Board of Directors - Open Meeting (Thursday 6 June 2024)

Thu 06 June 2024, 12:45 PM - 04:45 PM

Webinar teleconference

East Kent Hospitals University NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

12:45 PM - 12:55 PM
10 min

24/16
Welcome and Apologies for Absence

To Note *Acting Chairman*

Verbal

12:55 PM - 12:55 PM
0 min

24/17
Confirmation of Quoracy

To Note *Acting Chairman*

Verbal

12:55 PM - 12:55 PM
0 min

24/18
Declaration of Interests

To Note *Acting Chairman*

24-18 - Board of Directors register of interests - June 2024.pdf (3 pages)

12:55 PM - 12:55 PM
0 min

24/19
Minutes of Previous Meeting held on 2 April 2024

Approval *Acting Chairman*

24-19 - Unconfirmed BoD 04.04.24 Open Minutes.pdf (18 pages)

12:55 PM - 12:55 PM
0 min

24/20
Matters Arising from the Minutes on 2 April 2024

Approval *Acting Chairman*

24-20 - Front Sheet Open BoD Action Log.pdf (3 pages)

12:55 PM - 12:55 PM
0 min

24/21
2024/25 Annual Planning and Cash Drawdown

Approval *Acting Chairman*

24-21 - Front Sheet 2024-25 Annual Planning.pdf (2 pages)

Patients

12:55 PM - 01:25 PM
30 min

24/22
Patient Story

Discussion *Chief Nursing and Midwifery Officer (CNMO)*

- 24-22.1 - Patient Story Board June 2024 FINAL.pdf (2 pages)
- 24-22.2 - Appendix 1 Patient Experience Story Board FINAL.pdf (4 pages)
- 24-22.3 - Appendix 2 National Cancer Patient Experience Survey 2022 FINAL.pdf (3 pages)

REGULATORY AND GOVERNANCE

01:25 PM - 01:30 PM
5 min

24/23
Acting Chairman's Report

Information *Acting Chairman*

- 24-23 - Acting Chairman BoD Report.pdf (2 pages)

01:30 PM - 01:40 PM
10 min

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

Discussion *Chief Executive*

- 24-24 - CEO Report to Board June 2024 V.1.pdf (6 pages)

01:40 PM - 02:10 PM
30 min

24/25
Integrated Performance Report (IPR)

Discussion *Chief Executive / Executive Directors*

- 24-25.1 - Front Sheet April IPR.pdf (2 pages)
- 24-25.2 - App 1 Board IPR Apr 24.pdf (59 pages)

24/25.1
Month 1 Finance Report

Information *Interim Chief Finance Officer (CFO)*

- 24-25 - Month 1 Finance Report.pdf (2 pages)

02:10 PM - 02:20 PM
10 min

24/26
Report on Journey to Exit NHS Oversight Framework (NOF4) and Integrated Improvement Plan (IIP)

Information *Chief Strategy & Partnerships Officer (CSPO)*

- **2023/24 IIP Closedown**
- **2024/25 Reset IIP**

- 24-26.1 - IIP Report 06.06.24.pdf (2 pages)
- 24-26.2 - App 1 Board IIP Report.pdf (22 pages)

02:20 PM - 02:30 PM
10 min

24/27
Board Assurance Framework (BAF)

Information *Director of Corporate Governance (DCG)*

- 24-27.1 - BAF Board June 2024 Cover sheet.pdf (3 pages)
- 24-27.2 - Appendix 1 BAF April 2024 FINAL v1.0.pdf (11 pages)

02:30 PM - 02:40 PM
10 min

24/28
Risk Register Report

Assurance *CNMO*

- 24-28.1 - Risk Report Board Public June 24 FINAL.pdf (8 pages)
- 24-28.2 - Appendix 1 Significant Risk Report 23 05 24.pdf (50 pages)

02:40 PM - 02:50 PM
10 min

24/29
Women's Care Group Maternity and Neonatal Assurance Group (MNAG) Chair's Report

Assurance *CNMO / Director of Midwifery (DoM)*

- **Maternity Incentive Scheme Year 6 Submissions**
- **Perinatal Quality Surveillance Tool (PQST)**
- **Perinatal Mortality Review Tool (PMRT)**
- **Avoiding Term Admissions into Neonatal Units (ATAIN)**
- **Saving Babies Lives Care Bundle (SBLCB)**
- **Training**
- **Care Quality Commission (CQC) Must and Should Do Requirement**
- **Obstetric Medical Workforce**
- **Neonatal Workforce**

- 24-29.1 - MNAG BoD Overarching report May 2024.pdf (6 pages)

02:50 PM - 03:00 PM
10 min

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

Patients Quality and Safety Partnerships Sustainability People

03:00 PM - 03:45 PM
45 min

24/30
Board Committee - Chair Assurance Reports:

Board Committee Chairs

24/30.1
Nominations and Remuneration Committee (NRC) - Chair Assurance Report (3.00 pm - 3.05 pm)

Assurance *Chair NRC - Dr Andrew Catto*

- 24-30.1 - NRC Board Chair Report 21.05.24 FINAL.pdf (2 pages)

24/30.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3.05 pm to 3.15 pm)

Assurance *Chair Q&SC - Dr Andrew Catto*

24-30.2 - QSC Chair's Report 230424 final.pdf (4 pages)

24/30.3
Finance and Performance Committee (FPC) - Chair Assurance Report (3.15 pm to 3.25 pm)

Assurance *Chair FPC - Richard Oirschot*

24-30.3 - FPC Board Report 30 April 2024.pdf (4 pages)

24/30.4
Integrated Audit and Governance Committee (IAGC) – Chair Assurance Report (3.25 pm to 3.35 pm)

Approval *Chair IAGC - Olu Olasode*

- **Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)**
- **Gifts, Hospitality and Conflicts of Interests Policy**

24-30.4.1 - IAGC Board Chair Assurance Report 26.04.24 DRAFT V1.pdf (5 pages)
24-30.4.2 - App 1 Standing Financial Instructions Draft 6.pdf (85 pages)
24-30.4.3 - App 2 Gifts Hospitality and Conflicts of Interests Policy v8 .pdf (35 pages)

24/30.5
People and Culture Committee (P&CC) - Chair Assurance Report (3.35 pm to 3.45 pm)

Assurance *Chair P&CC - Claudia Sykes*

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

24-30.5 - PCC Board report 23.5.24.pdf (3 pages)

Patients Quality and Safety

03:45 PM - 03:55 PM
10 min

24/31
Chief Nursing and Midwifery Officer (CNMO) Report:

CNMO

24/31.1
Patient Voice and Involvement Annual Report 2023-24

Information *CNMO*

24-31.1.1 - Patient Voice Involvement annual report 2023-24.pdf (3 pages)
24-31.1.2 - Appendix 1 Patient Voice Involvement Annual Report 2023-24.pdf (8 pages)

03:55 PM - 04:15 PM
20 min

24/32
Chief Medical Officer's (CMO's) Reports:

Chief Medical Officer (CMO)

24/32.1
Annual Organisational Audit (AOA)

Information *CMO*

24-32.1 - Annual Organisational Audit BoD AOA 6 June 2024.pdf (5 pages)

24/32.2
Paediatric Audiology Services

Assurance *CMO*

24-32.2 - Paediatric Audiology Assurance Report front sheet 6-6-24.pdf (4 pages)

04:15 PM - 04:25 PM
10 min

24/33
Safety, Fire and Statutory Compliance Update

Assurance *CSPO*

24-33 - Board Report Strategic Health & Safety Report.pdf (12 pages)

CLOSING MATTERS

04:25 PM - 04:30 PM
5 min

24/34
Any Other Business

Discussion *All*

Verbal

04:30 PM - 04:45 PM
15 min

24/35
Questions from the Public

Discussion *All*

Verbal

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

---

Date of Next Meeting: Thursday 25 July 2024

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JUNE 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ASHMAN, ANDREA	Chief People Officer	None	Appointed 1 September 2019
BAIRD, STEWART	Acting Chairman	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** Director of SJB Securities Limited (started 30 October 2013) **(1)** Non-Executive Director of Continuity of Care Services Ltd (started 1 October 2022) **(1)**	1 June 2021 (First term)
CATTO, ANDREW	Non-Executive Director	Group Chief Executive Officer, Integrated Care 24 (IC24) **(1)** (including Director of Cleo Systems 24 Ltd, Brightdoc 24 Limited, Idental Care 24 Ltd.) Board Member of east Kent Health and Care Partnership (HCP) **(1)** Director of Transforming Primary Care **(1)**	1 November 2022 (First term)
CORBEN, SIMON	Non-Executive Director	Director and Head of Profession, NHS Estates and Facilities, NHS England **(1)** School Governor, Twyford School (Winchester) **(4)**	1 October 2022 (First term)
DESAI, KHALEEL	Director of Corporate Governance	Non-Executive Director/Trustee of The Mines Advisory Group (MAG) Charity **(4)**	29 April 2024
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
GLENN, TIM	Interim Chief Finance Officer	Chief Finance Officer and Deputy Chief Executive, Royal Papworth Hospital NHS Foundation Trust (substantive role – on secondment to East Kent Hospitals) **(1)**	6 November 2023
HAYES, SARAH	Chief Nursing and Midwifery Officer	Charity Trustee, The 1930 Fund for Nurses (Charity) **(4)**	18 September 2023

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JUNE 2024

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

REGISTER OF DIRECTOR INTERESTS – 2024/25 FROM JUNE 2024

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022) Chair, East Kent Health and Care Partnership (HCP) (**1**) (1 January 2024) Chair, Kent and Medway VCSE Alliance **(5)** (September 2022)	1 March 2023 (First term)
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

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

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

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

Categories:

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

UNCONFIRMED MINUTES OF THE ONE HUNDRED AND THIRTY SEVENTH MEETING OF THE BOARD OF DIRECTORS (BoD) THURSDAY 4 APRIL 2024 1.00 PM HELD IN THE SEMINAR ROOMS, BUCKLAND HOSPITAL, COOMBE VALLEY ROAD, DOVER, KENT, CT1 0HD & WEBINAR TELECONFERENCE

PRESENT:

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

ATTENDEES:

Mr M Blakeman	Improvement Director, NHS England (NHSE)	MB
Ms M Cudjoe	Director of Midwifery (DoM) (minute 24/013.3)	MC
Ms R Ria	Staff Experience Story (minute number 24/007)	RR
Dr F Yasir	Staff Experience Story (minute number 24/007)	FY
Mrs N Yost	Executive Director of Communications and Engagement (EDC&E)	NY

IN ATTENDANCE:

Mr T Cook	Special Adviser to the Chairman and Deputy Group Company Secretary (GCS)	TC
Miss S Robson	Board Support Secretary (Minutes)	SR

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

Ms M Bonney	Governor
Miss L Coglan	Member of Staff
Mr N Daw	Member of Staff
Mr D Esson	Journalist – Kent Online
Ms C Heggie	Member of the Public
Ms L Judd	Governor
Ms C Knight	Member of Staff
Mrs B Mayall	Governor
Ms A Moore	Journalist – Health Service Journal (HSJ)
Mr D Richford	Member of the Public
Mr C Shorter	Governor
Ms M Warburton	Member of the Public

MINUTE NO.		ACTION
24/001	**CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE**	
	The Acting Chairman opened the meeting, welcomed everyone present, and noted apologies received from Ms S Hayes (SH), CNMO; Mr R Anakwe (RA), NED, not present; and Professor C Holland, Associate NED (non-Board member). The Acting Chairman welcomed Mr Blakeman, NHSE's Improvement Director, and congratulated Mr Hodgkiss on his appointment to the substantive COO role.	
24/002	**CONFIRMATION OF QUORACY**	
	The Acting Chairman **NOTED** and confirmed the meeting was quorate.	
24/003	**DECLARATION OF INTERESTS**	
	There were no new interests declared.	
24/004	**MINUTES OF THE PREVIOUS MEETING HELD ON 1 FEBRUARY 2024**	
	DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 1 February 2024 as an accurate record.	
24/005	**MATTERS ARISING FROM THE MINUTES ON 4 FEBRUARY 2024**	
	Action B/27/23 – Patient Story The CMO reported a meeting had been held with the data information team following presentation of the story, and using this around sharing learning across the organisation. As well as utilisation of equality and diversity data and patient disability information, noting this was an element with the Trust's ward accreditation programme. The Deputy CN stated there were a number of patient centred questions included within this programme that was being aligned with the Ward Managers development programme. There had been a review of patient visiting times enabling these to be during much more open periods, initial positive feedback with visitors being on the wards earlier in the morning, benefiting patients having visitors throughout the day. It was **AGREED** to close this action. **Action B/34/23 – NHS National Staff Survey results** This action was **AGREED** for closure following presentation for discussion at this meeting an NHS Staff Survey 2023 Report. **Action B/38/23 – Stillbirth rate** The Interim Deputy CN confirmed number of stillbirths and rate reported per 1000 births was included the Perinatal Quality Surveillance Tool (PQST) reports, and had been incorporated in the Women's Care Group Maternity and Neonatal Assurance Group Chair's Report presented. It was **AGREED** to close this action. **Action B/39/23 – Consider provision and appointment of Physician Associates within Maternity services to support additional staffing resources** The CMO reported the Associate Medical Director for Women's Services had no plans at the current time for the provision of Physician Associates within Maternity services. The team were working with KMMS around their feedback on these roles and would be looking at a forward programme.	

Action B/41/23 – Maternity theatre capacity risk at Queen Elizabeth the Queen Mother Hospital (QEQM)
The CSPO reported this issue remained on-going in respect of the estate and required funding for refurbishment, mitigations in place to address this issue, continued work to source additional capital funding, and confirmed there had been no serious incidents (SIs) associated with theatre capacity. It was noted this remained a risk for the Trust. It was **AGREED** to close this action.

Action B/42/23 – EU working time directive
The Deputy CN reported there was ongoing work with the Directors of Nursing reviewing any staff that had breached the EU working time directive that was being correlated against bank and NHS Professionals (NHSP) staff usage. The CPO commented this was around ensuring the contracts dovetailed to minimise breaches. It was **AGREED** to close this action.

The Board of Directors **NOTED** the action log, **NOTED** the updates on the actions, **NOTED** the actions for future Board meetings, **APPROVED** the one action recommended for closure, and **AGREED** the five actions noted above for closure.

24/006 **NHS STAFF SURVEY REPORT 2023**

The Acting Chairman acknowledged the very poor staff survey results, and the significant work needed to improve engagement and trust with the staff.

The CPO highlighted the following key areas:

- Response rate 41% against the national average of 46%, rate fallen for the second successive year, and three of the nine key themes scored the lowest of 122 acute trusts;
- Energetic presentation that morning on the findings from the Culture and Leadership Programme (CLP) from the staff CLP Change Champions across various areas within the Trust working to progress the CLP;
- Scores were below the national average in most questions, the biggest gap area from the national standard all related to advocacy (*i.e.* recommend as a place to work/be treated, and care being top priority), and challenges around advocacy, risk and culture needed to be addressed and improved;
- Three key priorities identified for action, values, voice and leadership, to be taken forward around:
  - large-scale engagement programme living the Trust's values and behaviours;
  - focussed and intensive support in specific areas where staff reported 'neither engaged or disengaged';
  - Year-round focus at local level through organisation and Care Group plans with monthly metrics assessing progress.
- Trust committed to make the organisation a better place to work for staff, increasing staff engagement, greater visibility of the Board of Directors, Executive Directors and Senior Leadership Teams (SLTs) listening and responding to issues raised by staff. Supported by the stable substantive Executive Team and Care Group Leadership Teams in place;
- Targeting middle leaders to support communication dissemination and staff engagement.

The Acting Chairman stated it was important that staff felt they were being listened to, their voices amplified, and felt valued.

The NEDs enquired what would be done differently to provide assurance of improved staff engagement and outcomes, as well as increasing the number of staff completing the survey in future. The CPO reiterated the Trust's stable leadership in place, teams working together, cascading regular staff communications, engagement events with staff, monitoring progress of local plans, challenge and hold SLTs to account against progress at the monthly Care Group Performance Review Meetings (PRMs).

The Acting Chairman enquired about next steps and actions to address the survey results and feedback. The CPO stated meetings would be held to formulate a plan and also develop a strategy, and agreed to provide an update at the June Board meeting on progress of these. It was noted an update on actions and progress would be presented to the Clinical Executive Management Group (CEMG) in May. The NEDs highlighted the need for co-designing and engaging with staff, and recognition of EDI through metrics, supporting staff with disabilities and who were carers, and measuring progress and performance. It was also noted the benefits of communications in promoting the NHS and Trust as a place to work, career opportunities and the diversity of roles in the NHS. The EDC&E stated developing a strategy should also include learning from positive staff feedback and areas of strong staff involvement. The CE commented the previous initiatives had been unsuccessful and the need to do things fundamentally differently and at pace to improve engagement with staff, alignment with the outcome of the CLP and key areas for targeting.

ACTION: Provide an update at the June 2024 Board meeting on progress to formulate a plan and develop a strategy on the next steps and actions to address the issues raised in the 2023 NHS Staff Survey results. — CPO

The Board of Directors discussed the programme of work and **NOTED** the response to the NHS Staff Survey results.

24/007 **STAFF EXPERIENCE STORY – FREEDOM TO SPEAK UP (FTSU) SERVICE**

The FTSU Guardian introduced the staff story and that the majority of the issues raised were about behaviours, all staff adhering to the Trust values, and the FTSU team continued to promote that staff lived by these values.

The member of staff explained their experience and story noting the following key points:

- Had provided suggestions on solutions and reaching a resolution, her concerns were listened to, managers were open and supportive, and was happy with the outcome that was positive for her ongoing working environment being moved to a different area;
- Spoke up regarding colleague's behaviour that was impacting them personally, affecting the team morale, as well as continuity and quality of care.

The CPO highlighted the positive outcome, the benefits of the FTSU team liaising with the staff member and local team, the importance of having strong supportive local leadership, listening to and supporting staff, and the courage of the staff member in speaking up.

The CSPO asked if anything more could have been done or any additional support provided. The member of staff commented she had experienced issues previously raised with managers and nothing happened, and escalated the behaviours to FTSU. She emphasised it was important to consider and look at the impact for the member of staff and also team members, and them being signposted to the internal support resources available. The FTSU Guardian commented that this case was being followed up with the team and FTSU team working with them to address behaviours that were counterproductive to the delivery of good care.

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

24/008 **ACTING CHAIRMAN'S REPORT**

The Acting Chairman highlighted the following key elements:

- Making progress to improve the wider elective waiting lists focussing on clearing the 78 week breaches;
- Improvement in the length of time patients were waiting to be seen in Accident & Emergency (A&E) and the Urgent Treatment Centres (UTCs), recognising demand continued to be high, 70.8% received care within four hours, an improved position from 68.5% in January, and the aim in March to achieve the national standard of 76%;
- Thanks to all the staff and teams who continued to work tirelessly delivering care to patients;
- Visited both Maternity units at William Harvey Hospital (WHH) and QEQM where substantial improvements had been achieved, improved culture, and team working. There was still more work to be done and it was important to continue to lobby to secure capital funding to enable the necessary estate infrastructure changes to be made.

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

24/009 **CHIEF EXECUTIVE'S (CE's) REPORT**

The CE reported on the following key points:

- Administrative and Clerical (A&C) consultation review, process ended the previous month, to ensure best use of staff resources, redeploying staff into suitable alternative roles where possible, recognising this had been difficult and upsetting for staff, and the need for lessons to be learnt;
- Concerns raised following an inspection of the Pharmacy Aseptic suite, interim actions and work had been undertaken, with more work to be done, noting challenges with the estate, and lessons learnt around ensuring prompt escalation of issues raised;
- Completion of the three-year expansion of WHH and QEQM Emergency Departments (EDs) providing significantly expanded and much improved environments;
- Positive staff listening events held in person and virtually (the latter averaging attendance of between 140 – 150), with staff engagement forum events continuing to cascade communications, and providing actions addressed from issues raised. Themes raised included staff living the Trust's values and behaviours, needing to see action on staff feedback, celebrating successes and improvements achieved.

The NEDs enquired whether the Aseptic issues had been resolved. The CMO stated these had not in the long term with mitigations in place. The CSPO reported this had been included within the longer term capital programme, the risk rating had been increased and currently working through the work that could be done.

The NEDs enquired about the EDs expansion builds and if there had been lessons learnt for consideration for future significant capital projects. The CSPO commented a lessons learnt review had been undertaken with NHSE and agreed to share this with the Board of Directors.

ACTION: Share lessons learnt review on the WHH and QEQM EDs expansion builds for information. CSPO

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

24/010 **INTEGRATED PERFORMANCE REPORT (IPR)**

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

- Non-compliant against the A&E standard in February, compliant in March with national requirement reporting 78.89% for all types of A&E activity, anticipating improving the Trust's position to the top quartile. Significant achievement and thanks to all staff for their continued support and hard work. March performance of Type 1, 4 hour compliance had increased by 5.2% against that reported in February;
- Improved cancer performance with significant reduction in the number of patients waiting over 62 days from 415 to 243 in January, and for February further reduced to 187 improvement against the 150 trajectory;
- Endoscopy backlog of approximately 14,000 patients waiting in January, 3,449 surveillance patients, extensive validation and surveillance programme carried out, 11,000 patients now on the waiting list with focussed work to ensure this returned to a stable position;
- Elective care trajectory set at a maximum of 651 patients over 78 week breaches by end of March, ahead of trajectory reporting 398, although there were a total of 496 patients where choice had been applied;
- Acknowledged improvements achieved, hard work of all the teams, whilst recognising there was still more to be done to further improve operational performance compliance. Trust remained an outlier against its 65 week, 75 week, and endoscopy positions, noting performance was moving in the right direction for cancer and A&E.

The CSPO enquired whether the improved performance had impacted on not using corridors for patient care. The COO confirmed corridor care had reduced, had not yet been eliminated, with significant reduction of 61% from March 2024.

The Board of Directors reiterated thanks to all staff for their continued hard work supporting performance improvements.

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

- Generally positive performance with metrics moving in the right direction, with the exception of statutory training for IPC compliance that was an area

of concern, medical job planning compliance was a key area of focus for the CMO's team that was having an improved impact;
- Sickness absence area of concern in meeting the 5% target threshold, achieving 4.8% in February. Reintroduction of psychological and counselling support on site for staff having a positive impact reducing sickness levels;
- Increase in vacancy rate, with vacancies being held with the A&C consultation;
- Drop in staff turnover rate, Trust retaining staff recruited, with premature turnover at around 14% that was being maintained against the previously set target of 25%. Interventions included newly developed onboarding package for newly appointed staff, this was being adopted across the Kent & Medway system;
- Appraisal compliance remained a challenge, particularly for A&C staff and ensuring updated reporting on Electronic Staff Record (ESR), with focussed work to address and improve this. Appraisals undertaken would be reviewed around the quality of these;
- Statutory training compliance showed sustained improved position above the threshold;
- Continued increase in medical job planning rate at 70.5% in February and on track to achieve 90% by April.

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

- Hospital Standardised Mortality Ratio (HSMR) generally as expected;
- Review being undertaken with increased number of deaths at one of the hospital sites to understand the reasons and identify any actions needed.

The CSPO and Deputy CN highlighted the following key points from the IPR and Quality and Safety (Q&S) metrics:

- Q&S dashboard currently identified two lines for incidents – moderate/severe, and patient incidents – moderate/severe, total incidents at 52 in line with previous months. Noting the difference in reporting due to moving to the Patient Safety Incident Response Framework (PSIF) and going forward these would be shown in only one line;
- Focussed work looking at pressure ulcers that were higher that they should be with ongoing work across wards to address and reduce numbers;
- Management of complaints process continued to be reviewed around quality of the responses, response times, and process mapping to identify any further areas to enable improvements. Care Group complaints and Complaints team functions now under one leadership responsible officer to ensure standardised and consistent way of working with robust support.

The NEDs raised an annual Patient, Advice and Liaison Service (PALS) report had been deferred in being presented to the Board, noting the CNMO was reviewing the overall process for complaints and PALS, and enquired when this would be available. The Deputy CN stated a draft report had been produced and it was expected this would be presented to the May Q&SC meeting, and following this reported to the Board.

ACTION: Present the Annual PALS report to the June 2024 Board of Directors meeting. — CNMO/ Deputy CN

The NEDs emphasised the work and interventions undertaken over the last couple of years that were having an positive impact on staff turnover and improvement in staff retention. The CPO commented the results of the staff survey covered the period prior to the interventions and CLP work, with work continuing to attract and retain staff. The NEDs highlighted the financial economy downturn and caution with this data, as generally this resulted in less movement of staff, particularly taking into consideration the Trust's geographical location.

The Board of Directors discussed and **NOTED** the metrics reported in the Integrated Performance Report.

24/010.1 **MONTH 11 FINANCE REPORT**

The Interim CFO reported on the following key points:

- Board and NHSE agreed year-end forecast outturn for Group of £117.4m deficit, month 11 position forecast was in line to deliver against this. Noting the underlying position was slightly better to that forecasted;
- Thanks to all Trust staff and teams for their hard work in supporting the significantly improved financial position and savings achieved;
- Draft annual plan for 2024/25 presented to FPC, and final plan would be presented to FPC for review and recommendation to the Board for approval.

The NEDs acknowledged the good news of the improved financial position at month 11 and reiterated thanks to staff in achieving this.

The Board of Directors reviewed and **NOTED** the financial performance and actions being taken to address issues of concern.

24/011 **REPORT ON JOURNEY TO EXIT NHS OVERSIGHT FRAMEWORK (NOF4) AND INTEGRATED IMPROVEMENT PLAN (IIP)**

The CSPO highlighted the following key points:

- Update on the 2023/24 IIP position against six areas of improvement;
- Significant progress made within the Leadership & Governance, Maternity, and People & Culture programmes, which continued to be rated green. Progress had been made in Quality & Safety (Q&S) remaining amber rated, expectation that this would be green at 2023/24 IIP closure;
- Review of evidence in respect of exit criteria against the milestones supporting Quarter 4 (Q4) 2023/24 closing position undertaken by Executives. Exit review panels to be held at end of April with ICB to review and assess the evidence and to discuss the 2023/24 IIP closure;
- Operational Performance and Financial Sustainability had not met exit criteria, recognising recent progress made in both these areas during Q4;
- 2024/25 IIP reset that would include Operational Performance and Financial Sustainability with the continued work required to improve from the current red rated position.

The Acting Chairman reported a Regional review meeting would be held in June to provide feedback to the Trust on its 2023/24 IIP and discuss the 2024/25 IIP reset.

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

24/012 **RISK REGISTER REPORT**

The Deputy CN highlighted the following key elements:

- Updated risk register report following detailed review and scrutiny of its content, structure and scoring methodology, strengthening governance and oversight to monitor progress of actions to mitigate risks;
- Reduction in the number of significant risks from 82 to 47;
- Robust, good mature challenging discussions of risks with Care Groups, Corporate teams, the Risk Review Group, CEMG, and Board Committees;
- To date, five deep dive reviews had been undertaken;
- Continuing to ensure the process was embedded and improvements were sustained (phase 2 for completion by end of June 2024) at operational level;
- Annual internal audit to be carried out in the next few weeks to review the risk management process;
- Good response rate from Board members and Care Group leaders on the risk maturity assessment about risk management processes.

The Acting Chairman asked for assurance that there were processes in place to ensure all risks in the Trust were escalated and included in the risk register. The Deputy CN emphasised there was always the possibility of unknown risks coming to the fore, but generally the processes in place and these being fully embedded would ensure all risks were captured. Care Groups reviewed their risk registers at the monthly Quality Governance meetings, including at specialty level, as well as monthly reviews by the responsible Executive Director lead (risks rated as high and above (15>). Care Group top risks would be presented and discussed at the monthly PRMs.

The IAGC Chair provided assurance of regular reporting and monitoring by the IAGC of the improved risk register, noting Internal Audit would be reviewing the framework, to assess and test (as well as reverse stress testing) the effectiveness of processes around risk scoring, controls, governance and appropriate escalation.

The Q&SC Chair commented the Q&SC were receiving greater assurance around the quality of the risks presented, robustness of the process and all risks captured, raising the challenges in managing the number of risks. The Q&SC had tested the risk register in respect of actions against specific risks, and this would continue to ensure continued assurance.

The P&CC Chair thanked the Deputy CN and the Risk team for their hard work in reviewing risk management and developing an improved register. It was raised the results of the Staff Survey and outcome of the CLP and whether people risks were sufficiently captured in the register. The Deputy CN confirmed people risks identified from the CLP were included in the register along and these would be reported to the P&CC.

The FPC Chair raised that the significant risk register included issues and these needed prompt management and action and suggested having a separate issues register. The Deputy CN commented there would be continued review of the register, learning and education in respect of appropriately describing the risks.

The Board of Directors received and **NOTED** assurance from the Significant Risk Report providing visibility of key risks facing the organisation and **SUPPORTED** the recommendations made within the paper transitioning into sustainable business as uses processes.

24/013 **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

24/013.1 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair reported on the following key issues:

- Approval of appointments of the COO and Director of Corporate Governance;
- Following detailed discussions and scrutiny approval to apply the 5% national pay award to eligible Executive/Very Senior Managers (VSMs).

The Board of Directors **NOTED** the 12 March 2024 NRC Chair Assurance Report.

24/013.2 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

- **PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) POLICY AND PLAN FOR 2024/25**

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

- Alternating monthly quality assurance and quality improvement meetings, enabling in-depth discussions of key issues;
- Focussed and robust discussion of care in the ED and patient flow, as well as review of complaints, and monitoring deteriorating patient improvement plan and progress against key deliverables noting good progress and completion of some;
- Update on the Fuller Report noting recommendations and satisfaction with progress made;
- Significant reduction in the number of Serious Incidents (SIs) over the last 12 months;
- Acceleration in closures of outstanding CQC Must-do and Should-do actions, exploring reasons behind this and improvements in culture and behaviours;
- Continued scrutiny and discussion of areas of concern, including radiation safety, assurance of oversight from the CMO and the need for continued clinical engagement in the assurance process;
- Key element in lowering number of C-difficile cases having effective antimicrobial stewardship processes and compliance with antibiotic prescribing. Robust discussion and the Antimicrobial Pharmacist invited to attend a future Q&SC meeting at end of year to provide a progress update;
- Concern about poor compliance with implementing National Institute for Health and Care Excellence (NICE) Guidelines, requesting a future report and presentation of an improvement trajectory to closely monitor progress to improve compliance;
- Preparations for the implementation of PSIRF noting and recommending approval of the PSIRF Policy and Plan for 2024/25.

DECISION: The Board of Directors:

- **NOTED** the 27 February and 26 March 2024 Q&SC Chair Assurance Report;

- **APPROVED** the PSIRF Policy and Plan for 2024/25.

24/013.3 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

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

- Continued appraisal non-compliance remained below the 80% threshold, had increased by 1.5% and currently at 73.9%, with identified areas of concern for focus. Further report to be presented in May 2024 for detailed focus, review and assessment of progress and what actions were needed to achieve 80% compliance by March 2025, preference of achievement earlier. This would support staff engagement in respect of discussions with staff, any issues staff had, as well as career progression and training;
- Statutory and mandatory training rated green overall in the IPR, noting areas of concern of non-compliance for targeting improvements, progress report requested for presentation in May 2024 to review and assess progress and any areas identified by the CQC;
- Verbal report from the 2 April meeting, with focus on the results of the Staff Survey, gaining assurance of the work on EDI and whether any additional support was needed to progress EDI.

The Board of Directors **NOTED** the 20 February 2024 P&CC Chair Assurance Report, and verbal update from the P&CC meeting held on 2 April 2024.

24/013.4 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair highlighted the following key points:

- Following CFC approval, recommendation for Board approval of the £169k Maternity Bereavement Suite (William Harvey Hospital (WHH)) grant application and agreement to underwrite any remaining cost for the relocation of this suite. This was a 'must do' requirement of the Care Quality Commission report, and also feedback from families for separate access and to improve the facilities. The redesigning of the suite had been undertaken in liaison with families, and building upon the good work of the bereavement team. There was limited Charity funds available within maternity and WHH, other funding sources had been agreed to be explored that included a fundraising campaign, and opportunity to utilise dormant restricted funds. If the Charity was unsuccessful in securing full funding, it was requested the BoD agree to underwrite any remaining cost.

DECISION: The Board of Directors **APPROVED** the £169k Maternity Bereavement Suite grant application and **AGREED** to underwrite any remaining cost of the application should the Charity be unsuccessful in securing the full cost via fundraising.

24/013.5 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair reported on the following key issues:

- Draft 2024/25 Annual Plan presented identifying Trust's deficit of around £85.5m in the next financial year, shared with NHSE and ICB who were supportive of this. Plan and risks were discussed in detail, high risk in respect of delivering the £49m Cost Improvement Programme (CIP), robust

management of its cost base, working collaboratively with Kent & Medway (K&M) System to support releasing beds for patients that meet the No Longer Fit to Reside (NLFT) criteria. The Draft Annual Plan was recommended for Board approval;
- CIP progress update included the Forecast Outturn (FOT) for 2023/24 of £13.1m would be achieved, with pipeline for 2024/25 risk adjusted to £36.0m that was a significantly improved position from the previous year, noting significant challenge remained to increase and develop schemes to achieve a minimum of £49m fully RAF-adjusted by the Year-End (YE);
- 2024/25 capital plan reviewed and refreshed based on highest risk items against the overall allocation of £22.1m. Draft 5-year plan showed costs of circa £438m to cover all the high-risk projects across the Trust, that was a significant risk. The draft timetable for the medium-term capital plan was noted and regular further progress updates would be presented;
- Noted the current performance metrics were moving in the right direction and reducing waits, thanks to all staff for their hard work supporting the improvements in performance over the last reporting month;
- Month 11 finance report showed Trust in line to deliver £117.4m deficit forecast for YE, positive news the run-rate had fallen within the month.

DECISION: The Board of Directors:

- **NOTED** the 27 February and 26 March 2024 FPC Chair Assurance Report;
- **NOTED** the Month 10 and 11 Financial Position;
- **APPROVED** the IPR;
- **APPROVED** the draft 2024/25 Annual Planning and to use this as the Trust's interim budget, pending the publication of planning guidance.

24/013.6 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

- **CONFIRMATION OF FINAL EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR) ASSURANCE OUTCOME**

The IAGC Chair reported on the following key points:

- Improvements in progress on follow up of actions in respect of Internal Audit reports, indicating positivity around controls in place and shift in culture, whilst recognising there was more still to be done;
- Detailed discussion of the External Audit Annual Audits, review and lessons learnt from 2022/23, noting the annual accounts for the last two years had been submitted late. This was around the need to receive assurance of a robust programme management and early escalation of any issues, to ensure the 2023/24 annual audit submission deadline was met;
- Acknowledged the improved new Board Assurance Framework (BAF);
- Finalised Good Governance Institute (GGI) governance review report to be presented to next Committee meeting in April, that would include how the recommendations would be implemented;
- Report on the financial controls review undertaken by PricewaterhouseCoopers (PwC) noting progress made against robust financial controls, and future monitoring. Further report to be presented at the July 2024 Committee meeting around assurance of embedding controls, continued robust financial management and these being sustained;
- Committee would review its annual work programme in the Summer against the GGI governance review report and recommendations.

The Board of Directors **NOTED** the 26 January 2024 IAGC Chair Assurance Report.

24/014 **CHIEF NURSING AND MIDWIFERY OFFICER'S (CNMO) REPORTS:**

24/014.1 **SERIOUS INCIDENTS (SI) REPORT**

The Interim Deputy CN highlighted the following key points:

- Assurance of the SI process around strengthening the investigation, management and lessons learnt, with action plans produced, and being monitored against progress and approval for closure. In January 2024 eleven action plans presented to SI Investigation Approval Panel (SIIAP) for approval, of which six were closed and additional work to be completed on the remaining five, providing assurance of robust scrutiny and challenge;
- Duty of Candour (DoC) compliance remained stable, recognising the importance and value of the verbal conversation and apology with the patient of the incident;
- Positive impact from the learning noting the example cases in the report, meeting with patients/families, receiving feedback about their poor experiences and the resulting impact on them, and what could be done to prevent recurring incidents.

The NEDs enquired about monitoring long standing SIs. The Interim Deputy CN confirmed a scorecard included in IPR where progress was monitored against closure of the long standing SIs. There was also commentary providing an explanation and reasons for delays, continued improved trajectory to close SIs currently around 90%. Continued oversight of the SI process by the ICB.

The CE highlighted the value of the meetings with patients/families and assurance that these would continue going forward, and ensuring the use of right language that could be easily understood. The Interim Deputy CN confirmed a robust process for continued meetings to be held providing staff with framework and questions to follow. Patients/families were given the opportunity to ask questions at the initial conversation and issuing letter, as well as when investigation report was provided when had more time to consider incident.

The Board of Directors discussed and **NOTED** the information contained within the SI report and took assurance of the efficacy of the overall incident management and DoC compliance processes in place within the Trust.

24/014.2 **CARE QUALITY COMMISSION (CQC) UPDATE REPORT**

The Interim Deputy CN highlighted the following key points:

- Focus driving forward closing actions from historic inspections;
- Preparation work in Maternity services to ensure appropriately prepared for a future potential inspection to be undertaken, to date unknown when this was likely to take place or the areas to be inspected.

The Acting Chairman raised the Maternity 2023 action plan and whether the 80% of Must Dos and 89% of Should Dos were closed at the end of March 2024. The Interim Deputy CN stated a meeting was being held at the end of April to review the action plan and evidence to assess if these could be closed. A quality review had

been undertaken in respect of Maternity services specific actions related to the Maternity Section 31 notice. An update would be provided on the closure of Must Do and Should Do Maternity 2023 action plan if achieved at the end of March 2024.

ACTION: Provide an update on the percentage of achieved closed Must Do and Should Do actions from Maternity 2023 action plan against the 80% Must Do and 89% Should Do expected to be closed at the end of March 2024. — CNMO/ Interim Deputy CN

The NEDs questioned the statement under Urgent and Emergency Care (UEC) March 2020 section in respect of Trust ensuring all staff had an appraisal and that this was closed in March 2024. It was queried how this could be closed when these items were not completed, and it was known that generally the Trust was not compliant with its appraisal rates and mandatory training. The Interim Deputy CN commented the evidence was reviewed in February and closed in March, noting this point specifically related to UEC and meeting the required 80% threshold. There was a robust process in place for reviewing evidence and closing actions.

The NEDs queried whether actions were being progressed and closed at the pace required. The Interim Deputy CN stated the current position was much more vigorous to ensure these were closed quickly, whilst recognising continued ongoing challenges to achieve closure. It was noted the importance of ownership to ensure continued progress and sustaining compliance. The Q&SC Chair reported the Q&SC had seen increasing improvement around ownership across the Trust.

The Board of Directors discussed and **NOTED** the CQC update report and progress of delivery of improvements related to CQC compliance to date.

24/014.3 **WOMEN'S CARE GROUP MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) CHAIR'S REPORT**

- **Perinatal Quality Surveillance Tool (PQST) and Maternity Dashboard**
- **Maternity and Neonatal Improvement Programme (MNIP)**
- **Kent County Council (KCC) Consultation**
- **Care Quality Commission (CQC) Update**
- **Clinical Negligence Scheme for Trusts (CNST) Compliance**
- **Maternity Information System**
- **Listening to Women and Families**
- **Obstetric Medical Workforce**
- **Small Steps Bereavement Team**

The DoM highlighted the key elements as noted below:

- Rolling 12 month stillbirth rate now at 1.59 per 1000 births compared to comparator average of 3.92 per 1000 births, extended perinatal rate (stillbirths and neonatal deaths up to 28 days) now at 3 per 1000 births compared to comparator average of 5.87 per 1000 births. Identified nationally disparities might exist within these outcomes and this was being explored locally. This was around looking at any inequalities, demographics, ethnicity and deprivation, to address any resulting action needed around targeted care, continuing to co-produce with service users;
- Focussed work on completing key actions within the Maternity Safety Support Programme and ensuring sustainability, visit by NHSE in February, and aim to exit in July 2024. Continuing to progress the MNIP, included actions and recommendations from the Independent Investigation into East Kent Maternity Services, Ockenden and national inquiries;

- All of the CQC should do actions had been completed, must do actions related to estate and environment work being undertaken. These included the WHH Bereavement Suite and funding had been approved by the East Kent Hospitals Charity supporting the work, once completed this would enable review of the WHH triage facility. Leaving the one remaining environment element of a second theatre at QEQM;
- Midwifery workforce continued to be a challenge, midwifery students would now be qualifying at the end of the year/January 2025, all had expressed interest to stay with the Trust and had been offered roles. Interim actions supported by 18 Internationally Educated Midwives (IEMs), of which 14 had completed their Objective Structured Clinical Examination (OSCE) qualification and starting the preceptorship programme, remaining four were due to complete this training at the end of the month;
- Focus on staff retention, how to further improve support for midwifery staff, and locally available opportunities in respect of career progression. Looking at Legacy Programme for retired midwives returning to support midwifery staff and students. Listening events held on each hospital site attended by CE and CNMO, and support from the ICB who had also provided safe confidential platforms for staff to be able to raise any concerns directly with the ICB. Feedback to staff on actions implemented as a result of concerns raised at these events to ensure staff were aware of the outcomes and that they were being listened to;
- Continuing to work closely with Maternity and Neonatal Voices Partnership (MNVP) and listening to women, with live social media events taking place enabling service users to provide feedback and receive responses;
- Walking the patch continued with positive feedback, talking to women and families, and also undertaking mock inspections. Areas identified to continue to progress were post-natal care, attitudes and behaviours that were being picked up as part of the culture work;
- Seven actions being progressed with the Maternity Information System (MIS) in response to National Patient Safety Alert, included in Trust's risk register as well as the ICB's. This was about a potential risk of accuracy of clinical information and data quality working closely locally looking at alternative IT solutions, had not been identified as an issue for the Trust;
- One year on since the launch of the Small Steps Bereavement team, with really positive feedback, service users nominated staff for a Mariposa award, who were successful and awards included Midwife of the Year, Outstanding Contribution and Obstetrics and Gynaecology doctor,
- CNST self-assessment submitted of Trust's full compliance, and were now in Year 6 with planning underway around the evidence required;
- As part of IIEKMS restoration work being progressed having a process that was trauma informed, no secondary harm caused, co-designed with women and families, and facilitated by restoration trained staff.

The Acting Chairman enquired about the feedback received from women and families. The DoM stated with talking to women and families as well as observing staff interactions with service users, feedback was they were being treated with kindness and compassion for those with current births against previous births their experience was much more positive. Some were anxious pre-accessing services due to media coverage and were happy with the level of care received, those requiring complex or emergency care had fedback positive experience. There had been negative experiences and these were in post-natal care, delays with discharges that were continuing to be worked on and what additional support could be provided (e.g. nurses on post-natal wards), these areas were impacted as a

result of any staffing challenges and sustaining 1:1 care in labour (mainly at WHH). Multi-disciplinary team continuing to work together, positive feedback from staff that they felt they were being listened to and were seeing improvements, negative feedback around staffing challenges and reliance on temporary staff. Supporting temporary staff ensuring up to date with training requirements and access to the MIS, and reducing additional workload impact on substantive staff. Staff engagement scores had increased.

The CMO asked about access to regional analgesia for women at WHH. The DoM stated this was monitored on the maternity scorecard, looking at incidents of delay more than 60 minutes, and no issues of concern had been raised about this.

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

24/015 **ANY OTHER BUSINESS**

There were no other items of business raised.

24/016 **QUESTIONS FROM THE PUBLIC**

The Chairman reported the questions received in advance of the meeting as noted below:

- Mr Newington submitted an issue relating to an outstanding Subject Access Request (SAR) being looked into in respect of being responded to within the required timeframe. Mr Newington provided details of the issues raised with the Chairman and CE, these were not shared due to patient data confidentiality. The Deputy CN would be responding to Mr Newington in writing about the issues raised.
- Ms Hart raised questions related to Internally Educated Nurses (IENs), how much money had been spent on employing overseas nurses, agency fees to finders, compensation to the Country, relocating costs, and ongoing support costs (i.e. accommodation). The Interim CFO acknowledged thanks to the IENs for their interest and support taking the decision to come and work at the Trust. He stated the cost for each IEN was approximately £13,000, this included recruitment, OSCE qualification, and provision of accommodation on arrival. Provision of funding from NHSE against these costs of around £5,000 per IEN, overall cost to the Trust of each IEN of around £8,000. The Trust over last year recruited 112 IENs, resulting in an overall net cost of just under £1m. Comparison of costs against that employing temporary nurses this cost would have been what the Trust would have paid for premium costs for a year, a financial saving.
- Mr Esson from KentOnline asked how much Trust needed to save/cut spending by this new financial year, to compensate for last years' overspend of about £50m, how Trust planned to make these savings, were redundancies/job cuts voluntary going to play a part in making savings, any plans where these would fall, Trust's forecast/planned deficit by end of this new financial year (2024/25), and if Trust was confident it could meet the deficit target without cuts to frontline services. The Interim CFO confirmed the CIP target 2024/25 was £49m, 73 schemes identified with a total of £49m to achieve this target, noting larger cost saving schemes included reducing patient LoS and theatre utilisation. This was around enabling patients to move through the hospital more timely, receiving treatment they needed, and ensuring they were transferred either to home or the community to access the appropriate ongoing care. Improvements in

procurement process and effective utilisation of NHS Supplies Chain, continuing to reduce agency staff expenditure and this being maintained. Current planning assumption for 2024/25 deficit was £85m, noting planning guidance just recently issued and details were being worked on. No plans to cut front line services and committed to improve these with the explained financial efficiencies.

- Ms Bonney, Governor, asked what was being done to stop flooding occurring in maternity at QEQM and the timeframe for this to be resolved. The CSPO reported flooding issues at QEQM were due to the age of the estate, the Trust was looking at long term solutions to refurbish the maternity facilities at this site that would take a couple of years to implement. Liaised with maternity team as it was not possible to fully mitigate these issues, confirmed timely response from the facilities team to incidents occurring and these being managed promptly. The facilities team continued to monitor this and undertake remedial works. The Acting Chairman and CSPO would liaise outside the meeting in respect of works that could be undertaken to stop the ingress of water.
- Ms Bonney, Governor, raised limited provision of toilet/bathroom/shower facilities in the maternity units allowing mothers to access these with their baby, and when appropriate bathroom facilities would be available. The CSPO explained in the short term a programme for additional facilities as well as refurbishment of existing facilities across the two hospital sites, long term aspiration of being able to provide en-suite facilities. The midwifery led unit (MLU) patient rooms included the provision of en-suite facilities.
- Ms Bonney, Governor, raised previous comments about corridors being used for equipment storage and nurses stations, these impeding emergency access particularly at WHH. The CSPO reported there had been improvements in corridor areas reducing usage. There were specific Care Group plans in place to ensure this was sustained, processes around authorisation and clear trigger points for corridor usage, the maximum number of patients in this area to ensure maintaining emergency access. This had been supported by the CNMO's decluttering programme across the Trust sites. The Interim Deputy CN emphasised the challenges with the age of the estate in respect of sufficient capacity to accommodate all the equipment required for patients (e.g. beds, medical equipment, it equipment for staff etc.).
- Ms Barton, Public Governor, asked for an update on the A&C staff consultations, if this had been completed, and the impact of reducing these roles. The CPO stated the roles and the work of A&C staff were very much appreciated and valued, noting the need to make significant changes to the composition of this workforce in the Trust and reduction in numbers. Confirmed the consultation closed on 22 March and currently working through the placement of staff directly affected, job matching and supporting staff through this process. The CPO was attending the next meeting of the Council of Governors and would be happy to provide a further update.

The Chair closed the meeting at 4.00 pm.

Date of next meeting: Thursday 6 June 2024.

Signature _____

CHAIR'S INITIALS ……

Date _____

CHAIR'S INITIALS ……

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Matters Arising from the Minutes on 4 April 2024**

Meeting date: **6 June 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 one action 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

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 4 APRIL 2024

1. Purpose of the report

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

2. Background

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

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

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/17/22	Amend the IAGC Terms of Reference (ToR) reflecting the substitute Board Committee member attendance if Committee Chair was unable to attend an IAGC meeting. The ToR will be re-reviewed following completion of the Good Governance Institute (GGI) Governance Review.	~~Oct-23~~/ ~~Jun-24~~/ Jul-24	Integrated Audit and Governance Committee (IAGC) Chair/ Director of Corporate Governance (DCG)	Open	Board Committee ToR will be reviewed by the DCG following the recommendations of the GGI Governance Review. **Item for future Board meeting.**
B/22/23	Present annually a Patient Advice and Liaison Service (PALS) report (December 2023), providing details about themes of complaints, timeline of responding to complaints, numbers of complaints and compliments received, lessons learnt, and any actions as a result of feedback received.	~~Dec-23~~/ ~~Feb-24~~/ Jun-24	Chief Nursing and Midwifery Officer (CNMO)	Open	January 2024 - Maternity complaints report to be presented to next meeting of the Maternity and Neonatal Assurance Group (MNAG) and following this will be presented and appended to the Board actions log at its next meeting. 01.02.24 - Action related to the wider Trust in respect of themes and lessons learnt. Patient Experience Committee (PEC) in place reporting into Q&SC, action to remain open for when PEC reports to Q&SC, and an update provided to the Board through the Q&SC Chair Assurance report. May 2024 – Update provided to the Board in the 28 May Q&SC Chair Assurance report.
B/33/23	Present an update to the Board on progress monitoring the gap analysis, action plan, work needed	~~Mar-24~~/ Jun-24	Chief People Officer (CPO)	Open	Lead Freedom to Speak Up Guardian working on a paper to be presented to the June 2024 Board meeting.

	and any additional support to enable implementation of the ten Sexual Safety in Healthcare - Organisational Charter commitments.				
B/40/23	Contact the Carer in a few months to have a discussion and evaluate progress of the Task and Finish Group, and the work and actions being taken forward and implemented to support carers.	Jun-24	CNMO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/01/24	Provide an update at the June 2024 Board meeting on progress to formulate a plan and develop a strategy on the next steps and actions to address the issues raised in the 2023 NHS Staff Survey results.	Jun-24	CPO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/02/24	Share lessons learnt review on the WHH and QEQM EDs expansion builds for information.	Jun-24	Chief Strategy and Partnerships Officer (CSPO)	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/03/24	Present the Annual PALS report to the June 2024 Board of Directors meeting.	Jun-24	CNMO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**
B/04/24	Provide an update on the percentage of achieved closed Must Do and Should Do actions from Maternity 2023 action plan against the 80% Must Do and 89% Should Do expected to be closed at the end of March 2024.	Jun-24	CNMO	Open	**Verbal update to be provided at 04.04.24 Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: 2024/25 Annual Planning and Cash Drawdown

Meeting date: 6 June 2024

Board sponsor: Interim Chief Finance Officer (CFO)

Paper Author: Director of Finance (DoF)

Appendices:

None

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The report is to update the Board on the current Annual Plan for 2024/25.
Summary of key issues:	The Board reviewed and considered the executive's proposed Annual Plan for 2024/25 at its Board Development Strategy Session held on 2 May. This note contains the key headlines from the trust's plan for formal sign off.

Performance Standard Included within NHS England National Guidance	Trust 2024/25 Plan
A minimum of 77% of patients seen within 4 hours in March 2025	The trust will work with system partners to meet the target of 77% of patients being seen within 4 hours in March 2025.
Waits of over 65 weeks for elective care need to be eliminated as soon as possible and by September 2024	The trust will deliver zero 65 week waits by the 31 March 2025 – this will require 9% more elective activity to take place at the trust than in 2023/24, something that our theatre utilisation work and length of stay reduction work suggests is possible.
Cancer performance against the headline 62-day standard needs to improve to 70% by March 2025	The Trust will deliver this standard through improved theatre utilisation and length of stay reduction.

We care

East Kent Hospitals University NHS Foundation Trust

	Performance against the 28 day Faster Diagnosis Standard to needs to improve to 77% by March 2025	The Trust will deliver this standard through improved diagnostic utilisation and targeted additional capacity.
	An increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24	The Trust will deliver this standard through improved diagnostic utilisation and targeted additional capacity.
	Systems should breakeven	The Trust has submitted a planned deficit of (£85.8m) which sits within a Kent and Medway ICS system deficit of (£134m). Within the (£85.8m) deficit the trust will need to deliver an internal cost improvement programme of £49m, and work with system partners to reduce patients waiting for secondary/community/social care leading to a further £7.5m of savings.
Key recommendations:	The Board of Directors is asked to **APPROVE** the final plan for 2024/25.	

Implications:

Links to Strategic Theme:	• Partnerships • Sustainability
Link to the Trust Risk Register:	**3664**: Failure to deliver the Trust financial plan for 2024/25 - Corporate Finance.
Resource:	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 & Performance Committee – 30 April 2024 and Board of Directors Development Strategy Session – 2 May 2024

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (BoD)

Report title: **Patient Story for the Board**

Meeting date: **6 June 2024**

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

Paper Author: **Associate Director of Patient Experience**

Appendices:

Appendix 1: Patient story
Appendix 2: National Cancer Patient Experience Survey 2022 Results

Executive summary:

Action required:	Discussion
Purpose of the Report:	The patient story relates to cancer services. The patient, Sara, has had a positive experience overall and her story provides an insight into what good looks like from a patient's perspective as well as some observations about what our patients and their family experience in our care. The report also provides a summary of the Trust's results from the national cancer survey 2022, published in July 2023.
Summary of key issues:	The report is a patient's story of living with terminal cancer and receiving good care both from East Kent Hospitals University NHS Foundation Trust (EKHUFT) and previous NHS trusts. The story shows that even when the quality of treatment and care given by staff is good, there are things we can learn from every patient's journey. It also shows that living with cancer is one part of a person's story. Sara recounts her husband's recent unplanned in-patient stay, and the impact this had on her and her husband when his discharge was delayed. The national Cancer survey 2022 results for East Kent highlight the wider patient experience of over 800 patients receiving care at East Kent in 2022. They highlight some great care and positive experiences. However, there was a noticeable difference in cancer patient's experience once they were an in-patient. Patients felt less involved, they and their family were not always listened to, they were not always kept informed about what would happen next. Cancer patients' experiences broadly reflect the wider patient experience at EKHUFT, that is that outpatient and day treatment is highly rated, but in patient care less so. This is not about the buildings or the quality of medical care – it's about the way patients feel and the experience they have once they are an in-patient. Their experience of life on the ward, and their feedback shows it is a less positive experience for a significant proportion of cancer patients.

	Our patients come to us at their most vulnerable and often at unexpected and difficult times, and rightly expect to be treated with care and compassion and to be kept safe. Whilst the clinical effectiveness of our services is good and often excellent, we do not always keep people free from harm and we do not always provide a good patient experience. This needs to improve, and many of the improvements needed relate to the culture of the Trust and to inpatient care, communication and administration. These improvements are possible. Putting patients first and valuing our staff must be our priority. There is good practice and positive patient experiences that we can celebrate, but there are areas that require improvement. The cancer services are now working with the Patient Voice and Involvement team and continue to work with the wider Kent and Medway Cancer Alliance and Macmillan to involve patients and their carers and families and to use their feedback to drive improvement in patient and family experience. This is detailed in the main report (appendix 1). During 2024-25 we will be focused on making improvements based on patient and family feedback, and doing so with the involvement of patients, carers, and families and the staff directly delivering their care.
Key recommendations:	The Board of Directors is asked to discuss Sara's story and **SUPPORT** actions being taken to improve the involvement of patients, carers and families in cancer services to provide equity of access, excellent patient experience and optimal outcomes.

Implications:

Links to 'We Care' Strategic Objectives:	• Our patients • Our quality and safety
Link to the Trust Risk Register:	**CRR 159**: Detriment to patients with a disability as we are non-compliant with the mandatory Accessible Information Standards.
Resource:	No
Legal and regulatory:	The Trust must comply with the Care Quality Commission Regulations. The Equality Act 2010 and the public sector equality duty under the Act require NHS organisations to demonstrate due regard to people with protected characteristics in the provision of healthcare. The NHS Health Inequalities Leadership Framework Board Assurance Tool supports NHS Trust Boards to deliver exceptional healthcare quality for all through equitable access, excellent experience and optimal outcomes.
Subsidiary:	No

Assurance route:

Previously considered by: Not applicable. Patient/family stories come direct to the Board. Appendix 2 was considered as part of a report to the Patient Experience Committee in January 2024 and in a highlight report to Quality & Safety Committee in March 2024

East Kent Hospitals University NHS Foundation Trust

PATIENT EXPERIENCE STORY

1. Purpose of the report

1.1 The report is a patient's story of living with terminal cancer and receiving good care both from EKHUFT and previous NHS trusts. The story shows that even when the quality of treatment and care given by staff is good, there are things we can learn from every patient's journey. It also shows that living with cancer is one part of a person's story. Sara recounts her husband's recent unplanned in-patient stay, and the impact this had on her and her husband when his discharge was delayed.

2. Background

2.1 Involving patients in their care, explaining treatment options, providing clear information – both before, during and after an episode of care, listening to patients and their carer/family about any worries, talking through the risks and benefits of any treatment, and arriving at informed consent are all fundamentals of effective clinical care, patient safety and excellent patient experience.

2.2 Under the Care Quality Commission (CQC) domain 'Responsive' there is a quality statement that "People who use services and those close to them (including carers and dependants) are regularly involved in planning and making shared decisions about their care and treatment, so it is centred around them and their needs."

2.3 The CQC 'I' statement that supports the patient's carer and family to be involved refers to "I am in control of planning my care and support. If I need help with this, people who know and care about me are involved."

3. Sara's story

3.1 This story is written in the patient's own words. Sara will attend the Board meeting when her story is discussed.

3.2 "My name is Sara Turle and to tell my story, I need to give you some background. In 2010, aged just 50, I was diagnosed with an aggressive Breast Cancer with spread and received everything bar the kitchen sink in treatments. Cancer changed my life and at end of 2014, aged 54, dealing with a combination of impact of treatments on my cognitive abilities and with that my well-being, I sadly gave up my role in education, having worked all my life from just 17.

3.3 Over the last ten years, I have worked passionately with the NHS on developing and promoting partnership working with patients; not just with my own healthcare but healthcare generally. Do with me, not to me, together. I absolutely believe best outcomes for all can only happen when we value and respect what we each can bring to the table.

3.4 Initially this working together was with the London Trust that saved my life but since early 2022, with my move to Kent it has been with Kent and Medway Cancer Alliance (KMCA) and NHS England (NHSE) Cancer Patient and Public Voice Forum.

3.5 The end of March 2023 was when my story with EKHUFT began. I'd had a lingering cold and cough and having seen my GP he told me to book a chest X-Ray which I did at Queen Elizabeth the Queen Mother Hospital (QEQM), Margate. I amazingly got an appointment for that afternoon but as I left my husband at the entrance, saying that I'd see him shortly, neither of us had any idea what was to come.

3.6 The X-Ray had shown fluid on my lung and within minutes I was being taken to an area for more investigations. I later found out that it was your Same Day Emergency Care (SDEC) Unit. I was taken in, and checks started swiftly, involving a number of staff, all who were focused, friendly and skilled, displaying kindness and compassion, despite cramped conditions.

3.7 The first person I want to highlight to you is Consultant Nurse, Janine Mair. She spoke to me throughout the afternoon involving me every step of the way, performed the removal of liquid from my lung, arranged for my return three days later for further tests when she was on duty for continuity of care, then found a private space for us to sit down in front of a computer screen, go through what had thus far been found, talked openly about what the significant evidence was pointing to and telling me what was going to happen next. We parted that evening with me thinking I was unlikely to see her again and as she warmly wished me well, I knew I would never forget Janine Mair.

3.8 Within a couple of weeks incurable lung cancer had been diagnosed and this is where I want to highlight my next member of staff, Sharon Gill, Lung Cancer Nurse Specialist (CNS). From the minute we first spoke on the phone, and I then met her, she has been the co-ordinator with so much of my care, the link in the chain and oh how I have appreciated her. She is reliable, does what she says, hugely knowledgeable, likable, funny, compassionate and is working together with me, listening to me and has handled well when I have asked for something that is slightly off the normal path. Long may she remain doing what she is doing.

3.9 To Carrie Merry and everyone in Team Viking Suite where I always feel a gentle hug as I enter, my Oncologist, Dr Jane Brown, CT Scan Teams across EKHUFT and the Cancer Care Line staff; I have appreciated everything that they do with me and for me. Healthcare is all about people and I am so grateful to the people of this Trust.

3.10 Over the last few months through my partnership work and meetings with Tracey Ryan, Macmillan User Involvement Manager from KMCA along with my own forays, I have begun to develop some wonderful patient partnership contacts within EKHUFT. Sarah Hayes (Chief Nursing and Midwifery Officer), Carolyn Maynard (Head of Nursing), Karen Edmunds (Associate Director of Patient Experience), together with Amanda Mitchell (Patient Involvement Officer) and Adam Littlefield (Lead for Patient Voice and Involvement) from Karen's team.

3.11 Since March of this year, I have also gained experience of being a carer for my husband, John, who badly broke his ankle, and we were whisked as a trauma call to William Harvey Hospital (WHH). We are extremely grateful for the speed in which he was seen and the skill and expertise that was delivered right through to surgery and on to his stay on Rotary Ward. The staff treated him very well and Rotary Ward was lovely with super staff.

3.12 However, two aspects were frustrating and impactful; no physiotherapy cover at weekends to clear his use of crutches for discharge and then the added time length of his discharge, resulting in an almost two day extended stay. This impacted negatively on our experience.

3.13 I am very grateful to Clare Hardwick (Associate Director of Therapy Services) and Carly Sheehan (Site Director of Nursing) for the opportunity to talk with them, share our experience and understand better why this happened, also hearing what they are working on to help improve this.

3.14 The first 15 steps is hugely important to me wherever I go. To receive that first smile of greeting, introduction and "how can I help you?" has the capacity to help better even the worst situation. It is my 'always event' that staff verbally and visually identify themselves and their role as part of a greeting. It is the beginning of everything for me and as the only one constant in my healthcare, it helps greatly with continuity of care. Emphasising the importance of this to all staff should be ongoing.

No one should ever not know who they are being treated by.

3.15 The passing of smokers; staff, patients, relatives as I enter and exit the hospitals, holding my breath as a lung cancer patient who has never smoked, is a poor first and last impression. Hospitals are places of great sadness, anxiety and stress. I do not wish to stop anyone smoking. I just ask that it is not done in my air space. I have actively raised this with the Trust and offered a possible solution.

3.16 Whilst I would love to see refurbishment and re-decoration to a lot of the buildings, inside and out, to improve better working conditions for staff and experience for patients, it is your wonderful staff who shine bright and make the biggest difference for patients, and I am so pleased for this opportunity to praise them and share my experience with you.

Care for staff, care for patients, care for all."

4. Actions taken to date

4.1 The Patient Voice and Involvement team reviewed the national Cancer survey 2022 results for East Kent Hospitals, which highlighted some excellent care, but also disparities between different 'tumour groups', ages of patients who responded and difference in experience between men and women. Gaps included a lack of data from patients of an ethnicity other than White, very few responses from patients under the age of 25 or in the 26 to 35 age bracket and some disparities between the experience of men and women.

4.2 To support the service we then looked at their survey data at a more granular (deeper) level to pull out some themes. This started a discussion about how the service can better involved patients both individually and collectively. The service felt that cancer patient participation groups for each site was an option to pursue, along with improving feedback from younger people with cancer, as very few people under 25 or in the 26 to 35 age bracket responded to the national survey. There was also limited feedback of the experiences of patients of ethnicities other than White.

4.3 The Patient Voice and Involvement team has met with the Head of Nursing for Cancer and colleagues, along with patients and other stakeholders including Macmillan several times over the past four months to discuss and plan their approach to patient participation.

4.4 This planning work is important, and we have involved people living with cancer from the start of these discussions, along with key operational colleagues.

5. Action planned for the next three to nine months

5.1 The Patient Voice and Involvement Team have developed a survey that cancer patients and their families and carers can complete. The questions focus on key issues from the 2022 National Cancer Patient Experience Survey that concern inpatient care and the plan is to share the survey across all EKHUFT sites, with existing patients and via the community groups people access for support people with cancer. We will then use the responses to create the basis of a set of localised Patient Participation Groups covering each hospital site, in collaboration with Danielle Mackenzie, Macmillan Lead Nurse for Personalised Care.

5.2 The Patient Voice and Involvement Team has set up links with existing cancer support groups across the community to facilitate this information gathering; from Macmillan and EKHUFT run groups to Social Enterprise Kent and independent groups ranging from mental health support groups to hairdressers who specialise in making wigs for cancer patients. Each survey will contain an informal offer of a conversation with one of our Patient Involvement Officers to encourage people to speak to us in a manner that they are comfortable with and build trust in the process.

5.3 Our Teenage Cancer Trust Nurse has worked with us to give us feedback from younger patients and our ongoing relationship with groups like the Folkestone Nepalese Community, Ethnic Minorities in Canterbury and Beyond the Page will provide feedback from underserved communities. There is an appetite to review the peer support available to inpatients and after we have developed our pilot for peer support in stroke services we hope to replicate the model in our cancer services.

6. Conclusion

6.1 The national cancer survey 2022 (Appendix 2) shows that there was a noticeable difference in cancer patient's experience once they were an inpatient. Patients felt less involved, they and their carer or family were not always listened to, they were not always kept informed about what would happen next. Cancer patients' experiences seems to reflect the wider patient experience at EKHUFT that out patient and day treatment is highly rated, but patient's experience of in-patient care is not. This is not about the buildings or the clinical care provided – it's about the way patients feel and the experience they have once they are an inpatient. Their contact with their consultant or Clinical Nurse Specialist (CNS) will be less frequent during this time. But they will experience life on the ward, and their feedback shows it is a less positive experience for many cancer patients.

6.2 Hearing positive patient stories is important at a time when the Trust faces significant challenges, both culturally and financially, and our staff are working very hard to reduce waiting list and provide high quality care. Our patients come to us at their most vulnerable and often at unexpected and difficult times and rightly expect to be treated with care and compassion and to be kept safe. Whilst the clinical effectiveness of our services is good, and often excellent, we do not always keep people free from harm and we do not always provide a good patient experience. This needs to improve, and much of the improvements needed relate to the culture of the Trust and to inpatient care, communication and administration. These improvements are possible, but they require the same level of focus as we apply to other priorities such as reducing waiting lists and sound financial management. Putting patients first and valuing our staff has to be our priority.

7. Recommendations

7.1 The Board of Directors are asked to discuss Sara's story and **SUPPORT** actions being taken to improve the involvement of patients, carers and families in Cancer services, in order to provide an excellent patient experience.

East Kent Hospitals University NHS Foundation Trust

National cancer patient experience survey 2022 results

1. Purpose of the report

The report summarises the results and findings of the Cancer Patient Experience Survey 2022, published in July 2023. The survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May, and June 2022. The fieldwork for the survey was undertaken between November 2022 and February 2023.

2. Background

2.1 For East Kent hospitals, 801 patients responded out of a total of 1,482 patients invited to respond, resulting in a response rate of 54%. 723 of respondents were White, 56 were not known, and 6 were Asian and 26 were other ethnicities that could not be shown due to small numbers.

2.2 A summary of the Cancer patient experience survey 2022 results was discussed at the Trust's Patient Experience Committee on 25 January 2024.

3. Findings

3.1 There was a noticeable difference in cancer patient's experience once they were an in-patient. Patients felt less involved, they and their family were not always listened to, they were not always kept informed about what would happen next. Cancer patients' experiences seems to reflect the wider patient experience at EKHUFT – out-patient and day treatment is highly rated, but in-patient care is not. This is not about the buildings, the food – it's about the way patients feel and the experience they have once they are an in-patient. Their contact with their consultant or Clinical Nurse Specialist (CNS) will be less frequent during this time. But they will experience life on the ward, and their feedback shows it is a less positive experience for many cancer patients.

3.2 Areas of quality that we need to recognise and maintain: There were areas where we scored more than 8 out of 10, which staff should be recognised for and supported to maintain:

- Care team reviewed the patient's care plan with them to ensure it was up to date – 9.7 out of 10
- Patient found advice from main contact person was very or quite helpful – 9.4 out of 10
- Enough privacy was always given to the patient when receiving diagnostic test results – 9.2 out of 10
- A member of their care team helped the patient create a care plan to address any needs or concerns – 9.1 out of 10
- Patient received all the information needed about the diagnostic test in advance – 9 out of 10
- Beforehand patient completely had enough understandable information about radiotherapy – 8.9 out of 10
- Patient had a main point of contact within the care team – 8.8 out of 10

- Beforehand patient completely had enough understandable information about surgery – 8.7 out of 10
- The whole care team worked well together – 8.7 out of 10
- Staff provided the patient with relevant information on available support – 8.6 out of 10
- Patient had completely had enough understandable information about progress with surgery – 8.5 out of 10
- Patient received easily understandable information about what they should or should not do after leaving hospital – 8.4 out of 10
- Patient was always treated with dignity and respect whilst in hospital – 8.2 out of 10
- Patient had completely had enough understandable information about progress with radiotherapy – 8.2 out of 10
- Administration of care was very good or good - 8.2 out of 10
- Treatment options were explained in a way that the patient could understand – 8.1 out of 10
- Patient was told about their diagnosis in an appropriate place – 8.1 out of 10
- Diagnostic test staff appeared to completely have all the information they needed about the patient – 8.1 out of 10
- Patient was given information that they could access about support in dealing with immediate side effects from treatment – 8.1 out of 10
- Beforehand patient completely had enough understandable information about immunotherapy – 8.1 out of 10
- Beforehand patient completely had enough understandable information about chemotherapy – 8.1 out of 10
- Patient found it very or quite easy to contact their main contact person – 8 out of 10

3.3 Areas for improvement: There were several areas where we scored between 7.9 and 6.6 out of 10, which were not as high as we would like them to be, and so we should look to improve:

- Hospital staff always did everything they could to help the patient control the pain – 7.9 out of 10
- Diagnostic test results were explained in a way the patient could completely understand – 7.9 out of 10
- Patient was told they could go back later for more information about their diagnosis – 7.8 out of 10
- Patient was involved as much as they wanted to be in decisions about their treatment – 7.7 out of 10
- Patient felt the amount of time waiting at the clinic / day unit for treatment was about right – 7.7 out of 10
- Cancer diagnosis explained in a way the patient could completely understand – 7.5 out of 10
- Patients were always able to discuss worries or fears with hospital staff whilst being treated as an outpatient or day case – 7.5 out of 10
- Family and / or carers were involved as much as the patient wanted them to be in decisions about treatment options – 7.4 out of 10
- The right amount of information and support was offered to the patient between final treatment and follow up appointment – 7.4 out of 10
- Patient felt the length of time waiting for diagnostic test results was about right – 7.3 out of 10
- Possible side effects of treatment were explained in a way the patient could understand – 7.3 out of 10

- Patient had confidence and trust in all the team looking after them during their stay in hospital - 7.2 out of 10
- Patient had completely had enough understandable information about progress with chemotherapy – 7.2 out of 10
- Beforehand patient completely had enough understandable information about hormone therapy – 7.2 out of 10
- Patient got the right level of support for their overall health and wellbeing whilst in hospital – 7.1 out of 10
- Patient was told sensitively that they had cancer – 7.1 out of 10
- Patient completely had enough understandable information about progress with immunotherapy 7 out of 10
- Patient was able to discuss their needs or concerns prior to treatment – 6.9 out of 10
- Patient was told they could have a family member, carer, or friend with them when told diagnosis – 6.8 out of 10
- Patient was offered information on how to get financial help or benefits – 6.7 out of 10
- Patient had completely had enough understandable information about progress with hormone therapy – 6.7 out of 10
- Patient was always offered practical advice on dealing with any immediate side effects of treatment – 6.6 out of 10

3.4 Areas for action: The areas where we scored less than 6.5 out of 10 that we need to discuss and act on where possible are:

- Patient was always able to get help from *ward staff* when needed – 6.5 out of 10
- Patient was always involved in decisions about their care and treatment *whilst in hospital* – 6.1 out of 10
- Patients family, or someone close, were able to talk to a member of the team looking after the patient *in hospital* – 6 out of 10
- Patient was given enough information about the possibility and signs of cancer coming back or spreading – 5.7 out of 10
- Patients were able to discuss their worries and fears with hospital staff *whilst in hospital* – 5.6 out of 10
- Patient felt possible long-term side effects were explained in a way they could understand in advance of treatment – 5.6 out of 10
- Care team gave family, or someone close, all the information needed to help care for the patient at home – 4.9 out of 10
- Patient was able to discuss options for managing the impact of any long-term side effects – 4.8 out of 10
- Patient could get further advice or a second opinion before making decisions about their treatment options – 4.2 out of 10
- Cancer research opportunities were discussed with the patient – 3.7 out of 10

4. Conclusion

4.1 The Cancer services are now working with the Patient Voice and Involvement team and continuing to work with the wider Kent and Medway Cancer Alliance and Macmillan Cancer. There is a shared recognition that there is a lot to celebrate, but also areas that need improvement. During 2024-25 we will be focused on making improvements where we can, and involving patients, their carers, and family in this journey.

East Kent Hospitals University NHS Foundation Trust

CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Chairman's Report

One of the great privileges of being the Chairman of EKHUFT is the opportunity to spend time with colleagues within our services. I was thrilled to be able to acknowledge and celebrate staff as part of events marking both the International Day of the Midwife and the International Day of the Nurse. It was also particularly timely to have a Theatre Appreciation Day across the Trust in May – thank you to all colleagues working within theatres for their dedication and care.

1) Finances

I confirmed in my last Board report that the Trust's financial position has sustained positive improvement. The 2023-2024 year-end position is worth dwelling on. The Group delivered the forecast deficit position of £117.4m for 2023/24. This included £13.1m of cost improvements made in 2023/24 and a significant improvement in the last two quarters of the year due to centralisation of non-pay and pay controls. However, the drive to deliver on our 2024-2025 Cost Improvement Programmes (CIPs) moves forward unabated. Our target for this year is to deliver a minimum of £49m CIPs and under the stewardship of Tracey (Chief Executive Officer (CEO)), Tim (Interim Chief Finance Officer (CFO)) and many others I am pleased to report the Trust is making good progress identifying and providing the Board assurance on the realisation of these savings. I want to thank all EKHUFT colleagues who understand the importance of achieving these savings, the individuals involved in supporting teams identify areas for CIPs and the Finance and Performance Committee in overseeing the delivery.

During April the Trust delivered its CIP target and overall delivered a deficit of £8.7m which was in line with the plan for Month 1. Whilst there remains a significant distance to travel to return the trust to a sustainable financial position, the in-month position represents the second lowest in month deficit since March 2023.

2) Emergency Department (ED) Performance

Further work continues to reduce delays through the Reducing Length of Stay programme and through the reset weeks which have occurred at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM). In that context, as far as our ED performance in April, 73% of patients who presented at all EKHUFT facilities were seen within 4 hours. The percentage of patients waiting for more than 12 hours in the department was ahead of the Trust's improvement trajectory at 10.1%, but we are working hard to reduce this further. Whilst there has been some improvement in our ED performance, I fully accept that for many patients, the delays and indeed environment within our EDs frequent fall well short of the standards we are looking to achieve.

As far as stay in hospital, there has been an increase in the number of patients who had stayed in hospital for more than 14 days; whereas those staying for more than 50 days reduced during the month and both metrics were significantly reduced compared to the same period in the previous year. Increasing the flow through our hospitals and discharging patients faster and in many cases, to more appropriate care pathways remains key to our future success.

3) Elective Waiting Lists

In relation to our waiting times, the Trust further improved it's 78-week plus patient waiting list to 465 in April, 65 weeks to 2,203 and 104 weeks to 15. The Board acknowledges the Trust-wide improvement focus and our target to clear all remaining 104-week patients (excluding patient choice) by the end of May, 78 weeks by the end of June. In the medium term, we are working towards clearing 65 weeks by the end of September 2024.

The number of patients on an endoscopy waiting list who have passed either their planned review date (for surveillance patients) or 6 weeks from GP referral continues to be a focus. There were 3,290 breaches but we have seen the Trust's clear improvement trajectory in place including enhanced booking utilisation, oesophago-gastro-duodenoscopy (OGD) validation and new triage process to commenced in June.

4) Cancer Treatment

The marked improvement in Faster Diagnosis Standards (FDS) I shared previously (Mar 2023, 68.2%) has been sustained; in April, the reported position was 67.6%. The Board was pleased to understand that this stability is primarily driven by focused FDS workstreams for both Urology and Lower GI.

For 2024/25 NHS England (NHSE) has set backlog targets of 6% for the 62-day backlog and 1% for the 104-day backlog. As far as the Trust, at the end of April, the Trust's position was 6.18% and 1.00%, respectively. This means the number of patients waiting over 62 days has increased from 187 at year-end to 235 in April, mainly due to histology reporting capacity and increased demand. The Board is monitoring the Trust's review its internal escalation process to ensure manageable volumes for teams supporting cancer pathways, with thresholds set to reflect known capacity providing a more targeted approach to address the longest delays.

In conclusion, I am pleased with the significant progress being across all of our key priorities but this is beginning of a long journey of improvement. Patients and the public can be assured that the Board of Directors and senior leaders across the Trust, remain committed to providing the best healthcare possible but we must deliver this change in a sustainable way such that these improvements become the norm for east Kent.

Acting Chairman
Stewart Baird

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 June 2024**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

None

Executive summary:

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

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

1. Purpose of the Report

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

2. Background

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

3. Clinical Executive Management Group (CEMG)

At meetings of the CEMG in April and May, the group approved an updated version of the Private Patients Policy to provide clear guidelines to staff for the management of private patients within the Trust.

4. Operational update

The length of time patients are waiting to be seen is continuing to reduce. As a Trust we still, however, have a long way to go, but there has been continued progress as we move into the new financial year.

At the end of April 2024, the Trust has 214 patients awaiting cancer treatment over 62 days. This is our lowest backlog for some time and in addition the number of patients waiting over 104 days has dropped from 47 to 37, marking a strong milestone of further improvement.

Since the beginning of January 2024, a huge effort has been made to address the number of patients waiting for an endoscopy across our surveillance, urgent and routine waiting lists. Over the last few months we have seen this backlog reduce from 13,350 at the start of January to 9,929 at the end of April. A special thank you is extended to the team for managing additional appointments, including weekends, resulting in the highest patient throughput for the months of March and April compared to any other month in the previous financial year. Further plans to improve our management of the demand for endoscopy are now well underway with a new internal triage service commencing from June and also a wider system initiative has been ratified to ensure referrals can be better managed in Primary Care with Quantitative Faecal Immunochemical Test (qFIT) testing now a mandated part of the referral process.

Efforts to mitigate long waiting times for planned treatments have also seen marked improvements. In January 2024, over 2,000 patients were at risk of exceeding the 78-week wait threshold; however, collective efforts have substantially reduced this number to 465 at the end of April. Whilst recognising the progress that has been made, the Trust acknowledges that these long waits for planned treatment fall below the standard of care expected by our patients. Detailed capacity planning and efficiency improvements are underway to ensure that these advancements continue throughout 2024/25 with a core target to clear all 78 week waits by the end of June.

As we continue striving for excellence, we remain committed to providing timely, high-quality care to our community, and I would like to extend a huge thank you to the teams across the Trust for their ongoing support and dedication to this.

5. Confirmation of Tier 1 status – Elective Recovery Plan

Following a review of elective and cancer performance and in agreement with the regional team, it has been confirmed that the Trust will be in Tier 1 for Elective, Cancer and Diagnostics from week commencing 29 April 2024.
This Tier 1 status will require the Trust to attend regular meetings with the NHSE team, focussed on progress and delivery of the national elective delivery ambitions and any actions associated with recovery. A criteria for de-escalation from Tier 1 will be agreed from the outset and reviewed regularly with the relevant national and regional NHSE teams.

6. Financial Performance and 2024/25 Business Planning/Outlook

The Trust's 2024/25 annual plan enables the Trust to:

- Ensure that a minimum of 77% of emergency patients will be seen at our hospitals within 4 hours of arrival in March 2025;
- Provide all patients requiring elective care at our hospitals to receive that care within 65 weeks of referral by the end of March 2025;
- Ensure that 70% of patients who are referred to the Trust with suspected cancer will be diagnosed and, where that diagnosis indicates cancer is present, will start treatment within 62-days by March 2025;
- Ensure that 77% of patients who are referred to our hospitals for a diagnostic test will receive that test within 28 days by March 2025;
- Increase the overall percentage of patients that receive a diagnostic test within six weeks compared to 2023/24; and
- Make a material first step towards financial sustainability by reducing the deficit at the Trust from £117.4m to £85.8m.

Fundamental to the delivery of the above is a step change in the productivity of the trust. To enable the delivery of this change a huge amount of work has gone into the infrastructure and planning of the Trust's 2024/25 £49m internal cost improvement programme. Indeed it is the detail of these plans that give me a great deal of confidence that the work has been done to put this trust in the best possible place to deliver for the patients of East Kent.

I'm also grateful to the Kent and Medway wider system for their commitment to reduce the number of patients waiting in our hospitals for onward care packages. Those system actions will contribute a further £7.5m in savings to the Trust's financial position.

At the end of month 1 (April 2024) the Trust delivered its Cost Improvement Programme (CIP) target, posting a deficit of £8.7m, which represents the second lowest in month deficit since March 2023.

7. Culture and Leadership Programme (CLP)

The Culture and Leadership Team and Change Ambassadors attended a Board of Directors meeting to share the findings from the Discovery phase. The main themes from the comprehensive diagnostic work were Vision, Value and Voice. The team did an excellent job presenting their findings and sharing their own personal experiences

as members of the change team. We heard very honest and comprehensive accounts of culture and leadership across the Trust, as well as receiving some clear recommendations as to what must be done to help support the changes our people want to see. We must now use this feedback to make real change and take meaningful, credible actions.

The next phase of this work will be broken down into two clear areas and will form part of our overall transformation work:

- Commencement of the design phase of the culture work where we will start to share and seek wider organisational engagement on the findings, sense checking the recommendations and priorities. We aim to recruit a further 150 change ambassadors in this next phase.

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

Additionally and further to feedback received through a series of administrative staff specific listening events held across the Trust, as part of our work to improve culture, dedicated admin forums have been established to provide those who work in an administrative capacity with the opportunity to help drive change and to share their thoughts on some of the issues which have been highlighted, including: how those in admin roles are recognised and feel valued as member of the Trust; how to access opportunities for training and development; induction processes and access to the right systems, equipment and breaks, as well as how to tackle the structure of leadership teams and behaviours within the Trust.

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

NHS Chief Executives and Chairs across the Kent and Medway system have met to co-produce a strategy for the NHS system in Kent and Medway, with the ambition of providing *responsive, sustainable healthcare with equity of access and improved patient experience and outcomes for everyone in Kent and Medway* over the next five years.

The Trust will be an active participant in the development of this strategy and we will report back once further work has been undertaken on it.

9. Equality, Diversity and Human Rights Week: 13 – 17 May 2024

We are proud to have participated in the national campaign for health and care organisations to celebrate Equality, Diversity and Human Rights Week, by promoting and celebrating the great work that is taking place across the Trust.
We must continue to encourage and celebrate diversity in all of its forms and whilst we know this will be a challenging task, given the current inequalities faced by our workforce and patients, we as a Trust are committed to taking all the necessary actions to achieve our aim of creating an inclusive organisation.
In celebrating Equality, Diversity and Human Rights Week, I would like to highlight some of the significant Equality, Diversity and Inclusion (EDI) and Staff Network achievements over the past year, which have included the launch of the 'See ME First' anti-racism campaign in October 2023 and the development of a leadership programme for staff from ethnic minority backgrounds to address the inequalities in

progression, whilst the Trust's five staff networks have continued to develop and are now a key mechanism for driving meaningful change, each with an Executive sponsor who will help to guide strategy, provide direction and raise the profile of these networks.

10. National recognition for our stoke team – visit from National Medical Director, Sir Steve Powis

National Medical Director, Professor Sir Steve Powis, visited the Trust's Stroke and Interventional Radiology services at Kent and Canterbury Hospital on Friday 3 May 2024, as part of a nationwide visit to comprehensive stroke centres and new standalone Mechanical thrombectomy (MT) centres.
This visit provided an opportunity for the Trust's Clinical Leads to showcase the work and training that is already underway and included a visit of the stoke unit whereby work continues on the new thrombectomy centre, which is the final phase of the three-year project to develop the Kent Interventional Radiology Centre.
The new thrombectomy unit will enable specialists to treat some of the most severe types of stroke by surgically removing blood clots from inside the brain for which patients from Kent and Medway currently have to travel by ambulance to The Royal London Hospital for thrombectomy treatment. The Trust will be the first to adopt an innovative model of local delivery outside of a neuroscience centre and will dramatical improve outcomes for patients of east Kent and the surrounding Kent and Medway system.

11. Multi-professional Falls Summit

More than 65 nursing, medical, and operational staff attended a multi-professional Falls Summit on 14 May 2024, led by Katy White, Interim Deputy Chief Nurse and Emma Bull, Lead Falls Nurse.

The multi-disciplinary group discussed contributory factors to the 24 in-patient falls that occurred between January – mid April 2024, which resulted in moderate or severe harm, and sadly five patients passed away following a fall, and the ways in which we as a Trust can mitigate and/or eliminate future harm.

From this summit, teams will collaborate to deliver quality improvement workstreams in line with the Patient Safety Incident Response Framework (PSIRF) plan, with a reduction in the number of moderate and above harms from falls by 10% (from the 2023/24 baseline of 49), one of the Trust's quality and safety breakthrough objectives for 2024/25.

12. International Nurse and Midwife day celebrations

Over the past month we have celebrated the International Day of the Midwife and International Day of the Nurse with events on each of the sites with our own awards ceremonies to recognise the contribution of our midwives and nurses in caring for our women, babies, and patients.

13. Theatre Appreciation Day

On Thursday 16 May, Theatre appreciation day was celebrated across the Trust, recognising the work of our theatre teams and those who contribute to ensuring that our theatres are safe, productive and the innovation and teamwork that is being developed throughout the theatre environment.

Departmental awards were presented to staff who have gone above and beyond in categories recognising patient safety, innovation and patient experience, whilst fun

awards were also presented by staff to those nominated by their colleagues who were most likely to make you smile, most organised, best laugh and best packed lunch.

14. Kent & Medway (K&M) Provider Collaborative

The K&M Provider Collaborative has been established by healthcare leaders, working together to deliver integrated healthcare for local communities. This initiative builds on years of collaboration, bringing together efforts under a shared Provider Collaborative Board focused on three main areas: Mental Health, Learning Disability and Autism (MHLDA), Community Health and Primary Care, and Acute Hospital Care, recognising the need for overlap due to patient pathways.

The collaborative is also working on a unified approach to support services, with the collective goal of improving access to care, delivering treatments closer to home, enhancing the efficiency of support services, and promoting sustainable practices.

15. Family and Friends Test (FFT) feedback pilot project

A pilot project which allows clinicians to receive feedback from the FFT is now being rolled out to all staff after nearly all participants reported improved morale during the pilot period.

The direct clinician feedback project is based on the FFT survey; a system whereby every patient has a unique number allowing them to give feedback after visiting one of our sites – as an outpatient, inpatient or an emergency department attendance. The FFT project gathers patient feedback, including star ratings and comments, and sends this directly to clinicians weekly, aiding both clinical and non-clinical insights. This initiative, named "Feedback Friday" has not only boosted morale but also fostered a culture of recognition and improvement within the team and emphasises the importance of acknowledging colleagues' efforts.

16. Conclusion

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

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 June 2024**

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

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

Appendices:

APPENDIX 1: April 2024 IPR

Executive summary:

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

	Patients • Type 1 Emergency Department (ED) performance reduced in April to 47.4%. • Cancer 28 Faster Diagnosis Standard (FDS) achieved 64.9% in month. • Diagnostics performance is 62.5% with the Endoscopy backlog continuing its significant reduction. **Quality & Safety** • Seven Serious Incidents (SIs) declared in the month. • 0 never events reported in April. • The number of overdue incidents reduced by a further 500. • Hospital Standardised Mortality Ratio (HSMR) remains below 100 and appears to have plateaued at an index figure of around 88. **People** • Sickness absence has reduced back under the 5% threshold in month at 4.7%. • Vacancy rate has tipped above the 10% threshold at 10.1%. • Staff turnover remains in line with the previous month at 9.3%. • Staff engagement score has dropped to 5.70. • Completed medical job plans has reduced to 45.3%. • Appraisal rates have increased by 3% to 76%. **Maternity** • One SI declared in the month of April in Maternity. • Complaint response times have deteriorated in month. • Perinatal mortality remains low and in line with the prior month. • FFT recommend rate is 91% for the month.
Key recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

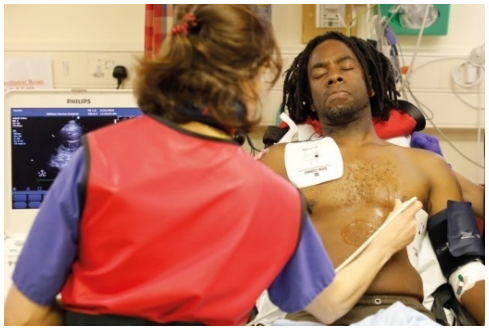
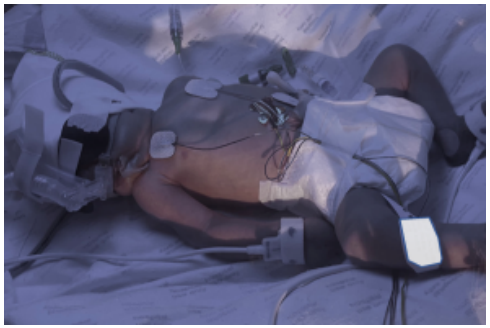
Integrated Performance Report

April 2024







Patients

Operational Performance

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Operational Performance	IIP		Type 1 Compliance 4hrs		Traj.	45.1%	48.1%	51.6%	46.5%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%
	IIP		12 Hr Total Time in Department		Traj.	10.5%	9.6%	8.7%	9.7%	10.2%	10.7%	10.4%	11.4%	11.1%	10.2%	9.5%	10.1%
	IIP		14D+ LOS		107	379	371	341	346	350	342	372	348	356	339	313	330
	IIP		Cancer 28d Combined Performance		75.0%	61.8%	64.7%	63.2%	60.5%	59.5%	63.6%	62.3%	68.6%	57.7%	66.9%	68.2%	64.9%
	IIP		Cancer 62d Combined Performance		70.0%	64.7%	68.8%	73.9%	67.1%	59.4%	63.8%	61.8%	63.5%	56.1%	56.1%	68.9%	67.7%
	IIP		Cancer Over 62d on PTL		200	308	325	313	327	403	366	308	404	415	243	187	235
	IIP		RTT 65w Breaches		Traj.	984	1,023	1,148	1,292	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203
	IIP		RTT 78w Breaches		Traj.	156	135	127	145	233	325	435	643	752	653	485	465
	IIP		RTT 104w Breaches		Traj.	10	12	4	9	9	8	12	12	6	13	24	15
	IIP		Endoscopy Backlog		Traj.	7,508	7,817	8,376	8,771	9,067	9,218	9,254	9,397	8,941	7,831	7,055	5,969
	IIP		DM01 Compliance		Traj.	58.6%	59.0%	55.9%	53.6%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%

April Performance Summary

Emergency Department: April saw a slight deterioration against the key ED access targets, with 73% of patients who presented at all EKHUFT facilities being seen within 4 hours and 47% of Type 1 patients being seen within 4 hours (within the trajectory set for improvement though). The percentage of patients waiting for more than 12 hours in the department slightly exceeded the improvement trajectory at 10.1%. Despite an increase in the number of patients who had stayed in hospital for more than 14 days, the number of patients >50 days reduced during the month and both metrics were significantly reduced compared to the same period in the previous year. Further work continues to reduce delays through the Reducing Length of Stay programme and through the reset weeks which have occurred at WHH and QEQM.

Cancer: The marked improvement in FDS reported at year-end (Mar 23, 68.2%) has been sustained; in April, the reported position was 67.6%. This stability is primarily driven by focused FDS workstreams for both Urology and Lower GI. The number of patients waiting over 62 days has increased from 187 at year-end to 235 in April, mainly due to histology reporting capacity and increased demand. For 24/25 NHSE has set backlog targets of 6% for the 62-day backlog and 1% for the 104-day backlog. At the end of April, the Trust's position was 6.18% and 1.00%, respectively. The Trust is reviewing its internal escalation process to ensure manageable volumes for teams supporting cancer pathways, with thresholds set to reflect known capacity providing a more targeted approach to address the longest delays.

Diagnostics: April has seen a further improvement of the DMO1 performance to 62.5% with the operational guidance target being 95% by end of March 2025. Some key actions taken are the introduction of weekly DM01 performance reviews and a Diagnostics Improvement Group to be set-up in June. Particular modalities of focus are MRI (3,363 breaches, 63.3%) where an extension of Estuary View's scanner has been approved & a review of internal booking processes is underway. Endoscopy (3,290 breaches) with a clear improvement trajectory in place including enhanced booking utilisation, OGD validation and new triage process to commenced in June.

Referral to Treatment Waiting Times: The trust further improved it's 78 week breaches to 465 in April, 65 weeks to 2,203 and 104's to 15. There is a clear trust-wide improvement focus with COO oversight. The key aims are to clear all remaining 104 week risks (excluding patient choice) by the end of May, 78 weeks by the end of June and an ambition to clear 65 weeks by the end of September 2024. The current remaining risks relate to Otology, Endoscopy & the backlog of Gastroenterology 1st Outpatient Appointments undated. Remedial trust plans are in place alongside Mutual Aid from Maidstone & Tonbridge Wells Hospital which is now underway.

Type 1 Emergency Department 4h Compliance

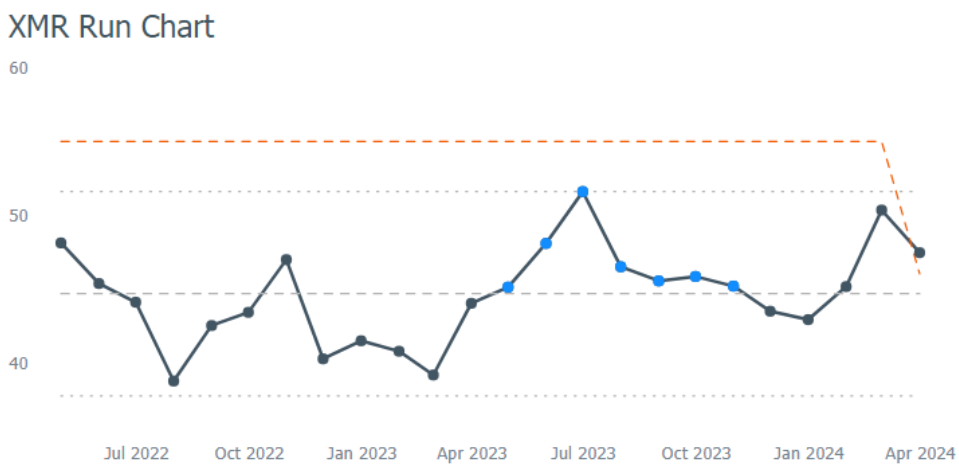
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Type 1 Compliance 4hrs

Timescale	Value	SPC
May-23	45.1%	
Jun-23	48.1%	
Jul-23	51.6%	
Aug-23	46.5%	
Sep-23	45.5%	
Oct-23	45.8%	
Nov-23	45.2%	
Dec-23	43.5%	
Jan-24	42.9%	
Feb-24	45.1%	
Mar-24	50.3%	
Apr-24	47.4%	



Understanding the most recent data point

Performance

47.4% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2023/4 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 • Deputy COO – UEC • Chief Nurse/ • CL ED	• Quarter 2 • Quarter 2	• SPOA model evaluation 23/4 due for completion end May 24 • Working group – revisit ToR and model of care for development – clear on areas of focus based on attendance data • Frailty model – task and finish group established to review model
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites	• CL ED • Deputy COO -UEC • Site MDs	• Quarter 2 • Quarter 1	• ED Internal professional standards drafted – awaiting LNC sign off • Safe and Effective ED workstream established – launch May '24 • Heatmap for demand profiles requested to ensure workforce alignment – due end Q1
Admission avoidance	• Front door alternatives to ED: • Review and development of AMU model and SDEC at WHH with direct access pathways • Review of effectiveness of AMU model and SDEC at QEQM	• WHH/QEQM Tri • Deputy COO-UEC	• Quarter 3	• AMU workstream established for WHH – direct access, workforce, pathways and data for demand and capacity to be completed Q1. • AMU model at QEQM under review – operational policies to be drafted for both sites to ensure standardisation – Q1

>12h Total Time In Emergency Department

Integrated Improvement Plan

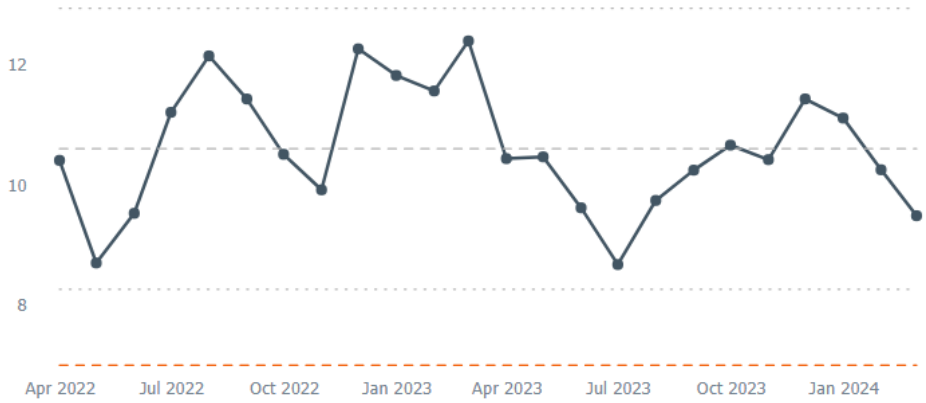
East Kent Hospitals University NHS Foundation Trust

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

12 Hr Total Time in Department

Timescale	Value	SPC
Apr-23	10.4%	
May-23	10.5%	
Jun-23	9.6%	
Jul-23	8.7%	
Aug-23	9.7%	
Sep-23	10.2%	
Oct-23	10.7%	
Nov-23	10.4%	
Dec-23	11.4%	
Jan-24	11.1%	
Feb-24	10.2%	
Mar-24	9.5%	

XMR Run Chart



Understanding the most recent data point

Performance

9.5%

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity (admitted patients)	• Improve timeliness for decision to admit • Direct pathways to assessments units once a decision to admit has been made • 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 Medical Director • Tri DoN	Quarter 3	• Medical workforce review underway supported by Deputy Medical Director • RLoS programme roll out – Internal flow and SAFER bundle core improvement programme to site Triumverates • Daily site management 'test of change' for remote site management • Workstream established to review direct admission pathways • RLoS – 0.5 day reduction in NEL in April 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 weekend planning and proactive transfer processes across sites	• Tri Care Groups	Quarter 3	• Diagnostics for key reasons for delays at weekend finalised • Workstream to be established for criteria led discharge • Escalation and discharge policies under review – to be finalised quarter 1 and to include expectations to support 7 day services
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 in place Dec QEQM with a plan to provide same service at WHH (2024)	• CG Tri WHH/QEQM	Quarter 1	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4 • Focus for 24/25 on escalation and capacity to manage long stayers

14 Day Length of Stay

Integrated Improvement Plan

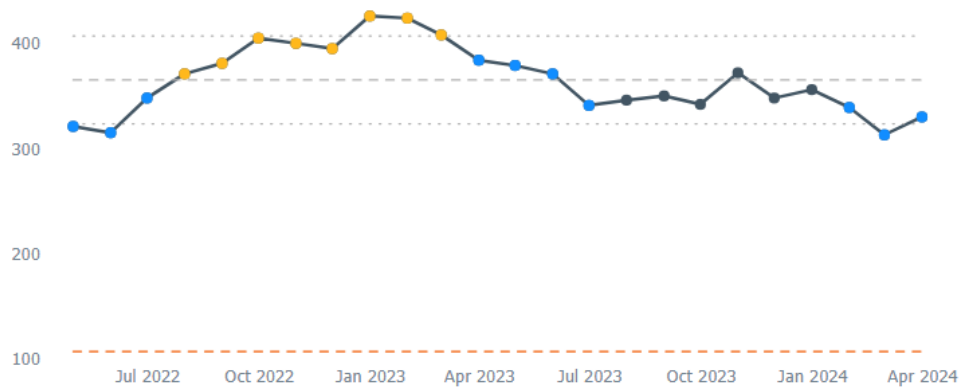
East Kent Hospitals University NHS Foundation Trust

The number of current inpatients with a length of stay of over 14 days in hospital as at the end of the reporting month.

14D+ LOS

Timescale	Value	SPC
May-23	379	
Jun-23	371	
Jul-23	341	
Aug-23	346	
Sep-23	350	
Oct-23	342	
Nov-23	372	
Dec-23	348	
Jan-24	356	
Feb-24	339	
Mar-24	313	
Apr-24	330	

XMR Run Chart



Understanding the most recent data point

Performance

330 — Variation indicates consistently falling short of the target

Variation

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

Flags — Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Deputy COO – UEC/DoN Care groups • COO/Deputy COO – UEC • Deputy COO/MD DCB	• Quarter 1 • Quarter 2 • Quarter 1	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for criteria to reside • MADE event/ care audit to be considered with regards to understanding reasons for residing and scoping opportunities for alternative models • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities • Therapy review underway
Patients not meeting the criteria to reside >14 days	• Demand and capacity for D2A pathways – working with HCP partners to review demand and capacity to mitigate delays for patients waiting to access D2A capacity • Review of internal codes – therapy reviews required for discharge – develop D2A approach	• COO/Deputy COO-UEC • System Partners	• Quarter 2 • Quarter 1	• Test and change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – programme overview for completion quarter 1
Grip and control – all LOS	• Implement weekly stranded reviews on all sites as per the SAFER bundle • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Quarter 1	• Discharge and escalation policy review in progress – complete Q1 • SAFER bundle – revisit and standardise process for consistent implementation Q1

Cancer 28d Faster Diagnosis

Integrated Improvement Plan

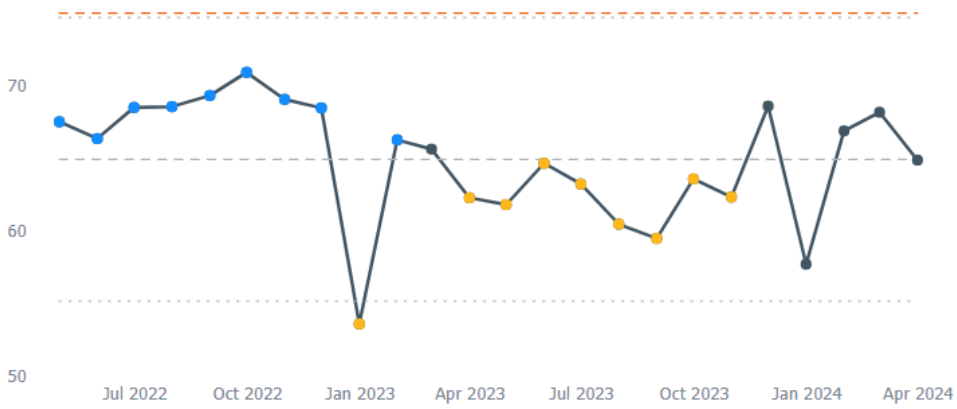
East Kent Hospitals University NHS Foundation Trust

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

Cancer 28d Combined Performance

Timescale	Value	SPC
May-23	61.8%	
Jun-23	64.7%	
Jul-23	63.2%	
Aug-23	60.5%	
Sep-23	59.5%	
Oct-23	63.6%	
Nov-23	62.3%	
Dec-23	68.6%	
Jan-24	57.7%	
Feb-24	66.9%	
Mar-24	68.2%	
Apr-24	64.9%	

XMR Run Chart



Understanding the most recent data point

Performance

64.9%

Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Diagnostic reporting for CT's & MRI's	Reduce referral to reporting to 10 days for CT and MRI Pilot of protected MRI slots for Urology	• Urology Team • Head of Imaging	• Ongoing • Apr 2024	• Implementation of STT Urology pathways commenced from w/c 15th April with an immediate impact on referral to MRI pathway timings and a reduced number of requested MRIs. • MRI pilot review set for end of May – reactive changes implement for some initial vetting and booking turnaround supported through prostate FDS working group. • Amended escalation process in place with Radiology from w/c 20th May targeted the longest delays – additional team touchpoints added for each Monday.
Endoscopy demand challenges affecting ability to treat cancer patients within 10 days of referral.	qFIT process to be consistently applied and sustained to reduce demand. To reduce waiting time to Scope to 10 days for 2ww patients via enhanced capacity	• Endoscopy Recovery Lead • Endoscopy Recovery Lead	• Apr 2024 • Apr 2024	• Task and finish group well established that includes actions for Endoscopy recovery. Endoscopy recovery plan now in place to delivery further enhancements in performance. • Full root and branch review of existing booking processes commenced with highest booking rates of all time achieved w/c 15th April. Programme to include consolidation of waiting list codes, review of booking utilisation rates and overall structure of administrative teams to support service delivery.
Waits for typing of cancer patient clinic letters , typing for Urology, Upper and Lower GI. Averaging 8-12 weeks.	Typing of letters for those tumour sites to be completed within 7 days.	• Care Group Lead Medical Secs	• Ongoing	• Updates on progress circulated to teams 3 times a week to support improvement • Improvement within all tumour groups seen with targeted work still required within Lower GI.

Cancer Patients 62d Performance

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

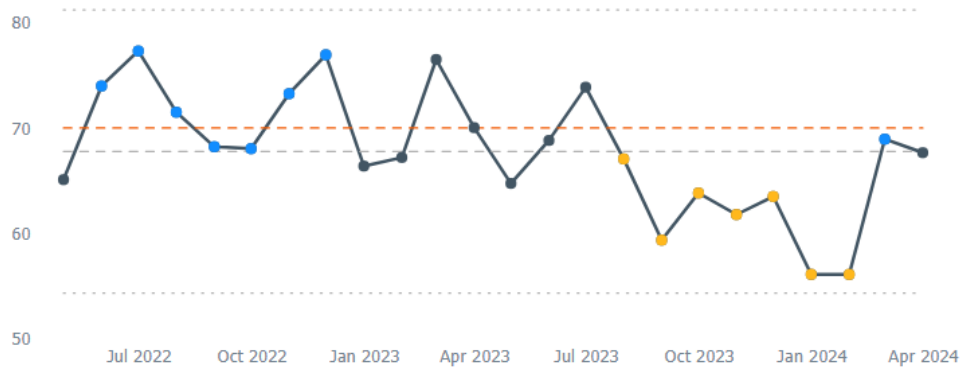
For all Cancer Treatments in the month, the % of patients on a Cancer Pathway receiving their treatment within 62d from their point of referral.

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

Cancer 62d Combined Performance

Timescale	Value	SPC
May-23	64.7%	
Jun-23	68.8%	
Jul-23	73.9%	
Aug-23	67.1%	
Sep-23	59.4%	
Oct-23	63.8%	
Nov-23	61.8%	
Dec-23	63.5%	
Jan-24	56.1%	
Feb-24	56.1%	
Mar-24	68.9%	
Apr-24	67.7%	

XMR Run Chart



Understanding the most recent data point

Performance

67.7%

Variation indicates inconsistently passing and falling short of the target

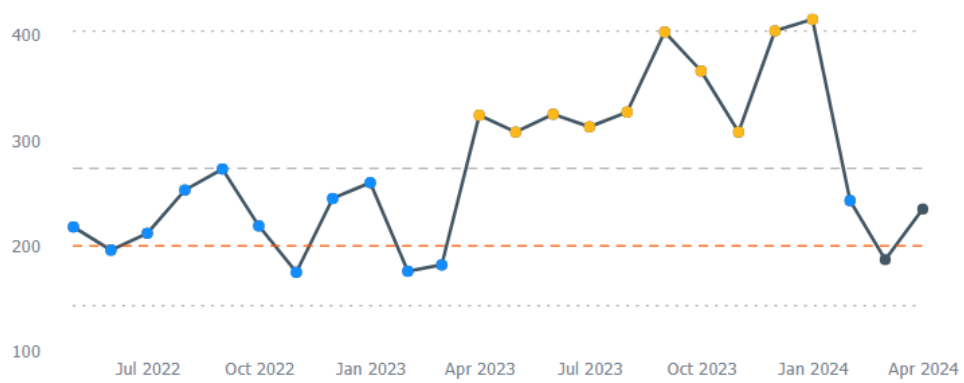
Variation

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

Cancer Over 62d on PTL

Timescale	Value	SPC
May-23	308	
Jun-23	325	
Jul-23	313	
Aug-23	327	
Sep-23	403	
Oct-23	366	
Nov-23	308	
Dec-23	404	
Jan-24	415	
Feb-24	243	
Mar-24	187	
Apr-24	235	

XMR Run Chart



Understanding the most recent data point

Performance

235

Variation indicates inconsistently passing and falling short of the target

Variation

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

Cancer Patients 62d Performance

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip & Control of Urology Backlogs.	• Programme Manager dedicated to review all procedures and ensure full utilisation of mutual aid.	• Programme Manager	• Ongoing	• Strong improvement in overall backlogs thanks to greater oversight on tumour site, implementation of transperitoneal biopsies and additional WLI's from consultants for clinics and surgical cases. • 104 position improved and sustained • Issues remain with consultant capacity post MDM supported by mutual aid arrangements and micro management of clinic vs list capacity based on in month demand.
Delays with radiology vetting, booking and reporting adding weeks to suspected cancer patient pathway	• Targeted waiting lists and prioritisation	• Head of Imaging	• Ongoing	• Amended escalation process in place with Radiology from w/c 20th May targeted the longest delays – additional team touchpoints added for each Monday. DCB Cancer Access meeting set for each Tuesday reviewing longer term improvement plans.
Challenges with access to Histopathology within 10 day turnaround time.	• Review of unnecessary referrals into Histopath. • Streamlining of MDT's to enhance Histopath capacity. • Active recruitment drive – albeit national shortages recognised.	• FDS Lead Clinician • Associate MD • Associate MD	• Q1 2024 • Q1 2024 • Ongoing	• Amended escalation process in place with Pathology from w/c 20th May targeted the longest delays – additional team touchpoints added for each Monday. DCB Cancer Access meeting set for each Tuesday reviewing longer term improvement plans. • Seeking funding to support administrative capacity to address staff sickness • FDS working groups established to refine and reduce biopsy requests.

Diagnostic Waiting Times: DM01

Integrated Improvement Plan

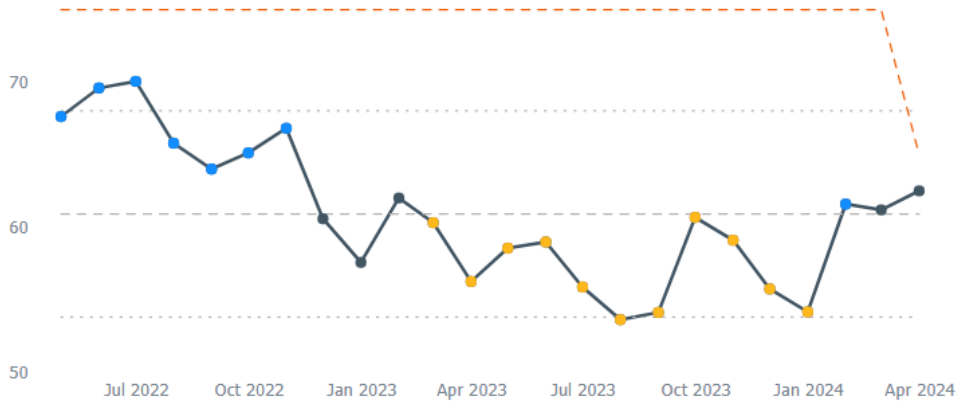
East Kent Hospitals University NHS Foundation Trust

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

DM01 Compliance

Timescale	Value	SPC
May-23	58.6%	
Jun-23	59.0%	
Jul-23	55.9%	
Aug-23	53.6%	
Sep-23	54.1%	
Oct-23	60.7%	
Nov-23	59.1%	
Dec-23	55.8%	
Jan-24	54.2%	
Feb-24	61.6%	
Mar-24	61.2%	
Apr-24	62.5%	

XMR Run Chart



Understanding the most recent data point

Performance

62.5%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
CT Performance • CT Cardiac • CT Vetting	• Cardiac | Clearance of backlog • Vetting | Clearance of backlog	• Head of Imaging • Head of Imaging	• Q2 2024 • Ongoing	• Extremely positive to share CT Cardiac beaches much improved with now only 2 patients beyond 6 weeks. A great improvement with the trust at full compliance in this area. • Vetting backlogs now fully cleared with only 101 breaches with a performance now above the standard at 97.2%.
MRI scanning capacity	• Development of improvement plan for MRI	• Head of Imaging	• May 2024	• MRI compliance up to 63.3% with key actions related to the extension of Estuary View's scanner until the end of May, a review of internal booking processes & a clear plan to be developed to clear GA backlogs. • ICB funded additional scanner for installation in Autumn 2024 @ QEQM.
Clear Governance Oversight on DM01	• Creation of Trust-wide DM01 Performance Review Group with reporting into Access & Planned Care Group	• Managing Director – DCB	• May 2024	• DM01 group formulated in May and all DM01 modalities to report into this group. • Particular focus on MRI, Breast Ultrasound, Paediatric Audiology and Echo which currently are the areas of non-compliance. • Recovery Plan to achieve 95% by end of March being formulated and presented at Access Meeting on 23rd May.

Endoscopy Backlog

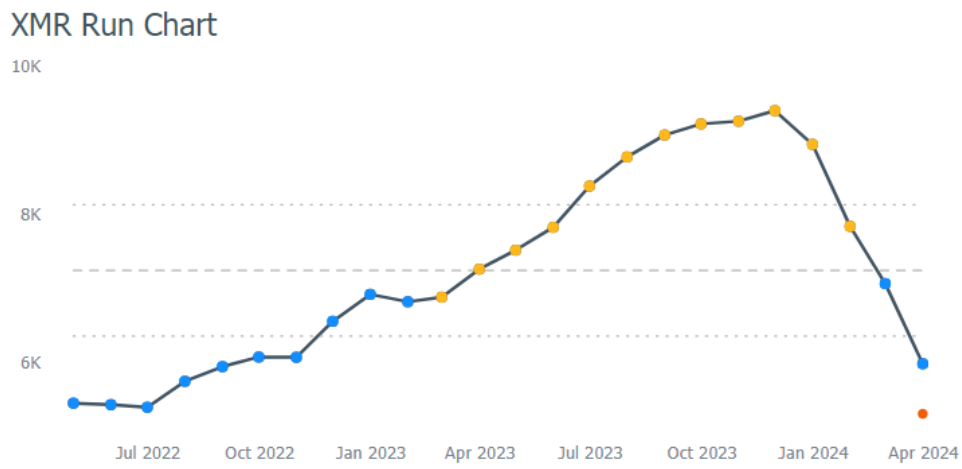
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

The number of patients on an endoscopy waiting list who have passed either their planned review date (for surveillance patients) or 6 weeks from GP referral.

Endoscopy Backlog

Timescale	Value	SPC
May-23	7,508	
Jun-23	7,817	
Jul-23	8,376	
Aug-23	8,771	
Sep-23	9,067	
Oct-23	9,218	
Nov-23	9,254	
Dec-23	9,397	
Jan-24	8,941	
Feb-24	7,831	
Mar-24	7,055	
Apr-24	5,969	



Understanding the most recent data point

Performance

5,969 — Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Ensure that booking team were not performing no booking tasks including reception. • Recruit reception staff. • Train other members of the team to book for Endoscopy patients.	• Endoscopy recovery lead	• Ongoing	• Activity and bookings are up with over 550 procedures planned for this week. • 1300 patients have been booked into the future with a target of getting to 2200 forward bookings to optimise efficiency. • A "hot house " training program has been developed to speed up training of booking team.
Demand management	• Implementing a Triage system to demand management the service.	• Endoscopy recovery lead • Clinical lead	• May 2024	• Process designed, sunrise chances made, SOP written. • New triage process to be launched at the Endoscopy clinical governance on the 24th of May.
Waiting list accuracy	• A program of staged validation against new clinical standards.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• validation program – Cohort 1 complete, Cohort 2 50% complete (surveillance). Over 500 patients have been removed who have had or no longer need the procedure). • cohort 3 (ODG patients) commenced on the 20th May (expected to remove 500 patients who no longer need the procedure). • Parallel Validation of the RECP and GA list complete.

Referral to Treatment Waiting Times: Long Waiting Patients

Integrated Improvement Plan

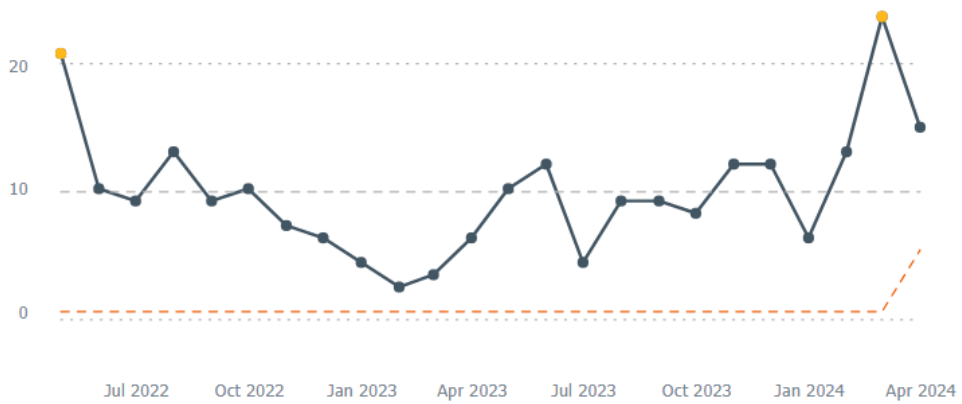
East Kent Hospitals University NHS Foundation Trust

This metric measures the number of RTT reportable patients waiting in excess of 104, 78 and 65 weeks to start treatment.

RTT 104w Breaches

Timescale	Value	SPC
May-23	10	
Jun-23	12	
Jul-23	4	
Aug-23	9	
Sep-23	9	
Oct-23	8	
Nov-23	12	
Dec-23	12	
Jan-24	6	
Feb-24	13	
Mar-24	24	
Apr-24	15	

XMR Run Chart



Understanding the most recent data point

Performance

15

Variation indicates inconsistently passing and falling short of the target

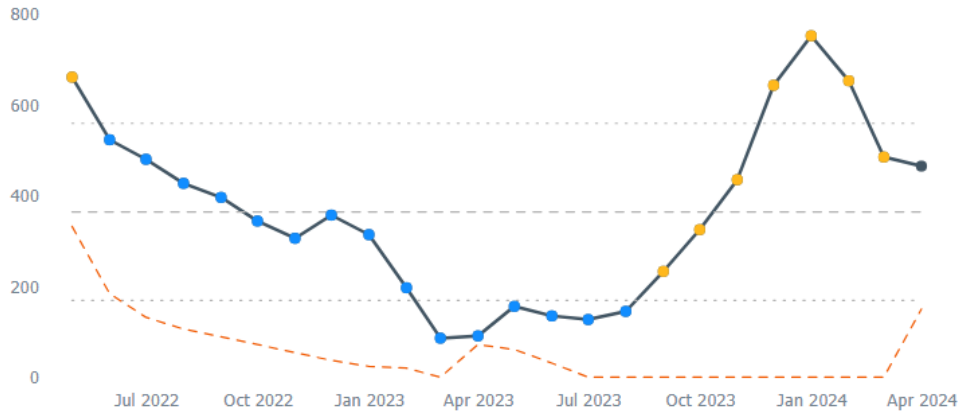
Variation

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

RTT 78w Breaches

Timescale	Value	SPC
May-23	156	
Jun-23	135	
Jul-23	127	
Aug-23	145	
Sep-23	233	
Oct-23	325	
Nov-23	435	
Dec-23	643	
Jan-24	752	
Feb-24	653	
Mar-24	485	
Apr-24	465	

XMR Run Chart



Understanding the most recent data point

Performance

465

Variation indicates consistently falling short of the target

Variation

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

Referral to Treatment Waiting Times: Long Waiting Patients

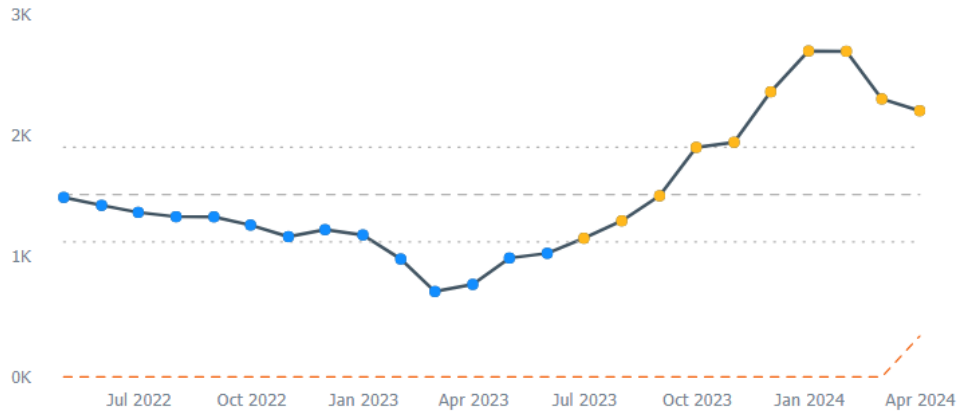
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

RTT 65w Breaches

Timescale	Value	SPC
May-23	984	
Jun-23	1,023	
Jul-23	1,148	
Aug-23	1,292	
Sep-23	1,499	
Oct-23	1,900	
Nov-23	1,942	
Dec-23	2,360	
Jan-24	2,698	
Feb-24	2,695	
Mar-24	2,301	
Apr-24	2,203	

XMR Run Chart



Understanding the most recent data point

Performance

2,203

Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Full Clearance of 104 week breaches and future management as never events excl. patient choice.	• Daily review of all 104 risks eight weeks ahead and escalations managed through Access meeting.	• DCOO	• Immediate	• Current forecast of 2 potential choice breaches in May, reduced on 15 in April and none forecast for June.
Trust-wide focus to clear all 78 week risks by end of June.	• Daily focus on 78 week clearance by Care Groups with COO oversight through Access • Recovery focus with ENT, Gastro & Colorectal as challenged specialities • Mutual aid commenced from MTW.	• COO • Care Groups • COO	• Immediate • Immediate • Immediate	• Daily cohort report in place with twice daily reviews by Care Groups. • Endoscopy capacity created, key challenge remains within Otology due to level of demand and remains a risk. • 169 patients sent and plans to send 94 related to this cohort across Gastro and ENT.
Trust-wide focus to clear all 65 week risks by end of September (RSP target is end of March 2025).	• Review waiting list shape and trajectories for key specialities. • Insourcing Options being reviewed for 2024/25. • ICB review planned to identify IS support for 65 weeks clearance. • Mutual aid commenced from MTW.	• BI Team • DCOO • DCOO • COO	• May 2024 • June 2024 • 17th May • Immediate	• In hand and on track for delivery. • Initial meeting with potential support partner on 18th April with plans to be devised to utilise dropped sessions from June/July 2024. • Meeting held with some key specialities identified for support (General Surgery) and actions underway. • Plans to send 637 – full pathway's for Gastroenterology, 640 for ENT & 150 full pathways for Pain Management.

Cancer Performance

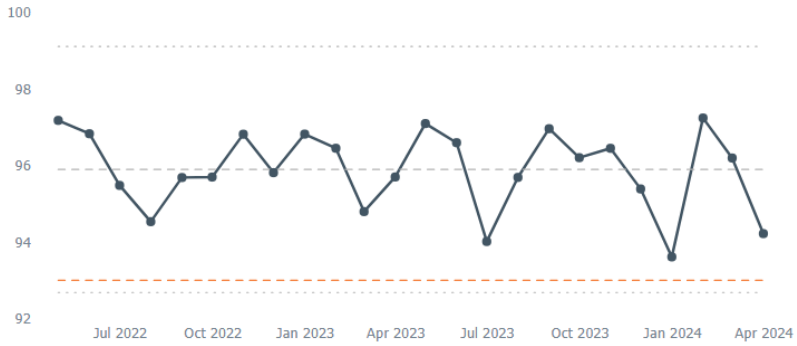
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Cancer 2ww Performance

Timescale	Value	SPC
May-23	97.1%	
Jun-23	96.6%	
Jul-23	94.0%	
Aug-23	95.7%	
Sep-23	97.0%	
Oct-23	96.2%	
Nov-23	96.4%	
Dec-23	95.4%	
Jan-24	93.6%	
Feb-24	97.2%	
Mar-24	96.2%	
Apr-24	94.2%	

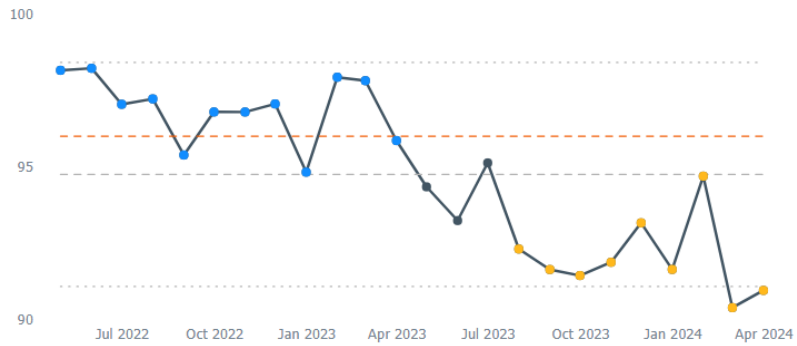
XMR Run Chart



Cancer 31d Combined Performance

Timescale	Value	SPC
May-23	94.3%	
Jun-23	93.2%	
Jul-23	95.1%	
Aug-23	92.3%	
Sep-23	91.6%	
Oct-23	91.4%	
Nov-23	91.9%	
Dec-23	93.2%	
Jan-24	91.6%	
Feb-24	94.7%	
Mar-24	90.4%	
Apr-24	91.0%	

XMR Run Chart



PERFORMANCE UPDATE

2ww performance saw a second consecutive decline in performance primarily driven by decreases in 2ww turnaround for Breast, Upper GI and Lower GI.

31 Day Performance saw a drop in position for March. Whilst there has been a slight tip up in April, increases in skin breaches has prevented any further recovery. Skin PTL meetings are being focused on those patients passed the MDM stage of the pathway to review all subsequent appointment dates, to bring forward where at all possible. A Skin Faster Diagnosis working group is also being established to refine referrals where at all possible and work to improve the structure of clinics slots to allow faster access to biopsy. This work will support the service during the expected uplift in referrals over the summer.

Actions to improve performance across all Cancer measures include; new Access meeting, £900K plan, MDM focus, review of escalation processes and working on Urology and Lower GI improvement plans.

RTT Performance

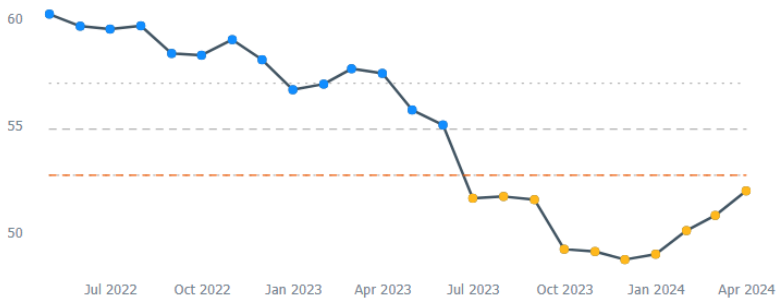
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

RTT Incomplete Performance

Timescale	Value	SPC
May-23	55.7%	
Jun-23	55.0%	
Jul-23	51.6%	
Aug-23	51.7%	
Sep-23	51.5%	
Oct-23	49.2%	
Nov-23	49.1%	
Dec-23	48.7%	
Jan-24	49.0%	
Feb-24	50.1%	
Mar-24	50.8%	
Apr-24	51.9%	

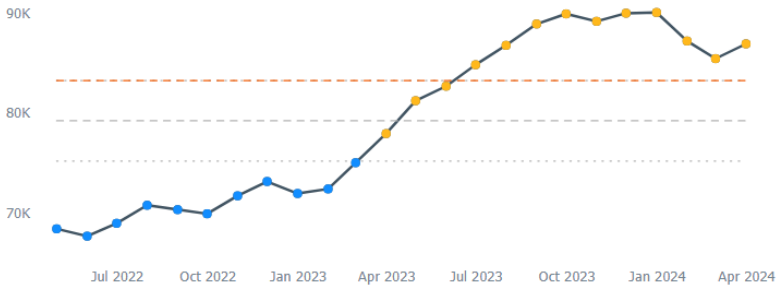
XMR Run Chart



RTT Total Incomplete Pathways

Timescale	Value	SPC
May-23	81.2K	
Jun-23	82.7K	
Jul-23	84.8K	
Aug-23	86.8K	
Sep-23	88.9K	
Oct-23	89.9K	
Nov-23	89.2K	
Dec-23	90.0K	
Jan-24	90.0K	
Feb-24	87.2K	
Mar-24	85.4K	
Apr-24	86.9K	

XMR Run Chart



PERFORMANCE UPDATE

External organisation (MBI) completed validation of all RTT pathways down to 34 weeks (15,260 records) & all of DM01 backlog to 6 weeks 7,923 records.

This means we now have a clean waiting list and hence drove the improvement in incomplete performance.

Revised Access Policy ratified on 9th May and used to inform RTT classroom training programme to commence from 3rd June across all sites. To include competency assessment tool and consultant sessions to be designed and commence from June/July.

Agreed that DQ issues highlighted from Luna reporting to feed into Information Assurance Committee from newly formed WL Data Quality Group now in place.

A key initiative was to develop a validation strategy to address the current patients awaiting validation >12 weeks.

Proposal made to Access and approved to commence from the end of May to operationalise a validation plan utilising text and e-mail technology.

This process will be piloted with an initial cohort and if successful after 1 week will be extended to contact all Gastroenterology patients waiting for their 1st OPA and then onto Pain Management for 1st OPA's undated in line with the trust's challenged specialities.

Trust Planned Care Governance oversight now in place through Planned Care Board with first meeting scheduled for 21st May 2024.

Efficiency Metrics

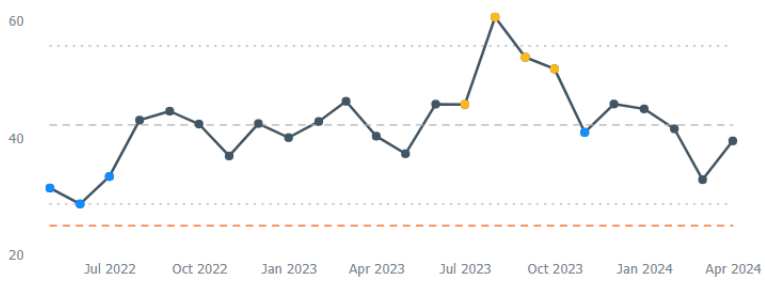
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

Timescale	Value	SPC
May-23	37	
Jun-23	46	
Jul-23	46	
Aug-23	61	
Sep-23	54	
Oct-23	52	
Nov-23	41	
Dec-23	46	
Jan-24	45	
Feb-24	42	
Mar-24	33	
Apr-24	39	

XMR Run Chart



Theatre Uncapped Utilisation

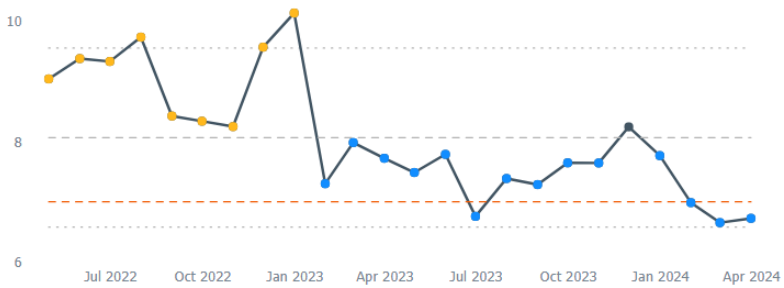
Timescale	Value	SPC
May-23	79.1%	
Jun-23	77.7%	
Jul-23	77.5%	
Aug-23	79.5%	
Sep-23	79.0%	
Oct-23	80.0%	
Nov-23	79.5%	
Dec-23	77.2%	
Jan-24	76.7%	
Feb-24	78.1%	
Mar-24	79.4%	
Apr-24	80.6%	

XMR Run Chart

DNA Rate OP New

Timescale	Value	SPC
May-23	7.5%	
Jun-23	7.8%	
Jul-23	6.8%	
Aug-23	7.4%	
Sep-23	7.3%	
Oct-23	7.6%	
Nov-23	7.6%	
Dec-23	8.2%	
Jan-24	7.8%	
Feb-24	7.0%	
Mar-24	6.7%	
Apr-24	6.7%	

XMR Run Chart



PERFORMANCE UPDATE

Theatre session opportunity reductions have been implemented with the implementation of 8-6-4-2 planning programmes led by Prism and MD for Surgery and Anaesthetics.

Right sizing theatres work programme well underway to confirm clear plan on how to further reduce lost sessions with greater engagement with Spencer and/or insourcing providers.

Theatre actual uncapped utilisation remains within normal variation with a particular improvement over Jan-Mar24.

Teams are being asked to book up to a minimum of 90% utilised in order to meet the aim of 85% actual utilisation moving forward.

The Elective Orthopaedic Centre is aiming for an actual utilisation of 90%.

The theatre improvement group now meets monthly with clear improvement trajectories agreed.

Improvements are being seen around the implementation of strong 8-6-4-2 processes and in session utilisation.

Prism extended for a further 12 weeks to support embedding of programme.

Further Faster Programme now underway with a key focus around Outpatient Transformation.

Governance arrangements agreed in May to report through Planned Care Board.

EKHUFT part of Cohort 2 and working with key specialities on improvements as part of the playbook self-assessments.

Increasing numbers of patients now have the ability to choose their appointment date as specialties are moving back to the electronic referral service (ERS) which appears to be having a positive impact and decreasing capacity lost due to DNA.

Further development of the patient portal continues.

East Kent Hospitals University NHS Foundation Trust

Quality & Safety

Domain	Nat	Flag	KPI	SPC	Thres.	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Quality	IIP		Falls with Harm		Sigma	2	3	2	2	8	6	2	3	2	10	4	8
	IIP		Pressure Ulcers		Sigma	85	92	78	76	62	103	82	84	113	90	77	84

April Performance Summary

Harm Events: The number of harm events relating to Falls and Pressure Ulcers. Falls data identified no change from normal variation.
The spike in pressure ulcers in October 2023 was attributed to End of Life (EoL) patients and patients receiving oxygen therapy. A meeting with palliative care and manual handling took place to explore mitigating actions and to explore the purchase of new turn beds for to improve comfort and care in EoL patients.

There was a spike in pressure ulcers in January 2024, predominantly hospital acquired grade 2 pressure ulcers. There was an identified increases in medical device related pressure damage, which is being addressed by the introduction of new NG dressings being trailed in ITU which will reduce NG related damage. The Tissue Viability Band 4 carries out bespoke training with high reporting ward staff.

The January spike was also prior to the introduction of Purpose T risk assessments across the Trust. Training and audits are in place to monitor the compliance and effectiveness of the new risk assessments which in conjunction with the Sunrise IT system team will be made electronic. Monthly ward walks, spot check audits with feed back to relevant clinical teams and meetings to explore purchase of new ED trolleys have all been put in place.

Falls (with harm)

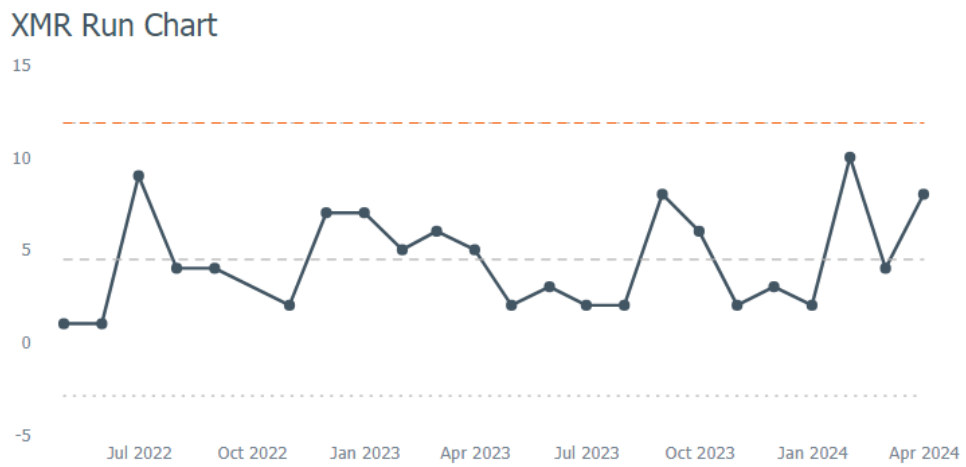
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Falls with Harm

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



Understanding the most recent data point

Performance

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

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Harm from falls increasing from January 2024	• Escalation sighting care group ownership • Falls summit focus on harm • Education delivered to doctors • Consultant support from falls geriatricians • Linking with FOC specialist teams and therapies	• Falls lead • Associate Director of FOC	• June 2024	• Project planning for Falls Summit May 2024 • Deputy Chief Nurse supporting • Recondition the Nation planning through therapies • Grand Round to be attended
FallStop face to face training discontinued June 2023.	• Liaise with RCP to introduce a national falls prevention training package. • Edits to package to include lying and standing BP. • Liaise with Learning and Development team to make mandatory on ESR	• Lead Nurse for Falls • CNS	• April 2024	• Agreed falls training package at SMET • Mandatory requirement of online training awaited by learning & development team (May 2024) • Moodle to go through SMET to be presented by the WFD team.
Unwitnessed falls continue to remain high in the most vulnerable patients.	• Falls team promote the use of Enhanced Observations Tool. • Falls team are part of EKHUFT working group for Enhanced Care.	• HON GSM QEQMH • Associate Director FOC	• September 2024	• The EKHUFT Enhanced Care Tool is now on Sunrise and is being piloted on a ward at QEQM. The proposal is to be rolled out across the Trust. • Roll out plan to be agreed. • EKHUFT working group with other trusts and community ICB led by Associate Director of Fundamentals of Care.

Falls (with harm)

Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Inability to embed consistent change through learning from incidents. Limitations to deliver targeted training.	• Identify high risk areas with repeat harm events and deliver consistent support. • CNS presence to support clinical areas trust wide • Review Falls Team skill mix and numbers to support proactive falls prevention	• Lead Nurse for Falls • CNS • DCN and ADON FOC	• July 2024 • July 2024 • July 2024	• Lead nurse and CNS cross site support where able.

Pressure Ulcers

Integrated Improvement Plan

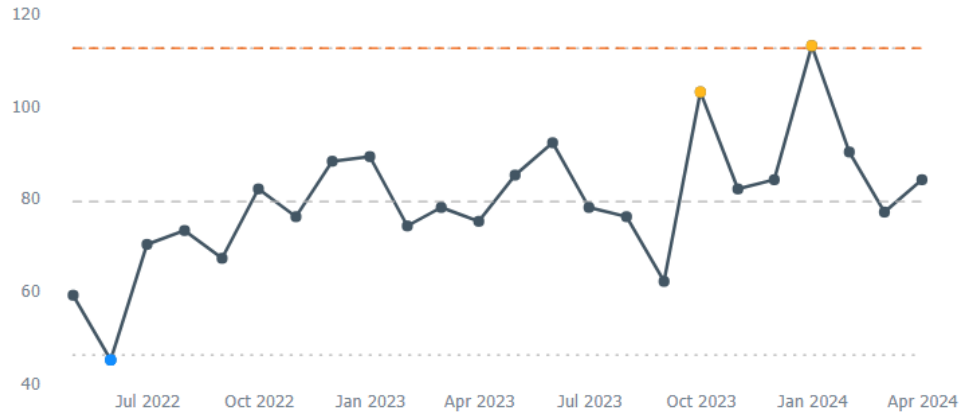
East Kent Hospitals University NHS Foundation Trust

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

Pressure Ulcers

Timescale	Value	SPC
May-23	85	
Jun-23	92	
Jul-23	78	
Aug-23	76	
Sep-23	62	
Oct-23	103	
Nov-23	82	
Dec-23	84	
Jan-24	113	
Feb-24	90	
Mar-24	77	
Apr-24	84	

XMR Run Chart



Understanding the most recent data point

Performance

84

Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Issues with skin inspection. Reporting skin intact on SBAR when patient known to have pressure damage or damage found as soon as patient transferred. Not looking at all body sites.	• PURPOSE T risk assessment prompts 13 areas vulnerable to pressure damage. • ED leads have highlighted with teams to ensure skin inspection is documented correctly or documented as not checked for accuracy. • Patient story to be shared at FOC meeting and included in all training modules	• Lead TVN Specialist	• July 2024	• Site based communications sent to ED • Added case study to all teaching and awareness sessions • Included in alterations to risk assessment, communicated in Tissue Viability Steering Group for care groups to ensure all patients are checked and no assumptions made over their skin integrity
Increased pressure damage noted to buttocks from prolonged periods in chair or laying on the back	• PURPOSE T risk assessment, provides specific plan of care to specify level of repositioning. • Continue to work with seating working group and MDG to improve quality of seating and to procure more active chair cushions	• Tissue Viability Team	• July 2024	• Monthly ward walks on each with Tissue and Moving and Handling • TV team audited the number of active chair cushions at QEQM and fed back to MDG • Raise incidents of unavailability so this can be monitored
Transition to Sunrise has contributed to gaps in repositioning whilst staff are transitioning.	• TV team to work with Sunrise to simplify the process and to produce a training module for the use of the Tissue Viability risk assessment and documentation • Spot check audits carried out in areas with lack of repositioning evidence.	• Lead TVN Specialist	• June 2024	• TV team carrying out spot check audits and feeding back to relevant clinical teams • Sunrise team have devised training module and will work with TV team on implementation

Quality & Safety

National Standards

NHS
East Kent
Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Quality	NAT		Clinical Incidents		Sigma	2,448	2,352	2,192	2,336	2,286	2,519	2,134	2,061	2,377	1,147		
	NAT		Patient Incidents		Sigma										763	1,948	1,944
	NAT		Never Events		0	1	2	1	0	0	1	0	0	1	0	1	0
	NAT		Serious Incidents		Sigma	5	13	11	12	13	13	14	7	15	10	7	7
	NAT		Patient Incidents - Moderate / Severe		Sigma										15	44	52
	NAT		Serious Incidents Breached exceed 60...		0	13	6	6	2	3	1	2	3	4	1	0	1
	NAT		Safeguarding Incidents		Sigma	21	24	22	27	40	36	48	34	42	38	55	35
	NAT		Safeguarding Children Training		90.0%	87.1%	87.8%	88.3%	89.5%	90.0%	90.1%	91.2%	91.4%	91.9%	93.6%	93.5%	94.3%
	NAT		Safeguarding Adults Training		90.0%	82.2%	83.1%	83.7%	85.6%	86.5%	87.2%	88.6%	89.1%	89.8%	91.7%	92.1%	93.2%
	NAT		Duty of Candour - Verbal		100.0...	100%	100%	100%	95.5%	100%	97.1%	96.3%	95.7%	95.2%	92.0%	100%	87.5%
	NAT		Duty of Candour - Written 15wd		100.0...	95.0%	95.7%	95.2%	100%	94.1%	94.1%	100%	85.0%	92.0%	100%	90.0%	60.0%
	NAT		Duty of Candour - Findings		100.0...	93.3%	87.5%	100%	92.3%	87.5%	85.7%	76.5%	100%	92.9%	100%	80.0%	83.3%
	NAT		IPC: EColi Infections		10	9	8	8	7	7	11	5	15	13	14	17	10
	NAT		IPC: CDiff Infections		6	15	9	12	13	11	9	13	11	11	8	14	4
	NAT		IPC: Klebsiella Infections		6	2	7	3	5	7	4	9	9	5	4	5	10
	NAT		IPC: Pseudomonas Infections		3	1	0	0	0	1	3	1	2	3	4	3	2
	NAT		IPC: MRSA Infections		Sigma	1	0	0	0	0	1	1	2	1	0	1	0
	NAT		IPC: MSSA Infections		Sigma	6	2	7	4	2	2	5	6	8	7	2	6
	NAT		Mixed Sex Breaches		Sigma	121	30	20	49	62	26	49	63	132	134	132	120
	NAT		FFT Satisfaction Level - ED		90.0%	83.5%	82.6%	84.1%	83.0%	81.3%	81.3%	81.5%	81.7%	80.9%	80.1%	80.5%	81.6%
	NAT		FFT Satisfaction Level - Outpatient		90.0%	95.0%	94.8%	95.2%	95.1%	95.2%	95.0%	95.1%	95.5%	95.5%	95.4%	95.2%	95.9%
	NAT		FFT Satisfaction Level - Inpatient		90.0%	88.9%	89.7%	89.8%	90.0%	88.8%	89.7%	87.7%	89.6%	90.1%	92.1%	89.9%	89.4%
	NAT		VTE Assessment Compliance		95.0%	88.6%	87.8%	88.0%	90.9%	91.2%	92.0%	92.1%	90.4%	91.6%	92.4%	92.4%	92.2%

Quality & Safety

Key Quality Indicators

East Kent Hospitals University NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Quality	KEY		Incidents - Moderate / Severe		Sigma	35	33	34	23	33	41	27	29	40	24		
	KEY		Overdue Incidents		0	3,340	2,938	2,395	2,669	2,980	3,353	3,293	3,614	2,986	1,663	1,358	822
	KEY		HSMR		96.0	94.7	94.0	92.1	91.3	89.8	87.4	85.4	88.4				
	KEY		Complaint Response		90.0%	68.9%	63.8%	63.2%	42.6%	33.3%	3.6%	5.0%	6.5%	9.7%	13.8%	17.7%	0.0%
	KEY		Complaints Number		Sigma	85	82	80	77	80	77	79	56	98	84	76	110

Serious Incidents

National Standard

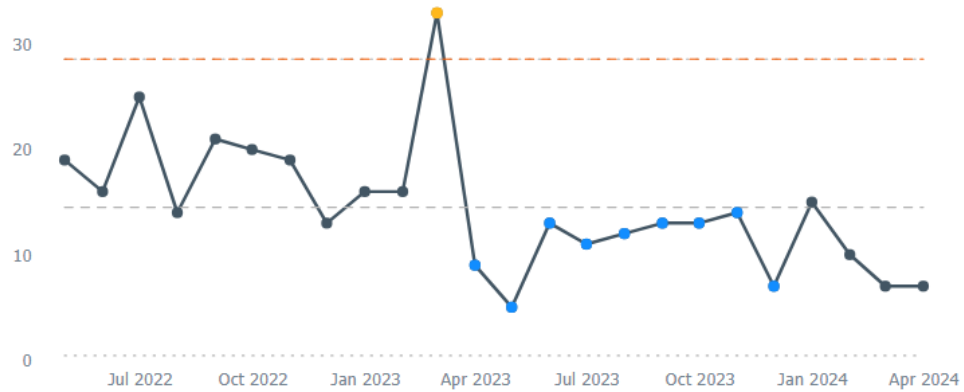
East Kent Hospitals University NHS Foundation Trust

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

Serious Incidents

Timescale	Value	SPC
May-23	5	
Jun-23	13	
Jul-23	11	
Aug-23	12	
Sep-23	13	
Oct-23	13	
Nov-23	14	
Dec-23	7	
Jan-24	15	
Feb-24	10	
Mar-24	7	
Apr-24	7	

XMR Run Chart



Understanding the most recent data point

Performance

7

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	Progress Update
• One Failure - to act on abnormal test results	• Sub-optimal care of deteriorating patient • Death referred to Coroner	• Care Group Leadership Team	• Within 60 days of each incident being reported on StEIS.	• These investigations are in progress.
• Two patient falls	• One subdural haemorrhage • One Subarachnoid haemorrhage	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• These investigations are in progress. • A falls summit has been organised to explore increase in number of harms from falls
Two delay in diagnosis	• Delayed diagnosis of PE resulting in patient death • Delay is identification of spinal epidural haematoma	• Care Group Leadership Team	• Within 60 days of each incident being reported on StEIS.	• This investigation is in progress.

Serious Incidents

National Standard

East Kent Hospitals University NHS Foundation Trust

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

StEIS Category	Issues Identified	OWNER	TIMESCALE	PROGESS UPDATE
One Maternity/Obstetric incident: mother only	• Probable avoidable abdominal surgery	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS.	• This investigations is in progress.
One Maternity/Obstetric incident: baby only	• Possible delay in escalation on identification of no FHB, leading to baby death.	• Care Group Leadership Teams	• Within 60 days of each incident being reported on StEIS	• Meets MNSI criteria.

Overdue Incidents

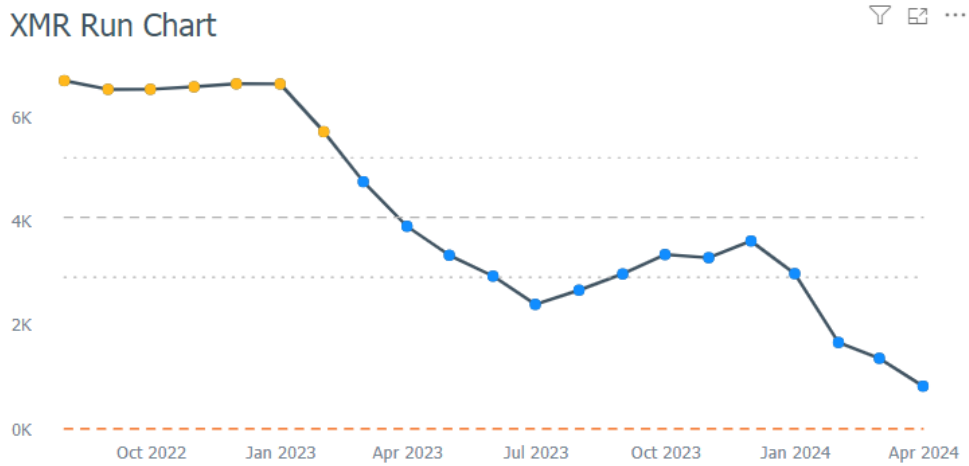
Key Quality Indicator

East Kent Hospitals University NHS Foundation Trust

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

Overdue Incidents

Timescale	Value	SPC
May-23	3,340	
Jun-23	2,938	
Jul-23	2,395	
Aug-23	2,669	
Sep-23	2,980	
Oct-23	3,353	
Nov-23	3,293	
Dec-23	3,614	
Jan-24	2,986	
Feb-24	1,663	
Mar-24	1,358	
Apr-24	822	



Understanding the most recent data point

Performance

822 — Variation indicates consistently falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The backlog of overdue incidents being investigated impacts on the timely learning from incidents report to prevent future harm.	• Additional support to close backlog now finished • The aim was to fully resolve the overdue incidents by 31/03/2023 and a significant reduction made. • As an average of 39 incidents are becoming overdue daily which is reduced from 60-80 in previous months, there is a risk in reaccumulating which has been escalated to CEMG.	• Director of Quality Governance	03/05/2024	The progress will continue to be monitored weekly with data being escalated via the weekly Quality Governance update report. Weekly meeting with the care group governance teams to maintain momentum in closing incidents.

Incidents Causing Harm

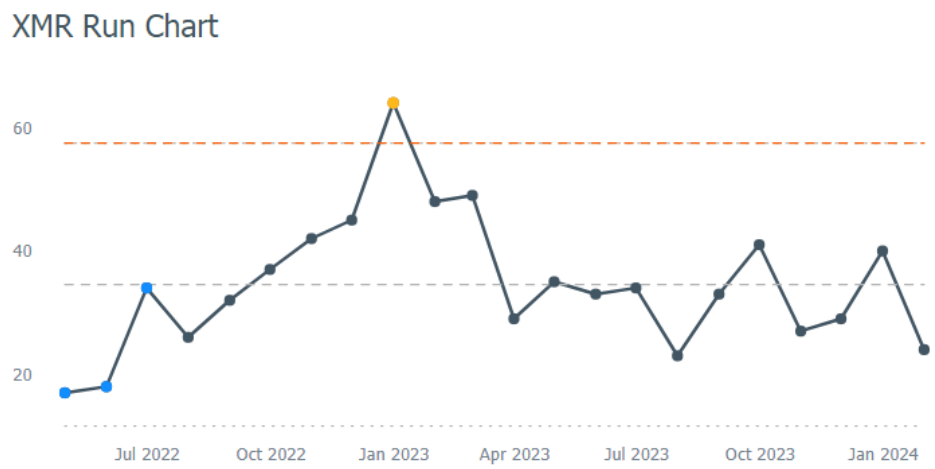
Key Quality Indicator

East Kent Hospitals University NHS Foundation Trust

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

Incidents - Moderate / Severe

Timescale	Value	SPC
Mar-23	49	
Apr-23	29	
May-23	35	
Jun-23	33	
Jul-23	34	
Aug-23	23	
Sep-23	33	
Oct-23	41	
Nov-23	27	
Dec-23	29	
Jan-24	40	
Feb-24	24	



Understanding the most recent data point

Performance

24

Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient had pre-chemo assessment at MTW where weight was recorded incorrectly and chemotherapy prescribed. Patient attended EKHUFT for chemotherapy to be administered. Not identified that weight incorrect and therefore higher dose given based on the prescription from MTW. Wrong weight was identified when patient was admitted with neutropoenia and tingling in hands and feet.	The incident was discussed at SIDP.As the correct pre-assessment process was followed and it is usual practice for the prescription at MTW to be administered at EKHUFT without re-assessment. For After Action Review (AAR) to be completed in collaboration with MTW to understand how the error occurred.	Cancer Matron.	June 2024	Collaboration with MTW commenced.
Patient's lower right leg was found to be cold, pale and swollen with purple toes following insertion of cannular in foot. Patient developed compartment syndrome for which surgery was required to relive pressure. Full recovery was made post surgery.	Cannular inserted by consultant in ED due to difficulty gaining access. Patient required urgent insulin IV and IV fluids to treat condition. Deemed not SI at SIDP as no omissions in care. Rare complication. For local investigation.	ED consultant	June 2024	DoC completed

Hospital Standardised Mortality Ratio (HSMR)

Key Quality Indicator

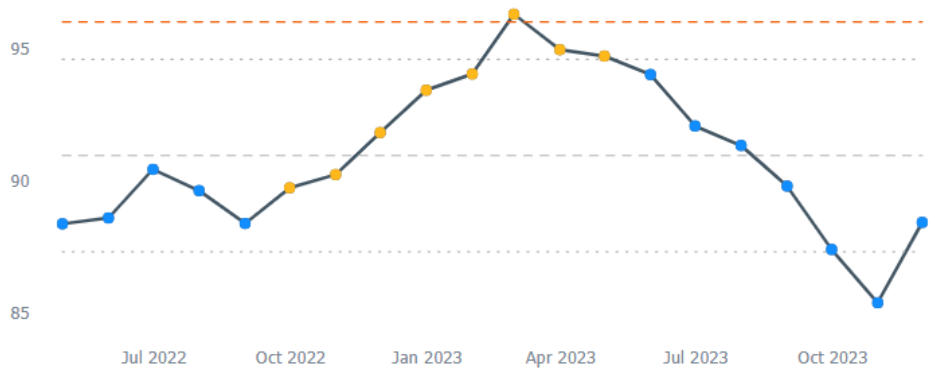
East Kent Hospitals University NHS Foundation Trust

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

HSMR

Timescale	Value	SPC
Jan-23	93.4	
Feb-23	94.0	
Mar-23	96.3	
Apr-23	94.9	
May-23	94.7	
Jun-23	94.0	
Jul-23	92.1	
Aug-23	91.3	
Sep-23	89.8	
Oct-23	87.4	
Nov-23	85.4	
Dec-23	88.4	

XMR Run Chart



Understanding the most recent data point

Performance

88.4	Variation indicates consistently passing the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
To agree, develop and implement a Trust-wide Fractured Neck of Femur Pathway that will address and improve the eight Key Performance Indicators on the National Hip fracture database	• Confirm comments from WHH regarding fast track process • Launch ring fencing/fast track pilot on Seabathing & Kings C1	• KCVH CG	• Ongoing	• Work to understand and mitigate risks of recent rise in mortality and identification of surgical site infection is complete. No definitive links identified. .
HSMR by site of discharge (January update): • K&C remains statistically lower than expected: 68.6 • QEQM improved to 'lower than expected': 91.2 • WHH remains 'as expected': 99.0	• Compare new data (January report) with previous and incorporate into current workstreams • Review impact of higher than avg patient complexity (Charlson Comorbidity) score.	• CMO	• Ongoing	• Identified at previous MSSG meeting for further investigation analysis.
WHH Relative Risk is statistically higher than expected for emergency weekday admissions for Acute MI and Pleurisy, pneumothorax, pulmonary collapse. It is also statistically higher than expected for emergency weekend admissions for Skin and subcutaneous tissue infections	• Continue to review and analyse data in MSSG • Identify any areas of concern and develop countermeasures for this to address relative risk above 100.	• CMO	• Ongoing	• Analysis ongoing • Progress noted at March MSSG but not able to finalise analysis at present. Further data requested.

VTE Assessment Compliance

National Standard

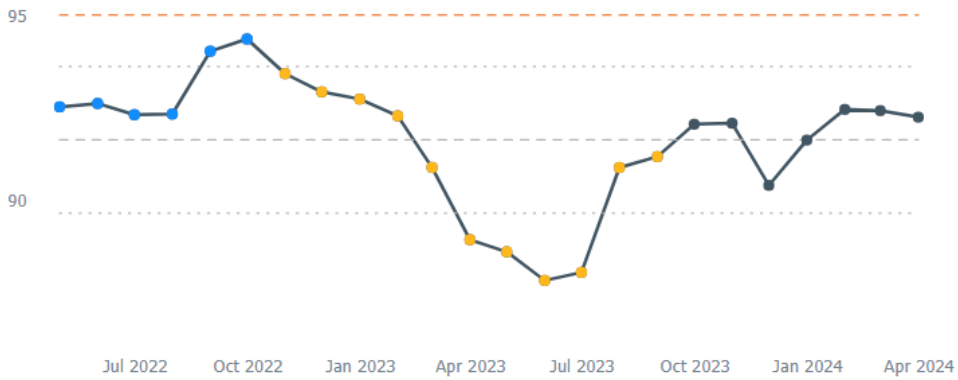
East Kent Hospitals University NHS Foundation Trust

This metric counts the proportion of adults (16+) who have had a Venous Thromboembolism (VTE) risk assessment at any point during their admission. The measure assumes patients in the following cohorts are automatically assigned as compliant; 1. Patients admitted for less than 6 hours, 2. Low-Risk cohort day case patients, 3. Acute medical unit (previously clinical decision units) admissions less than 13 hours & 4. Observation bay admissions less than 24hrs.

VTE Assessment Compliance

Timescale	Value	SPC
May-23	88.6%	
Jun-23	87.8%	
Jul-23	88.0%	
Aug-23	90.9%	
Sep-23	91.2%	
Oct-23	92.0%	
Nov-23	92.1%	
Dec-23	90.4%	
Jan-24	91.6%	
Feb-24	92.4%	
Mar-24	92.4%	
Apr-24	92.2%	

XMR Run Chart



Understanding the most recent data point

Performance

92.2%

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
VTE is not currently a mandatory form on Sunrise	• Clinical Design Authority have approved this change and process to follow to ensure this is progressed • Initial trial on inserting doc into daily clerking form were not an option • Next trial is also with clerking documents but is a confirmation field only (this will probably not affect compliance) • Final trials will be on ePMA system as MTW recommended	• Michael Jackson	• June 2024	• Awaiting updates regarding progressing mandatory form for Sunrise • National reporting re-commences July • Trust wide Improvement Plan for VTE developed from A3 focusing on VTE risk assessment
Awareness and training needs have been identified that will influence this metric. Training on this issue is not currently mandatory.	• Thrombosis group work with learning and development to deliver a VTE mandatory training session. • Multiple routes for education and awareness delivered through Thrombosis group	• Michael Jackson	• June 2024	• Awaiting update at next Thrombosis meeting in June
Women's Health VTE IP	• Guidelines on VTE treatment under review. • PIL re VTE has been developed • EDN Maternity compulsory from 18/6/24 (this should increase compliance)	• Michael Jackson	• Juiy 2024	• Awaiting update at next WH & VTE meeting

Incident Reporting

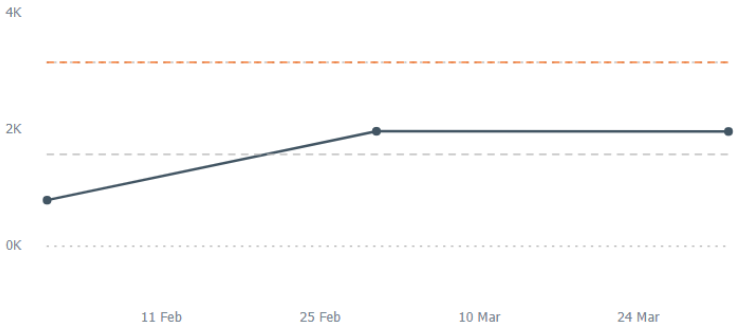
National Standard

East Kent Hospitals University NHS Foundation Trust

Patient Incidents

Timescale	Value	SPC
Feb-24	763	
Mar-24	1,948	
Apr-24	1,944	

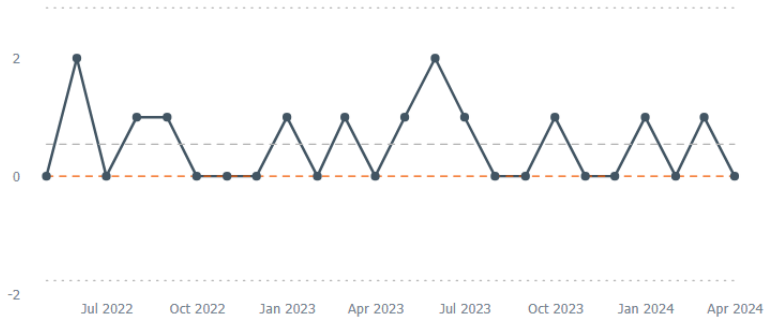
XMR Run Chart



Never Events

Timescale	Value	SPC
May-23	1	
Jun-23	2	
Jul-23	1	
Aug-23	0	
Sep-23	0	
Oct-23	1	
Nov-23	0	
Dec-23	0	
Jan-24	1	
Feb-24	0	
Mar-24	1	
Apr-24	0	

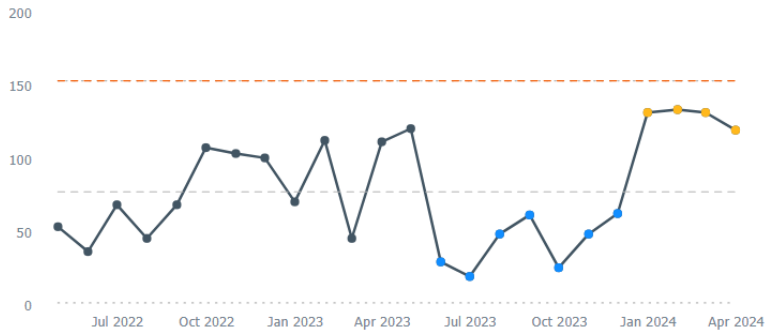
XMR Run Chart



Mixed Sex Breaches

Timescale	Value	SPC
May-23	121	
Jun-23	30	
Jul-23	20	
Aug-23	49	
Sep-23	62	
Oct-23	26	
Nov-23	49	
Dec-23	63	
Jan-24	132	
Feb-24	134	
Mar-24	132	
Apr-24	120	

XMR Run Chart



PERFORMANCE UPDATE

The way incidents are categorised changed on 13 February 2024 in line with LFPSE which has resulted in partial data for the month of February 2024. March 2024 shows a complete month for the revised metric, Patient Safety Incidents.

The appearance of slight drop in reporting levels is attributed to fact that now there are 4 options for reporting incidents (patient, staff, visitor, organisation). Incidents previous reported as clinical incidents are now being reported under other categories like organisation. The total number of incidents in unchanged from the normal variation.

There were nil never events in April 2024.

Duty of Candour

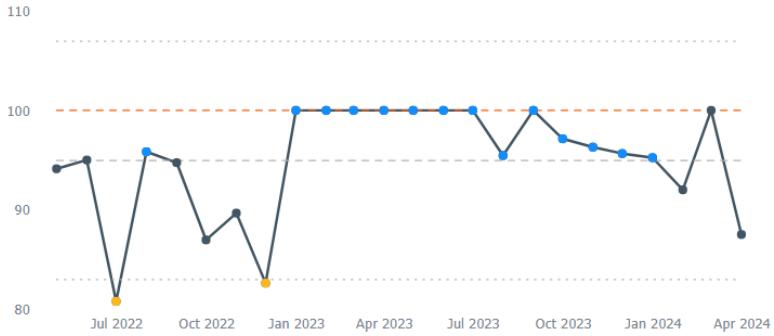
National Standard

East Kent Hospitals University NHS Foundation Trust

Duty of Candour - Verbal

Timescale	Value	SPC
May-23	100%	
Jun-23	100%	
Jul-23	100%	
Aug-23	95.5%	
Sep-23	100%	
Oct-23	97.1%	
Nov-23	96.3%	
Dec-23	95.7%	
Jan-24	95.2%	
Feb-24	92.0%	
Mar-24	100%	
Apr-24	87.5%	

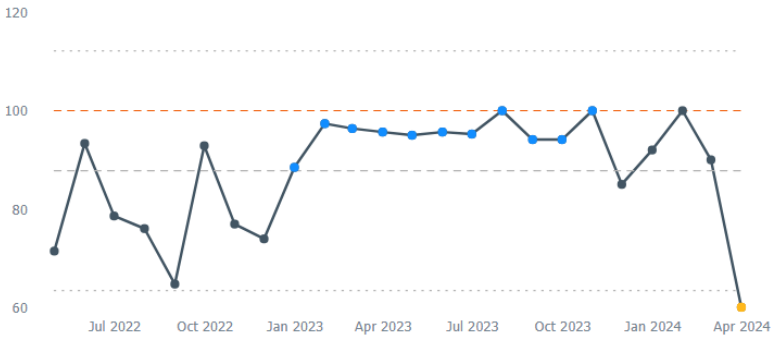
XMR Run Chart



Duty of Candour - Written 15wd

Timescale	Value	SPC
May-23	95.0%	
Jun-23	95.7%	
Jul-23	95.2%	
Aug-23	100%	
Sep-23	94.1%	
Oct-23	94.1%	
Nov-23	100%	
Dec-23	85.0%	
Jan-24	92.0%	
Feb-24	100%	
Mar-24	90.0%	
Apr-24	60.0%	

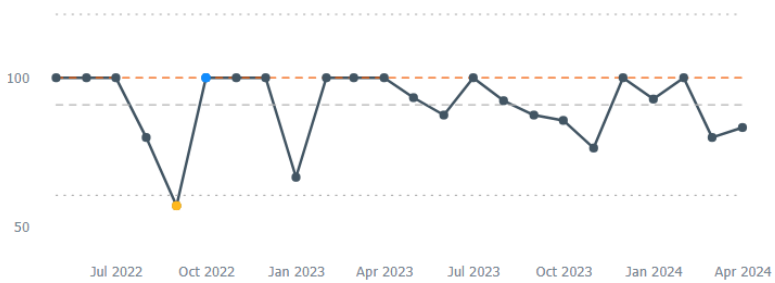
XMR Run Chart



Duty of Candour - Findings

Timescale	Value	SPC
May-23	93.3%	
Jun-23	87.5%	
Jul-23	100%	
Aug-23	92.3%	
Sep-23	87.5%	
Oct-23	85.7%	
Nov-23	76.5%	
Dec-23	100%	
Jan-24	92.9%	
Feb-24	100%	
Mar-24	80.0%	
Apr-24	83.3%	

XMR Run Chart



PERFORMANCE UPDATE

The Trust achieved 87.5% compliance for verbal duty of candour in April, with 1 out of 8 verbal conversions taking place outside of the 10 day timeframe, but has been completed.

Written duty of candour letters had 60% compliance rate in April. (2 out of 5 incidents having DoC completed outside of 10 day timeframe, but both have since been completed.

For Serious Incident cases submitted to the ICB (12 cases), the final duty of candour letter with findings shared, was 83.3% compliant in April. (2 case's breached the timeframe, but both have since been sent).

Twice weekly meetings between Governance leads and Heads of Patient Safety continue to address non-compliance and barriers to completion.

There has been an issue with the accuracy of data due to changes in the LFPSE fields on Datix, which are not showing accurately the status of each case. A data validation exercise will be completed to identify and address anomalies.

Complaints

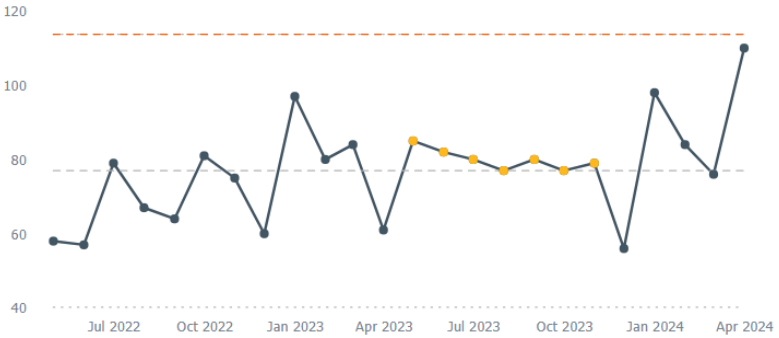
Key Quality Indicators

East Kent Hospitals University NHS Foundation Trust

Complaints Number

Timescale	Value	SPC
May-23	85	
Jun-23	82	
Jul-23	80	
Aug-23	77	
Sep-23	80	
Oct-23	77	
Nov-23	79	
Dec-23	56	
Jan-24	98	
Feb-24	84	
Mar-24	76	
Apr-24	110	

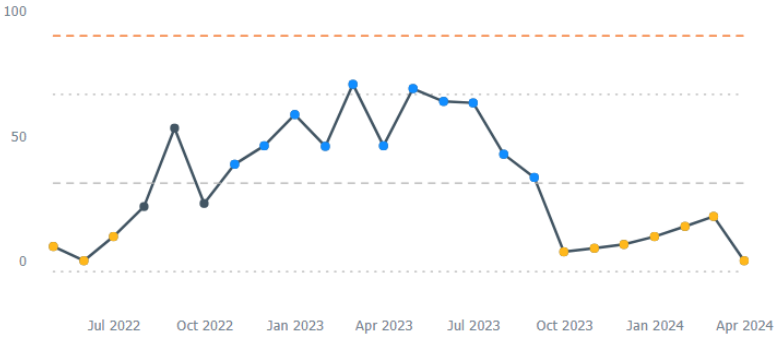
XMR Run Chart



Complaint Response

Timescale	Value	SPC
May-23	68.9%	
Jun-23	63.8%	
Jul-23	63.2%	
Aug-23	42.6%	
Sep-23	33.3%	
Oct-23	3.6%	
Nov-23	5.0%	
Dec-23	6.5%	
Jan-24	9.7%	
Feb-24	13.8%	
Mar-24	17.7%	
Apr-24	0.0%	

XMR Run Chart



PERFORMANCE UPDATE

April 2024 saw 1109 contacts to the department resulting in 106 new formal complaints and 530 new PALS contacts being taken forward. 10% of contacts in April 2024 were taken forward as new formal complaints. 97% of the new complaints were acknowledged within three working days, this is above the target of 90%.

As a seasonal comparison, in April 2023 there were 64 complaints and 530 PALS. A 70% increase in new complaints and a 26% increase in new PALS cases. The increase in complaints follows the trend being seen, however this large increase is unprecedented. We have been unable to identify a particular service area, or trend to account for the increase.

The increase in PALS contacts can be attributed to patients contacting PALS to make changes to their demographic information e.g. change of name, address, GP surgery. A new process has been implemented to ensure appropriate security checks are undertaken before such changes are made to patient records.

April 2024 saw a decrease in performance of responses within timescales from 15% in March to 0%. The centralisation of the complaints staff had an impact on performance. A plan is in place to embed the new process and staff, this includes a trajectory for responses; to complete all drafts due on, or before 30 April, by 28 June 2024.

Safeguarding

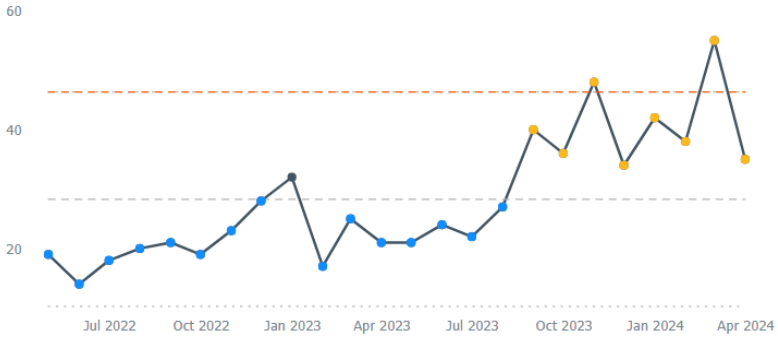
National Standard

East Kent Hospitals University NHS Foundation Trust

Safeguarding Incidents

Timescale	Value	SPC
May-23	21	
Jun-23	24	
Jul-23	22	
Aug-23	27	
Sep-23	40	
Oct-23	36	
Nov-23	48	
Dec-23	34	
Jan-24	42	
Feb-24	38	
Mar-24	55	
Apr-24	35	

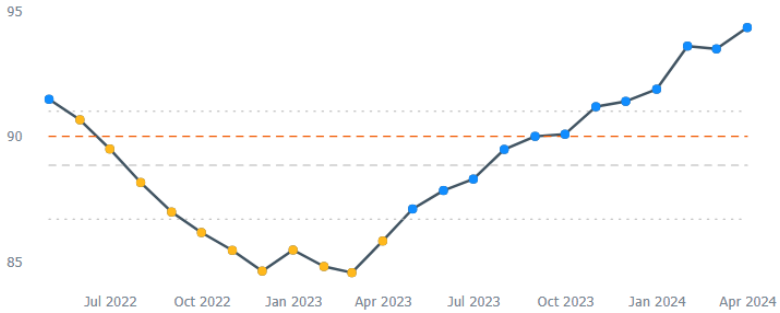
XMR Run Chart



Safeguarding Children Training

Timescale	Value	SPC
May-23	87.1%	
Jun-23	87.8%	
Jul-23	88.3%	
Aug-23	89.5%	
Sep-23	90.0%	
Oct-23	90.1%	
Nov-23	91.2%	
Dec-23	91.4%	
Jan-24	91.9%	
Feb-24	93.6%	
Mar-24	93.5%	
Apr-24	94.3%	

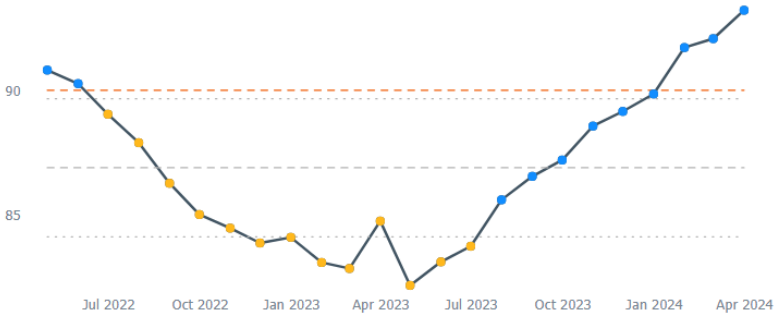
XMR Run Chart



Safeguarding Adults Training

Timescale	Value	SPC
May-23	82.2%	
Jun-23	83.1%	
Jul-23	83.7%	
Aug-23	85.6%	
Sep-23	86.5%	
Oct-23	87.2%	
Nov-23	88.6%	
Dec-23	89.1%	
Jan-24	89.8%	
Feb-24	91.7%	
Mar-24	92.1%	
Apr-24	93.2%	

XMR Run Chart



PERFORMANCE UPDATE

The reporting of all safeguarding metrics is outlined in the Business report and safeguarding dashboard with KPIs. This report goes to the Safeguarding Operational Group with exception to the Safeguarding Assurance Committee. Safeguarding metrics were also reported in Schedule 4 we are just completing Q4 for submission to the ICB.

The Safeguarding activity increased for children but has remained stable for adults . The highest category of incidents related to pressure sores and poor discharge .

Following the last report, the outstanding S42s have reduced a further meeting took place around the interface between the safeguarding team and the local authority

Care groups alongside the Safeguarding team are now completing safeguarding investigations the team are completing a SOP to support this work

Safeguarding supervision for case holder's remains an area for improvement

Training is over the required 85% for children's Level 1,2,3,4 and adults level 1,2,3,4

Progress against the safeguarding sustainability plan is presented monthly at the ICB oversight meetings these are now under NOF3

IPC - Infections

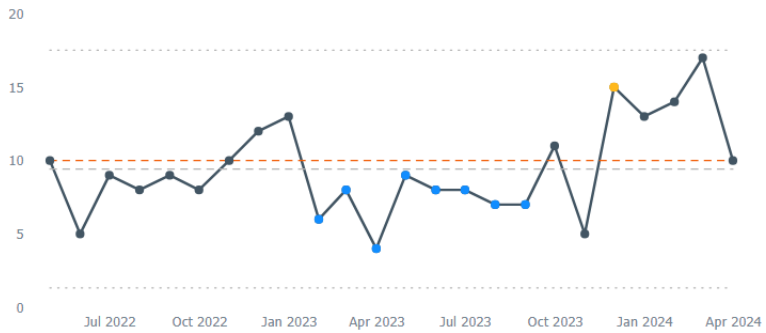
National Standard

East Kent Hospitals University NHS Foundation Trust

IPC: EColi Infections

Timescale	Value	SPC
May-23	9	
Jun-23	8	
Jul-23	8	
Aug-23	7	
Sep-23	7	
Oct-23	11	
Nov-23	5	
Dec-23	15	
Jan-24	13	
Feb-24	14	
Mar-24	17	
Apr-24	10	

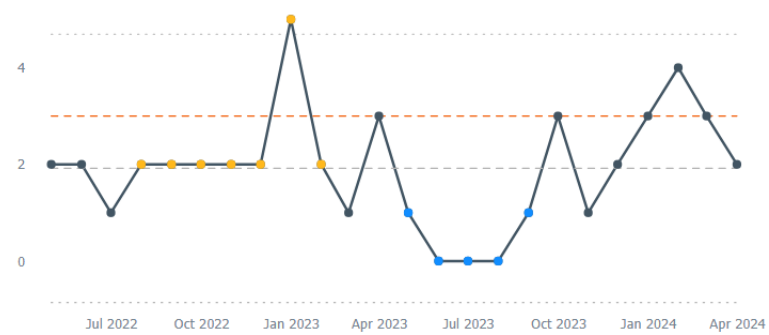
XMR Run Chart



IPC: Pseudomonas Infections

Timescale	Value	SPC
May-23	1	
Jun-23	0	
Jul-23	0	
Aug-23	0	
Sep-23	1	
Oct-23	3	
Nov-23	1	
Dec-23	2	
Jan-24	3	
Feb-24	4	
Mar-24	3	
Apr-24	2	

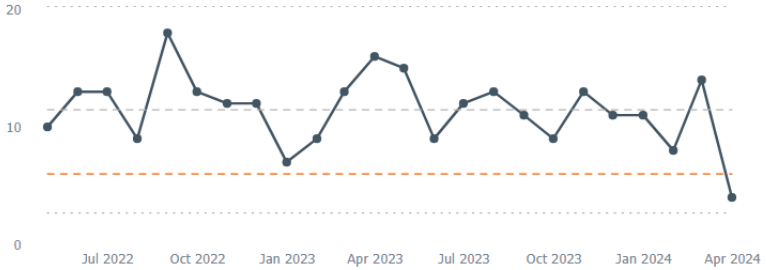
XMR Run Chart



IPC: CDiff Infections

Timescale	Value	SPC
May-23	15	
Jun-23	9	
Jul-23	12	
Aug-23	13	
Sep-23	11	
Oct-23	9	
Nov-23	13	
Dec-23	11	
Jan-24	11	
Feb-24	8	
Mar-24	14	
Apr-24	4	

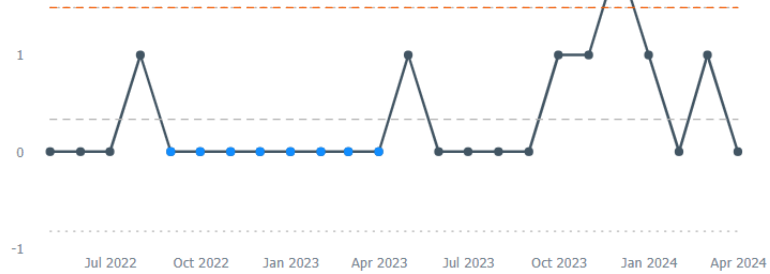
XMR Run Chart



IPC: MRSA Infections

Timescale	Value	SPC
May-23	1	
Jun-23	0	
Jul-23	0	
Aug-23	0	
Sep-23	0	
Oct-23	1	
Nov-23	1	
Dec-23	2	
Jan-24	1	
Feb-24	0	
Mar-24	1	
Apr-24	0	

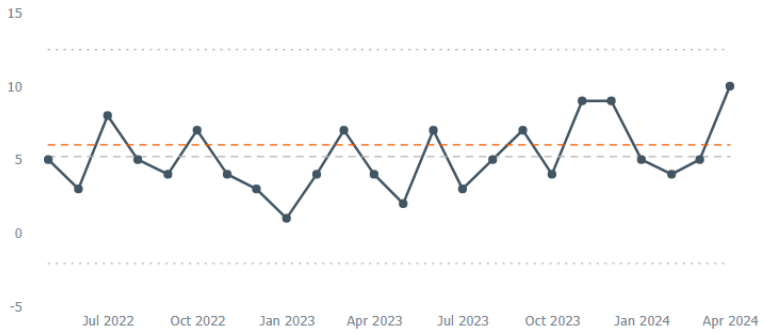
XMR Run Chart



IPC: Klebsiella Infections

Timescale	Value	SPC
May-23	2	
Jun-23	7	
Jul-23	3	
Aug-23	5	
Sep-23	7	
Oct-23	4	
Nov-23	9	
Dec-23	9	
Jan-24	5	
Feb-24	4	
Mar-24	5	
Apr-24	10	

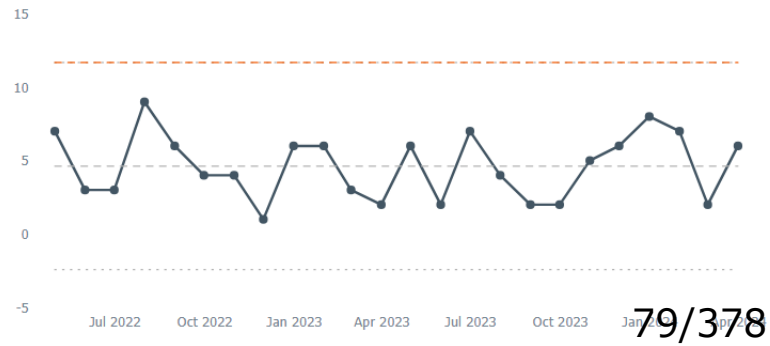
XMR Run Chart



IPC: MSSA Infections

Timescale	Value	SPC
May-23	6	
Jun-23	2	
Jul-23	7	
Aug-23	4	
Sep-23	2	
Oct-23	2	
Nov-23	5	
Dec-23	6	
Jan-24	8	
Feb-24	7	
Mar-24	2	
Apr-24	6	

XMR Run Chart



IPC - Infections

National Standard

East Kent Hospitals University NHS Foundation Trust

PERFORMANCE UPDATE

The 2024/25 thresholds have not yet been published, therefore the Trust are following the 2023/24 thesholds until new thresholds published

The formal reporting has now changed, and a patients inpatient stay is now measured from the time the ED team report 'decision to admit' and therefore the number of Hospital onset cases are likely to appear to have increased, owing to the time in ED being counted (previously the reporting timeframe started from the time and date a person was admitted to an inpatient bed on a ward) This means that a year on year comparison will not be possible, and our rates may incorrectly appear to have increased (we will report 'new reporting' for all cases that would previously not have been reported to allow comparison)

Gram negative Blood stream infections:
Pseudomonas infections continue to be significantly below threshold,
E-coli in April was exactly on the threshold (1 case reported due to new criteria)
Klebsiella in April was significantly above threshold with 10 reported (1 due to new definitions)

May is the month where the IPC team will be focussing on care of invasive 'lines' and these are most associated with the gram negative infections. The Klebsiella cases in April were predominantly due to urinary tract infections – so focus will also be hydration .

Clostridioides difficile
Whilst 2023/24 year end was significantly over threshold, April saw a significant reduction in cases, with just 4 cases reported. The IPC team continue to focus on the stool assessment tool and raise awareness of importance of antimicrobial stewardship

Staphylococcal blood stream infections:
MSSA bacteraemias continue to be within internal parameters, reporting 1 case above threshold – however there was one case reported using the new rule. There were no MRSA bacteraemias in April.

Incidents and Outbreaks:
There were 5 norovirus and one COVID outbreak in April.

IPC – Training Compliance

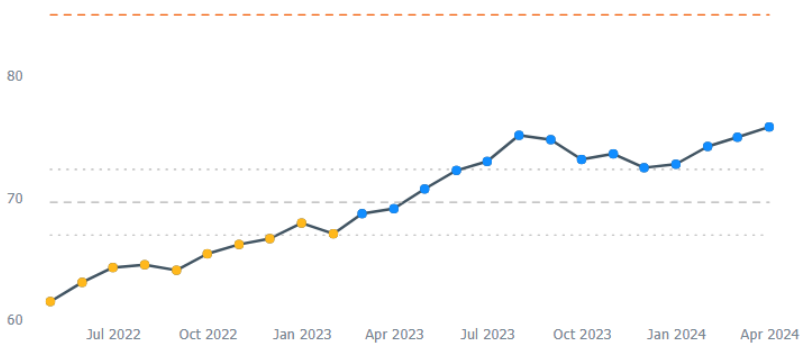
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

Hand Hygiene Training

Timescale	Value	SPC
May-23	70.7%	
Jun-23	72.2%	
Jul-23	73.0%	
Aug-23	75.1%	
Sep-23	74.7%	
Oct-23	73.1%	
Nov-23	73.6%	
Dec-23	72.4%	
Jan-24	72.7%	
Feb-24	74.2%	
Mar-24	74.9%	
Apr-24	75.8%	

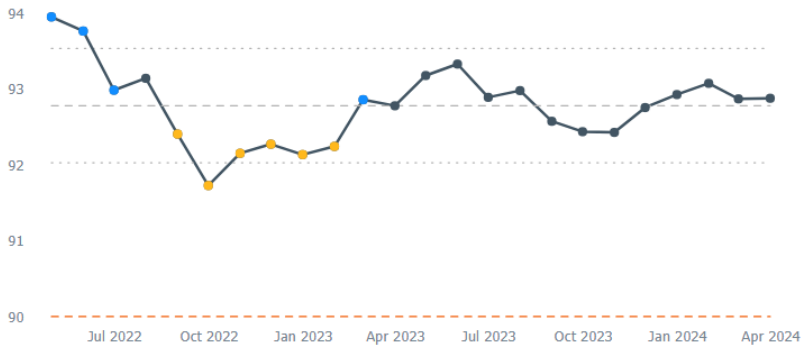
XMR Run Chart



Infection Control Training

Timescale	Value	SPC
May-23	93.2%	
Jun-23	93.3%	
Jul-23	92.9%	
Aug-23	93.0%	
Sep-23	92.6%	
Oct-23	92.4%	
Nov-23	92.4%	
Dec-23	92.8%	
Jan-24	92.9%	
Feb-24	93.1%	
Mar-24	92.9%	
Apr-24	92.9%	

XMR Run Chart



PERFORMANCE UPDATE

The Trust compliance with Infection prevention and control training remains at a good level , the IPC team are supporting areas where compliance is lower.

Hand Hygiene training is undertaken annually by all patient facing staff, rates continue to fluctuate, The IPC team have focussed on hand hygiene specifically in April, and there is a continued upturn in compliance. Focus continues on ensuring link workers are able to training staff, and upload compliance directly to ESR.

Friends & Family Test

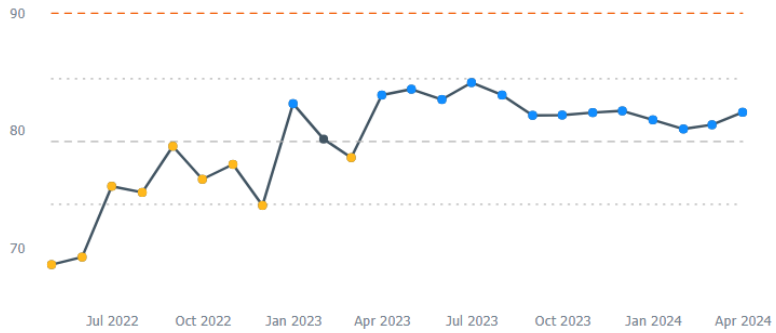
Statutory Metrics

East Kent Hospitals University NHS Foundation Trust

FFT Satisfaction Level - ED

Timescale	Value	SPC
May-23	83.5%	
Jun-23	82.6%	
Jul-23	84.1%	
Aug-23	83.0%	
Sep-23	81.3%	
Oct-23	81.3%	
Nov-23	81.5%	
Dec-23	81.7%	
Jan-24	80.9%	
Feb-24	80.1%	
Mar-24	80.5%	
Apr-24	81.6%	

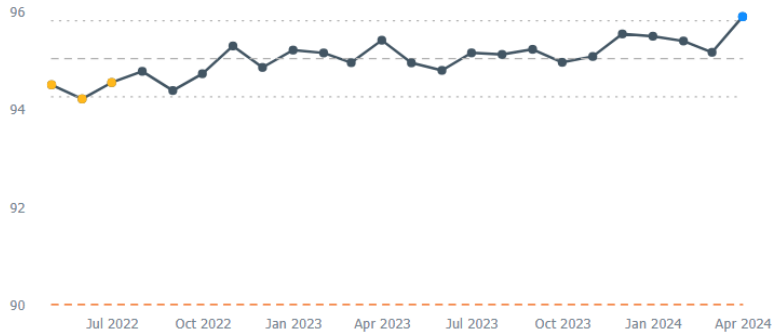
XMR Run Chart



FFT Satisfaction Level - Outpatient

Timescale	Value	SPC
May-23	95.0%	
Jun-23	94.8%	
Jul-23	95.2%	
Aug-23	95.1%	
Sep-23	95.2%	
Oct-23	95.0%	
Nov-23	95.1%	
Dec-23	95.5%	
Jan-24	95.5%	
Feb-24	95.4%	
Mar-24	95.2%	
Apr-24	95.9%	

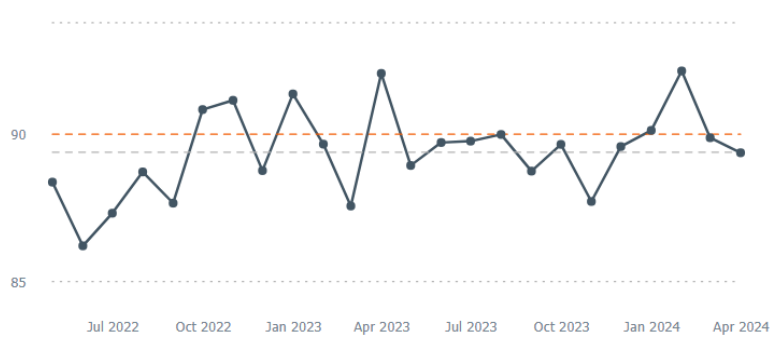
XMR Run Chart



FFT Satisfaction Level - Inpatient

Timescale	Value	SPC
May-23	88.9%	
Jun-23	89.7%	
Jul-23	89.8%	
Aug-23	90.0%	
Sep-23	88.8%	
Oct-23	89.7%	
Nov-23	87.7%	
Dec-23	89.6%	
Jan-24	90.1%	
Feb-24	92.1%	
Mar-24	89.9%	
Apr-24	89.4%	

XMR Run Chart



PERFORMANCE UPDATE

The trust's overall satisfaction level has remained over our target level of 90% for the past two years. **In April 2024 it was 93.5%.** Looking at overall satisfaction by hospital Care Groups, it varied from 90.9% for WHH Care Group, 91.7% at QEQM Care Group and 95.8% for K&CH Care Group.

For Urgent and Emergency Care our FFT satisfaction level was 81.6% overall, which is a slight increase. This is based on **2,926 responses** – 14% of those sent the survey. When breaking this down by site, QEQM ED scored 78.1% (a decrease), William Harvey ED scored 77.8% (a decrease), K&CH Urgent Treatment Centre scored 90.5% (a significant increase), and Buckland UTC scored 94.8% (a significant increase).

For out-patients, the satisfaction level was 95.9% overall, a slight increase. This is based on **13,753 responses** – 21.1% of people sent the FFT survey. The Satisfaction levels ranged from 97.2% at Buckland Hospital, 96.1% at Kent and Canterbury, 96% at Royal Victoria Hospital, 95.8% at QEQM and 95.2% at William Harvey Hospital. Looking at the themes of comments on FFT surveys, top positive themes were care given by staff sand staff attitude. Top negative themes were time waiting to be seen on site, poor communication, and poor administration.

For in-patients, the overall satisfaction score across the three sites was 89.4%, a further decrease compared to March and February. This is based on **965 responses**, which is 18.3% of those sent the FFT survey. The highest satisfaction level for in-patients was 92.7% (a decrease) at Kent and Canterbury, followed by 91.2% at QEQM (an improvement) and 86.2% at William Harvey (an improvement). Patient comments on FFT surveys shows that patients are satisfied with care given by staff and staff attitude but remain dissatisfied with communication and the discharge process.

How we compare with national data:
The most recent national data available is for March 2024. For Emergency Departments, Urgent Treatment Centres and Minor Injury Units the overall satisfaction level **nationally is 78%.** This means our Urgent and Emergency Care satisfaction level is 3.6% higher than nationally. For in-patient care, the **national** satisfaction level is **94%** and for outpatient care it is **94%.** Therefore, our satisfaction level for in-patients in April is **4% lower** and for out-patients remains over **2% higher.**

Friends and Family Test free text comments: the qualitative data (patient's comments) is a rich source of insight that satisfaction levels alone do not give. Our FFT Theming Tracker enables our services to theme free text comments as positive or negative and by subject. In April 2024 over 5,000 comments were themed. The top three positive themes were care given by staff, staff attitude and quality of treatment. The top negative themes were waiting time to be seen on site, poor communication and information, and poor administration.

People

People, Leadership & Culture

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
People	NAT		Sickness		5.0%	4.0%	4.1%	4.6%	4.7%	4.9%	5.2%	5.2%	5.5%	5.4%	4.6%	4.5%	4.7%
	NAT		Vacancy Rate		10.0%	8.2%	7.9%	7.2%	7.9%	7.4%	6.7%	7.5%	7.7%	7.9%	8.4%	8.7%	10.1%
	NAT		Staff Turnover Rate		10.0%	9.7%	9.6%	9.5%	9.2%	9.0%	9.1%	9.1%	9.3%	9.2%	9.2%	9.2%	9.3%
	NAT		Premature Turnover Rate		25.0%	14.1%	14.0%	13.8%	13.7%	13.3%	13.6%	13.9%	14.7%	14.1%	14.5%	14.9%	14.6%
	KEY		Appraisals Compliance		80.0%	67.4%	66.8%	72.4%	73.0%	73.3%	72.6%	72.9%	72.4%	73.9%	73.6%	73.8%	76.6%
	IIP		Staff Engagement Score		6.80	6.20	6.20	6.27	6.27	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70
	NAT		Statutory Training		91.0%	91.9%	91.9%	91.7%	92.1%	91.9%	90.1%	90.6%	90.8%	91.4%	91.9%	92.0%	92.2%
	KEY		Infection Control Training		90.0%	93.2%	93.3%	92.9%	93.0%	92.6%	92.4%	92.4%	92.8%	92.9%	93.1%	92.9%	92.9%
	KEY		Hand Hygiene Training		85.0%	70.7%	72.2%	73.0%	75.1%	74.7%	73.1%	73.6%	72.4%	72.7%	74.2%	74.9%	75.8%
	KEY		Medical Job Planning Rate		90.0%	50.4%	50.5%	58.7%	52.3%	58.1%	60.3%	58.3%	58.8%	61.1%	70.5%	45.3%	45.3%

April Performance Summary

People Metrics: Sickness absence has improved following the introduction of on-site clinical psychology and now sits below the alerting threshold. Episodes of stress, anxiety and depression have fallen from 254 in January to 220 in April and there has been a measurable reduction in psychological distress (as per the CORE10 instrument). This has led to an estimated financial saving of £115,947.86 across the first 2 months of the service. Vacancy rate has risen considerably to 10.1%, breaching the alerting threshold. This increase has been primarily due to a deliberate holding of vacancies as part of the review of Admin & Clerical establishments. Staff turnover remains stable (9.3%) and continues to achieve the desired industry 'gold' standard (≤10%). Premature turnover has improved to 14.6% and remains within the desired parameters (≤15%). Statutory training rates have been on an upward trajectory since October 2023 and now exceed the desired threshold at 92.2%. Compliance for medical staff is below the expected threshold, but is on an upward trajectory (at 78.1%). Infection control training remains stable at/around 93%. Hand hygiene training is below the desired threshold but continues to improve month on month (up 0.9%). Medical job planning rates remain at 45.3%. This appears due to the migration and new Job Planning round.

Engagement Metrics: Staff engagement levels fell by 43 points to 5.70 in April and represent a historic low. The primary driver of this is advocacy, with a minority of staff recommending the organisation as a place to work or be treated. Staff advocacy levels are the lowest in the country and have fallen further in the latest national quarterly pulse survey (to 4.99). Currently, only 30% of staff would recommend the organisation as a place to work; 43% would not. This is based on 2,485 respondents, with the response rate (25%) 4% ahead of the national average (21%). People Plans are being developed to tackle the engagement challenge at a local level, with actions also being proposed following analysis of free text comments from the national staff survey.

Leadership Metrics: 121 leaders have completed the new leadership programmes, with a further 138 leaders currently on-programme. 246 leaders have been trained in Team Engagement and Development (TED). A further 248 leaders have been trained in Wellbeing Conversation training for managers. Compassionate leadership has improved by 13 points to 6.77 (from 6.64). Line managers are responsible for 70% of the variance in staff engagement, and so achieving a critical mass of those trained in compassionate and collaborative leadership is critical. Further work in this space includes the development of a leadership strategy and the introduction of a leadership development framework, alongside further leadership modules

Staff Sickness

National Standard

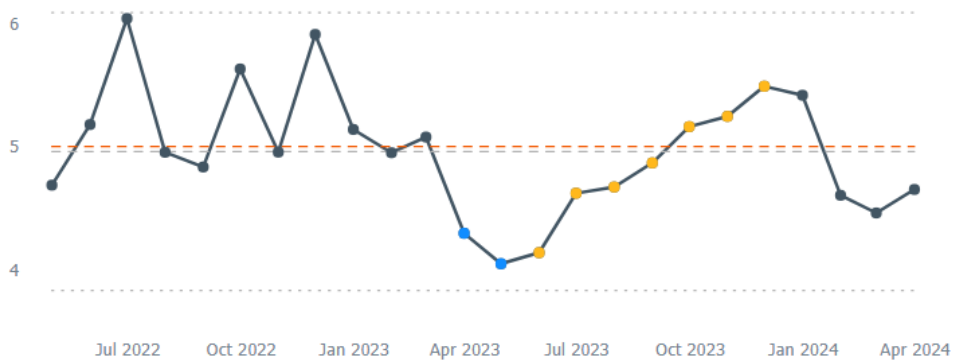
East Kent Hospitals University NHS Foundation Trust

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

Sickness

Timescale	Value	SPC
May-23	4.0%	
Jun-23	4.1%	
Jul-23	4.6%	
Aug-23	4.7%	
Sep-23	4.9%	
Oct-23	5.2%	
Nov-23	5.2%	
Dec-23	5.5%	
Jan-24	5.4%	
Feb-24	4.6%	
Mar-24	4.5%	
Apr-24	4.7%	

XMR Run Chart



Understanding the most recent data point

Performance

4.7%

Variation indicates inconsistently passing and falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **sickness absence** below 5%, and improved against our fellow Trusts in the ICB	• Working with NHSEI on the Absence Tool Kit to review current sickness management processes and develop actions for improvement.	• Heads of P&C, P&CBPs	• July 24 – ongoing	• "One Stop Shops" being developed to support line managers in brief refreshers on sickness absence, appraisal and health & wellbeing management.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	• Heads of P&C, P&CBPs, OH	• Ongoing	• Pro-Active Sickness Absence Working Group set up, improved support through EAP for anxiety and reintroduction of Clinical Psychology from February 24. Advertising and promoting the service
Improved pro-active absence management	• New P&C Care Group Teams to focus on absences through a Care Group deep dive, and P&C support.	• P&C Care Group Teams	• Ongoing	• Additional resource added in for 12 month focus on Sickness Absence with each Care Group identifying the target areas. Two key areas of focus (ED WHH and Maternity WHH) have supported a drop in sickness absence compared to the rest of the Trust.

Staff Vacancy Rate

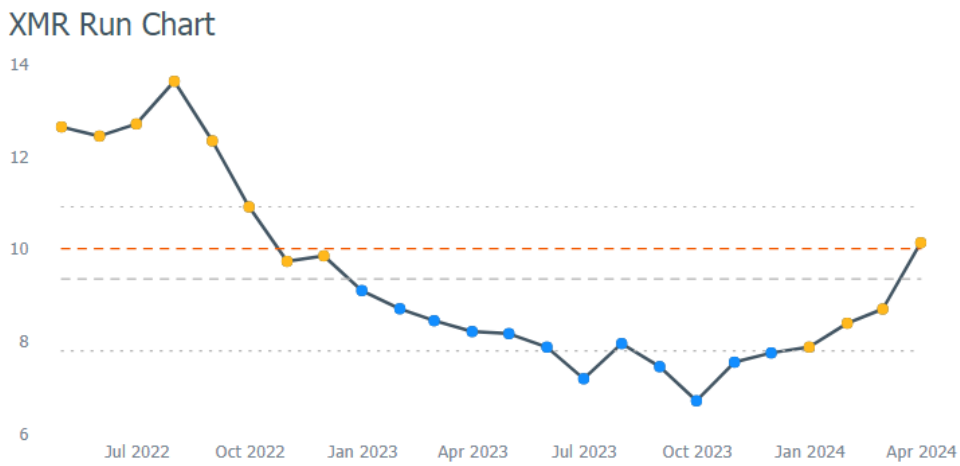
National Standard

East Kent Hospitals University NHS Foundation Trust

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

Vacancy Rate

Timescale	Value	SPC
May-23	8.2%	
Jun-23	7.9%	
Jul-23	7.2%	
Aug-23	7.9%	
Sep-23	7.4%	
Oct-23	6.7%	
Nov-23	7.5%	
Dec-23	7.7%	
Jan-24	7.9%	
Feb-24	8.4%	
Mar-24	8.7%	
Apr-24	10.1%	



Understanding the most recent data point

Performance

10.1%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Ascending Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place.	• Heads of P&C • P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working.
Reduction in Premium Pay by focusing on hard to recruit roles.	• Workforce Strategies developed for care Groups, focusing on those areas with hard to recruit posts, and a plan to address this.	• Strategic Workforce Lead • Heads of P&C • P&CBPs	• Ongoing	• Hard to recruit roles out to advert with social media campaigns. Support from ID Medical. ID Medical meeting with HOP&C and care Group Tri's to target areas for improvement.
Minimising risk of turnover by improving retention and reducing time to hire.	• Focus on time to hire, with Dashboard set up to monitor.	• Head of Resourcing	• Ongoing	• Time to hire reduced to 8 weeks. • Overall Nursing & Midwifery vacancy rate improved. • A&C vacancy rate increased as roles are held for pending review.

Staff Turnover Rate

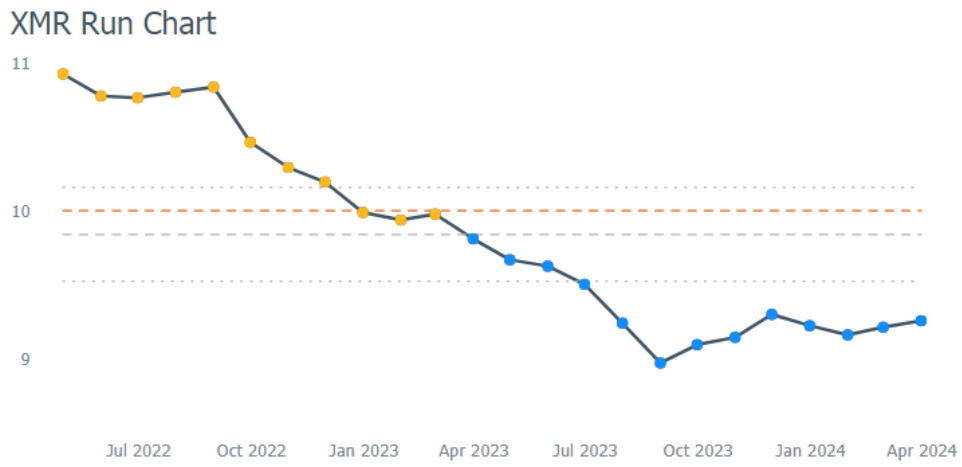
National Standard

East Kent Hospitals University NHS Foundation Trust

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

Staff Turnover Rate

Timescale	Value	SPC
May-23	9.7%	
Jun-23	9.6%	
Jul-23	9.5%	
Aug-23	9.2%	
Sep-23	9.0%	
Oct-23	9.1%	
Nov-23	9.1%	
Dec-23	9.3%	
Jan-24	9.2%	
Feb-24	9.2%	
Mar-24	9.2%	
Apr-24	9.3%	



Understanding the most recent data point

Performance

9.3%

Variation indicates inconsistently passing and falling short of the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	• Head of Staff Experience	• Ongoing	• Staff Turnover remains at **9.3%** and has achieved the gold standard (10%) for over a year. It appears to be stabilising at/ around 9%.
Maintaining **Nurse Turnover** against a gold standard of 10%	• Implementation of actions against the Nursing Workforce Retention Action plan	• Associate Director of Nursing	• Ongoing	• Nurse Turnover has been achieving the target (10%) for >18 consecutive months and has remained stable at / around **8.3%** for the last 10 months.
Reducing **Healthcare Support Worker** Turnover below 13.5%	• Introduction of the HCSW Voice Programme and continued delivery of the Ready to Care programme	• Matron for Recruitment & Career Dev.	• Ongoing	• HCSW Turnover has improved dramatically and continues on an improving trajectory. At **11.7%** it is >10% better than the same time last year.

Premature Staff Turnover Rate

National Standard

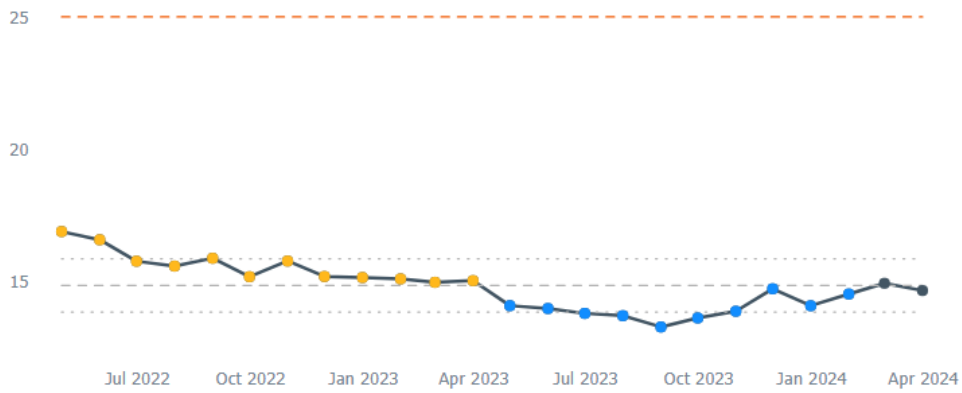
East Kent Hospitals University NHS Foundation Trust

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

Premature Turnover Rate

Timescale	Value	SPC
May-23	14.1%	
Jun-23	14.0%	
Jul-23	13.8%	
Aug-23	13.7%	
Sep-23	13.3%	
Oct-23	13.6%	
Nov-23	13.9%	
Dec-23	14.7%	
Jan-24	14.1%	
Feb-24	14.5%	
Mar-24	14.9%	
Apr-24	14.6%	

XMR Run Chart



Understanding the most recent data point

Performance

14.6% — Variation indicates consistently passing the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
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 (**14.6%**) has reduced back and remains within the desired parameters (≤15%).
Reduction in **Premature Turnover** below desired threshold of 15%	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Mar 24	• System-level managers guide to onboarding published by EKHUFT alongside an onboarding video developed with JustR and the ICB to support implementation.
Improvement in the **New Starter Experience** (as denoted by the Kent & Medway NSES)	• Efforts to improve the new starter experience through onboarding and induction	• Head of Staff Experience	• End Mar 24	• System-level data (~2500 respondents) gave credible intelligence which led to onboarding guide & video. NSES launched internally.

Staff Engagement Score

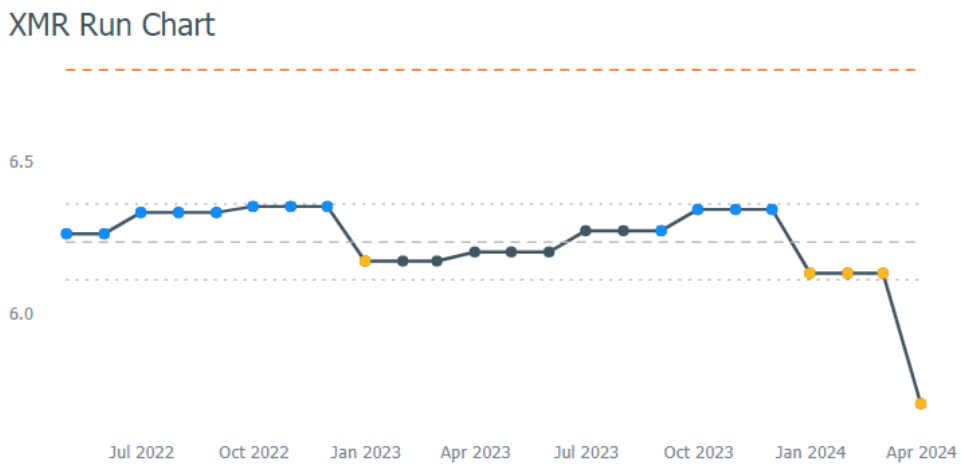
National Standard

East Kent Hospitals University NHS Foundation Trust

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

Staff Engagement Score

Timescale	Value	SPC
May-23	6.20	
Jun-23	6.20	
Jul-23	6.27	
Aug-23	6.27	
Sep-23	6.27	
Oct-23	6.34	
Nov-23	6.34	
Dec-23	6.34	
Jan-24	6.13	
Feb-24	6.13	
Mar-24	6.13	
Apr-24	5.70	



Understanding the most recent data point

Performance

5.70 — Variation indicates consistently falling short of the target

Variation

Variation	Special cause of concerning nature or higher pressure due to lower values
Flags	Outside Moving Range Limit Astronomical Point Two Out Of Three Beyond Two Sigma Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.3) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	• Head of Staff Experience	• End Mar 25	• Staff engagement (5.70) is at a historic low and continues to fall. April data indicates that advocacy is the primary driver of this, falling to 4.99 /10.
Actions/ interventions initiated to improve staff engagement	• Examples include; the introduction of a brand-new benefits platform to tackle satisfaction with pay, and a brand-new EAP to take more positive action on HWB	• Head of Staff Experience	• End Jul 24	• People Plans have been developed at a Care Group level and performance against these actions will be monitored monthly through PRMs. Actions have also been proposed followed analysis of the staff survey free text comments.
National Staff Survey 2024	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of associated results	• Head of Staff Experience	• End Nov 24	• Actions to drive greater response rates include; acting on feedback and closing the loop, reinforcing anonymity & confidentiality and agreeing 2024 incentives.

Statutory Training

National Standard

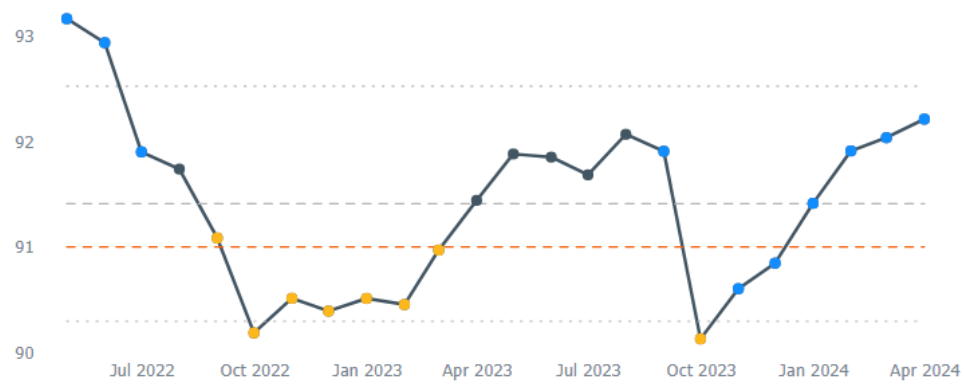
East Kent Hospitals University NHS Foundation Trust

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

Statutory Training

Timescale	Value	SPC
May-23	91.9%	
Jun-23	91.9%	
Jul-23	91.7%	
Aug-23	92.1%	
Sep-23	91.9%	
Oct-23	90.1%	
Nov-23	90.6%	
Dec-23	90.8%	
Jan-24	91.4%	
Feb-24	91.9%	
Mar-24	92.0%	
Apr-24	92.2%	

XMR Run Chart



Understanding the most recent data point

Performance

92.2%

Variation indicates inconsistently passing and falling short of the target

Variation

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

Flags: Ascending Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Medical staff levels of compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance.	• CMO	• Apr 24	• All Care Groups to target improvement within medical staff compliance. Compliance at 78.1%, and has increased for six months running.
Capacity within face to face statutory learning, particularly Resus.	• Resus team currently at 50% capacity due to vacancies and sickness absence. Being addressed through the Corporate Team	• Deputy Chief Nurse	• Ongoing	• Care Groups ensuring that the most essential, non-compliant staff are booked on Resus training first.
Low compliance with Trainee Drs, as they do not complete this on arrival, and no agreement to who chases this especially after rotation.	• P&C Leads to work with Med Ed on supporting improvements with this, particularly focusing on induction and rotation.	• DME	• End Mar 24	• Head of P&C to work with Care Groups to seek support from Med Ed management team.

Medical Job Planning Rate

Key People Metric

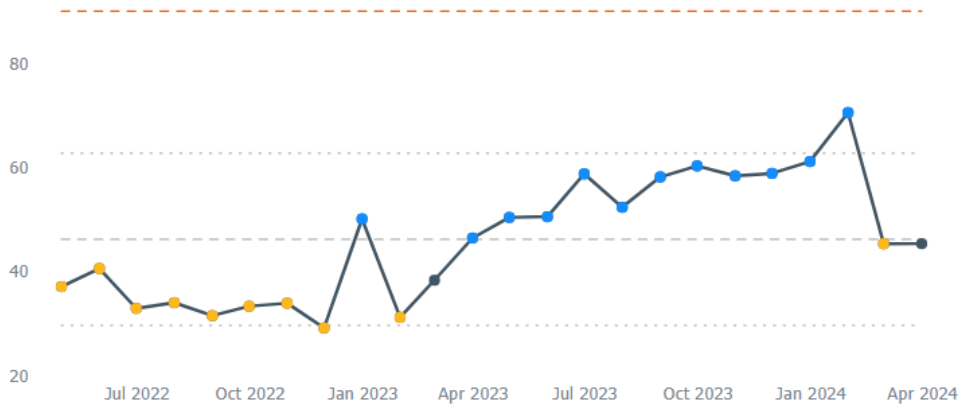
East Kent Hospitals University NHS Foundation Trust

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

Medical Job Planning Rate

Timescale	Value	SPC
May-23	50.4%	
Jun-23	50.5%	
Jul-23	58.7%	
Aug-23	52.3%	
Sep-23	58.1%	
Oct-23	60.3%	
Nov-23	58.3%	
Dec-23	58.8%	
Jan-24	61.1%	
Feb-24	70.5%	
Mar-24	45.3%	
Apr-24	45.3%	

XMR Run Chart



Understanding the most recent data point

Performance

45.3%

Variation indicates consistently falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Job planning compliance continues to improve across specialities, with a new job planning round commencing on the 1st April. Job-plans in discussion have increased, however this has eliminated expired job-plans.	• Continue frequent reminders • Continue contact with sign off leads to provide recommendations and advice	• CMO	• End Apr 24	• Job Planning compliance fell to 45.3% with 17%% in sign off stages. This is partially due to the migration and new JobPlanning round. Aim to achieve 90% by Apr 25
The new structure hierarchies for Specialities have been created on e-JobPlan however they have not yet been migrated.	• Wait until next cycle in April 2024 to move all into discussion and back to their correct hierarchy.	• CMO	• End Apr 24	• Sign-off and compliance issues noted by Allocate. Mitigations to occur in April due to issues in transferring DCC element. • New JobPlanning cycle has begun, transfer of remaining dept's underway
Job plans have been signed off sporadically and have not followed a job planning cycle. This impacts the Trusts ability to ensure its job plans are discussed and delivered with a demand and capacity focus that is also fair and transparent.	• Job planning policy updated to include job planning cycles • Job planning cycle to launch June 2024 commencing with clinical lead & management planning to scope demand, capacity, and resources.	• CMO	• End Jun 24	• Template for Clinical Leads/Managers in development with the dCMO • 90% compliance of current cycle on track (see above) • Levels of Attainment improvement project continues in order to fully realise the benefits of addressing this issue

Staff Advocacy Score

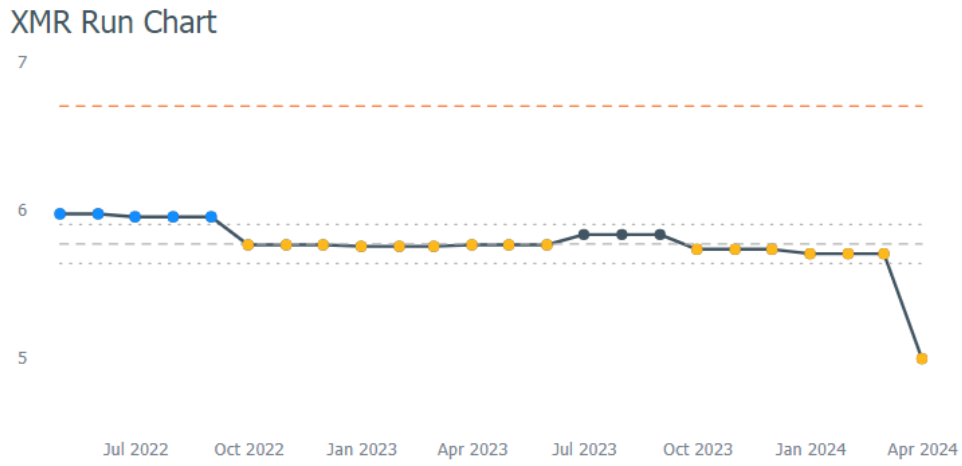
Key People Metric

East Kent Hospitals University NHS Foundation Trust

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

Staff Advocacy Score

Timescale	Value	SPC
May-23	5.76	
Jun-23	5.76	
Jul-23	5.83	
Aug-23	5.83	
Sep-23	5.83	
Oct-23	5.73	
Nov-23	5.73	
Dec-23	5.73	
Jan-24	5.70	
Feb-24	5.70	
Mar-24	5.70	
Apr-24	4.99	



Understanding the most recent data point

Performance

4.99 — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Advocacy levels (5.8) are significantly below the national standard (6.4)	• Continued action is required to repair the reputation of the organisation & the extent to which staff would recommend as a place to work and be treated	• Executive Team	• End Nov 24	• Staff Advocacy levels are the lowest in the country and have fallen further in the latest NQPS (to **4.99**). Only **30%** of staff would recommend the organisation as a place to work.
Staff Advocacy levels remain in Quartile 1 when benchmarked nationally	• Increased rollout of We Care as a programme to drive staff engagement levels	• Head of Transformation	• Ongoing	• Staff Advocacy levels are significantly (**62 points**) higher in We care areas than non-We care counterparts. Re-launch of We care planned.
The extent to which staff would recommend the Trust as a place to work or be treated	• Consider implementation of a multi-level 'People Plan' to tackle improving the staff experience at organisational, care group and specialty levels	• Head of Staff Experience	• End Nov 24	• Care Group People Plans have been developed and shared at CEMG. A series of Executive listening events and staff forums have been set-up to better understand, with remedial action to follow.

Appraisal Rates

Key People Metric

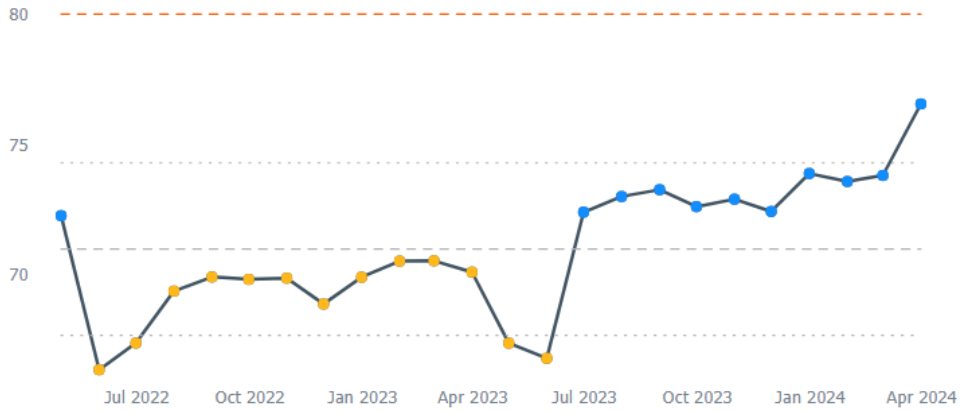
East Kent Hospitals University NHS Foundation Trust

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

Appraisals Compliance

Timescale	Value	SPC
May-23	67.4%	
Jun-23	66.8%	
Jul-23	72.4%	
Aug-23	73.0%	
Sep-23	73.3%	
Oct-23	72.6%	
Nov-23	72.9%	
Dec-23	72.4%	
Jan-24	73.9%	
Feb-24	73.6%	
Mar-24	73.8%	
Apr-24	76.6%	

XMR Run Chart



Understanding the most recent data point

Performance

76.6%	Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Managers not uploading completion dates to ESR	• Each Care Group identifying the areas where no or few uploads to ESR have been identified. Supporting those managers with ESR self service training.	• Heads of P&C	• End Mar 24	• Identifying areas where support needed for updated ESR training. "One Stop Shop" being developed to support in People & Culture refreshers, including appraisal and ESR self service.
Admin & Clerical appraisal rates remain below threshold, with 600 outstanding appraisals.	• Focus within the new Care Groups on improving A&C appraisal rates, and ensuring they are uploaded to ESR.	• Care Group MDs	• Ongoing	• New P&C Care Group teams to work locally with targeting areas of low A&C appraisal compliance. Additional issue with appraisal following A&C Consultation.
Quality of appraisal remains low, according to staff survey	• F2F meetings with line managers re: appraisal and Slido sent out to 600 staff asking for feedback on individual appraisals to identify reasons for low quality.	• Heads of P&C	• End Mar 24 - completed	• Approximately 70 responses to requests for suggested improvements to appraisal. These have been fed back to the OD team for action.

East Kent Hospitals University NHS Foundation Trust

Maternity

Maternity

Integrated Improvement Plan

NHS
East Kent Hospitals University
NHS Foundation Trust

Domain	Nat	Flag	KPI	SPC	Thres.	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Maternity	NAT		Serious Incidents Maternity		Sigma	1	3	2	0	2	2	1	2	2	0	0	1
	KEY		Maternity Incidents Moderate / Severe		Sigma	3	2	0	1	1	4	0	2	1	2		
	KEY		Maternity Patient Incidents Moderate /...		Sigma										0	8	1
	KEY		Maternity Complaints		Sigma	8	5	6	2	15	4	7	5	13	7	1	10
	KEY		Maternity Complaint Response		90.0%	16.7%	38.9%	50.0%	60.0%	60.0%	0.0%		33.3%	0.0%	12.5%	77.8%	0.0%
	KEY		Extended Perinatal Mortality		5.87	4.47	3.87	3.40	3.58	3.11	2.62	2.29	2.81	2.99	2.45	2.61	2.77
	NAT		FFT Maternity Response Rate		15.0%	14.9%	14.4%	15.4%	13.4%	11.5%	13.7%	16.1%	15.2%	14.1%	13.0%	11.6%	9.1%
	NAT		FFT Maternity Recommended		90.0%	92.1%	92.3%	91.6%	88.3%	90.7%	96.3%	93.0%	88.9%	93.5%	93.2%	89.8%	91.5%
	NAT		FFT Maternity (IP) Recommended		90.0%	92.6%	94.3%	94.3%	88.8%	90.6%	96.8%	93.8%	90.4%	94.1%	92.9%	90.9%	92.7%
	KEY		WH Engagement Score		6.90	5.87	5.87	6.15	6.15	6.15	6.38	6.38	6.38	6.35	6.35	6.35	6.07

April Performance Summary

Incidents: There were 2 serious incidents declared in April in Women's Health for Maternity. 1 has since been downgraded.

Complaints: 8 Stage 1 complaint was received in April for Maternity. This is an increase on the previous month.

Patient Involvement: FFT Response rate 9.1% - 91.5% extremely likely or likely to recommend

Staff Engagement: Score 6.07

Maternity Serious Incidents

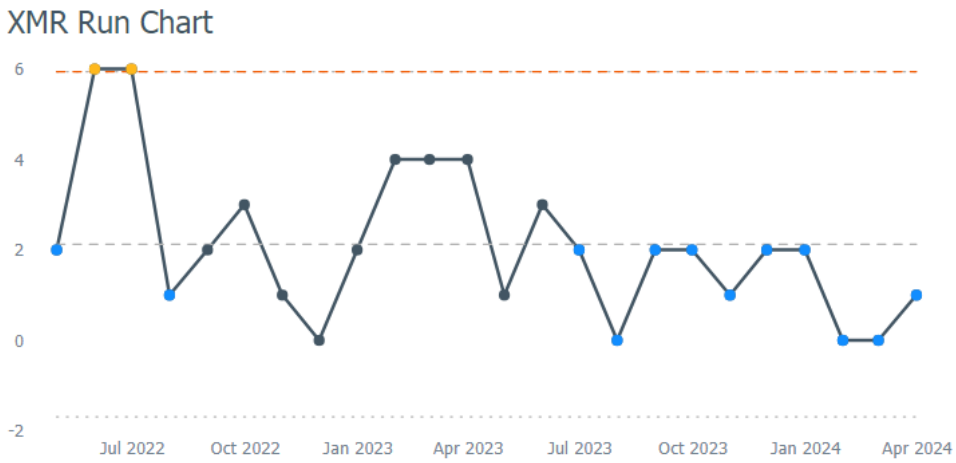
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Serious Incidents Maternity

Timescale	Value	SPC
May-23	1	
Jun-23	3	
Jul-23	2	
Aug-23	0	
Sep-23	2	
Oct-23	2	
Nov-23	1	
Dec-23	2	
Jan-24	2	
Feb-24	0	
Mar-24	0	
Apr-24	1	



Understanding the most recent data point

Performance

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

Variation

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

Flags — Below Mean Run Group

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGRESS UPDATE
There was 1 serious incident reported in April for Maternity.	Review of escalation processes to CCOT and Anaesthetics.	Head of Gov	July 2024	• Investigation in progress • Doc letter sent out 24/05/2024
At month end there were 7 open SI's in Maternity.	For all SI investigations to be completed within agreed timeframes.	Head of Gov.	Monthly – ongoing	All Maternity open SI's under investigation are within agreed timeframes. There are no SI breaches within Maternity. 5 are on extension.
Closure of actions from SI's on the datix actions module.	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of original June backlog and current position	Head of Gov.	31/03/24	The number of overdue actions from the original backlog (June) has reduced from 345 to 5 at 20/05/2024. The overall current overdue actions for the care group has decreased to 23. Patient Safety Matron vacancy has been recruited to. Substantive Head of Governance appointed commenced 28.3.24.

Maternity Incidents Causing Harm

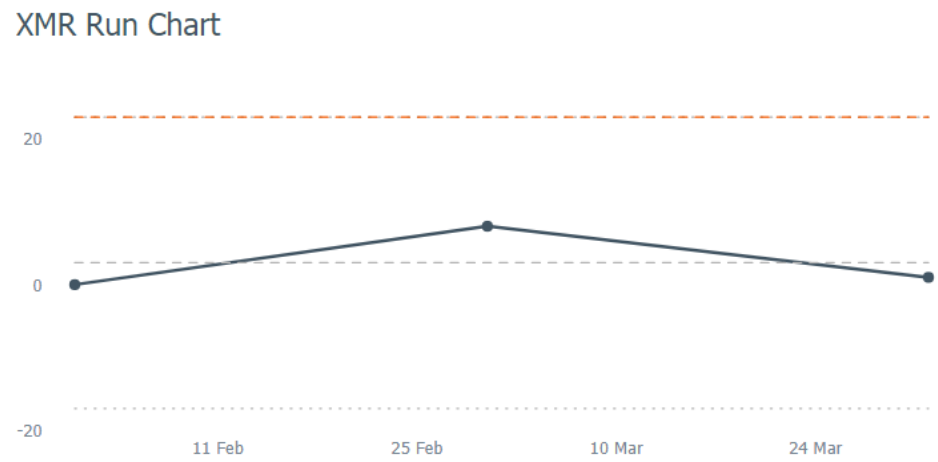
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Patient Incidents Moderate / Severe

Timescale	Value	SPC
Feb-24	0	
Mar-24	8	
Apr-24	1	



Understanding the most recent data point

Performance

1

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Rapid review of moderate incidents and other incidents on maternity trigger list.	• Rapid review process reviewed • MDT attendance • Learning identified	Head of Governance	Monthly - ongoing	• Rapid Review SOP updated and now live on Policy Centre • Themes and learning identified from rapid reviews disseminated via Message of the Week and Safety Threads. • Team Brief introduced for Ward Managers and Matrons to summarise key messages for the week with teams
Closure of datix open more than 6 weeks	• Focussed work to close open actions on datix module with action owners • Weekly progress reporting of backlog and current position	Head of Governance	31/03/2024	The number of open datix from the original June backlog for Maternity has reduced from 686 to 21 at 20/05/2024. The overall current overdue datix is 276 within Maternity which is a slight increase from the previous month. This is a priority for the Patient Safety Team to close these open datix, all of which have had an initial review at the time of reporting. To note all open Datix have undergone Triage and currently in investigation stage

Maternity Complaints

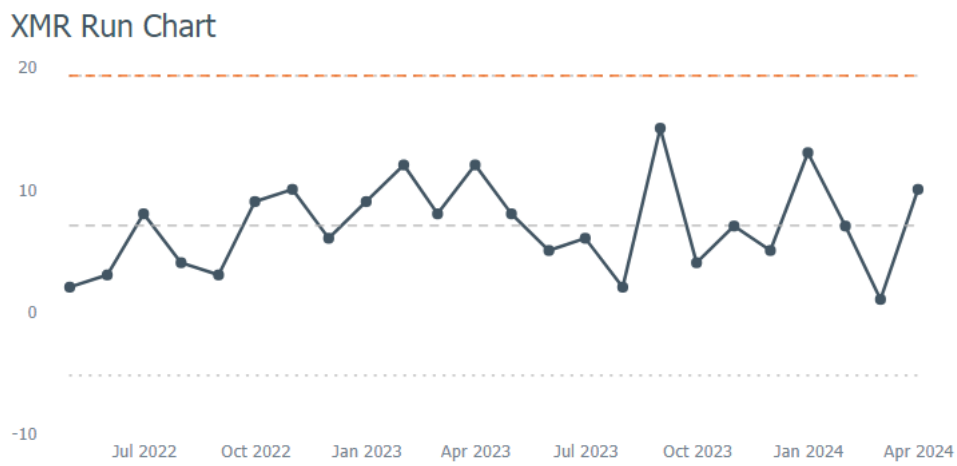
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Complaints

Timescale	Value	SPC
May-23	8	
Jun-23	5	
Jul-23	6	
Aug-23	2	
Sep-23	15	
Oct-23	4	
Nov-23	7	
Dec-23	5	
Jan-24	13	
Feb-24	7	
Mar-24	1	
Apr-24	10	



Understanding the most recent data point

Performance

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

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
8 Stage 1 complaints received in April 2024 for Maternity	Increase from the number of complaints received in previous month.	Patient Experience and Complaints Coordinator	Monthly reporting	• Submitted a total of 10 DDoM approved drafts to CPBS in April • A total of 7 cases were closed in April by sending the final Exec letters to patients. • At the end of April there are 30 open complaints in Maternity
Recurrent themes	The main themes are: Pain relief inadequate. Delayed discharge. Busy post natal wards. Poor communication during IOL.	Adaline Smith DDOM	Monthly	Themes arising from complaints have been included in the MNVP strategy and QI projects being co-produced. For example the team are currently developing a postnatal booklet . The MNVP have been surveying women in relation to antenatal education. The service is working with the region in relation to embedding PSCPs. There is a workstream dedicated to addressing culture and behaviours.

Maternity Complaints Response Rate

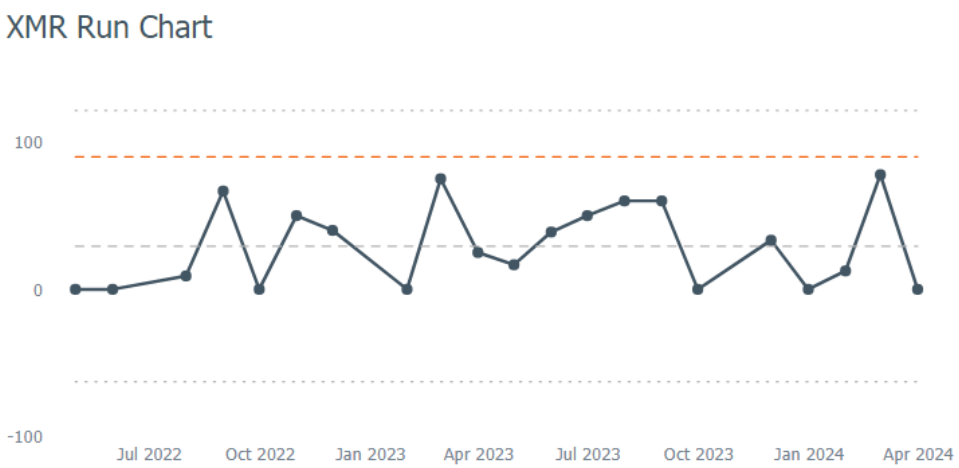
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

Maternity Complaint I

Timescale	Value	SPC
Apr-23	25.0%	
May-23	16.7%	
Jun-23	38.9%	
Jul-23	50.0%	
Aug-23	60.0%	
Sep-23	60.0%	
Oct-23	0.0%	
Dec-23	33.3%	
Jan-24	0.0%	
Feb-24	12.5%	
Mar-24	77.8%	
Apr-24	0.0%	



Understanding the most recent data point

Performance

0.0%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Competing priorities of clinical staff cause delays in case reviews and providing the Complaint Coordinator with comments for content	Complaint Coordinator has set up weekly 'huddle' meetings with HOMs and newly appointed Clinical Lead to try and spotlight urgent cases .	Patient Experience and Complaints Coordinator	• Weekly and • Bi-Weekly meetings	• Care group has robust process in place for ensuring quality of responses within timeframes. • Positive feedback has been received on the quality of the complaint responses. • At 02/05/2024 there were 30 open first complaints of which 7 have breached as of 02/05/2024.

Extended Perinatal Mortality

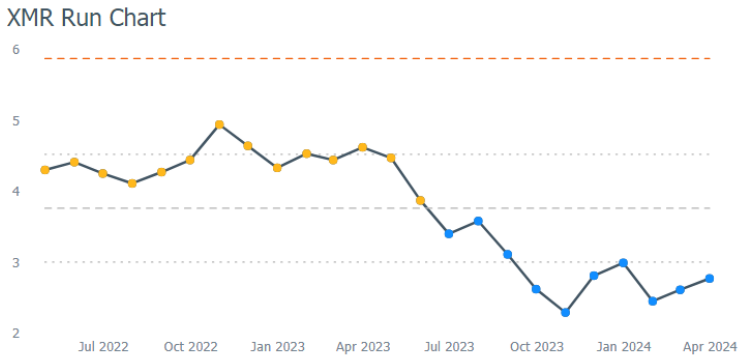
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

MBRRACE Ext Perinatal Rate 12m

Timescale	Value	SPC
May-23	4.47	
Jun-23	3.87	
Jul-23	3.40	
Aug-23	3.58	
Sep-23	3.11	
Oct-23	2.62	
Nov-23	2.29	
Dec-23	2.81	
Jan-24	2.99	
Feb-24	2.45	
Mar-24	2.61	
Apr-24	2.77	



Understanding the most recent data point

Performance

2.77 — Variation indicates consistently passing the target

Variation

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

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
In April there was 2 neonatal death reportable to MBRRACE	As of April the 12m rate is 1.39. The rate remains below the threshold of 1.96 deaths per 1000 livebirths, which is set at the average of the Trust's comparator group from the most recent MBRRACE data	PMRT Lead Midwife	Monthly	1. All reviewed through the Rapid Review Process
In April there were 2 stillbirths reportable to MBRRACE	The rolling 12 month rate for stillbirths is 1.39 which remains lower than both the threshold.	DDoM	Monthly	All cases reported via PMRT and reviewed with external input
Perinatal Mortality Review Tool	All neonatal deaths and stillbirths are reviewed through the Perinatal Mortality Review Tool by a multidisciplinary panel and external attendees (If over 22weeks gestation)	PMRT Lead Midwife	Monthly	100% of perinatal mortality reviews include an external reviewer

Maternity Friends & Family Test: Response Rate

Integrated Improvement Plan

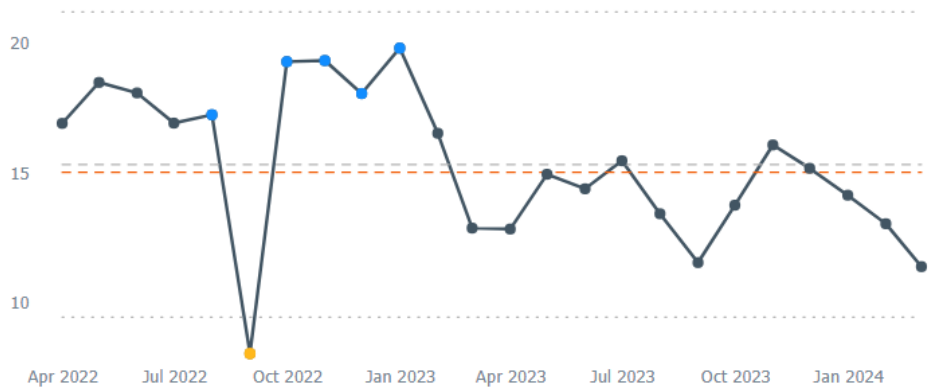
East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity Response Rate

Timescale	Value	SPC
Apr-23	12.8%	
May-23	14.9%	
Jun-23	14.4%	
Jul-23	15.4%	
Aug-23	13.4%	
Sep-23	11.5%	
Oct-23	13.7%	
Nov-23	16.1%	
Dec-23	15.2%	
Jan-24	14.1%	
Feb-24	13.0%	
Mar-24	11.4%	

XMR Run Chart



Understanding the most recent data point

Performance

11.4%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Response rates are typically low for FFT therefore only reflect a minority of women, birthing people and their families, and their experiences	Embedded communications plan and Patient Voices Model to improve service user and workforce engagement, feedback and experience	Patient Experience Midwives	March 2024	• This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval • The 2023/2024 work plan has now been finalised Walking the patch and 15 steps took place across both sites in April . Findings shared with responsible HOMS and Matrons for action • Feedback is being continually gathered through YVIH and FFT with guest questions scheduled for the coming months

Report not available on Dashboard

Maternity Friends & Family Test: Recommended

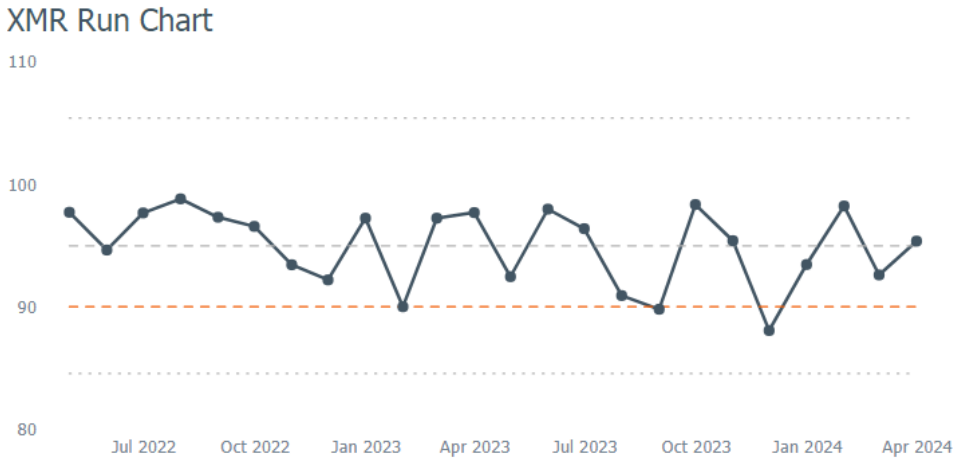
Integrated Improvement Plan

NHS East Kent Hospitals University NHS Foundation Trust

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

FFT Maternity Recommended

Timescale	Value	SPC
May-23	92.5%	
Jun-23	98.0%	
Jul-23	96.4%	
Aug-23	90.9%	
Sep-23	89.8%	
Oct-23	98.3%	
Nov-23	95.4%	
Dec-23	88.1%	
Jan-24	93.4%	
Feb-24	98.2%	
Mar-24	92.6%	
Apr-24	95.3%	



Understanding the most recent data point

Performance

95.3%

Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 89.6% extremely likely or likely to recommend which is a decrease in month.	PEM feedback to staff on a regular basis via personalised email and update posters on the units/community offices and in the monthly newsletter. The top 3 areas to improve are: 1. Communication and Information- the way things are explained in tone and what is happening- this is even across both sites 2. Staff Attitude- this has been seen more about the doctors and midwives on the PN ward at night at – across both sites 3. Quality of treatments (majority being about the Postnatal ward at WHH specifically)	PEM	Monthly	• There is now a PN steering groups which has led on from the discharge steering group to look at PN care • Exploring a NIPE rota for midwives to increase the NIPEs and speed up discharges. • Redecoration of both units. • In November there has been a standard of care embedded at WHH PN ward where the is an expectation of what should happen at what time. At 11 o'clock as well there is a safety pause where concerns can be escalated to those in charge and also any issues with discharged can be discussed. • There are now two Hubs on the wards- which are in 2 of the bays, this is to ensure and increase viability of the staff looking after the families in those bays. • Increase in comments concerning the attitude and communication of doctors will be reported back to the lead consultants of each site.

Maternity Friends & Family Test: Inpatient Recommended

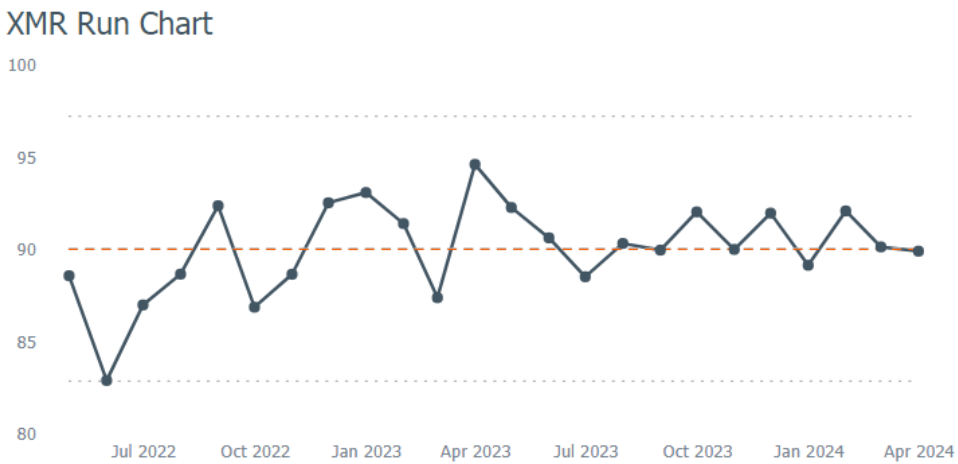
Integrated Improvement Plan

East Kent Hospitals University NHS Foundation Trust

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

FFT Satisfaction Level (IP)

Timescale	Value	SPC
May-23	92.3%	
Jun-23	90.6%	
Jul-23	88.5%	
Aug-23	90.3%	
Sep-23	90.0%	
Oct-23	92.0%	
Nov-23	90.0%	
Dec-23	92.0%	
Jan-24	89.1%	
Feb-24	92.1%	
Mar-24	90.1%	
Apr-24	89.9%	



Understanding the most recent data point

Performance

89.9% — Variation indicates inconsistently passing and falling short of the target

Variation

Variation: Common cause (no significant change)

Flags: No Special Cause Flags

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
The responses show 90.7% extremely likely or likely to recommend which is a decrease in month.	• Embedding in discharge process with the introduction of the new post natal discharge process . • Increase awareness via Maternity Voice Partnership • Include in Walking the Patch and standard work for the Discharge coordinators • Explore use of link to QR code • Matron worked clinically for 2 weeks in November to embed good practice. • Daily Gemba walks for senior team	Liane Ashley	May 24	This is a milestone within the Maternity and Neonatal Improvement Plan presented to Trust Board for approval LMNS continue to undertake further exploration of national data and opportunities to improve response rates

Women's Health Staff Engagement Score

Integrated Improvement Plan

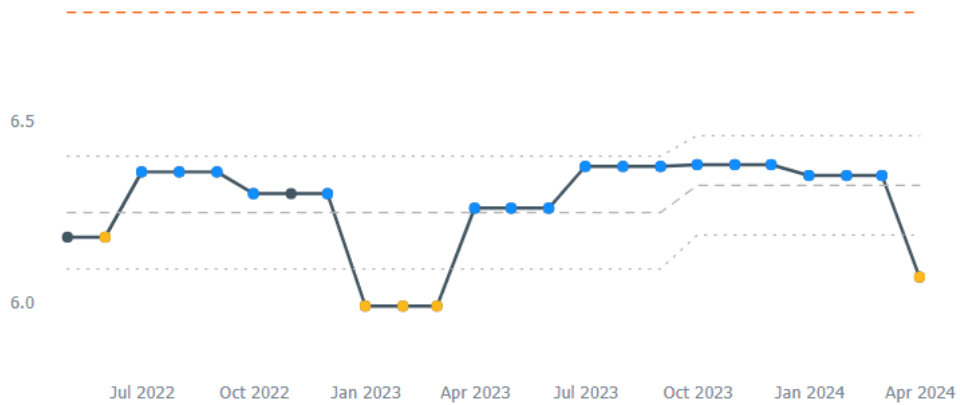
East Kent Hospitals University NHS Foundation Trust

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

Staff Engagement Score

Timescale	Value	SPC
May-23	6.26	
Jun-23	6.26	
Jul-23	6.38	
Aug-23	6.38	
Sep-23	6.38	
Oct-23	6.38	
Nov-23	6.38	
Dec-23	6.38	
Jan-24	6.35	
Feb-24	6.35	
Mar-24	6.35	
Apr-24	6.07	

XMR Run Chart



Understanding the most recent data point

Performance

6.07 — Variation indicates consistently falling short of the target

Variation

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Opportunities for Staff Engagement	• Introduction of " We Hear You " providing platform for feedback • Embedding Safety Champions Forum • Band specific Meetings /away days • Increase Appraisal rates and SMART objectives • Promoting Freedom to Speak Up Guardians and arrange dedicated walkarounds • Embedding retention conversations • Compassionate attendance at work conversations following absences	Adaline Smith DDOM	December 23	Score survey received . 8 sessions have been facilitated by Korn Ferry with good attendance from local teams.. Work is being planned in response to staff feedback SOP created by Associate Medical Director for "**Call for Concern** " **Shout out for Safety** QR code shared with staff QR code for EUREKA ideas advertised to encourage feedback from staff regarding innovative ideas . Introduction of communication champions

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Month 1 Finance Report**

Meeting date: **6 June 2024**

Board sponsor: **Interim Chief Finance Officer (CFO)**

Paper Author: **Interim Deputy CFO**

APPENDICES:

None

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the financial performance of April 2024 (Month 1).
Summary of key issues:	**CFO Update:** The Trust submitted the Board approved £85.8m deficit plan in line with national planning deadlines on the 2 May 2024. This report contains the high level financial performance of the trust in April 2024 (Month 1). In April (Month 1), the Group delivered a deficit position of £8,768k, against a deficit plan of £8,763k, an in-month adverse variance of £5k, as detailed below.

£000	Month 1 Plan	Month 1 Actual	Variance April
Clinical Income	£73,462	£73,587	-£125
Other income	£4,694	£4,553	£141
Employee Expenses	-£55,824	-£55,690	-£134
Other operating expenses	-£30,483	-£30,611	£128
Non-operating expenses	-£754	-£730	-£24
Technical adjustments	£142	£123	£19
TECHNICALLY ADJUSTED SURPLUS/ (DEFICIT)	**-£8,763**	**-£8,768**	**£5**

Clinical income overperformed in month due to Elective Recovery Fund (ERF) activity being higher than planned. Pay was £0.1m underspend in the month with agency costs continuing to reduce versus prior year. Non-pay was slightly overspent as a result of suffering additional costs mainly associated with ERF.

We care

East Kent Hospitals University NHS Foundation Trust

	A £49m in-year Cost Improvement Programme (CIP) target has been set for 2024/25, as part of the £85.8m deficit plan. The Month 1 CIP target was £1,382k and this was achieved for Month 1. The Group cash balance (including subsidiaries) at the end of April was £30.6m. The Trust drew £9.5m of working capital (Public Dividend Capital (PDC)) in the month.
Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of Month 1.

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 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 – 31 May 2024

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 June 2024**

Board sponsor: **Chief Executive (CE)**

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

Appendices:

Appendix 1: IIP progress Report

Executive summary:

Action required:	Information
Purpose of the Report:	This report has been provided to update the Board of Directors at East Kent Hospitals NHS University Foundation Trust (EKHUFT) on: • the closure of the 2023/24 IIP in April 2024 and offers assurance based on evidence reviews undertaken internally and confirmed externally to agree the closing position with line with the NHS England Recovery Support Programme (RSP) National Oversight Framework Segment 4 (NOF4) • the finalised 2024/25 Reset IIIP.
Summary of key issues:	**2023/24 IIP Closedown** • This report details the Q4 closing position of the six programmes, confirming that following both internal and external reviews, it has been agreed that fourteen of the twenty-eight exit criteria set have been met and will be supported to transition out of NOF4. • Programmes for Maternity, Quality & Safety, and the People element of People & Culture will transition to NOF3. Culture Improvement will form part of the Leadership, Governance & Culture workstream within the IIP 2024/25. This will also be joined by Operational Performance and Finance. • The report also details by RAG rating, the position of each of the exit criteria by programme, agreed at the end of Q4, based on all evidence gathered in support of closing down the 2023/24 programme. **2024/25 Reset IIP**

East Kent Hospitals University NHS Foundation Trust

	• The reset IIP for 2024/25 has now been agreed at Integrated Care Board (ICB) and regional level.
	• The reset consists of four programmes focused on those areas that did not meet the criteria to exit NOF4 in 2023/24:
	  ○ Leadership, Governance & Culture
	  ○ Operational Performance – Planned Care
	  ○ Operational Performance - Urgent & Emergency Care (UEC)
	  ○ Financial Recovery
	• The exit criteria have been agreed of which there are eleven in total. Quarterly milestones have been agreed for each of the improvement metrics.
	• The Trust's annual objectives have been aligned directly with the exit criteria requirements in the integrated improvement plan.

Key recommendations:	The Board of Directors is invited to **NOTE** and **DISCUSS** 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:

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

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

Journey to Exit NHS Oversight Framework 4 (NOF4)

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

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

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

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

High-level Summary of Programme Closing Position

Agreed Q4 Programme RAG	Summary
Leadership & Governance	During the IIP reporting period, the organisation has appointed substantively to all exec vacancies, with the exception of the experienced Chief Finance Officer (CFO) who is seconded to the organisation until November 2024. This post will be imminently out to advert. The Executive Team Leadership Development Programme has commenced and will continue to progress as the Board matures and reflects on new opportunities to ensure the Board is stable and effective, and will form one of the projects moving into the 2024/25 IIP. New organisational Governance Structures and Framework models have been produced aligning to the new organisational restructure. They continue to be implemented throughout the organisation, with some evidence of improvements being demonstrated. Significant progress has been made with reviewing the Board Assurance Framework (BAF) to agree the risk appetite statement and risk tolerance levels, with a number of risk register Board Development sessions undertaken. Corporate risk registers have now been reviewed and there is now just one Organisational Risk Register, with Significant risks having an executive owner, aligning to the BAF with regular discussions taking place at the relevant sub-committees. The strengthening of the BAF Governance Framework and Governance Regulatory Compliance will feature within the IIP 2024/25, overseen by the newly appointed Director of Corporate Governance. The Trust Board are currently working on a number of ways to respond to the Staff Survey results that were published in March. There have been a number of well attended listening sessions where staff were invited to engage with members of the Executive Team. The Trust Board has heard some very open and honest feedback from staff members at the April meeting and are well sighted on how if feels to be a staff member working in this organisation. Executive 'walk arounds' have been reintroduced in order to speak directly with colleagues and patients and receive feedback to enable change. Culture Improvement will be added to form the Leadership, Governance & Culture Programme as one of the four programmes of work contained in the 2024/25 IIP. During the Q4 external review, Integrated Care Board (ICB) and NHS England (NHSE) Regional representatives stated that there has been significant progress and improvement over the year and concluded that the overall RAG rating is green.
People and Culture	The organisation has provided a significant amount of evidence demonstrating there are improved processes for Freedom to Speak Up (FTSU), which further increased activity within contacts, evidencing staff are confident to speak up. Following the recommendation at the Q3 review, the national FTSU team have assisted the Organisation on how to offer further assurances on the workstream. These suggestions have been met and evidenced by the team. There is also a range of data supplied to evidence improvements including mandatory training for staff and an increase in user involvement through a variety of means. Interventions have been put in place to reduce sickness, with sustained improvements noted in the trajectory from April to September 2023 and in key areas of the organisation including Urgent and Emergency Care (UEC). Data demonstrates the organisation is no longer an outlier in the ICB. The team will continue to monitor the metrics associated as sustained Business As Usual (BAU). There are sustained improvements in the retention and turnover rates for all staff groups and sustained improvement in the vacancy rate of the hard to recruit specialties which consequently has reduced the agency spend. During the Internal Q4 review panel, there were lengthy discussions on the overall position for Q4. There have been some key achievements which have enabled three of the five areas of the programme to progress to the sustainability phase, to continue within People & Culture as BAU. However, the Trust recognises the severity of the staff survey results, and whilst work has begun in response it acknowledges that there is a significant amount of work to do. The panel agreed that the Q4 RAG would move from green to amber to reflect this. During the external review meeting, the panel acknowledged the considerable amount of work that has been achieved in all other areas of the programme, confirming that the other 4 elements will move from NOF4 to NOF3. The ICB representative was grateful to the team for the excellent working relationship formed and how engaging the team have been. Based on the significance of the staff survey results, this element of the programme will remain in NOF4 and will form part of the Culture Improvement workstream within the Leadership, Governance & Culture Programme in the 2024/25 IIP.

High-level Summary of Programme Closing Position

Programme	Summary
Quality & Safety	The organisation has been able to provide a significant amount of evidence demonstrating there are improved processes for the management of serious incidents to provide timely identification, effective investigation and closure within national guidelines. There is also evidence of learning from incidents being shared widely. For those serious incidents falling outside the required timeframes the teams can easily identify reasons why and implement plans to address this. The organisation has reviewed & reduced risks, with any significant risks having an executive owner. There has been improvements in recognising, responding and escalating the deteriorating patient resulting in the reduction of serious incidents relating to the suboptimal care of the deteriorating patient. The clinical harm policy is currently being produced to bring together the existing harm review processes for the Endoscopy and Cancer waits to ensure there is an overarching policy for a harm review process. The Trust are working with the system to think about a consistent approach between providers for Harm reviews. The evidence provided within the Safeguarding project demonstrates an improved position, supporting not just continuous sustainability but also demonstrable impact of the improvements undertaken to date. Safeguarding performance will continue be monitored through the Safeguarding Operational Group and the Safeguarding Assurance Committee in line with the national standards required in the Safeguarding Accountability and Assurance Framework (SAAF). The Q4 position of green RAG was agreed at the external panel meeting, where both NHSE and ICB representatives commended the Trust for the work that has been undertaken and recognised the impact this has made. The panel agreed that the Quality & Safety programme would transition from NOF4 into NOF3, acknowledging that certain elements will continue as a 'golden thread' through other workstreams of the 24/25 IIP. The Trust will continue to work regionally with the ICB post IIP re-set through the existing governance structures.
Maternity	The organisation has been able to provide evidence demonstrating improvement in maternity governance processes. The Maternity Quality & Safety Framework, produced in line with the new organisational Governance Structure and the appointments into key management and obstetric safety roles has enabled the teams to build a robust infrastructure in order to make these improvements. A significant focus has been given to clearing the number of breached serious incident (SI)/Healthcare Safety Investigation Branch (HSIB) investigations resulting in the backlog reducing from 11 in May 2023 to 0 in September 2023. This position has been sustained at the end of Q4 and there are currently no SI/HSIB breaches. Documentation is also now inline with a significant backlog acted upon with BAU now in place for regular review and audit. There has been recent discussions at Maternity Safety Support Programme (MSSP) regarding expired guidelines and Patient Information and Liaison Service (PILs) which the trust are addressing. Since the Health Education England (HEE) Quality Intervention report was published in June 2023 , work to improve the learning environment commenced within Maternity Services. Of the 18 actions, 4 related specifically to the learning environment. These have all been completed and student midwives returned to practice in Q3 2023/24. In January 24 the Clinical Negligence Scheme for Trusts (CNST) compliance was declared and approved at the Trust Board (also endorsed by the ICB). In addition, the team have been working to meet the requirements of the Care Quality Commission (CQC) 'must and should dos' from the publication of the inspection report in May 2023. 20 'must dos' and 18 'should dos' were identified across the service. A weekly 'Stop the Clock' forum chaired by the Director of Midwifery (DoM) was initiated to address these areas of concern. Currently, there are only 3 remaining 'must dos' and 1 'should do', with a clear plan to address the outstanding actions and those remaining out of the control for Maternity services with risks recorded on relevant registers. Based on a CQC rating requiring improvement in Safe and Well Led, Maternity Services were placed in to the Maternity Safety Support Programme (MSSP) in December 2019. The organisation was allocated NHSi Maternity Improvement Advisors (MIAs) for midwifery and obstetrics. The MIAs have been working closely with both the clinical and governance teams on raising standards through improved systems of controls and the mapping of clinical care pathways. The Trust are moving into the stabilisation phase with a further review in July 2024. The panel at the Q4 external review agreed that this programme RAG remains green and is to transition from NOF4 for to NOF3. The NHSE representatives said that the Trust was an exemplar and often refers to it when talking to Organisations entering RSP. They stated that East Kent is a good news story and an RSP success for the organisation. The ICB representative confirmed that there is a higher level of confidence in self assessment and a good process observed which provided assurance that the Trust knew what good looked like.

High-level Assurance on Programme/Project Delivery

Programme	
Operational Performance	Within Urgent Emergency Care, improvements in time to triage/time to first assessment have been evidenced through the implementation of the 'Front door model'. Whilst the organisation does not currently have consistent capacity to meet demand, the bed gap has reduced significantly and there are ongoing programmes of work to reduce further. The organisation recently launched a 'Trust-wide 're-set' of its emergency pathways to help staff to work differently to ensure the right patient is in the right bed first time. The organisation is now evidencing that it understands what is driving performance and is beginning to evidence that a number of key processes have been put into place to support the delivery of improvements required. It is appreciated these will take time to fully embed in order to demonstrate impact. There have been some very positive improvements within elective recovery with some of the highlights being: - Elective waits for patients over 78 weeks reduced to 495 from original forecast of over 2,000 breaches by the end of Q4. - MBI supported validation of all patients over 35 weeks providing trust with a clean waiting list for the first time in many years. - Clear reduction in Endoscopy backlogs from peak of 13,350 to below 11,000 with weekly Endoscopy Task & Finish group now well embedded. - Surveillance backlog fully completed with over 3,449 patients validated and entire DM01 backlog qFIT tested. Cancer 62 day waits down to 187 patients at the end of March, from a peak of over 500 at the end of December. The internal review panel agreed that the Q4 position will remain red and continue in NOF4 moving into the 2024/25 IIP. They discussed two key elements to be considered within the RSP refresh for 2024/25; new targets should be relative to national performance and in line with an organisation transitioning from NOF4 to NOF3. There were also discussions on potential new milestones that include delivery input from system/partners as an integrated improvement plan is not within the gift of EKHUFT alone. Unfortunately the ICB and Region colleagues were unable to attend the external panel review, however, it is unlikely that there would have been any change to the RAG rating. The 2024/25 IIP metrics have already been agreed moving forwards.
Finance	The Trust has experienced significant changes within its financial governance in the past 4 months, and with a supported system, it has enabled the delivery of the revised planned deficit. The Group delivered the forecast deficit position of £117.4m for 2023/24 (Revised deficit for 2023/24 agreed with the national team in January 2024). This included £13.1m of cost improvements made in 2023/24 and a significant improvement in the last 2 quarters of the year due to centralisation of non pay and pay controls. The agency spend being back within cap is also a significant achievement. The Trust has a credible and deliverable plan for 2024/25 and feel in a position where the culture change is evident. The risk adjusted total in the Cost Improvement Programme (CIP) is at £42.7m. The total value of Green schemes is £35.7m. At the Q4 External review panel, ICB and Region colleagues agreed that the hard work within Q4 was evident. They advised that whilst the Trust remains in an exceptional position, they recognise the positive improvements that have been made. The panel concluded that the Finance programme will remain in NOF4. The 24/25 IIP has a clear focus on delivering the plan, governance and the medium term plan.

Exit Criteria Oversight (1)

The table below details the 28 RSP exit criteria set for the 2023/24 plan, 14 have been achieved and will transition from NOF4 into NOF3
Detailing the future oversight of each area, offers assurance to the Board that the areas that transition to NOF3 will become BAU and continue to be monitored at a local level without the National support required in NOF4.

	Exit Criteria	Exit NOF4	Future Oversight Assurance
1	Executive leadership team posts filled.	Yes	Monitored through board and the ICB oversight meetings
2	Executive leadership development plan in place.	No	Component in 2024/25 IIP
3	Trust board sighted on key risks and actions taken via appropriate escalation routes	No	Component in 2204/25 IIP
4	Evidence of effective comms and engagement channels between the frontline and the Board and outwards to ICB/NHSE/system partners, inclusive of routes of escalation for risks and concerns	Yes	Weekly Board report offers assurance
5	In response to the 2022 Independent Investigation into Maternity Services, evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology to address culture, psychological safety and teamworking within the maternity service	Yes	This will continue to be overseen through the delivery of the Maternity and Neonatal Improvement Plan (MNIP)
6	The Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the Integrated Care System (ICS)	Yes	Monitored through Finance and Performance Committee (FPC) and Board
7	Evidence of staff and user involvement in improvements and changes made through methods of capturing feedback e.g., use of template proformas asking staff how they have been involved in specific improvements	Yes	Monitored through People & Culture Committee
8	Staff survey demonstrating an improvement in staff engagement and Trust leadership in line with national/peer/ICS	No	Component in 2024/25 IIP
9	Staff sickness and vacancy trajectories tracked and responded to in line with regional and national position with no evidence of being a significant outlier across the ICS	Yes	Monitored through People & Culture Committee
10	Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit specialties	Yes	Monitored through People & Culture Committee
11	International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024	Yes	Monitored through People & Culture Committee
12	Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process	Yes	Overseen by Quality & Safety Committee, reported to Trust Board

Exit Criteria Oversight (2)

	Exit Criteria	Exit NOF4	Future Oversight
13	Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity, with continuous cycle of review, assessment and implementation of best practice and learning	Yes	This will continue to be overseen by Safeguarding Assurance Committee
14	Evidence of improved and sustained maternity governance process in place	Yes	Monitored through Maternity Governance Processes
15	Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024	Yes	Monitored through Maternity Governance Processes
16	Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff	Yes	Monitored through MNIP
17	Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024, aiming to move the performance to the 76% floor for all types of the national plan	No	Component in 2024/25 IIP
18	Embedding of essential operational management including rota management, job planning, waiting list oversight and theatres scheduling	No	Component in 2024/25 IIP
19	Sustained improvement in cancer 62-day performance by March 2024	No	Component in 2024/25 IIP
20	Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024 with elimination of 78 week waits	No	Component in 2024/25 IIP
21	Agreed financial recovery plan in place supported by a clear evidence base, approved off by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system	No	Component in 2024/25 IIP
22	Delivery of the 23/24 planned deficit or better	No	Component in 2024/25 IIP
23	Evidence of improved delivery against agreed financial plans, trajectories, and envelopes	No	Component in 2024/25 IIP
24	The Trust fulfils its statutory duties with regard to financial management	No	Component in 2024/25 IIP
25	Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures	No	Component in 2024/25 IIP
26	That the Trust benchmarks well against the model hospital financial efficiencies, or where this is not the case has a trajectory which brings alignment as soon as possible	No	Component in 2024/25 IIP
27	The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place	No	Component in 2024/25 IIP
28	Control of the costs of overseas recruitment against plan	Yes	Monitored through BAU Governance processes

Impact to NOF4 Exit Criteria – Leadership and Governance - Q4 agreed position

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

Suggested Evidence

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

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

Impact to NOF4 Exit Criteria – Quality and Safety - Q4 agreed position

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1

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

Exit Criteria 2

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

Suggested Evidence

Governance

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

Reporting and Investigation of SIs

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

Learning from SIs and Never Events

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

Safeguarding

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

Impact to NOF4 Exit Criteria – People and Culture - Q4 agreed position

NHS
East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

- Evidence of improved FTSU processes and reduction in whistle-blowing
- Increasing inclusion and diversity awareness and response
- Staff/User Involvement improvement e.g. use of template proformas asking staff how they have been involved in specific improvements, Pulse surveys.

- Staff surveys showing improvement in response rate (41.9% in 2020, national average was 45.4%) and outcomes for engagement, morale, safe environment: bullying and harassment, safety culture (outliers nationally).

- Reduction in sickness rate and plans in place for staff wellbeing.

- Healthcare Support Worker (HCSW) - pipeline/progress and tracking retention of these staff at 3/6/12 months.
- RN recruitment and tracking retention of these staff at 3/6/12 months.
- Evidence of medical workforce job planning and demonstration of compliance against the levels of attainment with trajectory to achieve level 4.
- Evidence of a Trust recruitment and retention strategy to support all areas.
- Evidence of workforce plans
- Sustained reduction in use of agency staff trajectory.

- Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit to specialties.
- Reduction in overspend for work permits.

Impact to NOF4 Exit Criteria – Maternity - Q4 agreed position

NHS East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

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

Impact to NOF4 Exit Criteria – Operational Performance - Q4 agreed position

East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4
Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024	Embedding of essential operational management including rota management, job planning, waiting list oversight and theatres scheduling.	Sustained improvement in cancer 62-day performance by March 2024	Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024.

Suggested Evidence

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

- Evidence the Trust embeds the basics of operational management; rota management, job planning, waiting list oversight, and theatre scheduling.

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

- Evidence the Trust understands what is driving performance and what they are trying to address with clear plans for consistent improvement and path to sustainability.
- Improvement delivery towards zero 65 week waits, and a drop in waiting list size.

Impact to NOF4 Exit Criteria – Finance - Q4 agreed position

NHS East Kent Hospitals University NHS Foundation Trust

Exit Criteria 1	Exit Criteria 2	Exit Criteria 3	Exit Criteria 4	Exit Criteria 5	Exit Criteria 6	Exit Criteria 7	Exit Criteria 8
Agreed financial recovery plan in place supported by a clear evidence base, approved off by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.	Delivery of the 2023/24 planned deficit or better.	Evidence of improved delivery against agreed financial plans, trajectories, and envelopes.	The Trust fulfils its statutory duties with regard to financial management.	Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.	That the Trust benchmarks well against the model hospital financial efficiencies, or where this is not the case has a trajectory which brings alignment as soon as possible.	The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place.	Control of the costs of overseas recruitment against plan.

Suggested Evidence

• Financial Recovery plan (FRP) and any supporting documentation • Evidence that the FRP has been approved by the ICB and NHSE.	• Delivery of the 2023/24 planned deficit or better.	• Evidence of delivery of financial trajectories set out in the FRP.	• Evidence that there is regular oversight by the Board and sub-committees on the progress against delivery against the FRP.	• Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures.	• Clear view on the drivers of deficit- what is structural, what is operational efficiency etc. and a plan for what is in the Trust's gift to change.	• System wide alignment of risks to the financial plan and shared view of mitigations, by both Trust and ICB.	• Evidence of a cash management plan in place.

NHS
East Kent
Hospitals University
NHS Foundation Trust

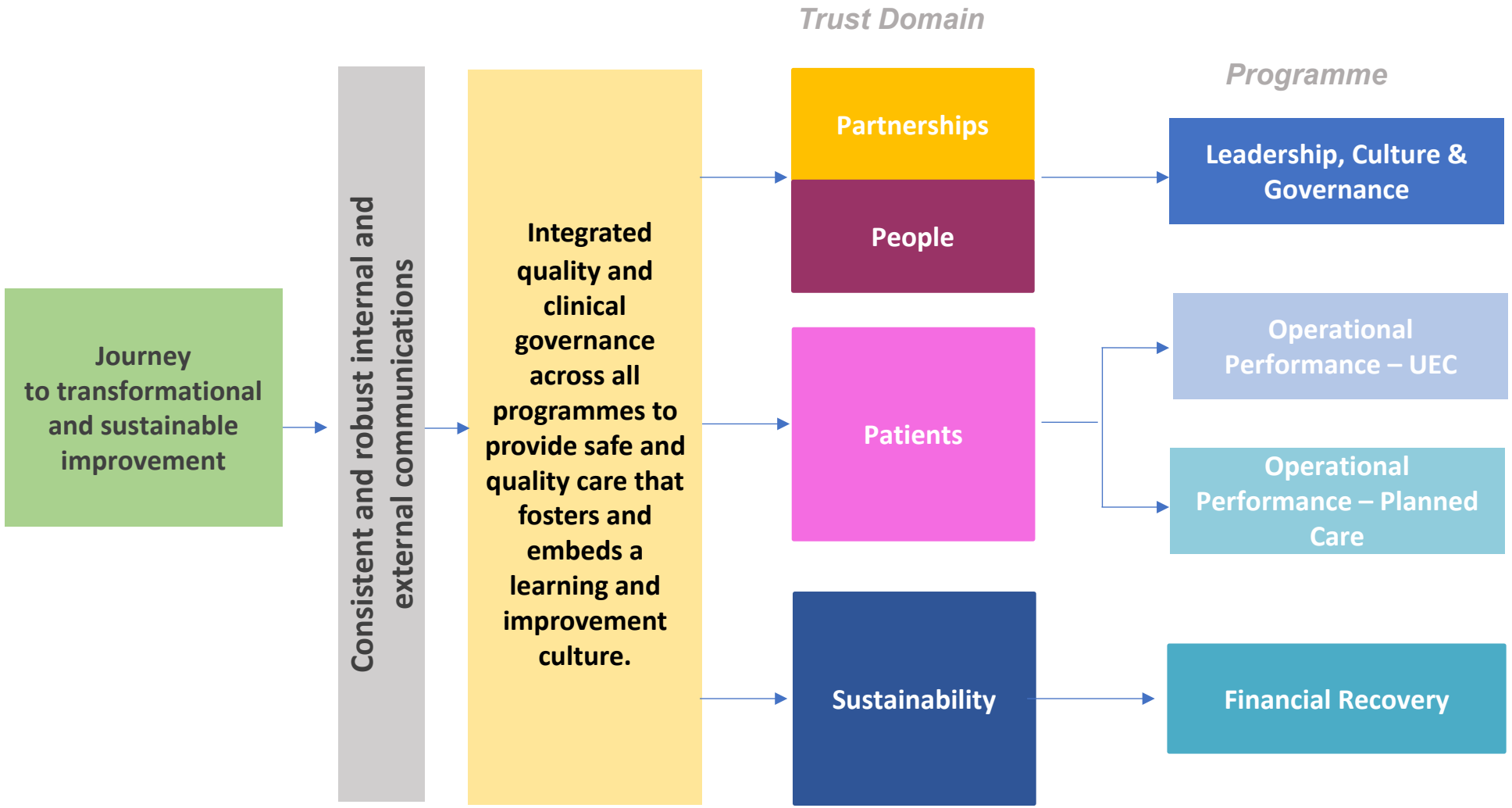
Reset Journey to Exit NOF4
2024/25 Reset Integrated Improvement Plan & Transition Criteria

East Kent Hospitals University NHS Foundation Trust

Reset Journey to Exit NOF4
2024/25 Reset Integrated Improvement Plan & Transition Criteria

Integrated Improvement Plan – Reset Proposal

East Kent Hospitals University NHS Foundation Trust



Reset – Transition Criteria, Suggested Evidence & Monitoring Metrics (1) Leadership, Governance & Culture

	Transition Criteria	Suggested Evidence	Monitoring Metrics
Leadership, Governance & Culture			
1	A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme	• 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)	• Board post recruitment including substantive Chair and • Chief Finance Officer • Board and leadership development plans • Recommendations implemented from GGI report and any internal follow up audits • Quarterly Board Assurance Framework (BAF) Update • Risk Register • Well Led framework adherence
2	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	• 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	• Staff survey and other regular surveys • Staff Engagement Score • Staff voice (i.e. FTSU/engagement) • CQC reports, letters and notices • Board reports and outcomes from Board discussions • MSSP reports
3	Development of organisation strategy for clinical pathways	• Trust organisation strategy for clinical pathways or equivalent developed with effective clinical and stakeholder engagement and plan for implementation developed	• Strategy document • Plan for implementation and delivery of strategy

Reset – Transition Criteria, Suggested Evidence & Monitoring Metrics (2) Ops - UEC

	Transition Criteria	Suggested Evidence	Monitoring Metrics
Operational Performance - UEC			
4	Consistent improvement in performance to deliver UEC type 1 to >50% and 12 hour waits to below 8%	• 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	• Type 1 Performance • All type performance • Patients waiting more than 12hrs in ED (%) • Tiering criteria • Length of Stay (7,14,21 day)
5	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.	• 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	• Virtual Ward utilisation • Risk register deep dive within annual workplan • Quality indicators e.g. reduction in number serious incidents in relation to deteriorating patients through UEC pathway, reduction in restrictive practices, etc • Clinical Harm Review process for any breaches

Reset – Transition Criteria, Suggested Evidence & Monitoring Metrics (3) Ops – Planned Care

	Transition Criteria	Suggested Evidence	Monitoring Metrics
Operational Performance – Planned Care (RTT, Cancer and Diagnostics)			
6	To deliver Zero 104 and 78 week waits with consistent reduction in overall Patient Tracking List (PTL) and 65 week waits in order to deliver zero by March 2025	• 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	• 104 weeks • 78 weeks • 65 week Cohort • 65 week actuals • Clinical Harm Review process for any breaches • Risk register deep dive within annual workplan • Overall PTL
7	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog	• 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	• 28d FDS • 62d backlog • 62d combined performance
8	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered	• 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	Diagnostic PTL • Percentage of >6ww DM01 CDC activity • Utilisation rates for CT, MRI, NOUS Endoscopy data • Incidents relating to diagnostics/treatment delays

Reset – Transition Criteria, Suggested Evidence & Monitoring Metrics (4) Finance

	Transition Criteria	Suggested Evidence	Monitoring Metrics
Finance			
9	Delivery of 2024/25 plan inclusive of the CIP, income and expenditure plans	• 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%	• Monthly Financial Plan vs Actual • Monthly and quarterly CIP plan vs actual
10	Robust financial oversight, governance, and a strong financial control environment in place	• 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	• Successful implementation of recommendations in PwC Financial Grip and Control Report
11	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable progress towards delivery	• 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	• Medium term financial plan

NHS
East Kent
Hospitals University
NHS Foundation Trust

True North & Breakthrough Objectives Linked to the Integrated Improvement Plan

	True North Strategic Objective	True North Measure	Annual Breakthrough Objective	Measure/ Aim
Quality & Safety	Reducing Harm and the delivery of safe services	To be in the top 20% of trusts with the lowest mortality Zero avoidable harms graded moderate or above	1. Reduce the numbers of moderate and above harms from falls 2. Reduce the numbers of moderate and above harms related to Pressure Ulcers	1. By 10% based on total of moderate and above harms from falls from 2023/24 baseline (49) 2. By 10% based on total of moderate and above harms related to Pressure Ulcers from 2023/24 baseline (17)
Patients	Patient, family and community voices will be at the heart of everything we do	Achieve an Overall score of 96% in the Friends and Family Test	Improvement in the FFT response rate	Achieve 30% Response Rate
	Timely access for all to planned and unscheduled care	95% of patients seen and treated or discharged from ED within 4 hours 85% of patients receive cancer treatment with 62 days No patient will wait longer than 18 weeks for treatment	1. To reduce the number of type 1 patients waiting more than 4 hours in ED 2. To reduce the number of patients waiting more than 12 hours in ED 3. To reduce the number of patients with an extended wait for diagnostics and planned care 4. To improve the waiting times for cancer treatment	1. Type 1 performance consistently better than 50% 2. 12 hour waits less than 8% of all attendances 3. Zero 65 week waits, Diagnostics 22% 4. Cancer FDS > 80%, 62 day > 75%
People	Our staff feel cared for as individuals and that teamwork, trust and respect sit at the heart of everything we do	To be in the top 25% of NHS organisations for the staff engagement score	Demonstrable improvement of the culture of the organisation	1. Staff survey response rate greater than 50% 2. Staff Engagement Score improvement to Quartile 3 nationally from Quartile 4
Partnerships	Working collaboratively to improve the health and outcomes of the local population and reduce health inequality	TBC	Development of organisational strategy for clinical pathways	Draft Strategy by March 25
Sustainability	To deliver financial sustainability	Achieve a sustainable breakeven, or better, position	Delivery of the 2024/25 Financial Plan	Delivery of the CIP and Expenditure Plans
Research and Innovation	To be a research centre of excellence	*To note: This is a newly added strategic domain and the work is underway to agree the Strategic and Annual Objectives*		

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **6 June 2024**

Board sponsor: **Director of Corporate Governance**

Paper Author: **Director of Corporate Governance**

Appendices:

Appendix 1: Board Assurance Framework (April 2024)

Executive summary:

Action required:	Information
Purpose of the Report:	Following the approval by the Integrated Audit and Governance Committee (IAGC) of the new format of the Trust's BAF, it is presented at this open Board as the position at end of April 2024.
Summary of key issues:	The 'Board Assurance Framework' or BAF brings together in one place the Principle Risks associated with EKHUFT delivering its Strategic Objectives. This is one element of a suite of mechanisms which the Board uses to assure itself on performance against our pillars of change and strategic objectives. 

East Kent Hospitals University NHS Foundation Trust

	For each strategic theme the key risks associated with that area, including: • the inherent risk score, current risk score and target risk score for that risk – the inherent risk score and target risk score will remain static for as long as the risk is 'live'; • the current risk score is updated to reflect changes in the risk environment and improved controls; and • the oversight Board Committee. Following the review of the Trust Strategic Objectives and Risk Appetite the BAF has been updated. The BAF will be reviewed monthly within Executive meetings and brought to each respective Committee and the full Board. Alongside the work on the BAF the Director of Quality Governance is overseeing work on updating and reviewing the Significant Risk Register. The BAF has been updated with current risks on the significant risk register. As the work on the risk register progresses this will be reflected in future versions of the BAF. The BAF will undergo a further review as part of a Committee Governance Review being undertaken by the Director of Corporate Governance in June.
Key recommendations:	The Board of Directors is asked to **NOTE** the April version of the BAF.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	This paper provides an update on the BAF as at April 2024.
Resource:	N
Legal and regulatory:	The work on governance and risk supports the trust to demonstrate how it meets legal and regulatory standards.
Subsidiary:	N

East Kent Hospitals University NHS Foundation Trust

Assurance route:

Each Executive lead has contributed to the content of the BAF.

The BAF will drive agendas of Board Committees.

East Kent Hospitals University NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)

APRIL 2024

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

Summary BAF Dashboard

Strategic Theme	Principle Risk	Oversight Committee	Inherent Risk Score	Current Risk Score	Change ↑↓↔	Target Risk Score	Previous Risk Trend *(for future iterations)*	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	20	↔	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	20	↔	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		July 2024/25 (Score 12)
	Ref: BAFFPC001 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.	Finance & Performance Committee (FPC)	20	20	↔	12		Q3-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	20	↔	12		Q3-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		Q3 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		Q3 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	16	↔	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)

STRATEGIC THEME: Our Quality & Safety:
Strategic Objective: Reducing Harm and Delivering Safe Services
We will do this by developing and fostering a safety culture in which all of us respond openly and learn when things go wrong, where we involve patients and families and do everything we can to improve the conditions where our staff work and patients are treated.

Executive Owner: Chief Medical Officer (CMO) and Chief Nursing and Midwifery Officer (CNMO)
Responsible Committee: Quality and Safety Committee

Risk Appetite
We have a **CAUTIOUS** appetite for **QUALITY** risks. Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
Risk Tolerance: The tolerance for quality risks is a low (6).

Principal Risks	Informed by Current Significant Risk Register Entries	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**	Ref 2808 QEQM Recognition and response to the deteriorating patient (16) Ref 3210 failures to comply with IPC standards (15) Ref 679 chemotherapy supply (15) Ref 3556 risk of pressure ulcers and falls (15) Ref 3333 Access to specialist input at KCH due to lack of ITU consultants (20) Ref 2158 delays in A&E chest x-ray reporting (16) Ref 2682 Radiation governance (16) Ref 2696 Resuscitation training (16)	Reducing and in line with any agreed trajectories • Cases of moderate harm and above for the top 5 recurring incidents • Number of repeat incidents • Reduction in trajectory of overdue incidents (4,439 in Feb 2023) • Number of hospital falls with harm • Hospital acquired pressure damage • ITU admissions relating to deteriorating patients improving inpatient survey score based on 10 selected question (in Oct 21 was 7.13 against target of 7.65) evidence that there are systems and processes in place within services/specialities to identify emerging risks and issues Quality Annual Account Progress against RSP Exit Criteria in relation to Quality	Quality strategy 2022-2026 Quality Governance Framework Mortality Governance reporting Falls group Tissue Viability Group Clinical Ethics Committee Regulatory Compliance and Oversight Group Clinical Audit and Effectiveness Committee	<u>Level 1- Team/Ward</u> Review of incidents Ward Accreditation Care Group Performance Review Meetings (PRMs) <u>Level 2 – Trust</u> Integrated Performance Report (IPR) – Quality Metrics Infection, Prevention and Control (IPC) Annual Report Quality Account CEMG Quality and Safety Committee including assurance reports from: ▪ Patient Safety Group ▪ Regulatory Compliance and Oversight Group ▪ Safeguarding Assurance Group ▪ Fundamentals of Care Group ▪ Medicines Oversight and Assurance Group ▪ CQC Oversight and Assurance Group ▪ Clinical Audit and Effectiveness Committee Trust Board including quarterly CQC Report <u>Level 3- Third party/independent</u> CQC inspection Internal Audit review of governance Benchmarking data for Critical Care and HCAI available Quality Account scrutiny NHSE oversight of RSP exit criteria	<u>Gaps in Controls</u> <u>Gaps in Assurance</u>	<u>Ward to Board Oversight:</u> 1. Quality and Safety Committee Structure & Effectiveness 2. Sub-Committee Review 3. Significant Risk Review Collaboration work between professional groups.	Review undertaken of the Quality and Safety Committee structure, which included a full review of the work planner. Committee has been split into two meetings (Assurance and Improvement) which will rotate bi-monthly to ensure appropriate scrutiny and review. ToR reviewed and refreshed, with updated membership. **(COMPLETE – February 2024)** The Quality and Safety Committee will include representative from Kent and Medway ICB **(COMPLETE – January 2024)** Quality and Safety Committee will rotate focus on a Trust Care Group at each meeting moving forward, to ensure appropriate scrutiny and accountability. **(COMPLETE – March 2024)** Effectiveness Review of the Committee to be undertaken to review the new implemented processes and ensure assurance is effective. **(August 2024)** Patient Safety Committee TOR review completed **(COMPLETE – February 2024)** Clinical Audit and Effectiveness Committee (CAEC) ToR review underway with clinical leaders across the Trust. **(May 2024)** Review undertaken of the full Significant Risk Register in collaboration with on site care group & clinical teams **(COMPLETE – March 2024)** Further work to be undertaken to implement clear risk review processes from ward to board. **(May 2024)** Engagement exercise underway to strength relationships between professional groups (such as medical staff and nursing staff). Update to be provided to show progress **(June 2024)**

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 Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**	Ref 1891 Overcrowding in ED (20) Ref 1831 Privacy and dignity in non-care spaces (15) Ref 2766 Lack of surgical admissions lounge impacts on patients experience and dignity (15)	Duty of Candour (all 3 metrics) Evidence to demonstrate the implementation of the National Patient Safety Incident Response Framework (PSIRF) Measure of lessons learnt / number of incidents within themes of PSIRF: 1. Delay / Failure 2. Medication (Administration) 3. Pressure Damage (Hospital Acquired) 4. Deteriorating Patient - Maternity (both Maternal and Neonatal Deterioration) Patient survey outcomes Duty of Candour measures Progress against RSP Exit Criteria in relation to Quality	Mortality review processes Review of Quality Governance arrangements Your Voice is Heard Patient Participation and Action Group Establishment of Participation Partners Reading Signals Oversight Group	<u>Level 1- Team/Ward</u> Care Group Performance Review Meetings (PRMs) Review of incidents <u>Level 2 – Trust</u> Duty of Candour Compliance reporting CEMG <u>Level 3- Third party/independent</u> ICB Safeguarding Assurance processes Coroner's Inquest outcomes Maternity Voices Partnership involvement in MNAG ICB oversight of SI reporting via Quality Meetings	<u>Gaps in Controls</u> Incomplete implementation of PSIRF <u>Gaps in Assurance</u> Limited assurance to understand how patients and families feel they are involved in their care due to national patient surveys. Work underway to review how this will be monitored.	Implementation of Patient Safety Incident Response Framework (PSIRF) <u>Improve Family & Patient Engagement to incidents and complaint investigations:</u> 1. Duty of Candour Compliance 2. Patient Participation Partners 3. Complaint / PALS	PSIRF Plan and Policy have been reviewed by CEMG, Quality and Safety Committee, Board of Directors and the Trust's Council of Governors. PSIRF will be implemented effective from April 2024 where it will become BAU. Further reporting and actions to be defined. **(April 2024).** Trust wide improvement in Duty of Candour compliance **(Ongoing Action)** Recruitment programme underway to recruit patient participation partners across the Trust. **(July 2025)** Ongoing work to improve family engagement in incidents and complaint investigations, including the Trust's response times to complaints. **(Ongoing Action)**
Ref: BAFQSC003 There is a risk that the trust won't continue to improve the experience of women and their families following the Independent Investigation into East Kent Maternity Services. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**	Ref 2934 obstetric theatre capacity (16) Ref 2565 midwifery staffing (16) Ref 2899 Obstetric workforce (16)	Progress against RSP Exit Criteria in relation to maternity Completion of CQC 'Must' and 'Should Do' in relation to Maternity CQC Inspections January 2023.	Reading the Signals Group Maternity and Neonatal Assurance Group CNST Reporting CQC Patient Survey	<u>Level 1- Team/Ward</u> <u>Level 2 – Trust</u> MNAG CNST incentive scheme outcomes Patient Experience Committee <u>Level 3- Third party/independent</u> HSIB outcomes MVP CQC inspection NHSE oversight of RSP exit criteria	<u>Gaps in Controls</u> Ability to improve maternity impacted by current estate challenges as referenced in wider estates BAF entry <u>Gaps in Assurance</u>	Maternity RSP Exit Criteria <u>Reading Signals Report</u> 1. Restorative Work Group (June 2024) 2. Dr Bill Kirkup Review CQC 'Must' and 'Should Do' from Maternity Inspections May 2023 Ongoing work to involve women from deprived communities	Stabilisation of criteria relating to maternity metrics and Maternity Improvement Plan (MIP). Review in July to exit oversight arrangements **(July 2024)** Work underway to launch restorative work with families involved in the Reading Signals Process **(June 2024)** Bill Kirkup presenting back to Reading Signals Group following the publication of the report **(May 2024)** A total of 20x Must Do and 18 Should Do requirements came out of the CQC Inspection. Only two Must Do requirements are outstanding. One relates to estates (see BAFFPC003). Second relates to enough maternity staff with the right training, skills and experience to keep women safe. Student Midwives returned to practice in July 2023, and are due to qualify in December 2024 which will mitigate this action. **(December 2024)** Launch of Patient Partners and a Patient Participation and Action Group work ongoing to target deprived communities **(Ongoing Action)**

STRATEGIC THEME: Our Patients:
Strategic Objective: Patients, Family & Community Voices
We will put patient, family and community voices at the heart of everything we do. We will be open and honest when things go wrong, we will constantly seek their feedback and design services with them, and make sure they are listened to, involved and their concerns are acted upon.

Executive Owner: Chief Nursing and Midwifery Officer (CNMO)
Responsible Committee: Quality and Safety Committee

Risk Appetite
We have a **MINIMAL** appetite for **REGULATORY** risks. We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
Risk Tolerance: The tolerance for regulatory risks is a **low (5)**.

Principal Risks	Informed by Significant Risk Register	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 16**		Compliance with CQC standards	CQC oversight arrangements in place Care Group governance includes CQC compliance and action plans CQC Oversight and Assurance Group which feeds direct to Board of Directors	<u>Level 1- Team/Ward</u> Care Group CQC Compliance and Action Plans <u>Level 2 – Trust</u> CEMG CQC Oversight and Assurance Group Trust Board <u>Level 3- Third party/independent</u> CQC inspection	<u>Gaps in Controls</u> <u>Gaps in Assurance</u>	Implementation of actions following CQC inspections in 2023 Self-Assessment Process	Improved oversight and assurance of CQC regulatory compliance improved with the addition of a CQC Oversight and Assurance Group which now provides regular updates to the Quality and Safety Committee and Trust Board **(COMPLETE – January 2024)** Outstanding actions still remain from the CQC Inspections in 2023. Updates to be provided regularly to Board **(July 2024)** A CQC Self-Assessment tool has been refreshed to reflect the updated CQC guidance and was approved at the March Oversight and Assurance Group. This tool will be rolled out to Care Groups and a programme will be established where triumvirate leads present the outputs at a bi-monthly CQC Check and Challenge meeting attended by the CNMO, CMO and Chief Operating Officer (COO). These meetings will commence in May 2024. **(May 2024)**

STRATEGIC THEME: Our Patients
Strategic Objective: Timely access for all of our patients to planned and unplanned care
We will do this by striving constantly to meet national standards for access and outcomes in planned and emergency care.

Executive Owner: Chief Operating Officer (COO) / Chief Strategy and Partnerships Officer (CSPO)
Responsible Committee: Finance and Performance Committee (FPC)

Risk Appetite
We have a MINIMAL appetite for REGULATORY risks. We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
Risk Tolerance: The tolerance for regulatory risks is a low (5).

Principal Risks	Informed by Significant Risk Register	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
Ref: BAFFPC001 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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**	Ref 1895 CT/MRI backlog (16) Ref 2406 loss of nuclear medicine service at WHH (16) Ref 1511 and 3557 increased LOS for MH patients awaiting beds (16) Ref 3264 Maxfax waits (16) Ref 2234 Histopathology TATs (16) Ref 2419 Data Quality issues (16) Ref 2850 Service delivery in patient service centre (16) Ref 3536 delays in endoscopy pathway (16) Ref 2766 Lack of surgical admissions lounge impacts on patients experience and dignity (15) Ref 3367 Lack of timely review of diagnostics (15)	UEC performance - Reduce Corridor Care - Use of escalation beds - Reduce length of stay (LOS) Cancer waiting times RTT performance DM01 Performance Progress against RSP Exit Criteria in relation to Operational Performance	Tier 1 Meeting Structures across Elective, Cancer & UEC Emergency Care Delivery Group Urgent Care Board Cancer Delivery Group Weekly Access Meeting Theatre Oversight Group (TOG) Theatre Implementation Group (TIG) Planned Care Board	<u>Level 1- Team/Ward</u> Care group oversight of constitutional standards Quality of data validation Care Group Performance Review Meetings (PRMs) <u>Level 2 – Trust</u> CEMG Integrated Performance Report (IPR) Performance Metrics Reviewed by Finance and Performance Committee & Trust Board Delivery of NHS Operating Plan <u>Level 3- Third party/independent</u> NHSE oversight of RSP exit criteria System Oversight Meetings including ICB/NHSE/Regional	<u>Gaps in Controls</u> Constitutional standards not fully met – RTT / DM01 / FDS / UEC. <u>Gaps in Assurance</u>	PRISM/KPMG review – Bed Modelling PRISM review of theatres (approx. 16 weeks) Length of Stay (LOS) Programme 24/25 Consultant recruitment ongoing Review of Site Team processes Ongoing tracking of delays to cancer diagnosis with actions to resolve Reset Patient Pathway Programme Trust Target of 78-week waits. Pathway to be reduced to 651 patients by end of FY23-24.	PRISM / KPMG review completed end of March 2024. Output is being taken forward to LoS programme **(COMPLETE – March 2024)** Programme is underway. Review to be fed back to Committee once complete **(June 2024)** Length of Stay (LOS) Programme launched for 24/25. The programme will continue across the full FY24/25 – updates to come to future committee meeting **(June 2024)** Underway – Medical Staffing Reports to be presented on a regular basis **(July 2024)** Review is underway **(July 2024)** Ongoing, regular updates to be provided to the committee **(July 2024)** Programme has been launched at each site, with a programme commencing across the year. Updates to be brought periodically to the committee **(COMPLETE – March 2024** The Trust met, and exceeded, this target with fewer patients waiting over 78 weeks**. (COMPLETE – March 2024)**
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**							
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**	Ref 2796 Renal machines at end of life (15) Ref 3384 insufficient capital for estates works needed (16) Ref 3553 Cath lab equipment failure (16)	Reporting against agreed capital plan Short Term Capital Plan Capacity loss as a direct result of infrastructure and/or equipment failure	The capital plan is prioritised to address the highest risk areas within the available financial envelope – Oversight via Capital Investment Group Business Case Scrutiny Group – Reviews all Business Cases Where slippage occurs, feasible alternative schemes are assessed and prioritised Activity plans monitoring Ongoing engagement and dialogue with the ICB and NHSE to both describe the risk and seek collaborative solutions	<u>Level 1- Team/Ward</u> Reporting of equipment or infrastructure failure Health and Safety audits Fire Safety Audits Care Group Risk Registers <u>Level 2 – Trust</u> Capital programme monitored through Capital Investment Group Oversight of risk through the Health and Safety Committee Risk Review Group (Executive Led) <u>Level 3- Third party/independent</u> Reporting and engagement with the ICB/NHSE	<u>Gaps in Controls</u> Significant gap between the overall capital requirements for the organisational and the forecast capital funding. Lack of complete asset replacement programme Ability to sustain some services in the event of infrastructure or equipment failure <u>Gaps in Assurance</u> Medium/Long-Term finalised Capital Plan.	2023-24 Capital Programme 2024-25 Capital Programme Full prioritisation of the infrastructure and equipment requirement Maternity Proposed Investment Assessment of the Trust estates & options appraisal.	The full capital programme for 2023-24 was delivered **(COMPLETE – April 2024)** Ongoing action for programme to be delivered throughout the year. Monitored via the Capital Investment Group (CIG). Currently on track for delivery **(Ongoing)** Prioritisation completed for 2024-25 and signed off via FPC **(COMPLETE – March 2024)** Initial case for funding submitted, with an aim to fund the scoping of a full business case. Outline business case by September. **(September 2024).** Procurement process started to find a supplier who can complete a review of Trust estate. **(June 2025)**

STRATEGIC THEME: Our People:
Strategic Objective: Care and Compassion
We will treat our patients and each other with care and compassion at all levels across the organisation, create teams that value and respect each other and always strive to deliver better outcomes for patients.

Executive Owner: Chief People Officer
Responsible Committee: People and Culture Committee

Risk Appetite
We have an **OPEN** appetite for **PEOPLE** risks. We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.
Risk Tolerance: The tolerance for people risks is a **moderate (12)**.

Principal Risks	Informed by Significant Risk Register	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**	Ref 3309 ED consultants QEQM (16) Ref 1628 Paediatric staffing in ED WHH (16) Ref 2899 Consultant obstetric workforce (16) Ref 3565 Midwifery staffing levels (16) Ref 2234 Histopathology vacancies (16) Ref 2850 Recruitment to Patient Service Centre (16) Ref 2620 Consultant Medical Microbiologist workforce (16) Ref 2195 Nursing skill mix in ED QEQM (16) Ref 2696 Resus team capacity to train (16) Ref 123 Medical staffing levels (15) Ref 2480 ITU nursing staff levels (15)	Vacancy rates Retention rates – department level Statutory / Mandatory training reporting Staff engagement scores – Quarterly Pulse Survey / Annual Staff Survey Occupational Health Surveillance Quarterly report Premium Pay Spend Guardian of Safe Working Feedback Progress against RSP Exit Criteria in relation to People and Culture	People plan Recruitment and Retention Plan Enhanced VCP - Additional scrutiny for 8d+ roles by CPO. Care Group Level Establishment Plans Trust Workforce Plan - Submitted to ICB to form part of ICB strategic workforce plan. Time to Hire metrics reviewed People & Culture Performance Review Meeting (PRM) – Bimonthly with CEO	<u>Level 1- Team/Ward</u> Care Group Business meetings Care Group Leadership Meetings w People & Culture Leads Monthly Service Provider Meetings (NHSP / ID Medical) <u>Level 2 – Trust</u> People and Culture Committee CEMG Staff Committee People and Culture Performance Review Meeting (PRM) <u>Level 3- Third party/independent</u> NHSE oversight of RSP exit criteria	<u>Gaps in Controls</u> Non-Compliance of externally led Mandatory. Resuscitation & Safeguarding are externally led, and as such, the Trust has limited control. <u>Gaps in Assurance</u>	Review of staff survey results and development of people centred action plan in response. P&C team developing care group specific plans in conjunction with triumvirates in response to staff survey results. Review of safe staffing levels to be completed by CNMO Appointment of a Clinical Psychologist Guardian of Safe Working reporting to P&CC to provide updates on key themes across the Trust.	A review of the staff survey results has been taken to People & Culture Committee and Clinical Executive Management Group (CEMG). Work is underway to initiate the next stage of the Culture and Leadership Programme (CLP) to take forward issues raised. A focus will be on individual care groups and these will be monitored through P&CC/CEMG. **(COMPLETE – April 2024)** Underway – specific concern areas & update on plans to be taken to future committee **(May 2024)** In progress with outcomes being shared via P&CC and to Trust Board **(June 2024)** Clinical Psychologist has been appointed to provide dedicated support the health and wellbeing of staff across the Trust **(COMPLETE – April 2024)** Guardian of Safe Working will provide regular reporting to the P&CC and Trust Board moving forward **(COMPLETE – April 2024)**
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**		WDES measures WRES measures Staff survey results Gender pay gap annual submission FTSU Guardian Contact / Themes Employee Relations Cases & Trust Tribunals Reporting against NHS People Plan Progress against RSP Exit Criteria in relation to People and Culture. Culture and Leadership Programme Insights & Engagement.	Equality and Diversity Strategy. Freedom to Speak up Guardian Culture and Leadership Programme Staff survey programme Patient Surveys	<u>Level 1- Team/Ward</u> Performance Review Meetings (PRMs) <u>Level 2 – Trust</u> People and Culture Committee CEMG Workforce Committee Culture and Leadership reporting Staff survey <u>Level 3- Third party/independent</u> NHSE oversight of RSP exit criteria WRES/WDES benchmarked data	<u>Gaps in Controls</u> <u>Gaps in Assurance</u>	<u>Culture and Leadership Programme (CLP)</u> 1. Launch of Staff-wide forum to amplify staff's voice and to enhance opportunities for two communication. 2. Increase voice opportunities by supporting Staff Networks and launching Admin Forum 3. Unified Vision and Values 4. Everyone feeling valued EDI Objectives across all senior leadership teams.	Initial paper shared with CEMG in April 2024. Communications campaign / action plan in development in collaboration with the CLP Programme. **(May 2024)** Ongoing action to support staff networks **(Ongoing)** Launch of new Admin Forum with an executive lead (Chief Operating Officer) **(May 2024)** 12-week staff engagement programme to be launched between May-June 2024 which will include staff listening events across all Trust sites **(June 2024)** Review Trust's approach to communicate what we are changing: "You said, we did" and celebrate and recognise our colleagues' achievement. **(August 2024)** Ongoing action over appraisal season April-June. **(June 2024)**

STRATEGIC THEME: Our People:
Strategic Objective: Engagement, Listening and Leadership,
We will engage, listen and strengthen leadership throughout the Trust, by creating and supporting compassionate leaders who listen to and involve staff, patients and their families, and who help us to become a diverse and inclusive employer, where staff feel valued and listened to.

Executive Owner: Chief People Officer
Responsible Committee: People and Culture Committee

Risk Appetite
We have an **OPEN** appetite for **PEOPLE** risks. We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.
Risk Tolerance: The tolerance for people risks is a **moderate (12)**.

Principal Risks	Informed by Significant Risk Register	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
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 Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 20**		Outcomes of well-led reviews Progress against RSP Exit Criteria in relation to Leadership and Governance	Governance Framework Integrated Improvement Plan	<u>Level 1- Team/Ward</u> Performance Review Meetings (PRMs) <u>Level 2 – Trust</u> Well-led review CEMG People and Culture Committee <u>Level 3- Third party/independent</u> CQC well-led review GGI review NHSE oversight of RSP exit criteria	<u>Gaps in Controls</u> <u>Gaps in Assurance</u>	Organisational Leadership Development 1. A Kind Life 2. Behaviour Framework 3. Leadership Development Programme Succession Planning model based on Scope for Growth to be rolled out to tier one leaders	Centrally funded roll out of the 'Kind Life' programme to leaders across the Trust. This included a session by the Board of Directors and multiple workshops across the Trust which resulted in approx. 250 leaders attending **(COMPLETE – February 2024)** Development of a behaviour framework on 'what good looks like' to support managers and hold staff to account **(May 2024)** A series of leadership development programmes have been launched (leading others, First-line leader and Mid-level leader) to cover all positive leadership behaviours. Programme underway with approx. 110 leaders completed, and 90 on programme **(Ongoing)** Launch of a standalone module on Compassionate Leadership for managers who may not need the full longer programme **(COMPLETE – March 2024)** Ongoing action **(June 2024)**

STRATEGIC THEME: Our Partnerships
Strategic Objective: Organisational Development
We will develop our organisation by creating a stable leadership which is open to challenge, is supported by strong governance, clear communication from ward to Board and promotes and values working with our partners in East Kent, Kent and Medway and beyond.

Executive Owner: Chief Strategy and Partnerships Officer
Responsible Committee: Finance and Performance Committee

Risk Appetite
We have a **MINIMAL** appetite for **REGULATORY** risks. We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
Risk Tolerance: The tolerance for regulatory risks is a **low (5)**.

Principal Risks	Informed by Significant Risk Register	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 16**		Development of the organisational strategy Defined timeline for the implementation of the strategic intentions	Trust governance structure Oversight through Care Group Performance Review Meetings	Level 1- Team/Ward Limited assurance due to the lack of a strategy Level 2 – Trust Limited assurance due to the lack of a strategy Monitoring of current strategic decisions and programmes of work i.e Stroke reconfiguration • CEMG • Capital Investment Group Board and sub-committees Reporting to Finance and Performance Committee Level 3- Third party/independent ICB Stroke Programme gateway reviews ICB Oversight Meetings	Gaps in Controls Lack of clinical strategy Lack of resources to develop strategy Gaps in Assurance	Initial scope for strategy development programme Launch stage one of strategy development programme: 1. Establish Integrated Strategy Steering Group 2. Clinical Strategy Engagement 3. Estates Strategy Engagement	Scope completed and presented to CEMG **(Complete – April 2024)** Formation of the steering group including Terms of Reference and Membership underway. First meeting due in May. **(May 2024)** Creation of a framework to ensure consistent approach, making clear of the context of the strategy process. Engagement with 32 specialities across the Trust, including clinical and operational colleagues **(July 2024)** Ensure a shared understanding of existing estates information and collate up to date information into one place, including the development of a critical infrastructure infographic **(July 2024)**
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 16**		Oversight framework CQC Ratings Integrated Improvement Plan Recovery Support Programme Oversight	Integrated Improvement Plan programmes CQC must and should do delivery action plans UEC and Planned Care improvement programmes linked to Tier 1 status ICB/EKHUFT leadership engagement Board to board with the ICB Membership of the Health and Care Partnership Board Leadership Participation in the Kent and Medway Acute Collaborative Network Engagement in the pathology network development Engagement in the HCP estates strategy development	Level 2 – Trust Integrated Improvement Plan is being delivered Consistent engagement with external partners Joint delivery plans in place such as Tier 1 delivery plan Level 3- Third party/independent NHSE oversight of RSP exit criteria	Gaps in Controls Controls and structures are in place but not fully delivering common aims and objectives Gaps in Assurance	Reset Integrated Improvement Plan (IIP) Integrated Care Board Strategy – EKHUFT Involvement	Draft plan shared with Board of Directors and Council of Governors in March/April. Awaiting final version **(June 2024)** Formation of ICB Strategy which covers People / Sustainability / Finance and Patient Experience & Outcomes metrics. EKHUFT will have a requirement to feed into the overall ICB position. Strategy to be formulated by June **(June 2024).**

STRATEGIC THEME: Our Sustainability:
Strategic Objective: Financial Sustainability
We will deliver high-quality, safe care, which is cost-effective and reduces waste and have a break even financial position.

Executive Owner: Chief Finance Officer
Responsible Committee: Finance and Performance Committee

Risk Appetite
We have a **CAUTIOUS** appetite for **FINANCIAL** risks. We are prepared to accept the possibility of limited financial risk. However, value for money is our primary concern.
Risk Tolerance: The tolerance for financial risks is a moderate (10).

Principal Risks	Informed by Current Corporate Risk Entries	Measures	Controls in place (Existing) How are we managing the risk?	Assurances – what is the evidence that controls are effective	Gaps in controls and assurance	Actions (SMART)	Progress (date)
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. Risk identified: October 2023 **Date last reviewed: April 2024** **Next review: July 2024** **CURRENT RISK SCORE: 25**	Ref 3383 Failure to deliver the financial plan for 2023/24 (16) Ref 3133 Trust will not meet its 2023/24 efficiencies target (20) Ref 3134 Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline (16) Pending approval Trust fails to identify £49m of savings for delivering 2024/25 (16) Pending approval Trust fails to deliver £49m of savings for 2024/25 (25) Pending approval System relationships and joint working fail to realise the cross-system savings required. (25)	Forecast against actual planned budget. Cost per WTE benchmarked with other NHS trusts. CIP forecast and delivery in 2024/25. Progress against RSP Exit Criteria in relation to finance.	Enhanced vacancy control panel now in place. Enhanced non-pay control panels now in place. Agreed independent forecast with NHSE and monitoring performance against that forecast at Care Group level. CIP identification at both Care Group, cross-Trust and system level underway. Monitoring of CIP identification and delivery on a by weekly basis through FIOB.	<u>Level 1- Team/Ward</u> Care Group Performance Review Meetings (PRMs) <u>Level 2 – Trust</u> Finance and Performance Committee (FPC) Monitoring of the output of vacancy control panels and non-pay panels Reduction in run-rate pay spend seen in month 9 Financial Improvement Programme Board (FIPB) <u>Level 3- Third party/independent</u> NHSE oversight of RSP exit criteria	<u>Gaps in Controls</u> Lack of detailed CIP plan for 2024/25. No agreed forecast position for 2024/25. <u>Gaps in Assurance (including outcomes of assurance processes)</u> Independent follow up assessment of controls implemented has not yet taken place (due May 2024).	CIP plans for 2023-24. CIP Plans for 2024-25 Agree forecast position for 2024/25.	Full CIP plans for 2023-24 were delivered. **(COMPLETE – April 2024)** CIP Plans scoped for year with a risk adjusted position of £43m, with a need to plan £49m. Aim for full scope of CIP 24-25 by May 2025. **(May 2025).** DRAFT Financial forecast was agreed at FPC and Trust Board March 2024. This was prior to publication of national operating guidance. Final forecast to be agreed **(June 2025).**

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Risk Register Report**

Meeting date: **6 June 2024**

Board sponsor: **Chief Nursing and Midwifery Officer**

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

Appendices:

Appendix 1: Significant Risk Report 23 May 2024

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through Clinical Executive Management Group (CEMG) and the appropriate Board Sub Committees to Board. This paper show movement in month, details those risks that have been de-escalated from the Significant Risk Register due to the mitigations in place and new risks. Escalations from the last Risk Review Group on 22 April 2024 are provided for information.
Summary of key issues:	Phase 1 of the Risk Review was completed at the end of March 2024. The review involved a comprehensive review of risk registers at corporate and clinical care group level and the creation of one Trust risk register – with a significant risk report (SRR) that would ensure that the highest risks to the organisation were visible at Subcommittee and Board level. A Risk Review Group has also been established. This meets monthly and is chaired by the Chief Nursing and Midwifery Officer. Phase 2 of the Risk Review involves embedding the improvements made into business as usual with appropriate oversight and governance. This work will continue to be refined and developed. We are awaiting the final report from the recent internal audit into risk management conducted on behalf of the Trust by RSM LLP. The draft report indicates the Board can take 'reasonable assurance' that the controls upon which the organisation relies to manage risk are suitably designed, consistently designed and effective. There are four management actions

	within the draft reports which once finalised will be integrated into the Risk Strategy and workplans. The final report is expected by the end of May 2024 and will be reported via the appropriate Sub Committees to Board. All of the risks contained in the significant risk report have had a 'review' within the last four weeks (at the time of writing) and there has been a significant improvement in ensuring actions are completed on time or updates are added where there is slippage. Monthly meetings with each accountable executive and the Associate Director of Quality Governance (in the absence of a Risk Manager) commenced in May to review the Significant Risk Report and any additional risks within the Corporate sections of the risk register. Other escalations from the last Risk Review meeting (22 April 2024) to CEMG are noted below for the information of the Board. • An external visit of the aseptic unit at Kent & Canterbury Hospital (K&C) took place on 12 March 2024 by the NHS Specialist Pharmacy Service Quality Assurance (QA) team (London & South East (SE) England). The unit's operation was deemed 'high risk' – with three deficiencies rated as 'critical'. Two are related to facilities and one to product approval. Since the last report to Quality & Safety Committee (Q&SC) the facilities risk has been upgraded from 15 (high) to 20 (extreme) (ref 679). An action plan is in place with oversight from the Chief Medical Officer (CMO). The action plan is linked to the risk record and is being updated regularly. • A formal process has been agreed whereby 2gether Support Solutions (2gether) will share their Risk Register monthly. All relevant risks 12 (moderate) and above will be added to the Trust Subsidiary Risk Register on 4Risk – and where relevant linked to existing risks. Any relevant risks with a score of 15 and above will be reported via the Significant Risk Report for the next meeting in June 2024 following validation at the Risk Review Group. The Subsidiary Risk Register will be reviewed quarterly on an ongoing basis via the Risk Review Group. It is also received at the contract monitoring meeting. 2gether representatives will continues to attend the Risk Review Group as members – to enable discussion about emerging risks via the clinical care group deep dives and escalations. • Interim Consultant, has been reviewing Spencer Wing, and will make recommendations in relation to risk management. It is recommended that the Subsidiary Risk Register also be used to enable transparency and representatives from Spencer Wing attend the Risk Review Group.

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to **SUPPORT** the recommendations above made within the paper. The Board of Directors is asked to **RECEIVE** the Significant Risk Report for assurance purposes and for visibility of key risks facing the organisation.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
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. There is one Risk Manager for the whole organisation who works within the Quality Governance directorate. This post is vacant as of the end of April 24. Recruitment has been unsuccessful and the job description is under review. Support is being provided by the Associate Director of Quality Governance and interim support sought.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer

Assurance route:

The Significant Risk Report was discussed at the Risk Review Group on 22 April 2024 and then presented at Clinical Executive Management Group (CEMG) on 1 May 2024.

It should be noted that as the Risk Register is a live document the supporting information provided in the Appendix was extracted on 23 May 2024. Whilst the Risk Register will contain updates since presentation at CEMG it will not include additional new risks as these require approval at the Risk Review Group ahead of CEMG.

We care

East Kent Hospitals University NHS Foundation Trust

SIGNIFICANT RISK REPORT

1. Purpose of the report

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

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

1.3 Escalations are presented as discussed and agreed at the Risk Review Group on 22 April 2024. These have previously been escalated to CEMG on 1 May 24 but are contained for completeness.

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 the Interim Consultant in October 2023.

2.2 The review has been supported corporately by the Trust Risk Manager and an Interim Risk Consultant (2 days per week). Phase 1 of this work was concluded at the end of March 2024.

2.3 One of the outputs of the Trust Risk Review was the creation of a Significant Risk Report. The latest is attached (Appendix 1) and summarised with priority actions noted.

2.4 The Risk Review Group was established in early February 2024. The fourth meeting was held on 22 April 2024 where there was a deep dive presentation received into the Diagnostics, Cancer and Buckland Care Group risks and Corporate Finance risks. Escalations are noted for the attention of CEMG. The next meeting is due to take place on 24 May 2024 when the Critical Care Anaesthetics and Specialist Surgery Care Group will be presenting.

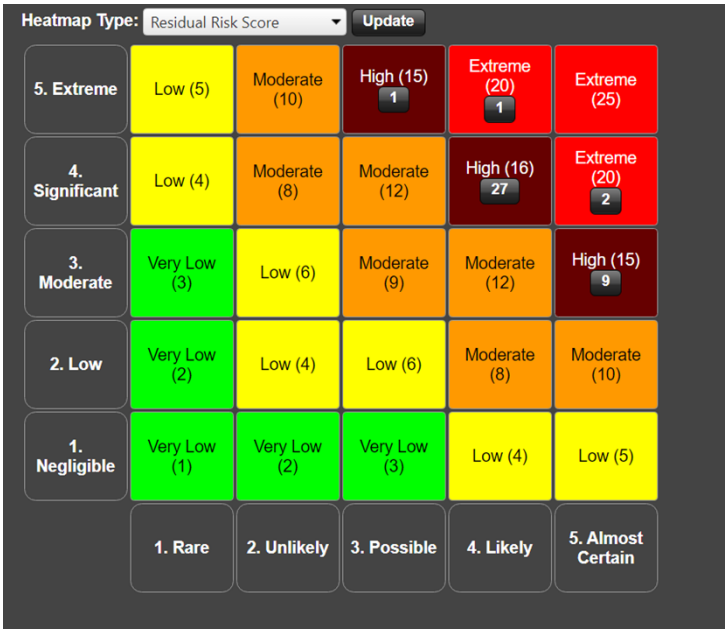
3. Current Significant Risk Register

3.1 There are currently 40 risks in total on the Significant Risk Report (down from 47 in the last report and 82 at the start of the review). These are shown by care group and residual risk rating below. The Significant Risk Report is at Appendix 1.

3.2 Whilst there has been an increase in risks with a residual score of a 16, there are currently only three ‘extreme’ risks (20 or above) compared to seven at the time of the last report due to mitigations enacted.

East Kent Hospitals University NHS Foundation Trust

	Residual Risk Score				
Care Group	**15**	**16**	**20**	**25**	**Total**
CCASS CG	2	2			4
DCB CG	1	8	1		10
K&C CG	1				1
QEQM CG	1	6			7
WHH CG	2	3			5
WCYP CG		4	1		5
Corporate Finance					
Corporate Medical	2				2
Corporate Nursing	1				1
Corporate Operations		3	1		4
Corporate Strategic Development & Capital Planning		1			1
TOTAL	**10**	**28**	**3**	**0**	**40**
CHANGE SINCE APRIL BOARD REPORT	**-5**	**+3**	**-3**	**-1**	**-7**



3.3 The five risks that are no longer on the Significant Risk Report are:

- Lack of skilled trained Intensive Therapy Unit (ITU) nurses (ref: 2480) (Critical Care, Anaesthetics and Specialist Surgery Care (CCAS) Care Group (CG)). Previous residual risk score 15 (high). Current score 12 (moderate).
- Risk of patient harm and to staff mental health as a result of mental health patients accessing Queen Elizabeth the Queen Mother Hospital (QEQM) Radiology to attempt self-harm (ref: 3465). Previous residual risk score 15 (high). Current score 9 (moderate).
- Delayed diagnostics for patients awaiting Endoscopy (Ref: 3536). Corporate Operations. Previous residual risk score 16 (high). Current score 12 (moderate). All endoscopy risks under review by the Deputy Chief Operating Officer (COO) for Planned Care.
- Non-delivery of the agreed Cost Improvement Programme (CIP) that contributes to the Trust deficit position (ref: 3133). Previous residual risk score 20 (extreme). Current score 12 (moderate). This risk has since been closed and will be updated for 2425 financial year.

3.4 There have been two closures of risks on the Significant Risk Report this month.

- Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline (ref: 3134). Corporate Operations. Previous residual risk 15 (high). This risk has been closed.
- Failure to deliver the financial plan of the Trust as requested for 2023/24 (ref: 3383). Corporate Finance and Performance Management. Previous residual risk 16 (high). This risk has been closed. A new emerging risk has been opened for 2024/25 financial year as below.

3.5 There is one additional new risk on the Significant Risk Report this month.

- There is a demand and capacity gap in respiratory sleep and diagnostic services which risks patients breaching Referral to Treatment (RTT), DM01 and Cancer targets (ref: 3642). QEQM CG. Residual risk score 16 (high).

3.6 There is one emerging risk on the Significant Risk Register. This risk is being further developed and aligned with the financial plan and Integrated Improvement Plan (IIP).

- Failure to deliver the Trust financial plan for 2024/25 (ref: 3664). Corporate Finance. Residual risk score 16 (high).

3.7 The risk score of a moderate risk has been increased so this is now on the Significant Risk Register.

- Exposure of staff to level of nitrus oxide from the use of Entonox in the maternity unit (ref: 2999). Women's Health, Children and Young People (WHCYP) CG. Residual risk score increased from 9 (moderate) to 16 (high). The score was increased due to findings of a recent external review that was commissioned with a medical gas company on 20 May 2024. The elevated risk related to the William Harvey Hospital (WHH) site (midwifery led and delivery suite). Immediate

mitigations have been put in place and retesting occurred on 22 May 2024. The risk score will be amended following receipt of the findings

3.8 The Risk Review Group has now met four times. Deep dives have been undertaken for Corporate Nursing, the WHH Care Group, Corporate Operations, QEQM Care Group, Corporate Medical, Diagnostics Cancer and Buckland Care Group and Corporate Finance. Critical Care Anaesthetics and Specialist Surgery Care Group will be presenting at the next Risk Review Group on Friday 24 May 24.

4. Sustaining and embedding the improvements (Phase 2) update

4.1 Phase 2 of the Risk Review involves embedding the improvements made into business as usual with appropriate oversight and governance. This will include further strengthening local care group governance processes around risk working with the Quality Governance Business Partners – and governance leads for the Diagnostics, Cancer and Buckland Care Group and Women's Health.

4.2 We have recently received the draft report and were invited to a feedback session following the recent internal audit into risk management conducted on behalf of the Trust by RSM LLP. The report indicates the Board can take 'reasonable assurance' that the controls upon which the organisation relies to manage risk are suitably designed, consistently designed and effective, and examples of good practice are noted. There are 4 management actions within the report which once finalised will be integrated into the Risk Strategy and workplans. The final report is expected by the end of May 2024 and will be reported with an associated action plan via Clinical Executive Management Group (CEMG) the appropriate subcommittees and to the next public Board.

5. Escalations from Risk Review Group (22 April 2024)

5.1 An external visit of the aseptic unit at Kent & Canterbury Hospital (K&C) took place on 12 March 2024 by the NHS Specialist Pharmacy Service QA team (London & SE England). The unit's operation was deemed 'high risk' – with three deficiencies rated as 'critical'. Two are related to facilities and one to product approval. Since the last report to Q&SC the facilities risk has been upgraded from 15 (high) to 20 (extreme) (ref 679). An action plan is in place with oversight from the CMO. The action plan is linked to the risk record and is being updated regularly.

5.2 A formal process has been agreed whereby 2gether will share their Risk Register monthly. All relevant risks 12 (moderate) and above have will be added to the Trust Subsidiary Risk Register on 4Risk – and where relevant linked to existing risks. Any relevant risks with a score of 15 and above will be reported via the Significant Risk Report for the next meeting in June 2024 following validation at the Risk Review Group. The Subsidiary Risk Register will be reviewed quarterly on an ongoing basis via the Risk Review Group. It is also received at the contract monitoring meeting. 2gether representatives will continue to attend the Risk Review Group as members – to enable discussion about emerging risks via the clinical care group deep dives and escalations.

5.3 Interim Consultant, has been reviewing Spencer Wing, and will make recommendations in relation to risk management. It is recommended that the Subsidiary Risk Register also

be used to enable transparency and representatives from Spencer Wing attend the Risk Review Group.

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.

Risk Register Report (By Residual Risk Ranking)

Report Date	23 May 2024
Comparison Date	In the past 30 Day(s)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
679	31 Aug 2016	Care Group - Diagnostics, Cancer and Buckland		Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Rebecca Morgan **Last Updated:** 06 May 2024 **Latest Review Date:** 06 May 2024 **Latest Review By:** Rebecca Morgan **Latest Review Comments:** Amended action regarding risk assessment as this was team to complete and submitted Added in actions regarding options paper and will adjust following CIG to break down actions to get to new build Added in and uploaded action plan for regional QA	**Cause** Aseptic unit failure Air handling unit failure Regional QA audit review (12.3.24) highlight 3 critical deficiencies which move the unit from medium to high risk unit Inability to recruit and retain staffs year on year increase in demand for chemotherapy. Aseptics unit has a maximum capacity of 70 makes daily. Capacity issues in commercial sector for supply of ready to use chemotherapy Isolator failure within the Aseptic unit Failure to obtain consumables due to non payment of invoices Unsuitable storage conditions of consumables and starting materials **Effect** 1. Failure to supply scheduled chemotherapy (as at 23.10.23 2500 treatments dispensed per month) 2. Cancellation of patients treatments 3. Rescheduling of patients treatments 4. Outsourcing of chemotherapy from a commercial market - excessive increase in costs that may not be met by NHS Specialised commissioning 5. Commercial market may not have capacity to support volume of work from EKHUFT especially at short notice 6. Risk of waste from outsourcing 7. Some treatments cannot be outsourced due to short expiries impacting on patient care 8. Increased risk of error as the unit is not designed as a 'dispensing' facility 9. Support for clinical trials would stop 10. Adverse publicity for the Trust 11. The effect of the unsuitable storage conditions of consumables and starting materials would affect the production process and ultimately the quality of the medicinal products 12. If Trust does not rectify the 3 critical deficiencies highlighted in regional QA report (12.3.24), the unit is extremely likely to be shut down, causing all of the above effects to occur.	Quality	I = 5 L = 5 Extreme (25)	Accountable pharmacist seconded 3 days / week from MTW in short term **Control Owner:** Rebecca Morgan		I = 5 L = 4 Extreme (20)	Options regarding future plan for APU presented at CIG. Presentation will be by strategic development but support for options provided by APU staff. Actions will be generated following outcome of CIG **Person Responsible:** Rebecca Morgan **To be implemented by:** 31 May 2024		I = 5 L = 2 Moderate (10)
								APU now has 5 working isolators which can be alternated between in case of a shut down for 2 isolators in a room **Control Owner:** Jenny Clements	Adequate				
								Business continuity plan in place **Control Owner:** Jenny Clements	Limited		Risk assessment for manufactured items which have visible particulate within. Update of processes to ensure medical staff aware when situation arises.- SOP to be updated - to be worked on with Lead Oncology Pharmacist and Accountable Pharmacist Currently any treatments with visible particles that are identified as not drug particulate are being remade. **Person Responsible:** Jenny Clements **To be implemented by:** 31 May 2024		
								Capacity plan in place, monitored and reviewed on a daily basis, (takes into account activity demand, staffing and isolator capacity). Breaches of capacity risk assessed. Activity demand reviewed monthly and reported through Governance structure. **Control Owner:** Jenny Clements	Limited				
								Control of consumable stock management and ordering - highlight supplier list in order of priority **Control Owner:** Jenny Clements	Adequate		Team to work with seconded Accountable pharmacist to follow action plan generated for regional QA by next regional inspection. Escalation of issues to Rebecca Morgan / Des Holden with any barriers to completion of timelines. **Person Responsible:** Jenny Clements **To be implemented by:** 28 Jun 2024		
								Daily review and inspection of clean rooms **Control Owner:** Jenny Clements	Adequate		Replacement of the unit with off site licensed facility as part of the ICS strategy and linked to the national aseptic review. **Person Responsible:** Will Willson **To be implemented by:** 30 Sep 2029	**04 Jul 2022** **Will Willson** National Aseptic review has allocated the £75M of capital, none has gone to London or the SE so therefore the case will not be reviewed until 2026. Action date to be updated	
								Embedded Quality Management System inclusive of: Weekly quality meetings Internal and External Inspections Error reporting and review Risk assessment on days where capacity exceeded Pharmacy QA resource to refer to **Control Owner:** Rebecca Morgan	Adequate				
								Estates PPM of building, AHU and clean room **Control Owner:** Jenny Clements	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								for the unsuitable storage conditions of stock and starting materials , storage boxes and and plastic pallets are being used to store starting materials and stock to minimize the transfer of microbiological organisms into the production unit **Control Owner:** Jenny Clements					
								Patient tracking list to support allocation of treatments to appts scheduled - **Control Owner:** Jenny Clements	Adequate				
								Quarterly PPM reports for all five isolators with supplier **Control Owner:** Jenny Clements	Adequate				
								Reduction in length of maximum expiry date of all manufactured products to 24 hours from time of manufacture. **Control Owner:** Jenny Clements					
								SLA in place with all suppliers for servicing and support **Control Owner:** Jenny Clements	Adequate				
								SLA with commercial companies supported by SOP for outsourcing **Control Owner:** Jade Winthrop	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1891	14 Jan 2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sandra Cotter **Last Updated:** 21 May 2024 **Latest Review Date:** 22 May 2024 **Latest Review By:** Emma Kelly **Latest Review Comments:** Reviewed with COO and Deputy COO 22/05/24	**Cause** The increasing demand for healthcare services within the Trust has surpassed the existing capacity, leading to strain on resources, longer waiting times, and compromised patient care. **Effect** Elevated patient dissatisfaction due to prolonged waiting times. Possible decline in the quality of the services provided. Increased risk of adverse patient outcomes. Strain on staff leading to burnout and decreased morale.	Quality	I = 4 L = 5 Extreme (20)	Daily board rounds at ward level to release beds **Control Owner:** Robert Hodgkiss	Limited	I = 4 L = 5 Extreme (20)	Expand trial of SPoA to QEQM **Person Responsible:** Sandra Cotter **To be implemented by:** 28 Jun 2024	**25 Apr 2024** **Sandra Cotter** SPOA pilot has been extended to Thanet from mid February . circa 5-10% reduction in conveyances seen . further review of the service is currently in progress with the ICB with the aim to establish a fully funded SPOA for EKUFT post June 24	I = 3 L = 2 Low (6)
								Daily sitrep calls with EK HCP and Kent and Medway OCC **Control Owner:** Robert Hodgkiss	Adequate				
								Kent and Medway UEC Delivery Board provides system wide strategic direction attended by the COO **Control Owner:** Robert Hodgkiss	Adequate		Further enhance collaboration with community healthcare providers to alleviate ED burden with measure attendance avoidance **Person Responsible:** Sandra Cotter **To be implemented by:** 30 Jun 2024	**29 Apr 2024** **Emma Kelly** SPOA pilot is reducing conveyances by circa 10%. Seeking funding from the ICB. Working with the HCP in expanding the virtual ward opportunity with a focus on the acute front door pathways. HCP invested in increased home care capacity for P2 and reviewing P3 capacity for dementia. Sandra Cotter, 19/04/24	
								Trust Access Standards monitored ‘ED 12 Hour Total Time in Department’ **Control Owner:** Robert Hodgkiss	Limited		Conduct a comprehensive review of current ED processes and identify areas for improvement - focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED **Person Responsible:** Sandra Cotter **To be implemented by:** 30 Jun 2024	**29 Apr 2024** **Emma Kelly** WHH and QEQM have prioritised the 12 hour admitted and non admitted waits with improvements seen in the non admitted pathway. The admitted pathway is supported by the Trust wide LOS programme and the sites reconfiguration programme. The Frailty Service has a focus to reduce un necessary admissions through ED via both the SPOA and the implementation of the frailty assessment units. There is a plan to move towards the implementation of a frailty strategy (Sandra Cotter, 29/04/24)	
											Trust wide LOS programme in place which will support the implementation and monitoring of the SAFER bundle **Person Responsible:** Kate Hannam **To be implemented by:** 27 Sep 2024		
											Utilise investment from the NHSE Bed Capacity Management System to invest in technology solutions, to more accurately manage the placement of admitted patients resource allocation **Person Responsible:** Kate Hannam **To be implemented by:** 29 Sep 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3386	17 Jul 2023	Care Group - Women's Health	Maternity	Potential risk of inaccurate records due to Euroking backcopying **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Michelle Cudjoe **Last Updated:** 24 Apr 2024 **Latest Review Date:** 24 Apr 2024 **Latest Review By:** Cherrie Knight **Latest Review Comments:** risk reviewed and actions updated	**Cause** Notified by digital midwife from another trust about some of their records showing inaccurate information. Known issue to us from 2020 when this was reported to E3. E3 backcopying information awaiting full breakdown but examples and how many records affected. Potential safeguarding risks declared at 28 weeks appearing as though reported at booking but not actioned or sweep given at term backcopying to appear it was given at 18 weeks. Parity uploading incorrectly has been raised in other trusts **Effect** Information logging incorrectly, data and reporting on inaccurate records	Quality	I = 4 L = 5 Extreme (20)	CIS team log ticket for all patient and pregnancy level questions to be immediately changed to contact only by Magentus **Control Owner:** Sharon Gough	Limited	I = 4 L = 5 Extreme (20)	IT to provide weekly (where possible) to Maternity teams on progress actions from the queries review with Magentus following the daily meetings **Person Responsible:** Sharon Gough **To be implemented by:** 30 Jun 2024	**25 Apr 2024** **Sharon Gough** Magentus have identified that the Solution will be in two parts - A patch which includes improved audit functionality and configuration changes. The configuration changes are currently being reviewed now, with the Workflow Data Dictionary having been reviewed and questions that the trust believe need their level changing have been submitted to Magentus to agree. Second meeting 25/04/2024. With regards to the software patch - this needs to be placed into version 1.734 in TEST (so the patch can be tested in EKHUFT) but we currently have issues with this version and have had to roll back to 1.7 at the beginning of the year. Magentus now understand the reason for these issues and have requested a meeting with EKHUFT which should be organised by next week. The NHSE deadline of June is very difficult and achieving this may not be possible. Advise going to be sought	I = 2 L = 2 Low (4)
								Daily meetings in place with Trust IT and Magnetus to review the queries and provide regular updates on progress **Control Owner:** Joanne Petcher	Limited				
								Following internal BCP meeting, the CPU space has been increased 19.04.24 to allow further usage space for E3 on the server. Outcomes of this increase are positive with the system not taking as long to process **Control Owner:** Jon McKinlay	Limited				
								Issue is known and being investigated by the LMNS and the regional digital group. **Control Owner:** Claire Bayat	Adequate				
1895	16 Jan 2020	Care Group - Diagnostics, Cancer and Buckland		Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Mark Eley **Last Updated:** 17 Apr 2024 **Latest Review Date:** 08 Apr 2024 **Latest Review By:** Deborah Thornton **Latest Review Comments:** Breast Consultant posts are out to advert, VCP have agreed the substantive posts and are awaiting shortlisting. CDC post 1 due to start imminently, 2 due to start in June and 1 awaiting confirmation.	**Cause** The reporting position has been under pressure since April 2019 due to severe operational difficulties resulting from significant unit failures. In order to recover access times and waiting list stability, additional capacity was engaged. Due to the current the demand on the service, the demand is exceeding the capacity due to the growth of ED imaging, requests, growth in inpatient requests, Increase staff sickness and reporting radiographers requiring to be clinical due to service shortfalls. New pathways being embedded within the Trust such as SDEC has caused additional service pressures. Limited knowledge of pathways or clinicians referring on inappropriate pathways. **Effect** Patient safety Radiologist well being This has increased the 2WW backlog reporting which is a clinical and patient risk affecting the Cancer PTL. Increase in urgent backlog reporting, delaying patient treatment. Increase in complaints being received	Quality	I = 4 L = 5 Extreme (20)	Ad hoc sessions by internal radiographers **Control Owner:** Gemma Matthews	Limited	I = 4 L = 4 High (16)	4 additional posts to be recruited to as part of vacancy factor **Person Responsible:** Beverley Saunders **To be implemented by:** 30 Aug 2024		I = 3 L = 3 Moderate (9)
								Backlog demand is being monitored by Head of Radiological Sciences **Control Owner:** Gemma Matthews	Limited		Waiting for 4 Radiologist to come into post following successful recruitment CDC business case. **Person Responsible:** Beverley Saunders **To be implemented by:** 31 Oct 2024		
								Five routine backlog cases identified for reporting each week **Control Owner:** Gemma Matthews	Adequate				
								Outsourced reporting **Control Owner:** Gemma Matthews	Limited				
								Patient harm being monitored via the Radiology Governance via a clinical harm review process **Control Owner:** Gemma Matthews	Limited				
								Two additional locum radiologists recruited **Control Owner:** Gemma Matthews	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2934	11 Aug 2022	Care Group - Women's Health	Maternity	Inadequate theatre capacity at QEQM for maternity services **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Karen Costelloe **Last Updated:** 22 May 2024 **Latest Review Date:** 05 Apr 2024 **Latest Review By:** Cherrie Knight **Latest Review Comments:** risk reviewed and actions updated	**Cause** Currently within maternity services at QEQM there is only one theatre within the maternity setting. There is only one obstetric theatre at QEQM, meaning potential for delays in emergency C/S and if this theatre has issues, the main theatre is some distance from the main obstetric unit. **Effect** - impact on theatre capacity - elective surgery being done in maternity theatres due to limited main theatre capacity causing an impact on emergency surgery - Delays in surgery being undertaken which can impact on patient safety and outcome -Overall the impact is that staff are not able to work as effectively as they might and this has a detrimental impact on their ability to ensure high standards of care. Inefficient working and diminished team communication.	Quality	I = 4 L = 5 Extreme (20)	Appropriate assessment of complexity of elective caesareans booked with RAG rating. A C-section SOP has been implemented to support this process.(effective controls for planned admissions) **Control Owner:** Clare Redfearn	Adequate	I = 4 L = 4 High (16)	additional section list to be explored at QEQM to have sections every day (Monday to Friday) to meet demand. **Person Responsible:** Zena Jacobs **To be implemented by:** 30 Jun 2024		I = 2 L = 2 Low (4)
								process in place to ensure women are ready and called for in a timely manner to take into account the distance between maternity and theatre to support lists running to time. **Control Owner:** Peymaneh Hajilou			progress plans with strategic development with potential NHSE funding to support the needed maternity estate expansion (including obs theatre) at QEQM **Person Responsible:** Karen Costelloe **To be implemented by:** 31 Aug 2024		
								risk assessment completed by MDT with mitigations to follow if a 2nd for any 2nd emergency C section requirements when the obs theatre and main theatre are already in use. **Control Owner:** Natasha Curtiss	Adequate				
								The number of ELCS is monitored daily with the clinical operational and theatre teams and adjustment made accordingly **Control Owner:** Zena Jacobs	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3566	02 Nov 2023	Care Group - Queen Elizabeth, The Queen Mother	QEQM General Surgery and Gastroenterology	Delayed diagnoses for patients awaiting endoscopy **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sandra Cotter **Last Updated:** 21 May 2024 **Latest Review Date:** 15 Apr 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed 9/4/2024	**Cause** 1. Covid pandemic resulted in long delays for routine patients 2. Governance structure around waiting lists lapsed during covid 3. Recruitment to hard to recruit areas **Effect** 1. Delayed diagnosis and therefore treatment for our patients 2. Potential harm to patients 3. Potential psychological damage to patients 4. Challenge of managing long waiting lists with defined capacity 5. Failure to meet the DM01 target 6. Cancellation of patients at short notice - estimated to equate to approx. 20 lists pcm.	Quality	I = 4 L = 4 High (16)	Business planning linked in with recovery plans for specialties monitored at weekly recovery meetings **Control Owner:** Sarah Hyett	Adequate	I = 4 L = 4 High (16)	Clinical performance manager to track untracked cancers and lead on DoC for any delayed diagnosis. This is ongoing **Person Responsible:** Bridget Creighton **To be implemented by:** 30 Sep 2024		I = 4 L = 2 Moderate (8)
								Extra lists undertaken for specialty interventions **Control Owner:** Sarah Hyett	Adequate		Review of insourcing opportunities through framework of Consultant only provision completed. This is linked to agreement of standardised rates for Consultants. On going review of insourcing requirements required. **Person Responsible:** Sarah Hyett **To be implemented by:** 30 Sep 2024		
								Recovery/trajectory plans in place for Endoscopy **Control Owner:** Sarah Hyett	Adequate				
								Support from NHSE **Control Owner:** Sarah Hyett	Adequate				
								Weekly KPI meetings at specialty level and Care Group level to review patients **Control Owner:** Sarah Hyett	Adequate		Endoval process to be revisited to check whether patients on waiting lists still wish to proceed with the procedure they are awaiting. All overdue surveillance validated and scopes booked for patients who breached over 2023 and those breached 31/10/2023 to 1/3/2024 to be clinically validated and actioned. **Person Responsible:** Sarah Hyett **To be implemented by:** 30 Sep 2024		
								Weekly recovery meetings to monitor **Control Owner:** Sarah Hyett			Ensure full utilisation of capacity **Person Responsible:** David Bogard **To be implemented by:** 30 Sep 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1628	15 Apr 2019	Care Group - William Harvey		Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the RCPH standards **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Carly Sheehan **Last Updated:** 17 Apr 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to > 15 risk , agreed with CN- SH	**Cause** Nurse staffing establishment lacks resilience ED nursing and medical staff may treat paediatric patients without the relevant competencies Paediatric patients are cared for in a separate area in ED and it is not always possible for a doctor to be present in the area at all times Issues with delays in specialist services reviewing children following referral which leads to increased ED stay. There are not always EPALS trained staff on duty **Effect** May not be able to provide a safe and sustainable service as not fully compliant with RCPCH standards.	People	I = 4 L = 5 Extreme (20)	Agreed dedicated Matron for WHH is going out to advert This position was advertised but we were unable to appoint. Adult Matron to step into seconded role for a six month period with an role advertised to backfill the adult matron position. **Control Owner:** Tomislav Canzek	Adequate	I = 4 L = 4 High (16)	Interviews are to take place for an interim Matron as the post was not recruited in to. Whilst this is being advertised CNO HON and Dir ON to support wider advertisement and knowledge of vacancy **Person Responsible:** Benjamin Hearnden **To be implemented by:** 31 May 2024		I = 2 L = 2 Low (4)
								Assistance/support from paediatric services are available when required **Control Owner:** Thomas Boon	Adequate		Medical staff to attend advanced training (PILS then APLS) Paediatric ED Consultant Leads in place for WHH and QEQMH 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 This is still work in prgress due date ammended **Person Responsible:** Thomas Boon **To be implemented by:** 30 Jun 2024	**29 Sep 2023** **Nicola Brooker** Due to staff absence this is now overdue with no other staff able to action this.	
								Daily huddles and escalation to Director of Nursing for UEC **Control Owner:** Joanna Williams	Adequate				
								Liaison across sites for cross cover **Control Owner:** Catherine Miller	Adequate				
								Long lines of agency staff are booked for continuity and to ensure gaps are filled. A doctor is allocated to oversee Paediatrics. **Control Owner:** Joanna Williams	Limited		Ensure staff are trained in resus and safeguarding training. Safeguarding training is monitored and reported monthly. Training is role specific. All nurses are PILS trained and Band 6 and above APOLS trained - training has been impacted by Covid restrictions. Ongoing monitoring. April 2023 PILS training impacted by training staff shortages and lack of spaces to book This is still a concern due date amended **Person Responsible:** Catherine Miller **To be implemented by:** 30 Jun 2024	**23 Dec 2020** **Janet Webber** 23/12/2020 RCN competencies in place for nursing and staff are working through them Expectations and programme in place to ensure EPLS and APLS training for medical and nursing staff. A doctor is available for Paediatric ED 24 hours a day. There is a building programme to address issues with space and isolation	
								QEQM ED adult nurses have received training competencies to be able to support the Paediatric team and deemed clinically competent. **Control Owner:** Joanna Williams	Adequate				
								Review of current establishments/booking of temporary staffing to bridge gap As of December, this is necessary for unexpected sickness absences as establishment of staff in place **Control Owner:** Joanna Williams	Adequate				
								Training and competency for existing medical and nursing staff to increase skills and knowledge safeguarding and resus training **Control Owner:** Rachel Perry	Limited				
								Use of Paediatric doctors within ED to support the Paediatric service. **Control Owner:** Hitendra Tanwar	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								WHH Five Registered nurses have been have been seconded into positions in the paediatric ED. They have all within first month of secondment signed off all of their paediatric competencies. This will be used to mitigate vacancies. **Control Owner:** Tomislav Canzek						
								Whilst a doctor may not always be present in the Paediatric area in ED, nursing staff are present to monitor and observe the children there and they will escalate any concerns to medical staff and take any necessary urgent actions **Control Owner:** Hitendra Tanwar	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3528	04 Oct 2023	Corporate - Operations		Patients are at risk of breaching the national cancer standards. This could result in patients waiting longer for treatment with associated poor patient outcomes and patient experience. **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sunny Chada **Last Updated:** 21 May 2024 **Latest Review Date:** 30 Apr 2024 **Latest Review By:** Sarah Collins **Latest Review Comments:** Reviewed 30/04/24	**Cause** Delays with diagnostic capacity are impacting the organisations ability to deliver and sustain positive cancer performance Surgical capacity issues with Head and Neck, Breast, Urology & Colorectal Vacancies within the specialist consultant workforce within urology are contributing to the delayed pathways Limited EMR availability , limited GA & Heavy sedation availability for colonoscopy also impacting EPIC introduction in GSTT & KCH with still impacting on delays TP biopsy delays also contributing to pathway delays Patient choosing to delay investigations and treatments **Effect** Patients are waiting longer for diagnostics and treatment plan Potential for emotional harm to patients Staff at risk of 'burn out' and stress due to attempting to provide quality care to patients affected by delays Risk of Trust reputational damage due to delays, poor outcomes and poor performance.	Quality	I = 5 L = 4 Extreme (20)	104 day process developed and being followed. Low volume TSSG less of a concern than High volume e..g Lower GI **Control Owner:** Michelle Burrough	Adequate	I = 4 L = 4 High (16)	Lead to support joint working with 2ww team to improve booking turn around times and capacity. Staffing has been highlighted on risk reference 2850 **Person Responsible:** Hannah Washington **To be implemented by:** 30 Apr 2024	**10 May 2024** **Hannah Washington** Continued work with weekly improvement meetings for Prostate, Gynae, Lower GI and Lung, which continue to have the 2ww teams presence. FDS Manager is working with Lung Navigator around 1st OPA's and ensuring clear escalation processes are followed when there is lack of capacity.	I = 3 L = 2 Low (6)
								Availability of high tech interventions locally, this includes work done by transformation lead e.g. Carbogen Nicotinamide in the Oncology Department at K&C a new treatment for prostate tumors which is already being used at MTW and east Kent patients previously had to travel to receive the treatment. **Control Owner:** Mark Nicholls	Limited		Faster Diagnosis Nursing Lead to support the implementation of straight to test (STT) and a standardised and consistent approach to achieve compliance **Person Responsible:** Vicki Hatcher **To be implemented by:** 31 May 2024	**08 May 2024** **Vicki Hatcher** 08.05.2024 Fortnightly prostate improvement meetings in place to embed the STT service and monitor progress. FDS Clinical nursing lead attended UGI TSSG pathway redesign meeting. FDS manager and Clinical nursing lead attend LGI TSSG with joint work planned for STT pathways for Kent and Medway. Data recording via Cquins measures for best practice timed pathways.	
								Daily report of patients over 62 days sent to all the Care Group Ops Managers which is followed up by a daily phone call for an update and decision. Out Patient booking managers and General Managers to monitor and resolve any capacity issues. Daily email sent to Pathway Manager at Maidstone and Tunbridge Well NHS Trust to escalate patients to book for Oncology. Director of Operations will liaise with Ops Directors in other Care Groups to expedite patient's treatment **Control Owner:** Sarah Collins	Adequate		Each TSSG to have identified patient information (and where located) relating to likely diagnostic procedures on Cancer pathway . **Person Responsible:** Chiara Hendry **To be implemented by:** 31 May 2024	**26 Apr 2024** **Michelle Burrough** Action handed over to MB. H&N and Lung have completed. Assurance from each of the other tumour sites to be reviewed in the breach meetings scheduled for May.	
								Implementation of UGI and Lung STT service in 2021 followed by the LGI STT service in 2023 **Control Owner:** Carolyn Maynard	Adequate		To monitor trust wide compliance with the completion of clinical harm reviews (CHR). A clinical harm review is completed for all patients who have a cancer diagnosis or RIP and wait more than 104-days on a cancer pathway **Person Responsible:** Michelle Burrough **To be implemented by:** 31 May 2024	**22 Apr 2024** **Michelle Burrough** Process for completion of 104-day clinical harm reviews embedded and supported with SOP. SOP currently under review and circulated for comments at Cancer Delivery Group meeting on 10/04/2024. Compliance monitored monthly. 2034/24 compliance and themes presented to Cancer Delivery Group on 10/04/2024. Monthly tumour site meeting in place to discuss breaches and actions.	
								The tumour site specific nurses provide a weekly update on the support provided and required for patients who are experiencing pathway delays to improve patient experience and outcome. This includes escalation regarding any concerns. Documenting all care on infoflex. Providing an overview of how this is done by each team-opportunity for shared learning and developing best practice. **Control Owner:** Carolyn Maynard	Adequate		Criteria for patients who fit the 104 CHR process to be applied. Currently biggest issue for Lower GI as high numbers of patients without a diagnosis at 104 plus. **Person Responsible:** Michelle Burrough **To be implemented by:** 31 May 2024	**22 Apr 2024** **Michelle Burrough** SOP currently under review with specific reference to CHR criteria. Updated SOP circulated for comments at Cancer Delivery Group on 10/04/2024.	

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Weekly cancer tumour site PTL meetings to monitor all cancer standards. Track patients through their pathway . Optomise pathway if can. **Control Owner:** Karen Rowland	Adequate		28 Day Performance Manager to work with all the tumour sites to improve engagement with 28 day patient letter turn around times. **Person Responsible:** Hannah Washington **To be implemented by:** 30 Jun 2024	**10 May 2024** **Hannah Washington** FDS Manager continues to work with Care Groups and Navigators to improve FDS communication and compliance. The aim is to improve processes and working relationships for this to have a noticeable difference. Currently fully staffed with Navigators with the FDS Manager completing training & focused work. Current FDS backlog at 488, with all tumour sites under 60 patients, except for Lower GI which has 200 patients. FDS Manger currently liaises directly with the Managing Directors for these to get the longest waiters pulled through.	
								Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers **Control Owner:** Karen Rowland	Adequate				
								Weekly tertiary centre PTL to escalate any patients of concern externally **Control Owner:** Sarah Collins	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2038	09 Apr 2020	Corporate - Operations		Misalignment between Demand and Capacity across the Trust's RTT, non-RTT and Cancer pathways **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sunny Chada **Last Updated:** 21 May 2024 **Latest Review Date:** 04 Mar 2024 **Latest Review By:** Sunny Chada **Latest Review Comments:** Update of IS records and addition of existing controls.	**Cause** The increasing demand for healthcare services within the Trust has surpassed the existing capacity, leading to strain on resources, longer waiting times, and compromised patient care. 1. Competing pressures from non elective flow for bed capacity and staff. 2. Lack of diagnostic capacity. 3. Specialty specific consultant vacancies within ENT (Otology), Dermatology, Urology, Endoscopy & Radiology. 4. Lack of clear validation oversight and training for specialities means patients on non-RTT pathways return to core waiting lists. 5. Endoscopy capacity and utilisation affecting performance. **Effect** Elevated patient dissatisfaction due to prolonged waiting times. Possible decline in the quality of the services provided. Increased risk of adverse patient outcomes. Strain on staff leading to burnout and decreased morale. The non clinically urgent elective cancellations and delays are leading to patients on the RTT pathway delays	Quality	I = 4 L = 4 High (16)	All 52 week breaches will be added to datix closely monitored by clinical and operational teams. Patients are monitored on a 3 monthly basis by post. Patients continue to be treated in clinical priority order. **Control Owner:** Desmond Holden	Adequate	I = 4 L = 4 High (16)	Development of a clear trust-wide improvement programme for 2024/25 via the following improvement groups: - 1. Outpatient Transformation. 2. Theatre Improvement. 3. Diagnostics Delivery Group. **Person Responsible:** Sunny Chada **To be implemented by:** 31 May 2024		I = 3 L = 2 Low (6)
								Consultants risk stratifying their outpatient and surgery waiting lists to identify any urgent cases that need to be seen or treated. **Control Owner:** Juliet Apps	Limited		ECIST Team supporting via the creation of the Data Quality Improvement Group to develop the following: - 1. Update of Access Policy. 2. Development of a clear Trust-wide 12 week validation programme. 3. Development of a PTL management training programme combined with a clear competency framework. **Person Responsible:** Sunny Chada **To be implemented by:** 03 Jun 2024		
								Daily elective PTL meetings to maximise capacity and maintain flow in conjunction with weekly access meetings at COO level to ensure grip and control. **Control Owner:** Sunny Chada	Adequate		To work with the theatres to secure additional sessions required to deliver the activity **Person Responsible:** Juliet Apps **To be implemented by:** 28 Jun 2024	**26 Apr 2024** **Rhiannon Adey** Working with Prism looking at theatre right-sizing being led by Loraine Turner and Anthony Adams. Insourcing secured for dermatology to achieve 62-day cancer exploring extension of insourcing with Sunny Chada. Work underway with MTW of movement of patients to achieve 78 week breaches for otology, FESS, Paed ENT and general ENT working with IS team. Locum secured for cornea vacancy to assist with corneal graft surgery (will depend on availability of tissue from tissue bank). Met with breast consultant regarding delays to their pathways around radiology and histology. Working with Managing Director to understand DCB solutions.	
								Early reporting of any equipment shortages or issues to ensure timely repair or procurement **Control Owner:** Juliet Apps	Limited				
								External validation team (MBI) commissioned to complete validation of all DM01 > 7 weeks (13,446) and 50% of the existing unvalidated RTT (13,000 commissioned). **Control Owner:** Louise Pallas					
								Independent Sector (IS) Capacity formally commissioned by the ICB to support the Trust in the specialities in most need. Weekly utilisation of IS capacity provided to Access meeting and ICB hold monthly contract monitoring meetings to ensure patients are not returned to the Trust post referral. **Control Owner:** Sara Lawson					
								NHSEI focus to have dates for all patients waiting over 65 weeks by the end of March 2024. Additional activity added to the business plan to enable delivery. **Control Owner:** Sunny Chada	Adequate		Creation of an Insourcing strategy for the Trust for 2024/25 to utilise any unmet capacity, whilst also generating income for the Trust. Full tendering programme and care group engagement required ahead of a clear plan for approval in Q2. **Person Responsible:** Sunny Chada **To be implemented by:** 01 Jul 2024		
								To maintain an equipment register that will proactively highlight any pending risks **Control Owner:** Juliet Apps	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Trust under Tier 1 oversight with fortnightly reviews of performance within Elective Recovery and also Cancer. **Control Owner:** Sunny Chada					
								Trust validation teams regularly review longer waiting patients to ensure harm is minimised wherever possible. **Control Owner:** Louise Pallas					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2999	02 Nov 2022	Care Group - Women's Health		Exposure of staff to levels of nitrus oxide from the use of Entonox in the maternity unit **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Cherrie Knight **Last Updated:** 23 May 2024 **Latest Review Date:** 23 May 2024 **Latest Review By:** Emma Kelly **Latest Review Comments:** Residual risk score was temporarily elevated to a 16 due to the failure of a recent test but an external provider. On 17 May 24 the failed test was passed and mitigations have been put in place relating to operational actions. Ben Stevens/Womens Health Leadership (Emma Kelly) 23 05 24	**Cause** Lack of controls: - Lack of training - Inadequate ventilation **Effect** Clinical Hazards: Prolonged over exposure to excessive Entonox levels above the safe work exposure limit (WEL) which could lead to detrimental effects to staff. •Can affect a woman's fertility. •Bodin et al (1999) found an association between exposure and reduced birthweight and an increase in SFGA babies •Developmental toxicity on the developing foetus and an increase in miscarriage. •Permanent inactivation of the body's stores of vital Vitamin B12. •Prolonged exposure can result in chronic illness from a multitude of debilitating symptoms and includes myleoneuropathy and sub acute degeneration. •Megablastic bone marrow changes •Folate metabolism and DNA synthesis is impaired (RCM Entonox Guideline 2018) Legal Hazards: Risk of enforcement action being leveled against the trust due to; •Failing to undertake a suitable and sufficient risk assessment (Regulation 6 COSHH regulations). There was no COSHH risk assessment for Entonox on the unit at the last HASTA audit (October 2022). •Failing to Prevent or control of exposure to substances hazardous to health (Regulation 7 COSHH regulations). •Failing to adequately monitor exposure at the workplace (Regulation 10 COSHH regulations).	Quality	I = 4 L = 5 Extreme (20)	do not touch notices placed by all air handling ventilation controls in all birthing rooms at WHH **Control Owner:** Jaynie Hollister		I = 4 L = 4 High (16)	re-test Entonox levels at WHH following initial findings from the initial external visit on 15th and 16th May 24 **Person Responsible:** Cherrie Knight **To be implemented by:** 24 May 2024	**23 May 2024** **Cherrie Knight** revisit undertaken 22/05/24. Awaiting official report from findings	I = 3 L = 3 Moderate (9)
								Entonox training video in place for all staff to understand what Entonox is and how to use the equipment during labour **Control Owner:** Will Willson			Annual report on compliance to the medical gases committee **Person Responsible:** Will Willson **To be implemented by:** 31 May 2024	**26 Feb 2024** **Cherrie Knight** dates being confirmed for external review	
								H&S audits in place annually which links to COSHH management. **Control Owner:** Daniel Dumbarton			low level extract air ventilation system controls have been miss used changing the ventilation from pull (pulling the air out of the room) to push (pushing air into the room from outside) or turned off. Action to progress minor works to have a guard over the controls. **Person Responsible:** Cherrie Knight **To be implemented by:** 07 Jun 2024		
								ventilation and AGSS in place at both WHH and QEQM (WHH is a temporary solution) **Control Owner:** Cherrie Knight			re-test Entonox levels at QEQM MLU following initial findings from the initial external visit on 17th May 24. This however does not mitigate the need for purair scavenging units in each room to meet HTM standards **Person Responsible:** Cherrie Knight **To be implemented by:** 14 Jun 2024	**23 May 2024** **Cherrie Knight** initial re-test scheduled for 5th June 24	
											with support from Oc Health plan for at risk staff to return to full clinical duties. **Person Responsible:** Cherrie Knight **To be implemented by:** 30 Jun 2024	**24 Apr 2024** **Cherrie Knight** staff returning to work will depend on the result of the external review and if further actions are required to mitigate any exposure	
											plan and install continuous gas monitoring systems in maternity areas using Entonox to provide assurance for the controls in place **Person Responsible:** Colin Comper **To be implemented by:** 30 Jun 2024	**24 Apr 2024** **Cherrie Knight** This will depend on the outcomes of the external review and if required or not	
											implement an external review to fully asses if the controls in place are working. **Person Responsible:** Cherrie Knight **To be implemented by:** 30 Jun 2024	**16 May 2024** **Cherrie Knight** all air ventilation system have been tuned back on. Escalation to estates to contact pur air company to have an engineer onsite asap. Request for medical gas testing to check levels again tomorrow pm.	
											Estates to review if an alert system can be installed in the midwifery office if any of the low level extract systems fail/switched off **Person Responsible:** Bob Mitchell **To be implemented by:** 30 Jun 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
											purair systems to be procured and installed in QEQM MLU rooms **Person Responsible:** Andrew Wakefield **To be implemented by:** 30 Jun 2024		
											Ventilation system alert alarm to be installed within Midwifery office at QEQM to alert team if the system fails. **Person Responsible:** Andrew Wakefield **To be implemented by:** 30 Jun 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2195	01 Oct 2020	Care Group - Queen Elizabeth, The Queen Mother		Due to large volumes of recruitment, risk of poor skill mix, junior nursing workforce **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Susan Brassington **Last Updated:** 12 Mar 2024 **Latest Review Date:** 26 Apr 2024 **Latest Review By:** Susan Brassington **Latest Review Comments:** Reviewed and still active	**Cause** Successful recruitment campaign has resulted in a large number of internally educated nurses being appointed without experience of working within the NHS. In addition, junior nurse educated in the UK have been recruited. Due to overcrowding additional escalation areas have been opened, along with boarding on ward, requiring staffing and nursing oversight. There are high numbers of patients who require enhanced supervision such as 1:1 care to maintain their safety Geographical location makes it a difficult to recruit to site. **Effect** *Managing the rosters to provide senior support to junior team is often challenging due to the number of senior vacancies. Education and support to our internally educated nurses. *Reduced skill mix on shift impacting on patient care *Senior nurses time taken away from clinical working due to volume of education needing to be provided. *Large volumes of flexible working requests from internal nursing team due to lack of family support	People	I = 4 L = 5 Extreme (20)	*Head of Nursing oversight of daily shift log *All staffing for the week is discussed at the weekly matrons meetings (Monday) *Weekend planning meetings each week within the Care Group to identify, discuss and mitigate risks. *Deputy and Head of Nursing sign off for use of 'hot shifts' weekly. *Acute Medical Units support ED staffing when needed. **Control Owner:** Joanna Williams	Limited	I = 4 L = 4 High (16)	Staffing levels to be reviewed and active recruitment, in line with the Care Group Recruitment Strategy **Person Responsible:** Susan Brassington **To be implemented by:** 31 Aug 2024	**02 Jun 2023** **Janet Webber** May 2023 - staffing levels have improved but skill mix is an issue due to a junior workforce being in place and need to staff escalation areas.	I = 3 L = 2 Low (6)
								Daily staffing reviews to look at numbers and skill mix to allow for staff to be reallocated to areas where staffing levels/skill mix pose a risk **Control Owner:** Susan Brassington	Adequate				
								Fulltime PDN's and clinical skills facilitators in place to support and develop clinical staff **Control Owner:** Susan Brassington	Limited				
								In ED an establishment review has been undertaken by the HoN and shift times changed to match activity - more staff are present in the afternoon to meet peek demand. Safe Staffing RAG score has been amended to reflect this and reported to effective nursing team and CQC **Control Owner:** Joanna Williams	Limited				
								In high long lines of temporary shifts are booked and enhanced rates of pay for agency and NHSP are in place for high risk areas such as ED **Control Owner:** Susan Brassington	Limited				
								Quality Strategy at QEQM has an education workstream to further map education requirements for both doctors and nurses. **Control Owner:** Joanna Williams	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2682	29 Nov 2021	Care Group - Diagnostics, Cancer and Buckland	Medical Physics	Increased likelihood of potential radiation incidents and regulatory breaches leading to patient, staff and public harm, due to repeated postponement of TRAC meetings **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Mark Eley **Last Updated:** 17 Apr 2024 **Latest Review Date:** 02 Apr 2024 **Latest Review By:** Julie Childs **Latest Review Comments:** Risk reviewed. No change. Continued meetings between CH and DH.	**Cause** Repeated postponement of Trust Radiation Advisory Committee meetings due to attendance and quoracy issues. **Effect** Lack of engagement of Trust in radiation safety and governance, resulting in increased likelihood of incidents and potential for regulatory breaches	Quality	I = 4 L = 4 High (16)	15-01-24 Associate Medical Director, (Nic Goodger) has identified an executive chair; Chief Medical Officer- Des Holden **Control Owner:** Julie Childs		I = 4 L = 4 High (16)	Radiation safety to be agenda item for all care group governance meetings and quarterly report to be submitted to TRAC. **Person Responsible:** Benjamin Stevens **To be implemented by:** 31 May 2024		I = 2 L = 2 Low (4)
								An executive chair has now been identified, (Chief Medical Officer- Des Holden). Terms of reference and attendance reviewed. Representation and information will be requested with templates provided by Medical Physics. Roles and responsibilities will be clarified by Medical Physics. CH has had follow-up meetings with DH. Rebranded meeting to be scheduled in June. In the meantime, radiation protection matters will continue to be escalated outside of the TRAC meeting. **Control Owner:** Claire Hooker			Attendance at TRAC meetings to be ensured and supported by care groups. **Person Responsible:** Benjamin Stevens **To be implemented by:** 31 May 2024		
								An executive sponsor for radiation protection has been identified, (Dylan Jones, COO). **Control Owner:** Ladan Najafi			Schedule quarterly meetings and ensure required staff are invited. **Person Responsible:** Desmond Holden **To be implemented by:** 31 May 2024	**15 May 2024** **Emma Kelly** CMO to Chair TRAC. Care Group asked to nominate clinical representatives and PA to the CMO to identify dates and send invites.	
								In-house RPS courses booked and advertised, (08-12-23, 09-01-24, 12-03-24) Trained RPSs should be more aware of their roles and responsibilities. **Control Owner:** Claire Hooker					
								New scoring as this risk is ongoing and as such poses corporate risks in terms of potential for regulatory enforcement, resulting in service, financial and reputational impacts **Control Owner:** Julie Childs					
								Quarterly meetings are scheduled. A non-quorate meeting took place on 13-04-23 **Control Owner:** Beverley Saunders					
								Radiation safety issues are progressed outside of TRAC meetings if necessary. **Control Owner:** Julie Childs					
								Requlat, quorate local radiation safety meetings and modality meetings to be re-established and maintained. **Control Owner:** Beverley Saunders	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Terms of reference and attendance reviewed. Representation and information will be requested with templates provided by Medical Physics. Roles and responsibilities will be clarified by Medical Physics. TRAC will be “relaunched / rebranded” with a meeting expected to be scheduled in May. **Control Owner:** Claire Hooker					
								There is a appointed chair for TRAC, (Dr Bev Saunders, Radiology Clinical Lead) **Control Owner:** Beverley Saunders					
								Upward reporting to Strategic Health and Safety Committee and Patient Safety Committee has been re-established and quarterly meetings attended by Head of Clinical Physics. **Control Owner:** Julie Childs					
3264	24 May 2023	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Maxillofacial	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 Owner:** Robert Hodgkiss **Delegated Risk Owner:** Loraine Turner **Last Updated:** 21 May 2024 **Latest Review Date:** 01 Feb 2024 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with CCASS Senior Leadership Team. Locum in place which is an effective control, new action added to move locum to short term contract. Specialty doctor recruited who commences in April, it is expected that the risk will then reduce.	**Cause** Two full-time speciality doctor vacancies - been unable to recruit since August 2022. **Effect** Increased wait time for first outpatient appointment. Delayed start to treatment and increase risk of 52 & 75 -week breaches.	Quality	I = 4 L = 5 Extreme (20)	Additional clinics to see longest waiters and clinical staff engagement to support (new patient clinics arranged at WLI in SPH in addition to additional clinics in dept) **Control Owner:** Abbie Rogers		I = 4 L = 4 High (16)	Recruitment into vacancies and reduce outpatient first appointment wait time. **Person Responsible:** Juliet Apps **To be implemented by:** 31 Aug 2024	**15 May 2024** **Emma Kelly** Gap reduced to 1x for speciality doctors and locum secured. Recruitment continues. Waiting time decreased to 33 weeks. Plan in place. Target date extended until end of August 24 to enable time to recruit and for successful candidate to start. Action owner suggested that residual risk has decreased to moderate. Juliet Apps to discuss at next care group governance meeting and then amend 15/05/24.	I = 4 L = 2 Moderate (8)
								Limited nursing staff. Increase use of agency but there is limited agency available due to speciality requirement - Dental Nurse. **Control Owner:** Donna Parker					
								Locum Speciality Doctor starts 31/05/23 - clinics to commence from 05/06/23, following local induction and e-learning to access systems. Locum Dr commenced in post and first OPA time reducing 1/9 - Locum released due to poor performance. Substantive staff to give additional capacity **Control Owner:** Abbie Rogers					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3557	02 Nov 2023	Care Group - William Harvey		Increased length of stay for mental health patients awaiting inpatient community beds **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Tammy-Ann Sharp **Last Updated:** 21 May 2024 **Latest Review Date:** 02 Apr 2024 **Latest Review By:** Rachel Perry **Latest Review Comments:** All mental health patients are escalated to the ICB daily for the Trust. Ongoing delays continue	**Cause** *Lack of acute inpatient mental health beds external to the Trust causing long waits in ED, as the ED is not a mental health environment or secure area. *Knowledge gap of general nursing and medical staff to manage significant mental health appropriately *There is a lack of assessment space and therapeutic intervention. *At QEQMH a temporary MH room due to building works and there is insufficient assessment space *Length of stay has doubled since this time last year **Effect** *Potential poor service to and environment for patients *Potential unsafe service to patients * Patient behaviour can escalate/ deteriorate and become challenging whilst waiting for mental health assessment which is a risk to staff and patients *Increased violence and aggression with assaults on staff	Quality	I = 4 L = 5 Extreme (20)	*Direct referral pathways to psychiatry and single point of access team at both WHH and QEQM. *Review of frequent attendees, meetings monthly with good representation from external partners. *Enhanced observation support worked employed by the Emergency Department to support the care for patients experiencing mental health illness. *Head of Nursing meets to review patients being brought into ED under 136 *Supportive visits from ICB - welcomed. *Length of stay of mental health patients is reported by the Fundamentals of Care Committee. **Control Owner:** Benjamin Hearnden	Limited	I = 4 L = 4 High (16)	Ongoing challenges with mental health capacity across the system remain. Patients continue to wait for placement or assessment for long periods of time. Every patient who is awaiting placement or assessment is escalated on the system call every morning. This is a Trust risk **Person Responsible:** Rachel Perry **To be implemented by:** 31 May 2024		I = 3 L = 3 Moderate (9)
											Work with external partners/commissioners to ensure provision of service meets the needs of mental health patients in a timely way. Ongoing meetings with KMPT November 2022 KMPT provide LP team to ED streaming at QEQMH This continues with a steering group in place Ongoing consultation and recent ICB visit and actions unidentified. This is still in progress - date amended **Person Responsible:** Benjamin Hearnden **To be implemented by:** 31 May 2024		
								A Frequent Attender review process is embedded with regular meetings and development of care plans and strategies to support patients to help them reduce attendance. **Control Owner:** Benjamin Hearnden	Limited		The UEAM team are working to identify and provide assessment facilities for patients awaiting inpatient beds This is still under review due date amended **Person Responsible:** Benjamin Hearnden **To be implemented by:** 30 Jun 2024		
								Agency Registered Mental Health nurses utilised to support staff when delays in psychiatric assessment occur and delays are reported on DATIX and escalated to Site Triumvirate. **Control Owner:** Benjamin Hearnden	Limited		Recruit mental health nurses. This is still in progress due date amended **Person Responsible:** Tomislav Canzek **To be implemented by:** 31 Jul 2024		
								An increase in DATIX incident reports relating to issues with MH patients exhibiting aggressive behaviour has resulted in Security staff being in place in the Observation bay at QEQMH. In addition, 4 EOSW have been appointed. Weekly Security meetings are utilised to align with Datix **Control Owner:** Benjamin Hearnden	Limited		Ensure safeguarding vulnerable adults and paediatric training compliance in place for all relevant staff. Compliance is monitored on an ongoing basis and also reinforced at Team Days November 2022 training is booked and planned in to 2023 **Person Responsible:** Benjamin Hearnden **To be implemented by:** 31 Aug 2024		
								Immediate work is being undertaken on the relatives room at WH which is currently being used as a Mental Health Assessment Room (relocated here due to Covid streams) is being undertaken to make it compliant with requirements for mental health areas. **Control Owner:** Benjamin Hearnden	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								The risk relating to the Trust not having a Ligature Policy in place has been raised at the Risk and CQC Assurance meetings. Ligature Risk Assessments have been undertaken for all areas and are reported and reviewed weekly by the Care Group Triumvirate **Control Owner:** Benjamin Hearnden	Adequate				
								There are delays in mental health assessments being undertaken and, where appropriate, patients with mental health conditions are cared for in the Observation Bays to ensure their comfort and safety. Both EDs now have 24 hour MH Liaison contact teams **Control Owner:** Hitendra Tanwar	Limited				
								We have an enhanced observation support worker 24/7 and use agency registered mental health nurses to match the demands, alongside agency CSW's. **Control Owner:** Benjamin Hearnden	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3553	31 Oct 2023	Care Group - William Harvey	Cardiology	Failure of Cardiac Catheter Suite equipment (Lab 1, 2 & 3) WHH **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Tammy-Ann Sharp **Last Updated:** 24 Apr 2024 **Latest Review Date:** 08 Apr 2024 **Latest Review By:** Alexandra Mcvey **Latest Review Comments:** Updated	**Cause** All 3 cardiac catheter labs at WHH require replacement due to the fact they are over 10 years old. This has led to an increasing frequency of breakdowns and also deterioration in image quality. **Effect** Potential inability to provide the regional PPCI service - divert to other sites may be required. Cancellation of electives leading to long wait time for cardiac angiography/PCI (approx 48 weeks). Potential harm to patients Loss of clinical income. QE inpatients have lengthy transfer times to the WHH waiting an average of 3 days longer than patients at WHH for NSTEMI Delays to patient flow Under utilisation of lab 3 due to poor image quality. Detrimental effect on reputation Deterioration in RTT position. Impact on staff morale Impact on recruitment and retention of clinical staff.	Quality	I = 4 L = 5 Extreme (20)	All procedures conducted in lab 3 to use LOW DOSE setting on the C-arm **Control Owner:** Merrill Schofield	Limited	I = 4 L = 4 High (16)	BCP to be updated following September 23 failure of both PCI labs at WHH and agreed with region. On-going along with other discussions around pPCI with the region. **Person Responsible:** Alexandra Mcvey **To be implemented by:** 30 May 2024		I = 3 L = 2 Low (6)
								Cardiology matron now in post and actively monitoring lab PTL and pulling/swapping patients across sites/ensuring better flow through the cath labs. **Control Owner:** Rebecca Enright	Adequate		Development of COPEL levels to manage specialty response to pressures similar to MOPEL and POPEL **Person Responsible:** Alexandra Mcvey **To be implemented by:** 31 May 2024		
								Datix completed for electives cancelled due to lack of capacity/lab break down etc **Control Owner:** Shirley Wilson	Adequate		Engineering assessment of lab equipment in labs 1. Lab 3 & lab 2 assessment complete - high priority for replacement. **Person Responsible:** Andrew Barrow **To be implemented by:** 31 May 2024		
								electives booked as agreed with lab lead around the PPCI's to try and minimise cancellations and avoid delays with PPCI **Control Owner:** Shirley Wilson	Adequate		Paper to go to EMT re installation plan and impact of lab closure for 8-12 weeks. Awaiting information from procurement to complete paper. **Person Responsible:** Alexandra Mcvey **To be implemented by:** 17 Jun 2024	**15 May 2024** **Emma Kelly** Awaiting costing information from procurement to add to the paper regarding impact of installation plan. This is being chased. The paper will then go to EMT with options to minimise operational service disruption. Emma Kelly (from Alex Mcvey)	
								Equipment moved between labs and between sites where possible. **Control Owner:** Alexandra Mcvey	Limited				
								Issues fixed as they occur in the labs. Electives cancelled as necessary to allow the PPCI service to run as priority **Control Owner:** Alexandra Mcvey	Limited		Exploration of running of weekend lists. Discussion re rates to be had with physiologists. More weekends being picked up - paper for enhanced rate for physiologists still to be drafted. Wider conversation around weekend NSTEMI and elective lists ongoing. **Person Responsible:** Alexandra Mcvey **To be implemented by:** 28 Jun 2024		
								maintenance carried out as per specification for equipment **Control Owner:** Alexandra Mcvey	Adequate				
								Monitoring will be on-going re radiation levels via medical physics **Control Owner:** Merrill Schofield	Adequate				
								Staff members are monitored by their dose badges for occupational exposure **Control Owner:** Merrill Schofield	Adequate				
								Utilisation of the second lab through job planning has increased use of both labs **Control Owner:** Alexandra Mcvey	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								Vacant lab sessions offered out as additional shifts to consultants on admin/SPA to increase capacity. **Control Owner:** Alexandra Mcvey	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2620	03 Nov 2021	Care Group - Diagnostics, Cancer and Buckland		Reduced Consultant Medical Microbiologist (CMM) workforce **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Samuel Moses **Last Updated:** 26 Mar 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** The current CMM workforce for East Kent is 3.5 as opposed to the required total number of 4.5. This in itself is an underestimate of current need. The maximum establishment ceiling of 5 WTE's existed for approximately 30 years and has not been assessed recently. Regionally (Kent & Medway) as well as nationally there are deficits in CMM workforce. The clinical service related to microbiology has changed over the past 10 years where the focus is more towards an integrated clinical infection service with infectious diseases physicians. This should have been reflected by an increase in CMM head count but perhaps not a practical possibility considering the existing challenges in recruitment. This is made evident in how postgraduate medical training has changed with most of the doctors coming out as dual accredited in microbiology as well as infectious disease/internal medicine. This is reflected in the recent RCPath/BIA/RCP guidance on Best Practise for delivering NHS Infection Services in UK https://www.rcpath.org/uploads/assets/6bf59929-d2e5-44d7-8fe9862bdb0fa787/BIA-Infection-Services-Standards-Doc-for-consultation-April-2021.pdf . The consensus trend is more towards Consultant in Infection with sub-specialisms such as Microbiology, Virology. In other words, most of the medical specialists are coming out trained as infection specialists and the numbers of sole microbiology trainees is dwindling with no sole microbiology training programmes. **Effect** The resulting effect of changes in microbiology practices is that it is more of a clinical infection service and less laboratory-based microbiology service. There is an increasing need for medically qualified infection doctors to deal with more ward based direct infection service, antimicrobial stewardship initiatives directly delivered for inpatient services as well as outpatient administered services where possible. The long-standing underfilling of microbiology workforce in the background of increasing complex patient services has led us to alternative ways of engaging of providing clinical microbiology advice using electronic consultation services such as careflow referral services. The careflow services to begin with were only 20 referrals a day but received	People	I = 4 L = 5 Extreme (20)	Current clinical establishment re-aligned to two Senior Clinical Fellows (ST6-8), 1 Junior Clinical Fellow (ST3-5) and 4.5 WTE CMM. Senior Clinical Fellows will be functioning at a higher level including 1 in 5 weekend on-calls under supervision from a second on-call CMM. **Control Owner:** Samuel Moses	Adequate	I = 4 L = 4 High (16)	To continue seeking locum or substantive recruitment for the vacant 1.0 wte CMM posts **Person Responsible:** Samuel Moses **To be implemented by:** 05 Jul 2024	**01 Jan 2024** **Samuel Moses** 1) Current locum CMM post extended for 26 weeks up to 19th of July 2024; to cover 1:5 site rotas, oncall evenings and weekend 2) 5th CMM post still in advert: closing date 14th of January 2024: Applications = 0	I = 4 L = 2 Moderate (8)
								We have recruited 3 clinical fellows and 1 Consultant Clinical Scientist in the recent past to help with pressures relating to service. Diagnostics is being predominantly managed by the Clinical scientist workforce. We have changed the duty desk services such that inpatient service burden is dealt with mostly via Careflow referrals, whilst the telephone duty desk service is reserved for external/GP referrals with initial reviews conducted by clinical fellows. On-call pack is available for Clinical Fellows for out-of-hours on-call service under CMM supervision who will be available as 2nd on-call. **Control Owner:** Samuel Moses	Adequate		To draft an integrated model of infection services in collaboration with acute medicine and acute specialities to deliver both direct patient care and diagnostic aspects of infectious services for the Trust with support of the CMO and workforce development team. **Person Responsible:** Samuel Moses **To be implemented by:** 31 Jan 2025	**11 Sep 2023** **Naomi Rogers** Dr Moses is liaising with Deputy Chief People Officer and team and has contacted senior medical executive regarding progressing the Infectious diseases/GIM workforce.	
											Reprofile roles at EKHUFT to consider recruiting Consultants in Infection who are dual accredited in Infectious Diseases/GIM as well as Microbiology. **Person Responsible:** Samuel Moses **To be implemented by:** 31 Jan 2025	**03 Jan 2023** **Samuel Moses** Email received from Richard Kingston, CD for General and Specialist Medicine regarding co-funding for 4xWTE ID/GIM Consultants. Initial response from Micro is that we cannot give up 2 CMM (Consultant Medical Microbiologist) WTE funding as we have a succession plan in place envisaging Senior Clinical Fellows and CESR path. Furthermore there is an existing interest in 0.5 WTE from a returning CMM who previously worked in EKHUFT.	

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					rapid responses from microbiology which has led to clinicians relying more on the the team for rapid decision making on patient discharges and parts of patient care pathways. This has led to the daily careflow referrals increasing from 20 to approximately 60 per day, including weekends which are only covered by one consultant on-call. Unless the Trust is able to fill its significant vacancies in acute medicine specialities, this trend on relying on microbiology services will continue to grow. The ensuing increased demand and pressure on CMM's needs to be addressed by either expanding the CMM workforce or the Trust employing infectious diseases/internal medicine consultants to take care of the burden that is increasingly placed on CMM's, in fact the recommendation of creating an infections diseases/GIM is one of the actions required. In the absence of the above there is a serious risk of work related stress and burnout of the CMM's as the current arrangement is not sustainable. Furthermore if the current situation continues, there is a risk to the quality and safety of patient care which could lead to an increased risk of adverse incidents, infection control lapses and sub-optimal monitoring of antimicrobial practice due to the lack of resources. The direct impact of trying to reconcile high quality and safe patient care with the limited resources could lead to the following: 1. Readjustment of clinical services: - absence of infection control doctor from within CMM's since 2020 - absence of CMM involvement in the sepsis pathway - reducing daily ITU ward rounds to 2/3 times a week - reduced CMM input into Trust IPC meetings (already occurring) - reduce periods for receiving calls from GP's (currently we are providing 9-5 service but likely to reduce to am only) - inability to provide regular antimicrobial stewardship rounds - inability for regular CMM sessions in other MDT's e.g. renal MDT, haematology MDT, ortho MDT, TB MDT 2. Adverse impact on patient outcomes - reduced CMM input e.g. IPC, AMS has had a negative impact on efforts to reduce C.difficle rates; inability to look into gram-negative bacteraemia which has been requested by IPC from CMM's for last couple of years. - inability to have a true picture of sepsis management outcomes in the							

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					Trust. - by not addressing the points above; this impacts the CQC audit outcomes. 3. Risk of maintaining current CMM's - continued service pressure has led to long-term sickness leave absence within the CMM workforce with a high chance of reoccurrence. - the increasingly busy clinical on-call service could lead to CMM's thinking of a better work life balance moving to a less intense workplace, and this has already happened twice already. Our current locum confirms that EKHUFT is one of the busiest places they have worked. 4. Risk of unprofessional workplace behaviour due to impact on mental health and workplace stress e.g complaints, bullying and harassment.								

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2850	13 Jun 2022	Care Group - Diagnostics, Cancer and Buckland		Risk to service delivery as a result of difficulty recruiting to Patient Service Centre **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Mark Eley **Last Updated:** 22 May 2024 **Latest Review Date:** 03 May 2024 **Latest Review By:** Daisy Morrison **Latest Review Comments:** Risk reviewed.x1 Band 4 have been approved through VCP. All other vacancies are being hold at VCP.	**Cause** Recruitment is an issue within PSC this is due to natural career progression within the trust and relocation out of area. Struggling to get any applicants for vacancies despite using all resources. Vacancy and Control Panel rejecting job vacancies, which is causing difficulty to recruit to vacant posts. **Effect** Staffing levels; high turnover, sickness, competencies and lack of suitable candidates within recent recruitment into Band 2 Assistant Administrator positions. Failure in retaining staff leaving for promotional roles, resulting in lose of knowledge. Staff working below pay band to support, lack of supervisory support. Supervisors currently bolstering band 2 and band 3 work. VCP rejection of Senior Administrator roles, resulting in not being able to recruit into 4 WTE Band 3 positions. Lack of promotional structure within departments results in Band 2's being headhunted. Wellbeing - Low morale, lack of staff to cover essential roles within department - answering phones, booking appointments, registering referrals. High levels of sickness. Risk of staff burnout. Risk of error in process with staff covering too much. Pressure on staff/panic. KPIS - Failure to maintain KPIs. Delay to patient care. Failure to deliver service. 2WW - Potential breach of 2WW pathways. Lack of staff to process referrals. Delayed cancer diagnosis. Failure of 28-Day faster diagnosis targets. Un-utillised capacity - waste of clinical time due to empty slots. Strike action - Failure to provide care groups with action to support strike impact. Patient Delay/Harm - potential increase in inpatients admissions. Impacting pathways and failure to achieve RTT. Potential SIs. Increased risk to service. Delay in registering referrals - potential to miss urgent referrals. Reputation - Failure to support services with their capacity and demand work and building clinics routinely or short notice. Care group relationship breakdown and dissatisfaction of services not being provided. Potential for care groups	People	I = 4 L = 4 High (16)	High sickness levels, on going support from People and Culture and Occupational Health for individual staff management. **Control Owner:** Tara Fuller		I = 4 L = 4 High (16)	Help improve DNA rates, DNA regression PTL has been divised by IT and being managed by the Reception team. Patients statically likely to not attend their appointments are being contacted to confirm appointments and reduce DNA rates this in turn reduces waiting list time **Person Responsible:** Jacob Reynolds-Wallder **To be implemented by:** 31 May 2024		I = 2 L = 2 Low (4)
								Prioritising urgent referrals for processing due to lack of staffing which is results in routine referrals being delayed **Control Owner:** Tara Fuller					
								Reception superiors to discharge PIFU patients from PTL who have reached their target date and PSC would be responsible for booking. Training complete, monitoring regularly. **Control Owner:** Angharad Lum	Limited		Working with IT on digital workstreams as part of the improvement transformation for Outpatients including streamlining processes for staff which will reduce amount of time spent processing referrals and post triage actions. **Person Responsible:** Tara Fuller **To be implemented by:** 31 May 2024		
								Reception team have taken over the HCC envoy texting response notifications and webserve requests to cancel/ rearrange appointments. **Control Owner:** Jacob Reynolds-Wallder			Wellbeing drop in sessions being held and individual stress assessments to be completed and action plans implemented **Person Responsible:** Tara Fuller **To be implemented by:** 31 May 2024		
								Rejected letters from synertec to be sent to new email account so they are not lost in the referral email account. Reception to be given access and training to look at. New email account set up, Reception have access. Monitoring and actioning **Control Owner:** Angharad Lum	Limited		Recruitment of 9 WTE Band 2 positions. 4 WTE Band 3's and 3 WTE Band 4's positions. Job vacancies are out to advert currently. Awaiting consultation review for likely positions to be filled. **Person Responsible:** Tara Fuller **To be implemented by:** 31 May 2024		
								Staff working overtime and NHSP to cover vacancies to ensure service covered. **Control Owner:** Angharad Lum	Limited				
								Strike activity reducing need for Reception cover, back office support given to processing referrals **Control Owner:** Tara Fuller					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					withdrawing funding from PSC to be managed internally. Un-utillised capacity - waste of clinical time due to empty slots. Increased DNA rates due to lack of ability to follow OPD process. Complaints - Increased complaints. Loss of trust in healthcare at start of pathways. Poor FFT feedback. NHSP/OT - High cost to service (although offset with vacancy). Staff internally to PSC undertaking however concerns about burnout. Datix/Risk - Increased datix numbers for patient delay.								

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3642	14 Mar 2024	Care Group - Queen Elizabeth, The Queen Mother	QEQM General Medicine	There is a demand and capacity gap in respiratory sleep and diagnostic services which risks patients breaching RTT, DMO1 and Cancer targets. **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sandra Cotter **Last Updated:** 21 May 2024 **Latest Review Date:** 01 May 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Action updated	**Cause** Inability to deliver the required activity and reporting due to staffing levels as demand has grown significantly from 2019/20 baseline .Resource has not increased for delivery of extra activity. **Effect** Sustained backlog of sleep studies not being scored and therefore patients progression on RTT pathways is delayed. This increases backlog on sleep clinics and therefore is insufficient follow up capacity in these clinics for the 9000 patients who sit on these waiting lists. Sleep study kit is end of life and subject to multiple breakdowns. Old kit is being held together with tape increasing infection risks. The number in EME at any one time means that there is sometimes not enough to deliver whole clinics and there is a reliance of short notice transfer of resource across sites. The service has no mitigation for late returns on devices and legal services has confirmed there is little can be done about this issue. Lung function does not have the capacity to meet demand and therefore is focusing on clinically urgent and cancer pathways. Backlog of routine has improved from 1500 to 500 but there is still inadequate capacity to progress this further and deliver lung function in a 6-week period. Currently routine wait for LFT is 1 year. Impact on ability to support local LFT at WHH which drives DNA rates for appts offered at less local sites, Risks to delivery of the DMO1 performance on sleep studies and resource is pulled from other diagnostics to support this, hence backlogs elsewhere Currently 12-week backlog for scoring sleep studies following the test, this is potentially the entire 18-week pathway just for test and report alone so adversely affecting Trust performance. Unable to deliver a sustained triage system for sleep clinics relying on activity provided from Respiratory Nurse Consultant who should be delivering clinical care for acute patients. Inability to deliver a robust and sustainable training programme for specialist nurses and physiologist which impacts recruitment and retention. Delay is managing FSNs in a timely manner as we have no flexibility in the system to manage this with admin and clinical shortages. Such FSNs will be raised as a separate risk to this for ease of management and closure. Inability with current systems to	Quality	I = 4 L = 4 High (16)	Additional locum resource for increased activity/demand **Control Owner:** David Boyson	Limited	I = 4 L = 4 High (16)	PMO support for business case completion through efficiencies programme. The review will lead to a business case to outline where investment is required and the performance, safety and financial benefits of doing so. 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 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:** Nicola Williams **To be implemented by:** 31 May 2024		I = 3 L = 3 Moderate (9)
								Additional NHSP utilised with admin vacancy money to maintain as much full booking as possible **Control Owner:** David Boyson	Limited				
								Gap analysis for sleep submitted to MD/LFT gap analysis being completed to from business case for resource increase **Control Owner:** David Boyson	Limited				
								LFT currently delivered across other sites for WHH cohort **Control Owner:** David Boyson	Limited		Establish fully remote CPAP monitoring service to achieve discharge profile of 50% current WL. Funding for modems for home monitoring being explored. **Person Responsible:** Nicola Williams **To be implemented by:** 30 Jun 2024		
								Locum cover for substantive gaps and recovery for sleep scoring backlog clearance over next 11 weeks **Control Owner:** David Boyson	Limited				
								Resource diverted from other diagnostics to support DMO1 performance **Control Owner:** David Boyson	Limited		New procurement award for devices across 2 companies to mitigate lone company FSNs **Person Responsible:** Nicola Williams **To be implemented by:** 30 Jun 2024		
								Sleep kit on MDG portal and procurement worklist for replacement: currently offering additional capacity for sleep over weekends if kit available and staff willing **Control Owner:** David Boyson	Limited		Review options for localised LFT service at WHH with associated income and financial/performance trajectory-- staff, equipment and Consultant support **Person Responsible:** Nicola Williams **To be implemented by:** 31 Aug 2024		
											Establish revised training programme for existing and new staff including tertiary colleague support to improve recruitment and retention. Apprenticeships have started **Person Responsible:** Nicola Williams **To be implemented by:** 31 Oct 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					effectively monitor and discharge patients from sleep clinics linked to their device adherence. This is driving clinical backlogs and financial pressures as the service cannot identify those patients who are not adhering to treatments and lacks ability to discharge effectively and recall devices for reconditioning and reuse for next patient. Inability to provide robust leadership across the service due to reductions in these senior roles and a reliance on external support from Nurse Consultant and General Manager. Risks around governance mitigated currently by interim secondment of clinical project lead that neds to become substantive. Reliance on a 1 company award for devices and an in-house reliance on admin staff for mask swap out support which drives increases in reduced clinic unitisation and booking processes. The above issues rely on partial bookings and reduces fully booked appts which are demonstrating an increased DNA rate as evidenced on Trust dashboards. Possible impact on other pathways of care without robust plan for diagnostics (AAA pathways)							
2419	14 May 2021	Corporate - Operations	Information Management	Data Quality issues created by administrative staff **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Sunny Chada **Last Updated:** 22 May 2024 **Latest Review Date:** 22 May 2024 **Latest Review By:** Emma Kelly **Latest Review Comments:** Reviewed with COO and Deputy COO for planned care 22/05/24. Risk linked with overall RTT risk for Trust. Deputy COO to review and advise if this should be a stand alone risk or merged.	**Cause** Administrative and clinical staff too often do not use the electronic systems properly meaning that we have poor data quality; not discharging in a timely manner, discharge and readmission rather than transfer, merging patient's details mistakenly, allowing men to be recorded as having babies, admin staff admitting patients all under the same/wrong consultant (in breach of clinical guidelines) and so on. **Effect** It creates a lot of wasted time for the IT and Information teams in correcting the data held against patients and reduces the Trust's ability to present correctly the costs incurred in treating patients and to plan in particular our elective plans for recovery as so many patients are recorded on the wrong type of pathway or waiting list. There is also a patient safety risk that we simply do not know which patient is where and could not safely evacuate the hospital for example. More likely we are not able to monitor and audit the care of a patient if we do not know which doctor a patient is under at any one time.	Quality	I = 4 L = 4 High (16)	DQ issues are overseen by the Information Assurance Committee which reports into the CEMG. A DQ dashboard is presented monthly and available live and a programme of work to address DQ issues is updated each month **Control Owner:** Marc Farr		I = 4 L = 4 High (16)	Insourcing support being provided by MBI to administratively validate a proportion of the DM01 and RTT waitlist reviewing and updating the patient status and requirements **Person Responsible:** Sunny Chada **To be implemented by:** 26 Apr 2024	**15 May 2024** **Emma Kelly** Work on track - status to be updated 22 May 24 (meeting with COO and Deputy COO)	I = 3 L = 2 Low (6)
											A comprehensive training program is in development for Waiting List Data Quality Improvement aims to enhance confidence in the trust's waiting list information by establishing an efficient feedback loop. This program specifically targets priority pathway cohorts, monitors error and correction rates, and draws insights from validation outcomes, thereby contributing to overall improvements in data quality. Establish working group, to include DQ Assurance, BI, Ops, with IST lead pending identification of trust lead **Person Responsible:** Sunny Chada **To be implemented by:** 22 May 2024	**15 May 2024** **Emma Kelly** Date amended to 22/05/24 - update meeting to be held with COO, Deputy COO and AD QG.	

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3309	15 Jun 2023	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	Inability to recruit Emergency Department Consultants and Acute Consultants at QEQM **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 17 Apr 2024 **Latest Review Date:** 10 May 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed with ADN	**Cause** Geographical location of hospital makes it hard to recruit suitably qualified ED and Acute consultants and lack of a Paediatric Emergency Medicine Consultant . Organisational reputation of minimal consultants in post **Effect** *Lack of senior oversight and support *Increased of use of locum consultants and financial impact on organisation *Education and training, not always available on the QEQM site and junior doctors are required to travel to WHH for consultant education. *Availability of locums * Limitations to SDEC service at the weekend as not always possible to provide consistent medical cover resulting in patients being seen in ED rather than SDEC contributing to overcrowding in ED	Quality	I = 5 L = 5 Extreme (25)	CESER programme in place to develop middle grade doctors to consultant level **Control Owner:** David Bogard Daily staffing reviews which are esclaated and reported to Executive Team **Control Owner:** David Bogard Liaison with WH to devise a cross site plan and ensure cross site cover **Control Owner:** David Bogard Use of locum consultants **Control Owner:** David Bogard	Limited Limited Limited Limited	I = 4 L = 4 High (16)	*Active recruitment with dedicated HR support to the Care Group *Digital and social media campaign *Awaiting commencement of recruited Consultant Trajectory is for 10 Consultants t be in post by September 2024. **Person Responsible:** Wayne Kissoon **To be implemented by:** 01 Nov 2024	**08 Mar 2024** **Janet Webber** Riks 2939 and 2688 merged with this risk	I = 2 L = 2 Low (4)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2234	11 Nov 2020	Care Group - Diagnostics, Cancer and Buckland		Failure to meet national histopathology TAT's to support cancer pathway **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Mark Eley **Last Updated:** 21 May 2024 **Latest Review Date:** 16 May 2024 **Latest Review By:** Naomi Rogers **Latest Review Comments:** Overall turnaround time KPI in April for histology cases reported in 10 days has decreased to 25% compared to last month 44%. Overall backlog position at the end of month shows worsened position 2100 cases compared to 1600 cases last month (<500 cases). This adverse position is a direct result of locum and consultant unavailability and admin staff unavailability supporting the manual entry of results from LDPath. From July the NHSP WTE equivalent (currently responsible for 60% of skin reporting) will reduce by half.	**Cause** Consultant substantive workforce is now 10.8 WTE's (budgeted 16.6 WTE) and supported by 1.2 WTE bank locums and 1.5 WTE agency locums, together with costly outsourcing of low risk cases at a rate of 40 cases a day (£35 per case). 80% reporting capacity required to maintain a good performance and safe backlog; currently maintaining 50%. Modelling performed by EKHUFT as part of K&M Pathology Network 'post pandemic' indicates additional 4.4 WTE's required (i.e. 21.0 WTEs') necessary to meet RCPath target 90% and 98% by April 25. Vacancy gap currently mitigated by using a combination of locums and fixed term NHS pay rate recruitment; • 1.2 WTE NHSP (60% of all skin reporting) • 1.5 WTE premium pay locums • 2.0 WTE full time, fixed term specialist doctors into consultant positions, with a view to creating 2.0 WTE consultants at the end of FT contract • 3.0 WTE specialty doctors with FRCPath Part 2 examinations with the view to create specialist doctors, ultimately creating 3.0 WTE consultants (NB: 1.0 WTE funded by deanery so can be replaced once in consultant position; 1.0 WTE funded by trust grade position; 1.0 WTE occupies a consultant position already) • Out to advert for 1.0 WTE consultant – other vacancies mapped against locum hire • K&M Pathology Network to support bid for additional medical staff recruitment at MTW and EKHUFT • Digital referral through outsourcing agency Source-LDPath of low clinical risk cases that would otherwise be 'de-prioritised' In addition department has continued to see a significant increase in workload volume and workload complexity comparative to previous pre-covid years. In September the average number of specimens per case was 3.1, compared to 1.6 in 2019. The number of cases seen in 2022-23 was 10% higher than 2019-20, with 20- 30 % increases in certain subspecialties, notably breast and	People	I = 4 L = 5 Extreme (20)	Cancer pathway patients prioritised from within the workload. **Control Owner:** Marcus Coales	Limited	I = 4 L = 4 High (16)	1.0 WTE histopathologist vacancies are being advertised on a rolling basis but currently unsuccessful in recruitment. However alternative recruitment solutions being explored such as fixed term consultant staff on NHS pay rates via an agency and finders fee. **Person Responsible:** Stuart Turner **To be implemented by:** 30 Jun 2024	**14 Mar 2024** **Naomi Rogers** 1 x WTE was used to recruit to a 1 year FT position. We have x3 WTE positions mapped against bank and locum hire, which we cannot be without, even if we managed to recruit. Locums cannot be hired without position numbers. More establishment needed	I = 4 L = 2 Moderate (8)
								Locum support when available and position numbers available and outsourcing non-complex histology cases to LD Path **Control Owner:** Stuart Turner	Adequate				
								The short term mitigation is to put in place additional NHSP. **Control Owner:** Stuart Turner	Limited		Review a workforce/workload points based manager system to manage workload in line with RC Path Guidance **Person Responsible:** Sophie Coales **To be implemented by:** 31 Mar 2025	**14 Mar 2024** **Naomi Rogers** Implementation date extended as digital pathology tech will be used to instigate this now	
								We have recruited x3 FT proto -consultants in addition to the x1 FT consultant. In a year at least x2 of them will be consultant level. These are x2 specialist and x1 specialty grade doctors. **Control Owner:** Marcus Coales	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					prostate. In 2023-24 this increase has been a further 10%, with yet more increases in breast, prostate and GI biopsies. Greater than 40 histology cases are being referred to LDPath each day (15% of daily workload and equivalent to 2.0 WTE consultants daily reporting workload). Once the reports are received back from LDPath they require manual transcription back into APEX by under established histopathology admin staff, creating a secondary backlog whenever there is any staff absence from the admin team. Additional admin staff above establishment are being recruited at risk with the approval of the People and Culture team. Breast Histopathologist availability less than 50% capacity due to unplanned sick leave, together with further 15% increase in workload relative to 2022-23, has led to delays in reporting breast pathology specimens. This results in a delay of treatment plans for some breast patients. **Effect** Histopathology is not achieving 90% compliance against nationally required 10 day turnaround time Further increase in backlog due to lack of admin staff reporting LDPath cases. Lack of Breast Histopathologists results in a delay of treatment plans for some breast patients.							

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2158	20 Aug 2020	Care Group - Diagnostics, Cancer and Buckland		Risk of Patient harm and treatment due to unreported A&E chest xrays - **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Mark Eley **Last Updated:** 17 Apr 2024 **Latest Review Date:** 08 Apr 2024 **Latest Review By:** Deborah Thornton **Latest Review Comments:** This has been discussed at PRM in March 2024. A report is to be completed to discuss the future management of the reporting of A&E Chest X-rays	**Cause** Since the introduction of the "failsafe reporting" for all 40,000 ED CXR's, Radiology have been unable to keep up with the demand of meeting the expected and agreed 10 day reporting TAT. for ED CXR's. This is in addition to the 40,000 plain film GP CXR referrals we also report on a yearly basis. That are within the expected TAT. Due to the increase expectation this can lead to delayed reporting for other modalities and subsequently delays with patient's being referred for further investigations for incidental findings. There is now 8 vacancies with the reporting workforce. **Effect** Unreported chest x-rays result in delay of patient diagnosis and treatment. One pathway prioritised over the other. Creating a backlog in chest xray reports	Quality	I = 4 L = 4 High (16)	All backlog reports are captured on a weekly run and escalated. Harm review can be ascertained **Control Owner:** Gemma Matthews	Adequate	I = 4 L = 4 High (16)	Paper being drafted about whether Radiology should report ED Chest X-rays. **Person Responsible:** Gemma Matthews **To be implemented by:** 30 Jun 2024		I = 2 L = 2 Low (4)
								Clinical Lead has assigned weekly designated workstream to ensure the reporting of examinations are completed within the local agreed TAT. **Control Owner:** Beverley Saunders	Adequate				
								To reduce uneccessary reporting, the CEMG has agreed that CXR's on deceased patients can be auto -reported with Trust agreement **Control Owner:** Beverley Saunders					
								Weekly incidental finding of a probable cancer report, is generated by the Governance Team to highlight patient's who require review under MDM. This is to ensure appropriate follow up can take place and reduce clinical harm due to delays. **Control Owner:** Deborah Thornton	Substantial				
								Weekly PTL meeting in place to monitor backlog and escalate where appropriate **Control Owner:** Gemma Matthews	Substantial				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2565	21 Sep 2021	Care Group - Women's Health		There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and there families **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Michelle Cudjoe **Last Updated:** 29 Feb 2024 **Latest Review Date:** 29 Feb 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Exec risk owner added due to risk rating >15, agreed with CN-SH	**Cause** Sub-optimal staffing levels and inability to cover shifts on a daily basis across hospital and community services. Whilst the funded establishment has been increased , recruitment has been slow resulting in insufficient establishment that supports a labour ward coordinator to be supernumerary on every shift supported by a band 7 operational role Vacancy, maternity leave and sickness impact on staffing NHSP and agency midwifery cover to fill gaps in rotas has been in consistent with poor uptake, coupled with unreliable agency compliance Lack of Maternity Support Workers at WHH to release Midwifery time **Effect** Non compliance with fundamentals of care impacting on the clinical outcomes for women and babies Poor staff morale leading to sickness and poor professional behaviour Dilution of skill mix due to recruitment of newly qualified band 5s Non compliance with national recommendations. Inability to provide 1:1 care in labour and supernumary band 7 labour ward coordinator status Inability to sustain a homebirth service 24/7 Inability to sustain Midwifery Led Units on both sites 24/7 (WHH closed) Difficulty in re establishing appropriate postnatal care at home Concerns raised by the women during feedback sessions over staffing numbers	People	I = 4 L = 5 Extreme (20)	10 am service SITREP staffing reviews undertaken to identify gaps and put in place actions eg: re location of staff to address **Control Owner:** Michelle Cudjoe	Adequate	I = 4 L = 4 High (16)	Developing a coproduced plan with staff and RCM members around how the on-call system is fairly applied and to explore improved retention strategies. **Person Responsible:** Adaline Smith **To be implemented by:** 31 May 2024	**29 Apr 2024** **Emma Kelly** RCM are currently reviewing equity for on calls across systems. We await the final review. We will then meet with RCM members and staff to share the findings and review our on call system. Once fully recruited are on call system will be reviewed in totality. Emma Kelly (with Adaline Smith, 29/04/24)	I = 4 L = 2 Moderate (8)
								Active utilisation of escalation policy to manage activity vs staffing. Including divert escalation between sites. **Control Owner:** Michelle Cudjoe	Adequate				
								All shifts to be released to NHSP as soon as possible. Where possible agency lines booking in place **Control Owner:** Joanne Shayler	Adequate		Explore further the use on non Midwife roles (Registered Nurses/Nursery Nurses/ MSW's) to release Midwifery time **Person Responsible:** Adaline Smith **To be implemented by:** 31 May 2024	**29 Apr 2024** **Emma Kelly** HoM for WHH has developed a JD for B6 Nurses to work in pre and post op surgical care and in the postnatal ward environment. To be advertised. Emma Kelly (With Adaline Smith, 29/04/24)	
								Daily review of staffing by operational lead and senior team. Out of hours the manager on call will facilitate this. Long line of agency set up where there are on going gaps **Control Owner:** Joanne Shayler	Adequate				
								International recruitment of 18 wte midwives. **Control Owner:** Michelle Cudjoe	Adequate				
								NHSP offered through community **Control Owner:** Angela Kelly	Adequate				
								Recruitment approach modernised to maximise the opportunities by working with HR and use of social media **Control Owner:** Michelle Cudjoe					
								Specialist midwives redeployed in times of increased acuity and escalation **Control Owner:** Adaline Smith	Adequate				
								Suspension of continuity of carer **Control Owner:** Sarah Hayes					
								Utilisation of managers on call and community midwives to support. **Control Owner:** Michelle Cudjoe	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2899	15 Jul 2022	Care Group - Women's Health		consultant obstetric vacancies at QEQM may result in an inability to deliver the service **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Zoe Woodward **Last Updated:** 24 Apr 2024 **Latest Review Date:** 08 May 2024 **Latest Review By:** Emma Kelly **Latest Review Comments:** Action updated to reflect recruitment activity on 2nd May 24 (Emma Kelly in liaison with Zoe Woodward)	**Cause** Number of consultant vacancies at QEQM have been out to advert for considerable periods of time (rolling adverts) without successful recruitment. In addition there are currently 4 substantive consultants not doing full on call duties due to OH recommendations. 2 substantive consultants not delivering full on call duties due to job plan changes (leadership and post retirement This puts significant pressure on the remaining consultant body to cover the on call rota. There are 10 consultants doing on calls (it is a 16 person rota) and these same consultants are then being asked to step down to cover gaps in the registrar and SHO rotas as well as trying to keep elective work going. Agency locums is heavily used to help cover activity. Disparity in the rate of pay for consultants working additional shifts compared to other departments. Middle grade vacancies are a challenge in terms of recruitment due to the inability to provide housing for overseas doctors coming to the UK. **Effect** It is becoming increasingly difficult to cover the on call rota: - this is at the expense of benign gynae activity being cancelled to which will an adverse effect on our waiting lists. - financial impact on the care group with the use of high premium cost agency staff. Increased pressure on the current consultant workforce leading to burnout - increased sickness and occupational health referrals. Impact on training due to using locums. Possible closure of the unit due to unsafe staffing. Negative impact on restore and recovery work. Consultants less likely to cover additional shifts if paid less than other departments. Ongoing shortages across the obstetric workforce is impacting on the compliance with PROMPT training in terms of delivery as well as participation.	People	I = 4 L = 5 Extreme (20)	Consultants working additional shifts to cover workload and acting down to cover junior gaps where required **Control Owner:** Natasha Curtiss Job plan review has been undertaken to aligned current activity and ways of working to ensure current establishment are working as efficiently as possible. **Control Owner:** Zoe Woodward recruitment incentive has been applied to all QEQM consultant vacancies **Control Owner:** Cherrie Knight Risk escalated to Trust Board in October 2022 and Monthly at PRM. **Control Owner:** Cherrie Knight use of high cost agency staff to cover activity of vacant positions **Control Owner:** Zena Jacobs	Limited Limited Limited Limited Limited	I = 4 L = 4 High (16)	Readvertise for the 3 vacancies at QEQM . Post held off until after april so that the cohort who get their CCT in october could apply **Person Responsible:** Zoe Woodward **To be implemented by:** 31 Jul 2024		I = 3 L = 3 Moderate (9)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3617	12 Dec 2023	Care Group - Diagnostics, Cancer and Buckland	Audiology	Insufficient Tympanometers - Risk to service delivery **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Mark Eley **Last Updated:** 22 Apr 2024 **Latest Review Date:** 11 Apr 2024 **Latest Review By:** Karen Dyer **Latest Review Comments:** 11.04.2024 Business case has been passed to MDG on 25.03.2024. Ben Thompson MDG Governance has secured quote and PAQ forms completed. Awaiting update on MDG for funding source Executive risk owner added as > 15 risk, agreed with CN- SH.	**Cause** Urgent replacement of irreparable Tympanometers: Annual Tympanometer (Middle Ear Analyser) calibration between the 27.11.23 & 29.11.23 4 old Tympanometers were condemned as unrepairable 1 at K&C, 1 at RVHF and 1 at WHH **Effect** if not replaced as a matter of urgency this will severely affect service activity/provision/CIP targets across the main sites for these mandatory tests. On an ENT Clinic every patient needs tympanometry so approximately 12 patients a day per Tympanometer = 48 day = 240 a week = 960 > 1000 a month With the new coding this would be the loss: If all Adults = £115 per test If between 5 and 18 years = £122 per test If 4 years and under = £143 per test	Quality	I = 4 L = 4 High (16)	K&C currently 'sharing' 3 x tympanometers between 5 clinical rooms RVHF currently 'sharing' 1 tympanometer between 2 clinical rooms WHH currently 'sharing' 1 tympanometer between 2 clinical rooms. This is results in delays in clinic due to having to clean equipment between transfer and resulting in delays to patient wait times. Now affecting service delivery for all diagnostics and patient satisfaction **Control Owner:** Karen Dyer		I = 4 L = 4 High (16)	need to purchase 4 x replacement tympanometers. Condemned equipment was not trust standard as old equipment. Business case would be for 4 x path Medical tympanometers which is the trust standard 09.03.2024 - Is now with MDG for costing and funding - KD met with BT in MDG 24.01.2024 - business case done and on portal - awaiting to secure funding **Person Responsible:** Karen Dyer **To be implemented by:** 31 May 2024		I = 4 L = 2 Moderate (8)
3354	27 Jun 2023	Care Group - Queen Elizabeth, The Queen Mother		Clinical environment not fit for purpose in many areas **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Susan Brassington **Last Updated:** 18 Mar 2024 **Latest Review Date:** 26 Apr 2024 **Latest Review By:** Susan Brassington **Latest Review Comments:** reviewed and still current	**Cause** Old estate poorly maitained means many areas are not fit for purpose. Examples include: Lack of space for staff to work effectively - office/access to quiet area staff toilets/rest rooms etc. Floors not able to take patients above a certain weight Storage limited resulting in clutter/falls risk/fire risk Repairs are not addressed in a timely manner once reported to the Estates Team **Effect** Impact on patient pathways and access to care IPT risk health & safety issues Staff morale staff conflict due to having to work in space limited areas Infection risk due to storage of kit Fire risk due to access/clutter staff unhappy/low morale	Quality	I = 4 L = 4 High (16)	Staff are aware of the need to report estates issues promptly having taken appropriate remedial action and to record and follow up on requests to estates, escalating as necessary **Control Owner:** Susan Brassington	Limited	I = 4 L = 4 High (16)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair. List of estates issues from closed ward risks attached **Person Responsible:** Susan Brassington **To be implemented by:** 30 Nov 2024	**08 Mar 2024** **Janet Webber** Ward estates issue closed and added to this overarching risk	I = 2 L = 2 Low (4)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2696	15 Dec 2021	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Resus	There is a risk that staff will not be sufficiently trained in resuscitation due to the size of the resuscitation team **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Gemma Oliver **Last Updated:** 22 Apr 2024 **Latest Review Date:** 22 Apr 2024 **Latest Review By:** Gemma Oliver **Latest Review Comments:** Resus team expanded to include 3 more resus officers to be up and running spring/summer 2024.	**Cause** The ratio of resuscitation officers to clinical staff is below the Resuscitation Council UK requirements Skill mix of the team does not meet the needs of the service Maternity leave and sickness absence Inadequate capacity within K&CH training room to deliver the amount of training required within the Trust Staff within the team are asked to provide clinical support to the front line High DNA rate due to ward pressures **Effect** Increased risk of harm to patients as clinical practitioners will not be able to recognise a deteriorating patient Breach of resuscitation training targets Increased risk of financial settlements to patients or relatives following legal proceedings Reputational damage due to failure in care for EKHUFT patients Difficulty in recruiting clinical practitioners due to reputational damage	Quality	I = 4 L = 4 High (16)	Ad-hoc NHSP/overtime if team are required to work clinically **Control Owner:** Peter Samworth	Limited	I = 4 L = 4 High (16)	**Person Responsible:** **To be implemented by:**		I = 4 L = 2 Moderate (8)
								Ad-hoc training undertaken for high risk areas e.g. ED, ITU **Control Owner:** Peter Samworth	Adequate				
								Audits undertaken of resuscitations that take place in the Trust **Control Owner:** Peter Samworth					
								Diary management undertaken to fit as many sessions in as possible **Control Owner:** Peter Samworth	Limited				
								Dickon Weir-Hughes review undertaken in to workforce and training **Control Owner:** Michelle Rose	Limited				
								DNA rate sent to ward managers **Control Owner:** Peter Samworth	Limited				
								Encourage staff to contact the Resus team for ad-hoc training where there are a number of people that are non-compliant **Control Owner:** Peter Samworth	Limited				
								Expand resus team **Control Owner:** Peter Samworth					
								Funding received from ICB to source external company to deliver resuscitation training **Control Owner:** Gemma Oliver					
								Move capacity away from K&CH to other sites **Control Owner:** Peter Samworth	Adequate				
								Reduced face-to-face training time to encourage staff to attend **Control Owner:** Peter Samworth	Limited				
								Regular meetings at WHH to discuss CPR figures and the importance of attending training **Control Owner:** Peter Samworth					

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2808	06 May 2022	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	There is a risk of patient harm occurring due to delays in recognising and escalating deteriorating patients in ED due to capacity **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Susan Brassington **Last Updated:** 17 Apr 2024 **Latest Review Date:** 10 May 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Risk reviewed ADN	**Cause** The increase in patient attendances and in corridor care mean that monitoring of patient's and that the recognition of patient deterioration is not always identified in a timely manner. Staffing levels are impacted on by acuity and overcrowding and do not always support documentation and timely sepsis screening Recruitment of large volumes of new nurses without ED experience has diluted the skill mix and proven to have impacted on recognition of deteriorating patients. **Effect** *Patient deterioration is not always promptly identified and escalated, potentially resulting in a poor patient outcome. *Observations not always taken in a timely manner or repeated within recommended timeframe. *Delay in critical medications being administered.	Quality	I = 5 L = 4 Extreme (20)	Adverse incidents resulting from lack of timely recognition and deterioration are recorded on Datix and investigated. Findings and identified actions are implemented and shared with staff at team and governance meetings **Control Owner:** Janet Webber	Limited	I = 4 L = 4 High (16)	Participation in relevant audits relating to deteriorating patients and development and implementation or robust actions to address gaps and identified areas where improvement is needed. **Person Responsible:** Joanna Williams **To be implemented by:** 31 May 2024	**05 Apr 2023** **Janet Webber** April 2023 - risk score increased due to data and increase in incidents and SIs relating to deteriorating patients	I = 3 L = 2 Low (6)
								Dedicated education teams to support the junior workforce and upskill the ED and AMU teams. **Control Owner:** Joanna Williams	Limited		System work being undertaken to improve flow **Person Responsible:** Susan Brassington **To be implemented by:** 30 Sep 2024	**09 Feb 2024** **Rhiannon Adey** Updated by Director of Nursing, QEQM. Co-located Safe Haven in place and Thanet SPOA	
								Improving access to resuscitation training **Control Owner:** Joanna Williams	Limited				
								Launch of quality strategy with deteriorating patient being a dedicated workstream. Actions from workstream include NEWS2 nurse that has positively impacted on time to treatment, escalation and recognition of deteriorating patients, proving better patient outcomes. **Control Owner:** Joanna Williams	Limited				
								Recruited into all band 5 vacancies across the ED and AMU's, providing safer staffing numbers **Control Owner:** Joanna Williams	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2406	04 May 2021	Care Group - Diagnostics, Cancer and Buckland		Delay to patient diagnosis from potential loss of Nuclear Medicine service at WHH **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Mark Eley **Last Updated:** 17 Apr 2024 **Latest Review Date:** 08 Apr 2024 **Latest Review By:** Deborah Thornton **Latest Review Comments:** The Gamma camera has been taken out of service at WHH, building works due to start in May	**Cause** The Skylight Gamma Camera located in Nuclear Medicine at WHH is 18 years old. •Unavailability of spare parts •Un-validated and out dated software for image processing •Potential for unintended radiation exposures to patients •Only one maintenance provider currently available (single tender SLA) •This single provider has recently given written notification that they plan to end support in March 2024. There is no alternative as the manufacturer (Philips) have confirmed that they no longer provide any support for this system (Document available). •The most recent service carried out on the camera indicated imaging artefacts developing which cannot be corrected for. These are currently outside the required field of view, however these have the potential to deteriorate which could end in the critical failure of the equipment. (Service report available). The current infrastructure of the department is tired and requires updating to fully comply with current infection control and EA guidance. Equipment No: 109293 **Effect**	Quality	I = 4 L = 5 Extreme (20)	Current SLA in place with gamma camera service engineer for routine servicing, 3 times per year and robust breakdown cover. **Control Owner:** Mark Dwyer	Adequate	I = 4 L = 4 High (16)	To confirm programme of work for Installation **Person Responsible:** Colin Fell **To be implemented by:** 31 May 2024		I = 2 L = 2 Low (4)
								Routine gamma camera QC carried out by NM Physics. Quarterly testing. **Control Owner:** Lois Collins	Limited		Camera to be installed / work to be completed. **Person Responsible:** Colin Fell **To be implemented by:** 30 Jun 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					Complete loss of Nuclear Medicine service at WHH.This gamma camera supports a wide range of patients who have been referred for diagnostic Nuclear Medicine investigations and contributes to about one-third of the imaging capacity for nuclear medicine. This includes, for instance, parathyroid imaging for endocrinology, paediatric renal imaging, as well as the WACU pathway's VQ lung service. If the equipment malfunctioned, these investigations would have to be imaged at Kent & Canterbury, which would affect the present wait times for 2WW and Urgent patients. Loss of service at WHH would reduce our current imaging capacity by a third, impacting heavily on the already huge backlog of patients waiting for a nuclear medicine study. A datix (WEB229525) was raised on the 13th October due to an equipment failure of the skylight. At the point of system failing two patients had been administered radioactive tracers that could not then be imaged. This falls within the criteria notification of a radiation incident notifiable to the CQC. The full report/investigation can be found on the Datix entry. The CQC were informed within 24 hours of the incident. A full report will be submitted to the CQC at the end of November 2022. With no plan for replacement and the skylight a similar incident occurring is very likely. Two datix investigations were raised in November 2022 for the same currently unresolved camera fault (as of 28/11/2022 WEB231686 & WEB228801). The camera will not be used clinically until this fault is resolved. This is impacting on clinical capacity during a period when Nuclear Medicine is already experiencing a large patient backlog. This includes delay to urgent investigations such as VQ Lung scans from SDEC that can currently only be offered at KCH until the camera at WHH is back in service. Update 19/12/2022 MD: The camera has been returned to service following further investigations and work by the service engineers as well as subsequent testing by NM Physics.							

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3384	13 Jul 2023	Corporate - Strategic Development & Capital Planning		The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** **Last Updated:** 26 Apr 2024 **Latest Review Date:** 23 May 2024 **Latest Review By:** Emma Kelly **Latest Review Comments:** Exec led review with Ben Stevens, 23 May 24	**Cause** Aged estate Limited capital investment over a number of years Limited access to capital above the Trust allocation to address all issues **Effect** - Resulting in poor patient and staff experience - Loss of activity due to service interruption - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	Regulatory	I = 4 L = 5 Extreme (20)	A 6 facet estates survey has been undertaken which will be used as a benchmark to prioritise backlog maintenance requirements. **Control Owner:** Benjamin Stevens		I = 4 L = 4 High (16)	Prioritised and signed off capital expenditure plan for 2024/25 **Person Responsible:** Benjamin Stevens **To be implemented by:** 31 May 2024	**23 May 2024** **Emma Kelly** 2425 Plan went to Board Development Day in April 24. Awaiting final confirmation from ICB re funding and then this will go back to Board for final approval. Ben Stevens, 23/05/24	I = 4 L = 3 Moderate (12)
								Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Benjamin Stevens			Engage a partner through Procure 23 to undertake the production of an “estates master plan and development opportunities” document **Person Responsible:** Nicky Bentley **To be implemented by:** 31 Aug 2024		
								Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2023/24. **Control Owner:** Benjamin Stevens			Progress to full business case for the replacement of maternity facilities at QEQM **Person Responsible:** Nicky Bentley **To be implemented by:** 30 Sep 2024		
											Deliver the 24/25 Capital programme as per the signed off plan **Person Responsible:** Nicky Bentley **To be implemented by:** 30 Apr 2025		
3210	11 Apr 2023	Corporate - Nursing	Infection Prevention and Control	Failure to comply with the NHS standard contract for infection prevention and control **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Lisa White **Last Updated:** 12 Feb 2024 **Latest Review Date:** 01 May 2024 **Latest Review By:** Lisa White **Latest Review Comments:** New financial year, awaiting current national thresholds, IPC improvement plan based on 2023/24 learning	**Cause** Inconsistent application of IPC, hygiene and Antimicrobial Stewardship (AMS) practices and protocols Fragility of infrastructure **Effect** Potential harm to patients Breaches of externally set objectives Possible regulatory action Prosecution Litigation Reputational damage	Quality	I = 3 L = 5 High (15)	Collaboration and agreement with 2gether Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning **Control Owner:** Lisa White	Limited	I = 3 L = 5 High (15)	Deliver antimicrobial stewardship strategy **Person Responsible:** Veronica Chorro-Mari **To be implemented by:** 31 Mar 2025		I = 3 L = 2 Low (6)
								Compliance with requirements of the Hygiene Code with a plan to address any gaps **Control Owner:** Lisa White	Adequate		Collaborative working with the system on C. difficile **Person Responsible:** Lisa White **To be implemented by:** 31 Mar 2025		
								Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS) **Control Owner:** Lisa White	Adequate		Develop and implement 2426 IPC Improvement Plan as per PSIRF methodology **Person Responsible:** Lisa White **To be implemented by:** 31 Mar 2025		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2796	26 Apr 2022	Care Group - Kent and Canterbury and Royal Victoria		There is a risk of delay in dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** David Topham **Last Updated:** 21 May 2024 **Latest Review Date:** 21 May 2024 **Latest Review By:** Genevieve McCourt **Latest Review Comments:** This is risk is been carefully managed by the Renal Team and reviewed by frequently	**Cause** Currently have 175 HD machines in use across the dialysis service . This includes machines for the six dialysis units , Home Haemodialysis Service and Acute Dialysis Service on Marlowe Ward We have 19 out of the 175 machines which are > 17 years old. This is 10% of our total fleet which increase the risk of machines having a fault either before or during patient's treatment which has meant some patients have had an incomplete dialysis session due to this impact. Therefore patients are receiving suboptimal treatment due to the reduction in dialysis treatment time Replacements for the dialysis machines (medical equipment) should be 10 years. Medical devices request submitted by renal technical manager via the procurement portal in 2020. We previously had rolling replacement programme of 19 new machines a year which is no longer in place. We had 26 machines replaced in 2020, 8 in 2021 and 1 in 2022- none in 2023. (Only 20% replaced in the last 3 years) We have asked for 6 new machines from Phase 1 of the renal business case 2021/2022 to help with the increased dialysis activity which was agreed at SIG to be funded by MDG but has not happened **Effect** There has been a significant increase in frequent breakdowns across the service which is being managed by the renal technical service on a daily basis. Due to poor reliability of these machines we unable to sustain effective dialysis service. The increase in dialysis activity has meant that machines are doing more hours (On average 12 hours per patient which is 384 hours for 32 new patients from the additional twilight shifts) We have spent 250K spend on machine repairs in 24 months . A dialysis machine costs around £11-14K depending on specification of machine.	Quality	I = 4 L = 5 Extreme (20)	All breakdowns of machines are referred on a daily basis to renal technical team either via designated email or phone call in and out of hours . **Control Owner:** David Topham Monthly report being completed by Lead Renal technical manager which is presented at the Medical Devices Operational Group **Control Owner:** David Topham	Adequate Adequate	I = 3 L = 5 High (15)	**Person Responsible:** **To be implemented by:**		I = 2 L = 3 Low (6)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
678	31 Aug 2016	Care Group - Diagnostics, Cancer and Buckland		Insufficient Pharmacy support for the safe (and secure) use of medicines on wards **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Rebecca Morgan **Last Updated:** 20 May 2024 **Latest Review Date:** 20 May 2024 **Latest Review By:** Rebecca Morgan **Latest Review Comments:** Created some actions regarding how we can create clinical capacity and recruitment options	**Cause** Must do from CQC in Dec 2023 states clinical pharmacy must be present on each medical ward at WHH / QEQM which reduces the impact of the risk assessed clinical service New national standards release which state pharmacist / bed ratios which are not met at EKHUFT e.g. NICU (2023, ITU at QEQM and K&C (longstanding GPIC) Paediatrics (2023) Trust practice Increased activity for pharmacy generated by care groups ; Wards expanded or services developed within the Trust without consultation with pharmacy. This includes escalation areas and changes in pathway including from one site to another. Pharmacy then expected to provide an operational / Clinical service to these areas without additional funding. Extra, multiple escalation areas opened up with current issues with demand/flow has created a context in which many of the standard approaches to pharmaceutical care a less effective as well as increasing the bed to pharmacist ratio New EPMA system introduced in April 2023 has added to the pressure by increasing processes time by up to 50% and reduced the impact of the team to monitor performance Fully established would provide cover to 60% of clinical areas but delays due to VCP is impacting R&R and therefore reducing this further High vacancy rate of foundation (band 6) pharmacists (38%) and specialist clinical (band 7) pharmacists (20%) impacted by the recruitment by many other organisations which isn't in line with AFC banding. **Effect**	Quality	I = 3 L = 5 High (15)	Health Building Note 14-02 – Medicines storage in clinical areas **Control Owner:** Elizabeth Shutler		I = 3 L = 5 High (15)	Review of clinical workforce model to medicine wards at QEQM/WHH with gap in workforce submitted (business case) to organisation to meet the CQC Must do **Person Responsible:** Kamaldeep Sahota **To be implemented by:** 31 May 2024		I = 2 L = 2 Low (4)
								Risk assessment for clinical service and prioritisation of services delivered to high risk clinical areas first mitigates some of this risk but CQC have reduced the impact on this control. **Control Owner:** Rebecca Morgan	Adequate		Submit BC for NICU and Paeds to meet national standards **Person Responsible:** Anthony Evans **To be implemented by:** 31 May 2024		
								Staff have been recruited into new posts and trained to increase the number of staff available to cover. This lessens the impact but does not reduce the likelihood of this occurring again. **Control Owner:** Rebecca Morgan	Adequate		Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments (see action plan for 'operation streamline' in document. This includes a review of late night model to reduce ToiL system and working with operational leads. (RM as ED is on sick leave) **Person Responsible:** Rebecca Morgan **To be implemented by:** 28 Jun 2024		
											Recruit to establishment for clinical pharmacy before starting CQC BC recruitment by considering innovative recruitment options .g. band 6-7 progression, **Person Responsible:** Rebecca Morgan **To be implemented by:** 31 Jul 2024		
											Recruit following BC approval for medical wards **Person Responsible:** Kamaldeep Sahota **To be implemented by:** 30 Nov 2024		
											Consider Full 7 day service from Pharmacy following action from CQC Must do **Person Responsible:** Will Willson **To be implemented by:** 31 Dec 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
					Patient Safety Wards only covered on a risk associated basis Medicines reconciliation rate low eDN screening rate is low screening focused on supply only rather than regular review of patients delayed discharges missed doses of medicines Support for audit limited Support for training/education of staff limited including medical and nursing staff patient harm through poor prescribing reduced monitoring of CD use Morale of staff is low due to not feeling effective in their role Inability to provide a weekend, late night and on-call pharmacy service which will lead to harm and delays in patient flow. This includes ITU, AMU 7 day services. Senior staff covering gaps on clinical rosters e.g. weekends and late nights and the inability to plan and mitigate these gaps. Inability to plan the service for the next few years e.g. trainees and NMPs Poor reputation regarding pharmacy workforce and development opportunities impacting recruitment. Reduction in appraisal & mandatory training rate within team Reduction in ability to provide medical education training Inability to support clinical pharmacy team training & supervision Inadequate induction of new staffs. Wellbeing of staff is significantly impacted Increased sickness levels Increase costs from overtime for senior staff on NHSP Regulatory Failure to meet CQC Must do							

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2979	07 Oct 2022	Care Group - Critical Care, Anaesthetics and Specialist Surgery	Ophthalmology	Delays to patient care and poor patient experience due fragile YAG Laser machine at QEQM Eye Clinic **Risk Owner:** Benjamin Stevens **Delegated Risk Owner:** Loraine Turner **Last Updated:** 13 May 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as >15 risk, agreed with CN-SH	**Cause** Laser machine was 1st commissioned in 2005 -now 17 years old Poor performance due to age of machine These may impact on both patient and staff safety. Poor focusing of laser beams reported. Laser beam focus deteriorates during the clinic High power sometimes required **Effect** Increased risk of macular oedema to patient. Risks of damage to intra ocular lens. Patients are needing subsequent visits to the clinic to check for any residual effects. Patients required to travel to other sites for treatment Laser sometimes taking longer to perform Stress for staff performing yag laser. Cancellation of clinics due to a defective machine is not good for Trust's reputation	Quality	I = 5 L = 4 Extreme (20)	Machine to be regularly maintained and checked **Control Owner:** Stella Adegoke	Limited	I = 5 L = 3 High (15)	Replacement YAG Laser to be funded and purchased **Person Responsible:** Howard Ford **To be implemented by:** 31 Aug 2024	**01 May 2024** **Emma Kelly** 10th and 17th May - supplier demos happening. Implementation date changed to align with procurement processes. Emma Kelly (on behalf of Howard Ford)	I = 3 L = 1 Very Low (3)
3625	05 Jan 2024	Care Group - William Harvey		Capacity and demand for ED care resulting in corridor care **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Tammy-Ann Sharp **Last Updated:** 21 May 2024 **Latest Review Date:** 02 Apr 2024 **Latest Review By:** Rachel Perry **Latest Review Comments:** Trust Full capacity SOP remains outstanding, ED escalation flow chart reviewed and in use. Further guidance on capacity issues sent to On call team. Corridor care reducing but still remains in use daily.	**Cause** Due to the ongoing challenges with LOS and in patient ward capacity patients with DTA's are held in the ED - on average 30 pts per day. This adversely affects the departments ability to safely and effectively manage ED patients, and give a good patient experience to those awaiting beds. **Effect** Inability to offload ambulances into a recognised clinical area. Continuous 'corridor care' ie care given outside of a recognized clinical area (ref NHSE). Patient safety potentially compromised. Staff welfare impact. Poor patient experience. Increase complaints	Quality	I = 4 L = 5 Extreme (20)	Review of ED Corridor Care SOP and review of ED escalation flow chart (within SOP) **Control Owner:** Rachel Perry Updated trust full capacity protocol **Control Owner:** Rachel Perry		I = 3 L = 5 High (15)	Send CQC action plan - must and should do's as this will have signed off documents listed as controls This has still not been achieved date amended **Person Responsible:** Rachel Perry **To be implemented by:** 28 Jun 2024		I = 3 L = 5 High (15)

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
1831	13 Nov 2019	Care Group - Queen Elizabeth, The Queen Mother	QEQM Urgent and Emergency and Acute Medicine	Privacy and dignity will be adversely affected when patients are treated in non-care spaces **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Susan Brassington **Last Updated:** 17 Apr 2024 **Latest Review Date:** 10 May 2024 **Latest Review By:** Janet Webber **Latest Review Comments:** Reviewed with ADN	**Cause** Due to overcrowding and demand not all patients are able to be cared for in an identified designated care space. Corridor care standing operating procedure is audited and shows patient groups often fall outside of this category, negatively impacting privacy and dignity due to overcrowding. **Effect** Patients are being cared for in identified non-clinical areas such as corridors when this is not appropriate. This is resulting in incidents occurring and complaints being received. In addition, it causes potential obstruction of corridor pathways	Quality	I = 4 L = 5 Extreme (20)	2 hourly board rounds in place within the Emergency Department. To help with flow, at these board rounds patients are identified for alternative pathways to reduce the overcrowding. **Control Owner:** Joanna Williams	Limited	I = 3 L = 5 High (15)	Monitoring of use of corridor areas as patient areas using DATIX reports and harm reviews as necessary as an ongoing process **Person Responsible:** Joanna Williams **To be implemented by:** 31 Jul 2024	**12 Mar 2024** **Janet Webber** Request for Risk to move to Urgent, Emergency and Acute Medicine Risk Register	I = 3 L = 2 Low (6)
								A corridor dashboard has been put in place to faciliitate monitoring and DATIX reporting **Control Owner:** Janet Webber	Adequate				
								All use of non care spaces is reported via fundamentals of care and to the board **Control Owner:** Joanna Williams	Limited				
								Audits on the use of non-designated areas for clinical care are carried out and reported to the Fundamentals of Care committee. **Control Owner:** Joanna Williams	Limited				
								DATIX reports are completed for each patient cared for in a non-clinical area and escalated to the COO, with senior staff walking the floor and offering apologies to patients and monitoring the situation **Control Owner:** Joanna Williams	Adequate				
								The Site Management Team produce a daily report on the use of the corridors and length of time patients are there (for both EDs). This data will also be input onto Datix for monitoring purposes. **Control Owner:** David Bogard	Adequate				
								The Site team report on a shift basis any use of the corridors within the EDs. **Control Owner:** Joanna Williams	Adequate				
								There are exclusion criteria in place for corridor care and corridor boxes, care plans and buzzers have been initiated. The corridor SOP has been updated in January 2023 **Control Owner:** Joanna Williams	Adequate				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2599	13 Oct 2021	Corporate - Medical		There is a risk of inadequate medical staffing levels and skills mix to meet patients needs **Risk Owner:** Desmond Holden **Delegated Risk Owner:** Helen Mackie **Last Updated:** 12 Feb 2024 **Latest Review Date:** 09 Feb 2024 **Latest Review By:** Helen Mackie **Latest Review Comments:** Review the medical recruitment process. included as theme in CIP program. 1'st meeting 8,02,24 e-mail to DV re the task and finish group	**Cause** An inability to recruit in key specialties and to key grades. Insufficient substantive consultant staff requiring long term locums to cover vacancies Lack of central medical function **Effect** Patient outcomes Experience and safety Financial impact due to cover with high cost locums	People	I = 3 L = 5 High (15)	Associate Medical Director in post to innovate in medical recruitment **Control Owner:** Desmond Holden		I = 3 L = 5 High (15)	Deliver a fit for purpose medical appraisal platform **Person Responsible:** Jason Watson **To be implemented by:** 30 Aug 2024	**12 Mar 2024** **Jason Watson** Competitive procurement process complete with revised specification document aligned to this risk. New provider transition expected to be complete in May 2024.	I = 3 L = 2 Low (6)
								Locum policy describing induction for locum doctors **Control Owner:** Fiona O'Neill					
								Medical recruitment team have process in place to check and challenge requests to extend locums beyond two years **Control Owner:** Kelly Martella	Adequate		Review the consultant medical recruitment process - focusing on specialities (HCOOP first tranche) **Person Responsible:** Twyla Mart **To be implemented by:** 31 Aug 2024	**20 May 2024** **Emma Kelly** There is a PID in place and work ongoing with Helen Mackie. Working on trial with one department/speciality (HCOOP). In the next 4 weeks reviewing JD and Adverts, producing videos in department for social media, putting together adverts and posters for member of staff to present to geriatric conference in Sri Lanka, creating a QR codes for easier links to adverts and application process, making jobs more flexible working with medical school (split speciality posts), work with department to shorten time to short list. Time to hire KPIs improved significantly April 24 57 days (326 days previous). Target is 90 days. April/May 24 =- recruited to 3x hard to recruit areas. Due date amended to reflect work described. Emma Kelly (Twyla Mart) 20/05/24	
								Task and finish group established around medical recruitment including consultants **Control Owner:** Desmond Holden	Limited				
											Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. CESR). **Person Responsible:** Kelly Martella **To be implemented by:** 02 Sep 2024		

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
3556	02 Nov 2023	Care Group - William Harvey		Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring **Risk Owner:** Sarah Hayes **Delegated Risk Owner:** Carly Sheehan **Last Updated:** 23 Apr 2024 **Latest Review Date:** 23 Apr 2024 **Latest Review By:** Carly Sheehan **Latest Review Comments:** Reviewed risk and implementation of the improvements work for the ED floor is ongoing with plans to support and enhance DAP- Action owner changed to Diwakar Sharma	**Cause** Inability to provide appropriate care spaces for the number of patients in the department. Inability to provide beds with pressure relieving mattresses in designated escalation areas. Occupancy within ED for patients with a Decision to Admit is extended. Staffing ratios not optimal for nurse to patient due to additional escalation areas being utilised. **Effect** *Overcrowding in ED Departments *Patients being cared for and treated outside of a designated area within the department *Inability to safely observe, monitor and care for patients due to excessive demand and /or low staffing *Reduced flow through the ED departments, and hot floor due to low numbers of discharges in wards In addition there are times when patients remain in ambulance queues as there is no space for them to be moved into the ED.	Quality	I = 5 L = 5 Extreme (25)	Board patients in wards and AMU against Definite discharges to decongest departments and utilise DAP including the improvements to the AMU model **Control Owner:** Rachel Perry	Limited	I = 3 L = 5 High (15)	Regular audits of the ED care plan to ensure that the actions that are prompted by this are delivered **Person Responsible:** Tomislav Canzek **To be implemented by:** 31 May 2024	**15 May 2024** **Emma Kelly** Regular audits in place . Recent results to be reviewed by Head of Nursing to assess whether action can be closed. Emma Kelly (in liaison with Ben Hearnden)	I = 3 L = 2 Low (6)
								Funded GP service running out of ED **Control Owner:** Diwakar Sharma	Adequate		Continued Implementation of the Emergency Floor Improvement plan which includes direct pathways such as right sizing SDEC, SEAU and UTC **Person Responsible:** Rachel Perry **To be implemented by:** 01 Jul 2024		
								Patient pathway review/retraining of triage and ENP staff Urgent Treatment Centre being planned **Control Owner:** Benjamin Hearnden	Adequate				
								Working with external partners to explore alternative pathways and provision of services **Control Owner:** Diwakar Sharma	Limited				
								Working with patients to improve knowledge/health education and use of alternative pathways **Control Owner:** Benjamin Hearnden	Limited				
								Working with SECAmb to reduce conveyances to ED **Control Owner:** Benjamin Hearnden	Limited				

Risk Register Report (By Residual Risk Ranking)

Risk Ref	Created Date	Risk Register	Sub Risk Area	Risk Title	Cause & Effect	Risk Category	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
2766	01 Apr 2022	Care Group - Critical Care, Anaesthetics and Specialist Surgery		There is a risk that patients are cancelled and theatres starts are delayed due to a lack of surgical admissions lounge at WHH, this impacts on patient's experience and dignity **Risk Owner:** Robert Hodgkiss **Delegated Risk Owner:** Loraine Turner **Last Updated:** 21 May 2024 **Latest Review Date:** 07 Mar 2024 **Latest Review By:** Janet Murat **Latest Review Comments:** Executive risk owner added as risk >15, agreed with CN-SH	**Cause** Higher volume of elective admissions in CDSU due to closure of SAU and A&E expansion building work. This risk was previously mitigated by using the post-op area to admit patients, however, due to Channel Day change of use to an escalation area, this is blocking beds and impacting flow of elective surgery from Recovery to the ward for 2nd stage recovery and discharge. **Effect** Increased activity and not enough space in pre-op area, only 6 cubicles to admit all elective patients. Post op area currently being used to admit CDSU theatre lists but flow of patients is impacted by delays transferring to the ward from Recovery caused by volume of patients and pm admissions. Delayed theatre starts Poor patient experience and increased complaints. Inability to meet statutory requirements of delivering same-sex accommodation Cancellation of patients due to running out of theatre time	Quality	I = 3 L = 5 High (15)	Day surgery use lounge chairs to keep trolley spaces free **Control Owner:** Christine Boswell	Adequate	I = 3 L = 5 High (15)	Work with Prism around theatre utilisation to improve productivity Establish task and finish group for theatre right sizing **Person Responsible:** Anthony Adams **To be implemented by:** 31 May 2024		I = 3 L = 3 Moderate (9)
								Incident completed each time a list is delayed due to staff being unable to complete admission paperwork **Control Owner:** Lynda Marshall	Adequate		Return of surgical admissions unit at WH Awaiting site lead update for estate allocation of SAL **Person Responsible:** Anthony Adams **To be implemented by:** 31 May 2024		
								Quality Impact Assessment completed **Control Owner:** Gemma Oliver	Adequate				
								Reducing theatre lists to accommodate patients being admitted to Channel Day Surgery Unit **Control Owner:** Anthony Adams	Limited				
								Review daily and work with day surgery to cohort patients together where appropriate **Control Owner:** Christine Boswell	Adequate				
3367	03 Jul 2023	Corporate - Medical		Lack of timely review of diagnostic test results **Risk Owner:** Desmond Holden **Delegated Risk Owner:** **Last Updated:** 12 Feb 2024 **Latest Review Date:** 01 Feb 2024 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Target score updated in line with Trust risk appetite for quality.	**Cause** Sunrise system does not have a functionality whereby a consultant is able to review on one page all test results that sit under them for all patients. What they are required to do is to review the test results within each patients records. The challenge is that as a result of difficulty within the Sunrise system or PACS system staff are not always able select the correct consultants because of the way the system is designed therefore regularly they have to select an incorrect consultant **Effect** Consultants are overwhelmed with test results that do not relate to the patients that are under them and that these test results are then sent on to another consultant providing they are reviewed in a timely manner Patients will have a delay in medical and nursing response to abnormal test results. We are aware that these issues relate to radiology, pathology including histology and haemotology.	Quality	I = 3 L = 5 High (15)	Radiology have implemented a number of fail safe processes. including spreadsheets of all query cancer results to the Cancer Nurse Specialists weekly. **Control Owner:** Gemma Matthews	Limited	I = 3 L = 5 High (15)	To understand the issues and Trust processes across the specialties to identify the causes of this risk **Person Responsible:** Samantha Gradwell **To be implemented by:** 28 Jun 2024	**24 Apr 2024** **Emma Kelly** An initial review was undertaken but this is an area of significant risk that should be picked up as a theme within the new PSIRF framework. Action due date extended. Joint ownership: Sammie Gradwell and Mike Bedford	I = 3 L = 2 Low (6)
											Developing a page on Sunrise for consultants to review all results that are allocated to them **Person Responsible:** Michael Bedford **To be implemented by:** 31 Jul 2024		

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

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

Meeting dates: **9 April 2024 and 13 May 2024**

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

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

Quorate: Yes

Appendices:

Appendices Provided in Reading Room (Documents for Information)
Appendix 1: Perinatal Quality Surveillance Tool (PQST) Report (April and May 2024)
Appendix 2: Perinatal Mortality Review Tool (PMRT) Quarterly Report – Q4 2024/25
Appendix 3: Avoiding Term Admissions into Neonatal Units (ATAIN)
Appendix 4: Saving Babies Lives Care Bundle (SBLCB) Safety Action 6
Appendix 5: Quarter 4 Training Report
Appendix 6: Care Quality Commission (CQC) Must and Should Do Requirement Update
Appendix 7: Obstetric Medical Workforce Paper
Appendix 8: Neonatal Workforce Paper

Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Perinatal Quality Surveillance Tool (PQST) and Maternity Dashboard	**PQST and Maternity Dashboard presented for the period March and April 2024** A paper was presented each month highlighting areas of positive performance and areas for improvement that the team are currently addressing from both the PQST tool and the overarching maternity scorecard • The rate of reportable neonatal and perinatal deaths remains lower than the Trust comparator group average. The rolling 12-month Stillbirth rate is now at 1.39 per 1000 births, this is much lower than the comparator average of 3.92/1000. • The extended perinatal rate (Stillbirths and Neonatal deaths up to 28 days) is now at 2.77 per 1000 births and this is much better than the comparator average of 5.87 per 1000 births.

	• The team is now exploring disparities that may exist within these outcomes. An Equality, Diversity and Inclusion (EDI) task and finish group was set up and has met twice since the last Board meeting. • The Neonatal death rate remains higher than the local average/upper confidence level, largely caused by three NNDs in December 2023. Overall there have been eight NNDs in the past 12 months. The rate is still well below the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK comparator group threshold of 1.96 per 1000 births. • One: One care in labour and the supernumerary status of the coordinator were both achieved and 100% compliant. • 0 Serious incidents (SIs) or Maternity and Newborn Safety Investigation (MNSI) referrals in March. There was one SI in April and one neonatal death which is subject to review. • Safeguarding training: Compliance just below 90%. Twenty staff who have not attended in the last year have now been booked to attend. • PRactical Obstetric Multi-Professional Training (PROMPT) compliance remains above 90% for all staff groups. • Friends and Family Test (FFT) response rate between 5-11% with better uptake from Your Voice is Heard (YVIH) with 70% responses. The team continue to review and take measure to improve the uptake of FFT.
Maternity and Neonatal Improvement Programme (MNIP) Update	The DoM discussed the progress report from each of the six maternity workstreams. A detailed report is provided for each workstream on a monthly basis demonstrating progress against the Year 1 milestones. Most of these have already been achieved and work has also commenced against the Year 2 milestones. The team met in April 2024 to review progress and agree priorities for Year 2. These include in month successes and any risks to the individual workstreams. A Year 2 MNIP summary document has been formulated which includes the six team objectives and priorities for Year 2. This is being aligned to achievement reviews with every midwife being allocated an objective in relation to the improvement programme.
Clinical Negligence Scheme for Trusts (CNST)	The service declared full compliance with the Maternity Incentive Scheme (MIS) Year 5 Safety Actions. This self-assessment was confirmed by the Local Maternity and Neonatal System (LMNS) and has since been approved by NHS Resolutions (NHSR). The MIS Year 6 data collection period commenced on 2 April 2024 so the service continues to work towards achieving full compliance with the Year 6 requirements. At the April MNAG the following papers were discussed in compliance with CNST reporting: • **Q4 PMRT Report** - The report confirms that during the Quarter 4 reporting period the service has used the tool to the required standard as

	set out in NHSR, CNST MIS Year 5.
	• **Q4 Avoiding Term Admissions into Neonatal Units (ATAIN) Report** - The report confirmed an ongoing audit and action plan as required. This action plan is monitored via MNAG and mechanisms are in place for sharing learning from the ongoing audit.
	• **Q4 Training Report** - The following highlights were noted:
	  • Compliance for all staff groups for fetal monitoring at the end of quarter 4 is above the stretch target for Saving Babies Lives version 3 and at the time of the report was at 97.9%.
	  • The Fetal Monitoring Team have recently acquired new members of the team who as well as providing full day teaching annually for all relevant staff groups, now provide weekly teaching sessions available cross site with the option for staff to attend face to face or virtually, each Friday.
	  • Compliance for all staff groups is above 90% with all groups excluding anaesthetic doctors being above 95%, this group sits just below the stretch target at 94.9%. This achievement evidences that the action plan for CNST is to ensure that 90% anaesthetic consultants and anesthetic doctors has been achieved.
	• **Q4 Saving Babies Lives (SBL) Report** - The third LMNS review of evidence is currently ongoing. An action plan has been created for each outstanding element and intervention to ensure compliance. The exceptions are as follows:
	  • Element 1: Self-assessment showed 80% implementation. The outstanding interventions relate to the expansion of an in-house smoking cessation service. The business has recently been approved for this to be implemented across the service.
	  • Element 4: Self-assessment showed 80% compliance. Completion of action plans where compliance is lower than expected within audits will increase compliance to 100%.
	  • Element 5: Self-assessment showed 96% compliance. Approval of the Continuity of Carer (CoC) implementation plan would increase compliance to 100%.
	  • Element 6; Self-assessment showed 67% compliance. This element is new within SBLCB. Completion of action plans where compliance is lower than expected within audits and training compliance will increase compliance to 100%.
	  • **Q4 SI/Duty of Candour (DoC)/Early Notification Scheme (ENS) Report** - The following highlights were noted:
	  During Q4 there were two maternity SIs, both of which occurred at William Harvey Hospital (WHH).
	
	Some key learning themes were highlighted and action taken relating to:
	• Categorisation of Cardiotocograph (CTG) and over-reliance on the Dawes-Redman.
	• Categorisation of emergency caesarean section.

	• Detection of small for gestational age (SGA) during the antenatal period and at birth to prompt enhanced postnatal observations of the baby. • Timely activation of 2222 neonatal emergency call. Four members of the patient safety team have also commenced the NHS England (NHSE) Patient Safety Syllabus Training (Levels 3 & 4). The report confirms that during the Quarter 4 reporting period the service has reported 100% of qualifying cases to MNSI and to NHSR's ENS as set out in NHSR, CNST MIS Year 5 version 1.1. There were no new cases in this quarter and one final report received from MNSI and shared with ENS.
Care Quality Commission (CQC) Update: Estates and Minor Work	The paper focussed on estates work that has been undertaken in response to the CQC Must and Should Do's. Whilst there have been significant improvements across the sites, some minor works have been slower to complete than anticipated. The Operations team are reviewing what the barriers are and have been asked to provide an update at the next MNAG. The new medication room opened in April. The two remaining Must Do requirements relate to: • ***Regulation 15 - Environment and facilities:*** The Bereavement Facility at WHH, WHH triage work and the second theatre at QEQM are still outstanding and until resolved the Trust cannot declare full compliance with Regulation 15(1) (c). In addition to the longer term plans to progress building the second theatre at QEQM the service is reviewing an interim measure within the existing footprint. • ***Regulation 18 - enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.*** This requirement is now at an overdue status due to the impact in the cessation of the midwifery programme of education at Canterbury and Christchurch University last year. It is most likely the requirement will remain in an overdue status as the student midwives are not due to qualify until December 2024. All of the current students have expressed an interested in staying at the Trust and have been offered midwifery positions. A number of actions have been undertaken to preserve safe midwifery staffing. The next staffing review is due to be reported in June when the service should have received the full Birth Rate Plus review.

Obstetric Workforce	• Despite consultant expansion over the last five years, there remains a shortfall. This shortfall was identified in early 2023 by NHSE when they undertook some mapping work to align current job plans with activity. • There remain ongoing challenges in terms of recruitment and rota gaps for the consultant workforce, which is now beginning to add strain to the ability of the team to support compliance for mandatory training especially aligned to PROMPT. A review of the sustainable model for the obstetric workforce has taken place. This has resulted in a number of actions including: 1) A review of the 24-hour consultant on call rota at the WHH. This has led to a change to the 24-hour on call rota at WHH which started in January 2024. 2) Ongoing work on the business case for four additional middle grades (trainees). (Required discussion with Kent Surrey and Sussex (KSS)) This will facilitate the development of a two tier on call rota for the WHH. 3) Development of a new 'Portfolio pathway to specialist registrar (Certificate of Eligibility for Specialist Registration (CESR)) post as part of the 'growing our own' initiative. Recently advertised on Trac. 4) Changing a traditional consultant post which has not been recruited to into a specialist grade post. Job description completed. Awaiting approval at Vacancy Control Panel (VCP).
Neonatal Workforce	• Junior doctor workforce fully compliant as per British Association of Perinatal Medicine (BAPM) recommendations. Awaiting commencement of one Senior House Officer (SHO) post in May 2024. There are gaps in registrar rota currently: - due to lack of trainees sent from deanery (two vs five compared to other units within the deanery); - step down of one registrar to SHO rota due to issues identified with competence. • Consultant rota non-compliant. 1:5.5 Whole Time Equivalent (WTE) (1:8 WTE). - One long term sickness followed by resignation in January 2024; • - Long term sickness (0.5 WTE) - on phased return, currently not contributing to clinical shifts on neonatal rota making it 1:5 WTE. • WHH Neonatal Intensive Care Unit (NICU) have increased to 68.6% of registered workforce holding the qualified in specialty qualification. There is currently a 10.0 WTE vacancy across Band 5, 6 and 7s. QEQM Special Care Baby Unit (SCBU) have 2.45 WTE band 6 vacancies, with 56.4% of registered workforce qualified in specialty (against a target of 70%). An action plan with mitigation is in place. **Actions for medical workforce at WHH** 1. Deanery approached to increase the number of trainees to East Kent on par with other level 3 units across the deanery. Support from Local

	Faculty Group (LFG) Lead and Director of Medical Education required to progress this. 2. Increase number of staff grade registrars to ensure there is room for adjustment in case of sickness or unforeseen circumstances. Interviews on Friday. 3. As per BAPM in order to provide excellence in perinatal care, there is an ambition to provide 12 hours on site cover which will require two more consultants making compliment of 1:10 WTE consultants to deliver as recommended. This requires business planning to move forward. 4. Three month locum to help fill in the gap in consultant rota until September to mitigate.
Feedback from Board Level Safety Champions	The Acting Chairman has taken up the role of Non-Executive Director (NED)/Maternity Board Level Safety Champion together with the CNMO the Executive Lead. Each month the Board Level Safety Champions undertake 'walk abouts' in the clinical areas listening and responding to staff. In the month of May Board Level champions and the Chief Executive Officer (CEO) attended celebratory events at each acute site on Integrated Development Model (IDM) with an awards ceremony that was supported by the Midwifery Professional Midwifery Advocates (PMA) team. Staff feedback on the whole was positive. The main themes arising from the Safety Champion discussions include: • Midwifery staffing particularly at the WHH site. • Estates work (either linked to a lack of pace or the quality of work undertaken). The actions taken as a result of any concerns raised is feedback to the team via the maternity communication channel, at team meetings or team away days and as a "You said we did" document.
Matters to escalate to Quality and Safety Committee (Q&SC) and Board	- Internal Escalation from Neonatal unit in relation to Neonatal Deaths. - Midwifery Staffing and current mitigation. - Pace of work in relation to minor works. - *Reading the Signals* recommendation in relation to restoration and Trust's response.

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	6 June 2024

East Kent Hospitals University NHS Foundation Trust

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

Committee: **Nominations and Remuneration Committee (NRC)**

Meeting date: **21 May 2024**

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

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary

Annual NHS Fit and Proper Person Test (FPPT) Submission	• The Committee received assurance of the outcome of the annual FPPT audit and submission, noting:
	  • Board members (voting and non-voting) made Fit and Proper Person declarations in line with the Trust's Policy, and self-declared compliance with the Regulations;
	  • Trust's FPPT Policy will be reviewed in alignment with the new FPPT Framework published by NHS England. The updated Policy to be presented to the next NRC meeting in July 2024.

Remuneration and bonus arrangements for Executive and Senior Team members of 2gether Support Solutions (2gether) and Spencer Private Hospitals (SPH)	• The Committee received limited assurance from the paper setting out bonus pay arrangements for each subsidiary company. • The Committee considered and noted the revised terms of reference (ToR) for 2gether's NRC, agreed the Director of Corporate Governance to provide 2gether with a framework for this Committee to operate under. The reviewed and revised ToR will be re-presented to the Trust's NRC for approval. • The Committee noted no bonus payments had been awarded to staff of 2gether for 2023/24. • The Committee noted the bonus payments for the Managing Director; and Chief Finance Officer (CFO) for SPH (noting amendment of job title from Commercial and Finance Director), the salary benchmark and uplift for SPH's CFO. • The Committee noted the outcome report awaited on the Governance Review of the Group subsidiaries. It was important to ensure robust governance arrangements in place, and any SPH

We care

	bonus arrangements needed to align with the Trust's requirements and actively sourcing and increasing income. • The Committee noted formal objectives are being developed.
Chief Finance Officer (CFO) Job Description	• The Committee approved the CFO job description and salary range for the recruitment of a substantive CFO, noting the recruitment process will commence as soon as possible.
Executive Directors' End of Year Appraisals and Objective Setting 2024/25	• The Committee discussed and noted a summary report on the appraisals for Executive Directors along with set objectives for 2024/25 and provided additional feedback on these.
Chief Executive Officer (CEO) – Annual Appraisal 2023/24 and Objectives 2024/25	• The Committee discussed and noted a report on the CEO's 2023/24 annual appraisal and objectives set for 2024/25.

Other items of business

- The Committee noted the 2024 Annual NRC Work Programme.
- The Committee noted the Board Register of Interests.

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

Item	Purpose	Date
The Committee asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 6 June 2024

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **23 April 2024**

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

Paper Author: **Executive Assistant**

Quorate: No (although active steps are being taken to replace the vacant NED position)

Appendices:

None

Declarations of interest made:

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

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

Agenda item	Summary
INTEGRATED PERFORMANCE REPORT (IPR)	The Committee received the report and **NOTED** that there had been a reduction in incident reporting due to the new categorisation of the Learning from Patient Safety Events (LFPSE) data. The Committee was also made aware that there was a zero-breach position for Root Cause Analysis (RCA) and that compliance with Duty of Candour (DoC) was also showing a positive position.

We care

DEMONSTRATING IMPROVEMENT FROM LEARNING FROM DEATHS PROCESS INCLUDING THE LEAD MEDICAL EXAMINER REPORT	The Committee received the report and **NOTED** the following key updates; • The overall Hospital Standardised Mortality Ratio (HSMR) was lower than expected (although there was variation across the sites). • There had been a round table discussion to review the cardiac arrest rate at William Harvey Hospital (WHH) and ongoing investigations were taking place. • The Medical Examiner report highlighted that there had been an increase in the number of patients who had been readmitted following a recent discharge. A deep dive was now taking place into these deaths. • Informal primary care feedback on the Single Point of Access (SPoA) Service suggested that it had impacted on Emergency Department (ED) referrals. The Committee agreed to a) review the SPoA outcomes and b) receive a further update regarding how feedback from Structure Judgement Review (SJR) and the Medical Examiner Service was triangulated with other Trust Governance processes. Integrated Care Board (ICB) colleagues updated the Committee regarding the system wide learning from Serious Incidents following diagnostic delays.
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS, CLINICAL ASSESSMENT SERVICE (CAS) AND PSIRF UPDATE)	The Committee received the report and **NOTED** that teams were working hard to close all open Serious Incidents ahead of the implementation of the Patient Safety Incident Response Framework (PSIRF). The Committee were assured that the trajectory for National Institute for Health and Care Excellence (NICE) compliance had been reviewed and the target was to achieve 90% compliance over the next 12 months. It was confirmed that following the 3 recent Transfusion Associated Overload (TACO) deaths, detailed work was taking place taking into recent Patient Safety Alert.

East Kent Hospitals University NHS Foundation Trust

PROGRESS AGAINST TRUST-WIDE FALLS IMPROVEMENT PLAN	The Committee received the report and **NOTED** the progress on the Falls Improvement Plan, which included that; • Focused work was taking place with the Deputy Chief Nurse with regards harms and fundamental of care. • The Trust was focusing on a multi-professional approach to falls and the falls team were also working with partner agencies. • A Falls Summit took place on 14 May 2024 with the clinical teams. • The wait times within our ED impacted on the number patient harms, especially related to pressure ulcers and focused work was taking place to address this.
PROGRESS AGAINST TRUST-WIDE TISSUE VIABILITY IMPROVEMENT PLAN	The Committee received the report and **NOTED** the progress on the Tissue Viability Improvement Plan, which include that: • The Teams were working to increase the understanding of ward staff, regarding what issues could be attributed to care on the wards. • The number of hospitals acquired pressure ulcers per month had shown an increasing trajectory over the past year. This had been due to an increased number of patients being treated within the Trust and the increased length of stay in our EDs.
DEMENTIA STRATEGY UPDATE	The Committee received the report and **NOTED** that report provided assurance on the progress of the actions set out within the Dementia Strategy. The Committee were advised that the Dementia Strategy Oversight Group fed into the Mental Health Group and work was taking place to establish patient representatives.
ORGAN DONATION ANNUAL REPORT	The Committee were asked to **NOTE** the Organ Donation Annual Report. The Committee were advised that the recent renal review had stated that there had been an increase in Kidney Transplants in the Trust over the last year.
UPDATE ON HARM REVIEW PROCESS	The Committee received the report and **NOTED** the updates to the harm review process which included: • The development of one overarching policy with a Standard Operating Procedure (SOP) to include both planned and unplanned care. • To work with the Integrated Care Board (ICB) to reflect on the Harm Review process of others across the system. • To ensure the Harm review process was aligned to the PSIRF approach that was being implemented. • To agree on how we will proportionately measure our Harm Reviews of those waiting in the ED for over 12 hours to ensure there was learning from this process.

East Kent Hospitals University NHS Foundation Trust

Referrals from other Board Committees

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

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	To Board on 6 June 2024

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **30 April 2024**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Board Assurance Framework (BAF) And Principal Mitigated Financial and Performance Risks	The outgoing Deputy Company Secretary updated the Committee that the BAF had been amended in consultation with Executive Directors and risk owners to ensure the BAF risks were clearer and better defined. The Committee recognised the changes but expressed its desire to have the BAF more closely linked with the Significant Risk Register and both documents playing a key role in the Committee's agendas. The Committee welcomed the Trust's new Director of Corporate Governance in this regard, who will take over ownership (at Executive level) of the BAF and work with Quality Governance to ensure it is a 'living' up to date document driving the Committee's work. The Director of Corporate Governance has committed to working with the Chair of FPC to ensure the evolution of the BAF and its alignment to the Significant Risk Register in subsequent meetings. The Committee received **LIMITED ASSURANCE** on the BAF with work still required to ensure it fulfils its purpose and provides assurance on principle risks the Committee is responsible for.
Significant Risk Register	The Trust's Director of Quality Governance updated the Committee on the ongoing work driven by the Quality Governance team to ensure the executive risk owners and deputies keep the significant risks up to date, and also ensure that corrective actions are updated.

We care

	In addition, a number of risks were highlighted and discussed. It was acknowledged that this is a work in progress as the current iteration of the Significant Risk Register (SRR) included risks which went back to March 2023. The Committee received **LIMITED ASSURANCE** and recognised the work done on the SRR and welcomed the further work which was in train. It agreed to continue to monitor the changes and urged the alignment of the SRR and BAF as discussed in the previous item.
Annual Plan - BAFFPC005	The Committee welcomed the Interim Chief Finance Officer's (CFO')s confirmation that the Annual Financial Plan had been cross-checked against the NHS England (NHSE) published guidance of 27 March 2024 and that it had met the necessary requirements. It was now submitted as a final Plan. In doing so, the Interim CFO flagged to the Committee: 1. Delivery of the Trust's £49m Cost Improvement Programme (CIP): whilst significant progress in identification and risk management had been agreed, the residual delivery risk associated with the programme was being mitigated by monitoring financial performance and CIP performance at the bi-weekly Financial Improvement and Oversight Board. 2. Cost base control: The Trust is actively managing the risk of unforeseen cost pressures in year. To mitigate this risk the Trust will monitor performance against budgeted position monthly in Performance Review Meetings (PRMs). 3. Income growth: Discussions with the Integrated Care Board (ICB) remain ongoing. 4. The delivery of the reduction in patients who classified as not fit to reside. The Committee agreed with the Interim CFO that CIP phasing will be brought back to each of the Committee's meeting so that it can be monitored on a monthly basis. The Committee received the report and endorsed the Annual Plan Sign Off report.
Patients No Longer Fitting the Criteria to Reside (RTS POST 7 DAYS) Length of Stay (LoS) and Bed Plan Update (Including Internal and NFC2R) – BAFFPC002	The Chief Operating Officer (COO) presented a high-level evaluation of the approaches and impact of PRISM at Queen Elizabeth the Queen Mother Hospital (QEQM) and KPMG/We Cares at William Harvey Hospital (WHH), to support improvement opportunities with regards to reducing length of stay at the hospital sites. The Committee, in particular, noted the following recommendations:

	• Engagement at the outset to design, develop and launch the programmes is essential to support 'ground up' cultural change with regards to patient flow and to ensure sustainability. • Clarity of scope with agile governance processes to ensure the programme is on track for delivery is essential to ensure any risks/barriers are mitigated and successes are shared. • Priorities for areas of focus should be agreed based on impact and where possible be Trust wide to reduce variability across sites and secure pace of impact. • Effective and efficient systems and processes which support Board to Ward proactive management and escalation of issues is essential to support the SAFER ward bundle implementation. The Committee also recognised opportunities to learn from the whole exercise and oversight of such projects. The Committee **NOTED** the report regarding PRISM and KPMG and were **ASSURED** that recommendations would be acted upon where relevant and **LIMITED ASSURANCE** as to the process.
Cost Improvement Programme (CIP)	The Committee were encouraged by the Interim CFO's update that a new Financial Recovery Director had started with the Trust. The Committee noted that the CIP plan had achieved £48m with an imminent commitment to £49m. In this context, the COO also updated the Committee on theatre and outpatients. Crucially, there was a set level of activity to be delivered on the 2024/25 plan, which each Care Group now able to track on a daily basis, month on month performance. The Committee also received assurance on the work being done on Procurement within the wider CIP and confirmed the areas which were being looked at.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received information from the COO's report that the Trust was on target to ensure patients waiting over 104-weeks were booked by the end of May. In addition, any 104-week wait patients after May, would be treated as a never event. The Trust is also committed to eradicate the 78 week waits by the end of June. The Committee was also encouraged to receive confirmation that the COO was working with neighbouring Trusts to transfer patients across all pathways, particularly those patients who had been waiting for over 41 weeks for their first outpatient's appointment, in order to tackle waiting lists.

East Kent Hospitals University NHS Foundation Trust

	The Committee took **LIMITED ASSURANCE** of the target to eradicate the 104-week waiters by the end of May, 78-week waiters by the end of June and 65-week waiters by the end of September.
Month 12 Finance Report	The Interim CFO assured the Committee that the Group delivered the forecast deficit position of £117.4m for 2023/24, reflecting the revised deficit for 2023/24 agreed with the Board and NHS England in January 2024. This included £13.1m of cost improvements made in 2023/24 and a significant improvement in the last two quarters of the year. The Group cash balance (including subsidiaries) at the end of March was £32.4m. The Trust drew £7.9m of working capital (Public Dividend Capital (PDC)) in the month, making a total of £95.8m for 2023/24. Total capital expenditure at the end of March was £32.3m spend against the available funding of £32.22m. The Committee also noted that the Trust had delivered its Capital programme in line with the funding provided. The Committee has **ASSURANCE** on the Month 12 Finance Report.
Winter Plan 2023/24 – Progress Against System Schemes	The Committee received an update and **NOTED** the brief update of the lessons learnt regarding the Winter Plan.
Update on External Engagement of the 5-Year Capital Plan	In addition to reviewing the 5-year Capital Plan, the Committee was assured of the 2023/2024 capital programme close down. It acknowledged that this was a significant achievement for the Trust and reflected movement in the right direction.
Capital Investment Group (CIG) Assurance Report	The Committee received an update and **NOTED** the update of the CIG report
Business Case Scrutiny Group (BCSG) Assurance Report	The Committee received an update from the BCSG and **NOTED** the update of the Business Case Investment Policy. **The Committee agreed to recommend the policy to the Integrated Audit and Governance Committee (IAGC) - APPROVED.**

Referrals from other Board Committees

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

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from FPC.	Assurance	To Board on 6 June 2024.

NHS
East Kent
Hospitals University
NHS Foundation Trust

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

Committee: Integrated Audit and Governance Committee (IAGC)

Meeting date: 26 April 2024

Chair: Dr Olu Olasode, Non-Executive Director

Paper Author: Board Support Secretary

Quorate: Yes

Appendices:

Appendix 1: Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)
Appendix 2: Gifts, Hospitality and Conflicts of Interests Policy

Declarations of interest made:

No additional declarations of interest made

Assurances received at the Committee meeting:

Agenda item	Summary

Internal Audit Progress Report and Draft Head of Internal Audit Opinion	• The Committee received **Assurance** and noted the Internal Audit progress report:
	  • Two final audit reports issued since last meeting:
	  • Capital Management (Partial Assurance);
	  • Discharge Planning (Reasonable Assurance).
	  • Two draft reports issued on Doctor Payments (additional advisory review) and Cashflow Management.
	• The Committee noted good progress and assurance moving in right direction in respect of the management of follow up of actions, and that overdue actions are being progressed and completed.
	• The Committee noted future progress update reports will include continued progress of audit follow-up actions, with particular focus at future meetings on the Locum Recruitment and Legal Services audits. This is around assurance of actions and that learning is being embedded.
	• The Committee noted the draft 2023/24 Head of Internal Audit Opinion unchanged from 2022/23 with adequate and effective frameworks in place. It was noted the further enhancements recommended to ensure improvements and consistency of the controls in place, and that these are fully embedded.

2022/23 Accounts Process – Lessons Learned	• The Committee received **Assurance** and noted the 2022/23 accounts process lessons learned report. • The Committee noted the key areas identified for improvement and lessons learnt a focus for the 2023/24 annual accounts audit to support ensuring the Trust meets the submission deadline. • The Committee noted a potential gap and risk following a number of key members of the Finance team staff who had left the Trust ahead of the completion of this audit at a critical period at year-end.

We care

	This risk had been addressed with recruitment of senior experienced support on an interim and substantive longer term.
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 noted conflicts of interest testing had identified management actions for prompt implementation in respect of non-compliance for staff required to make declarations. Progress will be monitored to ensure improved compliance.
LCFS Work Plan 2024/25	• The Committee received **Assurance** and approved the 2024/25 LCFS Work Plan.
LCFS Annual Report: Year Ended 31 March 2024	• The Committee received **Assurance** and noted the LCFS Annual Report for the year ended 31 March 2024, remaining overall green rated with one requirement rated red.
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. • The Committee noted progress of the 2023/24 annual accounts audit and regular meetings being held to review and monitor progress to ensure achievement of submission by the required deadline. • The Committee emphasised the deadline for submission of the annual accounts must be met.
External Audit 2023-24 Audit Plan	• The Committee received **Assurance** and noted the 2023-24 External Audit Plan.
Technical Accounting Items 2023/24	• The Committee received **Assurance** and noted the 2023/24 technical accounting items report.
Going Concern Review 2023/24	• The Committee received **Assurance** of the considered evidence that the Group is a 'going concern', and agreed there were no material uncertainties that may cast significant doubt about its ability to continue over the next 12 months at the statement of financial position date.
Draft Group Accounts 2023/24	• The Committee received **Assurance** and noted the draft Group Accounts for 2023/24, for final presentation on 26 June ahead of formal submission on 28 June.
Annual Accounts Process and Timetable 2023/24	• The Committee received **Assurance** and noted the process and timetable for submission of the 2023/24 annual accounts.
Review of Accounting Policies 2023/24	• The Committee received **Assurance** and approved the draft accounting policies 2023/24.
Provider Licence 2023/24 – Annual Self-Declaration	• The Committee received **Partial Assurance** from the annual self-declaration. Noting non-compliance against criteria 4 in the FT4 declaration relating to established and effectively implemented systems/processes, and the ongoing governance improvement work.

	• The Committee provided feedback, noting the document is factorial covering 2023/24 and agreed to remove two sentences relating to the current year 2024/25. • The Committee approved the annual statutory declaration certificates recommending these for approval by the Board of Directors (BoD) at its Closed meeting at the end of June 2024.
2023/24 Annual Report • **Compliance against Foundation Trust (FT) Code of Governance** • **Annual Governance Statement (AGS)**	• The Committee received **Assurance** from the early first draft version presented, welcoming feedback and comments for inclusion ahead of final presentation for approval by the BoD at its end of June meeting. • The Committee noted production of the document in line with the NHS Foundation Trust Annual Reporting Manual. • The Committee approved the first draft version of the 2023/24 Annual Report, revised version to be presented to early June Closed BoD meeting, and final version to the end of June Closed BoD meeting for approval for submission.
2023/24 Quality Account Report	• The Committee received **Limited Assurance** from the verbal report noting the draft report to be presented to the Clinical Executive Management Group (CEMG) in May, then to Quality & Safety Committee (Q&SC) in May, and final presentation to IAGC and BoD at its meetings at the end of June 2024. • It was agreed following presentation and input from CEMG and Q&SC, the draft document to be circulated to IAGC for feedback and comments ahead of its final presentation for approval to IAGC and BoD at the of June.

Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)	• The Committee received **Assurance** from the annual review of SFIs and SoD.
	• The Committee noted:
	  • Document updated in respect of governance arrangements moving from the Strategic Investment Committee to Business Case Scrutiny Group and Capital Investment Group;
	  • No proposed changes to delegated limits;
	  • Ensuring continued robust financial controls with the inclusion of no permanent or fixed-term contract employees to be appointed without the approval of the Chief Executive or formally-constituted Trust-wide recruitment panel.
	• The Committee approved the SFIs and SoD draft version (Appendix 1) recommending this to the BoD for approval.

Good Governance Institute (GGI) Governance Review	• The Committee received **Assurance** from the GGI governance review report, noting the recommendations and next steps for implementation. • The Committee noted work already commenced on next steps and the Trust's Director of Corporate Governance (DCG) will lead and oversee the required actions. • The Committee agreed a progress update report to be presented at its next meeting in July covering progress to date and review of the appropriateness of the maturity matrix. An action plan to be produced and presented at its October 2024 meeting and a progress update at its January 2025 meeting. To provide assurance for monitoring of progress on the recommendations,

	next steps, responsible leads, and timeframe for completion of actions.
Board Assurance Framework (BAF)	• The Committee received **Assurance** from the further completed and improved new BAF format following extensive review, updated with input from Executive Leads and the Chief Executive. • The Committee noted the completed version had been presented to each of the Board Committees, who had signed off their accountable risks. The further updated version will be presented to the May 2024 Board Committee meetings for ongoing scrutiny and to challenge progress and delivery against the set target dates.
Risk Review Group Chair Report and Significant Risk Report	• The Committee received **Assurance** from the improved and updated Significant Risk Report, with scrutiny of high rated risks above 15 by the Risk Review Group. • Phase 1 of risk review completed and moving to business as usual in risk management ensuring appropriate local governance and oversight. • Trust's Internal Auditors to undertake an annual internal audit reviewing the processes in place, that these are appropriate to manage risks and that the organisation is focussing on all its risks. • The Committee noted a separate report to be produced to include issues (crystallised risks). • The Committee requested a progress update and assurance of the processes in place aligning its subsidiary risks with the Trust's risks.

2024/25 Annual Programme for Clinical Audit	• The Committee received **Assurance** and approved the 2024/25 Clinical Audit programme, noting ongoing monitoring by the Clinical Audit & Effectiveness Committee (CAEC), Clinical Executive Management Group (CEMG), and Q&SC.
	• The Committee noted:
	  • Programme reflected key national and local drivers for improvements;
	  • Included 217 overall Trust audits (in comparison with 240 in 2023/24, and 270 in 2022/23), and 147 local audits (21 in response to patient safety concerns (14%));
	  • Additional 70 National Audits (40 currently mandatory);
	  • Annual Clinical Audit Symposium held with good engagement and attendance from staff.

Data Security and Protection Toolkit (DSPT) Submission 2023/24 – Progress Report	• The Committee received **Assurance** from the progress report and Trust on track to meet the annual submission in late May/early June with confidence of achieving compliance. • Continued annual risk in achieving the 95% training compliance requirement, an ongoing challenge for all trusts.
Training Needs Analysis (TNA) – DSPT Submission 2024	• The Committee received **Assurance** from the TNA undertaken and approved the proposed 90% set internal target for staff Data Security/Information Governance (IG) training compliance for the 2024/25 annual DSPT submission. Target reduction from the previously externally set target of 95%. • The Committee discussed concern with reducing the target, noting 95% had been achieved over the last couple of years, and the

	perception of this message throughout the organisation. It was noted 95% was a challenging target to achieve. The Committee emphasised it was important that staff maintained compliance against all mandatory training and not just data security and IG, and compliance needed to be monitored with targeted focus reminding staff that were not compliant to complete their training.
Losses and Special Payments Report	• The Committee received **Partial Assurance** from the report, noting for the period 1 April 2023 to 31 March 2024, totalled £454k (333 cases), an increase in comparison to the previous financial year of £317k (395 cases) and cost of £137k.
Single Tender Waiver (STW) Report	• The Committee noted the STW report deferred to be presented to the next Committee meeting in July 2024.
Gifts, Hospitality and Conflicts of Interests Policy	• The Committee received **Assurance** and approved the Gifts, Hospitality and Conflicts of Interests Policy (Appendix 2) and recommends this for approval by the Board of Directors.

Other items of business
The Committee noted the 2024/25 IAGC Annual Work Programme, there will be a future discussion of this with the Trust's DCG in liaison with the Chief Executive and Interim Chief Finance Officer. This will be to ensure the programme reflects the recommendations of the governance review and the Trust's governance mapping structure.

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 6 June 2024.
The Committee asks the BoD to **APPROVE** the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD)	Approval	To Board on 6 June 2024.
The Committee asks the BoD to **APPROVE** the Gifts, Hospitality and Conflicts of Interests Policy.	Approval	To Board on 6 June 2024.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
(SFI's)

Incorporating

Reservation of Powers to the Board of Directors

and

Detailed Scheme of Delegation

Approved by: Integrated Audit and Governance Committee, 26th April 2024
Issued By: Chief Finance Officer

Table of Contents

24/30.4 - APPENDIX 1

Note: This document should be read in conjunction with the Trust's Standing Orders which are part of the Trust Constitution and can be found on the Trust website at http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/statements-and-declarations

24/30.4 - APPENDIX 1

1 Forward

1.1 The East Kent Hospitals University NHS Foundation Trust is a public benefit corporation which was established on 1st March 2009 under the Health & Social Care (Community Health & Standards) Act 2003 subsequently consolidated into Chapter 5 of the National Health Service Act 2006. NHS Foundation Trusts are governed by a range of statutes, including the National Health Service and Community Care Act 1990 (NHS & CC Act 1990), the National Health Service Act 1977 (NHS Act 1977) and the Health and Social Care Act 2012. The statutory functions conferred on the Trust are set out in the NHS & CC Act 1990 (Schedule 2), Chapter 5 of the National Health Service Act 2006 and the Trust's Constitution.

1.2 As a public benefit corporation, the Trust has specific powers to do anything which appears to be necessary or desirable for the purposes of, or in connection with, its functions. In this respect it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.3 The Membership and Procedure Regulations 1990 (SI (1990)2024) require Trusts to adopt Standing Orders (SO's) for the regulation of their procedures and business whilst the "Directions on Financial Management in England" issued under HSG (96)12 in 1996, require Health Authorities to adopt Standing Financial Instructions (SFI's) setting out the responsibilities of individuals. These Directions are not mandatory on NHS Foundation Trusts but are being observed, as far as they are relevant, as a matter of good practice.

1.4 In addition the Code of Accountability for NHS Boards (published by the Department of Health in April1994) requires Boards to draw up SO's, a Schedule of Decisions Reserved to the Board and SFI's. The Code also requires Boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, the East Kent Hospitals University NHS Foundation Trust's Board of Directors has in place locally generated rules and instructions, including financial procedural notes, for use within the Trust. Collectively these must comprehensively cover all aspects of financial management and control of resources. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1.5 The Code of Accountability requires that each Foundation Trust shall give, and may vary or revoke, SFI's for the regulation of the conduct of its directors and employees in relation to all financial matters with which they are concerned. These SFI's are issued in accordance with the Code. They shall have effect as if incorporated in the Board of Directors' SO's

2. Terminology

2.1 Any expression to which a meaning is given in the Health Service Acts or in the Financial Directions made under the Acts shall have the same meaning in these SFI's and in addition:

"Accounting Officer" means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Integrated Audit and Governance Committee" means the Integrated Audit & Governance Committee which is a statutory committee of the Board of Directors.

"Authorisation Agreement" refers to the document issued by the Regulator at the inception of the Trust authorising it to operate as a Foundation Trust in accordance with Chapter 5 of the NHS Act 2006.

"Board" means the Board of Directors of the Trust as set out in the Constitution and consisting of a Chairman and Non-executive directors (appointed by the Council of Governors) and the Executive Directors, appointed by the non-executive directors and (except for his own appointment) by the Chief Executive.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chairman of the Board (or Trust)" is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer/accounting officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services, whether by the Trust (within available resources) or from the Trust by purchasers (i.e. Commissioners) of NHS Care.

"Committee" means any committee or sub-committee established by the Council of Governors or the Board of Directors for the purposes of fulfilling its functions.

"Constitution" means the document of that name approved by the Board of Directors and the Council of Governors which describes the operation of the Foundation Trust.

"Council of Governors" means the body of elected and appointed governors, authorised to be members of the Council of Governors meeting in public, presided over by a Chairman, acting as a collective body accordance with the Constitution.

"Deputy Chairman" means the non-executive director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

"Chief Finance Officer" means the Chief Finance Officer of the Trust.

"Funds held on trust" shall mean those funds which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Pt. 11, Chap 2 of the NHS Act 2006. Such funds may or may not be charitable.

"Governor" shall mean a member of the Council of Governors whether elected or appointed to the Council of Governors in accordance with the Constitution.

"Legal advisor" means the properly qualified person engaged by the Trust to provide legal advice.

"Mandatory services" are those services which the Regulator has deemed it compulsory that the Trust provides, as listed in the Authorisation Agreement.

"NHS England " is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety (including the National Reporting and Learning System), Advancing Change Team and Intensive Support Teams and is responsible for overseeing Foundation Trusts and NHS Trusts as well as independent providers that provide NHS funded care

"Nominated employee" means an employee charged with the responsibility for discharging specific tasks within SO's and SFI's.

"Non-Executive Director" means a person appointed as a Non-Executive Director of the Trust under paragraphs 15 to 19 (inclusive) of Schedule 7 of the NHS Act 2006 and in accordance with paragraphs 21/22 of the Constitution.

"Provider Licence" means the Licence of the Trust issued by Monitor (now NHSE) with any amendments for the time being in force.

"SFI's" means Standing Financial Instructions.

"SO's" mean Standing Orders as constituted under the Trust's Licence Conditions.

"Trust" means the East Kent Hospitals University NHS Foundation Trust.

"Company Secretary" means a person appointed to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors, the Chairman and the Council of Governors and to monitor the Trust's compliance with the law, SO's, the Constitution, Licence conditions, statutory provisions and guidance and direction given by NHS England.

2.2 Wherever the title Chief Executive, Chief Finance Officer or other nominated employee is used in these instructions it shall be deemed to include such other director or employee that has been duly authorised to represent them.

2.3 Wherever the term "employee" is used and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.4 The Trust has established a wholly owned subsidiary, 2gether Support Solutions Ltd, (2gether) as a Property Facilities Management Company that will provide an Operated Healthcare Facility (OHF) to the Trust. Under the supporting agreements the Trust has made available the supply of assets to 2gether from which 2gether provides a fully functioning building or facility within which medical and nursing professionals can treat and care for their patients. Under the OHF, 2gether makes available to the Trust the properties from which the Trust will deliver its NHS clinical services. As a wholly owned subsidiary 2gether has developed a simplified version of the Trust's SFI's incorporating a scheme of delegation with delegated authority to officers of equivalent seniority as specified by the Trust.

2.5 "Procurement Services" are currently provided to the Trust under contract by 2gether.

2.6 The approved SFI's for 2gether Support Solutions is included as an appendix to this document. Where the Foundation Trust SFI's refer to "2gether Nominated Officer" this can then be referenced in that Appendix.

3. Introduction

3.1 Save as otherwise permitted by law, at any meeting the Chairman of the Board of Directors shall be the final authority on the interpretation of SO's (on which they should be advised by the Chief Executive or Secretary to the Board).

3.2 These SFI's detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy and the sector regulator's policies, in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

3.3 The Single Oversight Framework details how NHS England oversees and supports all NHS Trusts. Additional financial guidance is included in The NAO's Code of Audit Practice, and the Department of Health & Social Care Group Accounting Manual (DHSC GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

3.4 These SFI's identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These SFI's should therefore be read in conjunction with the Trust's detailed corporate policy documents, financial procedures and any departmental procedure notes. All financial procedures must be reviewed by the Chief Finance Officer before being approved in line with the Policy for the Development and Management of Organisation Wide Policies and Other Procedural Documents.

3.5 Should any difficulties arise regarding the interpretation or application of any of the SFI's then the advice of the Chief Finance Officer must be sought before acting. The user of these SFI's should also be familiar with and comply with the provisions of the Trust's SO's.

3.6 Failure to comply with the Scheme of Delegation, SFI's and SO's can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

3.7 Overriding SFI's – If for any reason these SFI's are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Integrated Audit and Governance Committee for referring action or ratification. All directors and employees have a duty to disclose any non-compliance with these SFI's to the Chief Finance Officer as soon as possible.

3.8 Employees of the Trust should note that the Scheme of Delegation, SFI's and SO's do not contain every legal obligation applicable to the Trust. The Trust and each employee of the Trust must comply with all requirements of legislation (which shall mean any statute, subordinate or secondary legislation, any enforceable community right within the meaning of section 2(1) European Community Act 1972 and any applicable judgment of a relevant court of law which is a binding precedent in England) and all guidance and directions binding on the Trust. Legislation, guidance

and directions will impose requirements additional to the Scheme of Delegation, SFI's and SO's. All such legislation and binding guidance and directions shall take precedence over the Scheme of Delegation, SFI's and SO's which shall be interpreted accordingly.

4. Responsibilities and Delegation

4.1 The Board of Directors

4.1.1 The Board exercises financial supervision and control by:

(a) Formulating the financial strategy;
(b) Requiring the submission and approval of budgets and annual financial plans;
(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
(d) Defining specific responsibilities placed on directors and employees as directed in the Scheme of Delegation document.

4.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board itself in formal session. These are set out in the "Reservation of Powers to the Board" document.

4.1.3 All other powers have been delegated to such other committees as the Trust has established, or directly to an executive director. Full details of Reserved matters and Delegated powers are set out in the Trust's Scheme of Delegation.

4.1.4 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

4.2 The Chief Executive and Chief Finance Officer

4.2.1 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

4.2.2 Within the SFI's, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accounting Officer, to NHS England, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

4.2.3 It is a duty of the Chief Executive to ensure that directors and employees and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

24/30.4 - APPENDIX 1

4.3 The Chief Finance Officer

4.3.1 The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

(d) ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors:

(e) referring all cases of fraud to the Local Counter Fraud Specialist;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(f) the provision of financial advice to the Board of Directors, employees and the Council of Governors;

(g) the design, implementation and supervision of systems of internal financial control; and

(h) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

4.4 Board of Directors and Employees

4.4.1 All directors and employees, individually and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of SO's, SFI's, Financial Procedures and the Scheme of Delegation; and

(e) reporting suspected theft, fraud or bribery to the Chief Finance Officer.

4.5 Contractors and their employees

4.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

4.5.2 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

4.5.3 Where services are outsourced by the Trust, the Chief Finance Officer should be assured that the outsourced agent has suitable systems and control mechanisms in place

5. Audit

5.1 Integrated Audit and Governance Committee

5.1.1 In accordance with Schedule 7 (paragraph 23) of the 2006 Act and both the Trust's Constitution and SO's, the Board of Directors shall formally establish the Integrated Audit and Governance Committee of Non-Executive directors, with clearly defined terms of reference and will follow guidance from the NHS Audit Committee Handbook, the NHS Integrated Governance Handbook, National Audit Office Code of Audit Practice, the Code of Governance and Compliance Framework. The Committee will perform such monitoring, review and other functions as are appropriate. In particular the Audit Committee will scrutinise and review the Trust's systems of governance, risk management and internal control by:

(a) monitoring and reviewing the effectiveness of the Trust's Internal Audit function and counter-fraud / bribery arrangements, including approval and review of annual audit plans;
(b) monitoring the integrity of the financial statements and formal announcements relating to financial performance, and reviewing significant financial reporting judgments;
(c) reviewing the Trust's internal controls (clinical and financial) and risk management systems;
(d) reviewing and monitoring the external auditor's independence and objectivity and the effectiveness of the audit process
(e) Approving the annual audit plan and arrangements for the auditor to supply non-audit services; and
(f) reviewing arrangements by which Trust staff may raise concerns.

5.1.2 Where the Integrated Audit and Governance Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may be brought to the attention of the Regulator (to the Chief Finance Officer in the first instance) and the Council of Governors.

5.1.3 It is the responsibility of the Chief Finance Officer to ensure that an adequate Internal Audit service is provided and the Integrated Audit and Governance Committee shall be involved in the selection process when an Internal Audit service provider is changed.

5.1.4 The Integrated Audit and Governance Committee has a responsibility for assessing the external (financial) auditors on an annual basis, both in terms of the quality of their work and the reasonableness of their fees. The Committee is then responsible for making a recommendation to the Council of Governors with regard to their reappointment or otherwise.

24/30.4 - APPENDIX 1
5.2 Audit responsibilities of Chief Finance Officer

5.2.1 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards as defined within NAO Code of Audit Practice and Public Sector Internal Audit Standards
(c) in conjunction with NHS Counter Fraud Authority, deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption (as defined in the Trust's Anti-Fraud Policy);
(e) ensuring that an annual Internal Audit report is prepared for the consideration of the Integrated Audit and Governance Committee and the Board of Directors. The report must cover:
    (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance;
    (ii) major internal financial control weaknesses discovered;
    (iii) progress on the implementation of internal audit recommendations;
    (iv) progress against plan over the previous year;
(f) ensuring that a 3-year strategic internal audit plan is prepared for the consideration of the Integrated Audit and Governance Committee and the Board; and
(g) ensuring that an annual Internal Audit Plan is produced for consideration by the Integrated Audit and Governance Committee and the Board, which sets out the proposed activities for the coming year.
(h) Only the Chief Finance Officer may commission the procurement of internal audit services (including services akin to internal audit services), having sought the approval of the Audit & Risk Assurance Committee.

5.2.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) access at all reasonable times to any Trust land, premises or to directors and employees of the Trust;
(c) the production of any cash, stores or other property of the Trust under the control of a director or an employee; and
(d) explanations concerning any matter under investigation.

5.2.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

24/30.4 - APPENDIX 1

5.3 Internal Audit

5.3.1 In accordance with the requirements of the Accounting Officer Memorandum issued by the Regulator, the Trust is required to establish an independent and objective Internal Audit function. It is the responsibility of the Chief Finance Officer to ensure that this function is in place and operates efficiently and effectively, and accords with the objectives, standards and practices set out in the NAO Code of Audit practice and Public Sector Internal Audit Standards.

5.3.2 Internal Audit primarily provides an independent and objective opinion to the Accounting Officer, the Board of Directors, and the Integrated Audit and Governance Committee on risk management, control, and governance (by measuring and evaluating their effectiveness in achieving the organisation's agreed objectives) and to the External Auditor on financial systems and records used to prepare the annual accounts.

5.3.3 To fulfil these functions, Internal Audit will undertake a systematic review in accordance with the agreed annual internal audit plan. This will include a review of the overall arrangements the Board itself has in place for securing adequate assurances, and will provide an opinion on those arrangements to support the Annual Governance Statement. This will entail reviewing the way the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.

5.3.4 In addition, Internal Audit will provide specific assurances on the areas covered in the Internal Audit Plan as approved by the Integrated Audit and Governance Committee, and will work alongside other professionals wherever possible to advise on systems of control and assurance arrangements. This is a distinct role, quite different to reviewing and commenting on the reliance of the assurances themselves, which is the responsibility of the Board

5.3.5 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
(b) the adequacy and application of financial and other related management controls;
(c) the suitability of financial and other related management data;
(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    (i) fraud and other offences;
    (ii) waste, extravagance, inefficient administration; and
    (iii) poor value for money or other causes.
(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from NHS England.
(f) Internal Audit shall review the Board Assurance Framework

5.3.6 The Head of Internal Audit or Internal Audit provider will normally attend Integrated Audit and Governance Committee meetings and has a right of access to all Committee members, the Chairman and Chief Executive of the Trust.

5.3.7 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Integrated Audit and Governance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

5.4 External Audit

5.4.1 The Trust is required to have an external auditor and is to provide such information and facilities as are necessary for the auditor to fulfil their responsibilities under Chapter 5 of the 2006 Act. The external auditor is appointed by the Council of Governors on the recommendation of the Integrated Audit and Governance Committee

5.4.2 Under Schedule 7 (paragraph 23) of the 2006 Act, and the Trust's Constitution, it is the responsibility of the Council of Governors at a General Meeting to appoint or remove the external

auditor on behalf of the Trust. As part of the appointment process, the Trust must ensure that the auditors meet the selection criteria set out in NAO Code of Audit practice

5.4.3 Subject to annual assessment by the Integrated Audit and Governance Committee, the Council of Governors may re-appoint the external auditor for the following year without the need for a formal selection process. However, in accordance with the NAO Code of Audit Practice and Department of Health & Social Care "Guidance on the local procurement of External Auditors for NHS Trusts and ICBs", a market testing exercise will be undertaken as a minimum every five years.

5.4.4 Under the NAO Code of Audit Practice, an External Auditor may, with the approval of the Council of Governors, provide the Trust with services outside the scope of the audit (see 5.4.5 below). Before engaging the auditor for additional services this will be reported to the Integrated Audit and Governance Committee for approval, or if timing precludes this, then it will be agreed jointly by the Chair of the Integrated Audit and Governance Committee and the Chief Finance Officer, and reported to the next meeting of the Committee.

5.4.5 The NAO have issued a guidance note (AGN01) in September 2022 outlining new requirements in relation to procuring non-audit services provided by the External Auditor. The detail is included in the trust "policy for procuring non-core audit services" but in essence the new requirements place a cap on the value of non-audit services that can be provided to the Trust that these cannot exceed 70% of the total fee for all audit work carried out under the code in any one year.

5.4.6 The Integrated Audit and Governance Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

5.5 Fraud, Bribery and Corruption

5.5.1 In line with the Trust Anti-Fraud, Bribery and Corruption Policy, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with directions issued by NHS Counter Fraud Authority "Standards NHS for Providers, Fraud, Bribery and Corruption" and NHS England's "Managing conflicts of Interest in the NHS – Guidance for Staff and Organisations".

5.5.2 The Trust shall nominate a suitably qualified person or provider to carry out the duties of the Local Counter Fraud Specialist as specified in the NHS Counter Fraud Authority standards.

5.5.3 The Bribery Act 2010 outlines corporate and individual offences as defined within these SFI's (24.1.4). All staff and contractors should be made aware of the Act to ensure compliance. Any breach of the Act may result in criminal proceedings.

5.5.4 The Local Counter Fraud Specialist shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority in accordance with NHS Counter Fraud Authority Standards.

5.5.5 The Chief Finance Officer should also prepare a "Counter Fraud Policy and Response Plan" that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

5.5.6 The Local Counter Fraud Specialist will attend the Integrated Audit and Governance Committee meetings when necessary and has a right of access to all Committee members, the Chair and Chief Executive of the Foundation Trust.

5.5.7 The Local Counter Fraud Specialist will provide a written report to the Integrated Audit and Governance Committee, at least annually, on counter fraud work within the Trust.

5.6 Security Management

5.6.1 In line with his responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

5.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.

5.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Strategic Development and Capital Planning and the appointed Local Security Management Specialist (LSMS).

5.7 NAO Code of Audit Practice

5.7.1 The Trust has a responsibility, under its Licence conditions, to comply with the NAO Code of Audit Practice as approved by the Regulator. The Chief Executive has overall responsibility for ensuring compliance with the Code.

6. Financial Targets

6.1 The Trust is required to meet such financial targets as are specified by the Regulator, either under the terms of the initial Authorisation agreement or subsequently. These specifically include the requirement to ensure that income from the supply of NHS funded goods and services are greater than income from other sources.

6.2 Whilst there is no specific target regulating overall revenue performance in Foundation Trusts (e.g. a requirement to break-even year on year), the Regulator has the power to intervene in the Trust's affairs and potentially to place the Trust in Special Administration where financial viability is seriously compromised.

6.3 The Chief Executive has overall executive responsibility for the Trust's activities and in this capacity is responsible for ensuring that the Trust maintains its financial viability and meets any specific financial targets set by the Regulator. In this capacity the Chief Executive is responsible for setting appropriate internal targets in order to ensure financial viability

6.4 The Chief Finance Officer is responsible for:

(a) advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate;
(b) ensuring that adequate systems exist internally to monitor financial performance;
(c) managing the cash flow and external borrowings of the Trust in order to remain within HM Treasury "Managing Public Money" guidelines; and
(d) providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.

7. Business Planning, Budgets, Budgetary Control and Monitoring

7.1 Preparation and Approval of Plans and Budgets

7.1.1 Under the terms of Schedule 7 (paragraph 26) of the 2006 Act and its Constitution, the Trust is required to provide the Secretary of State with information concerning its forward plans for each financial year. In this respect, the Council of Governors is responsible for providing the Board with its views on those forward plans when they are being prepared and the Board correspondingly has a duty to consult them. The Chief Executive will therefore compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;
(b) details of major changes in workload, delivery of services or resources required to achieve the plan;
(c) all requirements defined within the Single Oversight Framework for NHS Providers and Annual Plan advice as issued; and
(d) information about activities other than the provision of goods and services for the purpose of the Health Service in England, and the income to be generated therefrom, and the percentage such income bears to total planned income; the Trust has a legal duty to ensure that such income in total is lower than income from the supply of NHS-funded goods and services.

7.1.2 With regard to clause 7.1.1 (d) and prior to submission of the Plan, the Council of Governors must determine whether it is satisfied that the carrying on of these activities will not to any significant extent interfere with the fulfilment by the Trust of its principle purpose or the performance of its other functions. A proposed increase of 5% or more in such income in any financial year (compared to total planned income) shall be put to the vote and may be implemented only if more than 50% of the Governors that voted to approve.

7.1.3 Once approved, the Chief Executive will be responsible for submitting the Business Plan to the Secretary of State via NHS England. The Chief Executive is also responsible for ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.

7.1.4 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of forecast income and cash;
(e) identify all sources of those funds; and
(f) identify potential risks.

7.1.5 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

7.1.6 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled. All budget holders will sign up to their allocated budgets at the commencement of each financial year. Care Group Directors will be required to prepare and sign off Care Group business plans

7.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

7.2 Budgetary Delegation

7.2.1 The Chief Finance Officer (on behalf of the Chief Executive) may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget and the staffing levels associated with the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

The Detailed Scheme of Delegation is contained within Appendix 2 of this document.

7.2.2 **Budget Holders do not have authority to exceed their budgets**. Expenditure is authorised by the Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. It is the responsibility of budget holders to maintain income and expenditure within budgetary limits. If it becomes apparent that this may not be possible, budget holders must notify their line manager and the relevant Care Group Finance Lead. If the Care Group Finance Lead is also of the opinion that there may be an income shortfall or expenditure overspend, the budget holder must then advise the Chief Finance Officer of the risk and proposed corrective action.

7.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

7.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Finance Officer (on behalf of the Chief Executive).

24/30.4 - APPENDIX 1
7.3 Budgetary Control and Reporting

7.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board and/or designated Board Committee e.g. Finance and Performance Committee (FPC) in a form approved by the Board containing:
    a. income and expenditure to date showing trends and forecast year-end position;
    b. movements in working capital;
    c. movements in cash and capital;
    d. capital project spend and projected outturn against plan;
    e. explanations of any material variances from plan; and
    f. details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.
(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, workload and manpower budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers.

7.3.2 Each Budget Holder is responsible for ensuring that:

(a) they remain within their budget allocation;
(b) any likely overspending on expenditure or reduction of income which cannot be met by virement within Care Groups is not incurred without the prior consent of the Board;
(c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
(d) no permanent or fixed-term contract employees are appointed without the approval of the Chief Executive or formally-constituted Trust-wide recruitment panel taking account of available resources and the manpower establishment as approved by the Board;
(e) that any proposal to increase revenue or capital spending has an appropriate funding stream, follows the formal process set out in the Trust's Business Case Policy for any proposed service development, and has been agreed by the Chief Executive and signed off by the Chief Finance Officer or any Trust Committee to whom this role has been delegated e.g. Capital Investment Group (CIG) and Business Case Scrutiny Group (BCSG)This applies to all revenue or capital developments whether part of Annual Business Plan discussions or separate business case initiatives, however funded; and
(f) they identify and implement cost improvements income generation initiatives in accordance with the requirements of the approved budget.

7.3.3 The Chief Executive is responsible for identifying and implementing cost improvements, income generation initiatives and other efficiency/ productivity improvements in accordance with the requirements of the Annual Plan and a balanced budget.

7.3.4 The Chief Finance Officer is responsible for advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and will also advise on the financial implications of future plans and developments proposed by the Trust.

Further guidance on the responsibilities of budget holders is contained in the Financial Management and Control of Resources Policy

24/30.4 - APPENDIX 1

7.4 Capital Expenditure

7.4.1 The general rules applying to delegation and reporting contained in section 5 of the SFI's "Detailed Scheme of Delegation" shall also apply to capital expenditure. The Trust has delegated the responsibility for delivery of the approved capital programme to its wholly owned subsidiary, 2gether, given the majority of the Trust's assets are maintained as part of the OHF. The exceptions are IT and directly managed schemes. The Trust Scheme of Delegation plus 2gethers implied SFI's, take account of these arrangements.

7.5 External Performance Information and Monitoring Returns

7.5.1 The Chief Executive, on behalf of the Trust, is responsible for providing the Regulator with such information as is necessary to monitor compliance with the terms of the Authorisation agreement.

7.5.2 The Chief Executive, on behalf of the Trust, is also responsible for ensuring that the Trust contributes to standard national NHS data flows which are required for NHS policy development/ funding.

7.6 The Trust's Operational Framework and Performance Management Framework

7.6.1 The Trust's Performance Management Framework and the Operational Framework describes how the Care Groups are performance managed. The Framework enables Care Groups to earn autonomy giving greater freedom and authority to develop services. Care Groups are managed according to the level of performance achieved in each of seven domains, aligned to the Trust's Strategic and Annual Objectives, covering Quality (Patient Safety; Effectiveness; Patient Experience), Valuing People, Innovation, Access & Productivity and Finance. Each domain has a named Executive Director.

8. Annual Accounts and Reports

8.1 In accordance with Schedule 7 (paragraph 25) of the 2006 Act and the Trust's Constitution, the Trust must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of the Secretary of State, direct. The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare annual accounts in accordance with the Regulator's Group Accounting Manual (GAM) and any other NHS England guidance, the Trust's accounting policies, and International Financial Reporting Standards;
(b) prepare and submit annual accounts to the Board and an audited summary of the main Financial Statements to an annual members meeting convened by the Council of Governors, certified in accordance with current guidelines; and
(c) ensure that a copy of the annual accounts, and any report of the external (financial) auditor thereon, is laid before Parliament and sent to the Regulator.

8.2 The annual accounts should, in accordance with the requirements set out in the Accounts Direction, include an Annual Governance Statement within the financial statements.

8.3 The Trust's annual accounts must be audited by an external (financial) auditor appointed by the Council of Governors and be presented at the annual members' meeting.

8.4 In accordance with Schedule 7 (paragraph 26) of the 2006 Act, the Trust will also prepare an annual report which, after approval by the External Auditor and the Board of Directors, will be presented to the Council of Governors. It will then be submitted to parliament and the Regulator, published and made available to the public. The annual report will comply with the ARM for NHS Foundation Trusts issued each year by NHSE.

8.5 The Trust is to comply with any decision that the Regulator may make as to the form of the annual report, the timing of its submission and the period to which it relates.

8.6 The Chief Nurse and Midwifery Officer and Chief Medical Officer/ Chief Operating Officer, on behalf of the Trust, will prepare an annual Quality Report (including the Quality Account) in such form and engaging in such external consultations as the Regulator may direct.

24/30.4 - APPENDIX 1

9 Bank Accounts and Treasury Management

9.1 General

9.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued by the Regulator. The Trust will operate in line with its Treasury Policy.

9.1.2 The Board shall approve the banking arrangements and the level of Working Capital Facility (if any). Approval and execution of Facility Agreements is delegated to the Chief Finance Officer or Chief Executive Officer following the Trust Board approval.

9.2 Bank and Paymaster Accounts

9.2.1 The Chief Finance Officer is responsible for:

(a) commercial and Government bank accounts;
(b) establishing separate bank accounts for the Trust's charitable funds
(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and
(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

9.2.2 No employee other than the Chief Finance Officer will open any bank account in the name of the Trust (or relating to any activities of the Trust).

9.3 Banking Procedures

9.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank and Paymaster accounts which must include:

(a) the conditions under which each bank account is to be operated; and
(e) those authorised to sign cheques or other orders drawn on the Trust's accounts.

9.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

9.4 Competitive Tender and Review of banking services

9.4.1 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

9.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for Government Banking Service accounts.

24/30.4 - APPENDIX 1

9.5 External Borrowing

9.5.1 As a Foundation Trust, the Trust generally has freedom to access working capital (i.e. borrow externally) subject to three constraints:-

(a) availability of Secretary of State loans and/or additional Public Dividend capital;
(b) prohibition on the use of protected assets as security for borrowing; and
(c) any additional degree of scrutiny required by financial institutions.

9.5.2 These freedoms are reduced if the Trust is in Financial Special measures and guidance from NHS England will be sought

9.5.3 External debt should be kept within designated limits, taking account of affordability in terms of capacity to generate operating revenue to service debt and the impact on the Continuity of Service Risk Rating.

9.5.4 For larger scale projects, current Department of Health & Social Care requirements and approval mechanisms under the Private Finance Initiative continue to apply. It is the responsibility of the Chief Executive, on behalf of the Trust, to ensure that these requirements are complied with.

9.5.5 If required, the Trust must ensure that a sufficient Working Capital Facility is available from the Department of Health & Social Care, via NHSE. Such Working Capital Facility should be reviewed on a periodic basis to ensure value for money. The Trust must have procedures in place for the draw down against the facility to ensure that only appropriate authorised transactions take place. All such short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

9.5.5 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new PDC borrowing, within the limits set by the Department of Health & Social Care. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

9.5.6 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

9.5.7 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

9.5.8 The Chief Finance Officer is responsible for ensuring that the Trust operates within NHSE guidance when making decisions regarding capital investment/external borrowing, specifically by providing appropriate advice to the Board on affordability/ serviceability of debt.

9.5.9 The Chief Finance Officer is responsible for ensuring that the Trust operates at all times within any borrowing limit set by the Regulator and the Board receives regular reports on the overall indebtedness of the Trust as against that limit

9.5.10 Any short-term borrowing must be with the authority of two authorised signatories, one of which must be the Chief Executive or the Chief Finance Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

9.5.11 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board

9.6 Investments

9.6.1 Under the terms of the 2006 Act and its Constitution, the Trust may invest money (other than money held by it as a Trustee) for the purposes of or in connection with its functions. This may include investment by forming or participating in forming bodies corporate or by otherwise acquiring membership of bodies corporate.

9.6.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

9.6.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

9.6.4 In the case of temporary cash surpluses, these may only be held in such form and with such public or private sector organisations as are approved by the Board within the Treasury Policy. In giving approval to the mechanisms for short term investment, the Board will take account of instructions or guidelines issued by the Regulator to Foundation Trusts

9.6.5 For other longer term forms of investment the approval of the Board will be obtained before proceeding.

10. Income, Fees/Charges, Security of Cash, Cheques and Negotiable Instruments

10.1 Income Systems

10.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

10.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

10.1.3 The Chief Finance Officer will ensure that appropriate systems are in place to comply with national requirements and timescales for invoicing and reconciliation of contract income receivable under the terms of contracts with NHS Commissioners

10.2 Fees and Charges

10.2.1 The Trust will price its service contracts with NHS healthcare commissioners according to national tariffs. In areas where national tariff arrangements do not apply, the Trust shall follow the Department of Health & Social Care's guidance in the "Costing Manual" in setting prices for NHS service contracts.

10.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health & Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in NHS England's "Managing Conflicts of Interest in the NHS – Guidance for Staff and Organisations" shall be followed.

10.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

24/30.4 - APPENDIX 1

10.3 Debt Recovery

10.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

10.3.2 Income not received should be dealt with in accordance with losses procedures.

10.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

10.4 Security of Cash, Cheques and other Negotiable Instruments

10.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

10.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

10.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

10.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

10.5 Money laundering Regulations

10.5.1 Under no circumstances will the Trust accept cash payments in excess of 15,000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempts by an individual employee to effect payment above this amount shall be notified immediately to the Chief Finance Officer.

24/30.4 - APPENDIX 1

11. Legally-Binding Contracts for Provision of Services (see SFI 24.6)

11.1 Contracts

11.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in the Terms of Authorisation/Provider Licence and related schedules.

11.1.2 The Chief Executive, as the accounting officer, is responsible for ensuring the Trust enters into suitable legally-binding contracts with NHS commissioners for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator, and the provision of other services.

11.1.3 In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- service priorities contained within the Trust's Business Plan and agreed with healthcare commissioners;
- the national tariff and Operating framework, and other agreed local pricing mechanisms;
- the provision of reliable information on cost, volume and quality of services;
- relevant National Service Frameworks and guidelines published by the National Institute for Health and Clinical Excellence;
- agreed developments or investment plans; and
- Commissioning Rules, approved forms of NHS contract and applicable guidance from NHS England.

11.1.4 The Chief Finance Officer shall produce regular reports detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income.

11.1.5 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible employee should ensure that the Director of Commissioning, Contracting and Costing is informed before an appropriate contract is present and signed by both parties before goods or services can be provided to or by the Trust. The advice of the Associate Director of Procurement and Managed Equipment Services, 2gether, and the Income and Contracting Manager shall be sought in compliance with the Policy on Service Level Agreements (SLA's).

11.1.6 All SLA's and contracts shall be legally binding, shall comply with best costing practice/best value for money and shall be so devised as to manage contractual risk, insofar as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income/minimise expenditure.

11.1.7 In carrying out these functions, due regard shall be given to the following matters:

- Costing and pricing of goods and services
- Payment terms and conditions
- Billing systems and cash flow management
- The contract negotiating process and timetable
- The provision of contract data
- Contract monitoring and performance management arrangements
- Amendments to contracts
- Applicability of Value Added tax
- Any other matter relating to contracts of a legal or non-financial nature

11.2 Involving Partners and jointly managing risk

11.2.1 The Chief Executive shall ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this.

11.3 Reports to the Board on contracts

11.3.1 The Chief Executive, as the accounting officer, will need to ensure that regular reports are provided to the Board detailing planned, actual and forecast income from contracts with NHS Commissioners. This analysis will particularly highlight the impact of differences between planned and actual numbers of patients treated across Healthcare Resource Groups (HRG's) at speciality level and outline any action required to address such variances. Periodically, at intervals to be agreed with the Board, the Chief Finance Officer (on behalf of the Chief Executive) will also provide information on the impact of differences between the actual cost to the Trust of treating patients in individual HRG's and the relevant national tariff.

12. Terms of Service, Allowances and Payment of Directors and Employees

12.1 Remuneration Committee and Nominations Committee

12.1.1 The Board shall establish a Remuneration Committee and Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its areas of responsibility, its composition, and the arrangements for reporting. The Committee/s will fulfil the role of the Remuneration Committee and Nominations Committee (for Executive Directors) described in the Trust's Constitution and the NHS Foundation Trust Code of Governance. The purpose of the Committee/s will be to:

(a) decide on the appropriate remuneration, allowances and terms and conditions of service for the Chief Executive and other Executive Directors including:
    a. all aspects of salary (including performance-related elements/bonuses);
    b. provisions for other benefits, including pensions and cars; and
    c. arrangements for termination of employment and other contractual terms;
(b) recommend and monitor the level and structure of remuneration for senior management
(c) agree and oversee, on behalf of the Board of Directors, the performance management of the Executive Directors, including the Chief Executive, and a process for the identification and nomination of Executive Directors (including the Chief Executive). The nominations process will include the Chief Executive, except in the case of the appointment of a Chief Executive. The appointment of the Chief Executive will require the approval of the Council of Governors; and
(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

12.1.2 The Committee shall report in writing to the Board the basis for its recommendations and decisions. Minutes of the Committee should accurately record decisions made.

12.1.3 The Board will be notified of approval (or otherwise) by the Clinical Executive Management Group of the Chief Executive's recommendations regarding remuneration and conditions of service for those employees not covered by the Remuneration Committee.

12.1.4 The Trust will remunerate the Trust Chair and non-executive directors in accordance with the decisions of the Council of Governors taking into account any guidance issued by NHS England and the Code of Governance.

12.2 Funded Establishment

12.2.1 The staffing plans incorporated within the annual budget will form the funded establishment.

12.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or as defined in the Scheme of Delegation.

12.3 Staff Appointments

12.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive (as a specific one-off approval, or under general delegation to an approved budget holder with regard to their line management responsibilities);

(b) and within the limit of their approved budget and funded establishment unless approved by the Chief Finance Officer and Chief People Officer;
(c) and (where required) with the approval of any formal process in place to review Trust vacancies.

12.3.2 The Chief Executive will prepare procedures for the determination of commencing pay rates, condition of service, etc, for employees for approval by the Clinical Executive Management Group on behalf of the Board

12.4 Processing Payroll

12.4.1 The Chief Finance Officer is responsible for arranging the provision of an appropriate payroll service. Together with the service provider, the Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates; and
(d) agreeing method of payment.

12.4.2 Together with the service provider, the Chief Finance Officer will issue instructions in compliance with the standard operation of the national NHS Electronic Staff Record System regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act 1998;
(g) methods of payment available to various categories of employees;
(h) procedures for payment by cheque, bank credit, or cash to employees;
(i) procedures for the recall of cheques and bank credits;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash; and
(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

12.4.3 Managers authorised under the Scheme of Delegation have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer and the Chief People Officer must be informed immediately; and
(d) reviewing actual establishment monthly and comparing this to budgeted establishment to identify adverse variances which should be reported to the Executive Performance Reviews.

12.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

12.5 Contracts of Employment

12.5.1 The Board shall delegate responsibility to the Chief People Officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

13. Non-Pay Expenditure (see SFI 24)

13.1 Delegation of Authority

13.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers which will comply with any requirement specified by NHSE including those under financial special measures. The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
(b) the maximum level of each requisition and the system for authorisation above that level.

13.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

13.2 Requisitioning

13.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Associate Director of Procurement & Managed Equipment Services, 2gether shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

13.3 System of Payment and Payment Verification

13.3.1 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

13.3.2 The Chief Finance Officer will:

i. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFI's and regularly reviewed;
ii. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;
iii. be responsible with the financial services provider for the prompt payment of all properly authorised accounts and claims;
iv. be responsible with the financial services provider and the Associate Director of Procurement & Managed Equipment Services, 2gether where applicable, for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
    a. A list of employees (including specimens of their signatures) authorised to certify invoices;
    b. Certification that:
        i. goods have been duly received, examined and are in accordance with specification and the prices are correct;
        ii. work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
        iii. in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
        iv. where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
        v. the account is arithmetically correct;
        vi. the account is in order for payment.
v. A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and
vi. Instructions to employees regarding the handling and payment of accounts within the Finance Department; and
vii. be responsible for ensuring that payment for goods and services is only made once the goods and services are received.

The only exceptions are set out in SFI 13.4.

13.4 Prepayments

13.4.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages, taking into account lost investment interest or cost of working capital financing incurred
(b) The appropriate employee must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (considering the Public Contracts Regulations: 2015 where the contract is above a stipulated financial threshold);
(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

13.5 Official orders

13.5.1 The Trust operates a strict 'No purchase order (PO) no payment' policy and invoices received from suppliers for goods or services, not included on the Purchase Order (PO) exception list, that do not quote a PO will be returned without payment.

13.5.2 Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Chief Finance Officer;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive; and
(e) be used for the purchase of all goods and services excluding those on the PO Exception List.

13.6 Duties of Managers and Employees

13.6.1 Managers and employees must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
(b) contracts above specified thresholds are advertised and awarded in accordance with Public Contracts Regulations: 2015;
(c) all contracts are made in accordance with the Procurement to Payment Policy
(d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health & Social Care/NHS England;
(e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
    a. Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
    b. conventional hospitality, such as lunches in the course of working visits; and
    c. sponsorship appropriate to the needs of the service.

(This provision needs to be read in conjunction with the Trust Constitution SO 6 within Annex 7 and SO's 6 and 7 within Annex 8, together with the principles outlined in the national guidance "Managing Conflicts of Interest in the NHS – guidance for staff and organisations" published by NHSE effective 1/6/2017

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;
(g) all goods, services, or works are ordered on an official order except purchases from petty cash and other specific areas agreed by the Chief Finance Officer;
(h) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase and Services are not trialled or piloted in circumstances that could commit the Trust to a future uncompetitive purchase;
(k) changes to the list of employees authorised to certify invoices are notified to the Chief Finance Officer;
(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer; and
(m) petty cash records are maintained in a form as determined by the Chief Finance Officer.

13.6.2 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of 2gether Support Solutions Ltd.

13.7 Grants to Local Authorities and Voluntary Bodies

13.7.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with this Act and any applicable guidance from the Regulator.

14. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

14.1 Capital Investment

14.1.1 As part of the annual planning process, the Board of Directors shall approve a programme of building, equipment and information technology schemes known as the capital programme. Where a requirement not in the approved programme arises during the year, approval shall be in accordance with the Scheme of Delegation and Business Case Procedure, and a report shall be made to the next meeting of the Board of Directors showing the impact on the capital programme.

14.1.2 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) shall ensure that the capital investment is not undertaken without confirmation of commissioners' support (where relevant) and consideration of the availability of resources to finance all revenue consequences, including capital charges.

14.1.3 For every capital expenditure proposal the Chief Executive shall:

(a) ensure that a business case is produced, in the format approved by the Trust, taking into account guidance contained within NHS England Capital guidance, Investment and property business case approval guidance for NHS Trusts and Foundation Trusts, the Trust's Business Case Procedure, and any other relevant guidance, in a level of detail appropriate to the value of the project, setting out:
    a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
    b. the involvement of appropriate Trust personnel and external agencies; and
    c. appropriate project management and control arrangements; and
(b) require the Chief Finance Officer to ensure that financial aspects of business cases receive appropriate professional scrutiny.

14.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Health Building Note 00-08.

14.1.5 The Chief Finance Officer shall ensure that the construction industry tax deduction scheme is operated in accordance with HM Revenue and Customs guidance.

14.1.6 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;
(b) authority to proceed to tender (see SFI 24); and
(c) approval to accept a successful tender (see SFI 24).

14.1.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance the Trust's SO's.

14.1.9 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes and procedures for the regular reporting of expenditure to date and forecast.

14.1.10 Following the national implementation of IFRS16 from 1 April 2023 the Chief Finance Officer shall issue guidance to the Group to ensure the collection and assessment of all relevant information relating to leases to cover:

(a) Procurement to notify the Financial Accounts team of all potential leases through Requisitions received
(b) Financial Accounts to assess lease agreements under the terms of IFRS16
(c) Financial Accounts team to create necessary account codes and journals for the correct accounting treatment of leases
(d) Comprehensive Lease Register, with supporting auditable information relating to the lease contract, to be maintained by the Financial Accounts team
(e) Financial Accounts to convert Subsidiary accounting for leases so the Group is accounted for under IFRS16 on a monthly basis

14.2 Private Finance (see SFI 24.25)

14.2.1 Where appropriate the Trust should test for PFI when considering capital procurement. When the Trust proposes to access PFI finance, the following procedures shall apply:

(a) The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;
(b) The Trust must seek all applicable approvals and comply with the requirements of NHSE and the Department of Health & Social Care; and
(c) The proposal must be specifically agreed by the Board of Directors.

14.3 Asset Registers

14.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

14.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Group Accounting Manual (GAM).

14.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets capitalised under IFRS16.

14.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.3.6 The value of each asset shall be indexed or otherwise re-valued in accordance with methods specified in the GAM for Foundation Trusts and relevant accounting standards.

14.3.7 The value of each asset shall be depreciated using methods and rates as specified in the GAM for Foundation Trusts and relevant accounting standards.

14.4 Security of Assets

14.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset; and
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

14.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

14.4.6 Where practical, assets should be marked as Trust property.

14.5 Protected Assets

14.5.1 A register of Protected Property is required to be maintained in accordance with requirements issued by the Regulator. In accordance with Condition CoS2 of the Provider Licence, the asset register shall list every Relevant Asset used by the Trust for the provision of Commissioner Requested Services. The term 'relevant asset' means any item of property, including buildings, interests in land, equipment (including rights, licences, and consents relating to its use) without which the Trust's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced.

14.5.2 Planned changes in Relevant Assets will be notified to NHSE through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected together with proposed disposals and acquisitions. The Trust may dispose or relinquish control over any relevant asset where NHSE has given general consent in relation to either transactions of a specified description, or relevant assets of a specified description.

24/30.4 - APPENDIX 1

15 Stores and Receipt of Goods

15.1 General position

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of replacement cost and net realisable value; and
(d) obsolete or excess stock – valued at net realisable value

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers in individual areas. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Employee; the control of any fuel oil and coal is the responsibility of 2gether Support Solutions Ltd.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Employee. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

15.2.6 The designated Manager/Pharmaceutical Employee shall be responsible for a system for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Employee shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see SFI 16). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by NHS Supply Chain

15.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods in areas not serviced by 2gether Support Solutions Ltd Supply Chain staff. The authorised person (normally the budget holder) shall check receipt against the delivery note and ensure credit is received where an overcharge has occurred.

24/30.4 - APPENDIX 1

16. Disposals and Condemnations, Losses and Special Payments

16.1 Disposals and Condemnations

16.1.1 Under the terms of the Authorisation agreement, the approval of the Regulator is required prior to the disposal of any protected assets (above any "de minimis" limit where specified). There are no external restrictions on the disposal of other assets provided that the proceeds are used to further the Trust's public interest objectives. The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will consult the Associate Director of Procurement & Managed Equipment Services, 2gether or nominated 2gether officer as appropriate and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 Unserviceable articles with an estimated replacement cost of at least £100 shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and
(b) recorded by the Condemning Employee in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

16.1.4 The Condemning Employee shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

16.2 Losses and Special Payments

16.2.1 NHS Providers must follow the requirements of HM Treasury's "Managing Public Money" (sections 4.10 and 4.13), in full, in respect of recording and reporting losses and special payments.

16.2.2 This will include contacting NHS England to seek HM Treasury approval for any proposed special severance payments or any claims of a novel or contentious nature

16.2.3 Any employee discovering or suspecting a loss of any kind which is not of a trivial nature must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, either directly or via the Risk Management Department.

16.2.4 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the Local Security Management Specialist (LSMS) and police if theft or arson is involved. The Chief Finance Officer must comply with any requirements of the Regulator and Secretary of State regarding the reporting of fraud and corruption.

16.2.5 Any employee may contact the Local Counter Fraud Specialist directly if fraud, bribery or corruption is suspected, in accordance with the Trust's Anti-Fraud, Bribery and Corruption Policy.

16.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Board,
(b) the Local Security Management Specialist (LSMS), and
(c) the External Auditor.

16.2.7 Within limits delegated to it by the Department of Health & Social Care, the Board shall approve a scheme of delegation for the writing-off of losses.

16.2.8 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.9 For any loss, the Chief Finance Officer should ensure consideration is given as to whether any insurance claim can be made.

16.2.10 The Chief Finance Officer shall ensure that a Losses and Special Payments Register is maintained in which write-off action is recorded

16.2.11 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health & Social Care or in accordance with instructions from HM Treasury "Managing Public Money" and the Regulator as specified in the GAM.

16.2.12 All losses and special payments must be reported to the Integrated Audit and Governance Committee on a regular basis at least twice per annum.

17. Information Technology and Financial Information Systems

17.1 General

17.1.1 The Trust, under the terms of its Authorisation agreement, is required to participate in national information technology developments, in accordance with any guidance issued by the Regulator. This requirement extends to the Chief Finance Officer in fulfilling his/her responsibilities for the computerised financial data of the Trust as set out below.

17.1.2 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Chief Finance Officer is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.3 The Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

24/30.4 - APPENDIX 1

17.2 Responsibilities and duties of other Directors and Employees in relation to computer systems of a general application

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the ICB wish to sponsor jointly) all responsible directors and employees will send to the Director with responsibility for IM&T:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

17.3 Contracts for Computer Services with other health bodies or outside agencies

17.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

17.4.1 The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 Requirements for Computer Systems which have an impact on corporate financial systems

17.5.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) the financial systems are the prime repository of financial data;
(c) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(d) Finance staff have access to such data;
(e) data from subsidiary systems feeding the financial systems is fully reconciled to the financial systems;
(f) reporting from subsidiary systems of financial data agrees with the financial systems; and
(g) such computer audit reviews as are considered necessary are being carried out.

18. Patients' Property

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance);
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions; and
- that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Secretary of State instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19. Funds Held on Trust

19.1 Corporate Trustee

19.1.1 SO 2.4 of the Trust Constitution Annex 8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust. Although the management processes may overlap with those of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the need for compliance with Charities Commission regulations, guidance and best practice.

19.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for management of public monies within the main Trust, and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

19.1.3 The Chief Finance Officer shall ensure that each charitable fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

19.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

19.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

19.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust employees must take account of that guidance before taking action.

19.3 Applicability of Standing Financial Instructions to funds held on Trust

19.3.1 In so far as it is possible to do so, most of the sections of these SFI's will apply to the management of funds held on trust.

19.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20. Acceptance of Gifts by Staff and Link to Standards of Business Conduct

20.1 The Company Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff as set out in the Trust's Anti-Fraud, Bribery and Corruption Policy. This policy follows the guidance contained in "Managing Conflicts of Interest in the NHS – guidance for staff and organisations" (issued by NHS England, effective 1 June 2017) see SO 7 of the Trust Constitution Annex 8 and SFI 13.6).

21. Retention of Records

21.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health & Social Care guidelines.

21.2 The records held in archives shall be capable of retrieval by authorised persons.

21.3 Chief Executive approval is required prior to any proposed action to destroy records before the end of the retention period set by Trust policies.

22. Risk Management and Insurance

22.1 Programme of Risk Management

22.1.1 Risk management, control and governance comprise the policies, procedures and operations established to ensure the achievement of objectives, the appropriate assessment of risk, the reliability of internal and external reporting and accountability processes, compliance with applicable laws and regulations, and compliance with the behavioural and ethical standards set for the organisation.

22.1.2 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health & Social Care/NHSE assurance framework requirements, which must be approved and monitored by the Board via the Board Assurance Framework.

22.1.3 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;
(b) engendering among all levels of staff a positive attitude towards the control of risk;
(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) contingency plans to offset the impact of adverse events;
(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
(f) a clear indication of which risks shall be insured;
(g) arrangements to review the Risk Management programme;
(h) regular review of compliance with all statutory regulatory requirements; and
(i) ensuring appropriate responses to all interventions, reports and requirements from all statutory regulatory bodies.

22.1.4 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement on the effectiveness of Internal Control /Quality Governance arrangements within the Annual Report and Accounts as required by the ARM for NHS Foundation Trusts issued annually by the Regulator.

22.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

22.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

22.3 Insurance arrangements with commercial insurers

22.3.1 Trusts may enter into insurance arrangements with commercial insurers as follows:

(a) Trusts may enter into commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
(b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;
(c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the Department of Health & Social Care; and
(d) The Trust shall arrange appropriate Directors and Employees insurance to cover the risk of legal action against its directors.

22.4 Arrangements to be followed by the Board in agreeing Insurance cover

22.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

22.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer shall ensure that formal documented procedures (administered by the Legal Services Department) are drawn up for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

22.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

23. Consultation

23.1 The Trust shall take into account the legal duties of consultation that are applicable to the Trust when considering any changes to service provision at an early stage and seek advice where necessary.

23.2 Section 242 of the NHS Act 2006 sets out the Trust's duty as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, included in and consulted on:

(a) The planning of the provision of those services
(b) The development and consideration of proposals for changes in the way those services are provided; and
(c) Decisions to be made by that body affecting the operation of those services.

23.3 Regulation 4A of the Local Authority (Overview and Scrutiny Committee's Health Scrutiny functions) Regulations 2002 sets out that the Trust needs to consult with the Overview and Scrutiny Committee of a Local Authority where:

(a) The Trust proposes to make an application to the Regulator to vary the Terms of its Authorisation; and
(b) That application, if successful, would result in a substantial variation of the provision by the Trust of protected goods or services in the area of that local authority

24. Tendering and Contracting Procedures

24.1 Duty to comply with Standing Financial Instructions

24.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SFI's. The Trust will ensure compliance with the Public Contract Regulations 2015 (as may be amended from time to time) and relevant NHS guidance on procurement (including but not limited to), the Principles Rules for Cooperation and Competition, and the Procurement Guide for Commissioners of NHS-funded Services.

24.1.2 The Associate Director of Procurement & Managed Equipment Services, 2gether is responsible for the production and operation of the Procurement to Payment Policy and detailed tendering and contracting procedures along with the provision of advice and guidance to managers. All budget holders are required to comply with these policies and procedures

24.1.3 This Section 24 should be read in conjunction with Section 5 of the Detailed Scheme of Delegation, in Appendix 2 of these SFI's.

24/30.4 - APPENDIX 1

24.1.4 All personnel involved in tendering and contracting activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not breach the Act.

24.1.5 The Bribery Act 2010 defines the two sections below:

(a) Two general offences of bribery – 1) Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly and 2) requesting or accepting a bribe whether in exchange for acting improperly, or where the request or acceptance is itself improper; and
(b) The new corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

24.2 Directives Governing Public Procurement

24.2.1 The Trust shall comply with the Public Contracts Regulations 2015 and all relevant directives and policies set by Government and promulgated by the Department of Health & Social Care, for awarding all forms of contracts, shall have effect as if incorporated in these SO's and SFI's.

24.4 Capital Investment

24.4.1 The Trust shall comply as far as is practicable with the requirements of the guidance published by NHSE on capital investment including 'NHS Capital regime, Investment and property business case approval guidance for NHS Trust and Foundation Trusts and other relevant guidance.

24.5 General Applicability

24.5.1 Subject to the exceptions set out in 24.7.1 and 24.7.2, the Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the provision of services including sub contracted clinical services and all forms of management consultancy services;
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- for disposals of tangible and intangible property (including equipment and intellectual property).

24/30.4 - APPENDIX 1
24.6 Purchase of Health Care Services

24.6.1 Where relevant, the Chief Executive shall nominate employees to commission contracts with providers of healthcare in line with a commissioning plan approved by the Board.

24.6.2 Where the Trust plans to commission contracts with providers of healthcare, the Trust must invite tenders for the supply of such healthcare services. These SO's and SFI's shall apply and need to be read in conjunction with SFI 11.

24.7 Exceptions and instances where formal quotation and tendering need not be applied

24.7.1 Provider Selection Regime

The Health and Social Care Act 2022 replaces the Public Contracts Regulations 2015 and the Procurement, Patient Choice and Competition Regulations 2013.

This change in legislation impacts on:
Integrated Care Boards
NHS England
Local Authorities
NHS Trusts and Foundation Trusts (when arranging the provision of healthcare services by other providers)

Formal quote and tendering procedures need not be applied where:

(a) the estimated whole life expenditure or income does not, or is not reasonably expected to, exceed £10,000 excluding VAT;
(b) where the supply is proposed under special arrangements negotiated by the Department of Health & Social Care in which event the said special arrangements must be complied with.
(c) regarding Losses and Special Payments as set out in SFI 16*; and*
(d) where the supply can be obtained under a framework agreement that has itself been procured in compliance with the duties set out in SFI 24.2 and where the Trust is entitled to access such framework agreement.

24.7.2 Subject to the duties at SFI 24.2 (and to obtaining appropriate advice and documentation from the Trust's Procurement Services Department and where it considers necessary external professional advice) formal tendering procedures may be waived in the following circumstances <u>but only in the event that the financial thresholds within the Public Sector Contract Regulations 2015 are not breached:</u>

(a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in the formal tender waiver proforma;
(b) where the requirement is covered by an existing contract let by the Trust or partner organisation;
(c) where the timescale genuinely precludes competitive tendering. Failure to plan the requirement properly is not regarded as a justification for a tender waiver;
(d) where specialist expertise is required and can be demonstrated to be available from only one source;
(e) when the requirement is essential to complete a project or procurement, and arises as a consequence of a recently completed assignment and engaging different suppliers for the new task would be inappropriate;
(f) there is a clear benefit to be gained from maintaining continuity with an earlier project or supply of goods/services. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and
(g) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

24.7.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a provider originally appointed through a competitive procedure, except where this represents an extension to a contract agreed in the original contract to tender.

24.7.4 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver (including any subsequent increase in value) and the reasons should be documented and recorded in an appropriate Trust record and reported to the Integrated Audit and Governance Committee, the form and content of such reports to be determined by that Committee.

24.8 Fair and Adequate Competition

24.8.1 Where the exceptions set out in SFI 24.7 do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

24.9 Items which subsequently breach thresholds after original approval

24.9.1 Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Finance Officer and be recorded in an appropriate Trust record.

24.15 Tender reports to the Trust Board

24.15.1 Reports to the Trust Board will be made on an exceptional circumstance basis only, including for the purpose of approving all contracts over the financial limit stated in the Reservation of Powers and Scheme of Delegation.

24.16 Firms invited to tender/quote

Pre-qualification

24.16.1 The Associate Director of Procurement & Managed Equipment Services, 2gether, is responsible for carrying out pre-qualification technical, financial and economic checks on firms from whom tenders and quotations may be invited.

Financial Standing and Technical Competence of Contractors

24.16.6 The Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of contractors. The Director with lead responsibility for technical/clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

24/30.4 - APPENDIX 1
Quotations: Competitive/Non-Competitive

24.17 General Position on quotations (values quoted exclude VAT)

24.17.1 Quotations are required where formal tendering procedures are not adopted and where the intended whole life expenditure or income exceeds, or is reasonably expected to exceed £10,000 but be below £25,000.

24.18 Competitive Quotations

24.18.1 Quotations will be obtained in accordance with the Trust's Procurement to Payment Policy.

24.18.2 Quotations should be obtained from at least 2 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust through the Procurement Services Department using the e tendering system.

24.18.3 Quotations should be submitted electronically unless the Chief Executive or his nominated employee determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record

24.18.4 All quotations should be treated as confidential and should be retained for inspection.

24.18.5 The Chief Executive or his nominated employee should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

24.19 Non-Competitive Quotations

24.19.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible employee, possible or desirable to obtain competitive quotations;
(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts; and
(c) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this section apply.

24.20 Quotations to be within Financial Limits

24.20.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFI's except with the authorisation of either the Chief Executive or Chief Finance Officer.

24/30.4 - APPENDIX 1
Authorisations

24.21 Authorisation of Tenders and Competitive Quotations

24.21.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in accordance with Section 5.4 of the Detailed Scheme of Delegation in Appendix 2 of these SFI's.

24.21.2 Note: Urgent matters may be dealt with under SO 4.2 of the Trust Constitution Annex 8 (by the Chairman and Chief Executive, reported at the next Trust Board) or under the Reservation of Powers Introduction and Principles of Delegation section within Appendix 1 of these SFI's. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Chairman after taking appropriate advice from the Chief Finance Officer. If both Chairman and Chief Executive are absent, and the matter cannot reasonably wait until their return, delegated powers may be exercised by the individual formally deputised by the Chief Executive.

24.21.3 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

24.22 Instances where formal competitive tendering or competitive quotation is not required

24.22.1 Competitive tendering or a competitive quotation is not required when

(a) the Trust shall uses the NHS Supply Chain for procurement of goods and services; or
(b) the Trust uses a National or Regional Framework Contract to which it has legitimate access

However, in all cases the route to market must demonstrably deliver best value for money. This may be required to be determined through the use of a 'mini competition' procedure.

24.23 Private Finance for capital procurement (see SFI 14)

24.23.1 Where appropriate, the Trust should market-test (competitively tender) for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
(b) The Trust must seek all applicable approvals and follow the requirements of NHSE guidance including "Risk Evaluation for Investment Decisions by NHS Foundation Trusts";
(c) The proposal must be specifically agreed by the Board of Directors of the Trust; and
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

24/30.4 - APPENDIX 1

24.24 Compliance requirements for all contracts

24.24.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

The Trust's SO's and SFI's;

(a) Procurement Directives and other statutory provisions;
(b) any relevant directions and best practice notes;
(c) such of the NHS Standard Contract of Conditions as are applicable;
(d) the Care Quality Commission's "Essential Standards for Quality and Safety";
(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and
(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an employee who shall oversee and manage each contract on behalf of the Trust.

24.25 Personnel and Agency or Temporary Staff Contracts

24.25.1 The Chief Executive shall nominate employees with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

24.26 Disposals (See SFI 16)

24.26.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated employee;
(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the Procurement to Payment Policy of the Trust;
(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;
(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and
(e) land or buildings concerning which Department of Health & Social Care guidance has been issued but subject to compliance with such guidance.

24/30.4 - APPENDIX 1

24.27 In-house Services

24.27.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

24.27.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up to ensure a clear separation of duties between the tender and the house bid teams:

(a) Specification group, comprising the Chief Executive or nominated employee/s and specialist;
(b) In-house tender group, comprising a nominee of the Chief Executive and technical support; and
(c) Evaluation team, comprising normally a specialist employee, a Procurement Services representative and a Chief Finance Officer representative. For services having a likely annual expenditure exceeding £250,000, a non-executive director should be a member of the evaluation team.

24.27.3 All groups should work independently of each other and individual employees may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

24.27.4 The evaluation team shall make recommendations to the Board.

24.27.5 The Chief Executive shall nominate an employee to oversee and manage the contract on behalf of the Trust.

24.28 Applicability of SFI's on Tendering and Contracting to funds held on trust (see SFI 19)

24.28.1 These Instructions shall not only apply to expenditure by the Trust but also to works, services and goods purchased from the Trust's charitable funds.

24.29 Joint Ventures and Trading Arms

24.29.1 When the Trust proposes to enter into an agreement between two or more parties to undertake economic activity together, this may take the form of a contractual joint venture or an incorporated joint venture. A robust commercial agreement covering entry, running and exit from the joint venture is required with a detailed project programme, including those activities that are specific to the joint venture in question.

24/30.4 - APPENDIX 1

25 NHSE Framework and Compulsory guidance for Finance and use of resources

- Approved Costing Guidance - Costing principles and guidance for NHS-funded services
- Department of Health & Social Care Group Accounting Manual (GAM) - This provides the detailed requirements for accounts for NHS trusts and NHS foundation trusts, and annual report requirements for NHS trusts.
- FT Annual Reporting Manual (ARM) – contains the formal accounts direction and requirements for annual reports for foundation trusts
- Use of Resources: assessment framework - aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and performance in English NHS acute hospitals.
- Reducing expenditure on NHS agency staff: rules and price caps - Sets out all the rules for NHS providers on agency expenditure, which are collectively known as the 'agency rules'.
- 2024/25 NHS Payment scheme: - Information about the currencies and prices to use in 2024/25 financial year.
- Supporting NHS Providers on executive HR issues - Guidance on a range of executive HR issues including appointments process, salaries, severance and moves.
- Consultancy spending approval criteria for providers - This guidance is for NHS providers looking to commission consultancy services.
- Single Oversight Framework for NHS Providers - Sets out how NHSE oversee NHS trusts and NHS foundation trusts, helping us to determine the level of support they need.
- NHS Operational planning and contracting guidance - Provides an update on the national priorities and long-term financial challenges for local systems.
- NHS Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.

Appendix 1 to Standing Financial Instructions

Reservation of Powers to the Board of Directors

1. Introduction and Principles of Delegation

1.1 Section 5.1 of the Annex 8 SO's of the Trust Constitution provides that "subject to the Regulatory Framework and such guidance as may be issued by NHS England (NHSE), the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 or by a director or an employee of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit". The Code of Governance also requires that there should be a formal schedule of matters specifically reserved to the Trust Board.

1.2 This document outlines which powers are reserved to the Board - generally matters for which it is held accountable to the Sector Regulator and the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 Board members share corporate responsibility for all decisions of the Board. Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to NHSE for the discharge of those responsibilities. Non-Executive Directors are appointed by the Council of Governors to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through Parliament and to the local community. All members are required to subscribe to the Code of Conduct and declare any conflicts of interest.

1.4 This Scheme should be read in conjunction with SO's (within the Trust's Constitution) and all other SFI's. Arrangements for the exercise of functions by delegation are covered in SO section 4 of the Annex 8 SO's of the Trust Constitution and in the introduction to SFI's.

24/30.4 - APPENDIX 1

2. Roles and Responsibilities

2.1 Role of the Chairman

2.1.1 The role of the Chairman is to:

- provide leadership to the Board; set its agenda which should be forward looking with a concentration on strategic matters;
- enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team;
- ensure that key and appropriate issues are discussed by the Board in a timely manner, and ensure that enough time is allowed for discussion of complex or contentious issues;
- ensure the Board has adequate support and is provided efficiently with all the necessary data, information and advice on which to base informed decisions;
- lead Non-Executive Board members through a formally-appointed Nominations Committee of the Board for the appointment of the Chief Executive and other Executive Directors;
- appoint Non-Executive Board members to Integrated Audit and Governance Committee, Finance & Investment, Nominations, Remuneration and Charitable Funds Committees of the main Board;
- act as Chair for the Council of Governors;
- ensure effective communication with the members and that the Board develops an understanding of the views of members of the public;
- take the lead in providing suitable induction for Non-Executive Directors, identifying and meeting the development needs of the Non-Executive Directors; and
- ensure that the performance of the Board as a whole, and of Non-Executive Directors individually is evaluated annually.

2.2 Senior Independent Director (SID)

2.2.1 The SID should be available to members of the Board of Directors and the Council of Governors if they have a concern that contact through the normal channels of Chairman and Chief Executive has failed to resolve or where such contact is inappropriate. The SID may also act as the point of contact with the Board of Directors for Governors when they discuss, for example, the Chair's performance appraisal and his or her remuneration and other allowances.

2.2.2 To be in a position to undertake this role, the SID should attend sufficient meetings with the Council of Governors to listen to their views.

2.2.3 The SID should:

- lead a meeting of the Council of Governors at least annually, without the Chairman present, to appraise the Chairman's performance; and
- lead a meeting of the Non-Executive Directors at least once a year, without the Chairman present, to appraise the Chairman's performance.

24/30.4 - APPENDIX 1

2.3 Council of Governors

2.3.1 The specific statutory powers and duties of the Council of Governors are to:

2006 Act:

- appoint and, if appropriate, remove the chair;
- appoint and, if appropriate, remove the other non-executive directors;
- decide the remuneration and allowances, and the other terms and conditions of office, of the chair and non-executive directors;
- approve the appointment of the chief executive;
- appoint and, if appropriate, remove the NHS foundation trust auditor; and
- receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report.

Amendments to the 2006 Act made by the 2012 Act:

- Hold the NEDs individually and collectively to account for the performance of the Board of Directors;
- Represent the interests of members of the Trust as a whole and the interests of the public;
- Approve “significant transactions” as defined in NHSE guidance;
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- Approve amendments to the Trust’s constitution.

2.3.2 In addition

- in preparing the NHS foundation trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors and must consult them on any proposal to increase income not related to the provision of NHS healthcare by more than 5% of total planned income.

2.3.3 In the event that there is disagreement between the Board of Directors and Council of Governors the Board of Directors and Council of Governors dispute resolution procedure will be followed.

2.4 Role of the Chief Executive

2.4.1 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Committee of the Board shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally, and those functions that have been delegated to other directors and employees.

2.4.2 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer the Chief Executive is responsible and accountable to Parliament via the Regulator for the funds entrusted to the Foundation Trust.

2.4.3 The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with the Trust’s Provider Licence and public service values, and for the maintenance of proper financial stewardship.

2.4.4 The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The duties of the Chief Executive as Accounting Officer are laid out in the Accounting Officer Memorandum; see section 4.1 of this scheme.

2.5 Caution over the Use of Delegated Powers

2.5.1 Powers are delegated to directors and employees on the understanding that they do not exercise delegated powers in a way which could reasonably be anticipated to cause public concern.

2.6 Directors' Ability to Delegate their own Delegated Powers

2.6.1 The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

2.7 Absence of Directors or Employee to Whom Powers have been Delegated

2.7.1 In the absence of a director or employee to whom powers have been delegated those powers shall be exercised by that director or employee's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Chairman after taking appropriate advice from the Chief Finance Officer. If both Chairman and Chief Executive are absent, and a matter cannot reasonably wait until their return, delegated powers may be exercised by the individual formally deputised by the Chief Executive.

3 Reservation of Powers to the Board of Directors

3.1 Introduction

3.1.1 The Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself and to ensure that management arrangements are in place to enable clear delegation of its other responsibilities. These reserved matters are set out in paragraphs 1.2 to 1.10:

3.2 General Enabling Provision

3.2.1 The Board of Directors may determine any matter it wishes in full session within its SO’s and statutory powers. NHS Foundation Trusts must comply with legislation and guidance issued by Parliament, and by NHSE, the Sector Regulator, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. The powers of the Board of Directors are subject to the Constitution and Authorisation of the Foundation Trust.

24/30.4 - APPENDIX 1

3.3 Functions and Duties of the Board of Directors

3.3.1 The Board of Directors has seven key functions for which it is held accountable by the Sector Regulator of NHS Foundation Trusts (NHSE):

(a) to ensure effective financial stewardship through value for money, financial control and financial and strategic planning;
(b) to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
(c) to appoint, appraise and remunerate senior executives;
(d) to ratify the strategic direction of the organisation within the overall policies and priorities of Parliament and the NHS, define its annual and longer term objectives and agree plans to achieve them;
(e) to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
(f) to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs; and
(g) to ensure that the Trust maintains robust clinical governance arrangements underpinning safe, effective and efficient services to its patients.

3.3.2 It is the Board's duty to:

(a) act within statutory financial and other constraints;
(b) be clear what decisions and information are appropriate to the Board of Directors and draw up SO's, a schedule of decision reserved to the Board of Directors and SFI's to reflect these;
(c) ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored with senior executives held to account;
(d) establish performance and quality measures that maintain the effective use of resources and provide value for money whilst ensuring patient safety is maintained;
(e) specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board of Directors can fully undertake its responsibilities; and
(f) establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board of Directors.

3.4 Regulation and Control

3.4.1 Approval, suspension, variation or amendment of SO's, a schedule of matters reserved to the Board of Directors, SFI's and the Scheme of delegation of powers from the Board of Directors to employees.

3.4.2 Approval of the Trust's Treasury Policy including authorisation of institutions with which investments may be made. Approval of banking arrangements. Approval of a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and CFO.)

3.4.3 Requiring and receiving the declaration of directors' and senior employees' interests which may conflict with those of the Trust and determining the extent to which that individual may remain involved with the matter under consideration.

3.4.4 Regular review of the capacity and capability of the Trust to provide the mandatory services referred to in the Provider Licence.

3.4.5 Disciplining directors who are in breach of statutory requirements or SO's.

3.4.6 Ensuring that policies are in place for disciplining employees of the Trust.

3.4.7 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.

3.4.8 To receive reports from committees including those which the Trust is required by the Provider Licence or other regulation to establish and to take appropriate action thereto.

3.4.9 To confirm the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.

3.4.10 Ratification in formal session of any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 4.2 of Annex 8 within the Trust Constitution (emergency powers).

3.4.11 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for Funds held on Trust.

3.4.12 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

3.4.13 Ratification, or otherwise, of instances of failure to comply with SO's brought to the Chief Executive's attention in accordance with SO 4.6 of Annex 8 within the Trust Constitution.

3.4.14 Approval of procedures for declaration of hospitality and sponsorship.

3.4.15 Ensuring proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.

3.4.16 Provide evidence through use of the Board Assurance Framework that the Trust is doing its 'responsible best' to manage itself to meet its objectives and protect patients, staff, the public and other stakeholders, against risks of all kinds.

3.4.17 Regular review of compliance with all statutory requirements.

3.4.18 Ensuring appropriate responses are in place to respond to interventions, reports and requirements of statutory regulatory bodies of the Trust's services and facilities.

3.5 Appointments and Remuneration

3.5.1 The appointment and dismissal of committees (and individual members) which are directly accountable to the Board of Directors.

3.5.2 Confirming the appointment of members of any committee of the Trust as representatives on outside bodies.

3.5.3 Reviewing the recommendations and decisions of the Remuneration Committee regarding pay and terms of service of directors and senior employees.

3.5.4 Following consultation with the Council of Governors, appoint one of the non-executive directors as Senior Independent Director to act in accordance with NHSE's Code of Governance and the Trust's SO's.

3.5.5 Consideration and authorisation of a Mutually Agreed Resignation Scheme (MARS).

3.6 Strategy, Policy Determination, Plans and Budgets

3.6.1 Definition of the strategic aims and objectives of the Trust. Approval of strategy, business plans, budgets and workforce plans, and the capital programme. Approval of the Trust's Annual Business Plan prior to submission to NHSE.

3.6.2 The approval of significant management policies, including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff (where not specifically delegated to the Remuneration Committee or Executive Team).

3.6.3 Approval and monitoring of the Trust's strategy, policies, procedures and programmes for the management of risk.

3.6.4 Approval of major changes to the Trusts' corporate structure.

3.6.5 Ensuring adequate succession planning for the Board

3.6.6 Determination of in-house services to be subject to competitive tender

3.6.7 Approval to engage in tendering for the provision of healthcare related services (where not specifically delegated to the Finance and Performance Committee under the 'Commercial Tenders' Policy)

3.7 Direct Operational Decisions

3.7.1 Ratify proposals for the acquisition, disposal or change of use of land and/or buildings (subject to NHSE's approval in the case of property designated as Protected in the Trust's Authorisation). Approve Outline and Full Business Cases for capital and service investment, in accordance with any delegated limits from the Department of Health & Social Care and as set out in the Business Case procedure.

3.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £1.5m.

3.7.3 Acceptance of formal written tender evaluation reports and approval of individual purchasing contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,500,000 over a 3 year period or the period of the contract if longer. (SFI 24.23.1).

3.7.4 Approval of transactions with a value in excess of that currently specified in the table of financial limits as delegated within the Scheme of Delegation, Appendix 2 Section 5 of these SFI's.

3.7.5 Agreement of action on litigation against or on behalf of the Trust, subject to delegated limits set out in Section 11 of the Detailed Scheme of Delegation, Appendix 2 Section 5 of these SFI's.

3.7.6 Review of use of NHSLA risk pooling schemes (LPST, CNST, and RPST). Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.

3.7.7 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by Parliament, NHSE and the Care Quality Commission.

3.7.8 Approve PFI proposals.

3.7.9 Approve the opening or closing of any bank or investment account. Approval of loans taken out with repayment periods in excess of one year. Approval of a Working Capital Facility within NHSE's guidance on Operating Cash.

3.8 Financial and Performance Reporting Arrangements

3.8.1 Approval of the Trust's performance management framework known as the Operational Framework. Continuous appraisal of the affairs of the Trust by means of the receipt of reports as the Board of Directors may require from directors, committees, and employees of the Trust as set out in management policy statements and in respect of powers delegated to committees. All monitoring returns required by NHSE, the Care Quality Commission and the Charity Commission shall be reported, at least in summary, to the Board of Directors.

3.8.2 Approval of the Trust's Annual Report and Annual Accounts prior to submission to Parliament, NHSE and the Council of Governors.

3.8.3 Approval of the Annual Report and Accounts for funds held on trust.

3.8.4 Approval of the Annual Plan prior to submission to the Secretary of State.

3.8.5 Approval of the Trust's Quality Report and Quality Account.

3.9 Audit Arrangements

3.9.1 Ensure external audit arrangements (including arrangements for the separate audit of funds held on trust) are in place taking appropriate action.

3.9.2 The receipt of the annual management letter from the external auditor and agreement of action on the recommendation taking account of the advice, where appropriate, of the Integrated Audit and Governance Committee.

3.9.3 The receipt of the annual report from the internal auditor and the agreement of action on the recommendations where appropriate of the Integrated Audit and Governance Committee.

3.10 Corporate Governance Matters

3.10.1 Undertaking a formal review (annually) of the performance of the Board along with that of its Committees and individual Directors. Determining the independence of Non-Executive Directors;

3.10.2 Review of the Trust's compliance with the regulators Code of Governance (annually);

3.10.3 Review of this Reservation of Powers to the Board (annually);

3.10.4 Approval of amendments to the Constitution in conjunction with the Council of Governors.

24/30.4 - APPENDIX 1

4 Delegation of Powers

4.1 Delegation to Committees

4.1.1 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be determined by the Board of Directors, taking into account where necessary the requirements of the Secretary of State and or the Charity Commission (including the need to appoint an Integrated Audit and Governance Committee, and a Remuneration Committee). Terms of reference covering decisions and duties delegated by the Board of Directors will be reviewed by each Committee annually and submitted for Board approval. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with SO 5.5 of Annex 8 of the Trust Constitution, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

4.2 Delegation derived from Accounting Officer Memorandum

4.2.1 The Accounting Officer Memorandum is reproduced in full in Section 4.1 of this scheme. The personal responsibility of the Chief Executive as Accounting Officer cannot be delegated except in the particular circumstances set out in the document, and to the extent that the Chief Finance Officer has operational responsibility for the preparation of accounts and effective financial management, information and processes as described in SFI's.

5 Scheme of Delegation to Employees

5.1 SO's and SFI's set out in some detail the financial responsibilities of the Chief Executive (CE) and Chief Finance Officer. Specific responsibilities relevant to other directors, budget holders and all staff are summarised in section 4.3 of this appendix.

5.2 The scheme of delegation covers only matters delegated by the Board of Directors to directors and certain other specific matters referred to in SFI's.

5.3 Section 5 sets out the Detailed Scheme of Delegation applicable to all Care Groups.

5.4 Directors are responsible for ensuring adherence to the provisions of Sections 4 and 5, and for maintaining an appropriate structure of authorised signatories, with procedures for approval of expenditure (including financial limits as necessary) in accordance with the Trust's Authorised Signatory procedure.

24/30.4 - APPENDIX 1

6 Scheme of Delegation Implied by:

6.1 NHS Foundation Trust Accounting Officer Memorandum

6.1.1 Introduction

1. The National Health Service Act 2006 (the Act) designates the Chief Executive of an NHS foundation trust as the Accounting Officer.
2. The principal purpose of the NHS foundation trust is the provision of goods and services for the purposes of the health service in England. The NHS foundation trust has a general duty to exercise its functions effectively, efficiently and economically.
3. The Act specifies that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. An Accounting Officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.
4. Associated with these duties are the further responsibilities which are the subject of this memorandum. It is incumbent on the Accounting Officer to combine these duties with their duties to the Board of Directors of the NHS foundation trust.
5. It is an important principle that, regardless of the source of the funding, Accounting Officers are responsible to Parliament for the resources under their control.

6.1.2 Responsibilities of NHS England

1. In relation to NHS foundation trusts, it is the responsibility of NHS England - Sector Regulator of NHS Foundation Trusts, to be satisfied that the NHS foundation trust is compliant with the governance and continuity of services requirements of their provider licence.

6.1.3 The general responsibilities of an NHS Foundation Trust Accounting Officer

1. The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the NHS foundation trust as a whole;
- financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust; and
- financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.

24/30.4 - APPENDIX 1

6.1.4 The specific responsibilities of an NHS foundation trust Accounting Officer

1. The essence of the Accounting Officer's role is a personal responsibility for:

   - the propriety and regularity of the public finances for which he or she is answerable;
   - the keeping of proper accounts;
   - prudent and economical administration;
   - the avoidance of waste and extravagance; and
   - the efficient and effective use of all the resources in their charge.

2. As Accounting Officer you must:

   - personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by NHSE in accordance with the Act;
   - comply with the financial requirements of the Provider Licence;
   - ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust);
   - ensure that the resources for which you are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
   - ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;
   - ensure that any protected property (or interest in) is not disposed of without the consent of NHSE;
   - ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the NHS foundation trust's staff, including yourself; and
   - ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

3. An Accounting Officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels:

   - have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
   - are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money; and
   - have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

4. Accounting Officers must make sure that their arrangements for delegation, promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the Government Internal Audit Standards.

6.1.5 Advice to the board

1. An Accounting Officer has particular responsibility to see that appropriate advice is tendered to the Board of Directors and the Board of Governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Accounting Officers will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to

their own duty as Accounting Officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.

2. The Board of Directors and the Council of Governors of an NHS foundation trust should act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman is contemplating a course of action involving a transaction which you as Accounting Officer consider would infringe these requirements, however, you should set out in writing your objection to the proposal and the reasons for this objection. If the Board of Directors, Council of Governors or Chairman decides to proceed, you should seek a written instruction to take the action in question. You should also inform NHSE of the position, if possible before the decision is taken or in any event before the decision is implemented, so that NHSE, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that you are overruled, the instruction must be complied with, but your objection and the instruction itself should be communicated without undue delay to the NHS foundation trust's external auditors and to NHSE. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction.

3. If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to your wider responsibilities for economy, efficiency and effectiveness, it is your duty to draw the relevant factors to the attention of the Board of Directors and the Council of Governors and to advise them in whatever way you deem appropriate. If your advice is overruled, and the proposal is one which as Accounting Officer you would not feel able to defend to the PAC as representing value for money, you should seek a written instruction before proceeding. NHSE should be informed of such an instruction, if possible before the decision is implemented. It will then be for NHSE to consider the matter, and decide whether or not to intervene.

4. If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 13 and 14 before the decision is taken, you must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.

24/30.4 - APPENDIX 1

6.1.6 Appearance before the Committee of Public Accounts (PAC)

1. The Comptroller and Auditor General (C&AG) may, under the National Audit Act 1983, carry out examinations into the economy, efficiency and effectiveness with which the NHS foundation trust has used its resources in discharging its functions. An Accounting Officer may expect to be called upon to appear before the PAC from time to time to give evidence on the reports arising from these examinations or reports following the annual certification audit, and to answer the PAC's questions concerning expenditure and receipts for which he or she is Accounting Officer. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence.

2. An Accounting Officer will be expected to furnish the PAC with explanations of any indications of weakness in the matters covered by paragraphs 8 - 15 above, to which their attention has been drawn by the C&AG or about which they may wish to question the Accounting Officer.

3. In practice, an Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his or her accountability. Nor, by convention, does the incumbent Accounting Officer decline to answer questions where the events took place before taking up appointment: the PAC may be expected not to press the incumbent's personal responsibility in such circumstances.

4. The PAC has emphasised the importance it attaches to accuracy of evidence, and the responsibility of witnesses to ensure this, in order to ensure that relevant lines of enquiry may be pursued at its hearings. The Accounting Officer should ensure that he or she is adequately and accurately briefed on matters which are likely to arise at the hearing. The Accounting Officer may, however, ask the PAC for leave to supply information not within his or her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the PAC has contained errors; these should be made known to the PAC at the earliest possible moment.

5. In general, the rules and conventions governing appearances of officials before parliamentary committees apply to the PAC, including the general convention that officials do not disclose the advice given to the board. Nevertheless, in a case where the procedure described in paragraph 13 was used concerning a matter of propriety or regularity, the Accounting Officer's advice, and it’s overruling by the board, would be disclosed to the PAC. In a case covered by paragraph 14, where the advice of an Accounting Officer has been overruled in a matter not of propriety or regularity but of prudent and economical administration, efficiency or effectiveness, the C&AG will have made clear in the report to the PAC that the Accounting Officer was overruled. The Accounting Officer should seek to avoid disclosing the advice given to the board, though subject to their agreement the Accounting Officer should be ready to explain the reasons for their decision.

24/30.4 - APPENDIX 1

6.1.7 Absence of an Accounting Officer

1. An Accounting Officer should ensure that he or she is generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior employee in the NHS foundation trust who can act on his or her behalf if required.

2. If it becomes clear to the Board of Directors that an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Chief Finance Officer, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted.

3. The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.

Sources

This document is based on the guidance outlined in *Managing Public Money*, updated in May 2023 available on the following website link: https://www.gov.uk/government/publications/managing-public-money

24/30.4 - APPENDIX 1
6.2 Scheme of Delegation from Standing Orders

SO REF*	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	Chairman	Final authority in interpretation of Standing Orders (SO's).
3.2	Chairman	Call meetings.
3.9	Chairman or Deputy Chairman	Chair all Board meetings and associated responsibilities.
3.15	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings.
3.16	Chairman	Having a second or casting vote
3.30	Integrated Audit and Governance Committee	Integrated Audit and Governance Committee to review every decision to suspend SO's (power to suspend SO's is reserved to the Board of Directors)
4.2	Chairman & Chief Executive	The powers which the Board of Directors has retained to itself within these SO's may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
4.5	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion.
4.6	All	Disclosure of non-compliance with SO's to the Chief Executive or Chair of the Audit Committee as soon as possible.
6.8	Company Secretary	Maintain Register(s) of Interests.
7.1	All staff	Comply with the Trust's Anti-Fraud, Bribery and Corruption Policy and Code of Conduct, and with national guidance contained in "Managing conflicts of Interest in the NHS – guidance for staff and organisations"
7.8	All	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board of Directors.)
8.1&8.3	Company Secretary	Keep seal in safe place and maintain a register of sealing.
9.1	Executive Director, Risk & Legal Services Manager, Claims Manager	Approve and sign all documents which will be necessary in legal proceedings.

* SO Annex 8 within the Trust Constitution

24/30.4 - APPENDIX 1
6.3 Scheme of Delegation from Standing Financial Instructions

Nominated employees and the areas for which they are responsible are incorporated into the Trust's Detailed Scheme of Delegation document, SFI's set out detailed responsibilities of the Chief Finance Officer, Financial and other responsibilities of the Chief Executive are covered in SFI's and the Accounting Officer Memorandum.

SFI clauses applicable to other directors, to budget holders (all levels) and line managers, and in some cases to all employees and contractors, are summarised in the following table.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.3 & 4.5.2	Chief Finance Officer	Reviews all financial procedures ahead of approval in line with the Policy for the Development and Management of Organisation Wide Policies and Other Procedural Documents, and the form in which financial records are kept
3.3-3.7	All employees and contractors	Duty to comply with SFI's and report any breaches
4.2.3	Chief Executive	To ensure that all directors and employees are made aware of their responsibilities under SFI's
4.4.1	All	Responsible for security of Trust property, economy and efficiency in use of resources; avoid loss and report suspected fraud.
5.2.2	All	Internal audit are entitled to access all records and premises, and have access to all directors and employees.
5.2.3	All	Notify Chief Finance Officer of any suspected irregularity relating to cash, stores, property or other financial matter
5.6.3	Director of Strategic Development and Capital Planning	Key tasks relating to security management (with the Local Security Management Specialist)
7.1.6	Budget holders	Provide information for compiling annual budgets. Sign off budgets and prepare and sign off business plans at the commencement of the financial year.
7.2.2-7.2.4, 7.3.1 to 7.3.4	Budget holders	Budgetary control arrangements to meet agreed budgets
7.6.1	Care Group Directors	Achieve performance targets. Report on performance to the Board, Finance and Performance Committee and Executive Team.
7.6.3	Domain leads	Nominated Executive Directors agree changes to scoring/weighting/RAG rating thresholds
7.6.4	Chief Finance Officer	Ensure Performance Management framework is in place. Maintain Operational Framework.
9.5.6 & 9.5.10, 9.6.4	Finance managers	Employees authorised to make short term borrowings and invest cash surpluses (within the Treasury policy)
10.2.2 – 10.2.3	All	Ensure Chief Finance Officer approves all fees and charges where not covered by statute or determined by DHSC. For sponsorship income ensure the Trust's Ethical guidance and NHS England's "Managing Conflicts of Interest in the NHS – Guidance for staff and Organisations" is followed. Notify Chief Finance Officer of monies due from contracts, leases, tenancy agreements, private patients and other transactions
10.4.2-10.4.4	All	All cash, cheques and payable orders received must be banked intact with no disbursements or encashment of private cheques or IOUs. Unofficial funds deposited for safekeeping in Trust safes are subject to strict procedures and obtaining written indemnities.
10.5.1	All	Money laundering regulations - cash payments in excess of 15,000 Euros will not be accepted.
11.1.5 to 11.1.7	All	Formal signed SLA's/contracts are required before goods or services can be provided to or by the Trust
12.3.1	All	Limits on employing permanent and temporary staff which must fit within approved budget levels
12.4.3	Line managers	Delegated responsibility for completion and submission of time records, termination and other payroll-related notifications which must be made in a timely manner
12.5.1	Chief People Officer	Ensuring Contracts of employment comply with legislation. Dealing with variations and terminations.
13.2.1	Approved requisitioners	Obtain best value for money in requisitioning goods and services (on Procurement Services advice)
13.4	Budget holders	Must submit formal request (to Chief Finance Officer) for payment in advance of goods/service being received.
13.6	All	Duties of managers and employees in relation to procuring goods and services, raising requisitions, goods on loan, verbal orders and petty cash.

13.6.2	Director of Strategic Development and Capital Planning	Audit of contracts to ensure compliance with Concode and Estatecode
14.1	Director of Strategic Development and Capital Planning	Planning and reporting on the capital programme
14.1.7	Capital project managers	Expenditure on individual schemes under the approved capital programme requires specific authority to proceed.
14.4.3-5	All	Report discrepancies in the asset register (annual verification exercise for budget holders). Report damage and loss of property and equipment. Assets should be marked as Trust property.
15.2	Relevant managers and departmental employees	Stock control arrangements.
15.3.1	Budget holders and ward/department al nominees	For goods obtained through the NHS Supply Chain ('stock' requisitions) check deliveries against the delivery note and follow up to ensure credit is received.
16.1.2	Budget holders	Condemning and disposal procedures
16.2.2	All	Notifying losses, actual and suspected.
16.2.3	All	Notifying suspected fraud (see Anti-Fraud Policy)
17.2.1	All	Notify Director of Strategic Development and Capital Planning of any proposed new IT systems/applications.
18.2	Chief Nurse and Midwifery Officer/Director of Quality	Patient's property: ensuring systems and procedures are in place covering written and oral advice to patients and relatives. Ensuring Relative Support Officer function is provided.
18.6 & 18.7	Relevant ward/department al managers	Staff to be informed, on appointment, of their responsibilities for patients' property.
19.3.1	All	These SFI's apply also to charitable funds
20	All	Staff to be aware of Trust policy on accepting gifts (see Anti-Fraud policy) plus NHS England's "Managing Conflicts of Interest in the NHS – Guidance for staff and Organisations"
21	All	Archiving and destroying records
22.1.2	Company Secretary	Preparation and maintenance of the Board Assurance Framework.
22.1.2	Chief Nurse and Midwifery Officer/Director of Quality	Preparation and maintenance of the Quality Governance Statement.
22.1.4	Company Secretary	Annual Governance Statement
22.1.2	Chief Nurse and Midwifery Officer/Director of Quality	Responsible for Trust-wide risk management strategy, processes and Board-level reporting.
22.1.3	Company Secretary	Preparation and maintenance of the Corporate Risk Register.
22.1.3	Care Group and Executive Directors	Ensuring formalised Care Group/corporate governance structures in accordance with the Trust's Risk Management Strategy.
22.3.1c	Budget holders	Income generating activities may require commercial insurance
24	All	Tendering procedures

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS (SFI's)

Detailed Scheme of Delegation

Last Approved by: Board of Directors 6th June 2024

Issued By: Chief Finance Officer

Next review: April 2025

Appendix 2 to Standing Financial Instructions

Detailed Scheme of Delegation

The delegation shown in the following Detailed Scheme of Delegation is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Employees as appropriate.

The use of commas in the table below is a substitute for "or". Where the authority of more than one employee is required this is clearly indicated by the use of 'and'.

24/30.4 - APPENDIX 1
Schedule A: Requisitioning and payment of invoices (Budget Holders)

A1. Approval of requisitions and invoices for payment within delegated budget in conjunction with Unit 4 Business World e-requisitioning and workflow structures:

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post (Budget Holder)**	**Reference** SFI13 and 24 (to comply with any specific requirements laid down under NHSE financial special measures)
Up to £500	AfC 4	
Up to £1k	AfC 5	
Up to £5k	AfC 6/7	
Up to £25k	AfC 8a/8b	
Up to £50k	AfC 8c/8d	
Up to £250k	AfC 9/VSM	
Up to £500k	AfC 9/VSM and Executive Director	
Up to £1.0m	AfC 9/VSM and Chief Exec and Finance Director	
Over £1.0m	Trust Board	
Budget virement	As above	See Budget Virement Policy
Items below £5k not funded within Care Group budgets	Managing Director	
Non-pay expenditure over £5k for which no specific budget has been set up and which is not subject to funding under delegated powers of virement.	Managing Director & Director of Finance	
Approving payment of invoices in excess of tender/order price: 5% of order value(up to maximum £50 per order)	Payments Manager	Above this limit is referred to the Procurement Services Department to investigate to request a credit note if appropriate or, if the higher price is correct, to obtain budget holder approval at the correct authorisation level and amend the purchase order accordingly.

(1) The Assistant Director of Finance (Financial Management) has delegated authority from the Chief Finance Officer to allocate funds from central resources and reserves as operationally required

Additional controls operated by the Procurement Services Department and the Finance Department may be applicable from time to time. All requisitions authorised as per schedule A above will, at a value of >£500 be sent to a special authorising panel for review and final authorisation. Panel establishment and conduct will be reviewed and confirmed by the Trust Clinical Executive Management Team.

24/30.4 - APPENDIX 1

A2. Expenditure from Charitable Funds – per request:

Delegated Matter	**Authority Delegated to Grade/Post (1)**	**Reference** SFI 19
Up to £2k	Delegated signatory (known as fund managers)	
Up to £30k	Delegated signatory and Executive Team member or Assistant Finance Director	
Up to £100k	Delegated signatory and CFO (or Director of Finance in absence of CFO)	
Over £100k	Board of Directors on recommendation of Charitable Funds Committee (CFC)	

(1) A separate authorised signatory list is maintained for charitable funds. The Business Case procedure is applicable to purchases over £5k from charitable funds. The Trust's SO's, SFI's, quotation/tendering requirements and Scheme of Delegation are all applicable to charitable funds.

Schedule B: Signing orders and contracts
(including subsequent variations) for goods and services (Procurement Services)
B1. Within delegated budget in conjunction with Unit 4 Business World e-requisitioning and workflow structures:

Delegated *Matter (contract value including non-reclaimable VAT)*	**Authority Delegated to Grade/Post (Procurement Services)**	**Reference**
Up to £2.5k	Assistant Buyer	
Over £2.5k and up to £5k	Buyer	
Over £5k and up to £25k	Senior Buyer	
Over £25k and up to £100k	Category Manager (1)	
Over £100k and up to £250k	Senior Category Manager, Head of Procurement	
Over £250k	Associate Director of Procurement & Managed Equipment Services, 2gether, 2gether nominated officer	

(1) All contracts are signed by category manager or above

B2. Authority to exceed specific ordering limits by up to 5% once a tender has been formally accepted, where the contract value is exceeded by:

Delegated Matter *(including non-reclaimable VAT)*	**Authority Delegated to:**	**Reference**
Up to £20k	Category manager	
Over £20k and up to £100k	Head of Procurement, Associate Director of Procurement & Managed Equipment Services, 2gether	
Above £100k or 5% above contract value	Further authorisation to be sought from original approving body	

(1) Excludes 2gether contract variations within the wholly owned subsidiary (see A1).

(2) Additional controls operated by Procurement Services and the Finance Department may be applicable from time to time.

24/30.4 - APPENDIX 1

C2: Approval of capital schemes where tender or cost is over budget:

Delegated Matter *(including non-reclaimable VAT)*	**Authority Delegated to Grade/Post**	**Reference**
Up to £10k	Director of Finance	Reviewed by Capital Investment Group
Up to £100k	Chief Executive or CFO	Reviewed by Capital Investment Group
Over £100k	Chief Executive's Group, Board Committee or Board of Directors	Referred back to the original authorising body

C3: Approval of capital schemes miscellaneous:

Delegated Matter	**Authority Delegated to Grade/Post**	**Reference**
C3a. Selection of architects, quantity surveyors, consultant engineer and other professional advisors within PCR: 2015	Director of Operations plus Managing Director or Director of Finance	
C3b. Financial monitoring and reporting on all capital scheme expenditure	Director of Finance	Reported to Trust Board, Finance and Performance Committee and Capital Investment Group
C3c. Taking on or termination of leases with annual rental of up to £150k	2gether nominated officer and Director of Finance	Refer to Assistant Director of Financial Accounting to advise on IFRS16 issues.
C3d. Taking on or termination of leases with annual rental of over £150k	2gether nominated officer and CFO	As above
C3f Impacting on protected services and/or protected assets	NHSE	

24/30.4 - APPENDIX 1
Schedule D: Quotation, Tendering and Contract Procedures
D1: Competition requirements:

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post**	**Reference** SFI 24
Ensuring value for money is obtained for goods and services purchased under £10k	Budget signatories (within delegated limits)	
Obtaining a minimum of 2 formal written quotations on a competitive basis for goods and services between £10k and £25k, on a whole-life basis for expenditure or income.	Budget signatory (within delegated limit) **and** Procurement Services Department in accordance with Trust Procurement to Payment Policy.	
Obtaining formal written competitive tenders for goods or services above £25k.	Budget Director (or AFD in their absence) **and** Associate Director of Procurement & Managed Equipment Service, 2gether	

D2: Waiving competition requirements: Authorisation for a single tender action and waiver of tendering requirements:

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post**	**Reference** SFI 24
Up to 500k	Director of Finance	
Up to £1.5m	CFO or Chief Executive	
Over £1.5m	Board of Directors	

D3: Opening tenders and quotes:

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post**	**Reference** SFI 24, and Estates Tendering Procedure Manual
Up to £25k	Category Manager, Senior Category Manager – Procurement Services	
For electronic tenders above £25K	Senior Category Manager, Head of Procurement, Associate Director of Procurement & Managed Equipment Services, 2gether.	SFI 24.13.2

24/30.4 - APPENDIX 1

D4: Acceptance of tenders and quotes:

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post** (after due process including approval of the relevant budget holder/service Director as applicable)	**Reference** SFI 24.16 and Scheme of Reservation 1.7.3
Up to £10k	2gether nominated officer (within delegated limits)	
Up to £25k	Associate Director of Procurement & Managed Equipment Services, 2gether, Head of Procurement, Senior Category Manager	
Up to £100k	Associate Director of Procurement & Managed Equipment Services, 2gether and 2gether nominated officer	
Up to £250k	Director of Finance	
Up to £500k	Chief Executive and CFO, and 2gether nominated officer.	
Up to £1.5m	Any two of: Chief Executive, CFO or 2gether nominated officer	
Over £1.5m	Board of Directors	Or, if urgent, Chairman and Chief Executive, reported at the next Board meeting (SO 4.2)

D5: Authority to issue a letter of intent:

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post**	**Reference**
Up to £25k	Associate Director of Procurement & Managed Equipment Services, 2gether, Head of Procurement, Senior Category Manager, Procurement Services Department	
Up to £100k	Associate Director of Procurement & Managed Equipment Services, 2gether nominated officer	
Up to £500k	Chief Executive, CFO	
Over £500k	Chief Executive, CFO with Board approval	

D6: Commercial Tenders (new markets and competition for provision of services)

Delegated Matter ***(contract value including non-reclaimable VAT)***	**Authority Delegated to Grade/Post**	**Reference** Strategic Development Policy agreed at Finance and Performance Committee
Services currently provided by the Trust): - Up to £499k per annum - £500k to £999k per annum - above £I.0m per annum	Executive Management Team Finance and Performance Committee Board	
New business: - Up to £249k per annum - £250k to £499k per annum - above £500k per annum	Executive Management Team Finance and Performance Committee Board	

24/30.4 - APPENDIX 1
Schedule E: Business Case Delegated Authority:

APPROVAL GROUP	OVERALL/ SELF-FUNDING	REVENUE FUNDING REQUIRED	CAPITAL FUNDING REQUIRED
Care Group Boards	Approve investment proposals within Care Group "redistributable resource" (approved budget baseline). **EXCEPT** New Service Business cases/impact on other Care Groups or Business cases with a contract activity Impact	-	-
	Then to (if applicable):		
Business Case Scrutiny Group for all Business cases and Capital Investment Group (CIG) for capital cases	Approve self-funding business cases up to £1.25m cost impact over five years (<= £250k p/a average cost)	Approve non-self-funding business cases up to £750k cost impact over 5 years (<= £150k p/a average cost)	Approve up to £500k Capital Investment (only) - no revenue cost impact
	Then to (if applicable):		
Clinical Executive Management Group (CEMG)	Approve self-funding Business cases from >£1.25m to < £2.5m cost impact over five years (<= £500k p/a average cost base change)	Approve Non self-funding Business Cases up to £1.75m cost impact over five years (<= £350k p/a average cost)	Approve >£500k to <£1m Capital Investment
	Then to (if applicable):		
Finance & Performance Committee (FPC)	Approve self-funding Business cases from >£2.5m to < £5m cost impact over five years (<= £1m p/a average cost base change)	Approve Non self-funding Business cases up to £2.5m cost impact over five years (<= £500k p/a average cost)	Approve >£1m to <£2.5m Capital Investment
	Then to (if applicable):		
Trust Board of Directors (BoD)	Approve self-funding Business cases over £5m cost impact over five years (> £1m p/a average cost base change)	Approve Non self-funding Business cases over £2.5m over five years (> £500k p/a average cost)	Approve over £2.5m Capital Investment

24/30.4 - APPENDIX 1

Delegated matter	Authority delegated to (lowest level)	Reference documents
1. Management of budgets **1.1 Responsibility for keeping within budgets**		SFI 7, 12, 13 and Performance Management Framework
Clinical Care Group	Care Group Director	
Corporate directorates	Executive Director	
Corporate budgets	Assistant Finance Director	
Individual budget	Delegated budget signatory	
2. Bank accounts	CFO. Day to day authorisations in accordance with bank mandates approved by the Board	SFI 9
Approve working capital facility and Trust's main commercial bankers	Board of Directors	
Approve external Investment Management contracts	Finance and Performance Committee	
Investment of surplus cash in accordance with Policy	Assistant Finance Director	Treasury Policy
3. Setting of fees and charges		SFI 10
Private Patients, Overseas Visitors, other patient services Income Generation	Director of Commissioning, Contracting and Costing	
NHS Service Level Agreements – local tariffs	Director of Commissioning, Contracting and Costing	
Approving credit notes to be raised by the Trust	In line with authority for raising invoices. Credit notes over £1k are subject to review by the Financial Accountant.	
4.1 Engagement of Temporary Staff	Note: This section is subject to the operation of any additional vacancy control processes authorised from time to time by the CEO. Note also that Care Groups may impose additional counter-signatory requirements.	SFI 12.3.1 and 24.27 Refer to the Trust's agency staff approval process
a. Non-Medical Consultancy Staff - all appointments	Care Group Director and Executive Director. Any appointment costing more than £50k will require pre-approval from NHSE.	DHSC guidance on procurement of management consultants
b. Individual temporary staff where the aggregate commitment in any one year is more than £25,000	Care Group manager and Care Group Finance Lead	This section should be read in conjunction with the NHSE Guidance on agency staff usage and the bank procedure. Where proposed expenditure is not covered within the delegated budget, additional approval must be obtained from the Chief Finance Officer and Chief People Officer
c. Booking of bank staff	Budget Signatory (within delegated budget)	This section should be read in conjunction with the NHSE Guidance on agency staff usage and the bank procedure. Where proposed expenditure is not covered within the delegated budget, additional approval must be obtained from the Chief Finance Officer and Chief People Officer
d. Booking of framework agency staff e. Booking off-framework agency staff	Budget Signatory (within delegated budget) Care Group Director	This section should be read in conjunction with the NHSE Guidance on agency staff usage and the bank procedure. Where proposed

f. Renewal of Fixed Term Contract	Deputy budget manager (subject to relevant vacancy controls for clinical and non-clinical staff) with change forms signed off by Care Group Finance Lead/HR Business Partner	expenditure is not covered within the delegated budget, additional approval must be obtained from the Chief Finance Officer and Chief People Officer
Approval of temporary, bank or fixed term contract staff outside budget limits	CFO and Chief People Officer	

24/30.4 - APPENDIX 1

4.2 Trust's Solicitors		
a. Engagement	Chief Executive	
b. Referral of a case etc to appointed Solicitors	Legal Services Managers	Trust's Policy on obtaining Legal Advice
5. Agreements and licences		
Preparation and signature of tenancy agreements and licences for staff	2gether nominated officer and CFO or DoF	Subject to Trust Staff Accommodation Policy
Extensions to existing leases	2gether nominated officer and CFO or DoF	
Letting of premises to outside organisations (in accordance with Estate Code)	2gether nominated officer	
Approval of rent based on professional assessment	CFO	
Charitable funds properties: Letting premises to outside organisations Approval of rent based on professional assessment Appointment of agents to manage external letting	Charitable Funds Committee Charitable Funds Committee CFO	
6. Condemning and Disposal		SFI 16
Items obsolete, obsolescent, redundant, irreparable or not cost-effective to repair:	Note: liaison with Procurement Services is required for all disposals to ensure Health and Safety issues are addressed	Sale of protected assets (land and buildings) requires Board and NHSE approval
Estimated replacement cost up to £5k	Budget Manager and Senior Category Manager: Procurement Services	
Estimated replacement cost over £5k	In line with delegated budgetary approval	
Mechanical and engineering plant	2gether nominated officer and DoF	Note: capital receipts may not always be available for reinvestment in the area which generated the sale.
Sale of property (land/buildings)	Finance and Performance Committee to approve sale at market valuation +/- parameters for ED approval of subsequent offer	Note: capital receipts may not always be available for reinvestment in the area which generated the sale.
Other	Budget Manager and Senior Category Manager: Procurement Services (after reporting to DoF and Senior Financial Accountant)	Note: capital receipts may not always be available for reinvestment in the area which generated the sale.
Sale of Charitable funds properties	Charitable Funds Committee to recommend sale at market valuation +/- parameters for Board approval. CFO or CE approval of subsequent offer	
7. Losses and Special Payments Note. The Trust has delegated authority to write off losses without limit, except that: Any novel, contentious or repercussive cases have to be referred for DH approval. Proposed staff severance payments that exceed legal or contractual obligations require prior approval from Treasury.	Note: a summary of all losses and special payments is reported to the Integrated Audit & Governance Committee. Cases over £250k are reported separately in the annual accounts. All individual cases of £250k and above require Board approval. All cases above £50k require approval from the CE and CFO and will be reported to the Finance and Performance Committee. All cases above £1k require two signatures	SFI 16 and DHSC Group Accounting Manual (GAM)
a. Loss of cash: theft, fraud, overpayment or other reason	Assistant Director of Financial Accounting and DoF	Subject to Debtors Policy for writing off bad debts and recovery of losses due to fraud

b. Fruitless Payments (incl. Abandoned capital schemes):		
Up to £50,000	Executive Director	
Over £50,000	Trust Board	
c. Claims abandoned. Private patients, overseas visitors and other including NHS and non NHS debtors	DoF	Subject to Debtors Policy for writing off bad debts.
d. Damage to buildings, fittings, furniture and equipment, loss of equipment including IT and property in stores and in use, due to culpable causes (e.g. fraud, theft, arson, administrative failure)	Two of 2gethers nominated officers or DoF and Legal Services Managers or Local Counter Fraud Specialist and /or Local Security Management Specialist	
e. Compensation payments made under legal obligation resulting from a Court Order or legally binding arbitration award.	Deputy Director of Risk, Governance & Patient Safety or Corporate HR Manager PLUS Executive Director or DoF	
f. Extra contractual payments to contractors	2gether nominated officer and DoF	
g. Ex-gratia payments to patients and staff for loss of personal effects:		
i)Less than £1,000	Legal Services Managers	
ii) Between £1,000 and £5,000	Legal Services Managers and Deputy Director of Risk, Governance & Patient Safety (DDRGPS)	
iii)Over £5,000	DDRGPS PLUS an Executive Director	
h. Clinical negligence negotiated settlements (with legal advice)	DDRGPS PLUS an Executive Director	Note: the NHSLA has financial responsibility for all cases covered by the scheme. However, it may allow the Trust to settle low-level cases directly
i. personal injury claims involving negligence where legal advice has been obtained and guidance applied	DDRGPS PLUS an Executive Director	NHSLA guidance

j. Other ex gratia payments relating to clinical negligence and personal injury claims not subject to legal advice • Under £1,000 • Between £1,001 and £5,000 • Between £5,000 and £50,000 (in practice legal advice would be sought for a claim at this level, or for clinical negligence would be processed through the NHSLA)	Legal Services Managers Legal Services Managers and DDRGPS DDRGPS and an Executive Director or DoF	Note: Redress policy being developed; payments to be approved by Care Group Directors
k. Other ex gratia including maladministration up to £50,000 Bands as section j above	As section j above	Note: where complainant has suffered no financial loss, compensation can only be justified in very exceptional circumstances
l. Other – settlements on termination of employment:		
i) contractual	Head of Employee Relations and Assistant Finance Director	
ii) Under legal obligation	As section e above	
iii) other	Treasury approval	HR Policy derived from Treasury guidance in DHSC Group Accounting Manual (GAM)
m. Payment of Court Disclosure Orders	Legal Services Managers	On instruction from Trust solicitors
8. Reporting of incidents to the Local Counter Fraud Specialist or Trust's Local Security Management Specialist and the Police		SFI 5
a. Where a criminal offence is suspected:-		
i) Criminal offence of a violent nature, theft or criminal damage	Responsible Manager And Security Manager	All security related incidents of theft or criminal damage must be notified to the Chief Executive, NHS Counter Fraud Authority and the Police by the LSMS.
ii) Other security breach or knowledge of unreported security incident	Responsible Manager and Security Manager	
b. where a fraud is involved	Employee to notify CFO or Local Counter Fraud Specialist	In accordance with the Trust's Anti-Fraud Policy
9. Petty Cash		SFI 13
a) Disbursement from local imprest/cashiers office	Imprest holder	
b) Request for reimbursement cash/general office funds:-		
• Up to £100 per item	Budget Signatory	
• Up to £200 per item	Deputy Budget Manager	
• Over £200 per item	Budget Manager or Senior Financial Accountant	
c) Reimbursement of Patients monies	Cash/general office staff, Relative Support Officer	
10. Receiving Hospitality		
In excess of £25 per item received (or offered and refused) - Applies to both individual and collective hospitality receipts, in accordance with Trust guidelines and SO's	Declaration required in Trust's Hospitality register (held by Company Secretary	Trust guidance on sponsorship and "Managing Conflicts of Interest in the NHS – A guide for staff and organisations"

11. Implementation of internal and external audit recommendations	Lead director and designated manager	SFI 5
12. Maintenance and update of Trust Standing Financial Instructions	Assistant Finance Director	
13. Investment of Charitable Funds	CFO as Trustee (if absent: DoF)	In accordance with policies agreed by the CFC and ratified by TB
14. Personnel and Pay	Note: this section is subject to the operation of any additional vacancy control processes authorised from time to time by the CEO	Vacancy control panel currently in force
14.1 Authority to fill funded post on the establishment with permanent staff.	Budget signatory and all Requests to Recruit are signed off by Care Group Finance lead and relevant Care Group Director or Deputy to Executive Director	Recruitment and financial management procedures
14.2 Authority in exceptional circumstances to appoint permanent staff to post not on the formal establishment.	AFD to obtain formal approval from Chief People Officer and CFO	Resourcing Dept Procedures and Case of need
14.3 Additional Increments The granting of additional increments to staff within national terms and conditions and the Trust's starting salaries policy	Employee Relations Manager following application from Care Group (Director or approved nominee)	AFC Management Guidance on Starting Salaries
14.4 Grading of Posts All requests shall be dealt with in accordance with Trust Procedure	Head of Employee Relations and Care Group Finance Lead	HR Policies
14.5 Establishments		
Responsibility for creating and maintaining a Trust-wide approved staffing establishment	CFO and Chief People Officer with appropriate sign off by the Chief Nurse and Midwifery Officer and Director of Quality and Chief Medical Officer	
Additional posts to the agreed establishment with specifically allocated finance agreed by Chief Finance Officer and Chief People Officer.	Relevant budget holder and Finance Manager and Care Group Lead and HR Business partner (clinical posts also signed off by the Head of Nursing or Clinical Lead as appropriate)	Resourcing Dept Procedures and Change to Authorised Establishment procedures
14.6 Pay	Note: This section is subject to the operation of any additional pay control processes authorised from time to time by the CEO. Note also that Care Groups may impose additional counter-signatory requirements.	
Authorisation of standing data forms affecting pay, new starters (within establishment), leavers and variations (except increments, re-grading and ad-hoc payments dealt with separately in this Scheme)	Budget signatory	
Authorisation of time and attendance on rostering system	Line manager (minimum level is budget signatory)	
Authorisation of overtime within budget	Budget signatory	
Authorisation of non-Agenda for Change or payment outside of national terms and conditions for medical staff	Head of HR and DoF	
Authorisation of travel, subsistence and expenses claims	Budget signatory for Cost Centre charged	
14.7 Approval of additional payments to staff:		
Performance Related Pay Assessment	Remuneration Committee	
Other payments	DoF and Head of HR	

14.8 Leave		See also Medical & Dental Terms & Conditions, and AfC T&C of Service. Refer also to Trust HR Policies.
Maintaining adequate leave records	Line manager	
Approval of annual leave	Line manager	
Medical Staff Leave of Absence - paid and unpaid	Care Group Chief Medical Officer	
14.9 Special leave arrangements		Special Leave Policy, Flexible Working Policy, Annual Leave Policy, Parents Toolkit
Compassionate leave up to 3 days	Line manager	
Paternity leave	Line manager	
Carers leave, up to 3 days	Line manager	
Special leave	Line manager	
Leave without pay	Line manager	
Time off in lieu	Line manager	
Maternity Leave - paid and unpaid	Line manager	
Flexitime – setting maximum level of accrued flexitime	Line manager	
Buying and selling annual leave	Line manager	
Flexible retirement	Line manager	
14.10 Sick Leave		Trust Sick leave policy
Extension of sick leave on half pay up to three months (in exceptional circumstances)	DoF and Head of HR	Sickness Absence Policy, and terms and Conditions for Agenda for change staff and Medical staff
Extension of sick leave on full pay (in exceptional circumstances)	Head of HR and an Executive Director	
Return to work part-time on full pay to assist recovery	Line manager, in consideration of Occupational Health advice	
14.11 Study Leave		
Senior Medical staff study leave	Clinical Lead and Director of Med Education	Trust guidelines
Junior medical staff study leave	Relevant Consultant Educational Supervisor, Care Group Support Assistant and Clinical Tutor	KSS Deanery guidelines
All other study leave	Deputy budget manager and line manager	Trust study leave policy

14.12 Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by employees taking up new appointments (providing consideration was promised at interview)	Chief People Officer/ Head of HR	Removal expenses guideline
14.13 Authorised Car & Mobile Phone Users		
Requests for posts to be authorised as car users	Budget manager (in line with Trust policy)	
Requests for posts to be authorised as mobile telephone users	Budget manager (and in line with Trust policy)	
14.14 Mutually Agreed Resignation Scheme (MARS)	Board	Subject to NHSE guidelines. Refer to the Trust MARS policy
14.15 Redundancy	CFO and Chief People Officer	
14.16 ill Health Retirement		
Decision to pursue retirement on the grounds of ill-health (final decision rests with the Pensions Agency)	Line manager	
14.17 Dismissal	Dismissing Manager (and in line with HR policy)	Trust disciplinary policies. Delivering Performance Policy, Sickness Absence Policy
15. Authorisation of new drugs where no specific source of funding or income has been identified	CFO on the recommendation of the Drugs & Therapeutics Committee	D&TC Terms of reference
16. Authorisation of Sponsorship Deals	Chief Executive, Chief Medical Officer and Director of Research and Innovation	Trust Policy: Ethical Guidelines on the Relationship between Trust Employees and the Biomedical Industry
17. Authorisation of funded Research Projects	Director of Research and Innovation	In line with Trust Policy for Management of R&D
18. Authorisation of Clinical Trials	Chief Executive, Chief Medical Officer and Director of Research and Innovation	
19. Insurance Policies and Risk Management		
a. management of the RM programme	Chief Nurse and Midwifery Officer & Director of Quality	
b. Insurance arrangements	CFO and Legal Services Managers	
c. Payment of third party claims, pending recovery from the NHSLA (above the excess), and the Commissioner, based on request from NHSLA and Trust's solicitors	Legal Services Managers (over £50,000 also requires approval from the Assistant Finance Director - Financial Accounting)	NB excess may be recoverable under historic agreement with host commissioner
20. Patients and relatives complaints		Trust complaints procedure
a. overall responsibility for ensuring that all complaints are dealt with effectively	CE, Deputy Chief Nurse and Midwifery Officer and Director of Quality	
b. responsibility for ensuring that complaints relating to a Care Group are investigated thoroughly	Care Group Top Team	
c. Coordination/facilitation of complaints	Head of Patient Experience Team	
d. coordinating the management of medico-legal complaints	Chief Medical Officer or CNDQ and Legal Services Managers	

24/30.4 - APPENDIX 1

21. Relationships with Press		
a. Non-emergency general enquiries	Trust Comms lead	Using Comms protocol on out of hours enquiries
b. Emergency, out of hours	On-call Exec Director via the switchboard operator	Using Comms protocol on out of hours enquiries
22. Infectious Diseases & Notifiable outbreaks	CNDQ and Chief Nursing and Midwifery Officer	Trust Infection Control policy
23. Patient Services		
a. Variation of operating and clinic sessions within existing numbers	Managing Director	
b. All proposed changes in bed allocation and use		Notified to ICBs etc.
Temporary	Chief Operating Officer	
Permanent	Chief Operating Officer	
c. Activity monitoring and reporting	chief Operating Officer	
24. Review of Fire precautions	Fire Safety Officer	
25. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	2gether nominated officer	
26. Review of Medicines Inspectorate Regulations	Associate Chief Medical Officer, Director of Pharmacy	
27. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Head of Strategic Intelligence	
28. Information Governance including Data Protection, Data Security and Caldicott Guardian arrangements		
a. Overall responsibility: SIRO	CFO	
b. Information (activity and contract minimum data)	Head of Information Services	
c. IT security and controls	Director of IT	
d. Overall Information Governance controls	Information Governance Manager	
e. Care Group controls	Care Group nominated leads	
f. Freedom of Information requests	Deputy Director Risk Governance and Patient Safety	
g. Publication scheme	Deputy Director Risk Governance and Patient Safety	
h. Data Protection Act requests and compliance	Information Governance Manager	
i. Review of Trust's compliance with the Access to Records Act	Information Governance Manager	
j. Review of the Trust's compliance with the code of practice for handling confidential information	Information Governance Manager	

24/30.4 - APPENDIX 1

29. Retention of Records: a. maintaining archives and compliance with Trust Policy b. Control of access to central clinical records c. Policy lead	Heads of Department Patient Access Service Manager Board Secretary	SFI 21
30. Monitor proposals for contractual arrangements between the Trust and outside bodies	Managing Director, DoF, Associate Director of Procurement & Managed Equipment Services (as appropriate)	
31.The keeping of a Declaration of Interests Register	Company Secretary	SO's Section 6*
32. Attestation of Sealings in accordance with Standing Orders	Chairman, Executive Directors	SO's Section 8*
33. The keeping of a register of Sealings	Company Secretary	SO's Section 8*
34. The keeping of the Gifts and Hospitality Register	Company Secretary	
35. Clinical Audit: ensuring programme of risk management includes clinical audit	Chief Medical Officer and CNDQ with Chair of Clinical Audit and Effectiveness Group	SFI 22
36. Control of Stores		SFI 15
a. Central stores and materials management stock (managed by 2gether as part of the OHF)	Associate Director of Procurement & Managed Equipment Services	
b. Formal stocks (full stock take monthly or annually as agreed. Stocks included as part of the OHF are managed by 2gether)	Managers of Pharmacy, Theatres, Day Surgery, Cardiology, Haemophilia, Blood transfusion, Radiology, Audiology, AND Assistant Director of Financial Accounting	Trust Stocktaking procedure
c. Other stock holding	Budget signatories	

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University

NHS Foundation Trust

TRUST POLICY

Gifts, Hospitality and Conflicts of Interest Policy

Document properties:	Detail:
Version	7.0
Author	Director of Corporate Governance
Policy Owner	Director of Corporate Governance
Executive Director Responsible for Policy	Chief Executive Officer
Approving committee	Board of Directors
Date approved	
Date ratified by Policy Authorisation Group	
Date issued	
Next scheduled review date	

Applies to:	Yes/No
Trust staff (specify groups e.g. clinical/non-clinical)	All Trust staff, non-executive directors and governors
Subsidiaries	No
2gether Support Solutions Ltd. as a service provider (hard and soft facilities services)	No

Version Control Schedule

Version	Date	Author	Status	Comment
1	August 2011	Trust Secretary	Approved	
2	October 2012	Trust Secretary	Approved	
3	October 2014	Trust Secretary	Approved	Fully reviewed and simplified
4	April 2017	Trust Secretary	Approved	New Guidance from NHS England to be implemented by June 2017
4.1	January 2019	Trust Secretary	Approved	Amendments made to reflect revised process for declaration.
5	July 2021	Group Company Secretary	Approved	
6.0	December 2021	Interim Deputy Trust Secretary	Approved	Updates to reflect new system for declarations on Self Service (ESR).
7.0	March 2024	Director of Corporate Governance		Refreshed policy to update definitions and information flow. Updated to align with NHS England reporting guidance on band 8d & decision makers (previously 8a)

Policy Reviewers

If policy references children/young people or includes references to medicines policy must be reviewed by the relevant group.

Title and Care Group of Individual	Date Consulted
Local Counter Fraud Specialist, RSM-UK	March 2024
Tracey Fletcher, Chief Executive Officer	April 2024

Name of Committee	Date Reviewed
Policy Authorisation Group	April 2024
IAGC	April 2024
Board of Directors	June 2024

Summary of Key Changes from Last Approved Version

Updated to align with NHS England reporting guidance on band 8d & decision makers (previously 8a)

Associated Documentation

Professional Codes of Conduct / ethics

Standing Financial Instructions

Anti-Fraud, Bribery and Corruption Policy

Financial Management and Control of Use of Resources Policy

Managing Close Personal Relationships at Work Policy

Procurement to Payment Policy

Working Time Regulations and Secondary Employment Managers Toolkit

Disciplinary Procedure

Freedom to Speak Up policy

Sponsorship of Clinical Research Studies policy

Supplier Representatives Policy

Standing Financial Instructions and Scheme of Delegation

EKHUFT Trust Constitution

Policy Reference Guide

For quick reference, this table summarises the actions required by this policy. However, this does not negate the need for staff and others to be aware of and to follow the further detail set out in this policy. Not adhering to the policy could damage the reputation of individuals working for EKHUFT and the trust itself.

As a member of staff you should ….	EKHUFT will ……
Know this policy and follow it. Refer to NHSEngland guidance for the rationale behind the policy. **Seek guidance** if you are not sure what is requiredof you. **Speak up** If you think the Trust is not living up tothe policy. Regularly consider what interests you have and declare these as they arise. **If in doubt, declare.** Use common sense and judgement to consider whether your interests could affect the way NHSmonies [1] are spent. **NOT** misuse your position to further your own interests or those close to them. **NOT** be influenced or give the impression that you have been influenced by outside interests or through the acceptance of gifts or hospitality. **NOT** allow outside interests to inappropriately affect the decisions you make when using NHSresources. Make an annual declaration of your interests (evenif a nil return) if you are required to do so under thispolicy. Make a declaration of your interests as soon as anew interest becomes known.	Make this policy and the supporting processes**as clear as possible** to help staff understand what they need to do. Identify a team or individual who will: • **Keep this policy under review** to ensure EKHUFT is in line with guidance • **Provide advice**, training and support for staff on how interests should be managed • **Maintain register(s) of interests** • **Audit this policy** and its associated processes and procedures at least once every three years The contact for this policy is the Director of Corporate Governance **NOT** avoid managing conflicts of interest. **NOT** interpret this policy in a way which stifles collaboration and innovation with partners of the Trust.

This policy is consistent with guidance published by NHS England. To further assist staff using the Policy the following Question and Answer documents have been created by NHS England and can be found using the following links:

NHS Provider manager Q&A

NHS Provider clinical staff Q&A

NHS Provider medical staff Q&A

Contents

1. Policy Description

1.1. The declarations of interest, gifts and hospitality policy describes the business conduct behaviour East Kent Hospitals NHS Foundation Trust (EKHUFT) expects from all staff who may potentially benefit through the interests they may hold with third parties external to EKHUFT, or as the recipient of gifts, hospitality, or sponsorship arrangements.

1.2. It aims to ensure that the people who work for and with EKHUFT are protected from any suspicion or allegations of impropriety, bribery, or fraud, or subject to undue influence in the conduct of EKHUFT business.

1.3. It also serves as an important defence against any actions brought against individuals under the 2010 Bribery Act.

2. Equality Impact Statement

2.1. This policy has been subject to an Equality Analysis (EA), it is not anticipated that it will have an adverse impact on any of the protected equalities groups. The EA is set out in Appendix C.

3. Introduction

3.1. EKHUFT is committed to providing best value for taxpayers and ensuring that decisions are taken transparently and clearly.

3.2. This policy will help all staff, volunteers, and employees of organisations who do business with and on behalf of EKHUFT to act with the highest standards of integrity, use NHS monies wisely, and act in the best interest of the patient.

3.3. Not adhering to this policy could damage the reputation of EKHUFT and could expose EKHUFT staff and others to disciplinary action, criminal prosecution, or significant reputational damage.

4. Definitions

4.1. A list and explanation of the terms used in this policy is set out in Appendix A. This includes the definition of an actual, potential, and material conflict of interest.

5. Purpose and Scope

5.1. This policy will help staff to manage conflicts of interest risks effectively. It:

5.1.1. sets out consistent principles and rules;

5.1.2. gives guidance about how to approach and manage interests; and

5.1.3. provides simple advice about what to do in common situations.

5.2. The policy cannot cover or anticipate all situations or circumstances that might arise, staff are therefore asked to think about the principles in this policy and take a common-sense approach; ask yourself if your approach might compromise your own or EKHUFT's reputation.

5.3. This policy covers all individuals on differing employment terms and/or terms of engagement and will be referred to as 'staff' or 'you' throughout the policy and are listed below. Whilst the term staff will be used for the purpose of this policy this does not always imply/infer a contractual relationship.

- All salaried employees whether full time or part time, permanent or temporary
- Individuals employed via an honorary contract
- All prospective employees who are part way through recruitment.
- Bank and agency workers, and individuals employed via a personal services or company contract
- Contractors and sub-contractors
- Non-executive directors
- Volunteers
- Committee or sub-committee and advisory group members (who may not be directly employed or engaged by EKHUFT).

5.4. This policy is particularly applicable to staff who have a decision-making influence – staff who can authorise expenditure and/or exercise discretion in the area of patient care – hereafter referred to as 'decision-making staff'. All decision-making staff are required to make an annual declaration even if they have no interests to declare. At EKHUFT this group includes:

- Executive and non-executive directors;
- Clinical directors and divisional managers;
- Senior directors reporting to an executive director;
- Medical and dental consultants and speciality doctors;
- Those staff at Agenda for Change band 8d or above;
- Members of advisory groups or panels which contribute to direct or delegated decision making on the commissioning or provision of NHS or other taxpayer funded services;
- Clinical and administrative staff who are involved in the purchasing of goods, equipment, medicines, or medical devices and those who can make formulary decisions; and those who have the power to enter contracts on behalf of EKHUFT (these staff should be identified by name on an annual basis).

  This reference to clinical and administrative staff will include:

  - Heads of departments or services

- Members of the estates and facilities team
- Members of the strategy team
- Members of the finance teams
- Members of staff undertaking research
- Pharmacy staff
- Procurement and ICT procurement staff.

5.5. Staff must also follow the code of conduct of their relevant professional body where appropriate.

5.6. Relevant staff are required to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. See Disclosure UK/APBI website. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants, and benefits in kind provided to healthcare organisations

5.7. The granting of consent to disclosure as part of the above does not negate the requirement to declare these payments in accordance with this policy.

6. Duties

6.1. **The EKHUFT Board of Directors** has a responsibility to ensure that conflicts of interest in business matters are avoided, and that there is a mechanism in place for recognising, reporting, and dealing with potential conflicts for corporate decisions.

6.2. **The Chief Executive** has responsibility for ensuring that EKHUFT meets all duties in relation to this policy

6.3. **Director of Corporate Governance** has delegated responsibility from the Chief Executive for ensuring that:

6.3.1. This policy is reviewed/updated when necessary

6.3.2. A register of interests is maintained and published in accordance with this policy

6.3.3. Mechanisms are in place for any breaches of the policy to be appropriately investigated/ reviewed:

6.3.4. Interests published in the register are reviewed

6.3.5. Any conflicts are being managed appropriately and any concerns are raised with the relevant manager and escalated to a senior director or the Chief Executive if necessary

6.3.6. A process for the regular monitoring of this policy

6.3.7. The policy is appropriately disseminated to staff and persons associated with EKHUFT.

6.4. **Directors, line managers, and heads of department** are responsible for:

6.4.1. Ensuring that staff within their own directorates/departments have read and understand this policy and are competent to carry out their duties in accordance with the procedures described.

6.4.2. Reporting any findings of conflict of interest or ethical misconduct in business dealings to their relevant Executive Director or to the Chief Executive or to the Trust Chair or to the Director of Corporate Governance for advice and/or action

6.5. **All staff:**

6.5.1. It is the responsibility of all staff to ensure there are no actual or perceived conflicts of interest between their interests and their EKHUFT duties.

6.5.2. All staff

6.5.2.1. Should familiarise themselves with the rules set out in this policy.

6.5.2.2. Must ensure that they do not abuse their official position for personal benefit or for the benefit of any associate of theirs.

6.5.2.3. Make their line manager or any other staff they work with or to aware of any material conflicts of interest they have.

6.5.3. If staff have concerns regarding a conflict of interest or other ethical misconduct in respect of themselves or a colleague, they should raise it first with their line manager. If they feel it is not adequately dealt with, they should raise it with the Director of Corporate Governance or raise it as an issue using the EKHUFT raising concerns policy.

6.5.4. If there is a suspicion or allegation of bribery or fraud, staff should use the processes set out in the EKHUFT anti-fraud and bribery policy and contact the Local Counter Fraud Specialists (LCFS) on: 020 3201 8000 or email natalie.nelson@rsmuk.com or contact NHS Counter Fraud Authority on 0800 028 40 60.

7. Identification, Declaration and Review of Interests

7.1. **What is an Interest?**

Interests fall into the following categories:

7.1.1. **Financial Interests:** Where you may get direct financial benefit* from the consequences of a decision you are involved in making or because of your position in the organisation.

**This may be a financial gain, or avoidance of a loss.*

This could include where you are:

- A board director, or senior employee, in another organisation which is doing, or is likely to do business with an organisation receiving NHS funding.
- A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS finding.
- Someone in receipt of a grant or other payments such as honoraria.
- Someone in outside employment or in receipt of a secondary income.
- Someone in receipt of sponsored research.

7.1.2. **Non-financial professional interests**: Where you may obtain a non-financial professional benefit from the consequences of a decision you are involved in making, such as increasing your professional reputation or promoting your professional career.

This could include where you are:

- An advocate for a particular group of patients.
- A clinician with a special interest.
- An advisor for a national body for example the National Institute of Health Care Excellence.
- Someone in a research role.

7.1.3. **Non-financial personal interests:** Where you may benefit personally in ways which are not directly linked to your professional career and do not give rise to a direct financial benefit, because of decisions you are involved in making in your professional career.

This could include where you are:

- A member of a voluntary sector board or a position of authority within a voluntary sector organisation.
- A member of a pressure group or equivalent with an interest in healthcare.

7.1.4. **Indirect interests**: Where you have a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making. This could include your close relatives, close friends and associates and business partners but could extend beyond to acquaintances with whom you have significant contact.

7.2. EKHUFT needs to be aware of all cases where staff, or their close relatives or a close associate, has a **material** interest.

7.3. Staff may also hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be as damaging as an actual conflict of interest. All interests should be declared where there is a risk of **perceived improper conduct.**

7.4. **The responsibility for identifying and declaring actual, potential, or perceived conflicts of Interest rests with the individual.** All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If you are in any doubt as to whether an interest is material **you should declare it**, so that it can be considered.

7.5. Material interests should be declared:

- On starting employment/on appointment with EKHUFT and at least annually for decision making staff, thereafter
- At the beginning of a new project/piece of work/tender panel
- When you move to a new role, or your responsibilities change significantly
- As soon as circumstances change, and new interests arise
- In any meeting where interests you hold are relevant to the matters under discussion.

7.6. Interests should be declared using Self Service ESR. Information on how to access this can be found via the following link: https://video.ekhuft.nhs.uk/cumulusclips/members/ESRSelfService/

7.7. Individuals are required to keep their own records up to date.

7.8. **Review of Interests**

7.8.1. Decision making staff will receive regular e-mail notifications reminding them to make a declaration and/or update the interests they have declared/declare any new interests that have arisen since they last made a declaration. Decision making staff, even if they have no interests to declare, must still make a declaration confirming this at least once a year. This is called a NIL return.

7.9. Failing to declare interests or make an annual NIL return (as required) could result in disciplinary action.

8. Records and Publication

8.1. All declarations will be recorded on the EKHUFT Register of Interests and once they have been reviewed by the line manager, any material interests will be published on the EKHUFT website.

8.2. Line managers should keep a record of any action taken to manage any perceived/potential/actual risks associated with any interests declared by their staff.

NOTE: If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should talk to their line manager who should contact the Director of Corporate Governance to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception.

Information will not be withheld or redacted merely because of a personal preference.

8.3. After expiry, an interest will remain on the published register for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

8.4. Under the Trust's standard contract, the Trust is required to publish on its website the name and position of any decision-making staff who have neither completed a declaration of interest nor submitted a nil return in respect of that contract year.

9. Implementing the Policy

9.1. **Management of Interests – General approach**

9.1.1. If an interest is declared but there is no risk of a conflict arising, then no action is warranted.

9.1.2. If a material interest is declared or a perceived/potential conflict is identified, then staff should seek advice from their line manager and/or the Director of Corporate Governance to discuss how that conflict might be resolved. Options may include:

- Reorganising the individual's responsibilities or changing their line management;
- Removing the individual from the decision-making process, for example in a tender exercise or interview process;
- Restricting the individual's access to information;
- Agreeing with the individual that they give up the interest;
- Agreeing to keep a potential conflict under review in case it becomes an actual conflict.

9.1.3. Each case will be different and context specific, and EKHUFT will always clarify the circumstances and issues with the individuals involved.

9.1.4. Line managers should consider what actions are necessary to mitigate against a conflict and may seek advice about this from the Director of Corporate Governance.

9.1.5. If the member of staff is not happy with the resolution proposed to manage a conflict, they should raise it with the relevant Executive Director and Chief People Officer.

10. Management of Interests - Common Situations

10.1. This section sets out the principles and rules to be followed in common situations, and what staff should declare. See Appendix B for summary of common situations.

10.2. Staff should be aware that the offer of a gift or hospitality may constitute a bribe, and this should be considered in all circumstances to protect staff and the Trust from criminal prosecution. Where there is a suspicion that any offer may have a corrupt intention i.e. may constitute a bribe, it must be declined, declared, and reported to the EKHUFT Local Counter Fraud Specialist.

10.3. **Dealing with Gifts**

10.3.1. Staff should not ask for gifts, or accept gifts or rewards that may affect, or be seen to affect, their professional judgement or if acceptance of a gift could affect or be perceived to affect the outcome of a business transaction. Staff should always ask themselves if a gift is excessive, or if it could it be construed as being able to influence a decision or cast doubt on the integrity of a decision.

10.3.2. It is better to declare an offer of a gift if you are not sure whether you are required to do so. If you are unsure about the appropriateness of the gift being offered, it should be declined and declared.

10.3.3. Gifts of cash or cash equivalent e.g. gift cards, lottery tickets, and personal cheques, whatever the value must always be declined and declared. However, if the donor is particularly insistent, they can be referred to the EKH Charity – information about ways to give is available on the EKH Charity public website: https://www.ekhcharity.org.uk/

10.3.4. The offer of a trade or discount loyalty card from any company/organisation doing business with or seeking to do business with EKHUFT are classified as gifts and must be declined and declared. Staff may only take advantage of discounts which have been formally negotiated by EKHUFT. A list of these can be found on the Staff benefits and discounts page on the staff intranet.

10.3.5. A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

10.4. Gifts from Patients, families etc

10.4.1. Gifts from a patient as a legitimate expression of gratitude should be dealt with as follows:

- Gifts of cash and vouchers to individuals must always be declined (and declared).
- Staff must not ask for any gifts.
- Gifts up to the value of £50 may be accepted and need not be declared.
- Gifts over £50 should be declined and declared.
- A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value)
- Multiple gifts from the same source received over a 12-month period, should be treated in the same way as a single gift over £50, where the cumulative value exceeds £50, and each gift declared once the limit has been exceeded.

10.5. Gifts from Actual and Potential Suppliers

- Gifts from suppliers or contractors doing business or likely to do business, with EKHUFT should be declined and declared whatever the value.
- Low cost branded promotional aids such as pens or calendars may, however, be accepted where they are under the value of £61 and need not be declared, although staff should consider if the acceptance can be justified.

[1] APBI code of practice

10.6. **Gifts - What staff should declare?**

- Their name and role within EKHUFT.
- A description of the nature and value of the gift, including its source and circumstances surrounding the offer.
- Details of previous gifts offered by same source where value of each gift fell below
- £50 and so were not declared at the time.
- Date of offer and receipt.
- Whether gift was accepted or declined and reasons
- Any other relevant information e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy.

10.7. **Dealing with Hospitality**

10.7.1. Staff should not ask for, or accept hospitality that may affect, or be seen to affect, their professional judgement or if acceptance of the hospitality offered could affect or be perceived to affect the outcome of a business transaction. The offer of hospitality where there is a suspicion that the offer may have a corrupt intention i.e., may constitute a bribe, must be declined, and declared and reported to the EKHUFT Local Counter Fraud Specialist.

10.7.2. Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the occasion, nature, and purpose of the event.

10.7.3. Staff should ask themselves if the offer of hospitality is excessive, if the frequency can be justified, or if the offer could it be construed as being able to influence a decision or cast doubt on the integrity of a decision. In any event the hospitality should be similar to the scale of hospitality that EKHUFT, as the employer, would be likely to offer or the member of staff would be prepared to pay for themselves. If in doubt, contact your line manager or the Director of Corporate Governance.

10.7.4. Caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and **must be declared**, if modest and reasonable.

10.7.5. Senior approval must be obtained prior to acceptance.

10.7.6. Staff should be particularly cautious about accepting hospitality during a procurement exercise; any hospitality accepted **must be declared** and must be approved by the appropriate executive director prior to acceptance.

10.7.7. Invitations to sporting and entertainment events, tickets for non-work-related meals or events, holidays (including accommodation) and free first-class travel (rail or air fare) must always be **declined and declared**.

10.7.8. It is better to declare an offer of hospitality if you are not sure whether you are required to do so or whenever the hospitality could affect or be perceived to affect the outcome of a business transaction.

10.8. **Hospitality includes:**

10.8.1. Meals and Refreshments

10.8.1.1. Hospitality up to the value of £25 may be accepted and need not be declared.

10.8.1.2. Where hospitality between £25 and £75 is accepted this must always be declared.

10.8.1.3. Hospitality over a value of £75 should be declined and declared unless (in exceptional circumstances) senior approval is given. A clear reason why permission to accept has been given should be recorded on the Register.

10.8.1.4. A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

10.8.1.5. Staff should not accept repeated hospitality from the same source.

10.8.2. Travel and Accommodation

10.8.2.1. Modest offers to pay some or all the travel and accommodation costs related to attendance at events may be accepted and must be declared.

10.8.2.2. Offers which go beyond modest or are of a type that EKHUFT itself might not usually offer, need approval by an executive director, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Register as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:

- business class travel and accommodation (including domestic travel)
- offers of foreign travel and accommodation

10.9. **Hospitality - What staff should declare?**

- Their name and role within EKHUFT.
- The nature and value of the hospitality including the circumstances surrounding the offer.
- Hospitality accepted from the same source received over a 12-month period, should be treated in the same way as a single acceptance of hospitality over £75, where the cumulative value exceeds £75 and declared.
- Date of receipt.
- Whether the offer was accepted or declined and reasons
- Any other relevant information e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy.

10.10. **Outside Employment**

10.10.1. Staff should declare any existing outside employment on appointment and any new outside employment when it arises, this includes speaking at conferences and lectures for which a fee is paid directly to them, even if they donate this fee to charity.

10.10.2. Where a risk of conflict of interest arises, the general approach outlined in section 10.1 should be considered and applied to mitigate any risks.

10.10.3. If a member of EKHUFT staff is engaged in or wishes to engage in outside employment, even if their contract of employment or terms and conditions of engagement permit this, they must still seek prior approval from their line manager. This is to ensure EKHUFT is satisfied there are no conflicts of interest or health and safety issues for the member of staff and that this work will not adversely affect their EKHUFT employment. Such permission will not unreasonably be refused.

10.10.4. The line manager should record the decision, by email or more formally in a letter, and place a copy of the recorded decision on the individual's personal file. The Director of Corporate Governance must also be sent a copy of the decision made.

10.10.5. Examples of work which might give rise to a conflict include:

- Employment with another NHS Body
- Employment with another organisation that supplies goods to EKHUFT
- Self-employment
- Undertaking private practice not related to clinical practice e.g. participating in surveys and focus groups. If the organisation carrying out the survey or focus group is a supplier or contractor doing business (or likely to do business) with EKHUFT then the offer of payment should be declined.

10.10.6. EKHUFT may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

10.10.7. For the avoidance of doubt staff are reminded that they:

- Are not permitted to undertake work elsewhere whilst on sick leave from EKHUFT
- Cannot engage in private work or work for an additional employer during hours when they are employed to work by EKHUFT

10.10.8. Any individual suspected of either of the above may be referred to our Counter Fraud Service for further investigation; this could end in dismissal or possible prosecution. Please refer to the Anti-Fraud & Bribery Policy and Disciplinary Procedure for further detail.

10.11. **Outside Employment - What should be declared?**

- Staff name and role within EKHUFT.

- The nature of the outside employment e.g. who it is with, a description of duties, time commitment.
- Relevant dates.
- Other relevant information e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy.

10.12. **Shareholding and other ownership issues**

10.12.1. Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership, or consultancy which is doing, or might be reasonably expected to do, business with EKHUFT.

10.12.2. Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general approach outlined in section 10.1 should be considered and applied to mitigate any risks.

10.12.3. There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

10.13. **Shareholding and other ownership issues - What staff should declare?**

- Their name and their role within EKHUFT
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy.

10.14. **Patents**

10.14.1. Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by EKHUFT.

10.14.2. Staff should seek prior permission from EKHUFT before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on EKHUFT's own time, or uses its equipment, resources, or intellectual property and in addition, abide by the requirements of the EKHUFT Intellectual Property Rights Policy.

10.14.3. Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general approach outlined in section 10.1 should be considered and applied to mitigate any risks.

10.15. **Patents – What staff should declare?**

- Their name and role with EKHUFT.

- A description of the patent.
- Relevant dates.

10.16. **Loyalty Interests**

10.16.1. Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory, or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision-making forums that can influence how EKHUFT or other NHS organisations spend taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that EKHUFT does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.
- See Appendix A (Glossary of terms), for definition of 'close relative' and 'close associate.'

10.17. **Loyalty Interests – What staff should declare?**

- Their name and role with EKHUFT.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy.

10.18. **Donations**

10.18.1. Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted with prior line manager approval but must always be declared using Self Service (ESR). A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

10.18.2. Staff must not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

10.18.3. Staff must obtain permission from the organisation if, in their professional role, they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

10.18.4. Donations, when received, must be made to a specific charitable fund (never to an individual) and a receipt should be issued.

10.18.5. Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal

10.19. Sponsored Research

10.19.1. Funding sources for research purposes must be transparent.

10.19.2. Any proposed research must go through the relevant NHS Health Research Authority or other approvals process.

10.19.3. There must be a written protocol and written contract or agreement between staff and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

10.19.4. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy, or sell any medicine, medical device, equipment, or service.

10.19.5. Staff must declare involvement with sponsored research to the organisation via Self Service (ESR).

10.20. Sponsored Research - What should be declared?

10.20.1. Written records of sponsorship of research must be retained in line with the above principles and rules.

10.20.2. Staff should declare:

- Their name and role within EKHUFT.
- Nature of their involvement in the sponsored research.
- Relevant dates.
- Other relevant information e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy.

10.21. Sponsored Posts

10.21.1. External sponsorship of a post requires prior approval from Human Resources.

10.21.2. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

10.21.3. Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements

should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

10.21.4. Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

10.22. Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

10.23. **Sponsored Posts – What should be declared?**

- EKHUFT will retain written records of sponsorship of posts in line with the above principles and rules.
- Staff should declare any other interests arising because of their association with the sponsor, in line with the content in the rest of this policy.

10.24. **Clinical Private Practice**

10.24.1. Clinical staff must declare all private practice on appointment via Self Service (ESR), and/or any new private practice when it arises including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

10.24.2. Clinical staff must (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000 c56/Non-Divestment_Order_amended.pdf

10.24.3. Hospital consultants must not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf. Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11. Management of interests – advice in specific contexts

11.1. **Strategic Decision-Making Groups**

11.1.1. In common with other NHS bodies EKHUFT uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selecting medicines, equipment, and devices.

11.1.2. The interests of those who are involved in these groups should be well known so that they can be managed effectively. At EKHUFT these groups are:

- Board of Directors
- Council of Governors
- Procurement Strategy Group
- Procurement Assurance Group
- Care Group Procurement Boards
- Care Group Working Groups
- All Established Tender Panels
- Consultant Recruitment Panels
- Board Remuneration Committee
- Council Nomination & Remuneration Committee

11.1.3. These groups should adopt the following principles:

11.1.3.1. Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests.

11.1.3.2. Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.

11.1.3.3. Any new interests identified should be added to the relevant EKHUFT register(s).

11.1.3.4. The vice chair (or other non-conflicted member) should chair all or part of any meeting if the chair has an interest that may prejudice their judgement.

11.1.3.5. If a declaration is made during a meeting, then the individual concerned must remove themselves from the meeting when the Committee discusses topics that relate to the declared subject matter.

11.1.3.6. If a member has an actual or potential interest the committee chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.

- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

11.1.3.7. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

11.2. **Procurement**

11.2.1. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour – which is against the interest of patients and the public.

11.2.2. Those involved in procurement exercises for, and on behalf of, EKHUFT should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes.

11.2.3. For example members of any tender evaluation or assessment group or members of the final decision-making panel are responsible for declaring or re-declaring material interests at the beginning of the process and as they arise.

11.2.4. At every stage of procurement steps should be taken to identify and manage conflicts of interest to protect the integrity of the process.

11.2.5. If you are unsure of the process or for further advice about how to manage an effective and transparent procurement process staff should contact details of our procurement team are available for all procurement professionals though the EKHUFT website.

11.2.6. The Procurement Department operate fully transparent procurement processes and procedures for all contracting, tendering and quotations which are supported and underpinned by the Trust's Standing Financial Instructions and Scheme of Delegation. The Procurement to Payment Policy can be reviewed to find further information.

11.3. **Pro-Bono Work**

11.3.1. Any pro-bono work that is, any work undertaken voluntarily and without payment or at a reduced fee, which is completed by an organisation should not affect any future tender decisions.

11.3.2. When any pro-bono work is offered to EKHUFT, this should be subject to review and must be approved prior to commencement by the Chief Financial Officer.

11.4. **Pro-Bono Work – What should be declared?**

- EKHUFT will retain a written record of Pro-Bono Work in line with the above principles and rules.

11.5. **Awards and prizes**

11.5.1. If staff are approached by an outside organisation or individual about the offer of an award or prize which is in any way connected to their official duties, they must seek advice from the Director of Corporate Governance before accepting it.

11.5.2. Staff will normally be allowed to accept the award, subject to consideration of propriety or risk of public scrutiny, and provided the award is: offered in recognition of personal achievement and is not or cannot be construed as a gift or inducement or payment for a professional or personal advantage to which other rules apply. Acceptance need not be declared providing prior advice has been sought from the Director of Corporate Governance.

12. Dealing with Breaches

12.1. There will be situations when interests will not be identified, declared, or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. These situations are referred to as '**breaches'**.

12.2. Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Local Counter Fraud Specialist, the Freedom to Speak Up Guardian, the Chief People Officer, the Director of Corporate Governance, or their line manager depending on the level of confidentiality they require.

12.3. To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised refer to the EKHUFT raising concerns policy. Any concern raised will be dealt with sensitively and in confidence where necessary, appropriate, and explicitly requested.

12.4. EKHUFT will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances. Following investigation EKHUFT will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- If appropriate, refer the breach to the Declaration of Interests Oversight Group
- Take appropriate action as set out in the next section.

13. Taking action in response to breaches

13.1. Action taken in response to breaches of this policy will be in accordance with the EKHUFT disciplinary policy and procedures and could involve leads from the workforce directorate, Local Counter Fraud Specialists, the Trust's auditors, and/or members of the senior management or executive teams.

13.2. Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process, and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

13.3. Inappropriate or ineffective management of interests can have serious implications for EKHUFT and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

13.4. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrongdoing or fault then EKHUFT can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach.

13.5. This includes:

- Employment law action against staff, (both informal and formal action) as set out in the EKHUFT disciplinary and maintaining high professional standards policies.
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action (which could include civil and criminal sanctions), such as investigation and prosecution under fraud, bribery and corruption legislation as set out in the Anti Fraud and Bribery Policy.

14. Learning and transparency concerning breaches

14.1. Reports on breaches, the impact of these, and action taken will be considered by the Integrated Audit and Governance Committee at least annually.

14.2. In the interest of openness, anonymised information on breaches, the impact of these, and the lessons learnt, and action taken as a consequence will be published on the EKHUFT website.

15. Dissemination and training requirements

15.1. Staff should read and understand the guidelines laid out in this policy. The policy will be disseminated to staff through the operational line management structure and brought to their attention at induction.

15.2. There are no training requirements associated with the implementation of this policy. Ad hoc training sessions may be provided based on individual, and group needs. A quick reference guide will be available on the Declarations of Interests page on the staff intranet.

16. How the policy will be monitored

16.1. The table below sets out how EKHUFT will monitor the delivery of the policy. Additional work may be commissioned to meet organisational needs.

16.2. Where a lack of compliance is found the identified group, committee or individual will identify required actions, allocate responsible leads, and target completion dates. An assurance report will subsequently be presented to show how any gaps have been addressed.

What in the policy is going to be monitored	Monitoring method	Who will lead the monitoring?	How often?	Where will it be reported?
That the procedures setout in the policy have been followed includingthe completion of the register(s)	Audit	Director of Corporate Governance	Annually	Integrated Audit and Governance Committee
Breaches	Audit	Director of Corporate Governance	Quarterly	Integrated Audit and Governance Committee – through the regular reportsof the LCFS –where fraud isthe issue.
Breaches	Audit	Chief People Officer	Annually	Integrated Audit and Governance Committee –through the raising concerns annual review
Breaches	Audit	Director of Procurement	Annually	Audit Committee – through the regular reportsof the LCFS – where fraud isthe issue.
Training and awareness	Audit	Local Counter Fraud Specialist	Six-monthly	Audit Committee

17. Policy Development, Approval and Authorisation

17.1. This policy will be received by the Policy Authorisation Group prior to review and approval by the IAGC and Board of Directors.

18. Review and Revision Arrangements

18.1. The policy will be reviewed in three years' time unless an earlier review is required. This will be led by the Director of Corporate Governance.

19. Policy Implementation

19.1. Refer to Appendix D.

20. Document Control including Archiving Arrangements

20.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.

20.2. This policy will be uploaded to the Trust's policy management system.

20.3. Version 6 of this policy will be retained within the Trust's policy management system for future reference.

21. References

21.1. ABPI: The Code of Practice for the Pharmaceutical Industry (2021)

21.2. ABHI Code of Business Practice

21.3. Conduct and Capability Procedures for Medical and Dental staff

21.4. Department of Health Document 'Commercial Sponsorship – Ethical Standards for the NHS'

21.5. Freedom of Information Act 2000

21.6. NHS Code of Conduct and Accountability (July 2004)

21.7. Staff Terms and Conditions of Service

21.8. The Nolan Committee's Seven Principles of Public Life

21.9. NHS Employers: Managing Conflicts of Interest/Common situations

21.10. NHS Health Research Authority

22. Appendices

Appendix A – Glossary of Terms

Term	Explanation
Benefits in kind	Any type of benefit that an individual receives that has some implicit value
Bribery and corruption	Dishonest or unethical conduct in an official capacity including: ▪ To request, agree to receive, or accept (directly or through another party) a gift, financial or other advantage, as an inducement or reward for doing, or refraining from doing something ▪ or showing favour or disfavour to any person to gain a personal, commercial, or other advantage The scope of the Bribery Act 2010 extends to bribery taking place overseas, as well as conniving or turning a blind eye to bribery
Close association/close associate	A common-sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates including colleagues, and business partners but could extend beyond to acquaintances with whom you have significant contact.
Close relative: *for example*	Partner or spouse Parents (or parents of a partner or spouse) Children (or children of a partner or spouse)Siblings (and their partners) Grandparents (and their partners) Aunt or uncle (and their partners)
A Conflict of Interest	A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. A conflict of interest may be: ▪ **Actual** – there is a material conflict between one or more interests ▪ **Potential** – there is a possibility or a perception of a material conflict between one or more interests
Declaration of interest	A formal statement of any, or no, interests in other organisations
Donations	A charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive.
Fees	Money paid to staff for a service provided to the individual or organisation
Gifts	Gifts mean any item of cash, goods, or any service or a combination from a third party that is provided for personal benefit or at less than the commercial value.

Hospitality	Food, drink, accommodation, entertainment, travel, or attendance at an event as a corporate guest, for which no payment, or minimal payment is made by the recipient, or an offer to carry out work for the individual's benefit by potential or current suppliers
Intellectual property	Products of innovative and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images.
Interest	A claim, right, legal share, or participation in another organisation or involvement with another person that may have a business relationship with EKHUFT, or the wider NHS.
Legitimate business reason	In the course of the employee's official duties and responsibilities and has a benefit to the Trust
Material Interest	An interest that a reasonable person would consider when making a decision because the interest has relevance to that decision
Sponsorship	Funding (all or part costs) from an external source including funding of all or part costs of staff members, staff training, events, equipment or posts, pharmaceuticals, costs associated with meetings, such as hotel and transport costs including travel (UK and abroad) and provision of any free services such as speakers
Research sponsor	An individual, company, institution, organisation, or group of organisations that takes on responsibility for initiation, management, and financing (or arranging the financing) of the research.[2]

[2] Health Research Authority

Appendix B – Common Situations

Gifts

Staff should not accept gifts that may affect their professional judgement, and gifts of cash or vouchers offered to individuals should always be declined and declared.

Gifts valued at over £50 should only be accepted on behalf of an organisation (i.e. to an organisation's charitable funds).

Gifts from suppliers or contractors should routinely be declined and declared, except for low-cost branded promotional aids.

Hospitality

Meals and refreshments must only be accepted where there is a legitimate business reason, and the value falls below £75.

Particular caution should be exercised when the offer is from actual or potential suppliers whatever the value.

Offers of business class or first-class travel and accommodation need approval by senior staff and should only be accepted in exceptional circumstances.

Outside employment

The involvement of staff in outside roles (i.e. directorships, non-executive roles, self- employment, consultancy work, charitable trustee roles) brings a wealth of skills, knowledge, and experience but it's important that the existence of these is known to avoid conflicts of interest occurring.

Shareholding

Staff should declare any shareholdings or other ownership interests in any company that might reasonably be expected to do business with their employing organisation.

There is no need for staff to declare shares or securities held in pension funds.

Patents

Staff are encouraged to be innovative in their practice and the development and holding of patents is welcomed but needs to be appropriately managed.

Staff should declare patents and other intellectual property rights they hold and should seek prior permission before entering into any agreement with bodies regarding product development and research.

Loyalty interests

These are based on relationships (i.e. with another NHS organisation, charity, advisory group, family members, close friends, close business associates) and can often be hard to define.

The scope of loyalty interests is potentially huge, so sound judgement is required for making declarations.

Donations

Can be in the form of a direct cash payment or through the application of a will or similar directive.

Donations, when received, should be made to a specific charitable fund.

Donations from suppliers should be treated with caution/not routinely accepted and must always be declared.

Staff must obtain permission from their organisation if as part of their professional role they intend to undertake fundraising activities on behalf of a charitable campaign.

Sponsored research

Whilst sponsorship is vital in helping to meet the costs of running events, permit innovative research to take place, and provide extra capacity and capability by funding new roles, caution must be exercised to ensure there is no conflict of interest.

In all instances, sponsors should not have any undue influence, or access to information by which they could gain a commercial advantage.

Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new arrangements when they arise.

Hospital consultants are already required to provide their employer with this information by virtue of their terms and conditions of service.

Clinical staff should seek prior approval from their employer before taking up private practice and ensure that NHS commitments take precedence over private work.

Appendix C – Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis

Job title: Interim Director of Corporate Governance

Care Group/Department: Trust Management

Date completed: February 2024

Who will be impacted by this policy

[x] Staff (Trust)

[x] Staff (Other)

[ ] Clients

[ ] Carers

[ ] Patients

[ ] Relatives

Assess the impact of the policy on people with different protected characteristics

When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.

Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
Age	**None**	**None**
Disability	**None**	**None**
Gender reassignment	**None**	**None**
Marriage and civil partnership	**None**	**None**
Pregnancy and maternity	**None**	**None**
Race	**None**	**None**
Religion or belief	**None**	**None**
Sex	**None**	**None**
Sexual orientation	**None**	**None**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.

Has there been specific consultation on this policy?

The Local Counter Fraud Service will review the policy.

Did the consultation analysis reveal any difference in views across the protected characteristics?

Not applicable – no consultation analysis

Mitigating negative impact:

(Where any negative impact has been identified, outline the measures taken to mitigate against it.)

Not applicable – no negative impact identified

Conclusion:

It is believed that there is no discrimination through implementation of this policy.

Appendix D – Policy Implementation Plan

Policy Title: Gifts, Hospitality and Conflicts of Interest

Implementation Lead: Director of Corporate Governance

Staff Groups affected by policy: All

Subsidiary Companies affected by policy: None

Detail changes to current processes or practice:

- Updated to align with NHS England reporting guidance on band 8d & decision makers (previously 8a)

Specify any training requirements:

- None

How will policy changes be communicated to staff groups/ subsidiary companies?

- Trust News
- Notification of change to declarations on Self Service (ESR).
- Policy update section following approval by the Trust Board.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Board Assurance Report – People & Culture Committee (P&CC)**

Meeting date: **23 May 2024**

Board sponsor: **Chair, People and Culture Committee**

Paper Author: **Chair, People and Culture Committee**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	Report from the People & Culture Committee.
Summary of key issues:	**Equality, Diversity and Inclusion (EDI)** The Committee now has a greater focus on EDI and will discuss this at every meeting. The Head of EDI presented an update on the EDI strategy, highlighting areas of progress and areas of concern. The Committee noted that whilst there is a lot of work being done across the Trust to embed EDI, this is still very silo-ed, and significant development work remains. It is vital to ensure that every staff member feels EDI is their responsibility, and that managers ensure this is embedded within recruitment processes, staff support, and an improved understanding of reasonable adjustments available for staff with disabilities. The latest Workforce Race Equality Standard (WRES) data for the Trust shows that 7% of non-clinical and 31% of clinical staff are from Black, Asian, and Minority Ethnic (BAME) backgrounds (note that a significant percentage of staff have not completed this information). The staff survey highlighted significant gaps between the experiences of staff from White and BAME backgrounds, therefore this remains a key action area for the Trust. **Appraisals – partial assurance - 76% (target 80%)** The Committee received a detailed report on appraisal compliance. There is a renewed focus on this across the Trust. Appraisal compliancy is particularly low in Corporate and Strategic Development & Capital Planning Care Groups. These groups are 11% below the other Care Groups, who are close to, or at 80%, compliance. There are also large number of appraisals overdue in some key clinical areas e.g. maternity, radiology and theatres. The Chief Executive Officer (CEO) and Executives present committed to a renewed focus on these specific areas. The Committee noted that meeting appraisal completion targets was only the first step towards improved staff support, there would also need to be work done to ensure the quality of appraisals and ongoing

meaningful supervisions, training and development discussions, as part of the commitment to improving staff experience at the Trust.

Training compliance – assurance - 92.2% (target 91%)
The Committee received a detailed report on mandatory and statutory training compliance to ensure that the headline figure of overall compliance in the Integrated Performance Report (IPR) did not lead to false assurance over specific training areas. Good progress is being made, but areas of concern on hand hygiene and resus training due to the lack of trainers. The Chief Nursing & Midwifery Officer (CNMO) will review alternative approaches to training delivery to ensure compliance meets the target in both these areas in the next three months.

Staffing – partial assurance
Staff turnover remains below 10%, which is positive.

The Committee discussed specific staffing challenges, as detailed in the Significant Risk Register, as several of these risks had been present for some years. The Chief Medical Officer (CMO) reported good progress recently in consultant recruitment, and felt that there was beginning to be momentum about coming to East Kent. The link with the Medical School was helping with this. The CNMO reported that there were still challenges with recruitment of nursing and junior grades.

The recent Trust Pulse surveys showed a deterioration in staff engagement – at 5.7% this is at an historic low, and significantly below the target of 6.8%. The Committee reviewed the action being taken within the Trust as part of the Culture and Leadership programme. This includes establishing a Staff Council, listening events, a focus on values and behaviours, and more training for line managers.

Guardian of Safe Working update

The Committee received an update from the Guardian of Safe Working. The Guardian of Safe Working is responsible for ensuring safe working hours for doctors and dentists in training. In the period January-March 2024, 90 exception reports were submitted, mainly relating to working hours and rest periods. 44 were from Foundation Year 1 doctors, mainly in General Surgery in Queen Elizabeth the Queen Mother Hospital (QEQM). The report highlighted a number of issues including the availability of accurate data and the completeness of reporting from all doctors.

The Committee also discussed the ongoing issue with the work intensity and training environment for the foundation doctors in Urology and Vascular. The relocation of Kent & Medway Vascular Services to a single unit at Kent & Canterbury Hospital (K&C) in April 2024 exacerbated the issues. The increased number of vascular referrals and patients has not been supported with an increase in junior doctors.

The Committee requested an update on these issues in four months.

East Kent Hospitals University NHS Foundation Trust

	Accommodation strategy – not assured The Committee reviewed a presentation highlighting the concerns around accommodation provided by the Trust for some staff and students. The accommodation was often very old and in poor repair, and had suffered from a lack of funding for several years, as the limited Trust capital funding available had prioritised clinical delivery and patient care. The Committee requested an action plan to address what could be mitigated in the short term, and for clarity over compliance with relevant legislation. The Committee discussed the need for an accommodation strategy as soon as possible, to mitigate remaining risks with existing accommodation or to look at alternatives. There will be an ongoing need for accommodation for Trust staff and students, and this needs to be planned and funded.
Key recommendations:	The Board of Directors is asked to **NOTE** the report from the People and Culture Committee.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	No
Legal and regulatory:	No
Subsidiary:	No

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Voice and Involvement Annual Report 2023-24**

Meeting date: **6 June 2024**

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

Paper Authors: **Associate Director of Patient Experience and Lead for Patient Voice and Involvement**

Appendices:

Appendix 1: Patient Voice and Involvement Annual Report 2023-24

Executive summary:

Action required:	Information
Purpose of the Report:	The Patient Voice and Involvement annual report provides an overview of how the Trust has implemented the Patient Voice and Involvement Strategy over the previous 12 months, through the work and support of the Patient Voice and Involvement team.
Summary of key issues:	The Patient Voice and Involvement team are tasked with delivery of the Trust's Patient Voice and Involvement Strategy published in March 2022. This was a new approach for the Trust and the first time that there had been a dedicated team to support patient, family, and community involvement and to improve how the Trust learns from patient feedback and uses it to drive improvement. In the reporting period (April 2023 to March 2024), the Patient Voice and Involvement Team has gathered and / or analysed over 40,000 pieces of patient feedback: • **A third of all written Friends and Family Test (FFT) responses received by the Trust were themed by our team** (13140 since June 2023, averaging 1314 a month; the total themed across the Trust in this period was 41645. • We have been co-producing patient feedback surveys with several clinical and operational teams within the Trust, with an average of 12 surveys running concurrently at any given time and have had **1225** patient/carer/family responses to these. • The team has responded to **204** Care Opinion posts and progressed with colleagues, averaging 17 a month. We have also received a similar amount of monthly feedback from Healthwatch Kent. • The team has been actively reaching out to stakeholder organisations, individual patients and community groups as well as receiving contact from patients via our contact

	points (telephone and email). Some of this provides specific or anecdotal feedback we can use and sometimes it is more of a developmental conversation to encourage continued collaborative working; **over 3000 people and stakeholder groups have been worked with across our communities**. Our Patient Participation and Action Group (PPAG) now has 21 members, and we continue to recruit passionate people with lived experience to work with us on a more formal basis. The group still needs to grow in diversity, but the PPAG can respond to ad-hoc requests for their input on the wording of patient information and letter templates, as well as more involved strategic work like the Patient Portal, the annual Quality Account and upcoming 15 Steps pilot and Cancer forums. The team carries out on-going community engagement to gather feedback from a range of local communities, especially those who do not normally get their voices heard. Most of the feedback that we hear across all channels is positive, ranging from around 60% in individual interactions to over 90% in the FFT data we review. It is important to emphasise this at every interaction with internal and external stakeholders and our team is fostering a culture of celebrating success as a priority alongside learning from more concerning feedback. The key themes we have heard less positive feedback on are: • Care Given by Staff • Quality of Treatment • Staff Attitude • Communication & Information • Waiting Times: On-site and for follow-up treatment Responding to feedback from patients on communication and information we have: • Changed the guidance on Staff zone for staff leaving answer machine messages for patients to improve communication. • Produced new wording for AD detail reminders for staff that will make us more accessible to patients and colleagues. • Improved the wording on outpatient letter templates to reduce Did Not Attend rates and improve patient experience • Gathered correct numbers for IT rolodex, Directing translation requests We have looked at how we can better support carers of our patients and involve them as expert partners in care. This includes providing information for staff to raise their awareness about the importance of recognising and involving carers / families, developing a Carers policy, and developing a carers leaflet that will be launched in the summer.

	We receive a significant amount of positive feedback in the community for both our approach and the Trust's commitment to hearing the voices of patients, their families and for working with them. On several occasions, a patient who was considering making a complaint has instead worked with us collaboratively to feel heard and see their issues resolved, feeding into our more strategic work as a team.
Key recommendations:	The Board of Directors is asked to **NOTE** progress in delivering the Patient Voice and Involvement Strategy.

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships
Link to the Trust Risk Register:	**CRR 118**: There is a risk that the underlying organisational culture impacts on improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours. **CRR 159**: Detriment to patients with a disability as we are non-compliant with the statutory Accessible Information Standard.
Resource:	N
Legal and regulatory:	The Trust must comply with the Care Quality Commission Regulations. The Equality Act 2010 and the public sector equality duty under the Act require NHS organisations to demonstrate due regard to people with protected characteristics in the provision of healthcare. The NHS Health Inequalities Leadership Framework Board Assurance Tool supports NHS Trust Boards to deliver exceptional healthcare quality for all through equitable access, excellent experience and optimal outcomes.
Subsidiary:	N

Assurance route:

Patient Experience Committee - 23 May 2024 and Quality and Safety Committee - 28 May 2024.

NHS
East Kent
Hospitals University
NHS Foundation Trust

PATIENT VOICE AND INVOLVEMENT ANNUAL REPORT 2023-24

1. Introduction

1.1 The Patient Voice and Involvement (PV&I) team are tasked with delivery of the Trust's Patient Voice and Involvement Strategy published in March 2022. This was a new approach for the Trust and the first time that there had been a dedicated team to support patient, family and community involvement and to improve how the Trust learns from patient feedback and uses it to drive improvement. Previously, some public engagement had been supported by the Communications team and Head of Volunteering and public services. However, the Trust had found it challenging to embed patient and public involvement without a resource to support this. Consequently, the Trust had fallen behind other trusts in Kent and Medway and nationally.

1.2 The Patient Voice and Involvement team is now well established. The team consists of the Lead for Patient Voice and Involvement, three Patient Involvement Officers, each based at one of the three main sites, a Patient Feedback Co-ordinator, and a Clinical Patient Information Leaflet Co-ordinator. The team is one of three teams that sit under the Head of Patient Voice and Involvement. The other teams are Volunteering and Public Services and Chaplaincy. All three teams are part of the Corporate Nursing Directorate. This supports closer working with nursing leaders across the Trust and is helping to make improvements in areas where we have found in hard to embed improvements, for example, the Accessible Information Standard (AIS).

2. Inputs

2.1 In the reporting period (April 2023 to March 2024), the Patient Voice and Involvement Team has gathered and / or analysed over 40,000 pieces of patient feedback:

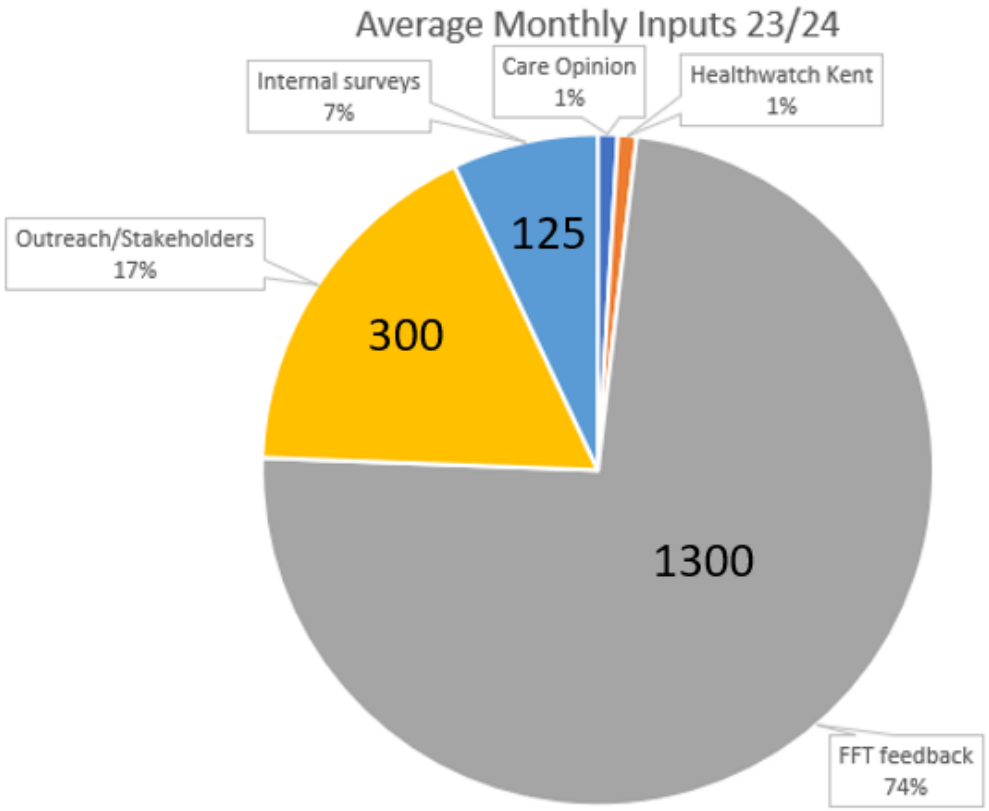
- **A third of all written Friends and Family Test (FFT) responses received by the Trust were themed by our team** (13140 since June 2023, averaging 1314 a month; the total themed across the Trust in this period was 41645.

- We have been co-producing patient feedback surveys with several clinical and operational teams within the Trust, with an average of 12 surveys running concurrently at any given time and have had **1225** patient/carer/family responses to these.

- The team has responded to**204** Care Opinion posts and progressed with colleagues, averaging 17 a month. We have also received a similar amount of monthly feedback from Healthwatch Kent.

- The team has been actively reaching out to stakeholder organisations, individual patients and community groups as well as receiving contact from patients via our contact points (telephone and email). Some of this provides specific or anecdotal feedback we can use and sometimes it is more of a developmental conversation to encourage continued collaborative working; **over 3000 people and stakeholder groups have been worked with across our communities**. This work is detailed in the next section.

Figure 1: Chart showing average monthly inputs (insights into patient, family, and community experience)



3. Engagement

3.1 Internal Engagement:
We regularly conduct training around engagement ('Seeing the Person'), Equality and Diversity and Health Inequalities with staff ranging from Health Care Support Workers to Junior Doctors. In 2024 we also started attending the New Staff Induction and Leadership Programme for Staff from Ethnic Backgrounds marketplace events. We attend team meetings and study days across the Care Groups to listen to ideas and pass on feedback. This has led to a cultural shift in how colleagues collaborate with what is still a new team in many colleagues' eyes. We have supported interview panels for many roles up to Board level, the Well Led Inspections and the last two rounds of Ward Accreditation visits.

3.2 Projects that have developed from this work include: Theatre feedback gathering, Patient Advice and Liaison Service (PALS)/Complaints letter wording, Did Not Attend (DNA) feedback work with Outpatients, Freedom to Speak Up data triangulation, Well Led Inspections, Ward Accreditations, and the Equality Delivery System (EDS).

3.3 Community Engagement:
We have attended meetings with community groups across East Kent, working with them to encourage service users to share feedback. These include Diabetes UK, Mental Health Together, Herne Bay and Canterbury Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual (LGBTQIA) groups, Canterbury Christ Church University, Demelza Hospice, Pilgrim's Hospice, Thanet Children's Centres, Thanington Community Centre, Adults Without Children, Age UK, Ethnic

Minorities in Canterbury, Deaf Together (Ashford and Margate groups), Social Enterprise Kent Community Forums, Speak Up CIC, and Take Off CIC.

3.3 Healthwatch Kent developed a Stakeholder Engagement Initiative that we supported in all three main hospitals that led to useful feedback for our Outpatients colleagues. We are also on the East Kent Virtual Wards working group to ensure we can report patient feedback on this new service.

3.4 We have met one-to one with over 60 patients and community members to hear their feedback about the Trust's services. These meetings happen in environments that people are comfortable in and often take a few hours or multiple sessions to effectively gain trust and get a clear idea of their entire experience and often involve a significant amount of restorative justice. We always offer people the choice of talking to a male or female team member and often speak to them outside of office hours to meet their needs, which has been well-received.

3.5 Our focus in all community work is to investigate the causes and impacts of health inequalities and we have been able to gather feedback about many people with protected characteristics and health inclusion groups' experiences in our care, as outlined in the Outcomes section.

4. Patient Participation Action Group (PPAG)

4.1 Our PPAG now has 21 members, and we continue to recruit passionate people with lived experience to work with us on a more formal basis. The group still needs to grow in diversity, but the PPAG can respond to ad-hoc requests for their input on the wording of patient information and letter templates, as well as more involved strategic work like the Patient Portal, the annual Quality Account and upcoming 15 Steps pilot and Cancer forums.

4.2 The PPAG meets every two months and is co-chaired by a Participation Partner. Six Participation Partners now sit on the Patient Experience Committee, a sub-committee of the Quality and Safety Committee.

5. A snapshot of the last quarter

5.1 The team carries out on-going community engagement to gather feedback from a range of local communities, especially those who do not normally get their voices heard. In the last quarter of 2023-24, we completed proactive community-based outreach with the Folkestone Nepalese Centre (focussing on the cancer patient pathway and the support that Armed Forces veterans can access), Speak Up CIC (mental health), Mental Health Matters and a Thanet District Council meeting (to review the impact of the Safe Haven at Queen Elizabeth the Queen Mother Hospital (QEQM's) opening on our Emergency Department (ED) and wider issues at the Young People's User Voice Local Mental Health Network), the Ashford, Hythe, Lyminge, Romney Marsh, Dover, Deal and Folkestone Integrated Care Board (ICB) Marketplace event at Ashford Age UK, The Cancer Alliance and a number of parenting groups.

5.2 We attended two Ward Accreditation days at William Harvey Hospital (WHH), hosted a staff and patient pop-up at QEQM, had a marketplace stall at the EKHUFT Leadership Programme Celebration Event and themed thousands of Friends and Family Test data to better share patient feedback with our colleagues.

5.3 We also supported our colleagues in IT by accompanying them to a Deaf Together group in Ashford and worked on the Delegated Authority and Chatbot elements of the new Patient Portal, liaised with ED colleagues and EK360 (the CIC which delivers Healthwatch) to collect feedback about our Enhanced Care offer at QEQM and met

with the Care Quality Commission (CQC) to develop the 2024 Children and Young People Survey.

5.4 Continuing much of the above work, we also began setting up Cancer Patient Participation Groups, developed our relationship with Canterbury Christ Church University to ensure the Patient Voice features heavily in the curriculum of all their students, attended Woodchurch Patient Participation Group for patient feedback, joined Social Enterprise Kent at the launch of their new offices and had Right Care, Right Person training with Kent Police and Community Sector colleagues.

5.5 The IT Team collaborated with us to review the delegated authority of the Patient Portal and develop their Chatbot, we met with EKHUFT teams and wider system colleagues to develop a Communication Passport, finalised the results of an Endoscopy Pre-Screening Survey to influence the team's planning and welcomed an Intern from East Kent College to the team.

5.6 In March we have continued our work on Enhanced Care, held two training sessions with Junior Doctors, liaised with the Royal British Legion to improve the care delivered to a patient, attended a Canterbury City Council community event in Thanington, and held a staff and patient pop-up at Kent & Canterbury Hospital (K&C). We will soon be meeting to secure the Trust's Veteran Aware accreditation, joining a Team Meeting with Head and Neck Speech Therapy and with the new GynaeOncology Family History and Genetics team to embed Patient Voice in their workstreams.

6. Key Themes Arising from Engagement with Patients, Cares, Families and Stakeholder Groups

6.1 The majority of feedback that we hear across all channels is positive, ranging from around 60% in individual interactions to over 90% in the FFT data we review. It is important to emphasise this at every interaction with internal and external stakeholders and our team is fostering a culture of celebrating success as a priority alongside learning from more concerning feedback.

6.2 The key themes we have heard less positive feedback on are:

- Care Given by Staff
- Quality of Treatment
- Staff Attitude
- Communication & Information
- Waiting Times: On-site and for follow-up treatment

Other recurring themes of less positive feedback are relationships between staff at EKHUFT and with external organisations, lack of joined up approach between acute and primary care, effective diagnostics and system flags, and support for families and carers.

7. Actions and Outcomes in 2023-24

7.1 We are seeing PV&I team's reputation in the Trust and relationships with colleagues improve month on month and as a consequence collaboration in the Trust is growing. Linking back to the key themes of feedback, we have completed the following pieces of work with Trust colleagues:

- Advised on the Terms of Reference for the Reading the Signals Oversight Group and attended the meeting to support people attending the meeting. This resulted in us co-producing two Community Family Voices sessions in local community centres for patients to attend and a significant number of one-to-one meetings with people affected by the Reading the Signals report.

Subsequently we supported the Patient Experience Midwives in community engagement opportunities, joined the East Kent Maternity and Neonatal Partnership and Trust representatives and we continue to focus on the experience of birth partners when we are engaging in the community. This work is fed back to colleagues in Maternity (Care Given by Staff/Quality of Treatment/Staff Attitude).

- Co-created the FFT theming Patient Tracking List (PTL), which provided themes to use in the process, including the 12 fundamentals of care, and developed training sessions for staff at Care Group and operational level that we are now rolling out to increase the impact of FFT data on a Trust-wide level (Care Given by Staff/Quality of Treatment/Staff Attitude).

- We co-produced a Supporting Gender Diverse Patients policy with members of the Transgender and LGBQIA+ community (Care Given by Staff/Quality of Treatment/Staff Attitude).

- Brought IT colleagues to community groups for them to trial the Patient Portal and our PPAG has a working group to support the development of this critical new way for patients to access their care (Communication & Information).

- The team led a Trust-wide review of the content and tone of patient letters that went live in March 2024 (Communication & Information).

7.2 Responding to feedback from patients, we have:

- Changed the guidance on Staff zone for staff leaving answer machine messages for patients to improve communication.
- Produced new wording for AD detail reminders for staff that will make us more accessible to patients and colleagues.
- Improved the wording on outpatient letter templates to reduce Did Not Attend rates and improve patient experience.
- Gathered correct numbers for IT rolodex, Directing translation requests (Communication & Information/Wait Times).

7.3 We receive a significant amount of positive feedback in the community for both our approach and the Trust's commitment to hearing the voices of patients, their families and for working with them. On several occasions, a patient who was considering making a complaint has instead worked with us collaboratively to feel heard and see their issues resolved, feeding into our more strategic work as a team.

7.4 We took four patient / carer / family stories to the Board in 2023-24. These provide an opportunity for the Board to hear directly from a patient, family member or carer. There is an opportunity for the services involved and the Trust to set out learning and actions related to the issues raised. Board members can ask questions and give an apology in person on behalf of the Trust and receive assurance of actions being taken.

7.5 In April 2023 the story related to a daughter whose mother attended the ED. There was a delay in identifying sepsis and the patient experienced failures in care and there was avoidable harm. The September story related to the experiences of Deaf people who use British Sign Language, a film was shown of a patient's story, voiced over, and signed by an actor. The barriers experienced by Deaf people lead to poor experiences of care and poor outcomes. The Deaf community's feedback has informed the improvements we've made to Interpreting and translation services and patient information.

7.6 The patient story in November 2023 was a patient's experience in the ED as someone with enduring mental health issues. The lack of holistic care and the challenges to providing a safe and therapeutic environment and ensure people get access to vital medication whilst in our care, were all highlighted. The February 2024 story was the carer of an older patient who was blind and nearing end of life. The carer was not listened to, the patient's needs related to communication and reasonable adjustments were not met, the patient's nutrition and hydration needs were not properly met, and the carer felt that unnecessary diagnostic tests were undertaken the day before her friend died.

7.7 We recently began hosting a student intern from the Bright Futures programme at East Kent College who is supporting our FFT theming work and is also representing the voice of young neurodiverse people in our team.

8. Case studies

8.1 Case Study 1: Stroke Discharge:

We heard from a number of patients about their experience being discharged having been treated after a stroke. Some was positive and some was less so and there was a lack of standardised experience for people.

8.2 After completing investigative work with Kent Community Health Foundation Trust (KCHFT) who deliver part of the patient support and The Stroke Association's community of carers and patients, we summarised findings to colleagues at EKHUFT. This led to a co-produced questionnaire to further understand patient experience that was carried out on wards and with discharged patients. The team called over thirty patients who had been discharged more than six months ago to gather feedback.

8.3 This feedback was then shared back to EKHUFT colleagues as well as the Stroke Association and KCHFT and an action plan was developed including a review of the Stroke Passport and Peer Support being delivered on our wards with volunteers from the Stroke Association.

8.4 Case Study 2: Mental Health Feedback

We heard from a number of people experiencing health inequalities that they felt their mental health condition was not supported in an acute setting. We met with community stakeholders (Porchlight, Dads Unltd, Insight, Umbrella, Speakup CIC, Safe Haven, Help for Heroes) to ask for more feedback and attended the Thanet Mental Health Plan to provide feedback.

8.5 We now share an update on mental health feedback with the Trust's Mental Health Lead to inform the Mental Health Strategy, have supported the rollout of the co-located Safe Haven at QEQM with patient feedback and community insights and share our findings with the KMPT Mental Health Together Lived Experience Team. We plan on developing an East Kent-wide Mental Health Passport for patients in the coming year with colleagues across the system.

8.6 Patient Feedback Case Studies

"I have been struggling to get through to the Maxillofacial unit - the phone lines are constantly engaged and tried for many months on and off. I did get through to Canterbury and the secretary promised to email my consultant's secretary, but nothing."

8.7 We took this feedback to colleagues at Maxillofacial and they were able to resolve the individual patient's issue and they also changed the information in their patient letters to give up-to-date contact numbers as well as amending their answering machine message to give patients a better idea of what would happen after they left a message.

8.8 *"I was waiting behind a young man trying to give his details to the receptionist. The young man was speaking quietly, obviously not wanting to share his information with the rest of the room. The receptionist repeated his information back to him very loudly the waiting room, which was full, would have heard every word. Date of birth, address, and reason for being there! I am unsure if she was abnormally loud spoken or that her microphone was turned on! At that point I turned and walked out. I would rather wait to access my GP services and not have my confidential information shared to all! May I suggest that people be given the choice to write their details or voice them! I was appalled and felt sorry for the young man. I couldn't interrupt, I have laryngeal palsy so am vocally disabled, otherwise I would have!!"*

8.9 We contacted this patient and had a conversation about what they would have preferred to have seen and co-produced new signage in the reception area to advise patients of the availability of a quiet room as well as encouraging the reception team to have some updated training in how they engage with people waiting and reduce the chance of someone overhearing private information.

9. Carers

9.1 The carers survey results showed overwhelming negative feedback. Carers have told us that they often feel ignored, are not involved, or valued or seen as part of the support network of patients. Carers are usually the patient's partner, son, daughter, friend, or neighbour, but they could be their child or sibling. What they have in common is they know the person who is our patient far better than we do.

9.2 In July 2023 we established a Carers Task and Finish Group. Their remit was to review the gaps / actions needed and create an action plan so that the Trust could support the NHS England Commitment to Carers. The Group consisted of the Head of Patient Voice and Involvement, Patient Involvement Officers, several nursing leaders, a Staff Wellbeing representative, the Allied Health Professionals (AHP) Workforce and Education lead, the Lead Specialist Nurse for Dementia, several carers organisations, including Carers Support East Kent and Crossroads Care Kent, Macmillan Care, Pilgrims Hospice, Age UK Thanet, Healthwatch Kent and individual carers.

9.3 The Group has developed and is implementing an action plan, with the Wellbeing team leading a workstream on supporting staff who are carers. The group has also written a Carers Policy which once approved by the Patient Experience Committee and Policy Authorisation Group, will be launched during Carers Week in June

10. Conclusion

10.1 The first full year of the Patient Voice and Involvement team's work has seen the team raise the profile of patient and family voices and the importance of patient, family, and community involvement. The team provide a first point of contact for voluntary, community and social enterprise (VCSE) sector organisations and have built strong working relationships with a wide range of them across East Kent.

10.2 The team has supported colleagues across the Trust to respond to and learn from patient feedback. The team's priority is always to listen to patients and their families about what matters most to them, and then reflect this back to colleagues and services in the Trust. The team all live in East Kent and their families and friends use local services. This makes improvement not only important, but it also makes it personal, and their dedication and passion has inspired and motivated both colleagues and local people to get involved in our improvement journey. This is just the beginning of delivery a five-year strategy.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Annual Organisational Audit (AOA)**

Meeting date: **6 June 2024**

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

Paper Author: **Revalidation Project Manager**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	The Annual Organisational Audit (AOA) for Medical Appraisal for 2023/24 is presented within this report.
Summary of key issues:	The AOA is an element of the Framework of Quality Assurance (FQA) and is a standardised template for all responsible officers to complete and return to their higher-level responsible officer. The AOAs from all designated bodies will be collated to provide an overarching status report of the responsible officer function across England. The report and its findings continue to highlight the impact of improvement workstreams related to medical appraisal and revalidation.
Key recommendations:	The Board of Directors is asked to **NOTE** the content of the report and its information provided in addition to the Annual Revalidation report.

Implications:

Links to Strategic Theme:	• Quality and Safety • People
Link to the Trust Risk Register:	2599 – There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs. 3445 – There is a risk poor appraisal completion rates results in staff not receiving structured annual discussion for development plans compromising acquiring requisite skills, staff experience, shared Trust values leading to poor patient experience and care.
Resource:	N
Legal and regulatory:	Y**:** This report links to the organisations responsibilities as a Designated Body as defined by 'The Medical Profession (Responsible Officers) Regulations 2010'.

East Kent Hospitals University NHS Foundation Trust

Subsidiary:	N

Assurance route:

Previously considered by: The contents/outputs of this paper have been considered by the Responsible Officer's Advisory Group (ROAG).

East Kent Hospitals University NHS Foundation Trust

ANNUAL ORGANISATIONAL AUDIT (AOA)

1. Introduction

1.1 The AOA is normally submitted to NHS England at the end of each financial year and it is organised in four sections around appraisal compliance.

2. Purpose of the Paper

2.1 This report seeks to inform the Board of Directors of the outcome of the 2023/24 AOA report.

3. AOA Structure

3.1 The report has been completed taking into consideration criteria set by NHS England as follows:

3.1.1 Number of Prescribed Connections:
Number of doctors with whom the designated body has a prescribed connection as at 31 March 2024.

3.1.2 Measure 1: Completed medical appraisal:
A completed annual medical appraisal is one where either:

a) All of the following three standards are met:

i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*.
ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting.
iii. the entire process occurred between 1 April 2023 and 31 March 2024.

Or

b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

For doctors who have recently completed training, it should be noted that their final Annual Review of Competency Progression (ACRP) equates to an appraisal in this context.

3.1.3 Measure 1a (Optional) Completed medical appraisal:
For designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all three standards defined in Measure 1 a)

above. This figure is not reported nationally and is intended to inform the internal quality processes of the designated body.

3.1.4 Measure 2: Approved incomplete or missed appraisal:
An approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an Approved incomplete or missed annual medical appraisal.

3.1.5 Measure 3: Unapproved incomplete or missed appraisal:
An unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an Unapproved incomplete or missed annual medical appraisal.

4. Outcome

4.1 The results of the AOA on appraisal compliance are as follows:

East Kent Hospitals University NHS Foundation Trust

	Number of Prescribed Connections	Completed Appraisal (1)	Completed Appraisal (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)
Consultants (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	520	409	112	10	101
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	224	160	25	6	58
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	203	141	15	4	58
Other doctors with a prescribed connection to this designated body (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	3	2	2	0	1
Total	950	712	154	20	218

5. Conclusion

5.1 The AOA for 2023/24 demonstrates another increase in connections (47 doctors) since the last AOA however, the rate of completed appraisals and appraisal quality continues to improve.

5.2 The implementation of the Responsible Officers Advisory Group (ROAG) is now a business as usual function and occurs monthly. The rate of positive revalidation recommendations and delivery of high-quality appraisals (as evidenced by the Appraisal Summary and Personal Development Plan (PDP) Audit Tool) continues to improve on a sustainable trajectory and is reviewed at every ROAG.

5.3 The total appraisal compliance for the Trust on 1 April 2024 is 76% which demonstrates a 4% decline compared to the previous two months. This decline has been attributed to the transition from our existing e-portfolio provider to our new provider. The transition is expected to complete in May 2024 and our appraisal compliance is anticipated to recover rapidly. The aim is for the organisation to achieve above 80% consistently for at least three months or longer this year.

5.4 This report will be reviewed and will inform the Statement of Compliance report required by NHS England in October 2024.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Paediatric Audiology Services**

Meeting date: **6 June 2024**

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

Paper Author: **Head of Community Child Health & Children and Young People (CYP) Therapy Service (Women's & CYP (W&CYP)) and Head of Audiology (DCB)**

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	The Care Quality Commission (CQC) have requested the Trust Board considers the assurance in relation to the safety, quality and accessibility of paediatric hearing services within the organisation.
Summary of key issues:	• NHS England (NHSE) and CQC have stated a requirement for Paediatric Audiology Services to be accredited through Improving Quality in Physiological Services (IQIPS) programme. • EKHUFT Paediatric Audiology Services are not accredited and have not had an external evidence-based assessment (both provided exclusively by United Kingdom Accreditation Service (UKAS) for audiology). • EKHUFT Paediatric Audiology Services are working towards achieving accreditation.
Key recommendations:	The Board of Directors is asked to consider and **NOTE** the assurance that they have about the safety, quality, and accessibility of EKHUFT children's hearing services/paediatric audiology. A report will need to be submitted to CQC addressing the key issues in 3.1 of the main body of this report.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	Risk 3660 – Paediatric Audiology. In process of being added to Acute Audiology Service Risk Register
Resource:	Yes - business case for funding of benchmarking and accreditation.

We care

East Kent Hospitals University NHS Foundation Trust

Legal and regulatory:	Yes - NHSE/CQC requirement for Paediatric Audiology Services to be IQIPS accredited or to have had an external evidence-based assessment.
Subsidiary:	No

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

PAEDIATRIC AUDIOLOGY SERVICES

1. Purpose of the report

1.1 To provide assurance in relation to the safety, quality and accessibility of children's hearing services

2. Background

2.1 Following a review of all new born babies born in England between 2018-2023 NHSE initiated a national review of all paediatric hearing services. A set of system recommendations for immediate action was received via the Integrated Care Board (ICB) and in Autumn 2023 East Kent Children's Hearing Service (Women and Children's Care Group) and Acute Audiology Service (Diagnostic, Cancer and Buckland Hospital Care Group) completed and submitted a desktop review against these recommendations.

3. CQC Request

3.1 The CQC have sent a letter and have asked the following:

- Whether you have achieved IQIPS accreditation, including whether there were any improvement recommendations made.
- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the Board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.
- NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

4. IQIPS Accreditation

4.1 East Kent Children's Hearing Service and Acute Audiology Service are not currently IQIPS accredited for Paediatric or Adult Services.

4.2 There is an NHSE requirement for Paediatric Audiology Services to be accredited by April 2025. The date for Adult Audiology accreditation is to be confirmed.

4.3 As there is overlap UKAS have advised a Trust wide approach to accreditation.

4.4 A Project Initiation Document (PID) has been developed and approved by both Care Groups Quality and Governance Committee. The next step will be to complete a gap analysis and develop and action plan.

4.5 There have been no incidents where a child has suffered detriment. There is a regular review of incident data via each Care Group Quality & Clinical Governance Committee. There were four incidents reported in the last year related to delay or where the child

has not received timely follow up care and support. These incidents were all investigated via Trust processes and the outcomes were all no or low harm.

4.6 The services are not IQIPS accredited at present. The external evidence-based assessment provision that has been requested cannot be provided because the only external evidence-based assessment is UKAS IQIPS (benchmarking).

4.7 Diagnostic New born Hearing Screening Programme (NHSP) Auditory Brain stem Response (ABR) testing follow an internal and external peer review process with West Kent Children's Hearing Service. The Consultant Audio Vestibular Physician also engages in quarterly peer review (London and Greater London area). All other audiological processes are reviewed via competencies, observation/ supervision and audit.

5. Action Required for Services

5.1 In order to meet the NHSE request for an external evidence-based assessment (bench marking), a business case will need to be developed to secure funding (approx. £20K + VAT).

5.2 Following the full bench marking assessment UKAS will provide a comprehensive report of the effectiveness of systems in place with any significant risks or gaps identified. The average time from application to granting of accreditation is 16 months.

5.3 In the meantime, a British Association of Audiology (BAA) Paediatric Quality Standards audit tool has been completed and a UKAS readiness self-assessment (gap analysis) has been started. A high-level review will be completed by 31 July 2024 with a more detailed review of evidence completed by 31 October 2024.

5.4 Following the self-assessment and the bench marking exercises an update will be provided to the October 2024 Board Meeting on progress towards full accreditation.

6. Conclusion

6.1 NHSE/CQC require Paediatric Audiologist Services to be IQIPS accredited. EKHUFT Paediatric Audiology services are not currently accredited and will need to engage with UKAS to complete a bench marking exercise and plan for IQIPS accreditation.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safety, Fire and Statutory Compliance Update**

Meeting date: **6 June 2024**

Board sponsor: **Chief Strategy and Partnerships Officer (CSPO)**

Paper Author: **Associate Director of Safety**
Section 6 provided by 2gether Support Solutions (2gether) Estates

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This report provides an update to the Board of Directors on the Trust's position in relation to the status and management of safety, fire and estates statutory compliance.
Summary of key issues:	• The current cumulative Health and Safety Toolkit Audit (HASTA) score continues to fluctuate, standing at c88.5% for year-end 31 March 2024 – a slight decrease from previous audit years. • HASTA Audits continue across all Care Group and Corporate areas. Support being provided to Care Groups to enable improved outcomes for this financial and future years. • From the 1 April, the Safety team has moved to EKHUFT. This team includes Health and Safety (H&S), fire safety and the Security Management Specialist. • In Q4 2023/24, the Trust reported five Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) incident to the Health and Safety Executive (HSE). • The overarching statutory compliance assurance level stood at c93% at the end of April, work remains ongoing to uphold and improve this position.
Key recommendations:	The Board of Directors is asked to **NOTE** and discuss the Trust's current position in relation to Health & Safety, and statutory compliance, especially in respect to the prevailing risks.

East Kent Hospitals University NHS Foundation Trust

Implications:

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	**SRR3354 –** Clinical environment not fit for purpose. **SRR3384** - Financial constraints for capital funding and assets replacement.
Resource:	No
Legal and regulatory:	• Health and Safety Legislation. • Estates legislative Statutory Compliance.
Subsidiary:	2gether provides health and safety advice and guidance in line with the Service Level Agreement. 2gether also provides the Trust's hard facilities management services.

Assurance route:

Previously considered by:

Strategic Health and Safety Committee
Capital Investment Group
Clinical Executive Management Group (CEMG)

East Kent Hospitals University NHS Foundation Trust

Safety, Fire and Statutory Compliance Update

1. Background and Executive Summary

1.1. This report updates the Board of Directors on the Trust's position in relation to the ongoing management of Health & Safety (H&S), and the estates statutory compliance.

2. Health & Safety

2.1 **HASTA:** Audits are scheduled throughout the year in all clinical and non-clinical wards and departments.

As the year has gone on the Care Group scores have fluctuated with the year on year accumulative total remaining lower than the previous two years. This has been communicated to the Care Group Safety leads, highlighted in Safety Link Worker meetings, and raised in the strategic H&S Committee. The Safety team continues support Care Groups to try and improve this situation.

Table 1: HASTA Score Card

HASTA Score-Card	2021/22	2022/23	2023/24
Cancer Services	96.1%	90.5%	83.2%↓
Children's Health	96.5%	97.4%	96.8% ↓
Corporate Services	90.8%	89.4%	87.7% ↓
Clinical Support Services	96.1%	95.4%	92.9% ↓
General Specialist Medicine	87.2%	89.7%	85.1%↓
Surgical & Anaesthetic	84.4%	86.8%	87.6% ↑
Surgery Head & Neck, Breast and Dermatology	88.3%	98.1%	97.9% ↓
Urgent and Emergency Care (UEC)	80.4%	84.1%	89.2% ↑
Women's Health	91.9%	81.9%	83.7% ↑
Trust Wide Totals	**90.2%**	**90.2%**	**88.5%** ↓

**Scores adjusted slightly due to new questions added regarding ligature and Covid Risk Assessment for the new financial year. This has affected previous scores due to the system*

administration adding the question sets to the previous year's scores also. There is a variance of 1-2% drop on scores previously reported.

2.2 **Training**: In Q4 2023/24 the partnership has remained focused on delivering link worker training. Other training that has taken place during this quarter includes:

a. First Aid at Work;
b. Institution of Occupational Safety and Health (IOSH) (managing safely);
c. IOSH (working safely);
d. Control of Substances Hazardous to Health (COSHH);
e. Fire Safety;
f. Risk Assessment Awareness.

2.3 **H&S Team Support:** The Safety Team has been involved in a number of activities to support the Trust's activities both proactively (focused training) and reactively (incident investigations). The Ligature Risk Assessment review programme has been undertaken with clinical teams, with the first two phases completed

2.4 **Safety Governance:** A new structure for safety governance has been devised, whereby a new H&S Group, a Security Management Group and the existing Joint Fire Safety Group will all feed into the Strategic H&S Committee. There will be links from the site groups.

2.5 **Safety Team move**: As at 1 April 2024, the safety team comprising (at time of writing) one Fire Safety Manager (FSM), two Safety Advisers, one Safety Manager, one Security Management Specialist and one Safety Co-ordinator are now EKHUFT employees. The team is led by the Associate Director of Safety. There are two vacant Fire Safety Adviser posts that have also come across from 2gether. This team sits within the Chief Strategy & Partnerships Officer's Directorate.

3. RIDDOR reports for Q4 2023/24

3.1 During Q4 2023/24 budget period, the Trust reported five RIDDOR events with the HSE.

3.1.1 January – zero reported.
3.1.2 February – four reported (two injuries sustained while carrying/lifting, one injury sustained by a moving object, one injury sustained due to a fall).
3.1.3 March – one reported (Physical assault by patient).

3.2 The Safety team continue to support teams with their reporting of incidents, investigations and advice on remedial actions.

4. Fire Safety Update

4.1 **Fire Safety Governance:** The first Joint Fire Safety Group (FSG) meeting of 2024/25 was held on 16 April and recent meetings have generally been well attended by site Managing Directors. This year's programme of meetings will be revised from June as part of the wider H&S review of the governance and terms of reference. The FSG continues to report to the Strategic Health & Safety Committee (SHSC). Sub groups will be formed at a tactical level for all sites chaired by the FSM/Site Directors.

4.2 **Fire Safety Plan:** The 2023/24 Joint Fire Safety Plan saw progress against most actions and is monitored by the membership of the FSG and SHSC. There was a lack of achievement with completion of an Authorising Engineer (Fire) audit and the introduction of a wider face to face training programme. Some of the additional issues introduced to the plan in December/January year to reflect issues raised in the Kent Fire and Rescue Service (KFRS) Regulatory Audit at Kent and Canterbury Hospital (K&C) in November such as space management and control and the requirement for mandatory evacuation training for ward managers were also not achieved. The 2024/25 joint Fire Safety Plan has been agreed in consultation with 2gether.

4.3 **Longer term Fire Safety Improvement Plan:** The multiyear Fire Safety improvement plan initiated from the Fire Compartmentation report, originally produced by the Safety Team in 2023, is being delivered by the 2gether Capital Project Team, supported by the Fire Safety Manager. There is currently a review taking place of the order of works with the understanding that the very high dependency areas prioritised initially are not accessible during the next few months before the onset of seasonal pressures on service delivery. The project proposals will be reported on separately by 2gether and it is vital that this plan addresses the priority risks over the next years as a holistic programme to enable the Fire Safety Manager to consult with the KFRS enforcing body.

4.4 **Fire Risk Assessments (FRAs) and support:** Table 2 (below) sets the number and type of outstanding actions identified through the risk assessment process. The actions are tackled on a risk basis and reported on at each FSG. The two substantial risks are Devon House and William Harvey Hospital (WHH) under croft which have been mitigated with work to reduce them. The Fire Risk Assessment Programme was suspended in October awaiting a Purchase Order (PO) being issued to the contractor and part of the backlog was completed in March 2024 for last year's reviews.

The provision of FRAs has transferred with the H&S Department to the Trust from 2gether. With the current situation of two vacancies as Fire Safety Advisors cannot be delivered by an in-house service. The Trust will need to use an external provider until the posts are filled with suitably competent staff. The recommendation is to continue with the existing contractor and a PO needs to be issued asap for the 2024/25 year reviews that are now due. There are currently approximately 100 FRAs that are overdue their annual review as at 1 May 2024.

Table 2: Outstanding Fire Safety Actions

Fire Risk Assessment Summary - March 2024						
		Action Risk Level				
FRA Risk Level		High	Medium	Low	Advisory	Total Actions
Intolerable	0					0
Substantial Risk	2	22	11	1		34
Significant Risk	0	1	3			4

Moderate Risk	**77**	180	489	102	26	**797**
Tolerable Risk	**276**	232	1222	330	113	**1897**
Trivial Risk	**6**	2	21	1	3	**27**
Total FRA's	**361**					**2759**

Risk level	Action and timescale
Intolerable	Premises (or relevant area) should not be occupied until the risk is reduced.
Substantial	Considerable resources might have to be allocated to reduce the risk. If the premises are unoccupied, it should not be occupied until the risk has been reduced. If the premises are occupied, urgent action should be taken.
Significant	Should the timescales for any moderate risk level reduction measures be such that the associated consequences of the risk constitute extreme harm to persons, urgent additional control measures should be considered.
Moderate	It is essential that efforts are made to reduce the risk. Risk reduction measures, which should take cost into account, should be implemented within a defined time period. Where moderate risk is associated with consequences that constitute extreme harm, further assessment might be required to establish more precisely the likelihood of harm as a basis for determining the priority for improved control measures
Tolerable	No major additional fire precautions required. However, there might be a need for reasonably practicable improvements that involve minor or limited cost.
Trivial	No action is required and no detailed records need be kept.

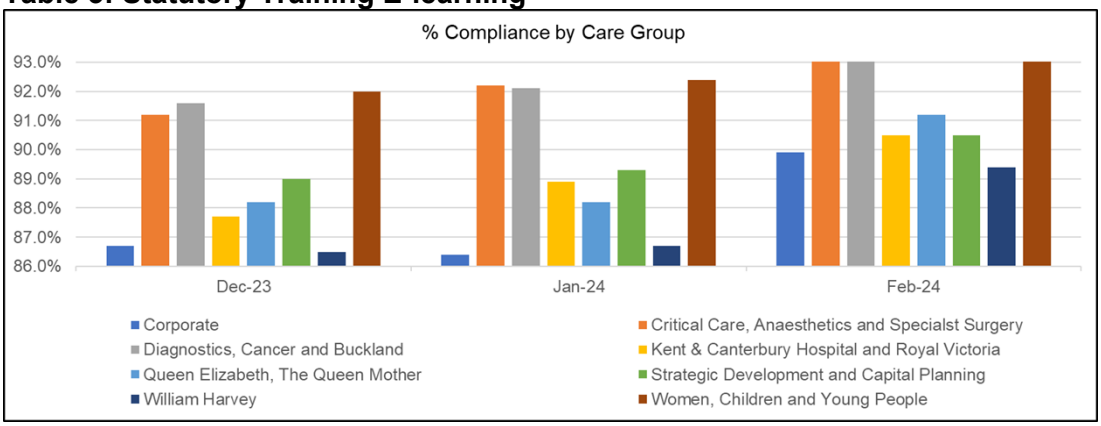
Identified Fire Safety Risk Ratings as at 1 May 2024

	QEQM	K&C	WHH	BHD	RVH	Total
Trivial Risk	0	3	3	0	0	**6**
Tolerable Risk	79	60	103	19	12	**273**
Moderate Risk	27	29	20	0	0	**76**
Significant Risk	0	0	0	0	0	**0**
Substantial Risk	0	0	1	0	0	**1**
	106	**92**	**127**	**19**	**12**	**357**

4.5 **Fire Training:** Learning and Development reported to the FSG an average of 91.5% completion of Statutory e-learning training across the Trust up to March 2024 (see Table 3 below). Fire Incident Manager and Fire Warden training courses have restarted on all three main sites, but take up has been limited. Site Managing Directors (MDs) are given the numbers of staff and

Department where they work each month for all training, and a summary of total numbers is below.

Table 3: Statutory Training E-learning



Site MDs are given the numbers of staff and Department where they work each month for all training, and a summary of total numbers is below. There has been additional bespoke Department / Ward based training (not recorded on Electronic Staff Record (ESR)).

Table 4: Training by site

SITE	Fire Warden	Fire Incident Manager	Fire Extinguisher
KCH	168	89	225
QEQM	111	41	127
WHH	248	146	228
BHD	12	4	31

The planned programme of ward-based face to face training is severely restricted due to the two vacant Fire Safety Advisors posts.

4.6 **Regulatory Interaction:** Following the Risk Based Audit undertaken by Kent Fire and Rescue Service (KFRS) in Clarke and Brabourne Wards at K&C on 15 November 2023 there have been no follow up visits planned. The action plan produced and incorporated into the main Fire Safety Plan continues to be monitored and progressed.

4.7 **Two vacant fire safety posts**: There are two fire safety advisors vacant posts in the Safety Team. These posts are for the fire risk assessment programme and for fire training. Recruitment will commence for one of the posts in the forthcoming period and engagement with a contractor to assist in the completion of the fire risk assessment programme.

5 Fire Safety Risks & Mitigations

The following table provides an overview of the current risk, mitigation, and planned activity. This is not comprehensive, but highlights revised or updated issues.

Risk Identified	Current Mitigation	Planned/Scheduled Activity
Lack of Fire Compartmentation in Bartholomew Unit / Coronary Care Unit WHH	Revised evacuation strategy based on whole floor needed to move. Increased fire training for staff to understand risks and urgency. Ski Sheets to replace straps for efficiency. Updated fire alarm and Change of cause and effect on fire alarm from roof space FRA reviewed with new evidence of roof issues No additional patients boarded on ward	Site Priority 1 for compartmentation project Thermal activated cameras in loft AE engaged for options Active system
Risk Identified	**Current Mitigation**	**Planned/Scheduled Activity**
Mattress evacuation straps identified as not suitable and Manual Handling (MH) team have stopped training with them	Ski sheets being used in higher risk areas such as Intensive Therapy Units (ITUs) and recommended for other reasons in areas such as Bartholomew, Kings C2, Brabourne	Plan to move to mattresses with evacuation straps built in, MH team arranging trial with procurement to purchase. Look to moving to ski sheets across all areas until the mattresses are in place
Patient care in corridors particularly in Emergency Departments (EDs) at WHH and Queen Elizabeth the Queen Mother Hospital (QEQM) blocking or restricting fire routes.	Revised escalation plan by EKHUFT managers of areas used Formal letter from 2gether issued previously to Trust outlining concerns. A Risk Assessments has been undertaken to stock take significant risks that will be submitted to the Fire safety group. The report has also been submitted to the contract performance group.	Plan to reduce corridor care to an absolute minimum. Monitoring of situation within EKHUFT continues at gold calls

East Kent Hospitals University NHS Foundation Trust

	Issue raised by KFRS during ED visit at WHH 16 Jan 2024 and letter received.	
Wedging of fire doors	Ongoing issue. Also raised by KFRS during ED visit at WHH 16 Jan 2024 and letter received. Staff training, Fire Warden Checks should be highlighting risk.	Communication strategy to be drawn up for Fire and H&S messages to be published in Trust news. Site Directors to be briefed about issue to pass on to staff.
Additional risks from "boarded" patients being placed in addition to existing wards at capacity	Managed by CSMs	Hospital and department management must consider the additional need for staff to evacuate areas, and determine whether adjacent areas can accommodate in an emergency evacuation. Evacuation plans should be reviewed and practiced
Risk Identified	**Current Mitigation**	**Planned/Scheduled Activity**
Fire compartmentation (fire doors, fire stopping of walls and ceilings and fire dampers in ventilation ductwork) is in poor condition.	Fire Compartmentation Report. Staff being informed in training of need to move to wider spread of evacuation.	Options for remediation methodology and outline costs being drawn up. Fire alarm zone sizes being reduced and programming revised.
Lack of fire drills over the last few years (significantly affected by staffing levels and Covid).	Fire training and procedures. Fire safety training strategy has been developed for EKHUFT, this has been submitted for consultation to Fire Safety Group in September.	Table top and actual fire drills will be scheduled in the forthcoming year. New Fire Advisors to support with delivery. Delivery planned to be face to face and live simulations carried out.
Lack of Annual Audit by Authorising Engineer (fire)	Fire Safety Group monitoring issues on a monthly basis.	Authorising Engineer tenders have been returned and scope being agreed before final appointment

We care

Gaps in assurance and support to face to face training (e-learning monitored and completed at present).	Some ad-hoc face to face training has been arranged and delivered, in specialist areas and where clinical staff need support around understanding of fire safety obligations. The Fire training strategy has been outlined to the Fire Safety Group	Fire training programme for 2023/24 includes plans for face to face training. Two new Fire Safety Advisors need to be recruited to support team to deliver training to the new plan in 2024 requires FSA to deliver or contractor
Obsolete fire panels at QEQM now replaced	Additional funding provided to replace all panels and remediate system.	Work complete on devices programming being carried out
Wireless systems installed in the past that are failing and not fit for purpose	Higher level of maintenance costing more	Consider cost effective business case to replace with conventional systems
K&C Fire Alarm system has issues on new install in Industrial / outpatients' area plus a number of obsolete panels	A survey being carried out by TFS to determine the compliance and identify issues	Need to review remedial work based on report when received
Minor Oxygen leak in K&C basement plant room	Gas monitoring being completed regularly, other fixed systems in place detection, barriers etc	Remediation work being scheduled as requires full Oxygen shut down to enable washers to be replaced.

6.0 Estates Statutory Compliance

6.1 The overarching statutory compliance assurance level stood at c93% at the end of April 2024, an increase of c1% in quarter. Despite historic funding issues we continue to work towards achieving a compliance level of c95%.

The following table provides a compliance overview by site.

Statutory Compliance – April 2024									
	KCH		WHH		QEQM		Total	Actual	March 2024
Compliant	112	92%	118	94%	111	93%	342	**93%**	91%
Non-Compliant	11	8%	12	6%	10	7%	32	**7%**	9%
TOTAL	**123**		**130**		**121**		**374**		

6.1.1 **Compliant Equipment Update (in period)**

6.1.1.1 Results of annual Emergency (EM) light tests reviewed and works being scheduled for repairs via mix of in-house and supply partners.
6.1.1.2 Water Hygiene - temperature monitoring and shower clean/descale.
6.1.1.3 COSHH audit now complete at K&C, carried out by H&S Department. Action plan agreed - similar TBA at WHH and QEQM.
6.1.1.4 Generator Testing and Maintenance.
6.1.1.5 Fire Alarm Servicing- all panels subject to major and minor service - 100% device testing complete.

6.1.2 **Non-Compliance**

6.1.2.1 Annual fire risk assessment reviews remain overdue in some areas. This is now a Trust responsibility with QFSM continuing to work through the backlog.
6.1.2.2 Fire Damper testing and inspection – work ongoing to seek appropriate route to market.
6.1.2.3 Fire Door Inspections - significant investment required to repair/replace fire doors across the portfolio – phased budget has been allocated to 2gether to deliver via its Capital Projects team.
6.1.2.4 Five Yearly fixed wire testing remain overdue at WHH and K&C – work is currently ongoing to stablish new delivery model. Electrical Installation Condition Report (EICR) observations from previous reports have now been processed for K&C for review and remediation as required.
6.1.2.5 Air Handling Unit (AHU) maintenance - Partial compliance Supplier BTU have made a start to some systems.
6.1.2.6 AHU Verifications - Delays in contract start due to end of year pressures within Procurement for April.

7. Critical Infrastructure/Backlog Maintenance

7.1 Our technical leadership teams continue to review the outstanding backlog maintenance priorities for each site; all items continue to be risk assessed in conjunction with the support of the Hospital Leadership Teams, the Director of Infection Prevention and Control (DIPC), and Deputy to prioritise patient safety. A combination of these processes provides a final risk allocation for use by the Patient Environment and Investment Committee (PEIC).

7.2 To date the Trust continues to allocate funding at levels below that to redress the historic backlog of critical works. At this point the Trust continues to face an increasing risk of critical system failures and potentially future building closures due to the aging and degradation of key technical systems.

7.3 Fire Compartmentation - One of the main critical infrastructure risks revolves around fire compartmentation i.e. fire breaks and fire doors. The Trust has recently agreed and is funding a five year programme to redress the identified compartmentation issues – with c£4m being allocated in the 2024/25 budget period.

7.4 Critical Infrastructure Report (CIR) - The existing CIR was commissioned via ARUP in 2021 post publication and in support of the Six Facet Estates Condition Survey report in 2020. Whilst both

reports have served the partnership well to date, it is recommended that both are refreshed sometime in the next 12 – 18 months: five *year re-inspection (six facet survey) is advised by NHS Estates within their code of land and property appraisals, 2007.*

8 Risk Management & Mitigation

8.1 The current compliance reporting model remains under development as part of a wider piece of work designed to improve the technical assurance levels within the estate. At this point the existing statutory compliance management process continues to remain inconsistent, mainly due to the challenges faced with the existing Planet CAFM system. Work remains ongoing to maintain the current management process to overcome the existing system shortfall.

Action Requested

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

------ End Report ------