Board of Directors - Open Meeting (Thursday 5 December 2024)

Thu 05 December 2024, 01:00 PM - 05:00 PM

Webinar Teleconference

Agenda

OPENING/STANDING ITEMS

01:00 PM - 01:10 PM
10 min

24/76
Welcome and Apologies for Absence

To Note *Acting Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

24/77
Confirmation of Quoracy

To Note *Acting Chairman*

Verbal

01:10 PM - 01:10 PM
0 min

24/78
Declaration of Interests

To Note *Acting Chairman*

24-78 - Board of Directors register of interests - November 2024.pdf (3 pages)

01:10 PM - 01:10 PM
0 min

24/79
Minutes of Previous Meeting held on 3 October 2024

Approval *Acting Chairman*

24-79 - Unconfirmed BoD 03.10.24 Open Minutes.pdf (16 pages)

01:10 PM - 01:10 PM
0 min

24/80
Matters Arising from the Minutes on 3 October 2024

Approval *Acting Chairman*

24-80 - Front Sheet Open BoD Action Log.pdf (5 pages)

REGULATORY AND GOVERNANCE

01:10 PM - 01:15 PM
5 min

24/81
Acting Chairman's Report

Information *Acting Chairman*

- 24-81 - Acting Chairman BoD Report Dec 2024.pdf (3 pages)

01:15 PM - 01:25 PM
10 min

24/82
Chief Executive's (CE's) Report

Discussion *Chief Executive*

- 24-82 - CEO Report Board Dec 2024.pdf (3 pages)

01:25 PM - 01:35 PM
10 min

24/83
Integrated Care Board (ICB) Strategy (Kent and Medway NHS Strategy 2024/25 - 2029/30)

Approval *Chief Executive / Chief Strategy & Partnerships Officer (CSPO)*

- 24-83.1 - ICB Strategy EKHUFT Front Sheet.pdf (3 pages)
- 24-83.2 - ICB App 1 Development FAQs.pdf (2 pages)
- 24-83.3 - ICB App 2 K&M NHS Strategy 2024-25-2029-30.pdf (13 pages)
- 24-83.4 - ICB App 3 Strategic Theme A3s enabler proposals.pdf (20 pages)
- 24-83.5 - ICB App 4 Equality Impact Assessment.pdf (8 pages)

01:35 PM - 02:05 PM
30 min

24/84
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 24-84.1 - Front Sheet October IPR.pdf (4 pages)
- 24-84.2 - App 1 Board IPR _v6.0_Oct24_FINAL.pdf (57 pages)

24/84.1
Month 7 Finance Report

Information *Chief Finance Officer (CFO)*

- 24-84.1.1 - Finance M7 Open Board Nov 2024.pdf (2 pages)
- 24-84.1.2 - App 1 Board Finance Report SHORT Final.pdf (6 pages)

02:05 PM - 02:15 PM
10 min

24/85
Report on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)

Discussion *Chief Strategy & Partnerships Officer (CSPO)*

- 24-85.1 - IIP Progress Report 22.11.24.pdf (2 pages)
- 24-85.2 - App 1 Board IIP Progress Report FINAL.pdf (12 pages)

02:15 PM - 02:30 PM
15 min

24/86
Trauma Unit Peer Review Report

Assurance *Chief Medical Officer (CMO) / Major Trauma Director*

Presentation

- 24-86 - Major trauma pressentation Board.pdf (28 pages)

02:30 PM - 02:40 PM
10 min

24/87
Board Assurance Framework (BAF)

Information *Director of Corporate Governance (DCG)*

- 24-87 - BAF Board 5 December 2024.pdf (7 pages)

02:40 PM - 02:50 PM
10 min

24/88
Risk Register Report

Assurance *Chief Nursing & Midwifery Officer (CNMO)*

- 24-88 - BoD Significant Risk Report 05.12.24 final.pdf (24 pages)

02:50 PM - 03:00 PM
10 min

TEA/COFFEE BREAK 2:50 - 3:00 (10 MINS)

03:00 PM - 03:10 PM
10 min

24/89
Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report

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

- 24-89 - BoD Overarching report MNAG November 24.pdf (8 pages)

03:10 PM - 03:20 PM
10 min

24/90
Care Quality Commission (CQC) Update Report

Assurance *CNMO*

- 24-90.1 - Board CQC Report Dec 2024 final.pdf (13 pages)
- 24-90.2 - App 1 WACA report Nov 2024.pdf (6 pages)

03:20 PM - 03:30 PM
10 min

24/91
Winter Planning and Capacity

Discussion *Chief Operating Officer (COO)*

Paper to follow

03:30 PM - 03:40 PM
10 min

24/92
Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)

Assurance *Interim Chief People Officer (CPO)*

- 24-92.1 - Front Sheet WDES WRES for Board.pdf (3 pages)
- 24-92.2 - App 1 WRES Action Plan 2024-25.pdf (6 pages)
- 24-92.3 - App 2 WDES Action Plan 2024-25.pdf (7 pages)

Patients - Quality and Safety - Partnerships - Sustainability - People

03:40 PM - 04:30 PM
50 min

24/93
Board Committee - Chair Assurance Reports:

Board Committee Chairs

24/93.1
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (3.40 pm to 3.45 pm)

Assurance *Chair NRC - Dr Andrew Catto*

Verbal

24/93.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3.45 pm to 3.55 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

24-93.2 - QSC Chair's Report Sept.pdf (5 pages)

24/93.3
Finance and Performance Committee (FPC) - Chair Assurance Report (3.55 pm to 4.05 pm)

Assurance *Chair FPC - Richard Oirschot*

24-93.3 - FPC Board Report Oct.pdf (5 pages)

24/93.4
People and Culture Committee (P&CC) - Chair Assurance Report (4.05 pm to 4.15 pm)

Approval *Chair P&CC - Claudia Sykes*

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

24-93.4 - PCC Board report 27.11.24.pdf (4 pages)

24/93.5
Charitable Funds Committee (CFC) - Chair Assurance Report (4.15 pm to 4.20 pm)

Assurance *Chair CFC - Claudia Sykes*

Verbal

24/93.6
Integrated Audit and Governance Committee (IAGC) - Chair Assurance Report (4.20 pm to 4.30 pm)

Approval *Chair IAGC - Dr Olu Olasode*

- **2gether Support Solutions Annual Report and Financial Statements 2023/24**
- **Spencer Private Hospitals 2023/24 Annual Report and Audited Financial Statements**
- **East Kent Hospitals Charity Annual Report and Accounts 2023/24 and Letter of Representation**

24-93.6.1 - IAGC Board Chair Report Nov 2024 Final.pdf (6 pages)
24-93.6.2 - App 1 2gether Annual Report Financial Statement 31.03.24.pdf (38 pages)
24-93.6.3 - App 2 SPH Limited 2023-24 accounts (signed).pdf (33 pages)
24-93.6.4 - App 3 EKHC Annual Report 2023-2024 V5.pdf (46 pages)
24-93.6.5 - App 4 EKHC letter of representation.pdf (3 pages)

04:30 PM - 04:40 PM
10 min

24/94
Research and Innovation (R&I) Report

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

24-94 - Research and Innovation Board Dec 2024 final.pdf (19 pages)

CLOSING MATTERS

04:40 PM - 04:45 PM
5 min

24/95
Any Other Business

Discussion *All*

Verbal

04:45 PM - 05:00 PM
15 min

24/96
Questions from the Public

Discussion *All*

Verbal

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

Date of Next Meeting: Thursday 6 February 2025

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM NOVEMBER 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
BAIRD, STEWART	Acting Chairman	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)**	1 June 2021 (First term)
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)** School Governor, Twyford School (Winchester) **(4)**	1 October 2022 (First term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023
HODGKISS, ROB	Interim Chief Operating Officer	None	2 January 2024

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM NOVEMBER 2024

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

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM NOVEMBER 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)
van der LEM, ANGELA	Chief Finance Officer	None	6 November 2024
VINER, DEBORAH	Interim Chief People Officer	None	2 September 2024
WALKER, CATHERINE	Non-Executive Director	Deputy Chair/Non-Executive Director/Senior Independent Director, Kent and Medway NHS and Social Care Partnership Trust **(1)** Chair of Advisory Appointments Committee, Kings College NHS Foundation Trust **(1)** Tribunal Member, Ministry of Justice **(1)** Panel Member/Chair, High Speed 2 **(1)** Panel Member/Chair, East West Rail **(1)**	25 October 2024 (First term)
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

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

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

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND FOURTIETH MEETING OF THE BOARD OF DIRECTORS (BoD)
THURSDAY 3 OCTOBER 2024 1.00 PM
HELD IN THE SEMINAR ROOMS, BUCKLAND HOSPITAL, DOVER AND WEBINAR TELECONFERENCE

PRESENT:

Mr S Baird	Acting Chairman (Chair)	SB
Dr A Catto	NED/Quality and Safety Committee (Q&SC) Chair/Nominations and Remuneration Committee (NRC) Chair	AC
Ms T Fletcher	Chief Executive (CE)	TF
Mr T Glenn	Interim Chief Finance Officer (CFO)	TG
Ms S Hayes	Chief Nursing and Midwifery Officer (CNMO)	SH
Mr R Hodgkiss	Chief Operating Officer (COO)	RH
Dr D Holden	Chief Medical Officer (CMO)	DH
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Mr B Stevens	Chief Strategy and Partnerships Officer (CSPO)	BS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair/People & Culture Committee (P&CC) Chair/*Reading the Signals Oversight Group* Chair	CS
Ms D Viner	Interim Chief People Officer (CPO)	DV

ATTENDEES:

Mr M Blakeman	Improvement Director NHS England (NHSE)	MB
Ms K Costelloe	Operations Director (Ops Director), Women's Health Care Group (WHCG) (Webinar) (minute number 24/069)	KC
Mr K Desai	Director of Corporate Governance (DCG)	KD
Ms C Doran	Quality Lead for East Kent locality, NHS Kent & Medway Integrated Care Board (ICB)	CD
Ms K Edmunds	Associate Director of Patient Experience (ADoPE) (minute number 24/059)	KE
Professor C Holland	Associate NED	CH
Ms S Hutchinson	Co-Chief Executive Officer, Beyond the Page (minute number 24/059) (supported by two members of the United Mothers Group)	SHu
Ms A Smith	Deputy Director of Midwifery (DDoM) (Webinar) (minute number 24/069)	AS
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Miss S Robson	Board Support Secretary (Minutes)	SR

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

Ms M Bonney	Governor
Ms C Heggie	Member of the Public
Ms V Jerram	Member of Staff
Ms B Mayall	Lead Governor
Ms A Mitchell	Member of Staff
Ms G Oliver	Member of Staff
Ms C Walker	Member of the Public
Ms M Warburton	Member of the Public
Ms H Waymouth	Member of Staff
Ms L Williams	Member of Staff

MINUTE NO.		ACTION

24/056 **CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE**

The Acting Chairman opened the meeting, welcomed everyone present, and noted apologies received from Mr S Corben (SC), NED/2gether Support Solutions (2gether) NED In-Common; and Dr O Olasode (OO), NED/Senior Independent Director (SID)/Integrated Audit and Governance Committee (IAGC) Chair.

The Acting Chairman thanked Tim Glenn, Interim CFO, for his support and hard work since joining the Trust on secondment in November 2023, noting this was Tim's last formal Board meeting. Tim would be leaving the Trust at the end of November, and the appointed substantive CFO, Angela van der Lem, was starting on 21 October 2024.

24/057 **CONFIRMATION OF QUORACY**

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

24/058 **DECLARATION OF INTERESTS**

There were no new interests declared.

24/059 **PATIENT STORY**

The ADoPE introduced representatives from Beyond the Page's United Mothers Group, who presented their experiences and barriers around accessing local health services, noting the following:

- Generally feedback from the community of migrant women living in Thanet was positive, noting there was always room for improvements;
- Short YouTube film shared on screen;
- Key themes identified from research where changes were needed across all health services including the following:
  - discrimination and bias existed in services;
  - users felt lonely and were spoken to differently;
  - English language and literacy a barrier, more support needed for women communicating their health issues, as well as understanding what health professionals were communicating to them was a high issue;
  - More recognition needed of diverse communities around communications and literature (in respect of translation and interpretation, although this related more for GP services), challenges with people not being able to access traditional and online communication. Provision of an interpreter not relying on a family representative that was positive, as some women might not wish a relative to interpret, recognising some women might be happy this was a relative. Health professionals to be aware and clear that what they had relayed had been understood in respect of medical terminology, and that some women might not wish a relative to be present in consultation room;
  - being given sufficient time during consultations, and awareness of the need to engage earlier within the early years services;

- difficulties accessing GP appointments resulting in attending Accident & Emergency (A&E), and some individuals returning to their home country as had been unable to access required treatment;
- consider needs of those waiting in A&E waiting area in respect of checking their needs around provision of drinks and food;
- additional engagement with Midwifery services around evidence based risks and higher maternity mortality of women from ethnic minorities.
- Stakeholder's group being scheduled with the Early Years services, Trust's Patient Experience team would be attending and it was hoped this would also include the Midwifery team.

The Acting Chairman enquired whether advocacy support was provided. Beyond the Page's Co-Chief Executive Officer emphasised they were a small non-profit Charity and in addition to the services they provided, were able to offer support with making appointments (including online), but not attending appointments.

The Acting Chairman asked what was the key area of support the Trust could provide. The Beyond the Page's Co-Chief Executive Officer stated the key area was communication, provision of information in multiple languages detailing all the services available. There was discussion about information provided on the Trust's website and how this could be accessed by users in their preferred language choice, noting other trusts used a system that enabled users to click their language of choice to enable the information to be appropriately translated. To look at information and this being provided in a simplified and easily understandable by users. The ADoPE reported the Patient Experience team were looking at patient information and this being produced for a reading age of nine, to enable this to be understandable and easier to translate, and staff awareness of this.

ACTION: Liaise working together to explore the feasibility of the Trust's website being able to translate/speak providing information/text into users preferred language choice. Also look at the feedback around difficulties of digital accessibility, and the feasibility of producing a video for health professionals raising awareness of how to speak/treat service users with empathy ensuring everyone had a positive patient experience when accessing healthcare services.. — EDC&E/ ADoPE

The EDC&E enquired whether sufficient time was allocated for appointments. The ADoPE commented if some services were aware an interpreter was required they booked a double appointment to ensure sufficient allocation of time, that this was advisable but unfortunately was not always followed, and sometimes the need for an interpreter was not picked up until much later.

The COO raised the employment opportunities within the Trust for the local population and what could be done to promote these within the community groups and with migrant women.

ACTION: Liaise with the ADoPE and Beyond the Page's Co-Chief Executive Officer to look at and explore the possibility of extending/promoting opportunities available with Apprenticeship roles to migrant women in the community. — Interim CPO

NHSE's Improvement Director enquired whether there was a nationally available document that provided information explaining about the NHS services, how these were delivered, and how they could be accessed. Beyond the Page's Co-Chief Executive Officer stated she was unaware there was and that this was covered in the classroom sessions provided by the Charity. The ADoPE commented this could be explored to look at producing this information locally.

The Board of Directors discussed and **NOTED** the Patient Story.

24/060 **MINUTES OF THE PREVIOUS MEETING HELD ON 25 JULY 2024**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 25 July 2024 as an accurate record.

24/061 **MATTERS ARISING FROM THE MINUTES ON 25 JULY 2024**

B/17/22 – Board Committees Terms of Reference (ToR)
It was noted as part of the external Governance Review, all Board Committee ToR would be reviewed in the New Year. The Board of Directors **APPROVED** this action for closure.

B/06/23 – Redesigning Patient Pathways in the Emergency Departments (EDs)
The COO reported once all of the new services had been introduced, there would be a review looking at new signage across all areas.

The Acting Chairman requested a map showing how ED services had improved (from where the Trust was five years ago against current position).

ACTION: Review with the CMO, CNMO and Care Groups following introduction of the new services to look at new signage across all areas reflecting these new services and triangulating this around having in place appropriate clear signage as well as well as signposting for patients. — COO

ACTION: Produce a map showing how ED services had improved (from where the Trust was five years ago against the current position). — COO

B/02/24 – Lessons learnt review on EDs expansion builds at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM)
The CSPO stated the After-Action Review executive summary report appended summarised the findings and recommendations, as well as good practice, areas for improvement and learning for future projects. Key areas of learning included consistency for large capital projects engaging Senior Responsible Owners (SROs)/Executive Sponsors providing clear oversight where there was multiple stakeholders. The Board of Directors **APPROVED** this action for closure.

The Acting Chairman commented on the positive engagement with users providing input and ideas around the design and to remember to do this for future projects.

B/03/24 – Patient Advice and Liaison Service (PALS)
It was noted the 2023 – 2024 Complaints, PALS and Compliments Annual Report presented at this meeting. The Board of Directors **APPROVED** this action for closure.

B/12/24 – NHS Kent & Medway Integrated Care Board (ICB) Strategy 2024/25 – 2029/30
It was noted the draft Strategy was presented and discussed at the 5 September Board Development Strategy Session. The Board of Directors **APPROVED** this action for closure.

B/13/24 – Changes to Hospital Standardised Mortality Ratio (HSMR)

It was noted an assurance briefing was circulated to Board members on the changes to HSMR. The Board of Directors **APPROVED** this action for closure.

B/14/24 – Equipment Wraps
The COO and CNMO reported to address the issues of holes in equipment wraps, provision of tins purchased that was anticipated would resolve this, with ongoing surveillance and scrutiny by the Infection Prevention and Control Committee and Q&SC. Future updates would be presented as part of the regular Q&SC Chair Assurance Reports. The Board of Directors **APPROVED** this action for closure.

The CMO highlighted the positive feedback from staff teams that their voices had been heard about this issue, that it had been taken forward, addressed and resolved.

B/15/24 – Care Quality Commission (CQC) Reports
Regular CQC reports were presented to Q&SC, a CQC and Well Led progress update report would be provided to a future BoD meeting. The CNMO would liaise with the Q&SC NED Chair about presenting a CQC and Well Led update report along with progress update on Must Do and Should Do requirements to a future BoD meeting following presentation at Q&SC.

ACTION: Liaise with the Q&SC NED Chair about presenting a CQC and Well Led update report with progress updates on Must Do and Should Do requirements (trajectory for closure by December) to a future BoD meeting following presentation at Q&SC. — CNMO

B/16/24 – CQC Open Requirements and Actions
It was noted the update presented on the number of open actions relating to Must and Should Do actions. The Board of Directors **APPROVED** this action for closure.

B/17/24 – NEDs feedback template for site visits
The DCG reported a feedback form had been produced looking at whether this could be completed and submitted as an online form. The Board of Directors **APPROVED** this action for closure.

B/18/24 – Admin & Clerical (A&C) listening actions
The COO reported the A&C Forum was now up and running and progress updates would be provided at the Culture and Leadership Programme Steering Group. The Board of Directors **APPROVED** this action for closure.

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

24/062 **CHAIRMAN'S REPORT**

The Acting Chairman highlighted the following key elements:

- Annual Members' Meeting (AMM) held 5 September, well attended (in person and online) with good discussion and questions;
- Thanks to all Trust staff, across all areas, who were working extremely hard managing patient demand, particularly increased demand in EDs. Staff were also supporting the Trust's improvement journey to exit NHS Oversight Framework (NOF4) working towards achieving improved NOF3 position;

- Recognised not all patients received the expected standard of care, committed to focussing on making improvements;
- Two NEDs regularly visited the Trust's two EDs (at varying times during the day and week) to see first-hand patient care and experience, and the increased demand on services experienced by the staff;
- National Staff Survey (NSS) launched, encouraged all staff to complete providing feedback, it was vital to hear from all staff about what was going well and not so well, along with what improvements were needed. Improvement in number of staff completed survey from the previous year

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

24/063 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE highlighted the following key points:

- Thanks to Tim Glenn, Interim CFO, for his commitment and support to the Trust and her personally, wishing him the very best for the future;
- Rob Hodgkiss, COO, would be leaving the Trust in early 2025, thanks to his leadership supporting the Trust in achieving performance improvements.

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

24/064 **INTEGRATED CARE BOARD (ICB) STRATEGY**

The CSPO provided a verbal progress update noting the following key points:

- Strategy currently being developed under four strategic themes:
  - Patient Experience, Access and Outcomes;
  - People;
  - Sustainable Services;
  - Financial Sustainability.
- Around a system approach sustainably working together to achieve this within described vision and goals;
- Good discussions and input from all parties across the Kent & Medway (K&M) system;
- Strategy expected to be presented to Boards in December 2024/January 2025 for approval.

The Board of Directors **NOTED** the verbal report on progress to develop an ICB Strategy.

24/065 **INTEGRATED PERFORMANCE REPORT (IPR)**

The following key performance points were noted for the month of August 2024:

Integrated Improvement Plan (IIP)

- Slight increase in response rate to 2024 NSS, as at previous day overall response rate currently of 32% (increase of 10% from the same time the previous year, equating to 3,209 respondents (1,000 more than previous year));
- Good progress against the Trust's IIP and its four workstreams.

Patients

- Continued good progress with improvements generally across all areas, with remaining challenges due to increased demand;
- Type 1 compliance continued to exceed tier 1 milestones in each month, August was 56.2%, this had continued to improve in September, aggregate A&E performance around 78%;
- Reduction in 12 hour total time in ED, was still not as the Trust would like, with ongoing work to further improve this supported by the alternative patient pathways to be implemented;
- Continued pressures with patient activity and increasing number of patients residing in the hospitals who no longer medically fit the requirements to reside in hospital. Work being progressed across the system to increase community capacity supporting these patients around their ongoing care and treatment needs;
- Cancer 28 day faster diagnosis compliance over last four consecutive months continued above 70%,which had also continued in September. Performance against the 62 day compliance at 73.9% in August;
- Significant work to improve performance against long waiting patients, 65 week waits now at 1,269 at August, reduced to 572 at end of September, with a clear plan to get these to zero by the end of December 2024;
- Endoscopy backlog reduced from a total of 14,000 patients in January, currently at a sustainable 5,000;
- Diagnostic compliance continued to improve, 63.9% at August;
- Thanks to staff across all the sites for their hard work in achieving these significant performance improvements.

Quality & Safety

- Continued work focussing on addressing and reducing the number of patient falls, with no increases seen;
- Overdue incident backlog had reduced significantly, on track to reduce this by the end of October;
- Slight increase in performance of complaint responses and on track to meet the 85% compliance trajectory by December;
- Duty of Candour (DoC) data was now up to date with a focus on ensuring going forward that DoC was met;
- Two never events reported in August, one related to a wrong site block and one wrong route administration of medication, immediate actions put in place along with supporting the patients and staff;
- Below *Clostridioides difficile* (C-dif) threshold, above thresholds for *Pseudomonas* and *Klebsiella*, Trust remained focussed on its CLEAN campaign.

The NEDs enquired how the complaint response trajectory would be achieved as significant improvement was required in only a few months, and how the Board could be assured about the quality of responses. The CNMO stated she along with the CMO signed off all complaint responses, of which had improved. There had been work with staff around training, centralisation of the Complaints team, and over the last month a 5% improvement in the response rate, noting a drop in those not satisfied with the response provided and that this needed to be assessed over a longer period, which was monitored by the Q&SC.

People

- Sickness absence improved in August, reducing to 4.52% (below the 5% threshold) this continued to relate to stress, anxiety and depression;

- Vacancy rate increased to 9.6% at the highest it had been for last 12 months. Primary reason for this was the holding of Band 2 Healthcare Support Worker (HCSW) vacancies due to current review being undertaken;
- Overall staff turnover at 8.9%, lowest for last 18 months. Nursing turnover continued to improve now at 7.8%, HCSW at 10.3%, increase in premature turnover the alerting threshold that had since reduced;
- Statutory training compliance continued to improve at 92.4%, medical staff compliance below expected threshold that had improved in month to 80.2%.

The NEDs raised an issue they had been made aware of following a site visit in respect of gaps in clinical supervision that potentially could be impacting increased staff sickness absence. It was agreed the NED and CNMO would have a discussion outside the meeting to review the specific area where this was raised.

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

24/065.1 **MONTH 5 FINANCE REPORT**

The Interim CFO reported on the following key points:

- At Month 5 Trust achieved its planned deficit, really positive position, thanks to all staff for their continued hard work and commitment, noting the current level of focussed work was unsustainable;
- Trust and Board were committed to reducing its deficit, recognising the significant improvements achieved, whilst recognising significantly more work was needed to ensure a continued improved sustainable financial position.

The Acting Chairman commended all Trust staff with the progress to deliver the Cost Improvement Programme (CIP) target, currently £0.3m ahead of plan year to date (YTD) currently at a total of £19m. Noting for the Trust to secure any additional funding that might become available, it needed to show robust grip and control of its finances and expenditure.

The Board of Directors reviewed and **NOTED** the financial performance of Month 5.

24/066 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO highlighted the following key points:

- Leadership, Governance & Culture programme rated amber, due to achievement of outstanding metrics (improved engagement plan, and increased NSS response rate). Confident milestones to be achieved by YE;
- Urgent and Emergency Care (UEC) and Planned Care programmes rated amber;
- Collation of evidence as progress was being taken forward;
- Thanks to all staff supporting to progress this complex IIP;
- Quarterly reviews of evidence providing assurance of progress working towards achieving the targets, and the support and confidence with partners of the improvement work.

NHSE’s Improvement Director acknowledged the significant improvements achieved to date, the realistic targets identified, whilst recognising the risks going

into the busy winter period that was a key challenge in achieving the targets. The NHSE oversight framework was likely to change in the next couple of months, he would work closely with and support the Trust to update its IIP reflecting any changes. He suggested it would be beneficial for a discussion about the IIP vulnerabilities, risks and mitigations at a future Board Development Strategy Session.

ACTION: Liaise with NHSE's Improvement Director to schedule a future Board discussion session about the IIP vulnerabilities, risks and mitigations in place at a future Board Development Strategy Session. — DCG

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

24/067 RISK REGISTER REPORT

The CNMO highlighted the following key elements:

- Risks monitored by the Board Committees, with identified responsible Executive Directors and Risk Owners;
- Risk related to cyber threats escalated to the Significant Risk Register (SRR), some risks had been consolidated, risks de-escalated following robust review of the mitigations in place;
- Working with 2gether Support Solutions (2gether) to ensure risks on their risk register where appropriate were represented on the Trust's Strategic Development, Capital Planning and Estates Risk Register.

The Acting Chairman suggested to support validating the risk management process was working effectively for NEDs as part of their site visits when interacting with staff any highlighted areas of concern and risks that needed addressing.

ACTION: Include in NED site visit feedback template section in respect of the risk management process and this supporting validation that this was effective, taking into consideration feedback from interacting with staff during these visits and their feedback on any areas of concern. — DCG

The Associate NED raised concern about the impact for staff in respect of violence and aggression, their experience, physiological harm and receiving an update on the actions to support staff and reduce incidents. The CSPO reported increased security presence had been put in place, specifically overnight at WHH and QEQM and that staff had the required skill set to intervene as well as de-escalation. The CNMO stated a great deal of work had been undertaken to address this issue and agreed to liaise with the P&CC NED Chair about future quarterly progress update reports being presented to this Board Committee.

ACTION: Liaise with the P&CC NED Chair to agree timeline for presentation of future quarterly progress update reports to P&CC on the actions to address and support reducing incidents of violence and aggression against staff, ensuring staff were supported in managing their experience and physiological harm. — CNMO

The Board of Directors:

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

24/068 **INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT 2023-2024**

The CNMO highlighted the following key elements:

- As part of CNMO role this incorporated the role of Director of IPC (DIPC), noting a Deputy DIPC in place along with a full IPC team;
- Annual report presented through the governance structure including the IPC Committee and Q&SC, with regular IPC reports presented to Q&SC;
- Challenges due to Trust's age of its estates in maintaining appropriate IPC and hygiene, noting improvements in rate of C-dif, and working hard to reduce rates of other infections;
- Focussed workstream being taken forward on Antimicrobial Stewardship;
- Plan for the next year around work reducing infections (particularly bloodstream and inline infections), and promoting Trust's CLEAN campaign;
- Implementation of Patient Safety Incident Response Framework (PSIRF) would be around themes investigations.

The Acting Chairman enquired how the Trust performed against peer trusts. The CNMO stated historically Trust's performance was poor and that over the last year its performance had improved and was no longer an outlier. Focussed improvement work would continue, Nationally there had been a change to reportable thresholds increasing that required to be achieved.

The Acting Chairman raised the point in the report that the Trust had breached most of the external thresholds for reportable infections and would be beneficial for the Board to receive a summary index of how the Trust performed against its peers.

ACTION: Circulate to Board members the summary report provided to the ICB on the Trust's IPC performance and how it performed against its peers. — CNMO/ Deputy DIPC

DECISION: The Board of Directors received and **APPROVED** the IPC Annual Report 2023-2024.

24/069 **WOMEN'S CARE GROUP MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) CHAIR'S REPORT**

The Deputy DoM highlighted the following key points:

- Maternity and Neonatal Improvement Programme Board meetings had started with Executive Senior Responsible Officers (SROs) holding workstream leads to account;
- Continued improvement work aiming to achieve a CQC good rating;
- Overdue Policies: 15 out of 106 Guidelines expired, 5 out of 59 Patient Information Leaflets (PILs) expired, due to delays with the improvement work the service aimed to clear these backlogs by October;
- Plans for dedicated bereavement suite in labour ward were complete;
- Business case for £25m new proposed two obstetric theatres and consultant led delivery suite at QEQM were progressing (now at design phase) with £1.6m funding awarded for initial works. Temporary solution around reconfiguration of recovery area with labour ward to a treatment room being scoped supported by theatres, anaesthetics and clinical teams;
- Service continued working towards achieving full compliance with Year Six Clinical Negligence Scheme for Trusts (CNST) requirements, noting

pathways of care into transitional care (TC) in place, as well as weekly cross-site Multi-Disciplinary Team (MDT) meetings;
- Review of sustainable model for obstetric workforce, review and change to WHH 24-hour consultant on-call rota, business case submitted for four additional middle grades (trainees) to facilitate development of a 2 tier on-call rota for BoD approval of the action plan;
- Neonatal nursing workforce action plan for BoD approval, WHH NICU non-compliant at 68%, and QEQM SCBU non-compliant at 56.4%, Trust continued to actively recruit staff;
- Fetal Anomaly Screening Programme (FASP) update, immediate actions being progressed (including team working), further progress update report to be presented to MNAG;
- Perinatal Quality Surveillance Tool (PQST) update, one new risk added to risk register in respect of lack of compliance with annual Newborn and Infant Physical Examination (NIPE) training, weekly reviews of training data to ensure compliance and meeting the planned trajectory;
- External review final report of neonatal deaths expected by December 2024, to identify any common factors, themes or care, any recommendations to improve care and reduce preventable neonatal mortality. All deaths were reviewed internally by the Trust;
- Student midwives due to qualify in December, all of current students had expressed an interest in staying with the Trust and had been offered midwifery positions;
- Update on Entonox risk assessment and the actions.

The COO commented on the neonatal nursing workforce that was a challenge nationally, and enquired how the Trust compared with other trusts, noting it would be beneficial for this data to be included in future reports. The CNMO confirmed the Trust was not an outlier in respect of it being non-compliant and that London trusts were operating at a lower percentage.

ACTION: Include in future MNAG Char Assurance Reports a summary of comparison data on how the Trust compared with similar Trusts in respect of its neonatal nursing workforce percentage.

CNMO/ DoM/ Deputy DoM

The Acting Chairman enquired about the maternity staff response rate to the NSS. He continued to visit the sites with the CNMO, that there had been a noticeable change in staff culture who were much more open, and it was important to drive forward the minor works needed and that these be completed quickly. The WHCG Ops Director confirmed the current response rate for maternity of 11% compliance (improvement on the previous week), WH at 19.4%, obstetrics and gynaecology at 29.3%, recognising more work was needed to further improve these numbers. It was noted the two outstanding CQC Must Do requirements (out of 20) related to environment and facilities with mitigations in place awaiting funding for the proposed two new obstetric theatres at QEQM.

The Board of Directors:

- **NOTED** the MNAG Chair Assurance Report from the 13 August and 10 September 2024 MNAG meetings;
- **APPROVED** the Obstetric Medical Workforce (CNST Safety Action 4) action plan in relation to the middle grades;
- **NOTED** and **APPROVED** the Neonatal Nursing Workforce (CNST) action plan.

24/070 **COMPLAINTS, PATIENT ADVICE AND LIAISON SERVICE (PALS) AND COMPLIMENTS ANNUAL REPORT 2023-2024**

The CNMO highlighted the following key elements:

- Further work was still needed around complaint themes and compliments;
- Trust's process for managing complaints, compliments and PALS was patient-focused and based on the Parliamentary Health Service Ombudsman (PHSO) six principles for good complaint handling;
- Regular reports presented to Q&SC.

The Acting Chairman emphasised the need to ensure focus on investigating, resolving and responding to complaints quickly. The NEDs highlighted the benefits of sharing learning and what was happening in other areas across the organisation, noting this appeared to be in place at WHH but not at QEQM. It was important staff were informed of compliments received and asked how these were feedback. The CNMO stated learning was a key priority of focus in the New Year, the Trust's IT team were working on how Friends and Family Test (FFT) feedback could be easily accessed by clinicians, and a system used by other trusts was being explored. It was noted the ongoing work in respect of back to basics that was key in supporting positive patient experience, recognising the need for continued close monitoring. The CE commented she often received compliments direct that she shared with the appropriate staff as well as responding to the author.

DECISION: The Board of Directors **APPROVED** the Complaints, PALS and Compliments Annual Report 2023-2024 for publishing on the Trust website, for public review.

24/071 **WINTER PLANNING AND CAPACITY**

The COO provided a verbal report highlighting the following key elements:

- Winter planning was ongoing, staff working extremely hard. Anticipated the plan would be confirmed for sign off in the next couple of weeks and expected the full Winter Plan would be presented to the October FPC and November Q&SC meetings;
- Work in respect of alternative pathways, progressing initiatives, and reducing length of stay (LoS), noting the bed deficit remained at 86 beds;
- Meeting held with ICB that morning with discussions about additional funding capacity provision to support Pathway 1 patients to support reducing the bed deficit to 56;
- Continued significant demand on the Trust's services resulting in the increased pressure and escalation to OPEL4.

The NEDs raised concern about the number of No Longer Fit to Reside (NLFTR) patients, the actions to reduce these and what care could be provided outside the hospital (e.g. care homes), as well as supporting patients in the EDs who were being managed for longer periods due to increased demand. The COO commented this was a system wide issue for resolving with ongoing discussions across the system, as well as raising the Trust's challenges on how this could be effectively addressed supported by winter funding.

The Board of Directors **NOTED** the verbal progress update in respect of winter planning and capacity.

24/072 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

24/072.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair highlighted the following key issues:

- Ratification of current Interim Deputy CPO acting up as Interim CPO, and appointment and salary of CFO, Angela van der Lem;
- Approval applying annual award (cost of living pay uplift) of 5% for all Very Senior Managers (VSMs) backdated to 1 April 2024;
- Progress update on the recruitment process for substantive CPO and COO;
- Appointment of new NED, alignment of NED commitments with current NEDs in post, and commitments to be further reviewed in six months;
- Approval of the Fit and Proper Persons Requirements Policy.

The Board of Directors **NOTED** the 1 October 2024 NRC Chair Assurance Report.

24/072.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

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

- Safe systems for controlled drugs (CDs) was an area of concern, deep dive to be carried out reporting to a future meeting to review and monitor that improvements were being made;
- National Institute for Health and Care Excellence (NICE) Guidance compliance improvement plan in place with shown improvements.

The CMO thanked the Kent & Canterbury Hospital (K&C) Medical Director for their hard work and support leading the NICE guidance improvement work increasing compliance, and testing compliance would be undertaken at the end of the year.

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

24/072.3 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- All performance metrics continued to improve;
- Patients NLFR had increased, area of concern approaching winter period;
- Work continued on the transition plan around the provision of support from PricewaterhouseCoopers (PwC) to ensure internal capacity in delivering the Financial Sustainability Plan (FSP) and CIP. Further report to be presented to a future FPC meeting;
- Month 5 financial position was on forecast against the annual plan;
- Business Planning Principles report to be presented to the next BoD meeting in December 2024 for approval;
- Thanks to Interim CFO for all his hard work in supporting the Trust to improve its financial position, robust financial expenditure oversight, and working towards being financially sustainable.

ACTION: Present Business Planning Principles report for approval at the next BoD meeting in December as part of the FPC Chair Assurance Report. CSPO

The Board of Directors **NOTED** the 29 August and 23 September 2024 FPC Chair Assurance Reports.

24/072.4 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

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

- Implemented process structuring agenda against Board Assurance Framework (BAF) risks supporting to ensure focus on key areas of risk;
- Vacancy rate 9.6% better than the alerting threshold of 10%, concern with increased HCSW vacancies currently 204 WTE (14%), review underway after which the Trust would resume recruitment to these positions;
- Concern about appraisal completion, remained below 80% target, at 74.8%, requested a further deep dive to be reported to November P&CC meeting. Was not assured the target would be achieved, more work needed to improve the completion percentage, as it was important for staff to have annual appraisals;
- Committee was not assured about the effectiveness of the Freedom to Speak Up (FTSU) service as had not received reports on service activities and cases for eight months, noting issues with staff resources. Discussions in respect of emergency mitigating measures around short-term cover to address the backlog of work, as well as longer term ensuring a more resilient service.

The Interim CPO reported priority work for FTSU would focus on addressing the backlog, reviewing the inbox and prioritising any trends, noting staff were able to raise any concerns direct to the Deputy CPO or herself. The Trust would be looking at alternative FTSU service options, noting the current structure was unsustainable, potential future options would be costed for consideration and discussion by the Executive team.

The Board of Directors **NOTED** the 25 September 2024 P&CC Chair Assurance Report.

24/072.5 **CHARITABLE FUNDS COMMITTEE (CFC) CHAIR ASSURANCE REPORT**

The CFC Chair reported on the following key points:

- Approval of 2023/24 East Kent Hospitals Charity Annual Accounts and Annual Report to be presented to the next IAGC meeting and following this to the December BoD for approval. Noting an unqualified opinion with very few queries raised by the auditors;
- Thanks to the Finance and Charity teams for all their hard work and support during 2023/24 FY supporting the Charity and producing its annual documentation for submission;
- Funding support to the WHH Twinkling Stars Bereavement Suite (£85k from John Swire Trust, and £30k from the WHH League of Friends);
- Approval of applications for grants, included renal observation machines (nine) at K&C funding cost of approximately £29k, and one cerebral function monitor machine at QEQM at a cost of £26k;
- Thanks to Interim CFO for his support and best wishes for the future.

The Board of Directors **NOTED** the verbal CFC Chair Assurance Report from the 1 October 2024 meeting.

24/072.6 INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT

The CFC NED Chair/IAGC member highlighted the following key points:

- Annual documents (2023/24 Annual Accounts, Annual Report, and Quality Accounts) reviewed and approved, recommended and approved by the BoD at its extra-ordinary meeting in June;
- BAF progress update reports included feedback from discussions at individual Board Committees, as well as feedback from the Committee Chairs on how aligning the agenda items to BAF risks was working in reviewing and monitoring progress to reduce risks. It was recognised the significant progress made in managing risks supported by Executives and staff, and returning to business as usual providing assurance of robust day to day operational management of risks.

The Board of Directors **NOTED** the 26 June and 26 July 2024 IAGC Chair Assurance Report.

24/073 MEDICAL APPRAISAL AND REVALIDATION

The CMO highlighted the following key points:

- Appraisal compliance remained steady at 83% amongst implementation of a new medical appraisal system;
- Rate of positive revalidation recommendations continued to improve;
- Aim to achieve 90% job planning compliance by 1 April 2025;
- Statement of Compliance (SoC) report required for agreement.

The Acting Chairman commented on the new e-portfolio system and if its implementation had been effective. The CMO confirmed there had been a great deal of work moving from the old to the new system and feedback that this had been successfully completed.

DECISION: The Board of Directors **NOTED** the Medical Appraisal and Revalidation report and **AGREED** the SoC linked to this report.

24/074 PAEDIATRIC AUDIOLOGY SERVICES

The CMO stated two reports had been received. One report about the Trust’s Newborn Screening Service that was identified to be low risk. The second report was around children that had not been tested through the Newborn Screening Service with concerns raised during their early years in respect of a risk in relation to Auditory Brainstem Response (ABR) testing including the quality of external peer review, and the Trust not having Improving Quality in Physiological Services (IQIPS) accreditation. It was noted the Trust’s progress to complete the accreditation process that was unlikely to be completed by April 2025 as IQIPS had advised a minimum of 16 months to complete. The Q&SC would be kept up to date on progress against the accreditation.

The Board of Directors **NOTED** the Paediatric Audiology Services Report, the issues identified and that the service were working to address these.

24/075 **ANY OTHER BUSINESS**

There were no other items of business raised.

24/076 **QUESTIONS FROM THE PUBLIC**

The Acting Chairman reported questions had been received in advance of the meeting, these related to individual complaints, and that the details would not be discussed in this Open BoD meeting. The following was noted:

- One question submitted related to complaint previously submitted by Mr D Marriott as well as a Freedom of Information (FOI) request that were being responded to by the Trust. This also included questions about the Trust's processes in respect of policies and procedures that would be responded direct. Mr Marriott had asked a question about the Trust's deficit that had been answered earlier in the meeting in respect of the Trust's financial position at the end of August 2024.
- Another question submitted related to a previously submitted complaint by Mr F Edwards, who had asked that this be noted by the BoD. It was noted both the Acting Chairman and CE were aware of the details of this complaint, and a response would be provided direct to Mr Edwards.

The Acting Chairman reported an issue that had been raised with him about individuals smoking in the outside area of the main entrance at WHH, he had discussed this with the CNMO, as was upsetting for those entering/exiting the hospital, and what could be done to stop people smoking in this area. The CNMO stated the Trust and its teams were committed to appropriately challenging individuals across all of its hospital sites, all of which were non-smoking sites. In conjunction with challenging individuals offering the provision of tobacco dependency support. The Trust was looking at providing smoking shelters on the sites away from the hospital buildings and where these could be located, noting this that had proven successful at another Trust, the Trust's Smoke-Free Policy would also be reviewed. The CE highlighted the importance of when the smoking shelters were in place, to publicise these with a relaunch for staff, patients and the public about the availability of the shelters, appropriately challenging individuals not adhering to the Trust's policy, and the zero tolerance policy to its staff.

The CMO reported funding support from the ICB and Public Health around smoking dependencies and the Trust would be working with the Community Trust on a plan to utilise this support.

The Chair closed the meeting at 4.30 pm.

Date of next meeting: Thursday 5 December 2024.

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 3 October 2024**

Meeting date: **5 December 2024**

Board sponsor: **Acting Chairman**

Paper Author: **Board Support Secretary**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: None

MATTERS ARISING FROM THE MINUTES ON 3 OCTOBER 2024

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/06/23	01.06.23 - On completion of the ED works review the UEC services, front door patient pathways, management of patients, and patient flow to develop a sustainable Trust strategy. 05.10.23 - Provide a progress update in December 2023 on progress in respect of redesigning patient pathways at the front door, management of these patients, and patient flow.	~~Dec-23~~/ ~~Feb-24~~/ ~~Jun-24~~/ ~~Jul-24~~/ ~~Oct-24~~/ Dec-24	Chief Operating Officer (COO)	Open	**01.02.24 -** Trust would be looking at and reviewing the front door services to redesign patient pathways through ED, ensuring these were simplified and less complicated to benefit the care and experience of patients, as well as supporting staff to manage demand. A further update would be provided at a future Board meeting. **04.04.24 –** The Trust is reviewing and resetting patient pathways across the Trust. An update will come to Board when available. **03.10.24 -** Once all of the new services had been introduced, there would be a review looking at new signage across all areas.
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.	~~Jun-24~~/ ~~Jul-24~~/ ~~Oct-24~~/ Dec-24	Chief People Officer (CPO)	Open	**06.06.24 -** Initial principles implemented with training sessions provided, information available for staff on the Trust's staff intranet, liaising with other Trusts in respect of training best practice. Development of a specific policy around sexual safety and speaking up, and accessing support. Lead Freedom to Speak Up Guardian working on a paper to be presented to the July 2024 Board meeting. **July 2024 -** Update on Sexual Safety will be included in the regular six monthly Freedom to Speak Up (FTSU) report due to be presented to the October 2024 Board meeting, deferred to December 2024. **September 2024 -** The FTSU Team is experiencing a high number of absences. As a

					result, interim measures have been put in place to maintain the service by the Executive Team acting through the CPO as a priority. There is also a project to consider partnership working to ensure resilience and reliability of the service. This is being considered with the involvement of all key stakeholders. In the interim, the CPO will continue to report to the P&CC and to the Chair recognising this is a priority for the Board. This is also now a Significant Risk for the Trust.
B/05/24	Present the NHS Kent & Medway Integrated Care Board (ICB) Strategy 2024-25 – 2029/30 to the Board of Directors.	~~Jul-24~~/ ~~Oct-24~~/ Dec-24	Chief Strategy & Partnerships Officer (CSPO)	To Close	**July 2024 -** Verbal update provided at 25.07.24 Board meeting. **October 2024 -** Verbal update provided at 03.10.24 Board meeting. **December 2024 -** Strategy presented at 05.12.24 Board meeting for approval. **Action for agreement for closure at 05.12.24 Board meeting.**
B/09/24	Next PV&I Annual Report for 2024-25 to include statistics and data on how feedback from patients was being provided shown as a pie chart.	Jun-25	CNMO	Open	Item for future Board meeting.
B/10/24	Provide an update on the action and what was being done to address incidents of assaults on staff ensuring staff were protected and supported.	~~Jul-24~~/ ~~Oct-24~~/ Dec-24	CSPO	Open	**25.07.24 -** Wider review being undertaken of the security service provision, and the Trust's requirements around the specification of this service as well as staff training provision. This is around mitigating actions to keep staff safe. Report to be presented following this review towards the end of the year.
B/15/24	Present progress update CQC reports to the BoD at each of the bi-monthly meetings (increasing frequency from quarterly) to ensure oversight of progress to close the Must and Should do requirements.	~~Oct-24~~/ Feb-25	Director of Quality Governance (DQG)	Open	**03.10.24 -** The Quality and Safety Committee received a full update report on 24 September. In summary there are 12 Must Do (out of 28) and 7 Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans). The number of open actions related to each Must and Should Do is shown in the table below. There is a total of 32 out of 206 actions open across all action plans. Of these 32 open actions, 28 are expected to close by 30 October and 4 are expected to close by 31 December 2024.

B/20/24	Liaise with the ADoPE and Beyond the Page's Co-Chief Executive Officer to look at and explore the possibility of extending/promoting opportunities available with Apprenticeship roles to migrant women in the community.	Dec-24	Interim Chief People Officer (CPO)	Open	Verbal update to be provided at 05.12.24 Board of Directors meeting.
B/21/24	Liaise with NHSE's Improvement Director to schedule a future Board discussion session about the IIP vulnerabilities, risks and mitigations in place at a future Board Development Strategy Session.	Jan-25	DCG	Open	Being explored for discussion at the January 2025 Board Development Strategy Session.
B/22/24	Include in NED site visit feedback template section in respect of the risk management process and this supporting validation that this was effective, taking into consideration feedback from interacting with staff during these visits and their feedback on any areas of concern.	Dec-24	DCG	Open	Verbal update to be provided at 05.12.24 Board of Directors meeting.
B/23/24	Liaise with the P&CC NED Chair to agree timeline for presentation of future quarterly progress update reports to P&CC on the actions to address and support reducing incidents of violence and aggression against staff, ensuring staff were supported in managing their experience and physiological harm.	Dec-24	CNMO	Open	Verbal update to be provided at 05.12.24 Board of Directors meeting.
B/24/24	Circulate to Board members the summary report provided to the	Dec-24	CNMO/ Deputy DIPC	To Close	Summary report circulated to Board members on 02.12.24. **Action for agreement for**

	ICB on the Trust's IPC performance and how it performed against its peers.				**closure at 05.12.24 Board meeting.**
B/25/24	Include in future MNAG Chair Assurance Reports a summary of comparison data on how the Trust compared with similar Trusts in respect of its neonatal nursing workforce percentage.	Dec-24	CNMO/ DoM/ Deputy DoM	Open	Verbal update to be provided at 05.12.24 Board of Directors meeting.
B/26/24	Present Business Planning Principles report for approval at the next BoD meeting in December as part of the FPC Chair Assurance Report.	Dec-24	CSPO	To Close	Business Planning Principles provided in supporting documentation for Board members for approval at 05.12.24 Board of Directors meeting. **Action for agreement for closure at 05.12.24 Board meeting.**

Chairman's Report, December 2024

Purpose of the report
To report on the Chair's activities; any decisions taken by the Board outside of its meeting cycle; update the Board on the activities of the Council of Governors (CoG); and to bring any other significant items of note to the Board's attention.

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

Opening remarks
As we approach the end of the calendar year, and once again manage the considerable, additional winter pressures we face as a Trust, it is important we allow ourselves a moment of reflection on the last 11 months.

Looking back over 2024, I am struck by the effort and focus of our colleagues towards getting the Trust back to a level of operating that the public of Kent expect and deserve. As a Trust we will end 2024 in a far better position than we started but recognise there is still a significant journey ahead of us. That said, I must recognise all of the efforts from colleagues across all our hospitals, both patient facing and those supporting in different roles. To you all, I say thank for all the work you have put in and thank you for the improved performance our patients are seeing every day.

There are a range of specific and concrete examples of this in the Board papers but I want to pick one or two here. It is a huge credit to staff across the Trust that we have now successfully met vitally important elective care and cancer targets set by NHS England (NHSE). These targets are set by NHSE to ensure that patients receive care in the best possible way to meet their needs. The Trust has now exited Tier 1 oversight, a heightened level of NHSE monitoring and scrutiny, for electives and diagnostics and exited tiering for cancer showing a sustained improved performance for reducing the number of people waiting for treatment in these areas.

The work of **endoscopy team** in more than halving our waiting list in a year is really impressive. The team had almost 14,000 patients waiting for the procedure in September last year, which meant those needing a non-urgent test could wait more than a year. But after 12 months of focus on investigating the issues and working to find sustainable solutions - combined with a temporary increase in capacity – the waiting list is now around 4,900, and the team hope to be at a steady state of around 4,500 by the end of the year. This means patients will be removed from the list at the same rate new referrals are added, minimising any delays.

On a more general level, I was delighted for our emergency department team at William Harvey Hospital (WHH), who were named **Team of the Year in the Nursing Times Awards** in October. The team won the prestigious award for improving patient and staff experience within the department by investing in the nursing staff and their development, creating a team ethos around learning, development and evidence-based care. A richly deserved award.

I had the privilege of opening the Trust's **Celebration Awards** in October. The organisers

had more than 260 nominations for the awards across nine categories and the judging panel had the very difficult task of shortlisting the teams and individuals who would go forward to the awards evening.

Members of our Executive team made the presentations and led thanks to all those shortlisted for going above and beyond for our patients and each other. On behalf of the Board, I want to celebrate and mention here the very deserving winners:

- Outstanding contribution to improving culture award: **Hansaka Seneviratne**
- Excellence in team-working award: **Dr Diana Iskander and the BachB research team**
- Partnership working award: **Nutrition team at QEQM**
- Excellence in quality and safety improvement award: **Maternity practice development team**
- Improving timely access to care award: **Stroke Bridging Team**
- Excellence in research and innovation award: **Dr Diana Iskander and the BachB research team**
- Rising star award: **Zoe Montellano**
- Outstanding support worker award: **Debbie Towe**
- Inspirational leader award: **Michael Mark Dalauidao**

The judges described a hugely challenging task to pick the winners so a huge "well-done" to all the runners up too in each category.

As one of the Board Safety Champions for Maternity, I again visited our services on several occasions. I met with both medical, midwifery and Healthcare Assistant (HCA) teams as well as hearing from managers on the huge progress across both our maternity units. I remain in awe of the incredible work being carried out every day and again thank all our colleagues here for the tremendous progress being made.

MPs briefings
Together with Tracey, we were thrilled to have the opportunity to meet with East Kent's Members of Parliament. Tracey and I met with Sojan Joseph (Ashford), Polly Billington (East Thanet), and Roger Gale (Herne Bay and Sandwich) and updated our MPs on the Trust's current performance and winter pressures; progress on improving the Trust's financial position; improvements in maternity; staff recruitment and retainment and staff engagement.

We agreed the meetings were helpful to all of us and we look forward to a continuing and close engagement.

Council of Governors
I chaired another of our regular Council of Governors meetings in October. They are always an important assurance meeting bringing together our Governors and Board members. Governors represent the views of their constituencies and work in partnership with the Trust at a strategic level. The Governors took the opportunity of hearing directly from each of our non-executive director chairs of Board sub-committees and their assessment of the performance of the Trust. The Governors were also able to hear directly from Tracey and other executive directors. We combined the meeting with joint visits to services across William Harvey. I spent time speaking to colleagues in our Maternity Department in my role as Champion and had the benefit of many very open and direct conversations; while also meeting families.

I want to thank our Governors on behalf of the Board for their continued commitment to representing the views of our communities and the time they give to the Trust.

Board changes
The Trust has been successful in securing a new Chief People Officer. Details will be shared in due course but we are pleased that a new, permanent and locally based replacement will be in post on 3 March 2025. This is a vitally important role which will oversee the considerable responsibility for the stream of work related to securing the full complement of staff we need; embedding our values and culture; and building on our staff engagement and Equality, Diversity and Inclusion (EDI) work.

In relation to the departure of Rob, our Chief Operating Officer, in January, we are currently interviewing and hope to secure a replacement before the end of the year.

In other recruitment developments, Catherine Walker, our newest appointment to the Board as a non-executive director (NED), has started in earnest. Catherine is on the People & Culture and Quality & Safety committees and has already participated in both.

Sadly, we will be saying goodbye to Simon Corben, who leaves his role as a NED on the Trust's Board in January. Simon has brought invaluable insight and very sound analysis to the Board and the work of the Trust. His wealth of NHS and estates experience will be missed; as will his supportive, encouraging and fun manner in conducting his professional responsibilities. On behalf of the Board and the Trust as a whole, we thank Simon for his considerable contribution and look forward to his ongoing counsel and support beyond the Board.

Board Governance
The Board has continued to meet collectively in-between these Board meetings to receive assurance, training and immerse ourselves in the work of the Trust.

Our Development Days have focused on a wide-range of areas including the Trust's safeguarding practices; progress in maternity; our infrastructure challenges and possible capital funding; and of course, our winter plans.

It is on the winter pressures where I will end this report. As a Trust and Integrated Care Board (ICB) region we have prepared detailed plans for the challenges we know we are seeing already as the weather deteriorates. You can find these in the Board papers. Nonetheless the Board recognises the strain on patients and staff of the increase in demand over these months. We are acutely aware of the impact and we are hopeful that working collectively as a regional system we can mitigate the challenges. But that does not negate the individual toll on everyone of what is a very pressurised number of months. I want to thank our fully committed colleagues for their resilience and determination to provide safe, high-quality care. We are all very grateful.

Acting Chairman
Stewart Baird

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **5 December 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: N/A

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)

4. Operational update

The detailed report on our operational performance and specifically the timeliness of patients being able to access treatment, is within these Board papers. The improvements in this area have been noted by colleagues at NHSE who have assessed the Trusts position and moved us to Tier 2 for Elective and Diagnostics and out of Tier 1 for Cancer services. This is a positive reflection of all the work that has been done to improve waiting times for planned care. Thank you to all those involved in this area of our work.

Across all areas within the Trust, improvements are being made. At the end of October our Accident & Emergency (A&E) position was 74.4% with our Type 1 performance (for our sickest patients) 54.1%.

At the end of October 2024, the Trust had 193 patients awaiting cancer treatment over 62 days, a reduction on the position reported for August. We have seen the improved position with both the 28-day Faster Diagnostic and 62-day performance standards maintained.

The focus on reducing the number of patients waiting for an endoscopy across our surveillance, urgent and routine waiting lists continues. The total backlog is 4,700 patients at the end of October. Across all our other diagnostic areas, recovery of the position continues and our DM01 position at the end of October was 77%.

Efforts to mitigate long waiting times for planned treatments continue to see marked improvements. At the end of October there were 11 patients exceeding the 78-week wait threshold.

5. National NHS Annual Staff Survey

The 2024 National NHS Annual Staff Survey response window has now closed and the Trust has had over a 57% response rate. This is a significant increase on last year's response rate of 41%. It is very positive that more staff feel able to and sufficiently engaged to provide us with their views and concerns. The feedback from staff through the survey will not be available until mid-March and we should be

mindful that there is still significant work to be done on the cultural issues within the Trust.

6. East Kent Hospitals University NHS Foundation Trust strategy

Work is well underway in the development of the Trust's Strategy with forums established within the Trust and with external stakeholders. Meetings have been held with over 40 clinical services and specialties and the information coming out of those meetings is being pulled together and analysed.

The Integrated Care Board has been leading a piece of work bringing together Primary Care, NHS Providers, and the ICB to develop a strategy for the population of Kent & Medway that will guide the way to equitable, sustainable and responsive healthcare. The four strategic themes are: (1) Patient experience, access and outcomes, (2) People, (3) Sustainable services and (4) Financial Sustainability. The strategy document is now in the process of being presented at each of the provider Boards as well as the ICB Board.

Engagement to inform the development of a new 10-Year Health Plan has begun under the direction of the Department of Health & Social Care. Further details can be accessed through www.change.nhs.uk

In formulating our own strategy we will take into consideration development of both of these strategies as they also work through their individual processes.

7. Conclusion

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

REPORT TO BOARD OF DIRECTORS (BoD)

Report title:	**Integrated Care Board (ICB) Strategy (Kent and Medway (K&M) NHS Strategy 2024/25 – 2029/30)**
Meeting date:	**5 December 2024**
Board sponsor:	**Chief Strategy & Partnerships Officer (CSPO)**
Paper Author:	**K&M NHS Chief Executive**

Appendices:

Appendix 1: Development Frequently Asked Questions (FAQs)
Appendix 2: K&M NHS Strategy 2024/25 – 2029/30
Appendix 3: Strategic Theme A3s and enabler proposals
Appendix 4: Equality Impact Assessment

Executive summary:

Action required:	**Approval**
Purpose of the Report:	To update the Board on the development of the ICB strategy for K&M.
Summary of key issues:	**Introduction** NHS provider organisations, primary care and NHS K&M have come together to produce our NHS Strategy 2024/25 - 2029/30. We know we can achieve more collectively, rather than individually, to meet the health needs of our population and this strategy outlines our ambition and vision for NHS services of the future. It does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships. It recognises the challenges we can best address together and, unlike our Integrated Care Strategy, focuses only on healthcare services. This paper outlines the approach taken to developing the strategy and addresses key questions about its purpose. The strategy document describes the shared ambition, our strategic themes, goals and how we will work together in delivery to improve the health outcomes of our population. **Development** The NHS strategy development has taken a co-production approach. Executives from across NHS provider trusts and primary care leads have participated in a number of workshops over the last six months. These workshops agreed the continuous improvement approach, defined a shared ambition and then shared and discussed data to determine the focus of the strategy. Data came from a wide range of sources, for example PowerBI, our organisational reporting, Joint Strategic Needs Assessments, staff surveys, the GP patient survey, Office for Health Improvement and Disparities, Office of National Statistics, Fingertips, Public Health England, Hospital Episode Statistics (HES), K&M Cancer Alliance, and the Quality Outcomes Framework reporting. It compared K&M against other systems in the South East and nationally as well as within K&M.

	The critical success factors for delivery have also been a key topic of conversation throughout the strategy development. Initially an Executive project group met weekly, supported by a weekly working group of continuous improvement experts from each of the organisations. These groups co-designed, delivered and facilitated the early workshops. Subsequently the Chief Executives as Senior Responsible Officers (SROs) for each of the themes and enablers, supported by a group of Executives, further developed the key targets and early thinking on implementation plans. Some of the key questions that we addressed during the development phase are included as Appendix 1. **Continuous Improvement** A continuous improvement approach has been adopted for the development of the strategy. This aligns with NHS Impact and the journey all NHS trusts are on in developing their improvement cultures. Whilst there are some differences in approaches between the organisations, we have sought to define a common language during our workshops and to utilise a common A3 methodology in determining our targets and delivery plans. The use of improvement methodology to a system strategy has been challenging and has required some flexibility in application. We have sought to apply the principles of the methodology to the work undertaken and this is work that will continue over the next phase. **The NHS Strategy** The NHS Strategy is attached as Appendix 2, with more detailed A3s in Appendix 3. These A3s describe the thinking and collective agreement to this point. It is recognised that the breakthrough objectives in particular will need further refinement as we move forward. The strategy explains why we need to work differently together, focusing on a 'left shift' to prevention and primary and community care. It defines the shared ambition for the NHS in K&M, confirms the adoption of the NHS values and sets our areas of focus, the strategic themes. For each theme it outlines the 3-5 year targets and then initial 12-18 month breakthrough objectives. Since the improvement approach is an iterative process, these breakthrough objectives are still subject to development but we are committed to the overarching aims. Finally, the strategy describes how we will work together, focusing not just on the delivery architecture but also the culture and approach to continuous improvement.
Key recommendations:	The Board of Directors is asked to: • **NOTE** the co-production approach to the development and delivery of NHS Strategy. • **APPROVE** the NHS Strategy endorsing the direction of travel as described in the A3s.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People

	• Partnerships • Sustainability
Link to the Trust Risk Register:	Key risk is operational / delivery pressures impacting ability to allocate sufficient time and resource to deliver the strategy resulting in unsustainable services, poorer outcomes and an inability to meet future demand. Mitigated by Chief Executive Officer (CEO) and Executive leadership and delivery architecture embedded in existing programmes.
Resource:	No new resources requested. Delivery plan to be developed.
Legal and regulatory:	The strategy will assist the NHS in Kent and Medway meeting constitutional standards in the future.
Subsidiary:	N

Assurance route:

Previously considered by: K&M NHS July 2024 Board – draft review and further development agreed.

Appendix 1

Why do we need an NHS strategy?

The strategy describes the key challenges we face as an NHS system. We know we can achieve more collectively, rather than individually, to improve the health of the people of Kent and Medway. Producing this strategy has brought NHS provider organisations, primary care and NHS Kent and Medway together to consider how they best deliver the improvements needed to meet the health needs of our population.

Why doesn't this strategy include all of our statutory responsibilities?

NHS organisations have a range of statutory responsibilities, with regulation, to ensure their delivery. These will always be a focus for individual boards; however, this strategy focuses on what we will be doing jointly to tackle our collective challenges and achieve our shared ambition.

How does this strategy fit alongside existing work?

This strategy sets a framework for the NHS system to work together to deliver greater improvements than can be individually achieved. It does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships. It is supported by a range of subject specific strategies and plans, for example the Primary Care Strategy, NHS Estates Strategy and financial recovery plans.

How will you learn from others?

Q Health published a framework for improving health and care across systems (available here: Improving across health and care systems: a framework | Q Community). We have and will continue to use this to shape how we deliver the strategy. We will continue to look to learn from other integrated care boards and health economies as well as NHS England (through initiatives, such as NHS Impact).

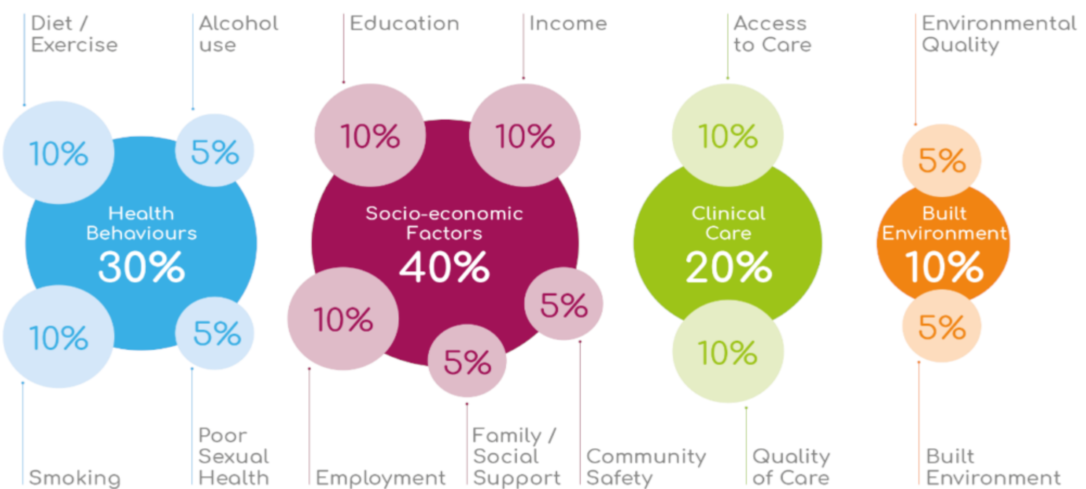
How does this align to our individual organisational or partnership strategies?

This strategy does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships. We recognise some challenges cannot be tackled by one organisation and this strategy sets out areas of focus for us as an NHS system to deliver greater improvements than can be individually achieved.

How is this different to our integrated care strategy?

Kent and Medway's Integrated Care Strategy was developed with a broad range of partners, and focuses on the wider, social determinants of health such as education, housing, environment, transport, employment and community safety. As demonstrated

by the Robert Wood Johnson model, these account for 80 per cent of the variation in health outcomes. This strategy focuses only on healthcare and the impact that has on our health outcomes. It is a strategy for the NHS partners in Kent and Medway.



Based on: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, US County health rankings model 2014
https://www.countyhealthrankings.org/sites/default/files/media/document/CHRR_2014_Key_Findings.pdf

How will this strategy be delivered?

Producing this strategy is the first stage of our partnership work. We are continuing to work together to agree how we achieve our stated goals, identifying specific programmes of work that will deliver our targets in the first 12 to 18 months of our strategy.

Who is this strategy for?

This strategy is for NHS providers, primary care and NHS Kent and Medway. It is for our people and our population, to demonstrate how we are setting our ambition and vision for NHS services of the future.

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

Version 9.1
8 October 2024

Contents

Foreword 3
Executive Summary 4
Where are we now? 6
About us – key facts 6
Why we need to work differently together 7
Where do we want to get to? 8
Theme 1: Patient Experience, Access and Outcomes 8
Theme 2: People 9
Theme 3: Sustainable Services 10
Theme 4: Financial Sustainability 11
How will we get there? 12
Appendices 13

Foreword

Responsive, sustainable healthcare with equity of access and outstanding patient experience and outcomes for everyone in Kent and Medway.

This is our shared ambition for the NHS system in Kent and Medway.

The NHS in Kent and Medway provides healthcare services to our 2 million population. In 2023/24, we offered almost 11 million GP appointments, provided day case and inpatient surgery for 189,000 people, and supported over 18,000 births. We are proud of the care that we provide but recognise that we do not always get it right.

We are clear that we need to work together and differently. While we provide excellent healthcare across Kent and Medway, there is variation in access, experience and outcomes for patients. We cannot meet existing demand, and this will grow in future years. Our services are not sustainable. We also increasingly spend more than we receive.

These challenges cannot be overcome by sovereign organisations working separately. Acting together, Primary Care, NHS providers and NHS Kent and Medway ICB have produced this strategy. We have used data and feedback from our patients, the public and our stakeholders to identify four strategic themes.

This strategy will guide our way to equitable, sustainable and responsive healthcare.

Paul Bentley
NHS Kent and Medway, the Integrated Care Board

Mairead McCormick
Kent Community Health NHS Foundation Trust; Chair of Primary & Community Provider Collaborative; SRO for East Kent Health & Care Partnership

Jayne Black
Medway NHS Foundation Trust; Chair of Acute Care Provider Collaborative

Miles Scott
Maidstone and Tunbridge Wells NHS Trust; SRO for West Kent Health & Care Partnership

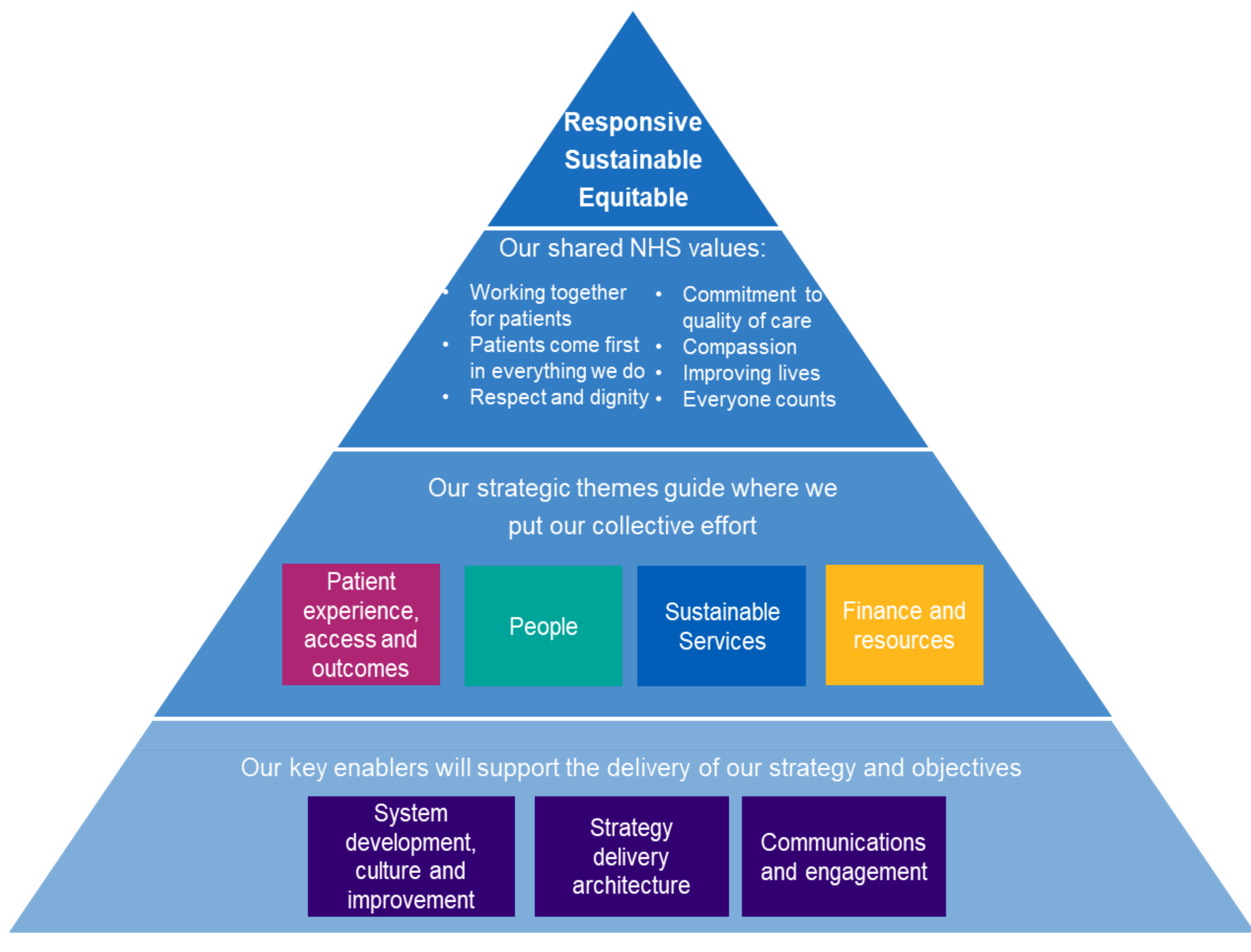
Dr Jonathan Bryant
GP Partner Member, NHS Kent and Medway

Sheila Stenson
Kent and Medway NHS and Social Care Partnership Trust; SRO for Provider Collaboratives and Chair of Mental Health, Learning Disabilities & Autism Provider Collaborative

Tracey Fletcher
East Kent Hospitals University NHS Foundation Trust

Jonathan Wade
Dartford and Gravesham NHS Trust; SRO for Dartford, Gravesham and Swanley Health & Care Partnership

Executive Summary



In each of our strategic themes we will achieve:

	Our Vision	Year One
Patient experience, access and outcomes	Patients in Kent and Medway will experience good, comparable outcomes, irrespective of where they live or what their background is. They will be partners with the NHS in their healthcare and we will support them with high quality, timely and accessible services.	Reduce variation in access to circulatory disease pathways, particularly for vulnerable groups. Focus on Making Every Contact Count.

People	We will have a skilled, healthy, engaged, productive and affordable workforce who are reflective of our local population that can meet the operating model and patient need. We will develop the right workforce for the long-term Kent and Medway model through workforce planning, enabling digital and by working as a single NHS team across the area, including primary care. Staff will move easily between organisations feeling safe and valued. Our workforce will be digitally capable, aided by common systems across our organisations and always seeking to use technology to free time to care.	Design an affordable system workforce plan which supports the needs of the clinical operating model. Develop our Health and Care Academy and work with our local medical school to develop our future workforce. Focus on the digital ability of our workforce.
Sustainable Services	We will provide sustainable, resilient healthcare that allows people to live, age and die well. We will empower people to self-manage where they can and deliver timely proactive services enabling care at home for our older population.	Focus on identifying vulnerable people who have the greatest need for unplanned care using risk stratification at local level. Each of these people will have a comprehensive assessment and tailored plan for their care in an emergency.
Financial Sustainability	We will have a financially sustainable system with sector-leading levels of productivity. Services will be supported by adequate resources, and funds will be directed towards their intended purpose and be able to support the other strategic themes. The approach to this will be developed in alignment with the themes of the Darzi review most applicable to financial recovery: re-engage staff and patients, shift care closer to home in a neighbourhood NHS, drive productivity and tilt towards technology. We will create a financial environment that enables future investment, both revenue and capital, in prevention and service provision.	Deliver year one of our agreed Financial Recovery Programme.

Where are we now?

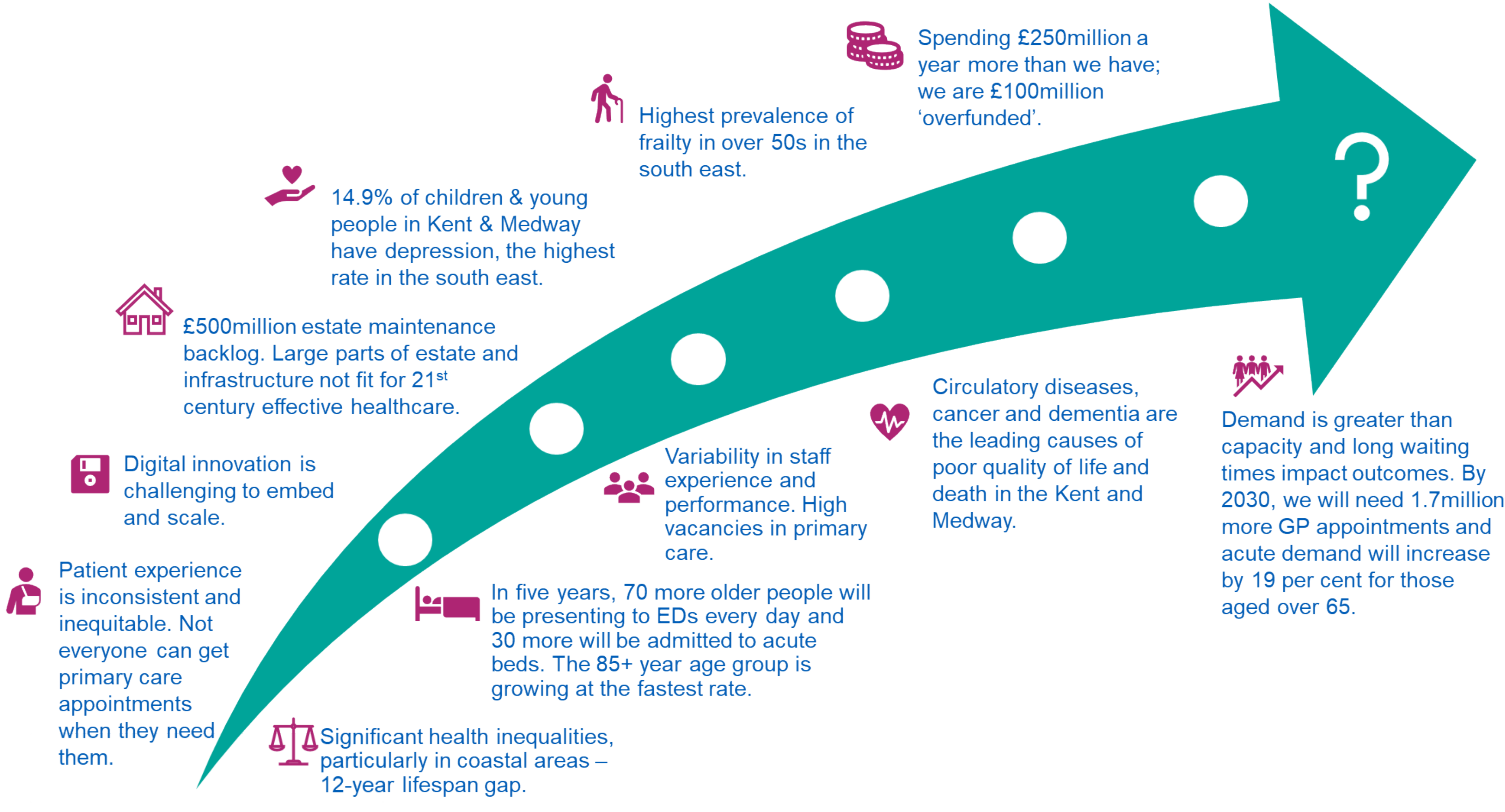
About us – key facts

2 million people	Over **40,000** people working in the NHS	**6** NHS provider trusts and **1** integrated care board
11 million appointments in GP surgeries, **2.1 million** outpatient appointments	**164,000** day case and **25,000** inpatient surgeries	**Over 18,000** births
Over **£4.2** billion spent in 2023/24	**4** Health and Care Partnerships	**3** provider collaboratives
Over **2,000** mental health service users are treated in hospitals, and **54,000** in the community	**325** pharmacies, offering more than just prescriptions	Over **2.2 million** community care contacts
407 dental practices, **800,000** patients treated	**149** optometrists	**185** GP practices in **42** primary care networks

NHS

Why we need to work differently together

Some of our key challenges now and into the future are:



Where do we want to get to?

Almost all our patients will start a healthcare journey with an appointment in primary care, whether that's general practice, dentistry, pharmacy or optometry. For the overwhelming majority, there will be no need to go anywhere else. As the NHS changes to meet future challenges, more conditions will be treated in primary care or the community.

Our strategy is focused on improving the health outcomes of our population and shifting care from hospitals to primary and community care. This will require changes in our services, our workforce and how our funding flows. For each of our strategic themes this document describes our vision, our goals and how we plan to reach these.

Theme 1: Patient Experience, Access and Outcomes

Vision	Goals
Patients in Kent and Medway will experience good, comparable outcomes, irrespective of where they live or what their background is. They will be partners with the NHS in their healthcare and we will support them with high quality, timely and accessible services.	To reduce unwarranted variation against national measures, and within Kent and Medway, of: • patient outcomes • patient experience • patient access

Across Kent and Medway some people have a lower life expectancy; some wait longer than others; some receive poorer care; and for some their experience is poor. We will work together to reduce waiting times and raise outcomes to match the best in the region. We will initially focus on circulatory disease, which in Kent and Medway is increasing at a faster rate than the national average and is a leading cause of the life expectancy gap.

From primary care to referral to very specialist centres, all parts of the NHS play a critical role in the diagnosis and management of circulatory disease.

We will focus on circulatory disease because:

- It is the leading cause of the life expectancy gap in the South-East Region, and Kent and Medway has a higher prevalence of key risk factors than the national average.
- We can be better at every level of the health service from GP to specialist.
- Risk factors and access issues are similar for other health conditions, which will increase our impact.

We will: improve diagnosis rates, reduce admission rates, improve disease management, and work with patients to co-design our approach across public health, primary, community and acute care.

Theme 2: People

Vision	Goals
We will have a skilled, healthy, engaged, productive and affordable workforce who are reflective of our local population that can meet the operating model and patient need. We will develop the right workforce for the long-term Kent and Medway model through workforce planning, enabling digital and by working as a single NHS team across the area, including primary care. Staff will move easily between organisations feeling safe and valued. Our workforce will be digitally capable, aided by common systems across our organisations and always seeking to use technology to free time to care.	• To be recognised as anti-discrimination employers. • To have an attraction and retention strategy that targets key roles, making them a career of choice. • To deliver the NHS workforce across the system within the agreed cost, improving workforce productivity and eliminating duplication. • To maximise training and development opportunities for a range of routes including apprenticeships and through our Health and Care Academy. • To develop a shared workforce that supports new operating models, including a shift to primary and community care. • To realise a year-on-year improvement in the levels of staff engagement, staff survey results and inclusivity.

Our people, leadership and organisations work in silos. People often have different experiences of work and inequity of opportunity. This is particularly true for colleagues with protected characteristics. There is variation across Kent and Medway in the availability of some skills, leading to unsustainable services. The current workforce model is unaffordable and therefore we need a smaller workforce with more targeted skills.

We will plan for a workforce that is affordable. To do this, we will make the NHS a career of choice in Kent and Medway where a shared workforce targets particular skills. We will reduce duplication and improve productivity while training and developing our staff for the roles of the future. This will include increasing our digital capabilities and needing more staff in primary and community care, and fewer in secondary care.

Our national staff survey and quarterly pulse survey results will provide us with the measurements we need to target changes and track our improvements. We will focus on improving staff engagement, promoting a good work life balance and being an anti-discrimination system.

In the first year of our strategy, we will design an affordable system workforce plan, which supports priorities identified through the ‘Patient, Access and Outcomes’, ‘Sustainable Services’ and ‘Finance and Resources’ themes.

Theme 3: Sustainable Services

Vision	Goals
We will provide sustainable, resilient healthcare that allows people to live, age and die well. We will empower people to self-manage where they can and deliver timely proactive services enabling care at home for our older population.	We will make services sustainable by: • Promoting self-care which is digital-first and supported by integrated neighbourhood teams or wider multidisciplinary teams in primary care and communities. Focusing on optimal care for long term conditions. • Supporting children's mental wellbeing • Only admitting to hospital people whose needs cannot be met elsewhere and who we will discharge as soon as they could be treated somewhere else. • Co-ordinating clinical pathways across providers, removing duplication of clinical activity and allowing more patients to be seen quicker and less often. • Having a shared responsibility to plan for the end of life that allows people to die with dignity and comfort in their preferred place of death. • Working with the 'Financial Sustainability' theme to ensure our changes make financial sustainability possible.

The way we currently work does not meet demand, now or into the future. The population of Kent and Medway is increasing, with the over 85year age group growing at the fastest rate. Frailty, dementia, ageing well and long-term conditions are the areas with greatest demand on our services. 56% of the population registered with a GP has at least one long-term condition, which is the highest across the South-East Region.

We will provide sustainable services by promoting self-care and using digital technologies. We will focus on optimal management of long term conditions, working with people to prevent deterioration of health equitably, informed by Core20PLUS5. We will only admit to hospital people whose needs cannot be met elsewhere, and we will discharge them as soon as they could be treated somewhere else. Across our services we will seek to reduce the duplication we know exists.

Our key areas of focus will be: children who are obese, children's mental wellbeing; self-management and secondary prevention for people with long term conditions; keeping people that call 999 out of hospital; and maximising care in the community.

In the first year we will focus on identifying vulnerable people who have the greatest need for unplanned care using risk stratification at local level. Each of these people will have a comprehensive assessment and tailored plan for their care in an emergency.

Theme 4: Financial Sustainability

Vision	Goals
We will have a financially sustainable system with sector-leading levels of productivity. Services will be supported by adequate resources, and funds will be directed towards their intended purpose and be able to support the other strategic themes. The approach to this will be developed in alignment with the themes of the Darzi review most applicable to financial recovery: re-engage staff and patients, shift care closer to home in a neighbourhood NHS, drive productivity and tilt towards technology. We will create a financial environment that enables future investment, both revenue and capital, in prevention and service provision.	• The system and all partners are in recurrent financial balance, having reduced the cost base by £300million, creating headroom to invest in prevention and service transformation (including strategic capital investment) • Improved productivity across all services, including the reduction in waste and duplication not just doing more for the same cost. • Equitable services that all improve outcomes. • An engaged population that take personal responsibility for health prevention and self management of long term conditions, reducing health service interventions and treatments • A digitally enabled and transformed effective operating model that supports a system-wide recurrent balance whilst improving quality and operational performance. • Early prevention and intervention to reduce reactive and resource-intensive health interventions. • Integrated commissioning with Local Authorities to reduce overall health and care costs.

Despite ambitious efficiency plans, we continue to spend more money than we have available, and the position is deteriorating. In addition, the current operating model doesn’t achieve equitable access, outcomes and experience, resulting in health inequalities and poor workforce morale.

We will change our operating model to focus on value, prevention and empowering the population to manage their own health. By improving our productivity and reducing late, reactive and resource-intensive health interventions, we will bring our NHS system into financial balance and reduce the cost base.

In the next year we will: identify 75% of our Cost Improvement Plans for 2025/26 before the end of 2024, review the viability of our least value-adding services by March 2025 and ensure wherever services are available patients are treated in Kent and Medway rather than other areas, review how we provide back-office services, develop plans for a secondary care estate supported by a plan to prioritise delivery of care out of hospital and deliver our environmental sustainability targets, review our approach to interoperability for our electronic patient records, and work with the ‘Sustainable services’ theme to identify how a shift in funding from acute to primary, community and preventative care, along with the above plans, achieves financial sustainability.

How will we get there?

We recognise and welcome the role of the sovereign organisations in all parts of our NHS system. This strategy is focused on the additional effort that we can collectively achieve to go further and faster in tackling our shared challenges and meet the health needs of our population.

To deliver our strategy we will:

- recognise the value in our organisations and NHS system, using existing governance arrangements, rather than creating additional layers. For example, our Health and Care Partnerships, Provider Collaboratives and transformation programme boards such as Urgent and Emergency Care, Elective, Diagnostics etc.
- use our current Chief Executives' Group as an overarching Programme Board.
- continue to look to our Chief Executive Senior Reponsible Officers (SRO) to lead the implementation of our plans in each theme.
- resource a programme management office to co-ordinate planning and deliver a standardised process for reporting against delivery

We have taken a continuous improvement approach to the development of this strategy and will continue to use improvement tools in the delivery. But improvement does not stop there. We need to be a self-improving system. A system that learns from what works well and shares that rapidly and widely, as well as a system that learns from what does not work well to adapt and try again.

We will use an agreed set of principles and behaviours to support our work which will align with NHS Impact best practice.

Appendices

Strategic theme A3s and enabler proposals

The following appendices are the outputs of the continuous improvement methodology we have used to co-produce our strategy. They have been developed and approved by the SROs and the executive teams dedicated to each strategic theme and enabler. As we develop our countermeasures, or implementation plans, they will remain live documents which we will share with each other regularly to achieve the aims of our strategy.

Appendix 3 – Strategic Theme A3s and enabler proposals

The following appendices are the outputs of the continuous improvement methodology we have used to co-produce our strategy. They have been developed and approved by the SROs and the executive teams dedicated to each strategic theme and enabler. As we develop our countermeasures, or implementation plans, they will remain live documents which we will share regularly to achieve the aims of our strategy.

Together, we can

Version 9.1
8 October 2024

Strategic Theme 1: Patient Access, Outcomes & Experience

Background

Patient satisfaction with NHS care is not only based on how effective treatment is, but on how it feels whilst our patients are receiving their care.

Pathways of care are often fragmented which means that there are large differences in what, where and how each organisation provides services across our area. Patients also report a lack of communication between services and a lack of digital accessibility.

This means that our patients are much less able to choose and access the care that's right for them, at a time they want to simply because of where they live. This has a significant impact on experience and outcomes.

Therefore the people of Kent and Medway are living in ill health, and have a lower life expectancy than other parts of the country.

In, and within, Kent & Medway, cancer, dementia and common diseases such as atrial fibrillation, coronary heart disease, high blood pressure, stroke and diabetes, show significant variation in morbidity and mortality rates, when compared to the rest of the country. Several of these circulatory conditions are revisable, and others changeable, which means we have an opportunity as Kent and Medway health partners to work together to provide our citizens the best possible services that support them to live in good health and with a high quality of life.

Problem statement

The people of Kent & Medway have a lower life expectancy than other parts of the country and there is variation in access to healthcare, positive patient outcomes and in how our patients experience the care they receive. There is a life expectancy gap of 12 years in the county.

Vision Statement:

Patients in Kent and Medway will experience comparable good outcomes, irrespective of where they live or what their background is. They will be partners with the NHS in their healthcare and we will support them with high quality, timely and accessible services.

Current state data:
Full data pack available, key points:

- Circulatory diseases are the leading cause for the life expectancy gap in the SE Region, and are growing faster than nationally.
- K&M has a higher prevalence of AF and hypertension than the national average.
- Qualitative patient experience feedback focuses on waiting times, access to primary care, communication between services, mental health service access, digital (but not always), patient centred care. Triangulated through national and local surveys at all service levels, Healthwatch data, population health (JSNA) outputs.
- Data collated for provider collaborative work programmes support the rational for focussing on Circulatory Diseases as a comorbidity.

Root cause analysis:
See attached Fish Bone analyses which identify the key root causes

Together, we can

Strategic Theme 1: Patient Access, Outcomes & Experience continued

Goals

To reduce unwarranted variation against national measures, and within Kent and Medway, of:

- patient outcomes
- patient experience
- patient access

Targets

- To improve patient experience against national measures, and within Kent and Medway
- To improve patient access against national measures, and within Kent and Medway
- To focus on circulatory disease for the following reasons:
    - It is a leading cause of the life expectancy gap in Kent and Medway.
    - Improvement actions can be applied at every tier of the health and care system.
    - Risk factors and access issues are similar for other leading causes and:
  - To:
    - improve diagnosis rates
    - reduce admission rates
    - manage to target
    - co-design public health, primary, community and acute solutions

Breakthrough objectives

Access – Identification and reduction of variation in the cardiovascular pathway for vulnerable groups, levelling up to the best performance with a particular focus on primary care access.

Experience – Identify areas of disjointed care in the cardiovascular pathway for patients and identify solutions with patients, families and advocates recognising the conversation is often initiated in primary care.

Outcomes – risk stratification of all patients on a holistic basis with a focus on psychological health – Making Every Contact Count

Implementation plan

Through Provider Collaboratives

Together, we can

Patient Access – key contributing factors to the identified problem

Late Diagnosis
- Fewer treatment options
- Poorer outcomes
- Heavier resource implications for services

System Barriers
- Appointment (all areas) capacity hinder timely intervention
- National drivers
- Workforce capacity
- Financial sustainability

Unwanted Variation
- Mismatched service offer across geography
- Referral arrangements (treatment options)
- Commissioned service variation

Environment
- Physical capacity to meet demand
- Geographical spread of services
- Appropriate level of equipment

Behaviors
- Previous experience
- Lack of knowledge
- Late/changing notifications
- Time/day of the week

Data Challenges
- Understanding (analysis) why variation occurs
- Input data quality
- Interoperability
- Soft intelligence gaps

Problem

The people of Kent & Medway have a lower life expectancy than other parts of the country and there is variation in **access to services.**

This is important because people are experiencing a poorer quality of life and fewer healthy life years.

Key: red circles are the top contributors

Together, we can

Patient outcomes - key contributing factors to the identified problem

Together, we can

Patient experience - key contributing factors to the identified problem

Personal interactions
- Increased demand impacts attentiveness level
- Un-compassionate communication reported through FFT/surveys etc
- Responsiveness of interactions

Organisational culture
- Unique language and jargon not user friendly
- Focused toward recovery and sustainability
- Unhelpful variation across ICS

Patient and family perception
- Negative views based on previous experiences
- Not treating the person
- Driven by media and external sources

Healing Environment
- Physical capacity limitations and aged estate
- Cleanliness and noise due to relentless demand and age/design of facilities
- Privacy issues due to age and design of facilities

Safe and Timely treatment
- Accurate diagnoses
- Delays in access and transfers to multiple services
- Increased acuity/complexity due to delays

Continuum of care
- Lack of consistency in quality of services provided across the spectrum of health and care providers
- Lack of coordinated health care across the system
- Disjointed pathways due to lack of joined up strategic approach

Problem

The people of Kent & Medway have a lower life expectancy than other parts of the country and there is variation in **experience.**

This is important because people are experiencing a poorer quality of life and fewer healthy life years.

Key: red circles are the top contributors

Together, we can

Strategic Theme 2: People

Background

Our organisations, leadership and colleagues work in silos. To deliver our new models of care and ways of working, our workforce and skills may be in the wrong place and need to move across organisational boundaries to match skills to strategic ambitions for primary and secondary care. Our colleagues have different experiences of work and have inequity of opportunities. This is particularly true for colleagues with protected characteristics. Colleague's experiences of work are directly impacted by our leaders who also receive differing development and well-being support across our organisations. Colleagues leave through their own attrition and rotate through our organisations in an unplanned way.

Our local workforce pipeline is limited and does not reflect the diversity of our population and needs to grow to address future demand. Our training and development of colleagues is procured, delivered and received in silos with a missed opportunity for system working, targeting and developing the pipeline for the Long-Term Workforce Plan, including growth in places at the Kent and Medway Medical School and areas of occupational shortage and high demand.

Individual Trusts and the ICB have their own People strategies aligned to the national People Plan and other national priorities.

Problem statement

Organisational boundaries create legal, cultural, policy and statutory obstacles to working in a collegiate way. Education and workforce planning is disconnected / abstract and removed from operating model development / clinical pathways. It is not targeted or sufficiently specific to meet anticipated demands. We are not established to address the shift to prevention nor to enhancing community care. Without a joined up, clinical, operational and workforce model incorporating primary care, we cannot deliver an affordable workforce that is appropriately trained, skilled, engaged and valued for the future.

Vision Statement:

We will have a skilled, healthy, engaged, productive and affordable workforce who are reflective of our local population and that can meet the operating model and patient need

We will develop the right workforce for the long-term Kent and Medway model through workforce planning, using digital as an enabler and by working as a single NHS team across the area, including primary care. Staff will move easily between organisations feeling safe and valued. Our workforce will be digitally capable, aided by common systems across our organisations and always seeking to use technology to free time to care.

Current state data:

Full data pack available, key points:

- Full data available from National Staff Survey results
- Overall colleagues with protected characteristics have a worse experience of work
- Too many healthcare workers feel stressed, work extra hours and do not look forward to coming to work
- Over half the organisations in K&M have seen a fall in staff engagement and people feeling they have a voice that counts
- Most organisations have seen an improvement in the theme of working flexibly and feeling they are a team
- Vacancy rates are up to 10%, but are improving
- 24% of GPs are aged 55 of over
- More generalist workforce skilled at manging complex care for multiple conditions required – ageing population increases complexity and multimorbidity

Together, we can

Strategic Theme 2: People continued

Goal:
- To be recognised by our staff as anti-discrimination employers and a system that will not tolerate this behaviour
- To have a Kent and Medway attraction and retention strategy that targets roles that support our future operating model across the care system as a career of choice in Kent and Medway
- To deliver a total workforce within system planned FTE and cost, improving workforce productivity and eliminating duplication
- To maximise the opportunities presented through apprenticeships and other training and development routes delivered by the system Health and Care Academy and HEE institutions including KMMS and CCCU
- To develop an approach to enable a shared workforce, which is digitally enabled within a suitable legal framework that supports new operating models
- To realise a year-on-year improvement in the levels of staff engagement identified through key domains within the quarterly pulse survey and National Staff Survey

Targets:
- Skills supply: system contractual vacancy level less than 7% with reduction in vacancy in hard to recruit roles and key posts.
- Realise year on year improvement in levels of staff engagement increasing advocacy scores specifically in 'recommend the organisation as a place to work and as a place to be treated'. Target score to achieve the upper quartile of 7.03.
- Effective provision of a system Health and Care Academy that will optimise the provision of local apprenticeships, development programmes and opportunities for local people to support reductions in health inequalities and widening participation (Increase in Levy spend). Specifically focusing on nursing and midwifery, therapies and theatre staff thereby reducing our reliance on international recruitment.

Targets (continued):
- Undertake an assessment of General practice vacancy and skill gaps testing plans against the trajectories and devising effective responses
- Employers of choice, a great place to live and work. Includes flexible working, good work life balance and delivery of the people promise with a focus on being non-discriminatory employers. System turnover (losses outside of the system) is less than planned monthly average for 24/25, 37,106 FTE and £179m cost.

Breakthrough objectives
- System workforce plan including primary care designed to address the gaps in support of the clinical operating model and the identified key health inequalities, in particular arising from strategic themes 1 &3.
- Develop system Health and Care Academy with focus on activity to support workforce aspirations for domain 1&3.
- Extend and enhance digital capabilities of our workforce.
- One offer to work in Kent and Medway supported by a shared people service.
- Work with our local medical school to develop a plan for expansion and support to the strategic themes.

Implementation Plan:

Through K&M CPO group

Together, we can

Strategic Theme 3: Sustainable Services

Background:

Our population is increasing, with the over 85yr age group growing at the fastest rate. As this cohort are the highest users of healthcare services, we know demand is going to continue to increase, particularly for frailty, dementia, ageing well and long-term conditions. 56% of the population registered with a GP have at least one long-term condition, which is the highest across the SE Region. We also have the highest prevalence of frailty in the over 50's age group in the SE Region with coastal areas most affected. Childhood obesity rates are increasing and childhood depression is the highest in the SE Region.

Only 2% of spend in Kent and Medway is allocated to preventing ill-health, meaning that our current model of care is focused on 'repair and recover', where, by definition, our patients will have already been negatively impacted by their healthcare concerns at the point as which they access our services. Kent & Medway (K&M) have the highest A&E attendance across SE Region when comparing 2022/23 with 2019/20 activity levels. 11,605 patients out of 2 million population are generating 52,136 ED attendances, 1.1 million GP encounters and 47,330 emergency admissions. There are consistently 550+ patients occupying acute beds that do not require acute care and at further risk of harm from long length of stay decreasing their potential to return to independent living.

Those living in the most deprived areas of K&M have the shortest life expectancy and the most health needs. However, services are not always accessible to those most in need for a wide variety of complex reasons – not all within the sole influence of the NHS. We know that timely access to services is a determining factor in health outcomes.

The model of care in the UK is over reliant on acute care. This model of care, with the increase in demand and limited workforce, means some services are unsustainable and others will become unsustainable in the future. An inconsistent and siloed approach to pathway/care design and delivery leads to further variation in outcomes for our population.

Together, we can

Problem Statement:

Our current ways of working and our infrastructure do not meet demand now or into the future. Through inefficiency and duplication, we contribute to some of this demand, leading to "waste" of our valuable and limited health resources. Services are not sustainably delivered for patients or for the system. Collectively, this results in adverse impact on the health and wellbeing of our population.

Vision Statement:

We will provide sustainable, resilient healthcare that allows people to live, age and die well. We will empower people to self-manage where they can and deliver timely proactive services enabling care at home for our older population.

Current state data:

Risk stratification data sets by PCN population
Health inequalities data
Primary care activity
NCTR
SPOA and ambulance conveyance data sets
Health insights and palliative and end of life care data

Root cause analysis:

Lightfoot analysis and algorithms to support paradigm shift

Strategic Theme 3: Sustainable Services continued

Goal:
To have improved the sustainability of services by:

- Promoting self-care for children and adults through education and access to expertise which is digital-first and supported by integrated neighbourhood teams and/or wider multidisciplinary teams in the community where people live. Focusing on optimal care for long term conditions.
- Supporting children's mental wellbeing
- Admitting people to hospital who require clinical management that can only be delivered in this environment and will only remain in this environment for essential care that cannot be delivered in the community.
- Co-ordination of Clinical pathways across providers which removes duplication of clinical activity, providing a holistic service that allows more patients to be seen quicker and less often
- A shared responsibility to plan for the end of life, that allows people to die with dignity and comfort, in their preferred place of death.
- Working with the 'Financial Sustainability' theme to ensure our changes make financial sustainability possible.

Targets:

Short term

- Children who are obese or at risk of obesity have a proactive plan delivered at a neighbourhood level that supports return to a healthy weight.
- Children's mental wellbeing supported
- People with long term conditions have a plan to self manage supported by the integrated neighbourhood teams, and with a focus on secondary prevention
- All care and residential home patients have a proactive care plan with RESPECT completed and accessible
- All PCN populations are risk stratified and those utilising the highest resource have a proactive plan that halves their utilisation of unplanned pathways.
- Each HCP to deliver a 15% reduction of conveyance to hospital for unplanned care from 22/23 baseline
- Reduction of 25% NCTR patients in acute, community and mental health hospitals

Long term

- People will only attend an acute hospital for care that cannot be delivered or supported in the community

Breakthrough objectives:
CGA/ACP/RESPECT for all vulnerable cohort at PCN level identified through risk stratification

Implementation Plan:
Ageing well programme and Community and provider collaborative programmes

Together, we can

Strategic Theme 4: Financial Sustainability

Background:
The 2024/25 NHS system has a planned deficit of £120m, which assumes stretching efficiencies of £400m which represent 10% of the system allocation. If we continue with the current service models, we won't have the resources to respond to expected patient needs now and in the future. We do not commission based on population need. Our operational model is to react to demand rather than targeted at long-term solutions that reduce/re-direct demand and does not allow us to deliver our constitutional requirements. The NHS financial pressures are mirrored in our local government partners and across the non NHS and VCSE provider landscape.

There are a lack of shared incentives which creates duplication and can lead to poor patient experience and outcomes. There is not a culture of "a single NHS pound", instead each team/organisation focus on their budget, resulting in missed opportunities to improve care and productivity. There is a lack of robust contract management and duplication of contracts impacting value for money.

Spend on agency varies between organisations, efficiency plans are being underachieved, procurement costs vary, increases in cost due to patient need (1:1 care) and drivers of the deficit show elective, better use of beds, workforce, primary care and community and commissioning savings as the biggest areas of opportunity.

Digital and AI are not progressing as a system and productivity is not as good as it would otherwise be. K&M is the least digitally mature system in the South East Region and is ranked 32 out of 42 ICS. £500m (and growing) estate maintenance backlog meaning large parts of estate and infrastructure are not fit for 21st century effective healthcare. Our estate is not aligned to demand reducing access to services.

Problem Statement:

i) The ICS is planning a deficit of £120m in 2024/25 and 10% efficiencies.
ii) Our modelling shows that continuing the current service models will result in a higher deficit which will likely result in poorer outcomes for patients.
iii) There is a resource gap to delivering constitutional standards, demand and capacity requirements consistently across ICS.
iv) Material parts of the ICS estate and equipment are not fit for purpose. There is insufficient capital to deliver backlog maintenance, asset renewal and essential developments to match service plans;
v) There has been a reduction in productivity in aggregate since 2019/20, with a particular growth in pay costs.
vi) Demand and capacity pressures and market sustainability in primary and social care are detrimentally impacting spend in acute, mental health and community care. These are drivers of poorer productivity and outcomes.
vii) There is significant variation in financial systems, capacity and expertise across the system. There is also variation in financial performance across the system and inconsistent ownership of the system financial gap.

Vision Statement:
We will have a financially sustainable system with sector-leading levels of productivity. Services will be supported by adequate resources and funds will be directed towards their indented purpose and be able to support the other strategic themes. The approach to this will be developed in alignment with the themes of the Darzi review most applicable to financial recovery:

- *re-engage staff and re-engage patients;*
- *lock in the shift of care closer to home*;
- *simplify and innovate care delivery for a neighbourhood NHS;*
- *drive productivity in hospitals; and,*
- *tilt towards technology.*

We will create a financial environment that enables future investment, both revenue and capital, in prevention and service provision.

Together, we can

Strategic Theme 4: Financial Sustainability continued

Goals

- The system and all partners are in recurrent financial balance, creating headroom to invest in prevention and service transformation (including strategic capital investment)
- Improved productivity across all services, including the reduction in waste and duplication not just doing more for the same cost (cost per weighted activity unit, reference costs, workforce productivity metrics s outlined by NHSE benchmarks)
- We stop providing services which are not delivering improved outcomes and reduces inequalities for patients to enable us to focus on delivery of equitable services which deliver the right (efficient) service in the right place at the right time.
- We have an engaged population that take personal responsibility for health prevention and self management of long term conditions reducing health service interventions and treatments
- A digital enabled and transformed effective operating model that supports a system-wide recurrent balance (model approved by all ICS Boards) whilst improving quality and operational performance.
- Demonstrable up-streaming of service provision, reducing reactive and resource-intensive health interventions.
- Integrated commissioning with Local Authorities to reduce overall health and care costs, driving the BCF to transform services

Targets:

- Achieve annual control total and develop bridging schemes as a system,
- Develop the framework and baseline assessment for a multi-year financial plan to 2029/30 by October 2024. This will be based on an understanding of cost drivers & productivity, include system efficiency & income plans, have identified SROs, delivery dates, scheduled savings plans and specific targets on pay.

Targets (continued):

- System and partners deliver financial balance in 2024/25.
- 75% of 2025/26 CIP plans identified before end of December 2024 and at least 75% of schemes recurrent.
- Delivery of improvement trajectory of key productivity measures (as outlined in FRP)
- Assess viability of services and decommission least value-adding and inequitable services by March 2025.
- Define and implement effective system operating model by Autumn 2024.
- By March 2025 develop a plan to move to single back-office services.
- Develop a plan for the strategic rationalisation of the secondary care estate by September 2025, supported by a plan to up-stream the delivery of care out of hospital and meet our environmental sustainability targets.
- Develop governance and implement approach for EPR convergence and interoperability to enable efficiency by the end of 2024

Break Through Objectives:

Alongside this A3 the workstream have developed a supporting Financial Recovery Plan (FRP) this plan includes a number of breakthrough objectives and targets in organisations and and the system. The key breakthrough objective identified therefore is delivery of year one of the FRP and progress on year tow as per the timetable in the FRP

Implementation Plan:

The ICS has developed a financial recovery plan framework through multi—disciplinary executive level system workshops. This will then be developed into a detailed financial recovery plan to return to a financially sustainable position by 2026/27.

Together, we can

Enabler 1: System development, culture and improvement

Workstream aim

- Assess the readiness of the system to undertake improvement work
- Define a set of principles at provider, place/ collaborative and ICB
- Agree and implement a set of behaviours across the system to support continuous improvement
- Align improvement work to NHS Impact, Improving Care Together best practice
- Define, secure and allocate improvement support for the system
- What is the single biggest priority we should focus on in each of the Places and Provider Collaboratives?
    - Identify what data is required
    - Which Provider will be Lead Provider for each of these priorities (sharing method with other providers)
- Ongoing work to prioritise schemes for this year. Kent workforce, single recruitment and leadership development are key focus for discussion

Together, we can

Readiness to start change

Ability to commit resources for an extended period of time and confidence in position

SECURITY

WILLINGNESS

Know the change is required (for themselves and the organisation)

COMMITMENT

Clarity of purpose - Leaders understand the vision and commit fully to the approach

Buy in of Board, staff and regulator and a trust in leadership

PERMISSION

ABILITY FOR LEADERSHIP TO COMMIT

Key leadership team members substantive, stable and likely to remain in post for next 18 months

STABILITY

STAYING POWER

Recognise it takes time, attention and discipline and are in it for the long haul

ABILITY TO FOCUS

Decisions won't be compromised by other programmes outside scope of control (e.g. special measures) or significant operational, quality or financial pressures

- Building of existing work
- Using existing groups where possible for this work
- Governance though existing committees

Focus on ICB and Provider Collaboratives

Focus for ICB:

For NHS IMPACT Strategy (Alignment) and governance (enable) underpinned by robust system wide data

Focus for Provider collaboratives / Place (improve) Improvement to models of care

	[principles]	[leadership]	[management]	[front-line]
ALIGN	Create value for the patient Create constancy of purpose Think systemically	**Establish Direction** **Develop** a vision and strategies to achieve that vision. **Set** high but reasonable targets. **Communicate** the direction on a regular basis.	**Organizing & Translating** **Establish** a structure to achieve the plan. **Organize** and **allocate** resources. **Monitor** structure to ensure consistency and alignment to plan.	**Setting & Achieving Goals** **Identify** meaningful goals that can be accomplished in their area that directly affect the overall vision and strategy. Daily **report** on status and needed support.
ENABLE	Lead with humility Respect every individual	**Motivate, Mentor, Inspire** **Energize** people to develop and overcome barriers to change. Daily **be in** the work area to **listen** to understand. **Embrace** failure; **celebrate** success.	**Empower, Involve & Coach** **Empower** authority within parameters of area to improve and solve problems. **Break-down** silos by **involving** cross-functional teams to solve value stream issues. **Coach** problem solving daily.	**Develop & Share** Be a self-developer. **Find** opportunities to grow and develop to better support the organization. **Share** with others what is working and what is not working.
IMPROVE	Focus on process Embrace scientific thinking Flow & pull value Understand & manage variation Assure quality at the source Seek perfection	**Break-through Thinking** Continuously **learn** by listening, seeing and translating observations. Support new models of care delivery developed by front line.	**Monitor & Maintain Predictability** **Monitor** the outputs of each system to ensure stability and a standard outcome. Continuously **challenge** the process to identify areas of improvement.	**Adapt & Adjust** **Adapt** the tools by making incremental adjustments that all shifts agree with. **Treat** tools as a countermeasure not a solution. Structurally **solve** area problems daily.

e can

Source: Collaboration with Institute for Enterprise Excellence and Catalysis, 2013

Best Practice

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

Together, we can

What could our improvement framework include?

Leadership behaviours
Supporting and empowering teams to deliver and improve at all levels – including leadership behaviours

Strategy
Definition, deployment and review of system strategy inc. longer term initiatives

Strategy Cascade & Performance Goals
Translation of strategic objectives into operational (annual) goals at all levels of the system

Step change and Transformation projects
Looking at the **method** and **prioritisation** for delivering larger complex change projects

Performance , Operational and Quality Management and Governance
Management of performance against standards and targets

Escalation management
Issue resolution and escalation

Engagement
Communicate and bring **patients** and **staff** together on strategy and improvement

Centre of Excellence
A core team focused on setting standards and delivering improvement

HR, Digital, Finance and BI
Integration, alignment and support from key enabling corporate functions

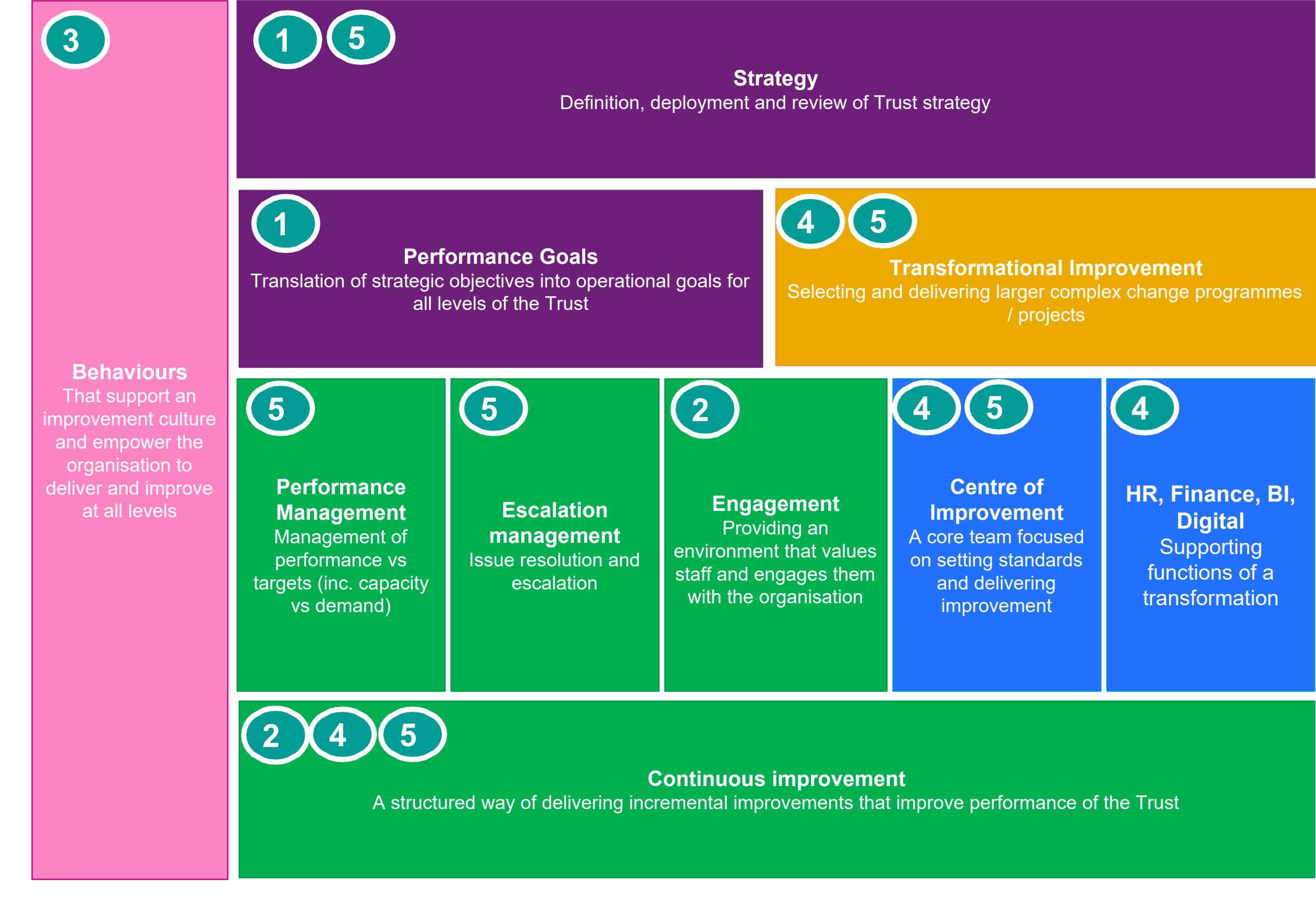
Daily management and Continuous improvement
A structured way of delivering incremental improvements at the frontline as part of daily management.

Key: Behaviours | Strategy | Projects | Support | CI

Together, we can

Aligned to NHS IMPACT

1. **Building a shared purpose and vision**
2. **Investing in people and culture**
3. **Developing leadership behaviours**
4. **Building improvement capability and capacity**
5. **Embedding improvement into management systems and processes**



Together, we can

Enabler 2 - Strategy delivery architecture

Roles and Responsibilities

- Use existing governance and architecture arrangements, rather than create additional layers.
- Propose to extend existing Chief Executives Group as overarching Programme Board (suggest a Part B to existing meeting, with PMO and other execs in attendance as appropriate).
- Subject to confirmation of specific programmes of work from each strategic theme, existing delivery partnership arrangements are to be utilised, i.e.
  - Provider collaboratives
  - Transformation programme Boards such as UEC, elective, diagnostics, cardiovascular, etc
  - Existing professional groups, such as CFOs and CPOs
- NHS Providers and Health and Care Partnerships will be foundation delivery vehicles to the above
- Primary care to be enhanced in the above groups if not already established
- Programme Management Office to be established to co-ordinate planning and deliver a standardised process for reporting against delivery

Together, we can

Strategy delivery architecture

'keep it simple'

K&M Chief Executives Group (Part B)

PMO

Strategic Theme 1	Strategic Theme 2	Strategic Theme 3	Strategic Theme 4
Patient experience and outcomes *Focus on circulatory disease: Pathway reviews, removal of unwarranted variation and single aligned approach at all levels*	**People** *Design an affordable system workforce plan which supports the needs of the clinical operating model*	**Sustainable services** *Identify vulnerable cohort through risk stratification at PCN level. Comprehensive assessment and tailored plan for each individual.*	**Finance Sustainable services** *Deliver Year 1 of our Financial Recovery Programme and progress Year 2*
SRO: Jayne Black **Lead Execs:** Sarah Phillips / Paul Lumsdon	**SRO**: Sheila Stenson **Lead Execs**: Andrea Ashman / Natalie Davies	**SRO**: Mairead McCormick **Lead Execs**: Steve Orpin /Kate Langford	**SRO**: Miles Scott **Lead Execs**: TBC, Ivor Duffy
System Delivery Group Acute provider Collaborative	**System Delivery Group** K&M Chief People Officers	**System Delivery Group** Aging Well Prog Board, Reporting to Community Services PC	**System Delivery Group** K&M Chief Finance Officers
Assurance: ICB Improving Outcomes and Efficiency Committee	**Assurance**: K&M People Committee	**Assurance**: ICB Inequalities Prevention and Population Health Committee	**Assurance**: ICB Productivity and Investment Committee

Together, we can

Equality, Diversity and Inclusion Impact Assessment

Stage 1

Section 1: Policy, Function or Service Development Details
This section requires the basic details of the policy, function or service to be reviewed, amended or introduced.

Section 2: Assessing Impact
This section asks the author to consider potential differential impacts the policy, function or service could have on each of protected groups. There is a separate section for each characteristic, and each should be considered individually.

Authors should refer to relevant evidence to inform the assessment, and to understand the likely demographics of the patient population who will be impacted by the policy, function or service. For example, findings from the Joint Strategic Needs Assessment (JSNA). It may be that no evidence is available locally. In this case, relevant national, regional or county-wide data should be referred to.

Authors must consider what action they will take to mitigate any negative outcomes identified and what actions they will take to ensure positive impacts are realized.

A link is provided to the legal definition for each of the protected characteristic groups.

Section 3: Equality Act 2010
This section asks the ICB's equality, diversity and inclusion lead to consider compliance to the Equality Act (2010). Within the Equality Act, NHS Kent and Medway as a public authority has a legal requirement to promote equality and set out how we plan to meet the "general" and "specific" duties specified in Section 149 (1) of the Public Sector Equality Duty.

As a public authority NHS Kent and Medway is required to pay "due regard" to the three aims of the general equality duty to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having "due regard" for advancing equality involves:

- Removing or minimising disadvantages people encounter due to their protected characteristics

- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people

- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

NHS Kent and Medway are legally bound to demonstrate that we are taking action to promote equality in relation to policy making, development of policies and procedural documents, alongside the delivery of services, service developments and employment.

Within the Act, we also have a legal duty to show that we have given due regard to the nine protected characteristics below:

- Sex
- Ethnicity
- Gender
- Disability
- Religion / belief
- Sexual orientation
- Gender reassignment
- Marriage or civil partnership • Pregnancy / maternity
- Age.

The Human Rights Act

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. The Act sets human rights in a series of 'Articles' and each Article deals with a different right. There are 16 Articles; details of which are at: www.equalityhumanrights.com/en/human-rights/human-rights-act.

Article 14: Right to freedom from discrimination (which in effect means protection from discrimination for any other reason that is not one of the protected characteristics e.g. socio-economic status).

Section 4: Conclusions & Recommendations

Now the impact has been assessed, the reviewing panel is asked to consider whether, based on the findings, they agree with the findings and any mitigating actions.

Section 5: Planning Ahead

It is the responsibility of the Senior Responsible Officer accountable for the Strategy, Policy, Function of Service to sign-off your EIA, which should be through the governance arrangements/committees/Boards for the programme/area of work it supports.

Section 1: Policy, Function or Service Development Details (to be completed by the author)

Division: Strategy
Directorate: System Strategy
Senior Officer responsible for assessment: Rachel Hewett, Director of System Strategy
Date of assessment: 15th August 2024
Is this a (please confirm): New assessment

Defining what is being assessed:

What is the title of the policy, function or service this impact assessment applies to? Kent and Medway NHS Strategy 2024/25 – 2029/30

Please briefly describe the purpose and objectives of this policy, function or service NHS provider organisations, primary care and NHS Kent and Medway have come together to produce the NHS Strategy 2024/25-2029/30. We know we can achieve more collectively, rather than individually, to meet the health needs of our population and this strategy outlines our ambition and vision for NHS services of the future. It is focused around 4 strategic themes: Patient experience, access and outcomes, People, Sustainable Services and Finance and resources.

Who is intended to benefit and in what way? It is intended to improve the health outcomes of all the Kent and Medway population by NHS organisations working collectively on issues that cannot be addressed by individual organisations.

What is the intended outcome of this policy, function or service? The following outcomes are hoped to be achieved by this service. The strategy will be used to agree new work, and extend current work, to tackle the challenges we have identified together. These challenges include increasing demand, a growing and ageing population, the need to stay within our financial means, a siloed workforce with inequity of experience and inequity of patient experience, access and outcomes.

Who are the main stakeholders in this piece of work? The NHS Strategy has been developed and will be implemented by the ICB, NHS providers and primary care. We have used feedback from patients and the public and will continue to engage as we develop our delivery plans.

Who is responsible for implementing this change to policy, function or service? (Please provide contact details). The Chief Executive Officers across Kent and Medway are each leading a theme or enabler of the NHS Strategy and will be responsible for delivery.
What factors may contribute to the outcomes of this policy, function or service? Identifying these will help you to design any public-facing communications to support your initiatives We will need to continue ensuring the voices of patients and the public are included as we develop our strategy and implementation plans. Partnership working, including through system structures such as the Provider Collaboratives, will be key. Each of the strategic theme areas is interdependent on the others, for example ensuring a workforce model that delivers the changes required to make services sustainable.

What factors may detract from the outcomes of this policy, function or service? Identifying these will help you to design any public-facing communications to support your initiatives Some of the factors identified above as contributing to the outcomes make also detract from them, for example challenging finances, workforce shortages and the need for enhanced partnership working.

Section 2: Assessing Impact (to be completed by the author)

When completing this section please give consideration to the fact that a differential impact may be positive or negative.

1. Could there be a differential impact due to *racial/ethnic groups*?	Yes	
What evidence exists for this? The implementation plans are yet to be confirmed, however the strategy aims to reduce health inequalities by considering the needs of local populations and using population health data to identify those at risk of inequity. The vision for the Patient access, experience and outcome theme includes ensuring patients "experience good comparable outcomes, irrespective of where they live or what their background is". In addition the People theme champions an inclusive workforce which is "reflective of our local population" and our aim to become an anti-discrimination system.		

2. Could there be a differential impact due to *disability*?	Yes	
It is recognised that people with some disabilities are more likely to require healthcare services and so are more likely to be impacted by this strategy. The strategy should have a positive impact as it looks to reduce health inequalities, particularly in the Patient access, experience and outcomes theme. The People theme is focused on ensuring all staff feel "safe and valued" and recognises that experience for staff with protected characteristics is currently inequitable as evidenced in our staff survey results. One of the goals is to improve these results, particularly in relation to engagement and inclusivity.		

3. Could there be a differential impact due to *gender*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

4. Could there be a differential impact due to *sexual orientation*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

5. Could there be a differential impact due to *religion or belief*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

6. Could there be a differential impact due to people's *age*?	Yes	
The strategy addresses the needs of the whole population, of all ages. The Sustainable services theme has a focus on children's mental health and wellbeing as well as childhood obesity. It also promotes a shared responsibility for improvements in end of life care.		

7. Could there be a differential impact due to *marital/civil partnership status*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		
8. Could there be a differential impact due to a person being *trans-gendered or transsexual*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care.		

9. Could there be a differential impact due to a person being *pregnant or having just had a baby*?	Yes	
The strategy will have a positive impact as it looks to reduce health inequalities by considering the needs of the local population to enable greater provision of care. There is a recognition that prevention of poor health and future good health outcomes start from the earliest years of life and reducing childhood obesity is a goal for the Sustainable Services theme.		
10. Are there any *other* groups that may be impacted by this proposed policy, function or service (e.g. speakers of other languages; people with carers, those with an offending past, or people living in rural areas, homeless or war veterans) but are not recognised as protected characteristics under the Equality Act 2010?	Yes	
The scope of the Strategy is very broad and has the ability to impact on all of the population of Kent and Medway. It aims to tackle health inequalities, increase local community and primary care, improve self-management of long term conditions and improve the productivity of services.		

NB: Remember to reference the evidence (i.e. documents and data sources) used

Section 3: The Equality Act 2010 (to be completed by the Senior Responsible Officer for the Policy, Function or Service Development Details)

Under The Equality Act 2010, the ICB is required to meet its Public Sector Equality Duty. Does this impact assessment demonstrate that this policy, function or service meets this duty as per the questions below?

A 'no' response or lack of evidence will result in the assessment not being signed off.

11. The need to eliminate discrimination, harassment and victimisation	Yes	
The content included in Section 2 of this report and the accompanying actions identified in Section 4 demonstrate that the NHS organisations in Kent and Medway have given due regard to the local communities that they serve in a way that meets obligations under the Public Sector Equality Duty.		

The strategy seeks to improve services and highlight and reduce inequalities thereby providing responsive, sustainable and equitable care.		
12. Advance equality of opportunity between people who share a protected characteristic and those who do not	Yes	
The content included in Section 2 of this report and the accompanying actions identified in Section 4 demonstrate that the NHS organisations in Kent and Medway have given due regard to the local communities that they serve in a way that meets obligations under the Public Sector Equality Duty. The strategy seeks to improve services and highlight and reduce inequalities thereby providing responsive, sustainable and equitable care.		
13. Foster good relations between people who share a protected characteristic and those who do not	Yes	
The content included in Section 2 of this report and the accompanying actions identified in Section 4 demonstrate that the NHS organisations in Kent and Medway have given due regard to the local communities that they serve in a way that meets obligations under the Public Sector Equality Duty. The strategy seeks to improve services and highlight and reduce inequalities thereby providing responsive, sustainable and equitable care.		

NB: Remember to reference the evidence (i.e. documents and data sources) used

Section 4: Action Plan

The below action plan should be started at the point of completing the Impact Assessment (as impacts are identified), however, it is an ongoing action plan that should support the project throughout its lifespan and therefore, needs to be updated and directly linked to other action plans associated with the programme on a regular basis.

Potential Impact identified	Which Protected Characteristic group will be impacted upon?	Action required to mitigate against/support implementation of impact	Deadline	Who is responsible for this action (Provider/ICB- please include job title where possible)?	Update on actions (to be provided throughout project)	RAG rating
	All	Ensure that detailed equality analysis and mitigation is in place for specific service changes or projects that happen as a result of the strategy	Ongoing	CEO SRO for each strategic theme and enabler		

Key-
Red- Not started
Amber- Started but delayed
Green- On track
Blue- Completed
Please note this can be amended to reflect status as per any other action plan you may have linked to this work

Section 5: Sign Off (to be completed by author and the Senior Responsible Officer for the Policy, Function or Service)

Date of next review	When strategy is next updated	
Areas to consider at next review (e.g. any data gaps to be established)	See action plan	
Signed (Author) R Hewett	Date	15/08/24
Signed (Senior Responsible Officer for the Policy, Function or Service)	Date	

REPORT TO BOARD OF DIRECTORS (BoD)

Report title:	**Integrated Performance Report (IPR)**
Meeting date:	**5 December 2024**
Board sponsor:	**Chief Strategy & Partnerships Officer (CSPO)/Chief Finance Officer (CFO)**
Paper Author:	**Chief Strategy & Partnerships Officer**

Appendices:

APPENDIX 1: October 2024 IPR

Executive summary:

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

	• DM01 has alerted positively with an increase in performance of 8 percentage points to 77%. • The Endoscopy backlog has halved over the month, now down to 663 patients. • Though it is not yet flagging a statistical improvement it is worth noting that Cancer 62d combined performance has exceeded the national standard for four consecutive months, sustaining the improvements seen in quarter two. • The financial efficiency programme, financial deficit (in month), Type 1 four-hour Emergency Department (ED) Compliance and the number of patients on a Cancer Pathway for over 62d are all demonstrating improving performance but are currently not demonstrating a stable enough position to consistently pass the thresholds set. Progress this year is positive. **Patients** • Consistent reductions in 78 & 65 week breaches continue into month seven with remaining challenges to demand seen in ENT, adult and paediatric. • Type 1 Compliance continues to exceed the tier 1 milestones in each month. • Improvements in 62d Cancer standard sustained with performance above the national standard for four consecutive months. • A deterioration in length of stay of more than 14 days was seen in October and a deep dive to understand the key drivers is in place; the deterioration in the number of patients on the RTS >7 days was noted and makes a significant contribution to the deteriorating length of stay. **Quality & Safety** • There were no new Never Events reported in October, however, one of September's Never Events was declared on StEIS in October following the IPR presentation and therefore appears on the scorecard for October. Details are on slide 15. • FFT Satisfaction levels for Outpatients, Overdue Incidents, Adult & Child Safeguarding and Venous Thromboembolism (VTE) Screening Compliance are all demonstrating a statistical improvement. • Compliance across all Duty of Candour metrics is improving with both verbal and written compliance hitting 100%. **People** • Sickness absence rates have inflected up and above the alerting threshold of 5% (to 5.09%) for the first time since January (5.42%). This is due to a significant increase in the number of people absent with coughs, cold and influenza (S13). • Appraisal compliance continues to improve and is now at 79.4%, less than 1% from the desired threshold. • Staff turnover has improved again to 8.8% and continues the positive trend that has been observed across the last two years.

	Finance • The Group has delivered the Year to Date (YTD) plan of £52,420k to Month 7 deficit. The continued delivery of the plan is a significant strategic achievement for EKHUFT. • Trust pay expenditure increased in month due to the various pay awards made in month, however, the underlying run rate on substantive pay has remained steady. • The emerging risk to the submitted 2024/25 financial plan relating the pay award remains. This has been offset by non-recurrent benefits YTD, however, if additional funding is not agreed, it could be a risk to our year-end position. • Trust non-pay run rate increased in month, mainly in drugs including rechargeable drugs and spend covered by Recovery Support Programme (RSP) funding. • The Trust has delivered £26m of efficiencies in the first seven months, £0.3m above the YTD plan. **Maternity** • The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the October 12 month rolling rate at 4.09 per 1,000 births. This rate includes stillbirths and neonatal deaths, and whilst the stillbirth rate remains significantly low (1.71 per 1,000 against a threshold of 3.61 per 1,000), the neonatal death rate is 2.39 per 1,000 against a threshold of 1.82 per 1,000. An external review is currently in progress. • At month end (October 2024) there are five open cases referred to and accepted by MNSI for external Patient Safety Incident Investigation (PSII). • One moderate / severe patient safety incident was reported in October.
Summary recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report

Implications:

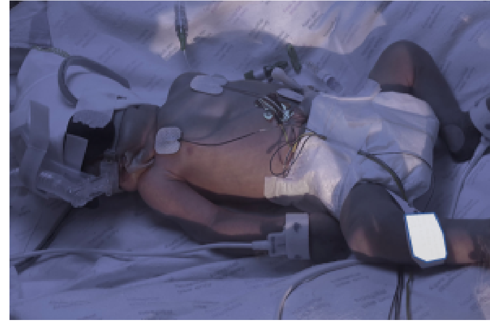
Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Trust Risk Register:	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There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

Assurance route:

Previously considered by: Finance and Performance Committee – 26 November 2024, Quality and Safety Committee – 26 November, and People & Culture Committee – 27 November 2024

Integrated Performance Report

OCTOBER 2024



NHS
East Kent
Hospitals University
NHS Foundation Trust

Integrated Performance Report

Statistical Process Control

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

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

Our Trust Integrated Performance Report incorporates the use of SPC Charts to identify common cause and special cause variations and uses NHS Improvement SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

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

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and Common Cause (i.e. no significant change.

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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

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

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

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

Integrated Improvement Plan (IIP)

Summary Highlights

Executive Summary:

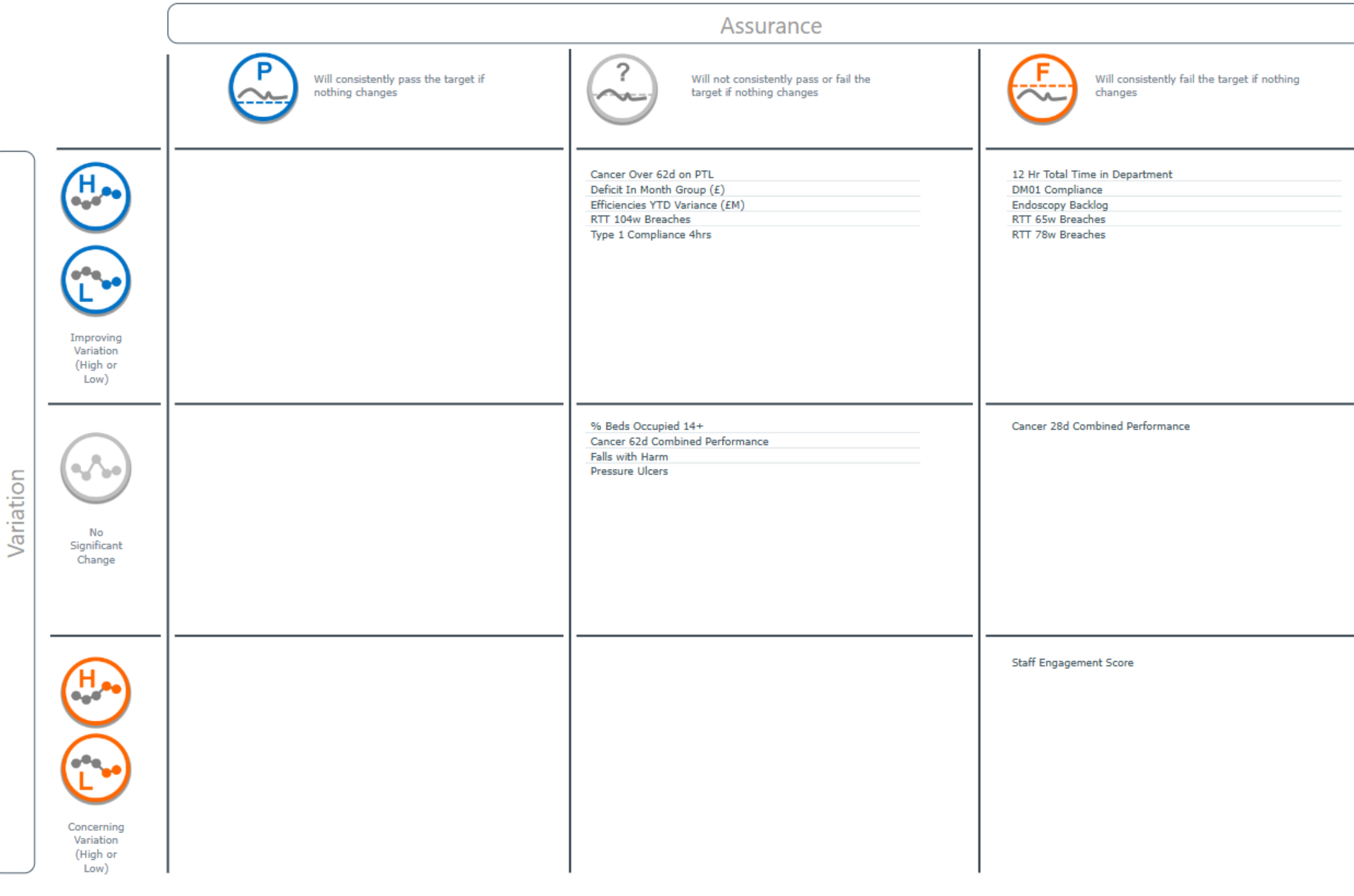
DM01 Performance, reduction of the Endoscopy Backlog, reduction in elective long waiting patients and the number of patients with a total time in the ED department of over 12h are all showing statistical improvement. DM01 has alerted positively with an increase in performance of 8 percentage points to 77%. The Endoscopy backlog has halved over the month, now down to 663 patients.

The financial efficiency programme, financial deficit (in month), Type 1 four hour Emergency Department Compliance and the number of patients on a Cancer Pathway for over 62d are all demonstrating improving performance but are currently not demonstrating a stable enough position to consistently pass the thresholds set. Progress this year is positive.

A number of IIP metrics have started to show positive improvements with a reduction to 50% demonstrating no significant change on a monthly basis. These remaining metrics will not consistently pass or fail the assurance targets if nothing changes.

Though it is not yet flagging a statistical improvement it is worth noting that Cancer 62d combined performance has exceeded the national standard for four consecutive months, sustaining the improvements seen in quarter two.

Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds. Metrics cannot be updated until early 2025 due to the national embargo, but recovered slightly in Q2 (by 25 points, to 5.95). There remains a considerable gap to the 6.80 target, which is primarily anchored by advocacy.



NHS East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP)

Exit Criteria Metrics: Dashboard

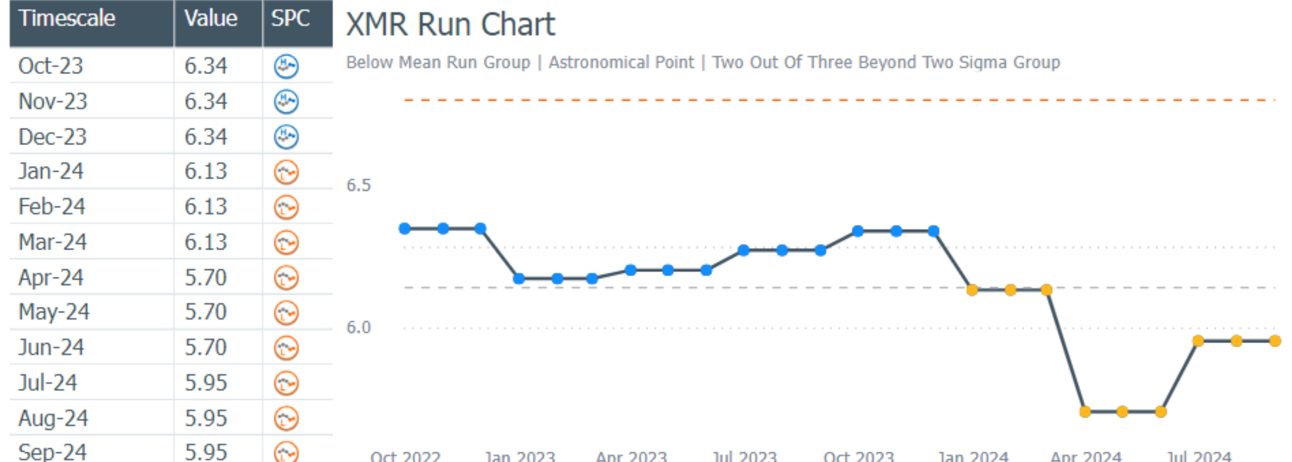
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
People	IIP		Staff Engagement Score			6.80	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70	5.95	5.95	5.95	
Patients	IIP		Type 1 Compliance 4hrs			50.0%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%
	IIP		12 Hr Total Time in Department			8.0%	10.4%	11.5%	11.1%	10.3%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%	9.2%	9.7%
	IIP		% Beds Occupied 14+			30.0%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%
	IIP		Cancer 28d Combined Performance			77.0%	62.5%	68.7%	57.8%	66.9%	68.3%	64.9%	70.2%	70.4%	72.6%	71.0%	70.2%	70.4%
	IIP		Cancer 62d Combined Performance			70.0%	61.8%	63.5%	56.1%	55.6%	69.1%	66.2%	64.1%	63.0%	71.6%	73.2%	72.8%	72.0%
	IIP		Cancer Over 62d on PTL			200	308	407	419	244	188	236	237	233	203	244	215	193
	IIP		RTT 65w Breaches			575	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656	1,360	1,269	572	346
	IIP		RTT 78w Breaches			0	435	643	752	653	485	465	272	82	35	32	34	11
	IIP		RTT 104w Breaches			0	12	12	6	13	24	15	1	1	0	1	0	0
	IIP		Endoscopy Backlog			1,763	9,408	9,572	9,116	8,005	7,238	6,153	5,170	4,108	3,018	1,997	1,304	663
	IIP		DM01 Compliance			75.0%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%	61.3%	63.9%	68.4%	77.0%
Quality	IIP		Falls with Harm			11	2	3	2	10	4	6	3	4	2	7	5	6
	IIP		Pressure Ulcers			112	82	84	113	91	76	84	84	82	79	72	77	91
Sustainability	IIP		Deficit In Month Group (£)			7.4M	6.5M	9.3M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M
	IIP		Efficiencies YTD Variance (£M)			0.0	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1	0.3	0.3	0.3

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
Oct-23	6.34	
Nov-23	6.34	
Dec-23	6.34	
Jan-24	6.13	
Feb-24	6.13	
Mar-24	6.13	
Apr-24	5.70	
May-24	5.70	
Jun-24	5.70	
Jul-24	5.95	
Aug-24	5.95	
Sep-24	5.95	



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/09/2024 the latest Staff Engagement Score performance is 5.95 against a static target of 6.80 (higher is better).

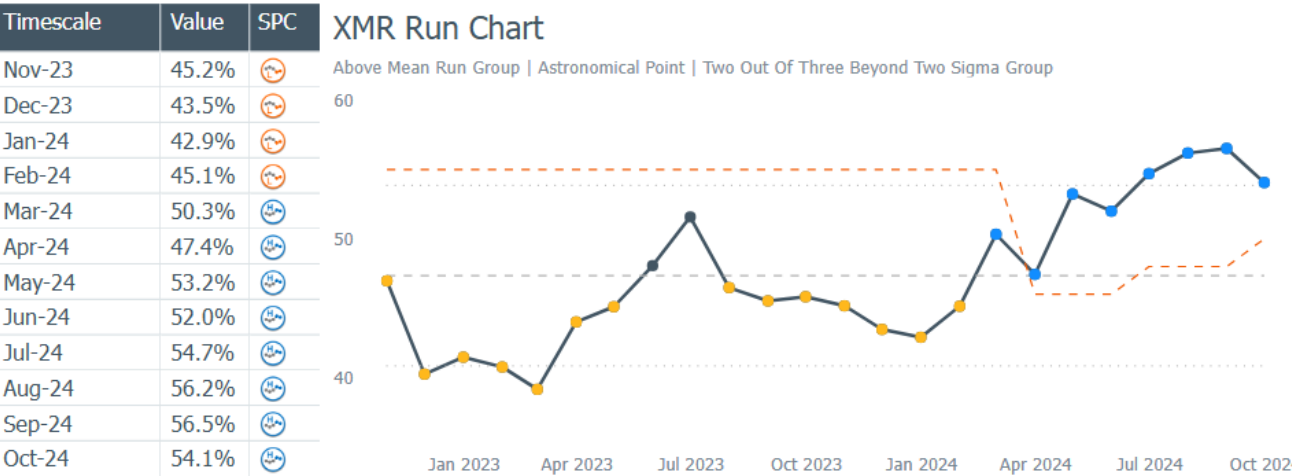
Performance is statisticaly declining, and cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (5.95) are below the national average (6.50).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Staff Experience	End Mar 25	• Staff engagement metrics cannot be updated until early 2025 due to the national embargo, but recovered slightly in Q2 (by 25 points, to 5.95). There remains a considerable gap to the 6.80 target, which is primarily anchored by advocacy. A more progressive and sustainable plan has been proposed to attend to this, and is currently with EMT for approval. This will align with the new strategy, establish an annual rhythm and lead to the strategic deployment of a wider body of key stakeholders to drive toward desired standards.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across CLP immediate actions delivery plan and local Care Group People Plans	Head of Staff Experience	End Nov 24	• A proposal first socialised at CEMG (16/10) has also been taken to EMT (20/11) and represents a sustainable, evidence-led and long-term (people) plan to attend to staff survey outcomes. The current process is protracted and misapplication of the national embargo inhibits progress. Core to the ethos of the 2025 plans will be a more progressive and innovative approach based on the principles of sharing earlier and acting quicker. It is proposed that results are shared in January, under the national embargo, and plans finalised with a view to being enacted before the embargo is lifted and results published in March.
2024 NHS Staff Survey	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of associated results	Head of Staff Experience	End Nov 24	• The response rate to this years' staff survey is the highest in the Trusts' history (57%), with feedback from more colleagues than ever has been recorded before (5648). It is representative, with 6 of the 7 staff groups >50%. Six of the eight Care Group or Corporate areas are also >50% with only two areas below this threshold (all above 47%). Activity continues and planning is already underway for managing the communications and related action to follow.

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Timescale	Value	SPC
Nov-23	45.2%	
Dec-23	43.5%	
Jan-24	42.9%	
Feb-24	45.1%	
Mar-24	50.3%	
Apr-24	47.4%	
May-24	53.2%	
Jun-24	52.0%	
Jul-24	54.7%	
Aug-24	56.2%	
Sep-24	56.5%	
Oct-24	54.1%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest Type 1 Compliance 4hrs performance is 54.1% against a Trajectory target of 50.0% (higher is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

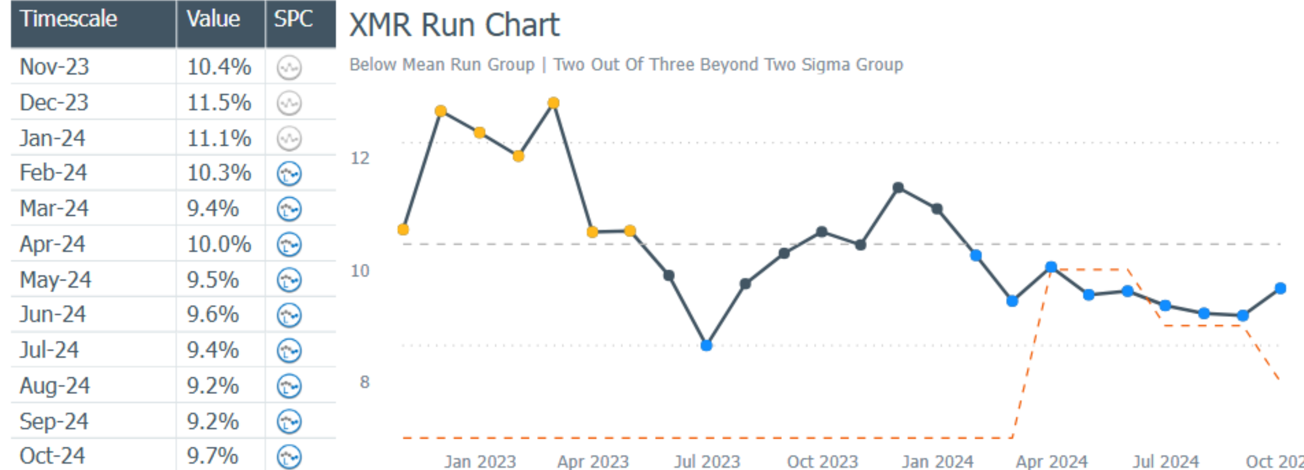
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2024/5 to incorporate functions of an 'emergency portal' – advice and guidance, same day emergency care access – primary and secondary care; acute GP referral management; ambulance 'stack reviews'; frailty response, care home support and update of DOS. • Development of direct access pathways and extending use of the virtual wards, same day emergency care services	• COO • Dep COO UEC • CN/CL ED	• Q3 • Q3	• Performance 54.1% which is ahead of trajectory for Q3 • SPOA – implementation of single SPOA model being finalised for implementation in Dec 24– increase community capacity being recruited to further support the SPOA attendance avoidance • Frailty model: winter funding secured to support QEQM and WHH frailty SDEC test of change • Acute Virtual ward – winter funding secured for test of change for acute virtual ward at QEQM and WHH
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites; introduce CDU at WHH Q3	• CL ED • Dep COO UEC • Site MDs	• Q3 • Q3	• ED Internal professional standards drafted; mechanism for monitoring being developed in conjunction with escalation framework Safe & Effective ED workstream established: focus on validation, roles and escalation through patient pathways for phase 1 • Heatmap for demand profiles requested to ensure workforce alignment: due M8
Admission avoidance	Front door alternatives to ED: • Review & development of AMU model & SDEC at WHH with DA pathways • Review of effectiveness of AMU model and SDEC at QEQM	• SiteTri • Dep COO UEC	• Q3	• AMU workstream established for WHH: direct access, workforce, pathways & data for demand and capacity completed: pilot started 11/9 • AMU model at QEQM under review – operational policies drafted for both sites to ensure standardisation – concept test through Sept/Oct

NHS
East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP)

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department



Timescale	Value	SPC
Nov-23	10.4%	
Dec-23	11.5%	
Jan-24	11.1%	
Feb-24	10.3%	
Mar-24	9.4%	
Apr-24	10.0%	
May-24	9.5%	
Jun-24	9.6%	
Jul-24	9.4%	
Aug-24	9.2%	
Sep-24	9.2%	
Oct-24	9.7%	

Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest 12 Hr Total Time in Department performance is 9.7% against a Trajectory target of 8.0% (lower is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

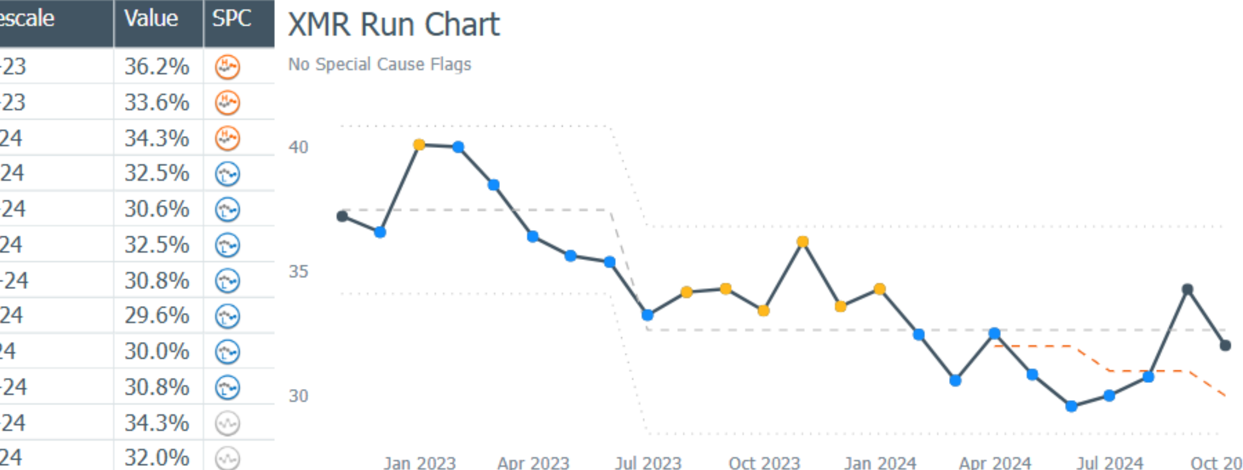
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment units; aligned to demand • Improve flow into downstream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

Integrated Improvement Plan (IIP)

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

% Beds Occupied 14+

Timescale	Value	SPC
Nov-23	36.2%	
Dec-23	33.6%	
Jan-24	34.3%	
Feb-24	32.5%	
Mar-24	30.6%	
Apr-24	32.5%	
May-24	30.8%	
Jun-24	29.6%	
Jul-24	30.0%	
Aug-24	30.8%	
Sep-24	34.3%	
Oct-24	32.0%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/10/2024 the latest % Beds Occupied 14+ performance is 32.0% against a Trajectory target of 30.0% (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

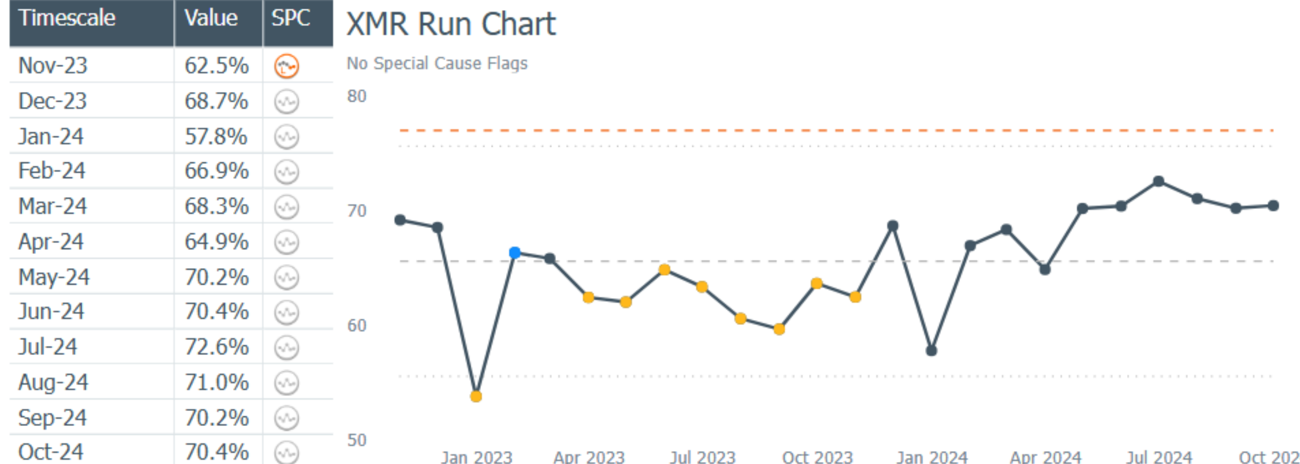
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Dep COO UEC/CG DoN • COO/Dep COO UEC • Deputy COO/MD DCB	• Q3 • Q3 • Q3	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for C2R • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities – pilots for acute medicine virtual ward August QEQM and Sept for WHH • Therapy review underway • Review of function of site discharge coordinators – listening events held on both acute sites in October – follow up event planned Dec 24
Patients not meeting the criteria to reside >14 days	• Demand and capacity for D2A pathways – working with HCP partners to review demand and capacity to mitigate delays for patients waiting to access D2A capacity • Review of internal codes – therapy reviews required for discharge – develop D2A approach	• COO/Deputy COO-UEC • System Partners	• Q3 • Q3	• Test of change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – on-going discussions with ICB to expand D2A pathways as part of winter resilience. • Revised model for management of complex patients – soft launch Sept-Nov
Grip and control: all LOS	• Implement weekly stranded reviews on all sites; SAFER • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Q3	• Discharge and escalation policy review in progress – for sign off • SAFER bundle – revisit and standardise process for consistent implementation– impact assessment Q2 and Q3 • Stranded review and escalation process drafted for consideration.

NHS
East Kent Hospitals University
NHS Foundation Trust

Integrated Improvement Plan (IIP)

Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance



Timescale	Value	SPC
Nov-23	62.5%	
Dec-23	68.7%	
Jan-24	57.8%	
Feb-24	66.9%	
Mar-24	68.3%	
Apr-24	64.9%	
May-24	70.2%	
Jun-24	70.4%	
Jul-24	72.6%	
Aug-24	71.0%	
Sep-24	70.2%	
Oct-24	70.4%	

Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/10/2024 the latest Cancer 28d Combined Performance performance is 70.4% against a static target of 77.0% (higher is better).

Performance is not changing significantly and cannot deliver the target without intervention.

The biggest contributing factors are: 07 - Lower GI (38.2% , 379*), 09 - Gynaecological (60.0% , 174*), 11 - Urological (65.7% , 132*). *Breaches

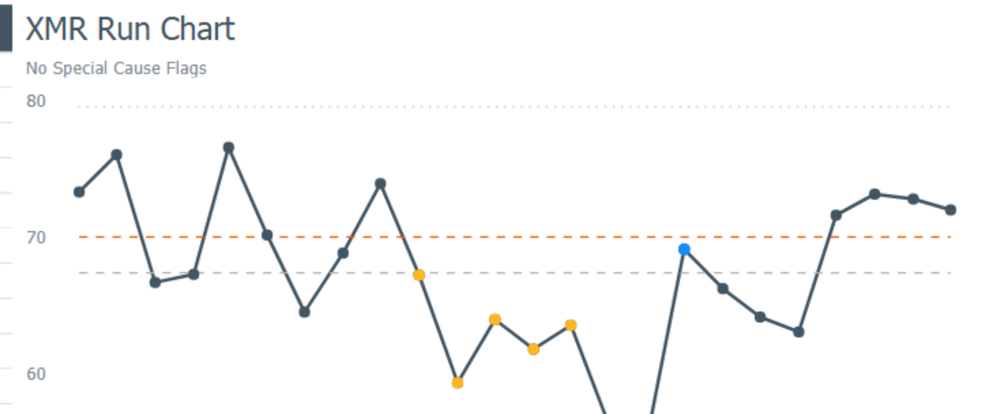
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Guided Biopsy, US. • Endoscopy booking turnaround times • Breast US booking turnaround times	• Radiology • Endoscopy	• Funding – July 24 to March 25	• Plans are in development to support services where additional funding from tiering has supported additional capacity – Endoscopy, US, radiology reporting. The Breast team working to implement OSS clinic at KCH in the coming months providing increased capacity substantively. • Additional US insourcing capacity paused pending the finalisation of the tender process. Expect additional US capacity be re-instated in December. • Dermatology implementing additional punch biopsy clinics supported by tiered funding
Letter backlog	• Timely consultant dictation of cancer outcome letters to patients • Timely administrative support to process dictated letters	• Cancer compliance • Admin • Consultants	• Ongoing	• Amended escalation process to highlight all breaches by month ensuring teams are sighted on any outstanding letters from the months prior. Improvements in the letter backlog being realised week-on-week • Colorectal benign letter template approved and available on Winscribe
Rapid Access 1st OPA	• Recovery from non-compliant position	• PSC Team • All specialties	• Q3	• Specialties set the ambition of reducing 1st OPA to 10 days from referral in November, and then to maintain or achieve incremental improvement in December and January. • Patient service centre set the ambition of ensuring all patients are contacted within 5 days of referral where capacity permits. Additional resource is being secured to achieve this goal. • Escalation and contact point process amended to provide specialties with a clear view of capacity requirements on a weekly basis.

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Nov-23	61.8%	
Dec-23	63.5%	
Jan-24	56.1%	
Feb-24	55.6%	
Mar-24	69.1%	
Apr-24	66.2%	
May-24	64.1%	
Jun-24	63.0%	
Jul-24	71.6%	
Aug-24	73.2%	
Sep-24	72.8%	
Oct-24	72.0%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/10/2024 the latest Cancer 62d Combined Performance performance is 72.0% against a static target of 70.0% (higher is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

The biggest contributing factors are: 01 - Breast (56.3% , 28*), 11 - Urological (68.6% , 22*), 07 - Lower GI (55.6% , 16*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Nov-23	308	
Dec-23	407	
Jan-24	419	
Feb-24	244	
Mar-24	188	
Apr-24	236	
May-24	237	
Jun-24	233	
Jul-24	203	
Aug-24	244	
Sep-24	215	
Oct-24	193	

XMR Run Chart

Below Mean Run Group |

400
300
200
100
Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest Cancer Over 62d on PTL performance is 193 against a static target of 200 (lower is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 07 - Lower GI (62*), 11 - Urological (36*), 08 - Skin (26*). *Number

NHS East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance >62d PTL Patient Actions

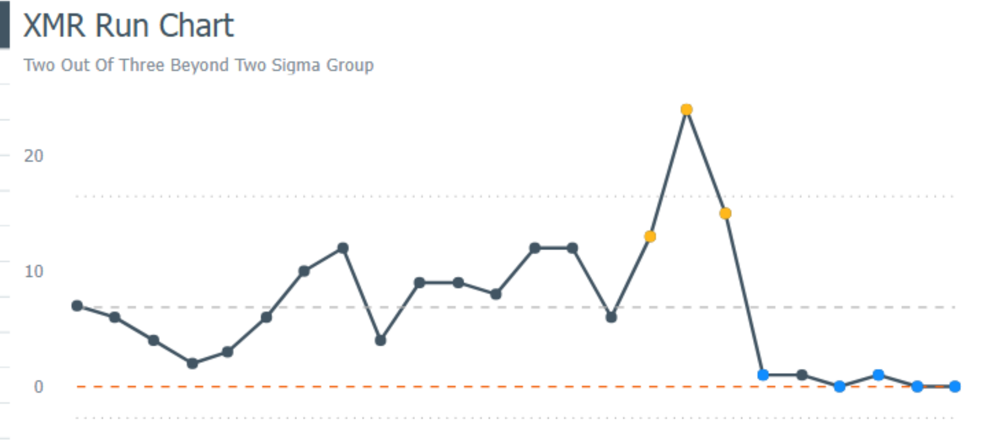
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern	• Cancer Operational lead/ compliance	• Ongoing	• Targeted escalation for patients against agreed thresholds for Histopathology, Radiology and Endoscopy. • Escalations driven by stratified data across the PTL to identify specialties where we are seeing growth across the PTL prior to breach
Capacity for diagnostics	• Staff vacancies contributing to reduced radiological diagnostics	• Radiology	• Q3	• Tiering funding provided to support insourcing for US, Guided CT and US biopsy, endoscopy • Successful recruitment across the clinical team within radiology will boost substantive capacity
Urology surgical capacity	• Limited consultant robotic capacity	• Urology	• Q3	• Mat leave return in September for consultant to support RALP – likely to be independent by end Q3. • Kidney robotic consultant locum supported by tiered funding – a successful applicant has been employed who will increase the available robotic surgical capacity with clinics booked from late November.
Surgical booking out times	• Elongated time between MDM and surgical treatment	• All surgical specialties	• Ongoing	• Close monitoring of booking out times for all surgical treatments across all specialties supported by 31D breach reviews • Cancer services reviewing the time from MDM to Decision to Treat discussions due to the impact on the 62d compliance standard
Effective implementation of Tiered Funding	• Ensuring all funding streams are implemented to maximise impact on FDS and 62 compliance	• All specialties	• Year end 24/25	• Operational implementation being monitored through Cancer Weekly Access. Financial controls in place • Consideration to divert some funding from the initial bids to other priority areas. Update of planned reallocation of funding issued to NHSE
Impact of patient holidays on suspected cancer pathways	• Patients being referred from GP with holidays booked. • The cancer pathway clock starts with the initial patient interaction, with no holiday pauses allowed, increasing the risk of delayed urgent diagnostics.	• All specialties with STT pathways	• Q3	• Working with primary care partners to provide updated communication to GPs outlining the impact diagnostic pathways and risks to patients when referred with known holiday causing delay to urgent suspected cancer diagnostic
Pathway awareness	• Patients being referred to Urgent Suspected Cancer Pathways without an awareness of the likely clinical appointments or likely diagnostic tests	• All specialties	• Year end 24/25	• The Cancer Alliance 28-day pathway patient information leaflet is set for release in October 2024. • Ensuring initial clinical discussions clearly outline the urgent suspected cancer pathway process.
MTW H&N	• Patients being transferred from MTW for cancer surgery impacting on clinical capacity	• Compliance/H&N	• Q3	• Cancer compliance working with the specialty to ensure pathway transfer is robust and the Trust is able to track and manage these patients

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

Timescale	Value	SPC
Nov-23	12	
Dec-23	12	
Jan-24	6	
Feb-24	13	
Mar-24	24	
Apr-24	15	
May-24	1	
Jun-24	1	
Jul-24	0	
Aug-24	1	
Sep-24	0	
Oct-24	0	



Understanding the Latest Performance

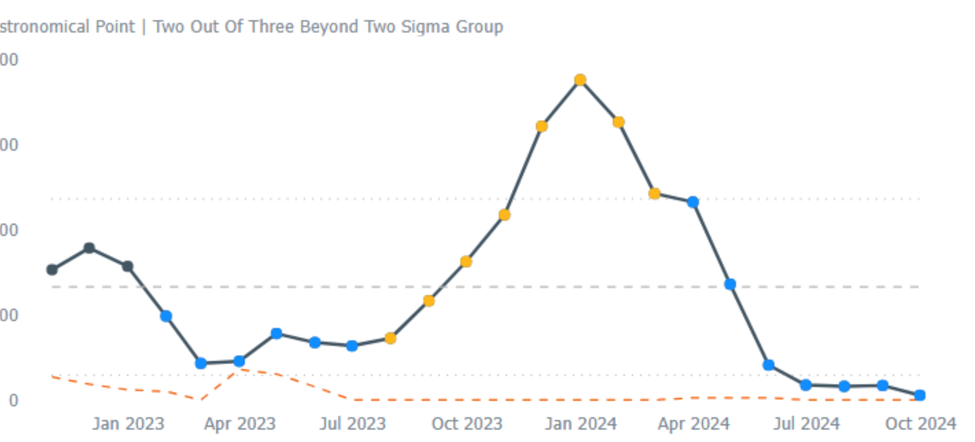
Improvement flag alerting for 4 periods

For the month beginning 01/10/2024 the latest RTT 104w Breaches performance is 0 against a static target of 0 (lower is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

RTT 78w Breaches

Timescale	Value	SPC
Nov-23	435	
Dec-23	643	
Jan-24	752	
Feb-24	653	
Mar-24	485	
Apr-24	465	
May-24	272	
Jun-24	82	
Jul-24	35	
Aug-24	32	
Sep-24	34	
Oct-24	11	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest RTT 78w Breaches performance is 11 against a Trajectory target of 0 (lower is better).

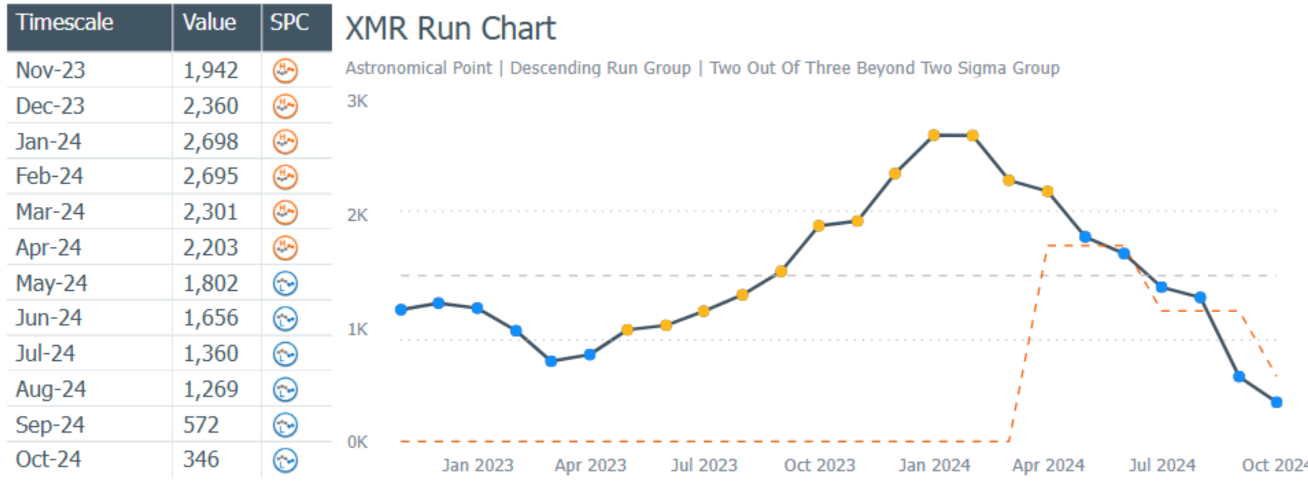
Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 120 - EAR NOSE AND THROAT (6*), 215 - PAEDIATRIC EAR NOSE AND THROAT (4*), 320 - CARDIOLOGY (1*). *Breaches

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches



Timescale	Value	SPC
Nov-23	1,942	
Dec-23	2,360	
Jan-24	2,698	
Feb-24	2,695	
Mar-24	2,301	
Apr-24	2,203	
May-24	1,802	
Jun-24	1,656	
Jul-24	1,360	
Aug-24	1,269	
Sep-24	572	
Oct-24	346	

Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest RTT 65w Breaches performance is 346 against a Trajectory target of 575 (lower is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 215 - PAEDIATRIC EAR NOSE AND THROAT (180*), 120 - EAR NOSE AND THROAT (92*), 104 - COLORECTAL SURGERY (16*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to eradicate 65 weeks by end of March 2025	• Weekly clearance against trajectory monitored at Access with clear delivery plans for non-compliance. • 12 week contact validation programme commenced to support clearance plan. • Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting. • Theatre programme to improve utilisation to 85% and drive clearance of backlog. • All internal capacity being directed to key risk cohorts from dropped sessions • Two additional Ophthalmic Consultants to commence. • Independent Sector capacity aligned to support risk cohorts	• COO • Dep COO • COO • MD – CCAS • MD - CCAS • MD – CCAS • Dep COO	• Ongoing • Ongoing • Ongoing • Jul-Sep • Ongoing • Aug-Oct • Ongoing	• Performance shared weekly with all specialities on track with paeds ENT mitigations required. • Commenced 11th June with small pilot and 2,000 patients contacted in July and now BAU. • In place • Commenced • Commenced • Appointed, one commenced and one planned start date middle October • Commenced

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; Long Waiter Actions

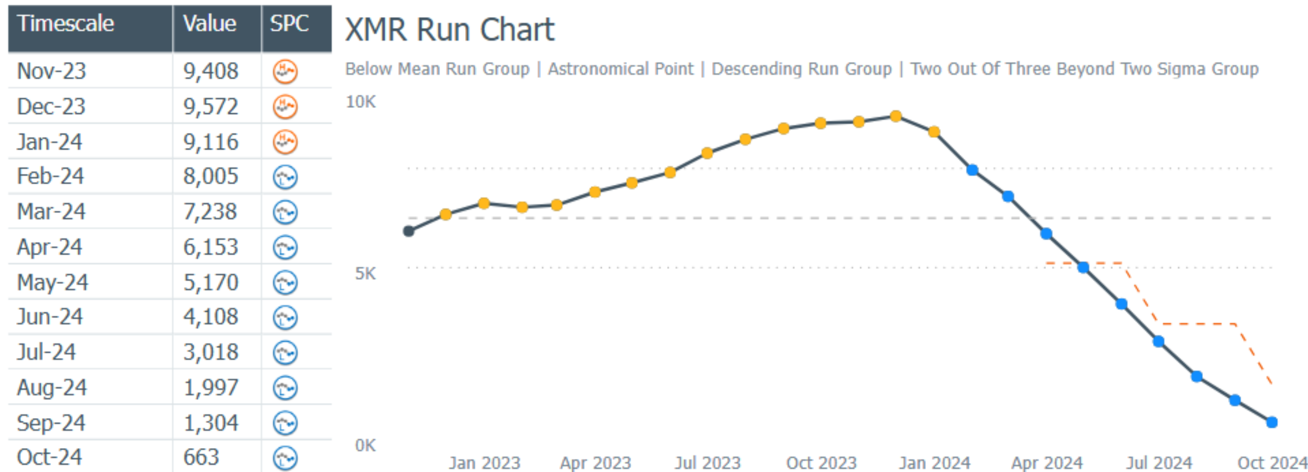
RTT Long Waiter Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to clear all 78 week risks.	• GiRFT team secured 20 pts for Otology Capacity from BHR.	COO	• August	• Capacity fully utilised.
	• Development of Choice Application SOP to manage non-admitted choice in line with revised Access Policy	Dep COO	• Ongoing	• Commenced
	• Additional Gastroenterology 1st OPA's Commissioned to support current backlog via Insourcing	COO	• September	• Commenced
	• Deep dive into Upper & Lower GI and H&N inc. Paediatric ENT with respective teams daily focus and review of position, inc. 'super validation' process in place with key admin/Ops staff	Dep COO	• Ongoing	• Commenced
	• Swap out of theatre capacity to accommodate longest waits in H&N and Paediatric ENT inc. Paediatric ward capacity	Dep COO	• September -December	• Commenced
	• MTW support for ENT, Chronic Pain and Gastro patients	COO	• Ongoing	• Regular weekly transfer process in place and all of this cohort is now fully transferred.
	• Paediatric ENT reviewing immediate capacity plans	CCAS/WYCP	• 21st August	• Additional capacity on line from end September
	• Additional adult and paediatric ENT capacity secured with I.S.	I.S. Lead	• Ongoing	• Commenced

NHS East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits



Endoscopy Backlog

Timescale	Value	SPC
Nov-23	9,408	
Dec-23	9,572	
Jan-24	9,116	
Feb-24	8,005	
Mar-24	7,238	
Apr-24	6,153	
May-24	5,170	
Jun-24	4,108	
Jul-24	3,018	
Aug-24	1,997	
Sep-24	1,304	
Oct-24	663	

Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest Endoscopy Backlog performance is 663 against a Trajectory target of 1,763 (lower is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: Colon (278*), Dual (167*), OGD (146*). *Overdue Waiters

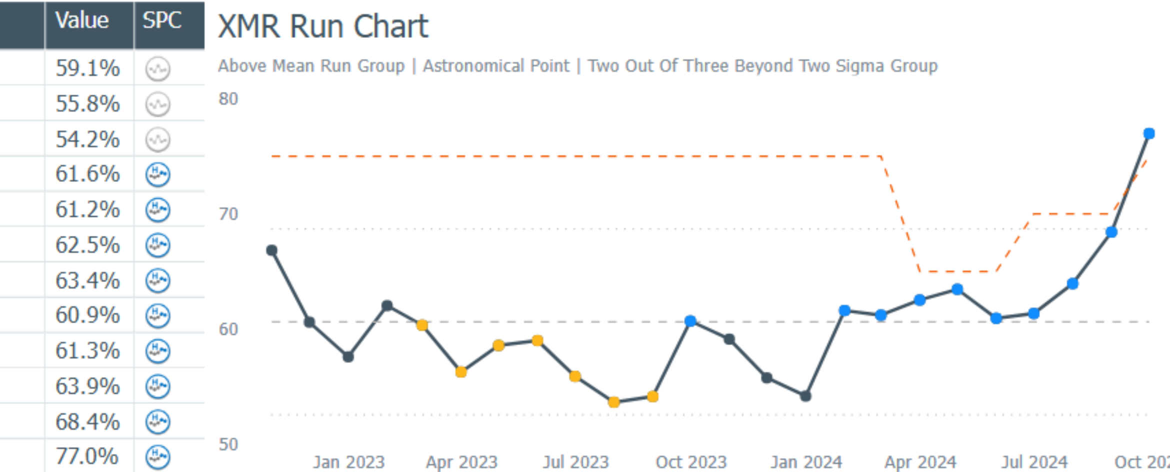
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Reception staff workforce review. • Business planning for 25/26 to ensue ongoing sustainability.	• Endoscopy recovery lead	• Ongoing	• Activity now sustained at 550 procedures a month. • Forward booking now sustained at 1200 -1500 patients. • On Trajectory to be compliant with JAG waiting lists standards.
Demand management	• Implementing a Triage system to demand management the service.	• Endoscopy recovery lead • Clinical lead	• ongoing	• Process designed, sunrise chances made, SOP written. • New Triage process started – currently rejecting around 40 patients a week ongoing. • Engagement with Colorectal surgeons starting, but need to improve.
Waiting list accuracy	• A program of staged validation against new clinical standards.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• Validation program – Complete • Program of BAU waiting maintenance now in place. • Program to reduce the number of waiting lists down from 21 underway.

Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Nov-23	59.1%	
Dec-23	55.8%	
Jan-24	54.2%	
Feb-24	61.6%	
Mar-24	61.2%	
Apr-24	62.5%	
May-24	63.4%	
Jun-24	60.9%	
Jul-24	61.3%	
Aug-24	63.9%	
Sep-24	68.4%	
Oct-24	77.0%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest DM01 Compliance performance is 77.0% against a Trajectory target of 75.0% (higher is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: MRI (80.3% , 1,588*), Echocardiography (29.4% , 841*), Non Obstetric Ultrasound (79.4% , 524*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
MRI back log	• MSK demand management • Capacity and Template review. • Booking team and process review.	• DM01 recovery lead / HOO for Imaging	• Ongoing	• Initial referral standards circulated with ICB GP`s waiting feedback. • Bookings efficiency in core capacity has increased activity by 10%. • Extension of a mobile unit with CDC funding increasing capacity. • DM01 performance up to 84.4%, the best performance in over 4 years.
NOUS back log	• Review underutilised capacity • Booking team and process review.	• DM01 Rec Lead / HOO for Imaging	• Sept 24	• New booking visualisation tool working well supporting the team to use all capacity. • DM01 up 4% in to week to 85.4%, best performance for 18 months. • Although the service continues to improve, a major review of the booking and capacity underway to ensure service sustainability.
Echocardiography Back log	• Capacity gap	• Cardiology GM	• Ongoing	• Performance improved to 51% due to better chronological booking, with the total PTL remaining at 1170. • Insourcing delayed due to staffing issues with the provider. • Funds allocated to support a validation program.
Dexa back log	• New machine in place.	• Dexa Service Manager	• Sept 24	• Field safety on scanner to not scan patients that have active implanted medical devices . Agreement reached with MFT to treat these patients.
Cardiac MRI Back log	• Validation, review outsourcing process	• Cardio GM	• Sept 24	• Validation program to commence. • Delays with outsourcing impacting on recovery.

Integrated Improvement Plan (IIP)

Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Nov-23	2	
Dec-23	3	
Jan-24	2	
Feb-24	10	
Mar-24	4	
Apr-24	6	
May-24	3	
Jun-24	4	
Jul-24	2	
Aug-24	7	
Sep-24	5	
Oct-24	6	

XMR Run Chart

No Special Cause Flags

15
10
5
0
-5

Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/10/2024 the latest Falls with Harm performance is 6 against a (6 Sigma Threshold) target of 11 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Harm from falls increasing since July 2024.	• Areas reviewed for immediate learning • Review undertaken to identify trends • Directors of Nursing meeting with teams • Hot Spot areas identified at WHH. • Care Group to share improvements at next quarterly Falls Steering Group. • Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework.	ADoN Falls Lead DoN Care Groups Falls Lead	• 48hours • 19th November • 48hours • December 12th. • November 2024	• Review undertaken identified theme around patients being left on or in a toilet and then falling. • Discussion being had with nursing teams regarding balance of privacy and dignity vs falls risk. • Hot spots wards working with falls team and through 'We Care' to identify trends in all falls and actions being put in place to address. • Trajectory set for 5% reduction at WHH in all falls across next three months • Agreed with Care Groups will discuss identified themes and learning from incidents including risk mitigation at quarterly Falls Steering Group. • Action now completed.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient risk assessments not always completed timely and comprehensively by registered staff member. Findings not always acted upon correctly.	• Information shared at Falls Steering Group to Care Groups. • Moodle training developed for to End of Bed (EOB) risk assessment to be added to ESR to support 1 yearly mandatory training for Multifactorial Risk Assessment Care Plan completion. • Included as mandatory part of Ward Accreditation, supported by Falls specialist nursing team.	Falls Lead Learning and Development.	• September 2024	• Associate Director of Fundamentals of Care and Chief Nursing Information Officer reviewing all risk assessments on Sunrise. Workshop to review on 12/12/24. • Falls dashboard to be created to include MFRACP completion including time reports and clinician status completing. IT agreed and in queue for Sunrise amendments. • EOB risk assessment module for ESR completed. ADoN FOC and ADoN WFD to review and develop governance processes. Timeframe to be confirmed. • Completed.
Lack of access to falls training.	• Mandatory training package developed inline with national RCP standard. • Training to be agreed as mandatory. • Package to be available to access on ESR.	Falls Lead Head of Learning and Development for the People and Culture Team	• July 31st 2024	• Provisional date given 1st December awaiting confirmation.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
National Audit of Inpatient Falls (NAIF) recommendations for a comprehensive multifactorial risk assessment identifies the 4AT and the lying and standing blood pressures as key assessments in patients at risk of falls.	• NAIF quality improvements to be driven through audit and clinician support.	Falls Lead Consultant Falls Lead EKHUFT Audit team	• October 2024	• Action completed

NHS East Kent Hospitals University NHS Foundation Trust

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Nov-23	82	
Dec-23	84	
Jan-24	113	
Feb-24	91	
Mar-24	76	
Apr-24	84	
May-24	84	
Jun-24	82	
Jul-24	79	
Aug-24	72	
Sep-24	77	
Oct-24	91	

XMR Run Chart

No Special Cause Flags

120
100
80
60

Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/10/2024 the latest Pressure Ulcers performance is 91 against a (6 Sigma Threshold) target of 112 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
A consistent theme in audits and incidence data is that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies and increase in pressure ulcer development or deterioration.	• To review pressure ulcer training with a view to produce a mandatory module. Moodle training being developed regarding end of bed risk assessments.	TV Lead ADN for FOC	December 2024 June 2025	• Lead TVN presented at Statutory Mandatory and Essential Training Steering Group represented on 13th November 2024. • To design a two day clinical induction programme for new starters to include all aspects of Fundamentals of Care
	• Liaising with Sunrise regarding simplifying the risk assessment process.	ADN for FOC	November 2024	• Associate Director of Fundamentals of Care and Chief Nursing Information Officer reviewing all risk assessments on Sunrise with an aim to simplify the process. Clinical Workshop on 12/12/24.
	• Working with the Quality improvement and ward accreditation teams to audit identified areas of concern. These areas to present improvements to TVSG.	QI Lead	March 2025	• Continual project as part of CQUIN. Results presented to individual areas and local action plans presented to Tissue Viability Steering group. Providing training to areas identified in the ward accreditation as not meeting target for PURPOSE T completion.
	• Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework.	TV lead/Care groups	January 2025	• TWIP discussed with DCN, ADoN for FOCC and TVN Lead Nurse. • Focus for next six months identified.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning. With an increase in shear. Increase in category 2 pressure damage in October resulting in blistering of the skin.	• Tissue Viability and Manual Handling Working with high reporting areas to improve repositioning techniques. Manual handling team looking at areas with low training and audit compliance to target for training.	TV and MH Leads	December 2024	• As part of Worldwide Stop the Pressure Week Tissue Viability and Manual Handling visiting clinical areas to promote the use of correct slide sheet usage. Tissue Viability liaising with MH for areas concerning shear damage.
	• To develop guidance on the repositioning of patients with unstable spinal issues.	TV Lead	March 2025	• Short guidance provided in update Pressure Ulcer Prevention policy. Awaiting update form NHS England. Liaising with national TVNs and spinal specialists regarding the guidance. National guidance is being developed.
	• TVNs attending ward meetings to discuss barriers to repositioning and gain feedback from clinical staff. To inform Trust wide improvements	TV lead	December 2024	• TVNs have been attending the ward managers meetings this is informing Trust wide Improvements. Action now Complete
	• To procure further Latera Turn beds to ease the comfort of patients in pain or at end of life to allow for repositioning.	TV Lead	February 2025	• MDG has authorised now with charities. To be discussed in Charities meetings in November for WHH and QEQM. QEQM charities have accepted the bid for 2 beds for Sandwich Bay.
An increasing number of hospital acquired moisture associated skin damage (MASD) is contributing to the high numbers of hospital acquired pressure ulcers.	• Identify suitable incontinence products with colleagues from the Procurement Team, To include a trust wide education programme on the correct use and application of incontinence products.	TV Lead	January 2025	• Education to be rolled out alongside trial. Local representative attending Stop the Pressure study day on 20th November. Some ward areas organising for bespoke training to raise further awareness.
	• Embed MASD pathway and the correct use of barrier products Trust wide	TV Lead	December 2024	• Pathway embedded and part of the Pressure Ulcer Prevention policy. Working with Procurement regarding the correct usage of the products to improve compliance with pathway and reduce costs associated with inappropriate product usage.
Delay in obtaining appropriate support surface for the most vulnerable patients starting within the Emergency Departments..	• To improve the trollies in ED to include a high specification mattress.	MH Lead	February 2025	• Early issue identified regarding Imaging. Deadline extended. Meeting held to discuss appropriate SOP for trolley usage. Currently at QEQM feedback positive. Urgent Meeting on 18th November to discuss a retrial.
	• Training on accurate risk assessment will improve the compliance with pressure ulcer prevention strategies. Modules being developed for pressure ulcer risk assessment and correct interventions on ESR.	WDET/ FoC	March 2025	• Risk assessment module for ESR completed. ADoN FoC and ADoN WFD to review and develop governance processes. Timeframe to be confirmed.

Integrated Improvement Plan (IIP)

Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
Nov-23	6.5M	
Dec-23	9.3M	
Jan-24	11.0M	
Feb-24	10.2M	
Mar-24	12.2M	
Apr-24	8.8M	
May-24	7.3M	
Jun-24	7.1M	
Jul-24	8.3M	
Aug-24	6.3M	
Sep-24	7.3M	
Oct-24	7.5M	

XMR Run Chart

Below Mean Run Group |

10M
5M
Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest Deficit In Month Group (£) performance is 7.5M against a Trajectory target of 7.4M (lower is better).

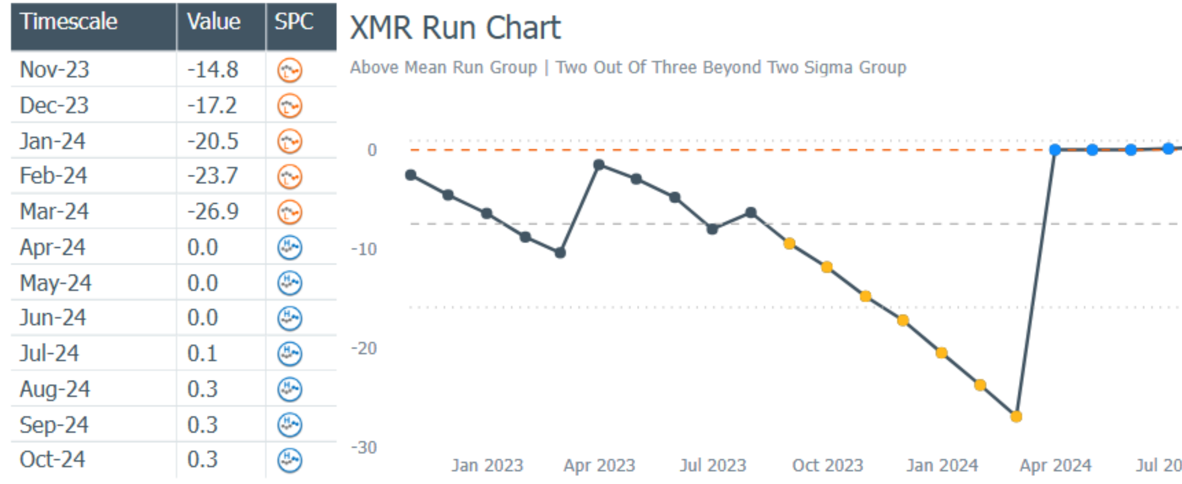
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining achievement of financial plan through Quarters two to four	• Increase level of CIP plan being developed to mitigate any potential slippage against efficiency schemes • Embedded bi-weekly FIPB with full Care Group representation and Theme lead presentations on a rotation basis	• Theme leads • PMO	• Q3 & Q4	• In year we are on plan to deliver the CIP target with tight continued focus on the recurrency of individual themes to support year on year benefits. • Looking to 25-26 and our FSP for the coming financial years, the Trust has launched its CIP development plan for 25/26 in November. The Trust is required to deliver a level of CIP which will support meeting the FSP year 1 deficit plan of 67.1m in 25/26 with at least the same level of ambition as being delivered in year.
Currently 3 additional cost pressures are being mitigated on a non-recurrent basis	• Reporting into the ICB on the shortfall of the pay award funding. YTD £1.2m & £2.1m estimated FYE. HCP monies have reduced from prior year by £1.4m YTD and £2.4m FYE. The number of working days ERF baseline change has impacted the Trust by £1.4m YTD and £2.4m FYE	• CFO	• Q4	• On-going monitoring of the financial impact of the pay awards. • Delivery of the NLF2R has reduced both pay and non pay in year, however the total number of NLF2R patients leaving the has reduced in month.

NHS
East Kent Hospitals University
NHS Foundation Trust

Integrated Improvement Plan (IIP)

Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)



Timescale	Value	SPC
Nov-23	-14.8	
Dec-23	-17.2	
Jan-24	-20.5	
Feb-24	-23.7	
Mar-24	-26.9	
Apr-24	0.0	
May-24	0.0	
Jun-24	0.0	
Jul-24	0.1	
Aug-24	0.3	
Sep-24	0.3	
Oct-24	0.3	

Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/10/2024 the latest Efficiencies YTD Variance (£M) performance is 0.3 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £49m Recurrent CIP target for 2024/25	• PWC support to PMO function • Financial Recovery Director in post	Financial Recovery Director	• On-going	• The trust is £0.3m above plan with CIP delivery at Month 7 of £26.1m, of which £7.2m is non-recurrent. • £56.1m risk-adjusted schemes (in-year effect) identified as at 18/11/24 against £49m CIP target, of which £56.1m are green schemes.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director DOF	• On-going	• CIP Methodology defined for each scheme. • CIP reporting process streamlined. • CIP forecasting in process of validation with Theme leads and Finance business partners.
Insufficient PMO Resource to support the development and execution of the CIP Programme	• PWC support to PMO function in place • Formulate a new PMO structure and resourcing profile	Financial Recovery Director	• November 2024	• New PMO Structure proposed and approved by Execs. Trust to proceed with securing the necessary resources to bolster the PMO and support the CIP programme effectively. • 2 Band 7 posts have been appointed to, following internal expressions of interest for secondment opportunities. Band 7 and Band 8a external adverts closed and shortlisting completed.

Patients

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

Assurance

Patients

Executive Summary:

Unplanned Care
Attendances were above contract at Trust level in October 2024 for Type 1 and 2 (WHH 110% and QEQM 107%) although admissions were below plan (WHH 79% for +1 LOS and 28% for zero LOS; QEQM (90% for +1 LOS and 56% for zero LOS) linked predominantly to internal medicine and the lack of effective flow through the AMUs. The trajectories for improvements in key UEC targets were achieved in October (with the exception of those waiting over 12 hours and ambulance handover) and against the National position, EKHUFT ranked 29/122 for overall ED compliance and 79/122 for Type 1 performance.

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

A slight increased stay for NEL patients was noted in October 24 but remains on trajectory for improvement in LOS reduction, and is supporting a reduction in patients delayed discharges from the ICU as well as reduced corridor care and additional patients on wards.

A deterioration in length of stay of more than 14 days was seen in October and a deep dive to understand the key drivers is in place – the deterioration in the number of patients on the RTS >7 days was noted and makes a significant contribution to the deteriorating length of stay.

Planned Care
Robust plans in place to manage 78 weeks to single figures, noting challenges with capacity within paediatric ENT.

Robust plans in place to manage the 65 week clearance involves Insourcing, MTW support, GiRFT input to Otology capacity & trust focus on chronological booking with revised performance dashboard in place.

Endoscopy waiting list is now down to 4,850. Waiting list size is sustainable at the current run rate, operating a 6.5 day week.

Theatre improvement plan enacted to improve utilisation and average case per list with an agreed focus around reduction of day 1-7 cancellations.

DM01 improvements program delivering improvements in line with the submitted Trajectory with plans in place for all modalities.

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

Patients

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
Patients	NAT		ED Compliance			73.0%	70.3%	69.0%	68.8%	70.8%	73.1%	71.8%	76.0%	75.2%	76.3%	77.4%	76.8%	74.4%
	IIP		Type 1 Compliance 4hrs			50.0%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%
	IIP		12 Hr Total Time in Department			8.0%	10.4%	11.5%	11.1%	10.3%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%	9.2%	9.7%
	NAT		12Hr Trolley Waits			0	1,168	1,260	1,368	1,111	1,131	1,207	1,227	1,189	1,085	1,033	1,017	1,171
	NAT		Ambulance Handovers within 30m			95.0%	88.7%	89.4%	89.4%	88.0%	87.9%	88.3%	92.6%	88.1%	87.7%	89.8%	88.6%	86.6%
	IIP		% Beds Occupied 14+			30.0%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%
	KEY		Super Stranded >21D			107	261	244	244	229	209	224	214	205	203	212	237	212
	NAT		Not Fit to Reside (pats/day)			100.0	206.7	176.4	184.5	166.2	168.9	171.9	170.5	171.8	180.4	189.3	197.4	195.0
	IIP		Cancer 28d Combined Performance			77.0%	62.5%	68.7%	57.8%	66.9%	68.3%	64.9%	70.2%	70.4%	72.6%	71.0%	70.2%	70.4%
	NAT		Cancer 31d Combined Performance			96.0%	92.7%	94.0%	92.5%	95.3%	91.5%	93.5%	96.2%	95.0%	96.3%	95.7%	95.8%	94.5%
	IIP		Cancer 62d Combined Performance			70.0%	61.8%	63.5%	56.1%	55.6%	69.1%	66.2%	64.1%	63.0%	71.6%	73.2%	72.8%	72.0%
	IIP		Cancer Over 62d on PTL			200	308	407	419	244	188	236	237	233	203	244	215	193
	KEY		Cancer Over 104d on PTL			0	67	65	84	62	43	38	36	42	39	54	50	36
	KEY		Cancer Rapid Access Perf			93.0%	96.2%	96.0%	93.0%	97.1%	95.9%	94.5%	94.6%	96.1%	94.7%	91.2%	94.0%	82.4%
	NAT		RTT Incomplete Performance			50.6%	49.1%	48.7%	49.0%	50.1%	50.8%	51.9%	52.0%	51.0%	50.3%	50.8%	50.9%	50.5%
	NAT		RTT Total Incomplete Pathways			87.6K	89.2K	90.0K	90.0K	87.2K	85.4K	86.9K	87.5K	85.8K	85.6K	88.1K	86.7K	86.0K
	NAT		RTT 52w Breaches			5,653	6,194	6,459	6,912	6,691	6,613	6,356	5,700	5,186	4,773	4,657	3,735	3,353
	IIP		RTT 65w Breaches			575	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656	1,360	1,269	572	346
	IIP		RTT 78w Breaches			0	435	643	752	653	485	465	272	82	35	32	34	11
	IIP		RTT 104w Breaches			0	12	12	6	13	24	15	1	1	0	1	0	0

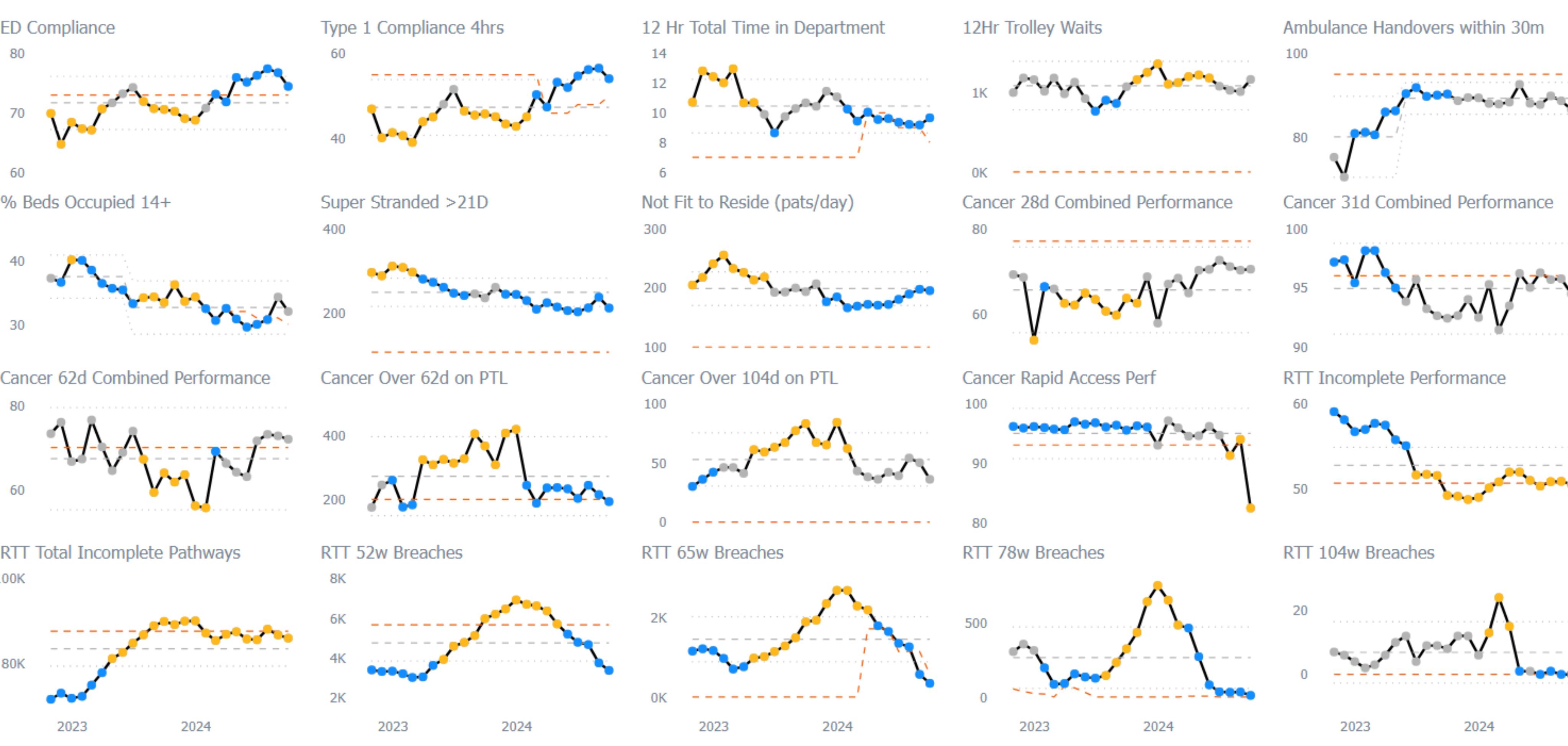
Patients

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
	IIP		Endoscopy Backlog			1,763	9,408	9,572	9,116	8,005	7,238	6,153	5,170	4,108	3,018	1,997	1,304	663
	IIP		DM01 Compliance			75.0%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%	61.3%	63.9%	68.4%	77.0%
	KEY		Theatre Session Opp.			25	41	46	45	42	33	40	40	33	40	51	39	44
	NAT		DNA Rate OP New			7.0%	7.6%	8.2%	7.8%	7.0%	6.7%	6.7%	6.8%	6.8%	7.3%	7.6%	7.7%	7.4%
	NAT		Theatre Uncapped Utilisation			85.0%	79.4%	77.2%	76.7%	78.1%	79.2%	80.7%	78.5%	79.9%	78.0%	79.2%	77.1%	77.7%

Patients

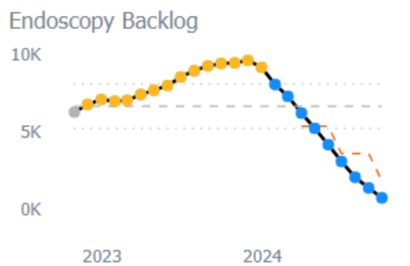
KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Improvement programme for Theatre Utilisation	• Robust programme in place to ensure clear deliverables in utilisation with a sustainable plan supported by the PMO and Transformation team	• MD - CCAS	• Ongoing	• 8642 fully established with floorplan to forward plan in line with job plans • Rightsizing of theatres underway and alignment of job plans to facilitate • All surgical specialty's utilisation review enacted and progress being made • WLI approval process now in place to ensure effective use of additional capacity
Criteria to reside and Reasons for Delayed Discharge (RfDD)	• Task and finish group established with partners to develop and implement SOP for effective daily management and escalation of patients who are delayed in their pathway – either for those who are meeting the criteria to reside and RfDD	• Deputy COO UEC • Care Group Tri	• Q3	• Task and finish group established • Implementation of new codes and initial analysis of reasons to reside with MADE event planned November 2024 • Draft SOP developed – draft standards developed for review

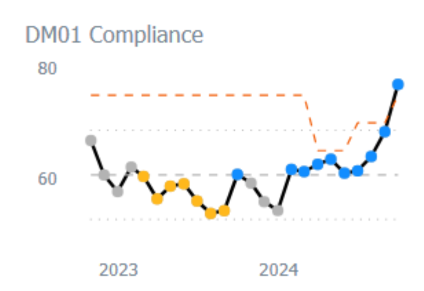
Patients

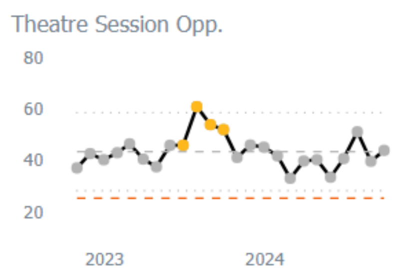


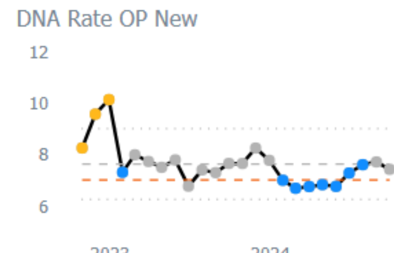
NHS
East Kent
Hospitals University
NHS Foundation Trust

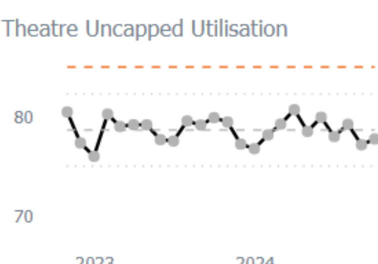
Patients











Quality and safety

Assurance

Variation	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)	FFT Satisfaction Level - Outpatient	Clinical Incidents NICE Compliance Safeguarding Adults Training Safeguarding Children Training Serious Incidents Serious Incidents Breached exceed 60-day deadline	Complaint Response Overdue Incidents VTE Assessment Compliance
No Significant Change		Complaints Number Duty of Candour - Findings Duty of Candour - Verbal Duty of Candour - Written 15wd Falls with Harm FFT Satisfaction Level - Inpatient Incidents - Moderate / Severe IPC: CDiff Infections IPC: EColi Infections IPC: Klebsiella Infections IPC: MRSA Infections IPC: MSSA Infections IPC: Pseudomonas Infections	FFT Satisfaction Level - ED
Concerning Variation (High or Low)		Patient Incidents	

Quality and safety

Executive Summary:

Safeguarding Incidents:
Our overall training compliance as a Trust is over 85% for both adults and children at all levels . Where there are groups of staff pockets below 85%, we are considering support to achieve the compliance levels needed. These are monitored through the safeguarding operational group. The ambition remains for this to be achieved by the end of 2024. Following an incident there is a need to review the TNA for Managers that provide advice for clinical teams. Face to face supervision following safeguarding incidents and children's care episode where safeguarding is identified and delivered work continues, a bench marking exercise is in progress to assess how other trusts are achieving this . Datix involving safeguarding are reviewed daily through duty and site teams. The backlog of section 42 investigations has been reduced we now have 35 awaiting Terms of reference and 14 open section 42s we are working on demonstrating learning themes are captured and embedded in the care groups.

Complaint Response:
October 2024 has seen an increase in performance of response, a trajectory has been set and will mean the Key Performance Indicator (KPI) of 85% compliance is on track to be met by December 2024.

Overdue Incidents:
Despite a significant reduction, the rate has plateaued over recent months. A total of 588 incidents became overdue in October which is a considerable factor as to why the overall number of overdue incidents does not appear to be improving. The Local Risk Management System team is currently exploring with Datix the functionality of setting up automated warning emails when incidents are approaching their breach date. There has been a noticeable change in which handlers have the most overdue incidents in the past month, due to governance staff spending one-to-one time with handlers to support the closure of incidents. No single handler has more than 14 overdue incidents at present, which is an improvement. The QGBP has been informed that the Care Groups with greater numbers need intensive support with direct support from the DDQG. All other areas where they have smaller numbers have been asked to reduce their numbers to less than 20. We anticipate that there should be less than 200 overdue incidents by January 2025. The QG Matrix Baseline Assessment has also driven this renewed focus by the Care Groups as they cannot achieve higher levels with overdue incidents.

Never Events:
There were no new Never Events reported in October, however, one of the September Never Events was declared on StEIS in October following the IRP presentation and therefore appears on the scorecard for October. Details are on slide 15.

Duty of Candour:
For the past 6 months, there has been a drive to ensure that Clinical Staff complete each element of the Duty of Candour with support. This has meant that compliance has dropped owing to varying levels of engagement from staff in the Care Groups In October 100% compliance was achieved for verbal and written components, which is a significant improvement. Due to 2 of 17 findings being shared outside of the 10-day target set by the trust, only 88.2% compliance was achieved in the third component. The focus in November and December will be to improve the compliance of the findings component, to achieve 100% compliance across all areas of DoC.

Quality and safety

Executive Summary:

InPhase:
A project manager has been appointed for the implementation of InPhase. Implementation of the system has commenced. The Policy, Risk, and CQC apps will be the first to transition; planned for completion by the end of December 2024. The Policy App will include guidelines however guidelines will remain accessible via Eolas and the link on Sunrise. The project team continues to work to ensure data transfer adheres to information governance requirements. The Operational meetings are weekly and the first Project Board has been held. A communication plan is under development to ensure staff receive timely updates and training as the rollout of system apps occurs. The remaining Apps are planned to transition by the end of March 2024.

Infection Prevention and Control:
Following the new thresholds being released in August, C-dif cases remain below both current and previous thresholds, E-coli is currently also below threshold, however Pseudomonas blood stream infections, which previously were under threshold, are now breaching, and Klebsiella continues to be above threshold, focus remains on reducing these. The October rates have reduced compared to September, however it will not be possible for the Trust to achieve the threshold for pseudomonas by year end, but focus on line care continues.

Mixed Sex Breaches
69 breaches occurred in month. Owing to the challenges on the WHH site for capacity SDEC had patients remaining in beds within it overnight. On three occasions it has been identified there were 13 breaches with same sex accommodation. These were identified via Datix. The remainder of the breaches occurred owing to patients being unable to be stepped down from critical care within the expected four hours. To provide assurance on the internal reporting of Zero internal breaches, work has commenced on gathering data centrally regarding Mixed sex accommodation in relation to toilet and showering facilities.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
Quality	NAT		Clinical Incidents			2,934	2,134	2,061	2,377	1,147								
	NAT		Patient Incidents			2,480				762	1,951	1,938	1,979	1,846	2,040	1,864	1,891	2,105
	NAT		Never Events			0	0	0	1	0	1	0	0	1	0	2	2	1
	NAT		Serious Incidents			21	14	6	15	10	7	6	4	3	0	0	0	0
	KEY		Incidents - Moderate / Severe			60	27	30	40	23								
	NAT		Patient Incidents - Moderate / Severe			64				12	39	37	27	48	38	38	36	48
	KEY		Overdue Incidents			0	3,293	3,614	2,986	1,663	1,358	822	1,406	1,557	1,164	724	688	659
	NAT		Serious Incidents Breached exceed ...			0	2	3	4	1	0	1	1	0	1	3	1	1
	IIP		Falls with Harm			11	2	3	2	10	4	6	3	4	2	7	5	6
	NAT		Safeguarding Incidents			53	48	35	42	34	53	33	50	32	29	28	31	33
	NAT		Safeguarding Children Training			90.0%	91.2%	91.4%	91.9%	93.6%	93.5%	94.3%	93.6%	93.3%	92.3%	91.8%	91.2%	91.3%
	NAT		Safeguarding Adults Training			90.0%	88.6%	89.1%	89.8%	91.7%	92.1%	93.2%	93.5%	93.6%	93.0%	93.4%	92.7%	93.0%
	NAT		Duty of Candour - Findings			100%	81.3%	100%	92.9%	100%	100%	100%	81.3%	85.0%	91.7%	75.0%	94.6%	88.2%
	NAT		Duty of Candour - Written 15wd			100%	96.6%	85.0%	88.5%	95.5%	89.5%	70.0%	64.0%	64.3%	48.4%	83.3%	88.9%	100%
	NAT		Duty of Candour - Verbal			100%	96.2%	95.7%	90.9%	91.3%	94.7%	76.2%	78.3%	78.9%	87.0%	87.9%	100%	100%
	NAT		IPC: EColi Infections			13	5	15	13	14	17	10	11	16	14	13	16	9
	NAT		IPC: CDiff Infections			12	13	11	11	8	14	4	4	6	9	8	12	10
	NAT		IPC: Klebsiella Infections			7	9	9	5	4	5	10	7	7	9	7	11	5
	NAT		IPC: Pseudomonas Infections			2	1	2	3	4	3	2	2	4	5	2	4	2
	NAT		IPC: MRSA Infections			0	1	2	1	0	1	0	0	0	0	1	0	0
	NAT		IPC: MSSA Infections			6	7	6	8	7	2	6	7	5	8	6	8	5

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
	IIP		Pressure Ulcers			112	82	84	113	91	76	84	84	82	79	72	77	91
	NAT		Mixed Sex Breaches			156	49	63	132	134	132	120	24	36	76	56	57	68
	KEY		Complaint Response			90.0%	5.0%	7.8%	10.0%	15.5%	18.8%	0.0%	4.5%	7.9%	17.1%	19.7%	32.1%	52.6%
	KEY		Complaints Number			119	87	61	96	81	78	102	105	82	100	97	100	92
	NAT		FFT Satisfaction Level - ED			90.0%	81.5%	81.7%	80.3%	79.4%	80.5%	81.6%	83.7%	83.8%	83.6%	87.6%	84.0%	82.6%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.1%	95.6%	95.5%	95.4%	95.2%	95.9%	95.7%	95.7%	95.4%	95.6%	95.8%	95.4%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	87.7%	89.6%	90.0%	92.0%	89.9%	89.4%	91.1%	90.5%	92.3%	91.2%	90.0%	88.9%
	NAT		VTE Assessment Compliance			95.0%	92.1%	90.4%	91.6%	92.4%	92.5%	92.3%	93.2%	93.4%	92.7%	93.3%	93.7%	94.1%
			NICE Compliance			48.0%						4.3%	8.6%	16.5%	25.2%	34.4%	50.0%	62.9%

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Serious Incidents	• One open SI - breach being updated by care group post-SIIAP review. For re-review 25/11/2024.	• Head of Patient Safety and Improvement	30/11/2024	
Patient Safety Incident Response (PSIR) Framework: National and Local Patient Safety Incident Investigations (PSIIs)	Current open PSIIs Nationally reportable: 7 MNSI: 5 Local: 4 • PSII Extension justifications reviewed by SIIAP pending LRAP commencement. • PSII metric to be added to the scorecard from January 2025. • PSIR Plan review to commence January 2025 to align refreshed plan with Quality Account timeframes (April 25 to March 26). • SIIAP will transition to the Learning Response Approval Panel with Terms of Reference aligned to the NHS Oversight requirements.	• Head of Patient Safety and Improvement	Ongoing March 2025	• Draft ToR for LRAP for review early December 2024. • Weekly report to Executives includes detail of PSIIs.
Overdue incidents	• Governance Managers focus on supporting closure of incidents in areas with highest number of overdue incidents (e.g. EDs and Acute Medicine) • Governance staff daily ward visits to support and coach handlers to review and close incidents within the 6 week timeframe. • Corporate led weekly review of overdue incidents with quality governance teams and twice weekly governance calls. • Weekly reports of overdue incidents are sent to Triumvirates to provide accurate data on progress. • Identified that incidents tipping over into overdue are the main issue, thus focus will shift to prevention.	• Head of Patient Safety and Improvement • Care Group Directors	30/12/2024	In response to feedback from clinical staff indicating a lack of time ringfenced for review and closure of incidents, quality governance staff will: • From w/c 25/11/2024, run a weekly report of incidents due in the next two weeks will be followed up with handlers. The aim being to prevent tipping into overdue. • Continue the process for escalation to Heads of and Directors of Nursing and Medical Directors to enable senior oversight and support. In relation to medical delays, escalation to the Chief Medical Officer will occur after 4 days of no response.
Complaint Performance is below the standard we would expect	• Specific resource continues to be focussed on response reviewing within the complaints team. • Weekly reporting is provided to the CNMO and also triumvirates, to identify breaching complaints and also age of complaints. • Enhanced escalation process with the triumvirates supporting to promote quality and responsive resolutions. • Complainants are updated and advised of any delays within the complaints process.	• Head of CPBS	• Ongoing in line with agreed trajectory for clearing the complaint breaches	• Trajectory set from 1 August, with progress planned, within current resource, to meet target of 85% within timescales by end of December 2024. • Meetings with care group specialties to discuss progress with trajectories and aged complaints. • Escalation process ongoing with support from triumvirates. • The number of complaints over 60 working days has significantly reduced from 239 at the end of August, to 120 as at 18.11.2024.

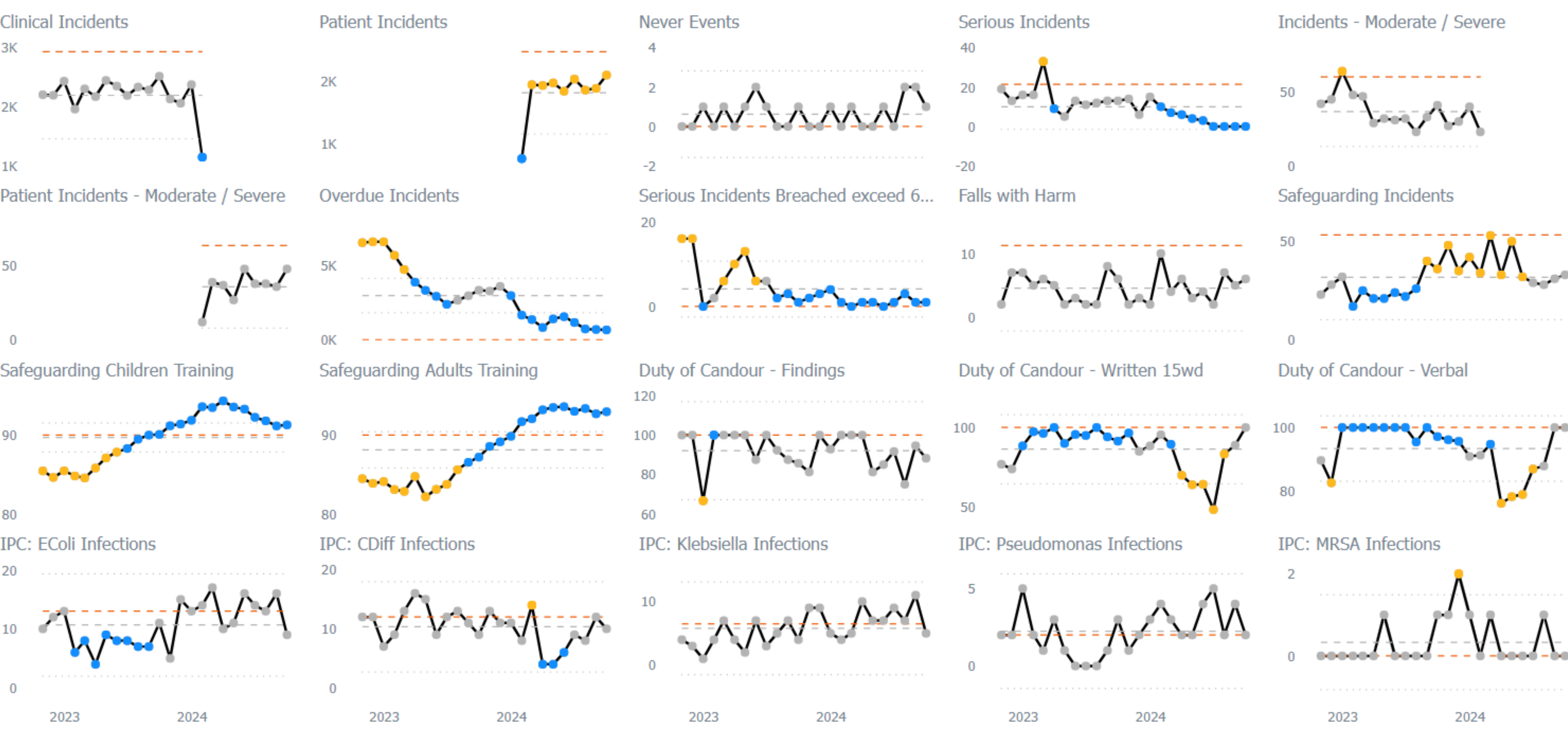
Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
There were no new Never Events reported in October 2024, however as one of the September NEs was declared on StEIS in October, it is included in the October data. Retained Foreign object port-procedure	• Incidents escalated to IRP • PSII's to be completed within 14 weeks • DOC undertaken • Clinical Staff Supported • ICB and CQC informed • Immediate learning shared across the organization	Director of Quality Governance	• 31/12/2024	• Ensure current Never Event investigations have a full systems analysis (as per PSIRF requirements)
IPC Measures: Due to changes in thresholds, Klebsiella and Pseudomonas Blood stream infections are now over the threshold, and without intervention will breach	• CLEAN campaign continues with focus on antimicrobial stewardship • Environmental and equipment reviews continue	• IPR Team	January 2025	• Trust wide review of FR cleaning ratings and additional protocols commenced • Trust wide review of roles and responsibilities for cleaning in process • Training from Tristel team completed Trustwide
Continued mixed sex breaches	• Clear escalation plan put in place SDEC • Full capacity protocol	• ADoN for SDEC WHH • Chief Operating Officer	• October 2024	• Meeting held with key stakeholders and plan agreed • Presented to CEMG for discussion 2nd October, awaiting final sign off.

Quality and safety

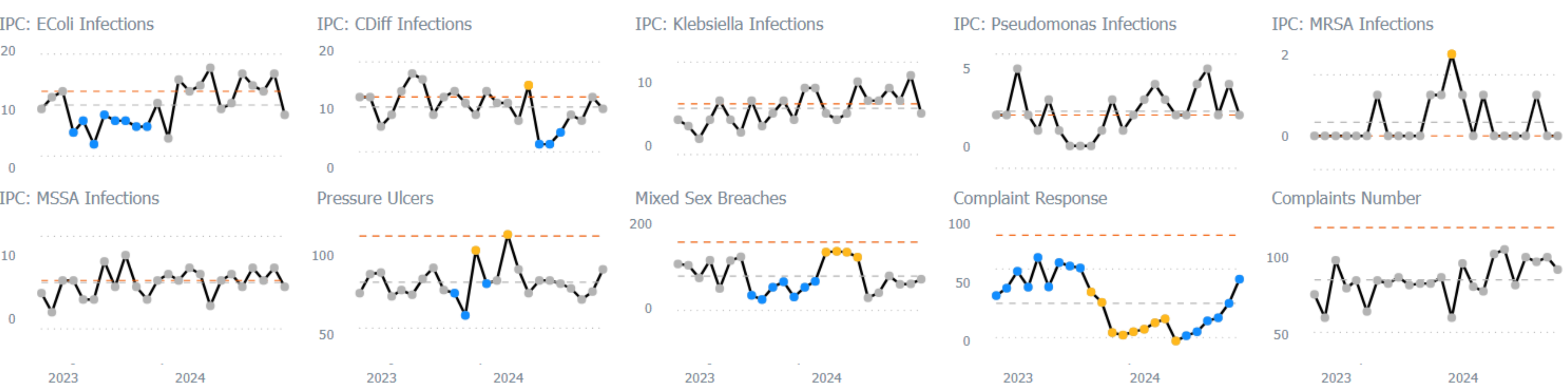
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity) and patient experience once on a ward (e.g. being moved several times, lack of handover of key information)	• Improve communication with and involvement of carers / families of patients. • Supporting patients living with dementia by having fewer moves around wards • Supporting the wellbeing of parents / carers whose child / children are receiving inpatient care (Sophie's Legacy) (providing food and drinks when parents/carers stay on the ward with their child). • Supporting patients to get up and dressed; not stay in bed.	• Matron and ward managers • With support from the Dementia team, and Lead for Moving and Handling • Patient Voice and Involvement team	• By early October 2024	**COMPLETED:** • Carers policy published 14.6.24 and on Staff Zone and public website. • Carers leaflet printed + online version on patient information library (link from Carers page) • Updated carers page on Staff Zone • Expanded use of Carers Passports • John's Campaign is on-going • Audit of chairs on wards and plans to improve bedside seating. • Carers Survey continues to indicate a lack of involvement of carers / family in their loved one's care, with only 52.9% of carers saying they were asked about the needs of the person they look after to help plan their care, and only 51.3% saying they were asked if they wanted to be involved in the care of the patient and 36% of people saying they were **not** involved as much as they wanted to be in decisions about their loved one's care and treatment.
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity) and patient experience once on a ward (e.g. being moved several times, lack of handover of key information)	• Improve communication with and involvement of carers / families of patients. • Supporting patients living with dementia by having fewer moves around wards • Supporting the wellbeing of parents / carers whose child / children are receiving inpatient care (Sophie's Legacy) (providing food and drinks when parents/carers stay on the ward with their child). • Supporting patients to get up and dressed; not stay in bed.	• Matron and ward managers • With support from the Dementia team, and Lead for Moving and Handling • Patient Voice and Involvement team	• By early October 2024	**COMPLETED:** • Carers policy published 14.6.24 and on Staff Zone and public website. • Carers leaflet printed + online version on patient information library (link from Carers page) • Updated carers page on Staff Zone • Expanded use of Carers Passports • John's Campaign is on-going • Audit of chairs on wards and plans to improve bedside seating. • BSL video interpreting posters with QR code to provide direct access to 'Interpreters Live' **DELAYED:** • Communication passport for people with hearing or visual impairments being developed in partnership with KCC Sensory Services team

Quality and safety



NHS
East Kent
Hospitals University
NHS Foundation Trust

Quality and safety



Quality and safety

Staff Type	Vacancy Rate Oct-24 (Target 10%)	Sickness Rate Oct-24 (Target 5%)	Safe Care Red Flags Oct-24
Registered Nursing & Midwifery	6.00%	4.79%	485
Registered Nursing Associate	N/A	N/A	
Health Care Support Worker	15.04%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Oct-24	Avg Fill Rate Day Oct-24	Avg Fill Rate Night Oct-24
Registered Nursing & Midwifery	6.8	89%	93%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	3.2	82%	100%

Safe Staffing:
CHPPD is calculated by dividing the number of actual nursing (both registered and HCSW) hours by the number of patients on the ward at 23:59; this advises of the 'nursing' or care hours that are available to each patient per day.

Currently our CHPPD is higher than our peer organisations. Further work is required to review the budgets to ensure only staff working within the inpatient area are allocated to the budget identified. This work is anticipated to be completed as part of the governance process following the bi-annual establishment review.

The average fill rate for October 2024 is at an acceptable level, however one red shift was declared in critical care. A round table has been undertaken to ensure the shift was escalated in real time and to support learning. A red shift escalation process is currently in development to support timely escalation both in and out of hours.

People

Assurance

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

NHS East Kent Hospitals University NHS Foundation Trust

Executive Summary:

Sickness absence rates have inflected up and above the alerting threshold of 5% (to 5.09%) for the first time since January (5.42%). This is due to a significant increase in the number of people absent with coughs, cold and influenza (S13). This has risen considerably from 0.24% in August to 0.47% in September and 0.76% in October – almost tripling in a three month period. Whilst remaining the number one reason for sickness absence, stress, anxiety and depression rates remain consistent. This has been related to introduction of face-to-face counselling, a business case of which has been submitted to continue this from February 2025.

Vacancy rate has improved further to 8.6%, down from a height of 9.6% just two months ago. This returns the Trust to the position held from March to July. The highest vacancy rate is in the Women, Children & Young People Care Group (9.4%) which is primarily driven by vacancies across Women's Services. The lowest is across the Critical Care, Anaesthetics and Specialist Survey Care Group (6.1%).

Staff turnover has improved again to 8.8% and continues the positive trend that has been observed across the last 2 years. Turnover is currently the lowest it has been in over 2 years and there remains a positive trajectory. Nursing turnover continues to improve and is now at 7.3% - also the lowest it has been in 18 months. In fact, there has been a continuous and positive reduction in nurse turnover since February 2023. Health Care Support Worker turnover has reduced from a height of 24% in May '23 and currently stands at 9.3%. It is worth noting however that this has risen this month from an all-time-low of 7.6% in September. Premature turnover remains at 14.8% - with almost a third of all premature turnover in the Corporate Care Group.

Appraisal compliance continues to improve and is now at 79.4%, less than 1% from the desired threshold. This is the highest it has been in over 24 months. Rates are highest in Strategic Development and Capital Planning (84.1%) and lowest in Corporate (66.1%).

Statutory training compliance appears to be plateauing at 92% following a steady period of improvement from October '23 to June '24. All Care Groups are above 90% and although compliance for medical staff is below the expected threshold, this has responded positively in-month and improved again to 80.9%.

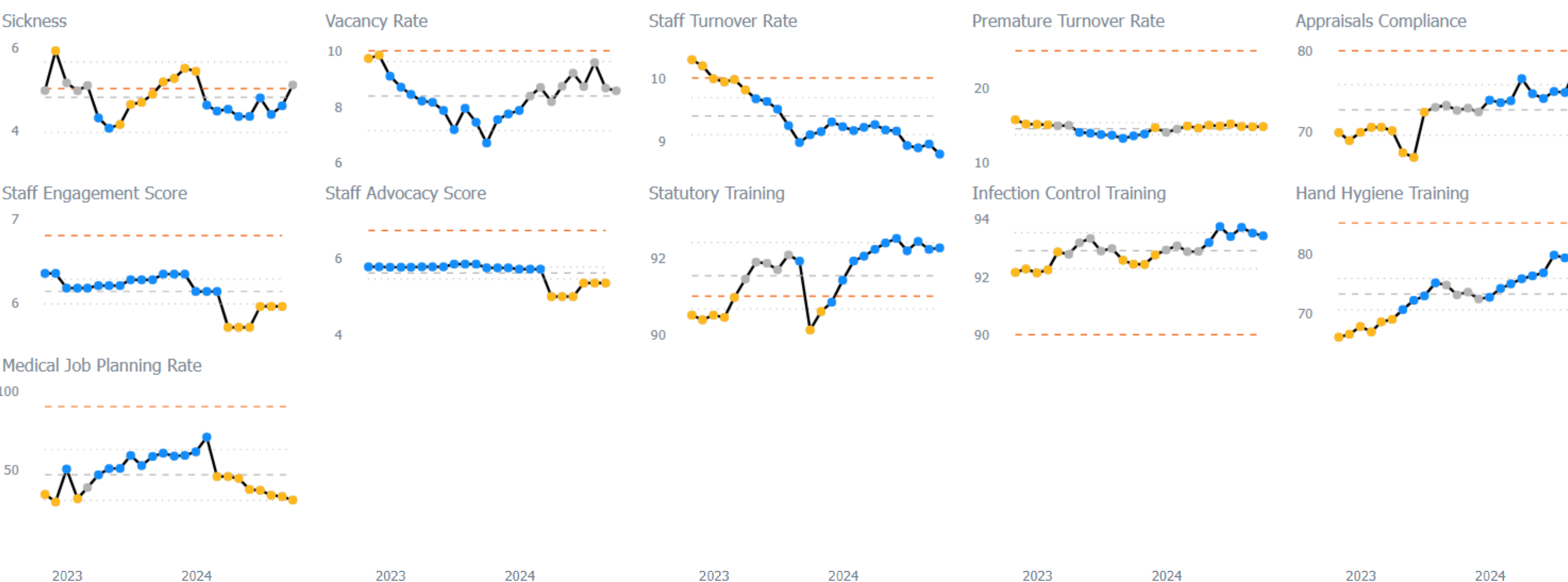
People

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
People	NAT		Sickness			5.0%	5.2%	5.5%	5.4%	4.6%	4.5%	4.5%	4.3%	4.3%	4.8%	4.4%	4.6%	5.1%
	NAT		Vacancy Rate			10.0%	7.5%	7.7%	7.9%	8.4%	8.7%	8.2%	8.7%	9.2%	8.7%	9.6%	8.7%	8.6%
	NAT		Staff Turnover Rate			10.0%	9.1%	9.3%	9.2%	9.2%	9.2%	9.3%	9.2%	9.2%	8.9%	8.9%	8.9%	8.8%
	NAT		Premature Turnover Rate			25.0%	13.9%	14.7%	14.1%	14.5%	14.9%	14.6%	15.0%	14.9%	15.2%	14.9%	14.8%	14.8%
	KEY		Appraisals Compliance			80.0%	72.9%	72.4%	73.9%	73.6%	73.8%	76.6%	74.7%	74.1%	75.0%	74.8%	77.9%	79.4%
	IIP		Staff Engagement Score			6.80	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70	5.95	5.95	5.95	
	KEY		Staff Advocacy Score			6.70	5.73	5.73	5.70	5.70	5.70	4.99	4.99	4.99	5.34	5.34	5.34	
	NAT		Statutory Training			91.0%	90.6%	90.8%	91.4%	91.9%	92.0%	92.2%	92.4%	92.5%	92.2%	92.4%	92.2%	92.2%
	KEY		Infection Control Training			90.0%	92.4%	92.8%	92.9%	93.1%	92.9%	92.9%	93.2%	93.7%	93.4%	93.7%	93.5%	93.4%
	KEY		Hand Hygiene Training			85.0%	73.6%	72.4%	72.7%	74.2%	74.9%	75.8%	76.3%	76.8%	79.7%	79.2%	79.0%	79.1%
	KEY		Medical Job Planning Rate			90.0%	58.3%	58.8%	61.1%	70.5%	45.3%	45.3%	44.1%	37.0%	36.5%	33.3%	32.5%	30.3%

People

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working. • Vacancies in maternity will fall significantly with the recruitment of student midwives, due to be in post later this year. • Vacancies at Band 2 remain paused whilst the Trust undertakes the Nationally expected work reviewing Band 2/3 roles.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• 403 staff have accessed the service, with 971 counselling sessions delivered and clinically reliable change in 82.1% of staff. • New bid for funding from the East Kent Charity to combine with EAP funds and continue to deliver on-site clinical psychology from February 2025 (when it is currently due to expire).
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 remains around **8.8%** and has achieved the gold standard (10%) for over a year. It is currently at the lowest rate the Trust has seen in 2 years.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Staff Experience	• Complete	• Premature turnover (**14.8%**) has reduced back and remains within the desired parameters (≤15%).
Staff Engagement levels (5.95) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2024 staff survey, with the launch linked to the Culture & Leadership programme implementation.	Head of Staff Experience	• End Mar 25	• The response rate to the National NHS Staff Survey is a marker of engagement in itself and acts as a precursor to the scores which are released in January '25. Currently the Trust has one of the highest response rates in the country (57%), has achieved a majority response and the highest number of respondents in the Trusts' history.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Sept 24	• All Care Groups to target improvement within medical staff compliance. Compliance at 80.9%, which is the highest it has been in 4 years.

People



Sustainability

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes
Improving Variation (High or Low)		Deficit In Month Group (£) Efficiencies YTD Variance (£M) WTE worked (All Pay Spend) WTE worked (Premium Pay)	Efficiencies Green Schemes (£M)
No Significant Change		Premium Pay Variance to Plan (£)	
Concerning Variation (High or Low)		Total Pay Spend In Month	

Sustainability

Executive Summary:

The Group has delivered the YTD plan of £52,420k to Month 7 deficit. The continued delivery of the plan is a significant strategic achievement for EKHUFT.

Trust pay expenditure increased in month due to the various pay awards made in month, however the underlying run rate on substantive pay has remained steady. There has been a slight uptick in agency spend, mainly for medical staffing. YTD the Trust is favourable to plan in pay by £3.5m, of which the successful reduction of NLF2R patients is showing the benefit of a reduction in pay spend as well as delivery of CIP schemes.

Trust non pay run rate increased in month, mainly in drugs including rechargeable drugs and spend covered by RSP funding.

The emerging risk to the submitted 2024/25 financial plan relating the pay award remains. This has been offset by non-recurrent benefits YTD, however if additional funding is not agreed, it could be a risk to our year-end position. The change in ERF baseline due to the increased number of working days has impacted the Trusts ERF by £1.4m YTD and a FYE of £2.4m. As previously reported the Trust has seen a reduction of HCP monies for prior year projects by £1.4m YTD and FYE of £2.4m. At present the Trust is mitigating these risks.

The Trust has delivered £26m of efficiencies in the first seven months, £0.3m above the YTD plan.

Sustainability

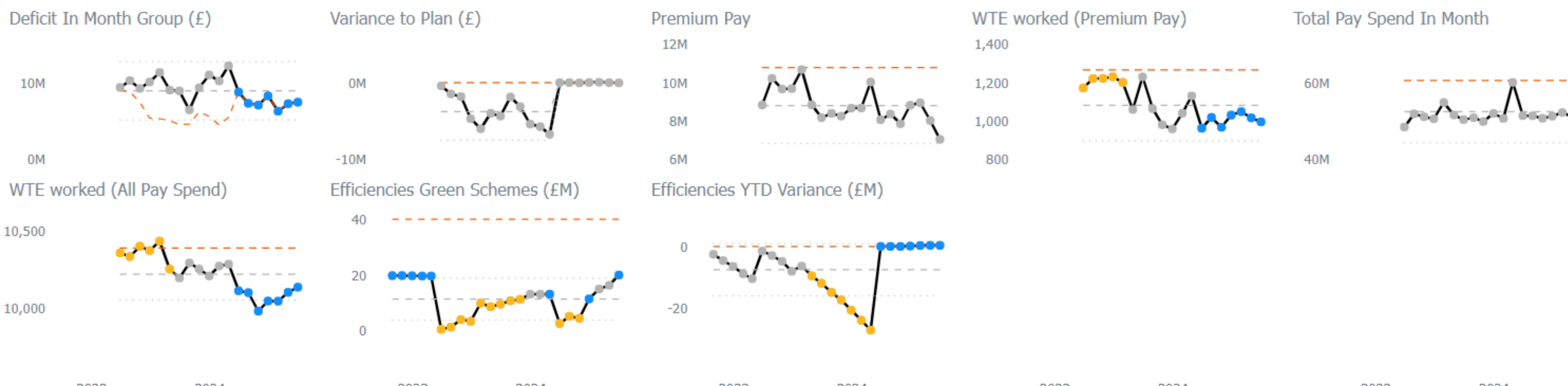
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
Sustainability	IIP		Deficit In Month Group (£)			7.4M	6.5M	9.3M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M
	KEY		Variance to Plan (£)			0K	-1,86...	-3,11...	-5,381K	-5,721K	-6,718K	-5K	5K	-28K	20K	53K	1K	-31K
	KEY		Premium Pay			11M	8.4M	8.3M	8.7M	8.7M	10M	8.1M	8.4M	7.9M	8.8M	8.9M	8.0M	7.0M
	KEY		WTE worked (Premium Pay)			1,267	1,065	981	959	1,041	1,131	963	1,019	968	1,031	1,049	1,017	996
	KEY		Total Pay Spend In Month			61M	51M	50M	52M	51M	60M	51M	51M	51M	51M	52M	51M	66M
	KEY		WTE worked (All Pay Spend)			10,389	10,294	10,255	10,210	10,274	10,286	10,115	10,103	9,984	10,049	10,048	10,105	10,1...
	KEY		Efficiencies Green Schemes (£M)			40	11	11	13	13	13	3	5	4	11	15	16	20
	IIP		Efficiencies YTD Variance (£M)			0.0	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1	0.3	0.3	0.3

NHS East Kent Hospitals University NHS Foundation Trust

Sustainability

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• ID Medical Managed Service meeting with each Care Group, reviewing each Medical worker for alternative options. • Working with CMO/DCMO to meet with Managing Directors and Medical Directors to highlight the issue and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• The ID Medical Managed Service have met and are working with QEQM, WHH & Women's & Children to source alternative, more cost efficient candidates to replace those high-cost long term locums. Alternative candidates (x2) have now been secured for QEQM due to start in early December. • New meetings are to be scheduled with the CMO/DCMO, IDM alongside the SE collaborative., first one has recently taken place at KCH. • July communication went out from the CPO to say all new agency workers will be on DE only. This has led to an increase in our DE throughput, currently at 89%. This is expected to exceed 90% in the coming weeks.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• July 25	• Signed up to the rate card and commenced on 1st June 24, with the second step down to be applied from the 1st October 24. • Only areas above cap are Maternity and Paediatrics. Rates have now been agreed for Maternity until the end of 2024, agency usage is then expected to be removed from January 2025. • IDM are continuing to work with all of our approved agency suppliers in order to ensure we are identifying any additional savings opportunities.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• Ongoing	• South East Temp Staffing Collaborative team met with CMO & DCMO as part of the consultation. • The rate card was approved by the board on the 11th September, IDM have sent a communication out to all of approved suppliers to address any outliers. • CMO, DCMOP are currently reviewing the rate cards to establish where the Trust sits against the step downs. • The ID Medical managed service are working with our approved suppliers in order to reduce rates in line with the ceilings. Updates are to be provided on a weekly basis.

Sustainability



Maternity

Variation	Assurance: P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)		Serious Incidents Maternity	
No Significant Change	Extended Perinatal Mortality	FFT Maternity (IP) Recommended FFT Maternity Recommended Maternity Complaint Response Maternity Complaints Maternity Incidents Moderate / Severe Maternity Patient Incidents Moderate / Severe	
Concerning Variation (High or Low)		FFT Maternity Response Rate	WH Engagement Score

Maternity

Executive Summary:

The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the October 12 month rolling rate at 4.09 per 1,000 births.
This rate includes stillbirths and neonatal deaths, and whilst the stillbirth rate remains significantly low (1.71 per 1,000 against a threshold of 3.61 per 1,000), the neonatal death rate is 2.39 per 1,000 against a threshold of 1.82 per 1,000. An external review is currently in progress.

A task and finish group has been formed to explore the Friends and Family Test (FFT) maternity response rate including

- What is our current data: response rate and feedback
- When and how are women asked to complete it?
- What can we do differently to promote awareness and increase completion at each required touchpoint
- Implement ideas for change

At month end (October 2024) there are 5 open cases referred to and accepted by MNSI for external Patient Safety Incident Investigation (PSII). The service currently has 2 internal PSII's. Please view table of progress related to maternity service PSII's (slide 54).

1 moderate / severe patient safety incident was reported in October. This incident was reported under the staff wellbeing category – immediate actions in regard to TRIM and staff support was facilitated at the time of this incident.

External and Internal PSII's

MNSI | Local PSII

MI-037522	Final report received (from MNSI)	No Safety Recommendations 1 Safety Prompt – explore potential barriers to enable timely escalation to neonatal team
MI-037577	Draft report received for factual accuracy	Proposed: 1 Safety Recommendation - The Trust to ensure a process is implemented to ensure staff confirm the required ventilator settings prior to a baby being placed on a ventilator and perform regular checks of the ventilator settings whilst the baby remains ventilated. The Trust to develop and implement an induction training programme for all new staff in the neonatal unit on use of ventilators. 2 Safety Prompts – • NLS algorithm during neonatal resuscitation, staff education to ensure compliance with timing for chest compressions. • therapeutic cooling should only be started once a baby is in a stable condition following resuscitation and should be kept warm.
MI-037583	Draft report received	Assessment for factual accuracy in progress
MI-037872	Awaiting draft report	Investigation remains in progress
MI-038554	Awaiting draft report	Investigation remains in progress
WEB282476	Investigation in progress	Immediate actions taken in response to incident
WEB278381	Investigation complete	Investigation report presented at the learning response approval panel (LRAP) minor amendment required. Report to be shared with NHSE (antenatal screening) Nationally Reported

MNSI safety recommendations and safety prompts are monitored via the care group governance processes alongside actions aligned to local PSII's

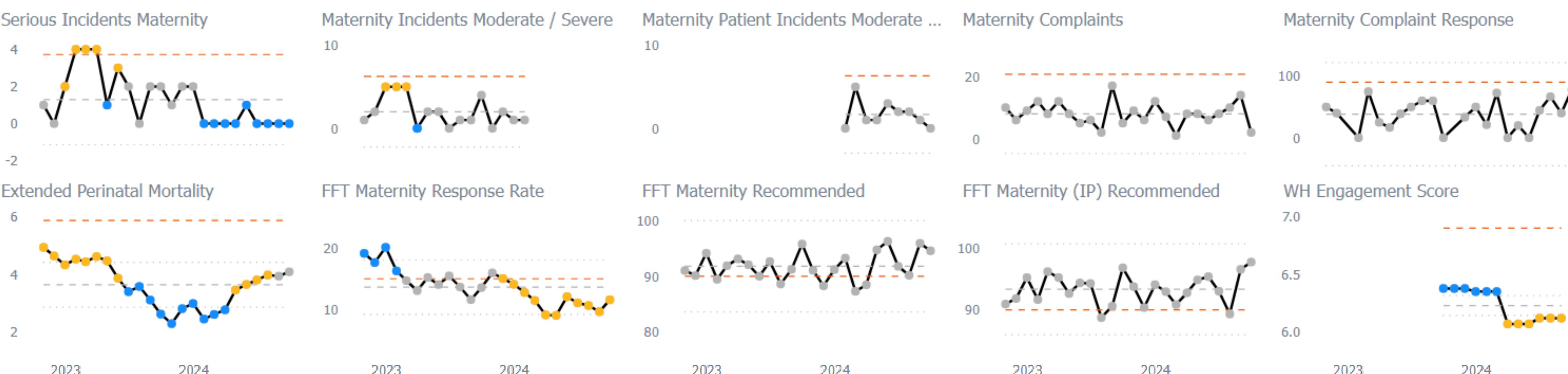
Maternity: Metric Dashboard

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24
Maternity	NAT		Serious Incidents Maternity			4	1	2	2	0	0	0	0	1	0	0	0	0
	KEY		Maternity Incidents Moderate / Sev...			6	0	2	1	1								
	KEY		Maternity Patient Incidents Moderat...			6				0	5	1	1	3	2	2	1	0
	KEY		Maternity Complaints			21	9	6	12	7	1	8	8	6	8	10	14	2
	KEY		Maternity Complaint Response			90.0%		33.3%	50.0%	21.1%	72.7%	0.0%	20.0%	0.0%	44.4%	66.7%	40.0%	77.8%
	KEY		Extended Perinatal Mortality			5.87	2.29	2.81	2.99	2.45	2.61	2.77	3.46	3.65	3.81	3.98	3.94	4.09
	NAT		FFT Maternity Response Rate			15.0%	16.0%	15.0%	14.1%	12.8%	11.5%	9.2%	9.1%	12.1%	11.1%	10.7%	9.7%	11.6%
	NAT		FFT Maternity Recommended			90.0%	91.1%	88.3%	91.2%	93.3%	87.3%	88.5%	94.7%	96.3%	91.8%	90.2%	95.9%	94.6%
	NAT		FFT Maternity (IP) Recommended			90.0%	93.8%	90.4%	94.1%	92.9%	90.9%	92.7%	94.8%	95.3%	93.0%	89.3%	96.5%	97.7%
	KEY		WH Engagement Score			6.90	6.38	6.38	6.35	6.35	6.35	6.07	6.07	6.07	6.12	6.12	6.12	

Maternity: Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		• QR codes being introduced on Congratulations on your Birth Cot Cards • Promotion of the FFT as well as the YVIH initiative • Exploration of text reminders • Work with the LMNS to promote engagement • Publication of a single thematic tool for all sources of patient feedback
Overdue Incidents	• Email and communication with individual action owners with ongoing monitoring and expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Denise Newman • Head of Governance		• Downward trajectory • Agreed number of incidents to be closed by teams on a daily basis • All overdue incident handlers for Women's Health emailed weekly • Number of maternity overdue incidents in September is **47.** • Continued monitoring of incident management has identified an increase in maternity overdue incidents to **64** (as of 21st Oct) initiating increased surveillance and support.
External Review Neonatal Deaths	• Aggregate review of all NNDs from 1st April 2023 to 31st March 2024 by an external Neonatologist, senior midwife and Neonatal Nurse	• Adaline Smith Dep Director of Midwifery		• Honorary contracts now in place . • All families will be contacted by the PMRT midwife to inform them followed by a letter • Plan for report to be available to the Trust by early December • Education on signs of life in the extremely premature baby to be shared
Engagement Score 6.07	• Board Level meetings with staff and actions taken to close the loop on feedback • Several platforms for escalating concerns • Focus on RCS facilitated by PMA team • Explore promotion of the national staff survey	• Care Group Quadrumvirate		• Survey Monkey undertaken shared in various forums • Pulse Survey results now available • Senior team all trained on the use of TED to be able to obtain real time information from teams • The WCYP score remains the highest in the Trust
Complaints	• Temporary depleted staffing resource within Governance Team	• Denise Newman, Head of Governance		• Complaints manager appointed with commencement date of 11th November • Compliance / Quality / Assurance Midwife successfully recruited to commences November • Interim local action plan developed with DDOM for maintenance of service provision within governance team. • **46** current open complaints at various stages of completion. **6** currently breaching care group deadlines.

Maternity: Metric Run Charts



NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 7 (M7) Finance Report**

Meeting date: **5 December 2024**

Board sponsor: **Chief Finance Officer**

Paper Author: **Interim Deputy Chief Finance Officer**

APPENDIX 1: M7 Finance Report

Executive summary:

Action required:	**Information**
Purpose of the Report:	The report is to update the Board on the financial performance to October (M7).
Summary of key issues:	The Trust, in line with national change, has received Non-recurrent Deficit Support Revenue Allocation to M7 of £47.9m (£78.4m for the full year). This non-recurrent allocation reduces our planned deficit for 2024/25 from £85.8m to £7.4m, which has become the month 12 full year deficit plan. Due to this allocation being non-recurrent in nature, we are presenting the finance report with this deficit support income 'below the line', in order to ensure continued focus on the underlying deficit position and enable more transparent year on year comparisons. Excluding the Non-recurrent Deficit Support Revenue Allocation (from Plan and Actuals), in November (M7) the Group delivered the in-month deficit plan of £7,420k and the Year to Date (YTD) deficit plan to M7 of £52,435k, as detailed below.

£000	YTD Plan	YTD Actual	YTD Variance
Patient care income	£543,184	£533,008	£10,176
Other income	£38,114	£38,763	(£649)
Employee Expenses	(£407,241)	(£404,293)	(£2,948)
Other operating expenses	(£221,356)	(£215,406)	(£5,950)
Non-operating expenses	(£5,499)	(£4,903)	(£596)
Technical Adjustments	£363	£411	(£48)
TECHNICALLY ADJUSTED SURPLUS/(DEFICIT) EXCLUDING DEFICIT SUPPORT	**(£52,435)**	**(£52,420)**	**(£14)**

Patient care income has underperformed YTD by £10.2m predominantly due to three reasons. Firstly, within Spencer Private Hospitals (SPH), underperformance is due to consultant availability affecting activity levels (i.e. reducing activity), although improvements were seen in M7. Secondly, this is due to the successful reduction in patients residing in our hospital past the RTS < 7 days date. The trust has seen a (£2.0m) reduction in planned

	income from the risk sharing agreement it holds with the Integrated Care Board (ICB). The reduction in income is offset by the reduction in pay costs. Lastly, this is due to underperformance in Elective Recovery Fund (ERF); under-performance of some income generating cost improvement schemes (Cost Improvement Programme (CIP)) (*To* note – *CIPs overall are on plan*) and a change in the ERF calculation (communicated by NHS England (NHSE) to Trusts in September), such that a higher number of working days is now required to generate the same income. Other income is overachieving by £0.6m YTD, predominantly driven by education and training income exceeding plan. Within employee expenses, as instructed by NHSE, the pay plan has been adjusted to match the increase in income to support the pay awards. Despite this uplift, an estimated shortfall remains of £2.1m for the year and £1.2m YTD. This is currently offset by non-recurrent benefits in the YTD position. A £49m in-year CIP target was set for 2024/25. CIP delivery is £0.3m ahead of plan YTD to M7. The Trust has recognised recurrent savings of £18.8m YTD to October and non-recurrent savings of £7.2m. Total capital expenditure at the end of October was £6.6m spend against a plan of £12.9m. A list of high priority schemes was presented to and approved by the Finance and Performance Committee (FPC) in October in response to the slippage reported in October 2024 in order to ensure that the capital available to the Trust in budget for 2024-25 is fully utilised. The majority of these approved schemes were priorities which the Trust was unable to include in its 2024/25 Capital Plan, due to a lack of available capital funding, in the main having been brought forward into 2024-25 from 2025-26.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of M7.

Implications:

Links to Strategic Theme:	Having Healthy Finances by providing better, more effective patient care that makes resources go further.
Link to the Trust Risk Register (SRR):	**SRR 3664**: Failure to deliver the Trust financial plan for 2024/25.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee - 26 November 2024.

Finance Performance Report 2024/25

October 2024

Chief Finance Officer
Angela van der Lem

Group Summary

Month 07 (October) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	493.968	482.283	(11.685)	0.000	0.000	0.000	12.422	10.475	(1.947)	(1.679)	(1.690)	(0.011)	504.711	491.068	(13.643)
NHS Income From Commissioners - Drugs	31.353	34.912	3.559	0.000	0.000	0.000	2.220	1.667	(0.553)	0.000	0.000	0.000	33.573	36.579	3.006
NHS Income From Commissioners - Devices	4.900	5.360	0.460	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	4.900	5.360	0.460
Other Income	39.071	39.834	0.763	93.028	86.511	(6.517)	0.008	0.032	0.024	(93.993)	(87.614)	6.379	38.114	38.763	0.649
Total Income	**569.292**	**562.390**	**(6.902)**	**93.028**	**86.511**	**(6.517)**	**14.650**	**12.174**	**(2.476)**	**(95.672)**	**(89.304)**	**6.368**	**581.298**	**571.771**	**(9.528)**
Substantive Staff (inc. Apprenticeship Levy)	(332.383)	(327.630)	4.753	(23.993)	(24.291)	(0.298)	(5.006)	(4.408)	0.598	1.463	0.452	(1.011)	(359.919)	(355.877)	4.042
Bank Staff	(25.704)	(27.698)	(1.994)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(25.704)	(27.698)	(1.994)
Agency/Contract	(19.698)	(18.909)	0.789	(1.495)	(1.251)	0.244	(0.425)	(0.525)	(0.100)	0.000	(0.033)	(0.033)	(21.618)	(20.718)	0.900
Total Employee Expenses	**(377.785)**	**(374.237)**	**3.548**	**(25.488)**	**(25.542)**	**(0.054)**	**(5.431)**	**(4.933)**	**0.498**	**1.463**	**0.419**	**(1.044)**	**(407.241)**	**(404.293)**	**2.948**
Drugs	(27.101)	(26.694)	0.407	0.000	0.000	0.000	(2.331)	(1.667)	0.664	1.638	1.469	(0.169)	(27.794)	(26.891)	0.902
Rechargeable Drugs	(28.140)	(32.215)	(4.075)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(28.140)	(32.215)	(4.075)
Rechargeable Devices	(4.900)	(5.360)	(0.459)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(4.900)	(5.360)	(0.459)
Supplies and Services - Clinical	(28.636)	(26.401)	2.235	(24.541)	(32.962)	(8.421)	(1.035)	(1.292)	(0.257)	0.923	0.869	(0.054)	(53.289)	(59.786)	(6.497)
Supplies and Services - General	(86.018)	(86.390)	(0.372)	(17.367)	(10.645)	6.722	(0.177)	(0.138)	0.039	86.087	81.802	(4.285)	(17.475)	(15.371)	2.104
Clinical negligence	(20.451)	(20.451)	(0.000)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(20.451)	(20.451)	0.000
Depreciation and Amortisation	(13.336)	(13.295)	0.041	0.000	(0.580)	(0.580)	(0.123)	(0.197)	(0.074)	0.000	0.000	0.000	(13.459)	(14.072)	(0.613)
Other non pay	(31.851)	(26.449)	5.402	(24.458)	(15.881)	8.577	(5.103)	(3.680)	1.423	5.564	4.750	(0.814)	(55.848)	(41.260)	14.588
Total Other Operating Expenses	**(240.433)**	**(237.255)**	**3.178**	**(66.366)**	**(60.068)**	**6.298**	**(8.769)**	**(6.974)**	**1.795**	**94.212**	**88.891**	**(5.321)**	**(221.356)**	**(215.406)**	**5.950**
Non Operating Expenses	(5.517)	(5.176)	0.341	0.146	0.352	0.206	(0.128)	(0.080)	0.048	0.000	0.001	0.001	(5.499)	(4.903)	0.596
Profit/Loss	**(54.443)**	**(54.278)**	**0.165**	**1.320**	**1.253**	**(0.067)**	**0.322**	**0.187**	**(0.135)**	**0.003**	**0.007**	**0.004**	**(52.798)**	**(52.831)**	**(0.034)**
Less Technical Adjustments	0.363	0.411	0.048	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.000)	(0.000)	0.363	0.411	0.048
Technically Adjusted Profit/Loss	**(54.080)**	**(53.867)**	**0.213** 1	**1.320**	**1.253**	**(0.067)** 2	**0.322**	**0.187**	**(0.135)** 3	**0.003**	**0.007**	**0.004** 4	**(52.435)**	**(52.420)**	**0.014** 5
Non Recurrent Deficit Support Revenue Allocation	47.934	47.934	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	47.934	47.934	0.000
Deficit Support Adjusted Profit/Loss	**(6.145)**	**(5.933)**	**0.213**	**1.320**	**1.253**	**(0.067)**	**0.322**	**0.187**	**(0.135)**	**0.003**	**0.007**	**0.004**	**(4.500)**	**(4.486)**	**0.014**

1. Trust:

The Trust, in line with national change, has received Non-recurrent Deficit Support Revenue Allocation to month 7 of £47.9m (£78.4m for the year). This non-recurrent allocation reduces our planned deficit from £85.8m to £7.4m. Due to this allocation being non-recurrent in nature, we are presenting the finance report with this deficit support income 'below the line' enabling the focus to remain on the recurrent position. Excluding the Non-recurrent Deficit Support Revenue Allocation, the Trust year-to-date deficit is £53.9m against a plan deficit of £54.1m; a £0.2m favourable variance YTD . The key drivers include:

- Income from patient care activities is £7.7m below plan. Overperformance in drugs and devices is £4.0m. Following national guidance, the funding of the Agenda for Change and Medical pay awards has been incorporated into both the plan and actuals YTD to month 7, removing the previously reported overperformance of £1.8m YTD. There is income underperformance in ERF of £7.9m YTD including CIPs, together with £2m underperformance against ICB discharge funding due to a successful project reducing inpatients not fit to reside and a national change on ERF Baseline funding of £2.4m FYE (£1.4m YTD).
- Other operating income is £0.8m above the plan year-to-date, primarily due to higher income from education and training, and car parking, totalling £1.2m. This increase is partially offset by cash and charitable contributions, which are £0.2m below the plan, along with a £0.1m shortfall in staff accommodation rental income.
- Employee expenses are £3.5m favourable to plan YTD, mainly driven by substantive and agency staff underspends (£5.5m in total) offset by a £2m overspend on bank staff.
- Other operating expenses are £3.2m favourable to plan YTD. Overspend on rechargeable drugs and devices and non-clinical supplies & services totals £4.9m, offset by £8.0m in underspend on clinical supplies, healthcare purchases, premises, and other costs.

2. 2gether Support Solutions

2gether Support Solutions reported a YTD surplus of £1.3m; which is £0.07m below the plan. Income overperformance relating to consumables is offset by income underperformance relating to catering retail and an increase in pay costs reflecting the impact of the nationally agreed 5.5% pay award.

3. Spencer Private Hospitals

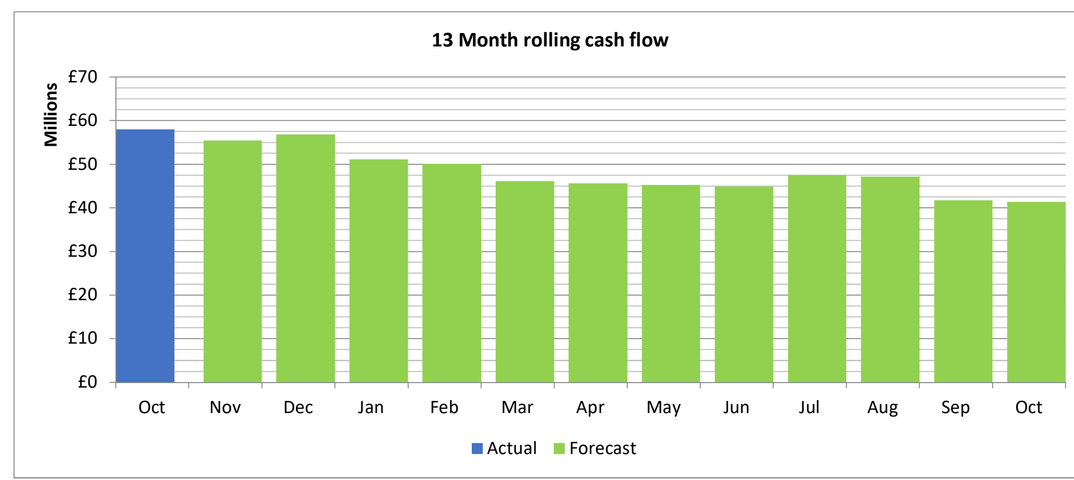
Spencer Private Hospitals operating profit and profit after tax level is a YTD surplus of £0.2m, which is £0.1m below plan but shows an improvement over the previous month. This improvement is primarily due to increased surgical activity levels and additional income from a backdated NHS tariff uplift.

4. Consolidation Adjustments

Consolidation adjustments remove all inter-company transactions for income and expenditure, indicating that we are on track with the year-to-date plan.

5. Group

The Group reported a £0.01m favourable variance to plan as of Month 7.



Unconsolidated Cash balance was £57.9m at the end of October 2024, £47.7m above plan.

Cash receipts in month totalled £151.4m (£58.5m above plan):

- K&M ICB paid £114.7m in October (£57.5m above plan - This includes unplanned receipts received in month for non-recurrent deficit support £45.8m, £12.6m backpay and £1.5m invoices cleared offsettting the contract value £2.4m below plan)
- NHS England paid £26.0m in October (£3.3m above plan on the contract payment - of which £1.9m relates to Education Funding)
- VAT received was £5.0m in October (£1.5m above plan)
- Other Receipts totalled £5.7m (£1.7m above plan - £1.1m received from Spencer Hospitals)
- No PDC Revenue Support was received in month (£7.0m below plan) - see Revenue Support commentary.

Cash payments in month totalled £105.0m (£13.5m above plan)

- Creditor payment runs including Capital payments were £35.5m (£7.6m above plan).
- £17.1m payments to 2gether were £3.1m above plan.
- Total payroll was £51.8m, £2.8m above plan (inc PAYE, NI and Pensions)

2024/25 Cash Plan

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

Revenue Support

In Q1 2024/25 the Trust received £21.5m of PDC Revenue Support. In Q2 2024/25 the Trust received a further £21.5m.

In September the Trust was notified of a £78.45m FYE non-recurrent deficit support revenue allocation and received a cash payment of £45.8m from K&M ICB in Month 7, which will be followed by £6.5m per month in months 8 - 12.

In light of this allocation, no further PDC Revenue support requests are expected to be made this financial year.

Creditor Management

The Trust paid to 30 day creditor terms for Non NHS suppliers in Month 7.

At the end of October 2024, the Trust was recording 42 creditor days (Calculated as invoiced creditors at 31st October/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 07 (October) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**379.770**	**371.825**	**(7.945)**	**67.469**	**66.615**	**(0.854)**	**4.408**	**4.368**	**(0.040)**	**(145.701)**	**(144.231)**	**1.470**	**305.946**	**298.577**	**(7.369)**
Inventories	7.878	6.827	(1.051)	5.245	5.245	0.000	0.047	0.051	0.004	0.000	0.000	0.000	13.170	12.123	(1.047)
Trade Receivables	37.592	31.106	(6.486)	25.520	7.009	(18.511)	5.397	4.465	(0.932)	(31.706)	(14.226)	17.480	36.803	28.354	(8.449)
Accrued Income and Other Receivables	(3.504)	(3.691)	(0.187)	(0.127)	(0.158)	(0.031)	(0.134)	(0.069)	0.065	0.000	0.000	0.000	(3.765)	(3.918)	(0.153)
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	17.955	57.929	39.974	12.413	23.002	10.589	2.049	3.280	1.231	0.000	0.000	0.000	32.417	84.211	51.794
Current Assets	**59.921**	**92.171**	**32.250**	**43.051**	**35.098**	**(7.953)**	**7.359**	**7.727**	**0.368**	**(31.706)**	**(14.226)**	**17.480**	**78.625**	**120.770**	**42.145**
Payables and Accruals	94.290	83.767	(10.523)	23.247	13.471	(9.776)	5.103	5.320	0.217	(27.854)	(10.578)	17.276	94.786	91.980	(2.806)
Deferred Income and Other Liabilities	8.100	15.223	7.123	0.000	0.000	0.000	0.000	0.000	0.000	(0.006)	(0.023)	(0.017)	8.094	15.200	7.106
Provisions	10.035	10.975	0.940	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.035	10.975	0.940
Borrowing	4.270	2.988	(1.282)	2.524	2.517	(0.007)	0.105	0.092	(0.013)	(4.334)	(4.422)	(0.088)	2.565	1.175	(1.390)
Current Liabilities	**116.695**	**112.953**	**(3.742)**	**25.771**	**15.988**	**(9.783)**	**5.208**	**5.412**	**0.204**	**(32.194)**	**(15.023)**	**17.171**	**115.480**	**119.330**	**3.850**
Provisions	3.423	3.327	(0.096)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.423	3.327	(0.096)
Borrowing	71.611	69.958	(1.653)	50.475	48.989	(1.486)	1.964	1.902	(0.062)	(115.804)	(113.117)	2.687	8.246	7.732	(0.514)
Non Current Liabilities	**75.034**	**73.285**	**(1.749)**	**50.475**	**48.989**	**(1.486)**	**1.964**	**1.902**	**(0.062)**	**(115.804)**	**(113.117)**	**2.687**	**11.669**	**11.059**	**(0.610)**
Net Assets	**247.962**	**277.758**	**29.796**	**34.274**	**36.736**	**2.462**	**4.595**	**4.781**	**0.186**	**(29.409)**	**(30.317)**	**(0.908)**	**257.422**	**288.958**	**31.536**
Public Dividend Capital	559.544	602.468	42.924	30.267	30.267	0.000	0.048	0.048	0.000	(30.315)	(30.315)	0.000	559.544	602.468	42.924
Retained Earnings	(373.566)	(386.692)	(13.126)	5.085	6.468	1.383	1.736	1.925	0.189	0.363	0.537	0.174	(366.382)	(377.762)	(11.380)
Revaluation Reserve	61.983	61.981	(0.002)	0.000	0.000	0.000	2.812	2.812	0.000	(0.535)	(0.535)	0.000	64.260	64.258	(0.002)
Taxpayers Equity	**247.961**	**277.757**	**29.796** 1	**35.352**	**36.735**	**1.383** 2	**4.596**	**4.785**	**0.189** 3	**(30.487)**	**(30.313)**	**0.174** 4	**257.422**	**288.964**	**31.542**

1. Trust:

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

Current Assets - Current assets have Increased from the 2023/24 opening position by £32m mainly due to £40m increase in cash balance. Please see Cash and Working capital pages for additional details.

Current Liabilities - Current liabilities has decreased by £3.7m due to reduction in payables (See Working Capital sheet for more detail) offset by increase in other liabilities and provisions.

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

Public Dividend Capital - Increased to date by £43m reflecting PDC revenue support received up to September 2024.

2. 2gether Support Solutions:

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

Current Assets - This has decreased from opening position by £8m mainly due to reduction in receivables. which led to increased cash balance.

Current Liabilities - have decreased by £9.8m from the opening position, primarily due to reduction in payables.

3. Spencer Private Hospitals:

Current Assets - Increased mainly due to invoice receivables.

Current Liabilities - Increased mainly due to payment of creditors.

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

Capital Programme £000	Annual Plan	Annual Forecast	Year to Date Plan	Year to Date Actual	Year to Date Variance
Critical Priorities (PEIC)	4,000	4,000	2,405	1,150	1,255
MDG - Medical Devices Replacement	2,249	2,249	1,115	333	782
Diagnostics Clinical Equipment Replacement Programme (ERP)	3,618	3,618	1,987	547	1,440
IDG - IT Systems Replacement	700	700	555	5	550
Electronic Medical Records (EMR)	800	800	476	221	255
Subsidiaries - 2Gether Support Solutions (2SS)	618	618	337	92	245
Subsidiaries - Spencer Private Hospitals (SPH)	150	150	75	157	(82)
Mechanical Thrombectomy	2,028	2,028	1,507	1,279	228
Renal – Expansion of dialysis services (Phase 2)	964	0	455	0	455
Stroke HASU	1,118	1,118	234	148	86
Pathology S8 - GP and Community Order Comms (LIMS)	140	140	140	140	0
Maternity Estates Review	1,594	0	200	10	190
Diagnostics Imaging (QEQM MRI)	2,100	2,100	350	0	350
Community Diagnostics Centre (CDC) - Buckland (EKHUFT)	1,033	1,033	1,033	786	247
Fire Compartmentation Strategy	4,000	4,000	1,228	880	348
Digital Histhopathology - 2024/25 (Year 2)	407	407	357	316	41
QEQM MRI Power Upgrade	45	45	45	0	45
Donated Assets	900	662	450	429	21
Vacuum Assisted Biopsy and Excision System (VAB/VAE)	0	70	0	0	0
TransNasal Endoscopy Service (TNE)	0	450	0	0	0
Subsidiaries Right of Use Assets (RoUA) - IFRS16 Leases	0	103	0	103	(103)
Trust IFRS16 Acquisitions	242	139	0	78	(78)
All Other	0	(14)	0	(113)	113
	26,706	**24,416**	**12,949**	**6,561**	**6,388**

Funded By:	Plan	Forecast	Change (+) increase (-) reduction
Operational Capital	21,887	21,887	0
Donations	900	662	(238)
PDC	1,347	1,867	520
	24,134	**24,416**	**282**
Under/(Over) Commitment	**(2,572)**	**0**	

The Group's gross capital year-to-date expenditure to the end of Month 7 2024/25 was £6.6m. This represents a £6.4m underspend against the YTD Plan of £13m.

In September 2024, the Capital Investment Group (CIG) commissioned the capital scheme leads to produce a monthly reforecast of their respective schemes for Months 6 to 12 to quantify risk of non-delivery by the end of the financial year and to enable the CIG to review and recommend proposals for re-distribution of slippage.

The outcome of the capital re-forecast exercise resulted in £4.47m of internal capital slippage that could be made available for internal redistribution to other schemes.

A list of high priority schemes totalling £5.17m was presented to and approved by the Finance and Performance Committee in response to the £4.47m slippage reported in October 2024.

The majority of these approved schemes were priorities the Trust was unable to include in its 2024/25 Capital Plan, due to a lack of available capital funding. These schemes also include the procurement of 2 Mobile CT Scanners to increase the flexibility of our diagnostic provision and the creation of a bereavement suite in the maternity unit at WHH to better support parents who have suffered loss.

Cost Improvement Summary
Month 07 (October) 2024/25

Delivery Summary	This Month			Year to Date		
Programme Themes £000	Plan	Actual	Variance	Plan	Actual	Variance
0.01 Estate Utilisation & Rationalisation	39	39	(0)	191	167	(24)
0.02 Procurement	693	492	(201)	3,980	3,153	(827)
0.03 Digital Utilisation & Rationalisation	8	(2)	(10)	42	19	(23)
0.04 Income – Capture, Coding and Pricing	633	633	-	2,833	2,833	-
0.05 Financial Control & Governance	6	22	16	58	151	93
0.06 Low Value Interventions	1	-	(1)	1	-	(1)
0.07 Drugs & Devices	53	157	104	667	1,022	355
0.08 Length of Stay	1,193	219	(974)	2,481	1,608	(873)
0.09 Medically Optimised for Discharge Pathway	-	-	-	-	-	-
0.10 Theatre Utilisation	676	675	(1)	3,011	2,308	(703)
0.11 Admission Avoidance	-	-	-	-	-	-
0.12 Outpatients	284	103	(181)	1,988	1,964	(24)
0.13 Diagnostics	161	299	137	1,205	1,836	631
0.14 Medical Staffing	618	226	(392)	3,075	1,483	(1,592)
0.15 Nursing and Midwifery	262	45	(218)	1,248	679	(569)
0.16 Allied Health Professionals	96	93	(3)	518	507	(11)
0.17 Other Workforce	250	225	(25)	1,241	1,281	40
Care group Led Schemes **	(473)	1,280	1,753	3,166	7,033	3,867
Grand Total	**4,501**	**4,505**	**4**	**25,705**	**26,045**	**340**

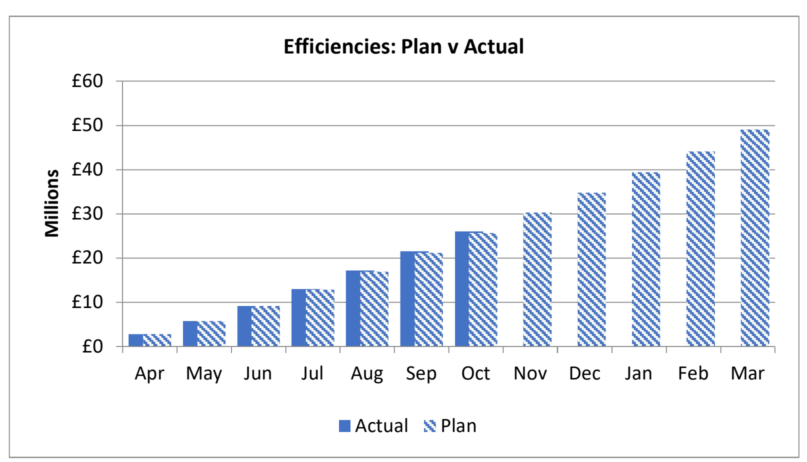
Delivered £000		
Month	Target	Actual
April	2,786	2,786
May	2,957	2,957
June	3,440	3,440
July	3,715	3,837
August	4,057	4,221
September	4,247	4,298
October	4,501	4,505
November	4,597	
December	4,517	
January	4,630	
February	4,636	
March	4,915	
	49,000	**26,045**
		53.2%

Efficiencies

The agreed Efficiencies plan for 2024/25 is £49.0m. CIP delivery is above plan to Month 7 by £0.34m. Recurrent savings of £3.2m have been delivered in October, and £18.8m on a YTD basis.

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

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



REPORT TO BOARD OF DIRECTORS (BoD)

Report title:	**Report on Journey to Exit NHS Oversight Framework 4 (NOF4) and Integrated Improvement Plan (IIP)**
Meeting date:	**5 December 2024**
Board sponsor:	**Chief Executive (CE)**
Paper Author:	**Chief Strategy and Partnerships Officer (CSPO)**

Appendices:

Appendix 1: Journey to Exit NOF4 – IIP Progress Report, November 2024

Executive summary:

Action required:	**Discussion**
Purpose of the Report:	This report has been provided to update the Board of Directors at EKHUFT on delivery progress of the IIP during October 2024, details the external Quarter 2 (Q2) performance review and offers assurance based on evidence gathered for how this is influencing the transition criteria set within the NHS England Recovery Support Programme (RSP) National Oversight Framework Segment 4 (NOF4).
Summary of key issues:	The report includes an update by programme and project. At the Q2 external review with the Integrated Care Board (ICB) and Region colleagues the Leadership, Governance and Culture programme was rated amber for performance, green for evidence supporting transition and an overall programme RAG of amber. All Q1 metrics have been met, four of the seven Q2 metrics have also been met, with plans to meet in Q3. The Q2 review rated the Urgent Emergency Care (UEC) programme amber for both performance and evidence to support transition, with an overall programme RAG of amber. All Q1 metrics were met and two of the four Q2 metrics were met, with plans developed to achieve the remaining metrics. The Q2 review agreed that the Planned Care programme was amber for performance, green for evidence supporting transition and an overall programme of amber. One metric form Q1 remains outstanding and continues to be outstanding for Q2. Six of the seven Q2 metrics have been met and a plan is being developed to achieve the remaining metric. The Q2 review rated the Finance Programme green for both performance and evidence to support transition, with an overall programme RAG of green.

	The Project Management Officer (PMO) continue to work to align IIP associated risks with the Trust significant risk register. PMO continues to collate evidence in preparation for the Q3 reviews in January.
Key recommendations:	The Board of Directors is invited to **DISCUSS** and **NOTE** the report.

Implications:

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

Assurance route:

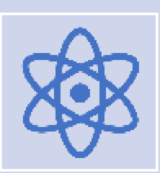
Previously considered by: Clinical Executive Management Group (CEMG)

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

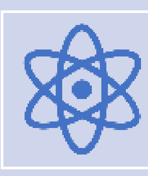
Journey to Exit NHS Oversight Framework 4 (NOF4) – IIP Progress Report

November 2024

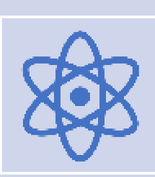
Purpose of Report



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 transition criteria set within the NHS England Recovery Support Programme National Oversight Framework Segment 4 (NOF4). The report also acknowledges the key risks to delivery of the IIP, highlighting current mitigations in place.



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



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

Q3 Performance Metrics Progress for M7

Quarterly Performance Metrics - Leadership, Culture & Governance - M7

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metric	RAG position at M7
1	A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme	• 24/25 Board development programme in place • All substantive Managing Director posts appointed to	• Recruitment to substantive CFO post • Recruitment to Substantive Chair post • At least one Board development session • Managing Director Development Plan developed and agreed	• At least one Board development session • 100% of Board to have undertaken a 360 degree review • Evidence of Board receiving oversight of regulatory actions with clear improvement plans and following up on actions • Delivery of CQC Must Do's (within capital restrictions)	• CPO recruited, Interview dates agreed for substantive Chair. COO not recruited to with mitigation plan being developed. • Board Development session took place in November • Regulatory Oversight Group in place, meeting bi-monthly and reporting into Quality & Safety Committee, then to Trust board. • CQC Must Do's are on track to complete by end of Q3 • An aspirant directors programme is currently being sought for the MDs.
2	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	• Evidence of consultant engagement events • Relaunch of 'we care' including roll out of training events • Phase 2 CLP – design stage commenced	• Consistent application of 'we care' QI methodology 'sustain' • Active and effective FTSU service and evidence of learning from concerns raised	• Evidence of improved and effective engagement of staff, patients and wider stakeholders • Increased uptake of staff survey in 24/25 • Evidence of safety improvements and maintenance of quality standards • FTSU Report to Board on learning and changes	• Staff Survey response rate at 57%, highest recorded in the organisations history. • F2F counselling re-introduced in February 2024, 234 clients (staff) have been seen, with 724 counselling sessions delivered across a 6-month period. Across 6-month pre and post implementation, sickness absence has reduced from 5.14% (above alerting thresholds) to 4.51% (below alerting thresholds). • Plan for FTSU has been agreed by the Exec and business case to be submitted to the nest BCSG.
3	Development of organisation strategy for clinical pathways	Commence development of organisation strategy for clinical pathways.	• Stage 1 – Completion of Situational analysis and background information • Development of site estates master plans	• Finalised summary of the situational analysis to allow progress to the next stage of development. • Engagement with external support partner	• All Service/speciality meetings have now taken place and the immediate service risks / escalations continue to be collated for Executive Teams consideration and action. • short term (1-2 year) vision and goals will be collated and shared with Care Group Leadership Teams and the Business Planning Team for consideration as part of the business planning process. • Kaleidoscope commenced work with the Trust with an initial planning meeting held on the 1st October. Kaleidoscope and the EK Strategy team ran a joint session at the leadership day on 10th October and they joined the staff forum on 29th October. Patient and Partner Engagement events are to be held on all sites during November and December.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Quarterly Performance Metrics – Urgent Care - M7

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metrics	RAG position
4	Consistent improvement in performance to deliver UEC type 1 to >50% and 12 hour waits to below 8%	**Type 1 – 46%** **12h - <10%**	**Type 1 - 48%** **12h - <9%**	**Type 1 – 50%** **12h - 8%**	• The Type 1 trajectory at Month 7 was achieved with a performance of 54.7% against a Q2 target of 50% . This continues to be the highest performance for the past 2 years. In Month 7, 9.6% of patients were waiting in the department >12 hours against a quarter average of 8% - this remains an area of focus by the care groups but does reflect the pressure in the system with an increase in attendances above contract levels. • Targeted interventions to improve this position include the opening of the CDU at WHH in November as well as the launch of the new acute medicine model. Funding from the winter system schemes is also supporting extending the frailty front door pilots at the front door, the expansion of the acute virtual wards on both acute sites and extending CT scanning into the evening and weekends.
5	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.	**14+ LoS – 32%** **Evidence of updated/review safety & harm prioritisation policies**	**14+ LoS – 31%** **Reduction in deteriorating patient/serious incidents across the UEC pathway**	**14+ LoS – 30%** **Reduction in deteriorating patient/ serious incidents across the UEC pathway** **Exit Tier 1**	• The LoS for NEL >14 days performance in Month 7 was recorded at 32% against a target of 30%. There has been an improvement from Month 6 which was recorded at 34.3%. The delivery of this trajectory is at risk due to the changes in contract provider of the P1 pathways and the increase in patients not meeting the criteria to reside. There has now been the formation of a national oversight group (DSOG) who are meeting to review P1, P2 and P3 patients with a view to see what support can be given. • Following the implementation of the SOP in Q2, a process review will be undertaken in Q3 to refine the process further. Further work on communication across ED's is being undertaken, the Director of Quality Governance presented at ECDG to discuss process and share learning. Q3 will aim to sustain the current level of harms that occur in our ED's. Data is being reported for deteriorating patients with a critical care admission with learning shared at M&Ms.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Quarterly Performance Metrics – Planned Care - M7

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metric	RAG position
6	To deliver Zero 104 and 78 week waits with consistent reduction in overall PTL and 65 week waits in order to deliver zero by March 2025	104ww – less than five 78 ww – zero 78 weeks by June 2024 65ww reduction of 25% (from March 24 outturn)	78 ww - zero maintained 65ww – reduction of 50% (from March 24 outturn)	78 ww – zero patients maintained 65ww – reduction of 75% (from March 24 outturn)	• There are currently 11 78 ww, with clear plan to reduce to 0 by the end of Dec through insourcing that commenced 23rd November • 65ww delivering above trajectory, with a March baseline of 2301, Q3 reduction of 75% (575 remaining). Current position is 250, on track to reduce to 0 in M12.
7	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 70%** **Faster Diagnostic Standard – 75% or above** **Exit Tier 1 for cancer**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 70%** **Faster Diagnostic Standard – 75% or above**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 75% or greater** **Faster Diagnostic Standard – 80% or above**	• 62d backlog: August – 244, September – 215, October - 193 • 62d compliance: August – 73.15%, September – 72.79%, October 72.61% (unvalidated) • 28d compliance: August – 71.05%, September – 69.56%, October – 70.39% (unvalidated) • Moving out of Tier 1 for Cancer, with official notification received on 8th November.
8	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered	**Diagnostics – to achieve 35%** **Endoscopy Backlog/ Surveillance List – reduction of 25% on March 24 baseline**	**Diagnostics – to achieve 30%** **Endoscopy Backlog / Surveillance List – reduction of 50% on March 24 baseline**	**Diagnostics - to achieve regional mean of 22% (mean based on 23/24)** **Endoscopy Backlog / Surveillance List - reduced to zero**	• DM01 position M7 – 77% - on target to achieve the Q3 metric • Endoscopy backlog reduced from March outturn of 7238 to 663 at M7 and is on track for Q3 delivery

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Quarterly Performance Metrics – Finance - M7

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metrics	RAG position
9	Delivery of 2024/25 plan inclusive of the CIP, income and expenditure plans [Phasing subject to finalisation of the plan]	**A year to date deficit of £23.1m or better by the end of Q1.**	**A year to date deficit of £45.0m or better by end of Q2 (£21.9m in the quarter).**	**A year to date deficit of £67.1m or better by end of Q3 (£22.1m in the quarter).**	• Deficit delivered in M7, £15k ahead of plan YTD • Achievement of £4,505k in month 7 with a YTD total CIP of £26,045k (ahead of plan by £340k YTD)
10	Robust financial oversight, governance, and a strong financial control environment in place	**Re-audit of controls by Finance Recovery Director to demonstrate progress on implementation. Report shared with FIOB and partners as necessary by the end of Q1**	**Formal re-audit of controls commissioned with report available by end of Q2 with aim to move to near 100% compliance.**	No metric set	
11	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable progress towards delivery	**Initial scoping and engagement plan complete by end of Q1**	**Near final document for discussion shared with partners by the end of Q2**	**Final agreed document with partner support agreed and taken through Board by the end of Q3**	• Financial Sustainability Plan draft completed and shared with NHSE and other system partners. • On target for submission to December Trust Board for approval. • Interdependence with ICB recovery plan is both a key risk and opportunity. The trust is actively engaged in the system process, supporting the leadership of a system wide workshop with Miles Scott (CEO at MTW) who is CEO SRO at a system level for the plan production.

Key	RAG position
Green	On track
Amber	Off track but plans in place to recover position in next quarter
Red	Off track

Evidence Supporting Transition to NOF3

Impact to NOF4 Transition Criteria – Leadership, Governance & Culture – Q2

Transition Criteria RAG agreed at Q2 External Review meeting 22nd October 2024

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

Suggested Evidence

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

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

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

Impact to NOF4 Transition Criteria – Urgent & Emergency Care – Q2

Transition Criteria RAG agreed at Q2 External Review meeting 22nd October 2024

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

Suggested Evidence

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

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

Impact to NOF4 Transition Criteria – Planned Care – Q2

Transition Criteria RAG agreed at Q2 External Review meeting 22nd October 2024

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

Suggested Evidence

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

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

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

Impact to NOF4 Transition Criteria – Finance - Q1

Transition Criteria RAG agreed at Q2 External Review meeting 22nd October 2024

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

Suggested Evidence

Transition Criteria 1

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

Transition Criteria 2

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

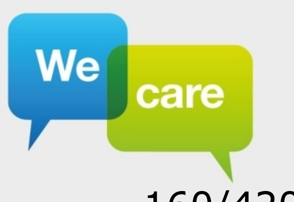
Transition Criteria 3

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

Trust Board Major Trauma

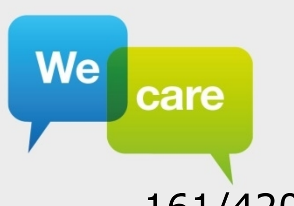
5 December 2024

Dr Natasha Newton
Trauma Director



Background to Trauma Care

Complex major trauma affects all ages, genders, and backgrounds. The patients we serve range from the most vulnerable and abused children, to functional, employable adults, who need to return to the workforce, to the elderly who sustain injuries which signify the very last days of their lives.



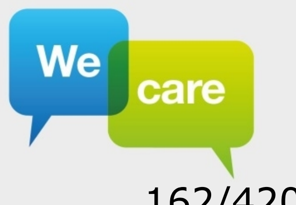
Background to Trauma Care at EKHUFT

Two Emergency Departments (EDs):
Queen Elizabeth the Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH)

QEQM "Local Emergency Hospital (LEH)"
WHH "Trauma Unit (TU)"

>1000 ISS 9 pts PA

Elderly Trauma 50:50 split two sites



Background to Trauma Care at EKHUFT

Two EDs:
QEQMH and the WHH

Export | Chat in Teams | Get insights

Navigation

Darent | King's | Maidstone | Medway | Princess Royal | Queen Elizabeth | Tunbridge | University | William

TARN ANALYTIC

DEMOGRAPHICS

DEMOGRAPHICS | INCIDENT MAP | TRENDS

Injury Mechanism

Crush
Vehicle incident/collision
Other
Fall > 2m
Fall < 2m

Age Band

Female | Male

200
150
100
50
0

0-9 | 10-19 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70-79 | 80-89 | 90+

DATE SELECTION

1/1/2021 | 1/1/2022

TOTAL SUBMISSIONS
508

DIRECT ADMISSIONS
508

LOS
9

ISS
9

Most Severely Injured Body Region

Limbs | Chest | Spine | Head | Multiple

ISS Band

> 15
1 - 8
9 - 15

12months
WHH

Background to Trauma Care @ EKHUFT

Two EDs:
QEQMH and th

12months
QEQM

TOTAL SUBMISSIONS 455
DIRECT ADMISSIONS 455
LOS 8
ISS 9

NHS England (NHSE) "Major Trauma Quality Indicators (TQUIN)" Criteria

File Home Insert Page Layout Formulas Data Review View Help Accessibility Reminder Tell me what you want to do

All patients receive a rehab assessment. Rehab prescription fully automated from November

SELKaM PEER REVIEW MEASURES 2024-25 on behalf of LMTS

Description	Notes from Network	Evidence documents expected	Measure RAG rating	Comments from unit
The patient and or their family/carers should be provided with or have access to written information specific to the TU about the facilities, care and rehabilitation as specified in the NICE guideline – Major Trauma (NG39).	TUs may provide this information as a footnote to a rehab prescription or as general advice in publically accessible pages on the Trust website.	Operational policy.	Green	Certain information appears on the Rehab Prescription & there is a designated page on the Trust website which has information on the service.
Each patient should have an identified key worker to be a single point of contact for them, their carer/s or family doctor. The key worker should be a health care professional. The name of the patient's key worker should be recorded in the patient's notes and on their rehabilitation prescription.	In the majority of cases this will be the lead consultant for the admission. The Network is keen to understand how the patient and carers are made aware of this information.	Operational policy.	Green	The Consultant's name appears on the EDN which is given to the patient and sent to their GP

2024-25 LMTS Peer Review | Sheet1

NHSE "TQUIN" Criteria

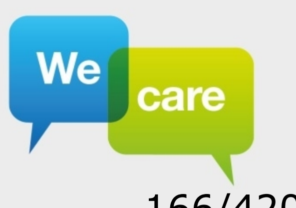
Measures

TQUIN measures 22

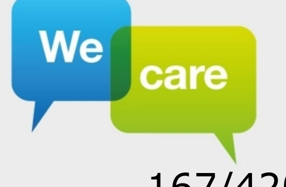
EKHUFT TU compliance

20 "Green"

2 "Amber"



Meeting the Criteria

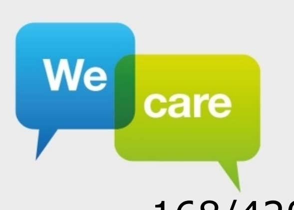


Meeting the Criteria

- Rehab Prescription

- Automatically attached to the Electronic Despatch Note (EDN)
- Populated during stay

T20-2D-303



Meeting the Criteria

- Rehab Prescription
- Automatically attached to the EDN
- Populated during stay

Patient and NOK contact details

Box for details of who will provide the therapy (Intermediate care team, Outpatient PT/OT, hand therapy, other)

Rehab Prescription

Consultant

Patient was most recently under the care of

Patient will have on-going care post discharge from

Trauma Patients

All injuries and dates of all surgery

Non-Trauma Patients

History of presenting cognition and details of treatment

T20-2D-303

Meeting the Criteria

- Rehab Prescription
- Automatically attached to the EDN
- Populated during stay

Box for details of who will provide the therapy (Intermediate care team, Outpatient PT/OT, hand therapy, other)

Rehab Prescription

Consultant

Patient was most recently under the care of

Patient will have on-going care post discharge from

Trauma Patients

All injuries and dates of all surgery

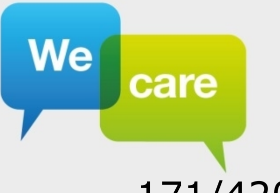
Non-Trauma Patients

History of presenting cognition and details of treatment

T20-2D-303

We care

Exceeding the Criteria



Exceeding the Criteria

- In house Transcarotid Artery Revascularization (TCAR) course

TCAR Course

24th November 2022

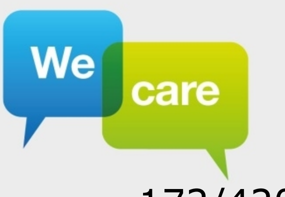
Estates Meeting room WHH

09:00 to 15:45

Day 4

Day 4

09:00	Introduction and Registration	Stefano Virruso
09:15	Elderly trauma	Natasha Newton
11:00	Break	
11:15	Traumatic brain injury	Erick Entrata
12:15	Pharmacology in brain injury	Rebecca Morgan
13:00	Lunch	
13:30	Principals of skin traction and practical (in trauma room Kings Floor)	Lindi Malindzisa Stefano Virusso
15:30	Evaluation	



Exceeding the Criteria

- In house TCAR course

TCAR Course

24th November 20

Estates Meeting roon

09:00 to 15:45

Day 4

Exceeding the Criteria

➢ Governance

Minutes

File Home Share View

This PC > Documents > Work > ABTRAUMA CARE FORUM > Minutes

Quick access
- Desktop
- Downloads
- Documents
- Pictures
- Minutes
- PEER REVIEWS
- Pembury
- REHAB

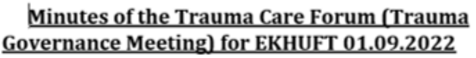
This PC

Network

Name	Date modified	Type	Size
2022.09.01 Minutes of the Trauma Care Forum....	14/09/2022 20:57	Microsoft Word 97 - ...	706 KB
2022.05.05 Minutes of the Trauma Care Forum....	18/05/2022 09:10	Microsoft Word 97 - ...	179 KB
2020.02.06 Minutes of the Trauma Care Forum....	20/02/2020 16:32	Microsoft Word 97 - ...	464 KB
2019.11.07 Minutes of the Trauma Care Forum....	05/12/2019 14:33	Microsoft Word 97 - ...	396 KB
2019.09.12 STEIS Minutes of the Trauma Care F...	10/10/2019 15:28	Microsoft Word 97 - ...	49 KB
2019.09.12 Minutes of the Trauma Care Forum....	19/09/2019 17:11	Microsoft Word 97 - ...	258 KB
2019.07.18 Minutes of the Trauma Care Forum....	15/08/2019 13:36	Microsoft Word 97 - ...	748 KB
2019.03.18 Minutes of the Trauma Care Forum....	07/05/2019 11:45	Microsoft Word 97 - ...	661 KB
2019.01.17 Minutes of the Trauma Care Forum....	07/05/2019 09:55	Microsoft Word 97 - ...	167 KB
2019 GENERIC Minutes of the Trauma Care Foru...	10/07/2019 17:13	Microsoft Word 97 - ...	653 KB
2018.11.15 Minutes of the Trauma Care Forum....	13/12/2018 11:56	Microsoft Word 97 - ...	128 KB
2018.09.18 Minutes of the Trauma Care Forum....	04/10/2018 16:29	Microsoft Word 97 - ...	1,028 KB
2018.07.17 Minutes of the Trauma Care Forum....	28/08/2018 12:21	Microsoft Word 97 - ...	616 KB
2018.04.10 Minutes of the Trauma Care Forum....	24/04/2018 14:32	Microsoft Word 97 - ...	300 KB
2018.01.18 Minutes of the Trauma Care Forum....	23/01/2018 16:58	Microsoft Word 97 - ...	323 KB
2017.11.21 Minutes of the Trauma Care Forum....	28/11/2017 13:07	Microsoft Word 97 - ...	53 KB
2017.09.19 Minutes of the Trauma Care Forum....	26/09/2017 14:38	Microsoft Word 97 - ...	36 KB
2017.03.28 Minutes of the Trauma Care Forum....	02/05/2017 18:01	Microsoft Word 97 - ...	42 KB
2017.01.19 Minutes of the Trauma Care Forum....	27/01/2017 16:17	Microsoft Word 97 - ...	51 KB
2016.09.27 Minutes of the Trauma Care Forum....	30/09/2016 10:46	Microsoft Word 97 - ...	43 KB
2016.07.26 Minutes of the Trauma Care Forum....	28/07/2016 09:13	Microsoft Word 97 - ...	297 KB
2016.05.03 Minutes of the Trauma Care Forum....	17/05/2016 15:06	Microsoft Word 97 - ...	36 KB
2016.03.39 Minutes of the Trauma Care Forum....	07/04/2016 15:49	Microsoft Word 97 - ...	50 KB
2016.02.02 Minutes of the Trauma Care Forum....	04/02/2016 11:23	Microsoft Word 97 - ...	53 KB
2015.09.04 Minutes of the Trauma Care Forum....	08/10/2015 17:39	Microsoft Word 97 - ...	31 KB

We care

Exceeding the Criteria

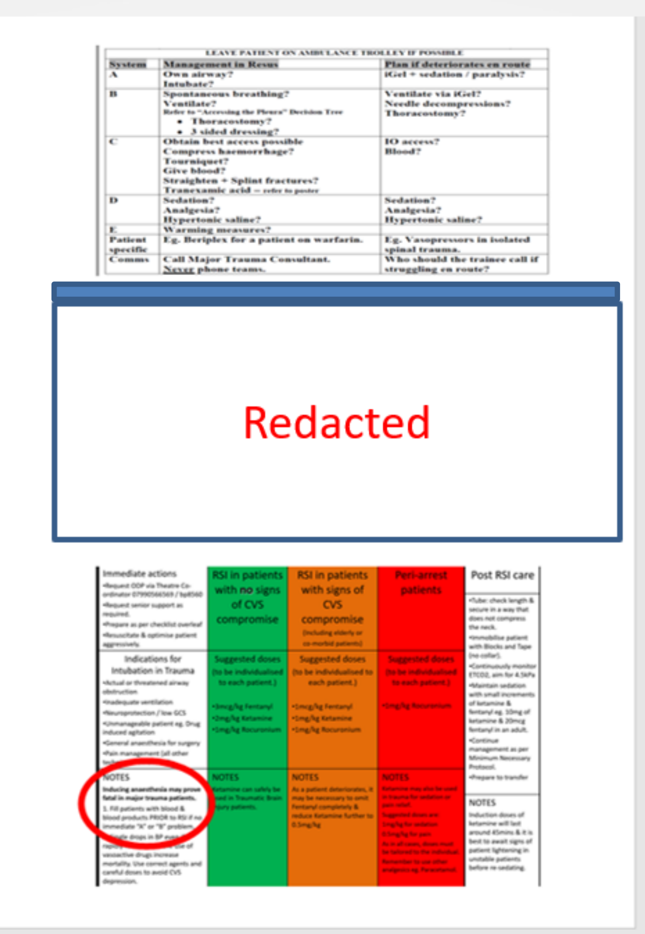


Minutes of the Trauma Care Forum (Trauma Governance Meeting) for EKHUFT 01.09.2022

Attendance: **Natasha Newton Trauma Director**
25 Staff members from EKHUFT and SECAmb attended via Teams, having pre-registered for secure sign in and signing confidentiality agreements. No persons without NHS / identifiable JESSOP professional email were admitted.

NOTE: ALL Major Trauma SOPs are on Microguide

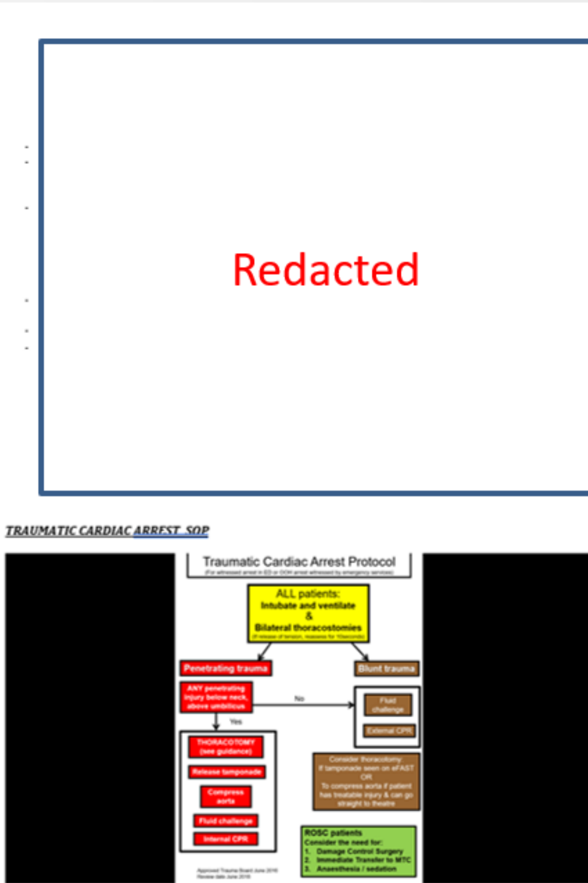
Redacted



LEAVE PATIENT ON AMBULANCE TROLLEY IF POSSIBLE		
System	**Management in Resus**	**Plan if deteriorates en route**
A	Own airway? Intubate?	iGel + sedation / paralysis?
B	Spontaneous breathing? Ventilate? Refer to "Accessing the Pleura" Decision Tree • Thoracostomy? • 3 sided dressing?	Ventilate via iGel? Needle decompressions? Thoracostomy?
C	Obtain best access possible Compress haemorrhage? Tourniquet? Give blood? Straighten + Splint fractures? Tranexamic acid – refer to poster	IO access? Blood?
D	Sedation? Analgesia? Hypertonic saline?	Sedation? Analgesia? Hypertonic saline?
E	Warming measures?	
Patient specific	Eg. Beriplex for a patient on warfarin.	Eg. Vasopressors in isolated spinal trauma.
Comms	Call Major Trauma Consultant. Never phone teams.	Who should the trainee call if struggling en route?

Redacted

Immediate actions	RSI in patients with no signs of CVS compromise	RSI in patients with signs of CVS compromise	Peri-arrest patients	Post RSI care
Indications for Intubation in Trauma	Suggested doses	Suggested doses	Suggested doses	
NOTES	NOTES	NOTES	NOTES	NOTES



2016.05.03 Minutes of the Trauma Care Forum....	17/05/2016 15:06	Microsoft Word 97 - ...	36 KB
2016.03.39 Minutes of the Trauma Care Forum....	07/04/2016 15:49	Microsoft Word 97 - ...	50 KB
2016.02.02 Minutes of the Trauma Care Forum....	04/02/2016 11:23	Microsoft Word 97 - ...	53 KB
2015.09.04 Minutes of the Trauma Care Forum....	08/10/2015 17:39	Microsoft Word 97 - ...	31 KB

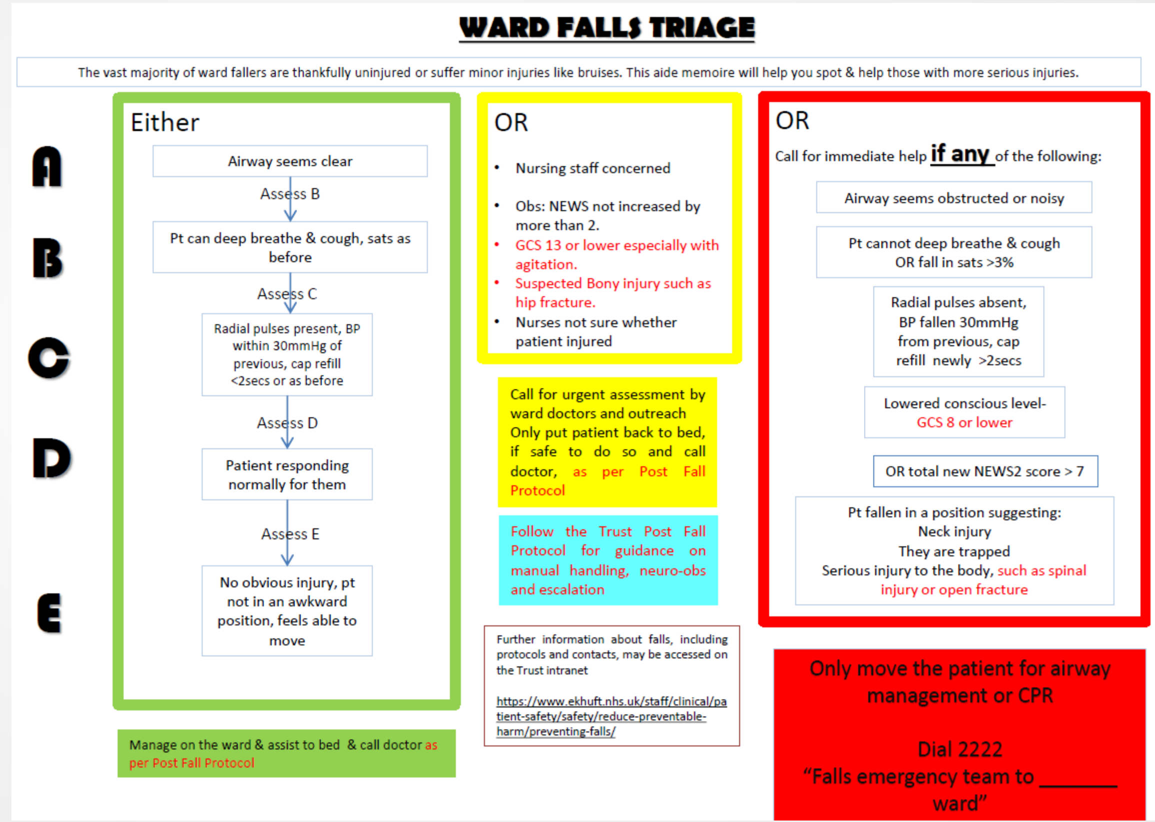
We care

Exceeding the Criteria

- In house Trauma Team Members (TTM) and Paeds TTM course

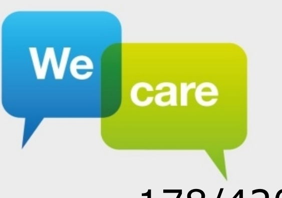
Exceeding the Criteria

- Ward fallers



Background to Trauma Care at EKHUFT

As reviewers we are very pleased to see that the work at the William Harvey and the diligence of your major trauma service remains, as previously described by the National Trauma Director, “flagship”, in most areas.



Background to Trauma Care at EKHUFT

As reviewers we are very pleased to see that the work at the William Harvey and the diligence of your major trauma service remains, as previously described by the National Trauma Director, “flagship”, in most areas.

Watch
EMERGENCY
Channel 4
9pm
from 12-15
August

Natasha Newton,
Consultant Anaesthetics

Celebrating our teams caring for major trauma patients

East Kent Hospitals University NHS Foundation Trust
August 8 ·

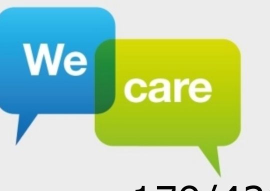
The incredible work of our staff will be featured in a new documentary series next week

Channel 4’s Emergency follows patients within London’s Major Trauma System, a world-first network of hospitals, air ambulances and paramedics that has improved survival rates for major trauma patients by 50%. William Harvey Hospital forms a vital part of this network.

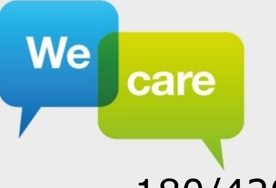
Watch **#Emergency** on Channel 4. Mon 12 – Thurs 15, 9-10pm. Catch up on All 4.

63 2 35

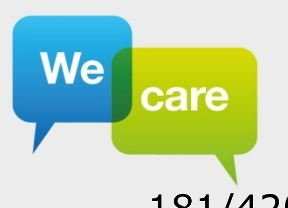
Write a comment...



NHS
East Kent
Hospitals University
NHS Foundation Trust


We
care

Trauma in East Kent
The Challenges



Challenges for Trauma

➢ Peer Review Outcome 2024

- As laid out in the National Service Level Agreement for NMTR, it is the Secretary of State's requirement that all trauma receiving hospitals have a minimum of 80% case ascertainment for their data…..
- not achievable unless there is one staff member per 500 cases as a minimum.
- It was highlighted …..in January 2023….. you require a minimum of 2 NMTR statisticians.
- ……without robust data you cannot guarantee to the assessors that patients who should otherwise survive are not dying at your hospitals.

We care

Challenges for Trauma

- Saving Lives

Ws & 95% CI

4
2
0
-2
-4

King's College Hospital
Princess Royal University Hospital Orpington
University Hospital Lewisham
Queen Elizabeth Queen Mother Hospital
St Thomas' Hospital
Maidstone General Hospital
Queen Elizabeth Hospital London
Tunbridge Wells Hospital
William Harvey Hospital
Medway Maritime Hospital

We care

Challenges for Trauma

- Saving Lives

Ws & 95% CI

4
2
0
-2
-4

King's College Hospital
Princess Royal University Hospital Orpington
University Hospital Lewisham
Queen Elizabeth Queen Mother Hospital
St Thomas' Hospital
Maidstone General Hospital
Queen Elizabeth Hospital London
Tunbridge Wells Hospital
William Harvey Hospital
Medway Maritime Hospital

We care

Challenges for Trauma

➢ Peer Review Outcome 2024

- Without robust data you will struggle to answer freedom of information requests, and complaints.

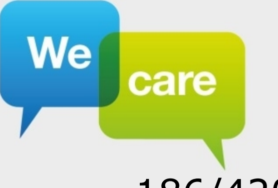
- [Nor can you] ensure TQUIN measures, such as the leadership and membership of your trauma calls and time to CT.

- You lack understanding of the burden that Major Trauma brings to other services such as critical care, paediatrics, radiology and therapies, or the evidence that you provide each required patient with a rehab prescription

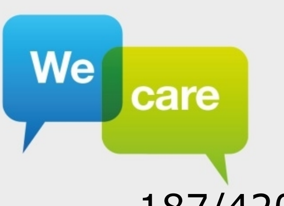
- As such, it is predicted that your rating in the TQUINs will also fall.

We care

NHS
East Kent
Hospitals University
NHS Foundation Trust


We
care

Thank you



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Board Assurance Framework (BAF)**

Meeting date: **5 December 2024**

Board sponsor: **Director of Corporate Governance**

Paper Author: **Director of Corporate Governance**

Appendices:

None

Executive summary:

Action required:	**Information**
Purpose of the Report:	EKHUFT's Board Assurance Framework or BAF is a key part of the Trust's strategic risk management process. Overseen by the Board and the Integrated Audit and Governance Committee (IAGC), assurance in a way that promotes good governance and accountability. It is a quarterly item for review at EKHUFT Board meeting. The purpose of a Board Assurance Framework (BAF) is to help a board of directors understand and manage the risks to achieving an organization's strategic objectives: • **Identify risks**: The BAF helps the board understand the risks to achieving its strategic goals. • **Identify assurance gaps**: the BAF helps the board identify areas where assurance is insufficient or missing. • **Identify areas for improvement**: the BAF helps the board identify areas where controls and assurances can be improved. • **Improve governance**: the BAF helps the board and management consider how to secure assurance in a way that promotes good governance and accountability.
Summary of key issues:	The Trust BAF was agreed at the Board Development meeting in early 2024. It has been designed to allocate risks to each relevant Board committee in line with EKHUFT's 'We Care' strategic objectives: • Our patients • Our people • Our future • Our sustainability • Our quality and safety EKHUFT's BAF has taken on an increasingly vital role in its assurance processes. The BAF – and specific risks allocated to each Committee – now form the framework for their work and agendas. The report identifies the Trust's BAF risks with reference to each Committee in the paper.

In addition, the Paper confirms the risk rating as endorsed by the IAGC.

Changes since the last review of the Board include:

1. Updating of BAF Risk 001:

   Previous wording:

   Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to deliver the constitutional standards which could result in harm, poorer outcomes and worse experience for patients.

   New wording:

   Due to significant waiting lists, in part, as a legacy of the Covid-19 pandemic, and misalignment between demand and capacity in certain specialties, there is a risk that the Trust is not able to deliver the constitutional standards within National timeframes which could result in harm, poorer outcomes and experience for our patients.

2. We are actively reviewing the inclusion of a digital/cyber risk to escalate from our Significant Risk Register to the BAF.

Changes to risk rating

BAF Risk	Inherent Risk Score	Current Risk Score	Change ↑↓↔	Target
Ref: BAFQSC001 Failure to (i) meet quality standards for clinical care; (ii) continuously improve care quality and safety; and/or (iii) engage patients and carers in that care, could result in patient harm, impaired outcomes, and poor experience for both patients and staff.	20	16	↓	12
Ref: BAFSQC003 There is a risk that the trust won't improve the experience of women and their families following the Independent Investigation into East Kent Maternity Services.	20	15	↓	6
Ref: BAFFPC001 Due to significant waiting lists, in part, as a legacy of the Covid-19 pandemic, and misalignment between demand and capacity in certain specialties, there is a risk that the Trust is not able to deliver the constitutional standards within National timeframes which could result in harm, poorer outcomes and experience for our patients.	20	16	↓	12
Ref: BAFFPC002 Due to constraints and sub-optimal patient pathways, the Trust is not able to deliver timely and responsive services, both elective and non-elective, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses.	20	16	↓	12

Key recommendations:	The Board of Directors is asked to review and **NOTE** the status of the Principle Risks in the BAF.

Implications:

Links to Strategic Theme:	This report aims to support the following 'We care' Strategic Objectives; • Our patients • Our people • Our future • Our sustainability Our quality and safety
Link to the Board Assurance Framework (BAF):	The entirety of the BAF is appended
Link to the Corporate Risk Register (CRR):	The SRR is linked to the BAF
Resource:	No
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	N/A

Assurance route:

The BAF is overseen by the IAGC and the specific BAF risks are considered and presented at each respective Committee.

Glossary of terms

Board Assurance Framework (BAF) – A tool for the Board corporately to assure itself about successful delivery of the organisation's strategic objectives.

Inherent Risk – The risk that an activity would pose if no controls or other mitigating factors were in place

Risk – Risk is the combination of the probability of an event and its consequence. Consequences can range from positive to negative.

Residual Risk – The risk that remains after controls are considered.

Risk Appetite – The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

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.

Target Risk – The desired risk level over a period of time after risk actions have been implemented.

Controls – How the risk is being managed

Assurance – The evidence that controls are effective

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

BOARD ASSURANCE FRAMEWORK (BAF)

December 2024

Strategic Theme	Principle Risk	Oversight Committee	Inherent Risk Score	Current Risk Score	Change ↑↓↔	Target Risk Score	Target Date
Quality and Safety	**Ref: BAFQSC001** Failure to (i) meet quality standards for clinical care; (ii) continuously improve care quality and safety; and/or (iii) engage patients and carers in that care, could result in patient harm, impaired outcomes, and poor experience for both patients and staff.	**Quality & Safety Committee (Q&SC)**	**20**	**16**	↓	**12**	**Q4 2024/25 (Score 16)**
	Ref: BAFQSC002 Failure to identify harm and involve patients and their families in their care and investigations, and use opportunities to embed a culture of safety and learn from when things don't go well and share best practice across the organisation	**Quality & Safety Committee (Q&SC)**	**20**	**20**	↔	**12**	**Q4 2024/25 (Score 16)**
	Ref: BAFSQC003 There is a risk that the trust won't improve the experience of women and their families following the Independent Investigation into East Kent Maternity Services.	**Quality & Safety Committee (Q&SC)**	**20**	**15**	↓	**6**	**July 2024/25 (Score 15)**
Patients	**Ref: BAFQSC004** There is a risk we fail to meet our statutory and regulatory requirements resulting in regulatory action, harm to patients and staff and damage to our reputation.	**Quality & Safety Committee (Q&SC)**	**16**	**16**	↔	**9**	**Q4 2024/25 (Score 12)**
	Ref: BAFFPC001 Due to significant waiting lists, in part, as a legacy of the Covid-19 pandemic, and misalignment between demand and capacity in certain specialties, there is a risk that the Trust is not able to deliver the constitutional standards within National timeframes which could result in harm, poorer outcomes and experience for our patients.	**Finance & Performance Committee (FPC)**	**20**	**16**	↓	**12**	**Q4 2024/25 (Score 16)**
	Ref: BAFFPC002 Due to constraints and sub-optimal patient pathways, the Trust is not able to deliver timely and responsive services, both elective and non-elective, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses.	**Finance & Performance Committee (FPC)**	**20**	**16**	↓	**12**	**Q4 2024/25 (Score 16)**
	Ref: BAFFPC003 We are unable to address or mitigate effectively infrastructure and safety system risks due to insufficient capital funding impacting on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.	**Finance & Performance Committee (FPC)**	**20**	**20**	↔	**12**	**Q4 2024/25 (Score 16)**
People	**Ref: BAFPCC001** A failure to recruit and retain staff could lead to: the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	**People & Culture Committee (P&CC)**	**20**	**20**	↔	**9**	**Q4 2024/25 (Score 14)**
	Ref: BAFPCC002 A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of which could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	**People & Culture Committee (P&CC)**	**20**	**20**	↔	**12**	**Q4 2024/25 (Score 16)**

	Ref: BAFPCC003 Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically-led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain	**People & Culture Committee (P&CC)**	**20**	**20**	↔	**12**	**Q4 2024/25 (Score 16)**
Partnerships	**Ref: BAFFPC004** We are unable to deliver the strategic intentions of the trust due to the lack of a trust strategy that would support and enable the delivery of sustainable services and the future viability of the organisation.	**Finance & Performance Committee (FPC)**	**16**	**16**	↔	**8**	**Q4 2024/25**
	Ref: BAFFPC005 We are unable to foster and maintain effective collaborative working relationships with Health and Care Partnership, System and regional partner organisations and regulatory bodies to deliver on common aims and objectives.	**Finance & Performance Committee (FPC)**	**16**	**12**	↔	**8**	**Q3 2024/25**
Our Sustainability	**Ref: BAFFPC006** There is a risk that the Trust, as part of the Kent and Medway ICS, is unable to deliver the scale of financial improvement required to achieve breakeven or better within the funding allocation that has been set over a 3-year period. This would lead to regulatory action and/or limits on our ability to invest in strategic priorities/provide high quality services for patients.	**Finance & Performance Committee (FPC)**	**25**	**25**	↔	**16**	**Q2 2024/5 (Dependent on agreed period set by System)**

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Risk Register Report**

Meeting date: **5 December 2024**

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

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

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This paper presents the current Significant Risk Register (SRR) Report to ensure the Board has oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through the Clinical Executive Management Group (CEMG) and the appropriate Board Sub Committees to Board. This paper demonstrates movement in month, details those risks that have been de-escalated from the SRR due to the mitigations in place and new risks.
Summary of key issues:	The majority of the risks contained in the significant risk report have had a 'review' within the last four weeks. As of 20 November 2024, when the SRR was extracted there are eight risks with associated overdue actions. These have been escalated with risk owners and delegates. There have been significant improvements in ensuring records are reviewed and updates provided but it is essential that this process becomes embedded within strengthened business as usual governance arrangements. Monthly meetings are now in place with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular monthly oversight and scrutiny. The Risk Review Group on 24 September received a deep dive presentation from Children and Young People (WCYP Care Group). All Clinical Care Groups have now reported (and all Corporate Care Groups with the exception of People and Culture which is to happen in December). The October meeting was stood down due to a high number of apologies. A refreshed planner has been developed which will be approved at the next Risk Review Group on 26 November 2024.

	There were no specific escalations received from the Risk Review Group. The Head of Risk Management and Assurance post has been vacant since April 2024 with the Associate Director of Quality Governance covering essential tasks and ensuring progress with embedding and strengthening improved risk management arrangements continues. We have been out to recruit previously and have been unsuccessful but are pleased to announce that we have now recruited. The successful candidate is due to start on the 25 November 2024. Work priorities by the end of Q4 2024/25 will include a refresh of the Training Needs Analysis and introduction of an enhanced training offer for risk, completion of actions from the last risk audit and reviewing the risk tolerances with the Board. In addition, we are due to rollout InPhase (Quality Management System) for Risk which will be a significant undertaking in terms of corporate resource and require input and engagement from Care Group and Corporate Leads.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Trust Risk Register:	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the CRR.
Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer Private Hospitals

Assurance route:

Previously considered by: Clinical Executive Management Group on 6 November 2024 and the Integrated Audit and Governance Committee on 1 November 2024.

A risk report will also be received by the Quality and Safety Committee on 26 November 2024, the Financial and Performance Committee on 26 November 2024 and the People and Culture Committee on 27 November 2024.

It should be noted that as the Risk Register is a live document the supporting information was extracted on 20 November 2024.

SIGNIFICANT RISK REPORT – Board of Directors

1. Purpose of the report

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

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

1.3 The last Risk Review Group took place on 24 September 2024 as the October 2024 meeting was cancelled. The next meeting is on Tuesday 26 November 2024. There were no escalations reported.

2. Background

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

2.2 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is summarised in Section 3 of this report.

2.3 The Risk Review Group was established in early February 24. The Group, which meets monthly and is chaired by the CNMO, by the October 2024 meeting will have received deep dive presentations from all Clinical Care Groups and by December 2024 for all Corporate Care Groups. A work planner for the next 12 months will be presented for sign off at the next Risk Review Group meeting on 26 November 2024.

3. Current Significant Risk Register

3.1 There are currently 29 risks in total on the Significant Risk Report (down from 31 in the October Board report).

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

3.3 There are overdue actions associated with eight of the risks (marked in bold for clarity). These have been escalated for immediate attention with the Risk Owners and Delegates.

3.4 The Significant Risk Register is summarised below:

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to Oct 24 report	Target Risk Score	Actions summary
1891	Corporate Operations **Accountable Executive: Chief Operating Officer (COO)**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	⟺	Low (6)	Conduct comprehensive review of current Emergency Department (ED) processes and identify areas for improvement - focus initially on opportunity to reduce the number of patients spending 12+ hour in ED Person Responsible: Interim Managing Director Due: 31 Dec 2024 Given no investment from NHS England (NHSE) Bed Capacity Management System seek alternative options. Person Responsible: Interim Managing Director Due: 31 Dec 2024 Demand and capacity modelling to be completed by Health and Care Partnership (HCP) for all P1 to P3 patients Person Responsible: Interim Managing Director Due: 29 November 24 Updated Full Capacity Protocol to be signed off, distributed and

						monitoring processes in place Person Responsible: Interim Managing Director Due: 30 Nov 2024
3386	Care Group - Women's Health **Accountable Executive: CMNO**	Potential risk of inaccurate records due to Euroking back copying	Extreme (20)	⟷	Low (4)	IT to provide weekly updates to Maternity teams on progress actions from the queries review with Magentus following the daily meetings. Person Responsible: Clinical Information Systems (CIS) Manager Due: 06 Dec 2024
2406	Care Group - Diagnostics, Cancer and Buckland (DCB) **Accountable Executive: Chief Strategy & Partnerships Officer (CPSO)**	Delay to patient diagnosis from potential loss of Nuclear Medicine service at William Harvey Hospital (WHH)	High (16)	⟷	Low (4)	**Instillation is pending minor works completion (required for license renewal).** **Person Responsible: Chief Technologist Nuclear Medicine & Osteoporosis** **Due: 31 Oct 2024**
2934	Care Group - Women's Health **Accountable Executive: CPSO**	Inadequate theatre capacity at Queen Elizabeth the Queen Mother Hospital (QEQM) for maternity services	High (16)	⟷	Low (4)	Progress plans with strategic development with potential NHS England (NHSE) funding to support the needed maternity estate expansion (including obs theatre) at QEQM Person Responsible: Operations Director Due: 30 April 2025 Review and implement solutions

						with clinical teams for late theatre starts and overruns Person Responsible: Service Manager Due: 30 November 2024 Review and improve the efficiency of C-Section lists Person Responsible: Service Manager Due: 2 Dec 2024
3354	Queen Elizabeth Queen Mother (QEQM) Care Group **Accountable Executive: CPSO**	Clinical environment not fit for purpose in many areas	High (16)	↔	Low (4)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair. List of estates issues from closed ward risks attached. Person Responsible: Director of Nursing Due: 30 Nov 2024
3553	William Harvey Hospital (WHH) Care Group **Accountable Executive: CPSO**	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH	High (16)	↔	Low (6)	Exploration of running of weekend lists. Paper for enhanced rate for physiologists still to be drafted. Wider conversation around weekend NSTEMI and elective lists ongoing. Person Responsible: General Manager Due: 2 Dec 2024 Business Continuity Plan to be updated following Sept 2023 failure of both Percutaneous

						Coronary Intervention (PCI) labs at WHH and agreed with region. Discussion to be had with radiology re role of Interventional Radiology (IR) suite in BCP given that they have the same equipment. New BCP template circulated and discussed with emergency planning. Person Responsible: General Manager (GM) Due: 29 Nov 2024 Cath labs form part of trust FSP programme – COO taking forward re bid for capital. GM to provide COO with summary slides with risks, mitigations, costs etc. Person Responsible: General Manager Due: 29 Nov 2024 Business case for installation to be submitted. Currently in draft format. Person Responsible: General Manager Due: 29 Nov 2024
2158	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive:**	Risk of Patient harm and treatment due to unreported A&E chest xrays	High (16)	⟺	Low (4)	External review by Regional Adviser commissioned and report received. Meeting to be arranged with care group leaders to

	Chief Medical Officer (CMO)					discuss outputs of report and agree action plan. Person Responsible: CMO Due: 20 Dec 2024
678	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments. Person Responsible: Deputy Lead CS Pharmacist Due: 30 December 2024 Recruit following Business Case (BC) approval for medical wards. Person Responsible: Deputy Lead CS Pharmacist Due: 1 Jan 2025 Consider Full 7-day service from Pharmacy following action from Care Quality Commission (CQC) Must Do. Person Responsible: Director of Pharmacy Due: 31 Dec 2024 **Work is happening within the Care Group (CG) to define the best leadership structure for the pharmacy service.**

						This includes consideration of how staff can work differently to address issues such as medicines reconciliation. **Person Responsible: Managing Director** **Due: 31 Oct 2024** Start to recruit to GSB BC (assuming case is approved) submitted Oct 2024 Person Responsible: Deputy Lead CS Pharmacist Due: 31 Jan 2025
2796	Kent & Canterbury and Royal Victoria Care Group **Accountable Executive: CPSO**	There is a risk of delay in dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old	High (15)		Low (6)	**In the process of finalising the rolling replacement programme for dialysis machines across all dialysis units to ensure there is clearly shown sub-set within the Medical Devices Group (MDG) capital allocation that will be reviewed monthly at the Trust's Capital Investment Group.** **Person Responsible: General Manager** **Due: 30 Sept 2024**
1831	Queen Elizabeth Queen Mother Care Group	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)		Low (6)	Reverse rating streaming in place to identify patients who need resus and those who are well enough to be cared for in non-care space. Ongoing

	Accountable Executive: CNMO					monitoring via incident reporting Person Responsible: Deputy Head of Nursing Due: 31 Jan 2025 Fundamentals of care training to be completed by staff re privacy and dignity Person Responsible: Deputy Head of Nursing Due: 31 Jan 2025
3556	William Harvey Hospital Care Group **Accountable Executive: CNMO**	Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring	High (15)	⟺	Low (6)	Continued Implementation of the Emergency Floor Improvement plan which includes direct pathways such as right sizing Same Day Emergency Care (SDEC), Surgical Emergency Admissions Unit (SEAU) and Urgent Treatment Centre (UTC) Person Responsible: Head of Operations Due: 30 Nov 2024
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	High (15)	⟺	Low (6)	**Developing a page on Sunrise for consultants to review all results that are allocated to them** **Person Responsible: Chief Clinical Information Officer** **Due: 01 Oct 2024**

679	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)	⟷	High (15)	Options regarding future plan for APU presented at Capital Investment Group (CIG). Presentation will be by SD but support for options provided by APU staff. Actions will be generated following outcome of Strategic Investment Group (SIG) Person Responsible: Director of Pharmacy Due: 31 Dec 2024 Replacement of the unit with off site licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Person Responsible: Director of Pharmacy Due: 30 Sep 2029 Commence £250k of remedial work required. Person Responsible: Chief Medical Officer Due: 31 Dec 2024
3557	Care Group – William Harvey **Accountable Executive: COO**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟷	Moderate (9)	Recruit mental health nurses. New mental health lead appointed and will start on 3/12. Person Responsible: Specialist Nurse Practitioner Due: 02 Dec 2024

						Work with external partners/commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with Kent & Medway NHS and Social Care Partnership Trust (KMPT) Ongoing consultation and recent Integrated Care Board (ICB) visit and actions unidentified. This is still in progress - date amended Person Responsible: Associate Director of Nursing Due: 29 Nov 2024 Ensure safeguarding vulnerable adults and paediatric training compliance. Compliance is monitored on an ongoing basis and also reinforced at Team Days. Person Responsible: Associate Director of Nursing Due: 30 Nov 2024
3642	Care Group – Queen Elizabeth, The Queen Mother **Accountable Executive: COO**	There is a demand and capacity gap in respiratory sleep and diagnostic services which risks patients breaching Referral to	High (16) Care Group to consider whether can be downgraded (COO)	⟺	Moderate (9)	New procurement award for devices across 2 companies to mitigate lone company FSNs Person Responsible: General Manager Due: 25 Nov 2024

		Treatment (RTT), DMO1 and Cancer targets				Establish fully remote Continuous Positive Airway Pressure (CPAP) monitoring service to achieve discharge profile of 50% current WL. Funding for modems for home monitoring being explored. Person Responsible: General Manager Due: 25 Nov 2024 Programme Management Office (PMO) support for business case completion through efficiencies programme. It is primarily focused on the Respiratory Diagnostic services; Sleep Disordered Breathing- 'sleep service/ CPAP service', and Respiratory Physiology testing - 'lung function'. It also encompasses the domiciliary Non-Invasive Ventilation (NIV) service- 'NIV', which is not a diagnostic service but a large (separate) outpatient service that runs alongside the sleep service as there is much overlap of work, equipment and staffing. Person Responsible: General Manager Due: 26 Nov 2024

						Review options for localised Liver Function Tests (LFT) service at WHH with associated income and financial/performance trajectory-- staff, equipment and Consultant support Person Responsible: General Manager Due: 26 Nov 2024
1895	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment	High (16)	⟷	Moderate (9)	External review to be undertaken by Regional Advisor. Person Responsible: Chief Medical Officer Due: 20 Dec 24. **4 additional posts to be recruited to as part of vacancy factor. Interviewing on 3/9.** **Person Responsible: Consultant Radiologist** **Due: 30 Sept 2024** Waiting for 4 Radiologist to come into post following successful recruitment Community Diagnostic Centre (CDC) business case. Person Responsible: Consultant Radiologist Due: 31 Oct 2024

1628	Care Group – William Harvey **Accountable Executive: CNMO**	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the Royal College of Paediatrics and Child Health (RCPH) standards	High (16)	⟺	Low (4)	Advertise and recruit into Matron post. Interim in place in meantime. Person Responsible: Associate Director of Nursing Due: 2 Dec 2024 Medical staff to attend advanced training (Paediatric Immediate Life Support (PILS) then Advanced Paediatric Life Support (APLS)). Paediatric ED Consultant Leads in place for WHH and QEQM. All new doctors are booked for PILS and Registrars are expected to undertake APLs but this has been impacted due to Covid-19. April 2023 PILS training impacted by training staff shortages and lack of spaces to book. Person Responsible: Consultant Due: 31 Dec 2024
2234	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)	⟺	Moderate (8)	1.0 Whole Time Equivalent (WTE) histopathologist vacancies are being advertised on a rolling basis but are currently unsuccessful in recruitment. Alternative solutions being explored such

						as fixed term consultant staff on NHS pay rates via an agency and finders fee. Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 30 Nov 2024 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Person Responsible: Chief Medical Officer Due: 6 Jan 2025 Review a workforce/ workload points-based manager system to manage workload in line with RC Path Guidance. Person Responsible: Head Biomedical Scientist Cellular Pathology Due: 31 Mar 2025 Kent and Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance & resilience. Person Responsible: Head Biomedical

						Scientist Cellular Pathology Due: 30 Apr 2025
2899	Care Group – Women's Health **Accountable Executive: CMO**	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service	High (16)	⟺	Moderate (9)	Re-advertise for the 3 vacancies at QEQM. Post held off until after April so that the cohort who get their Certificate of Completion of Training (CCT) in October could apply Person Responsible: Consultant Due: 28 Mar 2025
3384	Corporate – Strategic Development & Capital Planning **Accountable Executive: CPSO**	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement	High (16)	⟺	Moderate (12)	Deliver the 2024/25 Capital programme as per the signed off plan Person Responsible: Director of Strategy & Business Development Due: 30 Apr 2025 **Progress to full business case for the replacement of maternity facilities at QEQM** **Person Responsible: Director of Strategy & Business Development** **Due: 31 October 2024** **Engage a partner through Procure 23 to undertake the production of an "estates master plan and development opportunities" document**

						Person Responsible: Director of Strategy & Business Development **Due: 31 October 2024**
2599	Corporate – Medical **Accountable Executive: CMO**	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)	⟺	Low (6)	**Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. Certificate of Eligibility of Specialist Registration (CESR))** **Person Responsible: Head of Medical Workforce** **Due: 2 Sept 2024** Review the consultant medical recruitment process – focussing on specialities (Health Care of Elderly People (HCOOP) first tranche) Person Responsible: Workforce Information & Rostering Project Lead Due: 30 Nov 2024
3700	Corporate – Finance & Performance Management **Accountable Executive: Chief Finance Officer (CFO)**	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners	Extreme (20)	⟺	Moderate (12)	Agreement of the Medium Term Financial Plan (MTFP) with Board, ICB & NHSE Person Responsible: CFO Due: 31 Dec 2024

3701	Corporate – Nursing **Accountable Executive: CNMO**	Staff may experience physical and psychological harm as they are frequently subjected to verbal and physical abuse from patients exhibiting challenging behaviours	High (16)	↔	Low (6)	Security service provision contract will form basis of specification for 2gether to tender the service. Service to be re-tendered, contract awarded and live by April 2025 Person Responsible: Associate Director of Safety Due: 01 Apr 2025 Liaising with KMPT to agree a tiered training approach to meet needs of all staff groups Person Responsible: Deputy Chief Nurse Due: 31 Jan 2025
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery (CCASS) **Accountable Executive: COO**	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)	↔	Moderate (8)	Work with site triumvirate on priority for critical care wardable patients to be discharged from Critical Care Person Responsible: Director of Nursing Due: 29 November 2024
3699	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Loss of blood and blood products impacting patient safety and significant financial loss, due to staff not being alerted to a temperature control failure following failure of the trust wide blood	High (15)	↔	Very Low (1)	Equipment has been delivered. Risk to be closed once operational and risk mitigated.

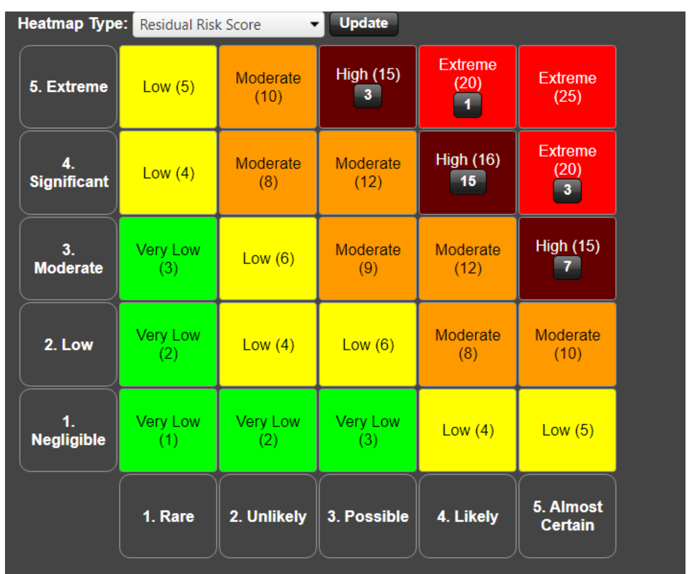
		transfusion laboratory remote temperature alert system				
1814	Corporate – Strategic Development & Capital Planning **Accountable Executive: CSPO**	Loss of access to key operational / clinical systems from threats (cyber, air con, break of external circuits, fire, floods etc) for a protracted period	High (15)	↔	Moderate (10)	No Actions
1350	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	↔	Very Low (3)	Run a table top exercise (with Emergency Preparedness, Resilience and Response (EPPR) team) to simulate robot failure and subsequent actions to inform contingency plans Person Responsible: Chief Pharmacy Technician Due: 30 Nov 2024 Replace robot. Present case for replacement to DCB finance and Performance meeting to get the case approved in advance of business planning and should capital become available in the interim

						Person Responsible: Chief Pharmacy Technician Due: 1 Jul 2025
3720	Care Group – Queen Elizabeth, The Queen Mother **Accountable Executive: CPSO**	Lack of Fire Door Compliance	High (16)	⟺	Low (6)	There is an Estates programme of work to replace the fire doors Person Responsible: Director of Nursing Due: 31 Dec 2024
3719	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	There is a risk of patient harm from availability, delays and errors in Systemic Anti-Cancer Therapy (SACT) prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent and Medway Cancer Collaborative (KMCC)	High (15)	⟺	Low (5)	**ARIA system failure to be included in local business plans** **Person Responsible: Clinical Matron** **Due: 31 Oct 2024** New E-prescribing system to be procured and implemented across the Cancer Alliance Person Responsible: Interim Head of Operations Due: 31 Mar 2025

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

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG		1			1
DCB CG	4	4	1		9
K&C CG	1				1
QEQM CG	1	3			4
WHH CG	1	3			4
WCYP CG		2	1		3

Corporate Medical	2				2
Corporate Nursing		1			1
Corporate Operations			1		1
Corporate Strategic Development	1	1			2
Corporate Finance			1		1
TOTAL	**10**	**15**	**4**	**0**	**29**
CHANGE SINCE OCT REPORT	**0**	**-2**	**0**	**0**	**-2**



4. Changes since the last report

4.1 New risks or escalations to the Significant Risk Report since last report

- No new risks or escalations. This in part due to the cancellation of the October Risk Review Group. A number of emerging risks will be reviewed at the meeting on 26 November 2024 and if approved will be open risks – and reported to CEMG and the appropriate subcommittee.

4.2 De-escalations from the Significant Risk Report

- Increased likelihood of potential radiation incidents and regulatory breaches leading to patient, staff and public harm, due to repeated postponement of TRAC meetings (risk ref: 2682). DCB Care Group. Risk reduced to a residual risk rating of 8 (Moderate) on 18/11/24 as TRAC meetings now established and 2x successful meetings have happened. Effectiveness to be reviewed and then potential closure.

4.3 Closure of risks

- There is a risk that patients will breach the 52 week wait standard for a maxillofacial first outpatient appointment due to an inability to recruit specialty doctors (risk ref: 3264). Risk closed on 06/11/24. Vacancies have been recruited into and first outpatient appointment waiting time reduced accordingly (currently 36 weeks).

5. Corporate Risk Management Infrastructure

5.1 The Head of Risk Management and Assurance has been successfully recruited to. Angela Callaghan will be joining the Trust on 25 November 2024. The Head of Risk Management and Assurance is also responsible for Policies (via the Policy Manager) and Clinical Guidelines and CAS Alerts (via the Clinical Guidelines and CAS Alerts Officer). Work priorities by the end of Q4 2425 will include a refresh of the Training Needs Analysis and introduction of an enhanced

training offer for risk, completion of actions from the last Risk audit and reviewing the Risk Tolerances with the Board.

5.2 Project planning for the implementation of InPhase continues. Risk is to be the first module rolled out with a planned go live date before the end of the December 2024 (although this is under review due to some delays from the provider). The rollout will require input and support from all Care Group and Corporate Leads to ensure the progress improving our recording and management of risks is maintained despite changes to the system. One of the significant benefits will be in the ability to report in an integrated way (as the system will also be used for incidents, policies, guidelines, CQC assurance, complaints, Pals, clinical audit and effectiveness and safeguarding). All modules should be rolled out by the end of March 2025.

6. Conclusion

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

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

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

Meeting dates: **8 October 2024 and 12 November 2024**

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

Paper Author: **Adaline Smith Deputy Director of Midwifery (DDoM)**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	**Summary**
Maternity and Neonatal Improvement Programme (MNIP) Update	In addition to workstream reviews at MNAG, programme Board meetings have now started with executive Senior Responsible Officers (SROs) holding workstream leads to account. At each MNAG meeting a detailed report was presented for each workstream highlighting progress made in month and any milestones that were off track against the year one trajectory. The reports and exceptions were approved by MNAG. **Workstream1: Developing a positive culture.** **Top 3 successes** NHS Annual Staff Survey Response rates Celebratory events and Awards /nominations Identification of critical posts for succession planning **Top 3 areas of concern** Quarterly survey results re: Health and wellbeing Complaints re communication from midwives Maternity Freedom to Speak Up Guardian (FTSUG) **Workstream 2: Developing and sustaining a culture of safety learning and support.**

	Top 3 successes Progression of Maternity Patient Safety Incident Response Framework (PSIRF) Plan Improved Q3 Stop the Clock results Sustained reduced stillbirth rates v 2010 rates **Top 3 areas of concern** A backlog of historical patient safety related activities Neonatal deaths (Including by Equality, Diversity and Inclusion (EDI)) and Hypoxic-ischaemic Encephalopathy (HIE) rates 'Off track' workstream tasks **Workstream 3: Clinical Pathways that underpin safe care.** **Top 3 successes** EMC Pathway launched 8 October 2024 Plans for launch of Diabetes care in pregnancy group Nationally comparable clinical outcomes **Top 3 areas of concern** Delayed Royal College of Obstetricians and Gynaecologists (RCOG) Team of the Shift (escalation framework) Postpartum Haemorrhage (PPH) PPH>=1500ml per 1000 higher than ntl and regional avg. Modified Early Warning Score (MEWS) completion and compliance **Workstream 4: Listening to and working with women and families with compassion.** **Top 3 successes** Launch of Perinatal Mental Health Service project group Progression of tackling health inequalities via EDI group Improved Your Voice is Heard (YVIH) results for October (Inc. Postnatal care) **Top 3 areas of concern** Neonatal deaths by ethnicity and Inherited Metabolic Diseases (IMD) 1 & 2 Friends and Family Test (FFT) response rate Embeddedness of intentional rounding tool **Workstream 5: Growing retaining and supporting our workforce.** **Top 3 successes** Identification of critical posts for succession planning Joint working with Staff Experience team (staff survey) Recognition and reward events **Top 3 areas of concern** Health Education England (HEE) Requirements Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) work pending

	Analysis of feedback from Stay /Exit Interviews **Workstream 6: Infrastructure and Digital.** **Top 3 successes** Completion of all Maternity Incentive Scheme (MIS) procurement milestones New birthing pool under construction in Room 2 (William Harvey Hospital (WHH) Midwifery Led Unit (MLU)) Clinical reviews of Phase 1 architect plans **Top 3 areas of concern** Non-compliance with environmental checks re: minor works Progression of E3 developments pending National Patient Safety Agency (NPSA) deadline CQC: Relocation of Twinkling Stars /2nd Obstetric theatre
Clinical Negligence Scheme for Trusts (CNST) Compliance **Obstetric Medical Workforce**	**November 2024:** Following last month's CNST Safety Action 4 report to MNAG, the paper concluded processes are in place to provide assurance against the 4 key outputs. In line with the Royal College of Obstetricians and Gynaecologists (RCOG) requirements all our long-term locums are up to date or are booked this month to be compliant against mandatory maternity training (Fetal Monitoring, Prompt and Resus). **Oct 2024**: CNST Safety Action 4 requires the Board to have oversight of obstetric medical workforce in relation to 4 key outputs: 1) The employment of short-term (2 weeks or less) locum doctors 2) The implementation of the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance 3) The implementation of RCOG guidance on compensatory rest where consultant sand senior Speciality and Specialist (SAS) doctors are working as non-resident on call out of hours and do not have sufficient rest to undertake their normal working duties the following day. 4) Trust / organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document "Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology" into their service. This paper confirms that in relation to these standards the Trust has not employed a short-term obstetric locum over the last year.

<table>
<tr><td></td><td>If there was a need to employ a short-term locum an up to date Standard Operating Procedure for this is on policy centre and includes the need for a certificate of eligibility as per the RCOG guidance.

Long-term locums all have a formal induction which is in line with the RCOG requirements. An audit of compliance is undertaken every 6 months.

The job plans for Consultants and SAS doctors are set up such that no clinical duties the day after our twilight / night on call are required. This can be evidenced by the medical rosters.</td></tr>
<tr><td>Avoiding Term Admissions into Neonatal Units (ATAIN)</td><td>2 Papers were presented at MNAG as a requirement of CNST Safety Action 3
Paper 1 informed MNAG of the quarterly review of all babies admitted to the Neonatal Unit (NNU) including data for pathways of care into transitional care with the focus on minimising separation of mothers and babies. In October 3.2% of babies born at term were admitted to NICU/SCBU against the national comparator of 4.5%. Adherence to the Bobble Hat pathway showed a decline in Q2 . This paper also contains an overarching action plan linked to transitional care.

Paper 2 supports the Quality Improvement (QI) project commenced following having review of all neonatal admissions, the team identified hypothermia as a main indication for term admissions. The aim of the QI project is to reduce neonatal admissions linked to hypothermia. A policy review has been undertaken and a number of initiatives implemented. A post implementation review is scheduled. The project has been shared with the Local Maternity and Neonatal System (LMNS) in line with CNST recommendations</td></tr>
<tr><td>Legal Claims</td><td>A report was brought to MNAG as a requirement for CNST Safety Action 9 where all Trusts are required to review their scorecards making this exercise meaningful to triangulate the data alongside historical claims, and any action taken then presenting these alongside current and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows the team to act quickly if any historical themes re-emerged.

<table><tr><th>Current Status</th><th>Volume</th><th>Comments</th></tr><tr><td>Open</td><td>42</td><td>• Incident date range – 2014 to 2022
• Creation date range - 2017 to 2024</td></tr><tr><td>Closed</td><td>73</td><td>• 43 settled with damages
• 30 nil damages</td></tr><tr><td>Total</td><td>115</td><td>• + 12 Incidents (Before Letter of Claim)</td></tr></table></td></tr>
</table>

Themes identified within incidents reported featured in open claims

Recognition and timely management of sepsis	Recognition and treatment of sepsis is a focussed QI project within the maternity PSIRP / MNIP , working in close collaboration with critical care /outreach team.
Wound infection	Surgical Site Infection is a focussed QI project within maternity PSRIP working collaboratively with IPC team.
Post partum Haemorrhage (PPH)	Identification and management of PPH is a focussed QI project within the maternity PSIRP / MNIP Upward trajectory of PPH >1500mls identified during Q2 – Deep dive review of these cases underway.
HIE (brain injury)	The service reported 5 neonatal cases to MNSI for investigation One draft report received in September for factual accuracy checking – No Safety recommendations The remaining 4 cases remain open MNSI investigations
Stillbirth /Neonatal death	The service notified MBRRACE of 11 cases that met criteria for review via PMRT during Q2. All cases that meet criteria are reviewed utilising the PMRT and learning shared with the wider maternity service team.

The themes identified within claims, incidents and complaints analysis are featured in the workstreams within the Maternity and Neonatal Improvement Programme and Patient Safety Incident Response QI plan.

Perinatal Mortality Review Tool (PMRT)

- The report confirms that during the Quarter 2 reporting period the service has used the tool to the required standard as set out in NHS Resolution, CNST Maternity Incentive Scheme Year 6.
- During Quarter 2, there have been a total of 8 cases reported. Of these 8 cases, 1 of the cases was not supported
- Of the 7 supported cases, 4 were neonatal deaths and 3 were still births/Intrauterine deaths (IUD'S).
- Within the last quarter the Trust reported all cases to MBRRACE within 7 days of the death, with surveillance being completed within one calendar month.
- Within the last quarter the Trust had a 100% compliance rate of commencing the review within the allocated time scales.
- There is a 100% compliance with external reviewers at PMRT meetings, however this is as a result of the bereavement and governance midwives from neighboring trusts supporting one another. The LMNS meet quarterly to discuss running themes and issues. The last meeting was on 24/06/2024. The next meeting is scheduled for 7 October 2024.
- The board generated report shows the cases that have published reviews within this quarter at the Multidisciplinary PMRT meeting. All cases are on schedule to be completed in the time frame and adhering to the time frames set by the national framework for PMRT reviews.

Following reviews of all deaths within the reporting period a comprehensive

	plan supports the actions identified.
Perinatal Quality Surveillance Tool (PQST) September 2024	September data: • Total Babies born in September 518. • There was 1 moderate incident reported for maternity during the month of September. • Supernumerary status compliance reported at 100% at WHH, 99.7% at Queen Elizabeth the Queen Mother Hospital (QEQM). An exception report was completed (embedded in PQST) On discussing this incident with the operational midwife, it was confirmed that the coordinator had maintained her supernumerary status throughout the shift. • Compliance of 1:1 in Labour was reported as 100% QEQM 100% at WHH. • Level 3 Safeguarding compliance as of the end of September has remained above the 90% threshold (92.9%). • Child protection level 3 compliance as of the end of September remains compliant at 96%. • 1 Maternity and Newborn Safety Investigation (MNSI) referral in September. • Mothers and Babies: Reducing through Audits and Confidential Enquiries across the UK (MBRRACE) neonatal deaths – 1 death reportable in September (38 weeks) External aggregated review of extreme pre-term birth in progress. • Update on progress with Care Quality Commission (CQC) action plan. • Maternity cover for Maternity and Neonatal Voices Partnership (MNVP) (Jasmine Bundock) has commenced in her role, handover and priorities shared. **Top 3 risks remain:** • Obstetric workforce at QEQM. • Theatre capacity at QEQM. • National alert regarding Euroking maternity information system. • Daily Sitrep continues oversight of any reported red flags, concerns escalated in the previous 24 hours, Governance, Safeguarding and Mental Health team now attend Sitrep daily. **Current PSII due for completion October 2024** • Missed or delayed combined screening in pregnancy. • New process implemented across service to enable timely blood sampling following first trimester Ultrasound Scan (USS). • Failsafe systems reviewed. • Reported externally to Public Health England (PHE).

	Patient Experience • Friends and Family (FFT) received 148 responses, which is an overall 8. %response rate. • YVIH Response rate Key Performance Indicator (KPI) - 70%. The service achieved a response rate of 81% (the team spoke to 392 families) this is an increase from August which was 78.5%. • Of the families that responded in September **89.4%** said they would return to East Kent for their maternity care this is a decrease from last month on 92.8%. • Ethnicity, Deprivation and EDI captured within the theming. • In examining the ethnicity response, there are good response rates from the global majority groups. • No guest questions this month or until the new year due to the team conducting the C-section Surgical Site Infection (SSI) discharge questions. • 141 staff complimentary emails sent. **Training and Education** • Training compliance for fetal monitoring remains above 90% for all staff groups and will continue to be above this 90% in October and November. • Practical Obstetric Multi-Professional Training (PROMPT) compliance for all staff groups with the exception of obstetric doctors and consultants is ≥90%. Obstetric doctors' compliance will be 95.2% by the end of November. • PROMPT compliance for Obstetric consultants will currently remain below 90% as there are 3 consultants that do not have a training date. To reach compliance of ≥90% by the end of November, 3 additional consultants need to be booked for and attend PROMPT training in November. • Maternity support workers currently sit just below compliance of 90% but the trajectory for October and November increases to 92.3%. • Newborn Life Support (NLS) compliance for Obstetric Consultants for September is 91.2% but this will fall to 88% in November as 4 consultants will be out of date with training. • NLS compliance for Obstetric doctors has been impacted by the trainee rotation however by the end of November the compliance will be 90.5%
Feedback from Board Level Safety Champions	Together with the Chief Executive Officer (CEO) both the Non-Executive Director (NED) for Maternity and the Executive Director (ED) for Maternity undertake regular walkabouts and listening events across the service. Feedback from the and October/November listening events was generally positive. The following issues were raised and have been/are being addressed:

<table>
<tr><td></td><td>
<table>
<tr><th>Safety Champions Feedback</th><th>Issues escalated</th><th>Actions</th></tr>
<tr><td>24/10;/2024 WHH /NICU
07/11/2024 WHH Folkstone
Walkaround with Safety Champion Stewart Baird and Sarah Hayes</td><td>Overall good visits - clean / tidy / records all up to date
1:1 with a member of the medical workforce

Please wit to be seated sign in different languages now in place to ensure women are checking in on arrival to Triage
Visibility of women/birthing people in waiting room</td><td>Stewart Baird to follow up with the obstetrician and feedback any areas for action with DOM /Clinical lead

Minor works submitted to replace studded wall with one way glass to allow visibility</td></tr>
</table>
</td></tr>
<tr><td>Matters to escalate to Quality & Safety Committee (Q&SC) and Board</td><td>1. Limited access to Freedom to Speak Up Guardian (FTSUG) owing to staffing constraints.
2. Positive feedback from Quality Assurance (QA) visit for Screening.
3. CNST, preparation for Local Maternity and Neonatal System (LMNS) peer review, challenge remains with Obstetric workforce training.
4. Impact of Estates on clinical care in relation to Triage.</td></tr>
</table>

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
MNAG asks the BoD to discuss and **NOTE** this MNAG Chair Assurance Report.	Assurance	5 December 2024
MNAG asks the BoD to approve the Obstetric Medical Workforce (CNST Safety Action 4) action plan in relation to the middle grades.	Approval	5 December 2024

REPORT TO BOARD OF DIRECTORS (BoD)

Report title:	**Care Quality Commission (CQC) Update Report**
Meeting date:	**5 December 2024**
Board sponsor:	**Chief Nursing and Midwifery Officer (CNMO)**
Paper Author:	**Head of Compliance and Assurance** **Associate Director of Quality Governance (on behalf of Director of Quality Governance)**

Appendices:

Appendix 1: Ward & Clinic Accreditation update

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-September to early November and includes: • summary of progress with the CQC self-assessment and check and challenge meeting programmes. Information is also attached in relation to the Ward & Clinic Accreditation programme – the vehicle for CQC assessment and improvement at ward/clinical level. • update on performance against the most recent CQC inspection reports (May and July 2023) published in December 2023. • update on performance against 'historical' open CQC action plans (2018, 2020 and 2021). • update on maternity Section 31 enforcement notice. • summary of CQC queries. • summary of recent engagement meeting with the CQC. • recent CQC publications.
Summary of key issues:	All Care Groups have now attended a CQC self-assessment check and challenge meeting and the process is being further developed for the next round of meetings. This includes consideration of the granularity of assessment (care group, speciality and or ward/clinic – using Ward and Clinic Accreditation as the vehicle for the latter), how we rate services (moving from 'met' or 'not met' to the CQC current ratings) and how we triangulate results and ensure our governance is improvement focused. Culture, staffing, environment, equipment and documentation were the most common identified areas of concern, and safe the lowest scoring domain (based on a rating of 'met' or 'not met' as a domain).

	Implementation of the InPhase CQC application over the coming months will improve visibility, reporting and efficiency of CQC self-assessment and action plan management. Closure of actions for the 2023 inspection action plans continues with an additional 6% of actions closed since the last Board report. 9% of overall actions (18 actions out of 206) remain open with further closures expected over the forthcoming reporting period. Some are still incomplete post their extended due dates and are with the relevant executive director for decision on next steps. The well led plan is included within these figures: there are 3 actions outstanding. The monthly submissions of the Section 31 return for Maternity were sent on 1 October and 1 November 2024. CQC queries have continued at a slightly increased level and responses have been submitted on time. The CQC has recently reverted to their previous engagement and inspector model and an engagement meeting was held on 4 November 2024 using their new agenda format. Meetings will now be bi-monthly for 1.5 hours with the next meeting on 16 January 2025.
Key recommendations:	The Board of Directors is asked to receive and **NOTE** the report and the assurance provided in relation to progress with inspection action plans, query management, and the CQC self-assessment and check and challenge meeting programme.

Implications:

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

Assurance route:

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

Care Quality Commission (CQC) Update Report

1. Purpose of the report

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

- summary of progress with the CQC self-assessment and check and challenge meeting programmes;
- update on performance against the most recent CQC inspection reports (May and July 23) published in December 23;
- update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
- update on maternity Section 31 enforcement notice;
- summary of CQC queries;
- summary of recent engagement meeting with the CQC;
- recent CQC publications.

2. Background

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

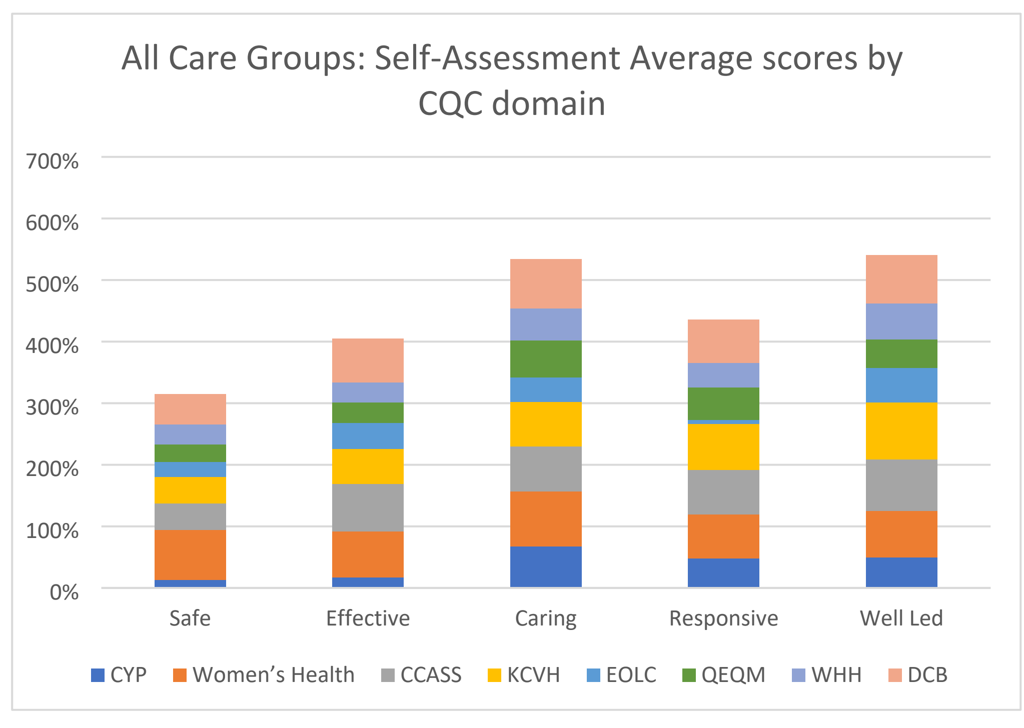
3. CQC Self-Assessment Programme and Check and Challenge Meetings

3.1 The CQC self-assessment check and challenge meetings, chaired by the CNMO, and attended by the Chief Medical Officer (CMO), Chief Operating Officer (COO), Director of Quality Governance (DQG), Associate Director of Quality Governance and members of each Care Group's leadership team, commenced in May 2024.

The percentage of Quality Statements rated as fully met within their self-assessments is shown in the table below. It should be noted that the assessment only allowed the answers 'met' or 'not met'.

Date of meeting	No of assessments completed	Percentage of Quality Statements rated as fully met					
			Safe	Effective	Caring	Responsive	Well Led
23.05.24	3	Children & Young People (CYP)	13%	17%	67%	48%	50%

09.07.24	2	Women's Health	81%	75%	90%	71%	75%
23.05.24	14	Critical Care, Anaesthetics & Specialist Surgery (CCASS)	43%	77%	73%	73%	84%
23.07.24	17	Kent & Canterbury Hospital/ Victoria Hospital (KCVH)	43%	57%	72%	74%	92%
14.08.24	2	End of Life Care (EOLC)	25%	42%	40%	7%	56%
11.09.24	4	QEQM	28%	33%	60%	53%	47%
18.09.24	5	WHH	33%	33%	52%	40%	58%
07.10.24	17	Diagnostics, Cancer & Buckland (DCB)	49%	71%	80%	70%	78%



3.2 Care Group leadership teams identified their top five areas for improvement and celebration and shared these at the meetings. These have been analysed and the following five areas identified as the most commonly occurring areas for improvement across the Care Groups:

- Staffing
- Culture
- Environment and facilities
- Equipment
- Documentation

Next steps

3.3 A review of the CQC self-assessment and check and challenge meeting processes is underway to establish what has worked well and what could be improved. Views from everyone involved in the process will be sought.

3.4 The CQC application on the Trust's new InPhase information system will be implemented over the coming months; self-assessments will be completed on this system after it has been piloted and implemented. This will enable improved visibility of current status, reporting, action plan management and evidence collation functionality.

3.5 As part of the InPhase implementation, a decision will be made regarding the level at which every self-assessment should be undertaken to ensure consistency across the Trust. In this first wave of assessments the granularity varied – with some undertaken at service, speciality, care group or site level. It is agreed that consistency is needed and a decision will be made on how the ratings are represented.

3.6 Ward accreditation is a vital delivery model of CQC self-assessment and improvement at ward level. See Appendix 1 for further information. The Compliance and Assurance team support the visit programme and are members of the Ward Accreditation Steering Group.

3.7 CCASS are the next Care Group to present and the first Care Group to present for the second time; they have been asked to review and update their self-assessments and action plans for their second check and challenge meeting on 20 November 2024.

4. Update on performance against the most recent 2023 CQC inspection report

4.1. The most recent inspections at the Trust took place in May 2023 (medical care, children and young people and urgent and emergency care at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM)) and July 2023 (well led). The resulting inspection report was published in January 2024 and an action plan was developed by each Care Group/speciality. These action plans have been monitored on a monthly basis at Inspection Action Plan Review Groups for each action plan, chaired by the Compliance and Assurance Team, and attended by speciality leads. The following action plans are in place:

- 2gether action plan
- CYP action plan
- DCB action plan
- QEQM GM action plan
- QEQM UEC action plan
- WHH GM action plan
- WHH UEC action plan
- Well Led action plan
- Corporate Nursing/Medical/Operations action plan

4.2. Monthly reports showing progress and status of each action plan have been provided to the CQC Oversight and Assurance Group (CQC O&AG) and on to the Regulatory Oversight Group (ROG) and Quality and Safety Committee since the plans' commencement in January 2024.

4.3. This report includes the current status of the must and should do requirements, and how many associated actions remain open. It shows the status at 29 October 2024, as reported to CQC O&AG.

4.4. Statutory and mandatory training for doctors had an extended target date of 30 September 2024, as agreed by the CMO. This target has not been met and the CMO has been informed. Discussions are in place about the actions required to recover this position.

4.5. There are nine Must Do (out of 28) and four Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans or on two sites). The number of open actions related to each Must and Should Do is shown in the table below. There is a total of 18 out of 206 (9%) actions open across all action plans, compared to 32 (15%) open actions at the time of the September 2024 report.

4.6. Of these 18 open actions:

- Six relate to training, mostly for medical staff. A six-month extension to 30 September 2024 was agreed for medics to achieve the compliance rates seen across nursing, midwifery, allied health professionals and clerical and managerial groupings. This has not been met and the CMO has been asked to advise of next steps.

- Six actions relate to trust-wide Standard Operating Procedures (SOPs) and subsequent implementation, relating to escalation areas, corridor care and 24-hour plus patients. These were expected to be finalised by 30 October and this has been delayed. They are expected to be approved by 30 November 2024.

- Three actions relate to staffing (Allied Health Professionals (AHPs) and pharmacy):

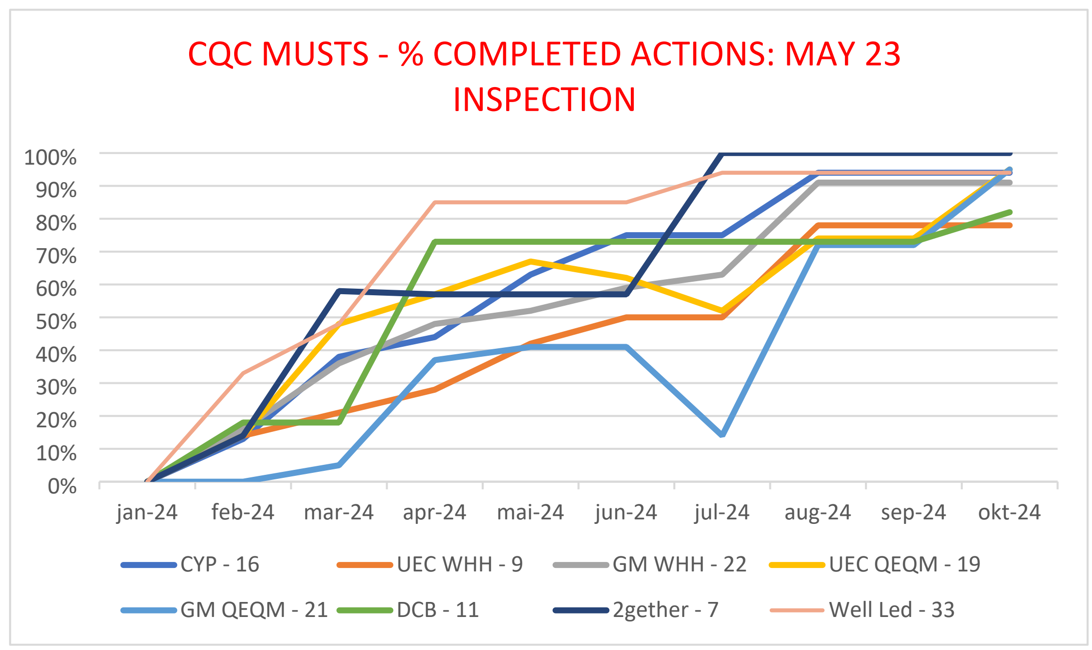
- Pharmacy: The business case for pharmacy has been approved by the care group, reviewed by the deputy head of finance and is now with the executive team. Due date of 31 December 2024.

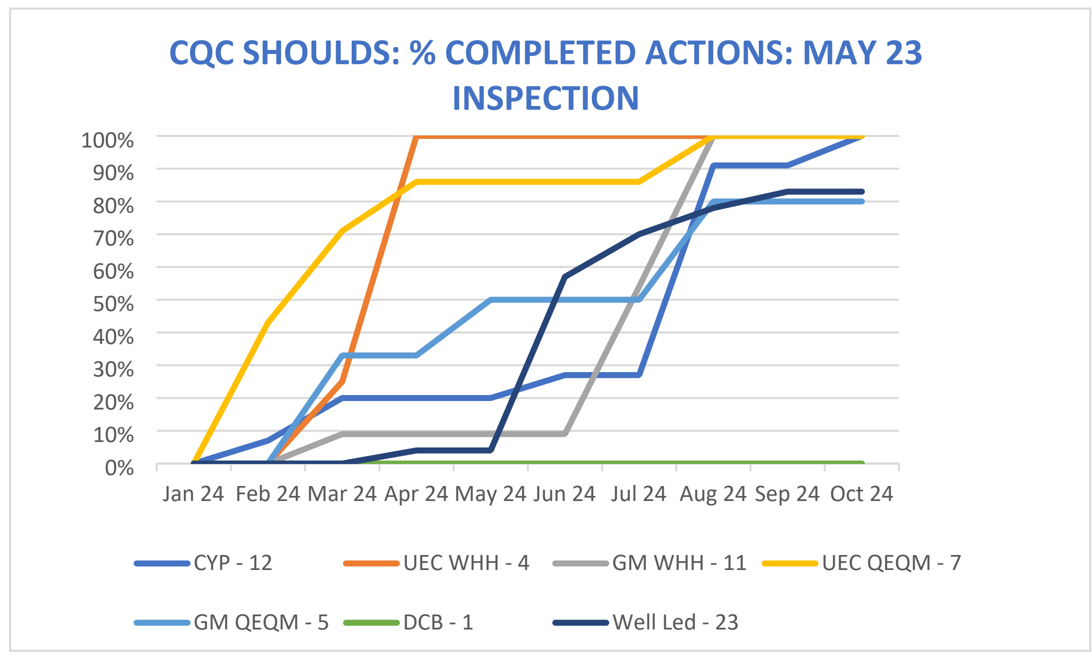
- AHPs: The Deputy Chief AHP will be supporting the Operations Director DCB and therapy services to review the therapy inpatient provision. Within WHH, a new therapy delivery model has commenced with inpatient therapists allocated to each ward. This development work will continue with a focus on QEQM, front door and associated workforce. This work will be reported and reviewed through the DCB care group and an appropriate strategic group. Due date of 31 December 2024.

- Three actions on the well led plan relate to Freedom to Speak Up (FTSU) and operationalisation and continuation of work of people in interim roles – see update in section 5 below.

OPEN REQUIREMENTS AND ACTIONS

Action plan	Open Must Do Requirements	Open Should Do Requirements	Total number of actions on plan	Number of open actions (29/10/24)
Well led	0 of 4 (0%)	3 of 8 (38%)	56	3
2gether	0 of 4 (0%)	N/A	7	0
QEQM UEAM	1 of 6 (17%)	0 of 3 (0%)	26	1
QEQM GM	1 of 7 (7%)	1 of 5 (20%)	26	2
WHH GM	2 of 8 (25%)	0 of 4 (0%)	33	2
WHH UEAM	2 of 4 (50%)	0 of 2 (0%)	13	2
WCYP	1 of 11 (9%)	0 of 9 (0%)	28	1
DCB	1 of 11 (9%)	1 of 1 (100%)	12	3
Corporate	3 of 4 (75%)	1 of 1 (100%)	5	4
TOTAL			**206**	**18 (9%)**





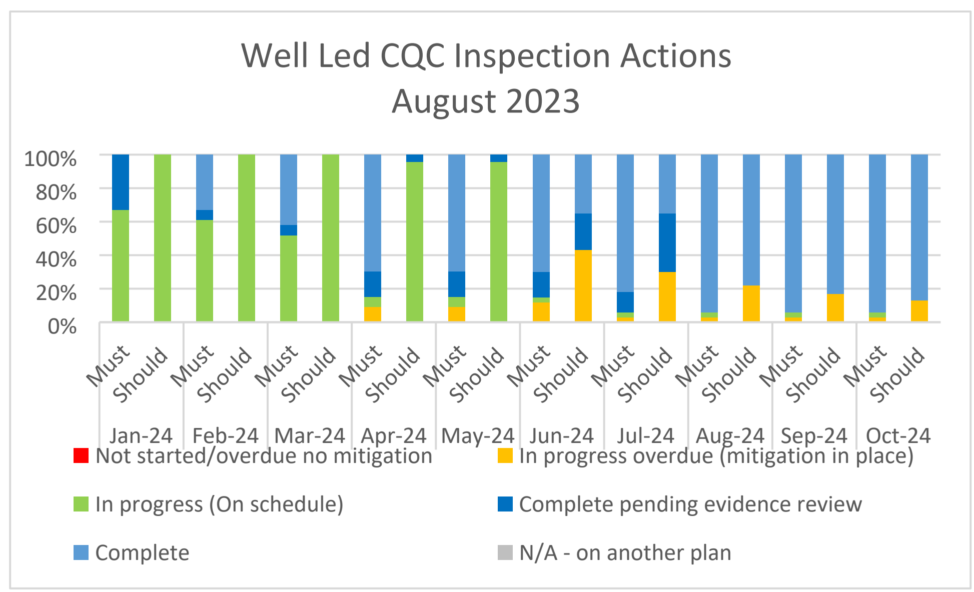
5. Well Led inspection report

5.4. There are four must do requirements comprising of 33 actions. All four requirements have been closed.

5.5. There are eight should do requirements comprising of 23 actions. Two should do requirements remain open with three associated actions yet to be completed; each of these is overdue beyond its extended due date.

5.6. The two should do requirements with three overdue actions that remain open on the plan are with the Chief People Officer for confirmation of next steps:

- **SD24: The leadership team should consider how future leaders operationalise the vision and support continuation of work introduced by people in current interim roles.**
  - Develop a suite of tools to enable effective handovers when leaders leave their role (People & Culture) – due 01/10/24.
- **SD25: The Trust should ensure the Freedom to Speak Up processes are sufficiently resourced to support staff to raise concerns.**
  - Improve FTSU resources and accessibility for staff by promoting via improved communications channels (People & Culture) – due 31/07/24.
  - Development of Trust-wide Key Performance Indicators (KPIs) and dashboard on speaking up (People and Culture) – due 31/07/24.



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

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

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

CG and Speciality	Requirement	Status
WHH UEC 2020	MD01.UEC.WHH The trust must ensure staff complete their mandatory training and each module meets their compliance	Data 30.10.24: **Medical:** Statutory compliance 72% (target 91%)

CG and Speciality	Requirement	Status
	targets, including; Mental Capacity Act training, life support training, and dementia training. (Also on May 2023 action plan) MD28.UEC.QEQM&WHH.2023 The service must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.	8 of 9 courses below Trust target. Mandatory compliance 69% (target 85%) 9 of 11 courses below Trust target.
WHH UEC 2020	SD05.UEC.WHH The trust should ensure all staff have access to the training needed for their role including advanced life support.	Data 31.10.24 **Nursing:** Resuscitation level 2 adult: 86% Resuscitation level 3 adult: 80% Resuscitation level 3 paeds: 72% **Medical:** Resuscitation level 2 adult: 72% Resuscitation level 2 paeds (PHLS): 72% (target for all 85%)
WHH GM 2021	SD02.MED.K&C & WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Portal data 31.10.24 **Medical** Statutory compliance – 77.5% (target 91%) 8 of 9 courses below Trust target Mandatory compliance – 63.2% (target 85%) 9 of 9 courses below Trust target.
KCH GM 2021	SD02.MED.K&C & WHH.2021 The trust should ensure that all staff complete their mandatory training. (Also on May 2023 action plan)	Data 31.10.24 **Medical** Statutory compliance – 75% (target 91%) 8 of 8 courses below Trust target Mandatory compliance – 64.1% (target 85%) 10 of 10 courses below Trust target.
WHH UEC 2020	MD16.UEC. WHH The trust must ensure critical fluids and medicines are administered and recorded in a timely manner.	AD Quality Governance is meeting with CMO in November 2024 to discuss evidence required for closure.
QEQM UEC 2020	MD01.UEC.WHH The trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. Also on 2023 action plan MD28.UEC.QEQM & WHH.2023 The service must ensure medical and nursing	Data 31.10.24 **Medical** Statutory compliance 91% (Target 91%) 4 of 9 courses are below the Trust target. Mandatory compliance 78% (Target 85%) 4 of 11 courses are below the Trust target.

CG and Speciality	Requirement	Status
	staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.	
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH The trust should ensure medicines reconciliation is undertaken in a timely manner	AD Quality Governance is meeting with CMO in November 2024 to discuss evidence required for closure.
QEQM UEC 2020 S29a	SD01.UEC.QEQM & WHH (2020) The trust should consider how to recruit a full establishment of emergency department consultants and SD02.UEC.QEQM (2021) The trust SHOULD meet the Royal College of Emergency Medicine requirements for the number of consultants employed within the department.	Increase to 8 Whole Time Equivalent (WTE) consultants. Paediatric Emergency Medicine (PEM) Consultant recruited to and started in post. Risk downgraded on risk register.
End of Life Care (EOLC) 2018	MD37 Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).	Deputy CMO is co-chairing a task and finish group with the Trust Mental Capacity Act (MCA) Lead to address the issues identified. Awaiting confirmation that actions are in place to be managed by task and finish group.

7. Update on Maternity Section 31 Enforcement and January 2023 Inspection Action Plan

7.4. The Trust submitted the monthly Section 31 notice requirement for Maternity on 1 October and 1 November 2024. There are now only 2 must do requirements that remain open, relating to staffing and estate. This was discussed with the CQC at the engagement meeting with the CNMO on 4 November, and the CQC are considering the frequency of reporting.

8. CQC Queries Update

8.4. There were 26 queries received from the CQC during September and October 2024, which is an increase of six in comparison to the previous two months. During that period, 25 were fully responded to, the others remained ongoing. 10 of these queries had deadlines set by the CQC, nine of which were met with one requiring an extension of a day.

8.5. At the end of October, 14 query responses remained open.

8.6. On a bi-annual basis the CQC Oversight and Assurance Group receive a report detailing themes from the enquiries to ensure solutions are put in place Trust wide as required.

9. CQC Engagement

9.4. An engagement meeting was held between the CQC, CNMO, Director of Quality Governance, Associate Director of Quality Governance and Head of Compliance and Assurance on 4 November 2024. This was the first meeting since May 2024, with our new inspection team in attendance, using the CQC's revised engagement framework.

9.5. A broad agenda was shared by the CQC ahead of the meeting and a slide pack containing updates on the ward accreditation programme, safeguarding, serious incidents, staffing, patient flow, discharges, electives, endoscopy, clinical audit, training, risk, staff engagement, board changes, areas of media interest, cardiology and respiratory services, and maternity was shared by the CNMO during the meeting.

9.6. Meetings will now be bi-monthly for 1.5 hours with the next meeting scheduled for 16 January 2025.

10. CQC publications

10.4. The CQC have shared the following publications during September and October 2024. These updates have been shared at the CQC Oversight and Assurance Group, Regulatory Oversight Group and Quality and Safety Committee.

- The safer management of controlled drugs: Annual update 2023 Published: 11 July 2024 The safer management of controlled drugs: Annual update 2023 - Care Quality Commission (cqc.org.uk)
- Response to the interim findings of the Dash review into CQC's operational effectiveness Published: 26 July 2024 Response to the interim findings of the Dash review into CQC's operational effectiveness - Care Quality Commission
- A message from Kate Terroni, Interim Chief Executive, CQC A message from Kate Terroni, Interim Chief Executive, CQC (govdelivery.com)
- Working with National Voices and the Point of Care Foundation on Regulators' Pioneer Fund project Published: 20 February 2024 Working with National Voices and the Point of Care Foundation on Regulators' Pioneer Fund project - Care Quality Commission (cqc.org.uk)
- CQC Annual report and accounts Published: 30 July 2024 Annual report and accounts 2022/23 - Care Quality Commission (cqc.org.uk)
- New resource aimed at encouraging improvement in NHS maternity services Published: 19 September 2024 New resource aimed at encouraging improvement in NHS maternity services - Care Quality Commission
- National review of maternity services in England 2022 to 2024 Published: 19 September 2024 National review of maternity services in England 2022 to 2024 - Care Quality Commission

- Developing an engagement and health inequalities improvement framework for integrated care systems: progress update Published: 25 September 2024 Developing an engagement and health inequalities improvement framework for integrated care systems: progress update - Care Quality Commission
- CQC reports on safe use of radiation in healthcare settings Published: 26 September 2024 CQC reports on safe use of radiation in healthcare settings - Care Quality Commission
- Sir Julian Hartley will be appointed as CQC's new Chief Executive Published: 7 October 2024 Sir Julian Hartley will be appointed as CQC's new Chief Executive - Care Quality Commission
- Re-building a trusted approach to our regulation Published: 3 October 2024 Re-building a trusted approach to our regulation - Care Quality Commission
- Review of CQC's single assessment framework and its implementation Professor Sir Mike Richards report Published: 15 October 2024 Review of CQC's single assessment framework and its implementation - Care Quality Commission
- CQC responds to reviews by Dr Penny Dash and Professor Sir Mike Richards Published: 15 October 2024 CQC responds to reviews by Dr Penny Dash and Professor Sir Mike Richards - Care Quality Commission
- Kate Terroni to leave CQC Published: 22 October 2024 Kate Terroni to leave CQC - Care Quality Commission

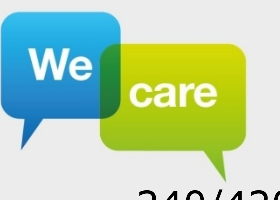
11. Conclusion

11.1 The Board of Directors is asked to receive the attached report and the assurance provided by the closures from CQC inspection action plans since the last report, and the focussed attention being placed on closing these. 9% of actions now remain open, an improvement of 6% since the last report. Some are still incomplete post their extended due dates and are with the relevant executive director for decision on next steps.

11.2 The Board has been provided with information about the Check and Challenge meetings, and the output from these with culture, staffing, environment, equipment and documentation the commonest identified areas of concern, and safe the lowest scoring domain. All Care Groups have now attended a Check and Challenge meeting and the process is being further developed for the next round of meetings.

11.3 The CQC has recently reverted to their previous engagement and inspector model and an engagement meeting was held on 4 November 2024 using their new agenda format. Meetings will now be bi-monthly for 1.5 hours with the next meeting on 16 January 2025.

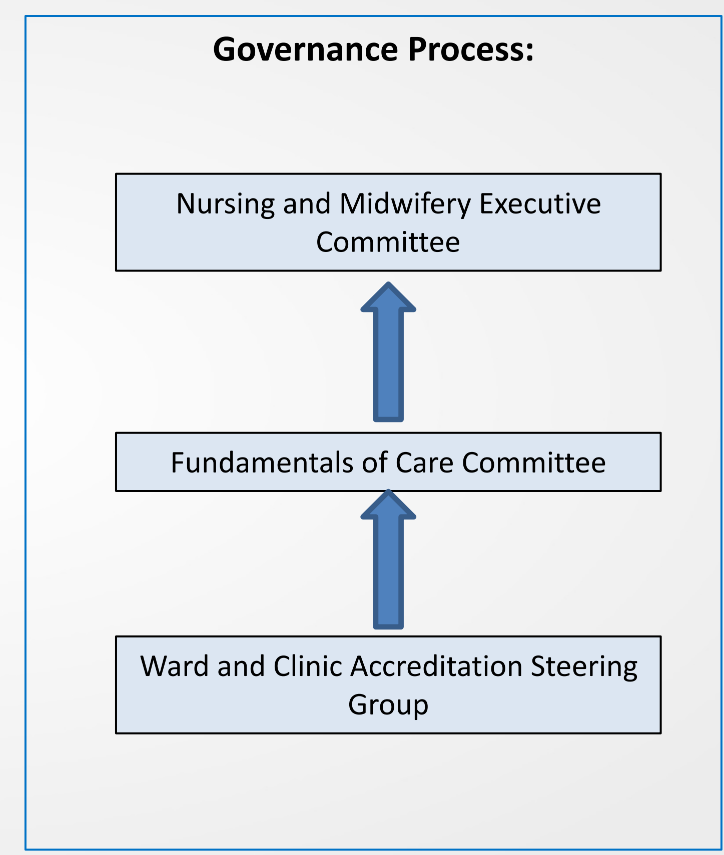
Ward & Clinic Accreditation Update Report

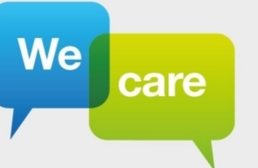


EKHUFT Journey

Background:

- Currently in year 2 of the Ward Accreditation process.
- A strengthened tool has been utilised for 2024.
- A Ward and Clinic Accreditation Steering Group has been developed to strengthen the governance.
- A study day has been held for Ward and Dept Champions.
- Currently consulting on mandatory questions to ensure they are safety critical.
- A Gold ward must have a subsequent 'sense check visit' to ensure sustainability of standards prior to achieving award.
- Increased numbers of staff undertaking peer accreditation.
- Tendable Platform under review.





The Accreditation Process

Framework aligned with Trust, national & Care Quality Commission (CQC) standards. 13 sections:

- Safe ward and environment
- Safe and effective workforce
- Patient experience
- Sepsis and deteriorating patient
- Infection prevention and control
- Tissue viability and pressure ulcers
- Medications safety
- Safeguarding
- Nutrition and oral hygiene
- Falls prevention
- Governance, risk and incident management
- Quality improvement and innovation
- Culture and leadership

All questions are available for all staff to review on the Staff Zone.

The day prior to the accreditation visit, data is pulled relating to datix incidents, complaints, online completion of documentation.

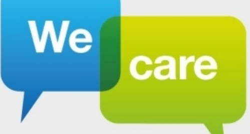
On the day;

- 1 member of W&CA team co-ordinating all day.

Rest of team staggered throughout the day:

- 1x Director of Nursing (DoN)/Associate DoN (ADoN)
- 1x Infection, Prevention and Control (IPC)
- 1x specialist nurse
- 1x member of Patient Voice Team
- Peer reviewers

Grade Metrics	Percentage range
Gold	Score of 90% or more AND all questions above 60%
Silver	Score of >75% AND all mandatory questions above 60%
Bronze	Score of >60% AND all mandatory questions above 60%
White (Requires immediate improvement)	Score less than 60% OR mandatory questions not met



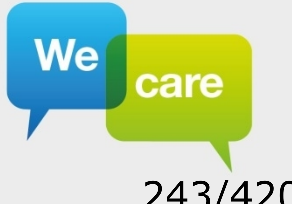
Accreditation Results for 2024 to date.

Queen Elizabeth the Queen Mother Site				
Ward/Area	Annual Accreditation grade	First Reassessment grade	Second Reassessment grade	Third Reassessmen t grade
Critical Care	Silver (78%)			
CSM	White (75%)	Planned		
Birchington	White (41%)	Bronze (79%)		
ED	White (54%)	Bronze (76%)		
Rainbow	White (76%)	Bronze (76%)		
SCBU	White (75%)	Bronze (75%)		
AMU B	White (70%)	Bronze (70%)		
Kingsgate	White (69%)	Bronze (69%)		
AMU A	White (64%)	Bronze (64%)		
St Margarets	White (67%)	Planned		
St Augustines	White (50%)	White (68%)	Bronze (68%)	
Quex	White (48%)	White (69%)	Planned	
Fordwich	White (61%)	White (61%)	Planned	
Deal	White (57%)	White (66%)	Planned	
Seabathing	White (57%)	White (65%)	White (65%)	Planned

Kent and Canterbury Site				
Ward/Area	Annual Accreditation grade	First Reassessment grade	Second Reassessment grade	Third Reassessment grade
Critical Care	Silver (91%)			
Invicta	White (83%)	Bronze (83%)		
EKNR	White (68%)	Bronze (68%)		
Kingston	White (61%)	Bronze (61%)		
Mt/McMaster	White (56%)	White (75%)	Bronze (68%)	
Kent	White (60%)	White (60%)	Planned	
Brabourne	White (69%)	White (69%)	Planned	
Clarke	White (59%)	White (68%)	White (68%)	Planned
Marlowe	White (41%)	White (65%)	White (65%)	Planned
Harbledown	White (55%)	White (60%)	White (60%)	Planned

William Harvey Site				
Ward/Area	Annual Accreditation grade	First Reassessment grade	Second Reassessment grade	Third Reassessm ent grade
Channel Day	White (73%)	Planned		
Kings C2	White (55%)	Bronze (73%)		
ED	White (43%)	Bronze (71%)		
NICU	White (67%)	Bronze (67%)		
Critical Care	White (67%)	Bronze (67%)		
Padua	White (66%)	Bronze (66%)		
Kings A2	White (62%)	Bronze (62%)		
Cambridge J1	White (65%)	Bronze (65%)		
Cambridge J2	White (54%)	White (76%)	Bronze (76%)	
Kings D F	White (68%)	White (68%)	Bronze(68%)	
Folkestone	White (56%)	White (64%)	Bronze (64%)	
AMU	White (41%)	White (61%)	Bronze (61%)	
Kings C1	White (57%)	White (74%)	Planned	
Cambridge L	White (63%)	White (63%)	Planned	
Kings D M	White (77%)	White (77%)	Planned	
Kings B	White (65%)	White (65%)	White (65%)	Planned

- Wards/Depts achieve White if the mandatory questions aren't achieved.
- Wards/Depts achieve White if the overall score is <60%.
- If a reassessment is necessary, the maximum final award is Bronze, irrespective of % achieved.



Themes from Accreditation

Highest Scoring Questions		
Question Text	**Category Name**	**Answer score (%)**
Is Safeguarding training up to date for staff?	Safeguarding	98
Appropriate PPE is available for all infectious diseases?	Infection Prevention and Control	97
Have you been treated with dignity and respect within this ward / department?	Patient experience	96
Do you routinely check patients' NEWS/PEWS/MEOW scores at the beginning of each shift to highlight those at risk of deterioration?	Sepsis and Deteriorating patient	96
Has the ward had any Never Events in the last 12 months	Governance, Risk and Incident Management	95

Lowest Scoring Questions		
Question Text	**Category Name**	**Answer score (%)**
Have you been asked since admission if you have any religious, spiritual or emotional needs?	Patient experience	15
Have any abnormalities in lying and standing blood pressure been acted upon?	Falls Prevention	19
Is the bed rail risk assessment reassessed daily, and/or upon clinical change, transfer or post fall?	Falls Prevention	21
Are any computers left unlocked and unattended?	Governance, Risk and Incident Management	22
Are there any potential information governance breaches within the ward?	Governance, Risk and Incident Management	22

Actions:

- Individual wards develop targeted action plans for their area.
- Trust-wide themes are shared with Subject Matter Expert Leads for more comprehensive review.

Outcomes

Achievements:

- Ward and Clinic Accreditation is embedded in the organisational culture.
- All wards were accredited 2022/23.
- All wards will have been reaccredited in 2024.
- All wards will have achieved Bronze or above by January 2025.
- Increasing numbers of nursing and multidisciplinary staff involved as accreditors.
- Multiple celebratory events at certificate presentation, shared widely on social media.

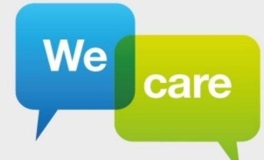
Impact:

- Assurance is provided from ward to board about consistency in quality of care.
- Patients and public are able to see certificates of grades on wards.
- Staff feel deflated by a White grade.
- Staff feel deflated by repeated reassessments.
- Staff are elated when they achieve all mandatory criteria and are awarded a Bronze.
- Healthy competition and sharing of action plans has resulted in improvements.
- Most wards are aiming for Silver or Gold next year!

Plans:

- To review and consult on whole tool via the steering Group.
- To review and consult on reaccreditation timescales depending on grades.
- To review the Digital Platform as Tendable contract ends in January 2025
- To continue to strengthen multidisciplinary involvement.
- To develop accreditation into the outpatient depts.
- T re each ward displays framed results for all to se

To support an area to achieve GOLD!



REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) Action Plans**

Meeting date: **5 December 2024**

Board sponsor: **Interim Chief People Officer (CPO)**

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

Appendices:

Appendix 1: WRES Action Plan
Appendix 2: WDES Action Plan

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	To present WRES and WDES action plans for discussion and assurance.
Summary of key issues:	Since 2019 all NHS organisations have been required to demonstrate how they are addressing race equality issues in a range of staffing areas through the Workforce Race Equality Standard (WRES). WRES is a set of nine specific measures (indicators) which enables NHS organisations to compare the workplace and career experiences of staff from BAME backgrounds from white backgrounds. Similarly, all NHS organisations have been required to demonstrate how they are addressing disability equality issues in a range of staffing areas through the Workforce Disability Equality Standard (WDES). The WDES is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. EKHUFT uses the metrics data to develop and publish an action plan, building on the 6 high impact actions shared in NHS England's (NHSE) Equality, Diversity and Inclusion (EDI) improvement plan. EKHUFT's data shows that BAME staff have poorer experiences compared to their white counterparts including bullying, harassment and less progression. Please see the respective WRES and WDES sections of the 2024/2025 EDI annual report for details via this link: Equality, diversity and inclusion (EDI). We present the Trust's Actions Plans in this area.

<table>
<tr><td></td><td>The focus of the Action Plans is to address the areas we have recognised as falling short. A snapshot is provided below:

Workforce Race Equality Standards report

➢ Data shows that 28.91% of EKHUFT staff are from a Black, Asian and Minority Ethnic (BAME) background, this is a 4% increase from 2023 and is predominately made up of our valuable internationally recruited staff. This representation is higher than the 2023 NHS national average of 26.4%.
➢ There are some small increases in numbers of BAME staff in band 7 plus clinical roles since 2023.
➢ White applicants are 3.57 times more likely to be appointed from shortlisting than BAME applicants. This is an improvement of 0.74 from 2023.
➢ Data shows that BAME staff are 3.42 more times likely to enter the formal disciplinary process that white staff. This is a worsening of 2.64 from 2023.
➢ BAME staff are 0.78 times more likely to access non-mandatory training and continuing professional development (CPD) in comparison to white staff. This is due to an increase of staff from BAME backgrounds accessing training and CPD and is an improvement from 2023.

Workforce Disability Equality Standards report

➢ Data shows 5.43% of staff with a disability in the workforce. EKHUFT is above the national average (4.9%) for overall headcount at 5.43% for disabled staff. There has been some increase in bands 7 and above, some due to increase in declaration rates. More work around declaration needed.
➢ 20.4% of disabled staff experienced harassment, bullying or abuse from managers in the last 12 months (Metric 4b).
➢ Non-disabled staff were 0.49 times more likely to be appointed from shortlisting (interview) compared to disabled staff across all posts. This is below the national benchmark.
➢ 47.2% of disabled staff believe that their organisation provides equal opportunities for career progression or promotion.
➢ 73.4% of disabled staff said that their employer had made adequate adjustments to enable them to carry out their work.
➢ 30.8% of disabled staff felt pressure from their manager to come to work despite not feeling well enough.</td></tr>
<tr><td>Key recommendations:</td><td>The Board of Directors is asked to NOTE the Action Plans for assurance.</td></tr>
</table>

Implications:

Links to 'We Care' Strategic Objectives:	This report aims to support the following 'We care' Strategic Objectives; • Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Trust Risk Register:	**CRR 118:** There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	Y - Trust needs to comply with the Equality Act 2010.
Subsidiary:	N

Assurance route:

Previously considered by: Clinical Executive Management Group (CEMG) on 16/10/2024, and People and Culture Committee on 27/11/2024.

East Kent Hospital University Foundation Trust's (EKHUFT) Workforce Race Equality Standard (WRES) Action Plan 2024/2025

Since 2019 all NHS organisations have been required to demonstrate how they are addressing race equality issues in a range of staffing areas through the Workforce Race Equality Standard (WRES).

WRES is a set of nine specific measures (indicators) which enables NHS organisations to compare the workplace and career experiences of staff from BAME backgrounds from white backgrounds.
EKHUFT uses the metrics data to develop and publish an action plan, building on the 6 high impact actions shared in NHS England's (NHSE) Equality, Diversity and Inclusion (EDI) improvement plan. EKHUFT's data shows that BAME staff have poorer experiences compared to their white counterparts including bullying, harassment and less progression. Please see the WRES section of the 2024/2025 EDI annual report for details via this link: Equality, diversity and inclusion (EDI).

A note on language: in the pursuit of equality, diversity and inclusion, language is powerful and can help to shift attitudes and behaviours. This document acknowledges that some definitions and terminology do not always reflect the identities or lived experience of individuals. The term 'Black, Asian and Minority Ethnic (BAME)' is used in accordance with NHSE guidance.

Our aim at EKHUFT is to become a truly inclusive organisation that eliminates the conditions where discrimination occurs

This includes supporting our valuable staff from BAME backgrounds

Create an environment in which staff from BAME backgrounds feel like they **belong** in the organisation

WRES Action Plan Objectives

Improve race related **equality, diversity, and inclusion** at EKHUFT

Ensure staff from BAME backgrounds have a **better experience** at work

WRES Measures (Indicators)
1. Percentage of BAME staff in each of the Agenda for Change pay Bands (AfC) 1-9 and Very Senior Managers (VSM) including executive Board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.
3. Relative likelihood of BAME staff entering the formal disciplinary process compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of BAME staff accessing non-mandatory training and continuing professional development compared to white staff.
5. Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
6. BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months.
7. BAME staff believing the trust provides equal opportunities for career progression or promotion.
8. Staff who have, in the last 12 months, personally experienced discrimination at work from any of the following - manager / team leader or other colleagues.
9. BAME Board representation. Percentage difference between the organisations’ Board voting membership and its overall workforce.

Objective 1:

Create an environment in which staff from BAME backgrounds feel like they **belong** in the organisation

Aim: Develop the Ethnic Diversity Engagement Network (EDEN) to raise awareness to the organisation and provide a safe space for staff from BAME backgrounds.

Actions	Rationale	Timescales	Stakeholders	Success Measures
a) Continue to embed the Staff Network Inclusion Forum.	Aim is to provide robust support from the EDI team to network co-chairs and contributors and encourage collaboration. To grow the network.	Launched July 2024, bimonthly forums held. Forum members to review in February 2025.	EDI team/all staff network co-chairs/2gether Support Solutions/Communications/Staff Experience	- Continuous feedback from forum members. - Formal review feedback in February 2025. - Collaboration between networks - Network growth
b) Launch and socialise Staff Network Policy	To raise awareness of the importance and value of Staff Networks. To provide network members with protected time to engage in network activity.	Staff Network Policy published in October 2024. February 2025; arrange a meeting with staff network reps and stakeholders to agree on a socialisation/ cascade plan	Staff Networks/EDI team/heads of care groups/heads of people and culture/business partners	- All networks having co-chairs and Executive Sponsors in place. - Increased awareness of staff networks - Network members getting protected time (data to be taken from health roster).

Objective 2:

Improve race related **equality, diversity, and inclusion** at EKHUFT

Aims: Raise awareness of race related issues. Improve race declaration rates on Employee System Records (ESR) to provide a more accurate workforce profile

Actions	Rationale	Timescales	Stakeholders	Success Measures
a) EDEN network in collaboration with EDI team to raise awareness of race related issues e.g. via See ME First anti-racism campaign.	National staff survey (NSS) results and WRES data show that our staff from BAME backgrounds have a worse experience at work then staff from white backgrounds, this includes racial discrimination and microaggressions. Education and awareness is needed.	EDEN network and EDI team to discuss at network meeting in 2024 and agree on See ME First relaunch date in 2025. This could include educational workshops/ sessions.	EDI Team/EDEN Staff Network/Network Executive Sponsors	NSS showing improvement in experiences of BAME staff. WRES showing improvement in experiences of BAME staff.
b) Improve ESR ethnicity declaration rates.	EKHUFT have a non-declaration rate of ethnicity of 22% in 2024, this means we are not capturing the full ethnic diversity of our workforce. Some of this is due to mistrust, stigma and challenges navigating ESR.	Communications articles and in-person sessions regarding the importance/value of declaring ethnicity to be launched after discussions with the EDEN network in Nov 2024. To include clear guidance and address issues of mistrust	EDI team/ EDEN staff network/Staff Experience	WRES; Reduce EKHUFTs non-declaration rate on ESR, of 22% in 2024 to 19% in 2025 National Staff Survey (NSS) improved experience of staff from BAME backgrounds.

Objective 3:

Ensure staff from BAME backgrounds have a **better experience** at work

Aim: Embed an inclusive and fair recruitment process to attract a diverse workforce and reduce disadvantage for staff from BAME backgrounds.

Actions	Rationale	Timescales	Stakeholders	Success Measures
a) Implement Debiasing and value based recruitment workstream under the Culture and Leadership Programme.	EKHUFTs WRES data shows that applicants from BAME backgrounds are 3 and a half times less likely to be appointed than white applicants. Recruitment process needs to be improved to be more equitable.	Working Subgroups identified and implemented in September 2024 looking at all aspects of the recruitment process. Pilot planned for January 2025.	Recruitment/EDI team/Learning and Development	WRES shortlisting indicator improvement. Debiasing and value-based recruitment approach implemented across the Trust as standard.
b) Create a new Equality and Health Impact Assessment (EHIA) form and guidance.	EKHUFT does not currently have a robust process in place to ensure that policies and decisions are fair and do not disadvantage people from protected groups including people from BAME communities.	Accessible EHIA form (now including health inequalities) and guidance document created by the EDI and Patient Voice and Involvement (PV&I) team, going through approval process in Nov/Dec 2024. EHIA Workshop delivered by EDI and PV&I to key policy writers/ decision makers in April 2024,next is January 2025.	EDI team/PV&I/Policy Authorisation Group/Heads of People and Culture/Governance	PAG feedback that EHIAs are completed to a high standard and embedded in policy making and review. EHIAs are completed as standard for organisational decisions.

East Kent Hospital University Foundation Trust's (EKHUFT) Workforce Disability Equality Standard (WDES) Action Plan 2024/2025

Since 2019 all NHS organisations have been required to demonstrate how they are addressing disability equality issues in a range of staffing areas through the WDES.

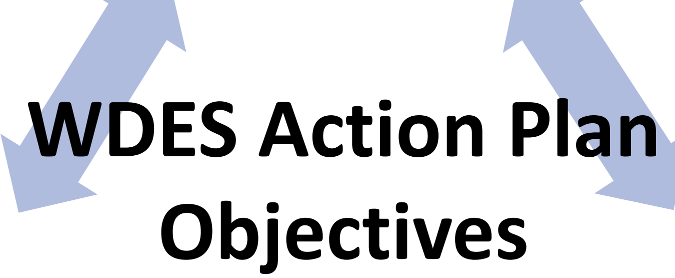
The WDES is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. EKHUFT uses the metrics data to develop and publish an action plan, building on NHS England's (NHSE's) 6 high impact actions in the Equality, Diversity and Inclusion (EDI) improvement plan. EKHUFT's data shows that disabled staff have poorer experiences compared to their counterparts without disabilities, including bullying, harassment and less progression.
Please see the WDES section of the 2024/2025 EDI annual report for details via this link: Equality, diversity and inclusion (EDI).

A note on language: in the pursuit of equality, diversity and inclusion, language is powerful and can help to shift attitudes and behaviours. This document acknowledges that some definitions and terminology do not always reflect the identities or lived experience of individuals.

Our aim at EKHUFT is to become a truly inclusive organisation that eliminates the conditions where discrimination occurs

This includes supporting our valuable staff who have disabilities and long term health conditions

Create an environment in which staff with disabilities feel like they **belong** in the organisation



WDES Action Plan Objectives

Improve disability related **equality, diversity, and inclusion** at EKHUFT

Ensure staff with disabilities have a **better experience** at work

WDES Measures (Metrics)
1. Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse. from: 1. Patients/Service users, their relatives or other members of the public 2. Managers 3. Other colleagues 4. Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
5. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

WDES Metrics Continued
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
8. Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.
9a. The staff engagement score for Disabled staff, compared to non-disabled staff.
9b. Whether the Trust has taken action to facilitate the voices of Disabled staff in the organisation to be heard.
10. Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated: · by voting and non-voting membership of the board · by executive and non-exec membership of the board.

Objective 1:

Create an environment in which staff with disabilities feel like they **belong** in the organisation

Aim: Develop the Disability and Neurodiversity Staff Networks to raise awareness to the organisation and provide a safe space for staff who have disabilities and long term health conditions.

Actions	Rationale	Timescales	Stakeholders	Success Measures
a) Continue to embed the Staff Network Inclusion Forum.	Aim is to provide robust support from the EDI team to network co-chairs and contributors and encourage collaboration. To grow the network.	Launched July 2024, bimonthly forums held. Forum members to review in February 2025.	EDI team/all staff network co-chairs/2gether Support Solutions/Comms/Staff Experience	- Continuous feedback from forum members. - Formal review feedback in February 2025. - Collaboration between networks. - Network growth
b) Launch and socialise Staff Network Policy	To raise awareness of the importance and value of Staff Networks. To provide network members with protected time to engage in network activity.	Staff Network Policy published in October 2024. February 2025; arrange a meeting with staff network reps and stakeholders to agree on a socialisation/ cascade plan	Staff Networks/EDI team/heads of care groups/heads of people and culture/business partners/staff network executive sponsors	- All networks having co-chairs and Executive Sponsors in place. - Increased awareness of staff networks - Network members getting protected time (data to be taken from health roster).

Objective 2:

Improve disability related **equality, diversity, and inclusion** at EKHUFT

Aim: Develop the Disability and Neurodiversity Staff Networks to raise awareness to the organisation and provide a safe space for staff with lived experience.

Actions	Rationale	Timescales	Stakeholders	Success Measures
a) Disability and Neurodiversity Staff Networks in collaboration with the EDI Team to raise awareness of disability, neurodiversity and non-visible disabilities e.g. via the Hidden Disability Sunflower Scheme.	EKHUFT is part of the Hidden Disabilities Sunflower Scheme. There is a lack of awareness and understanding of hidden disabilities. This creates a barrier to staff being provided with reasonable adjustments to enable them to do their job effectively.	EDI Team, Disability and Neurodiversity network to discuss at network meeting in 2024 and agree on relaunch date in 2025 and plan.	Disability and Neurodiversity staff networks/staff network executive sponsors/EDI team.	NSS showing improvement in experiences of disabled staff. WDES showing improvement in experiences of disabled staff. Use of workplace adjustment policy, toolkit and NHS passport.
b) Improve ESR disability declaration rates.	EKHUFT have a high non-declaration rate of disability of 41% in 2024, this means we are not capturing the full disability diversity of our workforce. Some of this is due to mistrust, stigma and challenges navigating ESR.	Communications articles and in-person sessions regarding the importance/value of declaring disability to be launched after discussions with the networks in Nov 2024. To include clear guidance and address issues of mistrust.	EDI team/ Disability and Neurodiversity staff networks/Staff Experience	WDES; Reduce EKHUFTs non-declaration rate on ESR, of 41% in 2024 to 38% National Staff Survey (NSS) improved experience of staff with disabilities.

Objective 3:

Ensure staff with disabilities have a better experience at work

Aim: Embed an inclusive and fair recruitment process to attract a diverse workforce and reduce disadvantage for candidates with disabilities or long-term health conditions.

Actions	Rationale	Timescales	Stakeholders	Success Measures
a) Implement debiasing and value based recruitment workstream under the Culture and Leadership Programme.	EKHUFTs recruitment process needs to be improved to be more equitable and accessible. This includes provision of reasonable adjustments to enable candidates to engage in the process.	Working subgroups identified and implemented in September 2024. Pilot planned for January 2025.	Recruitment, Resourcing/EDI team/Learning and Development/ Steering Group/Subgroups	WDES shortlisting indicator improvement. Debiasing and value-based recruitment approach implemented across the Trust as standard.
b) Create a new Equality and Health Impact Assessment (EHIA) form and guidance.	EKHUFT does not currently have a robust process in place to ensure that policies and decisions are fair and do not disadvantage people from protected groups including those with disabilities and long terms health conditions.	Accessible EHIA form (now including health inequalities) and guidance document created by the EDI and Patient Voice and Involvement (PV&I) team, going through approval process in Nov/Dec 2024. EHIA Workshop delivered by EDI and PV&I to key policy writers/ decision makers in April 2024,next is January 2025.	EDI team/PV&I/Policy Authorisation Group/Heads of People and Culture/Governance	PAG feedback that EHIAs are completed to a high standard and embedded in policy making and review. EHIAs are completed as standard for organisational decisions.

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

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

Meeting dates: **24 September 2024**

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

Paper Author: **Executive Assistant**

Quorate: **24 September 2024 – yes (from 12:45)**

Appendices:

None

Declarations of interest made:

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

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

Agenda item	Summary
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS, CAS AND PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) UPDATE) (August data)	The Committee received the report and **NOTED** the following key updates; • Substantial progress with closing open incidents and imbedding the process as 'business as usual', within the care groups. The improved collaborative approach between care groups had resulted in improvements and there was a clear trajectory for meeting the Key Performance Indicators. • After Action Review (AAR) training was in place and progressing well, in line with the Patient Safety Incident Response Framework (PSIRF) plan. • Implementation of NICE guidelines with evidence of implementation, had significantly improved during July 2024 and was at 25.2% against the trajectory of 26%. • There were currently issues with the recording of Duty of Candour compliance which were being addressed. • Changes to the legislation around death certification came into law on the 9 September. No death can be certified without a Medical Examiner or Coronial review. • There were currently three overdue Patient Safety Alerts: NatPSA/2023/010/MHRA: MHRA National Patient Safety Alert - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls and NatPSA/2023/013/MHRA: Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. NatPSA/2023/014/NHSPS (Alert from 2023-2024): Identified safety risks with the Euroking maternity information system.

PROGRESS AGAINST RECOMMENDATIONS FROM ASSOCIATION FOR PERIOPERATIVE PRACTICE (AFPP) REPORT - CRITICAL CARE, ANAESTHETICS AND SPECIALITY SURGERY CARE GROUP	The Committee received the report and **NOTED** the following key updates; • AfPP consultants undertook the peer reviews in January 2024 to find where practices were in line with, or deviating from, the AfPP Standards and Recommendations for Safe Perioperative Practice (2022). • The detailed reports from the AfPP, found several areas of excellent practice and noted some areas where practice could be improved to ensure the Trust was in line with AfPP standards. • Following the review, 41 actions were identified, currently 25 actions were closed with 16 on track for completion prior to the AfPP revisit, which was due to take place in November 2024. • Following the review, no never events had occurred in theatres and the number of serious site infections had reduced and was continuing to improved. This is kept under close review.
PROGRESS AGAINST PAEDIATRIC AUDIOLOGY IMPROVEMENT PLAN - WOMEN, CHILDREN AND YOUNG PEOPLE CARE GROUP	The Committee received the report and **NOTED** the following key updates; • NHS England (NHSE) have completed a national review of all paediatric audiology services. • Based on available evidence, further assurance was needed with an independent service review. • It was felt that there was a minimal risk of deafness not being identified. • The importance of finding a new peer review process a priority was noted by Q&SC. • Paediatric audiology will be kept under Q&SC review.
ENDOSCOPY UPDATE	The Committee received the report and **NOTED** the following key updates; • As a result of the program of works the endoscopy Patient Level Tracking (PLT) had reduced from over 13,000 patients to 5,200, with a trajectory of 4,800 by the end of October 2024. • 17 cases of potential harm across all waiting lists had been identified, the waiting list was under reviewed and could increase. It would be further reviewed at the December 2024 Q&SC. • It was confirmed that the endoscopy harms needed to be escalated to the public Board.

MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received the report and **NOTED** the following key updates;
	• 34 risks were included in the significant risk register, 26 were classified as quality risks.
	• Since the last meeting of this Committee 4 of the risks had been descaled, 1 escalated and 3 new risks had been added to the register. The 3 new risks were:
	  ○ Loss of blood and blood products affecting patient safety and significant economic loss to due staff not being alerted to a temperature control failure following failure of the trust wide blood transfusion laboratory remote temperature alert system (risk ref: 3699).
	  ○ Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward (risk ref: 3702).

	○ Staff may experience physical and psychological harm as they were often subjected to verbal and physical abuse from patients showing challenging behaviours (risk ref: 3701). And the 1 escalated risk: • Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot (risk ref: 1350). In August 24, the residual risk was escalated from moderate (12) to high (15).
CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received the report and **NOTED** the following key updates; • The CQC self-assessment programme continued with further Check and Challenge meetings taking place with the Care Groups. A Standard Operating Procedure (SOP) had been produced, summarising the process. The care groups had found the process valuable. Going forward, we move to a peer review process. • The closure of actions from the 2023 inspection action plans continued with an added 23% of actions closed since the previous update. A robust review process was now in place, and all 'should and must do' actions reviewed monthly.
QUARTERLY AUDIT UPDATE	The Committee received and **NOTED** the quarterly audit update.
MATERNITY & NEONATAL ASSURANCE GROUP (MNAG)	The Committee received the report and **NOTED** the following key updates • Neonatal medical and midwifery staffing levels remained an ongoing issue. • National Midwifery Council recently visited the Trust and were positive with the progress made. • The Maternity Incentive Scheme (MIS) Year 6 data collection period started on April 2, 2024. The service continued to work towards achieving full compliance with the Year 6 requirements. • The Clinical Negligence Scheme for Trusts (CNST) requirements included the need for a duty anaesthetist to be immediately available for the obstetric unit 24 hours per day/seven days per week. The maternity unit collected data in relation to anaesthetic attendance in the form of a monthly scorecard. • The plans for the dedicated 'Twinkling Stars' bereavement suite, within the labour ward were complete and the tendering process was now progressing. • The business case included the proposed designs for two new obstetric theatres and consultant led delivery suite at QEQM by extending out the back of the current labour ward. The bid for funding had progressed and was now in the design phase. • Neonatal death review had started and the findings reported to QSC in due course.
QUARTERLY MENTAL HEALTH UPDATE	The Committee received the report and **NOTED** the following key updates;

	• The report detailed the work of the Trust's Mental Health Steering Group. • An Associate Director of Mental Health had been appointed and was due to join the Trust on the 11 November. • Mental Health Strategy was now live on the intranet and Mental Health Policy was live on the Policy centre. • The All-Age Restraint Policy has been updated and was also live on the Policy Centre. • The Missing Persons Policy had been updated was now aligned with Right Care Right Person. • The had been an increased number of mental health patients absconding from our Emergency Departments and increased violence and aggression experienced by our staff. Guidance was being developed.
PROGRESS AGAINST TRUST-WIDE TISSUE VIABILITY IMPROVEMENT PLAN – DEEP DIVE.	The Committee received and **NOTED** the regulatory compliance chair's reports: • The number of hospital acquired pressure ulcers per month has been more stable over the first months of this financial year and was currently showing the beginning of a downward trend. This would continue to be monitored and reviewed as the winter months approached. • A 5% reduction in moderate harm pressure ulcers was achieved in 2023-24 compared to the previous year. A further 5% reduction would to be achieved in 2024-25. • The number of hospital acquired pressure ulcers per 1000 bed days continued to be static since April 2024. • All the actions identified in the plan would prevent moderate harm from pressure ulcers, however work was on going to ensure all the actions were fully imbedded.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and noted the IPR. Staffing data was to be incorporated into future IPR reports.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience Committee chair's reports.
MORTALITY SURVEILLANCE and STEEING GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the Mortality Surveillance and Steering Group chair's reports.

FUNDAMENTALS OF CARE CHAIR'S REPORT	The Committee received the report and **NOTED** the Fundamentals of Care Chairs reports. Mixed sex accommodation breaches: showed high rates of ITU stepdown breaches. Focussed work was taking place on flow and length of stay to address the breaches.

Referrals from other Board Committees

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

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report and the following key issues for escalation. • Paediatric Audiology • High level description of Endoscopy harms • Mixed sex breaches	Assurance	5 December 2024

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

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

Meeting date: **31 October 2024**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register	The Chief Nursing & Midwifery Officer (CNMO) presented the report. Important progress has and continues to be made in the Trust's risk management processes. The Committee received assurance that the updating of risks was being actively managed and overseen. It was asked to note two risks have been de-escalated since the previous meeting and the three overdue actions were live as of the 23 October 2024. The Committee received assurance the Significant Risk Register is being kept up to date and any corrective/mitigating actions are being monitored.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee reviewed its BAF Risks as it does at each Committee recognising the agenda had been framed with reference to the BAF. The Committee discussed the wording of FPC BAF Risk 001 relating to the impact of Covid. The revised wording needed further refining, which would be discussed by the Executive. This will be reviewed at the next meeting due to take place on the 26 November 2024. Six of the thirteen BAF risks had been allocated to FPC across three themes: patients, partnerships and sustainability. The significant risk register now aligns closely with the BAF risks, but some risks are managed in different committees, which will be updated on the report each month.

PricewaterhouseCoopers (PwC) Transition Plan	The Committee noted a verbal update of the transition plan and highlighted with an emphasis on reducing reliance on PwC resources. Some key points detailed below: PwC has been heavily involved in programme management and delivery roles, with the intention to transition away from this dependency over time. The current phase of their involvement concludes today (31 October 2024) with evidence of a reduction in resources and associated costs since earlier phases in May, June, and September. The agreement with PwC is to focus on four areas of delivery; Workforce, Care group reviews, Corporate reviews, Workforce-related initiatives supporting the Chief People Officer and existing workforce engagements will continue until tasks are completed.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee noted the IPR operational metrics and in particular noted the following key points: – Continued improvement in Accident & Emergency (A&E) for type one compliance which has continued into this month, to note Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) with 15% differential with QEQM in the mid 60's with compliance. – 20.5% of the Trust's bed base are occupied by patients who no longer meet the criteria to reside. – Cancer performance remains strong, the Trust is compliant with the 62-day national standard, the backlog at the end of October is currently at 196. – Endoscopy backlog continues to reduce to a level which is more sustainable. – At the end of September, the long waiting position ended with 34 of the 78-week breaches, currently on 14 78-week breaches and at the end of October 388 for the 65-week breaches. Therefore, these positions mean the Trust are no longer in the top 10 concerned trusts nationally, with confirmation that EKHUFT will be exiting Tier 1 for Cancer, Diagnostics and Elective. – The Chief Operating Officer (COO) shared the latest figures for diagnostics which shows the totality of patients on the waiting list at just over 20,111. – DM01 position currently reporting at 76.3% compliance which is the best performance for over four years. – Funding has been agreed though the Health and Care Partnership (HCP) to run a 7-day frailty pilot at the William Harvey Hospital (WHH) site.

	– It's been agreed with the Integrated Care Board (ICB) to buy an additional 45 beds to help unblock some of the long stay patients.
Patients no Longer Fitting the Criteria to Reside	The Committee noted the discussion in the We Care agenda item with nothing further to add.
Winter Plan	The Committee noted the update regarding the Winter Plan event which took place on the 18 October 2024. The aim is to get to 85% bed occupancy by Christmas Eve.
BAFFPC003 Update on the 2024/25 Cost Improvement Programme (CIP)	The Committee received an update and noted the following in the report: • The Trust had made good progress with over-performance against plan of £340k, with £21.5m YTD delivered against the plan of £21.2m. Looking ahead, the focus is on preparing for the 2025/26 financial year, with a strong outlook for the second half of the current year. The team are confident about delivering the remaining targets for this year and is in a good position for future planning, having already identified £36.3m in the sustainability plan for 2025/26.
Revised Capital Plan	The Committee received an overview of the Revised Capital Plan. It was reported a year-to-date underspend of over £5m on the capital plan as of month six. A detailed review was conducted with delivery leads for each scheme to identify the reasons for the underspends, the findings are outlined in the paper. A lessons-learned action plan will be at the January meeting, balancing the need for insight with the ongoing urgency of other projects. The **COMMITTEE** approved for the 2nd proposed mitigation list to move forward.
Month 6 Finance Report	The Committee received an update and noted the following in the report. The Interim Chief Finance Officer (CFO) reflected on the recent budget announcement and mentioned two key figures: 1. **£22b additional revenue** for the NHS. 2. **£3.1b in additional capital funding** for the NHS. The Interim CFO highlighted the capital funding is a significant increase, representing a 35% rise in capital projects, offering a big opportunity for the NHS to address productivity challenges. However, while the £22b revenue increase is generous compared to other sectors, the NHS is facing financial difficulties.

	The Interim CFO also reported to the committee a £6b overspend for the 2024-2025 financial year, which is partially covered by this £22b.
Safer Staffing Paper	The Committee noted the discussion of the Safer Staffing Paper and noted it would need to be presented at the next Business Case Scrutiny Group (BCSG) meeting. It was explained this paper would normally be presented through People and Culture and Quality committees, but as a large investment took place previously and will be presented at all committees.
Grip and Control Review IPP and Financial Sustainability Plan (FSP) Sign Off	The Committee received an update from the Financial Recovery Director and noted the report. A brief background update was given by the Interim Chief Finance Officer which was noted by the committee. A key point to note is to strongly continue with the Non-Pay Panel as well as the vacancy control panels. There are 18 actions, each with an exec owner and they are aware which will be progressed through the committee or through the relevant CIP scheme.
Financial Sustainability Plan Update	The Committee received an update from the interim CFO and noted the information was provided at the last board meeting and repeated at this committee.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee noted there were no business cases to discuss.
Capital Investment Group (CIG) Assurance Report	The report was taken as read with nothing further to add.

Business Case Scrutiny Group (BCSG) Assurance Report	The Committee noted there were no business cases to discuss.
Financial Improvement Programme Board (FIPB) Assurance Report	There was nothing further to add.
ID Medical	The Committee were updated by the Financial Recovery Director of ID Medical which is a review of the medical managed services providers for the agency staffing across medical and nursing.
2gether Support Solutions Review Update	The Committee noted this item would be deferred to the next meeting in November.
Patients Travelling Expenses Policy	The Committee agreed they were happy with the policy.
Feedback to Board of Directors	There was a referral to the Board recommending the Business assumptions for the business plan.
Referrals to Other Board Committees	The committee asked to refer to the Integrated Audit and Governance Committee to look at the internal order controls.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	5 December 2024

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

Committee:	**People & Culture Committee (P&CC)**
Meeting date:	**27 November 2024**
Chair:	**Claudia Sykes, Non-Executive Director (NED)/P&CC Chair**
Paper Author:	**Claudia Sykes, NED/P&CC Chair**
Quorate:	**Yes**

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: see below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention **Staff recruitment**	The Trust vacancy rate is 8.6% at the end of October. Within this the Committee discussed specific areas of focus: • Midwifery: this remains an area of high focus due to the high agency costs. The vacancy level of 33 Whole Time Equivalent (WTE) will reduce significantly in January when 26 newly qualified midwives are due to join. • Health care worker: the vacancy rate remains high at 14.86% (214 WTE). A national review of Band 2 and 3 positions is underway, and local recruitment activity will be refreshed once this is completed. The Committee also received the Nursing Establishment Review, presented by the Chief Nursing and Midwifery Officer (CNMO). This comprehensive staffing review was undertaken to ensure that in-patient wards, Acute Medical Units and Emergency Departments (EDs) are staffed in line with national safer staffing requirements and in an equitable manner across the three main hospital sites. The review proposes moving from agency staffing to substantive staffing in a number of areas. The Committee was **ASSURED** in relation to the proposals in the paper for safe staffing, and **APPROVED** the recommendations to be taken to the Board (see Board recommendation below). The Committee was **ASSURED** of the work being undertaken on staff recruitment.
BAF risk: recruitment and retention **Staff retention**	The Committee received an update on the National Staff Survey, which is still underway. The Trust response rate was at **57.4%** at 27/11/24 and the best EKHUFT has ever achieved. The Committee noted the hard work which had gone into increasing the staff response rates. The Trust then needed to ensure that issues raised were acted upon, and that improvements were visible to staff. The Committee commended the work done to increase the staff response rates this year.

<table>
<tr><td></td><td>The Committee noted that the Pulse survey shown in the Integrated Performance Report (IPR) would not be updated whilst the Staff Survey was underway and until results were released nationally.

The Committee reviewed results of exit interviews. Over the last 18 months, the Trust had received 1261 responses, a 32% response rate. The top 10 reasons for leaving were:

• Retirement age 12.1%
• Work-life balance 10.3%
• Relocation (UK) 7.5%
• Personal reasons 6.3%
• Lack of development opportunities 5.9%
• Career advancement 5.7%
• Further education or training 5.2%
• Working relationships – manager 4.8%
• Lack of job satisfaction 4.7%
• Excessive workload 4.2%

The Committee discussed the need to improve career progression in the Trust – the Interim Chief People Officer (CPO) confirmed that this was already being worked on, and would be a key priority once the new CPO joined. An overview of the Trust's career development pathways ensuring fair progression was to be presented to the Committee in March 2025.

The Committee also discussed other themes from the exit interviews: work-life balance/excessive workload; and also working relationship with line managers. These were potentially avoidable issues if interventions were made, where possible, to address staff concerns. Executive committee members commented that these areas should be improved by work underway, for example to ensure high quality appraisals were being undertaken which would help address individual training opportunities and career development, workload pressures and job satisfaction; by the "Back to Basics" manager training programme; and also the work on ensuring safe and substantive staffing levels across the Trust. These would however take time to embed and make a difference.</td></tr>
<tr><td>BAF risk: culture and values

Culture and Leadership Programme</td><td>An update was presented to the Committee on the Culture & Leadership Programme. Good progress was being made. The Staff Council had now been established, and would report into the P&CC twice a year.

The Committee discussed how to ensure that staff voice was heard both at this Committee and the Board. There were a number of routes: the Staff Council; Doctors' Voice group; staff networks; staff national and pulse surveys; staff stories at the Board. The Committee noted the need to ensure more regular staff stories at the Board, and also ensuring the voices of non-clinical staff were regularly heard. It was also noted that there were some incredible achievements from staff, as recognised in the recent Staff Awards.</td></tr>
</table>

BAF risk: culture and values **Freedom to Speak Up (FTSU)**	An update on the FTSU service was given at the Committee. FTSU emails are being answered on a timely basis now. A paper on options to ensure future sustainability and resourcing is being prepared for the Board. No information was received on the FTSU cases or themes, and it is now 11 months since the Committee has received a full FTSU report. The Committee was **NOT ASSURED** of the effectiveness and resourcing of the FTSU service.
BAF risk: culture and values **Equality, Diversity and Inclusion (EDI)**	The Head of EDI presented the annual Workforce Racial Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports. These had been submitted to NHS England. Key points from the EKHUFT reports: • **28.91%** of Trust staff are from a Black, Asian and Minority Ethnic (BAME) background. This is a 4% increase from 2023 and higher than the 2023 NHS national average of 26.4%. • White applicants are 3.57 times more likely to be appointed from shortlisting than BAME applicants. • **5.43%** of staff reported a disability, above the national average of 4.9%. • **20.4%** of disabled staff experienced harassment, bullying or abuse from managers in the last 12 months. The Committee discussed the reports and the wider EDI update. It was acknowledged that the Trust had not made as much progress in many areas as needed. EDI was still not embedded as it should be, and was still seen by some as the job of the EDI or People & Culture team. The Interim CPO and Chief Strategy and Partnerships Officer (CSPO) agreed to report back to the Committee in January with plans on closing some of the gaps highlighted in the reports. The Committee was **NOT ASSURED** of the progress on EDI.
BAF risk: culture and values	The Committee received a deep-dive report into both statutory and mandatory training and received **ASSURANCE** that most areas were compliant, above the targets of 91% and 85% respectively. The areas of concern related to hand hygiene and resus training. The CNMO gave an update on the action being taken to improve compliance in these areas. A report was also received on appraisal completion. Progress has been made in this area, and compliance is now at **79.4%** against the target of 80%. The Corporate department remains the worst for appraisal completion at 64% - the Interim CPO confirmed this will be an area of focus for the executive and corporate teams. The committee were **ASSURED** of progress on appraisals. It was noted that work on checking the quality of appraisals also needed to continue.

BAF risk: organisational development and resilience **Workforce planning**	Workforce planning and People Strategy updates were deferred to the January Committee. This would need to be a focus for the new substantive CPO. Out of the three BAF risks within the People and Culture responsibility, this remains the area with the most limited evidence and assurance so far.
BAF risk: organisational development and resilience **Well-led**	The Committee received a comprehensive report on the CQC Well-Led action plan as related to People & Culture. The Committee was **ASSURED** of the progress on the action plan.

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: None

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

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

RECOMMENDATION to the Board of Directors to **APPROVE** the additional investment into the nursing establishment for Adult In- patient wards, Paediatric wards, Acute Medical Units (AMUs) and Adult and Paediatric EDs, which includes**:**

- the staffing approach for the escalation areas and overflow areas in EDs;
- the phased introduction of 143.95 WTE Registered Nursing Associates (above current establishment) into the nursing workforce**,** and
- the aspiration for a phased increase in uplift from 22% to 25% for in-patient ward areas and AMUs by 2027/28 and from 25% to 27% in EDs by 2026/27.

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

Committee: **Integrated Audit and Governance Committee (IAGC)**

Meeting dates: **1 November 2024**

Chair: **Dr Olu Olasode, Non-Executive Director**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

Appendix 1: 2gether Support Solutions Annual Report and Financial Statements for the year ended 31 March 2024
Appendix 2: Spencer Private Hospitals (SPH) 2023/24 Annual Report and Audited Financial Statements
Appendix 3: East Kent Hospitals Charity (EKHC) Annual Report and Accounts for 2023/24
Appendix 4: EKHC 2023/24 Management Representation Letter

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** and noted the Internal Audit progress report:
	  ◦ One final audit report issued since the last IAGC meeting:
	    ▪ Procurement and Single Tender Waivers (STWs) follow up, progress was good, and more work was required to close down a high priority action on STWs.
	• The Committee noted 13 overdue and outstanding management actions, one high priority remained overdue on Legal Services, continued focus ensuring maintaining the improvements on actions being implemented. Process in place for escalation of any issues with the Chief Finance Officer (CFO) and relevant Executive Director.
	• Locum Recruitment re-review undertaken following outsourcing of this service, this identified the process in place provided assurance of the agreed tasks and process was working. It was suggested a further review be undertaken in six to eight months to provide assurance this was fully embedded.
	• The Committee noted benchmarking 2023/24 reports on Internal Audit Findings (improvement on the previous year at 30% above the national average of 24%), and Overseas Patients income (average in comparison with other trusts) reflecting the difficulties in collecting these payments.
	• The Committee requested an audit review in 2025 of the financial grip and control processes and actions implemented to provide assurance these were fully embedded.

	• The Committee raised concern about having a robust process and system in place for general procurement stock management control, which will be explored with improvement options by the CFO.
Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – LCFS Progress Report	• The Committee received **Assurance** and noted the LCFS progress report and detailed activity. • The Committee approved the 2024/25 Counter Fraud Work Plan and Strategy. • Finalised review of Trust's anti-bribery arrangements, concluded these were largely proportionate to the bribery risks identified and in line with adequate procedures. • The Committee raised concern with the declarations of interest benchmarking report, identifying the Trust significantly below subsector average of 70%. A progress update report and action plan was requested to be presented to the next Committee meeting in January 2025 on how compliance would be increased to achieve the average with a target date, with the aim to get above average. • The Committee noted the STW benchmarking report, in 2023/24 the number and total value had decreased, Trust was higher in terms of the number of STWs used in comparison to other similar sized organisations.
External Audit Grant Thornton (GT): External Audit Progress Report and Sector Update	• The Committee received **Assurance** from the External Audit Progress Report and Sector Update. • Lessons learnt from the 2023/24 annual accounts audit with key points for the External Auditors and Trust to implement ensuring an efficient audit for the upcoming 2024/25 audit. Meetings already held with early interim audit testing to be undertaken in preparation for the 2024/25 audit.
Draft Financial Sustainability Plan (FSP)	• The Committee received **Assurance** from the draft FSP, presented to Finance and Performance Committee (FPC) and BoD in October 2024, with the final plan to be presented in December for approval. • Plan set out the financial improvement initiatives to improve the Trust's financial position and sustainability. Finalised plan was a requirement of the Trust's Integrated Improvement Plan (IIP). Funding discussions were ongoing with the system about the Trust's challenges that included patients no longer fitting the criteria to reside and coastal communities.
Cost Improvement Programme (CIP) Month 6 Update	• The Committee received **Assurance** from the CIP performance report and actions being taken to ensure the CIP in-year target was delivered. • The Committee was assured around strong governance and oversight to ensure programme delivery, continuing to substantively recruit to the Programme Management Office (PMO) posts, planning for 2025/26 and the identification of savings schemes that will be closely monitored by the FPC.
Financial Improvement – Grip and Control Review	• The Committee received **Assurance** from the report presented, progress with the financial improvement and performance, as well as the processes in place to maintain ongoing financial grip and control.

	• The Committee noted future monitoring around financial performance and continued financial grip and control will be by the FPC.
Governance Improvement Framework: Programme of Work	• The Committee received **Partial Assurance** from the report and the progress made to improve the governance framework. • A follow-up review had been undertaken by the Good Governance Institute (GGI) on their governance review with feedback being presented to the November Board Development Strategy Session. • Evidence of the Trust's BAF driving assurance through its governance structure. • There remains ongoing work on the governance mapping to ensure this provided the necessary assurance of an appropriate governance structure in place and embedded. • The Committee raised key areas of development in respect of capital and digital, that needed Executive Director focus to ensure monitoring progress, and that this needed to be reflected in the governance structure.

Clinical Governance – Progress Update	• The Committee received **Assurance** from a verbal report on progress of the improvement work in respect of clinical governance.
	• The Committee noted the following:
	  • Staff training on the new Patient Safety Incident Response Framework (PSIRF);
	  • Implementation of new Trust-wide risk management and quality governance system, InPhase, migration process of information from legacy systems (Datix and 4Risk) to take around six months anticipated to be completed by 31 March 2025, to be closely monitored;
	  • Committee to receive six monthly clinical governance reports.

Policy Compliance	• The Committee received **Partial Assurance** from the progress report noting the following:
	  • 28 of 223 policies (12.6%) were past their review dates;
	  • 16 policies (7%) remained a concern and at risk with limited progress, and responsiveness from Care Groups remained a challenge. This was raised as an area of concern and whether this needed escalation, it was noted monitoring against progress of the policy review work was being undertaken through the Trust's governance structure.
	• The Committee discussed inconsistencies in respect of the presentation of policies to Board Committees for approval and noted a review of these to be undertaken to identify a mapping process around an appropriate framework within the governance structure for presentation, review and approval of policies.

Risk Register Report	• The Committee received **Partial Assurance** and noted the Significant Risk Register and the Committee's visibility of the key risks facing the organisation. • The Committee noted overdue actions associated with nine risks escalated for immediate attention of Risk Owners. • Trust had successfully appointed to the post of Head of Risk Management and Assurance due to commence in December.

	• The Committee noted the significant improvements achieved to date around the management of risks, noting it was important for this process to be strengthened and fully embedded within the organisation. • The Committee requested assurance of the Trust's visibility of risks and escalation of high level risks on its Group subsidiary risk registers.
Board Assurance Framework (BAF) Review	• The Committee received **Assurance** from the BAF, noting update on the process adopted within the Board Committees ensuring centrality of the BAF and this informing and driving these meeting agendas linking with the risk register. • The Committee noted update on the principle risks associated with delivering the Trust's Strategic Objectives and the assurance around the BAF and the risk management approach.
Review of Trust's Legal Services	• The Committee received **Partial Assurance** of the review of Legal Services, provision of interim support to cover and maintain this function. • Trust was looking at a case management system to support this service. • The Committee noted the extended period to implement the Internal Audit report recommendations within a six month target, and the Director of Corporate Governance as the responsible Director will continue to monitor and oversee the ongoing provision of this service.
Annual Report on Accessed Study Leave for 2023/24	• The Committee received **Assurance** from the 2023/24 Annual Report on Accessed Study Leave. • The Committee noted differentiating spend at William Harvey Hospital (WHH), Queen Elizabeth the Queen Mother Hospital (QEQM), Kent & Canterbury Hospital (K&C) and Buckland, with promotion across all Trust hospital sites of the availability and how to access and apply for this leave. Difficulty identifying equality of accessibility of this study leave due to Equality, Diversity and Inclusion (EDI) data information not being held by the Medical Education team.
NHS England (NHSE) Annual Undergraduate (UG) Financial Accountability Report	• The Committee received **Partial Assurance** from the 2022/23 NHSE Annual UG Financial Accountability Report and referred this to the Clinical Executive Management Group (CEMG) for a strategy discussion, and review of the data calculated prior to being centrally submitted. • Work was ongoing to complete the 2023/24 annual report for submission.
Losses and Special Payments Report	• The Committee received **Assurance** and noted the report on losses and special payments for the period 1 April 2024 to 30 September 2024, payments totalled £105k (110 cases), compared to £163k (139 cases) in the previous financial year (a decrease of £58k in year).
Single Tender Waiver (STW) Report	• The Committee received **Assurance** and noted the STW report for the period Quarters 1 and 2 for the Financial Year (FY) 2024/25.

	• The Committee noted the following key points: • Continued positive reduction in value of STWs year on year and to maintain focus on further reducing these; • 60 STWs approved, a total value of £3.5m. Increased number of STWs by 28% (13) compared to the same period in 2023/24, a 22% (£0.95m) decrease in value in the same period. • 34 STWs were rejected; • No Declarations of Interest; • 15 retrospective approvals of STWs (£1.2m).
Procuring Non-Core Services (Additional Services) from External Auditors Policy	• The Committee received **Assurance** following review of the Procuring Non-Core Services (Additional Services) from External Auditors Policy and approved this.
Patients Travelling Expenses Policy	• The Committee received **Assurance** and approved the Patients Travelling Expenses Policy.
2gether Support Solutions (2gether) Annual Report and Financial Statements for the Year Ended 31 March 2024	• The Committee received **Assurance** and approved 2gether's Annual Report and Financial Statements for the year ended 31 March 2024 (Appendix 1) recommending this for Board of Directors approval.
Spencer Private Hospitals (SPH) Audited Accounts 2023/24	• The Committee received **Assurance** and approved SPH's 2023/24 Audited Financial Statements (Appendix 2) recommending this for Board of Directors approval.
East Kent Hospitals Charity (EKHC) Annual Report and Accounts for 2023/24	• The Committee received **Assurance** and approved EKHC's Annual Report and Accounts for 2023/24 and the Management Representation Letter (Appendix 3 and 4) recommending this for Board of Directors approval.
External Audit Tender – Integrated Care System (ICS)	• The Committee received **Assurance** on progress of an ICS tender for the appointment of External Audit services across the ICS. • The Committee noted and approved the contract extension of its current External Audit services to November 2025 to cover the period for the 2024/25 year.
Counter Fraud and Internal Audit Services	• The Committee received **Assurance** and approved the contract award for its Counter Fraud and Internal Audit services, following due tender process and detailed evaluation.

Other items of business
The Committee noted the 2024/25 IAGC Annual Work Programme.

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 5 December 2024.

The Committee asks the BoD to approve 2gether's Annual Report and Financial Statements for the year ended 31 March 2024.	Approval	To Board on 5 December 2024.
The Committee asks the BoD to approve SPH's 2023/24 Audited Financial Statements.	Approval	To Board on 5 December 2024.
The Committee asks the BoD to approve EKHC's Annual Report and Accounts for 2023/24 and the Management Representation Letter.	Approval	To Board on 5 December 2024.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Registered number: 11385580

2gether Support Solutions Limited

Annual Report and Financial Statements

For the year ended 31 March 2024

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2gether Support Solutions Limited

Company Information

Directors	A J Bentley J N Churchward-Cardiff N J Webber S Corben P W Ryder G R Jenkins J R Ollis (resigned 7 May 2023)
Registered number	11385580
Registered office	Management Offices, William Harvey Hospital Kennington Road Willesborough Ashford Kent TN24 0LZ
Independent auditor	Grant Thornton UK LLP Statutory Auditor & Chartered Accountants Science Park 5 Benham Rd Chilworth Southampton SO16 7QJ
Accountants	Kreston Reeves LLP 37 St Margaret's Street Canterbury Kent CT1 2TU

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2gether Support Solutions Limited

Contents

	Page
Strategic Report	1 - 5
Directors' Report	6 - 10
Independent Auditor's Report	11 - 14
Statement of Income and Retained Earnings	15
Balance Sheet	16
Notes to the Financial Statements	17 - 35

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Strategic Report
For the year ended 31 March 2024

Introduction

The Directors present their Strategic Report and the financial statements for the year ended 31 March 2024.

Principal activities and business review

2gether Support Solutions Limited ("the Company") is a company incorporated and domiciled in the UK. The Company's registered office is Management Offices, William Harvey Hospital, Kennington Road, Willesborough, Ashford, Kent, TN24 0LZ. The Company is a wholly owned subsidiary of East Kent Hospitals University NHS Foundation Trust ("the Trust"). Details of the ultimate parent undertaking and controlling party are as disclosed in note 28.

The principal activities of the Company are to provide and operate hospitals, health care establishments and health care facilities including services related to these facilities and also to provide other support services. The Company aims to provide safe, efficient, sustainable and modern healthcare and working environments and to provide efficient and cost-effective support solutions. As part of an agreement to provide managed healthcare services, the Company operates a long-term lease arrangement with the Trust (the "Contract").

Principal risks and uncertainties

The Board, in discharging its duty to oversee the long term success of the business, has a role to ensure that opportunity is considered as well as risk. Risk typically continues to occupy more management time than opportunity and the Board challenge management to improve processes where required.

The Audit and Risk Committee provides oversight of the financial reporting process, the audit process, the Company's system of internal controls and compliance with laws and regulations. Additionally, the committee remit has expanded in the year to also provide oversight of the enterprise risk management and reporting.

The majority of the Company's income is secured under contracts with the Trust, a government funded entity. These contracts currently end in 2043. The Company lacks a diversified customer base, with the Trust as the primary customer. Like many NHS Trusts, the Trust is currently experiencing financial difficulties and this provides a specific customer risk to the Company. This risk is mitigated by the fact that the Trust is government funded and the Company's business is intrinsically linked with the continuing provision of essential public health services at the Trust.

The Company continues to maintain a comprehensive risk register (4Risk) as part of its enterprise risk management strategy. Progress is reviewed against the strategic business plan, which allows identification of key operational risks and mitigations. This is reviewed at the meetings of the Company Board and the meetings of the senior leadership team at the Management Board. The Company has a robust risk management process and culture, with continual review to ensure a positive risk management and health and safety culture is embedded within every area of the Company.

A principal risk carried by the Trust, which we provide support with, is managing and maintaining an aging portfolio of properties which require significant investment to maintain. When the Company took on the Contract in 2018, there was limited assurance of the levels of statutory compliance relating to the properties within the Contract. This area has therefore continued to be a key focused priority for the Company and the Company continues to improve the levels of statutory compliance which is dependent upon the agreed investment strategy from the Trust.

Additionally, the detailed review of the critical infrastructure undertaken, which determined the backlog of works and the level of investment required from the Trust, continues to be used to inform critical infrastructure requirements for maintenance, repairs and new capital developments and we provide advice to the Trust on the prioritisation of investment developments. We continue to remain dependent upon ongoing investment from the Trust to enable further reduction or mitigation of this risk and to ensure safe and effective environments are provided.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

The Health, Safety and Environment Committee (HSEC) is responsible for assuring the Board on matters and risk concerning the management and control of all Health, Safety and Environmental matters within the business. The HSEC advises senior managers and staff on health and safety issues and enables effective monitoring of systems and processes, including monitoring the uptake of relevant training programs. The HSEC promotes cooperation between all staff to deliver a safe working and care environment. Health and safety continue to be reviewed at all Company Board and Management Board meetings. Monthly directorate business performance reviews also focus on key risk management and operational performance.

The Company has continued to maintain the successful working relationship with the British Institute of Cleaning Science Limited (BICSc) as the provision of a clean and safe healthcare environment remains a key priority. Investing in training is part of our long-term commitment to the development and retention of our employees. As such, all domestic staff are BICSc trained in a number of skills critical to cleanliness in a healthcare environment, thereby allowing staff to assess and understand any infection risks posed by the delivery of services in this area.

We recognise that we continue to have a workforce retention risk that we manage given our geographical location and market factors, and include succession planning to facilitate our future strategy for the business. Management have focussed on reducing staff turnover rate and the level is now broadly comparable to the local market.

With regard to interest rates, there is no risk on the interest receivable on the finance lease, or payable under the loan from our parent company, as these are at a fixed rate of interest for the term. 2gether is benefitting from interest income on the cash balance held, with the Company's cash assets being held within the Government Banking Service. The Company does not hold investments other than cash and does not utilise complex financial instruments such as derivatives in its operations.

Our Procurement Team work with our supply chain (which includes the NHS Supply Chain) to proactively manage and mitigate inflationary pressures and any local or global supply chain issues to both the business and the Trust, with mitigation plans being in place to ensure essential suppliers are on hand as required. These include but are not limited to increased supplier cover, 'just in case' purchasing on key lines and maintaining increased stock holdings where required. The Trust, being our main customer, provides a continued undertaking to support costs above contract value where services are critical.

Future developments

The Company will continue to improve processes, services and solutions as part of the daily work performance. The Directors and senior management continually seek to achieve improvements in cost and quality along with the service to the Trust, and to strengthen performance through the evolution of systems, standards and tools. A business systems strategy is being compiled to facilitate further progress in respect of maximising efficiency in processes and the usage of systems across the business.

Going concern

The Directors have reviewed the financial forecasts up to the end of December 2025 and the underlying assumptions used to prepare them. The Directors have satisfied themselves that the assumptions are fair and reasonable and reflect the prospects for the business.

Although the Company enjoys a close relationship with the ultimate parent undertaking, the Company manages its cash flow independently and does not seek financial support from the Trust.

The Trust is currently in the Recovery Support Programme (RSP) segment 4 of the NHS System Oversight Framework (SOF4), with Finance as one of the strands – previously Financial Special Measures. Although the Company is not dependent on the Trust for financial support it must be acknowledged that a significant portion of the Company's turnover stems from the Trust.

The Directors have reviewed the commercial performance of the Company and in particular the sensitivity analysis of the Company's commercial prospects, which demonstrates that although the impact of an adverse change in activity levels or service pricing could be commercially significant to the Company, a number of measures put in place by the Company in order to mitigate the impact of such events along with the Company's record of stable business operations and good relationship with commercial stakeholders indicate that the risks deriving from this type of event can reasonably be regarded by the Directors as manageable business risks.

The Directors have assessed the Company's ability to continue as a going concern taking in to account all available information about the future, which is at least, but not limited to, twelve months from the date when the financial statements are authorised for issue. All expectations of the future are inherently uncertain; however, the Directors are confident that the Company has adequate resources for all reasonably expected eventualities. Thus, the Directors continue to adopt the going concern basis of accounting in preparing the financial statements.

Financial key performance indicators

The results of the Company are set out in detail on page 15.

Turnover for the year amounted to £159.9m (2023 - £149.0m). The increase in turnover in the year is the result of higher activity offset by a reduction in capital works undertaken for the Trust.

The operating profit of £2.0m (2023 - £1.4m) resulted from a gross profit of £15.9m (2023 - £13.4m) and administrative costs of £13.9m (2023 - £12.0m) during the year.

Taxation charge on ordinary activities was £0.9m (2023 - £0.4m) and the profit after tax for the period was £2.1m (2023 - £1.8m).

The strong liquidity position resulted in a positive cash balance of £12.4m (2023 - £9.1m) at the end of the period. There were no accelerated loan repayments (2023 - £8.0m) and no interim dividend payment (2023 - £4.0m) within the year.

Other key performance indicators

Key performance indicators are presented and monitored through the Management Board and the Company Board. These focus on the delivery of our facilities, projects and contract to ensure that these are managed efficiently, correctly, on time and on budget.

Service Performance indicators are presented to the Trust on a monthly basis with variances to cost, risks and/or operational issues addressed as a result of contract management between both the Company and the Trust.

Health and safety recorded 102 accidents over the year (2023 - 85), with the top two causes of injuries sustained remaining as slips, trips and falls, closely followed by manual handling. Of the 102 accidents, 16 were reported to the HSE due to the injury type or being at least a 7 day absence (2023 - 3), which included 6 slips, trips and falls injuries; 5 manual handling injuries; 1 injury due to machinery malfunction; 1 impact fracture; 1 injury from a patient assault; 1 burn injury; and 1 injury from a hand crush in a door. There were 9 recorded incidents of violence/aggression against 2gether staff (2023 - 5). There were 7 sharps injuries (2023 - 7). An incident Review Panel has been set up in the year to review any health and safety accidents or incidents, with any learnings and remedial actions being enacted. This may include changes to procedures, policies along with providing communication across the business highlighting further awareness for health and safety.

Domestic reactive works volume over the period totalled 98,399 (2023 - 95,684), increasing slightly on the prior year given increased activity by our customer.

The number of reactive portering requests over the period was 423,916 (2023 - 423,583).

Total switchboard calls answered over the period reduced on the prior year at 857,727 (2023 - 942,660).

Total helpdesk calls over the period remained fairly level at 372,032 (2023 - 376,362).

The average number of employees was 1,460 (2023 - 1,361). This can be split into average number of male employees 681 and female employees 779 (2023 - 638 and 723 respectively).

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Directors' statement of compliance with duty to promote the success of the Company

The Board of Directors consider, both individually and together, that they have acted in the way they consider in good faith, would be most likely to promote the success of the Company for the benefit of its members as a whole (having regard to the stakeholders and the matters set out in s172 of the Companies Act 2006) in the decisions taken during the year ended 31 March 2024.

The success of the Company is dependent on the support of all stakeholders. Working with stakeholders that share our values is important to us, towards shared long-term goals for sustainable success.

The Board and senior leadership team make decisions with a long-term view in mind and with the highest of standards of conduct in line with our policies. Reports across all areas of the business are regularly made available to the Board and its sub committees, to allow key decisions to be made with proper consideration and to assess the impact of decisions on stakeholders. The Company recognises that the ownership structure demands an important role in maximising the value and benefit to the NHS and wider community beyond economic gain.

The Board ensures that there is an effective culture that promotes the success of the Company, ensures the values and strategy align with the purpose of the Company, effectively identifies and builds on opportunities, and fosters effective stakeholder relationships. We have an open dialogue with our shareholders through group meetings, joint stakeholder meetings and committees, one to one executive meetings and Board to Board meetings, covering a wide range of subject matters. The shareholder views and feedback are considered as part of decision making. Staff feedback is equally important and we hold an annual staff survey to consider and act on any specific matters raised that require enhancement.

We engage with our people as highlighted in the 'Recruiting, Engaging and Retaining Talented Employees' within the Directors Report. We are pleased to continue supporting one of our primary goals in the payment of the Real Living Wage as a minimum for all staff, along with a strong emphasis on health and safety throughout the organisation. The Directors and senior leadership team meet periodically throughout the year with trade unions officials and staff representatives for meaningful conversation and information sharing on matters affecting the Company.

We have built a strong service orientated relationship with our primary customer, with the focus being around their requirements whilst mindful of the financial challenges of an NHS Trust. We strive to drive continuous improvement and innovation into our operations to drive long term relationships across each area of the business. To achieve this, the Directors and senior leadership team take the time to understand the real and perceived need of our primary customer by engaging with a variety of their stakeholders.

The Board recognises that our suppliers are integral to the success of the business and it is therefore essential that we build strong relationships in an ethical manner whilst meeting stringent quality, performance and delivery requirements. We aim to treat all fairly whilst ensuring their compliance with our high standards. Before engagement, we review their policies to ensure they match ours as set by the Board. The Company has a number of senior qualified procurement officers and managers that are experienced in supplier relationship management and procurement. As part of the Company's service offering the Company offers a fully compliant NHS framework procurement and supplier contract management service. The Company ensures that we pay suppliers in line with commercially agreed payment terms. We have a strong code of conduct and policies in relation to Anti Bribery and Corruption and Modern Slavery legislation.

We recognise the important role that our company plays in the local community. Social value principles are at the heart of the business, with a focus on creating opportunities in local employment and improving our environmental credentials.

Where needed, the Company has appointed relevant expert advisors to ensure that the Board are aware of, and the Company aims to meet all relevant obligations in regard to laws and regulations whilst identifying potential opportunities and risks for the business.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

This report was approved by the board and signed on its behalf.

P Ryder

P W Ryder
Director

Date: 22 October 2024

Directors' Report
For the year ended 31 March 2024

The Directors present their report and the financial statements for the year ended 31 March 2024.

Directors' responsibilities statement

The Directors are responsible for preparing the Strategic Report, the Directors' Report and the financial statements in accordance with applicable law and regulations.

Company law requires the Directors to prepare financial statements for each financial year. Under that law the Directors have elected to prepare the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including Financial Reporting Standard 102 ‘The Financial Reporting Standard applicable in the UK and Republic of Ireland'. Under company law the Directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs and profit or loss of the Company for that period.

In preparing these financial statements, the Directors are required to:

- select suitable accounting policies for the Company's financial statements and then apply them consistently;
- make judgements and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Company will continue in business.

The Directors are responsible for keeping adequate accounting records that are sufficient to show and explain the Company's transactions and disclose with reasonable accuracy at any time the financial position of the Company and to enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the Company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Principal activity

The principal activity of the Company is to act as a property facilities management company to provide an Operated Healthcare Facility (OHF) to the East Kent Hospitals University NHS Foundation Trust ("the Trust"). The Company provides and operates hospitals, health care establishments and health care facilities including related services related to these facilities and also to provide other support services.

Results and dividends

The profit for the year, after taxation, amounted to £2.1m (2023 - £1.8m).

There were no interim dividends paid during the year (2023 - £4.0m). The Directors do not recommend payment of a final dividend.

Directors

The Directors who served during the year were:

A J Bentley
J N Churchward-Cardiff
N J Webber
S Corben
P W Ryder
G R Jenkins
J R Ollis (resigned 7 May 2023)

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Financial risk management

Due to the continuing service provider relationship that the Company has with the Trust, the Company is not exposed to the degree of financial risk faced by traditional business entities. The Company has limited powers to borrow or invest surplus funds and the financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Company in undertaking its activities.

The Company has a risk and financial management framework, the primary objectives of which are to protect the Company from events that hinder the achievement of its performance objectives. The objectives of the financial risk framework are to limit undue counterparty exposure, ensure sufficient working capital and to manage other financial risks.

The Company’s principal financial instruments comprise bank balances, trade creditors, trade debtors, loans to the Company and lease arrangements. The main purpose of these instruments is to finance the Company’s operations.

Currency Risk

The majority of the Company's transactions, assets and liabilities are in the UK and sterling based. The Company has no overseas operations. Therefore, the Company has low exposure to currency rate fluctuations.

Interest rate risk

Most of the Company's financial assets and liabilities carry nil or fixed rates of interest to ensure certainty of cash flows.

Cash deposits as at 31 March 2024 were mainly held within commercial bank accounts (at fixed rates or linked to the bank base rate). The Company has loans of £52.0m (2023 - £53.8m) from the Trust; these loans are at a fixed rate of 3.5% per annum. Therefore, the Company is not exposed to significant interest rate risk.

Credit risk

Because the majority of the Company's income comes from contracts with the Trust, the Company has relatively low exposure to credit risk.

Liquidity risk

Liquidity risk is the risk that the Company will encounter difficulty in meeting its financial obligations as they fall due. The Company’s objective in managing liquidity risk is to ensure that this does not arise. Having assessed future cash flow requirements the Company expects to be able to meet its financial obligations through the cash flows that are generated from its operating activities.

Recruiting, engaging and retaining talented employees

We are committed to providing the highest levels of service to our customers and the Trust’s patients. With approximately 85% of our staff providing front-line activities, our people are critical to the delivery of outstanding services. We recognise and value their commitment, expertise and hard work in helping us achieve our goals.

This year we launched 2gether’s Vision, Mission and Values, re-focusing our attention on the core elements of our business. Our Vision is to ensure we are “Always delivering brilliant support solutions and facilities management for our customers”. Our Values set a framework within which our workforce may build respectful and caring working relationships, appreciate the efforts of colleagues, be curious about better ways of doing things, and support collaboration and improved productivity.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

As an organisation we work hard to recruit, train and engage our employees. We have improved our induction and onboarding process, allowing employees to better appreciate their important role in our success, and have further improved our turnover rates from 21% down to 17% in the past year. Once again, we improved our rates of pay and provided the Real Living Wage to our front-line staff. Thanks to the launch of a new employee engagement tool, employees can use their mobile phones and PCs to keep in touch with events and key information, and recognise colleagues. This is improving daily engagement and helping create a stronger sense of community, with nearly 50% employees using the platform and 60% users actively engaging each month. We also launched a new benefits and employee assistance platform, to better support employees in their daily lives.

A safe workplace is the foundation of our business. Our mission is to have the highest levels of safety; always and everywhere. The Health, Safety and Environment Committee, a committee of the Board of Directors, sets the governance framework throughout the business, supported by our Management Board and our site-based safety committees. A key are of focus moving forward is creating a proactive safety culture, actively reporting all near misses and learning shared throughout the organisation, and employees at all levels flagging and correcting potential safety concerns.

2gether is committed to promoting diversity and inclusion in all its activities, and works to ensure that no-one is discriminated against because of who they are, in particular with regard to age, disability, gender, sexual orientation, marital status, pregnancy or maternity, race, religion, belief and socio-economic status. Our employee networks include LGBTIA+, Disability, Women, Neurodiversity and Ethnic Diversity.

Engagement with suppliers, customers and others

We manage a complex supply chain solution for our customer as well as our own suppliers. It is therefore essential that we work with our suppliers in an ethical manner, ensuring that our suppliers provide goods and services that meet stringent quality, performance and delivery requirements. The Company ensures that we pay suppliers in line with commercially agreed payment terms. We have a strong code of conduct in relation to Anti Bribery and Corruption, and Modern Slavery legislation.

We have an open two way approach to dialogue with our primary customer and ensure that quality of service delivery to them is at the forefront of our operations, whilst aiming to provide continuous improvement in our service delivery and where possible, efficiencies for financial benefits.

Within the year, the Company completed and handed over two large capital build projects within the Operated Healthcare Facility which supports the built environment. The two substantial Emergency Department extensions at the William Harvey Hospital in Ashford and the Queen Elizabeth The Queen Mother Hospital in Margate were handed over in October 2023 and February 2024 respectively. Additionally, the Company has continued to undertake refurbishments of service streams to enable the Trust to improve patient pathways.

Disabled employees

Full and fair consideration is given to applications for employment from individuals who consider themselves to have a disability and we make workplace adjustments wherever possible to support disabled people into employment. If an employee becomes disabled, we will work with them and our occupational health advisors to support adjustments in the workplace to enable the individual to continue to work with us.

Qualifying third party indemnity provisions

The Company has granted an indemnity to one or more of its directors against liability in respect of proceedings brought by third parties, subject to the conditions set out in the Company's articles of association and the Companies Act 2006. Such qualifying third-party indemnity provision remains in force as at the date of approving the Directors' Report.

Greenhouse gas emissions, energy consumption and energy efficiency action

The Company tenant's energy use across the sites for 2024 was circa 95,457 MWh (2023 - 89,711 MWh).

Carbon emissions were 17,355 tCO2e (2023 - 19,348 tCO2e).

The Trust's Capital Projects Energy Performance Contract (EPC) Solar PV Systems installations at the William Harvey Hospital in Ashford, the Queen Elizabeth the Queen Mother Hospital in Margate and the Buckland Hospital in Dover generated 1,146 MWh to our distribution capacity for 2024 (2023 - 1,686 MWh).

The annual emissions for April 2023 to March 2024 were 522.76 kWh per occupied m2 of the total estate (2023 - 503.11 kWh per m2), and 465.48 kWh per m2 of the total estate (2023 - 460.56 kWh per m2).

The energy data comes from the billed usage during each financial year. The carbon emissions are calculated from the billed gas and electricity data using BEIS conversion factors as per the 'UK Government GHG Conversion Factors for Company Reporting' 2023 - 2024.

The Company is supporting the Trust in its commitment to the Greener NHS targets for reaching net zero emissions for the aspects controlled by 2040 (with an 80% reduction by 2032) and the elements influenced by 2045 (with an 80% reduction by 2039). The standardised NHS Emissions Quantification Recipe Book (NHS-EQRB) approach is being utilised to estimate emission footprints from 2019/20 to 2023/24 towards the development of an evidence-based Green Plan to be published in 2024/25. The estate portfolio is recognised to be the most considerable contributor to the Trust controlled emissions, and has therefore been a focus of works to date.

Historical energy efficiency works undertaken by 2gether have projected to have reduced spend on energy by more than £500k in 2023/24. The Trust was awarded £842k in late 2023 by the UK Department for Energy Security & Net Zero through the Low Carbon Skills Fund to develop designs for decarbonising heat at Kent and Canterbury Hospital, William Harvey Hospital and Queen Elizabeth, the Queen Mother Hospital. The design phase was completed at the end of March 2024 and work is underway to identify funding opportunities to continue the critical work across the estate as part of holistic works underway through a new Green Plan.

Following stakeholder engagement and development of a draft Green Plan, a new Sustainability and Energy Engineering Lead was appointed in early 2024 to support the finalising and publication of a strategy to coordinate the Trust's efforts towards the NHS England mandated emission reduction targets. The Green Plan is projected to prioritise:

- Continuing the decarbonisation of the estate with a focus on opportunities that maximise health co-benefits;
- Incorporating a standardised approach to measuring and monitoring the impact of Trust activity to support regional collaboration;
- Establishing a robust, supported colleague network to support the transformative change needed for sustainable service delivery;
- The Communications with stakeholders on progress and opportunities for involvement.

These focused areas have been chosen because of the environmental value it would add to the Trust's net emissions at the end of the next fiscal year. Focussing on these areas will also bring the Trust into compliance with required reports and actions on the NHS Sustainability Guidance Document.

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to patients and reflects the ethics of the staff. The national requirement, as set out in NHSE / I report 'Delivering a Net Zero NHS' is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. The Trust will be focussing on improving these areas over the coming five to ten years.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Matters covered in the Strategic Report

Information relating to business activities, likely future developments in the business, its financial position, its exposure to risks, and the Directors' assessment of going concern have been disclosed within the Strategic Report in accordance with section 414c(ii) of the Companies Act 2006.

Events after the Reporting Period

There have been no post balance sheet events that would require adjustment or additional disclosure in the accounts.

Disclosure of information to auditor

Each of the persons who are Directors at the time when this Directors' Report is approved has confirmed that:

- so far as the Director is aware, there is no relevant audit information of which the Company's auditor is unaware, and
- the Director has taken all the steps that ought to have been taken as a Director in order to be aware of any relevant audit information and to establish that the Company's auditor is aware of that information.

Auditor

The auditor, Grant Thornton UK LLP, will be proposed for reappointment in accordance with section 485 of the Companies Act 2006.

This report was approved by the Board and signed on its behalf.

P Ryder

P W Ryder
Director
Date: 22 October 2024

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Independent Auditor's Report to the Members of 2gether Support Solutions Limited

Opinion

We have audited the financial statements of 2gether Support Solutions Limited (the 'Company') for the year ended 31 March 2024, which comprise the Statement of Income and Retained Earnings, the Balance Sheet, and the 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 Company's affairs as at 31 March 2024 and of its profit for the year then ended;
- the financial statements have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- the financial statements have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

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 Company 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 Directors’ 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 Company’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 company to cease to continue as a going concern.

In our evaluation of the Directors’ conclusions, we considered the inherent risks associated with the Company’s business model including effects arising from macro-economic uncertainties such as rising costs due to inflation, we assessed and challenged the reasonableness of estimates made by the directors and the related disclosures and analysed how those risks might affect the Company’s financial resources or ability to continue operations over the going concern period.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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 Company'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.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

Other information

The other information comprises the information included in the Annual Report and Financial Statements, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information contained within the Annual Report and Financial Statements. 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.

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 themselves. 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.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Strategic Report and the Directors' Report have been prepared in accordance with applicable legal requirements.

Matter on which we are required to report under the Companies Act 2006

In the light of the knowledge and understanding of the Company and its environment obtained in the course of the audit, we have not identified material misstatements in the Strategic Report or the Directors' Report.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of Directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of directors

As explained more fully in the Directors' responsibilities statement set out on page 6, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Directors determine 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 Directors are responsible for assessing the Company'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 Directors either intend to liquidate the Company or to cease operations, or have 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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 applicable to the Company and determined that the following laws and regulations were most significant: Financial Reporting Standard 102 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' and the Companies Act 2006, and the relevant tax compliance regulations in the UK.
- We obtained an understanding of the legal and regulatory frameworks applicable to the Company and the industry in which it operates through our general and commercial and sector experience as well as discussions with management. We obtained an understanding of how the Company is complying with those legal and regulatory frameworks by making inquiries of management and of those responsible for legal and compliance procedures. We corroborated our inquiries through our review of board minutes.
- We assessed the susceptibility of the Company's financial statements to material misstatement, including how fraud might occur by meeting with management from different parts of the business to understand where it is considered there was a susceptibility of fraud. We also considered performance targets and their propensity to influence efforts made by management to manage earnings. We considered the processes and controls that the Company has established to address risks identified, or that otherwise prevent, deter and detect fraud; and how senior management monitors those processes and controls. Where the risk was considered to be higher, we performed audit procedures to address each identified fraud risk.
- Our audit procedures involved: journal entry testing, with a focus on journals indicating large or unusual transactions based on our understanding of the business; substantive testing of revenue transactions to ascertain the appropriate recognition of revenue within the year and enquiries of management. In addition, we completed audit procedures to conclude on the compliance of disclosures in the Annual Report and Financial Statements with applicable financial reporting requirements.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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;
- The engagement leader's 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 industry in which the Company operates
  - understanding of the legal and regulatory requirements specific to the Company.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including internal specialists, and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

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.

Use of our report

This report is made solely to the Company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the Company's members 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 Company and the Company's members, as a body, for our audit work, for this report, or for the opinions we have formed.

Sophie Murton

Sophie Murton FCA
Senior Statutory Auditor
for and on behalf of Grant Thornton UK LLP
Statutory Auditor, Chartered Accountants
Southampton

22 October 2024

2gether Support Solutions Limited

Statement of Income and Retained Earnings
For the year ended 31 March 2024

	Note	**2024 £000**	2023 £000
Turnover	4	**159,861**	149,014
Cost of sales		**(143,977)**	(135,664)
Gross profit		**15,884**	13,350
Administrative expenses		**(13,930)**	(11,969)
Operating profit	5	**1,954**	1,381
Interest receivable and similar income	9	**2,924**	2,920
Interest payable and similar expenses	10	**(1,825)**	(2,121)
Profit before tax		**3,053**	2,180
Tax on profit	11	**(948)**	(352)
Profit after tax		**2,105**	1,828
Retained earnings at the beginning of the year		**3,073**	5,245
Profit for the year		**2,105**	1,828
Dividends declared and paid	12	**-**	(4,000)
Retained earnings at the end of the year		**5,178**	3,073

There were no recognised gains and losses for 2024 or 2023 other than those included in the Statement of Income and Retained Earnings.

The notes on pages 17 to 35 form part of these financial statements.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2gether Support Solutions Limited
Registered number: 11385580

Balance Sheet
as at 31 March 2024

	Note		2024 £000		2023 £000
Fixed assets					
Intangible assets	13		**95**		131
Tangible assets	14		**946**		711
			1,041		842
Current assets					
Stocks	15	**5,245**		5,582	
Debtors: amounts falling due after more than one year	17	**63,968**		66,399	
Debtors: amounts falling due within one year	16	**30,407**		21,987	
Cash at bank and in hand	19	**12,413**		9,074	
		112,033		103,042	
Creditors: amounts falling due within one year	20	**(27,564)**		(18,576)	
Net current assets			**84,469**		84,466
Total assets less current liabilities			**85,510**		85,308
Creditors: amounts falling due after more than one year	21		**(50,065)**		(51,968)
Net assets			**35,445**		33,340
Capital and reserves					
Called up share capital	23		**30,267**		30,267
Profit and loss account	24		**5,178**		3,073
			35,445		33,340

The financial statements were approved and authorised for issue by the Board and were signed on its behalf by:

P Ryder

Ashley Bentley

P W Ryder
Director

A J Bentley
Director

Date: 22 October 2024

The notes on pages 17 to 35 form part of these financial statements.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

1. General information

2gether Support Solutions Limited ("the Company") is a private company limited by shares and is incorporated in England with the registration number 11385580. The Company operates from a number of locations across east Kent. The address of the registered office is Management Offices, William Harvey Hospital, Kennington Road, Willesborough, Ashford, Kent, England, TN24 0LZ.

The Company's principal activity is to act as a property facilities management company to provide an Operated Healthcare Facility (OHF) to the East Kent Hospitals University NHS Foundation Trust.

2. Accounting policies

2.1 Basis of preparation of financial statements

The financial statements have been prepared under the historical cost convention unless otherwise specified within these accounting policies and in accordance with Financial Reporting Standard 102, the Financial Reporting Standard applicable in the UK and the Republic of Ireland and the Companies Act 2006.

The functional and presentational currency of the Company is pounds sterling. The financial statements are rounded to the nearest thousand pounds.

The preparation of financial statements in compliance with FRS 102 requires the use of certain critical accounting estimates. It also requires management to exercise judgement in applying the Company's accounting policies (see note 3).

The following principal accounting policies have been applied:

2.2 Financial Reporting Standard 102 - reduced disclosure exemptions

The Company has taken advantage of the following disclosure exemptions in preparing these financial statements, as permitted by the FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland":

- the requirements of Section 7 Statement of Cash Flows;
- the requirements of Section 3 Financial Statement Presentation paragraph 3.17(d);
- the requirements of Section 11 Financial Instruments paragraphs 11.42, 11.44 to 11.45, 11.47, 11.48(a)(iii), 11.48(a)(iv), 11.48(b) and 11.48(c);
- the requirements of Section 12 Other Financial Instruments paragraphs 12.26 to 12.27, 12.29(a), 12.29(b) and 12.29A;
- the requirements of Section 33 Related Party Disclosures paragraph 33.7.

This information is included in the consolidated financial statements of East Kent Hospitals University NHS Foundation Trust as at 31 March 2024 and these financial statements may be obtained from www.ekhuft.nhs.uk.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.3 Going concern

At the time of approving the financial statements the Directors have reviewed the financial forecasts up to the end of December 2025 and the underlying assumptions used to prepare them, and have a reasonable expectation that the Company has adequate resources to continue in operational existence for the foreseeable future.

Although the Company enjoys a close relationship with the ultimate parent undertaking, East Kent Hospitals University NHS Foundation Trust, the Company manages its cash flow independently and does not seek financial support from the Trust.

The Trust is currently in the Recovery Support Programme (RSP) segment 4 of the NHS System Oversight Framework (SOF4), with Finance as one of the strands – previously Financial Special Measures. Although the Company is not dependent on the Trust for financial support it must be acknowledged that a significant portion of the Company's turnover stems from the Trust.

The Directors have reviewed the commercial performance of the Company and in particular the sensitivity analysis of the Company's commercial prospects, which demonstrates that although the impact of an adverse change in activity levels or service pricing could be commercially significant to the Company, a number of measures put in place by the Company in order to mitigate the impact of such events along with the Company's record of stable business operations and good relationship with commercial stakeholders indicate that the risks deriving from this type of event can reasonably be regarded by the Directors as manageable business risks.

The Directors have assessed the Company’s ability to continue as a going concern considering all available information about the future, which is at least, but not limited to, twelve months from the date when the financial statements are authorised for issue. All expectations of the future are inherently uncertain due to the current circumstances; however, the Directors are confident that the Company has adequate resources for all reasonably expected eventualities. Thus, the Directors continue to adopt the going concern basis of accounting in preparing the financial statements.

2.4 Revenue recognition

The Company acts as a property facilities management company to provide an Operated Healthcare Facility (OHF) to the East Kent Hospitals University NHS Foundation Trust.

Revenue is recognised to the extent that it is probable that the economic benefits will flow to the Company and the revenue can be reliably measured. Revenue is measured as the fair value of the consideration received or receivable, excluding discounts, rebates, value added tax and other sales taxes. The following criteria must also be met before revenue is recognised:

Revenue from rendering of services is recognised when the amount of revenue can be measured reliably and it is probable that future economic benefits will flow to the entity.

Revenue from rendering of services under the OHF is recognised on the provision of those services. This is normally on a straight-line basis over the term of the contract or over the agreed service period or, if the performance is other than straight line, as and when the service is performed. In cases where the Company cannot estimate the amount of services performed under the OHF, the Company accrues revenue to the extent of the expenses incurred where it is probable the expenses will be recovered.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.5 Operating leases: the Company as lessee

Rentals paid under operating leases are charged to the Statement of Income and Retained Earnings on a straight-line basis over the lease term.

Benefits received and receivable as an incentive to sign an operating lease are recognised on a straight-line basis over the lease term, unless another systematic basis is representative of the time pattern of the lessee's benefit from the use of the leased asset.

2.6 Leased assets: the Company as lessor

Where assets leased to a third party give rights approximating to ownership (finance lease), the lessor recognises as a receivable an amount equal to the net investment in the lease i.e. the minimum lease payments receivable under the lease discounted at the interest rate implicit in the lease. This receivable is reduced as the lessee makes capital payments over the term of the lease.

A finance lease gives rise to two types of income: profit or loss equivalent to the profit or loss resulting from outright sale of the asset being leased, at normal selling prices, reflecting any applicable discounts, and finance income over the lease term.

2.7 Interest income

Interest income is recognised in the Statement of Income and Retained Earnings using the effective interest method.

2.8 Finance costs

Finance costs are charged to the Statement of Income and Retained Earnings over the term of the debt using the effective interest method so that the amount charged is at a constant rate on the carrying amount. Issue costs are initially recognised as a reduction in the proceeds of the associated capital instrument.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.9 Pensions

NHS Pension Scheme

Certain past and present employees are covered by the provisions of two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Company is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the Company commits itself to the retirement, regardless of the method of payment.

Defined contribution pension plan

The Company operates a defined contribution plan for its employees. A defined contribution plan is a pension plan under which the Company pays fixed contributions into a separate entity. Once the contributions have been paid the Company has no further payment obligations.

The contributions are recognised as an expense in the Statement of Income and Retained Earnings when they fall due. Amounts not paid are shown in accruals as a liability on the Balance Sheet. The assets of the plan are held separately from the Company in independently administered funds.

2.10 Current and deferred taxation

The tax expense for the year comprises current and deferred tax. Tax is recognised in the Statement of Income and Retained Earnings through the profit and loss account, except that a charge attributable to an item of income and expense recognised as other comprehensive income or to an item recognised directly in equity is also recognised in other comprehensive income or directly in equity respectively.

The current income tax charge is calculated on the basis of tax rates and laws that have been enacted or substantively enacted by the balance sheet date in the countries where the Company operates and generates income.

Deferred tax balances are recognised in respect of all timing differences that have originated but not reversed by the balance sheet date, except that:

- The recognition of deferred tax assets is limited to the extent that it is probable that they will be recovered against the reversal of deferred tax liabilities or other future taxable profits; and
- Any deferred tax balances are reversed if and when all conditions for retaining associated tax allowances have been met.

Deferred tax balances are not recognised in respect of permanent differences except in respect of business combinations, when deferred tax is recognised on the differences between the fair values of assets acquired and the future tax deductions available for them and the differences between the fair values of liabilities acquired and the amount that will be assessed for tax. Deferred tax is determined using tax rates and laws that have been enacted or substantively enacted by the balance sheet date.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.11 Intangible assets

Intangible assets are initially recognised at cost. After recognition, under the cost model, intangible assets are measured at cost less any accumulated amortisation and any accumulated impairment losses.

At each reporting date the Company assesses whether there is any indication of impairment. If such indication exists, the recoverable amount of the asset is determined which is the higher of its fair value less costs to sell and its value in use. An impairment loss is recognised where the carrying amount exceeds the recoverable amount.

All intangible assets are considered to have a finite useful life.

Computer software is amortised over a 5-year period.

2.12 Tangible fixed assets

Tangible fixed assets under the cost model are stated at historical cost less accumulated depreciation and any accumulated impairment losses. Historical cost includes expenditure that is directly attributable to bringing the asset to the location and condition necessary for it to be capable of operating in the manner intended by management.

At each reporting date the Company assesses whether there is any indication of impairment. If such indication exists, the recoverable amount of the asset is determined which is the higher of its fair value less costs to sell and its value in use. An impairment loss is recognised where the carrying amount exceeds the recoverable amount.

The Company adds to the carrying amount of an item of fixed assets the cost of replacing part of such an item when that cost is incurred, if the replacement part is expected to provide incremental future benefits to the Company. The carrying amount of the replaced part is derecognised. Repairs and maintenance are charged to profit or loss during the period in which they are incurred.

Depreciation is charged so as to allocate the cost of assets less their residual value over their estimated useful lives, using the straight-line method.

The estimated useful lives range as follows:

Plant, machinery and equipment	- 5 years

The assets' residual values, useful lives and depreciation methods are reviewed, and adjusted prospectively if appropriate, or if there is an indication of a significant change since the last reporting date.

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount and are recognised in profit or loss.

2.13 Stocks

Stocks are stated at the lower of cost and net realisable value, being the estimated selling price less costs to complete and sell. Cost is based on the cost of purchase on a first in, first out basis.

At each balance sheet date, stocks are assessed for impairment. If stock is impaired, the impairment loss is recognised immediately in the Statement of Income and Retained Earnings.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.14 Cash and cash equivalents

Cash is represented by cash in hand and deposits with financial institutions repayable without penalty on notice of not more than 24 hours. Cash equivalents are highly liquid investments that mature in no more than three months from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

2.15 Provisions for liabilities

Provisions are recognised when an event has taken place that gives rise to a legal or constructive obligation, a transfer of economic benefits is probable and a reliable estimate can be made.

Provisions are measured as the best estimate of the amount required to settle the obligation, taking into account the related risks and uncertainties.

Increases in provisions are generally charged as an expense to profit or loss.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.16 Financial instruments

The Company has elected to apply the provisions of Section 11 “Basic Financial Instruments” of FRS 102 to all of its financial instruments.

Financial instruments are recognised in the Company's Balance Sheet when the Company becomes party to the contractual provisions of the instrument.

Financial assets and liabilities are offset, with the net amounts presented in the financial statements, when there is a legally enforceable right to set off the recognised amounts and there is an intention to settle on a net basis or to realise the asset and settle the liability simultaneously.

Basic financial assets

Basic financial assets, which include trade debtors, loan receivables, cash and bank balances, are initially measured at their transaction price including transaction costs and are subsequently carried at their amortised cost using the effective interest method, less any provision for impairment, unless the arrangement constitutes a financing transaction, where the transaction is measured at the present value of the future receipts discounted at a market rate of interest.

Discounting is omitted where the effect of discounting is immaterial. The Company's cash and cash equivalents, trade and most other debtors due with the operating cycle fall into this category of financial instruments.

Impairment of financial assets

Financial assets are assessed for indicators of impairment at each reporting date.

Financial assets are impaired when events, subsequent to their initial recognition, indicate the estimated future cash flows derived from the financial asset(s) have been adversely impacted. The impairment loss will be the difference between the current carrying amount and the present value of the future cash flows at the asset(s) original effective interest rate.

If there is a favourable change in relation to the events surrounding the impairment loss then the impairment can be reviewed for possible reversal. The reversal will not cause the current carrying amount to exceed the original carrying amount had the impairment not been recognised. The impairment reversal is recognised in the profit or loss.

Financial liabilities

Financial liabilities and equity instruments are classified according to the substance of the contractual arrangements entered into. An equity instruments any contract that evidences a residual interest in the assets of the Company after the deduction of all its liabilities.

Basic financial liabilities, which include trade creditors, bank loans and other loans are initially measured at their transaction price after transaction costs. When this constitutes a financing transaction, whereby the debt instrument is measured at the present value of the future receipts discounted at a market rate of interest. Discounting is omitted where the effect of discounting is immaterial.

Debt instruments are subsequently carried at their amortised cost using the effective interest rate method.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

2. Accounting policies (continued)

2.16 Financial instruments (continued)

Trade creditors are obligations to pay for goods and services that have been acquired in the ordinary course of business from suppliers. Trade creditors are classified as current liabilities if the payment is due within one year. If not, they represent non-current liabilities. Trade creditors are initially recognised at their transaction price and subsequently are measured at amortised cost using the effective interest method. Discounting is omitted where the effect of discounting is immaterial.

Derecognition of financial instruments

Derecognition of financial assets

Financial assets are derecognised when their contractual right to future cash flow expire, or are settled, or when the Company transfers the asset and substantially all the risks and rewards of ownership to another party. If significant risks and rewards of ownership are retained after the transfer to another party, then the Company will continue to recognise the value of the portion of the risks and rewards retained.

Derecognition of financial liabilities

Financial liabilities are derecognised when the Company's contractual obligations expire or are discharged or cancelled.

2.17 Dividends

Equity dividends are recognised when they become legally payable. Interim equity dividends are recognised when paid. Final equity dividends are recognised when approved by the shareholders at an annual general meeting.

3. Judgements in applying accounting policies and key sources of estimation uncertainty

The preparation of the financial statements requires the Directors to make judgements, estimates and assumptions that can affect the amounts reported for assets and liabilities, and the results for the year. The nature of estimation is such though that actual outcomes could differ significantly from those estimates.

The following judgements have had the most significant impact on amounts recognised in the financial statements:

Lease commitments

The Company has entered into a range of lease commitments. The classification of these leases as either financial or operating leases requires the Directors to consider whether the terms and conditions of each lease are such that the Company has acquired the risks and rewards associated with the ownership of the underlying assets.

Revenue recognition - principal vs. agent

A key judgement in recognising revenue is to distinguish where the Company acts in the capacity of principal or agent, so to determine the accounting as either gross or net respectively. The Directors exercise judgement to assess principal or agency by considering if it is the prime obligor in all the revenue arrangements, has pricing discretion and is exposed to credit risk, in which case the Company will be principal to the arrangement.

The Directors have assessed that the Company acts as principal in respect of all transactions.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

4. Turnover

The whole of turnover is attributable to the Company's principal activity of acting as a property facilities management company to provide an Operated Healthcare Facility (OHF) to the East Kent Hospitals University NHS Foundation Trust.

All turnover relates to the rendering of services within the United Kingdom.

5. Operating profit

The operating profit is stated after charging:

	2024 **£000**	2023 £000
Other operating lease rentals	**1,763**	1,235
Depreciation of tangible fixed assets	**268**	267
Amortisation of intangible fixed assets	**37**	37

6. Auditor's remuneration

During the year, the Company obtained the following services from the Company's auditor and its associates:

	2024 **£000**	2023 £000
Fees payable to the Company's auditor and its associates for the audit of the Company's financial statements	**86**	61

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

7. Employees

Staff costs, including Directors' remuneration, were as follows:

	2024 £000	2023 £000
Wages and salaries	**36,504**	30,488
Social security costs	**3,204**	2,660
Cost of NHS pension scheme	**676**	707
Cost of defined contribution scheme	**687**	532
	41,071	34,387

The average monthly number of employees, including the Directors, during the year was as follows:

	2024 No.	2023 No.
Management	**61**	57
Professional	**33**	28
Skilled	**74**	73
General	**1,121**	1,028
Administration and clerical	**180**	175
	1,469	1,361

Key management personnel compensation

The Directors and members of the senior management are considered to be key management personnel. The compensation paid or payable to key management for employee services is shown below:

	2024 £000	2023 £000
Wages and salaries	**1,048**	959
Social security costs	**132**	125
Cost of NHS pension scheme	**24**	22
Cost of defined contribution pension scheme	**54**	43
	1,258	1,149

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

8. Directors' remuneration

	2024 **£000**	2023 £000
Directors' emoluments	**389**	369
Company contributions to defined contribution pension schemes	**26**	23
	415	392

During the year retirement benefits were accruing to 2 Directors (2023 - 2) in respect of defined contribution pension schemes.

The highest paid Director received remuneration of £178k (2023 - £157k).

The value of the Company's contributions paid to a defined contribution pension scheme in respect of the highest paid Director amounted to £14k (2023 - £13k).

9. Interest receivable

	2024 **£000**	2023 £000
Interest receivable from group companies relating to the finance lease	**2,357**	2,580
Bank interest receivable	**567**	340
	2,924	2,920

10. Interest payable and similar expenses

	2024 **£000**	2023 £000
Interest payable by group undertakings (note 21)	**1,825**	2,120
Other interest payable	**-**	1
	1,825	2,121

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

11. Taxation

	2024 **£000**	2023 £000
Corporation tax		
Current tax on profits for the year	**1,109**	1,070
Adjustments in respect of previous periods	**6**	(8)
Total current tax	**1,115**	1,062
Deferred tax		
Origination and reversal of timing differences	**(167)**	(710)
Total deferred tax	**(167)**	(710)
Taxation on profit on ordinary activities	**948**	352

Factors affecting tax charge for the year

The tax assessed for the year is higher than (2023 - lower than) the standard rate of corporation tax in the UK of 25% (2023 - 19%). The differences are explained below:

	2024 **£000**	2023 £000
Profit on ordinary activities before tax	**3,053**	2,180
Profit on ordinary activities multiplied by standard rate of corporation tax in the UK of 25% (2023 - 19%)	**763**	414
Effects of:		
Capital allowances for year in excess of depreciation	**(7)**	(39)
Adjustments to tax charge in respect of prior periods	**6**	(8)
Short term timing differences	**7**	28
Finance lease timing differences	**587**	266
Short lease premium relief	**(408)**	(309)
Total tax charge for the year	**948**	352

Factors that may affect future tax charges

There were no factors that may affect future tax charges.

Deferred taxes have been measured at the rates the assets and liabilities are expected to unwind, using rates substantively enacted at the balance sheet date.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

12. Dividends

	2024 **£000**	2023 £000
Dividends paid on Ordinary share capital	**-**	4,000

An interim dividend of 13.22 pence per each Ordinary Share payable to shareholders registered at the close of business was declared and paid on 27 January 2023.

13. Intangible assets

	Computer software £000
Cost	
At 1 April 2023 (as previously stated)	**262**
Prior Year Adjustment	**(57)**
At 1 April 2023 (as restated)	**205**
At 31 March 2024	**205**
Amortisation	
At 1 April 2023 (as previously stated)	**130**
Prior Year Adjustment	**(57)**
At 1 April 2023 (as restated)	**73**
Charge for the year	**37**
At 31 March 2024	**110**
Net book value	
At 31 March 2024	**95**
At 31 March 2023	131

The brought forward cost and accumulated amortisation of computer software have been restated to correct an error in the classification identified during the period. The restatement did not have an impact in the prior year net book value recognised in the balance sheet, nor did it have an impact on the current or prior year profit or loss.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

14. Tangible fixed assets

	Plant, machinery and equipment £000
Cost	
At 1 April 2023 (as previously stated)	**1,338**
Prior Year Adjustment	**(123)**
At 1 April 2023 (as restated)	**1,215**
Additions	**504**
At 31 March 2024	**1,719**
Depreciation	
At 1 April 2023 (as previously stated)	**628**
Prior Year Adjustment	**(123)**
At 1 April 2023 (as restated)	**505**
Charge for the year	**268**
At 31 March 2024	**773**
Net book value	
At 31 March 2024	**946**
At 31 March 2023	711

The brought forward cost and accumulated depreciation of plant, machinery and equipment have been restated to correct an error in the classification identified during the period. The restatement did not have an impact in the prior year net book value recognised in the balance sheet, nor did it have an impact on the current or prior year profit or loss.

15. Stocks

	2024 £000	2023 £000
Medical and surgical supplies	**4,355**	4,775
Fuel	**601**	508
Soft facilities management consumables	**289**	299
	5,245	5,582

There is no significant difference between the replacement cost of the inventory and its carrying amount.

The carrying value of stocks is net of impairment losses. There were no impairment losses recognised in the years ended 31 March 2024 and 2023.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

16. Debtors: Amounts falling due within one year

	2024 **£000**	2023 £000
Trade debtors	**107**	765
Amounts owed by group undertakings	**5,851**	4,909
Other debtors	**50**	86
Other taxation and social security	**248**	1,328
Prepayments and accrued income	**22,622**	13,537
Deferred taxation	**1,529**	1,362
	30,407	21,987

Included within amounts owed by group undertakings is an amount of £2,431k (2023 - £4,705k), which is repayable as per note 18. All other amounts owed by group undertakings are unsecured, interest free, have no fixed date of repayment and are repayable on demand.

17. Debtors: Amounts falling due after more than one year

	2024 **£000**	2023 £000
Amounts owed by group undertakings	**63,968**	66,399

Amounts owed by group undertakings are repayable as per note 18.

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

18. Finance leases

Gross lease investments due:

	2024 **£000**	2023 £000
Within one year	**4,682**	7,062
Between 1-5 years	**23,408**	23,408
Over 5 years	**63,202**	67,884
Finance charges allocated to future periods	**(24,893)**	(27,250)
Net lease investments	**66,399**	71,104

Of which are receivable:

	2024 **£000**	2023 £000
Within one year	**2,431**	4,705
Between 1-5 years	**13,491**	13,035
Over 5 years	**50,477**	53,364
	66,399	71,104

On 1 October 2018 the Company acquired assets of £100.7m from East Kent Hospitals University NHS Foundation Trust, its parent undertaking, in connection with the provision of an Operated Healthcare Facility. The Trust retains control of the transferred assets resulting in a significant finance lease back to the Trust. The arrangement is for land and buildings over 25 years and equipment over 5 years.

19. Cash and cash equivalents

	2024 **£000**	2023 £000
Cash at bank and in hand	**12,413**	9,074

Docusign Envelope ID: 54526ED0-54F5-4AC4-B2C4-A985F1B3F478

20. Creditors: Amounts falling due within one year

	2024 **£000**	2023 £000
Trade creditors	**15,862**	6,814
Amounts owed to group undertakings (note 21)	**2,647**	2,321
Corporation tax	**256**	194
Other taxation and social security	**694**	628
Other creditors	**248**	214
Accruals and deferred income	**7,857**	8,405
	27,564	18,576

Amounts owed to group undertakings are payable as per note 21.

21. Creditors: Amounts falling due after more than one year

	2024 **£000**	2023 £000
Amounts owed to group undertakings	**50,065**	51,968

The Company has received a loan from East Kent Hospitals University NHS Foundation Trust, its parent undertaking. This loan is repayable by instalments ending 1 October 2043 and interest is charged on the loan at 3.5% per annum. The loan is secured in favour of East Kent Hospitals University NHS Foundation Trust by way of legal charges over all assets of the Company.

Analysis of the maturity of the loan is given below:

	2024 **£000**	2023 £000
Within one year	**1,903**	1,839
Between 1-2 years	**1,969**	1,903
Between 2-5 years	**6,332**	6,118
Over 5 years	**41,764**	43,947
	51,968	53,807

22. Deferred taxation

	2024 £000	2023 £000
At beginning of year	**1,362**	652
Charged to profit or loss	**167**	710
At end of year	**1,529**	1,362

The deferred tax asset is made up as follows:

	2024 £000	2023 £000
Fixed asset timing differences	**(215)**	(173)
Finance lease timing differences	**1,715**	1,502
Provisions for expenditure deductible in future years	**29**	33
	1,529	1,362

The net increase to the deferred tax asset expected in 2025 is £309k. This primarily relates to timing differences on finance leases and acquired tangible assets.

23. Share capital

	2024 £000	2023 £000
Allotted, called up and fully paid		
30,266,901 (2023 - 30,266,901) Ordinary shares of £1 each	**30,267**	30,267

There is a single class of Ordinary shares. There are no restrictions on the distribution of dividends and the repayment of capital.

24. Reserves

Profit and loss account

This reserve comprises all current and prior period retained profits and losses after deducting any distributions made to the Company's shareholders.

25. Pension commitments

NHS Pension Scheme

The pension cost charge represents contributions payable by the Company to the fund and amounted to £676k (2023 - £707k). Contributions totalling £87k (2023 - £86k) were payable to the fund at the balance sheet date and are included in creditors.

Defined contribution pension plan

The Company also operates a defined contributions pension scheme. The assets of the scheme are held separately from those of the Company in an independently administered fund. The pension cost charge represents contributions payable by the Company to the fund and amounted to £678k (2023 - £532k). Contributions totalling £152k (2023 - £124k) were payable to the fund at the balance sheet date and are included in creditors.

26. Commitments under operating leases

At 31 March 2024 the Company had future minimum lease payments due under non-cancellable operating leases for each of the following periods:

	2024 **£000**	2023 £000
Not later than 1 year	**1,068**	1,092
Later than 1 year and not later than 5 years	**717**	1,711
	1,785	2,803

27. Related party transactions

The Company is exempt from disclosing related party transactions with other companies that are wholly owned within the group.

28. Controlling party

The Company is a wholly owned subsidiary undertaking of East Kent Hospitals University NHS Foundation Trust.

The Directors regard East Kent Hospitals University NHS Foundation Trust as its ultimate parent undertaking and controlling party. East Kent Hospitals University NHS Foundation Trust heads the smallest and largest group for which consolidated financial statement are prepared that include the results of the Company. Those financial statements are available at www.ekhuft.nhs.uk. East Kent Hospitals University NHS Foundation Trust is registered at Trust Offices, Kent & Canterbury Hospital, Ethelbert Road, Canterbury, Kent, CT1 3NG.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

Company registration number 03130118 (England and Wales)

SPENCER PRIVATE HOSPITALS LIMITED

ANNUAL REPORT AND FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 2024

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

COMPANY INFORMATION

Directors	G D Bailey	
	J Jenner	
	H F Risebrow	
	A Andreou	
	J A Yanni	
	A Heselwood	(Appointed 2 February 2024)
Company number	03130118	
Registered office	1 & 3 Almond House Betteshanger Road Betteshanger Deal England CT14 0EN	
Auditor	Grant Thornton UK LLP Statutory Auditor & Registered Accountant Southampton Science Park Chilworth Southampton SO16 7QJ	
Business address	Spencer Private Hospital Ramsgate Road Margate Kent CT9 4BG	

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

CONTENTS

	Page
Strategic report	1 - 2
Directors' report	3 - 5
Independent auditor's report	6 - 9
Profit and loss account	10
Statement of comprehensive income	11
Balance sheet	12
Statement of changes in equity	13
Notes to the financial statements	14 - 30

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

STRATEGIC REPORT

FOR THE YEAR ENDED 31 MARCH 2024

The Directors present the Strategic report for the year ended 31 March 2024.

Fair review of the business

The principal activity of Spencer Private Hospitals Limited (the company) is the provision of private healthcare services within East Kent. The original site in Margate, within the grounds of Queen Elizabeth & Queen Mother Hospital, Margate, Kent, consists of inpatient and outpatient facilities. The Ashford hospital site consists of an inpatient facility, with a separate outpatient facility. The company also has access to inpatient beds and outpatient rooms within the main hospital at Canterbury.

Principal risks and uncertainties facing the business

Management continually monitor the key risks facing the company, together with assessing the controls used and actions necessary in managing these risks. The board of Directors formally reviews and documents the principal risks facing the business at least annually.

The principal risks and uncertainties facing the company are as follows:

- Economic downturn – The company acknowledges the importance of maintaining close relationships with its key customers in order to be able to identify the early signs of potential difficulties. With NHS contracts currently a key income stream, the company works closely with the local NHS trust and Integrated Care Boards (ICB's) to maintain good working relationships and frequent dialogue in order to best meet the needs of these customers and encourage early identification of potential issues or anticipated downturn in activity.
- Competitor pressure – The company reviews sales pricing, costs and provision of services on a continuous basis in order to maintain competitive pricing for all customers and meet the changing needs of customers, whilst maintaining profitability alongside high quality standards. Maintaining high quality standards and strong relationships with key customers is also a key factor in minimising competitor pressure.
- Skilled & content workforce - Ensuring that staff training and skill needs are met is a significant priority for the company. Recruitment is high on the agenda for all healthcare providers, with the workforce the company's most valued asset. Staff terms and conditions are reviewed regularly in order to retain and assist in recruiting quality staff. Efforts are made to gain honest and constructive staff feedback and engage staff in projects, both to improve employee wellbeing and to develop the company. Staff well-being is a key focus for all managers.
- Software - Systems are continuously reviewed and updated as necessary to ensure that they are reliable and meet the needs of the business. SPH has a detailed Digital Strategy approved by the Board which it is in the process of implementing. As a provider of NHS care, SPH complies with the Data Security and Protection Toolkit – a self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.
- Reliance on key suppliers – The company's purchasing activities could expose it to over-reliance on certain suppliers and inflationary pricing measures. The company manages this risk by ensuring there is enough breadth in its supplier base and regularly reviews costs and quality to identify areas where alternative suppliers should be sought.

Development and financial performance during the year

As reported in the company's Profit and loss account on page 10, turnover increased by £2.5m from £18.2m to £20.7m and profit before tax increased by £77K from £63K to £139K during the year.

The main drivers for the growth in turnover and profit were the expansion of services at the Canterbury site and the continued return to normal business activities across all sites after assisting the NHS in the Covid-19 pandemic response and subsequent bed pressures.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

Key performance indicators

Management use a range of performance measures to monitor and manage the business. The KPIs used to determine the progress and performance of the company are set out below:

Gross profit margin – A gross profit margin of 18% has been achieved (Prior year: 15%)

PLACE Inspection – Excellent (2022 - being the date of the last inspection: Excellent)

Infection Rates – Zero (2023: Zero)

CQC Inspection – Good rating and no improvements noted (2015 - being the date of the last formal CQC inspection: Good rating and no improvements noted). In line with Covid protocol CQC Engagement meetings have taken place regularly during the past years with no issues raised.

ISO9001:2015 – Maintained (2021 – being the date of the last assessment: Maintained)

ISO14001:2015 – Maintained (2022 – being the date of the last assessment: Maintained)

Food Hygiene Rating – Five (2022 - being the date of the last assessment: Five)

Financial position at the reporting date

The balance sheet shows that the company's net assets at the year end have increased from £5.1m to £5.4m. The company has invested £32K (2023 £30K) in tangible fixed assets in the year.

On behalf of the board

Geoff Bailey
....

G D Bailey

Director

15/10/2024

Date: ....

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

DIRECTORS' REPORT

FOR THE YEAR ENDED 31 MARCH 2024

The Directors present their annual report and financial statements for the year ended 31 March 2024.

Principal activities

The principal activity of Spencer Private Hospitals Limited (the company) is the provision of private hospital services in East Kent, with inpatient and outpatient facilities in Margate, Ashford and Canterbury. Both NHS and private patient treatments are carried out at each of the hospital sites. In addition to this the company provides assistance to the local NHS Trust in managing demand by means of the provision of beds.

Future developments

The company opened inpatient facilities at the Canterbury site in March 2022 and has seen steady growth in these services since that time. The company is considering a number of development opportunities. Staff wellbeing, retention of staff and strengthening and building relationships with medical professionals are key focus points. Staff and patient safety also remain a key focus. Infection control & social distancing measures continue to be monitored and reviewed regularly since the outbreak of the COVID-19 pandemic, to ensure that staff & patient safety are maintained at all times.

Qualifying third party indemnity provisions

The company has provided qualifying third party indemnity provisions in respect of its officers, including the Directors, which were in force during the year and at the date of this report.

Directors

The Directors who held office during the year and up to the date of signature of the financial statements were as follows:

G D Bailey	
J Jenner	
H F Risebrow	
A Andreou	
J A Yanni	
A Heselwood	(Appointed 2 February 2024)
S J Baird	(Resigned 1 February 2024)
K M Spence	(Resigned 7 July 2023)
V C Purday	(Resigned 31 May 2023)

Results and dividends

The results for the year are set out on page 10.

No dividends were paid during the year (2023: £92,294). The Directors do not recommend payment of a final dividend.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

Financial risk management

The company is subject to a number of financial risks including credit risk, cash flow and liquidity risk, inflation risk and interest rate risk. Financial risk is monitored via the management and committee structures and through adherence to the financial control framework set out in the company's financial policies.

Credit risk

The company receives the majority of its income from NHS organisations. Processes are in place to ensure adherence to the related contract terms, good communication with NHS representatives and timely resolution of any issues.

Cashflow and liquidity risk

The company mitigates cashflow and liquidity risk through careful monitoring and forecasting of cashflows.

Inflation risk

The company is exposed to inflation risk due to the impact of inflation on staff costs and other direct and indirect expenses. This is monitored and managed through the company's budgeting, reforecasting and forecasting processes.

Interest rate risk

The company is exposed to interest risk on group borrowings. The Directors do not consider this risk to be significant as a long-term repayment schedule is in place.

Matters covered in the strategic report

In accordance with section 414 of the Companies Act 2006 (Strategic Report and Directors' Report Regulations 2013), the company has chosen to include a Strategic report. The information covers the business review and principal risk and uncertainties.

Going concern

At the time of approving the financial statements, the Directors have a reasonable expectation that the company has adequate resources to continue in operational existence for the foreseeable future.

Although the company enjoys a close relationship with the ultimate parent, East Kent Hospitals University NHS Foundation Trust, the company manages its cash flow independently and does not seek financial support from the Trust.

The Trust continues to be in the Recovery Support Programme (formerly known as NHS England's Special Measures regime). Although the company is not dependent on the Trust for financial support, it is acknowledged that a proportion of the company's turnover stems from the Trust.

The Directors have reviewed the commercial performance of the company and the risk to the business, considering severe but plausible scenarios. The Directors have also considered macroeconomic factors including inflation and general economic conditions within the UK. The Directors have considered the strong relationship with the ultimate parent in regard to providing services, including theatre access, pathology and diagnostic services, the transfer of patients from the NHS Trust through the Inter Provider Transfer route, the provision of overflow beds to the Trust during periods of high demand, the increase in clinical professionals leaving their professions post Covid-19, the continuation of the standard and community contracts with the local ICB and the continued demand for private and NHS healthcare services as NHS waiting lists remain high nationwide. Having considered these factors the Directors have reasonable expectations that the risks derived from this situation can reasonably be regarded by the Directors as manageable business risks.

The Directors have reviewed the financial forecasts for at least 12 months from the date of these financial statements and the underlying assumptions used to prepare them. The Directors have satisfied themselves that the assumptions are fair and reasonable and reflect the prospects for the business.

Whilst there are still uncertainties around expectations of the future as the healthcare industry returns to business as normal, after making enquiries the Directors have a reasonable expectation that the company has adequate resources to continue in operational existence for the foreseeable future and opportunities to develop further. Accordingly, they continue to prepare the financial statements on a going concern basis.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

Directors' responsibilities statement

The Directors are responsible for preparing the Strategic report, the Directors' report and the financial statements in accordance with applicable law and regulations.

Company law requires the Directors to prepare financial statements for each financial year. Under that law they have elected to prepare the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law, including FRS 102 'The Financial Reporting Standard' applicable in the UK and Republic of Ireland).

Under company law the Directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs and profit or loss of the company for that period. In preparing these financial statements, the Directors are required to:

- Select suitable accounting policies and then apply them consistently;
- Make judgements and estimates that are reasonable and prudent;
- State whether applicable UK accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- Assess the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern.

The Directors are responsible for keeping adequate accounting records that are sufficient to show and explain the company's transactions and disclose with reasonable accuracy at any time the financial position of the company and enable them to ensure that the financial statements comply with the Companies Act 2006. They are responsible for safeguarding the assets of the company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Events after the reporting period

There have been no significant events after the year end that would require adjustment or disclosure within these financial statements.

Statement of disclosure of information to the auditor

The Directors confirm that:

- so far as each Director is aware, there is no relevant audit information of which the company's auditor is unaware, and
- the Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the company's auditor is aware of that information.

Auditor

In accordance with section 485 of the Companies Act 2006, a resolution proposing that Grant Thornton UK LLP be re-appointed will be put forward to the Board at a General Meeting.

On behalf of the board

Geoff Bailey
....
G D Bailey
Director 15/10/2024
....

SPENCER PRIVATE HOSPITALS LIMITED

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF SPENCER PRIVATE HOSPITALS LIMITED

Opinion

We have audited the financial statements of Spencer Private Hospitals Limited (the ‘company’) for the year ended 31 March 2024, which comprise the Profit and loss account, the Statement of comprehensive income, the Balance sheet, the Statement of changes in equity 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 company's affairs as at 31 March 2024 and of its profit for the year then ended;
- the financial statements have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- the financial statements have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

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 company 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 Directors’ 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 company'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 company to cease to continue as a going concern.

In our evaluation of the Directors’ conclusions, we considered the inherent risks associated with the company's business model including effects arising from macro-economic uncertainties such as rising costs due to inflation, we assessed and challenged the reasonableness of estimates made by the Directors and the related disclosures and analysed how those risks might affect the company's financial resources or ability to continue operations over the going concern period.

In auditing the financial statements, we have concluded that the Directors’ use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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 company'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.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

Other information

The other information comprises the information included in the Annual report and financial statements, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information contained within the Annual report and financial statements. 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.

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 themselves. 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.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Strategic report and the Directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Strategic report and the Directors' report have been prepared in accordance with applicable legal requirements.

Matter on which we are required to report under the Companies Act 2006

In the light of the knowledge and understanding of the company and its environment obtained in the course of the audit, we have not identified material misstatements in the Strategic report or the Directors' report.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of Directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of Directors

As explained more fully in the Directors' responsibilities statement set out on page 5, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Directors determine 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 Directors are responsible for assessing the company'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 Directors either intend to liquidate the company or to cease operations, or have no realistic alternative but to do so.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 applicable to the company and determined that the following laws and regulations were most significant: Financial Reporting Standard 102 ‘The Financial Reporting Standard applicable in the UK and Republic of Ireland’ and the Companies Act 2006, and the relevant tax compliance regulations in the UK.

- We obtained an understanding of the legal and regulatory frameworks applicable to the company and the industry in which it operates through our general and commercial and sector experience as well as discussions with management. We obtained an understanding of how the company is complying with those legal and regulatory frameworks by making inquiries of management and of those responsible for legal and compliance procedures. We corroborated our inquiries through our review of board minutes.

- We assessed the susceptibility of the company's financial statements to material misstatement, including how fraud might occur by meeting with management from different parts of the business to understand where it is considered there was a susceptibility of fraud. We also considered performance targets and their propensity to influence efforts made by management to manage earnings. We considered the processes and controls that the company has established to address risks identified, or that otherwise prevent, deter and detect fraud; and how senior management monitors those processes and controls. Where the risk was considered to be higher, we performed audit procedures to address each identified fraud risk.

- Our audit procedures involved: journal entry testing, with a focus on manual journals and journals indicating large or unusual transactions based on our understanding of the business; substantive testing of revenue transactions to ascertain the appropriate recognition of revenue within the year and enquiries of management. In addition, we completed audit procedures to conclude on the compliance of disclosures in the Annual report and accounts with applicable financial reporting requirements.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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.

- The engagement leader's 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 industry in which the company operates; and

  - understanding of the legal and regulatory requirements specific to the company.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including internal specialists, and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

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.

Use of our report

This report is made solely to the company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members 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 company and the company's members as a body, for our audit work, for this report, or for the opinions we have formed.

Sophie Murton

Sophie Murton FCA
Senior Statutory Auditor
for and on behalf of Grant Thornton UK LLP
Statutory Auditor, Chartered Accountants
Southampton

Date: 15/10/2024

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

PROFIT AND LOSS ACCOUNT

FOR THE YEAR ENDED 31 MARCH 2024

	Notes	2024 £	2023 £
Turnover	3	20,665,933	18,201,342
Cost of sales		(16,878,372)	(15,442,213)
Gross profit		3,787,561	2,759,129
Administrative expenses		(3,388,254)	(2,542,191)
Other operating income	3	4,829	4,829
Operating profit	4	404,136	221,767
Interest receivable and similar income	9	40,762	13,522
Other interest payable and similar expenses	8	(3,978)	(6,517)
Profit before taxation		440,920	228,772
Tax on profit	10	(139,326)	(62,634)
Profit for the financial year		301,594	166,138

The profit and loss account has been prepared on the basis that all operations are continuing operations.

The notes on pages 14 to 30 form part of these financial statements.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 MARCH 2024

	2024 £	2023 £
Profit for the year	301,594	166,138
Other comprehensive income		
Revaluation of tangible fixed assets	-	209,248
Total comprehensive income for the year	301,594	375,386

The notes on pages 14 to 30 form part of these financial statements.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

SPENCER PRIVATE HOSPITALS LIMITED

BALANCE SHEET

AS AT 31 MARCH 2024

	Notes	2024 £	2024 £	2023 £	2023 £
Fixed assets					
Intangible assets	**12**		35,906		2,871
Tangible assets	**13**		4,157,405		4,328,921
			4,193,311		4,331,792
Current assets					
Stocks	**14**	44,576		33,160	
Debtors	**15**	5,181,184		3,971,836	
Cash at bank and in hand		2,048,602		1,743,613	
		7,274,362		5,748,609	
Creditors: amounts falling due within one year	**16**	(5,009,565)		(3,923,562)	
Net current assets			2,264,797		1,825,047
Total assets less current liabilities			6,458,108		6,156,839
Creditors: amounts falling due after more than one year	**17**		(889,464)		(889,464)
Provisions for liabilities	**21**		(172,186)		(172,511)
Net assets			5,396,458		5,094,864
Capital and reserves					
Called up share capital	**22**		560,000		560,000
Revaluation reserve	**23**		2,812,242		2,812,242
Profit and loss reserves	**24**		2,024,216		1,722,622
Total equity			5,396,458		5,094,864

The financial statements were approved by the board of Directors and authorised for issue on 15/10/2024 and are signed on its behalf by:

Geoff Bailey
....
G D Bailey
Director

Company Registration No. 03130118

The notes on pages 14 to 30 form part of these financial statements.

SPENCER PRIVATE HOSPITALS LIMITED

STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 31 MARCH 2024

	Notes	Share capital	Revaluation reserve	Profit and loss reserves	Total
		£	£	£	£
Balance at 1 April 2022		560,000	2,602,994	1,648,778	4,811,772
Year ended 31 March 2023:					
Profit for the year		-	-	166,138	166,138
Other comprehensive income:					
Revaluation of tangible fixed assets		-	209,248	-	209,248
Total comprehensive income for the year		-	209,248	166,138	375,386
Dividends	**11**	-	-	(92,294)	(92,294)
Balance at 31 March 2023		560,000	2,812,242	1,722,622	5,094,864
Year ended 31 March 2024:					
Profit and total comprehensive income for the year		-	-	301,594	301,594
Balance at 31 March 2024		560,000	2,812,242	2,024,216	5,396,458

The notes on pages 14 to 30 form part of these financial statements.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

1 Accounting policies

Company information

Spencer Private Hospitals Limited, the "company", is a private company limited by shares incorporated in England and Wales. The registered office is 1 & 3 Almond House, Betteshanger Road, Betteshanger, Deal, England, CT14 0EN.

The principal activity of the company continues to be the provision of hospital services within east Kent.

1.1 Accounting convention

Basis of preparation of financial statements

These financial statements have been prepared in accordance with FRS 102 “The Financial Reporting Standard applicable in the UK and Republic of Ireland” (“FRS 102”) and the requirements of the Companies Act 2006.

The financial statements are prepared in sterling, which is the functional currency of the company. Monetary amounts in these financial statements are rounded to the nearest £.

The financial statements have been prepared under the historical cost convention, modified to include the revaluation of freehold properties at fair value. The principal accounting policies adopted are set out below.

Financial reporting standard 102 – reduced disclosure exemptions

This company is a qualifying entity for the purposes of FRS 102, being a member of a group where the parent of that group prepares publicly available consolidated financial statements, including this company, which are intended to give a true and fair view of the assets, liabilities, financial position and profit or loss of the group. The company has therefore taken advantage of exemptions from the following disclosure requirements:

- Section 7 ‘Statement of Cash Flows’: Presentation of a statement of cash flow and related notes and disclosures;
- Section 3 ‘Financial Statement Presentation’ paragraph 3.17(d);
- Section 11 ‘Basic Financial Instruments’ paragraphs 11.42, 11.44 to 11.45, 11.47, 11.48(a)(iii), 11.48(a)(iv), 11.48(b) and 11.48(c);
- Section 12 ‘Other Financial Instruments’ paragraphs 12.26 to 12.27, 12.29(a), 12.29(b) and 12.29A;
- Section 33 ‘Related Party Disclosures’: Compensation for key management personnel.

The financial statements of the company are consolidated in the financial statements of East Kent Hospitals University NHS Foundation Trust. These consolidated financial statements are available from its registered office, Trust Offices, Kent & Canterbury Hospital, Ethelbert Road, Canterbury, Kent, CT1 3NG.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

1 Accounting policies **(Continued)**

1.2 Going concern

At the time of approving the financial statements, the Directors have a reasonable expectation that the company has adequate resources to continue in operational existence for the foreseeable future.

Although the company enjoys a close relationship with the ultimate parent, East Kent Hospitals University NHS Foundation Trust, the company manages its cash flow independently and does not seek financial support from the Trust.

The Trust continues to be in the Recovery Support Programme (formerly known as NHS England's Special Measures regime). Although the company is not dependent on the Trust for financial support, it is acknowledged that a proportion of the company's turnover stems from the Trust.

The Directors have reviewed the commercial performance of the company and the risk to the business, considering severe but plausible scenarios. The Directors have also considered macroeconomic factors including inflation and general economic conditions within the UK. The Directors have considered the strong relationship with the ultimate parent in regard to providing services, including theatre access, pathology and diagnostic services, the transfer of patients from the NHS Trust through the Inter Provider Transfer route, the provision of overflow beds to the Trust during periods of high demand, the increase in clinical professionals leaving their professions post Covid-19, the continuation of the standard and community contracts with the local ICB and the continued demand for private and NHS healthcare services as NHS waiting lists remain high nationwide. Having considered these factors the Directors have reasonable expectations that the risks derived from this situation can reasonably be regarded by the Directors as manageable business risks.

The Directors have reviewed the financial forecasts together with the underlying assumptions under which they have been prepared forecast for at least 12 months from the date of the financial statements. The Directors have satisfied themselves that the assumptions are fair and reasonable and reflect the prospects for the business.

Whilst there are still uncertainties around expectations of the future as the healthcare industry returns to business as normal, after making enquiries the Directors have a reasonable expectation that the company has adequate resources to continue in operational existence for the foreseeable future and opportunities to develop further. Accordingly, they continue to prepare the financial statements on a going concern basis.

1.3 Turnover

Turnover is recognised at the fair value of the consideration received or receivable for goods and services provided in the normal course of business, and is shown net of VAT and other sales related taxes. The fair value of consideration takes into account trade discounts, settlement discounts and volume rebates.

When cash inflows are deferred and represent a financing arrangement, the fair value of the consideration is the present value of the future receipts. The difference between the fair value of the consideration and the nominal amount received is recognised as interest income.

Revenue from the sale of goods is recognised when the significant risks and rewards of ownership of the goods have passed to the buyer (usually on dispatch of the goods), the amount of revenue can be measured reliably, it is probable that the economic benefits associated with the transaction will flow to the entity and the costs incurred or to be incurred in respect of the transaction can be measured reliably.

Revenue from contracts is recognised at the fair value of the consideration received for those healthcare services provided in the normal course of business. Recognition of revenue & related costs is based on the date the service is provided.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

1 Accounting policies **(Continued)**

1.4 Intangible fixed assets other than goodwill

Intangible assets acquired separately from a business are recognised at cost and are subsequently measured at cost less accumulated amortisation and accumulated impairment losses.

Intangible assets acquired on business combinations are recognised separately from goodwill at the acquisition date where it is probable that the expected future economic benefits that are attributable to the asset will flow to the entity and the fair value of the asset can be measured reliably.

Amortisation is recognised so as to write off the cost or valuation of assets less their residual values over their useful lives on the following bases:

Software	over 5 years

1.5 Tangible fixed assets

Leasehold land and buildings are initially measured at cost and subsequently measured at valuation, net of depreciation and any impairment losses. Revaluation of leasehold land and buildings is carried out regularly, up to every five years, in line with the policies of the ultimate parent company, East Kent Hospital University NHS Foundation Trust.

All other tangible fixed assets are measured at cost, net of depreciation and any impairment losses.

Depreciation is recognised so as to write off the cost or valuation of assets less their residual values over their useful lives on the following bases:

Leasehold land and buildings	over 13.58 to 32.43 years
Plant and equipment	over 3 to 10 years depending on asset category
Motor vehicles	over 6 years

The gain or loss arising on the disposal of an asset is determined as the difference between the sale proceeds and the carrying value of the asset, and is credited or charged to profit or loss.

1.6 Impairment of fixed assets

At each reporting period end date, the company reviews the carrying amounts of its tangible and intangible assets to determine whether there is any indication that those assets have suffered an impairment loss. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss (if any). Where it is not possible to estimate the recoverable amount of an individual asset, the company estimates the recoverable amount of the cash-generating unit to which the asset belongs.

Recoverable amount is the higher of fair value less costs to sell and value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset for which the estimates of future cash flows have not been adjusted.

If the recoverable amount of an asset (or cash-generating unit) is estimated to be less than its carrying amount, the carrying amount of the asset (or cash-generating unit) is reduced to its recoverable amount. An impairment loss is recognised immediately in profit or loss, unless the relevant asset is carried at a revalued amount, in which case the impairment loss is treated as a revaluation decrease.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

1 Accounting policies **(Continued)**

1.7 Stocks

Stocks are stated at the lower of cost and net realisable value, being the estimated selling price less costs to complete and sell. Cost is based on the cost of purchase on a first in, first out basis.

At each reporting date, stocks are assessed for impairment. If stock is impaired, the carrying amount is reduced to its selling price less costs to complete and sell. The impairment loss is recognised immediately in profit or loss.

1.8 Cash and cash equivalents

Cash and cash equivalents are basic financial assets and include cash in hand, deposits held at call with banks and other short-term liquid investments with original maturities of three months or less.

1.9 Financial instruments

The company only enters into basic financial instruments transactions that result in the recognition of financial assets and liabilities.

Financial instruments are recognised in the company's balance sheet when the company becomes party to the contractual provisions of the instrument.

Financial assets and liabilities are offset, with the net amounts presented in the financial statements, when there is a legally enforceable right to set off the recognised amounts and there is an intention to settle on a net basis or to realise the asset and settle the liability simultaneously.

Basic financial assets

Basic financial assets, which include trade debtors, amounts owed by group undertakings, accrued income and cash and bank balances, are initially measured at transaction price including transaction costs and are subsequently carried at amortised cost using the effective interest method unless the arrangement constitutes a financing transaction, where the transaction is measured at the present value of the future receipts discounted at a market rate of interest. Financial assets classified as receivable within one year are not amortised.

Impairment of financial assets

Financial assets, other than those held at fair value through profit and loss, are assessed for indicators of impairment at each reporting end date.

Financial assets are impaired where there is objective evidence that, as a result of one or more events that occurred after the initial recognition of the financial asset, the estimated future cash flows have been affected. If an asset is impaired, the impairment loss is the difference between the carrying amount and the present value of the estimated cash flows discounted at the asset’s original effective interest rate. The impairment loss is recognised in profit or loss.

If there is a decrease in the impairment loss arising from an event occurring after the impairment was recognised, the impairment is reversed. The reversal is such that the current carrying amount does not exceed what the carrying amount would have been, had the impairment not previously been recognised. The impairment reversal is recognised in profit or loss.

Derecognition of financial assets

Financial assets are derecognised only when the contractual rights to the cash flows from the asset expire or are settled, or when the company transfers the financial asset and substantially all the risks and rewards of ownership to another entity, or if some significant risks and rewards of ownership are retained but control of the asset has transferred to another party that is able to sell the asset in its entirety to an unrelated third party.

SPENCER PRIVATE HOSPITALS LIMITED

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED 31 MARCH 2024

---

1 Accounting policies (Continued)

Classification of financial liabilities

Financial liabilities and equity instruments are classified according to the substance of the contractual arrangements entered into. An equity instrument is any contract that evidences a residual interest in the assets of the company after deducting all of its liabilities.

Basic financial liabilities

Basic financial liabilities, including trade and other creditors, loans from group undertakings and other loans that are classified as debt, are initially recognised at transaction price unless the arrangement constitutes a financing transaction, where the debt instrument is measured at the present value of the future payments discounted at a market rate of interest. Financial liabilities classified as payable within one year are not amortised.

Debt instruments are subsequently carried at amortised cost, using the effective interest rate method.

Trade creditors are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Amounts payable are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities. Trade creditors are recognised initially at transaction price and subsequently measured at amortised cost using the effective interest method.

Derecognition of financial liabilities

Financial liabilities are derecognised when the company's contractual obligations expire or are discharged or cancelled.

1.10 Equity instruments

Equity instruments issued by the company are recorded at the proceeds received, net of direct issue costs. Dividends payable on equity instruments are recognised as liabilities once they are no longer at the discretion of the company.

1.11 Taxation

The tax expense represents the sum of the tax currently payable and deferred tax.

Current tax

The tax currently payable is based on taxable profit for the year. Taxable profit differs from net profit as reported in the profit and loss account because it excludes items of income or expense that are taxable or deductible in other years and it further excludes items that are never taxable or deductible. The company's liability for current tax is calculated using tax rates that have been enacted or substantively enacted by the reporting end date.

Deferred tax

Deferred tax liabilities are generally recognised for all timing differences and deferred tax assets are recognised to the extent that it is probable that they will be recovered against the reversal of deferred tax liabilities or other future taxable profits. Such assets and liabilities are not recognised if the timing difference arises from goodwill or from the initial recognition of other assets and liabilities in a transaction that affects neither the tax profit nor the accounting profit.

The carrying amount of deferred tax assets is reviewed at each reporting end date and reduced to the extent that it is no longer probable that sufficient taxable profits will be available to allow all or part of the asset to be recovered. Deferred tax is calculated at the tax rates that are expected to apply in the period when the liability is settled or the asset is realised. Deferred tax is charged or credited in the profit and loss account, except when it relates to items charged or credited directly to equity, in which case the deferred tax is also dealt with in equity. Deferred tax assets and liabilities are offset when the company has a legally enforceable right to offset current tax assets and liabilities and the deferred tax assets and liabilities relate to taxes levied by the same tax authority.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

1 Accounting policies **(Continued)**

1.12 Employee benefits

The costs of short-term employee benefits are recognised as a liability and an expense, unless those costs are required to be recognised as part of the cost of stock or fixed assets.

The cost of any unused holiday entitlement is recognised in the period in which the employee's services are received.

Termination benefits are recognised immediately as an expense when the company is demonstrably committed to terminate the employment of an employee or to provide termination benefits.

1.13 Retirement benefits

Payments to defined contribution retirement benefit schemes are charged as an expense as they fall due.

1.14 Leases

Leases are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessees. All other leases are classified as operating leases.

Assets held under finance leases are recognised as assets at the lower of the assets fair value at the date of inception and the present value of the minimum lease payments. The related liability is included in the balance sheet as a finance lease obligation. Lease payments are treated as consisting of capital and interest elements. The interest is charged to profit or loss so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Rentals payable under operating leases, including any lease incentives received, are charged to profit or loss on a straight line basis over the term of the relevant lease except where another more systematic basis is more representative of the time pattern in which economic benefits from the leases asset are consumed.

Rental income from operating leases is recognised on a straight line basis over the term of the relevant lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight line basis over the lease term.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

2 Judgements and key sources of estimation uncertainty

In the preparation and presentation of the company's financial statements, the Directors are required to make judgements, estimates and assumptions that effect the amounts reported for assets and liabilities as at the balance sheet date and amounts reported in the profit and loss account and statement of comprehensive income. However, although the estimates and underlying assumptions are reviewed on an ongoing basis, actual results may differ from those estimates.

Estimation uncertainty - assessing the indicators of impairment

The company considers whether leasehold land and building are impaired. Where an indication of impairment is identified, the recoverable value of the assets is estimated. Revaluation of leasehold land and buildings is carried out regularly, up to every five years. In the prior year, the basis for the fair value determination including the necessary estimates involved is the valuation by independent real estate valuation experts using recognised valuation techniques. The fair value is assessed by using market-based evidence for similar properties sold in the local area. No valuation was carried out in the current year. After considering the local market, the Directors believe that the fair value of the property did not materially change since prior year and remains appropriate.

At 31 March 2024, the carrying value of leasehold land and building was £3,903,453 (2023: £4,036,720).

Critical judgement in applying the entity's accounting policies - Valuation of group loan balances

At the end of the reported accounting period the ultimate controlling party, East Kent Hospital University NHS Foundation Trust (EKHUFT), was in the process of winding down Healthex Limited and formally transferring its assets directly to EKHUFT. It is expected that once this process has been completed the calculation of the balance of loans from group undertakings will be reviewed and potentially reduced due to a recalculation of the interest charged on the outstanding loan. However, as at the time of signing the financial statements the formal transfer of assets has not yet been completed, the balances on the old loans for a total value of £889,914 have been recognised.

The Directors concluded that there are no other critical judgements made in applying the company's accounting policies that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities in the statutory accounts.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

3 Turnover and other operating income

An analysis of the company's turnover is as follows:

	2024	2023
	£	£
Turnover analysed by class of business		
Rendering of services	20,665,933	18,201,342

	2024	2023
	£	£
Other operating income		
Other income	4,829	4,829

	2024	2023
	£	£
Turnover analysed by geographical market		
United Kingdom	20,665,933	18,201,342

4 Operating profit

	2024	2023
Operating profit for the year is stated after charging:	£	£
Depreciation of owned tangible fixed assets	200,193	173,665
Depreciation of tangible fixed assets held under finance leases	2,904	2,904
Amortisation of intangible assets	2,979	1,675
Operating lease charges	159,314	139,926

5 Auditor's remuneration

	2024	2023
Fees payable to the company's auditor and associates:	£	£
For audit services		
Fees payable to the company’s auditor and its associates for the audit of the company’s annual financial statements	56,650	43,100

6 Directors' remuneration

	2024	2023
	£	£
Remuneration for qualifying services	328,303	366,585
Company pension contributions to defined contribution schemes	9,875	10,679
Compensation for loss of office	51,381	-
	389,559	377,264

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

6 Directors' remuneration **(Continued)**

The number of Directors, who are also the key management personnel, for whom retirement benefits are accruing under defined contribution schemes amounted to 2 (2023 - 2).

Remuneration disclosed above include the following amounts paid to the highest paid Director:

	2024	2023
	£	£
Remuneration for qualifying services	120,633	97,162
Company pension contributions to defined contribution schemes	8,085	5,492

7 Employees

The average monthly number of persons (including Directors) employed by the company during the year was:

	2024	2023
	Number	Number
Management	13	14
Administration and clerical	67	65
Nursing and clinical	51	48
Hotel services	13	12
	144	139

Their aggregate remuneration comprised:

	2024	2023
	£	£
Wages and salaries	4,174,526	3,845,517
Social security costs	398,488	380,600
Pension costs	105,306	97,381
	4,678,320	4,323,498

Additionally agency staff costs of £3,662,245 (2023: £2,798,051) and self-employed staff costs of £88,076 (2023: £272,278) were incurred.

8 Interest payable and similar expenses

	2024	2023
	£	£
Interest on finance leases and hire purchase contracts	3,978	6,517
Disclosed on the profit and loss account as follows:		
Other interest payable and similar expenses	3,978	6,517

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

9 Interest receivable and similar income

	2024	2023
	£	£
Interest income		
Interest on bank deposits	40,762	13,522

10 Taxation

	2024	2023
	£	£
Current tax		
UK corporation tax on profits for the current period	143,080	74,862
Adjustments in respect of prior periods	(3,429)	-
Total current tax	139,651	74,862
Deferred tax		
Origination and reversal of timing differences	(325)	(12,228)
Total tax charge	139,326	62,634

The actual charge for the year can be reconciled to the expected charge for the year based on the profit or loss and the standard rate of tax as follows:

	2024	2023
	£	£
Profit before taxation	440,920	228,772
Expected tax charge based on the standard rate of corporation tax in the UK of 25.00% (2023: 19.00%)	110,230	43,467
Tax effect of expenses that are not deductible in determining taxable profit	(792)	3,042
Under/(over) provided in prior years	(3,429)	-
Depreciation in excess of capital allowances	33,642	26,013
Deferred tax	(325)	(12,228)
Overprovision in current year	-	2,340
Taxation charge for the year	139,326	62,634

11 Dividends

	2024	2023
	£	£
Interim paid	-	92,294

An ordinary dividend of £nil (£92,294) was paid to Healthex Limited during the year.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

12 Intangible fixed assets

	Goodwill	Software	Total
	£	£	£
Cost			
At 1 April 2023	37,642	46,586	84,228
Additions	-	36,014	36,014
At 31 March 2024	37,642	82,600	120,242
Amortisation and impairment			
At 1 April 2023	37,642	43,715	81,357
Amortisation charged for the year	-	2,979	2,979
At 31 March 2024	37,642	46,694	84,336
Carrying amount			
At 31 March 2024	-	35,906	35,906
At 31 March 2023	-	2,871	2,871

13 Tangible fixed assets

	Leasehold land and buildings	Plant and equipment	Motor vehicles	Total
	£	£	£	£
Cost or valuation				
At 1 April 2023	4,036,720	961,397	17,424	5,015,541
Additions	-	31,581	-	31,581
Disposals	-	(54,645)	-	(54,645)
At 31 March 2024	4,036,720	938,333	17,424	4,992,477
Depreciation and impairment				
At 1 April 2023	-	674,278	12,342	686,620
Depreciation charged in the year	133,267	66,926	2,904	203,097
Eliminated in respect of disposals	-	(54,645)	-	(54,645)
At 31 March 2024	133,267	686,559	15,246	835,072
Carrying amount				
At 31 March 2024	3,903,453	251,774	2,178	4,157,405
At 31 March 2023	4,036,720	287,119	5,082	4,328,921

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

13 Tangible fixed assets **(Continued)**

The net carrying value of tangible fixed assets includes the following in respect of assets held under finance leases or hire purchase contracts.

	2024 £	2023 £
Motor vehicles	2,178	5,082

Land and buildings with a carrying amount of £4,036,720 were revalued at 31 March 2023 by Cushman and Wakefield, independent valuers not connected with the company on the basis of depreciated replacement cost. The valuation conforms to International Valuation Standards and was based on the cost of replacement of the asset with a modern equivalent. After considering the local market, the Directors believe that the fair value of the properties did not materially change since prior year and remain appropriate.

Leasehold land and buildings are carried at valuation. If leasehold land and buildings were measured using the cost model, the total amounts included would have been as follows:

	2024 £	2023 £
Cost	3,057,540	3,057,540
Accumulated depreciation	(1,882,774)	(1,779,119)
Carrying value	1,174,766	1,278,421

14 Stocks

	2024 £	2023 £
Finished goods and goods for resale	44,576	33,160

There is no significant difference between the replacement cost of the inventory and its carrying amount.

The carrying value of stocks are stated net of impairment losses totalling £NIL (2023 - £NIL). Impairment losses totalling £NIL (2023 - £NIL) were recognised in profit and loss.

SPENCER PRIVATE HOSPITALS LIMITED

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED 31 MARCH 2024

15 Debtors

Amounts falling due within one year:	2024 £	2023 £
Trade debtors	2,079,025	2,311,770
Amounts owed by group undertakings	1,407,809	764,835
Other debtors	1,661	1,001
Prepayments and accrued income	1,692,689	894,230
	5,181,184	3,971,836

Amounts owed by group undertakings are unsecured, interest free, have no fixed date of repayment and are repayable on demand.

16 Creditors: amounts falling due within one year

	Notes	2024 £	2023 £
Other loans	**19**	450	450
Obligations under finance leases	**18**	-	5,678
Trade creditors		1,138,243	1,065,233
Amounts owed to group undertakings		2,497,772	1,624,427
Corporation tax		143,079	75,267
Other taxation and social security		102,262	87,751
Other creditors		40,306	43,383
Accruals and deferred income		1,087,453	1,021,373
		5,009,565	3,923,562

Amounts owed to group undertakings are unsecured, interest free, have no fixed date of repayment and are repayable on demand.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

17 Creditors: amounts falling due after more than one year

		2024	2023
		£	£
Loans from group undertakings incurring interest of 4% plus Bank of England Base Rate, unsecured	19	889,464	889,464

Analysis of the maturity of loans is given below:

	2024	2023
Amounts due within one year		
Other loans	450	450
Amounts falling due between one and five years		
Loans from group undertakings	889,464	389,996
Amounts falling due after more than five years		
Loans from group undertakings	-	499,468
	889,914	889,914

18 Finance lease obligations

	2024	2023
Future minimum lease payments due under finance leases:	£	£
Within one year	-	5,678

Finance lease payments represent rentals payable by the company for certain fixed assets. Leases include purchase options at the end of the lease period, and no restrictions are placed on the use of the assets. All leases are on a fixed repayment basis and no arrangements have been entered into for contingent rental payments.

Hire purchase contracts are secured on the assets to which they relate.

19 Borrowings

	2024	2023
	£	£
Other loans	450	450
Loans from group undertakings	889,464	889,464
	889,914	889,914
Payable within one year	450	450
Payable after one year	889,464	889,464

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

19 Borrowings **(Continued)**

The loan from group undertakings was from Healthex Limited and was repayable over 20 years until March 2028 incurring interest of 4% plus Bank of England Base Rate. East Kent Hospitals University NHS Foundation Trust (EKHUFT) as the direct parent of Healthex Limited and the ultimate parent of Spencer Private Hospitals Limited was also party to the loan agreement.

On 29 September 2020 Healthex Limited was dissolved, causing a default event. Therefore, the loan became immediately repayable to East Kent Hospitals University NHS Foundation Trust. East Kent Hospitals University NHS Foundation Trust entered into an interest waiver and payment break with Spencer Private Hospitals Limited on 1 November 2020.

On 1 March 2021 a new loan agreement for £532,154 incurring interest of 3% plus Bank of England Base Rate repayable over 10 years was entered into with East Kent Hospitals University NHS Foundation Trust.

However, due to an unsatisfactory winding up of Healthex Limited, actions were taken by East Kent Hospitals University NHS Foundation Trust to restore Healthex Limited and transfer its assets to East Kent Hospitals University NHS Foundation Trust prior to the implementation of the new loan arrangement.

Therefore the Directors of Spencer Private Hospitals Limited and East Kent Hospitals University NHS Foundation Trust have agreed a long term liability for the original loan amount should be shown in the financial statements pending the transfer of assets as whilst at the year-end Healthex Limited had been restored and a new loan agreement had been entered into, the process of transferring the assets of Healthex Limited to East Kent Hospitals University NHS Foundation Trust could possibly require the reinstatement of the original loan liability with Healthex Limited and unanticipated delays to the restoration of Healthex Limited and the transfer of its assets to East Kent Hospitals University NHS Foundation Trust may necessitate a review of the new loan agreement.

Both the existing and the proposed new arrangement are unsecured loans. Loans from group undertakings and other loans are unsecured.

20 Retirement benefit schemes

Defined contribution schemes	**2024** **£**	**2023** **£**
Charge to profit or loss in respect of defined contribution schemes	105,306	97,381

The company operates a defined contribution pension scheme for all qualifying employees. The assets of the scheme are held separately from those of the company in an independently administered fund. Contributions totalling £40,367 (2023: £43,277) were payable to the fund at the balance sheet date and are included in creditors.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

21 Provisions for liabilities - Deferred taxation

Deferred tax assets and liabilities are offset where the company has a legally enforceable right to do so. The following is the analysis of the deferred tax balances (after offset) for financial reporting purposes:

Balances:	2024 £	2023 £
Accelerated capital allowances	172,186	172,511

Movements in the year:	2024 £
Liability at 1 April 2023	172,511
Credit to profit or loss	(325)
Liability at 31 March 2024	172,186

The deferred tax liability set out above is expected to reverse over the life of the qualifying assets being a period of 1 to 10 years and relates to accelerated capital allowances that are expected to mature within the same period.

22 Share capital

Ordinary share capital	2024 Number	2023 Number	2024 £	2023 £
Issued and fully paid				
Ordinary shares of £1 each	560,000	560,000	560,000	560,000

Each £1 Ordinary share ranks pari passu with regard to voting and dividend rights.

There is a single class of ordinary shares. There are no restrictions on dividends and the repayment of capital.

23 Revaluation reserve

Where tangible fixed assets are revalued, the cumulative increase in the fair value of the property at the date of revaluation in excess of any previous impairment losses is included in the revaluation reserve.

24 Profit and loss reserves

This reserve represents the accumulated profits and losses of the company.

Docusign Envelope ID: 29707960-2895-4F84-BDF6-B053402EB762

25 Operating lease commitments

Lessee

At the reporting end date the company had outstanding commitments for future minimum lease payments under non-cancellable operating leases, which fall due as follows:

	2024	2023
	£	£
Within one year	146,833	160,288
Between two and five years	183,281	234,395
In over five years	394,895	402,144
	725,009	796,827

Lessor

The operating leases represents the lease of part of the leasehold land and buildings to East Kent Hospitals University Foundation Trust.

At the reporting end date, the company had contracted with tenants for the following minimum lease payments:

	2024	2023
	£	£
Within one year	4,829	4,829
Between two and five years	19,316	19,316
In over five years	328,372	333,201
	352,517	357,346

26 Related party transactions

The company is a wholly owned member of East Kent Hospitals University NHS Foundation Trust and as such has taken advantage of the exemption permitted by Section 33 Related Party Disclosures, not to provide disclosures of transactions entered into with other wholly owned members of the Group.

27 Ultimate controlling party

Spencer Private Hospitals Limited is fully owned by Healthex Limited, whose registered address is Rm 171016, Management Offices William Harvey Hospital, Kennington Road, Ashford, Kent, United Kingdom, TN24 0LZ.

The ultimate controlling party is East Kent Hospitals University NHS Foundation Trust, the parent company of Healthex Limited, whose registered office address is Trust Offices, Kent & Canterbury Hospital, Ethelbert Road, Canterbury, Kent, CT1 3NG.

East Kent Hospitals University NHS Foundation Trust is also the parent company of the largest and smallest group for which the group accounts are prepared. The consolidated accounts of the group can be found at the registered office address above.

East Kent Hospitals Charity

Helping your hospitals go further

ANNUAL REPORT

2023/2024

Contents

Foreword	4
Fundraising Introduction	6
Fantastic Fundraisers	10
Corporate Support	18
Events and Campaigns	22
Projects	34
Financial Summary	44
Structure, Governance & Management	48
Objectives & Activities	54
Our Funds	58
Statement of Trustees’ Responsibilities	62
Independent Auditor's Report	64
Statement of Financial Activities	70
Balance Sheet	72
Cash Flow	74
Notes	76

01

Foreword

A huge thank you to everyone who raised or donated funds or items, or gave their time and support.

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 2024.

It is always humbling to see the many ways in which our local corporate sponsors, donors, staff and volunteers raise funds for the Charity, many of which are described in the next few pages of the Annual Report. A huge thank you to everyone who raised or donated funds or items, or gave their time and support.

It has been a pleasure to have the opportunity to visit many of the Trust departments in the last year which charitable funds have supported. These included the new bereavement suite and garden at the QEQM Hospital in Margate, the parent and breastfeeding rooms and facilities at the Neonatal Intensive Care Unit in William Harvey Hospital, plus seeing demonstrations of the new Children's interactive projector at the newly decorated William Harvey ED department, and the RITA machines used to engage with patients living with dementia. It was lovely to hear from the staff who see their patients benefitting from these facilities every day, and to see the difference that the charitable funds make.

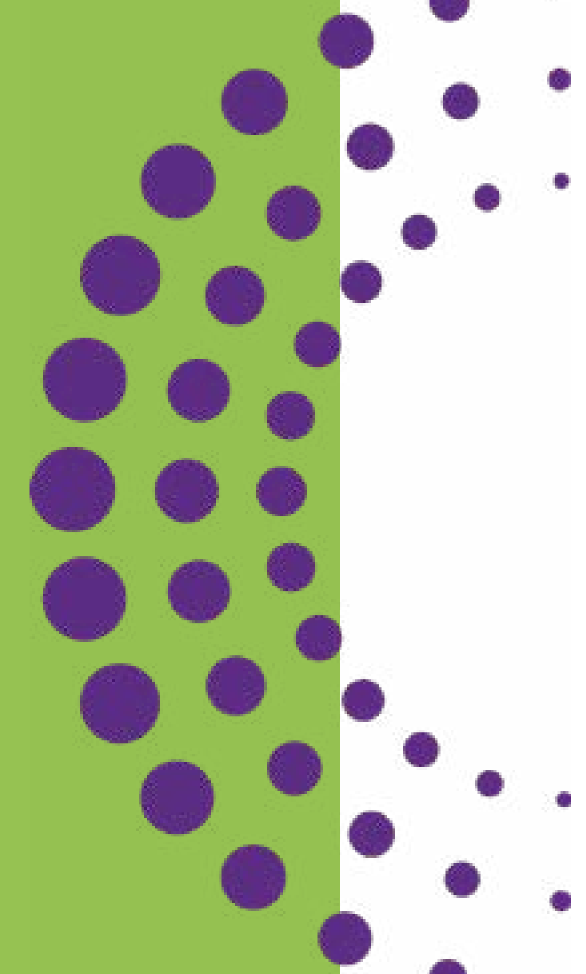
This year the charity has also been investing in wellbeing support for Trust staff. We know the direct link between staff wellbeing and high-quality patient care. The charity has helped fund wellbeing psychological support for staff, which has helped to reduced long term sickness absence.

The charity team work exceptionally hard to promote the charity and its activities, and launched a new website this year. A new online portal was also introduced to help Trust staff in applying for funds from the Charity, which has been well received.

We continue to work on our three-year strategy, diversifying the Charity's income sources, building more and deeper relationships with our local community. We all have a shared goal to deliver high quality patient care.

A huge thank you to the charity team who have worked so hard this year to deliver such a wide range of activities helping staff and patients.

Claudia Sykes
Chair of the Charitable Funds Committee



02
Fundraising Introduction

"We are so grateful to each and every supporter that has enabled our projects to come to fruition."

We are East Kent Hospitals Charity. We are here to help your hospitals. During this year we have faced many changes, offering us an opportunity to develop and evolve what East Kent Hospitals Charity can offer to our communities.

We have been delighted to be involved in so many diverse fundraising experiences, thrilled to work alongside our corporate supporters, and humbled to hear about the impact that our funding has made upon the patients, visitors and staff across East Kent Hospitals NHS Foundation Trust.

We are so grateful to each and every supporter that has enabled our projects to come to fruition. Our donors are often those with a very close personal connection to our hospitals who are keen to express their gratitude for the care that they received from our amazing NHS colleagues. We hope that we can demonstrate through this report our absolute commitment to ensuring that each and every penny raised has a significant and positive impact on the hospital experience for staff and future patients.

You can find out more about our fabulous fundraisers in the following pages, as well as the projects that we have been so proud to fund, such as the installation of charge boxes on one of our children's wards to ensure that families can stay in touch during a worrying time. We enhanced the fantastic new emergency departments at the Queen Elizabeth The Queen Mother Hospital and the William Harvey Hospital, and were delighted to be able to fund a powerful and award-winning film to be produced.

We've enjoyed reflecting on our achievements when compiling this report, and look forward to the coming year with enthusiasm and ambition for continuing our evolution and embracing all opportunities to make a real difference to our hospitals.

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.

The Charity Team

Danielle Neligan
HEAD OF CHARITY

Jenny Still
CHARITY ACCOUNTANT

Lizzie Warner
MARKETING AND PROJECTS OFFICER

Maddi Austin
MARKETING AND PROJECTS OFFICER

Sam Hill
CHARITY ADMIN OFFICER

03

Fantastic Fundraisers

Three Peaks Challenges

A group of nurses battled driving rain and winds of up to 70mph to raise money to help patients at the end of their lives. The team from the critical care unit at the William Harvey Hospital took on the Three Peaks challenge, with all proceeds going to the 3 Wishes Project, which grants wishes to patients who are dying.

Although bad weather and unsafe conditions forced them to abandon their climbs at Scafell Pike and Snowdon, they did successfully scale Ben Nevis and are officially classed as completing the challenge.

Judith Sloan, who took part in the challenge with Josh Dale, Harriet King, Ruth Lukehurst, Josh Morris and Tim Coleman, said: "We are a bit disappointed that we couldn't reach the top of all of the mountains but the decision was made on safety grounds.

"It was definitely a challenge and we worked so hard to train and prepare but the weather was just too bad on the day."

Team members Rachel Tappenden and Bonnie Ruddock were unable to take part in the climb but held a cake sale which raised £854.78, bringing their total raised to £6,108.05.

In May 2023, Darren, Matt, Gary and Simon also undertook the 3 Peaks Challenge within 24 hours. The distance they walked was over 23 miles, ascending 3,064 metres and driving over 462 miles within the period.

In total they raised an incredible £2,684.06 for the Viking Day Unit at the Queen Elizabeth The Queen Mother Hospital in Margate.

Westgate United Services Club

Members of Westgate United Services Club collected £3734.92 for East Kent Hospitals Charity, after chairman Glenn Nattrass chose it as his charity of the year.

The money will go towards refurbishment of the relatives and staff room at the critical care unit at the Queen Elizabeth The Queen Mother Hospital in Margate, where Glenn was treated after developing a blood clot in the artery that leads to his bowel. He needed major surgery over two days and at one point was told he had less than a 20 percent chance of surviving.

The club handed over a cheque to critical care nurse educator Tracy Lewis and head of charity Dee Neligan at their Christmas party.

Dad-of-one Glenn said: "If it wasn't for the wonderful staff in the critical care unit I wouldn't have made it from there to a ward, let alone to survive and lead a normal life.

"I quite literally owe them my life so this is a small way of giving something back and saying thank you."

The money was raised at a range of events, including a race night that netted more than £1,100. The team had originally set themselves a target of £2,000 but ended up collecting almost double that.

Graham Morris, from the club, said: "As usual we had fantastic support from our members and I would like to say a massive thank you to everyone who donated."

Students say thank you with fundraiser

A team of final year medical students swapped ward rounds for a rowing machine in March 2024, raising funds for the hospital where they completed a lot of their training.

The group were students at Kings College London, and had spent much of the past year on placement at the William Harvey Hospital in Ashford. They had been working on the Cambridge medical wards and raised money for our charity to support those wards.

Joe, one of the fundraising participants said: "We thought that since the staff and patients on these wards have done so much to help get us to the stage we're at now, it would be nice to try and do something to help them in return."

"We attempted to row a combined distance of 130km in 24 hours- the distance as the crow flies from Ashford to Cambridge."

"People will be doing different amounts and as a result it should be challenging for everyone."

Thanks to the combined efforts of the team, they raised £2429.63.

Saffery Farm

Saffery Farm continued to fundraise for Padua Ward in 2023, following the treatment that the farm owner's daughter has received there.

Money raised will help improve the experience for children at the William Harvey Hospital, from funding special devices for children's audiobooks, to 'mediteddies' which are designed to fit over IV bags, making treatment feel less scary for younger patients.

To date they have raised an amazing £7,072.89 from their annual pumpkin patch sales!

Gracie Grey's Day

A couple whose daughter died at just three months old raised money to thank the hospital teams who cared for her.

Mel and Alex Gray, from Tenterden, organised a fun day on Saturday, 19 August, in memory of Gracie, who was born 10 weeks early weighing just 3lb 5oz.

The tot was diagnosed with cerebral palsy after suffering brain seizures, and her parents were warned she would not live long.

After seven weeks in the neonatal intensive care unit (NICU) at the William Harvey Hospital in Ashford they were able to take her home to big brother Louie. The family spent six weeks together enjoying being a family of four before she lost her fight and died in her parents' arms.

Mel said: "We became close to some of the staff who really got me through some dark times, and we wanted to raise money to give something back and say thank you for all their care."

Beautician Mel and her tree surgeon husband Alex, who have become parents to Henry and Cooper since losing Gracie in 2019, raised an incredible £7387.26 at the event, and plan to run another in August 2024.

Canterbury Golf Club

Golfers swung into action to raise £8,580.94 to support people living with dementia across East Kent Hospitals.

Canterbury Golf Club's 2023 Seniors Captain David Spencer and Lady Captain Fran Fearn teed up a range of events over their year in office, supported by their members and friends.

The money will go to East Kent Hospitals Charity's dementia campaign, and will help fund interactive equipment that is used to provide comfort and distraction for people living with dementia while they are in hospital. It could also be used to fund a specialist chair allowing a patient's loved one to stay overnight by their bedside.

Head of charity Dee Neligan said: "At the start of the year we invited David and Fran to the Kent and Canterbury Hospital to see some of the work done by our incredible dementia team, and how our charity is able to support them.

"We were able to showcase the interactive equipment, which can be used in so many different ways, from promoting movement with a group or to provide distraction with a favourite song or re-watching a World Cup victory.

Events included a Christmas coffee morning organised by Fran, as well as a golf challenge by players Max and Ben Rutherford, Alex Beck and Kay Appleby, who played 72 holes in one day.

The club also hosted East Kent Hospitals' dementia associate practitioner Ann McGovern, who led two sessions training members to become Dementia Friends, helping them to understand more about dementia and how to help people with the condition.

Craft Support

We are so grateful to our crafty communities, who donate thousands of goodies every year. Pouring their time, energy and love into each item, we are thrilled to receive numerous twiddlemuffs, blankets and baby hats, amongst other things.

Each item is sent to various wards and departments across the hospitals, and given to patients to enhance their stay in the hospital. Whether they receive twiddlemuffs supporting dementia care, a beautiful blanket on the Critical Care Unit or a 'traffic light' hat for new-borns, they are all very much appreciated.

DBL Stitching Group craft items

Mont Ventoux Challenge

Ashford Wheelers climbed Mont Ventoux to raise money for Harbledown, a stroke ward in Kent and Canterbury Hospital.

Phil Fletcher, part of the seven cyclists taking on the challenge, decided to raise money for the ward after his wife, Jackie, suffered a stroke in 2021.

Phil said: "We just wanted to try and give back after everything they did for my wife, so we put our heads together and found a challenge."

A tough challenge for even the most seasoned cyclists, Mont Ventoux is located in the south of France and requires some serious determination to climb the steep mountain even just once.

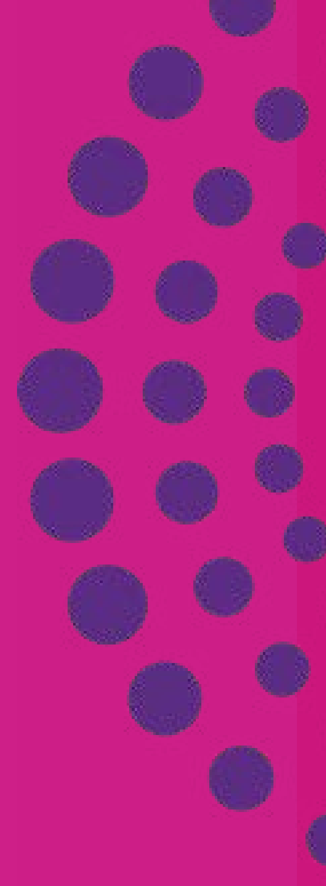
He said: "We cycled up and down as many times as we could over two days. Each climb was 21.5km, it was incredibly tough but the view at the end was beautiful.

"It's a bucket-list moment, but being able to do it for something so personal to me made it much more special."

Jackie suffered multi focal strokes at her home and was rushed to Kent and Canterbury Hospital after her quick-thinking son called 999.

Jackie said: "I received wonderful care in the Harbledown ward, although I was desperate to get home at the time. I am really grateful to Dr David Hargroves and the team who treated me."

Phil, his sons, Owen and Liam, and their teammates, Andrew Branson, David Hampton, Jonathan Hollidge and Darren Turner were proud to present Harbledown ward with a big cheque for £2,794.97.



04

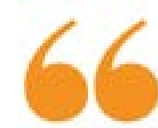
Corporate Support

Not only have we been supported by our amazing communities this year, we have also been delighted to work with a number of local and regional businesses who have offered their corporate support.

Barratt David Wilson, a housing development company selected the 3 Wishes Project at the QEQM Hospital as their charity to support during between February 2023 and February 2024, donating £4,000. We have an established relationship with the company, as they have previous donated towards Padua Ward at the William Harvey Hospital and our Covid-19 appeal 'Helping Your Hospitals'.
Thanks to their support the Critical Care Unit have been able to continue to deliver personalised end of life care and wishes to their patients and loved ones.

Spurdown Ltd is a property surveying company, based in Goudhurst. Following their 60th anniversary, the staff at Spurdown Ltd were asked to choose several local charities to donate to. Having discussed our various campaigns and projects, the team decided to select our Twinkling Stars campaign as the recipient of a donation of £1,000 in February 2024.

We are delighted to share that WW Martin- a construction company based in Ramsgate- have selected East Kent Hospitals Charity as their Charity of the Year 24/25, supporting the Special Care Baby Unit at the Queen Elizabeth The Queen Mother Hospital in Margate.
WW Martin have previously chosen us as their Charity in 22/23, with their fundraising benefiting the Emergence Department at the QEQM.
We are really excited to work closely with the company in the coming year.



Being able to support such an impactful project and a fantastic local charity is a real privilege.

More patients in critical care will have their last wishes come true thanks to ongoing support from Kent-based construction firm, Bauvill.

Between 21/22 and 22/23, Bauvill have kindly raised £30,701 for East Kent Hospitals Charity, with funds going directly to the 3 Wishes Project, a project which aims to bring comfort to patients who die in critical care by granting 'wishes' to patients at the end of their life. Following a cheque presentation in March, East Kent Hospitals Charity received a further £11,174.20 in April 2024.

Natalie Daly, ward manager for critical care said: "We are so grateful for Bauvill's continued support for the 3 Wishes Project. So far, we have granted 150 'wishes' which range from taking patients in to our garden, providing movie nights, bringing a family pet in to visit, or providing transport to bring people together for those important last hours."

Matt Gurr, Managing Director at Bauvill said: "We are very pleased to continue supporting East Kent Hospitals Charity as one of our nominated charities this year. We have partnered with East Kent Hospitals University Foundation Trust for a long time now, working alongside clinical teams as we deliver key infrastructure projects where we have witnessed first-hand the selfless care they provide to patients.

"We fundraised this year through a series of fundraiser events such as our annual Charity Gala Ball held at Gillingham Football Club, and our successful Golf Day at Ashford Golf Course. We've also received generous donations from our supply chain and members of staff.

"Being able to support such an impactful project and a fantastic local charity is a real privilege. It doesn't take much for us to help, but we like to think our contributions have a positive impact on patients, their families, and even staff members."

05

Events and Campaigns

We are so grateful for all donations that we receive, and have been developing our events offering over the last couple of years, to give those who want to support our Charity an opportunity to take part in a lifelong dream, 'bucket list' challenge, or simply to do something different.

We are signed up to the Run For Charity platform, with access to many local, regional and national fundraising event opportunities, as well as being in partnership with local businesses such as Boonies and The Wing Walk Company: giving our supporters a wide variety of choice when they fundraise for us.

Half Marathons

Five runners participated in the London Landmarks Half Marathon in April 2023, raising £2,116.56 in total for our charity!

We also had two runners in the Royal Parks Half Marathon. Their final total was an impressive £1,335 in donations, smashing their original target of £700.

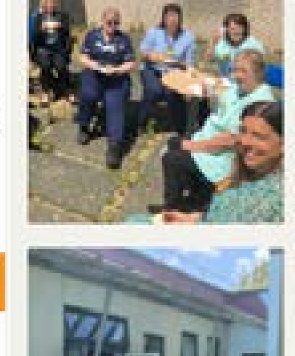
NHS 75

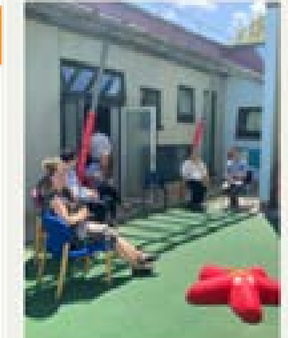
In previous years we have celebrated the NHS birthday by taking part in the NHS Charities Together 'Big Tea' initiative: pouring out our donor's thanks for incredible the work that EKHUFT and 2Gether Support Services do.

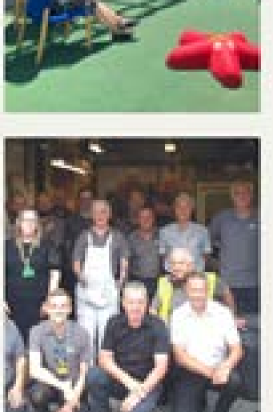
In 2023, we introduced the NHS 75 Big Tea fund, encouraging teams to spend up to £75 in their respective areas, in order that everyone could equitably 'raise a mug' to toast the NHS.

83 different wards, departments and services engaged with this initiative, costing us £1,663.00.

Teams across the Trust used this as a fundraising opportunity, and we received a total of £697.50 in donations.







Wing Walk

Three brave wing walkers undertook the challenge of a life time on the 28th August 2023. Strapped to the wings of a plane, each of them enjoyed ten minutes whizzing through the skies over Headcorn Aerodrome.

Carly, Louise and Wendy were delighted to have the chance to take part in the Wing Walk, each raising funds for departments within East Kent Hospitals that they wanted to 'give back' to.

Louise Linden decided to take on the challenge as part of celebrations for her 40th birthday this year and took to the skies at Headcorn airfield.

It was the culmination of a childhood dream for the mum of two, from Folkestone, who grew up imagining following in the slipstream of wing walkers who impressed crowds at the town's air shows.

She said: "It was definitely a once-in-a-lifetime experience. It was absolutely amazing and the views were fantastic. Once I was up in the air it was quite surreal, and I hadn't really prepared for the G-force and speed of the air rushing past – my arms were aching the next day."

Louise decided to raise money for East Kent Hospitals Charity, to benefit the neonatal intensive care unit at the William Harvey Hospital, where her son Oscar was cared for after he was born by emergency caesarean section.

The chartered accountant, who has already completed two sky-dives and a bungee jump, initially hoped to raise £1,000 but has now raised £2,485.95.

Carly Larkin, who works as apprenticeship and learner support lead for the Trust took to the skies in memory of her parents.

Carly said: "The wing walk was a truly epic experience, and a very emotional day.

"I carried a photo of them with me during the flight and it was a very special moment."

Survival Rewind

We were the charity partners for the Boonies Survival Rewind event on the 30th September and 1st October 2023.

The Survival Rewind was the ultimate obstacle course, open to families, teams and groups: offering an exhilarating activity to build teamwork skills and have loads of fun. We even had a hen party taking part!

There were 3km, 6km and 9km distances with up to 100 obstacles, including swimming elements marshalled by the RNLI. Children as young as 5 joined in, with diversions around the more difficult challenges.

This was the first year that the charity has participated in a partnership like this, and we hope to be able to continue the relationship and collaborate on a similar popular and highly visible local event in 2024

Festive Campaign 2023

Impact

The festive period is a key focal point for our charity each year, both in relation to the opportunities to engage with our communities and raise awareness of the charity and the work that we do, as well as enhancing the hospital experience for as many patients, visitors and staff as possible.

In 2023 we:

- Visited 256 wards, services and departments across the Trust, delivering seasonal chocolates and charity branded merchandise- an opportunity to say ‘thank you’ on behalf of our donors for the incredible work that EKHUFT and 2Gether Support Solutions do throughout the year.
- Supported 23 areas across the hospital with their festive celebrations or decorations as part of our annual ‘festive fund’ initiative.
- Thanked over 40 groups, individuals and companies who had made direct donations, including toys, games, chocolates etc. to wards across the hospitals.
- Received £9,143.40* in financial donations as a result of fundraising across our communities, and support from individuals. (*Total received was £13,035.51, but some funds were received outside of the reporting period).

Cards and Baubles

We sent our Christmas Cards to over 250 of our donors and supporters of 2023.

We included a newsletter 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.

Social Media

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 are available, particularly focussing on our amazon wishlists, which were very popular.

The campaign included native (non-paid) posts on Facebook and Instagram, which comprised 18 native posts and 33 native stories. We also ran paid adverts on Instagram and Facebook with a budget of £800. The paid adverts included a festive themed video and three static ads.

The social media campaign was extremely successful. It saw a combined reach of our content to 82,699 people during the period, which was a 5% increase on 2022, with a 6% increase in engagement.

Link clicks on paid ads increased by 2,850% when compared with the 2022 campaign, meaning the ads gained more engagement from those who were served them. The cost per link click on paid ads reduced by 95% when compared with 2022, meaning less was spent per result gained.

Stagecoach Trees

We were supported for the second year in a row by Stagecoach Bus East Kent, who provided us with additional Christmas Trees-allowing East Kent Hospitals Charity to spread more festive cheer across all five sites!

Get Started Art

During the festive period, we welcomed the Get Started Art community group who gave a generous direct donation of colouring books for the hospital's patients.

The group provide free arts and crafts materials to benefit disadvantaged children, vulnerable adults and people with learning disabilities, and distributed these with the support of Essex Freemasons and the Freemasons East Kent.

We also hosted the Lord Mayor of Canterbury, Lady Mayoress and Sherriff of Canterbury to Kent and Canterbury Hospital. They spent some time meeting various patient groups and helped us to distribute the Get Started Art materials across the hospital.

Constructing Christmas decorations

Darron Hughes, a carpentry lecturer at Canterbury College, enlisted his students to make Christmas decorations to raise money for Padua ward at William Harvey Hospital.

Darron said: "Students studying carpentry, bricklaying, plumbing, electrics, and engineering all got involved to make Christmas decorations. We made and sold wooden reindeers, copper Christmas trees, baubles and Christmas lights, and we also held raffles with prizes donated from local businesses.

"I think the students were a bit reluctant at first but they all got really into it, some helped even further by selling raffle tickets with me at our stalls."

Darron fundraises every year, but in 2023 he chose to raise money for Padua ward, where his son who was aged two at the time, spent some time following epileptic seizures.

He said: "This ward is close to my heart and it really means a lot to me to be able to give back to them. We spent some time there over Christmas once, we even went to one of their Christmas parties and so it feels really good to be able to support them through festive fundraising.

"We managed to do all of our fundraising in two weeks and I couldn't have done this without the help from my students, and my colleague Chloe O'Brien who was fundamental to helping us stay organised.

"This was our biggest fundraiser yet raising £819.69. We really enjoyed raising money for East Kent Hospitals Charity, in fact we're already thinking about our next fundraiser for them!"

Dee Neligan, head of charity at East Kent Hospitals Charity said: "We're so grateful to Darron, Chloe and all the students who helped raise money for one of our children's wards. We look forward to working with Darron again and seeing what he'll next come up with."

KMFM Bargain Hunter

Since 2022, we have been lucky enough to receive hundreds of direct donations of toys, games and other distraction items from the KMFM and Bargain Hunter 'Give a Gift' collaboration.

These generous donations are delivered directly to the children's wards across the Trust sites, ensuring that the patients there over the festive period have access to the toys during their stay- making their time in hospital just a little easier.

81 Colonels Lane

The family at 81 Colonels Lane, Boughton Under Blean selected our Tiny Toes campaign for their 2023 Winter Wonderland fundraiser, in memory of their son and brother Jack.

The tradition of putting up a fantastic Christmas display, featuring spectacular lights, a snow machine and festive music is one that the family have long enjoyed, and this year was the biggest one yet!

Thanks to the amazing support of the visitors who came from far and wide to see the display, the family raised £4570.77 through their JustGiving page alone.

06

Projects

We have funded projects worth £530,000 during 2023-24

Items that we have funded include 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.

Charge Boxes help parents keep in touch while their children are in hospital

Parents of poorly children can now more easily keep in touch with their loved ones, thanks to funding from East Kent Hospitals Charity.

The charity funded ChargeBoxes – special lockers where people can charge their mobile phones – for the children's wards at the Queen Elizabeth The Queen Mother Hospital in Margate and William Harvey Hospital in Ashford, costing £19,370.40.

The devices have also been installed in the emergency department at QEQM in 2022, allowing people to top up their phone's battery without needing to find somewhere to plug in a charger.

Emma Desmond, matron for acute child health at East Kent Hospitals, said they were proving popular with parents.

She said: "One parent asked if I had a charger they could borrow because they had been without a charged phone all night and were quite distressed about it.

"Having the ChargeBox will be a lifeline for families, particularly those who have been admitted as an emergency so may not have had time to pack a bag or bring a charger.

"It is a small thing that can make a big difference and help people stay in contact with relatives and friends, so we are very grateful to the charity for their support in funding the ChargeBoxes."

Between January 2024 and March 2024, 3,689 people used our ChargeBoxes at the QEQM hospital.

Captivating film praised by hospital workers

'Captivating', 'moving' and 'spellbinding' are just some of words hospital workers used to describe a powerful new film created by East Kent Hospitals' palliative care team, launched to mark Dying Matters Week (8-14 May 2023).

'Caring with Compassion' follows a man in the last days of his life, and the experiences of his family, as a powerful reminder of the importance of seeing the person, not the patient.

The palliative care team worked closely with Flix Films to develop the script, cast actors (including guest appearances from east Kent staff) and sensitively shot the film at William Harvey Hospital and other local locations.

Lucie Rudd, consultant nurse in palliative care said: "We are very proud of this film and delighted to start sharing it with our hospital colleagues and as a resource for colleagues across the NHS and our care partners.

"We know our human response is so important and we really want to encourage every member of hospital staff – it doesn't matter who they are in the team – that they can actually make a big difference."

Dr Chris Farnham, consultant in palliative medicine said: "We hope that the film reminds us all why we work here in hospital – to help care for our patients and their families. Caring with compassion is a very simple message but so important to everyone."

Leon Ancliffe, managing director of Flix Films, said: "We wanted to create a film that highlights the importance of compassion at the end of life and how a single moment can have a significant impact. We couldn't be happier with the response to the film and thank you to all those whose support and kindness made it possible."

We were thrilled to win an award at the Kent Healthwatch Recognition Awards in March 2024 for this film, which was funded for £21,520.

ANNUAL REPORT 2023/2024

New Emergency Departments

East Kent Hospitals Charity committed funding of £8,088 in 23/24, supporting the £30 million expansion of the Emergency Departments at the William Harvey Hospital in Ashford and the Queen Elizabeth the Queen Mother Hospital in Margate.

This included installing graffiti murals and an interactive projector at the Paediatric Waiting Room in the William Harvey in July 2023, as well as funding door surrounds and vinyls across both departments, improving the environment and therefore patient and staff experience.

Cat Miller, matron for the children's emergency department said: "It's fantastic to see our department expanding and to have a vibrant and colourful area for our incredibly hard-working team to care for our young patients and their families.

"Huge thanks to all the hospital teams involved, and to Bauvill, for their attention to detail, and to East Kent Hospitals Charity for generously funding the wall art and state-of-the-art interactive games system. This will not only ease anxieties of children but will be a vital piece of equipment for assessment."

Unusual visitors make poorly children smile

Poorly children were given a boost when some friendly animals paid a visit to them in hospital, in November 2023.

Michael Tyler from Creepy Claws, based at Teynham, near Faversham, bought some of his collection of more than 300 animals to visit Padua ward at the William Harvey Hospital, thanks to funding from East Kent Hospitals Charity- totalling £1,800.

Youngsters were able to meet Simon the royal python, Spud the werewolf guinea pig, Poppy the tarantula and Dusty the gecko, as well as an albino hedgehog, millipedes, and a scorpion.

The visit was arranged by the play specialists, and play leader Lorraine Cassar said: "Children can find being in hospital really boring so it's wonderful to be able to give them this experience and we're very grateful to East Kent Hospitals Charity for making it possible."

Padua Door Wraps

We funded Padua Ward's gorgeous door wraps, costing £4,975.20.

The Child Health team wanted to enhance the environment of the ward, making it more visually engaging for the patients staying on the ward, and ensuring that Padua felt a little bit less like a hospital.

We've had lots of wonderful feedback following the installation of the door wraps, and anticipate further applications from other Child Health services to mirror this project.

Dolphin Makeover

The Children's Assessment Centre at Kent and Canterbury Hospital received a makeover, thanks to funding from East Kent Hospitals Charity.

Working closely with the team at the Centre, we supported the design of a beach themed redecoration, as well as installing a 'quiet room' costing £5,172.61 in total.

Jess Baker, Operations Manager for the Centre said: "The Quiet Room at the Children's Assessment Centre at the Kent and Canterbury Hospital is a small room which is off our main waiting area in the reception. With your help, we have got a Television and high-back comfortable chairs for our patients and relatives.

"Our main reception area gets very busy at times and our quiet room is now much more inviting to children that would prefer a smaller quieter area to wait in, for children that would like to watch children's TV whilst they wait and for breast-feeding mums that need a little privacy."

Improving the environment for our X-ray patients

We were proud to have funded these graphics- installed in July 2023 within the radiology department at the William Harvey Hospital.

Costing £4,233.60, these graphics bring an incredible array of colour and light to the clinic rooms: providing distraction for patients whilst they await their x-rays.

Charity – Plans for Future Periods

Following the significant changes to staffing and structure within the charity during this year, a new strategy for the period 1st April 2024- 1st April 2026 was approved by the Charitable Funds Committee in June 2023.

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

Our vision remains: to enhance the hospital experience for all patients, staff and visitors. We are excited about the ambitious plans that we have in place to ensure that we can continue to provide sustainable, high quality and impactful projects, initiatives and equipment which meet our charity scope.

This year we have implemented several projects which offer increased efficiencies in our day to day work:

Application Portal

The new application process and portal gives our applicants a simplified user experience, with clear processes detailing the stages at which their application moves through.

Website

We launched our new website in the summer of 2023, offering our supporters an improved journey when making a donation, discovering the impact that our work has upon the Trust, and finding out how they can fundraise for us.

CRM Database

We realised our long-held aspiration when our new CRM system went live - offering the charity team a better way to navigate, utilise and interpret the support that we receive, assuring best practice and good governance in relation to our GDPR responsibilities.

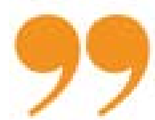
Our charity strategy focusses on building on our current achievements, understanding where our most likely sources of support are already rooted, and embracing opportunities that we have not previously approached, or had the resources to target.

As we move into 24/25, our invigorated strategic aims and focusses will be upon the growth of the charity, changing and evolving our visibility, maximising our potential and income generation opportunities.

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 £2.1m, of which £1.3m was held in restricted funds and £0.7m 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 £0.5m income for the year; a decrease of £0.3m when compared with 2022/23.

The charity has worked proactively with their Investment managers – Cazenove (part of the Schroders Group) to minimise the impact of volatile markets. 2023/24 saw a net unrealised gain on investments of £0.1m (Loss of £0.1m 2022/23).

Investment income received in the year from dividends and interest in respect of funds held with Cazenove was £75k, an increase of £3k from 2022/23. This represented a total yield of 4.77% for the year against a benchmark performance of 3%.

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 75% (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 £0.17m
- Building and refurbishment £0.13m
- Patient education and welfare £0.15m
- Staff education and welfare £0.08m

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 £107k (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 2024, there were a total of 46 individual funds established under this Umbrella registration. Of those funds 21 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 57.

The Charity has one small Endowment fund, which allows only the income to be spent, whilst the capital remains invested. The remaining 24 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 2024 was £2.1m.

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. From the December 2023 meeting the membership was reduced from seven Board members to four (two Executive Directors and two Non-Executive Directors).

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

Michelle Stevens
DIRECTOR OF FINANCE & PERFORMANCE

April 2022- December 2023

2/2 meetings attended

Ben Stevens
CHIEF STRATEGY & PARTNERSHIPS OFFICER

March 2023- Present

2/2 meetings attended

Tim Glenn
CHIEF FINANCE OFFICER

November 2023- Present

2/2 meetings attended

Dr Rebecca Martin
CHIEF MEDICAL OFFICER

March 2020- May 2023

2/2 meetings attended

Charitable Funds Committee - Non-Executive Directors

Luisa Fulci
NON-EXECUTIVE DIRECTOR

4/4 meetings attended

Claudia Sykes
CHAIR OF CFC/ NON-EXECUTIVE DIRECTOR

March 2023- Present

4/4 meetings attended

Richard Oirschott
NON-EXECUTIVE DIRECTOR

March 2023 - Present

2/2 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 4.1 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 2.6 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.

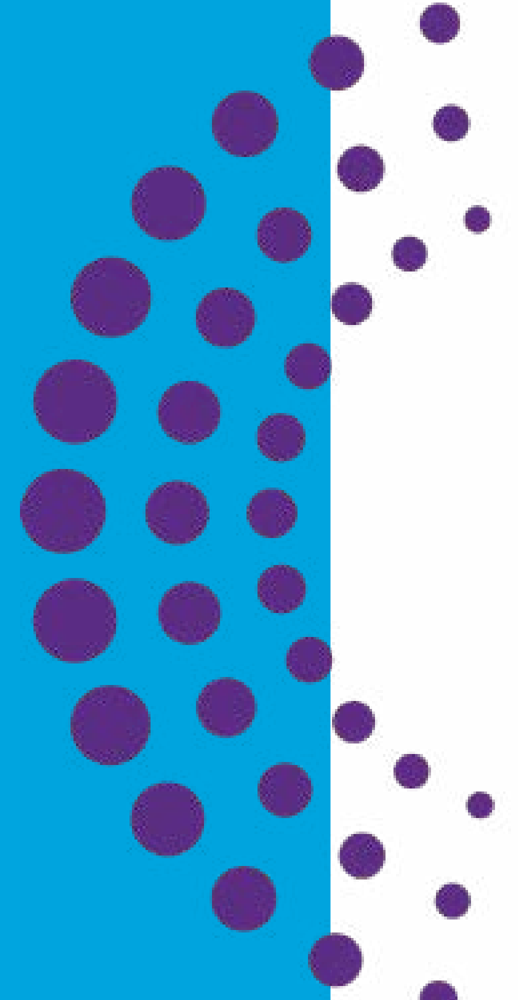
The principal aim of the Association is to promote the effective working of NHS Charities, collect donations made to the NHS and distribute to members via grants.

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 2024 was £1.6m (excluding cash of £20k).

2023/24 saw an unrealised gain on investments held of £0.1m. Dividends for 2023/24 were £75k.

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'.

ANNUAL REPORT 2023/2024

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 2024 the reserves were identified as below:

Total Endowment Funds £0.02m
Total Restricted Funds £1.3m

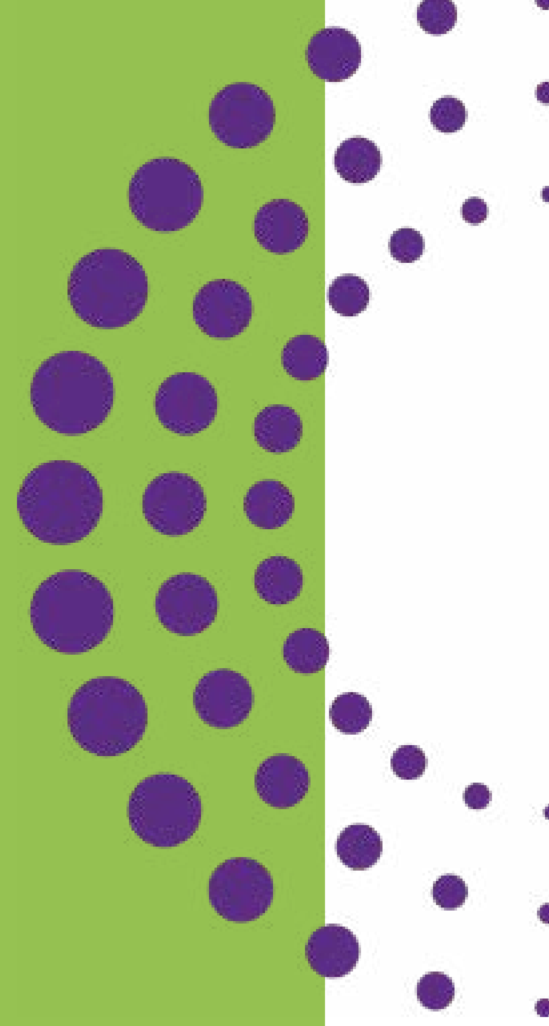
Total Unrestricted funds £0.7m
Less property funds (0.1m)
Freely available reserves £0.6m

The level of reserves held at 31 March 2024 is £0.3m 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.

10

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 86.

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

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 3 October 2024 by

Tracey Fletcher
CHIEF EXECUTIVE

Michelle Stevens
CHIEF FINANCE OFFICER

11

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;

Tim Glenn
CHIEF FINANCE OFFICER

Date: 3 October 2024

Claudia Sykes
CHAIR OF THE CHARITABLE FUNDS COMMITTEE

Date: 3 October 2024

12

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 2024, 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 2024 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 71, 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.

ANNUAL REPORT 2023/2024

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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

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.

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.

ANNUAL REPORT 2023/2024

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.

13

Statement of Financial Activities

Statement of Financial Activities for the year ended 31 March 2024

Income from	Note	Unrestricted	Restricted	Endowment	Total 2023/2024	Unrestricted	Restricted	Endowment	Total 2022/2023
	2	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Donations and legacies		232	181	0	413	192	555	0	747
Investment income		42	48	1	91	52	45	1	98
Total Income		274	229	1	504	244	600	1	845
Expenditure	3								
Raising funds	3.1	(74)	(81)	(1)	(156)	(85)	(75)	(2)	(162)
Charitable Activities	3.2								
Medical equipment		(56)	(111)	(1)	(168)	(119)	(293)	(1)	(413)
Building and refurbishment		(80)	(55)	0	(135)	(284)	(64)	0	(348)
Patient Education and welfare		(109)	(38)	0	(147)	(31)	(79)	0	(110)
Staff education and welfare		(74)	(6)	0	(80)	(2)	(23)	0	(25)
Audit Fees		(9)	(15)	0	(24)	(8)	(12)	0	(20)
Total expenditure on Charitable Activities		(328)	(225)	(1)	(554)	(444)	(471)	(1)	(916)
Total expenditure		(402)	(306)	(2)	(710)	(529)	(546)	(3)	(1,078)
Net gains/(losses) on investments	5	35	65	1	101	(40)	(79)	(1)	(120)
Net movement in funds		(93)	(12)	(0)	(105)	(325)	(25)	(3)	(353)
Fund balances brought forward		829	1,338	22	2,189	1,154	1,363	25	2,542
Fund balances carried forward		736	1,326	22	2,084	829	1,338	22	2,189

The accompanying notes form an integral part of these financial statements. All transactions are derived from continuing activities.

14

Balance Sheet

Balance Sheet as at 31 March 2024

	Note	Unrestricted	Restricted	Endowment	Total 2023/2024	Unrestricted	Restricted	Endowment	Total 2022/2023
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Fixed Assets	5								
Investments - Cazenove portfolio		499	1,041	22	1,562	826	1,617	22	2,465
Properties		113	0	0	113	104	0	0	104
Total Fixed Assets		612	1,041	22	1,675	930	1,617	22	2,569
Debtors due over one year	6	66	0	0	66	53	0	0	53
Current Assets									
Debtors due within one year	6	0	28	0	28	0	22	0	22
Cash held in investment portfolio	10	6	14	0	20	11	22	0	33
Cash at bank and in hand	10	161	335	0	496	109	213	0	322
Total Current Assets		167	377	0	544	120	257	0	377
Liabilities									
Creditors: Amounts falling due within one year	7	(109)	(92)	0	(201)	(274)	(536)	0	(810)
Total Net Current Assets/(Liabilities)		58	285	0	343	(154)	(279)	0	(433)
Total Net Assets		736	1,326	22	2,084	829	1,338	22	2,189
Funds of the Charity	8								
Endowment Funds	8.1	0	0	22	22	0	0	22	22
Restricted	8.2	0	1,326	0	1,326	0	1,338	0	1,338
Unrestricted	8.3	736	0	0	736	829	0	0	829
Total Funds		736	1,326	22	2,084	829	1,338	22	2,189

The accompanying notes form an integral part of these financial statements.

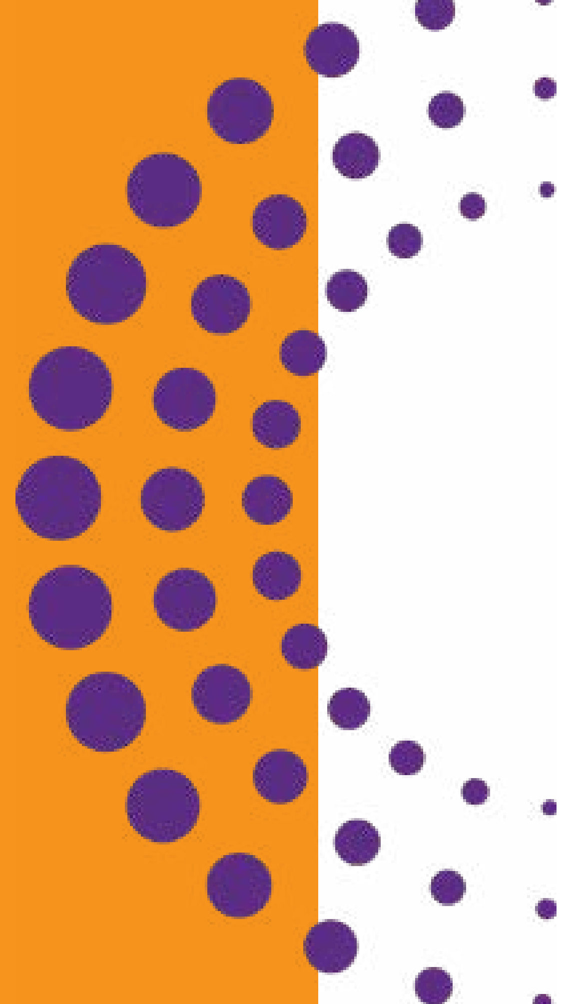
The financial statements were approved by the Trustee on 3 October 2024 and signed on its behalf by

Tim Glenn
CHIEF FINANCE OFFICER

Claudia Sykes
CHAIR OF THE CHARITABLE FUNDS COMMITTEE

15

Cash Flow



Cashflow as at 31 March 2024

Cash Flows from operating activities:	2023/24	2022/23
	£000's	£000's
Net cash used in operating activities	(886)	34
Cash flows from investing activities:-		
Dividends, interest and rents from investments	91	98
Proceeds from sale of investments	1,672	515
Purchase of investments	(724)	(492)
Charges applied to investments	8	9
Net cash provided by (used in) investing activities	1,047	130
Change in cash and cash equivalents in the reporting period	161	164
Cash and cash equivalents at the beginning of the reporting period	355	191
Cash and cash equivalent at the end of the reporting period	516	355
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	(105)	(353)
Adjustments for:-		
Gains on investments	(101)	120
Dividends, interest and rents from investments	(91)	(98)
Decrease in debtors	20	177
Increase in creditors	(609)	188
Net cash provided by (used in) operating activities	(886)	34

16

Notes to the financial statement for the year ended 31 March 2024

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 income is 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 income (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 income 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 2024. A valuation has been completed by Cushman and Wakefield professional valuers as at 31 March 2024 and in the opinion of the Trustees, the valuation remains materially accurate at 31 March 2024. 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 2023/24	Unrestricted	Restricted	Endowment	Total 2022/23
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Donations from Individuals	160	6	0	166	174	21	0	195
Donations from groups/orgs	17	1	0	18	5	0	0	5
Grants NHS Charities Direct	35	0	0	35	0	0	0	0
Grants Other	5	54	0	59	0	207	0	207
Corporate donations	2	5	0	7	6	1	0	7
Legacies	13	115	0	128	7	319	0	326
Other income	0	0	0	0	0	7	0	7
Total Donations and Legacies	232	181	0	413	192	555	0	747
Other trading activities	0	0	0	0	0	0	0	0
Investment								
Dividends from investment portfolio	28	46	1	75	26	45	1	72
Bank Interest	14	2	0	16	26	0	0	26
Total Investment income	42	48	1	91	52	45	1	98
Total income	274	229	1	504	244	600	1	845

3. Expenditure

	Unrestricted Activity	Support Costs	Restricted Activity	Support Costs	Endowment Activity	Total 2023/24	Unrestricted Activity	Support Costs	Restricted Activity	Support Costs	Endowment Activity	Total 2022/23
	£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	40	0	70	0	1	111	36	0	64	0	2	102
Fundraising general	27	0	4	0	0	31	48	0	2	0	0	50
Investment - portfolio	1	0	7	0	0	8	0	0	9	0	0	9
Investment - properties	5	0	0	0	0	5	0	0	0	0	0	0
Total	74	0	81	0	1	156	85	0	75	0	2	162
Charitable Activities (note 3.2)												
Medical Equipment	51	5	82	29	1	168	110	9	259	34	1	413
Builidng & refurbishment	73	7	41	14	0	135	263	21	57	7	0	348
Patient education & welfare	99	10	28	10	0	147	29	2	70	9	0	110
Staff education & welfare	67	7	5	1	0	80	2	0	20	3	0	25
Audit Fee	0	9	0	15	0	24	0	8	0	12	0	20
Total	290	38	156	69	1	554	404	40	406	65	1	916
Total Expenditure	364	38	237	69	2	710	489	40	481	65	3	1,078

Support Costs £108k for 2023/2024 (£105k 2022/2023) include governance costs £38k for staff pay (£33k 2022/2023), charity membership and registration fees £2k (£2k 2022/2023), and internal audit fees £1k (£1k 2022/2023). 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 2023/2024 (£24k completed by Azets Audit Services for a full opinion 2022/2023).

4. Net Movement in Funds

	Unrestricted Funds	Restricted Funds	Endowment Funds	Total 2023/24	Unrestricted Funds	Restricted Funds	Endowment Funds	Total 2022/23
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Net resources of general donations and fundraising	(169)	(125)	(2)	(296)	(338)	9	(3)	(332)
Net gain from fundraising events	(1)	0	0	(1)	1	0	0	1
Net loss from investment opportunities	0	0	0	0	0	0	0	0
Net gain from investment portfolio/bank	42	48	1	91	52	45	1	98
Gains & losses on investment assets	35	65	1	101	(40)	(79)	(1)	(120)
Net movement in funds	(93)	(12)	0	(105)	(325)	(25)	(3)	(353)

5. Analysis of Fixed Asset Investments

2023/2024 Investments	Portfolio	Invested Properties	Total fixed assets
	£000's	£000's	£000's
Market value at 1st April 2023	2,465	104	2,569
Less: Disposals at carrying value	(1,653)	0	(1,653)
add: Acquisitions - less cash	658	0	658
Net gain/loss on revaluation and sale	92	9	101
Charges applied to capital	0	0	0
Market value at 31 March 2024	1,562	113	1,675

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	492	0	492
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

	31 March 2024	31 March 2023
Uk Equities	225	404
Int equities	747	1,088
Other assets	266	554
Bonds	324	419
Total Portfolio	1,562	2,465

Material Investments held as part of Portfolio	31 March 2024
	£000's
Charities Property Fund	171
Man GLG Sterling Corporate Bond	94
SPDR S&P 500 UCITS ETF	83
JPM US Equity Income Fund	115
Vanguard S&P 500 UCITS ETF	197
SUTL Cazenove Charity UCITS Fund	156

Material Investments held as part of Portfolio	31 March 2023
	£000's
Charities Property Fund	233
Schroder Stirling 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

			31st March 2024			31st March 2023
Accrued Income	Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	£000's	£000's	£000's	£000's	£000's	£000's
Amounts falling due within one year:						
Prepayments	0	18	18	0	15	15
Legacies	0	0	0	0	0	0
Other Debtors	0	10	10	0	7	7
Amounts falling due over one year:						
Loan for property maintenance	66	0	66	53	0	53
Total debtors	66	28	94	53	22	75

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

			31st March 2024			31st March 2023
	Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	£000's	£000's	£000's	£000's	£000's	£000's
Amounts falling due within one year:						
Trade creditors	1	0	1	0	3	3
Audit	9	15	24	26	30	56
East Kent Hospitals University NHS Foundation Trust	99	77	176	248	503	751
Total creditors falling due within one year:	109	92	201	274	536	810

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 2023	Income	Expenditure	Transfers	Gains & Losses	Balance 31st Mar 2024
	£000's	£000's	£000's	£000's	£000's	£000's
KCH Longbotham	22	1	(2)	0	1	22
Total	22	1	(2)	0	1	22

8.2 Restricted Funds	Balance 31st Mar 2023	Income	Expenditure	Transfers	Gains & Losses	Balance 31st Mar 2024
Name of fund	£000's	£000's	£000's	£000's	£000's	£000's
QEQM General Purposes	550	36	(115)	0	26	497
KCH Mermikedes ITU	105	4	(19)	0	5	95
WHH Celia Blakey Unit	205	11	(27)	0	10	199
Ophthalmology fund	196	0	0	0	0	196
Buckland Fund	52	2	(7)	0	3	50
KCH Renal Fund	45	95	(14)	0	7	133
Others*	185	81	(124)	0	14	156
Total	1,338	229	(306)	0	65	1,326

8.3 Unrestricted Funds	Balance 31st Mar 2023	Income	Expenditure	Transfers	Gains & Losses	Balance 31st Mar 2024
Name of fund	£000's	£000's	£000's	£000's	£000's	£000's
EKHT Umbrella General Fund	108	98	(165)	0	3	44
QEQM Property Fund	160	13	(5)	0	9	177
WHH Neonatal Fund	41	32	(7)	0	3	69
QEQM Viking Day Oncology Fund	185	21	(25)	0	10	191
EKHT Surgery & Anaesthetics	62	6	(8)	0	4	64
Others*	273	104	(192)	0	6	191
Total	829	274	(402)	0	35	736

* All other funds are those where the balance at 31 March 2024 was below £50k

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
KCH Renal Fund	Any charitable purpose relating to NHS wholy or mainly for Buckland Hospital
Buckland Fund	Charitable purposes relating to Renal Care Unit Kent & Canterbury Hospital

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
WHH Neonatal Fund	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 2024 Total £000's	31st Mar 20223 Total £000's
Salaries & Wages	149	131
Social Security Costs	16	14
Pension	16	15
Total Staff Costs	181	160

	31st Mar 2024 Total £000's	31st Mar 2023 Total £000's
Average Number of Employees:		
Raising Funds	2.6	2.0
Charitable Activities	1.5	1.5
Total	4.1	3.5

One member of Fundraising staff received emoluments of £60k-£70k, no other members of staff exceeded £60k (no members of staff received emoluments exceeding £60k in 2022/2023). All staff members are employees of EKHUFT 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 2024 Total £000's	31st Mar 2023 Total £000's
Cash in hand	496	322
Cash held in investment portfolio	20	33
Total	516	355

ANNUAL REPORT 2023/2024

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 £0.2m as at 31/03/2024 (£0.8m 31/03/2023) and expenditure of £0.5m for 2023/24 (£0.9m 2022/23).

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 2022/23)

14. 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

Trust Offices
Kent & Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG
Tel: 01227 766877

5 December 2024

Azets Audit Services Limited
5th Floor Ashford Commercial Quarter
1 Dover Place
Ashford
Kent
TN23 1FN

Re: East Kent Hospitals Charity

To whom it may concern

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 period ended 31 March 2024. 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 responsibility our responsibilities as trustees as set out in the terms of your engagement letter dated 18 July 2024, under the Charities Act 2011 for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom 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 the 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.
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 applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

INTERNAL CONTROL AND FRAUD

7. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error, and we believe that we have appropriately fulfilled these

responsibilities. 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 where fraud 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.

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 31/03/2024 other than those disclosed in the accounts.

12. We have reviewed the residual values attached to fixed assets and confirm they are still appropriate and reasonable reflections of these assets condition and usage.

13. All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as appropriate.

14. 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.

15. We confirm that all bank accounts have been disclosed to you and are included within the financial statements.

16. We confirm that the charity has not contracted for any capital expenditure other than as disclosed in the financial statements.

ACCOUNTING ESTIMATES

17. 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

18. The charity has not granted any advances or credits to, or made guarantees on behalf of, directors other than those disclosed in the financial statements.

LEGAL CLAIMS

19. 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

20. 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.

21. 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

22. 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 legislative and accounting standards requirements.

24/93.6 – APPENDIX 4

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 action(s) 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 such 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 Angela van der Lem, Chief Finance Officer

Trustee :

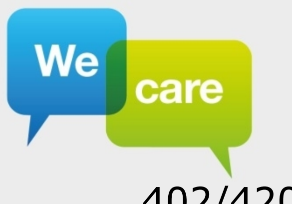
Date:

Research and Innovation (R&I) Board report December 2024

Ms Jessica Evans

Director R&I and EKHUFT Clinical Trials Unit

Consultant Colorectal Surgeon



Background

- Change of R&I strategy

Focus - commercial / interventional & homegrown

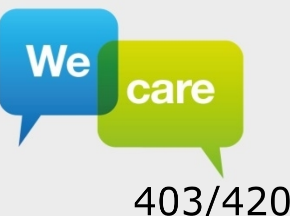
- Review of roles and responsibilities

Improve efficiency

Workforce planning

- Merger of oncology and haemoncology teams – Cancer research team

- Finance review

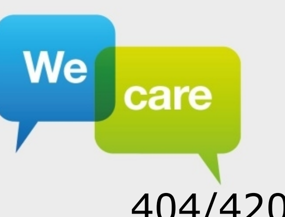


Recruitment

- Pledge for 2023-24 was 1067 and we exceeded the target with 1987 recruits. 2024-25 pledge is 1014 and we are on track to exceed it again this year.

- 2023-24 we opened 55 new studies, 84% of which were commercial/interventional.

Type	2023-24	2024-25
Non-commercial Observational	9 (16%)	5 (20%)
Commercial/Interventional	46 (84%)	20 (80%)
TOTAL	55	25



Recruitment to trials Apr 2023-Oct 2024

Emergency and trauma
Cardiovascular
Surgery
Renal
Gastrointestinal
Neurological
Cancer
Critical Care
Children
Anaesthesia, Perioperative Medicine and Pain...
Musculoskeletal
Hepatology
Mental Health
Stroke
Dementias and Neurodegenerative Diseases
Reproductive health and Childbirth
Infection
Haematology
Ear, nose and throat
Ophthalmology
Respiratory
Health services and delivery research
Genetics
Diabetes
Dermatology

0 50 100 150 200 250 300

■ 2024/25 ■ 2023/24

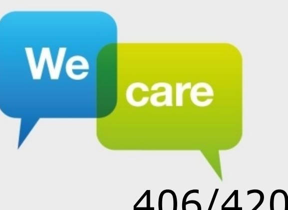
Commercial studies

- Cost savings 2023/24 - £143, 670, plus estimated drug cost savings in excess of £1.3M in 18 months

Income:

- 2022/23 - £566,095
- 2023/24 - £840,490

- 2024/25 Invoiced £825,000 FY so far, projected over £1M by end financial year



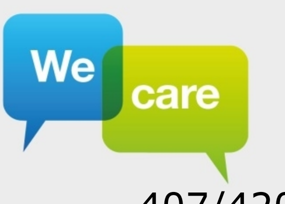
- **35 Grey Area Projects** (GAPs) registered and approved so far in 2024 (tracking ahead of last year's total of 42 for the whole year) – home grown research and innovation.
- **133 papers with EKHUFT authors.**

  Of which 64 had EKHUFT as first author.
- Successful appointment Anaesthetic & Haem **research fellow** - increased recruitment.
- Professor and 2 x joint clinical-academic Allied Health Professional (AHP) roles with Canterbury Christ Church University (CCCU)

- **Unsuccessful Robot bid from National Institute for Health & Care Research (NIHR) & commercial research centre**

- **Academic clinical fellows** – awarded NIHR

  Renal in place. Surgical start October 2025



Cancer team merger

- 2022-23, before the merger, the Haem Onc and Oncology teams set up **5 studies** (4 of which were commercial and/or interventional) and recruited 155 participants (7 to commercial studies and 98 to non-comm interventional).
- **2023-24** the teams set up **9 studies** (8 were commercial and/or interventional) and recruited 113 participants (including 8 to commercial studies and 96 to non-comm interventional studies).
- So far in 2024-25, the team has opened 5 new studies – all commercial, and recruited 67 participants, 11 to commercial studies and 54 to non-comm Interventional studies)

- That equates to an **increase in commercial and/or Interventional activity** post merger.

- Setup – increase in commercial/interventional studies from 80% in 2022-23 to 89% in 2023-24, then a larger increase with 100% of studies setup being commercial/interventional so far in 2024-25.

Clinical Trials Unit (CTU)

- Facility opened June 2022
- **8 open studies** running through CTU – mix of home grown (CI) and commercial.

- **5 successful grants (Total value £1.165m)**
- £70k NIHR ARC – Paediatric Speech & Language Therapy (SALT)
- £250k NIHR ICA – Paediatric Physiotherapist
- £125k.NIHR ICA – Paediatric Occupational Therapy (OT)
- £240k Innovate UK – External partner - extended reality for digital mental health.
- £500k ISOFITTER – Hypertension

- **4 grant applications submitted and under review (total value approx. £1.3M)**; 4 of which are with external partners (including Secondary Care, Primary Care, SMEs)
- **ICU mouthcare** – funded by Stryker.

We care

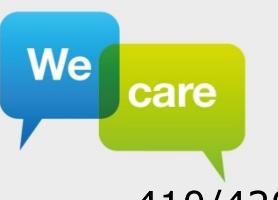
Studies opened in 2023/2024

- ANTIFECHEMO – still open (Adjuvant antimicrobial effects on human blood samples)
- Gum-GB – still open (Understanding changes in the gut microbiome in patients with gallstone disease and its impact on patient outcomes)
- VESPA – still open (Virtual Evaluations of joint health using wearable Sensors in Persons with haemophilia)

Closed studies in 2023/2024

- Home-based Electroencephalogram (EEG) neurofeedback to reduce chronic neuropathic pain, a cohort clinical trial – **over recruited**
- PROFILE – **over recruited (**Progression of haemophilic joint health)

- **11** studies currently in various stages of development



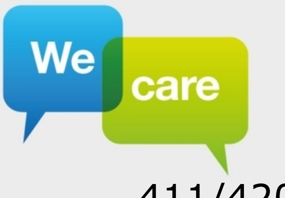
Other events

- September 2023 Board event

- March 2024 - **Let's Talk Research: Collaboration can make it happen!**

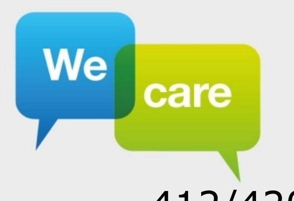
Organised and joint hosts. Excellent feedback.

- **Feb 2025 - PI meeting**

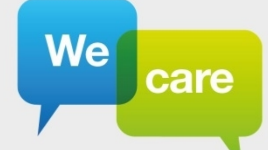


Six stages of crisis

Emotional Highs
Honeymoon
Community Cohesion
Heroic
Reconstruction
A New Beginning
Pre-Disaster
Disillusionment
Warning
Threat
Impact
Inventory
Trigger Events
Emotional Lows
Up to One Year
After Anniversary

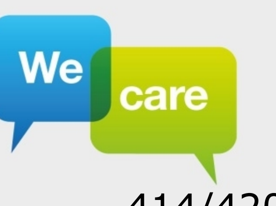


All externally funded



- Patients treated in research active institutes have better health outcomes.

- Clinical research is the single most important way in which we improve our healthcare – by identifying the best means to prevent, diagnose and treat conditions. *(gov.uk policy paper)*



Summary

- ‘New beginnings’ established
- Strategy progressing ahead of target
- Finances / income increasing

- *Challenges / the future*

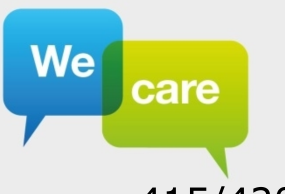
Ongoing increase interventional / commercial studies – space/ staff

Embedding research at the heart of everything we do

Care group adoption as part of every day practice

Large NIHR grants for Trust

Reaching point of having to turn away commercial Clinical Trial of an Investigational Medicinal Product (CTIMPs) (including cancer studies with novel treatment) – will cap commercial income and treatment options for patients.



Cancer RDT

- **TRAC** - this has been a benefit to the patient and organisation. De-escalating treatment therefore **massive cost** and time saving to the trust.

- **Her-2 Radical** - Again treatment de-escalated. **Top UK recruiter**

- **Optimissm** - Received notification in April '24 that the **study published in European journal of Haematology was one of the top 10 most-cited papers. MYELOMA study**, Dr Lindsay Cited.

- **RADAR** - **One of UK highest recruiters**. Personalised treatment and giving access to additional treatment for high risk patients.

- **FLAIR**- June '23 received copy of article in **The Lancet** with Dr Young cited.

- **MajesTEC-7** - **1st UK patient** recruited. Access to novel treatment.

- **Excaliber - highest UK recruiter**

- **Beigene 304/305** - Zanubrutinib proved to be of benefit with limited side effects in CLL. Long Term extension study opened to allow continued access

- **Polarix** - This study meant Polatuzimab became first line DLBCL

We care

QEOM RDT

- **NAIAD** -**cost saving £126,000** in GI genius equipment and service included and recruit 200 patients. Investigating if use **AI** increases polyp detection rates.

- **Silver** – **top recruiting international study**. Commercial study of wound dressings. Chief investigator at QE.

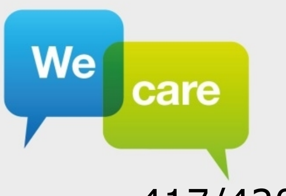
- **Harmonie** - a phase III randomised study of nirsevimab (versus no intervention) in preventing hospitalisations with RSV infection in babies. 19 babies recruited at QEQM. Link - Press Release: Nirsevimab delivers 83% reduction in RSV infant hospitalizations in a real-world clinical trial setting. They are hoping that this will become part of the vaccine program for infants.

- **SDEC study** –Randomised study duration of treatment in UTI. Determining length of antibiotic treatment in pyelonephritis. Will **change practice.**

- **Chelsea II-** end of life care study. New area of research in Trust.

- **Infinite lock** – commercial study in orthopaedics. Novel zip tie for shoulder dislocation.
- **SCBU** – **International study** surfactant down Endotrachael tube vs igel tube

- **Airways** – over recruitment. Randomising cardiac arrest comparison intubation
- **Radical** – randomised denervation spine. Pain control.



KCH RDT

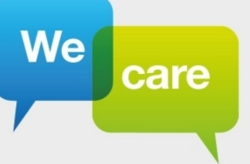
- **Turing** – 2nd highest recruiter nationally - A randomised, two-arm (1:1 ratio), double blind, placebo controlled phase III trial to assess the efficacy, safety, cost and cost-effectiveness of rituximab in treating de novo or relapsing NS in patients with MCD/FSGS (TURING)
- **Frexalt** – first recruit in Europe - comparing frexalimab (SAR441344) to placebo in adult participants with nonrelapsing secondary progressive multiple sclerosis – we were the lead for this one and Harikrishnan is CI.
- **Perseus** – highest recruiter nationally Comparing Oral SAR442168 to Placebo in Participants With Primary Progressive Multiple Sclerosis
- **Find-CKD** – 2nd highest recruiter nationally - Efficacy and safety of finerenone in subjects with non-diabetic CKD – recruited 6 patients
- **Origin-3** - first recruit nationally - Study to Evaluate the Efficacy and Safety of Atacicept in Subjects with IgA Nephropathy (IgAN) – recruited 2 against a target of 1
- **Sapphire** – first recruit nationally - Study of Obexelimab in Patients with Warm Autoimmune Hemolytic Anemia

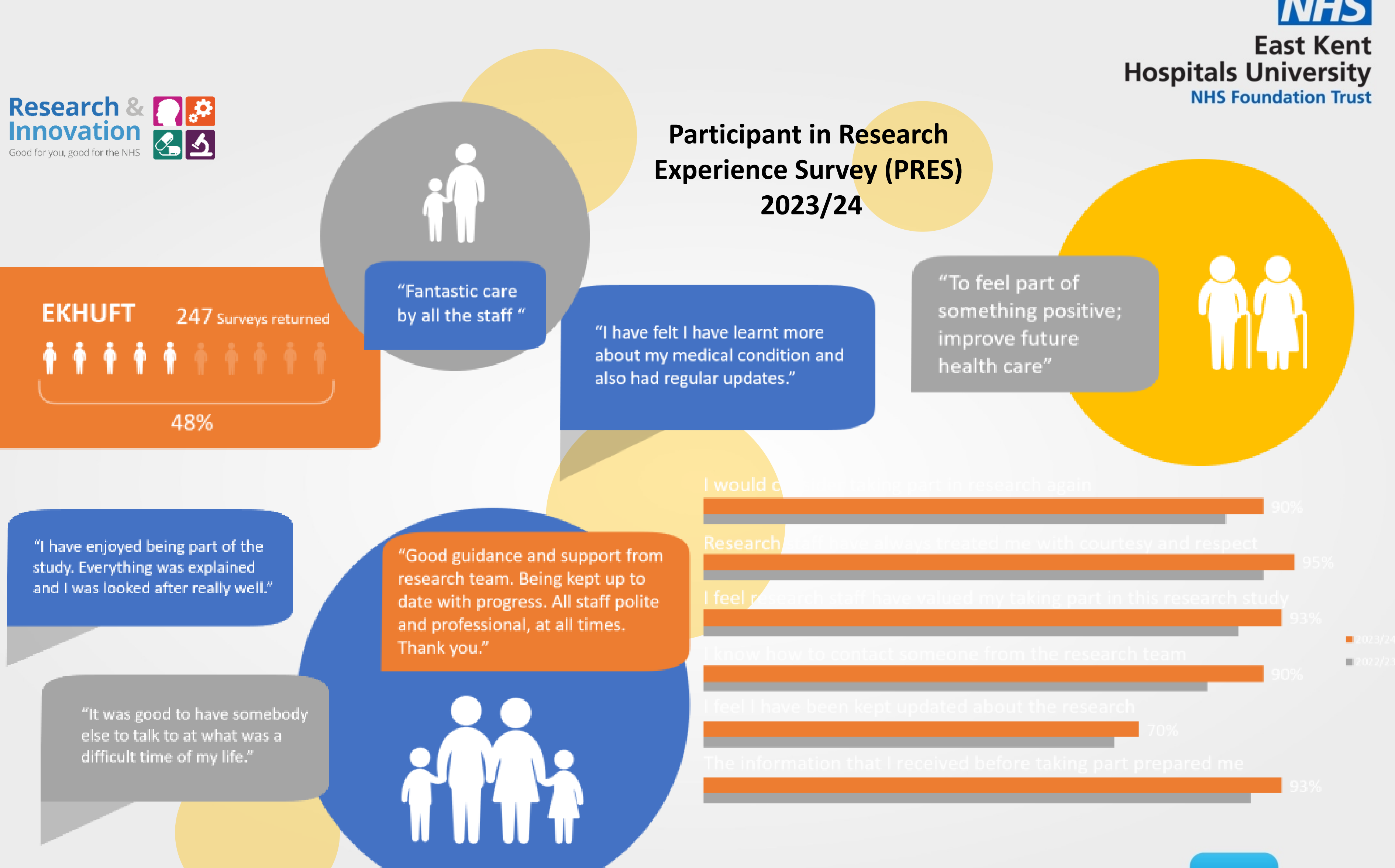
Feedback

"the team were very helpful and set-up time was good"

"Great team to work with, communication and feedback was from all departments."

"a pleasure to work with, always responsive and proactive."




Research & Innovation
Good for you, good for the NHS
NHS
East Kent Hospitals University
NHS Foundation Trust
Participant in Research Experience Survey (PRES) 2023/24
EKHUFT
247 Surveys returned
48%
"Fantastic care by all the staff "
"I have felt I have learnt more about my medical condition and also had regular updates."
"To feel part of something positive; improve future health care"
"I have enjoyed being part of the study. Everything was explained and I was looked after really well."
"Good guidance and support from research team. Being kept up to date with progress. All staff polite and professional, at all times. Thank you."
"It was good to have somebody else to talk to at what was a difficult time of my life."
I would consider taking part in research again
90%
Research staff have always treated me with courtesy and respect
95%
I feel research staff have valued my taking part in this research study
93%
I know how to contact someone from the research team
90%
I feel I have been kept updated about the research
70%
The information that I received before taking part prepared me
93%
2023/24
2022/23
We care