,280.

Toy Haul

Bells were jingling on a children's ward during the festive season – but it was belly dancers, rather than Santa Claus, bringing presents.

Louisa Chibnall, Lesley Harris, and dancers from Sparkles Belly Dance Classes, handed over a haul of toys for children on Rainbow Ward at the Queen Elizabeth The Queen Mother Hospital in Margate, and for babies on the Special Care Baby Unit (SCBU) there.

Mum-of-two Louisa chose East Kent Hospitals Charity to benefit from a belly dancing show featuring her students back in October, which raised more than £1,700.

She said: "My son Reuben was born eight weeks early and spent a month on SCBU. He's now one and doing really well but we have been to Rainbow Ward several times as he is quite susceptible to chest infections. Our experience of the teams there has been absolutely fantastic and I wanted to give something back to help say thank you to the staff and help them care for other children.

We bought everything on the ward's wishlists, and also bought extra pens and colouring books as well as items for the sensory room, and some massage chairs and foot massage machines for the staff.

It was the first show we've been able to have for three years and everyone worked so hard preparing for it and it was really spectacular. I'm really grateful to everyone who helped us to raise such an amazing amount for the hospital."

Tiny Toes Festive Fundraiser

The Racing Greyhound pub in Ramsgate selected our Tiny Toes campaign as their festive fundraiser, and thanks to the support of their customers, an amazing £1,257.80 was raised for the Special Care Baby Unit at the QEQM.

Festive Light Display

The Knight family from Folkestone have selected us as their charity to support since 2021 by putting on their fabulous festive light display. This year, they raised £237 for Padua ward, thanks to donations from their neighbours who came to view the lights!

Give a Gift Campaign

KMFM and Bargain Hunters partnered in 2022 as part of their 'Give a Gift' campaign, benefitting charities and organisations supporting children and young people. We were delighted to welcome them to all three of our acute sites, and gratefully received approximately £6,000 worth of gifts for the children's wards.

06

Projects

Projects and Impact

We have funded projects worth £754,000 during 2022-23. These include funding items of innovative medical equipment, patient and staff education and welfare and improving the hospital environment.

We are guided and inspired by staff across East Kent Hospitals University NHS Foundation Trust to implement these projects and initiatives that make such an impact on patients, staff and visitors to our hospitals.

Some inputs are very small indeed - such as the provision of 'bravery stickers' for children accessing care on the wards, or providing lifelike animal teddies to patients living with dementia - but they make a very big difference. We have also been pleased to be able to continue to provide ad hoc items for patients and families accessing the 3 Wishes Project across our Critical Care Units.

Other projects are more complex, and we have detailed a wide range of examples in the following pages. We are so grateful for the support of our fundraisers, donors and communities, whose efforts ensure that we can continue to provide such meaningful projects.

3 Wishes Project

We funded a vital project aiming to bring comfort to people who die in critical care, and their families, which has now been expanded to more hospitals across the Trust.

East Kent Hospitals was the first Trust in the country to pilot the 3 Wishes Project, which launched at the William Harvey Hospital in Ashford in November 2021 and allows staff to grant 'wishes' to patients at the end of their life.

More than 30 patients have been able to benefit from the initiative, and it has now been rolled out to the Kent and Canterbury Hospital, and the Queen Elizabeth The Queen Mother Hospital in Margate, thanks to our funding.

Sarah Whitney, clinical nurse educator in the critical care unit at the QEQM, said: "Generous funding from our charity means we can create meaningful, long-lasting memories and personal keepsakes while allowing families to spend precious time together in a less clinical environment. The 3 Wishes Project will enable us to enhance the end-of-life care we deliver and to respond to family and patient wishes in a more compassionate way."

The project was founded at a hospital in Ontario, Canada, and is now used in countries across the world. Wishes can include creating a personalised environment with photos, lighting and music, making keepsakes for families, or encouraging connections with family, friends or pets.

Staff celebrated the roll-out of the project by showcasing some of the items that can be offered to families, and taking part in a trial run of hand-moulding, which is one of the most popular memories families request. Between July and November, we have spent £2,989.72 on items for the 3 Wishes Project, across the Trust.

Critical Care Infographics

We funded the infographics featured in the William Harvey Hospital Critical Care Unit, costing £6,242.

These infographic designs assist understanding of the procedures and equipment being used within the Critical Care environment, reducing anxiety for patients and visitors, and providing the staff with a useful tool to illustrate the critical care journey. Additionally, the bespoke infographic is visually engaging and enhances the otherwise empty waiting room spaces.

Wellbeing Days

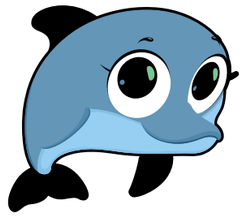
We worked closely with the team from the QEQM Emergency Department to identify how best
we can use our funds to promote wellbeing, following feedback from the team regarding their experience during the pandemic.

We funded five day long wellbeing sessions, costing £13,375: allowing the entire team to participate. The sessions were bespoke for the needs of the team and included sleep coaching, yoga, meditation, alpaca walks and an opportunity to support each other when reflecting on their experiences in ED.

Dolphin Privacy Screens

We funded privacy screens for Dolphin Ward at Kent and Canterbury Hospital, costing £2,216.

These screens offer poorly children an engaging focal point when on the ward, as well as providing privacy, particularly after they recover from a procedure.



Stroke Service Rehab Chairs

We approved funding for 18 specialist rehabilitation chairs for the stroke service at Kent and Canterbury Hospital in March 2022, costing £33,378.

Provided for the use of hyper acute, acute and neurology patients at the hospital, they provide a smart, enhanced environment, encouraging recovery and promoting effective rehabilitation for patients.

A physiotherapist who has been using these specialist chairs with their patients said:

"The chairs have been very well received and have consistently been in use since then on both the hyper acute and the acute stroke wards. They are definitely benefiting the patients as we expected. The key benefit is the increased opportunities patients have to get out of bed into a supportive chair, as before we were having to share a handful of these chairs with the entire two wards. This meant that patients were only able to sit out for short periods and not even every day. It has also meant that patients are able to leave the ward more often, either with visitors or staff. This was particularly popular in the warmer weather when they could access the wellbeing gardens at the 1937 entrance."

Hope Boxes

Children experiencing a mental health crisis can find some comfort thanks to a special box created by teams at the Queen Elizabeth The Queen Mother Hospital in Margate.

The health play specialists in the paediatric emergency department created a 'hope box', inspired by suicide prevention charity Papyrus.

We funded items in the box and it is designed to help children and young people who are upset, anxious or experiencing thoughts of suicide.

Health play specialist Lauren Clayson said: "The hope box is filled with things that can help children and young people feel better. We have included items to capture all five senses, such as stress balls, essential oils, hand cream, modelling clay, conversation cards and calming pictures.

We would like to say a huge thank you to East Kent Hospitals Charity for the funding and support."

Jo Williams, head of nursing for urgent and emergency care at the QEQM, said it was part of the package of support available to young people in crisis.

She said: "We have worked to improve how we care for people experiencing mental health difficulties, from dedicated spaces to specialist staff and additional training. The hope box is a fantastic initiative and will benefit so many young people, together with the other brilliant work our play specialists do every day with children who are worried or frightened."

Dee Neligan, senior charity officer from East Kent Hospitals Charity, said: "We were delighted to be able to fund this project. The box will make a real difference to the experience of children in the emergency department and we hope other teams will also be able to introduce it soon."

ED Phone Chargers

We installed phone chargers into the Emergency Department waiting area at QEQM hospital, following feedback from the team. Costing £9,920, the device is charity branded, and runs our marketing videos on a constant loop.

They have been incredibly popular with people presenting at ED, and between January and March 2023, 4100 people used the machine.

Charity – Plans for Future Periods

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During the period the Officers of the Charity presented to the Charitable Funds Committee (CFC) the Charity Strategy. The review and discussion set out the following key strategic aims and objectives for the period 1st April 2022 – April 2025. This reset the strategy to role the aims and objectives forward for another three-year period.

The agreed strategy aims to ensure the governance and management arrangements for East Kent Hospitals Charity (EKHC) continue to operate to an optimal standard by making the best use of resources available. The objectives and SWOT were reviewed. Members agreed the key objectives for the NHS Charity. The Charity is emerging from the COVID period as a dynamic and responsive charity, with a good site and community profile, ready to face the challenges of the changing NHS and charity landscape.

The vision for the Charity is to support the patients, visitors and staff through the services and facilities provided by the Trust. The work of the of the Charity will be promoted through strong internal links and partnerships across the communities served by the Trust.

The strategic aims are to maximise charitable income and the impact of grants to the Trust and ensure good governance and best practice in all charitable activities. The key objectives to support the Charity aims are summarised below:

- Maximising income through the investment portfolio (to monitor annual gross income from the investments to maximise return).
- Ensuring that there are robust cash planning policies and procedures in place to allow the planned reductions to the portfolio to be managed to minimise risk of financial loss.
- Ensuring that cash is invested to maximise income whilst in bank accounts which have a low credit risk.
- General awareness to increase general donations (impact reports and publicity on equipment funded by the charity).
- Gift aid.
- Improved grant application process.
- Developing a major appeal "Case for Support" in line with the Trust Cancer services plan.

The Committee received and discussed all the objectives and received assurance on the development work of the Fundraising Strategy. The trustees discussed in detail the future direction and noted the key objectives for the Charity for the next three-year period. Feedback was given by the CFC on the vision to support patients, visitors and staff. The promotion of the Charity will continue through strong internal links and partnerships across the community and key areas of focus including provision of contactless giving, enhanced branding and marketing, and upgrading the database system.

07

Financial Summary

> Without this support the work of the Charity to provide additional facilities, support to patients, relatives and staff and enhance the services provided by the Trust would not be possible.

The summary

The Charity's main source of income comes from the generosity and efforts of the public who give voluntary donations as a thank you for the care they or their friends and family receive. Donations are through fundraising, in memory of loved ones or legacies.

Without this support the work of the Charity to provide additional facilities, support to patients, relatives and staff and enhance the services provided by the Trust would not be possible.

The following figures provide an overview and are drawn from the full Annual Accounts at the back of this report.

At the end of the financial year the charity's total funds held were £2.2m, of which £1.4m was held in restricted funds and £0.8m in unrestricted funds.

Restricted funds are those which the donor has made a binding restriction on the purpose or location where their monies can be spent. Unrestricted funds reflect the wishes or expectations of the donor by supporting the service or specialty identified.

The charity's remaining funds balance is held in endowment. This fund allows the charity to spend the interest from the fund whilst holding the original value intact (capital value).

Going concern

The accounts have been prepared on a going-concern basis. The Trustees have reviewed the charity's plans and have not identified any material uncertainties relating to events or conditions that, individually or collectively, cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Where our income came from

The Charity received a total of £0.8m income for the year; an increase of £0.3m when compared with 2021/22.

The charity has worked proactively with their Investment managers – Cazenove (part of the Schroders Group) to minimise the impact of volatile markets. 2022/23 saw a disappointing net unrealised loss on investments of £0.1m (Gain of £0.2m 2021/22).

Investment income received in the year from dividends and interest £98k an improvement of £34k from 2021/22. This represented a total yield of 3.98% for the year against a benchmark performance of 3%.

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What we spent our funds on

The Charity spends the funds received in accordance with charity law, its grant making policy and respecting the wishes of the donors.

This year the Charity spent 83% (including support costs) of its total expenditure in providing equipment and supporting the wellbeing of staff and patients of the East Kent Hospitals University NHS Foundation Trust.

The Charity works hard to ensure that expenditure achieves benefits to the patients and visitors who use the facilities and the services which may not otherwise be possible within the constraint of the Trust's budgets.

Trustees consider each application (those over £25k) on merit and aim to support the patient, staff and visitor's wellbeing, experience and outcomes.

This is achieved through investment in medical equipment that provides technological advances in treatments, and supporting projects that include the equipping and refurbishment of staff and patient spaces. This often involves updating spaces for staff rest and respite, reflective spaces used by patients and their families, or rooms utilised for sensitive consultations - places where the atmosphere and environment leaves a lasting impact on the individual, their experience and wellbeing.

A summary of the categories of grants given to the Trust are listed below;

- Medical equipment £0.41m
- Building and refurbishment £0.35m
- Patient education and welfare £0.11m
- Staff education and welfare £0.03m

Accounting rules (FRS102) require that the governance and administrative costs be included in the value of the grant (charity activity) and therefore the accounts report the value of the grant plus apportioned costs of £104k (see note 3).

The Trustees review the costs on an annual basis to ensure that they reflect the requirements to administer the Charity in compliance with current legislation and effective day to day management of the funds.

The Charity is a member of the NHS Charities Together and uses their data to benchmark administration and fundraising costs. This comparison looks at NHS Charities of a similar size and geographical spread.

08

Structure, Governance & Management

The charity exists to raise and receive charity donations and covers the funds given to wards, departments and services provided by the East Kent Hospitals University NHS Foundation Trust.

The East Kent Hospitals Charity is a registered charity (number 1076555)*.

The charity exists to raise and receive charity donations and covers the funds given to wards, departments and services provided by the East Kent Hospitals University NHS Foundation Trust. The following hospitals are the primary sites although outreach and other units and clinics are supported:

- William Harvey Hospital (WHH), Ashford
- Queen Elizabeth The Queen Mother Hospital (QEQM), Margate
- Kent & Canterbury Hospital (K&CH), Canterbury
- Buckland Hospital (BHD), Dover
- Royal Victoria Hospital (RVH), Folkestone

The objectives of the Charity as stated in the governing document are:

'The Trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose relating to the National Health Service'.

At the balance sheet date, 31st March 2023, there were a total of 45 individual funds established under this Umbrella registration. Of those funds 22 are restricted, or special purpose funds and some of these are registered under the Umbrella as subsidiary charities governed by separate objects within the Charities Commission guidelines for fund expenditure. See page 69.

The Charity has one small Endowment fund, which allows only the income to be spent, whilst the capital remains invested. The remaining 22 funds are Unrestricted or Designated Funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.

The major funds within these categories are disclosed in Note 8 in the accounts. The total value of funds held at 31st March 2023 was £2.2m.

The Umbrella registration allows for a single set of consolidated accounts for all the subsidiary charities and funds held under the umbrella. However, separate accounts for each fund are maintained to enable identification of transactions and balances.

(*The charity was established in April 1999 by Declaration of Trust Deed as East Kent Hospitals NHS Trust Charitable Fund and amended by Trustee resolutions and supplemental deeds to incorporate name and structure changes.)

The contact address is:

East Kent Hospitals Charity
Level 3 Trust Offices,
Kent & Canterbury Hospital,
Ethelbert Road, Canterbury,
Kent CT1 3NG
Telephone: 01227 868748

The Trustees

East Kent Hospitals University NHS Foundation Trust (the Trust) is the Corporate Trustee, empowered by the NHS Act 2006. The Board of Directors effectively adopts the role of Trustee as defined by the Charity Commission.

Individual members of the Board are not trustees under Charity Law, but act as agents on behalf of the Corporate Trustee. The Council of Governors is responsible for the appointment of the Chairman and Non-Executive Directors (NEDs) and approving the appointment of the Chief Executive. The council of Governors are elected and appointed to post. For further details visit www.ekhuft.nhs.uk.

None of the Trustees have received reimbursements or remuneration from the Charity for either their work or expenses incurred in this financial year whilst undertaking their responsibilities for the Charity.

The following Trust Directors and Non-Executive Directors were/are members of the Charitable Funds Committee during the reported period and are considered to be the key management personnel for the charity:

Charitable Funds Committee- Executive Directors

Tracey Fletcher
CHIEF EXECUTIVE

April 2022- Present

0/4 meetings attended

Ben Stevens
CHIEF STRATEGY & PARTNERSHIPS OFFICER

March 2023- Present

1/1 meeting attended

Dr Rebecca Martin
CHIEF MEDICAL OFFICER

March 2020- May 2023

2/4 meetings attended

Liz Shutler
DIRECTOR OF STRATEGIC DEVELOPMENT AND CAPITAL PLANNING / DEPUTY CHIEF EXECUTIVE

January 2004- December 2022

2/3 meetings attended

Phil Cave
CHIEF FINANCE OFFICER

October 2017- March 2023

3/4 meetings attended

Charitable Funds Committee- Non-Executive Directors

Jane Ollis
CHAIR OF CFC/ NON-EXECUTIVE DIRECTOR

October 2021- February 2023

3/3 meetings attended

Luisa Fulci
NON-EXECUTIVE DIRECTOR

4/4 meetings attended

Claudia Sykes
CHAIR OF CFC/ NON-EXECUTIVE DIRECTOR

March 2023- Present

1/1 meeting attended

Nigel Mansley
NON-EXECUTIVE DIRECTOR

Left trust February 2023

3/3 meetings attended

Structure

Administrative Structure: Charitable Funds Committee

Acting for the Corporate Trustee, the Charitable Funds Committee (CFC) was established as a separate committee in August 2008 to provide a dedicated team to manage the affairs of the Charity independently from the business of the Trust, whilst still linking closely with its strategic objectives.

It is responsible for the management of the Charitable Fund under the Terms of Reference which are reviewed annually and updated where required to meet the changing needs of the Charity. The CFC meets routinely (quarterly) and additional meetings are held if required.

All new members of the CFC attend an induction course for Charity Trustees within 6 months of appointment unless they have proven knowledge and experience as a Trustee. Delegated signatories are provided with guidelines and information regarding the Charity to ensure they understand their responsibilities.

The CFC review the Charity's affairs as outlined below:

- Performance and management of investments
- Financial matters relating to cash management
- Charity Policies
- Management of properties
- Review grant allocations to achieve objectives
- Approval of Grants over £25k as per the Scheme of Delegation
- Recommendation of grants over £100k to the Board of Directors
- Approve Strategy
- Agree administration, fundraising and audit budget

The recommendations of the CFC are taken to the next available Board of Directors meeting for ratification. Members are required to disclose all relevant interests at the start of meetings and withdraw from decisions when a conflict of interest arises.

Officers

The Charity has 3.5 whole time equivalent (wte) staff employed by the Trust in accordance with the NHS Agenda for Change terms and conditions. Staff costs are recharged to the Charity as per budget agreed annually by the Charitable Funds Committee. Professional services and advisors are appointed by the Charity as required.

1.5 wte staff are responsible for the daily administration of the funds including applications, all financial transactions and procedures, policies and financial reporting to the CFC including the production of the Annual Accounts and Report.

The remaining 2.0 wte are employed as Fundraisers to the Charity, responsible for the management of all aspects of fundraising for the Charity including supporting internal and external fundraisers, overseeing and arranging fundraising events, volunteers and the marketing.

Advisors

Investment Managers

Schroder & Co Ltd
T/as Cazenove Capital
12 Moorgate
London
EC2R 6DA

Bankers

Lloyds Banking Group
2 City Place
Beehive Ring Road
Gatwick
RH6 0PA

Auditors

Azets Audit Services Ltd
Ashford Commercial Quarter
1 Dover Place
Ashford
Kent
TN23 1FB

Legal Advisors

Clyde & Co
St Boltolph Building
138 Houndsditch
London
EC3A 7AR

NHS Charities Together (formally Association of NHS Charities)

East Kent Hospitals Charity is an active member of the NHS Charities Together whose role is to support, and to be the voice, of all NHS Charities in England and Wales.

The principal aim of the Association is to promote the effective working of NHS Charities, collect donations made to the NHS and distribute to members via grants.

Being a member offers our Charity a wide range of support, networking and information services as well as adopting best practice across the sector.

To find out more please visit:
www.nhscharitiestogether.co.uk

09

Objectives & Activities

Grant Making Policy

The Charity makes grants from its unrestricted and restricted funds. A Scheme of Delegation is maintained for the authorisation of grants and signatories are aligned to The Trust delegated signatories.

The staff are made aware of the Trust's Standing Financial Instructions and Orders which are also applicable to the Charitable Funds. All signatories receive a monthly financial statement of all the charity's funds.

Grants are made for specific purposes and projects under an application process. All application over £25k are reviewed by the Charitable Funds Committee (CFC) to ensure that they meet the objectives of the Charity.

The CFC review the applications for quality, value for money and patient benefit. Where any expenditure is considered inappropriate feedback is provided to the applicant.
No fund is permitted to operate in an overdrawn position and although an application may be approved this may be subject to the ward or department securing the fundraising to support all or part of the project.

Risk statement

During the year the Trustees continued to review the major risks to the Charity. The Charity uses the Trust procedures and processes. These systems undergo annual audit and risk reviews and action plans to mitigate the risks.

The significant areas of risk have been identified as:

- Fall in investment capital and returns
- Reduction in income levels
- Reconfiguration of NHS services

The Trustees have mitigated these risks by:

- Retaining expert investment managers
- Maintaining a diversified low risk portfolio
- Review performance against benchmarks
- Utilise cash holdings in Short Term Deposits to maximise returns and diversify investment opportunities
- Reviewing the investment in Fundraising and analysing major and specific appeals and projects to identify effectiveness of approach and performance
- Working with the Trust to understand the changes in strategic approach to delivery of services.

In the Trustees' opinion all appropriate action has been taken to ensure the risks are mitigated.

Investment Powers

The investment powers are stated in the Declaration of Trust which provides for the following:

"To invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustees in their discretion think fit but so that the trustees:
a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;
b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures and traded options);
c) shall not have power under this clause to engage in trading ventures; and
d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments."

Investment Objective

The investment objective is to seek to maximise the total return from the fund consistent with a relatively low degree of risk. The target is to achieve a 3% return annually.

Trustees have directed the investment managers to take an ethical approach to the portfolio and that no investments should be made in the shares of tobacco producing companies and will also avoid investment in companies that have more than 10% of their turnover in:

- Alcohol Manufacture
- Armaments
- Gambling
- Pornography

The ethical restrictions are not considered to be so restrictive as to be likely to impact on long term performance.

Investment Performance

The Investment Managers were granted discretionary management powers under contract in January 2013.

The total value of the investment portfolio at 31 March 2023 was £2.5m (excluding cash of £33k). 2022/23 saw an unrealised loss on investments held of £0.1m. Dividends for 2022/23 were £98k.

The CFC monitored and reviewed the performance of the Investment Managers on a quarterly basis as part of the Finance report.

The investment managers are required to meet with the Trustees at least once in any one financial year, to explain any deviation from the anticipated rate of return in order that investment opportunities can be maximised. Investment managers are asked to explain exceptional losses and proposed recovery plans.

There is an annual review of the investment policy within the Charity Management Document to ensure that returns are maximised at medium to low risk. Unless the donor has expressed a specific request regarding investment, the investment of funds is in accordance with the Trustees Investment Act 1961.

Reserves Policy

The Trustees recognise their obligation to ensure that income received by the Charity should be spent effectively and promptly in accordance with the funds' objects.

It is however considered prudent that a minimum reserve of £0.3m should be held to cover contingencies, particularly stock market fluctuations. This sum has been identified as being equal to one year's operational costs and estimated outstanding commitments.

Charity Reserves as defined under SORP 2019 are those funds which become available to the charity to be spent at the Trustees' discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

Definition of Funds

Restricted Funds
Funds which are subject to specific trusts e.g. terms of will

Endowment Funds
Funds which are to be held as capital and only the income generated can be expended.

Designated Funds
Funds held for specific wards or services or a particular hospital in consideration of donors wishes. They do not form any binding Trust and can be transferred to general purpose funds at the discretion of the Trustees.

Unrestricted Funds
Funds which are expendable at the discretion of the Trustees, or designated in consideration of donors wishes.

The Trustees have reviewed Reserves Policy and have determined that it is necessary to retain reserves over the longer term to:

- Reduce the impact of risks from the external environment should the levels of income reduce significantly
- Continue their programme of support to the Trust.
- Hold sufficient reserves to ensure the charity can cover its ongoing operational costs to process outstanding commitments.
- Meet the cost of closure or transfer of the charity's affairs should the need ever arise

At the 31st March 2023 the reserves were identified as below:

Total Unrestricted funds £0.8m
Less property funds (0.1m)
Freely available reserves £0.7m

The level of reserves held at 31 March 2023 is £0.4m higher than the minimum requirement of £0.3m set out in the policy.

The majority of donations received are for specific wards and services and are held as designated to the Care Group or individual ward or department in recognition of the donor's wishes.

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Our Funds

Objects

The East Kent Hospitals Charity is registered with the Charity Commission (England and Wales) as an 'umbrella' charity under registration number 1076555.

Under the terms of the governing document, the Trustees can use the unrestricted funds to 'hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose relating to the NHS'.

The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the umbrella Charity. Some of these are registered with the Charity Commission as subsidiary charities of the Umbrella Charity. See Note 8.2 page 96.

Fund Structure

Where a donation is received under a legally binding trust, for example under the terms of a will, the funds are classified as restricted. Where the restriction is removed, either by the spending of original funds, or where no binding agreement is held, funds are re-classified as unrestricted and placed into general purpose funds or a fund that achieves the donor's wishes.

The Trustees periodically review balances held in designated funds to determine whether these funds are likely to be committed in the near future and the extent to which there is a continuing need identified for any particular fund(s). In the event that the need no longer exists, those funds will be redirected to the appropriate Care Group General Fund.

Further rationalisation is undertaken for individual funds that are not considered financially viable, or have the same objective as another fund. These funds will also be redirected to General Purposes or amalgamated with a similar fund.

The dissolution of special purpose funds is managed under Clause I in the governing documents, without the need for referral to the Charity Commission.

A continuing programme of rationalisation of funds is maintained to support the objectives of the Charity. Where funds have been received without forming a binding Trust they are designated to the appropriate Divisional Fund which is responsible for delivering the service and are classified as unrestricted.

Care Group Funds

The following funds are held as general-purpose funds for the wards and services managed under the clinical care group and are classified as unrestricted.

Urgent and Emergency Care incorporates the following specialties
Medicine & A&E

General & Specialist Medicine
Respiratory, Diabetes, General Medicine, Neurological Services, Cardiology, Renal, Tissue Viability, Gastroenterology Stroke , Health Care of Older People and integrated discharge team.

Surgery & Anaesthetics Services
Anaesthetics, Critical Care, Pain Services General Surgery, Urology

Upper Surgery – Head & Neck and Dermatology
Head and Neck, ENT, Maxillofacial, Ophthalmology, Breast Surgery & Dermatology.

Cancer Services
Cancer, Oncology and Blood Diseases and Haemophilia

Women's Services and Children's Services
Maternity, Child Health & Women's Health

Clinical Support Services
Pathology, Radiology Pharmacy, Audiology Therapies, Outpatients and Infection prevention & control

Registered Restricted Funds

The Charity holds funds for general purposes to benefit the specific NHS hospitals received through legacies and other binding agreements.

Buckland Hospital – Registration 1076555/5
Queen Elizabeth The Queen Mother Hospital – Registration 1076555/6
Royal Victoria Hospital – Registration 1076555/2
William Harvey Hospital – Registration 1076555/4
Kent & Canterbury Hospital - Registration 1076555/7

Other Restricted funds are held for specific purposes and/or wards and departments with the NHS Trust:

Special Care Baby Unit – William Harvey Hospital Registration 1076555/1

Heart Research – Kent and Canterbury Hospital Registration 1076555/20

Renal Unit Fund – Kent and Canterbury Hospital Registration 1076555/43

Chest Clinic – Kent and Canterbury Hospital Registration 1076555/18

Lesley Court Fund – Kent and Canterbury Hospital Registration 1076555/15

P Hall Legacy HCOOP – Kent and Canterbury Hospital Registration 1076555/12

The Trustee's Annual Report is approved and signed on behalf of the Corporate Trustee on 7 December 2023 by

Tracey Fletcher
CHIEF EXECUTIVE

Michelle Stevens
CHIEF FINANCE OFFICER

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Statement of Trustees' responsibilities in respect of the Trustees' annual report and the financial statements

Statement

Under charity law, the trustee is responsible for preparing a Trustee's Annual Report and the financial statements in accordance with applicable law and regulations. The trustee is required to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustee:

- Selects suitable accounting policies and then apply them consistently;
- Makes judgements and estimates that are reasonable and prudent;
- States whether the recommendations of the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- States whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements;
- Assesses the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Uses the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. It is responsible for keeping accounting records which are sufficient to show and explain the charity's transactions and disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. It is responsible for such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and has general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

On behalf of the Trustees;

Tracey Fletcher
CHIEF EXECUTIVE

Date: 7 December 2023

Michelle Stevens
DIRECTOR OF FINANCE & PERFORMANCE

Date: 7 December 2023

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Independent Auditors Report

Independent auditor's report to the corporate trustee of East Kent Hospitals Charitable Fund

Opinion

We have audited the financial statements of East Kent Hospitals Charitable Fund (the 'charity') for the year ended 31 March 2023, which comprise the Statement of Financial Activities, Balance Sheet, Cash Flow and notes to the financial statements, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- Give a true and fair view of the state of the charity's affairs as at 31 March 2023 and of its incoming resources and application of resources for the year then ended;
- Have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- Have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act. We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report.

We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the trustee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the charity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the charity to cease to continue as a going concern.

In our evaluation of the trustee's conclusions, we considered the inherent risks associated with the charity's business model, we assessed and challenged the reasonableness of estimates made by the corporate trustee and the related disclosures and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the corporate trustee with respect to going concern are described in the 'Responsibilities of the corporate trustee for the financial statements' section of this report.

Other information

The corporate trustee is responsible for the other information. The other information comprises the information included in the Trustee's Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

- The information given in the Trustee's Annual Report is inconsistent in any material respect with the financial statements; or
- The charity has not kept sufficient accounting records; or
- The financial statements are not in agreement with the accounting records and returns; or
- We have not received all the information and explanations we require for our audit.

Responsibilities of the corporate trustee for the financial statements

As explained more fully in the Statement of Trustees' responsibilities in respect of the Trustees' annual report and the financial statements set out on page 73, the corporate trustee is responsible for the preparation of the financial statements which give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the corporate trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the corporate trustee either intends to liquidate the charity or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at:
A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at:

www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

<u>Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud</u>

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK) .

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the charity and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (The Charities Act 2011, the Charities SORP and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' Ireland'(United Kingdom Generally Accepted Accounting Practice);

- We enquired of management and the chair of the Charitable Funds Committee concerning the charity's policies and procedures relating to:

  - the identification, evaluation and compliance with laws and regulations;

  - the detection and response to the risks of fraud; and

  - the establishment of internal controls to mitigate risks related to fraud or non compliance with laws and regulations.

- We enquired of management, the chair of the Charitable Funds Committee and internal audit as to whether they were aware of any instances of non compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the charity's financial statements to material misstatement, including how fraud might occur, by evaluating incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the risk of revenue recognition associated with voluntary income. We determined that the principal risks were in relation to:
  - Management override of controls, and in particular journal entries with characteristics we identified as high or elevated risk

  - Improper revenue recognition relating to voluntary income

  - Potential management bias in determining accounting estimates, especially in relation to the valuation of the Charity's investment properties.

- Our audit procedures involved:

  - Identifying and testing unusual journals made during the year and at the accounts production stage for appropriateness and corroboration;

  - Challenging assumptions and judgements made by management in its significant accounting estimates in respect of investment property valuations;

  - Evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions; and

  - Testing on a sample basis, donation and legacy income and gifts in kind and associated receivables to supporting documentation.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;

  - knowledge of the sector in which the charity operates; and

  - understanding of the legal and regulatory requirements specific to the charity

- In assessing the potential risks of material misstatement, we obtained an understanding of:

  - the charity's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.

  - the charity's control environment, including the policies and procedures implemented by the charity corporate trustee to ensure compliance with the requirements of the financial reporting framework.

ANNUAL REPORT 2022/2023

Use of our report

This report is made solely to the charity's corporate trustee, as a body, in accordance with Section 154 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's corporate trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its corporate trustee as a body, for our audit work, for this report, or for the opinions we have formed.

Azets Audit Services Ltd

Statutory Auditor, Chartered Accountants

Ashford

Azets Audit Services Ltd is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006.

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Statement of Financial Activities

Statement of Financial Activities for the year ended 31 March 2023

Income from	Note	Unrestricted	Restricted	Endowment	Total 2022/2023	Unrestricted	Restricted	Endowment	Total 2021/2022
	2	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Donations and legacies		192	555	0	747	185	268		453
Gifts in Kind		0	0	0	0	0	0	0	0
Investment income		52	45	1	98	28	35	1	64
Total Income		244	600	1	845	213	303	1	517
Expenditure	3								
Raising funds	3.1	(85)	(75)	(2)	(162)	(67)	(58)	(1)	(126)
Charitable Activities	3.2								
Medical equipment		(119)	(293)	(1)	(413)	(188)	(206)	(1)	(395)
Building and refurbishment		(284)	(64)	0	(348)	(178)	(177)	0	(355)
Patient Education and welfare		(31)	(79)	0	(110)	(55)	(97)	0	(152)
Staff education and welfare		(2)	(23)	0	(25)	(30)	0	0	(30)
Audit Fees		(8)	(12)	0	(20)	(21)	(20)	0	(41)
Total expenditure on Charitable Activities		(444)	(471)	(1)	(916)	(472)	(500)	(1)	(973)
Total expenditure		(529)	(546)	(3)	(1,078)	(539)	(558)	(2)	(1,099)
Net gains/(losses) on investments	5	(40)	(79)	(1)	(120)	103	124	2	229
Net movement in funds		(325)	(25)	(3)	(353)	(223)	(131)	1	(353)
Fund balances brought forward		1,154	1,363	25	2,542	1,377*	1,494*	24	2,895
Fund balances carried forward		829	1,338	22	2,189	1,154	1,363	25	2,542

The accompanying notes form an integral part of these financial statements. *Balances have been restated to correct categorisation of opening balances split between restricted and unrestricted funds: see note 14 for details.

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Balance Sheet

Balance Sheet as at 31 March 2023

	Note	Unrestricted	Restricted	Endowment	Total 2022/2023	*restated Unrestricted	*restated Restricted	Endowment	Total 2021/2022
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Fixed Assets	5								
Investments - Cazenove portfolio		826	1,617	22	2,465	1,271	1,338	22	2,631
Properties		104	0	0	104	89	0	0	89
Total Fixed Assets		930	1,617	22	2,569	1,360	1,338	22	2,720
Debtors due over one year	6	53	0	0	53	27	0	0	27
Current Assets									
Debtors due within one year	6	0	22	0	22	1	225	0	226
Cash held in investment portfolio	10	11	22	0	33	9	2	0	11
Cash at bank and in hand	10	109	213	0	322	1	176	3	180
Total Current Assets		120	257	0	377	11	403	3	417
Liabilities									
Creditors: Amounts falling due within one year	7	(274)	(536)	0	(810)	(244)	(378)	0	(622)
Total Net Current Assets/(Liabilities)		(154)	(279)	0	(433)	(233)	25	3	(205)
Total Net Assets		829	1,338	22	2,189	1,154	1,363	25	2,542
Funds of the Charity	8								
Endowment Funds	8.1	0	0	22	22	0	0	25	25
Restricted	8.2	0	1,338	0	1,338	0	1,363*	0	1,713
Unrestricted	8.3	829	0	0	829	1,154*	0	0	804
Total Funds		829	1,338	22	2,189	1,154*	1,363*	25	2,542

The accompanying notes form an integral part of these financial statements. *Balances have been restated to correct categorisation of opening balances split between restricted and unrestricted funds: see note 14 for details.

The financial statements were approved by the Trustee on 7 December 2023 and signed on its behalf by

Tracey Fletcher
CHIEF EXECUTIVE

Michelle Stevens
DIRECTOR OF FINANCE & PERFORMANCE

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Cash Flow

Cashflow as at 31 March 2023

Cash Flows from operating activities:	2022/23	2021/22
	£000's	£000's
Net cash used in operating activities	34	(348)
Cash flows from investing activities:-		
Dividends, interest and rents from investments	98	64
Proceeds from sale of investments	515	264
Purchase of investments	(492)	(304)
Charges applied to investments	9	9
Net cash provided by (used in) investing activities	130	33
Change in cash and cash equivalents in the reporting period	164	(315)
Cash and cash equivalents at the beginning of the reporting period	191	506
Cash and cash equivalent at the end of the reporting period	355	191
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	(353)	(353)
Adjustments for:-		
Gains on investments	120	(229)
Dividends, interest and rents from investments	(98)	(64)
Decrease in debtors	177	297
Increase in creditors	188	1
Net cash provided by (used in) operating activities	34	(348)

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Notes to the financial statement for the year ended 31 March 2023

Principal accounting policies

1.1 Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective date 1 January 2019, as per the October 2019 Charities SORP and the Charities Act 2011.

East Kent Hospitals Charity represents a public benefit entity as defined by FRS 102.

The Trustees consider that there are no material uncertainties about the Charity's' ability to continue as a going concern and uncertainties affecting the current year's accounts. The accounts are prepared on a going concern basis after consideration by the Corporate Trustee that there are no material uncertainties about the Charity's ability to continue as a going concern. Such consideration includes a review of committed income and expenditures, cash flows and reserves.

The Corporate Trustee does not consider that there are any sources of estimation uncertainty at the reporting date that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next reporting period.

In future years, the key risks are a fall in investment and voluntary income. Arrangements are in place to mitigate those risks (see the risk management and reserves sections).

1.2 Income: Donations, grants, legacies and gifts in kind.

All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. Income will only be deferred where terms and conditions have not been met or uncertainty exists as to whether the Charity can meet the terms and conditions within its control.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for as incoming resource once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control
- Where the amount of the legacy can be reliably estimated.
- Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is shown as a contingent asset.

Incoming resources from

Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by Trustees.

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods

1.3 Expenditure

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities.

Expenditure is recognised when the following criteria are met:
- There is a present legal or constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably. The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs and overheads from East Kent Hospitals University NHS Foundation Trust and the East Kent Finance Consortium and are apportioned on an average fund balance monthly across all funds. See note 1.1 and note 3.

Fundraising costs
The costs of generating funds are the costs associated with generating income for the charity. This will include the costs associated with investment managers, administration costs for management of investment properties and other promotional and fundraising events including any trading activities and for the salaries of the fundraisers as agreed with the Trust.

Charitable activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the Trustees and accepted by the beneficiaries. See note 3.

Analysis of grants
The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of its charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the statement of financial activities and further analysis in relation to activity is provided in note 3.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

1.4 Fixed assets: Investments fixed assets

Investments are a form of basic financial instrument. Investments held by the Trustees' investment managers are initially recognised at their transaction value and are subsequently measured at their fair (market) value as at the balance sheet date as reported by the Investment Managers (Schroders T/as Cazenove). The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the balance sheet at the current market value. The Trustees recognise that the main form of financial risk for the charity is the volatility in equity and other investment markets which are subject to global economic conditions and the investors' responses to global incidents. To minimise risk the Trustees have identified that longer term investment produces a more stable return than short term investments and holds a mixed portfolio to alleviate any single area of instability.

1.5. Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant, including expectations of future events that are believed to be reasonable under the circumstances. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. The valuation of Investment property is the most significant estimate within the accounts that has a significant risk of resulting in a material adjustment of the carrying amounts of assets and liabilities within the next financial year. The estimate is based upon the professional judgement of the Charity's valuer (as detailed in note 1.6).

1.6 Investment properties

Property assets are not depreciated but are shown at market value. Valuations are generally carried out annually by an appropriate professional. Valuation gains and losses are recorded in the Statement of Financial Activities with the balance sheet reflecting the market value at 31st March 2023. A valuation has been completed by Cushman and Wakefield professional valuers as at 31 March 2023 and in the opinion of the Trustees, the valuation remains materially accurate at 31 March 2023. The valuation is based on market value of similar residential properties adjusted to reflect the age of the tenant. This method reflects the restriction placed on the property bequeathed to the charity which prevents realisation.

Income and expenditure in respect of investment properties are reflected in the appropriate category in the Statement of Financial Activities. See notes 2 and 3.1.

1.7 Realised gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

Investment income and gains/losses are allocated monthly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.8 Cash and cash equivalents

Cash held in the bank and in hand is used to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term liquid investments usually held for a period of 3 months' notice interest bearing savings accounts. Cash held within the investment portfolio is identified in the balance sheet as reported by the investment managers.

1.9 Pensions

All the charity's staff as referenced in note 9 are employed by East Kent Hospitals University NHS Foundation Trust , with the cost of their employment being cross-charged to East Kent Hospitals Charity and are covered by the provisions of the NHS Pensions Scheme.

1.10 Irrecoverable VAT

Any irrecoverable VAT is charged to the Statement of Financial Activities.

1.11 Tax

East Kent Hospitals Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax.

1.12 Funds

The funds are classified in the accounts in three categories, Restricted, Unrestricted and Endowment Funds. Restricted Funds are funds which are to be used in accordance with specific restrictions imposed by the donor and/ or the Corporate Trustee at the inception of the fund. Unrestricted funds are those which the Corporate Trustee is free to use for any purpose in furtherance of the charitable objectives. Unrestricted funds include designated funds which are not legally restricted but which the Corporate Trustee has chosen to earmark for set purposes. Endowment funds are funds where the capital is held in perpetuity to generate income for charitable purposes and cannot itself be spent. The income earned on these funds will be categorised as restricted or unrestricted according to the restrictions imposed by the donor.

1.13 Financial Instruments

The Charity only has financial assets and financial liabilities that qualify as basic financial Instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of investments which are subsequently measured at fair value. A financial asset is derecognised when it is settled, or when the contractual rights to the cashflows expire. If substantially all the risks and rewards are transferred, the financial asset is derecognised. If substantially all the risks and rewards are retained, the financial asset is not derecognised. A financial liability is derecognised only when it is cancelled, expired or discharged.

1.14 Support, facilities and service costs

Support, facilities and service costs are those costs which do not relate directly to a single activity. These include some staff costs, facilities and costs of administration, costs of fundraising, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs and overheads from East Kent Hospitals University NHS Foundation Trust and are apportioned on an average fund balance monthly across all funds.

1.15 Recognition and valuation of Donated Goods

Donated goods, facilities and services are recognised when the Trustees have evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability.

1.16 Going concern

The financial statements have been prepared on a going concern basis which the Trustee considers to be appropriate for the following reasons:
- the business model of the charity is such but it's charitable activities are limited to those which it has sufficient funds from the excess of funding received over the costs of administering the charity.
- the Trustee has reviewed the cash flow forecast for a period of 12 months from the date of approval of these financial statements which indicate that the charity will have sufficient funds to meet it's liability.

2. Income

	Unrestricted	Restricted	Endowment	Total 2022/23	Unrestricted	Restricted	Endowment	Total 2021/22
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Donations from Individuals	174	21	0	195	151	11	0	162
Donations from groups/orgs	5	0	0	5	6	0	0	6
Grants NHS Charities Direct	0	0	0	0	0	0	0	0
Grants Other	0	207	0	207	0	0	0	0
Corporate donations	6	1	0	7	12	1	0	13
Legacies	7	319	0	326	16	256	0	272
Other income	0	7	0	7	0	0	0	0
Total Donations and Legacies	192	555	0	747	185	268	0	453
Other trading activities	0	0	0	0	0	0	0	0
Investment								
Dividends from investment portfolio	26	45	1	72	28	35	1	64
Bank Interest	26	0	0	26	0	0	0	0
Total Investment income	52	45	1	98	28	35	1	64
Other Income – Gifts in Kind	0	0	0	0	0	0	0	0
Total income	244	600	1	845	213	303	1	517

3. Expenditure

	Unrestricted Activity	Support Costs	Restricted Activity	Support Costs	Endowment Activity	Total 2022/23	Unrestricted Activity	Support Costs	Restricted Activity	Support Costs	Endowment Activity	Total 2021/22
	£000's	£000's	£000's	£000's		£000's	£000's	£000's	£000's	£000's		£000's
Raising Funds (note 3.1)												
Fundraising events	1	0	0	0	0	1	1	0	0	0	0	1
Fundraising salaries	36	0	64	0	2	102	39	0	49	0	1	89
Fundraising general	48	0	2	0	0	50	27	0	0	0	0	27
Investment - portfolio	0	0	9	0	0	9	0	0	9	0	0	9
Investment - properties	0	0	0	0	0	0	0	0	0	0	0	0
Total	85	0	75	0	2	162	67	0	58	0	1	126
Charitable Activities (note 3.2)												
Medical Equipment	110	9	259	34	1	413	167	21	183	23	1	395
Builidng & refurbishment	263	21	57	7	0	348	159	19	158	19	0	355
Patient education & welfare	29	2	70	9	0	110	49	6	87	10	0	152
Staff education & welfare	2	0	20	3	0	25	27	3	0	0	0	30
Audit Fee	0	8	0	12	0	20	0	22	0	19	0	41
Total	404	40	406	65	1	916	402	70	428	72	1	973
Total Expenditure	489	40	481	65	3	1,078	469	70	486	72	1	1,099

Support Costs £105k for 2022/2023 (£142k 2021/2022) include governance costs £33k for staff pay (£36k 2021/2022), charity membership and registration fees £2k (£1k 2021/2022), and internal audit fees £1k (£1k 2021/2022). The remainder of support costs are for staff pay and non-pay overheads to support charitable activities.

The fee for statutory audit completed by Azets Audit Services was £24k (including VAT) for a full audit opinion in 2022/2023 (£36k completed by Grant Thornton for a full opinion 2021/2022).

4. Net Movement in Funds

	Unrestricted Funds	Restricted Funds	Endowment Funds	Total 2022/23	Unrestricted Funds	Restricted Funds	Endowment Funds	Total 2021/22
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Net resources of general donations and fundraising	(3)	(9)	(3)	(332)	(354)	(290)	(2)	(646)
Net gain from fundraising events	1	0	0	1	0	0	0	0
Net loss from investment opportunities	0	0	0	0	0	0	0	0
Net gain from investment portfolio/bank	52	45	1	98	28	35	1	64
Gains & losses on investment assets	(40)	(79)	(1)	(120)	103	124	2	229
Unrestricted funds	(325)	(25)	(3)	(353)	(223)	(131)	1	(353)

5. Analysis of Fixed Asset Investments

2022/2023 Investments	Portfolio	Invested Properties	Total fixed assets
	£000's	£000's	£000's
Market value at 1st April 2022	2,631	89	2,720
Less: Disposals at carrying value	(492)	0	(492)
add: Acquisitions - less cash	493	0	493
Net gain/loss on revaluation and sale	(157)	15	(142)
Charges applied to capital	(9)	0	(9)
Market value at 31 March 2023	2,465	104	2,569

2021/2022 Investments	Portfolio	Invested Properties	Total fixed assets
	£000's	£000's	£000's
Market value at 1st April 2021	2,380	80	2,460
Less: Disposals at carrying value	(264)	0	(264)
add: Acquisitions - less cash	304	0	304
Net gain/loss on revaluation and sale	220	9	229
Charges applied to capital	(9)	0	(9)
Market value at 31 March 2022	2,631	89	2,720

	31 March 2023	31 March 2022
Uk Equities	404	545
Int equities	1,088	1,100
Other assets	554	596
Bonds	419	390
Total Portfolio	2,465	2,631

Material Investments held as part of Portfolio	31 March 2023
	£000's
Charities Property Fund	233
Schroder Sterling Corporate Bond Fund	120
Fidelity Global Dividend Fund	148
JPM US Equity Income Fund	213
Vanguard S&P 500 UCITS ETF	200
SUTL Cazenove Charity UCITS Fund	298

6. Analysis of Debtors

Accrued Income	Unrestricted Funds	Restricted Funds	31st March 2023 Total Funds	Unrestricted Funds	Restricted Funds	31st March 2022 Total Funds
	£000's	£000's	£000's	£000's	£000's	£000's
Amounts falling due within one year:						
Prepayments	0	15	15	0	0	0
Legacies	0	0	0	0	223	223
Other Debtors	0	7	7	1	2	3
Amounts falling due over one year:						
Loan for property maintenance	53	0	53	27	0	27
Total debtors	53	22	75	28	225	253

Debtors are monies due to the Charity which have been identified but not yet received.

The Charity has a long term arrangement for upkeep of a property which is held in Trust in equal shares with the Margate Civic Society.

The Charity pays for maintenance and insurance and charges against the estate at agreed rate of interest on funds expended which will be recovered from the estate on distribution, which is subject to a life tenancy and interest.

7. Analysis of Creditors

	Unrestricted Funds	Restricted Funds	31st March 2023 Total Funds	Unrestricted Funds	Restricted Funds	31st March 2022 Total Funds
	£000's	£000's	£000's	£000's	£000's	£000's
Amounts falling due within one year:						
Trade creditors	0	3	3	0	11	11
Audit	26	30	56	30	38	68
East Kent Hospitals University NHS Foundation Trust	248	503	751	214	329	543
Total creditors falling due within one year:	263	547	810	244	378	622

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

8. Details of Funds

8.1 Analysis of Funds

Endowment Funds	Balance 31st Mar 2022	Income	Expenditure	Transfers	Gains & Losses	Balance 31st Mar 2023
	£000's	£000's	£000's	£000's	£000's	£000's
KCH Longbotham	25	1	(3)	0	(1)	22
Total	25	1	(3)	0	(1)	22

8.2 Restricted Funds

Name of fund	Balance 31st Mar 2022 £000's	Income £000's	Expenditure £000's	Transfers £000's	Gains & Losses £000's	Balance 31st Mar 2023 £000's
QEQM General Purposes	683	193	(281)	0	(45)	550
KCH Mermikedes ITU	129	3	(20)	0	(7)	105
WHH Celia Blakey Unit	58	178	(19)	0	(12)	205
Ophthalmology fund	0	196	0	0	0	196
Others*	493	30	(226)	0	(15)	282
Total	1,363	600	(546)	0	(79)	1,338

8.3 Unrestricted Funds

Name of fund	Balance 31st Mar 2022 £000's	Income £000's	Expenditure £000's	Transfers £000's	Gains & Losses £000's	Balance 31st Mar 2023 £000's
EKHT Umbrella General Fund	284	47	(209)	0	(14)	108
QEQM Property Fund	173	27	(55)	0	15	160
EKHT Urgent & Emergency Care	86	3	(20)	0	(5)	64
QEQM Viking Day Oncology Fund	190	22	(16)	0	(11)	185
EKHT Surgery & Anaesthetics	70	1	(5)	0	(4)	62
Others*	351	144	(224)	0	(21)	250
Total	1,154	244	(529)	0	(40)	829

• Balances have been restated to correct categorisation of opening balances split between restricted and unrestricted: see note 14 for details.

8.4 Details of Material Funds

Endowment Funds

Name of Fund	Description of the nature and purpose of each fund
KCH Longbotham	Promoting any charitable purpose related to Kent & Canterbury Hospital services as Trustees see fit

Restricted Funds

Name of fund	Description of the nature and purpose of each fund
QEQM General Purpose	Any Charitable purpose relating to NHS wholly or mainly for Queen Elizabeth Hospital
Ophthalmology Fund	Purchase of Ophthalmology screening system
KCH Mermikedes ITU	ITU Charitable purposes relating to Intensive Care Unit Kent & Canterbury Hospital
WHH Celia Blakey Unit	Charitable purposes relating to NHS & provision of additional equip & staff training

Designated Funds

Name of fund	Description of the nature and purpose of each fund
EKHT Umbrella General Fund	Any Charitable purpose relating to East Kent Hospitals
QEQM Property Fund	Any Charitable purpose relating to NHS wholly or mainly for Queen Elizabeth Queen Mother Hospital
EKHT Urgent & Emergency Care	Any Charitable purpose relating to NHS & purchase of equipment & staff training
QEQM Viking Day Oncology Fund	Any Charitable purpose relating to NHS & purchase of equipment & staff training
EKHT Surgery & Anaesthetics	Any Charitable purpose relating to NHS & purchase of equipment & staff training

9. Staff Costs

	31st Mar 2023 Total £000's	31st Mar 2022 Total £000's
Salaries & Wages	131	129
Social Security Pensions	14	13
Pension	15	14
Total Staff Costs	160	156

	31st Mar 2023 Total £000's	31st Mar 2022 Total £000's
Average Number of Employees:		
Raising Funds	2.0	2.0
Charitable Activities	1.5	1.5
Total	3.5	3.5

No individual member of staff received emoluments exceeding £60k (No members of staff received emoluments exceeding £60k in 2021/2022). All staff members are employees of EKHUT and their salaries are apportioned to the Charity based on the portion of their time contributing to the activities of the Charity.

Staff members belong to the NHS Pension Scheme which is an unfunded defined benefit scheme which is accounted for as a defined contribution scheme. The recharge from East Kent Hospitals University NHS Foundation Trust to the Charity includes the contributions to that scheme. For more information on the NHS Pension Scheme refer to the East Kent Hospitals NHS Foundation Trust annual report and accounts.

As corporate Trustee, members of East Kent Hospitals University NHS Foundation Trust Board the give their time freely and receive no remuneration for the work that they undertake in relation to East Kent Hospitals Charity.

10. Analysis of Cash and Cash Equivalents

	31st Mar 2023 Total £000's	31st Mar 2022 Total £000's
Cash in hand	322	180
Cash held in investment portfolio	33	11
Total	355	191

Additional Notes

11. Meeting Fund Objectives

The Trustees review all unrestricted and restricted funds to ensure that there is a need and can meet the restriction of those funds.

12. Related party transactions

During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material
transactions with the East Kent Hospitals Charity.

The Charity has made revenue and capital payments to the East Kent Hospitals University NHS Foundation Trust where the Trustees are also members of
the Trust Board. The charity had a creditor of £0.8m as at 31/03/2023 (£0.6m 31/03/2022) and expenditure of £0.9m for 2022/2023 (£1.1m 2021/2022).

The charity had also had a debtor £7k as at 31/03/2023 (£nil as at 31/03/2022).

13. Charity Tax

East Kent Hospitals Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes. (The charity met the same tax definition in 2021/2022)

14. Prior Period Adjustment

	Restricted Funds Previously Reported 31 March 2022	Adjustments Made to Opening Balances	Restricted as at 1 April 2022
	£000's	£000's	£000's
Restricted Funds	1,713	(350)	1,363
Unrestricted Funds	804	350	1,154

The prior period adjustment has been made to correct an error in the disclosure of funds in the 2022 financial statements within note 8 and corrects the restricted and unrestricted funds previously reported.

18. Events after the End of The Reporting Period

There have been no events after the reporting period.

East Kent Hospitals Charity
Registered Charity Number 1076555

East Kent Hospitals Charity
Level 3 Trust Offices,
Kent & Canterbury Hospital,
Ethelbert Road, Canterbury,
Kent CT1 3NG
Tel: (01227) 868748

Email: ekh-tr.fundraising@nhs.net

Registered with FUNDRAISING REGULATOR

East Kent Hospitals University NHS Foundation Trust

Azets Audit Services Limited
5th Floor Ashford Commercial Quarter
1 Dover Place
Ashford
Kent
TN23 1FN

Re: East Kent Hospital Charity

Date: 28 November 2023

Dear Sirs

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your audit of the charity's financial statements for the year ended 31 March 2023. These enquiries have included inspection of supporting documentation where appropriate and are sufficient to satisfy ourselves that we can make each of the following representations. All representations are made to the best of our knowledge and belief.

GENERAL

1. We have fulfilled our responsibilities as trustees, as set out in the terms of your engagement letter dated 25 September /2023 under the Charities Act 2011, for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (UK Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view and for making accurate representations to you.
2. All the transactions undertaken by Charity have been properly reflected and recorded in the accounting records.
3. All the accounting records have been made available to you for the purpose of your audit. We have provided you with unrestricted access to all appropriate persons within the Charity, and with all other records and related information requested, including minutes of all management and trustee meetings.

ADJUSTMENTS & DISCLOSURES

4. The financial statements are free of material misstatements, including omissions.
5. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. (See the Audit Findings Letter for details of such uncorrected misstatements).
6. We have reviewed and approved all disclosures made in the financial statements and we are not aware of any other matters which require disclosure in order to comply with the requirements of the Charities Act 2011 or UK Generally Accepted Accounting Practice.

INTERNAL CONTROL AND FRAUD

7. We acknowledge our responsibility for the design, implementation and maintenance of internal control systems to prevent and detect fraud and error. We have disclosed to you the results of our risk assessment that the financial statements may be misstated as a result of fraud.
8. We have disclosed to you all instances of known or suspected fraud affecting the charity involving management, employees who have a significant role in internal control or others that could have a material effect on the financial statements.
9. We have also disclosed to you all information in relation to allegations of fraud or suspected fraud affecting the charity's financial statements communicated by current or former employees, analysts, regulators or others.

We care

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

ASSETS AND LIABILITIES

10. The charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets except for those that are disclosed in the notes to the financial statements.
11. There were no changes in fixed assets during the period ended 31 March 2023 other than those disclosed in the accounts.
12. All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as appropriate.
13. We have no plans or intentions that may materially alter the carrying value and, where relevant, the fair value measurements or classification of assets and liabilities reflected in the financial statements.
14. We confirm that all bank accounts have been disclosed to you and are included within the financial statements.
15. We confirm that the charity has not contracted for any capital expenditure other than as disclosed in the financial statements.

ACCOUNTING ESTIMATES

16. The methods, data and significant assumptions used by us in making accounting estimates, and their related disclosures, are appropriate to achieve recognition, measurement and disclosure that is reasonable in the context of the applicable financial reporting framework.

LOANS AND ARRANGEMENTS

17. The charity has not granted any advances or credits to, or made guarantees on behalf of, trustees other than those disclosed in the financial statements.

LEGAL CLAIMS

18. We have disclosed to you all claims in connection with litigation that have been, or are expected to be, received and such matters, as appropriate, have been properly accounted for and disclosed in the financial statements.

LAWS AND REGULATIONS

19. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements and disclosures, including non-compliance matters:
    a. Involving financial impropriety;
    b. Related to laws or regulations that have a direct effect on the determination of material amounts and disclosures in the charity's financial statements;
    c. Related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the charity's business, its ability to continue in business, or to avoid material penalties; and
    d. Involving management, or employees who have significant roles in internal control, or others.
20. We are unaware of any known or probable instances of non-compliance with the requirements of regulatory or governmental authorities, including their financial reporting requirements, and there have been no communications from regulatory agencies or government representatives concerning investigations or allegations of non-compliance, other than those already disclosed.

RELATED PARTIES

21. Related party relationships and transactions have been appropriately accounted for and disclosed in the financial statements. we have disclosed to you all relevant information concerning such relationships and transactions and we confirm that such information is complete. We are not aware of any other matters which require disclosure in order to comply with the requirements of company law or accounting standards.
22. All transactions undertaken with related entities are at arm's length.

We care

East Kent Hospitals University NHS Foundation Trust

SUBSEQUENT EVENTS

23. All events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed.

GOING CONCERN

24. We believe that the charity's financial statements should be prepared on a going concern basis on the grounds that the existing cash reserves will be more than adequate for the Charity's needs.

25. We also confirm our plans for future actions required to enable the charity to continue as a going concern are feasible.

26. We have considered a period of twelve months from the date of approval of the financial statements. We believe that no further disclosures relating to the charity's ability to continue as a going concern need to be made in the financial statements.

GRANTS AND DONATIONS

27. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of income.

DISCLOSURE OF INFORMATION TO THE AUDITOR

28. We acknowledge our legal responsibilities regarding disclosure of information to you as auditor and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware.

29. Each trustee has taken all the steps that they ought to have taken as a trustee in order to make themselves aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

.....

Signed on behalf of the Board of Trustees by:

Trustee :

Date:

We care

Audit findings report

East Kent Hospitals Charity

Year ended 31 March 2023

Strictly Private & Confidential

The Board of Trustees
East Kent Hospitals Charity
Kent and Canterbury Hospital
Trust Offices
Ethelbert Road
Canterbury
CT1 3NG

Our ref: MW/CDL/C-10016361
20/11/2023

Dear Sirs

East Kent Hospitals Ch larity
Audit findings for the year ended 31 March 2023
This Audit Findings Report highlights the significant findings arising from the audit for the benefit of those charged with governance. We appreciate that you may be aware of some of the matters contained in this report, however as required by International Standard on Auditing (UK) 260 we are communicating them to you formally.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (UK) (ISAs UK)), which is directed towards forming and expressing an opinion on the financial statements. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities, including those in respect of the preparation of financial statements.

There is more detail in respect of the responsibilities of the auditor and those charged with governance within our engagement letter. Our standard terms and conditions can be found at https://www.azets.co.uk/terms-of-business.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed primarily for the purpose of expressing our opinion on the financial statements. We do not accept any responsibility for any loss occasioned to any third party acting or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We would like to take this opportunity to record our appreciation for the kind assistance provided by your team during our audit. If we can be of any further assistance, please contact Michelle Wilkes.

Yours faithfully

Azets Audit Services Limited

Azets Audit Services

Contents

1. Executive summary

Audit overview

This table summarises the significant matters arising from the statutory audit of East Kent Hospitals Charity for the year ended 31 March 2023 for those charged with governance.

Audit opinion	We do not propose any modifications to our audit opinion which is unqualified. We have no matters to report regarding the adoption of the going concern basis or inadequate disclosures relating to material uncertainties. Our audit work is substantially complete and there are currently no matters which would require modification of our audit report, subject to the outstanding matters below: • Receipt of signed management letter of representation • Receipt of signed financial statements • Receipt of going concern assessment • Receipt of final PBSE information
Key findings on audit risks and other matters	We have reported our significant audit findings on pages 1-8. There were no audit adjustments made which impact the overall profit figure submitted for audit. We are pleased to report that the audit progressed well from our perspective and in accordance with the agreed timetable.
Audit adjustments	We are required to communicate all potential adjustments, other than those considered to be clearly trivial, to management and to request that management corrects them. Audit adjustments proposed can be seen in the reconciliation to accounts below. Consolidation, presentational and reclassification adjustments were proposed and accepted by management. The aggregate impact of unadjusted misstatements on the profit and loss account, were they to be processed, would result in a combined decrease to the profit of approximately £2,547 which is immaterial to the financial statements. All unadjusted differences are collectively and individually under materiality.
Accounting systems and internal controls	We have applied our risk based methodology to your audit. This approach requires us to document, evaluate and assess your business processes and internal controls relating to the financial reporting process. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we have reported these to you on page 7. No material weaknesses or significant deficiencies were noted.

2. Significant audit findings

This section of our report includes a summary of significant audit findings relating to significant risk areas identified at planning and other risk areas that required special consideration or arose during the course of the audit.

Significant risk areas identified at planning

Significant risks are risks that require special audit consideration and include identified risks of material misstatement that:

- our risk assessment procedures identified as being close to the upper range of the spectrum of inherent risk due to their nature and a combination of the likelihood and potential magnitude of misstatement; or
- are required to be treated as significant risks due to requirements of ISAs (UK), for example in relation to management override of internal controls.

Significant risks at the financial statement level

This section of our report includes a summary of significant audit findings relating to significant risk areas identified at planning and other risk areas that required special consideration or arose during the course of the audit.

Significant risk areas identified at planning

Significant risks are risks that require special audit consideration and include identified risks of material misstatement that:

- our risk assessment procedures identified as being close to the upper range of the spectrum of inherent risk due to their nature and a combination of the likelihood and potential magnitude of misstatement; or
- are required to be treated as significant risks due to requirements of ISAs (UK), for example in relation to management override of internal controls.

Significant risks at the financial statement level

Conclusions in relation to significant risks of material misstatement identified at the financial statement level are set out below. These are those risks considered to have a pervasive impact on the financial statements as a whole and potentially affect many assertions for classes of transaction, account balances and disclosures.

- Management override of controls – no unusual transactions were noted from review of adjustments including journals.
- Going concern – no issues were identified from review of the Charity's going concern assessment.

Significant risks at the assertion level for classes of transaction, account balances and disclosures

Conclusions in relation to significant risks of material misstatement identified at the assertion level for classes of transaction, account balances and disclosures are as follows:

- Fraud in revenue recognition – no issues were noted from audit procedures undertaken in relation to revenue recognition.
- Existence and recognition of restricted income – no issues were noted
- Existence and recognition of legacy income – no issues were noted from substantive audit testing undertaken in relation to legacies received during and after the period under review.
- Existence and recognition of donations and associated gift aid (where applicable) – no issues were noted
- Existence and recognition of restricted expenditure – no issues were noted from substantive testing undertaken on expenditure, including the recognition of restricted expenditure.
- Tracking of grant payable commitments – no issues were noted from detailed review of Charity's records in relation to grant commitments.

3. Going concern

As auditors, we are required to “obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern” (ISA (UK) 570).

Management’s assessment of going concern

East Kent Hospitals Charity has prepared its financial statements on the going concern basis. Management believe that the financial statements should be prepared on the going concern basis on the grounds that existing cash reserves or current and future sources of funding or support will be more than adequate for the charity's needs.

Management’s assessment covers a period of at least 12 months from expected date of approval of the accounts

Audit work performed

ISA 570 (revised) specifies mandatory procedures that we are required to carry out on going concern.

Our audit procedures performed include:

Review of meeting minutes

Review of management’s procedures for assessing going concern

Review of balance sheet liquidity & solvency

Review of compliance with key laws and regulations

Disclosures

We have reviewed the disclosures set out in the financial statements.

Conclusion

We concur with management’s assessment that it is appropriate to continue to adopt the going concern basis and there are no material uncertainties relating to going concern which should be disclosed in the financial statements.

4. Audit communication

Materiality

Whilst our audit procedures are designed to identify misstatements which are material to our audit opinion, we also report to those charged with governance and management any uncorrected misstatements of lower value errors to the extent that our audit identifies these.

Under ISA (UK) 260 'Communication with those charged with governance', we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA (UK) 260 defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria.

An omission or misstatement is regarded as material if it would reasonably influence the users of the financial statements. The assessment of what is material is a matter of professional judgement and is affected by our assessment of the risk profile of the business and the needs of the users.

Accounting policies

The accounting policies used in preparing the financial statements are unchanged from the prior year. These have been deemed appropriate for the audited period.

Presentation and disclosures

Our work included a review of the adequacy of disclosures in the financial statements and consideration of the appropriateness of the accounting policies and estimation techniques adopted by the entity. We identified a number of reclassification adjustments and some minor presentational issues in the financial statements, and these have all been amended by management.

Overall, we found the disclosed accounting policies, significant accounting estimates and the overall disclosures and presentation to be appropriate.

Fraud and suspected fraud

We have discussed the risk of fraud with management. We have not been made aware of any incidents in the period nor have any incidents come to our attention as a result of our audit testing.

Our work as auditor is not intended to identify any instances of fraud of a non-material nature and should not be relied upon for this purpose. In the event that the trustees wish to obtain enhanced assurance with regard to the effectiveness of internal control in preventing and detecting fraud we should be happy to provide additional services.

Written representations

We will present the final letter of representation to the Board to sign at the same time as the financial statements are approved.

Related parties

We are not aware of any related party transactions which have not been disclosed.

5. Unadjusted misstatements

Unadjusted audit differences

Our summary of unadjusted audit differences is presented below. We have discussed these with management and confirmed that all unadjusted differences are collectively and individually under materiality.

No	Detail	Assets	Liabilities	Equity	Profit / (loss)
Details of unadjusted audit differences		**Dr / (Cr) £**	**Dr / (Cr) £**	**Dr / (Cr) £**	**Dr / (Cr) £**
1	Missing VAT on prepayment	£1,453			(£1,453)
2	Under accrual for audit fees (late timing of Azets formal appointment)		(£4,000)		£4,000
Total		£1,453	(£4,000)		£2,547

6. Internal controls

Control environment

The purpose of the audit was for us to express an opinion on the financial statements. The audit included consideration of internal controls relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. Our audit is, therefore, not designed to identify all control weaknesses and the matters reported below are limited to those deficiencies that we have identified during the audit.

Follow up on prior year control recommendations

As part of our audit process, we have specifically followed up on control weaknesses and recommendations either raised in last year's report or carried forward from prior reports.

Control weaknesses and recommendations

Control weaknesses and recommendations identified from our current year work are summarised below. The control weaknesses are categorised into three risk ratings as shown in the key.

Key

1. Significant deficiency
2. Other deficiency
3. Other observations

Table of control weaknesses and recommendations

Risk rating	Control weakness identified	Implication	Recommendation	Management Response
1	Costs incurred in relation to the investment property are included within charitable expenditure. The expenditure should be allocated to the category, which is linked to the property classification, that is, raising funds.	There is potentially some non-compliance with the Charity SORP reporting requirements for this element of expenditure.	We recommend that going forward management review this accounting treatment and reclassify investment property costs to the raising funds section of the SOFA.	Management will review and reclassify in line with recommendation within 2023/2024 accounts.
2	The interest rate that the Charity receives on the property maintenance loan is set at 0.75%. Given the increases in the Bank of England base rate in 2022/23, this is no longer a market rate.	The Trustees of the charity are responsibly for safeguarding the assets of a charity and if investing the assets, yielding the best financial return within the level of risk	We recommend that management seek to find a mechanism to increase the interest on the maintenance loan.	Management will engage with the charity's legal advisors to discuss options to amend the rate of interest agreed with the Margate Civic Society.

		considered to be acceptable. Unless a programme related investment, this would be at least receiving a market level of return on the maintenance loan.	

7. Independence and ethics

In accordance with our profession's ethical requirements and further to our audit planning letter issued confirming audit arrangements there are no further matters to bring to your attention in relation to our integrity, objectivity, and independence.

We confirm that Azets Audit Services and the engagement team complied with the FRC's Ethical Standard.

We confirm that all threats to our independence have been properly addressed through appropriate safeguards and that we are independent and able to express an objective opinion on the financial statements.

Audit and non-audit services

The following services were provided in the year to 31 March 2023.

Audit services	Fees 2023 £	Fees 2022 £
Audit of charity	£20,000 + VAT	N/A


AZETS

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Maternity Incentive Scheme Year 5 Submissions – Report from Maternity and Neonatal Assurance Group (MNAG)

Meeting date: 7 December 2023

Board sponsor: Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Director of Midwifery (DoM)

Appendices:

Appendices Provided in Reading Room (Documents for Information)
Appendix 1: Maternity Dashboard
Appendix 2: Perinatal Quality Surveillance Tool (PQST)
Appendix 3: Maternity Workforce
Appendix 4: Obstetric Workforce
Appendix 5: Care Quality Commission (CQC) Update
Appendix 6: Maternity and Neonatal Improvement Programme (MNIP)
Appendix 7: Training Update
Appendix 8: Avoiding Term Admissions into Neonatal Units (ATAIN) Report

Executive summary:

Papers for discussion /approval	Summary
Maternity Dashboard	**Maternity Dashboard presented for the period October 2023** Paper highlighting areas of positive performance and areas for improvement that the team are currently addressing: • The rate of reportable neonatal and perinatal deaths remains lower than the Trust comparator group average. The rolling 12 month Stillbirth rate is now at 1.57 per 1000 births compared to the comparator average of 3.92/1000. • The extended perinatal rate (Stillbirths and Neonatal deaths up to 28 days) is now at 2.62 per 1000 births compared to the comparator average of 5.87 per 1000 births. • There was sadly one incidental maternal death - the woman was not pregnant at the time and unrelated to maternity care. • One:One care in labour and the supernumerary status of the coordinator were both achieved in month and 100% compliant. • Some workforce metrics are falling below required thresholds however which is linked to staffing challenges. Safeguarding training increased to 86% compliance.

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October Perinatal Quality Surveillance Tool (PQST)	**The PQST was presented for the month of October 2023** The metric contained in this paper is a sub-set of the maternity dashboard and provided detail on the Serious Incidents (SIs), lessons learnt and feedback from families. Currently the area of concern remains on standard 8 in relation to PRactical Obstetric Multi-Professional Training (PROMPT) due to anaesthetic workforce challenges. Anaesthetic training compliance for PROMPT increased to 83% for consultant attendance and has fallen for all other anaesthetic staff with the Clinical Negligence Scheme for Trusts (CNST) threshold now being 80%. The Medical Director and DoM are working with the Anaesthetic Team to progress compliance. There were four reported Moderate harm incidents in October, three at Queen Elizabeth the Queen Mother Hospital (QEQM) and one at William Harvey Hospital (WHH). Two Healthcare Safety Investigation Branch (HSIB) referrals for the month of October. Two SIs reported for maternity in September. Friends and Family Test (FFT) received a 12% response rate.
CNST Safety Action (SA) 5 Maternity Workforce Review	A six-monthly workforce paper was presented in compliance with CNST SA 5. The report demonstrated compliance with all five elements of the 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 five reporting period. It was noted that a full birthrate plus review is currently underway and the findings of this will be included in the next Board report
Obstetric Workforce Review	A review of the sustainable model for the obstetric workforce has taken place. This has resulted in a number of actions including:

	1) A review of the 24 hour consultant on call rota at the WHH. This has led to a proposed change to the 24 hour on call rota at WHH which will start in January 2024. There have been previous discussions with National Maternity Improvement Director for NHS England (NHSE) who is supportive of this change. 2) Development and submission of a business case for four additional middle grades (trainees). (Required discussion with Kent, Surrey, Sussex (KSS)) This will facilitate the development of a two tier on call rota for the WHH. 3) Development of a new 'Portfolio pathway to specialist register Certificate of Eligibility of Specialist Registration (CESR) post as part of the 'growing our own' initiative. Changing a traditional consultant post which has not been recruited to into a specialist grade post. In line with CNST Safety Action 4 an audit demonstrating compliance with criteria for employing short term doctors audit is also shared with the Board.
Care Quality Commission (CQC) Update: Maternity Live Quality Action Plan	A paper summarising the key must and should do's highlighted in the CQC reports for Maternity services at QEQM and WHH was discussed with updates provided to Maternity and Neonatal Assurance Group (MNAG). A total of 20 x 'Must Do' and 18 x 'Should Do' requirements were given across both sites. A live action plan that has been developed by the care group triumvirate and is reviewed at a monthly stop the clock meeting. A monthly report is submitted to the CQC in relation to actions being undertaken. A weekly meeting is now in place with the Estates team, the Chief Nurse and the Maternity team.
Maternity and Neonatal Improvement Programme (MNIP) progress report	The paper provided an update on the development of, and progress against, the MNIP since the content was agreed in June 2023 and approved by Trust Board in September 2023. In addition to progress against the MNIP, the content of the report aims to provide assurance on governance arrangements and management of the programme.
CNST SA 9 Maternity Claims/Incidents/Complaints and Learning	The paper provided evidence that in addition to the monthly Board review of the maternity and neonatal quality dataset the Trust's claims scorecard is reviewed alongside incident and complaint data. The claims scorecard data is used to agree targeted interventions aimed at improving patient safety and this is reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the Maternity Incentive

	Scheme (MIS) reporting period at a Trust level quality and was previously discussed in July 2023. In this period targeted interventions include medication management, recognition of deteriorating patients/enhance maternal care.
CNST SA 8 **Q2 Training update/Trainee Nursing Associate (TNA)/Three Year programme**	The TNA, training plan and Q2 training report was brought to the committee in compliance with CNST SA 8 and provided evidence that: • Training plans meet the requirements for the professional groups as set out in the MIS year 5, Core Competency Framework version 2, Saving Babies Lives Version 3 and training based upon current needs of the local maternity and neonatal system. • Local training plans are in place, the syllabus of which is derived from current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback. • The local training faculty is multi-professional and representative of the current maternity and neonatal teams, to ensure protected time, for the midwifery educators, obstetricians and anaesthetists to be able to support local training. MNAG validated and signed off the EKHUFT 3-year maternity training plan – to be reviewed three times a year locally and by the Local Maternity and Neonatal System (LMNS).
CNST SA 3 **Q2 report and approval of action plan**	Q2 – Avoiding Term Admissions into Neonatal Units (ATAIN) report and action plan In Q2 the admission rate for WHH was 3.4% and 4.5% at QEQM. The national average for Term admissions is currently 4.4%. The main reason for admission was respiratory causes and as such the team will be undertaking a deep dive into these cases. Learning from the reviews have been shared with the team and posters shared in each of the areas which have been included in the report. A resulting action plan was developed and the attached action plan was approved at MNAG. This will be shared with the LMNS.
Matters to escalate to Board	• SA 8 Challenges continue in relation to compliance with anaesthetic training despite amended standard to 80% compliance. • SA 6 Assurance in relation to the new elements of SA 6 will only become available after the LMNS review in December 2023.

	• SA 9 **Evidence that the Board Safety Champions meet with the Perinatal Quad and that any support required is being implemented** - The Board Safety Champions meet with the Quad on a monthly basis at the MNAG meeting. In the CNST year 5 reporting period the Board has supported the following initiatives which have been identified as areas to be progressed: - Incentivisation payments authorised owing to the existing midwifery staffing shortfalls. - Funding for all maternity staff to attend Enhanced Maternity Care training and backfill for Obstetrics and Anaesthetics to support the training. - Approval of minor works to enhance the maternity environment.

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
SA 3 ATAIN action plan for approval.	Approval	To BoD 7 December 2023
SA5 Maternity Workforce paper for approval.	Approval	To BoD 7 December 2023
SA8 TNA and 3 year training plan for approval.	Approval	To BoD 7 December 2023

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Serious Incident (SI) Report**

Meeting date: **7 December 2023**

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

Paper Author: **Acting Joint Head of Patient Safety**

Appendices:

Appendix 1: Serious Incident Report

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report is to enable the BoD to have greater oversight of all Patient Safety Incidents that have occurred in the Trust during the month of September 2023 and take assurance that these have been/are being managed in accordance with the NHS England (NHSE) Serious Incident Framework and that lessons have been learned and shared.
Summary of key issues:	Assurance of the efficacy of the overall incident management and Duty of Candour (DoC) compliance processes are currently reported to the BoD as part of the monthly Quality Governance Compliance Report (QGCR). The BoD will receive this report monthly. • In September 2023 the Trust declared 13 SIs. • None of these 13 incidents are being investigated by the Health Services Safety Investigation Body (HSSIB) or (Maternity and Neonatal Safety Investigations Special Health Authority (MNSI) Both of which were previously combined and known as HSIB. • In September the Trust held 18 SI Declaration Panels and four Serious Incident Investigation Approval Panels, the purpose of these panels is described in the body of the report. • As of the 30 September 2023 the Trust had 72 open SIs, 52 (72%) are under investigation and 20 have been submitted to the Integrated Care Board (ICB) for closure. One of these SIs breached the 60 day deadline or their extension date but was declared prior to 1 April 2023. • A DoC update is now included in this report. The Trust achieved 100% compliance for the Verbal and sharing the findings elements, however, 97.4% was achieved for the follow up letter as one letter breached the 15-day deadline.

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Key recommendations:	It is recommended that the BoD review and discuss the information contained within this report and takes assurance of the efficacy of the overall incident management and Duty of Candour compliance processes in place within the Trust.

Implications:

Links to 'We Care' Strategic Objectives:	• Quality and safety • People
Link to the Board Assurance Framework (BAF):	**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):	**CRR 107:** Inability to embed learning from incidents, complaints and claims across the Trust. **CRR 118:** There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace **CRR 133:** Patients will not be informed of incidents where the Trust may have caused/contributed to harm (DoC). This risk has recently been deescalated and is now risk CRR 2799 on the Quality Governance Risk Register.
Resource:	N
Legal and regulatory:	Y - The Trust is required to comply with the Care Quality Commission Regulations and the NHSE Serious Incidents Framework.
Subsidiary:	N

Assurance route:

Quality and Safety Committee (Q&SC) – 28 November 2023

East Kent Hospitals University NHS Foundation Trust

Serious Incident REPORT

October 2023 (September Data)

By
Acting Joint Head of Patient Safety and Improvement

Executive Sponsor
Chief Nursing and Midwifery Officer

CONTENTS

Patient Safety Incidents

The Trust is committed to ensuring the safety of everyone who uses its services and to improving the quality of care to patients. EKHUFT recognises the importance of reporting all incidents as an integral part of the risk management strategy, and follows the current national frameworks in understanding why an incident has occurred. Learning from reported incidents can improve patient experience and quality of care, lessons can be learnt and shared across the organisation to prevent recurrence and reduce the risk of harm. This report has maintained the Care Groups as they were prior to 14/08/2023 and transitioned to the new Care Groups from 01/09/2023.

THE FIGURES	THE HARM
SEPTEMBER 2023	**SEPTEMBER 2023**
2279	No Harm 1409
Patient Safety Incidents	Low Harm 828
82% of 2754	Moderate 29
total incidents reported	Severe 8
	Death 5
	Harm ungraded (under review) 0
	TOTAL 2279

The figures for this report were collated on 02/10/2023 and at that time there were five deaths reported on Datix in September:

1. A Structured Judgement Review resulting in poor care with a 50% chance or more of avoidable death. This case has been added to the possible Serious Incident list for presentation in October 2023.
2. Failure to refer to renal HOT clinic for biopsy to establish if there was a reversible cause for reduced renal function. Potentially avoidable death and added to possible Serious Incident (SI) list for presentation in October 2023.
3. Neonatal death following overnight deterioration and transport to London for possible surgery. This was discussed at Serious Incident Declaration Panel (SIDP), declared an SI and has been reported on StEIS.

4. Deterioration of patient admitted via HOT clinic for vascular intervention. Medical emergency call not put out. Potentially avoidable death and added to possible Serious Incident list for presentation in October.
5. Sub-optimal escalation of a deteriorating patient prior to transfer to ward; arrived in peri-arrest and with no plan. Unsuccessful resuscitation. Added to possible Serious Incident list for presentation in October 2023.

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Serious Incidents Reported on the Strategic Executive Information System (StEIS) by Category

Serious Incidents declared in September 2023

CATEGORIES OF HARM on StEIS

01/09/23 – 30/09/23

	No harm	Low	Moderate	Severe	Death	Total
Abuse/alleged abuse of adult patient by staff	0	0	0	1	0	1
Diagnostic incident incl delay	0	0	1	0	0	1
HCAI/Infection control incident	0	1	0	0	0	1
Incident affecting patient's body after death	0	0	1	0	0	1
Maternity/Obstetric incident: baby only	0	1	0	0	0	1
Pressure ulcer	0	0	4	0	0	4
Slips/trips/falls	0	0	0	1	0	1
Treatment delay	0	0	1	1	1	3
Total	0	2	7	3	1	13

**Please note: Table above shows incidents reported on StEIS from 1 to 30 September 2023, hence death figures are not comparable with those from the table on page 3, which shows incidents reported on Datix in September 2023. Only 1 of the deaths reported on Datix had been reported on StEIS during the same month as pending SIDP outcome.*

Serious Incident Investigations

(Process and Overview)

When an incident is identified that is significant in nature, significant in terms of potential learning and potentially reaches the threshold for declaring as a Serious Incident, it is presented by the Care Group Governance Team and the representing clinician at the SIDP which is chaired by either the Chief Nursing and Midwifery Officer (CNMO), Chief Medical Officer (CMO) or the

Director of Quality Governance (DQG). These meetings were held on a daily basis Monday – Friday until late September when this moved to twice weekly.

The Care Group Governance Team identify an Investigation Lead from senior medical, nursing or appropriate other senior professional, and facilitate a meeting to review the incident with the facts available using the current Root Cause Analysis templates. The investigation team will identify a Root Cause, prepare an SI report and develop an Action Plan alongside any actions already commenced or completed since the incident occurred. The completed report is scheduled for the Serious Incident Investigation Approval Panel 2 weeks before it is due to the Integrated Care Board (ICB) at which the CNMO, CMO and DQG to quality assure the report, make recommendations for changes or approve the report for ICB submission. The Care Group Governance Team and Investigation Lead attend this meeting.

In September 2023 there were 18 Serious Incident Declaration Panel (SIDP) meetings and four Serious Incident Investigation Approval Panel (SIIAP) meetings.

There were 12 Serious Incident reports were submitted to the ICB in September of which five had extensions granted; three were submitted before the new date breached and two breached the extension date (but both of the breaches were reported on StEIS prior to April 2023). One report breached the original target date without extension (reported on StEIS in June 2023).

INVESTIGATIONS Declared/Agreed

Activity and performance in September 2023

Non-SI investigations commenced during September 2023

(Investigations overview by type)

Investigation type	No.		Incident category
After Action Review (AAR)	2	1 1	Care / treatment Operations / procedures
Cancer 104-day Harm Review	0		
Clinical Case Review	0		
Infection Prevention and Control Root Cause Analysis (IPC RCA)	0		
Mortality and Morbidity (M&M) review, Perinatal Mortality Review	0		
Patient Safety Incident Investigation Report (PSIIR)	0		
Structured Judgement Review (SJR)	0		
Thematic review	0		

After Action Review is a shorter investigation process than the comprehensive SI report and aims to capture maximum learning in a timely way. A standard template is used.

Clinical Case Review: The Trust is in the process of designing a Clinical Case Review Form so that clinicians can capture salient contributing factors in an incident to elicit timely learning and clear outcomes.

Cancer 104-day Harm Review: Any patient exceeding 104 days on a cancer pathway is subject to a clinically led investigation of potential harm which is known as a clinical harm review. This applies to all specialities managing patients on cancer pathways.

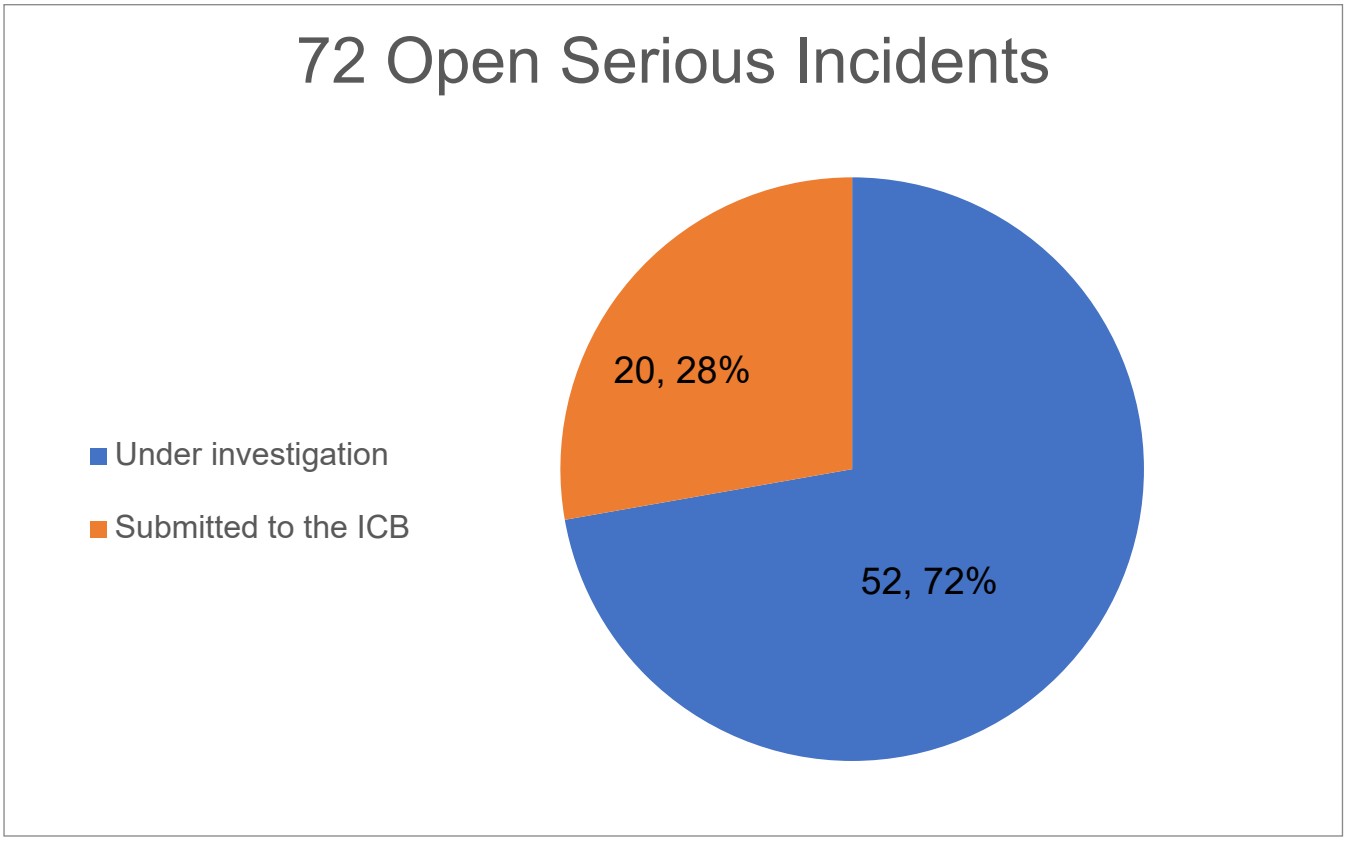
Mortality and Morbidity (M&M) review and Perinatal Mortality Review: Clinically led, multidisciplinary review of care to identify learning. External review is required for Perinatal Mortality Review.

Structured Judgement Review blends traditional, clinical-judgement methods with a standard format. The approach requires trained reviewers to make safety and quality judgements over phases of care and to make explicit written comments about care for each phase and to score for each phase to identify if appropriate care was given throughout.

Thematic review uses a specific methodology to identify patterns and themes within data, both quantitative and qualitative. Learning is drawn from the themes.

23/135.1 – APPENDIX 1

Total number of open Serious Incidents per Care Group as at 30 September 2023.



Of the 72 open Serious Incidents, the chart above shows 20 that sit with the ICB. Of these,12 were submitted to the ICB during September and the remaining eight had been submitted to the ICB prior to 1 September 2023 and await presentation at the ICB Closure Panel.

Of the 52 under investigation: 40 are not yet due, one has a downgrade request pending and three cases have breached. These were all from GSM and owing to the resource issues they have experienced these incidents have breached. Two have since been submitted so there is one remaining with the Patient Safety Team. There are eight Non-Closure Requests (NCR) pending.

Care Group	Open SIs
Corporate	1
Critical Care, Anaesthetics and Specialist Surgery	5
Diagnostics, Cancer and Buckland Care Group	3
Kent and Canterbury and RVHF Care Group	16
Queen Elizabeth the Queen Mother Care Group	15
William Harvey Care Group	14
Women, Children and Young People Care Group	18
Grand Total	72

Never Events

There were no Never Events reported on StEIS during September.

Duty of Candour

Between 1 and 30 September 2023 using the Duty of Candour documented on Datix, a total of 58 moderate, severe or death harm incidents (or declared as a Serious Incident) potentially required Duty of Candour. The Trust has achieved a 100% compliance rate for verbal Duty of Candour this month. Of the follow up letters required one letter was not sent to the patient within our 10-day deadline however it was sent within 20 days thus giving the Trust a 97.4% compliance rate. The Trust achieved a 100% compliance for sharing the findings with our patients. For Serious Incident cases submitted to the ICB and requiring Duty of Candour there is 100% compliance rate.

Work continues with the Care Groups to promote continuous improvements that will ensure the Trust achieves 100% compliance across all three elements consistently.

Learning from Incidents

There were nine cases closed on StEIS in September 2023. Below are two examples of the Learning Bulletins which are generated at the completion of an investigation to provide a concise learning tool for teams to share. The cases below have been anonymised as far as possible to make appropriate for sharing in a public forum.

The Incident-what happened?

An elderly patient was admitted to William Harvey Hospital (WHH) with a left neck of femur fracture on 22/04/2023 following an unwitnessed fall from an electric scooter.

The patient had a left cemented hemiarthroplasty on 22/04/2023 and was transferred to Kings D Female ward. On 26/04/2023 the patient was noted to be confused and 1:1 nursing was put in place.

On 06/05/2023 the patient was transferred to Kings A2 ward. 1:1 nursing continued, the patient remained confused, an activity chart and deprivation of liberty safeguards (DOLs) was put in place. On 08/05/2023 during handover from the day staff to the night staff the patient had a witnessed fall (by nurse in bay opposite). The 1:1 nurse had left the patient without informing the incoming team.

On 09/05/2023 the patient was mobilising with a frame, and complained of left leg pain. An x-ray was requested which showed a minimally displaced inter trochanteric fracture to the right proximal femur. The patient remained confused and following discussion with the family and the palliative care team, an End of Life plan was put in place. The patient was transferred to Kings C1 ward and sadly died at 05:14 hours on 11/05/2023.

The patient was discussed at the Pressure Ulcer and Falls Panel on 18/05/2023 and it was recommended for discussion at the SIDP and reporting as an SI due to there being no 1:1 supervision at the time of the fall.

The Learning–what we found

Good practice to share:
A Mental Capacity Assessment (MCA) was completed, along with daily activity chart.
Patient had DoL's in situ and 1:1 care requirement had been identified and shift filled.

Improvements required:

- Issue personal call bell to all 1:1 nursing staff.
- 1:1 staff to inform ward team when shift has ended and need for someone to take over.
- Review of enhanced care observation policy

The recommendations – how we can prevent recurrence

- Raise awareness of expectations of enhanced observation nursing (1:1)
- Education on correct procedure for lying/standing blood pressure measurements
- Order Enhanced Observation Tabard for nursing staff

What do we need to do?

- Purchase Enhanced Observation Tabards for staff to wear.
- Share learning Trust Wide
- Share findings and actions at daily huddles and team meetings.

The Incident – what happened?

This incident relates to a delay in diagnosis and treatment of a patient with Age-Related Macular Degeneration (AMD).

On the 29/11/2016, a patient was referred to East Kent Hospitals University Foundation NHS Trust Outpatient Services by community opticians due to concerns for the patient's vision. The patient was experiencing blurred vision and visual acuity was 6/6 in the left eye and 6/24 in the right eye.

The referral was received into the Patient Service Centre and the patient was added to the Ophthalmology waiting list. In March 2017, approximately 15 weeks after the referral being received, the community opticians highlighted to EKHUFT that the patient had not received an appointment. The patient was contacted by the Patient Service Centre to progress with booking an appointment and it was identified that the patient's demographics had not been updated.

Due to the changes within the IT system since 2016 it has not been possible to confirm whether an appointment has been scheduled prior to contact with the patient in March 2017 and it has not been possible to say with certainty why the demographics held at this time were incorrect or when they were changed.

The Learning – what we found

Good practice to share:

Regrettably, due to the time that has passed since this incident occurred and the changeover in patient administration systems, it has been difficult to draw definitive conclusions from this investigation.

The investigation did however find, that there was a missed opportunity to provide an earlier diagnosis of Age Related Wet Macular Degeneration (AMD) which led to a delay with instigating earlier treatment to prevent permanent eyesight loss. This was due to the patient's demographics not being updated upon receipt of the referral via post on 8 December 2016. It is assumed, based on the investigation undertaken that the Patient Service Centre team uploaded the referral to the EKHUFT patient administration system but did not cross check the demographics. This resulted in the patient's demographics not being updated to the most current information. However, it has not yet to date been possible to determine when or how this occurred due to the change in patient administration systems in 2018 resulting in no available audit data.

The patient was subsequently diagnosed with Wet Macular Degeneration in the left eye and was told to monitor the right eye as there was as subtle Dry Macular Degeneration. The patient was advised to report to the community optician should they feel any disturbance in the central vision or distortion of straight lines.

As per the investigation process, a clinical opinion was sought from the Ophthalmology consultant who advised the discrepancy in vision is due to the delay in the patient not being seen within a timely manner. The patient's vision deteriorated due to the progression of the disease.

Improvements required:

- Patient Service Centre are undertaking a process map of Pre-Registration to ensure a streamlined and robust process
- AMD patient referrals are sent to the Ophthalmology team who have a weekly team meeting to book the patient in within two weeks

• Pre-Registration guide given to all staff to adhere to which includes cross checking demographics • Incident debrief amongst Pre-Registration team
The recommendations – how we can prevent recurrence
• Pre-Registration Guide given to all staff to adhere to which includes cross checking demographics • Patient Service Centre are undertaking process map of Pre-Registration to ensure a streamlined and robust process • Incident debrief amongst Pre-Registration team • AMD patient referrals are sent directly to Ophthalmology who have a weekly team meeting to book patients within 2 weeks
What do we need to do?
The following action has now been completed and is in place; AMD patient referrals to be sent directly to Ophthalmology who have a weekly team meeting to book patients within 2 weeks this is now completed. The remaining actions below are outstanding with due dates for the end of September and end of December; • Pre-Registration guide given to all staff to adhere to which includes cross checking demographics, • Patient Service Centre are undertaking a process map of Pre-Registration to ensure a streamlined and robust process and • Incident debrief amongst registration team.

RECOMMENDATION: The Board is asked to review and discuss this report which details the management of Serious Incidents.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Safer Nursing Staffing

Meeting date: 7 December 2023

Board sponsor: Chief Nursing and Midwifery Officer (CNMO)

Paper Author: Head of Nursing Workforce and Education

Appendices:

Appendix 1: EKHUFT Safer Staffing September 2023

Executive summary:

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

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships
Link to the Board Assurance Framework (BAF):	**BAF 35** - Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.

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Link to the Corporate Risk Register (CRR):	**CRR 116** - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs. **CRR 68** – Risk to the delivery of the operational constitutional standards and undertakings. **CRR 76** Care is potentially compromised as a consequence of staffing not meeting planned numbers per shift. **CRR 84** – Lack of timely recognition and response to the deteriorating patient.
Resource:	Y - Safer Staffing Business Case approved December 2021
Legal and regulatory:	Y – Care Quality Commission (CQC), National Quality Board and NHSE.
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Safer Nursing Staffing

1. Purpose of the report

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

2. Background

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

3. Safer Staffing

3.1 Trust continues to monitor Nursing and Midwifery numbers and skill mix in response to clinical need daily and reports monthly to Quality and Safety.

4. Registered Workforce Reported Data

4.1 Vacancy rate against establishment for substantive beds and clinical areas for all registered nurses and midwives is 8.1%.
4.2 Vacancy rate against establishment for substantive beds and clinical areas for band 5 nurses has reduced to its lowest level of 5.2%.
4.3 Sickness absence rate for all registered nurses and midwives is 7.6%.
4.4 Turnover rate for all registered nurses and midwives is 7.7%.

5. Unregistered Workforce Reported Data

5.1 Vacancy rate for Healthcare Support Worker (HCSW) is 8.72%.
5.2 Turnover rate for HCSW is 11.6%.

6. Average Fill Rates

6.1 Registered Nurse (RN) Fill Rate Day 90%.
6.2 RN Fill Rate Night 92%.
6.3 HCSW Fill Rate Day 86%.
6.4 HCSW Fill Rate Night 105%.
6.5 The wards under their planned fill rate are moving staff to support the unfunded bed base as demonstrated on the table in the report.

7. NHS Professionals (NHSP) Golden Key Process

7.1 Process implemented to gain control of bank and agency shifts across Trust on 23 August.
7.2 This process is working well with better management of bank requests.
7.3 Since the 15 September all agency shifts are authorised by Head of Nursing (HoN)/Deputy HoN (DHoN).

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8. Agency Spend

8.1 Agency spend has been reduced for RNs.
8.2 HCSW agency code CSW03 has been discontinued in nearly all ward areas.

9. Unfunded Beds

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

10. Monitoring Harms

10.1 Reporting sore prevalence has increased this month. Not all pressure sores are hospital acquired.
10.2 Falls have reduced, however, there has been an increase of falls with harm.
10.3 Medicine errors have reduced but remain high.

11. Mitigation

11.1 Monthly Workforce Inpatient Scorecard, Planned v Actual Scorecard and Healthroster Dashboard created and shared with Chief Nurses Office & Director of Nursing (DoN's).
11.2 Monthly Nursing & Midwifery (N&M) Workforce Key Performance Indicators (KPIs) held with all Care Groups to review staffing levels, vacancies, establishments and the ongoing need for additional staff.
11.3 Daily staffing reviewed by HoN using the safe care live tool. This is escalated three times a day on site meetings and actions taken to maintain safe staffing.
11.4 Review meetings with NHSP take place and actions set.
11.5 A new training plan is being developed for nurse in charge to complete Safe care live, census data on time and with the right knowledge and skills. This will improve the Care Hours per patient day (CHPPD) data compliance.
11.6 HoN are using the golden keys for agency shifts following the review of safe staffing levels against establishment.
11.7 The enhanced care check list is being used to review patient with additional care needs, this has allowed cohorting patients appropriately or providing one to one support.

12. Bi-annual Nursing Workforce Establishment Review

12.1 Safer Nursing Care Tool (SNCT) data collected in September 2023, this data was not complete.
12.2 In December 2023 the SNCT tool will be up dated to include two additional acuity levels. This will provide us with more accurate detail of patient acuity and take place over 30 days.
12.3 Updated SNCT licences and implementation guidance have been obtained from Imperial College.
12.4 Training for the New tool will take place on 30 November and then rolled out to all the wards in the Trust.
12.5 Using the new SNCT tool, acuity data collection will take place in January 2024.
12.6 Establishment report will be reviewed with escalation areas recommendations.

12.7 Emergency Department (ED) safe staffing review will also be undertaken with guidance from a safe staffing fellow.

13. Conclusion

13.1 Trust continues to monitor the Nursing and Midwifery workforce to ensure that staffing is safe for the provision of patient care. actions are being implemented to improve safe care live compliance.

East Kent Hospitals University NHS Foundation Trust

Safer Staffing Report
October 2023

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

Authors – Head of Nursing for Workforce and Education;
Matron for Workforce and Retention

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Quality and Safety
Reducing harm and delivering safe services

East Kent Hospitals University NHS Foundation Trust

Areas of discussion	Overview	Care Group Actions
Establishment	• Wards are well established with nurse in charge and WM as supervisory. • 78 escalation beds still require substantive staff and bank staff to provide consistent care. • Queen Elizabeth the Queen Mother Hospital (QEQM) rosters require further input to match establishment. • Registered Nurse (RN) Band 5 vacancy at its lowest of 5.2%	• Staff moved to unestablished areas to be accurately recorded on Healthroster. • Formal consultation in progress at QEQM for shift start times and shift duration.
Agency/Bank	• Agency Nursing & Midwifery (N&M) contract awarded to ID Medical Managed Services - live 4 December 2023. • No Healthcare Support Worker (HCSW) agency use.	• Monitor, manage and reduce agency usage. • Provide further narrative for bank usage.
Sickness	• Both long term and short term sickness rates are being actively managed with Employee relation conversations as required but need to reduce further.	• Continue to work with HR to understand and apply policy to manage individual cases with the right outcome (Right to Work (RTW)).
Maternity Leave	• High levels of maternity leave across Trust.	• Recruit to backfill.
Safe Care Tool Compliance	• Shelford Group updated Safer Nursing Care Tool (SNCT) levels of care tool commences nationally this month. • Safe Care tool live not always being completed by all wards.	• To receive education and training to understand and apply correctly.
Roster Management Compliance	• Roster lead time has improved significantly but is not always being completed in the designated timeframe. • Owed hours requires management.	• Improvements in roster lead in time.

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

Monthly Ward Overview (fill rate) October 2023

						Average Fill Rate					
						Day			Night		
Hospital Site name	Ward name	Care Group	Specialty	Nurse to Patient Ratio	Skill Mix Ratio (RN/HCSW)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)
KENT AND CANTERBURY HOSPITAL	BRABOURNE HAEMATOLOGY WARD - K&C	Haematology Oncology	Cancer	1 - 4	73/27	79%	64%	-	100%	-	-
KENT AND CANTERBURY HOSPITAL	CLARKE WARD - K&C	KCH	Surgical	1 - 6	66/34	92%	96%	100%	77%	90%	100%
KENT AND CANTERBURY HOSPITAL	CRITICAL CARE - K&C	CCASS	Critical Care	1 - 1		86%	6%	-	93%	10%	-
KENT AND CANTERBURY HOSPITAL	HARBLEDOWN WARD - K&C	KCH	Stroke/Neuro	1 - 4	69/31	86%	83%	-	92%	99%	-
KENT AND CANTERBURY HOSPITAL	INVICTA T&O WARD K&C	KCH	Surgical	1 - 6	65/35	70%	49%	-	82%	39%	-
KENT AND CANTERBURY HOSPITAL	KENT WARD - K&C	KCH	Surgical	1 - 6	65/35	85%	114%	100%	104%	111%	-
KENT AND CANTERBURY HOSPITAL	KINGSTON WARD - K&C	KCH	Stroke/Neuro	1 - 6	62/38	84%	80%	-	98%	137%	-
KENT AND CANTERBURY HOSPITAL	MOUNT & MCMASTER WARD - K&C	KCH	Stroke/Neuro	1 - 6	62/38	85%	84%	-	90%	108%	-
KENT AND CANTERBURY HOSPITAL	NEUROREHAB NURSING	KCH	Stroke/Neuro	1 - 6	65/35	82%	90%	-	87%	126%	-
KENT AND CANTERBURY HOSPITAL	RENAL MARLOWE WARD - K&C	KCH	Medicine	1 - 6	66/34	86%	98%	-	94%	118%	-
KENT AND CANTERBURY HOSPITAL	RENAL MEDICAL TECHNOLOGY - K&C	KCH				-	-	-	-	-	-
KENT AND CANTERBURY HOSPITAL	ST LAWRENCE WARD - K&C	KCH	Surgical	1 - 6	65/35	90%	73%	-	102%	95%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ACUTE MEDICAL UNIT A - QEQM	QEQM	UEC	1 - 4	66/33	92%	84%	100%	89%	97%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ACUTE MEDICAL UNIT B - QEQM	QEQM	UEC	1 - 4	66/34	88%	85%	-	95%	115%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	BIRCHINGTON WARD - QEQM	Womens & Childrens	Gynaecology	1 - 6	65/35	85%	97%	100%	99%	99%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	BISHOPSTONE WARD - QEQM	QEQM	Surgical	1 - 6	65/35	103%	77%	-	98%	118%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CHEERFUL SPARROWS WARD FEMALE - QEQM	QEQM	Surgical	1 - 6	63/37	94%	83%	-	98%	99%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	CORONARY CARE UNIT - QEQM	Cardiology	Cardiac	1 - 3	74/26	84%	88%	100%	99%	97%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	DEAL WARD - QEQM	QEQM	Medicine	1 - 6	62/38	92%	96%	-	100%	100%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	DISCHARGE LOUNGE - QEQM	QEQM				21%	46%	-	0%	0%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	FORDWICH WARD - QEQM	QEQM	Medicine	1 - 4	66/34	92%	92%	100%	95%	106%	100%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	MATERNITY - QEQM	Womens & Childrens	Maternity			95%	82%	-	84%	78%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	QUEX MEDICAL WARD - QEQM	QEQM	Medicine	1 - 6	62/38	91%	76%	100%	87%	114%	100%
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	RAINBOW WARD - QEQM	Womens & Childrens	Paediatrics	1 - 4	83/17	78%	76%	-	83%	-	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SANDWICH BAY FRAILTY WARD - QEQM	QEQM	Medicine	Unfunded		94%	69%	100%	94%	138%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SEABATHING WARD - QEQM	QEQM	Surgical	1 - 6	62/38	81%	85%	-	93%	104%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	SPECIAL CARE BABY UNIT - QEQM	Womens & Childrens	Neonatal	1 - 2 HDU 1 - 3 SCBU		60%	52%	-	77%	47%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ST AUGUSTINE'S WARD - QEQM	QEQM	Medicine	1 - 6	62/38	85%	95%	-	87%	93%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	ST MARGARETS WARD - QEQM	QEQM	Medicine	1 - 6	61/39	99%	95%	-	83%	114%	-
QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL	VIKING DAY UNIT - QEQM	QEQM				92%	59%	-	-	-	

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

Monthly Ward Overview (fill rate) October 2023

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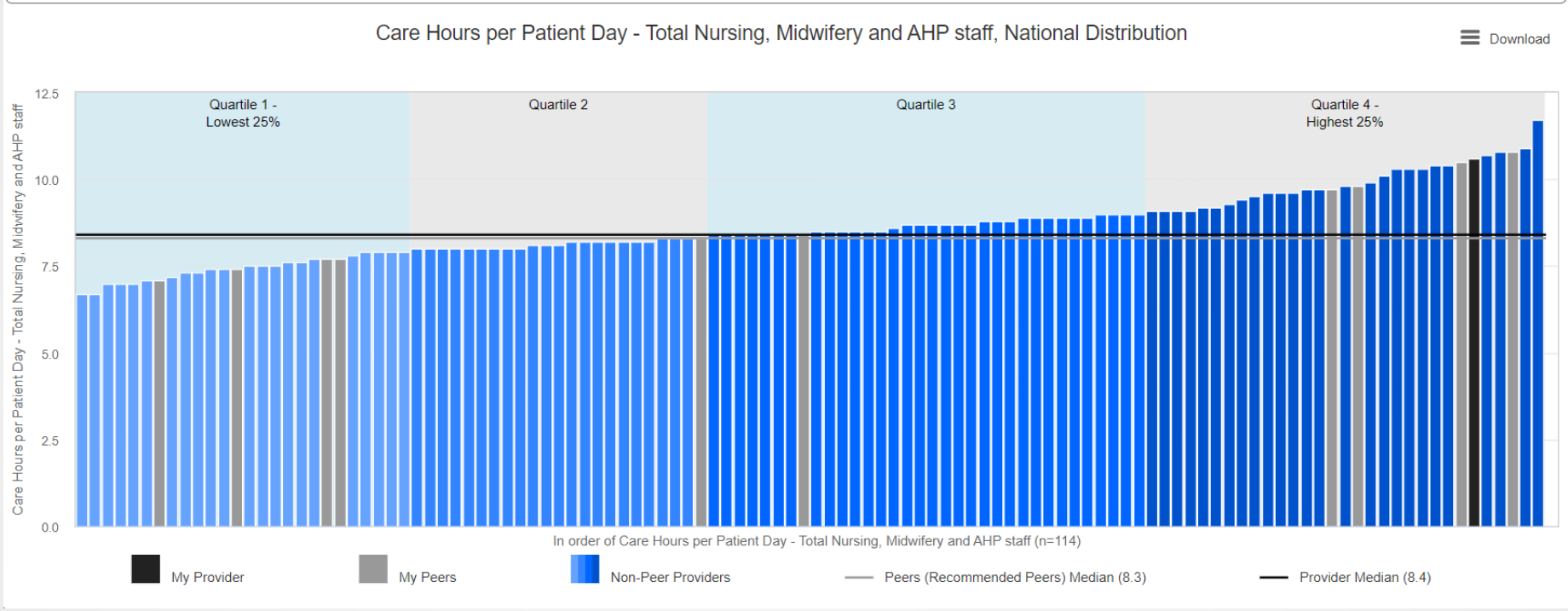
						Day			Night		
Hospital Site name	Ward name	Care Group	Specialty	Nurse to Patient Ratio	Skill Mix Ratio (RN/HCSW)	Average fill rat Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)
WILLIAM HARVEY HOSPITAL (ASHFORD)	ACUTE MEDICAL UNIT (AMU) - WHH	WHH	UEC	1 - 4	66/34	103%	110%	100%	130%	141%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	BARTHOLOMEW UNIT - WHH	Cardiology	Cardiac	1 - 6	70/30	97%	93%	-	99%	97%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE J1 WARD - WHH	WHH	Medicine	1 - 6	65/35	85%	109%	-	93%	176%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE J2 WARD - WHH	WHH	Medicine	1 - 4	62/38	112%	78%	-	101%	115%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE K WARD - WHH	WHH	Medicine	1 - 6	66/34	66%	110%	-	84%	111%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE L WARD - WHH	WHH	Medicine	1 - 6	66/34	101%	113%	-	114%	107%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE M1 WARD - WHH	WHH	Medicine	1 - 6	60/40	95%	103%	-	99%	131%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CAMBRIDGE M2 WARD - WHH	WHH	Medicine	1 - 6	60/40	89%	105%	-	99%	112%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CELIA BLAKEY - WHH	WHH				73%	80%	-	-	-	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CORONARY CARE UNIT - WHH	Cardiology	Cardiac	1 - 3	83/17	97%	87%	-	98%	100%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	CRITICAL CARE - WHH	WHH				84%	63%	100%	80%	91%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	DISCHARGE LOUNGE - WHH	WHH				222%	119%	-	-	-	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KENNINGTON FRAILTY WARD - WHH	WHH	Medicine	1 - 6	65/35	86%	105%	-	98%	140%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS A2 WARD - WHH	WHH	Surgical	1 - 6	68/32	88%	122%	-	90%	123%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS B WARD - WHH	WHH	Surgical	1 - 6	63/37	89%	111%	100%	96%	140%	100%
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS C WARD - WHH	WHH	Surgical	1 - 6	64/36	102%	96%	100%	85%	110%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS C2 MEDICAL WARD - WHH	WHH	Medicine	1 - 6	65/35	95%	106%	-	97%	145%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	KINGS D WARD - WHH	WHH	Surgical	1 - 6	62/38	96%	110%	-	97%	168%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	MATERNITY - WHH	Womens & Childrens	Maternity			73%	64%	-	77%	70%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	NEONATAL INTENSIVE CARE UNIT - WHH	Womens & Childrens	Neonates	1 - 1 ITU 1 - 2 HDU 1 - 3 SCBU		74%	42%	-	86%	45%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	OXFORD WARD - WHH	WHH	Medicine	1 - 4	65/35	94%	110%	-	99%	111%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	PADUA WARD - WHH	Womens & Childrens	Paediatrics	1 - 4	80/20	82%	-	-	90%	-	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	RICHARD STEVENS WARD - WHH	WHH	Medicine	1 - 6	66/34	106%	104%	-	99%	141%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	ROTARY SUITE - WHH	CCASS	Head and Neck	1 - 5	65/35	93%	81%	-	96%	99%	-
WILLIAM HARVEY HOSPITAL (ASHFORD)	SEACOLE WARD - WHH	WHH	Medicine	Unfunded		91%	60%	-	100%	91%	-

Care Hours Per Patient Day (CHPPD)

East Kent Hospitals University NHS Foundation Trust



CHPPD: Care Hours Per Patient Day shows staffing levels in relation to patient numbers and is recorded on Model Hospital. It shows staff time spent on direct patient care and is considered against quality and safety measures. The Trust is in the highest quartile based on the latest available benchmarking data on Model Hospital – August 2023. The Trust is 10.6, Peer median is 8.3, National median is 8.4.

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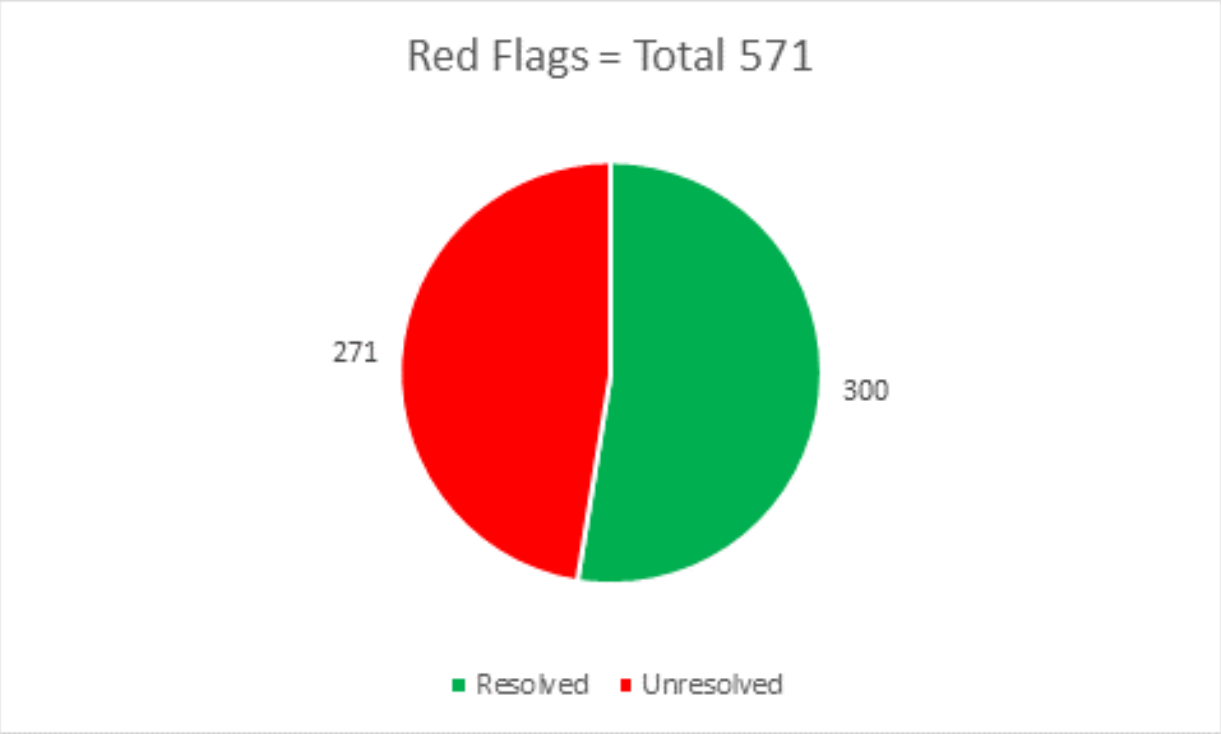
Red Flags



- Red flags have been raised for: unfunded beds; boarded patients; patients requiring enhanced observations; shortfall in RN's or HCSW on duty; and Bariatric patients.
- The new Safe Care tool gives more options for closing red flags which will assist in resolving them quickly.
- Matrons will receive training on Red Flag management during December

Ward Heat Maps: Workforce
Kent & Canterbury Hospital (K&C)

NHS
East Kent Hospitals University
NHS Foundation Trust

Care Group	Unit	Bank Usage%	Agency Usage %	Overall Owed Hours	Percentage Overall Owed Hours	Annual Leave % (11-17%)	Sickness %	Study Leave %	Total Unavailability %	Roster Full Approval Lead Time Days (42 Days)
344 K&C and RVH	BHD UTC	26.10%	0.00%	-32.67	-2.29%	14.96%	27.54%	3.09%	52.61%	39
344 K&C and RVH	KC Clarke Ward	9.32%	0.00%	38.59	0.45%	13.19%	6.12%	6.45%	33.96%	48
344 K&C and RVH	KC EAC Urology & Vascular	14.40%	0.00%	26.7	0.89%	12.26%	8.29%	5.77%	29.92%	45
344 K&C and RVH	KC Harvey Neurorehab	15.96%	0.00%	7.98	0.15%	11.29%	17.46%	2.29%	31.04%	40
344 K&C and RVH	KC Invicta	1.45%	0.00%	-21.35	-0.42%	14.25%	8.17%	5.77%	30.41%	48
344 K&C and RVH	KC Kent Ward	25.33%	0.58%	21.62	0.33%	13.55%	6.84%	3.47%	33.13%	45
344 K&C and RVH	KC Kingston	30.97%	0.00%	29.68	0.47%	14.44%	5.77%	6.07%	36.48%	47
344 K&C and RVH	KC Marlowe Ward	19.06%	0.00%	336.48	4.44%	14.43%	7.81%	5.13%	31.12%	37
344 K&C and RVH	KC Medical Day Unit	24.61%	0.00%	-20.82	-0.66%	11.44%	4.06%	3.10%	32.88%	38
344 K&C and RVH	KC Mount McMaster	17.58%	0.00%	107.85	1.60%	17.15%	10.44%	2.70%	31.96%	42
344 K&C and RVH	KC Renal Haemodialysis	8.36%	0.00%	77.2	1.37%	13.75%	8.45%	3.30%	31.99%	41
344 K&C and RVH	KC St Lawrence Ward	15.69%	0.00%	-31.92	-0.59%	13.27%	10.64%	6.56%	34.08%	48
344 K&C and RVH	KC Stroke (Harbledown)	13.76%	0.17%	30.28	0.39%	13.51%	3.07%	5.48%	24.81%	47
344 K&C and RVH	KC Theatres	4.08%	0.00%	16.31	0.14%	11.95%	5.62%	3.66%	24.24%	46
344 K&C and RVH	KC UTC	4.03%	0.00%	89.6	3.04%	15.94%	1.24%	4.47%	21.65%	45
344 K&C and RVH	QE UTC	20.20%	0.00%	-62.47	-2.75%	17.17%	10.31%	1.39%	29.33%	39
344 K&C and RVH	WH UTC	0.88%	0.00%	145.77	5.28%	13.41%	6.47%	5.81%	26.52%	39

We care

Ward Heat Maps: Workforce
William Harvey Hospital (WHH)

NHS
East Kent Hospitals University
NHS Foundation Trust

Care Group	Unit	Bank Usage%	Agency Usage %	Overall Owed Hours	Percentage Overall Owed Hours	Annual Leave % (11-17%)	Sickness %	Study Leave %	Total Unavailability %	Roster Full Approval Lead Time Days (42 Days)
344 WHH	WH A&E	12.21%	33.97%	708.91	3.62%	13.61%	5.90%	4.79%	28.37%	41
344 WHH	WH A&E - Paeds	16.18%	14.72%	1020.5	30.12%	9.33%	6.81%	4.04%	23.87%	39
344 WHH	WH AMU & SDEC	15.40%	12.06%	270.2	1.62%	14.20%	9.00%	2.26%	36.65%	32
344 WHH	WH Bartholomew	11.91%	0.00%	11.15	0.18%	12.87%	6.04%	4.01%	32.24%	52
344 WHH	WH Cambridge J1 Ward	24.53%	7.68%	-42.36	-0.70%	12.62%	3.78%	8.47%	44.27%	44
344 WHH	WH Cambridge J2	28.91%	4.64%	155.55	2.27%	13.72%	8.12%	7.25%	41.68%	44
344 WHH	WH Cambridge K Ward	21.88%	9.72%	124.48	2.08%	13.28%	5.53%	6.48%	34.61%	44
344 WHH	WH Cambridge L Rehab Ward	22.66%	12.56%	-16.17	-0.23%	14.63%	6.93%	6.41%	41.49%	13
344 WHH	WH Cambridge M1	21.66%	2.47%	92.65	1.94%	13.48%	4.12%	8.45%	33.32%	45
344 WHH	WH Cambridge M2 Ward	22.03%	2.39%	-117.02	-2.47%	13.10%	1.38%	11.57%	34.95%	46
344 WHH	WH CCU Bartholomew	23.97%	0.90%	-15.43	-0.33%	15.85%	5.19%	1.40%	39.53%	48
344 WHH	WH Kennington Ward	30.43%	2.28%	-26.93	-0.63%	12.07%	11.10%	4.42%	34.33%	46
344 WHH	WH Kings A2	14.00%	0.00%	-34.78	-0.67%	15.60%	5.51%	2.47%	33.86%	45
344 WHH	WH Kings B	20.68%	0.25%	-46.33	-0.78%	13.60%	5.66%	4.41%	40.63%	51
344 WHH	WH Kings C	20.02%	0.44%	2.1	0.03%	13.81%	12.84%	3.87%	38.19%	46
344 WHH	WH Kings C2	23.01%	2.99%	80.03	1.39%	10.46%	5.33%	9.31%	35.43%	44
344 WHH	WH Kings D	20.26%	0.59%	-61.43	-0.56%	13.60%	4.99%	3.56%	32.66%	49
344 WHH	WH Oxford Ward	24.90%	5.74%	106.9	2.34%	13.10%	10.63%	2.60%	30.61%	46
344 WHH	WH Richard Stevens Ward	30.81%	6.35%	22.2	0.36%	12.46%	8.81%	4.44%	34.01%	46
344 WHH	WH Seacole	82.69%	13.13%	-11.92	-7.94%	0.00%	0.00%	17.33%	17.33%	6
344 WHH	WH SEAU	28.67%	0.00%	35.58	1.43%	20.74%	6.01%	3.86%	36.56%	45

We care

Ward Heat Maps: Workforce
Queen Elizabeth the Queen Mother Hospital (QEQM)

East Kent Hospitals University NHS Foundation Trust

Care Group	Unit	Bank Usage%	Agency Usage %	Overall Owed Hours	Percentage Overall Owed Hours	Annual Leave % (11-17%)	Sickness %	Study Leave %	Total Unavailability %	Roster Full Approval Lead Time Days (42 Days)
344 QEQM	QE A&E	18.74%	21.14%	706.93	4.01%	11.35%	5.99%	4.40%	27.33%	40
344 QEQM	QE A&E - Paeds	5.23%	34.14%	38.1	1.24%	10.64%	6.05%	6.01%	35.74%	40
344 QEQM	QE AMU A	17.77%	0.00%	9.62	0.10%	14.28%	6.19%	4.22%	30.30%	40
344 QEQM	QE AMU B	31.23%	0.32%	77.82	1.06%	11.01%	3.43%	6.05%	32.66%	40
344 QEQM	QE Bishopstone Ward	29.80%	0.00%	84.12	1.63%	11.43%	8.66%	4.45%	30.37%	44
344 QEQM	QE Cheerful Sparrow Female	10.24%	0.00%	54.2	0.65%	14.30%	7.01%	7.30%	32.52%	44
344 QEQM	QE Cheerful Sparrow Male	57.13%	0.00%	-41.22	-3.20%	8.72%	10.62%	1.16%	20.81%	27
344 QEQM	QE Coronary Care Unit	11.15%	0.00%	-8.23	-0.22%	10.22%	4.40%	5.81%	27.96%	56
344 QEQM	QE Deal Ward	13.83%	0.00%	161.21	2.17%	14.31%	4.07%	10.23%	34.63%	41
344 QEQM	QE FAU	16.87%	0.00%	169.8	4.91%	8.88%	17.15%	5.90%	34.34%	45
344 QEQM	QE Fordwich	24.52%	0.00%	-3.14	-0.05%	13.62%	4.64%	2.96%	29.14%	34
344 QEQM	QE Quex Ward	16.80%	0.00%	226.73	3.29%	13.94%	4.79%	4.48%	28.78%	26
344 QEQM	QE Sandwich Bay Ward	24.26%	0.00%	-53.7	-1.15%	11.47%	1.37%	4.17%	24.67%	34
344 QEQM	QE SDEC	4.85%	0.00%	487.82	13.17%	15.60%	0.28%	6.44%	24.84%	40
344 QEQM	QE Seabathing	21.65%	0.00%	-80.44	-1.28%	11.94%	5.79%	7.23%	29.73%	47
344 QEQM	QE SEAU	12.15%	0.00%	18.6	0.95%	17.77%	1.77%	10.51%	30.05%	47
344 QEQM	QE St Augustine Ward	24.03%	0.00%	23.7	0.40%	13.35%	9.19%	2.48%	31.85%	19
344 QEQM	QE St Margarets Ward	28.71%	0.00%	39.27	0.76%	10.83%	5.17%	9.49%	26.78%	52

We care

Ward Heat Maps: Workforce Clinical Assessment Services (CCASS) & Diagnostics, Cancer & Buckland Hospital Dover (BHD)

NHS
East Kent Hospitals University
NHS Foundation Trust

Care Group	Unit	Bank Usage%	Agency Usage %	Overall Owed Hours	Percentage Overall Owed Hours	Annual Leave % (11-17%)	Sickness %	Study Leave %	Total Unavailability %	Roster Full Approval Lead Time Days (42 Days)
344 Critical Care, Anaesthetics & Specialist Surgery	KC Critical Care	7.95%	11.24%	-73.17	-1.15%	12.71%	10.36%	3.84%	39.83%	45
344 Critical Care, Anaesthetics & Specialist Surgery	KC Day Surgery	10.72%	0.00%	31.28	0.95%	6.40%	4.40%	2.30%	13.56%	46
344 Critical Care, Anaesthetics & Specialist Surgery	KC Day Surgery Theatres	11.81%	0.00%	86.13	2.36%	10.14%	2.31%	2.81%	16.54%	46
344 Critical Care, Anaesthetics & Specialist Surgery	KC Orthopaedic Theatre	1.57%	0.00%	-24.16	-0.34%	11.72%	3.37%	2.59%	20.06%	46
344 Critical Care, Anaesthetics & Specialist Surgery	Ophthalmic Theatres	0.00%	0.00%	2.28	0.08%	7.98%	4.35%	3.78%	21.39%	46
344 Critical Care, Anaesthetics & Specialist Surgery	QE Critical Care	9.04%	0.73%	2454.87	26.83%	9.98%	3.31%	7.12%	31.63%	53
344 Critical Care, Anaesthetics & Specialist Surgery	QE DSU Ward	7.52%	0.00%	-30	-1.09%	9.87%	8.36%	3.08%	27.32%	39
344 Critical Care, Anaesthetics & Specialist Surgery	QE Theatres	8.40%	0.03%	418.13	1.76%	11.04%	12.47%	2.39%	29.26%	39
344 Critical Care, Anaesthetics & Specialist Surgery	WH Critical Care	9.93%	2.93%	-57.61	-0.30%	14.15%	4.94%	5.25%	30.98%	39
344 Critical Care, Anaesthetics & Specialist Surgery	WH Day Surgery Ward	27.80%	0.00%	-42.05	-1.20%	8.72%	6.40%	8.78%	28.34%	25
344 Critical Care, Anaesthetics & Specialist Surgery	WH Rotary Suite	5.63%	0.00%	20	0.26%	16.13%	8.17%	2.03%	32.27%	53
344 Critical Care, Anaesthetics & Specialist Surgery	WH Theatres	6.36%	0.00%	433.34	2.56%	10.28%	10.67%	4.19%	27.90%	40
344 Critical Care, Anaesthetics & Specialist Surgery	WH Theatres - Anaesthetic	3.50%	0.00%	-38.32	-0.90%	10.76%	5.63%	0.60%	18.13%	40
344 Critical Care, Anaesthetics & Specialist Surgery	WH Theatres - Recovery	9.21%	0.00%	109.72	2.71%	13.87%	3.39%	2.51%	28.10%	40
344 Diagnostics, Cancer and BHD	KC Brabourne Haematology Ward	1.86%	0.00%	-10	-0.35%	13.49%	10.07%	0.44%	33.98%	41

We care

Ward Heat Maps: Workforce Women, Children & Young Persons

East Kent Hospitals University NHS Foundation Trust

Care Group	Unit	Bank Usage%	Agency Usage %	Overall Owed Hours	Percentage Overall Owed Hours	Annual Leave % (11-17%)	Sickness %	Study Leave %	Total Unavailability %	Roster Full Approval Lead Time Days (42 Days)
344 Women, Children and Young People	QE Birchington Ward	26.37%	0.00%	102.31	1.92%	11.76%	5.73%	3.00%	26.93%	31
344 Women, Children and Young People	QE Maternity MSW and MCA	25.60%	0.00%	45.07	1.42%	13.71%	22.37%	4.70%	41.42%	42
344 Women, Children and Young People	QE Maternity Wards & Triage	16.11%	0.00%	-193.13	-1.64%	13.39%	4.37%	6.59%	33.59%	42
344 Women, Children and Young People	QE MLU	9.94%	0.00%	377.6	43.81%	9.28%	21.40%	0.87%	31.55%	42
344 Women, Children and Young People	QE Rainbow Ward/Dolphin	18.33%	4.01%	-9.42	-0.14%	12.15%	8.91%	2.75%	28.50%	45
344 Women, Children and Young People	QE SCBU	7.15%	0.00%	5.5	0.17%	14.42%	6.97%	0.94%	27.21%	40
344 Women, Children and Young People	WH Maternity Labour and Folkestone	13.15%	29.44%	127.14	1.46%	14.43%	9.97%	7.11%	38.27%	32
344 Women, Children and Young People	WH Maternity MCAs and MSW	26.44%	6.18%	529.22	16.08%	17.21%	13.16%	5.82%	43.76%	32
344 Women, Children and Young People	WH NICU	13.72%	0.00%	-192.6	-2.03%	14.27%	6.47%	3.33%	33.86%	40
344 Women, Children and Young People	WH Padua Ward	8.48%	1.12%	20.63	0.34%	10.06%	3.57%	2.65%	25.19%	49
344 Women, Children and Young People	Women's Health Suite	8.06%	0.00%	9.92	0.26%	12.97%	4.72%	3.89%	31.73%	38

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Nursing & Midwifery (N&M) Vacancies – October data

NHS
East Kent Hospitals University
NHS Foundation Trust

	N&M All Bands	N&M Band 5	HCSW
Vacancy Rate	8.1%	5.2%	8.72%
Turnover Rate	7.6%		11.7%
Sickness Rate	5.06%		5.37%

Newly qualified nurses commenced their preceptorship in November
International nurse recruitment recruited 113 nurses in 2023 and achieved the target for the year of 112 nurses.

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Conclusion

- Monitoring the Nursing and Midwifery workforce takes place through Key Performance Indicator (KPI) meetings every month.
- Data shows safe staffing levels but that escalation beds have do not have permanent staffing establishments, this is being reviewed.
- Actions are in place to improve Safe care live data collection.
- Additional training is being provided for nurse in charge to complete safe care live.
- New national SNCT acuity levels have been introduced and will be applied to safe care and the SNCT data collection for January 2024.
- Agency and bank staffing rates have reduced this will continue to be monitored and reduced further.
- There are key metrics such as sickness and roster compliance which actions are being taken against.
- Next months report will include triangulation against harm metrics.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Research and Innovation (R&I) update**

Meeting date: **7 December 2023**

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

Paper Author: **Director of R&I and Clinical Trials Unit (CTU)**

Appendices:

Appendix 1: Haemo - oncology studies - examples

Executive summary:

Action required:	Information
Purpose of the Report:	To provide an update to the Board on R&I activity.
Summary of key issues:	• 2098 patients recruited 2022-23. • Offered treatments otherwise unavailable, no additional cost to Trust, cost saving. • Strategic move to interventional. • True North – The Future. Achieving targets. • Research Fellows – part of strategy to embedded research at the heart of everything we do. • Academic research fellows – joint with Kent and Medway Medical School (KMMS). Successful application for three. • CTU – already number of studies open across a wide range conditions. Increased working with external collaborators. • Aim – continue to increase interventional studies. Increase homegrown research. • Delivery staff (nurses, administrators and practitioners) funding is not by Trust.
Key recommendations:	The Board of Directors is asked to **NOTE** the R&I Report and Support for increased research activity to maximise impact and benefits to patients and staff.

Implications:

Links to Strategic Theme:	• Quality and Safety – research active institutions have better health outcomes. • Patients – care and treatment options otherwise unavailable at no additional cost to the Trust.

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	• People – improved staff retention and wellbeing. • Partnerships- research collaborations and working across other NHS trusts, medical school, universities, external companies. • Sustainability – cost savings – drug, device, follow up, reduced attendance to hospital. Income generation. i.e. we have studies currently open that make saving of between £48 and £66,500/ patient.
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	N/A
Resource:	N
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Research and Innovation (R&I) update

1. Purpose of the report

1.1 R&I and Clinical Trials Unit (CTU) update:

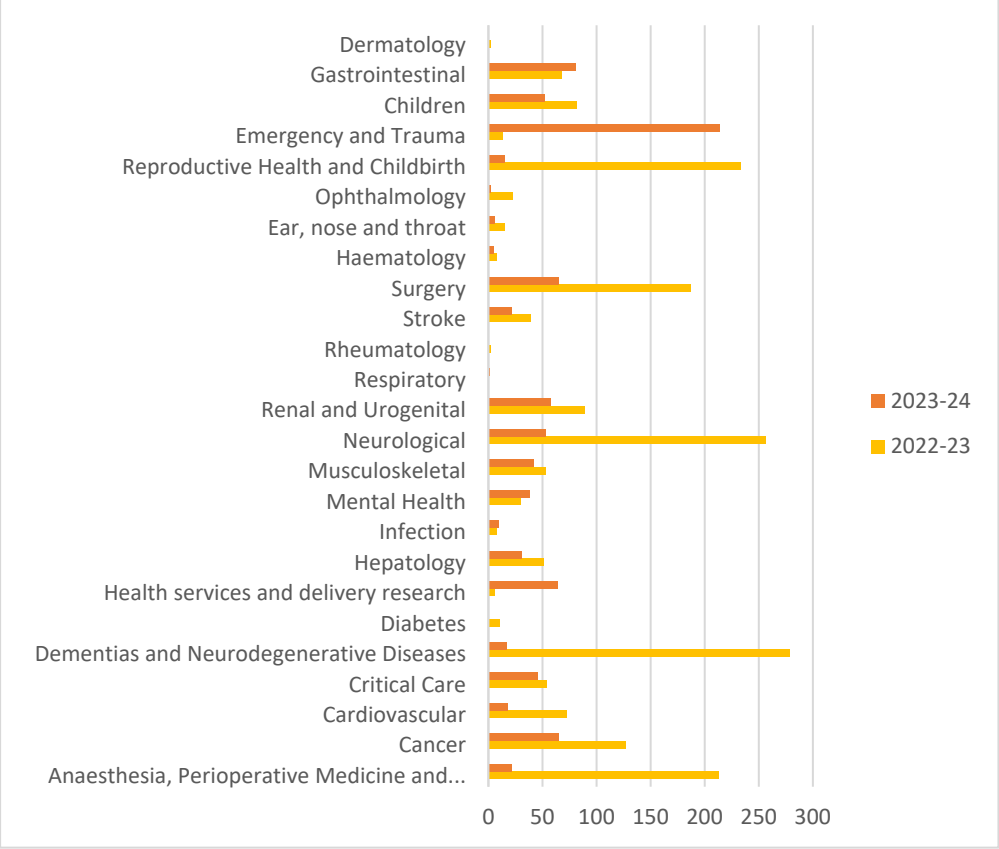
- 2098 patients recruited 2022/23.
- Update regarding True North and CTU.
- Advise regarding merger of Oncology and Haem-oncology teams at Kent & Canterbury Hospital (K&C).

2. Background

The R&I strategy is focussed on increased research activity across the Trust – particularly in relation to commercial and interventional trials as well as establishing East Kent as a centre of excellence for research. Last year we made progress in each of our key strategic areas and have built a reputation as a Trust that delivers high quality research, with fast set-up times and effective collaboration throughout. This reputation is evidenced through positive feedback from external partners and sponsors.

We recruited 2098 participants to trials in 2022/23. We are currently ahead of our target for 2023/24 (recruited 130% of plan for this point in the year). Planned recruitment target is lower than last year due to the switch in focus from non-commercial/observational to commercial/interventional studies which have lower targets to reflect the complexity of the trials:

Recruitment 01/04/2022 - 30/11/2023



Progress so far this Financial Year (FY):

We have set up 20% more studies in 2023/24 than the same period last year. We have started the same number of non-commercial studies as last year but increased the number of commercially-funded studies by 60% (5 more studies). The number of interventional studies set up has also increased from 18 to 26 in the same period last year, an increase of nearly 70%.

Our set-up time for new studies is currently an average of 51 days against a 70 day target, and we process 70% of study amendments on the same day they are received.

3. True North – The Future

- 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 and are not 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.
- Metric – patients recruited.
- Overall for year ahead of target of 1067 for year ending 31 March 2023.Total so far 908.
- Note successful appointment Anaesthetic and Haem research fellow - increased recruitment.

4. Advise regarding merger of Oncology and Haem-oncology teams at K&C

- Covid caused pause in oncology research.
- Cancer studies returning to previous levels.
- To ensure no further pauses to recruitment.
- Improve efficiency.
- Increase cross cover.
- Enable more patients to be offered interventional treatment.
- Requires space conversion.

CTU

- Facility opened June 2022.
- Three grants - £70k National Institute for Health and Care Research (NIHR) Assessment and Rehabilitation Centre (ARC) grant and NIHR £250k and £125k.
- Income 2023/24 Year to Date (YTD) £193,433.33, overall £458,818.44.

Current CTU Activity

- We currently have seven open studies running through East Kent CTU (EKCTU), one of which is a multicentre with ten sites currently open across England, Ireland and Wales.

- We have 12 studies in various stages of development, one of which will also be multicentre with around six-ten sites participating.
- We have one study where we are collaborating with a GP in primary care.
- DOLPHIN II has recruited 32 patients with more to be added soon. Antinfechemo has recruited 17 participants and Home-based Electroencephalogram (EEG) neurofeedback over-recruited their target with 11 participants.
- Two commercial studies already recruiting, CI site for one.
- Selected phase I - schizophrenia treatment with Kent and Medway NHS and Social Care Partnership Trust (KMPT).
- Selected phase II – diabetes.

5. Conclusion

- Continue to achieve and exceed targets.
- Move to more interventional and commercial studies in progress and evidenced.
- Rapid trial set up is improving reputation and making EKHUFT a first choice for commercial sponsors.
- First Trust to recruit to a number of complex interventional studies nationally and internationally, i.e SAPHIAIRE (haematology study. First global patient) and see appendix for haemo-onc examples.
- Cost savings on current studies now open range from £48 to £66,500 / patient.
  This does not include chemotherapy drug cost savings that are estimated to in excess of £1.2m for 18 months.
- Clinical trials unit gaining further momentum with increased number of studies open and requests for design/service from external bodies.
- CTU – Three grants - £70k NIHR ARC grant and NIHR £250k and £125k. Income 2023/24 YTD £193,433.33, overall £458,818.44
- Increased collaboration and work with external bodies.
- Research fellows appointed and established in anaesthetics and haematology – increased recruitment, staff retention and well-being.
- Academic clinical research fellows – joint with KMMS, competitive application. Three awarded.
- Areas for growth which will aid staff recruitment and patient treatment. However, to ensure success, patient safety and governance require joint working with R&I.

East Kent Hospitals University NHS Foundation Trust

Appendix 1:

Haemo - oncology studies - examples

AQUILA:
A Phase 3 Randomized, Multicenter Study of Subcutaneous Daratumumab Versus Active Monitoring in Subjects with High-risk Smoldering Multiple Myeloma

- 1st UK site open
- 1st UK patient recruit

EXACLIBER:
A PHASE 3, TWO-STAGE, RANDOMIZED, MULTICENTER, OPEN-LABEL STUDY COMPARING IBERDOMIDE, DARATUMUMAB AND DEXAMETHASONE (IberDd) VERSUS DARATUMUMAB, BORTEZOMIB, AND DEXAMETHASONE (DVd) IN SUBJECTS WITH RELAPSED OR REFRACTORY MULTIPLE MYELOMA (RRMM)

- 1st UK patient recruit

MajesTEC-7:
A Phase 3 Randomized Study Comparing Teclistamab in Combination with Daratumumab SC and Lenalidomide (Tec-DR) versus Daratumumab SC, Lenalidomide, and Dexamethasone (DRd) in Participants with Newly Diagnosed Multiple Myeloma Who are Either Ineligible or not Intended for Autologous Stem Cell Transplant as Initial Therapy.

- HRA approvals and SIV the same day. Site greenlighted within 48 hours of this and 1st UK patient consented and into screening within 4 days of greenlight. Rapid set up study, only 3 UK sites were identified for the rapid set up.

PLEIADES MMY2040:
A Multicenter Phase 2 Study to Evaluate Subcutaneous Daratumumab in Combination with Standard Multiple Myeloma Treatment Regimens

- Another rapid set up study.

GALLIUM:

Randomised, previously untreated with advanced NHL. R+Chemo vs GA101+chemo followed by antibody maintenance.

- Highest UK recruiter with 38 patients and 3rd highest globally.

QUAZAR:
A PHASE 3, RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY TO COMPARE EFFICACY AND SAFETY OF ORAL AZACITIDINE PLUS BEST SUPPORTIVE CARE VERSUS BEST SUPPORTIVE CARE AS MAINTENANCE THERAPY IN SUBJECTS WITH ACUTE MYELOID LEUKEMIA IN COMPLETE REMISSION

- Highest global recruiter with 22 patients

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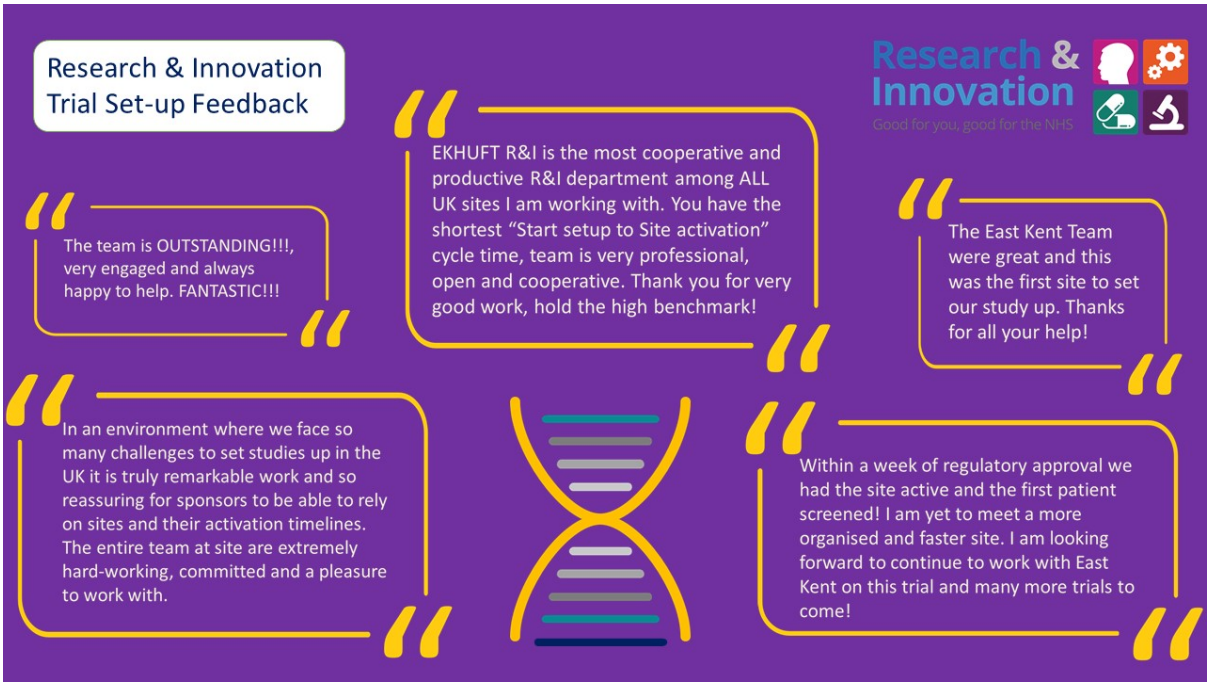
1580 GILEAD:

Dose Optimization Study of Idelalisib in Follicular Lymphoma

- 1st global patient

- Within our non-commercial portfolio we are frequently one of the highest national recruiters and been internationally highest recruiter for interventional studies such as Myeloma XI, Petrea, Pacifico, Destiny, Myeloma XV, Watch and Wait.

- Our investigators have been cited in many publications for their contributions to Commercial and Non-commercial work. These have been in the New England Journal, JCO, Lancet, BMJ, BLOOD.



We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **EKHUFT Winter Plan 2023/34**

Meeting date: **7 December 2023**

Board sponsor: **Interim Chief Operating Officer (COO) (Urgent & Emergency Care (UEC))**

Paper Author: **Programme Manager to the Chief Operating Officer**

Appendices:

Appendix 1: Tier 1 Winter update

Executive summary:

Action required:	Assurance
Purpose of the Report:	The purpose of this report is to inform the Board of the current work being undertaken in preparation for the anticipated uplift in demand for care and interventions, and most notably beds, throughout Winter 2023/24. The detail of the plans for Winter can be found in Appendix 1. The appended document acts as an update to the extended plan presented to Board in November 2023. The position of winter planning will be reviewed monthly at Clinical Executive Management Group (CEMG) throughout the winter period. The impact of the Length of Stay (LOS) workstreams and quantification of reduction in demand for beds will be presented to and monitored via the Finance and Performance Committee. Monthly updates will continue to be provided to Trust Board following the first presentation at the November 2023 Board.
Summary of key issues:	Work to date: The appended update focuses on work in train across key areas: • Improving flow through Emergency Department (ED); • Increasing capacity; • Improving discharge and supporting discharge enablement workstreams; • Expanding and better joined up health care outside the acute; • Making it easier to access the right care; • Winter escalation planning. This update was presented alongside Kent and Medway colleagues at the recent Tier 1 visits held on 29 and 30 November 2023.

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Improving Flow through ED:

- Execute NHS England's (NHSE's) Delivery Plan for recovering urgent and emergency care services;
- Focus on increasing capacity, growing the workforce, improving discharge processes, and expanding out-of-hospital care.

Increasing Capacity:

- ED Build initiatives across the UEC footprint, including dedicated care spaces. Build at William Harvey Hospital (WHH) complete, Queen Elizabeth the Queen Mother Hospital (QEQM) on schedule to complete February 2024;
- Implementation of Same Day Emergency Care (SDEC) provision for appropriate medical presentations;
- Virtual SDEC clinics to reduce reattendance and improve capacity;
- Growing the Workforce – Emergency Care Improvement Support Team (ECIST) review;
- Establishment of Care Group structure - Phase one complete;
- Overseas sourcing for nurse recruitment and ED Consultant recruitment plan- In progress.

Improving Discharge Processes:

- Embedding SAFER bundle principles across acute wards, working with PRISM and KPMG;
- Task force creation to reduce LOS and support sustained improvements post-consultancy programs;
- Engagement with Integrated Care Board (ICB) Discharge Task force for best practice sharing.

Expanding and better joined up health care outside the acute

- Expansion of P1 and P2 capacity in collaboration with Social Care;
- Implementation of GP Hub and Integrated Care Hubs;
- Development of co-located Safe Havens for mental health partnerships - Established at QEQM.

Ensuring Easy Access to the Right Care:

- Implementation of direct access pathways for more appropriate care locations – need to now monitor effectiveness and utilisation;
- Establishment of dedicated assessment units and reinforcement of alternative pathways to ED.

Winter Escalation Planning:

- Detailed review of substantive beds and the current escalation position across all sites;
- Super Surge planning collaboration with ICB for additional spaces;
- Trust-wide initiatives focusing on LOS and discharge enablement.

The current estimated winter position - EKHUFT Bed Modelling Waterfall

East Kent Hospitals University NHS Foundation Trust

	The waterfall presented in last month's Board update has been subject to review and amendment and the detail of mitigating schemes is determine. The current predictions estimate that there remains an unmitigated bed gap position of 46 beds and there remains a degree of risk with additional community capacity coming online in the expected timeframes. The Trust continues to work in partnership with Healthcare Partnership (HCP) colleagues to monitor and manage additional capacity. The focused work on reducing LOS is aimed to further reduce this gap and as this is modelled up and quantified this will be brought back to Board for assurance.
Key recommendations:	The Board of Directors is asked to **NOTE** the winter plan presented. The Board of Directors is asked to acknowledge the presented risks to the proposed schemes and the impact if the schemes do not deliver. Through regular updates to the winter plan, the status and position of the schemes proposed by the HCP will be communicated through the Trust's internal committees and the Trust Board. The impact of the LOS workstreams and quantification of reduction in demand for beds will be presented to and monitored via the Finance and Finance Committee.

Implications:

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

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Assurance route:

Previously considered by: CEMG - 18 October 2023

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NHS England
Tier 1 visit and Winter Update to Board

EKHUFT Urgent & Emergency Care (UEC) Improvement Plan – November 2023

East Kent Hospitals University NHS Foundation Trust

Context and Drivers for Change

- Emergency Department (ED), national outlier in the ED being the single point of access for all type 1 arrivals : Clinical models developed to provide alternative pathways to ED
- National outlier for Ambulance conveyances
- Workforce challenges – UEC Senior nurse turnover: ED Consultant vacant posts (Queen Elizabeth the Queen Mother Hospital (QEQM))
- ED builds QEQM/William Harvey Hospital (WHH)
- % of P3 requirements – national outlier
- Getting it Right First Time (GIRFT) review UEC July 2023 - system wide recommendations

This summary provides an overview of the programmes to deliver our UEC improvement plans, working with system partners and providers and aligning to the national priorities to transform patient care

EKHUFT Improving flow through ED

East Kent Hospitals University NHS Foundation Trust

Meeting this challenge will require sustained focus on five areas (NHS England (NHSE) Delivery plan for recovering urgent and emergency care services)

- **Increasing capacity** – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow. Delivery plan for recovering urgent and emergency care services
- **Growing the workforce** – increasing the size of the workforce, and supporting staff to work flexibly for patients
- **Improving discharge** – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter
- **Expanding and better joining up health and care outside hospital** – stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital
- **Making it easier to access the right care** – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it
- **To achieve 76%** of all patients being admitted, transferred or discharged within 4 hours by March 2024

Increasing capacity

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ED Build – increase of 21 dedicated care spaces cross UEC footprint

- ED build WHH 48 care spaces (new build) v 34 - Build complete
- ED Build QEQM 42 care spaces (new build) v 35 – Build due to complete February 2024

- Achieving same day emergency care (SDEC) provision for medicine, surgery and children. Increasing hours of provision for medical SDEC – 7 days a week . DAP for surgical and paediatric presentations
- 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.
- Clinical Decision Unit (CDU) ED models developed for patients requiring over 4 -12 hour care (QEQM in situ, WHH still being scoped)
- Formation of a clinical forum to decide on the optimal way to configure the on-site bed base
- Mental Health (MH) partnership – development of co-located Safe havens (QEQM) with Registered Mental Health Nurse (RMN) triage 24/7 support at front door

Growing the workforce

- Care Group structure in place August 2023
- Nurse recruitment – overseas sourcing. Emergency Care Improvement Support Team (ECIST) review of staffing just been undertaken
- ED Consultant recruitment plan, support from Integrated Care Board (ICB), QEQM plan in place to increase substantive cover, recent appointment of 4 ED Consultants (2 QEQM, 2 WHH)

Improving discharge

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Establishing and embedding of the SAFER bundle principles across Acute wards . Supported by PRISM QEQM (Oct 23) KPMG WHH (Nov 2023)

Established Discharge Taskforce led by care groups (WHH, QEQM, Kent & Canterbury Hospital (K&C)) to improve simple, pathway 0 discharges and compliment the work of the SAFER work. Focus Length of Stay (LoS) by ward, LLoS reviews

Involved with the ICB Discharge Task force – learning and sharing best practice :System wide Patient Choice Policy to support patients and carers

Recovery Treatment and Support (RTS)/Healthcare Partnership (HCP) interventions – developing the integrated hubs and move to a describe rather than prescribe for patients onward care needs. Aims to reduce waits for care and ensure right care first time

Site Focus plans

- Cross site review of daily rhythm and establishing programmes of work to deliver enhanced flow 7 days week
- Implementation Internal Professional Standard
- Review and update of the EHKUFT Internal Escalation plans in-line with Operational Pressures Escalation Levels (OPEL) framework
- Scoping and delivery plan for implementation of EBMS system underway
- Implementation of Care Coordination Centre best practice

Expanding and better joining up health and care outside hospital

Expansion of P1 capacity – joint partnership working with Social Care

Implementation of GP Hub

Implementation and roll-out of co-located Integrated Care Hubs

Increasing P2 capacity and expanding stroke bed provision

MH partnership – development of co-located Safe havens (QEQM)

Making it easier to access the right care

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- Implementation of direct access pathways, to provide direct access to more appropriate care locations such as SDEC and Urgent Treatment Centre (UTC) from the point of initial assessment
- Established dedicated Medical, Surgical, Paediatric assessment units (12 hour stay) with short stay units to support patients (48/72 hour stay)
- 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 senior doctor initial assessment role to improve the time to be seen by a senior clinical decision maker and optimising alternative pathways
- Delivering front door frailty provision via a roaming model in advance of being located in a new physical space with dedicated frailty units
- End of Life – dedicated space in place – QEQM

Review of ambulance conveyances to ED to identify opportunities for future avoidance

- SPOA (single point of contact , care co-ordination hub) pilot commenced Nov 2023
- 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 GIFRT team to confirm key further opportunities and to peer-review current practice. Key recommendations (5) shared with system partners and working groups set up

Partnership working /HCP schemes – integrated hubs and increasing Domiciliary care provision from the front door

- Increasing P2 community capacity (30 beds)
- Development of the Virtual Ward models, working with acute clinicians

UEC Performance – All Types

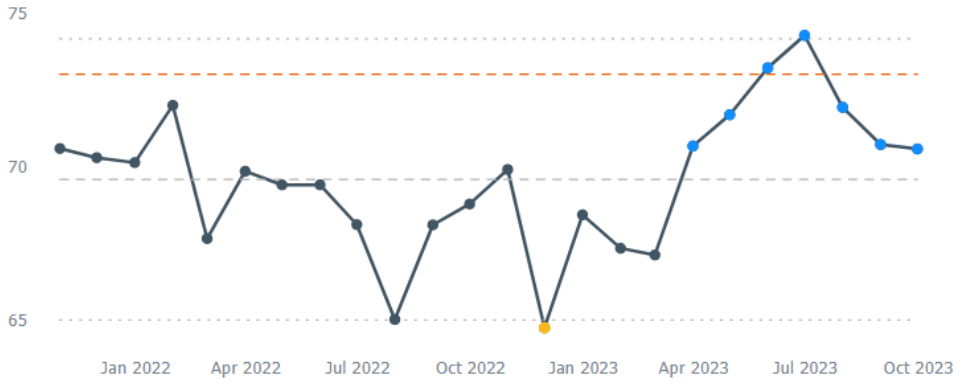
East Kent Hospitals University NHS Foundation Trust

Trust wide

ED Compliance

Timescale	Value	SPC
Nov-22	69.9%	
Dec-22	64.7%	
Jan-23	68.4%	
Feb-23	67.3%	
Mar-23	67.1%	
Apr-23	70.7%	
May-23	71.7%	
Jun-23	73.2%	
Jul-23	74.3%	
Aug-23	71.9%	
Sep-23	70.7%	
Oct-23	70.6%	

XMR Run Chart



Understanding the most recent data point

Performance

70.6%

Variation indicates inconsistently passing and falling short of the target

Variation

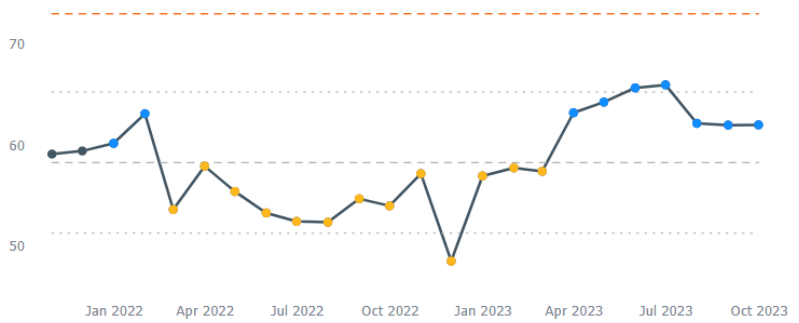
Variation: Special cause of improving nature or lower pressure due to higher values

Flags: Above Mean Run Group

WHH

Timescale	Value	SPC
01-Nov	57.1%	
01-Dec	48.4%	
01-Jan	56.9%	
01-Feb	57.7%	
01-Mar	57.4%	
01-Apr	63.2%	
01-May	64.2%	
01-Jun	65.6%	
01-Jul	65.9%	
01-Aug	62.1%	
01-Sep	61.9%	
01-Oct	62.0%	

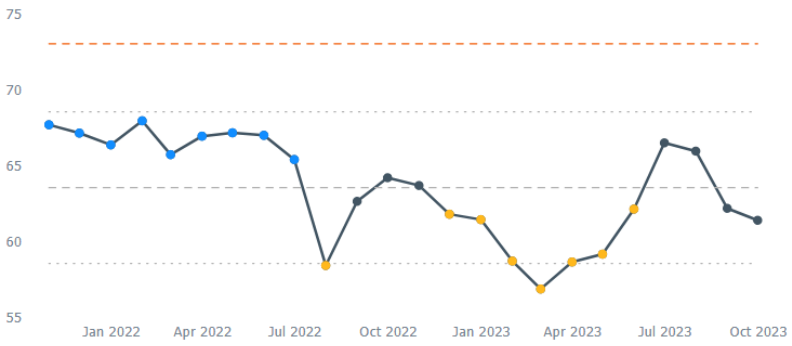
XMR Run Chart



QEQM

Timescale	Value	SPC
01-Nov	63.6%	
01-Dec	61.8%	
01-Jan	61.4%	
01-Feb	58.7%	
01-Mar	56.8%	
01-Apr	58.6%	
01-May	59.1%	
01-Jun	62.1%	
01-Jul	66.5%	
01-Aug	65.9%	
01-Sep	62.1%	
01-Oct	61.4%	

XMR Run Chart



Information for Performance

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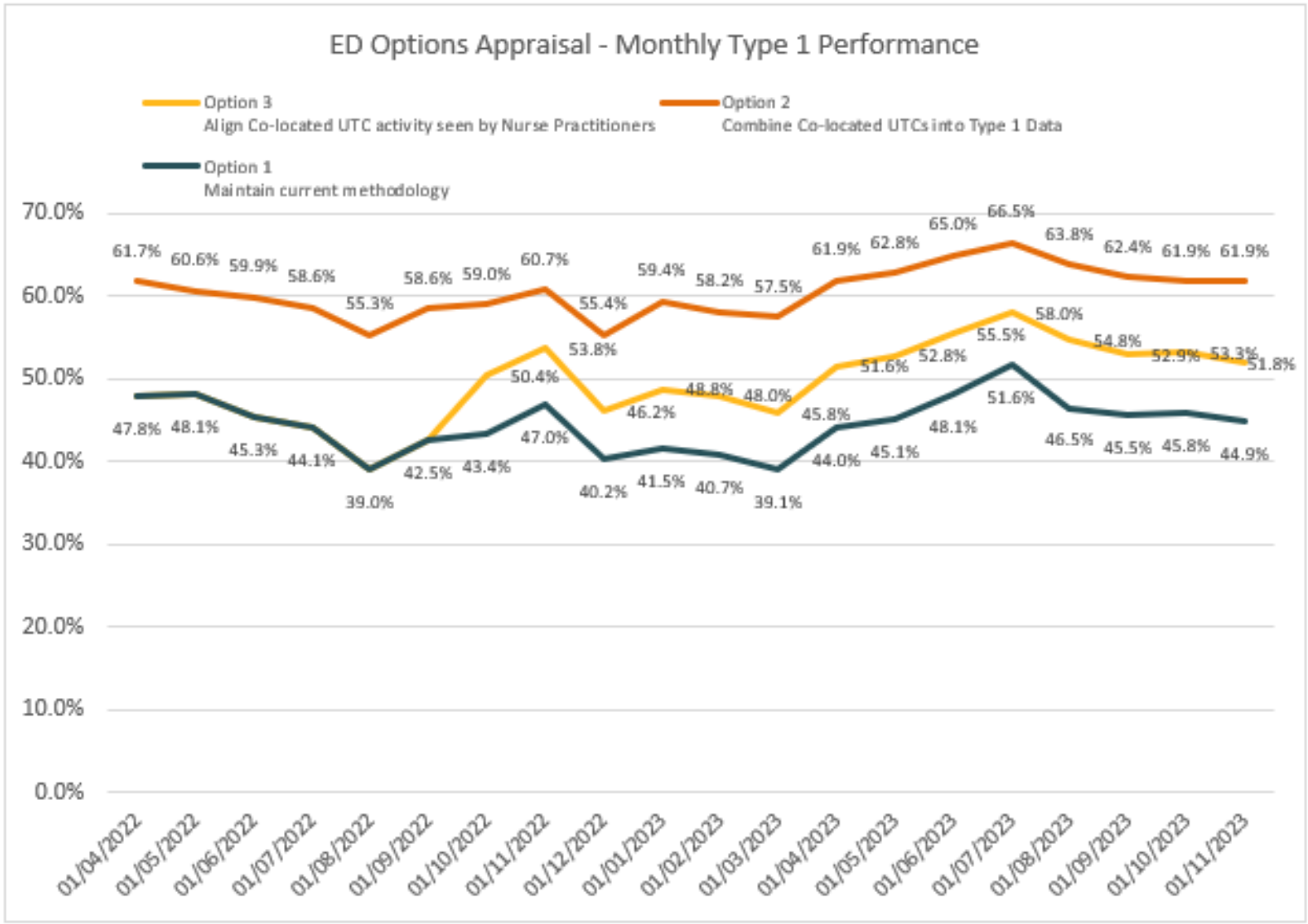

Winter escalation planning

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- **Substantive and Escalation position:**
  - Currently operating with an increased number of beds open and in use
  - Core beds operate at approximately 1074*
  - Recognised surge escalation beds at approximately 44* - this includes +1s in regular use, wards outlined for additional capacity based in planned discharges, and additional space on wards that could be utilised at times of extreme pressure

  **all capacity for core and escalation is being review across all sites – the stated figures are subject to change*

- **Super Surge planning:**
  - Collaboration with the ICB (Integrated Care Board) underway to quantify additional spaces that could be made available in super surge over winter this will include
    - Utilising patient facing ED spaces – likely impact on front door pathways
    - Consideration for the required number of surgical beds to support priority, inpatient, and day case activity across the sites
    - Identifying suitable spaces for patients in non-clinical areas. Capital investment would be required. Non-patient facing reconfiguration proposals are subject to clinical sign-off.

- **Trust wide Work in Progress:**
  - Trust wide initiatives ongoing, specifically related to Length of Stay (LoS) supported by the Trust wide Discharge Taskforce and underpinned by consultant-led improvement programmes led by Prism (QEQM) and KPMG (WHH)

Discharge enablement workstreams

East Kent Hospitals University NHS Foundation Trust

Discharge Task Force
Clinically led taskforce (Site Chief Medical Officer (CMO) and Site Director of Nursing (DoN))
Primary objective of maximise patient safety by enhancing flow, with the overarching goal across all sites to impact and reduce the Length of Stay.

This initiative aims to complement the ongoing work across the acute sites with Prism and KPMG acting as an additional layer with Prism and KMPG feeding into and reporting up to these taskforce groups. The taskforce will then support long-term and sustained improvements once these consultancy-led programs have concluded

- Requested to be set up at each site from w/c 20 November
- Review of extreme long length of stay patients – 50+ days – Executive oversight of extreme long-stay patients requested
- Review of long length of stay patients – 21 – 50 days
- Support long-term process change and sustained improvements once consultancy-led programs have concluded
- Task force to link in with the development of the Electronic Bed Capacity Management System - Business case for Phase 1 funding due for submission 4 December
- Terms of Reference provided
- Site base reporting feeding into the Emergency Care Delivery Group

Discharge enablement workstreams

East Kent Hospitals University NHS Foundation Trust

KPMG

- Continuation of the SAFER work started in August 2023
- Focus on embedding changes in discharge planning, improved board rounds, educating staff on the use of digital Patient Tracking List (PTL), identifying ward roles and responsibilities for supporting patient discharge
- Medical wards prioritised due to higher LoS
- Re-launch planned for 27 November – KPMG supported by Trust transformation team

PRISM

- The programme is in week 8
- Discovery phase completed and recommendations for key projects completed
- Key projects identified outlining areas of high-impact outcomes
- Furthermore, Prism are working with the QEQM teams to identify internal delays to inform additional internal actions