East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Revision to the Trust Constitution**

Meeting date: **3 April 2025**

Board sponsor: **Director of Corporate Governance**

Paper Author: **Director of Corporate Governance/Governor and Membership Lead**

Appendices:

Appendix 1: Trust Constitution

Executive summary:

Action required:	**APPROVAL** by the Board of the proposed changes to the Trust Constitution.
Purpose of the Report:	The Constitution was last reviewed in May 2021 and requires updating. It is the primary governing document for the Trust covering responsibilities and rules pertaining to: 1. Trust Members; 2. Trust Governors; and 3. Board of Directors.
Summary of key issues:	Led by the Council of Governors, this latest review is to codify expectations of Governor behaviour and conduct. There has been a complete revision to Annex 6 (Additional Provisions – Council of Governors) covering the following: 1. Lead Governor: a term of 1 year up to a maximum of 3 terms. 2. Further provisions as to eligibility to be a Governor to make them in line with 2006 Act. 3. Removal of a Governor from office - reasons and processes for the removal of a Governor. 4. Dispute resolution: process for dealing with disputes between the Council of Governors and the Board of Directors. This brings the Trust in line with best practice and ensure fair and appropriate mechanisms for responding to eventualities not currently covered in the Constitution. We also take this opportunity to tidy up outdated references and language, for example: • Non-gendered pronouns. • Removal of outdated references such as to ‘Monitor’. and • Use of ‘Chair’ rather than ‘Chairman’. Changes have also been made to the Fit and Proper declarations that Governors need to sign on induction and then on an annual basis. This is to make it consistent with legislation changes. **Procedure**

	Under paragraph 48 of the Constitution, "Amendment of the Constitution" requires: 48. Amendment of the constitution 48.1 The trust may make amendments of its constitution only if: 48.1.1 more than half of the members of the Council of Governors of the trust voting approve the amendments, and 48.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments. Subject to the discussion at Board, the proposed constitution will then be presented for approval at the next Council of Governors meeting. If changes are collectively agreed by the Board and Council of Governors, they will be adopted and subsequently presented for approval to the Trust's Members at the next Annual General Meeting.
Key recommendations:	The Board of Directors is asked to **APPROVE**, the changes to the Trust Constitution as per attached document and passed to the Council of Governors for approval.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	N
Legal and regulatory:	Yes
Subsidiary:	N

Assurance route:

Previously considered by: Task and Finish Group of the Council of Governors

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Constitution

~~10 AUGUST 2018 (Revised May 2021)~~ [ ] April 2025

NHS Foundation Trust Model Core Constitution

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1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

The 2006 Act is the National Health Service Act 2006.

The 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 13 of the constitution.

Constitution means this constitution and all annexes to it.

~~**Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.~~

~~NHS Improvement is the umbrella organisation that has brought together a number of bodies including Monitor.~~

The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. Name

The name of the foundation trust is East Kent Hospitals University NHS Foundation Trust (the trust).

3. Principal purpose

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 a staff constituency

5.3 Not used

6. Application for membership

An individual who is eligible to become a member of the trust may do so on application to the trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

8.1.1 theyhe areis employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have he has been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Not used

8.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 Not used

8.5 The minimum number of members and categories set out in the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and
9.1.2 invited by the trust to become a member of the Staff Constituency

shall become a member of the trust as a member of the Staff Constituency without an application being made, unless they informs the trust that they does not wish to do so.

10. Automatic membership by default – Volunteers

10.1 An individual who is:

10.1.1. eligible to become a member of the Public Constituency and have registered as a Volunteer the Trust; and

10.1.2 invited by the Trust to become a member of the Public Constituency

Shall become a member of the Trust as a member of the Public Constituency in which hethey resides without an application being made, unless hethey informs the Trust that hethey does not wish to do so.

11. Not used

12. Restriction on membership

12.1 An individual who is a member of a constituency, may not while membership of that constituency continues, be a member of any other constituency.

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

12.3 An individual must be at least 16 years old to become a member of the trust.

12.4 An individual who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him may not become or continue as members of the council of governors.

12.5 ~~**2.4**~~ Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 9 – Further Provisions.

13. Annual Members' Meeting

13.1 The trust shall hold an annual meeting of its members ('Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 10 – Annual Members' Meeting.

14. Council of Governors – composition

14.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

14.2 The composition of the Council of Governors is specified in Annex 4.

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency. The number of governors to be elected by each constituency is specified in Annex 4.

14.4 Subject to paragraph 14.5 below, if an elected member of the Council of Governors shall be removed, die or resign before the expiry of his term of office, then
the Council of Governors shall invite the next highest polling candidate for that seat at the most recent election, who is willing to hold office, to fill the seat for any unexpired period of the term of office. Candidates will be approached in the order of the percentage of votes received. If there is no

such candidate, then a by-election shall be conducted in the proceeding February.

14.5 If an elected member of the Council of Governors shall die or resign in the 6 months prior to the trust holding elections for the Council of Governors, the Council may elect that the position will remain vacant until such time as an election has been held and an individual has been appointed to fill such position on the Council of Governors.

15. Council of Governors – election of governors

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

15.2 The latest Model Election Rules are attached at Annex 5.

15.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution).

15.4 An election, if contested, shall be by secret ballot.

16. Council of Governors - tenure

16.1 An elected governor may hold office for a period of up to 3 years.

16.2 An elected governor shall cease to hold office if ~~he~~they ceases to be a member of the constituency by which ~~he~~they was elected.

16.3 An elected governor shall be eligible for re-election at the end of his term, but for no more than two further terms making a maximum of nine years in total as a governor for the Trust.

16.4 An appointed governor may hold office for a period of up to 3 years

16.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

16.6 An appointed governor shall be eligible for reappointment at the end of his term, but for no more than two further terms making a maximum of nine years in total.

17. Council of Governors – disqualification and removal

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

17.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

17.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

17.2 Governors must be at least 18~~6~~ years of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

17.4 NHS Improvement may remove one or all of the governors from the Council if this is necessary to deal with a situation where the trust is failing.

17.5 Governors will also be disqualified if they cease to meet the eligibility criteria, (mandatory or otherwise) for becoming governors, or if, through changing circumstances, they fall into the category of those who are excluded from becoming governors. Failure to meet the mandatory requirements under paragraph 17.1 will result in automatic termination. In circumstances where disqualification is under consideration for the non mandatory reasons set out in Annex 6, three weeks notice of the resolution must be given to the Council of Governors, and termination as a governor will require the approval of three quarters of those members of the Council of Governors present and voting at the meeting.

18. Council of Governors – duties of governors

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

18.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

18.1.3 to appoint, remove and decide upon the terms of office of the Chair and Non-Executive directors.

18.1.4 to determine the remuneration of the Chair and Non-Executive directors.
18.1.5 to appoint and remove the Trust's auditors.
18.1.6 to approve the appointment of the Chief executive.
18.1.7 to receive the annual report and accounts and auditors report at the annual members meeting.
18.1.8 to jointly approve changes to the Constitution with the Board.

18.2 The trust must make steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

19. Council of Governors – meetings of governors

19.1 The ~~Chairman~~Chair of the trust (i.e. the ~~Chairman~~Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28.1 below) or, in his absence the Deputy ~~Chairman~~Chair (appointed in accordance with the provisions of paragraph 30 below) shall preside at meetings of the Council of Governors. Should neither the Chair or Deputy Chair be available then the Senior Independent Director should stand in.

19.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons by resolution of the Council. ~~.~~

19.3 For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

20. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, are attached at Annex 7.

21. Not used

22. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the Chair and members of the Council of Governors as soon as ~~he~~they becomes aware of it. The Standing Orders or Policies applying to ~~for~~ the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion

of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

23. Council of Governors – travel expenses

The trust may pay agreed travelling and other expenses to members of the Council of Governors at rates determined by the trust and in accordance with the trust's policies.

24. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

25. Board of Directors – composition

25.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors. At least half the Board, excluding the ~~chairman~~Chair, shall be non executive directors.

25.2 The Board of Directors is to comprise:

25.2.1 a non-executive ~~Chairman~~Chair

25.2.2 a minimum of 5 and up to 8 other non-executive directors; and

25.2.3 a minimum of 4 and up to 7 executive directors.

25.3 One of the executive directors shall be the Chief Executive.

25.4 The Chief Executive shall be the Accounting Officer.

25.5 One of the executive directors shall be the finance director.

25.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

25.7 One of the executive directors is to be a registered nurse or a registered midwife.

26. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

27. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if –

27.1 ~~he~~they are~~is~~ a member of a Public Constituency, and

27.2 Not used

27.3 Not used

27.4 they are ~~he is~~ not disqualified by virtue of paragraph 33 and/or paragraph 2.3 of Annex 9 below.

28. Board of Directors – appointment and removal of ~~chairman~~chair and other non-executive directors

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the ~~chairman~~chair of the trust and the other non-executive directors.

28.2 Removal of the ~~chairman~~chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

28.3 Non Executive Directors may in exceptional circumstances serve longer than six years, subject to annual re-appointment and to serving up to a maximum of a further three years (making nine years in total).

29. Not used

30. Board of Directors – appointment of deputy ~~chairman~~chair

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy ~~chairman~~chair of the Board of Directors following a recommendation by the ~~Chairman~~Chair.

31. Board of Directors - appointment and removal of the Chief Executive and other executive directors

31.1 The non-executive directors shall appoint or remove the Chief Executive.

31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3 Not used.

31.4 A committee consisting of the ~~Chairman~~Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

32. Not used

33. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

33.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

33.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

33.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

33.4 A person who has been found, through due process, not to be fit and proper person on the grounds of a serious misconduct or incompetence.

33.5 a non executive director who ceases to comply with paragraph 27.

34. Board of Directors – meetings

34.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

34.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

35. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, are attached at Annex 8.

36. Board of Directors - conflicts of interest of directors

36.1 The duties that a director of the trust has by virtue of being a director include in particular:

36.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.

36.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

36.2 The duty referred to in paragraph 36.1.1 is not infringed if:

36.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 the matter has been authorised in accordance with the constitution.

36.3 The duty referred to in paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.4 In paragraph 36.1.2, “third party” means a person other than:

36.4.1 The trust, or

36.4.2 A person acting on its behalf.

36.5 If a director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the director must declare the nature and extent of that interest to the other directors.

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

36.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

36.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

36.9 A director need not declare an interest:

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

36.9.2 If, or to the extent that, the directors are already aware of it;

36.9.3 If, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered;

36.9.3.1 By a meeting of the Board of Directors, or

36.9.3.2 By a committee of the directors appointed for the purpose under the Constitution.

36.10 The Standing Orders at Annex 8 specify the arrangements for excluding a Director from discussion or consideration of any contract or other matter in which they have ~~he has~~ declared an interest as appropriate.

37. Board of Directors – remuneration and terms of office

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the ~~Chairman~~Chair and the other nonexecutive directors.

37.2 The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

37.3 Pending the establishment of such a committee the ~~Chairman~~Chair of the trust may make alternative provision for these matters to be decided

38. Registers

The trust shall have:

38.1 a register of members showing, in respect of each member, the constituency to which they belong~~s~~

38.2 a register of members of the Council of Governors;

38.3 a register of interests of governors;

38.4 a register of directors; and
38.5 a register of interests of the directors.

39. Admission to and removal from the registers

In relation to 38.1 above, the registers of members of the trust will be validated annually.

40. Registers – inspection and copies

40.1 The trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

40.2 Not used

40.3 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the trust, or their home, contact details or address, if the member so requests.

40.4 So far as the registers are required to be made available:

40.4.1 they are to be available for inspection free of charge at all reasonable times; and

40.4.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

40.5 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

41. Documents available for public inspection

41.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1 a copy of the current constitution.

41.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

41.1.3 a copy of the latest annual report.

41.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times.

41.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

41.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006.

41.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

41.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

41.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), ~~65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision),~~ 65KC (action following Secretary of State's rejection of final report) or 65 KD (Secretary of State's response to resubmitted final report) of the 2006 Act.

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

41.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act.

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

41.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

41.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

42. Auditor

42.1 The trust shall have an auditor.

42.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

43. Audit committee

The trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

44. Annual Accounts

44.1 The trust must keep proper accounts and proper records in relation to the accounts.

44.2 NHS Improvement may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

44.3 The accounts are to be audited by the trust's auditor.

44.4 The trust shall prepare in respect of each financial year annual accounts in such form as Monitor ~~may~~ ~~with the~~ ~~be approved~~al ~~by~~of ~~the~~ Secretary of State directs.

44.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

45. Annual report and forward plans and non-NHS work

45.1 The trust shall prepare an Annual Report and send it to NHS Improvement.

45.2 The trust shall give information as to its forward planning in respect of each financial year to NHS Improvement.

45.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

45.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

45.5 Each forward plan must include information about:

45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

45.5.2 the income it expects to receive from doing so.

45.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in paragraph 45.5.1, the Council of Governors must:

45.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

45.6.2 notify the directors of the trust of its determination.

45.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the

members of the Council of Governors of the trust voting approve its implementation.

46. Presentation of the annual accounts to the Governors and Members

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

46.1.1 the annual accounts

46.1.2 any report of the auditor on them

46.1.3 the annual report.

46.2 The documents shall also be presented to the members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

46.3 The trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 46.1 with the Annual Members' Meeting.

47. Instruments

47.1 The trust shall have a seal.

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. Amendment of the constitution

48.1 The trust may make amendments of its constitution only if:

48.1.1 more than half of the members of the Council of Governors of the trust voting approve the amendments, and

48.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

48.2 Amendments made under paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

48.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

48.3.1 At least one member of the Council of Governors must attend the next Annual Members' meeting and present the amendment, and

48.3.2 the trust must give the members an opportunity to vote on whether they approve the amendment.

48.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

48.5 Amendments by the trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

49. Mergers etc and significant transactions

49.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

49.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

49.3 A significant transaction is one which is deemed to be a significant transaction by NHS Improvements.

49.4 A significant transaction does not include:

49.4.1 a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the trust);

49.4.2 any agreement or changes to healthcare services carried out by the trust following a reconfiguration of services led by the commissioners of such services; and

49.4.3 any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the trust.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

The areas specified as areas for public constituencies are the six local authority areas described in the table below. In addition there is a rest of England and Wales public constituency. The table sets out the minimum numbers of members required in each area.

Constituency	**Minimum number of members**
Ashford Borough Council	100
Canterbury City Council	100
Dover District Council	100
Thanet ~~Shepway~~ District Council	100
Swale Borough Council	100
Folkestone and Hythe District Council	100
Rest of England and Wales	25

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 8.5)

~~There are no classes within~~ The Staff Constituency should comprise the different sites and locations of the Trust and nominations for Staff Governors should reflect the breadth and range of staff working for the Trust. The minimum number of members required in the Staff Constituency as a whole is 500

ANNEX 3 – THE PATIENTS' CONSTITUENCY

There is no Patients' Constituency.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 14.2 and 14.3)

The Council of Governors will consist of a ~~Chairman~~Chair and 19 governors as follows:

Type of Governor	Number of Governors
Elected Governors	
Public constituencies – residents of the following constituency areas	
Ashford Borough Council	2
Canterbury City Council	2
Dover District Council	2
~~Shepway District Council~~ Thanet District Council	2
Swale Borough Council	2
Folkestone and Hythe District Council	2
Rest of England and Wales	1
Staff Constituency	3
Appointed Governors	
Statutory	
Appointed jointly by: Ashford Borough Council Canterbury City Council Dover District Council ~~Shepway~~ Thanet District Council Swale Borough Council Folkestone and Hythe District Council	1
From partnership organisations*	
Appointed jointly by Canterbury Christ Church University University of Kent	1
Nominated by the following League of Friends to represent the interests of the League of Friends and other volunteers working with the Trust: ✦ The League of Friends of the Kent & Canterbury Hospital ✦ The League of Friends of the William Harvey Hospital ✦ League of Friends, Queen Elizabeth the Queen Mother Hospital ✦ League of Friends, Royal Victoria Hospital, Folkestone ✦ The League of Friends of Dover Hospitals	1

* Specified for the purposes of paragraph 9 (7) of Schedule 7 to the 2006 Act.

ANNEX 5 – MODEL ELECTION RULES

(Paragraph 15)

	Page

PART 1 - INTEPRETATION

1 Interpretation

1.1 In these rules, unless the context otherwise requires:

"2006 Act" means the National Health Service Act 2006;

"associate non-executive director" is member of the Board of Directors holding an Associate director office (not an executive office) of the Trust, without voting rights;

"corporation" means the public benefit corporation subject to this constitution;

"council of governors" means the council of governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"e-voting" means voting using either the internet, telephone or text message;

"e-voting information" has the meaning set out in rule 24.2;

"ID declaration form" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"lead governor" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance ~~(Monitor, December 2013)~~ or any later version of such code.

"list of eligible voters" means the list referred to in rule 22.1, containing the information in rule 22.2;

"method of polling" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

~~"Monitor" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;~~

NHS Improvement is the umbrella organisation that brought together a number of bodies ~~including Monitor.~~

"non-voting executive director" is a member of the Board of Directors holding an executive office of the Trust, without voting rights;

"non-voting non-executive director" is a member of the Board of Directors who does not hold an executive office of the Trust, without voting rights;

"numerical voting code" has the meaning set out in rule 64.2(b)

"polling website" has the meaning set out in rule 26.1;

"postal voting information" has the meaning set out in rule 24.1;

"telephone short code" means a short telephone number used for the purposes of submitting a vote by text message;

"telephone voting facility" has the meaning set out in rule 26.2;

"telephone voting record" has the meaning set out in rule 26.5 (d);

"text message voting facility" has the meaning set out in rule 26.3;
"text voting record" has the meaning set out in rule 26.6 (d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"voting information" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2 – TIMETABLE FOR ELECTIONS

2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.

Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3 Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 – RETURNING OFFICER

4 Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5 Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they ~~he or she~~ consider~~s~~ necessary for the purposes of the election.

6 Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7 Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 – STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8 Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9 Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10 Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an email address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11 Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

~~(b)~~(c) whether the candidate has within the preceding five years been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

12 Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that they are ~~he or she is~~ not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13 Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14 Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after they have ~~he or she has~~ received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's

nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15 Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the ~~name, contact address (which shall be the candidate's postal address), and~~ constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16 Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17 Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18 Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected

to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5 – CONTESTED ELECTIONS

19 Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more evoting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20 The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21 The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that they have ~~he or she has~~ not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22 List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by email to those members in the list of eligible voters for whom an e-mail address is included in that list.

23 Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, ~~contact addresses,~~ and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24 Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an evoting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25 Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26 E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are ~~he or she is~~ entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and
(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are ~~he or she is~~ entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than they are ~~he or she is~~ entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;
(iii) the voter's declaration of identity (where required);
(iv) the candidate or candidates for whom the voter has voted; and
(v) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27 Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28 Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they ~~he or she~~ considers necessary to enable that voter to vote.

29 Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they ~~he or she~~ can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they ~~he or she~~:

(a) are ~~is~~ satisfied as to the voter's identity; and

(b) have ~~s~~ ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if they ~~he or she~~ can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless they are ~~he or she is~~ satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30 Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless theyhe or she:

(a) areis satisfied as to the voter's identity,

(b) haves no reason to doubt that the voter did not receive the original voting information,

(c) haves ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31 Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32 ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33 Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they ~~he or she~~ wish~~es~~ to cast their ~~his or her~~ vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34 Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom they ~~he or she~~ wish~~es~~ to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35 Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom they ~~he or she~~ wish~~es~~ to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36 Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37 Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are ~~he or she is~~ to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are ~~he or she is~~ to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are ~~he or she is~~ to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, they are ~~he or she is~~ to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38 Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39 De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election they ~~he or she~~ shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40 Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 – COUNTING THE VOTES

STV41 Interpretation of Part 6

STV41.1 In Part 6 of these rules:
"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42 Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and
(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43 The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and
(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44 Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44 Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that they ~~he or she~~ can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty, and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown they ~~that he or she~~ can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45 First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46 The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47 Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of nontransferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of nontransferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48 Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of nontransferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of nontransferable votes, with
(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49 Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and (b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the subparcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value they ~~he or she~~ shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until ~~he~~they ha~~ves~~ dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or
(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50 Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51 Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which they obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51 Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 – FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who they have ~~he or she has~~ declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the ~~chairman~~chair of the NHS Trust, or

(ii) in any other case, to the ~~chairman~~chair of the corporation; and

(c) give public notice of the name of each candidate whom they have ~~he or she has~~ declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52 Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who they have ~~he or she has~~ declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS

Trust by section 33(4) of the 2006 Act, to the ~~chairman~~chair of the NHS Trust, or

(ii) in any other case, to the ~~chairman~~chair of the corporation, and

(c) give public notice of the name of each candidate who they have ~~he or she has~~ declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53 Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who they have ~~he or she has~~ declared elected to the ~~chairman~~chair of the corporation, and

(c) give public notice of the name of each candidate who they have ~~he or she has~~ declared elected.

PART 8 – DISPOSAL OF DOCUMENTS

54 Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55 Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the ~~chairman~~chair of the corporation.

57 Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58 Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and
(ii) that NHS Improvement has declared that the vote was invalid.

PART 9 – DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59 Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the ~~chairman~~chair of the corporation, and rules 57 and 58 are to apply.

STV59 Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
(ii) ballot documents which have preferences recorded for other

candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10 – ELECTION EXPENSES AND PUBLICITY

Election expenses

60 Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement under Part 11 of these rules.

61 Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62 Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63 Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64 Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(d) a photograph of the candidate.

65 Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11 – QUESTIONNING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66 Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS Improvement.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS Improvement by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as NHS Improvement may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If NHS Improvement requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS Improvement shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 NHS Improvement may prescribe rules of procedure for the determination of an application including costs.

67 Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they ~~he or she~~ think~~s~~ fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68 Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom they have ~~he or she has~~ voted.

69 Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70 Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 17.3)

1.0 **Disqualification.**

With reference to Section 17 and paragraphs 17.3 and 17.4 the following additional provisions are made as to the circumstances in which an individual may not become or continue as a member of the Council of Governors :-

1.1 In respect of elected governors, he or she is disqualified from being a public, or staff member of the relevant constituency

1.2 He or she is an executive or non-executive director of the Trust or, in respect of elected governors, a governor, non-executive director, chairman, or chief executive of another NHS Foundation Trust

1.3 He or she is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs

1.4 In respect of elected governors, he or she ceases to be a member of the trust

1.5 He or she has had their name placed on registers of Schedule 1 offenders pursuant to the Sex Offenders Act 1977 and/or the Children and Young Person Act 1933

1.6 He or she has failed to attend at least half of the meetings of the Council of Governors in any financial year without a reason acceptable to the Council

1.7 He or she has failed to attend three consecutive meetings without a reason acceptable to the Council

1.8 He or she has failed to declare a significant conflict of interest

1.9 He or she has a conflict of interest making membership of the Council untenable

1.10 He or she is guilty of conduct or actions prejudicial to the Council or the Trust

In all cases where disqualification is being considered for the above reasons, three weeks notice of the resolution must be given to the Council, and termination as a governor will require the approval of three quarters of those members of the Council of Governors present and voting at the meeting in accordance with paragraph 17.4

For the avoidance of doubt, an individual may not at the same time be both an elected and an appointed governor.

2.0 **Terms of office of Council members.**

~~2.1 In order to avoid the periods of office of members of the Council of Governors all ending at the same time, arrangements to stagger the initial terms of office on the establishment of the Council will be made.~~

~~2.2 As with elected governors, appointed governors may hold office for a period of up to three years and may serve for no more than three successive terms, making a total of nine years.~~

~~3.0 Performance evaluation~~

~~3.1 Led by the Chairman, the Council of Governors should periodically assess their collective performance. The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.~~

1. Elected Governors

A Member of the Public Constituency may not vote at an election for a public governor unless at the time of voting they have made and returned a declaration in the form specified in the Model Election Rules, that they are qualified to vote as a Member of the Public Constituency.

2. Appointed Governors

2.1 The Secretary (or such person as they may nominate) shall contact each relevant organisation in writing regarding the appointment of the Governor by it.

2.2 For the purposes of this paragraph 2 "relevant organisation" shall mean any local authority, university or other partnership organisation which is eligible to appoint a Governor to the Council of Governors under this Constitution.

3. Lead Governor

3.1 The Council of Governors shall appoint one of its public Governors as the Lead Governor in accordance with the conditions of appointment set out in the Lead Governor role description and approved by the Council of Governors and the Board of Directors.

3.2 The Lead Governor shall have the responsibilities, and perform the tasks, set out in the Lead Governor role description.

3.3 The term of the Lead Governor shall be selected by the Council of Governors for a term of one year up to a maximum of 3 years.

4. Further provisions as to eligibility to be a Governor

4.1 In addition to paragraph 17 of this Constitution, a person may not become or continue as a Governor if they are not a Member;

4.1.2 in the case of a public governor or staff governor they cease to be a Member of the Constituency or Class from which they were elected;

4.1.3 in the case of an appointed governor, the organisation which appointed them terminates that appointment;

4.1.4 they are a person who is not a fit and proper person as required by the NHS Provider Licence; Fit and Proper Person statement should be completed on an annual basis.

4.1.5 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

4.1.6 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

4.1.7 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

4.1.8 they are the spouse, partner, parent, child of, or occupant of the same household as a director or a member of the Council of Governors;

4.1.9 they are a director of the Trust;

4.1.10 they are a governor, non-executive director (including the chair) or, executive director (including the chief executive officer) of another NHS Body, unless they are appointed by an appointing organisation which is a NHS Body or the Chair agrees to them becoming, or continuing as, a governor of the Trust in exceptional circumstances;

4.1.11 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a NHS Body;

4.1.12 they are a person whose tenure of office as a Chair or as a member or director of a NHS Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

4.1.13 they have previously been removed as a Governor of the Trust;

4.1.14 they have previously been removed as a governor from another NHS foundation trust;

4.1.15 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of any Governor or Trust Code of Conduct;

4.1.16 they have committed a serious breach of the Trust's ~~Governor~~ Code of Conduct or which resulted in them being removed as a Governor from the Council;

4.1.17 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;

4.1.18 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

4.1.19 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales, and they have not subsequently had their name included in such a list;

4.1.20 they are deemed a vexatious or persistent complainant or litigant against the Trust without reasonable cause; or

4.1.21 they have failed to repay (without good cause) any amount of monies properly owed to the Trust.

4.2 For the purposes of this a vexatious or persistent complainant" shall be as defined in the Trust's Feedback Complaints and Patient Advice and Liaison (PALS) Policy (or such other policy that may replace it from time to time). In the event of a dispute regarding whether an individual is a vexatious or persistent complainant, the Chair in consultation with the Senior Independent Director and Company Secretary -shall make the final decision.

4.3 A person holding office as a Governor shall immediately cease to do so if they resign by notice in writing to the Secretary;

4.3.1 they become disqualified from office under this Constitution

4.3.2 they fail to attend three meetings of the Council of Governors in a period of one year unless the Lead Governor, Chair and Secretary are satisfied that the absence was due to a reasonable cause; and

4.3.3 they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.3.4 they have refused to undertake any training which the Council of Governors requires all governors to undertake unless the Lead Governor, Chair and Secretary are satisfied that the refusal was due to a reasonable cause; or

4.3.5 they are removed from the Council of Governors by a resolution passed under paragraph 17 of this Constitution

4.4 For the purposes of an absence this will ordinarily be considered to be due to a reasonable cause if it is due to:

4.4.1. ill health (provided that the Governor in question, or someone on their behalf, has advised the Secretary of such circumstances as soon as reasonably practicable); or

4.4.2 a personal or family emergency.

4.4.3 fFor the avoidance of doubt, work commitments will not be considered a reasonable cause unless the Trust has changed the date of the meeting of the Council of Governors at short notice.

4.4.3 fInstances of ill health will be reviewed on a case-by-case basis in consultation between the Lead Governor, Secretary, the Chair and the affected Governor with a view of acting in the best interests of the Trust.

4.5 Where a Governor becomes disqualified for appointment under this paragraph 4 or paragraph 17 of this Constitution, they shall notify the Secretary in writing without delay upon becoming aware the grounds for disqualification. Any failure to notify the Secretary of grounds for disqualification pursuant to this paragraph 4.5 shall result in such individual becoming ineligible to become a Governor at any future point.

4.6 If it comes to the notice of the Secretary that at the time of their appointment or later a Governor is disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

5. Removal of Governor from office

5.1 A Governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the Governors present and voting on the grounds that they have acted in a manner detrimental to the

interests of the Trust or otherwise bring the Trust into disrepute; or the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor, for example because:

5.1.2.1 the individual's continuation as a Governor would be likely to prejudice the ability of the Trust to fulfil its principal purpose or discharge its duties and functions;

5.1.2.2 the individual's continuation as a Governor would be likely to prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

5.1.2.3 the individual's continuation as a Governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

5.1.2.4 it would not be in the best interests of the Council of Governors for the individual to continue as a Governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors' affairs; or

5.1.2.5 the individual has failed to comply with the values and principles of the NHS, the Trust or this Constitution in his or her behaviour or conduct.

5.2 The ~~Chairman~~Chair, Lead Governor and Chief People officer will agree a process for investigating complaints against a Governor after taking advice from the Director of Corporate Governance which may lead to a removal of a Governor under this paragraph 5. Should the Complaint be against the Lead Governor then the Deputy Lead Governor will step in.

6. Vacancies amongst Governors

6.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

Appointed Governors

6.2 Where the vacancy arises amongst the Appointed Governor, the Council of Governor~~s~~ shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office or to commence a new term of office.

Elected Governors

6.3 Where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either call an election at the next yearly election cycle to fill the seat for the remainder of that term of office;

6.3.2 to call an election to fill the seat for a new term of office;

6.3.3 to recommend the second placed candidate in the previous election for that constituency for the remaining term.

6.4 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the Governor attending the meeting.

Staff Governors

6.5 Where the vacancy arises amongst taff governors, the Council of Governors shall be at liberty either call an election of the Staff Constituency at the next yearly election cycle to fill the seat for the remainder of that term of office;

6.3.2 to call an election to fill the seat for a new term of office;

6.3.3 to recommend the second placed candidate in the previous election for that constituency for the remaining term.

6.4 Staff Governors should collectively be representative of the wider staff population of the Trust including, in particular, professional group and site location. This can be achieved through priority candidates or categories of Staff Constituency voting provided for in Annex 2.

6.5 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the Governor attending the meeting.

7. Dispute Resolution

7.1 In the event of any dispute between the Council of Governors and the Board of Directors:

7.1.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

7.1.2 if the Chair is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and

7.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

7.1.4 it is the duty of the Chair to consider in consultation with ~~f~~ the Senior Independent Director and the Company Secretary whether it is appropriate for the Senior Independent Director to ~~should~~ represent the Council of Governors and the Board if there is ~~feels that the Chair has~~ a conflict of interest

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 16)

CONTENTS

INTERPRETATION

1. Save as otherwise permitted by law and subject to the Constitution, at any meeting the ~~Chairman~~Chair shall be the final authority on the interpretation of the Standing Orders, with a right of appeal to a committee of the Council of Governors convened for that purpose, whose decision shall be final and binding except in case of manifest error.

2. Any expression to which a meaning is given in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (and other Acts relating to the National Health Service or in the Financial Regulations made under the Act or regulations made under it) shall have the same meaning in this interpretation and in addition.

Council of Governors and (unless the context requires otherwise) "Council"	The Council of Governors of the Trust as constituted by the Constitution

Board of Directors	~~Chairman~~Chair, Executive and Non-Executive Directors of the Trust collectively as a body
~~Chairman~~Chair of the Council or ~~Chairman~~Chair of the Trust	Person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the ~~Chairman~~Chair of the trust" shall be deemed to include the Deputy ~~Chairman~~Chair of the Trust if the ~~Chairman~~Chair of the Trust is absent from the meeting or otherwise unavailable.
Chief Executive	Chief Executive Officer of the Trust
Committee	A Committee of the Council of Governors
Constitution	The Constitution of the Trust
Committee members	~~Chairman~~Chair of the committee and the governors (and other people by invitation) formally appointed by the Council of Governors to sit on or to ~~Chairman~~Chair specific committees.
Executive Director	A member of the Board of Directors holding an executive office of the Trust.
Member of the Council	A Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the ~~Chairman~~Chair)
Non-Executive Director	A member of the Board of Directors who does not hold an executive office of the Trust
SOs	Refers to the Standing Orders of the Council of Governors
Trust Secretary	A person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Council and the ~~Chairman~~Chair and NHS Improvement the Trust's compliance with the Statutory Framework and these Standing Orders.

Deputy ~~Chairman~~Chair	The Non-Executive Director appointment from amongst the Non-Executive Directors as Deputy ~~Chairman~~Chair by the Board of Governors in accordance with the constitution to take on the ~~Chairman~~Chair's duties if the ~~Chairman~~Chair is absent for any reason.

1. INTRODUCTION

1.1 Statutory Framework

The East Kent Hospitals University NHS Foundation Trust is a statutory body which became a public benefit corporation on 1 March 2009 following its approval as an NHS Foundation Trust by ~~Monitor~~, pursuant to the National Health Service Act 2006.

The statutory functions conferred on the Trust are set out in:

- The National Service Act 2006;
- The Health and Social Care Act 2012;

The trust is also required to comply with the licence granted to it by ~~Monitor~~NHSE .

All business of the Council of Governors will be conducted in the name of the Trust.

The Constitution, paragraph 20, requires the Council of Governors to adopt its own Standing Orders for its practice and procedure.

2. THE COUNCIL OF GOVERNORS

2.1 Composition of the Council

The composition of the Council of Governors is set out in the constitution.

One of the Governors shall be elected by the Council of Governors as the Lead Governor. The position of Lead Governor shall be determined by election annually on the basis of a secret ballot.

If a Governor resigns from office as Lead Governor, or dies in service, then the Council of Governors shall thereupon elect another Governor as the Lead Governor without delay. Any such Governor shall. complete the term of office of the of the Lead Governor they succeed.

The Lead Governor may preside at meetings of the Council of Governors in the following circumstances:

2.1.1 where matters relating to the Non-Executive Directors are being considered and, as a result, a conflict of interest exists relating to the ~~Chairman~~Chair and the Deputy ~~Chairman~~Chair.

2.2 Role of the ~~Chairman~~Chair

The ~~Chairman~~Chair is not a member of the Council of Governors. Under the Statutory Framework, the ~~Chairman~~Chair presides at meetings of the Council of Governors and has a casting vote.

Where the ~~Chairman~~Chair ceases to hold office, or where s/he has been unable to perform his/her duties as ~~Chairman~~Chair owing to illness or any other cause, the Deputy ~~Chairman~~Chair (a Non-Executive Director appointed by the Council of Governors) shall act as ~~Chairman~~Chair until a new ~~Chairman~~Chair is appointed or the existing ~~Chairman~~Chair resumes his/her duties, as the case may be. References to the ~~Chairman~~Chair in these Standing Orders shall, so long as there is no ~~Chairman~~Chair able to perform his/her duties, be taken to include references to the Deputy ~~Chairman~~Chair.

3. MEETINGS OF THE COUNCIL

3.1 Calling meetings

Ordinary meetings of the Council of Governors shall be held at such times and places as the ~~Chairman~~Chair may determine. Not less than 3 meetings will be held each year. One such meeting shall be combined with the Annual Members' Meeting. Meetings will normally be held in public. However the Council may resolve to exclude the public where it wishes to discuss particular issues in private session. The Council of Governors may also meet on an informal basis for development days (away days). For the avoidance of doubt, where a meeting of the Council of Governors is combined with the Annual Members' meeting, the meeting of the Council of Governors must be open to members of the public.

The ~~Chairman~~Chair may call meetings of the Council of Governors. If the ~~Chairman~~Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of governors including at least two elected and one appointed governor, has been presented to him/her, or if, without so refusing, the ~~Chairman~~Chair does not call a meeting within 14 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more governors may forthwith call a meeting of the Board.

3.2 Notice of meetings

Before each meeting of the Council of Governors, a notice of the meeting signed by the ~~Chairman~~Chair or by an officer of the Trust authorised by the ~~Chairman~~Chair to sign on his/her behalf shall be delivered to every member of the Council, or sent by post to the usual place of residence of such governor, no less than six clear days in advance of the meeting

3.3 Notice of business to be transacted

Before each meeting of the Council of Governors, an agenda setting out the business of the meeting, signed by the ~~Chairman~~Chair or by an officer of the Trust authorised by the ~~Chairman~~Chair to sign on his/her behalf shall be delivered to every member of the Council of Governors, or sent by post to the usual place of residence of such governor specifying the business proposed to be transacted at it so as to be available to the governor at least six clear days before the meeting, including weekends. Supporting papers, whenever possible, shall accompany the agenda, but will be dispatched no later than three clear days before the meeting save in an emergency.

Lack of service of the notice on any governor shall not affect the validity of a meeting.

In the case of a meeting called by the governors in default of the ~~Chairman~~Chair, the notice shall be signed by those respective governors and no business shall be transacted at the meeting other than that specified in the notice

A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or otherwise on the day following electronic or facsimile transmission.

3.4 Setting the agenda

The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an appendix to the Standing Orders.)

A governor desiring a matter to be included on an agenda shall make his/her request in writing to the ~~Chairman~~Chair at least 15 clear days including weekends before the respective meeting. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the ~~Chairman~~Chair.

For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

3.5 Attendance and questions from the public

The public shall be welcome at all meetings of the Council of Governors unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The ~~Chairman~~Chair may exclude any member of the public from a meeting of the

Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

Up to 15 minutes will be set aside at the end of each ordinary meeting to enable members of the public or other interested parties to ask questions of the Council. Questions on any matter that has been discussed at the meeting can be raised at this point. Questions on general matters related to the business of the Trust should be sent in writing to the ~~Chairman~~Chair at least 10 days prior to the meeting.

Nothing in these standing orders shall require the Trust to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the ~~Chairman~~Chair.

3.6 ~~Chairman~~Chair of meeting

At any meeting of the Council, the ~~Chairman~~Chair of the Council, if present, shall preside. If the ~~Chairman~~Chair is absent from the meeting, or absent temporarily on the grounds of a declared conflict of interest, the Deputy ~~Chairman~~Chair, if there is one, and s/he is present, shall preside. If the ~~Chairman~~Chair and Deputy ~~Chairman~~Chair are absent, such Non-Executive Director as the Non-Executive Directors present shall choose, shall preside. Where the ~~Chairman~~Chair, Deputy ~~Chairman~~Chair, and other Non-Executive Directors are all absent or have a conflict of interest, the Lead
Governor/Vice Chair of Governors (to be appointed from amongst the Council of Governors) shall preside at the meeting and shall have a casting vote

3.7 Notices of motion

A governor of the Trust desiring to move or amend a motion shall send a written notice thereof signed by at least one other Governor at least 15 days before the meeting to the ~~Chairman~~Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting without notice, on any business mentioned on the agenda

Emergency Motions:- Subject to the agreement of the ~~Chairman~~Chair, a Governor may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Council at the commencement of the business of the meeting as an additional item included in the agenda. The ~~Chairman~~Chair's decision to include or exclude the item shall be final

3.8 Motions: Procedure at and during a meeting

i) **Who may propose**

A motion may be proposed by the ~~Chairman~~Chair of the meeting or any Governor present. It must also be seconded by another member.

ii) **Contents of motions**

The ~~Chairman~~Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Council;
- the accuracy of minutes;
- that the Council proceed to next business
- that the Council adjourn;
- that the question be now put.

iii) **Motion once under debate**

When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business. (*)
- the motion be now put. (*)
- that a Governor be not further heard;
- a motion resolving to exclude the public, including the press

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.

iv) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Council. The ~~Chairman~~Chair's decision on this will be final

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

v) **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive / original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9 Withdrawal of motion or amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and consent of the ~~Chairman~~Chair.

3.10 Motion to rescind a resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the governor who gives it and also the signature of 4 other governors. When any such motion has been disposed of by the Council, it shall not be competent for any governor other than the ~~Chairman~~Chair to propose a motion to the same effect within 6 months, however the ~~Chairman~~Chair may do so if they ~~he/she~~ consider~~s~~ it appropriate.

If a Governor persistently disregards the ruling of the ~~Chairman~~Chair by behaving improperly or offensively or deliberately obstructs business, the ~~Chairman~~Chair may move that the Governor be not heard further. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the ~~Chairman~~Chair may move that either the Governor leaves the meeting room or that the meeting is adjourned for a specified period. If seconded, the motion will be voted on without discussion.

3.11~~Chairman~~Chair's ruling

Statements of governors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the ~~Chairman~~Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.12 Virtual Voting

In the event that a decision is required ahead of the next Council of Governors meeting a virtual vote will be proposed. Virtual voting shall be undertaken via a secure electronic system or NHS email and will be passed by a simple majority of the number of Governors on Council. Public Governors must be the majority of those voting. The decision will be ratified at the next public Council of Governors meeting.

3.13 Voting

Every question at a meeting shall be determined by a majority of the votes of the ~~Chairman~~Chair of the meeting and the governors present and voting on the question and, in the case of any equality of votes, the ~~Chairman~~Chair or person presiding shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the ~~Chairman~~Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request

If at least one third of the governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor present voted or abstained

If a governor so requests his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.

Confidential votes shall be used in extreme circumstances by agreement in Council and in a way which ensures that the individual's votes remain private. The timeframe for confidential votes shall be five days, but can be shorter if required, by agreement with Council.

3.14 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the ~~Chairman~~Chair or person presiding

No discussion shall take place upon the minutes except upon their accuracy or where the ~~Chairman~~Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting

Minutes shall be circulated in accordance with the Council's wishes. Where providing a record of a public meeting the minutes shall be made available to the public

3.15 Waiver of standing orders

These standing orders shall not be waived except:

3.15.1 where urgent action is required and the ~~Chairman~~Chair considers it to be in the interests of the Trust to waive one or more of the Standing Orders, s/he may do so, subject to such action being reported to and ratified by the next meeting of the Council

3.15.2 upon a notice of motion under Standing Order 3.7

3.15.3 at least half of the total number of governors, including not less than one third public governors, not less than one third staff governors and not less than one third appointed governors are present at the meeting

A decision to waive Standing Orders shall be recorded in the minutes of the next meeting of the Council of Governors

All waivers of Standing Orders shall be reported to the Board of Directors' Integrated Audit and Governance Committee. The Committee shall review every decision to waive the Standing Orders

3.16 Amendment of standing orders

These Standing Orders shall only be amended in accordance with paragraph 48 of the Constitution.

3.17 Record of attendance

The names of the ~~Chairman~~Chair and governors, and any invited attendees present at the meeting shall be recorded in the minutes

3.18 Quorum

No business shall be transacted at a meeting of the Council of Governors unless there is a quorum present consisting as follows:

3.18~~7~~.1 One third of the governors are present with the majority having been elected by one of the public constituencies

If insufficient members to constitute a quorum are in attendance within 30 minutes of the time fixed for a meeting, the meeting will stand adjourned for 7 days and at the reconvened meeting those present will constitute a quorum.

If a governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution because of the declaration of a conflict of interest they ~~he/she~~ shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting.

Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business

4. DELEGATION OF FUNCTIONS AND STATUS OF STANDING ORDERS

4.1 Delegation of powers to committees

The Council may not delegate any of its functions or powers to any subcommittees or committees of the Council.

4.2 Non-Compliance with Standing Orders

If for any reason these Standing Orders 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 Council for action or ratification. All members of the Council have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the constitution and the Statutory Framework , the Council of Governors may appoint committees of the Council of Governors consisting of a sub-set of Governors. The Council of Governors may not delegate any of its powers to a committee but committees may act in an advisory capacity to assist the Council of Governors in carrying out its functions.

The Committee can be substantive (for example Nominations and Remunerations Committee) or set up for the purposes of a task and will only exist until the task is deemed complete by the Council of Governors

The standing orders of the Council of Governors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or subcommittee established by the Council of Governors. The minimum quorum for any committee shall be ~~four~~ three.

Each such committee shall have such terms of reference and be subject to such conditions (as to reporting to the Council) as the Council shall decide and shall be in accordance with the Statutory Framework and any direction or guidance issued by NHS Improvement. Such terms of reference shall have effect as if incorporated into the standing orders.

The Council of Governors shall approve the appointments to each of the committees which it has formally constituted, and their chairs. The Council of Governors may request that external advisers assist them or any committee they appoint in carrying out its duties.

Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Statutory Framework, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Statutory Framework.

The committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.2 Nominations and Remuneration Committee

The Council shall appoint a Nominations and Remuneration Committee to be responsible for the identification and nomination of non executive directors, including the ~~Chairman~~Chair, and to make recommendations to the Council.

The Committee will also recommend to the Council the remuneration and terms of appointments of the ~~Chairman~~Chair and NEDs

The Nominations and Remuneration Committee will operate in accordance with guidance set out in the NHS Foundation Trust Code of Governance issued by NHS Improvement, or as shall from time to time be further issued by NHS Improvement.

5.3 Confidentiality

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council or shall otherwise have concluded on that matter.

A governor of the Trust shall not disclose any matter reported to the Council or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council or committee shall resolve that it is confidential.

A governor of the Trust shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the meeting which may take place on such reports or papers.

6. DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

Council members are required to declare interests which are relevant and material to the Council. Interests should be declared on appointment and updated to the Trust Secretary as circumstances change, and at least annually.

Interests which should be regarded as 'relevant and material' are set out in paragraph 22 of the Trust's constitution:

At the time Council members' interests are declared, they should be recorded in the Council's minutes. Any changes notified to the Trust Secretary in between meetings should be declared at the next Council meeting following the change occurring.

Council members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Council's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting, if a conflict of interest is established, the member of the Council concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

There is no requirement for the interests of Council members' spouses or partners to be declared. However, if the Council members' spouses or partners, if living together, have any pecuniary interest, direct or indirect, in contracts or proposed contracts with the Trust, this is regarded as relevant and should be disclosed.

If Governors have any doubt about the relevance of an interest this should be discussed with the ~~Chairman~~Chair or the Trust Secretary.

6.2 Register of Interests

The Trust Secretary shall maintain a register of members' interests. This will include details of all directorships and other relevant and material interests which have been declared by Council members as defined in Standing Order 6.1.

The register will be subject to regular review by the Trust Secretary at each meeting or as required by the Statutory Framework. The register will be updated as and when members' declare an interest/revise a declaration. Any such changes made will be declared and noted at the next meeting of the Council of Governors.

The register will be available to the public and the ~~Chairman~~Chair will take reasonable steps to bring the existence of the register of the attention of the local population and to publicise arrangements for viewing it.

In establishing, maintaining, updating and publicising the register, the Trust will comply with all requirements as laid out in the Statutory Framework.

7. DISPUTE RESOLUTION PROCEDURES

Provisions for the resolution of disputes about the constitution or its interpretation, whether raised by the Board of Directors or Council of Governors are specified in Annex 6 of this constitution. ~~, will be established. For the avoidance of doubt, these procedures will apply to disputes about the constitution or its interpretation between the Board of Directors and the Council of Governors.~~

~~Disputes shall be referred in the first instance to the Chairman of the Council of Governors.~~

~~If appropriate the Chairman may refer the dispute to a committee of the Council of Governors to advise the full Council of Governors.~~

~~Any unresolved dispute is to be submitted to an arbitrator agreed by the parties or nominated in default of agreement by decision of the Council and Board of Directors. The arbitrator's decision will be binding and conclusive on all parties.~~

8. PROCESS FOR THE APPOINTMENT OF NON-EXECUTIVE DIRECTORS

When a vacancy arises or is scheduled to arise ~~within 9 months,~~ a Nominations Committee shall be convened with clear terms of reference to advise the Council of Governors on the appointment of Non-Executive Directors.

9. PROCESS FOR THE APPOINTMENT OF THE CHAIRMAN

Subject to the provisions within the constitution in relation to the appointment and removal of the ~~Chairman~~Chair, the ~~Chairman~~Chair shall be appointed in accordance with the process of open competition.

When a vacancy arises or is scheduled to arise ~~within9 months~~, a Nominations Committee shall be convened with clear terms of reference to advise the Council of Governors on the appointment of the ~~Chairman~~Chair

10. PROCESS FOR THE APPOINTMENT OF AUDITORS

The Council will appoint external auditors following a recommendation from the Integrated Audit and Governance Committee to which will be delegated the tendering and selection arrangements. The recommendation will set out the reasons for the proposed choice of external auditor.

11. STANDARDS OF BUSINESS CONDUCT

11.1 Duty of compliance

Governors should comply with the Trust's values, the Trust's code of conduct, Trust's policy on Standards of Business Conduct, the requirements of the Statutory Framework as referred to in standing order 1.1 and any relevant guidance issued by NHS Improvement.

11.2 Canvassing of and recommendations by, members of the Council in relation to appointments

Canvassing of directors or governors of the Trust or of any committee of the Trust directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. This clause of the Standing Orders shall be brought to the attention of candidates.

A member of the Council shall not solicit for any person any appointment with the Trust or recommend any person for such appointment. This clause of the Standing Orders shall not preclude a member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or committees, whether solicited or unsolicited should be declared to the panel or the committee.

12. DECLARATION OF ELIGIBILITY

At their first meeting, all governors shall be required to sign declarations of their right to represent their constituency and to be a member ~~vote at Council~~ of the Council of Governors~~' meetings~~. These declarations shall be valid for 1 year and must be renewed annually ~~the duration of their term of office.~~ Declaration forms are attached.

13. MISCELLANEOUS

13.1 Standing Orders to be given to members of the Council

It is the duty of the Trust Secretary to ensure that existing and new members of the Council are notified and understand their responsibilities within the constitution and these standing orders.

13.2 Review of Standing Orders

These Standing Orders shall be reviewed every three~~wo~~ years or earlier with agreement of the Council of Governors in line with the Constitution

GOVERNORS' DECLARATION PART 1

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST (the "Trust")

I, ….....(insert name)
Of …..... (insert address)

Hereby declare that I am entitled to stand for election to the Council of Governors as a Governor elected by *one of the public constituencies / the staff constituency** because I am a member of one of the *public constituencies staff / constituency* * and that I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 of the National Health Service Act 2006 or under the constitution of the Trust.

(a)a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged,

(b)a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

(c)a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

Signed ….....

Print
Name…….....

Date of Declaration ….....

*delete as appropriate

PART 2

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST (the "Trust")

I, ….....(insert name)
Of …..... (insert address)

Hereby declare that I am entitled to vote at meetings of the Council of Governors as a Governor elected by *one of the public constituencies / the staff constituency** or because *I have been appointed as a Partner Governor* and that I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 of the National Health Service Act 2006 or under the constitution of the Trust.

(a)a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged,

(b)a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

(c)a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

Signed…….....

Print…….....
Name

Date of Declaration …....

*delete as appropriate

APPENDIX 1 TO COUNCIL OF GOVERNORS STANDING ORDERS

Not used

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 25 and 36)

CONTENTS

INTRODUCTION

Statutory Framework

East Kent Hospitals University NHS Foundation Trust (the Trust) is a body corporate which became a public benefit corporation on 1 March 2009 following its approval as an NHS Foundation Trust ~~by Monitor~~, pursuant to the National Health Service Act 2006 (the 2006 Act).

The Trust Offices are at Kent & Canterbury Hospital, Ethelbert road, Canterbury, CT1 3NG.

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 Act (as amended by the Health and Social Care Act 2012), by their constitutions and by the terms of their licence granted by ~~Monitor~~ NHSE (the Statutory Framework).

The functions of the Corporation are conferred by the Statutory Framework.

As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

Reservation and Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or subcommittee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit.
Delegated Powers are covered in a separate document (Standing Financial Instructions incorporating Reservation of Powers to the Board of Directors and Detailed Scheme of Delegation.

1 INTERPRETATION

1.1 Save as permitted by law and subject to the Constitution, at any meeting the ~~Chairman~~Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they ~~he/she~~ should be advised by the Chief Executive or Trust Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made under the 2006 Act shall have the same meaning in this interpretation and where there is a conflict between the 2006 Act and another legislative provision the 2006 Act interpretation shall prevail (unless, in either case, the context otherwise requires) and in addition:

"Accounting Officer" shall be the Officer responsible and accountable for funds entrusted to the Trust. ~~He~~They shall be responsible for ensuring the proper stewardship of public funds and assets and performing the functions delegated to him by the Constitution in relation to the Trust's accounts. For this Trust it shall be the Chief Executive.
"Trust" means East Kent Hospitals University NHS Foundation Trust.
"Board of Directors" and (unless the context otherwise requires) **"Board"** shall mean the ~~Chairman~~Chair and other non-executive directors, and the executive directors appointed by the relevant committee of the Trust.
"Council of Governors" means the Council of Governors of the Trust.
"Budget" shall mean 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;

"~~Chairman~~Chair" 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~~Chair of the Trust" shall be deemed to include the Deputy ~~Chairman~~Chair of the Trust if the ~~Chairman~~Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" shall mean the Chief Executive Officer of the Trust.

"Committee" shall mean a committee of the Board of Directors.

"Committee Members" shall be the directors formally appointed by the Trust to sit on or to chair specific committees.

"Constitution" means the constitution of the Trust.

"Contract" shall include any proposed contract or other course of dealing.

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

"Director" shall mean a person appointed as a director in accordance with the Constitution and includes the ~~Chairman~~Chair.

"Finance Director" shall mean the chief finance officer of the Trust. **"Funds held on trust"** shall mean those funds which the Trust holds on trust at its date of authorisation as an NHS Foundation Trust or chooses subsequently to accept. Such funds may or may not be charitable. **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing orders (SOs) and Standing financial Instructions (SFIs).

"Officer" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

"Trust Secretary" means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the ~~Chairman~~Chair and ~~monitor~~ the Trust's compliance with the Statutory Framework and these standing orders

2. THE TRUST

2.1 Preamble

All business shall be conducted in the name of the Trust.

2.2 The Trust has the functions conferred on it by the Statutory Framework.

2.3 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees, accountability for charitable funds held on trust is to the Charity Commission.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board. These powers and decisions and those delegated by the Board to officers and other bodies are set out in the Reservation of Powers to the Board of Directors.

2.6 **Composition of the Board**

In accordance with, but always subject to, the provisions of the Constitution, the composition of the Board shall be:

- The ~~Chairman~~Chair of the Trust
- A minimum of 5 and up to 7 other Non executive directors excluding the ~~Chairman~~Chair
- A minimum of 4 and up to 7 Executive directors including:
  - The Chief Executive (and Accounting Officer)
  - The Director of Finance
  - A medical or dental practitioner
  - A registered nurse or registered midwife.

2.7 **Appointment of the ~~Chairman~~Chair and other Non-Executive Directors**

The ~~Chairman~~Chair and the other Non-Executive Directors are appointed by the Council of Governors.

2.8 **Appointment of the Executive Directors**

The Chief Executive is appointed by the ~~Chairman~~Chair and other NonExecutive Directors, subject to the approval of the Council of Governors. The other Executive Directors are appointed by the Nominations Committee that the Board shall appoint from time to time for that purpose.

2.9 **Terms of Office of the ~~Chairman~~Chair and other Non-Executive Directors**

The regulations setting out the period of tenure of office of the ~~Chairman~~Chair and other Non-Executive Directors and for the termination or suspension of office of the ~~Chairman~~Chair and other Directors are contained in the Constitution of the Trust.

2.10 **Appointment of Deputy ~~Chairman~~Chair**

Subject to SO 2.11 below, the Council of Governors will appoint one of the Non-Executive Directors to be Deputy ~~Chairman~~Chair, following recommendation by the ~~Chairman~~Chair for such period, not exceeding the remainder of his term as a Director, as they may specify on appointing him/her.

2.11 Any Director so appointed may at any time resign from the office of Deputy ~~Chairman~~Chair by giving notice in writing to the ~~Chairman~~Chair. The Council of Governors may thereupon appoint another Non Executive Director as Deputy ~~Chairman~~Chair in accordance with the provisions of Standing Order 2.10

2.12 **Powers of Deputy ~~Chairman~~Chair**

Where the ~~Chairman~~Chair of the Trust has died or has ceased to hold office, or where they ha~~s~~ves been unable to perform his duties as ~~Chairman~~Chair owing to illness or any other cause, the Deputy ~~Chairman~~Chair shall act as ~~Chairman~~Chair until a new ~~Chairman~~Chair is appointed or the existing ~~Chairman~~Chair resumes his duties, as the case may be; and references to the ~~Chairman~~Chair in these Standing Orders shall, so long as there is no ~~Chairman~~Chair able to perform his duties, be taken to include references to the Deputy ~~Chairman~~Chair.

2.13 **Appointment and Powers of Senior Independent Director**

Subject to SO 2.14 below, the Board of Directors may appoint one of the independent Non Executive Directors (as defined in the NHS Foundation Trust Code of Governance ~~published by Monitor~~) to be the Senior Independent Director, in consultation with the Council of Governors for such period, not exceeding the remainder of his term as a Director, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Job Description", as amended from time to time by resolution of the Board.

2.14 Any Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the ~~Chairman~~Chair. The Board of Directors, in consultation with the Council of Governors, may thereupon appoint another independent Non Executive Director as Senior Independent Director in accordance with the provisions of Standing Order 2.13.

2.15 The posts and duties of the Deputy ~~Chairman~~Chair and Senior Independent Director may be combined. This decision may be reviewed at any time by the Board of Directors, in consultation with the Council of Governors.

2.16 The role of the Senior Independent Director will include acting as a conduit for concerns to be raised by governors if the usual mechanisms of contact and discussion have been exhausted and, subject to the agreement of the

Council of Governors, making arrangements for the annual evaluation of the performance of the ~~Chairman~~Chair. The process to achieve this evaluation and its outcome will be agreed with and reported to the Council of Governors.

2.17 **Joint Executive Directors**

Where more than one person is appointed jointly to an Executive Director post those persons shall count as one person for the purposes of these standing orders:-

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of a quorum.

2.18 **Role of Directors**

The Board will function as a corporate decision-making body, Executive and Non Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They are ~~He/she is~~ the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives.

(2) **Non-Executive Directors**

The Non Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(3) **~~Chairman~~Chair**

The ~~Chairman~~Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.19 **Corporate role of the Board**

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.20 **Scheme of Reservation and Delegation of Powers**

The Board may resolve that certain powers and decisions be exercised only by the Board. These powers and decisions are set out in the Reservation of Powers to the Board of Directors . Those powers which it has delegated to officers and other bodies are also contained in the Standing Financial Instructions and Detailed Scheme of Delegation.

3. MEETINGS OF THE BOARD

3.1 **Calling Meetings**

Ordinary meetings of the Board shall be held at such times and places as the Board may determine. All l meetings of the Board are to be held in public pursuant to clause 34 of the Constitution. Parts of these meetings may be held in closed session for special reasons.

3.2 The ~~Chairman~~Chair may call a meeting of the Board at any time. If the ~~Chairman~~Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him/her, or if, without so refusing, the ~~Chairman~~Chair does not call a meeting within fourteen days after such requisition has been presented to him, at the Trust's Headquarters, such one third or more directors may forthwith call a meeting.

3.3 **Notice of Meetings**

Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the ~~Chairman~~Chair or by an officer of the Trust authorised by the ~~Chairman~~Chair to sign on his behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to him at least six clear days before the meeting. The agenda will be sent to Directors six days before the meeting. The open agenda will be sent to the Council of Governors at the same time. Supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. A public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices, or on its website at least three clear days before the meeting.

3.4 Lack of service of the notice on any director shall not affect the validity of a meeting.

3.5 In the case of a meeting called by directors in default of the ~~Chairman~~Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.6 A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post or otherwise the day following electronic transmission.

3.7 **Setting the Agenda**

The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and that for special reasons certain items should be heard in a separate closed session.

3.8 A director desiring a matter to be included on an agenda shall make his/her request in writing or orally to the ~~Chairman~~Chair or the Trust Secretary at least 15 clear days before the meeting, subject to Standing Order 3.3. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the ~~Chairman~~Chair.

3.9 ~~**Chairman**~~**Chair of Meeting**

At any meeting of the Board, the ~~Chairman~~Chair, if present, shall preside. If the ~~Chairman~~Chair is absent from the meeting the Deputy ~~Chairman~~Chair, if there is one and they are ~~he/she is~~ present, shall preside. If the ~~Chairman~~Chair and Deputy ~~Chairman~~Chair are absent such non-executive director as the director's present shall choose shall preside.

3.10 If the ~~Chairman~~Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy ~~Chairman~~Chair, if present, shall preside. If the ~~Chairman~~Chair and Deputy ~~Chairman~~Chair are absent, or are disqualified from participating, such non-executive director as the director's present shall choose shall preside.

3.11 **Notices of Motion**

A director of the Board desiring to move or amend a motion shall send a written notice thereof at least 15 clear days before the meeting to the ~~Chairman~~Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations.

Emergency Motions:- Subject to the agreement of the ~~Chairman~~Chair, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the

business of the meeting as an additional item included in the agenda. The ~~Chairman~~Chair's decision to include or exclude the item shall be final.

3.12 **Motions: Procedure at and during a meeting**

i) **Who may propose**

A motion may be proposed by the ~~Chairman~~Chair of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

The ~~Chairman~~Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) **Motion once under debate**

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business. (*)
- the appointment of an ad hoc committee to deal with a specific item of business.
- the motion be now put. (*)
- that a member/director be not further heard;

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

iv) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board. The ~~Chairman~~Chair's decision on this will be final

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

v) **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.13 **Withdrawal of Motion or Amendments**

A motion or amendment once moved and seconded may be withdrawn by the proposer

3.14 **Motion to Rescind a Resolution**

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director(s) who gives it and also the signature of three other directors. Before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any director other than the ~~Chairman~~Chair to propose a motion to the same effect within six months; however, the ~~Chairman~~Chair may do so if they ~~he/she~~ consider~~s~~ it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.15 **~~Chairman~~Chair's Ruling**

Statements of directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the ~~Chairman~~Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.16 **Voting**

Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question. In the case of any equality of votes, the ~~Chairman~~Chair shall have a further or casting vote.

3.17 All questions put to the vote shall, at the discretion of the ~~Chairman~~Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.18 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.19 If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.20 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

- A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director, at the ~~Chairman~~Chair's discretion.

- A manager attending the Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director, unless approved by the ~~Chairman~~Chair. An Officer's status when attending a meeting shall be recorded in the minutes.

- For the voting rules relating to joint Executive Directors see Standing Order 2.17

3.21 Virtual Voting

In the event that a decision is required ahead of the next Board of Directors' meeting a virtual vote will be proposed. The vote will be passed if 75% of the Board members vote in favour and at least 50% of those voting are non-executive directors. The decision will be ratified at the next Board of Directors meeting.

3.22 **Minutes**

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it. A copy of the public minutes will be

sent to the Council of Governors as soon as practically possible after the meeting.

3.23 No discussion shall take place upon the minutes except upon their accuracy or where the ~~Chairman~~Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.24 **Waiver of Standing Orders**

Except where this would contravene any statutory provision or any guidance issued by ~~Monitor or~~ NHS Improvement, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and two Non Executive Directors, and that a majority of those present vote in favour of suspension.

3.25 A decision to waive Standing Orders shall be recorded in the minutes of the meeting.

3.26 The Audit Committee shall review every decision to waive Standing Orders.

3.27 **Suspension of Standing Orders**

Except where this would contravene any statutory provision or any guidance issued by ~~Monitor or~~ NHS Improvement, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive director and two non-executive directors, and that a majority of those present vote in favour of suspension.

3.28 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.29 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

3.30 No formal business may be transacted while Standing Orders are suspended.

3.31 The Integrated Audit and Governance Committee shall review every decision to suspend Standing Orders.

3.32 **Variation and Amendment of Standing Orders**

These Standing Orders shall only be amended in accordance with paragraph 48 of the Constitution.

3.33 **Record of Attendance**

The names and titles of the directors present at the meeting shall be recorded in the minutes.

3.34 **Quorum**

No business shall be transacted at a meeting of the Board unless at least one third of the whole number of the directors are present including at least one executive director and two non-executive directors.

3.35 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) they ~~he/she~~ shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee).

3.36 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.37 **Admission of public and the press**

3.37.1 Subject to paragraph 3.36.2, Board meetings shall be held in public but the whole or any part of the meeting may be held in closed session if the Board so resolves or any change in legislation dictates.

3.37.2 Individual members of the public and the press may, at the absolute discretion of the ~~Chairman~~Chair, be admitted to all or part of a closed session of a Board meeting**.**

3.37.3 When the public and press are admitted to all or part of a Board meeting, the ~~Chairman~~Chair (or Deputy ~~Chairman~~Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption

3.37.4 In the event that the public and press are admitted to all or part of a Board meeting they shall be required to withdraw if the Board so resolves.

3.37.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board or Committee thereof. Such permission shall be granted only upon resolution of the Board of Directors

3.38 **Observers at closed sessions of the Board of Directors meetings**

The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the closed session of the Board of Directors meetings and may change, alter or vary these terms and conditions as it deems fit.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Exercise of functions

Subject to the Statutory Framework and such guidance as may be issued by ~~Monitor or~~ NHS Improvement, 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 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders (SO 2.5) may in emergency or for an urgent decision be exercised by the Chief Executive and the ~~Chairman~~Chair, after having consulted two non executive directors where possible. The exercise of such powers by the Chief Executive and the ~~Chairman~~Chair shall be reported to the next formal meeting of the Board for formal ratification.

4.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or subcommittees, and their specific executive powers shall be approved by the Board.

4.4 Delegation to officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committees or sub-committees or jointcommittees shall be exercised on behalf of the Trust by the Chief

Executive. The Chief Executive shall determine which functions they ~~he/she~~ will perform personally and shall nominate officers to undertake the remaining functions for which they ~~he/she~~ will still retain accountability to the Trust.

4.5 The Chief Executive shall prepare a schedule of matters reserved to the Board and a scheme of delegation (Scheme of Reservation and Delegation of Powers) identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Reservation and Delegation of Powers which shall be considered and approved by the Board as indicated above.

Nothing in the Scheme of Reservation and Delegation of Powers shall impair the discharge of the direct accountability to the Board of the Finance Director or other executive director to provide information and advise the Board in accordance with any statutory requirements or guidance issued by ~~Monitor or~~ NHS Improvement. Outside these statutory requirements the roles shall be accountable to the Chief Executive for operational matters.

4.6 Overriding Standing Orders – If for any reason these Standing Orders 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 Board for action or ratification. All Board Directors and staff have a duty to disclose any noncompliance with these Standing Orders to the Chief Executive or ~~Chairman~~Chair of the Integrated Audit and Governance Committee as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Statutory Framework and any guidance as may be issued by Monitor or NHS Improvement, the Board may and, if so required by ~~Monitor or~~ NHS Improvement, shall appoint committees of the Board, consisting wholly of directors of the Board. The Trust shall determine the membership and terms of reference of these committees and shall if it requires to, receive and consider reports from them.

5.2 A committee appointed under SO 5.1 may, subject to any guidance issued by ~~Monitor or~~ NHS Improvement and to any restriction imposed by the Board, appoint subcommittees consisting wholly of one or more members of the committee.

5.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or subcommittee established by the Board.

5.4 Each such committee or sub-committee shall have such terms of reference and powers ,reviewed annually, and be subject to such conditions (as to reporting back to the Board), as the Board shall decide.~~.~~

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 The Board shall approve the appointments to each of the committees which it has formally constituted

5.7 **Confidentiality**

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.8 A Director shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

5.9 **Committees established by the Board of Directors**

The Board will establish committees required of it by legislation ~~or Monitor~~ or NHS Improvement's NHS Foundation Trust Code of Governance.
These will include:

5.9.1 **Integrated Audit and Governance Committee**

In line with legislation and the Code of Governance, the Board of Directors will establish and constitute an Integrated Audit and Governance Committee to provide the Board with an independent and objective review of its financial and non-financial internal control systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Board and reviewed on an annual basis.

The Integrated Audit and Governance Committee will be composed of a minimum of three independent non-executive directors, of which one must have significant, recent and relevant financial experience.

5.9.2 **Remuneration Committee**

A Remuneration Committee will be established and constituted by the Board of Directors, comprised of the independent non-executive directors. The terms of reference of the Committee will be approved by the Board and reviewed on an annual basis.

The purpose of the Committee will be:

5.9.2.1 to decide on the appropriate remuneration, allowances, and terms of and conditions of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);
(ii) provisions for other benefits, including pensions and cars;
(iii) arrangements for termination of employment and other contractual terms.

5.9.2.2 The Committee may also recommend and monitor the level and structure of remuneration for senior management

5.9.3 **Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

5.9.4 **Nominations Committee**

The Board shall appoint from time to time an Nominations Committee comprised of the ~~Chairman~~Chair, the other Non-Executive Directors and the Chief Executive (except in the case of appointment of the Chief Executive). The purpose of the Nominations Committee shall be to appoint the Executive Directors and the Chief Executive. The appointment of the Chief Executive shall require the approval of the Council of Governors.

5.9.5 **Other Committees**

The Board may also establish such other committees as required to discharge its responsibilities.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

The Directors shall declare any interests in accordance with paragraph 36 of the Constitution. All existing directors shall declare such interests. Any directors appointed subsequently shall do so on appointment or as soon as they arise.

6.2 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered. If directors have any doubt about the relevance of an interest, this should be discussed with the ~~Chairman~~Chair, or the Trust Secretary.

6.3 At the time directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

6.4 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a board meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 **Register of Interests**

The Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interests of directors. In particular the Register will include details of all directorships and other interests which have been declared by both executive and non-executive directors,. Attendees of Board Committees who are not Board directors will be required to declare any interests in accordance with paragraph 36 of the Constitution.

6.7 These details will be kept up to date on a regular basis, and the Register will be formally reviewed once a year.

6.8 The Register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.9 In establishing, maintaining, updating and publicising the Register, the Trust shall comply at all times with the Statutory Framework and any guidance issued by ~~Monitor or~~ NHS Improvement. In the event of conflict between these Standing Orders and the Statutory Framework or guidance issued by ~~Monitor or~~ NHS Improvement, the latter shall prevail.

6.10 Standing Order 6 applies to a committee or sub-committee of the Board as it applies to the Board and applies to all members of any such committee or sub-committee whether or not they are ~~he or she is~~ also a Director.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS staff', which has been adopted by the Trust as its Code of Conduct, and any guidance issued by ~~Monitor or~~ NHS Improvement. In addition, they must adhere to the Trust's Counter Fraud Policy and Procedure for East Kent Hospitals Staff, Trust Values, and any other guidance produced by the Trust

7.2 Interest of Officers in Contracts

If it comes to the knowledge of a director or an officer of the Trust that a contract in which they ha~~s~~ves any pecuniary interest not being a contract to which they are ~~is himself~~ a party, has been, or is proposed to be, entered into by the Trust they ~~he/she~~ shall, at once, give notice in writing to the Chief Executive of the fact that they have an ~~he/she is~~ interest~~ed~~ therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Chief Executive will ensure that such declarations are formally recorded.

7.4 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of directors or governors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.7 Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of

any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

7.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

7.9 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office within the Trust.

7.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, Standing Orders 6 and/or 8.2 may apply.

8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Directors of the Board, not from the originating department, and shall be attested by them. A report of all sealings shall be made to the Board at least quarterly.

8.3 Register of Sealing

The Trust Secretary shall keep a register in which they ~~he/she~~, or another manager of the Trust authorised by him/her, shall enter a record of the sealing of every document.

9. SIGNATURE OF DOCUMENTS

9.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or his nominated deputy, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings. .

9.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Reservation and Delegation of Powers but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed), which may only be

signed by the Chief Executive or his nominated deputy with a second Director as in 9.2 for documents requiring sealing.

10. MISCELLANEOUS

10.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

10.2 Review of Standing Orders

Standing Orders shall be reviewed annually by the Trust.

ANNEX 9 – FURTHER PROVISIONS

1. Membership of the Foundation Trust.

1.1 With reference to Section 12 and paragraph 12.4 of the constitution if a member of the Trust ceases to meet the criteria for initially becoming a member, they ~~he or she~~ will be automatically disqualified from membership.

1.2 Other criteria for exclusion or disqualification from membership are as follows:

- Anyone under the age of 16
- Anyone who has been involved in any act of violence or aggression against Trust staff (whether directly employed or not), or a Trust volunteer in the five years leading up to the next election. This will apply whether or not the act occurred on or off the Trust premises.
- Anyone who has been identified by court order as a vexatious complainant

2. ~~Chairman~~Chair and Non executive Directors.

2.1 With the exception of the arrangements set out section 28 of the constitution the first term of appointment of ~~Chairman~~Chair and Non Executive Directors will be by competition for a maximum of three years. Reappointment may be considered for a further three year term The Council of Governors will determine whether competition is required after discussion with the ~~Chairman~~Chair or Senior Independent Director (in the case of the reappointment of the ~~Chairman~~Chair).

Non Executive Directors may in exceptional circumstances serve longer than six years (e.g. two three year terms following authorisation of the NHS Foundation Trust) subject to annual appointment and to serving up to a maximum of three further years (making nine years in total).

2.2 Neither the ~~Chairman~~Chair nor the Non Executive Directors of the Trust may otherwise be employees of the Trust

2.3 Non executive directors will be subject to additional exclusion requirements over the mandatory ones. These are if:

- They are~~s~~ ~~He or she is~~ an executive director of the Trust or, a governor, nonexecutive director, ~~chairman~~chair, or chief executive of another NHS Foundation Trust
- They are ~~He or she is~~ incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs
- They ~~He or she~~ cease~~s~~ to be a member of the Trust

- They have ~~He or she has~~ had their name placed on registers of Schedule 1 offenders pursuant to the Sex Offenders Act 1977 and/or the Children and Young Person Act 1933
- They have ~~He or she has~~ failed to declare a significant conflict of interest
- They have ~~He or she has~~ a conflict of interest making appointment or continuation as a non executive director untenable
- They are ~~He or she is~~ guilty of conduct or actions prejudicial to the Council or the Trust.
- They are ~~He or she is~~ a person who has found through due process not to be a fit and proper person on the grounds of a serious misconduct or incompetence.

In addition non executive directors will be expected to adhere to the Code of Conduct for Directors

2.4 The ~~Chairman~~Chair should meet the qualification requirements for Non Executive Directors set out in the constitution, and be subject to the same disqualification and exclusion criteria

3. Statutory /Required Committees

3.1 The Trust will establish committees required by statute or by NHS Improvement.

4. NHS Foundation Trust Code of Governance

4.1 The Trust will have due regard to the Code of Governance published ~~by Monitor, as providing advice on good practice.~~ i~~I~~n accordance with ~~Monitor or~~ NHS Improvement's requirements it will make a disclosure statement concerning its compliance with the code, and give an explanation where it does not meet its provisions

5. Trust Secretary.

5.1 The Trust will appoint a Trust Secretary and define his or her role and responsibilities. The appointment and removal of the Trust Secretary will be a matter for the Chief Executive and the ~~Chairman~~Chair jointly

6. Resolution of disputes.

6.1 ~~Monitor's~~ NHSE code of Governance requires foundation trusts to put in place a procedure for addressing disagreements between the Council of Governors and Board of Directors (see para 6.4 to 6.8 in this Annex 9).

6.2 As with all grievances, a dispute should be declared only as a last resort. Established processes should be employed whenever possible to resolve disagreements between two key groups.

6.3 Any dispute not resolved by informal means should be subject to external review and dealt with in a timely manner. The recommendations arising from the external review will be binding on all parties.

6.4 In order for a dispute to be declared a majority of the Council of Governors or the Board of Directors must agree to this course of action.

6.5 **Level one.** The Chair will be informed, by Governors or Directors' that they consider there are grounds to declare a dispute. The Chair will seek to resolve matters informally, normally by asking the Senior Independent Director to investigate the issues and seek resolution. The Senior Independent Director will be assisted by the Trust Secretary. If there is no resolution at this stage a formal dispute will be declared and the process will move to level two.

6.6 **Level two**. The Senior Independent Director, Lead Governor and the Trust Secretary will arrange for independent individuals with relevant experience, for example, Chair, Non Executive Director, Governors of other Foundation Trusts to undertake an investigation. The investigation team will be assisted by the Trust Secretary. The investigation report will be received by the Senior Independent Director, Lead Governor and the Trust Secretary who will discuss the recommendations and agree an action plan for implementation.

6.7 In the event of any dispute about the entitlement to membership the dispute shall be referred to the Trust Secretary who shall make a determination on the point in issue. If the Member or applicant is aggrieved at the decision of the Trust Secretary ~~he~~they may appeal in writing within 14 days of the Trust Secretary's decision to the ~~Chairman~~Chair whose decision shall be final.

6.8 In the event of any dispute about the eligibility and disqualification of a Governor the dispute shall be referred to the Council of Governors whose decision shall be final.

7. Indemnity

7.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors

functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

7.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, Council members or Directors to meet all or any liabilities which are properly the liabilities of the Trust under the paragraph above.

8. Amending the constitution.

8.1 The constitution will be reviewed at least every two years. Any changes to it may only be made in accordance with paragraph 48 of the Constitution. The population figures of the Public Constituencies will be reviewed every five years.

ANNEX 10 – ANNUAL MEMBERS' MEETINGS

1. Interpretation

1.1. Any expression to which a meaning is given in the National Health Service Act 2006 has the same meaning in this interpretation and in addition:

CHAIRMAN 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;

MEMBER means a person who is a member of the Trust and whose name has been entered in the register of members;

OFFICER means an employee of the Trust;

TRUST means East Kent Hospitals University NHS Foundation Trust.

1.2. Save as permitted by law, the ~~Chairman~~Chair of the Trust shall be the final authority on the interpretation of these Standing Orders (on which they ~~he/she~~ shall be advised by the Chief Executive or Trust Secretary).

2. General Information

2.1. The purpose of the Standing Orders for Annual Members' Meetings is to ensure that the highest standards of corporate governance and conduct are applied to all Annual Members' Meetings.

2.2. All business shall be conducted in the name of the Trust.

3. Attendance

3.1. Each Member shall be entitled to attend an Annual Members' Meeting.

4. Meetings in Public

4.1. Annual Members' Meetings must be open to the public.

4.2. The ~~Chairman~~Chair may exclude any member of the public from an Annual Members' Meeting if they are ~~he is~~ interfering with or preventing the reasonable conduct of the meeting.

4.3. Annual Members' Meetings shall be held at such times and places that the ~~Chairman~~Chair may determine.

5. Notice of Meetings

5.1. At least 14 days before each Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the ~~Chairman~~Chair, or by an officer of the Trust authorised by the ~~Chairman~~Chair to sign on his behalf, shall be displayed at the Trust's head office and posted on the Trust's website.

6. Setting the Agenda

6.1. The ~~Chairman~~Chair shall determine the agenda for Annual Members' Meetings in consultation with the Council of Governors.

7. ~~Chairman~~Chair of Annual Members' Meetings

7.1. The ~~Chairman~~Chair, if present, shall preside. If the ~~Chairman~~Chair is absent from the meeting, the Deputy ~~Chairman~~Chair shall preside.

8. ~~Chairman~~Chair's Ruling

8.1. Statements made by any person at an Annual Members' Meeting shall be relevant to the matter under discussion at the material time and the decision of the ~~Chairman~~Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

9. Voting

9.1. Decisions at meetings shall be determined by a majority of the votes of the Members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

9.2. All decisions put to the vote shall, at the discretion of the ~~Chairman~~Chair of the meeting, be determined by oral expression or by a show of hands.

9.3. A Member may not vote at an Annual Members' Meeting unless they have ~~he/she has~~ made a declaration in the specified form that they are ~~he/she is~~ a member of a Public Constituency.

9.4. The form and content of the declaration for the purposes of paragraph 9.3 above shall be specified and published by the Trust from time to time and shall be so published not less than 28 days prior to the Annual Members' Meeting.

9.5. In no circumstances may an absent Member vote by proxy.

10. Suspension of Standing Orders

10.1. Except where this would contravene any statutory provision, any one or more of these Standing Orders may be suspended at an Annual

Members' Meeting, provided that a majority of Members present vote in favour of suspension.

10.2. A decision to suspend the Standing Orders shall be recorded in the minutes of the meeting.

10.3. A separate record of matters discussed during the suspension of the Standing Orders shall be made and shall be available to the Members.

10.4. No formal business may be transacted while the Standing Orders are suspended.

10.5. The Trust's Audit Committee shall review every decision to suspend the Standing Orders.

11. Variation and Amendment of Standing Orders

11.1. These Standing Orders may be amended in accordance with paragraph 48 of the Constitution.

12. Record of Attendance

12.1. The Secretary shall keep a record of the names of the Members present at an Annual Members' Meeting.

13. Minutes

13.1. The Minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next Annual Members' Meeting where they will be signed by the person presiding at it.

13.2. No discussion shall take place upon the minutes except upon their accuracy or where the ~~Chairman~~Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

13.3. The Minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website.

14. Quorum

14.1. No business shall be transacted at an Annual Members' Meeting unless at least 20 Members are present.

14.2. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such other time and place as the ~~Chairman~~Chair shall determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the

number of Members present at the adjourned meeting is to be the quorum.

East Kent Hospitals University NHS Foundation Trust

Chairman's Report, March 2025

After four years on the Trust Board – 15 months as its Acting Chair – I am writing my final Board report. I hope you will forgive a very personal, final reflection of my four years as I finish at the Trust.

I will step down from the Board on 31 April 2025 and Dr Annette Doherty will replace me as EKHUFT's Chair. Firstly, I am delighted that the Trust's Council of Governors has appointed Annette to the position after a long search. Annette also chairs Maidstone and Tunbridge Wells NHS Trust and will, I'm sure, bring all her experience and leadership skills to bear on the role. She will preside as Chair of a Trust which feels and operates very differently to when I started.

It is no exaggeration to say it has been nothing but a privilege to have been entrusted with the position of non-executive director and, latterly, Chair of East Kent Hospitals Trust. The Trust and the NHS has probably been through its most turbulent period over my tenure, which started in Covid, which I was reminded of this month when the Trust marked National Covid-19 day of reflection on March 10. Our Trust in particular has made important inroads into addressing fundamental issues and huge financial challenges in what I hope people will say is in an open, honest and accountable way. The Guardian Service, an independent provider who will offer staff around-the-clock access to independent support, as the provider of our Freedom to Speak Up service is a good example of this.

The work continues and there is much to do – we continue to await the Care Quality Commission (CQC) inspection of our maternity services from November for instance - but I am reassured by the upward trajectory and the desire and commitment of colleagues. I have seen the hard work resulting in real change for patients - from reducing the time people with suspected cancer wait for a definitive diagnosis, to seeing and treating patients across our services more quickly – the work done to reduce our endoscopy backlog has been really remarkable. I have also marvelled at new and innovative patient pathways and treatments, which have direct, real-time impact on the lives of patients. And this is all against a backdrop of unprecedented demand and while making significant financial savings.

On a personal level, I will, in particular, always hold very close my role of the maternity Board safety champion, which I accepted as part of my responsibilities as Chair. This, in particular, has given me the opportunity to speak to hundreds of staff and patients across our hospital sites. I have taken invaluable insight and often been awed by all of our incredible people and the care they give patients in their most vulnerable and anxious moments. I have seen compassion, kindness and determination. For this reason, I have tried to spend as much time as possible meeting staff to really

appreciate the very real challenges that you face on a day-to-day basis. Nowhere has this been more apparent than in our Emergency Departments (EDs). The scale of the ongoing challenge to provide emergency treatment is always very evident each time I have spent an evening observing in ED.

Finally, I want to thank and recognise my Board colleagues. As a NED, and then as Chair, I have had the support of all my Board colleagues, past and present. The Board often has had to confront tough challenges and make difficult decisions which requires debate and often disagreement. As a Board we have heard and respected our differing viewpoints but also come together as a unitary Board, respectfully and with a single focus on the patients of East Kent. I have appreciated the close, open and straightforward way in which Tracey and I have interacted as Chief Executive and Chair. Tracey and her wider Executive Teams have had a considerable impact on the improved performance of the Trust and I am grateful for the part they have played. This extends to the Trust's system partners regionally in the Integrated Care Board (ICB) and NHS England. Our position within NHS Oversight Framework 4 (NOF 4) has meant a close interaction and oversight and I thank them for the way in which this has been done.

Since our last Board in February, there are important developments for the Trust in relation to its business planning arrangements with the ICB for 2025/2026; the full results of our staff survey; and the imminent publication of the Trust strategy all covered in Tracey's Chief Executive Officer (CEO) report and items for discussion at the Board.

Therefore, I close by conveying my thanks to all my colleagues in East Kent and particularly frontline staff for accepting me as Chair. I will leave at the end of this month with huge hope and encouragement for the Trust in what it can achieve in its vital role providing health care to the people of 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: **3 April 2025**

Board sponsor: **Chief Executive**

Paper Author: **Chief Executive**

Appendices:

N/A

Executive summary:

Action required:	Discussion
Purpose of the Report:	The Chief Executive's Report provides a bi-monthly update on key activities and events in the Trust. The report highlights the national context, the Trust's developments, achievements and provides strategic updates.
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 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's Report provides a bi-monthly update on key activities and events in the Trust. The report highlights the national context, the Trust's developments, achievements and provides strategic updates.

2. CLINICAL EXECUTIVE MANAGEMENT GROUP (CEMG)

At meetings of the CEMG in February and March 2025, the group approved a revised Terms of Reference changing its name to the Trust Management Committee, alongside a review of its membership, purpose and the objectives of each of the separately focussed meetings; Quality & Operational Assurance and People & Integrated Systems.

The group also undertook a review of the Never Events that have occurred over the previous two years, received an update in relation to the progress that has been made towards demonstrating compliance with the seven-day service standards and an update on the implementation of the armed forces covenant and progress to becoming a veteran aware organisation.

3. INTERNAL UPDATE

3.1 Performance update

We are committed to meeting the national target of ensuring that no patient waits more than 65 weeks for planned care by the end of March 2025. Based on our current projections, we expect that fewer than 80 patients will be waiting beyond this timeframe. This marks a significant reduction from a peak of 2,698 in January 2024.

From 2025/26, the national standard for planned care waiting times will shift from focusing solely on the longest waiting patients to measuring the proportion of patients treated within 18 weeks of referral. In line with this change to the national standard, the Trust's goal for the next year will be to treat 60% of patients within 18 weeks — an improvement from our current position (52%).

At present, 3.6% of patients have been waiting over 52 weeks for planned care. We are working to reduce this figure to no more than 1% by the end of March 2026.

Our urgent care performance and flow remains under significant pressure. At the time of writing, in-month performance, for all types, against the 4-hour standard is 74.7% and the percentage of patients spending more than 12 hours in the corridor is 10.2%. We continue to work closely with partner organisations to achieve the 78.0% standard by the end of the year with ongoing improvements in our Urgent Treatment Centres (UTCs) (focused on 100% compliance across all our UTCs), increasing the number of patients who are accessing our Same Day Emergency

Care (SDEC) and improving response times across other clinical directorates to support the flow of urgent care patients.

3.2 Finance update

We are continuing to work with system partners in Kent and Medway Integrated Care Board (ICB) to submit the Trust's activity, workforce and financial plan for 2025/26. The national planning submission requires an improvement in productivity as well as delivery of a cost improvement plan (CIP). The Trust is on track for submission on 27 March 2025 in line with national guidelines, with Deficit Support Funding expected to be received as in 2024/25.

The CIP will help support the Trust in transformational change for its services, to deliver the best patient care and quality within the national financial parameters.

The financial settlement in 2025/26 will represent a significant challenge for the Trust to deliver alongside work to improve patient care and to deliver the national standards, it is however important that the Trust continues to make strides forward in 2025/26 to return to financial balance in the coming years.

Detailed finance information is available in the finance report with an update to be provided at the meeting.

3.3 People initiatives

3.3.1 Staff Survey update

Staff experience is primarily measured through the NHS Staff Survey. A new and different approach in 2024 enabled a critical mass of staff to respond (6,224). The Trust's response rate of 63% was the highest in the Trusts' history, one of the most improved in the country and means the Trust's response rate benchmarks in the top 10% of the 122 Acute Trusts nationwide.

A multi-disciplinary team has extensively reviewed the staff survey results and identified three key areas of focus. A quality improvement (QI) methodology has been adopted to drive continuous improvement against each of these. The approach is taking place across parallel, staggered workflows at three levels; Trust, Care Group and Corporate.

A root cause analysis is currently taking place through Trust-wide staff survey workshops, with informed, intelligent countermeasures to follow, alongside a more detailed analysis which will support the development of a 2-year strategic (organisational development (OD)) plan that ensures the most efficient and effective use of the available resource.

3.3.2 Launch of new Freedom to Speak Up (FTSU) service

The Trust's FTSU service has transferred to The Guardian Service, an independent provider who will offer staff around-the-clock access to independent support.

This enhanced service will ensure that any staff member with concerns about patient care and safety, poor practice, bullying and harassment, or unfair treatment can speak to external guardians in complete confidence at any time, who will help staff to identify their preferred resolution path, whether through informal discussions, facilitated meetings, or formal procedures, with clear escalation processes for any issues to protect patients and staff.

The Guardian Service will have direct access to senior decision makers within the Trust and will aim to resolve issues quickly while maintaining staff privacy and fostering an open and honest culture whereby all concerns are taken seriously.

4. EXTERNAL UPDATE

4.1 NHS England (NHSE), Department for Health and Social Care and ICB update

On 13 March 2025, Prime Minister, Sir Keir Starmer, announced that NHS England would be abolished with functions brought back into the Department of Health and Social Care (DHSC) to build a one-team approach, working towards the shared mission of building an NHS fit for the future.

In this announcement, ICBs were also asked to make 50 per cent reductions in their running costs by Q3 2025/26 and Trust's told to reduce their corporate services to pre-pandemic levels. It is expected that this process will take place over a two year period to deliver a much leaner top of the NHS and savings of around £500m. There will be significant impact on the teams and individuals who work within these organisations which we need to be mindful and supportive of over the coming months.

This follows the announcement in February from NHSE's Chief Executive, Amanda Pritchard, of her decision to stand down from the role at the end of the financial year. Sir James Mackey, who is currently Chief Executive of Newcastle Hospitals NHS Foundation Trust and National Director of Elective Recovery, has taken over from Amanda on a secondment basis as Transition Chief Executive Officer (CEO) of NHSE, working closely with her before taking up the post formally on 1 April 2025.

4.2 Community Health Services Procurement process

In December 2024, the Kent and Medway ICB launched an Invitation to Tender (ITT) exercise, covering adult and children's' community services, split into six lots, as follows:

Lot	Coverage	Annual Value
Lot 1	Adults: Dartford, Gravesham and Swanley	£20.0m
Lot 2	Adults: East Kent	£87.3m
Lot 3	Adults: Medway and Swale	£40.6m
Lot 4	Adults: West Kent	£40.8m
Lot 5	Children: Medway and Swale	£ 9.6m
Lot 6	Children: Dartford, Gravesham and Swanley; East Kent; West Kent	£31.7m

The Trust's Child Health Community services are part of the service tender and the child health team are actively engaged with the ICB to ensure that the full quantum of relevant services is correctly identified.

Bids had to be submitted by 14 February 2025 and each lot had to be bid for in its entirety. As a result, the Trust made an active decision not to bid for Lot 6 which contains an element of service currently provided by EKHUFT. Since the submission of bids, a comprehensive evaluation and moderation process has been undertaken by the ICB, involving 65 evaluators (including Subject Matter Experts and patients). A contract award recommendation report is expected to be reviewed and approved on by the ICB Board on 22 April 2205. Following this process, letters confirming the ICB's decision will be published to all bidders (successful and unsuccessful) and an 8-day 'stand still' period will then apply during which representations may be made.

After the statutory 'standstill' period, and if no representations are received, the successful bidder(s) will be notified. Contracts are scheduled to be signed by the end of June 2025 and mobilised between July and late October 2025.

5. OTHER AREAS TO NOTE

5.1 Developing our Trust Strategy

Since January, we have been working with our external partner, Kaleidoscope, to develop an overarching strategy for the Trust that sets out our purpose, vision and strategic aims.

The draft has been developed from the collation of all insights that were gathered during the engagement process with our staff, our patients and our partner organisations. The Strategy and Partnerships team hosted two Strategic Summit days on 22 and 24 January, attended by a wide range of senior leaders and speciality representatives from across the Trust, plus partner organisations, to discuss and prioritise the 354 service visions and goals that were put forward by the clinical teams as part of the 44 clinical engagement sessions. Each vision and goal was tested against the proposed strategic aims (Patients trust, Staff choose, Partners value) and for potential deliverability. Throughout both days, there was excellent engagement and conversations, with an agreed list of visions and goals identified and taken forward for a final Executive review. There was a collective understanding of the need for the Trust to move forward in a way that addresses both historic and future challenges.

The organisational strategy document has now had the content agreed and is currently being prepared for publication.

The next phase of this work is already underway - by the end of June a suite of underpinning strategies will be ready for review – this includes clinical, digital, people, estates and green strategies. Each strategy will provide further detail on the Trust's proposed programmes of work over the next ten years and will describe the expected outcomes for our patients, staff and partners.

5.2 National Covid-19 day of reflection – Monday 10 March 2025

The Lord Mayor and Lady Mayoress of Canterbury joined Trust staff to commemorate the five-year anniversary of the Covid-19 pandemic during a national Day of Reflection.

Chaplain-led services were held at all three acute sites on Monday 10 March, providing an opportunity for colleagues, patients, and visitors to grieve those lost and honour individuals still affected by their loss or the long-term after effects of the virus.

Participants were invited to light candles, write messages on a reflection wall and/ or place ribbons and notes on memory trees, with the hospital chapels remaining open and accessible for periods of quiet reflection and tributes.

5.3 Nursing Midwifery and Allied Health Professionals (AHPs) conference – Wednesday 12 March 2025

On Wednesday 12 March, an inaugural joint conference open to all nursing, midwifery, and AHPs, titled "Collaboration in Action: Nurses, Midwives, and AHPs Shaping the Future through the Four Pillars of Practice" was held.

The event attracted over 100 attendees from various disciplines and levels, fostering an atmosphere of engagement and collaboration. The programme featured breakout sessions focusing on critical topics such as clinical practice, research findings, education, career compass clinics, and improving end-of-life care, complemented by presentations from nurses, midwives, AHPs, and external keynote speakers, including Andrea Lewis, Regional Chief Nurse, Apama Belapurkar, Chief AHP Kent and Medway ICB and Kate Wilson, Regional Chief Midwife.

Plenary discussions addressed future workforce needs, education and training, and introduced the ambition strategies for nursing, midwifery, and AHPs, alongside insights from the inaugural cohort of Chief Nurse Fellows.

5.4 Registered Nurse Degree Apprentices

In early February, the first cohort of Registered Nurse Degree Apprentices (RNDA) celebrated their graduation with a ceremony at Canterbury Cathedral, attended by the workforce development education and training team.

The ceremony marks the end of their journey as students and sets a benchmark for future cohorts, demonstrating the success and importance of the RNDA programme ran in partnership with Canterbury Christ Church University.

5.5 National Chief Nursing Officer awards

Three dedicated healthcare professionals based at the Kent and Canterbury Hospital have been honoured with Chief Nursing Officer (CNO) awards from NHS England.

Ophthalmic technicians Sunitha Freddy, Kevin Taylor and Healthcare Assistant Helen Garlinge, were nominated by their colleagues for these prestigious awards, in recognition of their contributions and the dedication, care, and compassion shown to both patients and staff members. I would like to extend my congratulations to them all.

5.6 Occupational therapy apprentice of the year award

Caroline Palmer, an Occupational Therapy Apprentice at the Queen Elizabeth the Queen Mother Hospital (QEQM), has been recognised as Occupational Therapy apprentice of the year by the University of East London for her excellence, dedication, and commitment to healthcare.

Starting at the Trust in 2019 with no prior clinical experience, Caroline progressed from a therapy support worker to therapy assistant practitioner over three years before joining the Trust's apprenticeship program, which she is expected to complete in early 2026.

5.7 Special Educational Needs and Disabilities award

Helen Waymouth, the Trust's Head of Community Child Health, received a special acknowledgment honour at NHSE's Celebration of Best Practice Health Partnerships in Special Educational Needs and Disabilities awards for her implementation of the Balanced System in Kent, which has transformed speech and language support for children by replacing traditional referral and clinic appointments with accessible "talking walk-ins" at family hubs whereby families receive immediate advice, empowering parents and carers to better support their children's needs, with expert advice and guidance also provided for schools and nurseries.

6. CONCLUSION

6.1 On behalf of my executive colleagues, past and present, I would like to take this opportunity to recognise and thank Stewart for his time on the Trust's Board. He has been an example to us all in the way he has fulfilled his role on the Board, initially as a Non-Executive Director (NED), and for the last 15 months as Chair. His open and direct conversations with me and colleagues have always been inquisitive but also supportive; he has always shown considerable empathy, understanding and positivity. He has brought the Board together in his role as Chair in a way that has directly and positively contributed to the improvements we have been able to collectively make. On a personal level, I have found him to always be approachable, interested and willing to offer his perspective. We thank Stewart for his enormous contribution to the Trust and wish him all the very best when he leaves the Trust at the end of April.

I also welcome and look forward to working with Dr Annette Doherty, who has been appointed as the Trust's new Chair as of 1 May 2025. Annette brings a wealth of experience in the NHS from Cambridge University Hospitals NHS Foundation Trust as a NED and as Chair at Maidstone and Tunbridge Wells NHS Trust (MTW). I am looking forward to working with Annette as we continue to focus on improving the safety and quality of care for patients and the experience of our staff.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **3 April 2025**

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

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

Appendices:

APPENDIX 1: February 2025 IPR

Executive summary:

Action required:	Discussion
Purpose of the Report:	The report provides the monthly update on the Integrated Improvement Plan (IIP), Operational Performance, Quality & Safety, Workforce, Financial & Maternity organisational metrics. The metrics are directly linked to the Strategic and Annual objectives. The reported metrics are derived from: 1. The Trust Integrated Improvement Plan; 2. Other Statutory reporting; 3. Other agreed key metrics.
Summary of key issues:	The IPR has been subject to a review and refresh and a revised format is being presented from May 2024 onwards. The reported metrics have been grouped to give a detailed view of progress against the quarterly milestones for the Integrated improvement plan alongside a summary view of metrics falling within each strategic theme. The attached IPR is now ordered into the following strategic themes: • **Integrated Improvement Plan.** • **Patients,** incorporating operational performance metrics. • **Quality and Safety (Q&S),** incorporating Q&S metrics. • **People,** incorporating people, leadership & culture metrics. • **Sustainability, i**ncorporating finance and efficiency metrics. • **Maternity,** incorporating maternity specific metrics for quality and safety, Friends and Family Test (FFT) and engagement. Key performance points (February Reported Month): **Integrated Improvement Plan** • DM01 Performance, reduction of the Endoscopy Backlog, all Cancer standards and reduction in elective long waiting patients are all showing statistical improvement.

- All Cancer standards are now demonstrating statistical improvement and have achieved the national performance standards in February.
- The financial efficiency programme, Type 1 four hour Emergency Department Compliance and the number of patients on a Cancer Pathway for over 62d are all demonstrating improving performance but are currently not demonstrating a stable enough position to consistently pass the thresholds set. Progress this year is positive.
- The level of engagement with the 2024 NHS Staff Survey was the best in the Trust's history, with over 6,000 staff sharing their feedback and a response rate of 63%. Staff survey priorities have been identified and root cause analysis is currently taking place to ensure informed and intelligent action.

Patients

- There was an adverse movement in the Referral to Treatment (RTT) Long Waiter numbers during February which has delayed achievement against trajectory by one month. The end of year trajectory has been revised to achieving no more than 80 65+ week waiters as at the end of March 2025, with an aim of achieving zero 65 week waits at the end of April 2025.
- Type 1 Compliance continues to exceed the tier 1 milestones in each month.
- The Trust achieved all key Cancer standards in February, 62d GP Referral, 28d Faster Diagnosis Standard (FDS) and 31d First Treatment.
- DM01 performance has improved by a further 2.8% percentage points to 86.2% as at the end of February.

Quality & Safety

- There were no new Never Events reported in February.
- The Trust at the end of February had:
    - 10 nationally reportable Patient Safety Incident Investigations (PSIIs) ongoing;
    - 10 Local PSIIs.
- Our overall training compliance as a Trust is 92.9% for Adult Safeguarding and 91.4% for Children Safeguarding.
- Although work to reduce overdue incidents continues, despite great efforts, the number of overdue incidents has increased again in February. In February 664 incidents became overdue, with an average of 29 incidents becoming overdue daily (equal to the rate of 29 per day in January).

People

- Sickness absence rates remain above the alerting threshold, although dropped by 0.5% to 5.2%.
- Appraisal compliance has remained above the Trust-level threshold (80%), currently standing at 80.8%.
- Statutory training compliance decreased slightly to 92.3%. This continues to exceed the Trust-level threshold (91%).

Finance

- The Group has reported a Year to Date (YTD) deficit of £80.6m against a deficit plan of £82.5m to Month 11 delivering a better than plan YTD position of £1.9m.

	• Trust pay expenditure increased compared to Month 10 by £1.9m. The pay award shortfall is still impacting the Trust's run rate (£1.9m YTD and £2.1m for the year). This has been offset by non-recurrent benefits YTD, however if additional funding is not agreed, it could be a risk to our year-end position if not offset by other positive movements. • The Trust non pay run rate increased in month slightly by £0.5m this was mainly in Education and Training and the purchase of non NHS healthcare to support additional patient activity. • The Trust has delivered £44.5m of efficiencies to month 11, £0.4m above the YTD plan. **Maternity** • The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the February 12 month rolling rate slightly increased from the previous month (3.73 per 1,000 births) at 4.26 per 1,000 births. • No new referrals made to Maternity and Newborn Safety Investigations (MNSI) during February. Currently the maternity service has two open MNSI cases. • No new local PSII reported and commenced in month, two are ongoing. • Eight moderate patient safety incidents were reported in February.
Summary recommendations:	The Board of Directors is asked to **CONSIDER** and **DISCUSS** the metrics reported in the Integrated Performance Report.

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: M11 FINANCE REPORT

Meeting date: 3 APRIL 2025

Board sponsor: CHIEF FINANCE OFFICER (CFO)

Paper Author: INTERIM DEPUTY DIRECTOR OF FINANCE

APPENDIX 1: M11 FINANCE REPORT

Executive summary:

Action required:	Information
Purpose of the Report:	The report is to update the Board on the financial performance to February (M11).
Summary of key issues:	**CFO Update** **The Finance Report**: The Month 11 Year to Date (YTD) position is a favourable variance to plan by £1,876m for the Group. The Trust's position suggests that the Group will meet the plan for the full year, albeit with a need to proactively manage in year risks, which include operational pressures, surge demand and the impact on elective (i.e. planned) work. Excluding the Non-recurrent Deficit Support Revenue Allocation, the Group is reporting a YTD positive variance to plan to Month 11 of £1,876k, as detailed below.

	YTD Plan	YTD Actual	YTD Variance
£'000			
Patient care income	845,919	843,303	(2,616)
Other income	58,252	60,148	1,896
Employee Expenses	(630,381)	(637,515)	(7,134)
Other operating expenses	(348,302)	(341,892)	6,410
Non-operating expenses	(8,529)	(5,294)	3,235
Operating Surplus/Deficit	(83,041)	(81,250)	1,791
Technical adjustments	569.000	654.000	85.000
TECHNICALLY ADJUSTED SURPLUS/(DEFICIT) EXCLUDING DEFICIT SUPPORT	(82,472)	(80,596)	1,876

For the Trust, patient care income has underperformed YTD by £7.0m, despite an overperformance in rechargeable drugs and devices by £5.7m.

	The main drivers are due to a reduction in Elective Recovery Fund (ERF) income as compared to plan, the change in ERF baseline funding for the number of working days and an underperformance of income Cost Improvements (CIPs). Other operating income is adverse to plan by £0.3 in month and favourable to plan by £1.3m YTD. Income for education and training, research and innovation and carparking are favourable to plan YTD by a total of £2.0m, offset by below plan cash donations, charitable income and staff accommodation rental income totalling £0.5m. Trust employee expenditure increased compared to M10 by £1.2m. Bank spend increased by £82k and agency and Direct engagement spend increased by £0.5m. The run rate on substantive staff increased in month by £0.6m which equates to an overall increase in Whole Time Equivalent (WTE) usage of 100 WTE as compared to month 10. YTD the Trust is favourable to plan in pay by £2.2m. The Trust non-pay run rate increased in month slightly by £0.5m this was mainly in Education and Training and the purchase of non NHS healthcare to support additional patient activity. YTD the Trust is favourable to plan for non-pay of £2.8m. The pay award shortfall is still impacting the Trust's run rate (£1.9m YTD and £2.1m for the year). This has been offset by non-recurrent benefits YTD, however if additional funding is not agreed, it could be a risk to our year-end position if not offset by other positive movements. The change in ERF baseline due to the increased number of working days has also impacted the Trust's ERF by £2.2m YTD and a Financial Year End (FYE) of £2.4m. As previously reported the Trust has seen a reduction of Health and Care Partnership (HCP) monies for prior year projects by £2.2m YTD and FYE of £2.4m. The Trust has been mitigating these risks with non-recurrent benefits. **2gether Support Solutions (2gether):** 2gether reported a YTD surplus of £2m, which is in line with the plan. Income underperformance has been offset by underspends in non-pay costs, as well as bank interest received. **Spencer Private Hospitals (SPH):** SPH reported a YTD surplus of £0.3m in operating profit and profit after tax, £0.1m below plan. February income was below budget but costs have been well controlled in line with or below the income deficit. A £49m in-year CIP target was set for 2024/25. The Trust has recognised recurrent savings of £34.5m YTD to February and non-recurrent savings of £10m, totalling a delivery of £44.5m against a plan of £44.1m. Trust is currently on plan to deliver just under the full year target of £49m i.e. £48.5m forecast. The Trust cash balance (excluding subsidiaries) at the end of February was £37.5m. Total capital expenditure at the end of February was £17.5m spend against a plan of £23.7m.

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to review and **NOTE** the financial performance of M11.

Implications:

Links to Strategic Theme:	• Partnerships • Sustainability
Link to the Significant Risk Register (SRR):	**SRR 3664**: Failure to deliver the Trust financial plan for 2024/25.
Resource:	N - Key financial decisions and actions may be taken on the basis of this report.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

Previously considered by: Finance and Performance Committee

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2024/25

February 2025

Chief Finance Officer
Angela van der Lem

We care

Group Summary
Month 11 (February) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
	Year to Date			Year to Date			Year to Date			Year to Date			Year to Date		
(£'m)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Income From Commissioners - exc. D&D	776.861	764.206	(12.656)	0.000	0.000	0.000	19.231	16.533	(2.698)	(5.588)	(2.573)	3.014	790.505	778.165	(12.340)
NHS Income From Commissioners - Drugs	49.269	54.833	5.563	0.000	0.000	0.000	3.452	2.452	(1.000)	(5.018)	0.032	5.050	47.703	57.317	9.614
NHS Income From Commissioners - Devices	7.716	7.821	0.105	0.000	0.000	0.000	0.000	0.000	0.000	(0.005)	0.000	0.005	7.710	7.821	0.110
Other Income	60.501	61.752	1.251	146.187	143.577	(2.610)	0.013	0.043	0.030	(148.449)	(145.224)	3.225	58.252	60.148	1.896
Total Income	**894.347**	**888.611**	**(5.736)**	**146.187**	**143.577**	**(2.610)**	**22.696**	**19.028**	**(3.668)**	**(159.060)**	**(147.765)**	**11.295**	**904.171**	**903.451**	**(0.720)**
Substantive Staff (inc. Apprenticeship Levy)	(522.077)	(517.805)	4.272	(37.704)	(38.137)	(0.433)	(7.870)	(7.051)	0.819	10.779	0.637	(10.142)	(556.872)	(562.356)	(5.484)
Bank Staff	(40.088)	(43.192)	(3.104)	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.000	(0.001)	(40.086)	(43.192)	(3.106)
Agency/Contract	(30.403)	(29.415)	0.988	(2.349)	(1.805)	0.544	(0.669)	(0.747)	(0.078)	(0.002)	0.000	0.002	(33.423)	(31.967)	1.456
Total Employee Expenses	**(592.568)**	**(590.412)**	**2.156**	**(40.053)**	**(39.942)**	**0.111**	**(8.539)**	**(7.798)**	**0.741**	**10.778**	**0.637**	**(10.141)**	**(630.381)**	**(637.515)**	**(7.134)**
Drugs	(42.931)	(42.176)	0.755	0.000	(0.003)	(0.003)	(3.626)	(2.452)	1.174	2.574	2.131	(0.443)	(43.983)	(42.500)	1.483
Rechargeable Drugs	(44.228)	(50.388)	(6.160)	0.000	0.000	0.000	0.000	0.000	0.000	(0.000)	0.000	0.000	(44.228)	(50.388)	(6.160)
Rechargeable Devices	(7.716)	(7.821)	(0.105)	0.000	0.000	0.000	0.000	0.000	0.000	0.005	0.000	(0.005)	(7.710)	(7.821)	(0.110)
Supplies and Services - Clinical	(43.823)	(41.864)	1.959	(38.565)	(52.894)	(14.329)	(1.606)	(2.052)	(0.446)	1.444	1.129	(0.315)	(82.550)	(95.681)	(13.131)
Supplies and Services - General	(135.920)	(138.852)	(2.932)	(27.291)	(22.631)	4.660	(0.274)	(0.232)	0.042	135.516	137.403	1.887	(27.969)	(24.312)	3.657
Clinical negligence	(32.137)	(32.137)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.001)	0.000	0.001	(32.139)	(32.137)	0.002
Depreciation and Amortisation	(20.957)	(20.822)	0.135	0.000	(0.937)	(0.937)	(0.197)	(0.306)	(0.109)	(1.752)	0.000	1.752	(22.906)	(22.065)	0.841
Other non pay	(50.963)	(41.824)	9.139	(38.433)	(25.836)	12.597	(7.917)	(5.793)	2.124	10.496	6.465	(4.031)	(86.816)	(66.988)	19.828
Total Other Operating Expenses	**(378.674)**	**(375.884)**	**2.790**	**(104.289)**	**(102.301)**	**1.988**	**(13.620)**	**(10.835)**	**2.785**	**148.281**	**147.128**	**(1.153)**	**(348.302)**	**(341.892)**	**6.410**
Non Operating Expenses	(8.596)	(5.825)	2.771	0.226	0.620	0.394	(0.159)	(0.089)	0.070	0.000	0.000	0.000	(8.529)	(5.294)	3.235
Profit/Loss	**(85.490)**	**(83.510)**	**1.981**	**2.071**	**1.954**	**(0.117)**	**0.378**	**0.306**	**(0.072)**	**(0.000)**	**(0.000)**	**0.000**	**(83.042)**	**(81.250)**	**1.792**
Less Technical Adjustments	0.569	0.654	0.085	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.569	0.654	0.085
Technically Adjusted Profit/Loss	**(84.921)**	**(82.856)**	**2.065** **1**	**2.071**	**1.954**	**(0.117)** **2**	**0.378**	**0.306**	**(0.072)** **3**	**(0.000)**	**(0.000)**	**0.000** **4**	**(82.473)**	**(80.596)**	**1.877** **5**
Non Recurrent Deficit Support Revenue Allocation	75.394	75.394	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	75.394	75.394	0.000
Deficit Support Adjusted Profit/Loss	**(9.527)**	**(7.462)**	**2.065**	**2.071**	**1.954**	**(0.117)**	**0.378**	**0.306**	**(0.072)**	**(0.000)**	**(0.000)**	**0.000**	**(7.079)**	**(5.202)**	**1.877**

1. Trust:

The Trust, in line with national change, has received Non-recurrent Deficit Support Revenue Allocation to month 11 of £75m (£78.4m for the year). This non-recurrent allocation reduces our planned deficit from £85.8m to £7.4m. Due to this allocation being non-recurrent in nature, we are presenting the finance report with this deficit support income 'below the line' enabling the focus to remain on the recurrent position. Excluding the Non-recurrent Deficit Support Revenue Allocation, the Trust year-to-date deficit is £82.9m against a plan deficit of £84.9.9m; a £2m favourable variance YTD. The key drivers include:

- Income from patient care activities is £7.0m below plan, despite a £5.7m overperformance in drugs and devices. ERF income is £9.0m below plan YTD, including CIPs, with £3.0m underperformance in ICB discharge funding due to a successful project reducing inpatients not fit to reside, £2.2m YTD (£2.4m FYE) national adjustment in ERF Baseline funding.
- Other operating income is favourable to plan by £1.3m YTD. Income for education and training, research and innovation and carparking are favourable to plan YTD by a total of £2.0m, offset by below plan cash donations, charitable income and staff accommodation rental income totalling £0.5m.
- Employee expenses is favourable to plan by £2.2m YTD. Substantive staff are favourable to plan by £4.3m YTD, with underspends in most staffing groups except medical staff and senior managers. Expenditure on bank staff is adverse to plan by £3.1m YTD. Agency staff cost is £1m favourable to YTD plan.
- Other operating expenses are £2.8m favourable to plan YTD. A total YTD overspend of £10.3m on drugs, non-clinical supplies and services, and consultancy is offset by a £12.9m underspend on clinical supplies and services, healthcare purchases, premises, establishment, and other costs.

2. 2gether Support Solutions

2gether Support Solutions reported a YTD surplus of £1.9m, which is £0.1m behind budgeted profit. Trust capital expenditure is above plan in the month, but below plan YTD. Income underperformance has been offset by underspends in non-pay costs, as well as bank interest received.

3. Spencer Private Hospitals

Spencer Private Hospitals reported a YTD surplus of £0.3m in operating profit and profit after tax, which is £0.1m below plan—consistent with January's report. While income was below budget, costs were well controlled, remaining in line with or below the income deficit.

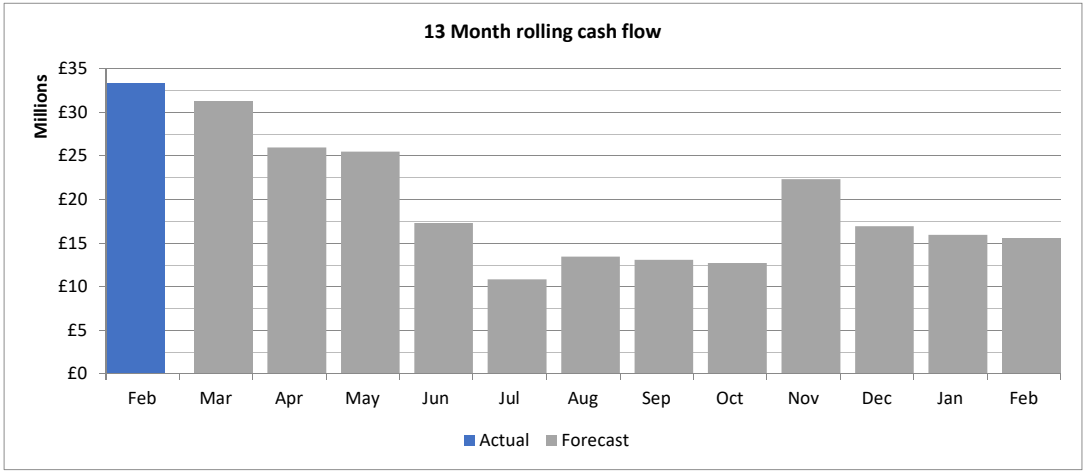
4. Consolidation Adjustments

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

5. Group

In Month 11, there is a £1.9m underspend against the planned deficit. However, the plan's profile for the final month of the year, along with the Trust's run rate, suggests that the Group will still meet the full-year target.

Cash Flow
Month 11 (February) 2024/25



Unconsolidated Cash balance was £37.9m at the end of February 2025, £27.5m above plan.

Cash receipts in month totalled £94.9m (£13.6m above plan):

- K&M ICB paid £66.0m in February (£8.8m above plan - this includes unplanned receipts received in month for non-recurrent deficit support £6.5m and £1.0m invoices cleared)
- NHS England paid £21.0m in February (£8.3m above plan due to the planned phasing of the quarterly Education funding)
- VAT received was £4.3m in February (£0.8m above)
- Other receipts totalled £3.6m (£1.2m above plan - of which, other NHS receipts were £0.3m over plan and receipts from Spencer Private Hospitals were £0.5m above plan)
- No PDC revenue support was received in month (£5.5m below plan) - see Revenue support commentary.

Cash payments in month totalled £90.3m (£10.0m above plan)

- Creditor payment runs including Capital payments were £23.3m (£8.1m above plan).
- £18.6m payments to 2gether were £4.6m above plan.

2024/25 Cash Plan

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

Revenue Support

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

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

In light of this allocation, no further PDC Revenue support requests are expected to be made this financial year although it is reviewed on a monthly basis should the cash position change.

Creditor Management

The Trust paid to 30 day creditor terms for suppliers in Month 11.

At the end of February 2025, the Trust was recording 41 creditor days (Calculated as invoiced creditors at 28th February/Forecast non-pay expenditure x 365).

Statement of Financial Position

Month 11 (February) 2024/25

	Trust			2gether Support Solutions			Spencer Private Hospitals			Consolidation Adjustments			Group		
(£'m)	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**	**Opening**	**To date**	**Movement**
Non Current Assets	**379.770**	**374.106**	**(5.664)**	**67.469**	**65.863**	**(1.606)**	**4.408**	**4.298**	**(0.110)**	**(145.701)**	**(142.751)**	**2.950**	**305.946**	**301.516**	**(4.430)**
Inventories	7.878	7.687	(0.191)	5.245	5.245	0.000	0.047	0.056	0.009	0.000	0.000	0.000	13.170	12.988	(0.182)
Trade Receivables	37.592	60.616	23.024	25.520	10.564	(14.956)	5.397	3.454	(1.943)	(31.706)	(16.959)	14.747	36.803	57.675	20.872
Accrued Income and Other Receivables	(3.504)	(3.547)	(0.043)	(0.127)	(0.217)	(0.090)	(0.134)	(0.081)	0.053	0.000	0.000	0.000	(3.765)	(3.845)	(0.080)
Assets Held For Sale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Cash and Cash Equivalents	17.955	37.922	19.967	12.413	27.887	15.474	2.049	3.278	1.229	0.000	0.000	0.000	32.417	69.087	36.670
Current Assets	**59.921**	**102.678**	**42.757**	**43.051**	**43.479**	**0.428**	**7.359**	**6.707**	**(0.652)**	**(31.706)**	**(16.959)**	**14.747**	**78.625**	**135.905**	**57.280**
Payables and Accruals	94.290	80.940	(13.350)	23.247	21.016	(2.231)	5.103	4.136	(0.967)	(27.854)	(13.305)	14.549	94.786	92.787	(1.999)
Deferred Income and Other Liabilities	8.100	24.796	16.696	0.000	0.000	0.000	0.000	0.000	0.000	(0.006)	(0.007)	(0.001)	8.094	24.789	16.695
Provisions	10.035	11.343	1.308	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	10.035	11.343	1.308
Borrowing	4.270	4.365	0.095	2.524	2.462	(0.062)	0.105	0.079	(0.026)	(4.334)	(4.473)	(0.139)	2.565	2.433	(0.132)
Current Liabilities	**116.695**	**121.444**	**4.749**	**25.771**	**23.478**	**(2.293)**	**5.208**	**4.215**	**(0.993)**	**(32.194)**	**(17.785)**	**14.409**	**115.480**	**131.352**	**15.872**
Provisions	3.423	3.451	0.028	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.423	3.451	0.028
Borrowing	71.611	67.774	(3.837)	50.475	48.391	(2.084)	1.964	1.891	(0.073)	(115.804)	(111.609)	4.195	8.246	6.447	(1.799)
Non Current Liabilities	**75.034**	**71.225**	**(3.809)**	**50.475**	**48.391**	**(2.084)**	**1.964**	**1.891**	**(0.073)**	**(115.804)**	**(111.609)**	**4.195**	**11.669**	**9.898**	**(1.771)**
Net Assets	**247.962**	**284.115**	**36.153**	**34.274**	**37.473**	**3.199**	**4.595**	**4.899**	**0.305**	**(29.409)**	**(30.316)**	**(0.907)**	**257.422**	**296.171**	**38.747**
Public Dividend Capital	559.544	603.815	44.271	30.267	30.267	0.000	0.048	0.048	0.000	(30.315)	(30.315)	0.000	559.544	603.815	44.271
Retained Earnings	(373.566)	(381.683)	(8.117)	5.085	7.204	2.119	1.736	2.042	0.306	0.363	0.535	0.172	(366.382)	(371.902)	(5.520)
Revaluation Reserve	61.983	61.981	(0.002)	0.000	0.000	0.000	2.812	2.812	0.000	(0.535)	(0.535)	0.000	64.260	64.258	(0.002)
Taxpayers Equity	**247.961**	**284.113**	**36.152 1**	**35.352**	**37.471**	**2.119 2**	**4.596**	**4.902**	**0.306 3**	**(30.487)**	**(30.315)**	**0.172 4**	**257.422**	**296.171**	**38.749**

1. Trust:

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

Current Assets - Current assets have increased from the 2023/24 opening position by £42.8m mainly due to £20m increase in cash balance and debtors increased by £23m. Please see Cash and Working capital pages for additional details.

Current Liabilities - Current liabilities have decreased by £4.7m due to reduction in payables (£13.4m - See Working Capital sheet for more detail) offset by increases in other liabilities and provisions by £16.7m and £1.3m respectively.

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

Public Dividend Capital - Increased to date by £44.3m reflecting PDC revenue support received up to September 2024.

2. 2gether Support Solutions:

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

Current Assets - Current assets have increased by £0.4m from the opening position, primarily due to a reduction in receivables, which has been offset by a higher cash balance.

Current Liabilities - Current liabilities have decreased by £2.2m from the opening position, primarily due to a reduction in payables.

3. Spencer Private Hospitals:

Current Assets - Current assets have increased primarily due to a decrease in trade receivables, which led to a corresponding rise in the cash balance.

Current Liabilities - Current liabilities have decreased primarily due to reduction in invoices payables and borrowing .

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

Capital Expenditure
Month 11 (February) 2024/25

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
Critical Priorities (PEIC)	4,000	4,510	3,838	2,988	850
MDG - Medical Devices Replacement	2,249	3,094	1,975	1,454	521
Diagnostics Clinical Equipment Replacement Programme (ERP)	3,618	806	3,287	806	2,481
IDG - IT Systems Replacement	700	1,399	695	690	5
Electronic Medical Records (EMR)	800	800	776	671	105
Subsidiaries - 2Gether Support Solutions (2SS)	618	618	577	243	334
Subsidiaries - Spencer Private Hospitals (SPH)	150	257	135	178	(43)
Mechanical Thrombectomy	2,028	1,685	1,507	1,663	(156)
Renal – Expansion of dialysis services (Phase 2)	964	0	964	0	964
Stroke HASU	1,118	795	874	468	406
Pathology S8 - GP and Community Order Comms (LIMS)	140	140	140	140	0
Maternity Estates Review	1,594	535	1,350	328	1,022
Diagnostics Imaging (QEQM MRI)	2,100	200	1,750	75	1,675
Community Diagnostics Centre (CDC) - Buckland (EKHUFT)	1,033	804	1,033	798	235
Fire Compartmentation Strategy	4,000	4,100	3,537	3,500	37
Digital Histhopathology - 2024/25 (Year 2)	407	407	397	210	187
QEQM MRI Power Upgrade	45	0	45	0	45
Donated Assets	900	674	810	674	136
Vacuum Assisted Biopsy and Excision System (VAB/VAE)	0	70	0	0	0
TransNasal Endoscopy Service (TNE)	0	450	0	0	0
Block and Beam replacement - WHH	0	372	0	255	(255)
Subsidiaries Right of Use Assets (RoUA) - IFRS16 Leases	0	329	0	329	(329)
ANPR Parking Equipment Replacement	0	625	0	166	(166)
Procurement of 2x Mobile CT Scanners & Generators	0	2,147	0	1,971	(1,971)
Thanet CDC	0	4,340	0	0	0
Maternity Estates Infrastructure Works	0	1,202	0	0	0
Trust IFRS16 Acquisitions	242	207	0	207	(207)
All Other	0	(302)	0	(302)	302
	26,706	**30,264**	**23,690**	**17,512**	**6,178**

Funded By:	Plan	Forecast	Change (+) increase (-) reduction
Operational Capital	21,887	22,180	293
Donations	900	674	(226)
PDC	1,347	7,409	6,062
	24,134	**30,264**	**6,130**

Under/(Over) Commitment	**(2,572)**	**0**

The Group's gross capital year-to-date expenditure to the end of Month 11 2024/25 was £17.5m. This represents a £6.2m underspend against the YTD Plan of £23.7m.

A further £8.4m capital expenditure needs to be incurred in M12 to deliver a breakeven capital programme in 2024/25 (excl. the impact of the £4.3m agreed underspend for Thanet CDC). At M11, aside from the risks detailed below, assurance was received from all capital leads that largely, the forecast can be achieved, although aknowledging the inherent degree of risk associated with expecting delivery of equipment or completion of build works within the last week(s) in March.

Risks flagged at M11:

• **Procurement of 2x Mobile CTs & Generator (£2.6m) -** whilst the Mobile CT units have been ordered and confirmation received they will be on site by the end of March, an order for the generator is yet to be placed, due to an inability to determine the specification requirements within the available time-frame; the reported slippage (of circa £0.525m) has largely been mitigated by bringing forward additional IDG planned spend from 25/26 into 24/25 (circa £0.375m) and going ahead with other smaller schemes.

• **Maternity Estates Infrastructure Works (£1.202m)** - a risks was flagged by estates in that the level of development works expected to be incurred by the end of March is circa £0.5m.

Other Highlights:

• **Thanet CDC (£4.3m) -** the proposal was originally phased over 2 financial years, with £0.52m to be allocated in 2024/25 and £3.8m in 2025/26. Following ongoing conversations with NHSE, the K&M ICB received a formal request from NHSE to broker the entire capital amount in 2024/25 and a letter of approval was received on the 4th December 2024 by the Trust, confirming the approval of £4.34m in 2024/25.

The brokerage agreement was confirmed by the ICB on 17th February 2025 and the Trust accepted the funding the same day.

The ICB also agreed to underwrite the over and underspends reported by the Trusts against this funding stream and re-provide a corresponding level of CDEL allocation in 2025/26 to EKHUFT and KCH for the completion of the Thanet CDC scheme.

Cost Improvement Summary

Month 11 (February) 2024/25

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
0.01 Estate Utilisation & Rationalisation	41	59	18	351	451	100
0.02 Procurement	791	484	(308)	7,153	5,063	(2,090)
0.03 Digital Utilisation & Rationalisation	31	4	(28)	144	32	(112)
0.04 Income – Capture, Coding and Pricing	633	633	-	5,367	5,367	-
0.05 Financial Control & Governance	6	22	16	81	245	164
0.06 Low Value Interventions	1	-	(1)	5	-	(5)
0.07 Drugs & Devices	58	178	121	891	1,782	891
0.08 Length of Stay	1,193	440	(753)	7,252	5,003	(2,249)
0.09 Medically Optimised for Discharge Pathway	-	-	-	-	-	-
0.10 Theatre Utilisation	341	46	(295)	4,631	3,709	(922)
0.11 Admission Avoidance	-	-	-	-	-	-
0.12 Outpatients	284	1,059	775	3,124	4,050	926
0.13 Diagnostics	261	300	39	2,249	2,844	595
0.14 Medical Staffing	500	244	(257)	4,470	2,474	(1,996)
0.15 Nursing and Midwifery	120	210	90	1,355	1,256	(100)
0.16 Allied Health Professionals	77	23	(54)	887	625	(262)
0.17 Other Workforce	248	195	(53)	2,234	2,043	(191)
Care group Led Schemes **	50	741	690	3,890	9,582	5,692
Grand Total	**4,636**	**4,636**	**1**	**44,085**	**44,526**	**441**

Delivered £000

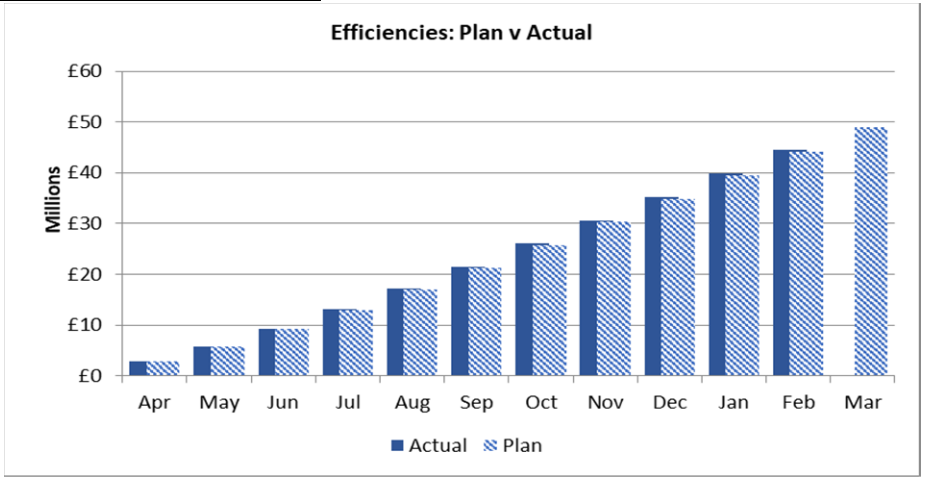
Month	Target	Actual
April	2,786	2,906
May	2,957	3,082
June	3,440	3,196
July	3,715	3,837
August	4,057	4,221
September	4,247	4,298
October	4,501	4,505
November	4,597	4,575
December	4,517	4,550
January	4,630	4,719
February	4,636	4,636
March	4,915	
	49,000	**44,526**
		90.9%

Efficiencies

The agreed Efficiencies plan for 2024/25 is £49.0m. CIP delivery is above plan to Month 11 by £0.44m. Recurrent savings of £3.8m have been delivered in February, and £34.49m on a YTD basis.

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

The PMO is collaborating effectively with the Financial Recovery Director and Director of Continuous Improvement. The focus is now on developing the detailed pipeline scheme PIDs for FY2526 based on areas included in the Financial Sustainability Plan. Efforts are on advancing projects through the gateway stages - Red, Amber and Pipeline, towards Green status.



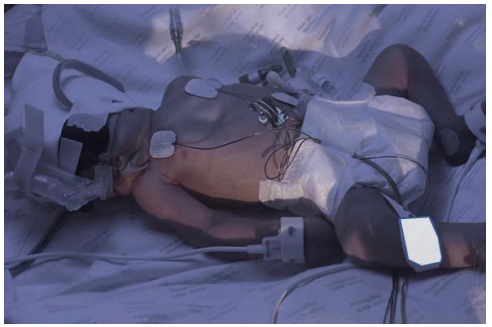
Integrated Performance Report

FEBRUARY 2025







Integrated Performance Report

Statistical Process Control

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

What is statistical process control (SPC)?

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

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

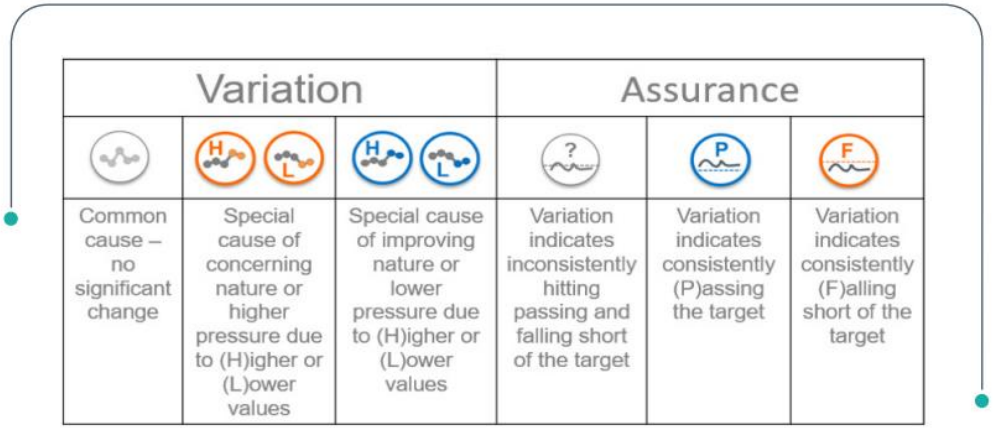
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

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

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

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



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

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

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

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

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

Integrated Improvement Plan (IIP)

Summary Highlights

Executive Summary:

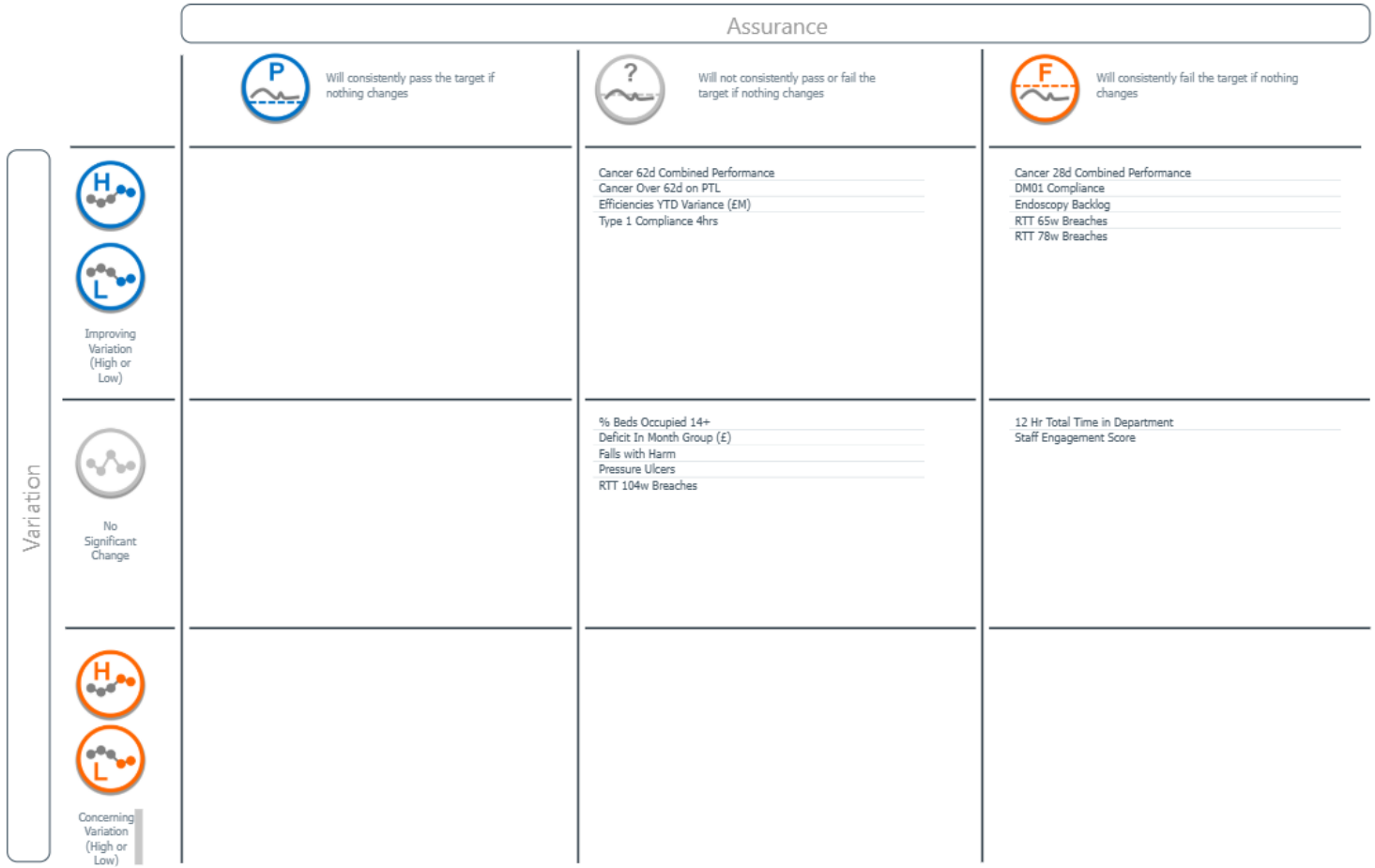
DM01 Performance, reduction of the Endoscopy Backlog, all Cancer standards and reduction in elective long waiting patients are all showing statistical improvement.

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

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

All Cancer standards are now demonstrating statistical improvement and have achieved the national performance standards in February.

Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds. The level of engagement with the 2024 NHS Staff Survey was the best in the Trusts' history, with over 6,000 staff sharing their feedback and a response rate of 63%. Staff survey priorities have been identified and root cause analysis is currently taking place to ensure informed and intelligent action.



Integrated Improvement Plan (IIP)

Exit Criteria Metrics: Dashboard

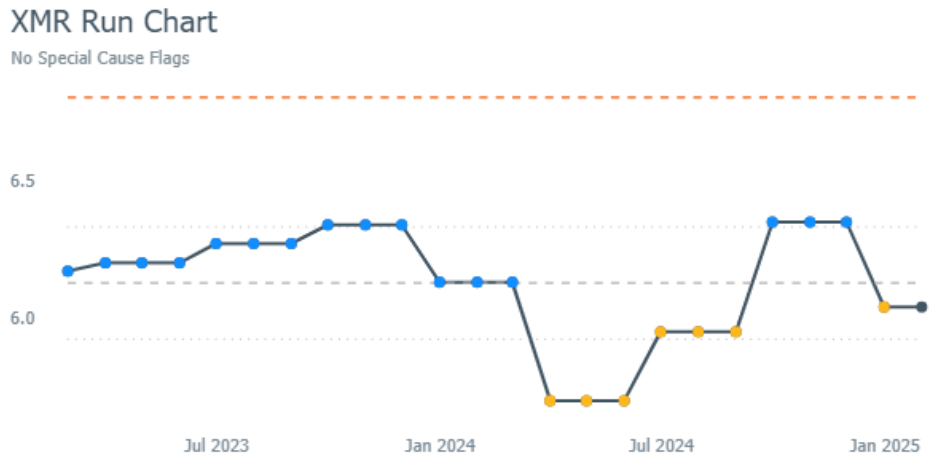
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
People	IIP		Staff Engagement Score			6.80	6.13	5.70	5.70	5.70	5.95	5.95	5.95	6.35	6.35	6.35	6.04	6.04
Patients	IIP		Type 1 Compliance 4hrs			50.0%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%	51.0%	50.1%
	IIP		12 Hr Total Time in Department			8.0%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%	9.2%	9.7%	9.5%	10.2%	10.9%	10.3%
	IIP		% Beds Occupied 14+			30.0%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%	33.9%	34.9%
	IIP		Cancer 28d Combined Performance			77.0%	68.3%	64.9%	70.2%	70.4%	72.6%	71.0%	69.8%	71.3%	71.8%	75.0%	66.5%	78.7%
	IIP		Cancer 62d Combined Performance			70.0%	69.1%	66.2%	64.1%	63.0%	71.6%	73.2%	72.8%	70.4%	74.1%	73.9%	69.0%	70.7%
	IIP		Cancer Over 62d on PTL			200	188	236	237	233	203	244	215	193	203	216	197	183
	IIP		RTT 65w Breaches			0	2,301	2,203	1,802	1,656	1,360	1,269	572	346	247	216	164	148
	IIP		RTT 78w Breaches			0	485	465	272	82	35	32	34	11	10	7	4	17
	IIP		RTT 104w Breaches			0	24	15	1	1	0	1	0	0	0	0	0	9
	IIP		Endoscopy Backlog			0	7,238	6,153	5,170	4,108	3,018	1,997	1,304	663	391	373	247	258
	IIP		DM01 Compliance			78.0%	61.2%	62.5%	63.5%	60.9%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%	83.9%	86.2%
Quality	IIP		Falls with Harm			12	4	6	3	4	2	7	5	7	9	8	1	4
	IIP		Pressure Ulcers			118	76	84	84	82	79	72	77	92	85	85	119	98
Sustainability	IIP		Deficit In Month Group (£)			4.9M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M	6.5M	4.9M
	IIP		Efficiencies YTD Variance (£M)			0.0	-26.9	0.0	0.0	0.0	0.1	0.3	0.3	0.3	0.3	0.3	0.4	0.4

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
Mar-24	6.13	
Apr-24	5.70	
May-24	5.70	
Jun-24	5.70	
Jul-24	5.95	
Aug-24	5.95	
Sep-24	5.95	
Oct-24	6.35	
Nov-24	6.35	
Dec-24	6.35	
Jan-25	6.04	
Feb-25	6.04	



Understanding the Latest Performance

ALERT: Variation flag has changed from Concern to Common Cause

For the month beginning 01/02/2025 the latest Staff Engagement Score performance is 6.04 against a static target of 6.80 (higher is better).

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

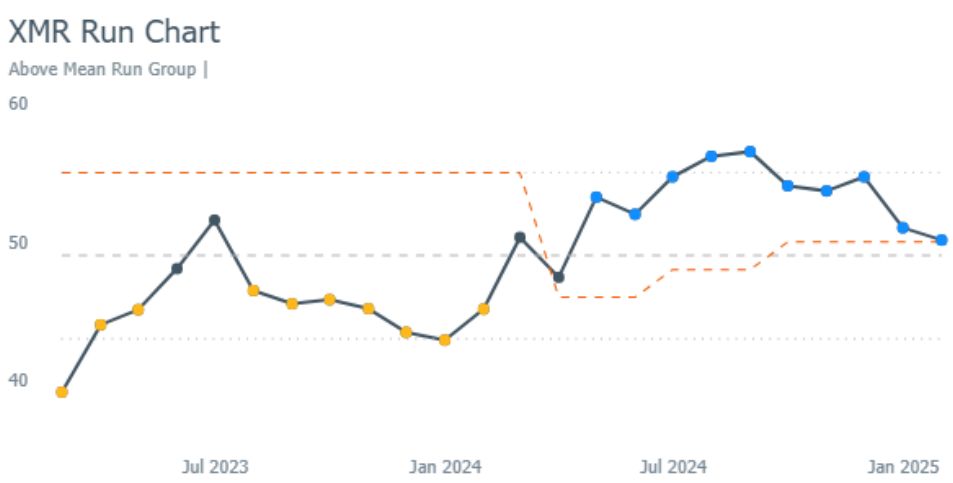
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (6.35) are below the national average (6.78).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Staff Experience	End Mar 26	• Staff survey priorities have been identified and root cause analysis is currently taking place to ensure informed and intelligent action. A number of organisational actions have already been initiated, ranging from; the development of a new Trust strategy, identification of areas where the gap in experience is most pronounced, the introduction of a new resolution framework and a comprehensive review of the suite of leadership programmes to ensure a focus on compassion and inclusivity. Actions will be captured through a staff survey delivery plan to follow in due course.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across NSS plan, CLP immediate actions delivery plan and local Care Group People Plans	Head of Staff Experience	End Feb 26	• A quality improvement (QI) approach has been taken to the staff survey results across three parallel, staggered workflows; Trust, Care Group and Corporate. Phases 1-3 of the A3 are complete for Trust and Care Group work, which has now moved to root cause analysis through open, Trust-wide workshops. Corporate Business units have also been initiated and are now undertaking phases 1-3. Current progress has been updated through EMT, CEMG and at Care Group PRM's. Countermeasures will be collated in April and summarised through a staff survey delivery plan.
2024 NHS Staff Survey	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of results	Head of Staff Experience	End Mar 25	• This action is now complete. The Trust achieved the highest response rate in it's history (63%) – a 22% increase year-on-year and harnessing the voice of >2200 more staff. The Trust benchmarks in the top 10% nationally of all 122 Acute Trusts and is in the top three Acute Trusts for improvement year-on-year. Planning is already underway for the 2025 NHS Staff Survey, and ensuring that the Trust continues to maximise staff voice throughout the year.

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
Mar-24	50.3%	
Apr-24	47.4%	
May-24	53.2%	
Jun-24	52.0%	
Jul-24	54.7%	
Aug-24	56.2%	
Sep-24	56.5%	
Oct-24	54.1%	
Nov-24	53.7%	
Dec-24	54.7%	
Jan-25	51.0%	
Feb-25	50.1%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest Type 1 Compliance 4hrs performance is 50.1% against a Trajectory target of 50.0% (higher is better).

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

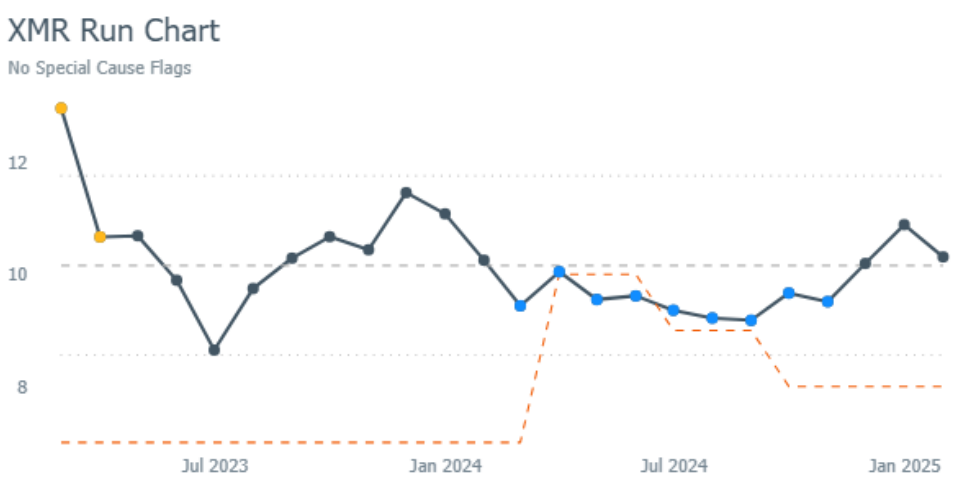
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2024/5 to incorporate functions of an 'emergency portal' – advice and guidance, same day emergency care access – primary and secondary care; acute GP referral management; ambulance 'stack reviews'; frailty response, care home support and update of DOS. • Development of direct access pathways and extending use of the virtual wards, same day emergency care services	• COO • Dep COO UEC • CN/CL ED	• Q4 • Q4	• Performance 50% • SPOA – implementation of single SPOA December 2024 –increase community capacity being recruited to further support the SPOA attendance avoidance – Q4 • Frailty model: winter funding secured to support QEQM and WHH frailty SDEC test of change • Acute Virtual ward – winter funding secured for test of change for acute virtual ward at QEQM and WHH – expansion to 12 per site from Feb '25 – achieved at WHH
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites; introduce CDU at WHH Q4	• CL ED • Dep COO UEC • MDs	• Q4 • Q4	• ED Internal professional standards drafted; mechanism for monitoring being developed in conjunction with escalation framework Safe & Effective ED workstream established: focus on validation, roles and escalation through patient pathways for phase 1 • Heatmap for demand profiles requested to ensure workforce alignment: due Q4
Admission avoidance	Front door alternatives to ED: • Review & development of AMU model & SDEC at WHH with DA pathways • Review of effectiveness of AMU model and SDEC at QEQM	• SiteTri • Dep COO UEC	• Q4	• AMU workstream established for WHH: direct access, workforce, pathways & data for demand and capacity completed: SDEC test of change in place. Inc. utilisation to support ED noted. GIRFT review of the Acute medical model at both sites in Feb – action plan in development to address areas of opportunity for imporvement • AMU model at QEQM under review; standardised operational policies drafted • Reset for front door in December; increased use of SDEC and frailty models noted

Integrated Improvement Plan (IIP)

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
Mar-24	9.4%	
Apr-24	10.0%	
May-24	9.5%	
Jun-24	9.6%	
Jul-24	9.4%	
Aug-24	9.2%	
Sep-24	9.2%	
Oct-24	9.7%	
Nov-24	9.5%	
Dec-24	10.2%	
Jan-25	10.9%	
Feb-25	10.3%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/02/2025 the latest 12 Hr Total Time in Department performance is 10.3% against a Trajectory target of 8.0% (lower is better).

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

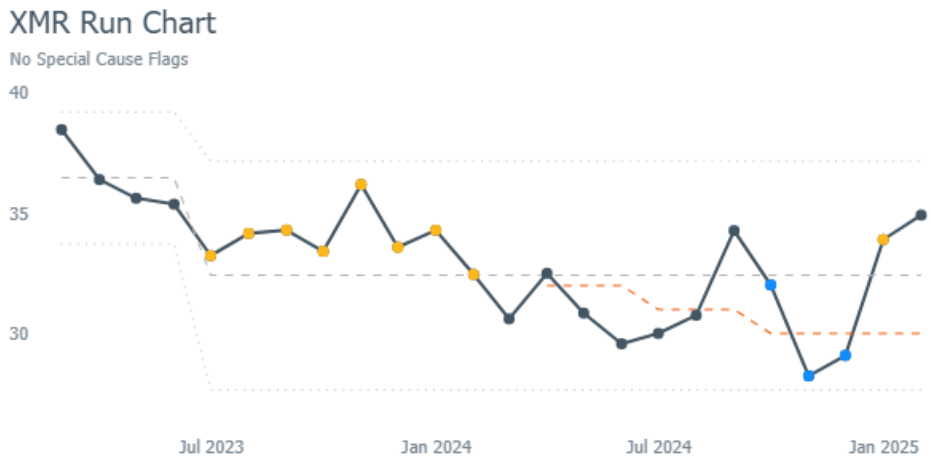
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment units • Improve flow into downstream wards – internal flow workstream from RLoS and proactive site management • Reducing Length of Stay Programme – reduce delays in patient pathways and robust and proactive management of flow	• Tri MD Tri DoN	Quarter 4	• Medical workforce review underway supported by Deputy MD • RLoS programme roll out; Internal flow and SAFER bundle core improvement prog. • Workstream established to review direct admission pathways • Cross site ED T&F group in place; development of 12h recovery plan including establishment of effective CDUs on both sites • RLoS; further reduction to support more patients managed through the core beds
Weekend profiles	• Improve discharge profile at weekends to match demand • Implement criteria led discharge • Review support functions at weekends to support discharges • Improve w/e planning & proactive transfer processes across sites	• CG Tri • DCMO	Quarter 4	• Diagnostics for key reasons for delays at weekend finalised – meeting with pharmacy established regarding times of operation and centralised model • Workstream to be established for criteria led discharge • Escalation and discharge policies under review; to be finalised quarter 4 & to include expectations to support 7d services being considered through CEMG
High number of Mental Health (MH) patients in ED with long waits	• Escalation SOP in place for delays in accessing mental health capacity • ICB support to EKMHT to manage OOA access • SAFEHAVEN roll out underway across both sites • Review Medway and lessons learned from safe Haven introduction and impact on patient wait times at the front door	• CG Tri WHH/ QEQM	Quarter 4	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4. Plan for Safe Haven at WHH in development • Focus for 24/25 on escalation and capacity to manage long stayers- SOP for escalation developed by MD for WHH and QEQM • Significant delays in mental health capacity impacting on flow through to their capacity – ICB engaged to support addressing gaps in social care access

Integrated Improvement Plan (IIP)

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

% Beds Occupied 14+

Timescale	Value	SPC
Mar-24	30.6%	
Apr-24	32.5%	
May-24	30.8%	
Jun-24	29.6%	
Jul-24	30.0%	
Aug-24	30.8%	
Sep-24	34.3%	
Oct-24	32.0%	
Nov-24	28.2%	
Dec-24	29.1%	
Jan-25	33.9%	
Feb-25	34.9%	



Understanding the Latest Performance

ALERT: Variation flag has changed from Concern to Common Cause

For the month beginning 01/02/2025 the latest % Beds Occupied 14+ performance is 34.9% against a Trajectory target of 30.0% (lower is better).

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

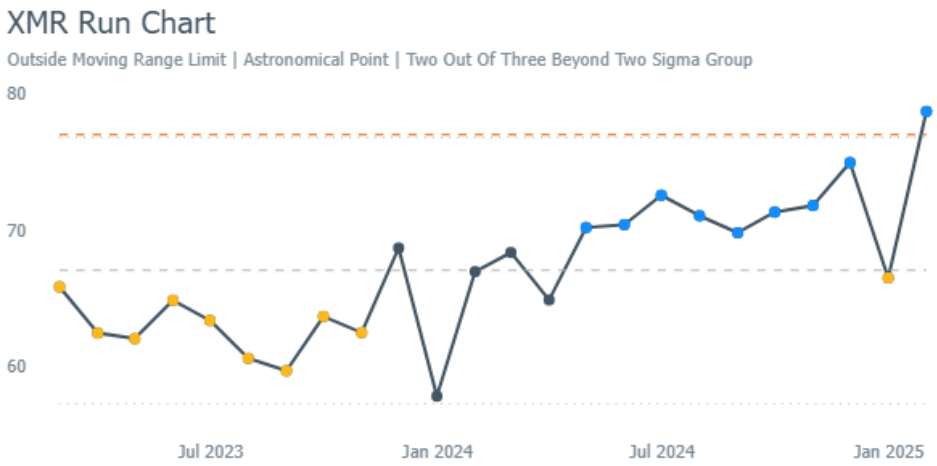
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Dep COO UEC/CG DoN • COO/Dep COO UEC • Deputy COO/MD DCB	• Q4 • Q4 • Q4	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for C2R • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities – pilots for acute medicine virtual ward August QEQM and Sept for WHH • Therapy review underway –test of change for ESD as part of winter scheme – Jan 25 • Review of function of site discharge coordinators – listening events held on both acute sites in October – follow up event January 25 with review also of IDT establishment wit the system partners
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	• Q4 • Q4	• Test of change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – on-going discussions with ICB to expand D2A pathways as part of winter resilience – reduction in wait times for P1 noted • Revised model for management of complex patients with escalation Q4
Grip and control: all LOS	• Implement weekly stranded reviews on all sites • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Q4	• LOS for patients >14 days under review at specialty level – focus on frailty • Discharge and escalation policy signed off CEMG Dec – chair sign off Jan 25 • SAFER bundle – revisit and standardise process for consistent implementation– impact assessment q4

Integrated Improvement Plan (IIP)

Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance

Timescale	Value	SPC
Mar-24	68.3%	
Apr-24	64.9%	
May-24	70.2%	
Jun-24	70.4%	
Jul-24	72.6%	
Aug-24	71.0%	
Sep-24	69.8%	
Oct-24	71.3%	
Nov-24	71.8%	
Dec-24	75.0%	
Jan-25	66.5%	
Feb-25	78.7%	



Understanding the Latest Performance

ALERT: Variation flag has changed from Concern to Improvement

For the month beginning 01/02/2025 the latest Cancer 28d Combined Performance performance is 78.7% against a static target of 77.0% (higher is better).

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

The biggest contributing factors are: 07 - Lower GI (65.2% , 210*), 08 - Skin (86.6% , 100*), 11 - Urological (71.0% , 97*). *Breaches

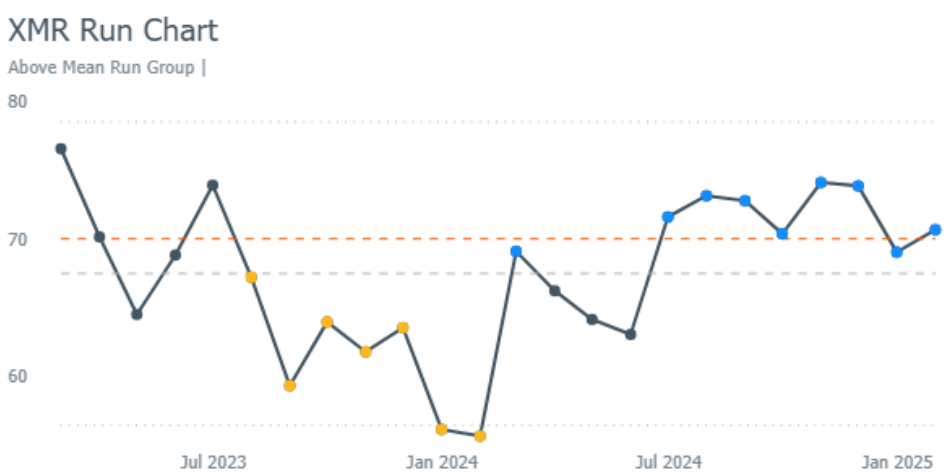
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Guided Biopsy, US. • Endoscopy booking times • Breast US booking times	• Radiology • Endoscopy	•Ongoing	• All teams have been focussed on a swift turn around recovery in January to reset the FDS position, clear patient waits and benign letter backlog, and return pathways to timeframes seen before Christmas. This has been achieved and gained upon with a Trust record high position for FDS. Early indications from March performance is this position will be sustain at year end. • The end of March 24 sees the conclusion of Tiered funding support. Teams have been planning to ensure sufficient substantive capacity is in place to support demand. For Breast, having additional insourcing activity throughout 24/25 has brought down the routine backlog and improved capacity for cancer one stop clinics. Whilst mitigations where possible have been put in place utilising newly recruited substantive staffing within radiology, there will be a decrease in capacity. The impact on routine and cancer pathways will be closely monitored throughout April and May.
Letter backlog	• Timely consultant dictation of cancer letters to patients • Timely admin support to process dictated letters	• Cancer compliance • Admin • Consultant	•Ongoing	• The letter backlog has increased in recent weeks. The escalation process remains in place and all teams have been requested, as part of the wider weekly operational access meetings to focus efforts to reduce the backlog as we plan for Easter. • Keeping the letter backlog down directly impacts the Trust's position for FDS.
Lower GI	• Key contributing specialty to the non compliant position • Low ranking specialty for 28D against national benchmarking data	• Specialty	• Q4	• There have been significant improvements in the LGI pathway – 1st OPA regularly taking place within one week of referral, Endoscopy wait times under 10 days and a reduction in inappropriate Virtual Colonography requests. • The newly ratified pathway will continue to be adopted in practice throughout 25/26.

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Mar-24	69.1%	
Apr-24	66.2%	
May-24	64.1%	
Jun-24	63.0%	
Jul-24	71.6%	
Aug-24	73.2%	
Sep-24	72.8%	
Oct-24	70.4%	
Nov-24	74.1%	
Dec-24	73.9%	
Jan-25	69.0%	
Feb-25	70.7%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

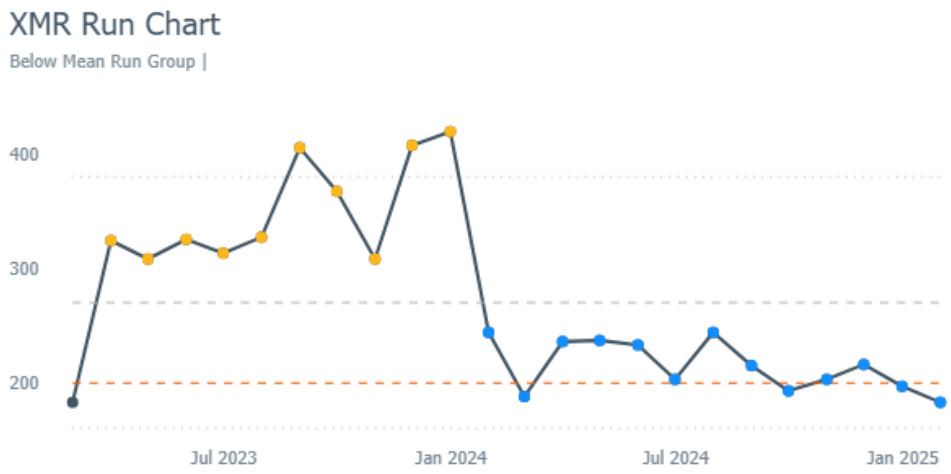
For the month beginning 01/02/2025 the latest Cancer 62d Combined Performance performance is 70.7% against a static target of 70.0% (higher is better).

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

The biggest contributing factors are: 11 - Urological (71.2% , 22*), 01 - Breast (63.8% , 21*), 07 - Lower GI (42.4% , 17*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Mar-24	188	
Apr-24	236	
May-24	237	
Jun-24	233	
Jul-24	203	
Aug-24	244	
Sep-24	215	
Oct-24	193	
Nov-24	203	
Dec-24	216	
Jan-25	197	
Feb-25	183	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest Cancer Over 62d on PTL performance is 183 against a static target of 200 (lower is better).

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

The biggest contributing factors are: 07 - Lower GI (80*), 11 - Urological (43*), 03 - Lung (16*). *Number

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

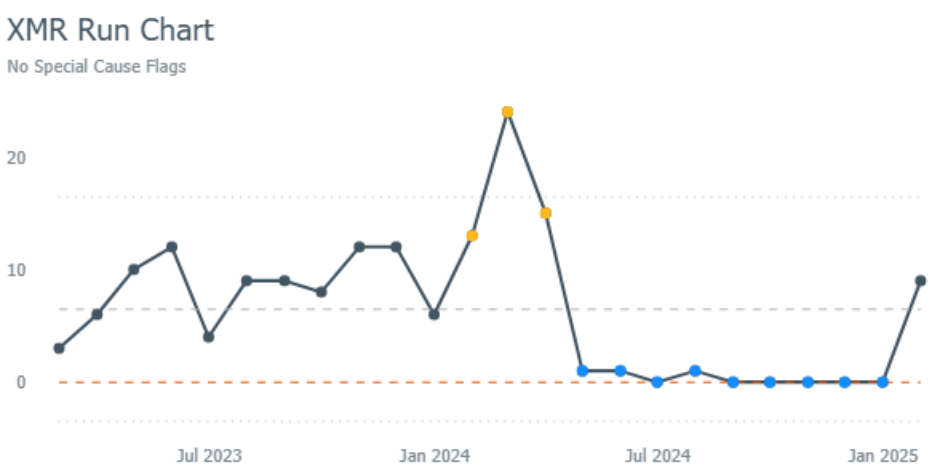
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern	• Cancer Operational lead/ compliance	• Ongoing	• Targeted escalation for patients against agreed thresholds for Histopathology, Radiology and Endoscopy. All diagnostics types now being escalated after a 7 day period. The majority of reporting is completed within 7 days. • 104 review now completed at operational access meetings with 63-104 watchlist being communicated. 104+ diagnostic reporting being escalated for 24 hour turnaround. • Weekly updates and clear actions to address the deteriorated FDS position have been communicated via the Trustwide operational access. The position has been recovered in month and February is on track to exceed target for FDS.
Capacity for diagnostics	• Staff vacancies contributing to reduced radiological diagnostics	• Radiology	• Ongoing	• Tiering funding is supporting insourcing and additional WLIs for US, CT/US guided biopsy, endoscopy. Via 25/26 Business Planning, capacity is being reviewed to ensure sufficient provision when tiering funding is no longer available. • Successful recruitment across the clinical team within radiology will boost substantive capacity for CT and US biopsy capacity
Urology surgical capacity	• Limited consultant robotic capacity	• Urology	• Q4	• Mat leave return in September for consultant to support RALP – the consultant is now independent and capacity for cancer surgery for RALP will continue to increased • Substantive consultant post advertised with suitable candidates shortlisted
Surgical booking out times	• Elongated time between MDM and surgical treatment	• All surgical specialties	• Ongoing	• Close monitoring of booking out times for all surgical treatments across all specialties supported by 31D breach reviews • Cancer services reviewing the time from MDM to Decision to Treat discussions due to the impact on the 62d compliance standard
Pathway awareness	• Patients being referred to Urgent Suspected Cancer Pathways without an awareness of the likely clinical appointments or likely diagnostic tests	• All specialties	• Year end 24/25	• The Cancer Alliance 28-day pathway patient information leaflet is set for release in October 2024. • Ensuring initial clinical discussions clearly outline the urgent suspected cancer pathway process.
MTW H&N	• Patients being transferred from MTW for cancer surgery impacting on clinical capacity	• Compliance / H&N	• Q3	• Pathway transfer now being monitored and an increasing number of patients are being transferred with the appropriate diagnostics completed. • Head & Neck surgical capacity remains challenged. Out to ad for substantive consultants.

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

Timescale	Value	SPC
Mar-24	24	
Apr-24	15	
May-24	1	
Jun-24	1	
Jul-24	0	
Aug-24	1	
Sep-24	0	
Oct-24	0	
Nov-24	0	
Dec-24	0	
Jan-25	0	
Feb-25	9	



Understanding the Latest Performance

ALERT: Variation flag has changed from Improvement to Commo...

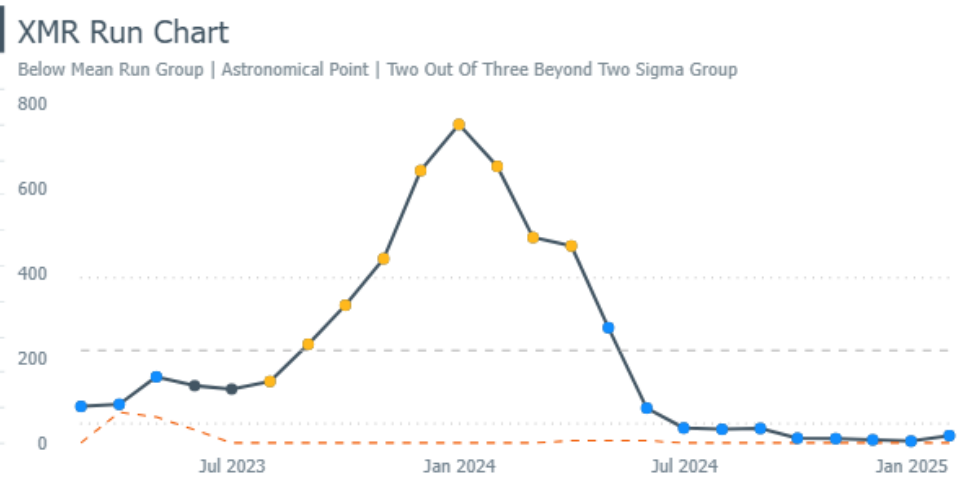
For the month beginning 01/02/2025 the latest RTT 104w Breaches performance is 9 against a static target of 0 (lower is better).

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

The biggest contributing factors are: 120 - EAR NOSE AND THROAT (3*), 104 - COLORECTAL SURGERY (2*), 100 - GENERAL SURGERY (2*). *Breaches

RTT 78w Breaches

Timescale	Value	SPC
Mar-24	485	
Apr-24	465	
May-24	272	
Jun-24	82	
Jul-24	35	
Aug-24	32	
Sep-24	34	
Oct-24	11	
Nov-24	10	
Dec-24	7	
Jan-25	4	
Feb-25	17	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest RTT 78w Breaches performance is 17 against a Trajectory target of 0 (lower is better).

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

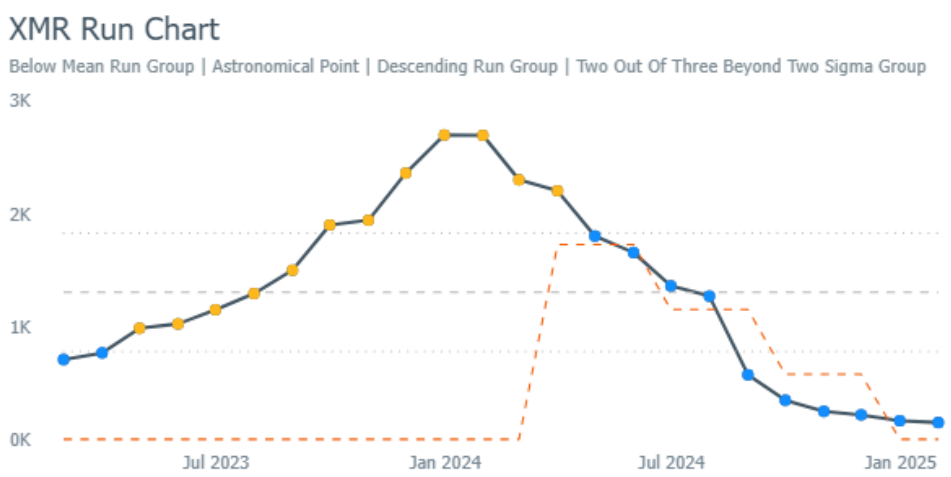
The biggest contributing factors are: 120 - EAR NOSE AND THROAT (5*), 100 - GENERAL SURGERY (4*), 104 - COLORECTAL SURGERY (3*). *Breaches

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches

Timescale	Value	SPC
Mar-24	2,301	
Apr-24	2,203	
May-24	1,802	
Jun-24	1,656	
Jul-24	1,360	
Aug-24	1,269	
Sep-24	572	
Oct-24	346	
Nov-24	247	
Dec-24	216	
Jan-25	164	
Feb-25	148	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest RTT 65w Breaches performance is 148 against a Trajectory target of 0 (lower is better).

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

The biggest contributing factors are: 120 - EAR NOSE AND THROAT (61*), 301 - GASTROENTEROLOGY (16*), 100 - GENERAL SURGERY (16*). *Breaches

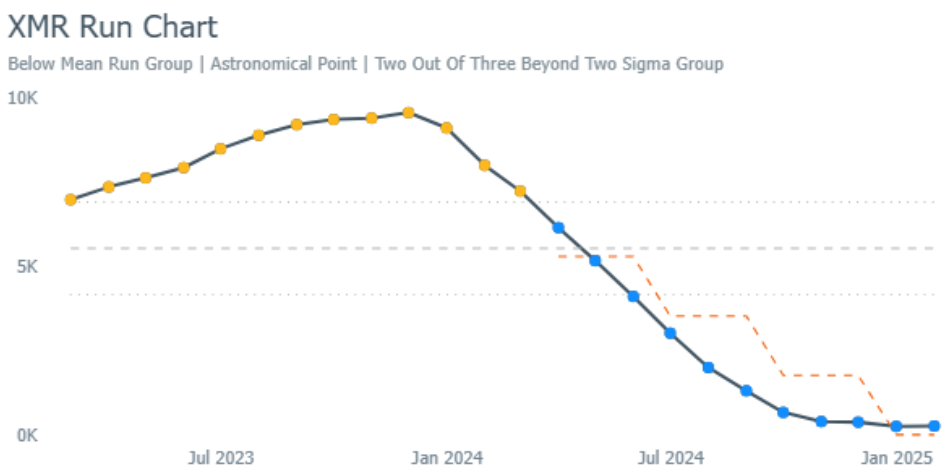
Drive to eradicate 65 weeks by end of March 2025	• Weekly clearance against trajectory monitored at Access with clear delivery plans for non-compliance.	• COO	• Ongoing	• Performance shared daily with all specialities, on track against trajectory. Assurance provided to region at fortnightly Tier 2 meetings.
	• Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting.	• COO	• Ongoing	• In place
	• Theatre programme to improve utilisation to 85% and drive clearance of backlog.	• MD – CCAS	• March 25	• Ongoing clinical engagement, strengthened weekly theatre scheduling and specialty action group meetings. Weekly forward and retrospective review of lists to optimise learning and implement appropriate interventions
	• All internal capacity being directed to key risk cohorts from dropped sessions	• MD - CCAS	• Ongoing	• Commenced – review of bookings to ensure patients are dated in chronological order and priority.
	• Independent Sector capacity aligned to support risk cohorts	• MD – CCAS	• Ongoing	• Ongoing

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Mar-24	7,238	
Apr-24	6,153	
May-24	5,170	
Jun-24	4,108	
Jul-24	3,018	
Aug-24	1,997	
Sep-24	1,304	
Oct-24	663	
Nov-24	391	
Dec-24	373	
Jan-25	247	
Feb-25	258	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest Endoscopy Backlog performance is 258 against a Trajectory target of 0 (lower is better).

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

The biggest contributing factors are: OGD (114*), Dual (81*), Colon (53*). *Overdue Waiters

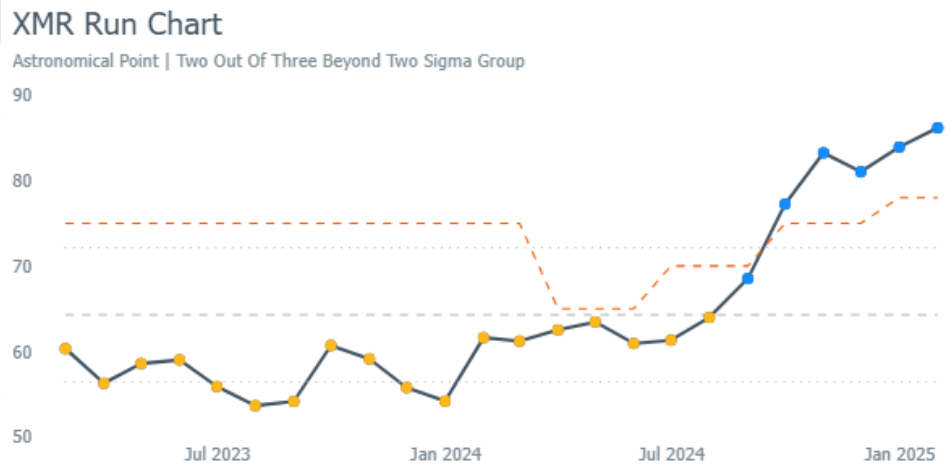
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Reception staff workforce review completed and additional staff required part of 25/26 business plans • Business planning for 25/26 to ensue ongoing sustainability.	• Endoscopy recovery lead	• Ongoing	• Activity now sustained at c.520 procedures a month (deliberately reduced from previous 550/month) • Forward booking now sustained at 1200 -1500 patients. • We now consistently have under 500 patients to book on the PTL all within the JAG standards
Demand management	• Implementing a Triage system to demand manage the service.	• Endoscopy recovery lead • Clinical lead	• ongoing	• Process designed, sunrise chances made, SOP written. • New Triage process started – currently rejecting around 40 patients a week ongoing. • Engagement with Colorectal surgeons starting, but need to improve. • Review of the STT requests / process commenced
Alternative Diagnostics to support demand	• Proposal to expand diagnostic tests to include Trans Nasal Endoscopy, Cytosponge and Colon Capsule • Business Cases to be written to support new pathways • Recruitment and implementation time scales to be agreed following approval to proceed	• Endo Recovery Lead • HoOps Gastro	• Complete • Ongoing	• All three business cases approved to facilitate phase 2 of the Endoscopy recovery plan

Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Mar-24	61.2%	
Apr-24	62.5%	
May-24	63.5%	
Jun-24	60.9%	
Jul-24	61.3%	
Aug-24	64.0%	
Sep-24	68.5%	
Oct-24	77.2%	
Nov-24	83.3%	
Dec-24	81.0%	
Jan-25	83.9%	
Feb-25	86.2%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest DM01 Compliance performance is 86.2% against a Trajectory target of 78.0% (higher is better).

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

The biggest contributing factors are: CT (87.4% , 507*), MRI (93.2% , 427*), Cardiac MRI (26.1% , 356*). *Breaches

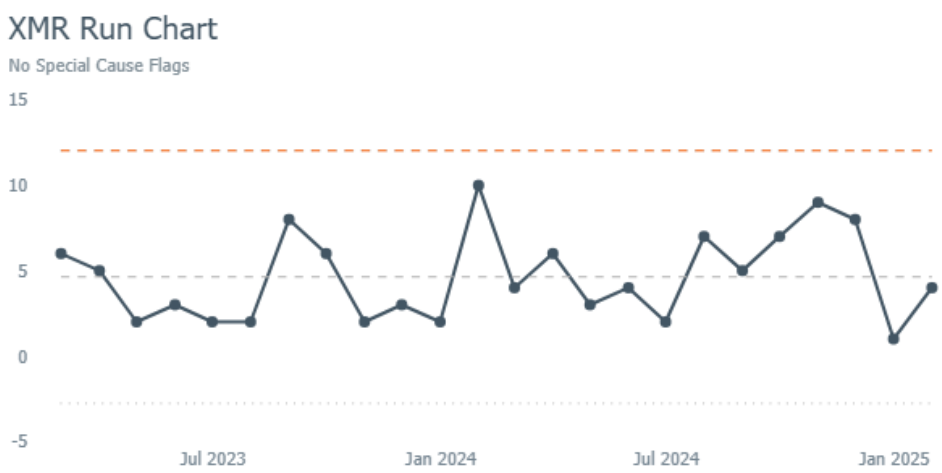
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Echocardiography Back log	• Capacity gap	• Cardiology GM	• Ongoing	• On going echo insourcing continues at proximately 25% of weekly TTE capacity, opportunity to increase insourcing capacity alongside demand. • Activity gap mitigation to be addressed as part of business planning. • Outsourcing stress echos to KIMs commencing
Cardiac MRI Backlog	• Recruitment to vacant consultant posts	• Cardiology GM	• March 2025	• Successful recruitment to two consultant posts which will provide additional capacity. First post will start in March 2025, second to commence in June 2025.

Integrated Improvement Plan (IIP)

Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Mar-24	4	
Apr-24	6	
May-24	3	
Jun-24	4	
Jul-24	2	
Aug-24	7	
Sep-24	5	
Oct-24	7	
Nov-24	9	
Dec-24	8	
Jan-25	1	
Feb-25	4	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/02/2025 the latest Falls with Harm performance is 4 against a (6 Sigma Threshold) target of 12 (lower is better).

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Harm from falls increased July-Dec 2024. Although acute drop noted in January. This however has steadily increased again for the month of February.	• Trends from Hot Spot areas identified Trust Wide, Care Group to report progress and local actions into Falls Steering Group.	ADoN/ Falls Lead/ Care Group DoNs.	March '25	• Hot spot wards working with Falls team and through 'We Care' to learn from trends in all falls and actions being put in place to address. • Hot Spot areas to share improvements at bi-monthly Falls Steering Group.
	• Undertake overarching review across all Fundamentals of Care workstreams, with particular scrutiny around sudden reduction in Falls with Harm and sudden increase in Pressure Ulcers with Harm in January 2025.	ADoN FoC	March 25	• Individual workstream reviews in progress and forum for specialist nurse lead in place to enable comparisons of hot spot areas, data and clinical reviews across FoC. • Reporting into March FoC Committee.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

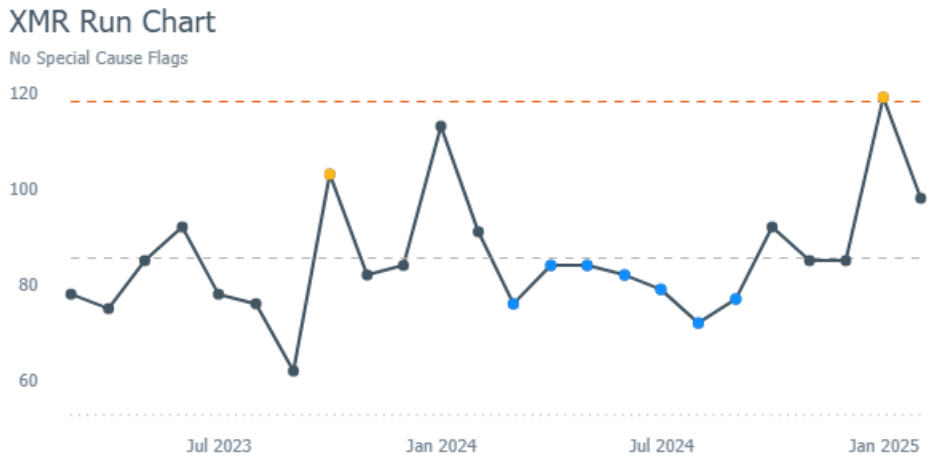
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
A consistent theme in audits and incidence data is that MFRACP risk assessments are incomplete or inaccurate leading to delayed Falls prevention and treatment strategies and increase in patient falls. Findings from completed risk assessments not always acted upon correctly.	• To provide training and education on risk assessment completion.	ADoN FoC/ADoN WDET. Falls Lead	June 2025 June 2025	• To design a two-day clinical induction programme for new starters to include all aspects of Fundamentals of Care • Training module designed to address the need for completion of the Multifactorial Risk Assessment Care Plan. To be added to ESR.
	• MHRA Trolley and Bed rail risk assessment education for completion as per alert to be provided.	Falls Lead/ADoN FoC	April 2025	• TNA presented at Statuory Mandatory Education and Training Group apporoved for mandatory status on ESR. Live date to be confirmed.
	• Falls dashboard to be created to include MFRACP completion including time reports and clinician status completing.	Falls Lead	March 2025	• IT agreed and in queue for Sunrise amendments. Date TBA.
	• Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework and Trust priorities.	Falls Lead/Care groups	April 2025	• TWIP to be reviewed. Developing transformative action plan for 2025/26. Stakeholder review meeting 14th March. Reporting into FoC Committee in March.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Mar-24	76	
Apr-24	84	
May-24	84	
Jun-24	82	
Jul-24	79	
Aug-24	72	
Sep-24	77	
Oct-24	92	
Nov-24	85	
Dec-24	85	
Jan-25	119	
Feb-25	98	



Understanding the Latest Performance

ALERT: Variation flag has changed from Concern to Common Cause

For the month beginning 01/02/2025 the latest Pressure Ulcers performance is 98 against a (6 Sigma Threshold) target of 118 (lower is better).

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

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Significant rise in number of pressure ulcers in January (similar to same period in 2024). Although lower in February remains higher than 2024	• Triangulate with the effects of amber staffing/changes in practice/norovirus/ward accreditation/harms data and noted decrease in falls. Report into March FoC Committee.	ADoN FoCC/ ADoN Workforce	March 2025 March 2025 March 2025 April 2025	• Data for high reporting areas in January reviewed and to be shared at FoC Committee on March 18th 2025. • ADoNs across the organisation providing feedback at March FoC Committee on actions and mitigations. • Care Group Action plans to be shared at FoC Committee. • Trustwide, multidisciplinary stakeholder event held on 26/2/25. Further analysis utilising QI methodology will support development of action plan and KPIs to present to FoCC in April
Delay in obtaining appropriate support surface for the most vulnerable patients starting within the Emergency Departments.	• To improve the trollies in ED to include a high specification mattress. • Training on accurate risk assessment will improve the compliance with pressure ulcer prevention strategies. Modules being developed for pressure ulcer risk assessment and correct interventions on ESR. • Produce Trust Wide Mattress selection guide to aid staff in choosing the appropriate support surface	AdoN FoCC ADoN FoC/ADoN WDET. ADoN UEAC WHH & QEQM	March 2025 April 2025 March 2025	• Mitigations in place for potential issues with Radiology concern as Linet Sprint trolley completed. Procurement compiling a report with recommendations. • Risk assessment module for ESR completed. ADoN FoC and ADoN WFD to review and develop governance processes. Mandatory pressure ulcer training module agreed at Statutory, Mandatory and Essential steering group. • One page guide produced for approval at FoCC in March.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

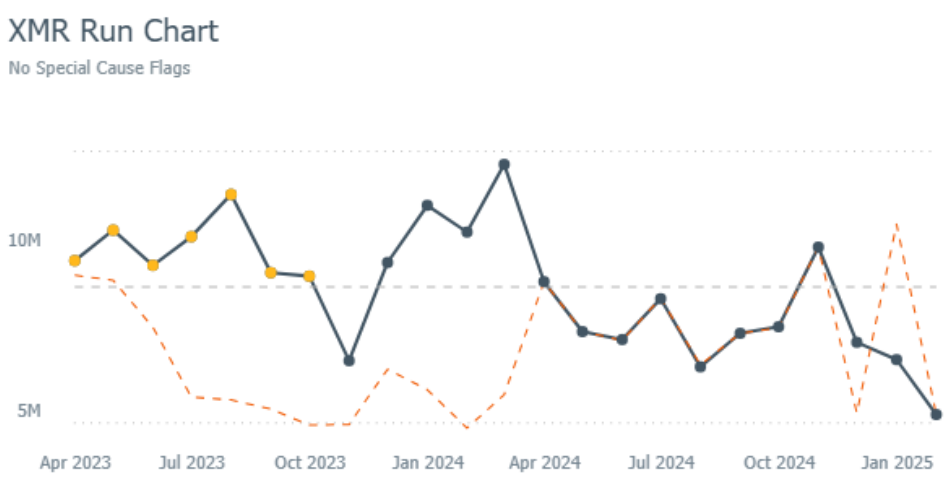
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning. With an increase in shear.	• To review current foam mattresses and tender for replacements. • To review data to drill down into themes and barriers for repositioning gaps. Attendance from specialist teams and clinical teams' representation.	Manual Handling & TV Lead TVN Lead TVN Lead	April 2025 April 2025 April 2025	• One mattress shortlisted as part of tender process. Demo day held. Update from Change Team; last adjustments to evacuation strap being made by company following feedback. • Mattress selection guide for staff developed on agenda for approval on FoCC March 18th. • Audit of all foam and hybrid mattresses completed across Trust in February, replacements with new ones as required. Recommendation report complete and to be approved by TVSG in March and FoCC April.
An increasing number of hospital acquired moisture associated skin damage (MASD) is contributing to the high numbers of hospital acquired pressure ulcers.	• Identify suitable incontinence products with Procurement Team, To include a trust wide education programme on the correct use and application of incontinence products. • Learning from incidents to be captured on Trustwide Improvement Plan to ensure correct actions are in place.	TVN Lead TVN Lead	June 2025 March 2025	• Reduced formulary with streamlined products confirmed in February. Ward Managers education programme in progress, with supplier support. Timescale extended for education programme. • Changeover to improved fixation pants planned in Feb to enhance compliance/appropriate use with continence products. Authorised by PAG.
A consistent theme in audits and incidence data is that risk assessments are incomplete or inaccurate leading to delayed pressure ulcer prevention strategies and increase in pressure ulcer development or deterioration.	• To review pressure ulcer training with a view to produce a mandatory module. Moodle training being developed regarding end of bed risk assessments. • Trust Wide Improvement Plan (TWIP) to be reviewed to align with Patient Safety Incident Review Framework and Trust priorities.	TV Lead TV lead/Care groups	May 2025 April 2025	• Tissue Viability now part of clinical induction from Feb 2025. • Developing transformative action plan for 2025/26. Stakeholders review meeting held on 26/2/25. To be presented to FoC Committee in April 2025.

Integrated Improvement Plan (IIP)

Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
Mar-24	12.2M	
Apr-24	8.8M	
May-24	7.3M	
Jun-24	7.1M	
Jul-24	8.3M	
Aug-24	6.3M	
Sep-24	7.3M	
Oct-24	7.5M	
Nov-24	9.8M	
Dec-24	7.0M	
Jan-25	6.5M	
Feb-25	4.9M	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/02/2025 the latest Deficit In Month Group (£) performance is 4.9M against a Trajectory target of 4.9M (lower is better).

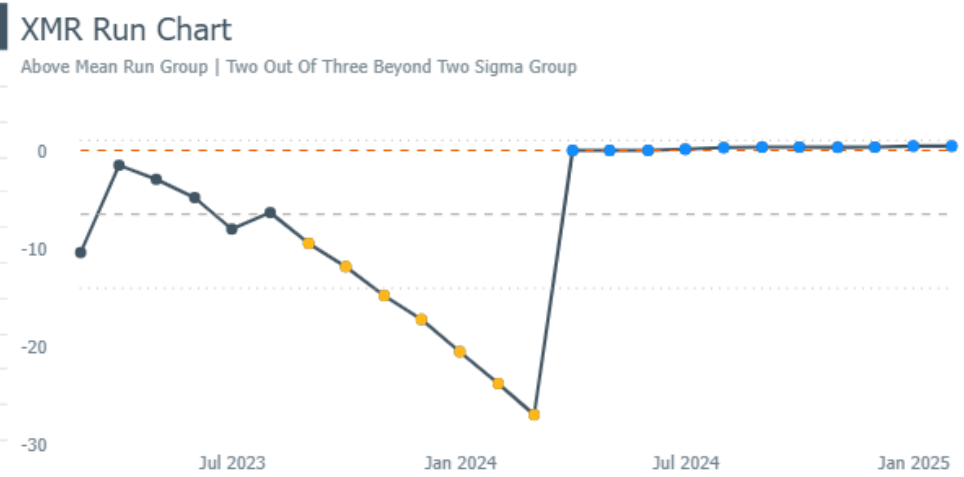
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining achievement of financial plan through Quarters two to four	• Increase level of CIP plan being developed to mitigate any potential slippage against efficiency schemes • Embedded bi-weekly FIPB with full Care Group representation and Theme lead presentations on a rotation basis	• Theme leads • PMO	• Q3 & Q4	• As at month 11, the Group has achieved a YTD position of £1.9m improvement compared to the planned deficit. The position suggests that the Group will meet the plan for the full year, albeit with a need to proactively manage in year risks, which include operational pressures, surge demand and the impact on elective (i.e. planned) work. • In year we are on plan to deliver the CIP target with tight continued focus on the recurrency of individual themes to support year on year benefits. As at month 11 the Trust has delivered 77.5% recurrent CIP programme YTD. • Looking to 25-26 and our Financial Sustainability Plan (FSP) for the coming financial years, the Trust launched its CIP development plan for 25/26 in November. The Trust is required to deliver a level of CIP which will support meeting the 25-26 (year 1) plan.
Currently 3 additional cost pressures are being mitigated on a non-recurrent basis	• Reporting into the ICB on the shortfall of the pay award funding. YTD £1.9m & £2.1m estimated FYE. • HCP monies have reduced from prior year by £2.2m YTD and £2.4m FYE. • The number of working days ERF baseline change has impacted the Trust by £2.2m YTD and £2.4m FYE	• CFO	• Q4	• On-going monitoring of the financial impact of the pay awards. • Delivery of the NLF2R has reduced both pay and non pay in year, however for month 11 the Trust invoiced the ICB for the in month total value of the agreement due to more patients meeting the criteria not being transferred onto the best care pathway for the on-going care.

Integrated Improvement Plan (IIP)

Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Mar-24	-26.9	
Apr-24	0.0	
May-24	0.0	
Jun-24	0.0	
Jul-24	0.1	
Aug-24	0.3	
Sep-24	0.3	
Oct-24	0.3	
Nov-24	0.3	
Dec-24	0.3	
Jan-25	0.4	
Feb-25	0.4	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/02/2025 the latest Efficiencies YTD Variance (£M) performance is 0.4 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £49m Recurrent CIP target for 2024/25	• PWC support to PMO function • Financial Recovery Director in post	Financial Recovery Director	• On-going	• The trust is £0.4m above plan with CIP delivery at Month 11 of £44.5m, of which £10m is non-recurrent. • Current year pipeline view is now broadly focused on delivering forecast year end position. • The key focus is now on development of FY25/26
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director DOF	• On-going	• CIP Methodology defined for each scheme. • CIP reporting process streamlined. • CIP forecasting in process of validation with Theme leads and Finance business partners.

Patients

Assurance

Variation

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

Patients

Executive Summary:

Unplanned Care

Plan – 80% NEL plan (+1 days) delivered cumulatively at Month 11 – Month 10 (88%) with an increase in ALOS of 1.04 days when compared to the trajectory (patients >2 days). The number of patients >7 days on the RTS caseload increased to an average of 171 patients against a trajectory of 78 which contributed negatively to the ALOS by approx. 1.22 days.

- The underperformance against the plan sits predominantly in Acute Internal medicine and reflects the lack of flow for patients through to the SDECs and AMUs on site – significant work is happening on both sites as part of the RLoS programme to redesign the front door services, coupled with the hospital flow work led by the care groups, to support improved flow through here – target quarter 4.
- 2054 patients were discharged during the month (NEL 2+days) – if they had the same ALOS as the baseline period (2+day LOS), there would have been an **additional 616 bed-days or 22 additional beds** required during this period.
- The number of patients in ED corridor >30 mins **decreased** in February compared to the previous year by 194 patients year although the average wait times **increased by 5.68** hours to 15.08. The number of patients **spending >12 hours in the department increased to 10.3%** and remains a significant challenge and focus for the Trust and system partners.
- An increase in patients >7 days on the RTS caseload was observed again in February to an average of 171 which is the highest position it has been for 13 months and is contributing to the increased LOS observed and challenges in flow through the three main sites. If the trajectory was met, the ALOS would reduce by approx. 1.22 days in month 11 to an ALOS position of 10.42 and a further reduction in beds of 93 against the baseline.

Planned Care

The Trust achieved all key Cancer standards in February, 62d GP Referral, 28d FDS and 31d First Treatment. The FDS position improved achieving a new Trust record for performance. This was driven by swift turnaround action plans implemented in January to recover post-Christmas performance. The teams remain committed to achieving the ambitious 7-day target for first outpatient appointments (OPA). The 104d backlog fluctuated throughout the month, ranging from 29 to 44 cases, ending at 44, equivalent to 1.60% of the total backlog.

There was an adverse movement in the RTT Long Waiter numbers during February which has delayed achievement against trajectory by one month. The end of year trajectory has been revised to achieving no more than 80 65+ week waiters as at the end of March 2025, with an aim of achieving zero 65 week waits at the end of April 2025.

Theatre utilisation was 76.6% in February 2025. Theatre Utilisation transformation programme of work is ongoing with senior level governance of scheduling processes and check and challenge of list level planned utilisation at specialty scheduling meetings. Transformation workstreams are being played into business plans for 2025/26 to ensure efficiencies are maximised to deliver the highest amount of activity possible within current resources.

DM01 performance has improved by a further 2.8% percentage points to 86.2% as at the end of February. Improvements in Radiology diagnostics and Endoscopy sustained into Q4. Key areas for recovery are Cardiac MRI and Echocardiography. Performance for sleep studies has improved since the end of the calendar year since the identification of additional capacity.

Patients

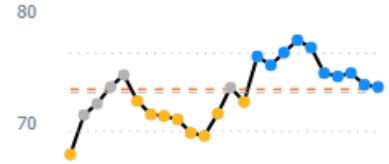
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Patients	NAT		ED Compliance			73.0%	73.1%	71.8%	76.0%	75.2%	76.3%	77.4%	76.8%	74.4%	74.1%	74.4%	73.4%	73.2%
	IIP		Type 1 Compliance 4hrs			50.0%	50.3%	47.4%	53.2%	52.0%	54.7%	56.2%	56.5%	54.1%	53.7%	54.7%	51.0%	50.1%
	IIP		12 Hr Total Time in Department			8.0%	9.4%	10.0%	9.5%	9.6%	9.4%	9.2%	9.2%	9.7%	9.5%	10.2%	10.9%	10.3%
	NAT		12Hr Trolley Waits			0	1,131	1,207	1,227	1,189	1,085	1,033	1,017	1,171	1,121	1,326	1,385	1,177
	NAT		Ambulance Handovers within 30m			95.0%	87.9%	88.3%	92.6%	88.1%	87.7%	89.8%	88.6%	86.6%	90.0%	88.4%	88.2%	87.7%
	IIP		% Beds Occupied 14+			30.0%	30.6%	32.5%	30.8%	29.6%	30.0%	30.8%	34.3%	32.0%	28.2%	29.1%	33.9%	34.9%
	KEY		Super Stranded >21D			107	209	224	214	205	203	212	237	212	178	184	224	239
	NAT		Not Fit to Reside (pats/day)			100.0	169.1	172.1	170.9	172.4	180.8	189.7	197.4	195.5	157.8	155.3	165.7	171.0
	IIP		Cancer 28d Combined Performance			77.0%	68.3%	64.9%	70.2%	70.4%	72.6%	71.0%	69.8%	71.3%	71.8%	75.0%	66.5%	78.7%
	NAT		Cancer 31d Combined Performance			96.0%	91.5%	93.5%	96.2%	95.0%	96.3%	95.7%	95.8%	93.4%	94.7%	97.2%	93.3%	96.5%
	IIP		Cancer 62d Combined Performance			70.0%	69.1%	66.2%	64.1%	63.0%	71.6%	73.2%	72.8%	70.4%	74.1%	73.9%	69.0%	70.7%
	IIP		Cancer Over 62d on PTL			200	188	236	237	233	203	244	215	193	203	216	197	183
	KEY		Cancer Over 104d on PTL			0	43	38	36	42	39	54	50	36	40	33	40	44
	KEY		Cancer Rapid Access Perf			93.0%	96.2%	94.8%	94.9%	96.1%	93.4%	90.6%	92.7%	82.3%	88.1%	93.2%	96.7%	97.7%
	NAT		RTT Incomplete Performance			49.8%	50.8%	51.9%	52.0%	51.0%	50.3%	50.8%	50.9%	50.5%	51.2%	52.0%	52.5%	52.8%
	NAT		RTT Total Incomplete Pathways			89.3K	85.4K	86.9K	87.5K	85.8K	85.6K	88.1K	86.7K	86.0K	85.6K	83.0K	81.2K	81.3K
	NAT		RTT 52w Breaches			5,622	6,613	6,356	5,700	5,186	4,773	4,657	3,735	3,353	3,119	2,959	2,861	2,621
	IIP		RTT 65w Breaches			0	2,301	2,203	1,802	1,656	1,360	1,269	572	346	247	216	164	148
	IIP		RTT 78w Breaches			0	485	465	272	82	35	32	34	11	10	7	4	17
	IIP		RTT 104w Breaches			0	24	15	1	1	0	1	0	0	0	0	0	9

Patients

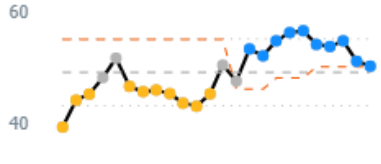
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
	IIP		Endoscopy Backlog			0	7,238	6,153	5,170	4,108	3,018	1,997	1,304	663	391	373	247	258
	IIP		DM01 Compliance			78.0%	61.2%	62.5%	63.5%	60.9%	61.3%	64.0%	68.5%	77.2%	83.3%	81.0%	83.9%	86.2%
	KEY		Theatre Session Opp.			25	33	40	40	33	40	51	39	44	35	45	36	39
	NAT		DNA Rate OP New			7.0%	6.7%	6.8%	6.9%	6.8%	7.2%	7.7%	7.8%	7.6%	7.7%	8.1%	7.6%	7.4%
	NAT		Theatre Uncapped Utilisation			85.0%	79.2%	80.7%	78.5%	79.9%	78.0%	79.2%	77.1%	77.7%	78.0%	76.7%	77.3%	76.6%

Patients

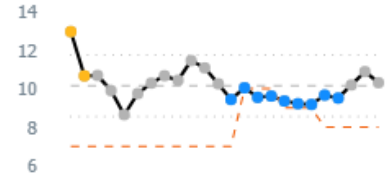
ED Compliance



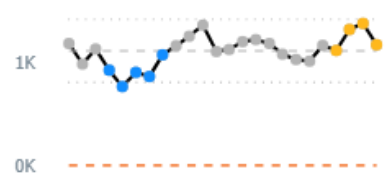
Type 1 Compliance 4hrs



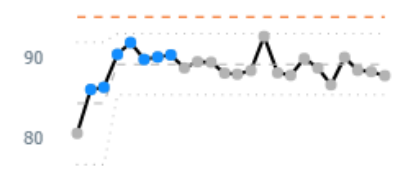
12 Hr Total Time in Department



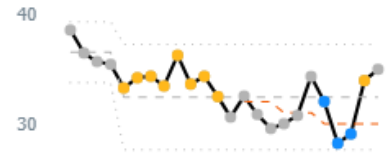
12Hr Trolley Waits



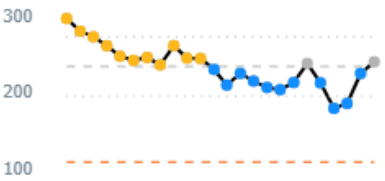
Ambulance Handovers within 30m



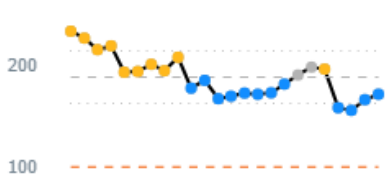
% Beds Occupied 14+



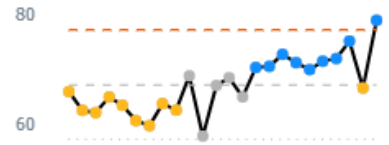
Super Stranded >21D



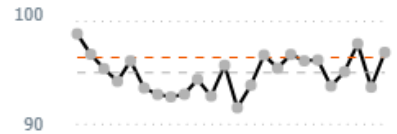
Not Fit to Reside (pats/day)



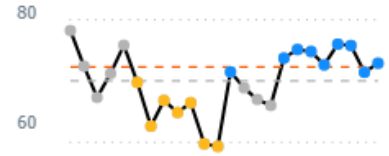
Cancer 28d Combined Performance



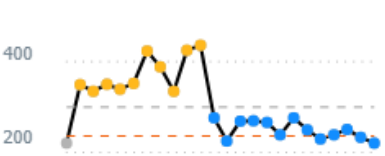
Cancer 31d Combined Performance



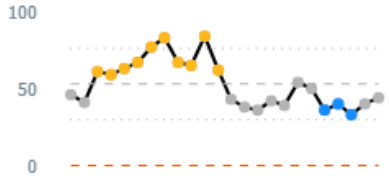
Cancer 62d Combined Performance



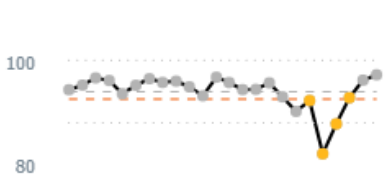
Cancer Over 62d on PTL



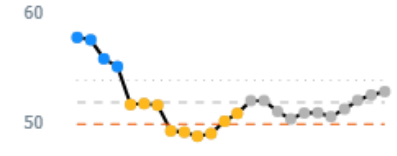
Cancer Over 104d on PTL



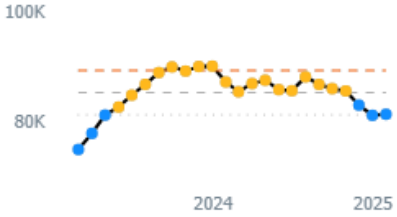
Cancer Rapid Access Perf



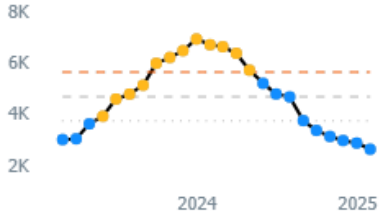
RTT Incomplete Performance



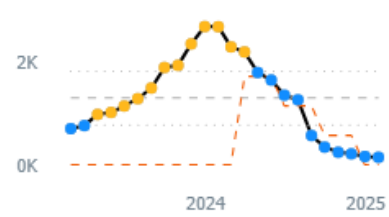
RTT Total Incomplete Pathways



RTT 52w Breaches



RTT 65w Breaches



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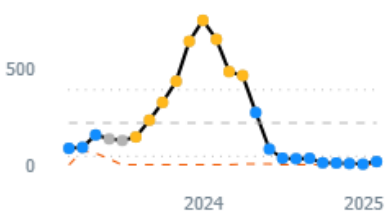

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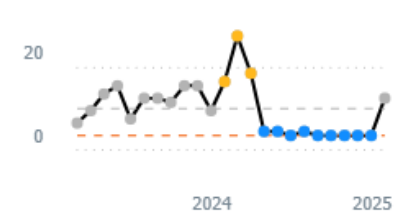
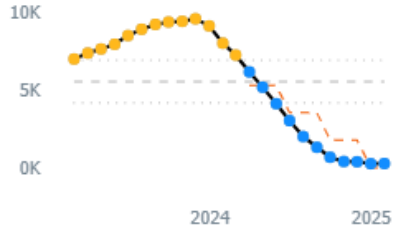
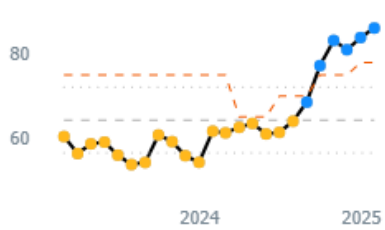


Patients

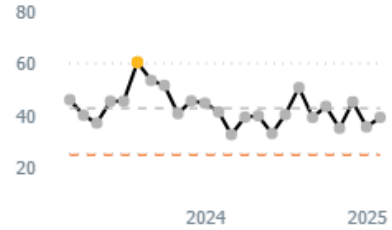
Endoscopy Backlog



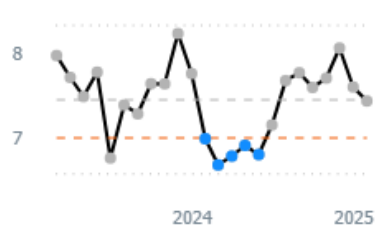
DM01 Compliance



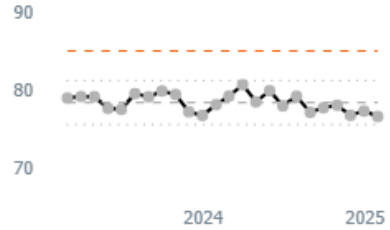
Theatre Session Opp.



DNA Rate OP New



Theatre Uncapped Utilisation



Quality and safety

Assurance

Variation	P — Will consistently pass the target if nothing changes	? — Will not consistently pass or fail the target if nothing changes	F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)		Safeguarding Adults Training Safeguarding Children Training	Complaint Response NICE Compliance Overdue Incidents VTE Assessment Compliance
No Significant Change	FFT Satisfaction Level - Outpatient	After Action Reviews (AARs) Complaints Number Duty of Candour - Findings Duty of Candour - Verbal Duty of Candour - Written 15wd Falls with Harm FFT Satisfaction Level - Inpatient IPC: CDiff Infections IPC: EColi Infections IPC: Klebsiella Infections IPC: MRSA Infections IPC: MSSA Infections	AARs Overdue FFT Satisfaction Level - ED
Concerning Variation (High or Low)		Patient Safety Incidents - Mod/Sev	HSMR

Quality and safety

Executive Summary:

Safeguarding :
Our overall training compliance as a Trust is 92.9% for Adult Safeguarding and 91.4% for Children Safeguarding. Medical and dental staffing groups is 73% for safeguarding children and 63.2% for safeguarding adults this is below the required 85% compliance described in CR3733, this has been addressed with the medical directors monitoring continues through the operational safeguarding group. The new safeguarding supervision model is now in place supported by the all-age safeguarding policy. Themes from safeguarding investigations are safe discharge ,formal assessment of capacity and support patients with complex behaviours .

Complaint Response:
KPI has been met for the third month. An issue has been identified with the IPR/dashboard reporting; when complaints are re-opened, this currently changes the agreed performance for the month the first complaint was closed. This will be rectified moving forward. Focussed work continues to ensure KPI compliance, along with a reduction of the 90+ working day old complaints and improving trust wide engagement with complaints.

Patient Safety Incident Investigations
Incidents are reviewed and investigated in accordance with the Trust's Patient Safety Incident Response Framework (PSIRF) Policy and Plan. There are national requirements for which a patient safety incident investigation (PSII) is required; and local requirements where the complexity and the potential learning is deemed to warrant a detailed systems analysis. PSIIs explore decisions and actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

The Trust at the end of February had:
10 nationally reportable PSIIs ongoing: 5 NEs, 1 medication incident identified through LfD, and 4 Maternity and Neonatal Safety Investigations (MNSI).
10 Local PSIIs including 1 new PSII's commenced in February: 1 Perforated duodenal ulcer with peritonitis.

Never Events:
There were no new Never Events reported in February. Current Never Event investigations are ongoing.

Duty of Candour:
In February, 96.3% compliance was achieved for verbal component due to 1 QEQM ED incident being completed outside of the 10-day KPI.
96% was achieved for written DoC due to 1 CCASS letter being sent outside of the 15-day KPI. These have both been completed
100% of sharing findings of the investigation in writing were completed within the KPI.
Twice weekly governance meetings are in place to identify and resolve barriers to completion and an escalation plan is in place to ensure cases approaching completion date are escalated to Triumvirate and DQG prior to becoming overdue.

Quality and safety

Executive Summary:

Overdue Incidents:
Although work to reduce overdue incidents continues, despite great efforts, the number of overdue incidents has increased again in February. In February 664 incidents became overdue, with an average of 29 incidents becoming overdue daily (equal to the rate of 29 per day in January). This offsets any closures of existing overdue incidents and accounts for why the total number does not appear to be reducing. Quality Governance staff continue to provide daily support to Care Group staff however clinical staff report challenges in ringfencing time to complete incident reviews. A draft SOP has been developed.
The SOP aims to ensure that, where necessary, bottlenecks for handlers are identified and managed, and there is oversight (and action) at the appropriate level within the Care Group structures to facilitate timely closure. Revised trajectories for each care group have been developed and shared with Quality Governance Business Partners. Quality Governance staff will continue to support clearance of the existing overdue incidents and continue to engage appropriate managers and leads.
Care Group Triumvirates to adopt and embed the SOP process within specialities to reduce 'tipping' to zero and sustain reductions in overdue incidents long term.
Review of incidents overdue by 6 months or more has identified the small proportion open for justifiable reasons e.g. safeguarding awaiting KCC, remaining SI, PSIIs.

InPhase:
There have been a number of functionality issues that have arisen during the first phase of implementation with the Risk, Policies and CQC Apps. All these issues were significant and stalled progress. Ideagen have now agreed to make all changes requested and we the APPs are now progressing. We have confirmed most of the dates for key milestones for all APPs. Stage 2 of the plan is progressing well with Clinical Audit, NICE and Alerts. The significant risk within the project have now been reduced as it was agreed to allowed the Datix contract to lapse for a further year, providing time for appropriate testing prior to go live. The remaining moderate risk relates to the development of the Legal APP. The two elements to this risk includes availability of the Interim Head of Legal to undertake the work required for the development of the APP and the possibility that there may be a gap in cover should her contract come to an end at the end of April 2025. This has been escalated to the Director of Corporate Governance and a plan has been agreed in relation to availability. We are awaiting an update on the plan for cover for Legal Services.

Infection Prevention and Control:
C-dif and E-coli cases remain below the current thresholds, however, the Trust has breached the year-end threshold for both Pseudomonas and Klebsiella, therefore significant focus continues to be on environmental factors that maybe influencing these cases. MRSA rates remain lower than the previous year, however MSSA rates have increased in February. There was a significant norovirus outbreak in QEQM hospital in January, impacting 11 wards, which closed on 29/01. An outbreak Closure and Learning Meeting took place on 07.02.2025, and there was a norovirus outbreak at WHH – which also affected multiple wards and patients, hwoever, having implemented learning from the QE outbreak, kept wards open, but the outbreak lasted significantly longer.

Mixed Sex Breaches
33 breaches occurred in month all owing to limited flow & capacity across the sites. This is the lowest number of unjustified breaches reported externally since May 2024.
- 32 patients were unable to be stepped down from critical care within the four-hour standard: 24 at WHH and 8 at QE.
- 1 patient on RSU at WHH was cared for in an escalation bed for more than 4 hours.

An internal assurance review is being undertaken within the theatre recovery and SAU areas.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Quality	NAT		Patient Safety Incidents			2,299	1,951	1,938	1,978	1,846	2,040	1,865	1,889	2,108	2,081	2,001	2,177	1,964
	NAT		Patient Safety Incidents - Mod/Sev			65	39	37	27	46	38	38	33	49	40	37	42	66
	NAT		Never Events			0	1	0	0	1	0	2	2	1	0	0	0	0
	NAT		PSII - National			0	1	0	0	1	4	3	2	2	1	1	0	0
	NAT		PSII - Local			0	0	0	0	0	1	2	0	0	2	0	2	1
	NAT		After Action Reviews (AARs)			0	11	9	7	3	11	6	5	6	13	11	6	5
	NAT		AARs Overdue			0	44	49	51	52	45	27	23	24	26	25	35	37
	KEY		Overdue Incidents			0	1,358	822	1,406	1,557	1,164	724	688	659	734	757	974	1,202
	IIP		Falls with Harm			12	4	6	3	4	2	7	5	7	9	8	1	4
	NAT		Safeguarding Incidents			54	53	33	50	32	29	27	31	33	38	34	16	25
	NAT		Safeguarding Children Training			90.0%	93.5%	94.3%	93.6%	93.3%	92.3%	91.8%	91.2%	91.3%	91.5%	91.7%	91.7%	91.4%
	NAT		Safeguarding Adults Training			90.0%	92.1%	93.2%	93.5%	93.6%	93.0%	93.4%	92.7%	93.0%	93.1%	93.3%	93.3%	92.9%
	NAT		Duty of Candour - Findings			100%	100%	100%	81.3%	89.5%	91.7%	74.3%	94.6%	87.5%	100%	100%	100%	100%
	NAT		Duty of Candour - Written 15wd			100%	89.5%	70.0%	64.0%	64.3%	50.0%	82.1%	88.9%	96.4%	97.2%	100%	100%	96.0%
	NAT		Duty of Candour - Verbal			100%	94.7%	76.2%	78.3%	78.9%	85.7%	87.5%	100%	95.8%	97.1%	100%	100%	96.3%
	NAT		IPC: EColi Infections			13	17	10	11	16	14	13	16	9	9	13	14	13
	NAT		IPC: CDiff Infections			12	14	4	4	6	9	8	12	11	11	9	11	8
	NAT		IPC: Klebsiella Infections			7	5	10	7	7	9	7	11	5	6	9	6	5
	NAT		IPC: Pseudomonas Infections			2	3	2	2	4	5	2	4	2	7	4	5	1
	NAT		IPC: MRSA Infections			0	1	0	0	0	0	1	0	0	1	0	0	0
	NAT		IPC: MSSA Infections			6	2	6	7	5	8	6	8	5	2	7	9	11

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
	KEY		HSMR			96.0	102.6	102.4	101.7	101.4	102.8	101.9	102.3					
	KEY		SHMI			1.070	1.051	1.061	1.051	1.126	1.133	1.131	1.140	1.140				
	IIP		Pressure Ulcers			118	76	84	84	82	79	72	77	92	85	85	119	98
	NAT		Mixed Sex Breaches			147	132	120	24	36	76	56	57	68	52	65	92	33
	KEY		Complaint Response			85.0%	18.6%	0.0%	4.4%	7.8%	16.2%	18.6%	31.6%	54.1%	71.4%	84.2%	86.1%	87.3%
	KEY		Complaints Number			120	77	100	105	77	92	87	90	85	83	94	117	99
	NAT		FFT Satisfaction Level - ED			90.0%	80.4%	81.6%	83.7%	83.8%	83.6%	87.5%	84.0%	83.0%	84.1%	82.6%	82.7%	82.0%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.2%	95.9%	95.7%	95.7%	95.4%	95.6%	95.8%	95.3%	95.7%	95.8%	96.0%	95.7%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	89.8%	89.4%	91.1%	90.5%	92.3%	91.0%	90.1%	88.9%	91.4%	91.1%	89.2%	88.4%
	NAT		VTE Assessment Compliance			95.0%	92.5%	92.3%	93.2%	93.4%	92.7%	93.5%	93.7%	94.2%	93.8%	92.7%	93.9%	94.4%
			NICE Compliance			81.0%		4.3%	8.6%	16.5%	25.2%	34.4%	50.0%	62.9%	63.4%	74.6%	83.1%	91.9%

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient Safety Incident Response (PSIR) Framework: National and Local Patient Safety Incident Investigations (PSIIs)	• Terms of Reference (ToR) for Learning Response Approval Panel (LRAP) have aligned to the NHS Oversight requirements. The draft ToR have been circulated for comments and will be finalised by the end of January 2025. • PSIR Plan review to commence January 2025 to align refreshed plan with Quality Account timeframes (April 25 to March 26). • Patient safety training programme in place: PSIRF, Swarm, AAR, Incident Investigation, Engagement/Duty of Candour, Human Factors.	• Head of Patient Safety and Improvement	31/03/2025	• Weekly report to Executives includes detail of PSIIs. • Training Needs Analysis in place. Review of training content underway to further align with the National Patient Safety Syllabus. • Swarm and AAR training was reintroduced in February 2025 with dates available on ESR at 3 acute sites
One new locally reportable PSII in February 2025	PSII: Delay in diagnosis of upper GI bleed • Presented at IRP. • DoC completed. • Investigation underway	• Head of Patient Safety and Improvement	20/06/2025	• Investigation scope and ToR under development
Increase in moderate and severe Harm incidents reported in February (66)	Themes identified: • 16 Tissue viability incidents, of which 5 relate to hospital acquired PU's • 11 known complication of procedures with no omissions in care identified • 4 incidents where harm is attributed to external organisations • 4 Maternity incidents, 1 Maternal sepsis, 1 management of labour issue, 2 known complications. All were discussed at Rapid review panel. • 4 inpatient falls (all discussed at FoC and for AAR's) • FoC reviewed 9 incidents, 8 incidents were discussed at Pre-IRP, 4 were presented to IRP and 1 incident was discussed at learning from deaths panel.	• Head of Patient Safety and Improvement	28/02/2025	• Incident themes reviewed monthly • All incidents managed via the PSIRF plan • A log of all incidents from Rapid review, pre-IRP and FoC are sent to IRP for executive oversight.
IPC Measures: Due to changes in thresholds, Pseudomonas and klebsiells Blood stream infections are over the threshold	• Environmental and equipment reviews continue • CLEAN 2 campaign to commence in April 2025 in collaboration with 2gether and focus on cleaning. • Trustwide mattress audit and replacement - completed	• IPC Team	April 2025	• Trust wide review of FR cleaning ratings and additional protocols continue • Trust wide review of roles and responsibilities for cleaning in process • Trust wide Mattress audit completed across three main sites
Continued mixed sex breaches	• An internal assurance review is being undertaken within the theatre recovery and SAU areas	• ADoN for FoCC/ADoN for CCASS	• March 2025	• Review of areas and process planned for March with a paper presenting options expected at FoCC and NMEC in April 2025.

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Complaint Performance was below the standard we would expect	• Complainants are called at the start of the complaint and updated/advised of any delays. • Specific resource continues to be focussed on response reviewing within the complaints team, to drive quality and timeliness of responses. • Weekly reporting for care groups is provided to identify breaching complaints and age of complaints. • An enhanced escalation process with the triumvirates to support responsive resolutions. • Fortnightly meetings with care group specialties to discuss progress with their complaints. • A programme of training for care group staff is ongoing; bite size sessions, concentrating on areas where improvement is required. • Targeted work on 90+ working day old complaints.	• Head of CPBS	• Ongoing in line with agreed trajectory for clearing the complaint breaches	• Trajectory set, to meet KPI target of 85% within timescales by end of December 2024. Trajectory and KPI met. • The number of stage 1 complaints over 60 working days has significantly reduced from 239 at the end of August, to 44 as at 28.02.2025.
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient experience once on a ward can be poor (e.g. being moved several times, lack of handover of key information)	• New inpatient survey to be developed to capture feedback whilst patients are with us (youth volunteers to support getting feedback). • Promotion of the carers leaflet and carers survey • Communication passport for people with hearing or visual impairments to be offered to patients on the wards. • Pilot 'What Matters to me' communication posters behind patient beds on each site.	• Patient Voice and Involvement team • Ward managers / QIWA team • Ward staff • Associate Directors of Nursing for SAGE and GM	• By April 2025 • By May 2025 • By May 2025 • By June 2025	In patient survey drafted with patient involvement. Waiting for CNMO sign-off. Plan to launch by end of April. 'What Matters to Me' posters now printed. Will be distributed to pilot wards by the end of April.

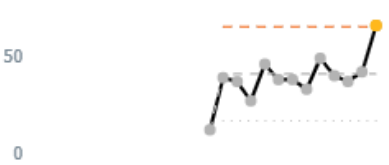
Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT ED: satisfaction levels remain below the Trust target of 90% satisfaction.				
Not all patients currently have their communication needs identified and recorded (i.e. those arriving by ambulance)	• Process to identify communication needs of patients arriving by ambulance.	• ED Managers	• By July 2025	
Limited use of telephone interpreters by ED (concerns that family are being used to interpreter)	• Staff to be made aware of the importance of using interpreters, especially to gain consent, explain diagnosis and treatment.	• ED Managers with support from Trust interpreting lead	• By May 2025	
Long waits in ED after triage to be treated remain a source of patient dissatisfaction. Patients are not always kept updated on waiting times.	• Improve communication with patients in ED waiting for treatment but not waiting to be admitted (e.g. Patient information app at WHH)	• ED Matron and senior nurses	• By June 2025	
Care in escalation areas remains a source of negative feedback.				
Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity).	• Comfort packs for patients being cared for in escalation areas. Family to be sign-posted to Carers Support Hospital Service. Carers Leaflet available.	• Assoc Directors of Nursing for UEAM / Heads of Nursing, plus, ED teams to signpost to support for carers	• By July 2025	Carers Support Hospital Service leaflet circulated to DoNs and UEAMs
	• New Linet trollies to be piloted in QEQM ED (to reduce pressure ulcers / falls)	• Lead for Moving and Handling /Lead for Tissue Viability	• By April 2025	Feedback from pilots at WHH and QEQM being collated..
	• Additional chair beds for side rooms to enable a carer / family member to stay over night where the patient needs a familiar person to support their care.	• Assoc. Director of Patient Experience / DoNs of K&CH, QEQM and WHH and UEAM senior teams	• By September 2025	Meeting held, numbers needed being scoped. Charitable funding bid to be made in due course.

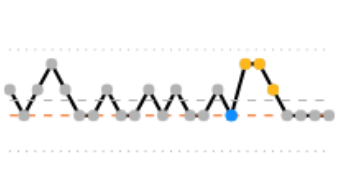
Quality and safety

Patient Safety Incidents

Patient Safety Incidents - Mod/Sev



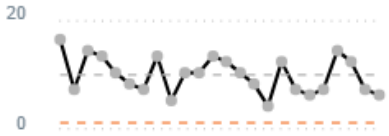
Never Events



PSII - National

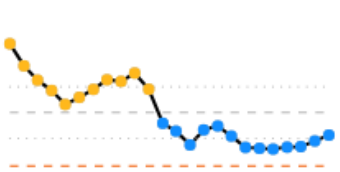
PSII - Local

After Action Reviews (AARs)

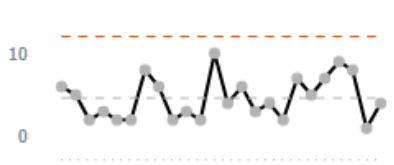


AARs Overdue

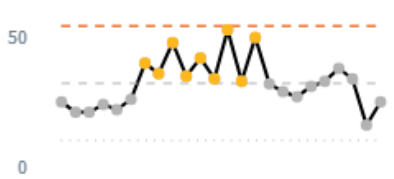
Overdue Incidents



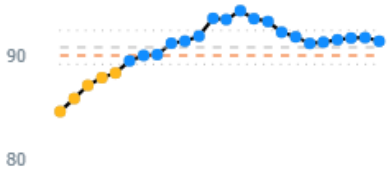
Falls with Harm



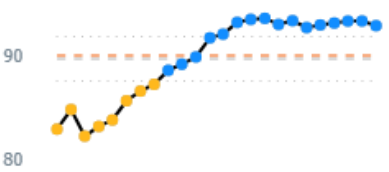
Safeguarding Incidents



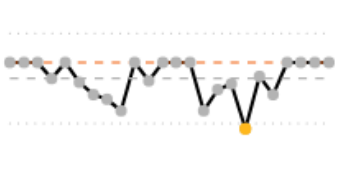
Safeguarding Children Training



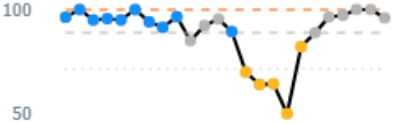
Safeguarding Adults Training



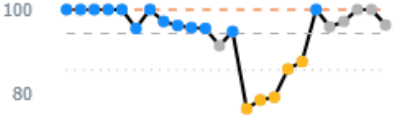
Duty of Candour - Findings



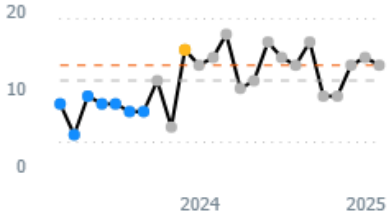
Duty of Candour - Written 15wd



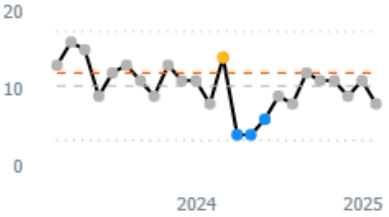
Duty of Candour - Verbal



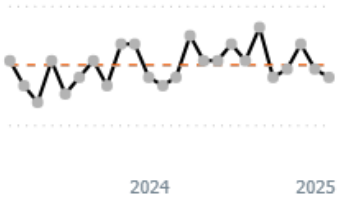
IPC: EColi Infections



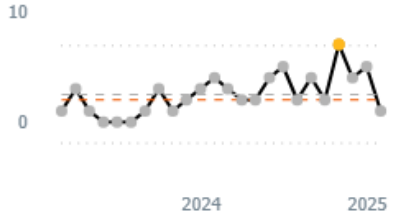
IPC: CDiff Infections



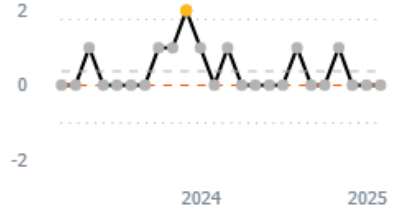
IPC: Klebsiella Infections



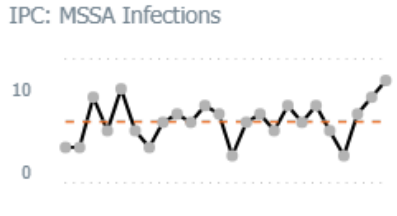
IPC: Pseudomonas Infections

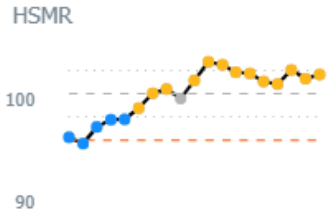


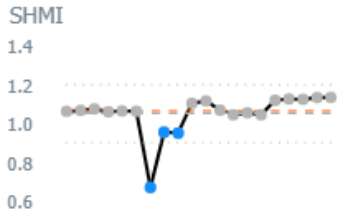
IPC: MRSA Infections

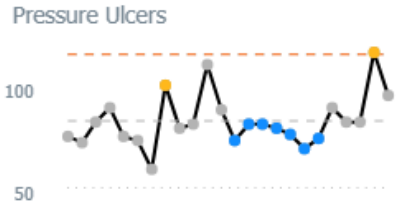


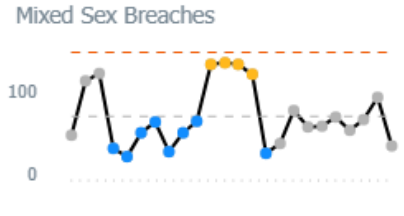
Quality and safety

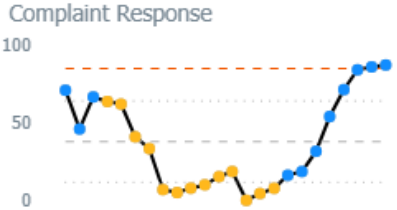


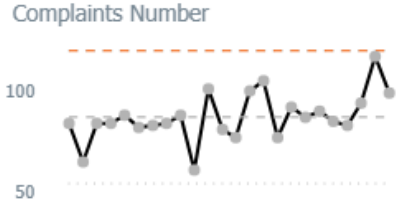


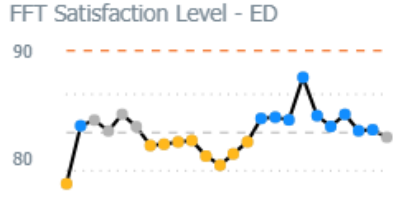


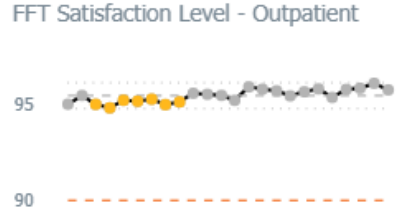


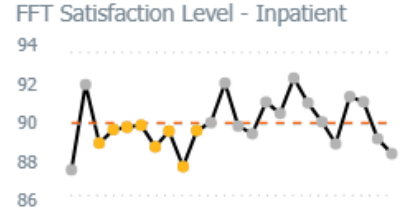


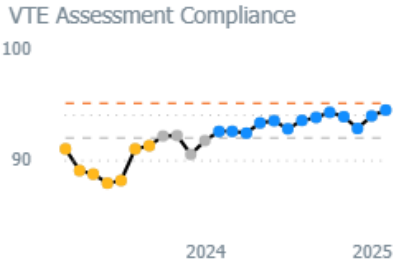


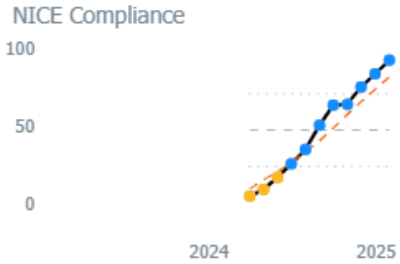












Quality and safety

Staff Type	Vacancy Rate Feb-25 (Target 10%)	Sickness Rate Feb-25 (Target 5%)	Safe Care Red Flags Feb-25
Registered Nursing & Midwifery	5%	5.39%	
Registered Nursing Associate	N/A	N/A	340
Health Care Support Worker	%	N/A	

Staff Type	Care Hours Per Patient Day (CHPPD) Feb-25	Avg Fill Rate Day Feb-25	Avg Fill Rate Night Feb-25
Registered Nursing & Midwifery	6.4	85%	90%
Registered Nursing Associate	0.1	100%	100%
Health Care Support Worker	3.0	80%	99%

Safe Staffing:

CHPPD is calculated by dividing the number of actual nursing (both registered and HCSW) hours by the number of patients on the ward at 23:59; this advises of the 'nursing' or care hours that are available to each patient per day. Currently our CHPPD is higher than our peer organisations but is improving.

Updated establishments and roster templates went live on the 27th January 2025 with continued recruitment into vacancies. The average fill rates for February 2025 remain at an acceptable level.

Several areas did work on amber shifts, as defined within our organisation. There were 6 red shifts within QEQM critical care. Round tables have been undertaken to ensure the shift was escalated in real time and to support learning. For the shifts whereby, the department was non-compliant to GPICS (3 night and 3 day shifts) staffing levels were supported by the nurse in charge taking care of a patient or patients co-located to enable a staff member to oversee more than one.

People

Assurance

Variation

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

People

Executive Summary:

Sickness absence rates remain above the alerting threshold, although dropped by 0.5% to 5.2%. The drop is related to a decrease in the numbers of staff absent with coughs, colds and influenza, although the numbers are significantly higher than las autumn – from 513 to 801 related episodes. Put in context, this has risen from accounting for 0.47% in September to 0.97% in February. By way of comparison, there have been 219 sickness episodes relating to stress, anxiety and depression, approximately the same as last month. An increase remains blunted by the provision of face-to-face counselling and the development of a greater network of wellbeing advocacy and peer support.

Vacancy rate has increased to 10.1%, having remained below the 10% threshold for the last year. The highest vacancy rates are in the QEQM Care Group (11.5%), primarily driven by UEAM (23.7%), and the K&C Care Group (9.96%), which is primarily driven by vacancies across Stroke (12.9%). The lowest is across the DCB Care Group (6.4%).

Staff turnover has improved (to 8.2%) and continues the positive trend that has been observed across the last 2 years. It is now the lowest it has been in over 2 years and remains on a positive trajectory. Nursing turnover continues to improve and is now at 6.7% - the lowest it has been in >18 months. In fact, there has been a continuous and positive reduction in nurse turnover since February 2023. Whilst positive, this still equates to 231 nurses and midwife leavers across the last 12 months. Health Care Support Worker turnover has reduced from a height of 24% in May ’23 and currently stands at 9.8%. Premature turnover increased to 15.0%. Taken together, DCB and CCASS account for over a third (37%) of all premature turnover.

Appraisal compliance has remained above the Trust-level threshold (80%), currently standing at 80.8%. In the clinical Care Groups, rates are highest in WCYP (84.9%). DCB and K&C Care Groups are below the 80% threshold. Corporate appraisal compliance remains the lowest at 73.4%.

Statutory training compliance decreased slightly to 92.3%. This continues to exceed the Trust-level threshold (91%). All Care Groups are above 90% and although compliance for medical staff remains below the expected threshold, this has responded positively in-month and improved again to 83.0%. Compliancy is highest against the Equality and Diversity modules (95.7%) and lowest against Information Governance (88.3%).

People

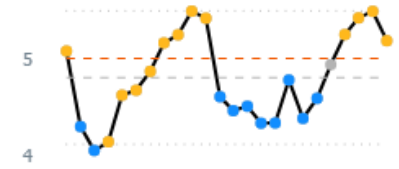
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
People	NAT		Sickness			5.0%	4.5%	4.5%	4.3%	4.3%	4.8%	4.4%	4.6%	4.9%	5.2%	5.4%	5.5%	5.2%
	NAT		Vacancy Rate			10.0%	8.7%	8.2%	8.7%	9.2%	8.7%	9.6%	8.7%	8.6%	8.7%	8.8%	9.0%	10.1%
	NAT		Staff Turnover Rate			10.0%	9.2%	9.3%	9.2%	9.2%	8.9%	8.9%	8.9%	8.8%	8.7%	8.4%	8.3%	8.2%
	NAT		Premature Turnover Rate			25.0%	14.9%	14.6%	15.0%	14.9%	15.2%	14.9%	14.8%	14.8%	14.4%	13.5%	13.5%	12.7%
	KEY		Appraisals Compliance			80.0%	73.8%	76.6%	74.7%	74.1%	75.0%	74.8%	77.9%	79.4%	80.3%	80.0%	81.4%	80.8%
	IIP		Staff Engagement Score			6.80	6.13	5.70	5.70	5.70	5.95	5.95	5.95	6.35	6.35	6.35	6.04	6.04
	KEY		Staff Advocacy Score			6.70	5.70	4.99	4.99	4.99	5.34	5.34	5.34	5.80	5.80	5.80	5.55	5.55
	NAT		Statutory Training			91.0%	92.0%	92.2%	92.4%	92.5%	92.2%	92.4%	92.2%	92.2%	92.4%	92.4%	92.5%	92.3%
	KEY		Infection Control Training			90.0%	92.9%	92.9%	93.2%	93.7%	93.4%	93.7%	93.5%	93.4%	93.3%	93.2%	93.1%	92.9%
	KEY		Hand Hygiene Training			85.0%	74.9%	75.8%	76.3%	76.8%	79.7%	79.2%	79.0%	79.1%	93.1%	92.9%	92.7%	91.7%
	KEY		Medical Job Planning Rate			90.0%	45.3%	45.3%	44.1%	37.0%	36.5%	33.3%	32.5%	30.3%	32.0%	27.9%	27.9%	32.1%

People

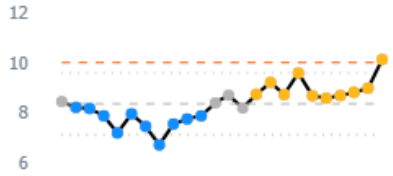
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• HCSW vacancies should improve following the B2 to B3 uplift. • Working with Finance, Temporary Staffing and the CMO office to target areas of long-term and high-cost medical agency, and alternative ways of working. • Vacancies in maternity improved to 10.7% following the recruitment of student midwives in September. This is lowest vacancy rate for over a year.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• 403 staff have accessed the service, with 971 counselling sessions delivered and clinically reliable change in 82.1% of staff. • New bid for funding from the East Kent Charity due at CFC in January 2025 , to combine EAP funds and continue to deliver on-site clinical psychology from February 2025 (when it is currently due to expire).
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Staff Experience	• Ongoing	• Staff Turnover remains around **8.2%** and has achieved the gold standard (10%) for over a year. It is currently at the lowest rate the Trust has seen in 2 years.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Staff Experience	• Complete	• Premature turnover (**15%**) remains within the desired parameters (≤15%), although has increased slightly in the last two months.
Staff Engagement levels (5.95) are below the national average (6.78)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2024 staff survey, with the launch linked to the Culture & Leadership programme implementation.	Head of Staff Experience	• Mar 25	• The response rate to the National NHS Staff Survey is a marker of engagement in itself and acts as a precursor to the scores which are released in January '25. The Trust closed with one of the highest response rates in the country (63%), has achieved a majority response and the highest number of respondents in the Trusts' history. Plans are underway to act on this early in 2025.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Dec 24	• Compliance is at 83.0%, which is the highest it has been in 4 years. All Care Groups are targeting improvement within medical staff compliance – with medical staff compliance lowest in the Corporate Care Group (76.5%).

People

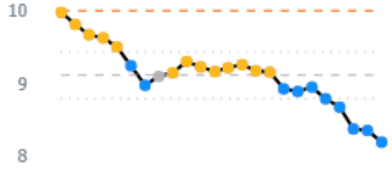
Sickness



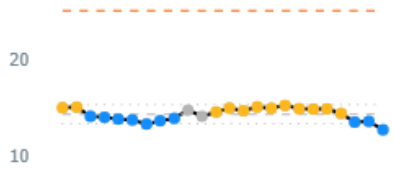
Vacancy Rate



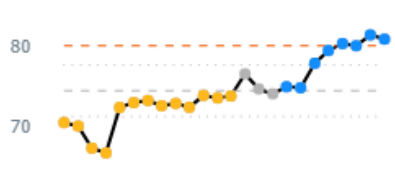
Staff Turnover Rate



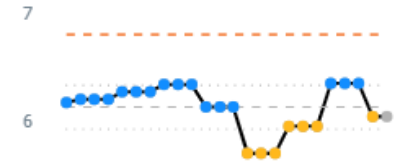
Premature Turnover Rate



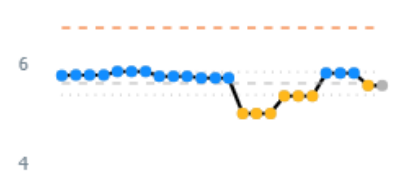
Appraisals Compliance



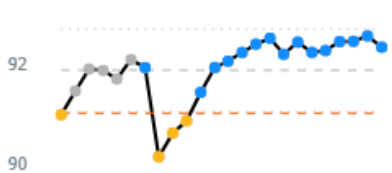
Staff Engagement Score



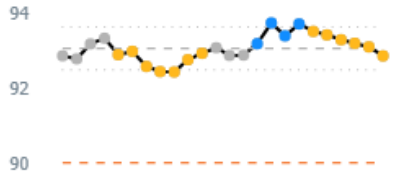
Staff Advocacy Score



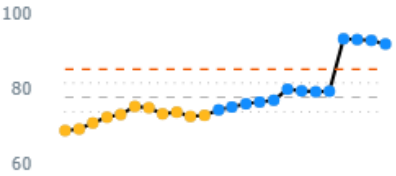
Statutory Training



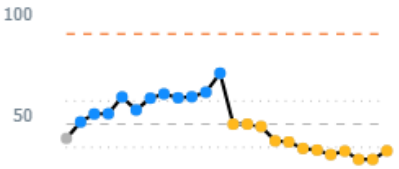
Infection Control Training



Hand Hygiene Training



Medical Job Planning Rate



Sustainability

Assurance

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

Sustainability

Executive Summary:

The Group has reported a YTD deficit of £80.6m against a deficit plan of £82.5m to Month 11 delivering a better than plan YTD position of £1.9m. The Group is forecasting to meet the plan for the full year, albeit with a need to proactively manage in year risks, which include operational pressures, surge demand and the impact on elective (i.e. planned) work. The Trust delivered a c£2.1m improvement YTD on plan.

Trust pay expenditure increased compared to month 10 by £1.2m. Bank spend increased by £82k and agency and Direct Engagement spend increased by £0.5m. The run rate on substantive staff increased in month by £0.6m which equates to an overall increase in WTE usage of 100 WTE as compared to month 10. YTD the Trust is favourable to plan in pay by £2.2m.

The Trust non pay run rate increased in month slightly by £0.5m this was mainly in Education and Training and the purchase of non NHS healthcare to support additional patient activity. YTD the Trust is favourable to plan for non-pay of £2.8m.

The pay award shortfall is still impacting the Trusts run rate (£1.9m YTD and £2.1m for the year). This has been offset by non-recurrent benefits YTD, however if additional funding is not agreed, it could be a risk to our year-end position if not offset by other positive movements. The change in Elective recovery Fund (ERF) baseline due to the increased number of working days has also impacted the Trust's ERF by £2.2m YTD and a FYE of £2.4m. As previously reported the Trust has seen a reduction of HCP monies for prior year projects by £2.2m YTD and FYE of £2.4m. The Trust has been mitigating these risks with non-recurrent benefits.

The Trust has delivered £44.5m of efficiencies to month 11, £0.4m above the YTD plan.

Sustainability

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Sustainability	IIP		Deficit In Month Group (£)			4.9M	12.2M	8.8M	7.3M	7.1M	8.3M	6.3M	7.3M	7.5M	9.8M	7.0M	6.5M	4.9M
	KEY		Variance to Plan (£)			0K	-6,718K	-5K	5K	-28K	20K	53K	1K	-31K	1K	-2,070K	3,954K	-2K
	KEY		Premium Pay			11M	10M	8.1M	8.4M	7.9M	8.8M	8.9M	8.0M	8.6M	8.6M	8.0M	7.6M	8.3M
	KEY		WTE worked (Premium Pay)			1,237	1,131	963	1,019	968	1,031	1,049	1,017	996	967	975	964	1,072
	KEY		Total Pay Spend In Month			61M	60M	51M	51M	51M	51M	52M	51M	66M	54M	54M	53M	55M
	KEY		WTE worked (All Pay Spend)			10,376	10,286	10,115	10,103	9,984	10,049	10,048	10,105	10,138	10,096	10,144	10,110	10,237
	KEY		Efficiencies Green Schemes (£M)			40	13	3	5	4	11	15	16	20	25	28	35	40
	IIP		Efficiencies YTD Variance (£M)			0.0	-26.9	0.0	0.0	0.0	0.1	0.3	0.3	0.3	0.3	0.3	0.4	0.4

Sustainability

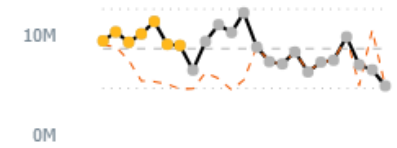
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• ID Medical Managed Service meeting with each Care Group, reviewing each Medical worker for alternative options. • Working with CMO/DCMO to meet with Managing Directors and Medical Directors to highlight the issue and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• The ID Medical Managed Service have met and are continuing to work with all Care Groups to source alternative, more cost efficient candidates to replace those high-cost long term locums. • 5 of 127 locums currently working at the Trust are engaged via standard placement. • A restriction is now in place in relation to new standard placement bookings. Our DE throughput, currently at 94%. A plan is now being established to replace the remaining 5 locums, one of whom is due to leave shortly. • CMO to be included in chasing ups feedback for potential CV swaps with high cost agency workers in order to support with improving our cap compliance.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• July 25	• Signed up to the rate card and commenced on 1st June 24, with the second step down to be applied from the 1st October 24. • Further reductions have been proposed which, if agreed upon, will be implemented in March 2025. • Only areas above the newly proposed cap are Maternity and Paediatrics. Rates had been agreed for Maternity until the end of 2024, although this has now been extended due to some delays with new starters, all will now be in post by July 25. • From the 01.03.2025 the Trust will be implementing a restriction on the use of agency staff for bands 2 and 3. • Meetings held with the SE collaborative to review all agency suppliers, discuss any issues and outliers as we work towards aligning our rates across Kent. Further meetings to be arranged with suppliers. SETS are to setup regular meetings with suppliers to understand what is driving rates and workforce pressures across the region. • No off-framework usage recorded. • Working with the ICB, a number of new controls/processes have been implemented to support with controlling overall demand and reduce our reliance on agencies. This will also support the Trust in achieving our objectives in relation to the workforce CIP schemes.

Sustainability

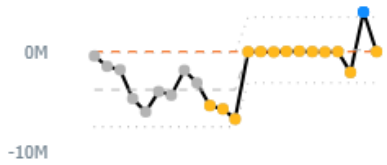
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales. • Regular meetings now held across the collaborative to current issues as we worked towards rate parity across the region.	CPO	• Ongoing	• Supplier Meetings have commenced with support from the SETS programme team. • The rate card was approved by the board on the 11th September, it was agreed that the collaborative would keep the rate ceilings stable over the winter period. However, it is proposed that new step-down plans will be issued in March 2025. • CMO, DCMOP are currently reviewing the rate cards to establish where the Trust sits against the step downs. • No off-framework usage recorded. • The ID Medical managed have provided a report detailing all locums engaged at the Trust and their hourly rates in comparison to the applied ceiling caps. IDM to provide a plan to bring those above the cap in line with the rate framework, starting with those closest to the current cap. Expected in February 2025. ID will now

Sustainability

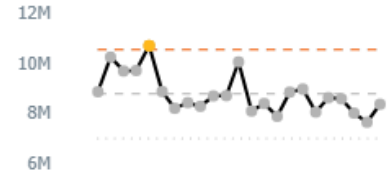
Deficit In Month Group (£)



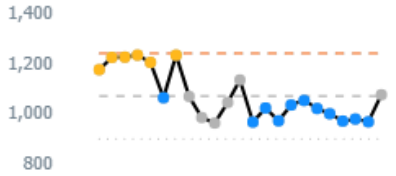
Variance to Plan (£)



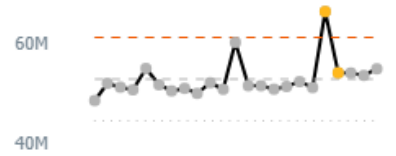
Premium Pay



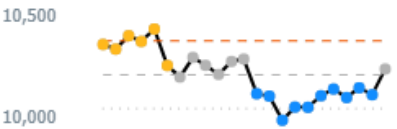
WTE worked (Premium Pay)



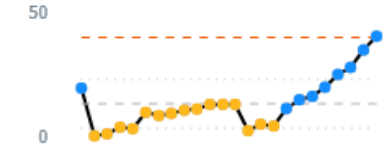
Total Pay Spend In Month



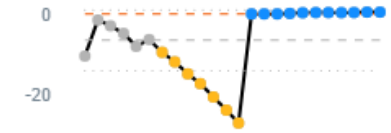
WTE worked (All Pay Spend)



Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



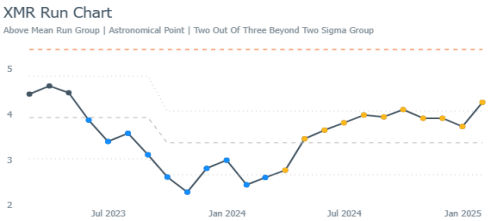
Maternity

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

Maternity

Executive Summary:

Morbidity & Mortality | MBRRACE Ext Perinatal Rate 12m	Feb-25	4.26



The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the February 12 month rolling rate slightly increased from the previous month (3.73 per 1,000 births) at 4.26 per 1,000 births. This rate includes both stillbirths and neonatal deaths.
In February, the neonatal death rate increased slightly at 2.05, with one neonatal death >24 weeks reported in month.
The stillbirth rate increased in February from 1.86 in January to 2.22 in February. The stillbirth rate remains significantly below the threshold of 3.61 whilst the neonatal death rate remains slightly above the threshold of 1.82.

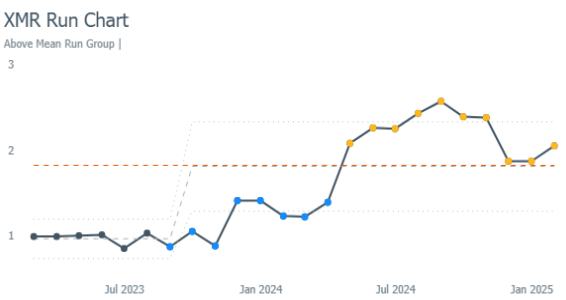
Metric Definition

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

Datasource: Euroking & PAS
Threshold based on the average of the Trust's comparator group (MBRRACE 2022). Average was 1.82

MBRRACE NND Rate 12m

Timescale	Value	SPC
Mar-24	1.22	
Apr-24	1.39	
May-24	2.08	
Jun-24	2.26	
Jul-24	2.25	
Aug-24	2.43	
Sep-24	2.57	
Oct-24	2.39	
Nov-24	2.38	
Dec-24	1.87	
Jan-25	1.87	
Feb-25	2.05	



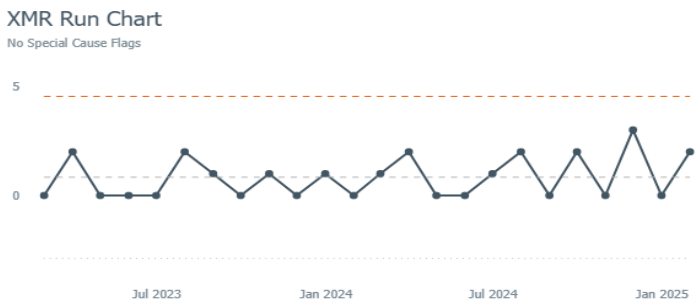
Metric Definition

MBRRACE Methodology used - stillborn babies born at 24+0 weeks gestation at EKHUFT. Reported by birth month. Terminations excluded.

Threshold is 24 per year, based on the range of the Trust's comparator group in the latest MBRRACE report (2021)

MBRRACE Stillbirths

Timescale	Value	SPC
Mar-24	1	
Apr-24	2	
May-24	0	
Jun-24	0	
Jul-24	1	
Aug-24	2	
Sep-24	0	
Oct-24	2	
Nov-24	0	
Dec-24	3	
Jan-25	0	
Feb-25	2	



The external independent review findings of all neonatal deaths between 31st March 2023 to 31st March 2024 (extended to include the deaths of babies in May 2024) was presented at MNAG on 11th March 2025 with associated action plan.

Maternity

Executive Summary:

CNST Year 6 – evidence of compliance for all 10 Safety Actions validated by LMNS in January 2025 and Trust Board declaration of full compliance submitted to NHSR on 13th February 2025.

The Friends and Family Test (FFT) maternity response rate, calculated using the national methodology based on delivery episodes, remains around the average of 10%. Though this month there has been an improvement to 12.3% a QR code has been agreed with IT to be added to the EDN and will go live as the EDNv2 is introduced imminently. The changes to text messages will also be set up top ensure they are sent in a timely manner as close to the appointment date.

PSII's

No new referrals made to MNSI during February 2025. Currently the maternity service has 2 open MNSI cases (1 new case referred in March 2025 - maternal death).

No new local PSII's reported during February 2025. Two ongoing PSII's:

- WEB295938 Mother admitted to ITU 4 days post caesarean section birth with suspected sepsis and ileus.
- WEB282476 Intrauterine death at term – report in process of completion following feedback from family following review of draft report.

8 moderate patient safety incident were reported in February under the following categories:

- Management of screening investigation samples
- PPH
- Return to theatre
- Communication
- Pre-term birth

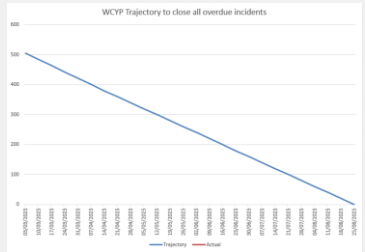
Two new risks added to the Risk Register:

- Risk ID 3775 – Lack of piped medical gasses to support neonatal resuscitation within the clinical areas of maternity – Risk rating 12
- Risk ID 3764 – Lack of infrastructure to enable training provision to meet national requirements for maternity services – Risk Rating 16

Maternity: Metric Dashboard

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-...	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Maternity	KEY		Mat Patient Safety Incidents Mod/Sev			7	5	1	1	2	2	2	1	0	3	2	5	8
	NAT		PSII - National (Maternity)			0	0	0	0	0	4	1	0	1	0	1	0	0
	NAT		PSII - Local (Maternity)			0	0	0	0	0	0	1	0	0	0	0	1	0
	KEY		Maternity Complaints			20	1	7	8	5	8	9	13	1	5	2	8	6
	KEY		Maternity Complaint Response			85.0%	66.7%	0.0%	20.0%	0.0%	42.9%	66.7%	50.0%	85.7%	100%	100%	100%	60.0%
	KEY		Extended Perinatal Mortality			5.87	2.61	2.77	3.46	3.65	3.81	3.98	3.94	4.10	3.91	3.91	3.73	4.26
	NAT		FFT Maternity Response Rate			15.0%	11.5%	9.2%	9.1%	12.1%	11.1%	10.7%	10.2%	12.2%	10.6%	10.0%	9.9%	12.3%
	NAT		FFT Maternity Recommended			90.0%	88.1%	91.9%	93.7%	95.2%	92.4%	88.4%	92.2%	95.6%	92.8%	90.4%	93.9%	91.1%
	NAT		FFT Maternity (IP) Recommended			90.0%	90.9%	92.7%	94.8%	95.3%	93.0%	89.3%	95.8%	97.1%	91.9%	95.0%	93.9%	94.8%
	KEY		WH Engagement Score			6.90	6.35	6.07	6.07	6.07	6.12	6.12	6.12	6.40	6.40	6.40	6.19	6.19

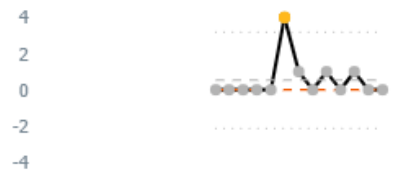
Maternity: Actions

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		Though their has been an improvement this month to 12.3% there is still work to be completed which should improve this completion significantly. From the 'go live' of EDNv2 which is imminently every EDN will have an individualised QR code for women / birthing people to scan prior to discharge - this will be for the birth and discharge from hospital elements of FFT. Women are able to opt-in to sharing their details should they wish to follow up with a conversation. Service users will continue to receive a text for the 36 week, discharge from community and hearing screening elements. The 36 week TOUCHPOINT will be sent nearer the 36 week date rather than postnatally after coding as it is now.
Overdue Incidents	• Email and communication with individual action owners with ongoing monitoring and expected completion date • Agreed with corporate team an understanding that some maternity incidents will remain open for longer than 6 weeks, given the complex nature of some investigations.	• Denise Newman Head of Governance		• Upward trajectory noted increasing number of overdue incidents in the month of February, impacted by key staff members / handlers absence. • Number of maternity overdue incidents in February is 205. • Continued monitoring of incident management with increased surveillance and support. • Working hard to comply with corporate set trajectory to reduce overdue incidents to zero by August 2025 
External Review Neonatal Deaths	• Aggregate review of all NNDs from 31st March 2023 to 31st March 2024 by an external Neonatologist, senior midwife and Neonatal Nurse	• Adaline Smith Dep Director of Midwifery		• External reviewers report received 31st January • Maternity and Neonatal teams working collaboratively to extract learning to inform action plan and quality improvement • Findings of review and action plan presented at MNAG in March and progress/ completion of actions will monitored via care group governance processes.
Complaints		• Denise Newman, Head of Governance		• There was a 50% reduction in stage 2 returner complaints in February • Complainants offered option for LRM within primary complaint response • Complaint response rate decreased from 100% to 60% in February predominantly due to absence of key stakeholders and increase in complaints received in month.

Maternity: Metric Run Charts

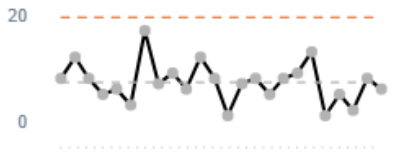
Mat Patient Safety Incidents Mod/Sev

PSII - National (Maternity)

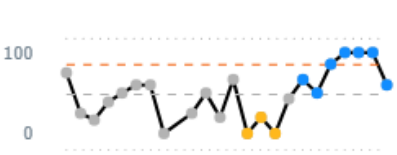


PSII - Local (Maternity)

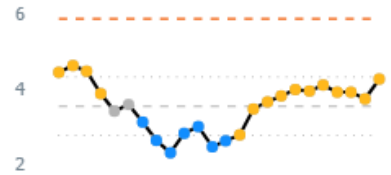
Maternity Complaints



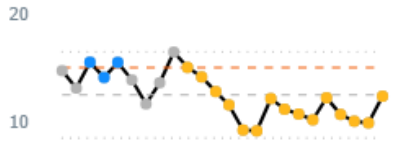
Maternity Complaint Response



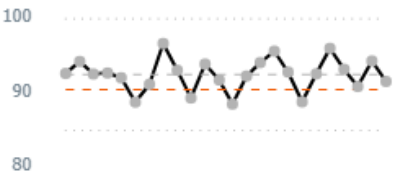
Extended Perinatal Mortality



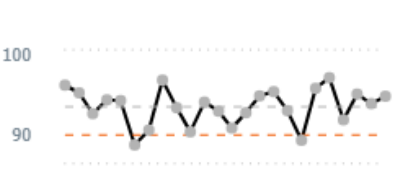
FFT Maternity Response Rate



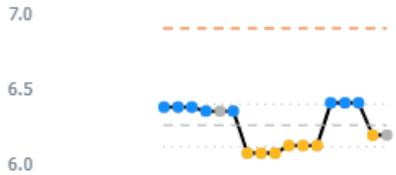
FFT Maternity Recommended



FFT Maternity (IP) Recommended



WH Engagement Score



East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

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

Meeting date: **3 April 2025**

Board sponsor: **Chief Executive**

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

Appendices:

Appendix 1: IIP Q3 External Review Papers

Executive summary:

Action required:	Discussion
Purpose of the Report:	This report has been provided to update the BoD at EKHUFT on delivery progress of the Integrated Improvement Plan (IIP) during February 2025 and offers assurance based on evidence gathered to support the transition criteria set within the NHS England (NHSE) Recovery Support Programme (RSP) NOF4.
Summary of key issues:	The IIP progress report includes an update by programme and project for Month 11, measured by the quarterly metrics set. The Leadership, Governance & Culture programme remains amber this month, with six metrics that remain outstanding. There are clear plans to deliver three of these in M12 and it is likely that three will not be met by the end of Q4. Urgent and Emergency Care (UEC) remains amber this month, achieving Type 1 in February. 12 hrs reduced slightly from M10, however, length of stay (LoS) has increased and both remain a focus, along with the levels of harm. Harms reviews are making good progress, with processes embedding and evidence of learning being shared. Planned Care also remains amber this month. Following a review and change in process, at the end of February, the Trust reported 9 x 104 week breaches, 16 x 78 week breaches and 151 >65 week breaches. Whilst this was unexpected, there is a new plan to clear by the end of Q4. 28d and 62d Cancer metrics remain areas of focus, accepting 10% fluctuations month on month. The Finance Programme remains to amber this month. Year to Date (YTD) deficit plan to Month 11 achieved by the Group. £1.9m above plan. Run rate

East Kent Hospitals University NHS Foundation Trust

	reductions continue and Cost Improvement Programme (CIP) delivery remains on track. The agreement of the medium-term financial plan remains a risk. Programme Management Office (PMO) continue to work to align IIP associated risks with the Trust significant risk register. PMO continues to collate evidence in preparation for the Q4 reviews in April.
Key recommendations:	The Board of Directors is invited to **DISCUSS** and **NOTE** the Journey to Exit NOF4 and IIP report.

Implications:

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

Assurance route:

Previously considered by: Clinical Executive Management Group (CEMG)

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

Journey to Exit NOF4 – IIP Progress Report
March 2025

Purpose of Report

East Kent Hospitals University NHS Foundation Trust

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

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

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

East Kent Hospitals University NHS Foundation Trust

Q4 Performance Metrics Progress for M11

Quarterly Performance Metrics - Leadership, Culture & Governance – M11

NHS East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metric	Q4 Metric	RAG position at M10
1	A Stable Executive team with clear and robust organisation wide governance in place supported by an agreed board development programme	• 24/25 Board development programme in place • All substantive Managing Director posts appointed to	• Recruitment to substantive Chief Finance Officer (CFO) post • Recruitment to Substantive Chair post • At least one Board development session • Managing Director Development Plan developed and agreed	• At least one Board development session • 100% of Board to have undertaken a 360 degree review • Evidence of Board receiving oversight of regulatory actions with clear improvement plans and following up on actions • Delivery of Care Quality Commission (CQC) Must Do's (within capital restrictions)	• At least one Board development session • All Board to have appraisals and personal development plan in place using 360 degree review	• Substantive Chair appointed, start date 1st May. • Board Development session to took place in March • 360 degree reviews are currently underway and will be completed by end of Q4. • Revised plan in place for completion of CQC Must Do's • Scope for MD development plans agreed by the AD of OD and Chief Operating Officer (COO), awaiting proposals.
2	Demonstrable improvement in the culture of the whole organisation in particular the safeguarding and the safety culture, and effective engagement with the workforce.	• Evidence of consultant engagement events • Relaunch of 'we care' including roll out of training events • Phase 2 Culture and Leadership Programme (CLP) – design stage commenced	• Consistent application of 'we care' Quality Improvement (QI) methodology 'sustain' • Active and effective Freedom to Speak Up (FTSU) service and evidence of learning from concerns raised	• Evidence of improved and effective engagement of staff, patients and wider stakeholders • Increased uptake of staff survey in 24/25 • Evidence of safety improvements and maintenance of quality standards • FTSU Report to Board on learning and changes	• CLP phase 3 – delivery phase in place and integral to workforce plans • People strategy 2025 onwards developed	• CLP has moved from Strategy & Partnerships into People & Culture, starting the integration of the CLP into workforce plans • People strategy development underway, first draft due by end of March along with strategy communication and engagement plan. • Independent FTSU provider Guardian commenced contract. First report due to Board April 25. • Staff Survey results have been published and action plans continue to be shared with staff
3	Development of organisation strategy for clinical	Commence development of organisation strategy for clinical pathways.	• Stage 1 – Completion of Situational analysis and background information • Development of site estates master plans	• Finalised summary of the situational analysis to allow progress to the next stage of development. • Engagement with external support partner	• Finalised clinical strategy signed • Engage with external partner and commence next phase of strategy development	• Following a significant period of engagement, with stakeholders, clinical teams and partners, the content of the Organisational Strategy has been agree by the Board. The draft is currently being refined. In addition, the clinical strategy is currently being drafted, in partnership with specialties who were involved in initial meetings and the two day summit. • Kaleidoscope continue to support the organisation with the development of strategies.

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

Quarterly Performance Metrics – Urgent Care – M11

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metrics	Q4 Metrics	RAG position at M10
4	Consistent improvement in performance to deliver Urgent and Emergency Care (UEC) type 1 to >50% and 12 hour waits to below 8%	**Type 1 – 46%** **12h - <10%**	**Type 1 - 48%** **12h - <9%**	**Type 1 – 50%** **12h - 8%**	Type 1 – 50% **12h - 8%**	• The Type 1 trajectory at Month 11 was achieved with a performance of 50.14% against a Q4 target of 50% . It has been consistently above 50% since May 24, with the highest performance since August 2021. • In Month 11, 10.% of patients were waiting in the department >12 hours against a quarter average of 8% - This has reduced slightly from M10. It remains an area of focus by the care groups but does reflect the pressure in the system with an increase in attendances above contract levels. • Engagement from Health and Care Partnership (HCP) through MADE events, with learning to be embedded throughout Q4. Targeted interventions to improve this position include the opening of the Clinical Decision Unit (CDU) at William Harvey Hospital (WHH) in November as well as the launch of the new acute medicine model. Funding from the winter system schemes is also supporting extending the frailty front door pilots at the front door, the expansion of the acute virtual wards on both acute sites and extending CT scanning into the evening and weekends.
5	Demonstrable quality, safety and operational improvements across the whole UEC pathway reducing the proportion of patients occupying beds with 14+length of stay.	**14+ LoS – 32%** **Evidence of updated/review safety & harm prioritisation policies**	**14+ LoS – 31%** **Reduction in deteriorating patient/serious incidents across the UEC pathway**	**14+ LoS – 30%** **Reduction in deteriorating patient/ serious incidents across the UEC pathway** **Exit Tier 1**	**14+ LoS – 30%** **Reduction in deteriorating patient/ serious incidents across the UEC pathway**	• The Length of Stay (LoS) for NEL >14 days performance in Month 11 was recorded at 34.9% against a target of 30%. This has risen by 1% from M10. The delivery of this trajectory is at risk due to the changes in contract provider of the P1 pathways and the increase in patients not meeting the criteria to reside. • Q3 Harm Review complete a total of 155 across both QE and WHH. Q4 reviews are underway and are now being overseen by the audit team, strengthening the governance processes. • The main focus from the Q4 reviews will be how the learning is implemented and the demonstration/evidence of best practice across the Organisation.

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

Quarterly Performance Metrics – Planned Care – M11

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metric	Q4 Metric	RAG position at M10
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	104ww – less than five 78 ww – zero 78 weeks by June 2024 65ww reduction of 25% (from March 24 outturn)	78 ww - zero maintained 65ww – reduction of 50% (from March 24 outturn)	78 ww – zero patients maintained 65ww – reduction of 75% (from March 24 outturn)	**78 ww – zero patients maintained** 65ww – reduction of 100% (from March 24 outturn)	• Due to a review and change in processes, a volume of long waiting patients were identified through validation that were being tracked independently of the live Patient Tracking List. These have all now been added to the live PTL and the process changed for pop on patients, supported by training for staff to minimise the risk of this reoccurring. As a direct result of this change, at the end of February, the Trust reported 9 x 104 week breaches, 16 x 78 week breaches and 151 >65 week breaches. Harm reviews are being conducted for all these patients. Trust continues to embed corrective actions and ensures immediate escalations to all system partners. • The end of March target is for zero >65s but due to the validation issue, the Trust is forecasting that 94 patients will still be waiting beyond the end of the month. The Trust has now moved from weekly to daily Referral to Treatment (RTT) touchpoints to support specialties with plans.
7	To deliver Cancer Faster Diagnosis Standard (FDS) c77% and 62d combined performance c70% with consistent reduction in 62d backlog	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 70%** **Faster Diagnostic Standard – 75% or above** **Exit Tier 1 for cancer**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 70%** **Faster Diagnostic Standard – 75% or above**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 75% or greater** **Faster Diagnostic Standard – 80% or above**	**62 Day backlog – within Fair Shares allocation (<200)** **62 day performance – 75% or greater** **Faster Diagnostic Standard – 80% or above**	• 62d backlog: December - 216, January – 197, February - 179 • 62d compliance: December 73.87%, January 71.94%, February 70.88% • 28d compliance: December 74.95%, January 67.2%, February 79.01%
8	Consistent trajectory towards DMO1 compliance c5% and endoscopy delivery plan agreed and delivered	**Diagnostics – to achieve 35%** **Endoscopy Backlog/ Surveillance List – reduction of 25% on March 24 baseline**	**Diagnostics – to achieve 30%** **Endoscopy Backlog / Surveillance List – reduction of 50% on March 24 baseline**	**Diagnostics - to achieve regional mean of 22% (mean based on 23/24)** **Endoscopy Backlog / Surveillance List – reduction of 75% on March 24 baseline**	**Diagnostics - to achieve regional mean of 22% (mean based on 23/24)** **Endoscopy Backlog / Surveillance List - reduced to zero**	• Weekly DM01 position is at 86.2%.Total DM01 PTL has reduced slightly to 16,000 patients • Endoscopy; DM01 PTL size has reduced further to 891. • Good progress has been noted by NHSE Regional Leads although some modalities require clear improvement plans and assurance before a decision is taken to take East Kent Diagnostics out of Tier 2 support. Plans for these will be discussed at the next Tier 2 meeting in March.

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

Quarterly Performance Metrics – Finance – M11

East Kent Hospitals University NHS Foundation Trust

	Transition Criteria	Q1 Metric	Q2 Metric	Q3 Metrics	Q4 Metrics	RAG position at M10
9	Delivery of 2024/25 plan inclusive of the Cost Improvement Programme (CIP), income and expenditure plans [Phasing subject to finalisation of the plan]	**A year to date deficit of £23.1m or better by the end of Q1.**	**A year to date deficit of £45.0m or better by end of Q2 (£21.9m in the quarter).**	**A year to date deficit of £67.1m or better by end of Q3 (£22.1m in the quarter).**	**A year to date deficit of £85.8m or better by end of Q4 (£18.7m in the quarter).**	• Year to Date (YTD) deficit plan to Month 11 achieved by the Group. £1.9m above plan. Run rate reductions continue. • CIP delivery slightly above plan YTD, as at Month 11. • Emerging risks relate to the shortfall in funding to cover the 23/24 and 24/25 pay reforms/pay awards (£2.1m), an ERF Central Baseline Adjustment for working days (£2.8m)
10	Robust financial oversight, governance, and a strong financial control environment in place	**Re-audit of controls by Finance Recovery Director to demonstrate progress on implementation. Report shared with FIOB and partners as necessary by the end of Q1**	**Formal re-audit of controls commissioned with report available by end of Q2 with aim to move to near 100% compliance.**	No metric set	No metric set	
11	Agreement of a Medium-Term Financial Recovery Plan (FRP) with system / region and national partners and demonstrable progress towards delivery	**Initial scoping and engagement plan complete by end of Q1**	**Near final document for discussion shared with partners by the end of Q2**	**Final agreed document with partner support agreed and taken through Board by the end of Q3**		• Financial Sustainability Plan draft shared with NHSE and other system partners in October. • Trust Board approval of Version 1 of the Plan in December 2024 for onward transmission to NHS England (NHSE), pending Integrated Care Board (ICB) engagement at ICB Productivity and Investment Committee on 28th January 2025. The ICB and SE Region supported the approach but advised more work needed before the end of March to close the £43M gap in Yr 3. • Interdependence with ICB recovery plan is both a key risk and opportunity. The Trust is actively engaged in the system process, supporting the leadership of a system wide workshop with Miles Scott (Chief Executive Officer (CEO) at Maidstone and Tunbridge Wells NHS Trust (MTW)) who is CEO Senior Responsible Officer (SRO) at a system level for the plan production.

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

East Kent Hospitals University NHS Foundation Trust

Evidence Supporting Transition to NOF3

Impact to NOF4 Transition Criteria – Leadership, Governance & Culture

Transition Criteria RAG agreed at External Q3 review 11th February 2025

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

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

Impact to NOF4 Transition Criteria – Urgent & Emergency Care

Transition Criteria RAG agreed at External Q3 review 11th February 2025

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

- Type 1 to exceed 50% sustainably
- 12 hours from arrival to be below 8%
- Sustainable removal of corridor care
- **Compliance with NHSE Tiering requirements and governance**
- Evidence of reduction of Length of Stay through improvements in simple and timely discharge
- **Patients requiring emergency care or experiencing a deterioration in their condition receive timely, appropriate escalation and treatment**
- **Evidence of effective safety prioritisation and harm avoidance processes across UEC pathways that incorporates sustained learning from incidents**

Impact to NOF4 Transition Criteria – Planned Care

Transition Criteria RAG agreed at External Q3 review 11th February 2025

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

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

Impact to NOF4 Transition Criteria – Finance

Transition Criteria RAG agreed at External Q3 review 11th February 2025

East Kent Hospitals University NHS Foundation Trust

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

Suggested Evidence

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

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

- Development of Medium-Term Financial Recovery Plan (FRP) with financial trajectories agreed with ICB & NHSE.
- Evidence FRP addresses key drivers of deficit as identified in PWC reports including workforce realignment/resizing.
- Evidence of alignment with the 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.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Significant Risk Register Report**

Meeting date: **3 April 2025**

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

Paper Author: **Head of Risk Management and Assurance (on behalf of Director of Quality Governance)**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This paper presents the current Significant Risk Report to ensure Board oversight of those risks rated as high and above (15>). All have an assigned Executive Director and are required to be updated monthly and reported through the Clinical Executive Management Group (CEMG) and the appropriate Board Sub Committees to Board. This paper demonstrates 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.
Summary of key issues:	The majority of the risks contained in the Significant Risk Report have had a documented review within the last 4 weeks. As of the 26 March 2025 when the Significant Risk Register was extracted there were five risks with associated overdue actions. There has been a 61% improvement in actions being completed within the specified timeframe/and or an update provided to document reason for the delay and where appropriate an extension. This is since the last Risk Review Group (17 March 2025). Monthly meetings continue with the executive leads for each significant risk (and their deputy/wider team as requested) to ensure regular oversight and scrutiny. The last Risk Review Group meeting was held on 17 March 2025. People and Culture provided a deep dive into their risks. Three significant risks were raised for approval, one significant risk was approved in principle but with further work needed and one existing risk was escalated but requiring further work and sign off. A Trust wide moderate risk was approved

	and there was one de-escalation of a significant risk in month. Full details are in Section 4. There were three areas of escalation from the meeting as shown below: ➢ Continued review of overdue risks by Care Groups and Corporate Leads. ➢ The Annual Risk Management Audit starts week commencing 24 March 2025. A Risk Questionnaire for leaders (all levels involved in risk) has been circulated and promoted. Care Groups and Corporate Leads were asked to promote (closed 21 March 2025). ➢ Training Needs Assessment and rollout plan – the Head of Risk Management and Assurance provided a Training Needs Analysis and a tiered rollout plan following piloting of the Fundamentals of Risk Management module. The pilot site will be Kent & Canterbury Hospital and Royal Victoria Hospital (KCRVH) Care Group. Following evaluation all Care Group Leadership teams will receive the training and Quality Governance Business Partners. Project planning for the implementation of InPhase continues. Several areas have been urgently escalated with the senior InPhase team due to a lack of functionality within the system, against the required specification. A technical meeting was held with the supplier on 30 January 2025 to go through solutions to the main issues that have been raised. A configuration meeting has been booked for early April 2025. We await further information from the suppliers about whether reporting concerns can be addressed. In the meantime, data has been extracted and uploaded and validation is to commence week/commencing 31 March 2025 to mitigate against further delays. The current 4Risk/4Policy has been extended for a further three months from 1 April 2025.
Key recommendations:	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 'We Care' Strategic Objectives:	• Our patients • Our people • Our future • Our sustainability • Our quality and safety
Link to the Corporate Risk Register (CRR):	This paper provides an update on the significant risks (to be known as the 'significant risk report') to the Trust which replaces the CRR.

East Kent Hospitals University NHS Foundation Trust

Resource:	Yes. Additional resource will be required to mitigate some of the significant risks identified.
Legal and regulatory:	Yes. The Trust is required to comply with the requirements of a number of legal and regulatory bodies including but not limited to: • NHS England • Care Quality Commission • Health and Safety Executive
Subsidiary:	2gether Support Solutions Spencer Private Hospitals

Assurance route:

Previously considered by: Clinical Executive Management Group on 5 March 2025.

Reports are provided to the following Sub Committees:

- Finance and Performance Committee (monthly) – 26 March 2025
- Quality and Safety Committee (bi-monthly) – 25 March 2025
- People and Culture Committee (bi-monthly) – 26 March 2025
- Integrated Audit and Governance Committee (quarterly)

It should be noted that as the Risk Register is a live document the supporting information was extracted on 26 March 2025.

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 The last Risk Review Group took place on 17 March 2025. A deep dive presentation was provided by People and Culture into their risks. Approved changes to risks are detailed within the paper in Section 4 as well as the escalations agreed at the meeting by the Chair (Director of Quality Governance on behalf of the CNMO).

2. Background

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

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

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

3. Current Significant Risk Register

3.1 There are currently 31 risks in total on the Significant Risk Report (down from 32 in the February Board report).

3.2 There has been one change to the residual risk scores of a risk which were also reported in the February report. All other risks still reported remain the same.

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

3.4 The Significant Risk Register is summarised below:

Risk Ref	Risk Register	Title	Residual Risk Score	Status compared to February report	Target Risk Score	Actions summary
1891	Corporate Operations **Accountable Executive: Chief Operating Officer (COO)**	Misalignment between Demand and Capacity across the Trust's urgent and emergency care pathway	Extreme (20)	⟺	Low (6)	Demand and capacity modelling to be confirmed by all systems partners for all P1 to P3 patients as part of the system wide better use of beds programme to inform 2526 redesign. Person Responsible: Interim Managing Director Due: 30 June 2025 Conduct a comprehensive review of current Emergency Department (ED) processes and identify areas for improvement – focussing initially on the opportunity to reduce the number of patients spending 12+ hour in ED. Introduction of Clinical Decision Unit (CDU) at William Harvey Hospital (WHH) required by end of Jan 25. 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: Interim Managing Director Due: 1 July 2025
3386	Care Group - Women's Health **Accountable Executive: CNMO**	Potential risk of inaccurate records due to Euroking back copying	High (16)		Low (4)	Work continues to implement MSR 2.1.1 into the Euroking Test environment to then be tested. If the testing is successful, then Trust to decide whether to move this into the live Euroking environment or stick with the current bespoke MSR. We were informed by Magentus that there are clinical risks noted against the bespoke MSR (which MSR 2.1.1 mitigates) so Magentus are going to send documentation regarding this so the Trust can make an informed decision. End date of Magnetus support as part of NPSA project unclear. Update to provided monthly. Person Responsible: Clinical Information Systems (CIS) Manager To be implemented by: 31 Mar 2025
2406	Care Group - Diagnostics, Cancer and Buckland	Delay to patient diagnosis from potential loss of Nuclear	High (16)		Low (4)	Associated work is required to allow camera under NM to open on.

	Accountable Executive: Chief Strategy & Partnerships Officer (CPSO)	Medicine service at WHH				discussed at Performance Review Meeting (PRM) on the 29/08/24 and awaiting update. this Administration of Radioactive Substances Advisory Committee (ARSAC) licence renewal to allow operational services to commence Person Responsible: Chief Technologist Nuclear Medicine & Osteoporosis To be implemented by: 30 Jun 2025
3354	Queen Elizabeth Queen Mother Care Group **Accountable Executive: CPSO**	Clinical environment not fit for purpose in many areas	High (16)	⟺	Low (4)	Estates issues for all ward areas to be addressed with the Estates team to ensure an ongoing programme of maintenance and repair. List of estates issues from closed ward risks attached March 2025 - A comprehensive list of all new Estates work required as well as outstanding estates work is being compiled via the daily Quality Improvement Meetings Person Responsible: Director of Nursing To be implemented by: 31 May 2025
3553	William Harvey	Failure of Cardiac	High (16)	⟺	Low (6)	Awaiting executive decision re capital

	Hospital Care Group **Accountable Executive: CPSO**	Catheter Suite equipment (Lab 1, 2 & 3) WHH				programme and order in which labs are replaced. Various papers and bids are underway and project sitting with strategic development. Person Responsible: General Manager (GM) To be implemented by: 30 Apr 2025
2158	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: Chief Medical Officer (CMO)**	Risk of Patient harm and treatment due to unreported Accident & Emergency (A&E) chest xrays	High (16)	⟺	Low (4)	External review to be undertaken by Regional Advisor. Meeting to be arranged with care group leaders to discuss outputs of report. Person Responsible: CMO To be implemented by: 31 Mar 2025
678	Care Group - Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Insufficient Pharmacy support for the safe (and secure) use of medicines on wards	High (15)	⟺	Low (4)	Review current working models to release clinical pharmacy time e.g. late nights, dispensary commitments. Person Responsible: Deputy Lead CS Pharmacist Due: 31 Mar 2025 **Submit Paeds case to BSG (submitted to DCB for approval) in Dec 2024 (as new format required)** **Person Responsible: Deputy Lead CS Pharmacist**

						Due: 31 Dec 2024 Consider Full 7-day service from Pharmacy following action from Care Quality Commission (CQC) Must do. Person Responsible: Director of Pharmacy Due: 1 Apr 2025 Start to recruit to GSB BC (assuming case is approved) submitted Oct 24 Person Responsible: Deputy Lead CS Pharmacist Due: 31 Jan 2025 **Work is happening within the care group to define the best leadership structure for the pharmacy service. This must deliver several operational and strategic Must Dos including a description of how many staff can work differently (medicines reconciliation on wards) if we are more efficient in our drug dispensing and discharge processes** **Person Responsible: Managing Director** **Due: 31 Oct 2024**
2796	Kent & Canterbury	There is a risk of delay in	High (15)	⟺	Low (6)	**In the process of finalising the rolling**

	and Royal Victoria Care Group **Accountable Executive: CPSO**	dialysis treatment due to high number of Renal Dialysis machines that are over 15 years old				**replacement programme for dialysis machines across all of the dialysis units to ensure that there is a clearly shown sub-set within the MDG capital allocation that will be reviewed monthly at the Trust's Capital Investment Group** **Person Responsible: General Manager** **Due: 30 Sept 2024**
1831	Queen Elizabeth Queen Mother (QEQM) Care Group **Accountable Executive: CNMO**	Privacy and dignity will be adversely affected when patients are treated in non-care spaces	High (15)	⟺	Low (6)	Fortnightly QEQM Urgent and Emergency Care (UEC) delivery Group set-up with a wide range of improvement programmes to support improvements in flow across the site. This delivery group provides the governance oversight on local care group improvement schemes and reports through to Trust Emergency Care Delivery Group for overall oversight. Person Responsible: Deputy Head of Nursing To be implemented by: 31 Mar 2025 Assess progress of clinical harm reviews and associated learning

						Person Responsible: Associate Medical Director To be implemented by: 31 Mar 2025 Reverse RATing streaming in place to identify patients who need resus and those who are well enough to be cared for in a non-care space. Ongoing monitoring via incident reporting. Person Responsible: Deputy Head of Nursing To be implemented by: 31 Mar 2025 Fundamentals of care training to be completed by staff re privacy and dignity. Training remains ongoing. Person Responsible: Deputy Head of Nursing To be implemented by: 31 Mar 2025 A proposal has been made and is being considered to utilise a corridor section for examination and checks on patients by putting a permanent curtain in place. Person Responsible: Deputy Head of Nursing To be implemented by: 30 Apr 2025

3556	William Harvey Hospital Care Group **Accountable Executive: CNMO**	Delays in delivery and personal care are resulting in an increased risk of pressure ulcers and falls occurring	High (15)	⟺	Low (6)	Continued Implementation of the Emergency Floor Improvement plan which includes direct pathways such as right sizing Same Day Emergency Care (SDEC), Surgical Emergency Admissions Unit (SEAU) and Urgent Treatment Centre (UTC) Person Responsible: Head of Operations To be implemented by: 31 Mar 2025
3367	Corporate Medical **Accountable Executive: CMO**	Lack of timely review of diagnostic test results	High (15)	⟺	Low (6)	**Developing a page on Sunrise for consultants to review all results that are allocated to them** **Person Responsible: Chief Clinical Information Officer** **Due: 01 Oct 2024**
679	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to supply, from Pharmacy, scheduled chemotherapy treatments to patients	Extreme (20)	⟺	High (15)	**Commence £250K of remedial work required.** **Person Responsible: Interim Accountable Pharmacist** **To be implemented by: 31 Dec 2024** Capital new build of aseptic unit now one of six key capital projects within EKHUFT financial recovery plan to be

						presented to NHS England (NHSE). Person Responsible: CMO To be implemented by: 31 Mar 2025 Assurance of completion of AHU Airis Q action plan by the Accountable pharmacist/Estates/production manager. Person Responsible: Pharmacy Quality Assurance & Quality Control Lead To be implemented by: 27 Jul 2025 Create and appoint to a substantive Accountable pharmacist to replace current interim role Person Responsible: Director of Pharmacy To be implemented by: 30 Sep 2025 Replacement of the unit with off site licensed facility as part of the Integrated Care System (ICS) strategy and linked to the national aseptic review. Person Responsible: Director of Pharmacy To be implemented by: 30 Sep 2029

3557	Care Group – William Harvey **Accountable Executive: COO**	Increased length of stay for mental health patients awaiting inpatient community beds	High (16)	⟺	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 Kent & Medway NHS and Social Care Partnership Trust (KMPT). KMPT provide LP team to ED streaming at QEQM.** **Steering group looking into recovery beds and safe havens across East Kent.** **Person Responsible: Associate Director of Nursing** **Due: 29 Nov 2024** **Ensure safeguarding vulnerable adults and paediatric training compliance in place for all relevant staff.** **Person Responsible: Associate Director of Nursing** **Due: 30 Nov 2024** **Recruit mental health nurses. New mental health lead appointed and will start in 3/12. Strategy and recruitment plan will sit within their portfolio for**

						registered mental health nurses **Person Responsible: Specialist Nurse Practitioner** **Due: 2 Dec 2024**
1895	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Current CT and MRI reporting backlog presents a clinical risk due to potential delays in diagnosis and treatment	High (16)	⟺	Moderate (9)	External review to be undertaken by Regional Advisor. Meeting to be arranged with care group leaders to discuss outputs of report. Person Responsible: CMO To be implemented by: 31 Mar 2025
1628	Care Group – William Harvey **Accountable Executive: CNMO**	Staffing mix and experience impact on the ability of the Care Group to provide services to paediatric patients in line with the Royal College of Paediatrics and Child Health (RCPH) standards	High (16)	⟺	Low (4)	Medical staff to attend advanced training (Paediatric Immediate Life Support (PILS) and then Advanced Paediatric Life Support (APLS)). Paediatric ED Consultants in place for WHH and QEQM. Person Responsible: Consultant Due: 31 March 2025 Advertise and recruit into Matron post. Use internal and external networks to promote role. Interim in place in meantime. Person Responsible: Associate Director of Nursing Due: 31 March 2025

2234	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to meet national histopathology Turnaround Time (TAT's) to support cancer pathway	High (16)	⟺	Moderate (8)	Review a workforce/workload points-based manager system to manage workload in line with RC Path Guidance Person Responsible: Head Biomedical Scientist Cellular Pathology To be implemented by: 31 Mar 2025 Kent & Medway Pathology Network (KMPN) Digital Histopathology & AI project to improve performance & resilience. NB: this is an adjunct to maintaining service delivery and performance and NOT all histology cases can be reported using AI. Person Responsible: Head Biomedical Scientist Cellular Pathology To be implemented by: 30 Apr 2025 Trust involved in discussions regarding a Kent & Medway Joint Venture. Trust to ensure areas of pressure are highlighted and worked up. Person Responsible: CMO To be implemented by: 01 Jul 2025

2899	Care Group – Women's Health **Accountable Executive: CMO**	Consultant obstetric vacancies at QEQM may result in an inability to deliver the service	High (16)	⟺	Moderate (9)	Re-advertise for the 3 vacancies at QEQM. Post held off until after April so that the cohort who get their Certificate of Completion of Training (CCT) in October could apply Person Responsible: Associate Medical Director Due: 28 Mar 2025
3384	Corporate – Strategic Development & Capital Planning **Accountable Executive: CSPO**	The ability to deliver safe and effective services & implement improvements across Trust estate is compromised due to financial constraints for capital funding and assets replacement	High (16)	⟺	Moderate (12)	Deliver the 24/25 Capital programme as per the signed off plan. Person Responsible: Director of Strategy & Business Development Due: 30 Apr 2025 Progress to full business case for the replacement of maternity facilities at QEQM. Person Responsible: Director of Strategy & Business Development Due: 01 Sept 2025
2599	Corporate – Medical **Accountable Executive: CMO**	There is a risk of inadequate medical staffing levels and skills mix to meet patients' needs	High (15)	⟺	Low (6)	Review consultant hard to recruit areas and identify plans Person Responsible: Head of People & Culture Services To be implemented by: 31 Mar 2025

						Programmes to support career progression and attraction of consultant posts for long term locums becoming substantive (i.e. Certificate of Eligibility of Specialist Registration (CESR). Person Responsible: Head of Medical Workforce To be implemented by: 30 May 2025
3700	Corporate – Finance & Performance Management **Accountable Executive: Chief Finance Officer (CFO)**	Failure to agree a Medium-term Financial Recovery Plan with System / Region and National Partners	Extreme (20)	⟺	Moderate (12)	Agreement of the Medium Term Financial Plan (MTFP) with Board, ICB & NHSE Person Responsible: CFO Due: 31 July 2025
3701	Corporate – Nursing **Accountable Executive: CNMO**	Staff may experience physical and psychological harm as they are frequently subjected to verbal and physical abuse from patients exhibiting challenging behaviours	High (16)	⟺	Low (6)	Liaising with KMPT to agree a tiered training approach to meet needs of all staff groups Person Responsible: Deputy Chief Nurse Due: 31 Jan 2025 Security service provision contract will form basis of specification for 2gether to tender the service. Service to be re-tendered, contract awarded and live by April 2025

						Person Responsible: Stuart Hammerton Due: 1 April 2025
3702	Care Group – Critical Care, Anaesthetics and Specialist Surgery **Accountable Executive: COO**	Delayed discharge of patients from Critical Care when medically fit to be transferred to the ward	High (16)	⟺	Moderate (8)	Corporate 'We Care' project to be implemented with the transformation team Person Responsible: Director of Nursing Due: 31 Mar 2025 Work with site triumvirate on priority for critical care wardables to be discharged from Critical Care Person Responsible: Director of Nursing Due: 31 Mar 2025
1814	Corporate – Strategic Development & Capital Planning **Accountable Executive: CSPO**	Loss of access to key operational / clinical systems from threats (cyber air con, break of external circuits, fire, floods etc) for a protracted period	High (15)	⟺	Moderate (10)	No actions
1350	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	Failure to provide ward stock medicines in a timely fashion due to obsolescence of Pharmacy TWS Distribution robot	High (15)	⟺	Moderate (12)	Need to have additional spare bands for the robot as down to the last two – find engineering companies who may make them. Quotes to be requested. Person Responsible: Chief Pharmacy Technician

						Due: 31 Mar 2025 Replace Robot – Present case for replacement to DCB finance and performance meeting to get the case approved in advance of business planning and should capital become available in the interim Person Responsible: Chief Pharmacy Technician Due: 1 July 2025
3719	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CMO**	There is a risk of patient harm from availability, delays and errors in Systemic Anti-Cancer Therapy (SACT) prescribing for adults due to system failures with the ARIA medonc system being out of date at Kent and Medway Cancer Collaborative (KMCC)	High (15)	⟺	Low (5)	ARIA system failure to be included in local business continuity plans Person Responsible: Clinical Matron To be implemented by: 31 Mar 2025 New E-prescribing system to be procured and implemented across the Cancer Alliance. Person Responsible: Interim Head of Operations To be implemented by: 31 Mar 2025
3727	Care Group – Critical Care, Anaesthetics and Specialist Surgery	Staff attendance with resus training	Extreme (20)	⟺	High (16)	Letter to be sent to all staff from Chief Nurse/Medical director if Did Not Attend (DNA)

	Accountable Executive: CMO					Person Responsible: Lead Resuscitation Officer Due: 31 Mar 2025
2123	Care Group – Diagnostics, Cancer and Buckland **Accountable Executive: CSPO**	Health and Safety Risk to staff and the potential unavailability of records at the point of need due to lack of storage space for Health Records	Extreme (20)	NEW	Low (4)	Executive team Risk Owner has changed to CSPO. Risk to be reviewed and actions updated. Person Responsible: CSPO Due: 31 Jan 2025
3752	Corporate – Nursing **Accountable Executive: CNMO**	There is a risk that the Trust is non-compliance with HBN 04-01 2009 as additional beds have historically been put in permanently into four bedded bays to create six bedded bays	Extreme (20)	⟺	Low (4)	Recommendation to Executive to pilot removing two additional beds on three wards – decision pending Person Responsible: CNMO Due: 04 April 2025 Undertake Trust-wide, a bed space measurement review (to be supported by Directors of Nursing on each site). Plan to be agreed as to the process for doing this Person Responsible: Interim Director of Quality Governance Due: 04 April 2025
3725	Corporate Services **Accountable Executive: Chief Executive**	Risk of inadequate legal services support due to vacancies and resignations	16	NEW	12	Expanding the range of external solicitors to achieve better service and value for money. Person Responsible: Director of Corporate Governance (DCG)

	Officer (CEO)					30 May 2025 Agreement on structure of legal function for example numbers of staff, through agreement with the Trust, and to commence permanent recruitment. Person Responsible: DCG 30 May 2025
3782	Corporate – Operations **Accountable Executive: COO**	Overdue Appointments for Patients on the Diabetes and Endocrine Outpatients Patient Tracking List (PTL)	Extreme (20)	NEW	16	Additional Clinics to clear the backlog, which can be supported by the nurse and the consultant completing the validation but will need additional resource. Person Responsible: Head of Operations To be implemented by: 30 Apr 2025
3764	Care Group - Women's Health **Accountable Executive: CNMO**	Lack of infrastructure to enable training provision to meet national requirements	High (16)	NEW	4	Put in place on SITREP over the weekend for team to discuss and action opening of 2 x rooms for Prompt either on delivery suite or Midwifery-Led Unit (MLU) for Monday morning. Escalation to Director on call if capacity constraints hamper this action. Person Responsible: Head of Operations To be implemented by: 09 February 2025

						Identify space within the organisation to enable assurance that the maternity training requirements can be delivered to meet NHSE and Maternity Incentive Scheme (MIS) national standards Head of Operations 30 March 2025 Business case for extension of the lease at St Pauls. Head of Operations 30 March 2025 Escalate the need for additional storage for essential on-site training equipment at WHH for prompt Head of Operations 31 March 2025

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

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

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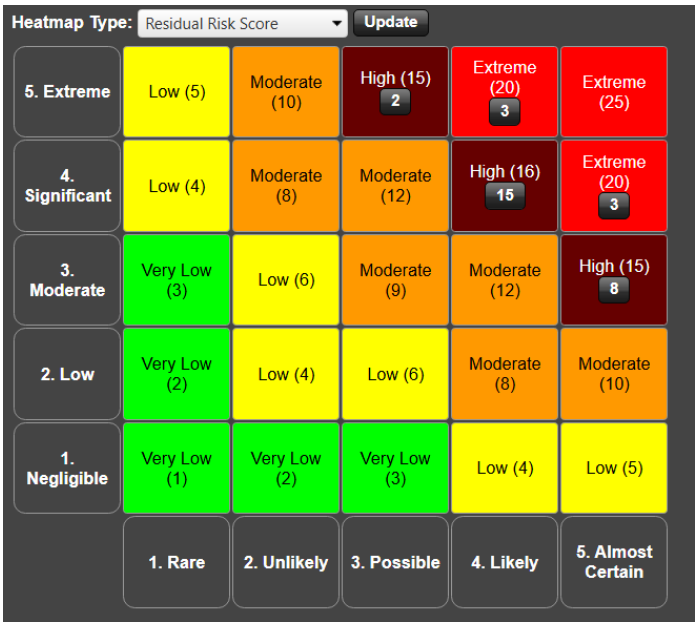
Corporate Strategic Development	1	1			2
Corporate Finance			1		1
Corporate Services		1			1
Corporate People and Culture	0				0
TOTAL	**9**	**15**	**7**	**0**	**31**
CHANGE SINCE LAST REPORT	**-2**	**+2**	**-1**	**0**	**-1**



4. Changes since the last report

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

- The lack of Legal Services Provision (risk ref: 3725) was escalated to the Significant Risk Register with a high risk scoring of 16.

- Risk related to potential patient harm caused by diabetes and endocrinology follow up waiting list backlog (awaiting risk ref). Corporate Operations. Residual risk rating 20 (extreme).

- Inability to reach agreement on Health Care Support Workers (HCSW) backpay with Unions which could result in a precedent-setting Tribunal claim or industrial action. Corporate People and Culture. Proposed residual risk rating 15 (high). Proforma approved for Corporate Nursing but agreed this would sit under People and Culture.

- Lack of infrastructure to enable training provision to meet national requirements. WCYP Care Group. Residual risk rating 16 (high).

In addition, the below risk was agreed in principle but requires completion of a new risk proforma and formal sign off at the April Risk Review Group meeting:

- The use of temporary staffing (in particular medical agency) and risk to delivery of financial recovery plan. Corporate People and Culture. Proposed residual risk rating 16 (high).

4.2 Other Trust wide risks brought to the attention of the Risk Review Group (12 and above)

The below Trust wide risk was approved:

- Potential Information Governance or General Data Protection Regulation (GDPR)/Data protection breach causing regulatory penalties, enforcement action and damage to Trust reputation. Corporate Strategic Development and Capital Planning. Residual risk rating 12 (moderate).

4.3 Escalations from the Significant Risk Report

It was proposed and agreed in principle that the below risk would be escalated to the Significant Risk Register pending a new risk proforma to be received by the Risk Review Group in April 2025:

- Failure to address poor organisational culture (risk ref: 1679). Corporate People and Culture. Previous residual risk rating 9 (moderate) to 16 (high).

4.4 De-escalations from the Significant Risk Report

Three risks were de-escalated and two were closed from the Significant Risk Register.

- Inadequate theatre capacity at QEQM for maternity services (Risk ref: 2934) Care Group – Women's Health. This has been de-escalated from a 16 (high) to a moderate (12).

- Failure to NHSE requirement to complete Improving Quality in Physiological Services (IQIPS) accreditation by April 2025 (Risk ref: 3660). This has been de-escalated from a 16 (high) to a moderate (9).

The below risk was de-escalated from the Significant Risk Register subject to mobilisation of the newly tendered service (week commencing 17 March 2025). It was agreed that this should remain a moderate risk and be kept under regular review until the service is embedded:

- Inability to provide Freedom to Speak Up (FTSU) statutory service (risk ref: 3761), Corporate People and Culture. Current residual risk rating 15 (high). Proposed residual risk rating 12 (moderate).

The below risk has been closed and replaced with new risks following an external visit by NHSE on 11 and 12 February 2025 and subsequent urgent recommendations.

- Failure to provide first audiology appointment within 6 weeks of referral (DM01) leading to delay in identification and treatment for children (risk ref: 3358) WCYP Care Group. Previous residual risk score 20 (extreme). Closed on 26 February 2025. It has been replaced with 3 moderate risks and an action plan is in place. Reporting will be received into Regulatory Oversight Group.

The below risk has been closed as the new temperature system is now operationally mitigating the risk.

- Loss of blood and blood products impacting patient safety and significant financial loss, due to staff not being alerted to a temperature control failure following failure of the Trust wide blood transfusion laboratory remote temperature alert system (risk ref: 3669) Care Group – Diagnostics, Cancer and Buckland (DCB Care Group).

5. Escalations from Risk Review Group

5.1 There were two areas of escalation from the meeting:

- The Annual Risk Management Audit starts week commencing 24 March 2025. A Risk Questionnaire for leaders (all levels involved in risk) has been circulated and promoted. Care Groups and Corporate Leads were asked to promote (closed 21 March 2025).

- Training Needs Assessment and rollout plan – the Head of Risk Management and Assurance provided a Training Needs Analysis and a tiered rollout plan following piloting of the Fundamentals of Risk Management module. The pilot site will be KCRVH Care Group. Following evaluation all Care Group Leadership teams will receive the training and Quality Governance Business Partners.

6. Corporate Risk Management Infrastructure

6.1 Project planning for the implementation of InPhase continues. Several areas have been urgently escalated with the senior InPhase team due to a lack of functionality within the system, against the required specification. A technical meeting was held with the supplier on 30 January 2025 to go through solutions to the main issues that have been raised. A configuration meeting has been booked for early April 2025. We await further information from the suppliers about whether reporting concerns can be addressed. In the meantime, data has been extracted and uploaded and validation is to commence week commencing 31 March 2025 to mitigate against further delays. The current 4Risk/4Policy has been extended for a further three months from 1 April 2025.

7. Conclusion

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

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BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

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

Meeting dates: **11 February 2025 and 11 March 2025**

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

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

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Clinical Negligence Scheme for Trusts (CNST) Compliance	The Maternity Incentive Scheme (MIS) Year six data collection period commenced on 2 April 2024. The service completed the Board declaration process and this was approved by the Trust Board and the Integrated Care Board (ICB) Accountable Officer (AO) prior to submission to NHS Resolution (NHSR). At the February MNAG the following paper was discussed in compliance with CNST reporting: **Q3 Avoiding Term Admissions into Neonatal Unit (ATAIN) report - CNST Safety Action 3** • Term admissions at EKHUFT for Q3 was 4.1%. With 4.1% at Queen Elizabeth the Queen Mother Hospital (QEQM) and 4.1% at William Harvey Hospital (WHH). • 109 babies received transitional care (TC) in Q3 2024. 13 babies were between 34-35+6-week gestation (Late pre-term). • Total Term Admissions at EKHUFT: 222 babies for Q3 2024-25. • The main reasons for admission were respiratory, infection and hypoglycaemia in line with the other units in the network. There are currently nine actions on the ATAIN action plan: • Two actions have been completed. • Five actions are on track.

	• Two at risk: **Action 5:** Review all 34-35+6 admissions at ATAIN. Explore if babies admitted to Special Care Baby Unit (SCBU) could have been cared for with Full TC. Undertake Audit during ATAIN meeting collating data to be reviewed **Action 7:** Update the TC guideline within the Trust. • There is evidence to demonstrate that data and learning themes are shared amongst the team in the form of a bi-monthly poster and where appropriate, individual support for staff is provided.
Perinatal Quality Surveillance Tool (PQST) December 2024 and January 2025	PQST is presented to the Board in keeping with the Ockenden recommendation. It contains the minimum dataset that the Board required oversight of. • Total Babies born in December: 475 and January: 499. • There were four moderate incidents reported for maternity during the month of December and four in January. • Level 3 Safeguarding compliance as of the end of December has remained above the 90% threshold (90.2%) and 93% in January. • Child protection level 3 compliance as of the end of December remains compliant at 92.9% and 94.3% in January 2025. • One Maternity and Newborn Safety Investigations (MNSI) referral in December and none in January 2025. • 3 Stillbirths reportable in December supported by Perinatal Mortality Review Tool (PMRT) process with no stillbirths or neonatal deaths in January 2025. • MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK: neonatal deaths – One death reportable in December. • PRactical Obstetric Multi-Professional Training (PROMPT) compliance was above 90% for all staff groups. • Fetal monitoring training compliance above 90% for all staff groups. Top 3 risks remain: 1 Inadequate theatre capacity at QEQM for maternity services 2 Consultant obstetric vacancies at QEQM may result in an inability to deliver the service 3 Lack of piped medical gasses to support neonatal resuscitation within the clinical areas of maternity Daily Sitrep continues oversight of any reported red flags, concerns escalated in the previous 24 hours, Safeguarding and Mental Health team now attend Sitrep daily. **Patient Experience** • Friends and Family Test (FFT) received 297 responses, which is an overall 7.9% response rate.

	• 43 compliment emails sent from FFT feedback. • Your Voice is Heard - Response rate Key Performance Indicator (KPI) - 70%. The service achieved a response rate of 80.7% and the team spoke to 368 families. • Of the families that responded in January 92.1% said that they would return to East Kent for their maternity care. • 17 (4.8%) of the families we spoke to said that they would not return to EKHUFT for future maternity care. • 93.3% were positive about Antenatal care. • 91.9% were positive about Intrapartum care. • 90% were positive about Postnatal care. • 100% were positive about Neonatal care. • 301 staff compliment emails sent in January. • Overall improvements seen in all aspects of maternity care provision when compared to January 2024 data.
Maternity Safety Support Programme (MSSP) Exit Paper and Sustainability Plan	The paper is brought to the Board for approval. It outlines the historical background to the service being added to the MSSP in 2019 and the impact of the improvement work which has resulted in the service being moved to the sustainability element of the programme in February 2024 and in January 2025 having collective agreement for EKHUFT to 'exit' the programme. The report details the regional oversight which will continue once the service exits the MSSP programme - a detailed sustainability plan is outlined in the paper.
Maternity and Neonatal Improvement Programme (MNIP) highlight reports	The MNIP was launched in June 2023. It is a three year programme, the service is currently in month 19 of the programme. 67% of the overall programme of work has been achieved. The overarching highlight report provides a summary of performance for each of the workstreams highlighting the top three areas of success and three areas of focus. Some key successes across the programme this month has included achieving the MIS Year 6 compliance, requesting to exit the MSSP, 14.8 newly qualified midwives joining the Trust and commencement of the building work at WHH for the bereavement suite which is compliant with National Bereavement Care guidelines. Areas of future focus include creation of a Multi-Disciplinary Team (MDT) compact to support MDT relationships, building of a second theatre at QEQM and a focus on all protected characteristics as a part of the Equality, Diversity and Inclusion (EDI) work being undertaken.
Neonatal Death Review	The review was commissioned by EKHUFT further to the identification of an increase in the number of neonatal deaths that occurred between 31 March 2023 to May 2024. Despite the local increase in the death rate the service remained below the comparator group of 1.96 per 1000 births. These cases were subjected to individual reviews. However, the aim of this collective review was to identify any themes or modifiable factors that contributed to the neonatal deaths and make recommendation for practice. 14 cases were independently reviewed and stated that:

	• The most frequent cause of death was complications related to extreme prematurity which accounted for 64% of cases. • There were no minor or major factors with midwifery care identified. Recommendations for maternity care were classed as 'wider learning'. These are usually non-causal recommendations identified through the course of an investigation. • Within neonatal care there were no major modifiable factors identified in any of the cases. Five recommendations (across four cases) were classed as 'minor' modifiable recommendations. • Duty of Candour (DoC) has been completed. • The report has been presented at MNAG and the resultant action plan will continue to be monitored there.
Maternity and Neonatal Independent Senior Advocate (MNISA) report	The report covers the first year of the MNISA pilot (an essential recommendation from the Ockenden report). The pilot is scheduled to end at the end of March 2025. During the one-year period 14 EKHUFT families were supported and themes from their feedback included. It is worthy of note that some of the recommendations are system recommendations and others Trust-wide. Where the service was provided with individual names action was taken as required. An action plan is being developed in response to the recommendations outlined in the report.
Perinatal Culture and Leadership Programme (CLP) summary report	There is a requirement for the Maternity service to provide a summary report in relation to the completions of the Perinatal CLP. The programme was delivered in three phases: 1. Eight face to face Quad development days. 2. Completion of a SCORE culture survey which was independently facilitated. 3. Participation in culture coaching sessions. The report provided assurance that each of the three phases of the programme has been successfully completed. The outputs from the Culture survey have been included into Workstream 1 of the MNIP. NHS England (NHSE) have fed back positively in relation to EKHUFTs participation in the programme and suggested that EKHUFT participates in the completion of a case study for national learning.
Matters to escalate to Quality & Safety Committee (Q&SC) and Board	Neonatal Death review. Review of Hypoxic-ischaemic encephalopathy (HIE) cases in last 12 months.

Other items of business:

None

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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	3 April 2025
The BoD is asked to **Approve** the Maternity Safety Support Programme (MSSP) Exit and Sustainability Plan.	Approval	3 April 2025

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Care Quality Commission (CQC) Update Report**

Meeting date: **3 April 2025**

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

Paper Author: **Associate Director Quality Governance for Director of Quality Governance**

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-January to early March and includes: • information on the inspection of Maternity Services in December 2024; • information on the inspection of Spencer Wing at Queen Elizabeth the Queen Mother Hospital (QEQM) in January 2025; • summary of progress with the CQC self-assessment and check and challenge meeting programmes; • update on Ward and Clinic Accreditation Programme (which is aligned with CQC single assessment framework); • update on performance against the CQC inspection reports from May and July 2023, published in December 2023; • update on performance against 'historical' open CQC action plans (2018, 2020 and 2021); • update on maternity Section 31 enforcement notice; • summary of CQC queries; • update on engagement meetings with the CQC; • recent CQC publications.
Summary of key issues:	The Maternity CQC draft report has been delayed until late March. It was anticipated in February 2025. The CQC Self-Assessment Programme continues with many Care Groups having their second Check and Challenge Meeting. All areas are showing progress in their improvements in comparison to their first self-assessments with the exception of End of Life Care (Trust wide) which has stayed the same. There are now only 5% of actions remaining open from the 2023 inspections (as of 18 March 2025 when Quality and Safety Committee paper was

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	submitted). Multiple actions are associated with medical compliance with statutory and mandatory training (urgent and emergency care and medical care) which is still not at Trust target. This has been escalated and is being led by the Chief Medical Officer (CMO).
Key recommendations:	The Board of Directors are asked to receive the attached report and the **ASSURANCE** provided in relation to progress with recent maternity inspection activity, query management, and the self-assessment and check and challenge meeting programme.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Trust Risk Register:	There is a risk of non-compliance with CQC regulations which would have an impact on registration and may lead to repeat enforcement action, improvement notices and a critical report (ref 3636). Residual Risk 12 (moderate).
Resource:	Y: Two outstanding CQC requirements relate to pharmacy (Must Do) and Allied Health Professions (AHP) staffing (Should Do). These may have a resource implication.
Legal and regulatory:	Y. Inability to provide assurance to our regulators impacting on the quality and safety of care provided to our patients and service users.
Subsidiary:	N

Assurance route:

Previously considered by: CQC Oversight and Assurance Group (March 2025) and Regulatory Oversight Group (February 2025).

A bi-monthly Chairs report is received from Regulatory Oversight Group to Clinical Executive Management Group (CEMG) (including CQC escalations). This was received at CEMG on 5 March 2025.

This paper was received at Quality and Safety Committee on 25 March 2025.

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CARE QUALITY COMMISSION (CQC) UPDATE REPORT

1. Purpose of the report

1.1 This report provides an update on CQC inspection activities, oversight, assurance and related improvement work. This report covers the period mid-January 2025 to early March 2025 and includes:

- information on the inspection of Maternity Services in December 2024;
- information on the inspection of Spencer Wing at QEQM in January 2025;
- summary of progress with the CQC self-assessment and check and challenge meeting programmes;
- update on Ward and Clinic Accreditation Programme (which is aligned with CQC single assessment framework);
- update on performance against the CQC inspection reports from May and July 2023, published in December 2023;
- update on performance against 'historical' open CQC action plans (2018, 2020 and 2021);
- update on maternity Section 31 enforcement notice;
- summary of CQC queries;
- summary of recent engagement meeting with the CQC;
- recent CQC publications.

2. Background

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

3. CQC Inspection of Maternity Services, December 2024

3.1 An unannounced, short-notice (24-hours) CQC inspection of Maternity Services at QEQM and WHH hospitals took place on 4 and 5 December 2024. Inspection teams spent two days on each site reviewing services. Online interviews took place the following week with managers and specialist leads. The Provider Information Request was responded to within one week and a total of 515 documents submitted to the CQC.

3.2 High-level feedback was provided by the CQC to members of the executive team on 13 December 2024. Positive feedback was given on improvement work, culture and leadership and the Your Voice is Heard work. Issues for improvement included the estate (in particular at the William Harvey Hospital (WHH)), post-natal discharge and delays in TTOs, and hybrid paper and electronic records systems.

3.3 The draft inspection report was anticipated in February for factual accuracy checks. The CQC apologised for the time taken for the Trust to receive this report during the CQC Engagement Meeting which took place on the 25 February 2025. They confirmed this has been due to operational issues within the CQC. The draft inspection report is now anticipated for late March. The CQC have been asked to confirm the anticipated date and reason for delay in an email to the CNMO.

3.4 The CQC has confirmed that the Trust should continue to provide monthly reports detailing improvement work following the Section 31 enforcement notice issued following the previous inspection in January 2023. The Trust will start to progress the application process for lifting the Section 31 in light of the delay.

4. CQC Inspection of Spencer Services, January 2025

4.1 The CQC made an announced 1 day visit to Spencer Wing located at the QEQM on the 21 January 2025. CQC provided verbal feedback on 22 January 2025 to Spencer colleagues.

4.2 Initial feedback was the unit was clean and tidy and had a good culture. Inspectors identified the unit was unique and had not previously inspected an organisation with this model of care. Inspectors highlighted there was no clear documentation to support staff when NHS patient transfers to the unit may be inappropriate. Inspectors felt this was a gap and requested that a Standard Operating Procedure (SOP) be produced as a matter of urgency as this would otherwise be a Must Do requirement. A Provider Information Return (PIR) was submitted to the CQC (which included the Transfer SOP) by Spencer Hospitals. The draft CQC report is awaited.

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

5.1 The self-assessment Check and Challenge meetings, chaired by the CNMO, and attended by the CMO, Chief Operating Officer (COO), Director of Quality Governance, Associate Director of Quality Governance and members of each Care Group's leadership team, commenced in May 2024.

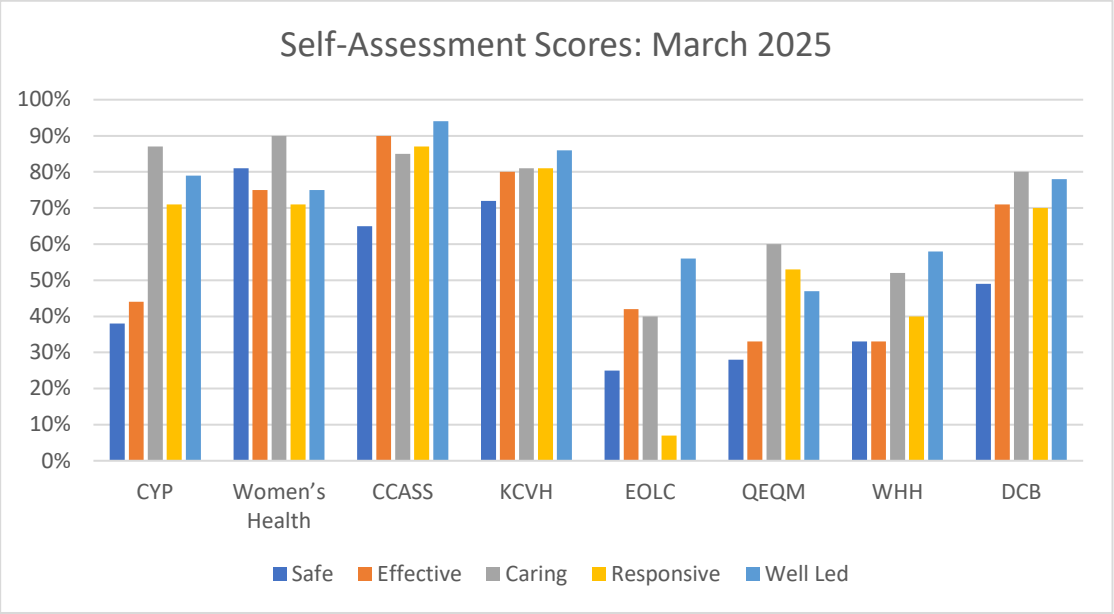
The percentage of Quality Statements rated as fully met within their self-assessments is shown in the table below. It should be noted that the assessment only allowed the answers 'met' or 'not met'. By the 4 March (CQC Oversight and Assurance Group meeting) the below Care Groups had had second Check and Challenge meetings (Children & Young People (CYP), Critical Care, Anaesthetics and Specialist Surgery (CCAS), Kent & Canterbury Hospital and Royal Victoria Hospital (KCVH) and End of Life (EoL) Care) and the results for these is shown in blue in the table below.

Since the 4 March, the QEQM and WHH Care Groups have also presented at the Check and Challenge meeting. These results will be reported in the next Quality and Safety Committee report.

East Kent Hospitals University NHS Foundation Trust

Date of meeting	No of assessments completed	Percentage of Quality Statements rated as fully met					
			Safe	Effective	Caring	Responsive	Well Led
23.05.24	3	CYP	13%	17%	67%	48%	50%
12.12.24			38%	44%	87%	71%	79%
09.07.24	2	Women's Health	81%	75%	90%	71%	75%
23.05.24	14	CCASS	46%	83%	78%	79%	90%
20.11.24			65%	90%	85%	87%	94%
23.07.24	17	KCVH	43%	57%	72%	74%	81%
06.01.25			72%	80%	81%	81%	86%
14.08.24	2	End of Life Care	25%	42%	40%	7%	56%
03.02.25			25%	42%	40%	7%	56%
11.09.24	4	QEQM	28%	33%	60%	53%	47%
18.09.24	5	WHH	33%	33%	52%	40%	58%
07.10.24	17	DCB	49%	71%	80%	70%	78%

The graph below shows the scores as at 6 March 2025. This reflects the re-assessed scores for the second round of data for CYP, CCASS, KCVH Care Groups and End of Life Care (Trust wide service). All other Care Groups shows the first round of data scores only. Three Care Groups that have presented re-assessed data have all shown improvement since their first meetings six months ago. The End of Life scores have remained the same.



5.2 A review of the self-assessment and Check and Challenge meeting processes is underway to establish what has worked well and what could be improved. Views from everyone involved in the process will be sought.

5.3 The CQC application on the Trust's new InPhase information system will be implemented over the coming months; self-assessments will be completed on this system after it has been piloted and implemented. This will enable improved visibility of current status, reporting, action plan management and evidence collation functionality. Implementation has been delayed due to both internal and external issues relating to the structure and set up of the system.

6. Ward and Clinic Accreditation update

6.1 A review has been completed of the Ward Accreditation tool to ensure this aligns with the CQC framework and can be used for the purpose of self-assessment at Ward and Clinic level. The refreshed tool has been in use from the January 2025 accreditation visits. The specialist tools for Emergency Department (ED), Neonatal Intensive Care Unit (NICU) and Maternity will also now be reviewed. The audit tools can be accessed by ward/clinical teams via the Ward and Clinic Accreditation Staff Zone page.

6.2 The Ward Accreditation visits are being supported by the Compliance and Assurance team – and the Care Group Leadership teams and their Speciality teams are being encouraged to release multi professional staff for the visits.

6.3 Between January and February 2025, 16 areas have had a clinical accreditation completed. 2 areas (QEQM Kingsgate Ward and WHH NICU) have achieved Silver awards. 14 other areas are currently White, with reassessment being scheduled. Four reassessments have been undertaken, all requiring further reassessment, and 12 additional reassessments have been scheduled for completion by the end of February 2025.

6.4 Overall there has been improvements in the accreditation grades for the assessed areas in 2025 when compared to their initial accreditation grades in 2024.

6.5 A Ward and Clinic Accreditation Steering Group has been established to strengthen governance processes. The Group meets monthly at present. Progress reports and updates are produced every three months and presented at the Fundamentals of Care Committee.

7. Update on performance against the 2023 CQC inspection report

7.1 Reports from the inspections that took place in May 2023 (medical care, children and young people and urgent and emergency care at WHH and QEQM) and July 2023 (well led) were published in January 2024 and an action plan was developed by each Care Group/speciality. The following action plans are in place:

- 2gether action plan - closed

- CYP action plan - closed
- DCB action plan
- QEQM GM action plan
- QEQM UEC action plan
- WHH GM action plan
- WHH UEC action plan
- Well Led action plan
- Corporate Nursing/Medical/Operations action plan - closed

7.2 Monthly reports showing progress and status of each action plan have been provided to the CQC Oversight and Assurance Group (CQC O&AG) and on to the Regulatory Oversight Group (ROG) and Quality and Safety Committee since the plans' commencement in January 2024. In addition to this to ensure pace of delivery a weekly meeting is held with the CNMO and Director of Quality Governance.

7.3 This report includes the current status of the must and should do requirements, and how many associated actions remain open. It shows the status at 27 February 2025, as reported to CQC O&AG.

7.4 Statutory and mandatory training for doctors had an extended target date of 30 September 2024, as agreed by the CMO. This target has not been met and the CMO has been informed. Discussions are in place about the urgent actions required to recover this position.

7.5 There are six Must Do (out of 28) and three Should Do (out of 25) requirements that remain open (some requirements feature on multiple action plans or on two sites). There is a total of 11 out of 206 (5%) actions open across all action plans, as shown in the table below.

7.6 Of these 11 open actions:

- Five relate to medical training compliance. A six-month extension to 30 September 24 was agreed for medics to achieve the compliance rates seen across nursing, midwifery, allied health professionals and clerical and managerial groupings. This has not been met and the CMO has been asked to advise of next steps.

- 3 actions relate to staffing (AHPs and pharmacy):

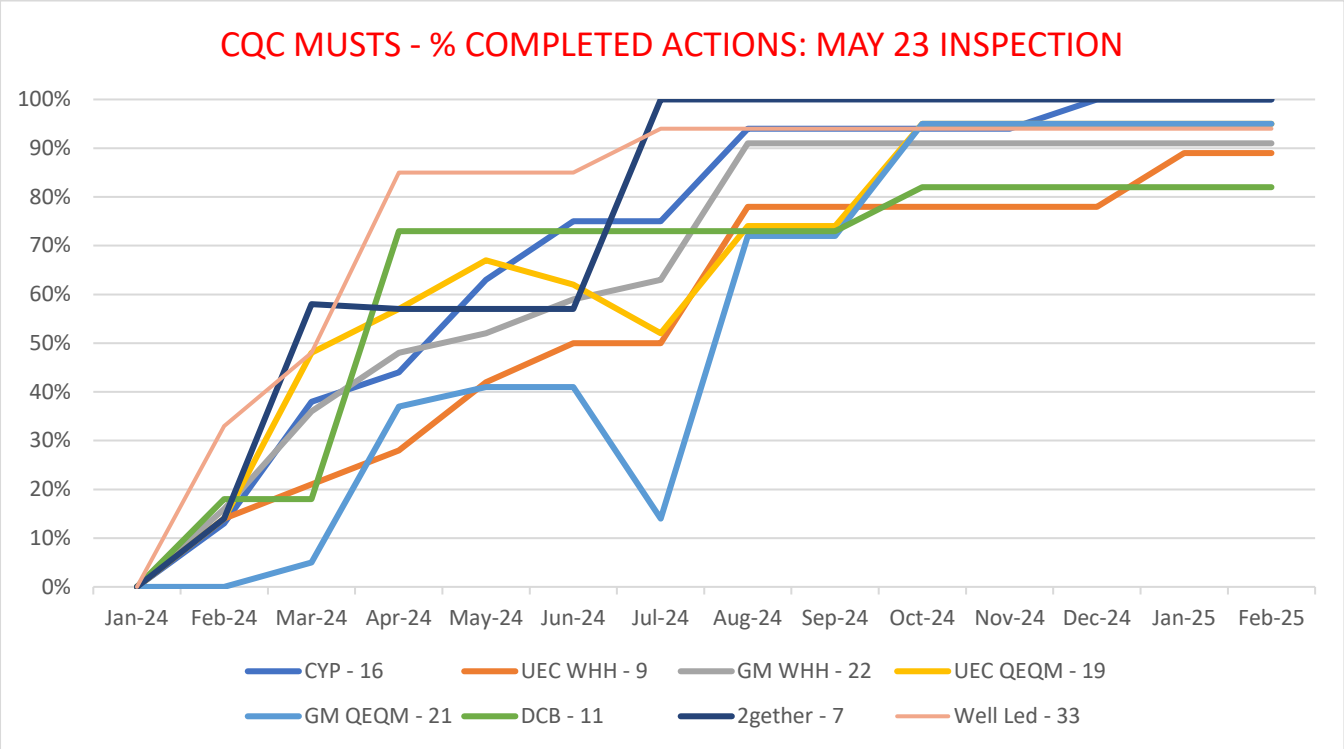
    - Pharmacy: The business case for pharmacy has been approved by the care group, reviewed by the deputy head of finance and is now with the executive team. This is a Must Do requirement.

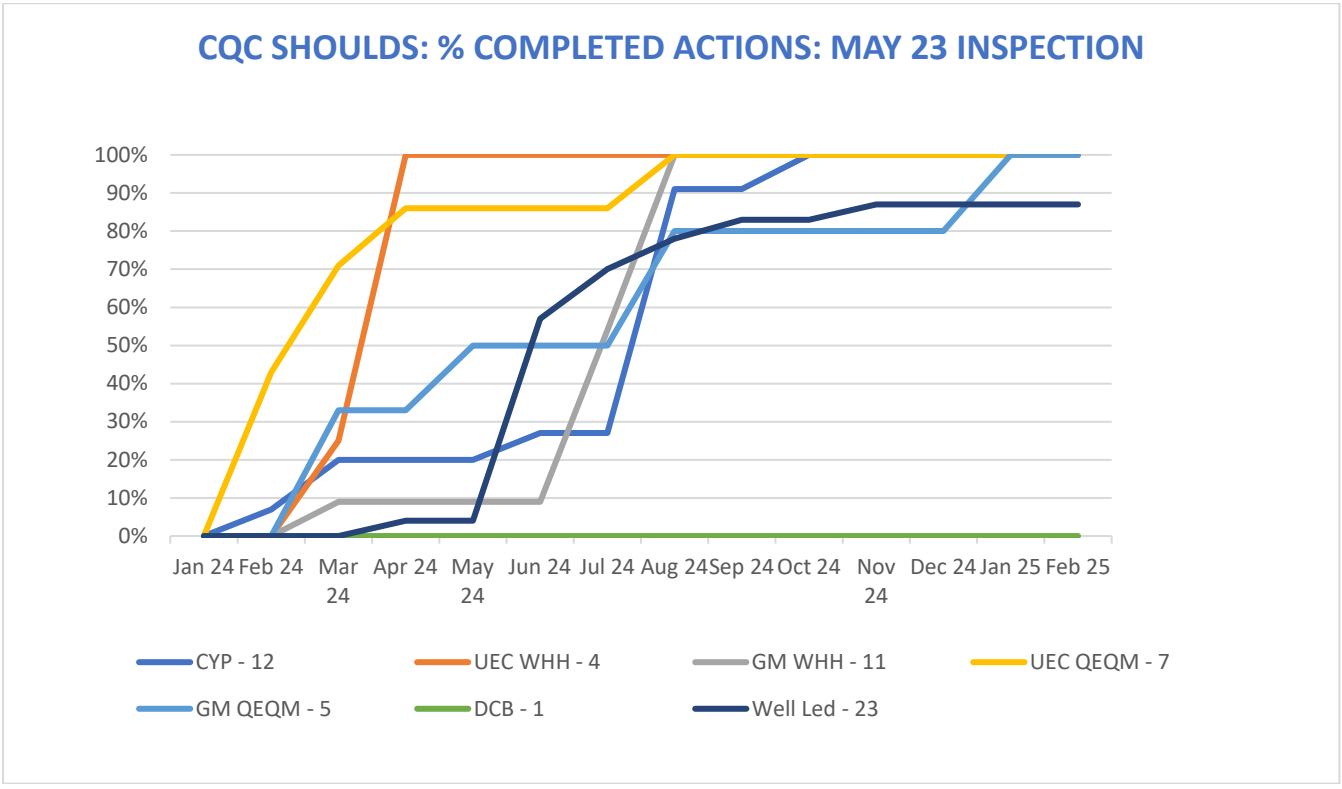
    - AHPs: An AHP Workforce Review is underway led by the Deputy Chief AHP. This is due to be reported to CEMG in April 25 and then upwards to sub-committees. This action will remain open until this work is completed.

- There are three actions open on the Well Led Plan – please see Section 6 below.

East Kent Hospitals University NHS Foundation Trust

OPEN REQUIREMENTS AND ACTIONS				
Action plan	**Open Must Do Requirements**	**Open Should Do Requirements**	**Total number of actions on plan**	**Number of open actions (31/01/2025)**
Well led	0 of 4 (0%)	2 of 8 (25%)	56	3
2gether	0 of 4 (0%)	N/A	7	0
QEQM UEAM	1 of 6 (17%)	0 of 3 (0%)	26	1
QEQM GM	1 of 7 (7%)	0 of 5 (0%)	26	1
WHH GM	2 of 8 (25%)	0 of 4 (0%)	33	2
WHH UEAM	1 of 4 (25%)	0 of 2 (0%)	13	1
WCYP	0 of 11 (0%)	0 of 9 (0%)	28	0
DCB	1 of 11 (9%)	1 of 1 (100%)	12	3
Corporate	0 of 4 (0%)	0 of 1 (0%)	5	0
TOTAL			**206**	**11 (5%)**





8. Well Led inspection report

8.1 There were four Must Do requirements comprising of 33 actions. All four requirements have been closed.

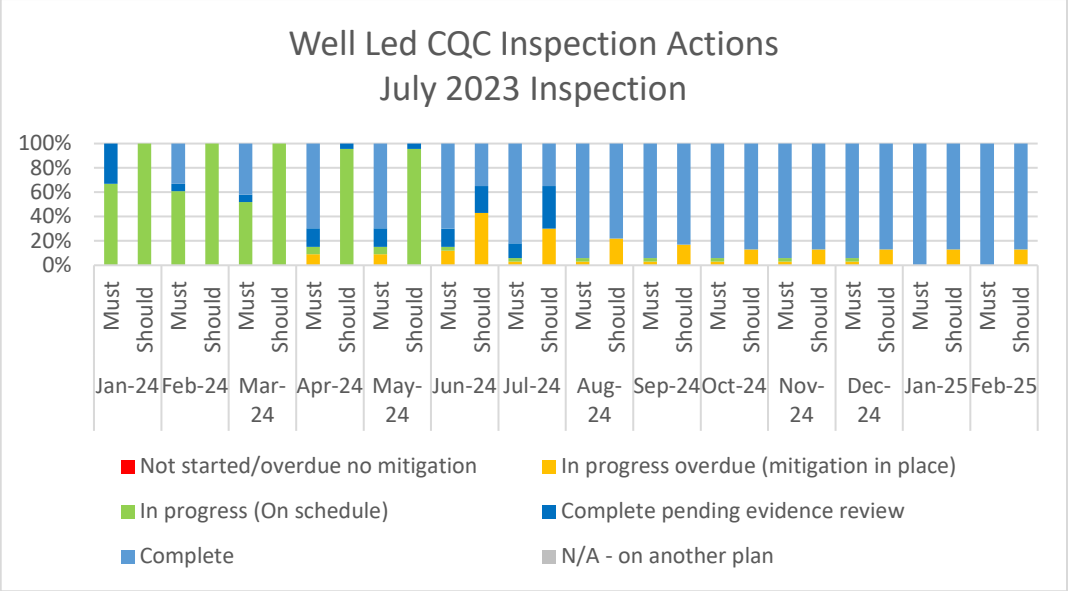
8.2 There were eight Should Do requirements comprising of 23 actions. Two Should Do requirements remain open with three associated actions yet to be completed; each of these is overdue beyond its extended due date.

8.3 The two Should do requirements with three overdue actions that remain open on the plan are as below. The FTSU action are due to closure on 17 March 2025.

- **SD24: The leadership team should consider how future leaders operationalise the vision and support continuation of work introduced by people in current interim roles.**
  - Develop a suite of tools to enable effective handovers when leaders leave their role (People & Culture) – due 01/10/24. Escalated to Chief People Officer (CPO).

- **SD25: The Trust should ensure the Freedom to Speak Up (FTSU) processes are sufficiently resourced to support staff to raise concerns.**
  - Improve FTSU resources and accessibility for staff by promoting via improved communications channels (People & Culture) – due 31/07/24.
  - Development of Trust-wide Key Performance Indicators (KPIs) and dashboard on speaking up (People and Culture) – due 31/07/24.

- This Should Do will close when the new FTSU service is operational – from 17 March 2025. At this point, the risk rating will also be decreased to moderate and the outputs of the service reviewed in line with the contract before the risk is closed.



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

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

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

CG and Speciality	Requirement	Status
WHH UEC 2020	MD01.Urgent and Emergency Care (UEC).WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. (Also on May 2023 action plan) MD28.UEC.QEQM&WHH.2023 The service must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the	Data 27.02.25 **Medical compliance WHH UEAM**: January 2025 Statutory compliance –80.9% (target 91%) 8 of 8 courses below Trust target Mandatory compliance – 75.5% (target 85%) 9 of 11 courses below Trust target

CG and Speciality	Requirement	Status
	appropriate level. Regulation 18 (1)(2)(c) Staffing.	
WHH UEC 2020	SD05.UEC.WHH The Trust should ensure all staff have access to the training needed for their role including advanced life support.	Data 27.02.25 **Nursing:** **January 2025** RESUS Adult 100% Resuscitation level 3 adult: 76.9% Resuscitation level 3 Paeds: 67.8% **Medical:** January 2025 RESUS Adult 62.7% RESUS Paed 73.1% (target for all 85%)
WHH GM 2021	SD02.MED.KCH & WHH.2021 The Trust should ensure that all staff complete their mandatory training. (Also, on May 2023 action plan)	Data 27.02.25 **Medical WHH GM** **January 2025** Statutory compliance –84.3% (target 91%) 6 of 8 courses below Trust target Mandatory compliance – 67.3% (target 85%) 9 of 10 courses below Trust target
KCH GM 2021	SD02.MED.KCH & WHH.2021 The Trust should ensure that all staff complete their mandatory training. (Also on May 2023 action plan)	Data 27.02.2025 **Medical KCH** **January 2025** Statutory compliance – 80.8% (target 91%) 8 of 8 courses below Trust target Mandatory compliance – 69.6% (target 85%) 9 of 10 courses below Trust target.
WHH UEC 2020	MD16.UEC. WHH The Trust must ensure critical fluids and medicines are administered and recorded in a timely manner.	Discussions ongoing with CMO and Director of Pharmacy. Further pharmacy support for ED WHH recruited.
QEQM UEC 2020	MD01.UEC.WHH The Trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act (MCA) training, life support training, and dementia training. Also on 2023 action plan MD28.UEC.QEQM&WHH.2023 The service must ensure medical and nursing staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the	Data 27.02.25 **Medical QEQM UEAM** **January 2025** Statutory compliance –87.5% (target 91%) 5 of 8 courses below Trust target Mandatory compliance – 79.1% (target 85%) 8 of 11 courses below Trust target

CG and Speciality	Requirement	Status
	appropriate level. Regulation 18 (1)(2)(c) Staffing.	
WHH & QEQM UEC 2020	SD03.UEC.QEQM & WHH The Trust should ensure medicines reconciliation is undertaken in a timely manner	Discussions ongoing with CMO and Director of Pharmacy to ascertain outcome measures to provide assurance that this can be closed.
QEQM UEC 2020 S29a	SD01.UEC.QEQM & WHH (2020) The Trust should consider how to recruit a full establishment of emergency department consultants and SD02.UEC.QEQM (2021) The Trust SHOULD meet the Royal College of Emergency Medicine requirements for the number of consultants employed within the department.	Increase to 8 WTE consultants. There are now just 1.5 WTE outstanding positions; all other consultants are in post.
EOLC 2018	MD37 Ensure that consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).	Deputy CMO is co-chairing a task and finish group with the Trust MCA Lead to address the issues identified. Awaiting confirmation that actions are in place to be managed by task and finish group.

10. Update on Maternity Section 31 Enforcement and January 2023 Inspection Action Plan

10.1 The Trust submitted the monthly Section 31 notice requirement for Maternity on 30 January 2025 and 27 February 2025. There remain only 2 must do requirements that remain open, relating to staffing and the aging estate. As discussed in 3.3 and 3.4 the removal of the Section 31 notice was discussed at the CQC engagement meeting on the 25 February 2025 and the Trust are looking to begin the application for consideration to request this enforcement.

11. CQC Queries Update

11.1 There were 16 queries received from the CQC during January and February 2025, which is a decrease of seven in comparison to the previous two months. During that period, 11 were fully responded to. Nine of these queries had deadlines set by the CQC, eight of which were met with one requiring an extension. One query did not require a response, this query was for discussion at the CQC engagement meeting. At the end of February, 17 query responses remained open, 13 remain open from 2024 and four remain open from 2025.

12. CQC Engagement

12.1 A bi-monthly Trust engagement meeting took place on 25 February 2025 between the CQC, CNMO, Director of Quality Governance, Associate Director of Quality Governance. This was a face to face meeting.

12.2 An agenda was shared by the CQC ahead of the meeting and a slide pack containing updates on safeguarding, serious incidents, staffing, patient flow, discharges, electives, endoscopy, clinical audit, training, risk, staff engagement and board changes was shared by the CNMO during the meeting. There was a focused review of the Emergency Departments (EDs).

12.3 The CQC Inspectors also requested to see a clinical area and were taken on a tour of K&C theatres by the Theatre Matron and Director of Nursing for CCAS Care Group where they told them about the recent improvements that had made and success in achieving Association for Perioperative Practitioners (AfPP) Accreditation.

13. CQC publications

13.1 The CQC have shared the following publications during January and February 2025. These updates have been shared at the CQC Oversight and Assurance Group and Regulatory Oversight Group.

- Terms of reference published for the second phase of the review into CQC's assessment framework and its implementation Published: 21 January 2025 Page last updated: 22 January 2025
- CQC appoints Interim Chief Inspector of Healthcare Published: 24 February 2025 Page last updated: 24 February 2025
- Opportunity to join the CQC Board Published: 4 February 2025 Page last updated: 4 February 2025

14. Conclusion

14.1 The Board of Directors is asked to receive the attached report**.**

14.2 Closures from CQC inspection action plans from the 2023 inspections have continued at pace with only 5% remaining open (and the closure of a further Should Do for Well Led projected for late March 2025).

14.3 Self-Assessment Check and Challenge meetings continue with Care Groups attending second meetings and self-assessments demonstrating improved scores across all CQC domains.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Safeguarding Annual Report 2023-24**

Meeting date: **3 April 2025**

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

Paper Author: **Associate Director of Safeguarding**

Appendices:

Appendix 1: Safeguarding Annual Report 2023-24
Appendix 2: Safeguarding Adult Report to Kent and Medway Safeguarding Adults Board (KMSAB)

Executive summary:

Action required:	**Approval**
Purpose of the Report:	We are required as a Trust to publish an Annual Report in relation to Safeguarding and we are seeking the Board's approval for publication. The purpose of the Annual Report covering April 2023 – March 2024 is to inform the Board of the safeguarding structures, governance arrangements and activity undertaken to fulfil the responsibilities to safeguard both our patient's and EKHUFT's continued registration with the Care Quality Commission (CQC) and to ensure the responsibilities under the Accountability and Assurance Framework (NHS England (NHSE) 2022) are fulfilled.
Summary of key issues:	Key achievements: • Achieved deliverable plan moved to sustainability plan. • Improved governance and audit arrangements. • Training compliance at level 1 and 4 for child and adult over 85%. • Female genital mutilation (FGM) reporting to Department of Health achieved. • Prevent reporting achieved. • Safeguarding Policies reviewed and updated. • Development of an All Age Duty system. • Development of a Mental Health policy and interim Mental Health lead in post. • Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) and Mental health Steering groups to deliver key workstreams including development of Sunrise MCA Documents – June 2023, bespoke MCA/DoLS Training Sessions and Mental Capacity Act and Deprivation of Liberties Policy. • Completion of MCA/DoLS Task & Finish Group (NHSE and Integrated Care Board (ICB) oversight ended – July 2023. • Transfer of Section 42 investigations to Care Group completion, with Safeguarding team supervision and quality assurance. • Increase in safeguarding awareness from the EKHUFT workforce demonstrated by an increase in duty contacts to the team.

East Kent Hospitals University NHS Foundation Trust

	• Domestic Abuse Policy implementation. Key challenges: • Training compliance at level 2 and 3 for adult. • Sustainability deliverance including workforce vacancy. • Attendance at Midwifery Supervision is 49% which is below the 75% expectation but a 50% increase from the previous year.
Key recommendations:	The Board of Directors is asked to discuss and **APPROVE** the Safeguarding Annual Report 2023-24 and **SUPPORT** the ongoing Safeguarding strategy and sustainability plan to create a Safeguarding Culture at EKHUFT.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • Partnerships
Link to the Trust Risk Register:	N/A
Resource:	N
Legal and regulatory:	Y - Statutory duties relating to seeking safeguarding assurance at all levels and how these fit in within the context of the Children Act, Care Act, Health and Social Care Act, Domestic abuse Act, Homelessness Reduction Act legislation and statutory guidance.
Subsidiary:	N

Assurance route:

Previously considered by: Safeguarding Assurance Committee 11.3.25, Quality and Safety Committee 25.3.25.

East Kent Hospitals University NHS Foundation Trust

Annual Report

All age safeguarding team

April 2023 – 2024

Salli Alihodzic

Carol Tilling
Martin Cripps
Danielle Michael

We care

East Kent Hospitals University NHS Foundation Trust

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East Kent Hospitals University NHS Foundation Trust

1. Purpose of the report

1.1 Safeguarding is everyone's responsibility. This Report describes the processes and systems in place across all trust sites to Safeguard adults, pregnant people, children and young people who are cared for at East Kent Hospitals University Foundation Trust (EKHUFT). It is the obligation of every NHS organisation and each individual working in the NHS to ensure that the principles and duties of safeguarding children, young people and adults identified as at risk are holistically, consistently and conscientiously applied, with the needs of children and adults at risk of abuse or neglect at the heart of all that we do.

1.2 The purpose of this Annual report, covering the period April 2023-March 2024 is to provide assurance to the Board that East Kent Hospitals University Foundation NHS Trust (EKHUFT) is fulfilling its statutory duties in relation to safeguarding children and adults defined within legislation (Children Act 1989 and 2004, Care Act 2014, Mental Capacity Act 2005 and 2019, Homelessness Reduction Act 2017, Domestic Abuse Act 2021) , following guidance from Working together to Safeguarding Children (2018) and CQC regulation 13.The report also highlights the outstanding risks and their current mitigations.

1.3 It is the obligation of every NHS organisation and each individual working in the NHS to ensure that the principles and duties of safeguarding children, young people and adults identified as at risk are holistically, consistently and conscientiously applied, with the needs of children and adults at risk of abuse or neglect at the heart of all that we do.

1.4 The report provides assurance EKHUFT is using data to drive improvements.

1.5 To safeguard EKHUFT's continued registration with the Care Quality Commission, it has to ensure the responsibilities under the Accountability and Assurance Framework (NHS England 2024) are fulfilled and the contractual requirements as laid out in Schedule 32 of the NHS Contract. EKHUFT has been in National Oversight Framework at level 4 during the period of this report. Assurance monitoring has been completed throughout the year by national and regional oversight measures. These include:

- Those who use services are safeguarded and their views used to formulate outcomes in a making safeguarding personal model.
- The support, risks and views of those people caring for patients requiring safeguarding are considered.
- Staff are suitably skilled and supported.
- There is safeguarding leadership.
- Commitment at all levels of the Organisation for Safeguarding including full engagement and support of local accountability and assurance structures.
- Ensuring a culture exists where safeguarding is everybody's business.
- Poor practice is identified and tackled.

2. Introduction

2.1 Executive accountability for Safeguarding is held by the Chief Nursing and Midwifery Officer (CNMO) of which there have been four (Two substantive and Two interims) within this period. The current CNMO has been in post since September 2023. This role is supported by the All-Age Safeguarding Team who provide both strategic, clinical and operational leadership for safeguarding within the Organisation. During this time period, the team have been led by an Interim Joint Head of Safeguarding, followed by a second Interim Head of All-Age Safeguarding and a Substantive Head of safeguarding appointed in January 2024.

2.2 During this reporting period, EKHUFT has remained in the National Recovery Support Programme. In relation to safeguarding, regular assurance was provided to NHSE and in August 2022, it was determined that sufficient evidence around systems and processes primarily around adult safeguarding had been received so enabling the removal of safeguarding from the programme

2.3 The Safeguarding team has remained in a development phase throughout 2023/24. The team has been led by two interim heads of safeguarding during this period whilst business planning took place. A new configuration of services and responsibilities has required the Safeguarding team to build relationships with new leadership team and ensure safeguarding has featured in new governance processes.

2.4 A Safeguarding Strategy is in place covering 2023-2026 this describes the core values, the priorities for the Trust and how they will be achieved.

2.5 To support delivery of the vision and values a new Safeguarding structure was put in place. The all-age duty safeguarding system was created. This supports a think family approach to safeguarding. Systems and processes were further developed to ensure the recording of safeguarding activity. Some interim roles remained in place to support the team management operationally from a management and administration perspective, whilst recruitment to the new roles was in progress. The team sit within the Corporate Care Group, Clinical Quality and Patient Safety.

2.6 The team has carried a significant deficit in workforce during the year and this continues to be the case. It has proved challenging recruiting to key leadership and operational positions this has impacted the ability to deliver the safeguarding sustainability plan.

3. Local Context

3.1 During this report period, EKHUFT sat within the area covered by one Integrated Care Board (ICB). We are a large acute hospitals Trust, with five hospitals and a number of community clinics serving approximately 700,000 people in East Kent. We also provide some specialist services for a wider population, including renal services in Medway and Maidstone and a cardiac service for all of Kent based at William Harvey Hospital (WHH), Ashford. In Kent there were 342,400 children and young people, with 52,752 under 16s living in poverty, which has risen from last year's number 50,252 (KSCMP 2023 – 2024.

3.2 Locally at EKHUFT, in the financial year 2023/24, there were 5758 babies born, which dropped slightly from last year. Among the total, 32 were born to mothers aged under 18, which matched the figures last year.

8,342 babies, children and young people were inpatients in our Neonatal Intensive Care Unit (NICU)/Special Care Baby Unit (SCBU) and inpatient children's wards and day unit, which was a rise from last year's figure of 7,939. 3,539 children and young people attended the Children's Assessment Units, which was another rise from last year's figures 2,605. A further 4,200 were inpatients on wards outside of Child Health, which was a steep rise compared to last year's 1,680 children. Children and young people also attended 97,114 initial and follow up outpatient appointments for under 18s. This data is utilised to determine the level of training required by

staff across the organisation (Appendix 1). Adults attended 728,494 outpatients' appointments, which rose from last year's 676,131 appointments. Across all sites, 70,525 under 18s were seen in the Emergency Departments (EDs) and Urgent Treatment Centres (UTCs), compared to last year's figures 72,192. There was a significant rise in adults attendances in EDs and UTCs this year 224,469, compared to 215,057 attendances last year.

3.3 Health Inclusion considerations

3.3.1 East Kent 88.6% of the population are White, 4.7% are Asian, 3.1% are Black, 2.4% are Mixed and 1.3% are Other. The five most widely spoken languages are English, Nepalese, Polish, Romanian and Slovak(census?0021). The percentage of lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and more (LGBTQIA+) people in Kent is 3.25% compared with 89.75% of people who identify as heterosexual or straight. 28.5% of the population in Kent and Medway have long-term conditions (so in East Kent that means over 180,000 people.

3.3.2 East Kent has a high percentage of its population living in coastal communities, it also has an aging population with poor employment opportunities. The highest areas of deprivation in East Kent are within Thanet and Romney Marsh.

3.3.3 The rural nature of areas within East Kent impact access to healthcare due to poor transport links and digital dead zones impacting ability to access some health and social care resources.

3.3.4 In Kent, in September 2023, the estimated number of rough sleepers was 126. This is up by 57.5% from the autumn 2022. **Canterbury** had the highest number of people who were rough sleeping on a single night in autumn 2023 this was the highest rate in Kent. **Thanet** and **Folkestone** also have high rates of rough sleepers (Annual Rough Sleeping Snapshot 2024 Department for Levelling Up, Housing and Communities (DLUHC)).

3.3.5 East Kent has a large transient population of asylum seekers and completed initial assessments for unaccompanied asylum-seeking children.

3.3.6 East Kent has a large number of military veterans, the largest number residing in Thanet (5,765 veterans). Dover had a higher-than-average proportion of veterans with 5.9% of the resident population aged 16 and above having served at some time in their life and Folkestone also has a higher-than-average number of veterans. A significant number of the veteran community are Nepalese.

3 Executive Summary

Statutory Responsibilities and Assurance

3.4 Safeguarding accountability sits with the CNMO as Executive lead. During this period, she had delegated representation on the Kent Safeguarding Children Multi Agency Partnership (KSCMP) through, the Kent and Medway Chief Nurse from the Integrated Care Board, who was the safeguarding executive lead. The Kent and Medway Safeguarding Adults Board she has attended herself or been represented by the Deputy Chief Nurse or Head of Safeguarding.

3.5 Safeguarding, Learning Disabilities and Mental Health were moved into the portfolio of the Deputy Chief Nurse to provide strategic leadership and oversight alongside the interim Heads of Safeguarding.

3.6 Named Professionals were in place for Children, Maternity and Mental Capacity. In January the Named Adult post became vacant, this was mitigated by the Deputy Head of Safeguarding whilst recruitment to the roles was prioritised

3.7 The All-Age Safeguarding Deliverables Action Plan was used to ensure sustained improvement. This considered safeguarding oversight and accountability at governance, executive, strategic, operational and frontline levels. The safeguarding governance included the Safeguarding Assurance Committee, which reported directly to the Quality and Safety Committee and then the Board, therefore, ensuring that all safeguarding activities and risks were cited through this process.

3.8 The Safeguarding Assurance Committee met bi-monthly during the report period, chaired by a Non- Executive Director. The purpose of the meeting is to provide assurance and identify risks and mitigations of all age safeguarding issues across the Trust. It also provides progress of actions identified from the deliverables, safeguarding sustainability plan, as well as Domestic Abuse and PREVENT activity. Progress from recommendations from the Child Safeguarding Practice reviews/ Safeguarding Adult Reviews/ Domestic Homicide Reviews /Local reviews is shared and the data which is necessary for statutory reporting. Any issues from this committee are escalated /reported to the Quality and Safety Committee and Trust Board

3.9 The Safeguarding Assurance Committee it held in two sessions, the open session invites the designated professions assigned to EKHUFT by the local Integrated Care Board (ICB). They provide can provide guidance and challenge to governance processes.

3.10 A Safeguarding Operational Group is in place to provide regular assurance of care group and Safeguarding team activity. There are a suite of key performance indicators for safeguarding and a dashboard that is linked to this, which enables practitioners to regularly review and report their safeguarding activities. There is monitoring safeguarding activities at Care Group level through the completion of safeguarding reports by Heads of Nursing. These reports are shared and discussed at the monthly Safeguarding Operational Group and any issues escalated to the Safeguarding Assurance Committee.

3.11 During this reporting period, Safeguarding has been removed from the National Recovery Support Programme. In relation to safeguarding, regular assurance was provided to NHS England (NHSE) at a national, regional and local level through an oversight group. Monthly the group determined if systems and processes for safeguarding had been effective by assurance received. The oversight meeting considered current progress against the safeguarding action plan, team structure and sustainability, Supervision programme , progress against the Safeguarding adult's self-assessment, current schedule 4 assurance, training and current open safeguarding risks.

3.12 A number of task and finish groups have been led by the Named professionals and Deputy Head of Safeguarding to progress Safeguarding policies and workstreams.

3.13 A Safeguarding training programme is in place with levels of training required

indicated through the electronic staff record to ensure EKHUFT staff receive the level of training required by the intercollegiate documents Adult Safeguarding: roles and competencies for healthcare staff (2019) Safeguarding Children and Young people: roles and competencies for healthcare staff (2021).

3.14 Processes, procedures, protocols and policies are in place to support staff in safeguarding, prioritising needs and decision making when caring for individuals and families where there are high levels of social complexity and risk of abuse or neglect.

3.15 Safeguarding supervision is received and delivered by the safeguarding team through formal and informal mechanisms. There have been challenges in ability to engage parts of the workforce in supervision.

3.16 EKHUFT complies with national standards set for safe recruitment including consideration of national requirements for modern slavery. A review of the process for pre-employment enhanced disclosure and barring checks (DBS) has been undertaken by the deputy head of safeguarding alongside the recruitment team. Processes are now in place, with pre-employment clearance at an appropriate level for all staff.

3.17 Key achievements

- **Creation of and all age duty system for the workforce to access safeguarding advice and support.**
- **New Safeguarding structure to fit the size of the Trust and the needs of the local population.**
- **Improved response to emerging safeguarding incidents issues and concerns.**
- **New leadership in areas of challenge.**
- **New Policies.**
- **New tools to enable better Safeguarding documentation.**

3.18 Priorities for 2024/25

- Recruitment into key positions.
- Fully embed safeguarding into new governance structures across the Trust.
- Work with new care groups to improve awareness and reposting of Safeguarding issues.
- Support care groups to improve the timeliness and quality of the section 42 responses.
- Improve safeguarding supervision compliance to meet policy requirements particularly for Midwives and develop of more flexible delivery and engagement options.
- Collaborate with multi-agency and multi-disciplinary colleagues to better support patients experiencing mental health challenges and learning disabilities.
- Implement an annual audit plan for adults which monitors and assesses safeguarding practices and outcomes.

4. Governance and accountability arrangements

4.1 Roles and responsibilities

4.1.1 The safeguarding structure includes the required roles from both intercollegiate documents.

4.1.2 The statutory lead roles identified in Working Together (2023), the Care Act(2014), section 11 of the Children's Act (2004), NAAF (2019) and The MCA Act (2005) includes the following designated roles.

Chief Executive holds overall responsibility for the Trust CMNO is the designated executive lead	Executive Lead-
Safeguarding children and young people_ roles and competencies for healthcare staff	Named Doctor for Safeguarding Children
Safeguarding Children in Care – Roles and competencies	Named Doctor for Children in Care
Safeguarding children and young people_ roles and competencies for healthcare staff	Named Nurse for Safeguarding Children
Adult Safeguarding: Roles and competencies for healthcare staff	Named Nurse for Safeguarding Adults – Vacant since Jan 24 at time of reporting
Safeguarding children and young people_ roles and competencies for healthcare staff	Named Safeguarding Midwife
Adult Safeguarding: Roles and competencies for healthcare staff	Named Nurse for MCA/DoLS

4.2 Statutory safeguarding responsibilities

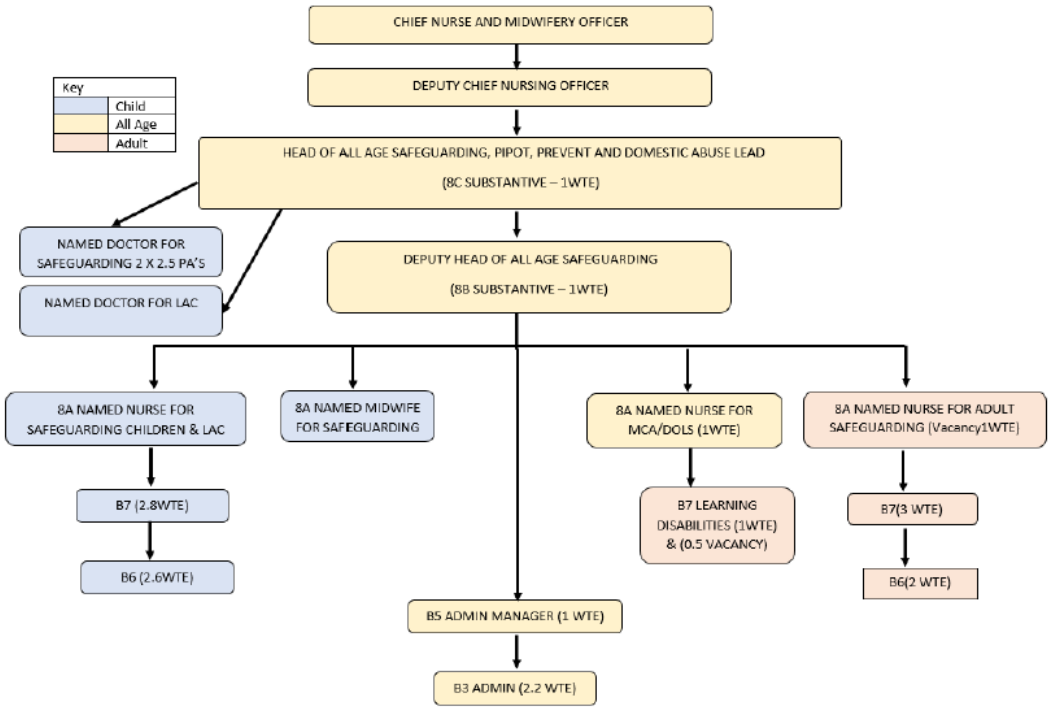
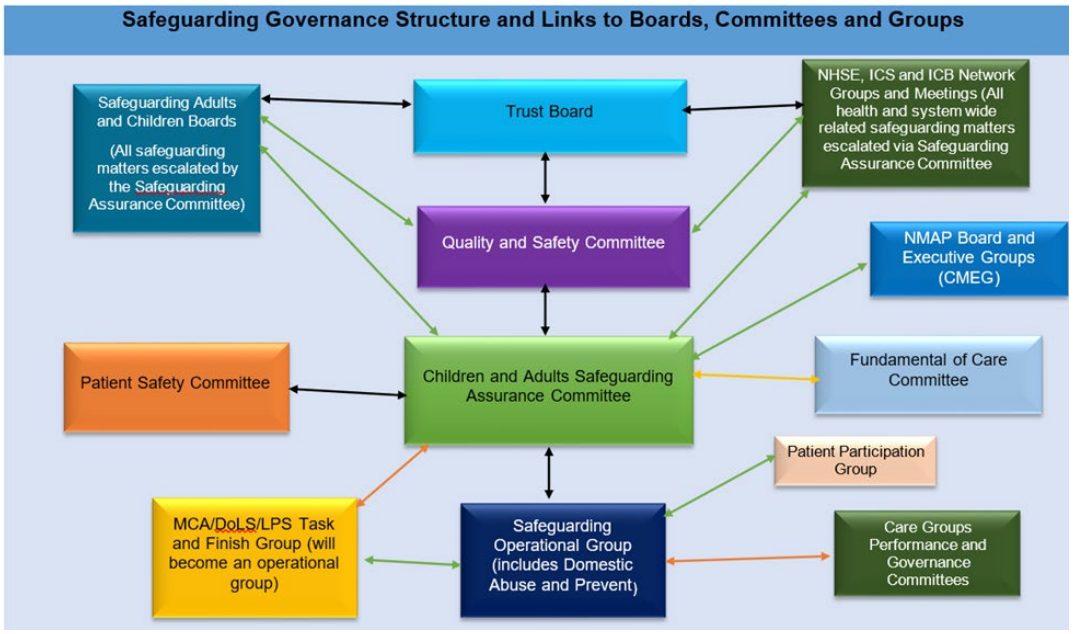


Figure 1: Safeguarding Team Structure

East Kent Hospitals University NHS Foundation Trust

4.2 Safeguarding governance structure



4.3 Reporting Framework

4.3.1 All Care groups operational safeguarding issues are dealt with and mitigated by the Safeguarding Operational Group and the Task and Finish Groups, where all Care Groups are represented.

4.3.2 The Safeguarding Operational Group reports to the Safeguarding Assurance Committee.

4.3.3 The Safeguarding Assurance Committee reports to the Quality and Safety Committee.

4.3.4 The Quality and Safety Committee reports to the Trust Board.

4.3.5 The Safeguarding Operational Group escalates all safeguarding concerns to the Safeguarding Assurance Committee, who then escalate to the Quality and Safety Committee, and this Committee then escalates to the Trust Board who have overall accountability and responsibility for safeguarding. Therefore, there is oversight of safeguarding at every level from Board to clinical level.

4.3.6 The Safeguarding Assurance Committee also escalates patient safety concerns identified to the Patient Safety Committee and for any quality-of-care concerns to the Fundamentals of Care Committee, and other Committees, Groups and Boards within the Trust.

4.3.7 All system wide safeguarding issues affecting patients are escalated to the Commissioners, Local Authority and NHSE though the Safeguarding Assurance Committee, with oversight from the Quality and Safety Committee and Trust Board depending on the nature of these and how they impact on the Trust.

4.4 Safeguarding Operational group

The Safeguarding Assurance Committee met bi-monthly during the report period, chaired by a Non- Executive The purpose of the meeting is to monitor governance and assurance, identify risks and mitigations of all age safeguarding issues across the Trust. It also provides progress of actions identified from the deliverables, safeguarding sustainability plan, as well as Domestic Abuse and PREVENT activity. It considered all safeguarding functions including adults, children's, maternity, learning disability and autism, MCA/ DoLS ,prevent, domestic abuse and mental health. The group invites both internal stakeholders as well as the

named designates from the Kent and Medway Integrated Care Board (ICB). The group is responsible for ensuring there are systems in place to recognise and support those both at risk of abuse and those who are experiencing abuse as per our statutory function. Progress from recommendations from the Child Safeguarding Practice reviews/ Safeguarding Adult Reviews/ Domestic Homicide Reviews /Local reviews is shared and the data which is necessary for statutory reporting. Any issues from this committee are escalated /reported to the Quality Committee and Trust Board

4.5 Safeguarding Assurance Committee

The Safeguarding Assurance Committee met bi-monthly during the report period, chaired by a Non- Executive Director. The purpose of the meeting is to monitor governance and assurance, identify risks and mitigations of all age safeguarding issues across the Trust. It also provides progress of actions identified from the deliverables, safeguarding sustainability plan, as well as Domestic Abuse and PREVENT activity. It considered all safeguarding functions including adults, children's, maternity, learning disability and autism, MCA/ DoLS, prevent, domestic abuse and mental health. The group invites both internal stakeholders as well as the named designates from the Kent and Medway Integrated Care Board (ICB). The group is responsible for ensuring there are systems in place to recognise and support those both at risk of abuse and those who are experiencing abuse as per our statutory function. Progress from recommendations from the Child Safeguarding Practice Reviews/ Safeguarding Adult Reviews/ Domestic Homicide Reviews /Local reviews is shared and the data which is necessary for statutory reporting. Any issues from this committee are escalated /reported to the Quality Committee and Trust Board.

4.5 Safer recruitment

The Interim Head of Safeguarding has led a task and finish group to review how agency and subcontracted services are monitored within the trust with a key focus on agency staff, how they are commissioned, the assurance provided in relation to training and competencies as well as induction and the support they are provided within the Trust. Assurance received from current services around competencies, safeguarding training, escalation and sanction placed on staff who are not compliant. As part of the work of the overall safer recruitment issues identified in the Recovery Support Plan for Safeguarding. An audit was completed on the level of DBS checks undertaken were in alignment with both the Trust Policy' Disclosure and Barring Checks Policy', guidance from the Disclosure and Barring Service and the NHS Employment Checks Standards. Overall, the audit showed that staff had the appropriate level of DBS for the level of regulated activity within their job role.

4.6 Participation in wider Trust governance meetings

The Interim Head of Safeguarding attends the Fundamentals of Care Committee and the newly established Nursing and Midwifery Executive Committee (NMEC) where information about themes / trends from a safeguarding perspective are shared with the leaders in the Care Groups. The Deputy Head of All Age Safeguarding also attends the Children's Services Improvement & Assurance Board and reports upon training compliance alongside the above issues. This Trust wide meeting provides the forum for improvement of services for children across EKHUFT and our membership ensures that safeguarding forms an explicit part of service development.

4.7 Care group governance Participation

The Deputy Head of All Age Safeguarding is an active participant of the Clinical Governance process within the Children's care group. The Safeguarding Midwife also attends clinical governance meetings with the Women's health team.

4.8 Service user Participation

The team works closely with the Patient Advice and Liaison Service and Patient Experience Team regarding any complaints or concerns that come into the Trust where safeguarding may be a factor for consideration. At the same time, there is team representation at the Serious Incident Panel meetings and safeguarding SIs are discussed at the weekly team case management meetings.

5. Safeguarding Sustainability

5.1 During this period, the Trust has been in the process of implementing the safeguarding sustainability plan. This has transitioned from the Safeguarding deliverables plan, with a clear focus on ensuring the Trust meets its statutory safeguarding duties. There has been significant progress across a number of workstreams.

5.2 The progress of the All Age Safeguarding Sustainability plan is reviewed quarterly. This includes review of current safeguarding activity workstreams, progress against external oversight objectives, care group input and feedback from the Committee. There continues to be progress. The details of the organisation's self-audit was provided as evidence submitted to NHSE and ICB Safeguarding Oversight meetings to support with the exit criteria for the Journey from SOF 4 to SOF 3.

5.3 Throughout the year, the Interim Head of Safeguarding has self-assessed safeguarding standards against the NHSE Safeguarding Accountability and Assurance Framework (SAAF). This is an ongoing process which is monitored through the external oversight group where progress is reviewed and outstanding activity required by the Trust discussed. This was presented to the Safeguarding Assurance Committee and the Quality and Safety Committee. The self-audit tool focuses on the systems and processes in place to ensure effective safeguarding response and identified the gaps in the benchmark indicators in each of the nine domains relating to this. A number of the areas have remained as amber as further work is required with regards to the quality of the evidence to ensure that this is robust and reflects the current systems and processes in place. This is under constant review and the Committee has ongoing oversight as evidence of the gaps identified is provided for assurance.

5.4 Externally, the Interim Heads of All Age safeguarding have been active members of and participants in the KMSAB Board and sub-groups and Domestic Homicide Local Partnership Board, the annual report submit for this year's activity and progress has been submitted (Appendix 2).

5.5 The Safeguarding leadership team are active members of the ICB led Child, Adult and All Age health reference groups. The Deputy Head of All Age safeguarding is an active member of the Policies and Procedures group of KSCMP.

6. Statutory Safeguarding reviews

6.1 As part of a national system to learn from, respond to and enhance the protection of adults with care and support needs, children, individuals with learning disabilities who have died or seriously harmed through abuse or neglect and those experiencing domestic abuse which has resulted in a homicide, EKHUFT are mandated to share relevant information and evaluate the Trust response to the individual need during any care episodes within the terms of reference.

6.2 EKHUFT have contributed to a number of learning reviews, including safeguarding adult reviews (SAR), Domestic homicide reviews (DHR), Children Safeguarding Practice reviews (CSPR) And Learning Disability (LEaDER).

6.3 Safeguarding Adult Reviews

The team participated in three SARs in this time period, compared to five last year. In addition, they completed a further 20 summary of agency involvements were provided, compared to eight last year which are used to evaluate if a safeguarding adult review is required. The work required for SARs is allocated and monitored through case management. When Kent SARs are published, they are reviewed for thematic learning, if this is pertinent to EKHUFT it is added to our SAR workstreams and progress against these actions has been monitored by the Safeguarding Assurance Committee.

6.4 Domestic Homicide reviews

The Domestic Violence, Crime and Victims Act 2004, Section 9, requires that, following a domestic homicide, the local area must organise a multi-agency review. This is a statutory requirement for EKUHFT and any subcontractors. The lead responsibility for co-ordinating Domestic Homicide Reviews (DHRs) lies with the local Community Safety Partnership (Police). The multiple agencies that had contact with the perpetrator and/or victim reflect on the contact and interventions each organisation has had, in order to see if opportunities were missed that may have prevented the homicide. During this time frame, there was participation and information gathering for four Kent cases, compared to three in the previous year.

6.5 LeDeR reviews

As part of the statutory requirements the Learning Disability Team complete LeDeR (Learning from Death of People with Learning Disabilities) notifications when a person with learning disabilities and/or Autism dies in hospital, during this reporting period there were 22 referrals made, and the team contributed to the local LeDeR Operational meetings.

6.6 Child safeguarding practice reviews

EKHUFT contributed to the completion of five reviews, compared to eight last year. This included work of the safeguarding team to gather relevant information about staff involved in the care episode to attend practitioner events and the formulation, monitoring and execution of required actions. These actions are tracked through case management and the Safeguarding assurance group

6.7 Child Death reviews

The Local ICB lead the Child death process once reported. The Trust has a guideline that supports staff in the process to follow. All unexpected Child deaths trigger a joint agency response (JAR) to establish initial clinical interpretation of cause of death, any identified concerns and support for the family. A lead clinician is identified to attend with the safeguarding team if there are any identified safeguarding concerns. Following this the ICB co-ordinate review through the child death overview panel and are responsible for distributing learning across the health system. Learning from unexpected child deaths is incorporated into peer review. The Safeguarding team are awaiting a memorandum of understanding from the Kent coroner's office regarding sampling required when a child is received in the hospital following death.

7. Other statutory Reporting

7.1 Female Genital Mutilation (FGM)

This is classified as a form of child abuse in the country and those participating in it can be prosecuted under the FGM Act (2003) The serious crime act(2015) requires all regulated health professionals in England and Wales to report any known cases of FGM where there is a risk to a child and directly identified cased in individuals to the police. Data about risk for 33 people was reported to the Department of Health as per statutory reporting requirements, Compared to 24 the previous year. There was no mandatory reporting required for individuals under 18.

7.1.1 FGM-IS system alerts the practitioner to FGM being within females in the family. The system can be checked if pregnant people under the age of 18 years present. If baby girls are born at EKHUFT to a mother with FGM then their details are added to FGM-IS, as a further safeguarding measure information about familial FGM is put in the baby's red book as per national guidance.

7.2 Child Protection Information System (CPIS)

The National CPIS project was implemented at EKHUFT in early 2018. Staff in unscheduled settings such as ED, children's wards and maternity access the system using their smart card through an icon on the ZENworks desktop. This allows the staff member to see if the child is on a child protection plan or is 'looked after 'and sends a message back to the Local Authority informing them of the attendance to EKHUFT. The UTCs now have a fully automated system so this area is no longer audited.

7.2.1 Audits of the use of the system have been undertaken on the children's wards and ED.

7.2.2 The Deputy Head of Safeguarding is involved in work to implement phase 2 for scheduled

7.2.3 Children within the Kent County Council (KCC) Level 4 children's social care cohort continue to be flagged on Allscripts. All children with this flag continue to be alerted to the safeguarding team in real time. In addition, there are a small cohort of children who are additionally flagged at the request of our multi-agency partners or the safeguarding team. There are governance arrangements in place around the flagging.

8. PREVENT

8.1 As an NHS organisation the Trust is required under the prevent duty (counter terrorism and security Act 2015) to provide training to ensure staff can recognise when a person is at risk of radicalisation and take steps to report **it.** The safeguarding team trained 3171 staff in PREVENT, compared to 2135 last year

8.2 Multi- agency, local Authority led Channel panels, supported by Kent Police aim to discuss the risks posed by an identified individual who is thought to have been showing signs or involved in activity which would indicate they have been radicalised and could pose a risk to the local population. No referrals were made to the Channel panel for patients of any age.

8.3 The Safeguarding team received 49 requests for information, compared to 36 last year in relation to individuals who have identified through the PREVENT process.

8.4 PREVENT data returns were completed and sent quarterly as per our statutory reporting requirements.

9. DOLS

9.1 The number of referrals for Deprivation of Liberty Safeguards (DoLS) remains proportionate to the size of the Trust. These figures are supplied by the DoLS office (KCC), these differ from the notifications we receive from staff. The DoLs office share this information with the safeguarding team. A DoLs checklist has been developed on sunrise to support staff which went live in June 2023. The need to inform the team is part of all training packages and on the staff intranet

9.2 The outcome of DoLS applications by EKHUFT notified to the CQC.

Site	2022-2023	2023-2024
Kent & Canterbury Hospital (K&C)	202	240
William Harvey Hospital (WHH)	533	443
Queen Elizabeth the Queen Mother Hospital (QEQM)	423	476
Total	1,158	1,310

Table 1: DoLs figures comparison

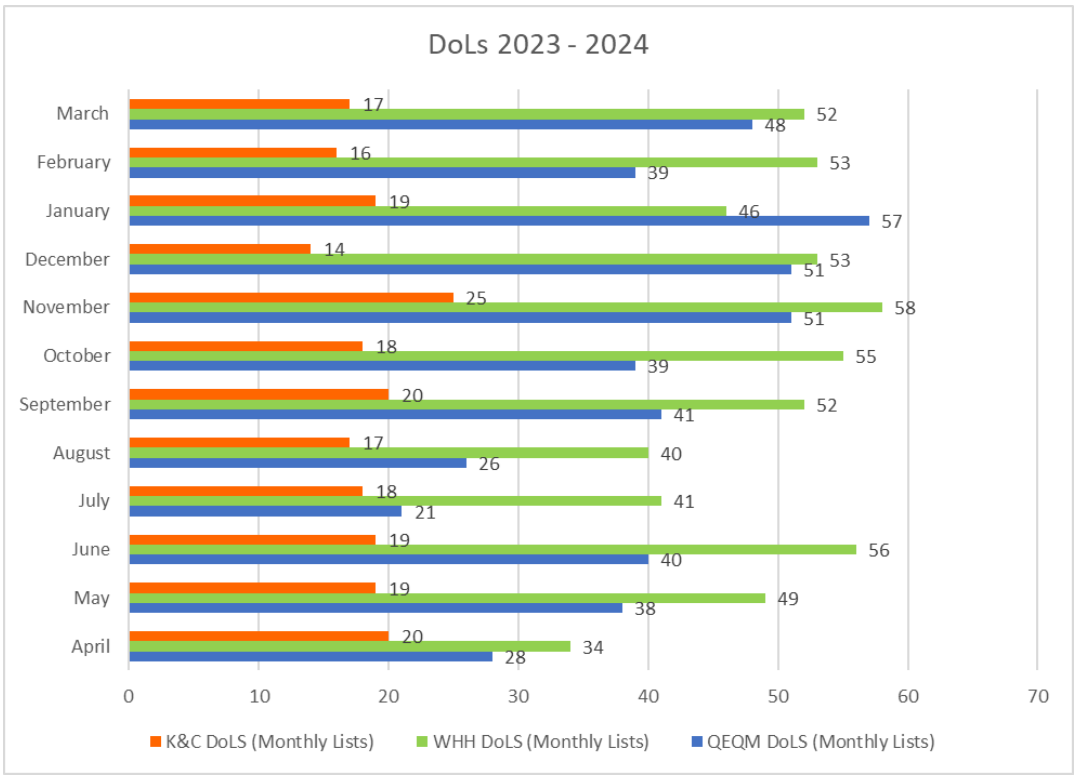


Figure 2: Number of DoLS at K&C, WHH & QEQM 2023-2024

10. Other Regulated Activity

10.1 Child protection medicals

There were 119 child protection medicals undertaken in the Community, compared to 81 last year.

10.2 Managing Allegations against Staff

All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are Datix reported and investigated by the Police where appropriate.

10.3 Managing Allegations Against Staff- Requiring referral to the Local Authority Designated Officer (LADO)

When an allegation is made against a member of the children's workforce, the needs of the child and other children with whom the professional comes into contact are considered paramount as advocated by the Children Act 1989. Employers, however, have an additional duty of care towards their staff and thus the complexities involved in responding to such allegations require balance and careful judgement to ensure risk and support are measured at both levels. During the year there have been seven cases where EKHUFT have been supported by the Kent Local Authority Designated Officer to enable us to support staff via a risk assessment in the workplace where there are safeguarding concerns, and they are part of the wider children's workforce. There were no themes/departments overly identified, except most cases have been where staff 's own children have been subject to child protection investigations or plans.

10.4 Managing Allegations Against People in a Position of Trust (PiPoT)

The Allegations of Abuse Neglect or Harm Against People in a Position of Trust (PiPoT) policy was strengthened to include all staff, volunteers and contractors at the Trust. A formal process

to support and manage the staff member to mimic the role of the Local Authority Designated Officer (LADO) service has been devised. There were 42 cases raised, compared to 37 cases last year.

11. All age Safeguarding activity

11.1 Duty

The All-age Safeguarding team continues to be a significant number of contacts to the All-Age team which provides assurance evidence that staff at EKHUFT have good awareness of what to do if they have concerns about a patient. The team provide advice and expertise to other staff at EKHUFT through the operation of a duty system, Monday to Friday 9-5, this includes midwifery, learning disability, homeless specialists, domestic abuse advisors and mental capacity and DoLS. This means both staff and outside multi agency partners receive a prompt response when they have a safeguarding concern.

11.2 Number of consultations

During the period of the report the team undertook **18304** consultations by phone, email, careflow or written format about children's safeguarding, compared to **17724** last year. **2966** for adult safeguarding, **509** for learning disability, **203** for domestic abuse and **321** for homelessness. There continues to be year on year growth.

11.3 Multi-Agency information sharing

11.4 Missing Persons

The Trust continue to be proactive working with our police partners to support the Missing Person agenda. The teams have undertaken reviews of people who went missing for the Police MCE Team to identify if any of these children have had engaged with the Trust at the point of the missing episodes. The adult team are also contacted daily for vulnerable missing adults (Table 2).

Activity	April 2022 – March 2023	April 2023 – March 2024
Missing and Child Exploitation reviewed children	1788	1074
Missing and Child Exploitation shared information	32	29
Missing Adults reviewed	549	660
Missing adults shared information	2	18

Table 2: Number of missing contacts from Kent Police

12. Supervision

12.1 It is essential that staff who are involved in safeguarding have access to supervision should they require it, the Intercollegiate document (2019) sets out the appropriate levels of supervision for specific roles. The two Trust supervision policies outline the ways different levels of supervision could be accessed. Improving engagement with supervision has been an all-age priority this year. The Trust is responsible for ensuring that its workforce is competent to carry out their responsibilities for safeguarding and promoting the welfare of children, to do this, it is key an environment is developed where they feel supported and able to raise concerns. Supervision is available in different formats and all staff are also able to access 'individual supervision' through the duty system.

12.2 For data purposes this is recorded as a 'Consultation' rather than a supervision episode. However, when consultation figures are included, the numbers provide assurance that many staff are accessing the Safeguarding team effectively for support.

12.3 The number of staff requiring group supervision has increased from 220 to 250 and further scoping is currently being undertaken to identify paediatric case-holding staff,

with four sessions being offered to those staff, as per the policy, the expectation is that they will attend three of those sessions meaning we would achieve attendance of 75% by the end of the year. The figure for attendance was **49%,** compared with **25%** the previous year.

12.4 As a result of poor compliance with supervision in Midwifery, it has been agreed to change the time of the sessions and reduce the volume of them to encourage more Community Midwives to attend. The CNMO and Director of Midwifery have been very supportive of implementing these changes. There is a plan to train more midwifery leaders in supervision.

12.5 Safeguarding Children Supervision has moved to a hybrid model across all specialities, with some teams returning to face-to-face sessions.
A reduction in ED figures was expected as the model of supervision has been reviewed with fewer cases being discussed but more emphasis on learning from the cases. 280 cases were discussed over the four sites, compared to 355 cases last year. The change has had very positive feedback from the ED staff.

12.6 The Named professionals deliver peer supervision for the safeguarding team as part of case management weekly and ad hoc on individual cases as required.

12.7 Paediatricians also attend 'Peer Review' where case discussion, learning and support are offered. This is run by the Designated and Named Doctors quarterly and is well supported by the Paediatric Medical teams from both the Acute and Community sector with 195 **people attending during the year**, compared to 172 people last year. Members of the safeguarding team and health professionals from across child health attend these sessions.

12.8 EKHUFT have a cohort of Trauma Risk Management (TRiM) practitioners and managers, this is an initiative which is designed to provide psychological support to staff in the aftermath of potentially traumatic incidents. Trim practitioners are trained to help individuals who may be distressed and to facilitate onward referral for specialist support if this is deemed necessary. The Safeguarding team have one member of staff trained as a practitioner and they have been available to support teams across the Trust when incidents have occurred.

13. Safeguarding Pregnant people and newborn babies

13.1 Maternity Safeguarding includes the assessment of social risk and provides a unique opportunity for the earliest intervention to minimise risk to the newborn baby when they arrive**.** It requires a holistic picture of the whole family or support network to consider safety, current risk or health issues which could affect the outcomes for the unborn baby and any other siblings. Professionals must try to enable the right support to be put in place to maximise parenting capacity whilst maintaining a safe environment**.**

13.2 The named midwife provides support to the community midwifery teams in recognising those people within their caseload who may require further support. The maternity support form acts as a way of considering concerns about the family pre-birth and once the birth has occurred. In addition, it is used to share information with the wider health network including health visitor and GPs. The role is supported by the Safeguarding children's advisors and practitioners.

13.3 The team received 4304 Maternity Support forms from Midwifery and determined safeguarding action plans for these families, this was compared to 3886 last year. 201 women and their babies and families were given additional support via a multi- agency pre- birth

plan at the time of delivery, compared to 215 last year. The threshold for pre-birth plan is determined by the local authority.

13.4 The named midwife alongside children's safeguarding advisors, the midwifery team, safeguarding adults and learning disability practitioners participated in a complex maternity task and finish group. This was developed in response to a Child Safeguarding Practice Review (CSPR) to improve the Trust response to increasing complex maternity cases.

14. Safeguarding Children

14.1 EKHUFT undertook 657 Referrals for Support (RFS) to the Local Authority, compared to 531 last year.

14.2 A process is in place to monitor the quality assurance of the referrals into Social Services. A Quality Assurance checklist has been devised, scoring referrals out of a possible ten and this has been incorporated into the Safeguarding Children Policy since 2018.

14.3 As a result of recording, EKHUFT can provide assurance that all the written referrals undertaken by our staff scored over 5/10 with most scoring 8/10 or above. This demonstrates similarity in the quality of referrals from the previous year.

14.4 Looked after children

14.5 A separate Annual report is produced for Looked After Children Reporting. The safeguarding team recognise the unique challenges faced by children who are currently in the care of the local authority. Whilst their needs will be individually assessed it is important that the EKHUFT workforce understand through training and case discussion the risks and health inequalities these young people face. The Named nurse for Safeguarding children also holds responsibility for looked after children.

14.6 Adoption forms recording health information are completed by the maternity team to capture Maternal and neonatal health history for children who are taken into the care of the local authority.

14.7 Paediatric Liaison

As part of information sharing arrangements identified in the Children Act (2004), all ED attendances to EKHUFT are shared with our primary care partners, i.e. GPs, Health Visitors and School Nurses. These are primarily undertaken electronically with the support of our IT team. However, for those children who do not have an identifiable Kent postcode, this is managed manually by the Safeguarding team

14.8 Was not Brought

Health exclusion is a significant factor for safeguarding particularly neglect. Early intervention can be hugely significant outcomes for individual children ensuring that there has been re-engagement with the health provision they require to achieve their own individual potentials outcomes This year, **2331** missed appointments were reviewed by the team. This work is a good example of multi-agency working and information sharing to work with families to enable safeguarding of children at risk. There has been a reduction in the volume of correspondence regarding children not being brought to their health appointments (Figure 3).

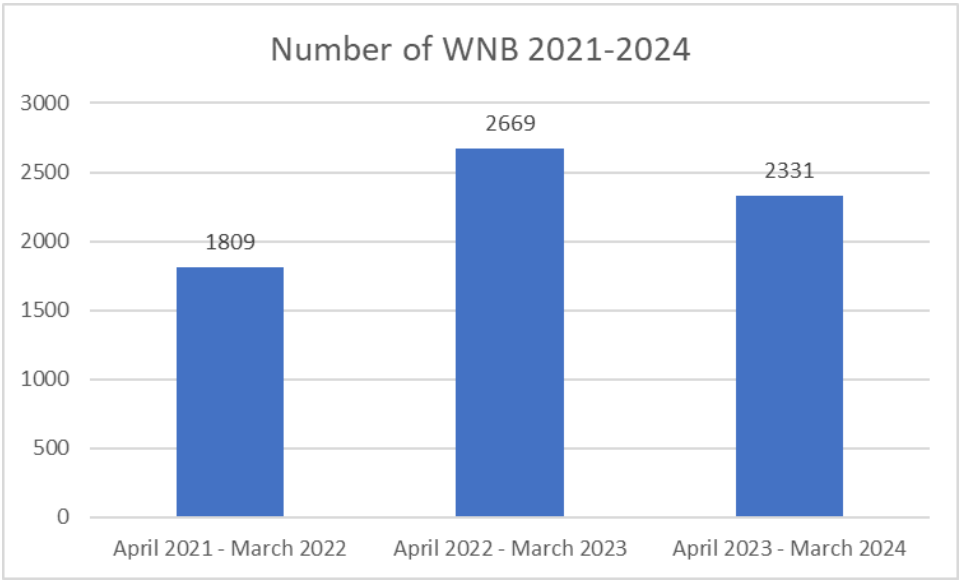


Figure 3: Decrease in WNB April 2023 – March 2024

15. Safeguarding Adults

15.1 Safeguarding adult referrals

The care Act (2014) provides a definition of individuals with care and support needs who may be at risk of abuse, neglect or exploitation. The team also consider what further support might be required under the well-being principle of the care Act The adult specialist in the team receive initial referrals identifying risk through the all-age duty system, these come in a range of formats.

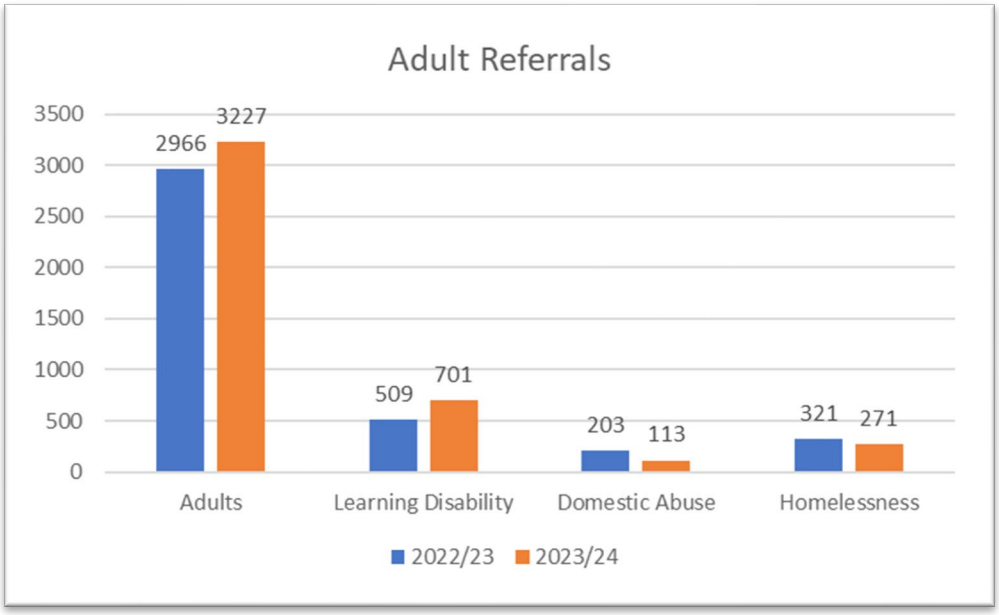


Figure 4: Number of Adult Referrals

15.2 Safeguarding Adult enquiries

15.3 Adult Social care Referrals

The EKHUFT workforce including the Safeguarding team raised 961 Kent Adult Safeguarding concerns forms compared with 634 in the previous year. The safeguarding dataset monitors the site care was accessed and the main theme of the referral.

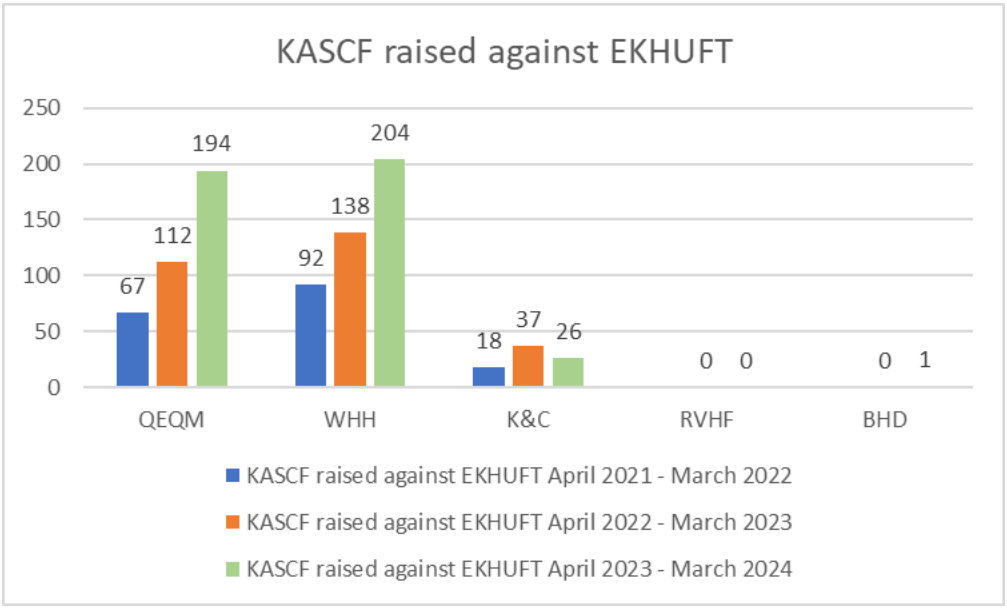


Figure 5: KASCFs raised against EKHUFT per site 2021-2024

Following receipt to the referral the local authority will decide if it meets threshold**.** All Section 42 Enquiries are notified to CQC by Social services. All cases raised as Care Act Section 42 Enquiries are logged on Datix and those meeting the criteria for a Serious Incident (STEIs) reported to the ICB. All allegations against staff are managed as per the Managing Allegations Against Staff Policy and are Datix reported and investigated by the Police where appropriate.

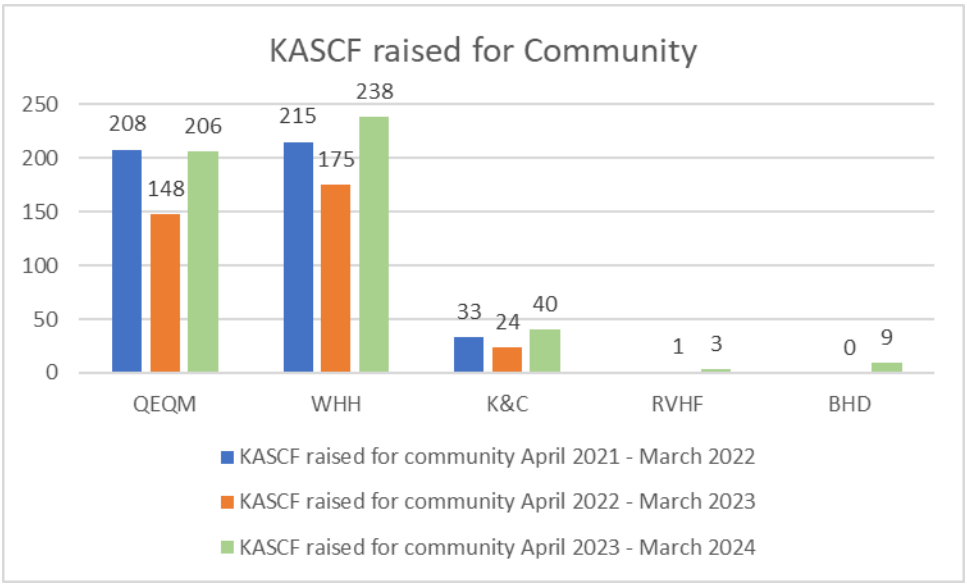


Figure 6: KASCFs raised by EKHUFT per site seven for community issues 2021-2024

The main themes for Community KASCFs were:

- Self- Neglect
- Neglect
- Financial abuse
- Domestic Abuse
- Physical abuse

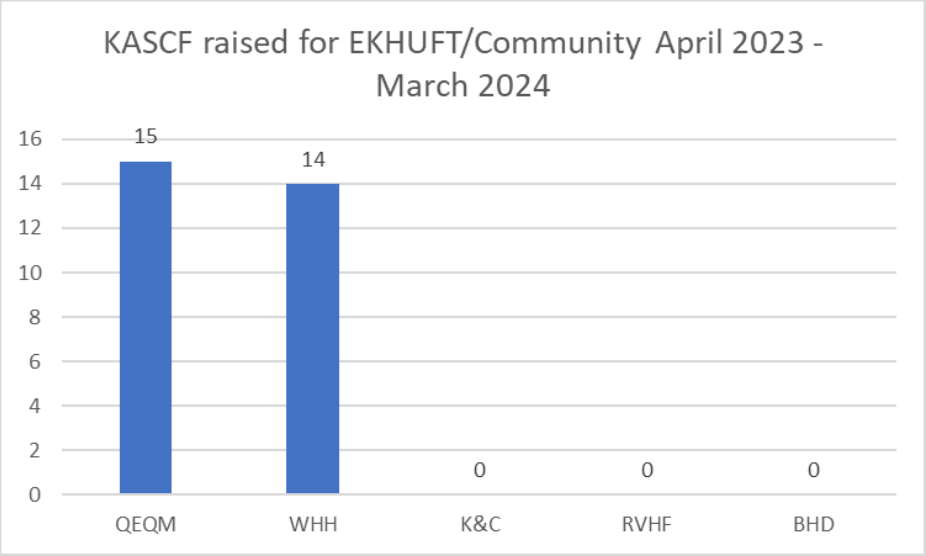


Figure 7: KASCFs raised for EKHUFT/Community 2023-2024

The number of KASCFs raised by the Trust in relation to issues in the Community which is positive and shows that staff are recognising omissions of care for patients coming into hospital (Figure 5).

15.4 Delegation of Section 42 Inquiry Officer (IO) report writing to the Care groups
Since January 2024 the Safeguarding team have begun the process of delegating the completion of IO reports to the leads within the care groups. Prior to the launch a training package was put in place which has included a number of sessions and a video was developed to aid high quality completion.

15.5 The Interim Head of Safeguarding chairs the Safeguarding operational group where themes emerging for individual care groups from S42 investigations are highlighted and discussed. A report from this group is then sent to Safeguarding Assurance committee for oversight of themes and areas for learning and improvement. Exceptions are shared with the Quality and Safety Committee and system wide issues shared with the Kent and Medway Safeguarding Adult Board.

15.6 The Kent and Medway Safeguarding Adults Board self-assessment was submitted and there are 12 Amber actions to complete and 1 red which is to create an Adults Was Not Brought policy, there is currently a task and finish group in place to complete this work.

16. Mental Capacity Act (Year)

16.1 A Named Nurse for MCA/DoLs was recruited to strengthen EKHUFTs understanding, application and Compliance with the MCA & DoLS.

16.2 A bespoke training package was devised and put in place along with development of a suite of support materials to aid assessing mental capacity, supporting best interest decision making and identifying any deprivation of liberty.

16.3 Current MCA/DoLS documents were updated in line with national standards and an MCA steering group was set up to inform the workstream.

16.4 An MCA /DoLS Policy is in place and MCA forms and training is included in the wider Safeguarding training needs analysis. Level three safeguarding training around MCA/DoLS has been strengthened and now incorporates lessons learned from Trust incidents. Bespoke MCA training sessions are recorded on staff Electronic Staff Record (ESR). An MCA competency

framework is being considered. The mental capacity assessment, best interests' checklist and decision recording and DoLS checklist documents are available on the staff EDS (sunrise).

16.5 An interim Mental Health Lead was appointed in October 2023 to support with the increase in patients experiencing mental health challenge who are accessing care. The Mental Health Policy which was drafted by the interim Head of Safeguarding was updated and approved. The required training package to support the policy was scoped with the support of Kent and Medway NHS and Social Care Partnership Trust (KMPT) who provide EKHUFT with a liaison psychiatry service.

16.6 A new mental health steering group was created to enable more effective system working. The work of the group has also included focus on developing patient pathways with consistent ways of working across all hospital sites within EKHUFT. A Mental Health Strategy was designed to be a joint 3-year strategy, with an expectation that the steering group will monitor the progress of this.

16.7 The Mental Health Lead has worked with the Health and Safety and Security leads to refresh safe patient searching in the security policy and the ligature risk assessments have been redesigned and there use needs rewording role out across all three main sites. This is supported by the Ligature Policy.

16.8 The safe use of restraint across the Trust has been an area of challenge. The primary need to use restraint has been patients presenting a risk of harm to themselves, followed by risk to staff and other patients. Consistent recording of restraint is an area for development. The all -age restraint policy has been refreshed. The new policy has required amendments to the current available training. The interim Mental Health Lead worked with the learning and development team to review the Maybo training package currently offered and assessed what will be required to ensure the new policy is effective. At the time of writing this report a review of current security arrangements are being undertaken to ensure the contract reflects the need of the Trust

16.9 Police will be implementing Right Care Right Person as of April 2024 and have led on 6-weekly meetings. EKHUFT stakeholders are participating to ensure staff understand the new way of working. Kent Police offered training to members of the EKHUFT workforce to improve multi agency understanding of how the police will respond to incidents or requests for support. There has also been multi agency work completed around 136 provision across Kent and Medway.

16.10 The SMART tool currently being used within ED settings across Kent and Medway to aid decision making for staff when patients present with mental health challenges is being reviewed. The interim Mental Health Lead is participating in the ICB led task and finish group.

16.11 A Safe Haven is now in place at the Queen Elizabeth the Queen Mother Hospital (QEQM) site. This is funded by the ICB for three years and there are steps underway to establish a further Safe Haven at the William Harvey Hospital (WHH) Site. The aim of this service is to support the increasing number of patients with mental health challenges to have a more appropriate place where they can get support if they are not requiring acute mental health or physical treatment.

16.12 The interim Mental Health Lead supported operationally with 21 complex cases and contributes to the reviewing of risk incidents where mental health has been a feature and attends the high intensity user meetings.

17. Learning disabilities

17.1 The Learning Disability Team continues to support patients aged 18 or over diagnosed with both learning disabilities and Autism or either condition needs who required additional support when attending the Emergency Departments, admitted in an emergency or planned way to a ward, or outpatients. The team offers advice and support during admission and identifying

reasonable adjustments. The Team consists of 1 x WTE Band 7 Learning Disability Nurse.

17.2 The number of patients who have accessed care at EKHUFT on the Learning Disabilities register was 2350 in April 2024 an increase of 16% since May 2023 and the 271 patients on the ASD register an increase of 52% from May 2023 . This is monitored quarterly by the Trust including the setting they have accessed.

17.3 A Learning Disability task and finish group has been exploring how we meet the needs of services users.

17.4 Work is ongoing on Easy read leaflets and electronic flagging to improve accessibility and empower staff to consider appropriate communication of information.

17.5 System working to ensure safe discharge where needs are complex and standard care pathways are not appropriate is in progress, with the ICB.

17.6 An acute learning disability liaison pathway has been developed to promote joint working with community teams during hospital admission and aid early consideration of onward discharge referrals which may be necessary . It also increased community learning disability teams awareness of patients health and enabled targeted support to patient and GP services to reduce attendance.

17.7 Online Tier 1 Oliver McGowen Training has compliance reached 87.6% in March 2024.

17.8 Work is ongoing with the Patient voice and IT team about the implementation of NHS reasonable adjustment flag.

18. Domestic abuse

18.1 The executive Lead for Domestic abuse was the Chief People Officer (CPO) during this period.

18.2 The Trust has a Domestic abuse policy.

18.3 The Domestic Abuse Hospital Independent Violence Advocates (HIDVA) project continues across QEQM, WHH & K&C, providing support to families and staff who are the subject of physical or psychological abuse via the provision of a dedicated Hospital Domestic Abuse Advocate. They have continued to provide support to staff and patients. The numbers of referral remain consistent, these are reported via the care flow system (Table 3). During this timeframe all HIDVAs were in post and covered all sites.

Activity	April 2022 – March 2023	April 2023 – March 2024
HIDVA Referrals	193	214

Table 3: HIDVA Referrals

18.4 The HIDVAs have also undertaken teaching sessions and participated in the Safeguarding All-Age team walkabouts and raising awareness across all sites.

18.5 As part of the Domestic Abuse workstream devised to strengthen and deliver the Trust's statutory duties on domestic abuse, a new stand-alone domestic abuse policy for patients and staff is in place to reflect the Domestic Abuse Act 2021 and National Institute for Health and Care Excellence (NICE) guidance (ph50). Training requirements have been refreshed, strategies for staff to use with patients and information for people managers supporting staff including the Trust's well- being services for staff. The HIDVA service have made podcast training videos for EKHUFT staff in support of the policy with practical hints and tips for staff.

18.6 Multi Agency Risk Assessment Conference (MARAC)

19.6.1 The Interim Head of Safeguarding and Deputy Head of Safeguarding continue to participate in health meetings led by the ICB regarding the proposed changes to the MARAC process this

workstream has experienced delays interim arrangements remain the same, currently the Safeguarding team spend 1-4 hours a week supporting the process.

19.6.2 The following number of cases had data provided for the victim, perpetrator and any children for the family shared with the MARAC service around recent attendances to EKHUFT (Table 8), this helps support the safety planning for the victims. All victims and their children are flagged for one year from the start of their safety plan via the alert system on Allscripts, allowing practitioners to be aware of this information and to incorporate this into their assessment of the patient at their attendance.

Sites	April 2022 – March 2023	April 2023 – March 2024
Ashford	173	181
Canterbury	166	200
Dover	179	163
Folkestone	91	150
Thanet	220	222
Total	578	916

Table 4: MARAC enquiries

20. **Homelessness**

20.1 EKHUFT have a statutory legal duty (Homelessness reduction Act 2017) to assist that individual; with their consent, to make a homelessness approach to the local authority. There is close liaison with all relevant Local Housing Authorities including the 'Rough Sleeper Teams' that sit within those local authorities. Encouraging Multi agency working when an individual is admitted to hospital and requesting complex discharge planning meetings, has enabled staff to address the complex issues, that often-mean individuals have multiple attendances to the acute EKHUFT setting.

20.2 There is one homeless nurse (Band 7), who covers all sites across the Trust, offering advice support and guidance when an individual is identified as being homeless. Staff are supported and signposted if an individual is identified as having Adult Safeguarding/ Self neglect issues and assist with suggestions with regard to appropriate referrals interventions. Many individuals who are homeless, have been excluded from GP practice, or have difficult registering – the Nurse is in communication with Integrated Care System (ICS) (CCG) special GP allocations scheme, if an individual is struggling to register it may be possible to assist.

20.3 The Safeguarding team work closely on this project with the Homelessness Pathway team to providing support on the interface between homelessness and safeguarding, this had resulted in work being strengthened around discharge and assess to support under the wellbeing principle of the Care act.

20.4 A significant proportion of individuals who are homeless have had significant past Trauma, EKHUFT staff are encouraged to adopt a trauma informed approach and to consider Adverse Childhood experiences. Awareness of this is included in level 3 training and is regularly highlighted in 'Safeguarding Matters' in Trust news.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	**TOTAL**
6	15	16	12	25	26	24	29	28	32	30	30	**273**

Table 5: Referrals to homeless pathway

21. Reachable moments

21.1 Reachable moments project supports young people attending hospital following suspected assaults ensuring they are offered support as part of a scheme launched by the Kent and Medway Violence Reduction Unit (VRU). As part of the 'Reachable Moments' project, youth workers were stationed at accident and emergency departments in Medway and Thanet to engage with those who may have been injured at the hands of others, including using weapons. Their role was to understand how they came to be hurt and what support they or their families may need to help them move away from criminal activity such as carrying knives or being involved in county lines or gang activity. Funded by the Home Office for an initial three-month period, the project is a partnership between the VRU, Kent County Council, Medway Council, NHS and the domestic abuse charity Oasis.

November 2022* – March 2023	April 2023 – June 2023	July 2023 – September 2023	October 2023 – December 2023	January 2024 – March 2024
28	21	33	43	52

Table 6: Reachable Moments per quarter

21.2 The safeguarding team interface with the community safety partnership to support disruption activity of county lines offending, with the aim to reduce the local exploitation risk. Offenders recruit, transport and exploit vulnerable individuals including children to carry out low level criminal activity essential to their operations victims can be harmed during high risk or gang related activity leading them to present in urgent and emergency care settings.

21.3 EKHUFT submit data to the Violence Reduction Unit around knife crime and injuries. There are challenges around this submission it is difficult for staff EKHUFT to record locations of incidents routinely and may put in patient identifiable data into free text areas meaning the transfer of EKHUFT information into the proforma provided is problematic. Data has been submitted and sent retrospectively for the year. There remain issues across the Kent health economy.

22. Risk Management

22.1 Care groups are responsible for reporting risk incidents the safeguarding team will report a risk when they become aware that a safeguarding risk has not been managed in an appropriate or timely way which has led to increased risk.

22.2 The Safeguarding team meet regularly with the Patient Safety team to consider any themes, delays and complex cases.

22.3 Themes from incidents are explored at the Safeguarding operational group.

22.4 At the end of this period of report there remained three open risks on the corporate register.

22.4.1 Safeguarding workforce.

22.4.2 Delays in section 42 investigation response.

22.4.3 Safeguarding Training compliance.

23. Partnership working

23.1 Multi-agency partnership working is essential for effective safeguarding. The ICB represents Health as one of the three statutory partners on both the Kent and Medway Safeguarding adults Board (KMSAB) and at Both the Kent and Medway Safeguarding children's partnerships.

23.2 The Interim heads of Safeguarding and deputy Head of safeguarding participate in the following subgroups of the Safeguarding Adult board, The Business group, the communications and engagement working group, Quality assurance working group, Policies, practices and procedures working group and is represented by KMPT at the SAR working group.

23.3 The ICB represent the all the provider organisations at the children's partnerships and the Safeguarding team are involved in task and finish groups as required.

23.4 The Named Professionals participate in the Adults, Children's and All Age health reference groups.

23.4 The Named Midwife participates In the National Safeguarding Maternity Network, South East Regional maternity network.

23.4 The Interim Heads of Safeguarding have participated in the Safeguarding Adults National Network.

24. Training

24.1 The annual figures show there has been an increase in meeting the agreed local compliance standard of over 85% at both level 2 and 3 (Table 7). Training at level 2 was delivered online. Level 3 has been delivered face to face during this period 4432 spaces were offered. The did not attend rate for training has been around 11% during the year with 529 staff not attending on the day, most staff cite clinical pressures as the reason for non- attendance. This has been raised with Heads of Nursing at the Safeguarding Operational Group regularly.

24.2 There remains constant drilling down into the data to ensure pockets of non-compliance in wards and departments are highlighted to care groups so action to improve and maintain compliance is undertaken. Support with data cleansing and bespoke training sessions has been provided by the Safeguarding team. During this timeframe progress for training compliance was monitored closely as part of the Safeguarding sustainability plan.

24.3 The training strategy and training needs analysis has been reviewed and updated against the current intercollegiate documents (RCPCH 2019 and RCN 2018).

24.4 There has been an increase of training sessions offered by the team, in addition staff who require only level 2 training are now able to achieve this through online training. There are more spaces available for the following year than those requiring level 3 training. All courses are overbooked.

2023-2024	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
L1 C	100	100	100	100	100	100	100	100	100	100	100	100
L2 C	77	79	80	81	83	83	84	86	86	87	89	89
L3C	82	83	84	85	86	87	87	88	88	89	92	92
L4 C	100	100	100	100	100	100	100	100	100	100	100	100
L1 A	100	100	100	100	100	100	100	100	100	100	100	100
L2 A	77	80	81	82	84	84	85	86	87	88	89	89
L3 A	68	59	61	63	67	70	72	76	77	79	84	85
L4A	100	100	100	100	100	100	100	100	100	100	100	100

Table 7: Training Compliance levels 2023-2024

25. External Audit

25.1 EKHUFT undertook the self- assessment Section 11 audit from the Kent Safeguarding Multi Agency Partnership in September 22, a small plan of three actions was identified to ensure our

full compliance with this. Delivery on these actions has been monitored by the Safeguarding Assurance Committee. There remains one outstanding action around levels of supervision.

25.2 EKHUFT undertook a self-assessment thematic SAF from Kent and Medway Safeguarding Adult Board in June 2022. All key areas were rated as amber and further evidence has been supplied throughout the year to move these to green. There remain outstanding actions in the report timescale which are being monitored by the Safeguarding Assurance Committee.

25.3 The Learning Disability Team completes the statutory LeDER and an annual NHSI Learning Disability Improvement Standards Benchmarking audits.

26. Internal Audit

26.1 A formal audit programme has been in place this year, with planned activity for quality assurance of safeguarding processes, guidance and policy, as well as assurance that recommendations undertaken for Serious Case Reviews and Rapid Reviews. In addition, audit results have been able to provide tangible assurance for the ICB metrics and will provide ongoing evidence for the S11 and SAF submissions. The team were fully supported by the audit team.

26.2 In August 2022 an MCA/DoLS Audit (supported by NHSE & ICB) found the workforce could not adequately demonstrate adherence of MCA. The actions were: Produce an MCA/DoLS policy, systematic changes to MCA/DoLS documentation, a clear DoLS Application & Tracking Process and to consider a bespoke MCA/DoLS training package with overarching training strategy.

26.3 CP-IS audits in ED and children's wards were undertaken during the year. Overall, the data showed that the staff on the wards consistently accessed CP-IS during the admission process, a 'message of the week' has been undertaken to re-enforce this practice. The ED team have also shown over 90% of attendances had CP-IS checked.

26.4 The quality of the completion of the maternity support form and safeguarding action plan has been audited quarterly. The results have been fed back to the women's health audit meetings and all actions from the identified recommendations have been delivered. This Quality Improvement Project (QIP) will continue.

26.5 Determining the efficacy of the Was Not Brought Policy for infants, children and young people. A regular undertaken, and the results shared in within the Child health audit meeting and then the subsequent Children and Young Person's Committee.

26.6 A baseline audit of the delivery of ICON at three agreed touchpoints during the maternity period to all pregnancies recorded on E3 (except where they opted out of data collection). We identified that the most utilised point was when the person moved from the hospital to community care after delivery. A full action plan and further audits have been agreed to improve upon our findings.

26.7 As part of the work of the overall safer recruitment issues identified in the Recovery Support Plan for Safeguarding, alongside a task and finish group to review agency and subcontracting arrangements for safeguarding. It was agreed that an audit of the level of DBS checks undertaken were in alignment with both the Trust's Policy Disclosure and Barring Checks Policy', guidance from the Disclosure and Barring Service and the NHS Employment Checks Standards.

27. Policies and guidelines

27.1 Relating to all age safeguarding were reviewed and the following actions were taken (as per 03/23):

27.2 In date, no action required

- Safeguarding Children and their Family's Supervision policy
- Was not Brought to health appointments for infants, children and young people
- Safeguarding Children policy
- Safeguarding Training Strategy and Training Needs Analysis
- Maternity support form guidance
- Fabricated and Induced Illness guideline
- Missing Person policy
- Domestic Abuse for patients and staff

27.3 Existing policy/guideline/strategy, updated and going through ratified

- Safeguarding Adult policy – replacing People at risk policy
- All Age Restraint and Safe Holding policy
- Managing Allegations of Abuse Neglect or Harm Against People in a Position of Trust (PiPoT)
- Mental Capacity Act/Deprivation of Liberty Policy
- PREVENT policy
- Safeguarding Adult Supervision guideline

27.4 Existing policy/guideline/strategy, updated and going through ratification process

- Child Death review guideline

27.5 New policy/guideline/strategy, written and going through ratification process

- Mental Health Policy
- Clinical restraint and Safe Holding Policy

References:

National Crime Agency (2021) National Strategic Assessment of Serious and Organised Crime

Royal College of Nursing (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff Inter-Collegiate Document (2018).
Royal College of Paediatrics and Child Health (2019) Safeguarding children and young people roles and competences for health care staff Intercollegiate Document

Safeguarding Accountability and assurance framework 3rd ed (NHSE,2019)

Working together to Safeguard Children: Statutory Guidance(DfE 2023)

Kent & Medway Safeguarding Adults Board (KMSAB)-

Annual Agency Safeguarding Reporting Template 2024

- The Care Act 2014 requires that Safeguarding Adult Boards produce an annual report detailing what the SAB has done during the year to achieve its main objectives and implement its strategic plan, and what each member has done to implement the Board's strategy.
- To meet this requirement and as part of the Board's quality assurance framework, all KMSAB partner agencies are required to complete this document annually, regarding adult safeguarding activity in the previous calendar year **(April 2023 to March 2024).** Agencies must detail how they met the Board's priorities. A good response provides examples of activity that has been undertaken and the difference it has made.
- Non statutory agencies should provide **2 examples** for each priority.

Difference between SAF and Annual Agency Report

Self-Assessment Framework	Annual Agency Report
The self-assessment framework sets out the standards and is a mechanism for your agency to provide assurance to the Board on how your agency is meeting them. Agencies have 18 months to meet all the standards set in the SAF.	The annual agency report is an opportunity for your agency to highlight and showcase specific pieces of work/projects that demonstrates good safeguarding practice and the benefits of this to the people you worked with during the year (April 2023 – March 2024) The annual agency report is a measure of what difference the standards set in the SAF are making.

- Reports will be peer reviewed at the Quality Assurance Working Group. Following this, a report will be made available to Board and Business Group Members.
- Verbatim sections of your return will be shared in the Board's annual report, **please remember that this is a public document so should be written using plain English with no acronyms**. Please ensure that you have relevant permission, and all examples are suitably anonymised for all inclusions.
- **Please note that this report is for adult safeguarding only.** Whilst Children's safeguarding is very important, the Board is not involved in overseeing this work.
- KMSAB members would recommend that other agencies with a responsibility for safeguarding complete this as a matter of good practice.
- A good example would be that you briefly describe the activity and then the impact of this.

Report Sign-off

Organisation	**East Kent Hospitals University Foundation Trust**

Details of person completing this return

Name	**Salli Alihodzic**
Role	**Associate Director of Safeguarding**
Signature	**Salli Alihodzic**
Email Address	**s.alihodzic@nhs.net**

Return Approved by Accountable lead for Safeguarding Adults

Name	**Sarah Hayes**
Role	**Chief Nursing and Midwifery Officer**
Signature	**Sarah Hayes**
Email Address	sarah.hayes@nhs.net

KMSAB Vision –

"Protect and prevent adults with care and support needs from the risk of abuse, or neglect; supporting and promoting their wellbeing, with all partners working together effectively, ensuring that the safeguarding system is always improving through learning.

Priority 1. Promoting person centred safeguarding - this means putting adults at the centre of our work.
Examples to consider: • In what ways have you been able to use the messages and tools developed by the Board and how did this help to raise awareness of adult safeguarding? • How has hearing from individuals helped you to improve the way you delivered adult safeguarding? • In what ways have you connected with forums/groups to share messages on adult safeguarding and the roles and responsibilities of the Board? What difference did this make. • How do you involve family and friends in safeguarding? • What were the highlights of actions that your agency took during safeguarding adults awareness week? What went well? Do you have any examples of where this made a difference? • Tell us about any community events you have hosted where you shared information on adult safeguarding. • You may want to share a short anonymised case study or any feedback you have received (with permission). • You may also want to share photos of events you have attended (with permission).

Please describe what you have done to meet this priority during 2023-2024

The trust used policy and guidance from the board to inform the formulation of its own local policies, guidance and standard operating procedures. The Safeguarding Operational Group, Safeguarding Matters (Trust News), staff internet and the Safeguarding team social media feed have been used to raise awareness of adult Safeguarding issues across the trust and to local service users

The trust has changed the structure of the Safeguarding team in response to the national feedback from service users in relation to a Think Family holistic approach to Safeguarding. The Trust has sought the views of carers through the work of the patient experience team and developed resources for carers based on their feedback. The Safeguarding Adults team have contributed to the work of the Complaints team in responding to services users concerns in relation to adult safeguarding. From this activity new guidance has been put in place in relation to enhanced care observations, discharge and a customer service approach to communication with patients

We have involved family and friends in the development of patient information leaflets to support how inpatients feel safe and can get support in the hospital. As a Trust we have also consulted the Patient participation action group on the content of our website to ensure it has accessible information to support safeguarding adults. The Trust has links to all the KMSAB leaflets so these can be utilised by our patients and staff

During Safeguarding Adults awareness week the Trust ran a social media campaign, we also ran drop in sessions at the site hubs for staff to drop in. Members of the Safeguarding team walked the wards – handing out leaflets and freebies. They visited as many areas as possible on each site talking to as many staff as possible – asking them about their understanding of each of the themes. They also used this to raise the profile of the safeguarding team and discuss training. The Safeguarding team gave out awards for excellence in safeguarding practice. The Safeguarding team linked with other support services in the hospital like the HIDVA, reachable moments, homeless team and substance misuse service.

Trust_News_1_December_2023 Findings

The Trust hosted a Safeguarding conference this was attended by members of our workforce and representatives from our multi agency partners. The Safeguarding team and practitioners involved have attended learning events following the conclusion of SARs the Trust has been part of.

Priority 2. Strengthening system assurance - How organisations are working together to support adults

Examples to consider:

- What has been the impact of any adult safeguarding assurance activity?
- Tell us about how you have improved multi-agency working.
- Tell us about what you have done to raise awareness of the roles and responsibilities of other partner organisations.

Please describe what you have done to meet this priority during 2023-2024

The Trust improved its mechanism to capture safeguarding activity through a new dataset, which enabled identification of any areas to focus improvement work and safeguarding resources .

This has included a review of the Trust wide adult Safeguarding policy, the development of a Mental Capacity and Deprivation of Liberty Safeguards policy and strengthening of our staff knowledge around escalation. The review of these policies has ensured they are in line with those of the Safeguarding Adults board and represent best evidence-based practice.

There has been new leadership within the trust and establishment of new care groups. The Safeguarding team have transitioned from separate Safeguarding Adults and Children's teams to an All Age Safeguarding team. The Chief Nursing and Midwifery Officer, has supported recently implemented systems and processes, new processes have enabled the Senior leadership teams to have greater understanding, safeguarding oversight and accountability at governance, executive, strategic, operational and frontline levels. The safeguarding governance includes the Safeguarding Assurance Committee, which reports directly to the Quality and Safety Committee and then the Board, therefore, ensuring that all safeguarding activities and risks were cited through this process.

Throughout 2023-2024, the Trust safeguarding Adults specialists saw changes in leadership, newly established policies, systems and processes, were supported by two interim Heads of Safeguarding with the new substantive Head of Safeguarding joining the Trust in January 24.

Throughout the year the Trust has been working to the All Age Safeguarding Deliverables Action Plan and Safeguarding sustainability plan addressing key objectives and actions, with the support of the ICB and National team oversight through SOF 4 measures in place. The Trust has had a focus on accessibility and significant work has been done to improve the identification of patients with learning disabilities and Autism this has included regular multi agency meetings with community care providers and the role out of Oliver McGowan training. The work around health inequalities and inclusion continues.

There has been an increase in the delivery of All age level 3 training over the year, this has meant as a Trust we have met our compliance targets, with a significant increase in levels of adult training compliance across all staffing groups .

The team have worked with local system partners to establish steering groups for Mental capacity, Mental health and more recently learning disabilities and autism. They have also introduced monthly meetings with Local Authority partners to discuss progress of section 42 enquiries, this includes tracking case management and themes

During this time the All age team have set up processes and continue to embed a system of Safeguarding Supervision. The All age team have continued to receive supervision, coaching and TRiM to manage the challenging cases they are involved with.

The Chief Nursing and Midwifery Officer maintains the statutory executive leadership for Safeguarding Adults and continued to attend the Kent and Medway Safeguarding Adults Board (KMSAB) executive meetings and if required delegated the responsibility for this. The Head of Safeguarding, Named Nurses and Safeguarding Specialist Practitioners have engaged with the work of the KMSAB subgroups the Trust remains committed to supporting KMSAB activities. The Trust publicise the work of the KMSAB through the Safeguarding matters newsletter, staff zone and through the mandatory training provided to the workforce. The team have contributed to the work of the board on understanding the roles and responsibilities all agencies through a case study scenario. The roles of partner agencies form an integral part of the training package delivered. The Safeguarding team through an all age duty system support all staff to navigate and understand their role and the roles of other agencies in safeguarding cases.

We have continued our direct daily work with Kent Police around missing vulnerable adults and support the Reachable Moments workers who support young people up to the age of 25 years. In East Kent, we have frequent contact with the Border Force and the Home Office Safeguarding team due to the unique health and safeguarding needs of new arrivals at the ports. The Safeguarding team received a training session from the Home Office Safeguarding team to share learning and experience.

Participation in the in annual Self-Assessment Framework (SAF) and Peer reviews, safeguarding Adults reviews (SARs) and Domestic Homicides Reviews (DHRs) as a member of the SAR and DHR panels, which were all attended by the Heads of Safeguarding has helped inform the work of the Trust through task and finish groups to improve standards in practice.

The Trust also attended the Adult and All Age Health reference group though these they have contributed to a systems-based approach to assurance on health-related activities. These groups help ensure the health system is meeting its statutory responsibilities relating to safeguarding adults.

Priority 3. Embedding improvement and shaping future practice – organisations keep getting better

Examples to consider:

- Provide a specific example of how learning from SARs/internal reviews has improved practice.
- Provide an example of how you have used data in relation to adult safeguarding to inform future planning.
- Tell us about any additional/updated safeguarding adults training/learning events you delivered in response to an identified learning need 2023/2024. Feedback from this.

Please describe what you have done to meet this priority during 2023-2024

A significant amount of improvement work has taken place over the course of the year. This has included work to improve the quality of discharge and discharge plan in response to learning from a SAR. An audit was undertaken following on from the SAR 55 work to integrate the quality of the discharge of patients with complex social needs. The results were presented to our Safeguarding Operational Group, this is being taken forward as a quarterly piece of work recognising the need to maintain standards in this area. Following a thematic review on restraint and learning from serious incident review, new training was procured for staff. The interim mental health lead for the trust, working with system partners has developed a mental health strategy, has been instrumental in developing new guidance around de-escalation, use of restraint and a new mental health policy. The support for adults experiencing mental health challenges alongside other co-occurring conditions has been a system wide challenge. The work of our MCA lead was presented at the KMSAB quality assurance working group. The work came from a CQC action the shared audit work undertaken on MCA and the improvement work that has resulted.

The Trust has developed a safeguarding adult dataset and case management system, it tracks activity and themes so we are able to focus on areas of need. It has also informed the trust safeguarding structure.

The staff zone was used to share learning from completed SARs across Kent , it was also used to share SAR 'Elizabeth Eastley', video for staff learning.

In January the Trust changed the way it completes section 42 enquiries moving them from completion by the Safeguarding team to completion at care group level with quality assurance by the Safeguarding team. This included a training package for staff completing investigating officer reports. It has also involved a high level of safeguarding supervision and wrap around support on completion. These steps were taken so that staff involved are invested in the actions necessary to improve practice and understand the learning. The themes and areas of good practice are shared in the Safeguarding operational groups so as a trust we can learn from good practice and from cases of abuse and neglect. The work of the Safeguarding operational group feeds through to the Safeguarding assurance committee the CMNO as the executive lead for Safeguarding , giving a clear view of safeguarding issues to the Board.

Think Family Safeguarding Champions have been recruited across the Trust. They have additional training throughout the year, they are being supported to identify safeguarding projects for their area to make safeguarding improvements. This team of champions work throughout the trust working to embed a safeguarding culture with support and supervision from the safeguarding team. They are also able to feedback any operational challenges to delivering safeguarding in particular areas across the trust geography.

Maternity safeguarding has been an area of development following on from the external reviews in this area. The named midwife for safeguarding has worked closely with the adult safeguarding team to improve the understanding of adult safeguarding in a maternity context this is supported in the trust Think Family duty system. The Trust have considered co-occurring conditions for families accessing maternity care through the work of the complex maternity cases task and finish group. This group has included representation from perinatal mental health, community teams, learning disability and Autism leads, children's safeguarding, adult safeguarding and the lead for mental capacity and DoLs. The work of the group has included reviewing resources to support families with learning disabilities and autism to assess the implementation of their use in the Trust. The use of inclusive language in maternity resources for families and staff has been explored and modifications made. the use of mental capacity assessments by staff within maternity.

Further evidence of Safeguarding activity throughout Kent and Medway

1. Strategic adult safeguarding issues for organisation over the previous year (April 2023 – March 2024) Please give your organisation's **Top 3 adult safeguarding strategic** issues in the previous year. How did you deal with them? What actions did you take?	1. Demonstrate sustainable safeguarding team workforce that is consistent with the requirements as outlined in the NHSE SAAF and statutory guidance. This has included a review of workforce within the safeguarding team. A new structure, dataset and governance system is now in place. To ensure timely response and investigation of what safeguarding activity is taking place, how it is recorded and how this is monitored and used for assurance is now clear and benchmarks in line with statutory expectations 2.Demonstrate up to date safeguarding polices that are consistent with statutory guidance and NHSE SAAF requirements relating to both children and adults. Trust policies in relation to safeguarding have been updated in line with available evidence base, local and national standard and are tracked. 3. Demonstrate a clear training and competency trajectory for all levels to ensure that the Trust achieves its statutory duties relating to this at all Care Group levels. A training needs assessment was completed and delivery of training increased to ensure the workforce are compliant with the intercollegiate requirements .
2. Any safeguarding priorities your organisation would like added to the KMSAB forward plan for 2024-2025	Addressing the impact of health inequalities on delivery of adult safeguarding Promotion of trauma informed practice into local safeguarding delivery Clear escalation process regarding delayed discharge for patients awaiting a care package/placement

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Nurse Staffing Establishment Review for In-Patient Wards, Acute Medical Units (AMUs) and Emergency Departments (EDs) (September - November 2024)**

Meeting date: **3 April 2025**

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

Paper Authors: **Joint Lead Nurse for Workforce and Education, ADoN for Workforce and Education for Nursing, Midwifery and AHP & Deputy Chief Nurse**

Appendices:

Appendix 1: National Quality Board Gap Analysis
Appendix 2: Bed capacity included in the establishment review
Appendix 3: Summary of Current and Proposed Nursing Establishments with Safer Nursing Care Tool (SNCT) Recommendations and Quality Metrics (for In-Patient Wards and AMUs)

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The purpose of this report is to provide assurance to the Trust Board that the Trust biannual establishment review process complies with the Developing Workforce Safeguards (NHSI 2018) and the National Quality Board Guidance (2016) on Safe, Sustainable, and Productive Staffing. The report provides an overview of the methodology used to review the staffing establishments for adult and children's In-patient ward areas, and EDs and presents the findings of the review. It also identifies where service changes have been made to areas (since the last review), and advises of the staffing requirements for these.
Summary of key issues:	• The January 2024 establishment review was delayed at several stages in the Trusts governance process and was presented and approved at Board in December 2024, with implementation taking effect in the rosters from 27 January 2025. • This review provides the outcome of the review undertaken between September - December 2024. • Areas that have had a change in function since the last review have been reassessed with a one area (William Harvey Hospital (WHH) Kings C1) being recommended to be increased by 5.24 Whole Time Equivalent (WTE). • Changes from the previous review are still being processed in the ledger and Electronic Staff Record (ESR). • Substantive recruitment activity commenced in December 2024, with a clear expectation this will eliminate the need for temporary staffing, unless there are exceptional circumstances and as agreed by the CNMO.
Key recommendations:	The Board of Directors is invited to:

	1. **NOTE** the content of the report and process and methodology behind the review; 2. Receive **ASSURANCE** that the safer staffing review has been undertaken in accordance with national guidance; and 3. **APPROVE** the recommendations made within the review.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Sustainability
Link to the Trust Risk Register:	**CRR 116** - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs. **CRR 68** – Risk to the delivery of the operational constitutional standards and undertakings **CRR 76** - Care is potentially compromised as a consequence of staffing not meeting planned numbers per shift **CRR 84** – Lack of timely recognition and response to the deteriorating patient
Resource:	N
Legal and regulatory:	Yes - National Quality Board Guidance & Care Quality Commission
Subsidiary:	N

Assurance route:

Previously considered by: Nursing & Midwifery Executive Committee 11 February 2025
Clinical Executive Management Group 19 February 2025
Quality and Safety Committee 25 March 2025

1. Purpose

1.1 This paper demonstrates how the Trust complies with the National Quality Board (NQB) requirement for a bi-annual strategic review of nursing and midwifery establishments.

1.2 It provides Trust Board with assurance of the work in progress to assess, monitor and manage levels of nursing and midwifery staff in the Trust and highlights any areas of concern.

1.3 It evidences our current level of compliance with the NQB guidance as outlined within the Developing Workforce Safeguards (2018) paper.

1.4 It provides the findings of the reviews which were completed across September 2024.

1.5 It outlines the recommendations, from the Chief Nurse on safe staffing levels across adult and children inpatient wards and EDs following this review.

1.6 It demonstrates the financial implications of these recommendations.

2. Background

2.1 In 2021, the Trust reviewed nursing workforce establishments and adjusted in-patient ward staffing levels to reflect national guidance and the Trust priorities. The business case at this time acknowledged the need to improve ward leadership, including nurse in charge status and 'right size' the workforce to enable safe patient care and sought investment of 369.32 WTE Registered Nurses (RNs) and 1.13 WTE Healthcare Support Worker (HCSW) for ward areas and AMUs only.

2.2 In January 2024, the Trust reviewed current staffing which involved a rigorous approach, using an updated version of SNCT© to capture changing patterns of patient acuity and dependency alongside more detailed professional judgement discussions with clinical staff. The staffing review also considered the staffing requirements of the EDs which did not form part of the 2021 review/business case.

2.3 The January 2024 staffing review included the approval of additional investment to staff adult inpatient wards, paediatric inpatient wards, AMUs and EDs including a staffing approach for the escalation and overflow areas in ED; a phased introduction of Registered Nursing Associates (RNAs); and the aspiration to achieve a phased increase in uplift from 22% to 25% for in-patient ward areas and AMUs by 2027/28 and from 25% to 27% in EDs by 2026/27.

2.4 This review was delayed at several stages in the Trust's governance process and was presented and approved at Board in December 2024, with implementation taking effect in the rosters from 27 January 2025.

2.5 The Trust is now in the process of recruiting to the approved January 2024 workforce establishment review.

2.6 It should be noted that it is recommended that SNCT© data collection is undertaken twice per year, six months apart. The September data collection was slightly later than anticipated owing to changes within the senior nursing workforce team.

2.7 Future SNCT© data collections will be achieved in January and June, allowing for seasonal variation to be captured.

3. Care Hours Per Patient Day (CHPPD)

3.1 For inpatient areas, the CHPPD for EKHUFT is 9.6 compared to a peer median of 7.9 and a provider median of 8.6 (based on September 2024 data) on Model Hospital as detailed in the graph (fig.1) below.

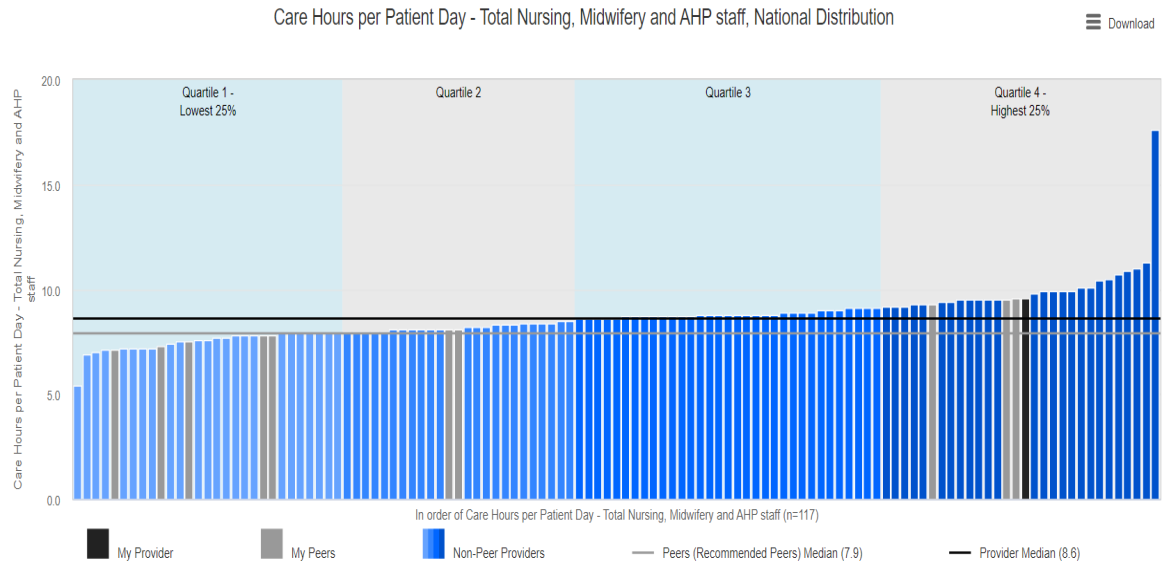


Figure 1 – Care Hours per Patient Day (Model Health System)

3.2 Improvement has been seen in the Trust's position for CHPPD but it is acknowledged that there is further potential for improvement. Further work is being undertaken to realign budgets and ESR to separate inpatient activity and clinic-based activity, which will provide increased accuracy and consistency to future CHPPD.

4. Setting evidence-based nursing Establishments

4.1 In line with the National Quality Board (NQB) guidance, nursing establishments at EKHUFT adult and children inpatient areas will be reviewed bi-annually; the Chief Nurse has also requested that ED is completed. This enables seasonable variance to be captured and reviewed appropriately.

4.2 It recommends a 'triangulated approach' and requires the provider to use evidence-based tools, professional judgement and outcomes to ensure the "right staff with the right skills are in the right place at the right time".

4.3 EKHUFT has chosen to use the Shelford Group Safer Nursing Care Tools (SNCT©) as its evidence-based workforce tool. The Trust holds the licences for Adult inpatient wards, Acute Assessment Units, Children's and young people, and ED; all were used in this review.

4.4 The Shelford Group SNCT© for adult In-Patient Wards and adult Acute Assessment Units in Acute Hospitals includes enhanced care needs in the acuity and dependency levels of patient care.

4.5 The SNCT© for Children and Young People is due to be updated and currently does not include any additional levels of care.

4.6 SNCT Masterclass training was provided through booking on ESR for all ward managers, matrons and nominated data collectors to attend as initial or refresher training to ensure adherence to the data collection process.

4.7 Furthermore, to comply with the NQB guidance, the following processes were adhered too:

- Staff were knowledgeable of the acuity and dependency levels through completion of the inter-rater reliability assessment.
- Only three data collectors were selected, the Ward Manager and two Band 6/senior Band 5 Registered Nurses (RNs).
- Data collection was undertaken for 30 days in adult in-patient wards, AMUs and children and young peoples' in-patient wards.
- Data collection was undertaken for 12 days in ED at the set twice daily times until the 24-hour period was captured. In line with the guidance the data collection was only for patients who had been in the department for less than 12 hours.
- External verification was completed by Matrons from different specialities within the care groups.

4.8 The Trust's current state of compliance with the National Quality Board guidance is outlined in Appendix 1, with details of actions currently being undertaken to achieve full compliance.

5. Maternity Services

5.1 Staffing for Maternity is assessed using Birth rate Plus®

5.2 The Birth rate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery, and the immediate post-delivery period, utilising the accepted standard of one midwife to one woman, in order to determine the total midwife hours, and therefore staffing required, to deliver midwifery care to women across the whole maternity pathway using National Institute for Health and Care Excellence (NICE) guidance and acknowledged best practice[1].

5.3 A full review using Birth rate Plus® was completed in 2024 with the baseline data being reviewed from 2023.

5.4 The report is currently being taken through the Trust governance process. **Establishment Review for existing adult and children's Inpatient areas & ED September 2024**

[1] Birth rate plus: What it is and why you should be using it. Royal College and Midwives

6.1 In-patient ward and AMU data collection began on 2 September 2024 and was completed on 1 October 2024.

6.2 ED data collection began on the 9 September 2024 and was completed on the 20 September 2024.

6.3 The results of the SNCT© were then analysed for each clinical area manually by the Joint Lead Nurse for Workforce and Education (Safe Staffing). The SNCT© data used in the review included a 22% uplift allowance for adult and paediatric inpatient wards and AMUs and a 25% uplift allowance for the EDs, as agreed in the January 2024 review

6.4 SNCT© results were presented in a pack to the senior leadership team for each clinical area with inclusion of workforce and quality indicators.

6.5 Check and confirm meetings were held with each clinical area during November/December 2024.

6.6 All check and confirm meetings were led by the Deputy Chief Nurse, Workforce, Strategy and Professional Standards.

6.7 Ward Managers, Matrons, Heads of Nursing, Associate Directors of Nursing, Directors of Nursing/Midwifery, Finance Leads, Human Resources Business Partners, and the Healthroster team were all invited to the meetings for their relevant areas of responsibility.

6.8 In attendance at the check and confirm meetings were Ward Managers, Matrons, Heads of Nursing, Associate Directors of Nursing (ADoN), Directors of Nursing/Midwifery and Workforce representatives. There was no attendance from Finance Leads, Human Resources Business Partners and only partial attendance from the Healthroster team.

6.9 During the check and confirm meetings, the current staffing rosters and funded establishment were considered alongside quality and safety metrics, current staffing utilisation, the SNCT© recommendations, changes to service and professional judgement.

6.10 The recommendations from the SNCT© data collection was reviewed and each Ward Manager was asked to verify that the patient acuity and dependency data over the SNCT© collection period was truly representative. The majority of areas agreed that it was, however where this was not the case this was recorded and explored in detail during the meeting.

6.11 National guidance on safe staffing for clinical specialties was considered, where relevant.

6.12 Individual ward environments and layouts were also considered during the meetings.

6.13 The quality metrics considered for each adult and child in-patient were: statutory training; mandatory training; Infection Prevention and Control (IPC) compliance; inpatient falls; medication errors; pressure ulcers; red flags; CHPPD; compliments; formal and informal complaints staff vacancies; and sickness / absence rates.

6.14 The quality metrics considered for each ED area were: statutory training; mandatory training; IPC compliance; initial assessment; sepsis screen; medicine errors; compliments; formal and informal complaints; staff vacancies; turnover; and sickness / absence rates.

6.15 The bed capacity included in the establishment review is detailed in Appendix 2.

6.16 In several of the ward areas there are also additional services in operation that are provided from within the clinical area's budget. The SNCT© tool does not consider additional services/clinic activity, so this was not included as part of this review and will be reviewed separately as part of the outpatient review being undertaken in January 2025. (Details of the wards with clinics are recorded in Appendix 3)

6.17 Following these detailed discussions, agreement was reached on the proposed staffing rosters for each in-patient area. For clinical areas where this agreement was not made at the check and confirm meeting, conversations and outcomes were shared and included.

6.18 As the Trust is still working through the National profile change of Band 2/3, these are not detailed within this review, however, will be part of the review which commenced in January 2025.

7.0 Overview by care group

7.1 For the majority of the inpatient wards there was minimal change proposed. In clinical areas whereby change is suggested this will be further reviewed at the next SNCT data collection due in January 2025.

7.2 SNCT data and quality indicators information shared at the check and confirm meetings are in Appendix 3 for the Inpatient areas.

7.3 William Harvey Hospital care group (excluding ED)

7.3.1 All areas were discussed over a 4-day period chaired by the Deputy Chief Nurse and supported by the Director of Nursing (DoN) for some of the meetings, and delegated responsibility to the ADoN for the remainder.

7.3.2 Quality and safety concerns were identified across several of the wards and supported informed decisions regarding staffing as detailed further below.

7.3.3 **For the following inpatient ward areas, the recommendation is to remain the same; Bartholomew, CCU at WHH, Cambridge J1, Cambridge J2, Cambridge M1, Cambridge M2 Kennington, Kings A2, Kings B, Kings C2, Kings D1, Kings D2, Oxford, Richard Stevens Unit.**

7.3.4 AMU services were reconfigured in November 2024 to AMU A, AMU B and Same Day Emergency Care (SDEC). Part of the rationale for this decision was owing to the quality and safety concerns identified within the areas. **Professional judgement was used at the check and confirm meetings to determine the staffing for each of these areas, using the proposals accepted in the January 2024 review for the previous configuration of the assessment units.**

7.3.5 Cambridge K quality indicators have been of concern and an action plan is in place to address. A substantive ward manager has been recruited and the care group are monitoring closely to determine if any further changes are required.

7.3.6 Kings C1 was decreased by a registered nurse during the day and the night in the January 2024 review, this has been raised as a risk owing to the increased acuity within the area with associated concerns over quality indicators. **The recommendation is for the RN to be returned to previous levels which equates to 5.24 WTE.** The data also indicates an increased level of dependent patients with high levels of enhanced care required to maintain patient safety and quality of care. Area is high for falls risk and action plans implemented to reduce pressure ulcer associated harm. **Recommended for the HCSW to stay the same currently with close monitoring by care group.**

7.3.7 Following the decision to separate the staff from Kings D1/D2 into two separate wards professional judgement was further applied with and the **recommendation is to reduce the HCSW at night on D1 to 2 and increase the HCSW at night on D2 to three**.

7.3.8 **A decrease in establishment by one HCSW per day shift is recommended for Coronary Care Unit (CCU) Queen Elizabeth the Queen Mother Hospital (QEQM)** following identification of improved change in pathways.

7.3.9 Recommendation for Richard Stevens is to remain the same, however, RADU and Hot clinic booking of staff needs to be in a separate budget.

7.3.10 Kennington is recommended to stay the same and staff need to be protected to remain in this area to support the complexity of two specialities.

7.3.11 Cambridge J2, whilst recommended to stay the same overall does require implementation of a band 6 24/7 which the care group are going to review.

7.3.12 Cambridge L are going to trial implementing a HCSW instead of using temporary registered nurse with the care group monitoring impact on quality indicators and address if required.

7.4 QEQM Care Group

7.4.1 **As noted in the January 2024 review several areas on this site were reconfigured during the last review and therefore professional judgement was predominantly used to determine the establishment set. Some of these areas ae still evolving and again where this is occurring professional judgement was heavily relied upon.**

7.4.2 **For the following inpatient areas, the recommendation is to remain the same; AMU A, AMU B, Bishopstone, Cheerful Sparrows Male, Cheerful sparrows female, Deal, Sandwich Bay, Fordwich, Seabathing and St Margarets.**

7.5.3 Quex ward has seen a considerable change following the last review with 12 trollies/chairs now being utilised within two bays for frailty assessment during the day and transferring to beds overnight. There are further plans to expand this service if successful. Recommendation to

remain the same however as service is proposed to expand this will need a full review by the care group, with approval from the chief nurse, prior to implementation.

7.5.4 St Augustines data indicates an increased level of dependent patients with an increase in therapeutic care needs of patients in this area. The service seeks to explore and introduce the role of the therapy HCSW within the ward team. **Recommendation to remain the same currently.**

7.5 Kent & Canterbury (K&C) Care Group recommendations for In-patient Wards

7.6.1 For the following inpatient areas the recommendation is to stay the same; Kingston, Marlowe, Clarke, Invicta, Mount McMaster, Kent, St. Lawrence, Harvey.

7.6.2 A full service review is being undertaken on Harbledown ward to provide assurance of compliance against standards for stroke services.

7.6 Women, Children & Young People (WC&YP) Care Group

7.6.1 Birchington currently has inpatient and outpatient activity being undertaken within it. The budget still requires separating, with the inpatient area being aligned to the recommendations approved in the January 2024 review. An increased dependency is noted at night owing to the number of outliers being placed within the ward. **The recommendation is to remain the same** and the HoM to authorise an extra HCSW, when assessed as required, to support the temporary change in patient group and therefore increased dependency within the ward.

7.6.2 Following the check and confirm meetings for the children's and young person's wards, **the recommendation is to stay the same** with the intention to work towards a split of budgets to accurately reflect establishment against inpatient and outpatient activity. Post-split the establishment will be able to be reviewed with accuracy.

8.0 Diagnostics, Cancer and Buckland (DCB) Care Group

8.1 Brabourne is a small inpatient ward with capacity for eight beds. It is recognised by Imperial College that SNCT© may not be accurate for a ward of this bed capacity so is to be relied upon with caution.

8.2 Following the check and confirm meeting, the overall WTE establishment for Brabourne ward **is recommended to stay the same**. The ward will be trialling a HCSW at night instead of two during the day and will monitor impact on quality indicators.

9.0 **Critical Care, Anaesthetics and Specialist Surgery (CCASS) Care Group**

9.1 Following the check and confirm meeting the **recommendation for Rotary ward is to remain the same.**

10.0 Emergency Department Nurse Staffing

There are two EDs in the Trust, one at WHH and the other at QEQM.

10.1 There has been an increase in patient activity and high numbers of patients categorised as 'Decision to Admits' (DTAs) remaining in the department for more than 12 hours, resulting in patients still being cared for in identified escalation spaces and corridors.

10.2 Data was collected for the first time using the Safer Nursing Care Tool (SNCT©) for EDs.

10.3 It should be acknowledged that the ED SNCT© recommendation for staffing carries limitations as it only accounts for the real-time assessment of a patient once within the first 12 hours of being within the department. The ED SNCT© tool doesn't account for fluctuations in the patient's level of care during their time in ED and for patients who are within the department for longer than 12 hours and therefore does not reflect the overall number of patients who are in the ED at any one time. Therefore, it is recommended an information provided is used with extreme caution if the department is experiencing significant DTAs during collection, which both WHH and QEQM EDs were.

10.4 Data to show the live accumulative patient activity during the data collection period was obtained from the Trust Business Intelligence Team to support the SNCT© recommendations.

10.5 Current staffing includes the assumption that corridor and overflow areas will continue to be staffed with temporary staffing as these are not clinically appropriate areas. These areas are being reviewed through the Trust's productivity programme.

10.6 Detail of the check and confirm meetings is concluded in Appendix 3 for ED.

11.0 **Adult ED WHH**

11.1 The SNCT recommends a significant decrease in establishment, which as advised above was noted with caution. ED had 9 medicine errors, 9 formal complaints and the initial assessment was recorded as 70% completed within time. Its staff turnover, sickness and statutory and mandatory training are within expected thresholds. **The recommendation is for the budgeted establishment to remain at its current point owing to this being the first-time data has been collected and the changes following the January 2024 had not yet being implemented.** Consideration is being given to including registered mental health nurses within the establishment

12.0 Children's ED WHH

12.1 Some of the quality indicators for ED are currently unable to be separated however those that can are reflected. Children's ED had 82% compliance with sepsis screening, 21.1% vacancies, 33% turnover, low sickness, are compliant with statutory training however mandatory training was at 84.3%. **The recommendation is for the budgeted establishment to remain at its current point owing to the changes following the January 2024 had not yet being implemented.**

13.0 Adult ED QEQM

13.1 The SNCT recommends a significant decrease in establishment, which as advised above was noted with caution. ED had seven medicine errors, six formal complaints, 90% compliance with sepsis screening and the initial assessment was recorded as 96% completed within time. Its

vacancies were 10%, sickness was 8.93% and mandatory training 89.2% with turnover and statutory training within expected thresholds. **The recommendation is for the budgeted establishment to remain at its current point owing to this being the first-time data has been collected and the changes following the January 2024 had not yet being implemented.** Consideration is being given to including registered mental health nurses within the establishment.

14.0 Children's ED QEQM

14.1 Some of the quality indicators for ED are currently unable to be separated however those that can are reflected. Children's ED had 90% compliance with sepsis screening, 6.6% vacancies, sickness was at 5.43%, are compliant with statutory training and mandatory training and turnover is within expected levels. **The recommendation is for the budgeted establishment to remain at its current point owing to the changes following the January 2024 had not yet being implemented.**

15.0 Financial Implication

15.1 The only change proposed is to Kings C1 at WHH, however following the professional judgement review for other areas at WHH no additional funding is required for the site.

16.0 Conclusion

16.1 The Trust Board is asked to acknowledge the bi-annual evidence-based nurse staffing review process undertaken in the Trust, confirm assurance it complies with developing workforce safeguards and approve the recommendations made.

16.2 Substantive recruitment to the previously approved staffing establishments is being managed in line with Trust's current workforce policies and procedures and will enable better quality and continuity of patient care and eliminate the need for temporary staffing, unless there are exceptional circumstances and as agreed by the CNMO.

16.3 Work continues to align the ledger and ESR to the approved January 2024 establishment review.

Appendix 1: National Quality Board Gap Analysis

Expectation 1	COMPLIANCE	EVIDENCE	ACTIONS
RIGHT STAFF			
1.1 Evidence based workforce planning	YES	Annual establishment reviews undertaken in line with Shelford Group Safer Nursing Care Tools (SNCT©) and compliant with the Developing Workforce Safeguards (2018) and National Quality Board guidance (2016) for safe, sustainable and productive staffing.	A full safe staffing review of in-patient wards, acute assessments units and ED's undertaken. 6 month bi-annual workforce establishment review to be undertaken in accordance with guidance – January and July SNCT data collection.
1.2 Professional Judgement	YES	Professional judgment applied alongside the evidence based SNCT©. This is particularly relevant when considering skill mix in areas and new roles in practice.	Professional judgement conversations held with nursing senior leadership teams to review SNCT© recommendations and consider patient and staff outcomes at the check and confirm meetings.
1.3 Compare staffing with peers	YES	Reporting and benchmarking monthly CHPPD against peers using Model Hospital. CHPPD being applied at granular level of the organisation through understanding and compliance of the system SafeCare.	Monthly unify data submitted to NHSE with narrative. CHPPD reported in monthly Board Integrated Performance Report (IPR). Monthly CHPPD data reviewed on Model Hospital to benchmark against peers and nationally. Monthly CHPPD data made accessible on Trust public facing webpage. To further embed knowledge of CHPPD across organisation.

Expectation 2	COMPLIANCE	EVIDENCE	ACTIONS
RIGHT SKILLS			
2.1 Mandatory training, development and education	Yes	Workforce establishments calculated within SNCT© at 22% for inpatient wards/AMU's and 25% for EDs in line with Royal College of Nursing (RCN) guidance and National best practice. Mandatory training available and bookable via ESR system.	Compliance with mandatory training is monitored through the Nursing Scorecard and Trust Dashboard by Care Group DoNs and ADoNs. Compliance of mandatory and statutory training discussed at monthly Key Performance Indicator (KPI) meetings and in bi-annual check and confirm meetings.
2.2 Working as a multi-professional team	YES	Commitment to investing into the role of the Registered Nursing Associate role and supporting using Apprenticeship levy. Commitment to aligning all Enhanced, Specialist, Advanced and Consultant roles.	EKHUFT promotes multi-professional team working and innovation. Emergency Surgical Ambulatory Clinic (ESAC) review undertaken with policy implemented and alignment of level of practice applicable to roles and banding being achieved.
2.3 Recruitment and Retention	Yes	Recruitment and retention to be reviewed by new CNMO workforce team. To ensure Trust achieving equality and diversity, plus enhancing opportunities of recruitment and ensuring that support is available for all new staff.	Corporate Workforce Development Education and Training (WDET) team has been reviewed and expanded to support Trustwide initiatives to enable successful recruitment and retention for our future workforce. Collaborative working with Equality Diversity and Inclusion (EDI) lead to ensure value-based recruitment and opportunities for career development. Restorative Clinical Supervision available to staff across workforce from a Professional Nurse Advocate. Pastoral Care team engaged in enabling retention across all roles within the workforce.

Expectation 3	COMPLIANCE	EVIDENCE	ACTIONS
RIGHT PLACE AND TIME			
3.1 Productive working and eliminating waste	Yes	Site Triumvirates review patient flow regularly and redeploy staff as required to mitigate risk and maintain safety.	Safe staffing policy includes escalation processes to guide staff. Red shift escalation process to be embedded. Nursing Scorecard developed with BI to support senior leads to monitor workforce data, including use of temporary staffing, and triangulate with quality of care.
3.2 Efficient deployment and flexibility	Yes	Daily SitRep completed by each Care Group to support safe patient care across all clinical areas, with redeployment of staff actioned as necessary to mitigate staffing shortfalls. Use of SafeCare Live to support real-time decision making for care groups, site team and senior leaders in the organisation. All in-patient areas (non-critical care) have SafeCare in place.	Safe Care masterclasses including appropriate use of red flags are available and bookable via ESR. SafeCare “sunbursts” being used at morning site meetings to support appropriate deployment of staff based on acuity and dependency, and not just staffing numbers. Nursing and Midwifery Workforce KPI meetings held monthly by the CNMO/delegated to DCN to monitor clinical areas compliance, with consideration of impact of deployment of staff. BI powered Nursing Scorecard with key metrics available to triangulate staffing position and BI powered Nursing Planning Tool to support efficient senior leadership and oversight of rosters and staffing deployment.
3.3 Efficient employment and minimising agency	Partial – Some bank and agency usage.	EKHUFT utilises NHS Professionals for Bank staff and ID Medical for agency staff. Minimal HSCW agency in use across in-patient wards.	Actively advertising and recruiting to vacancies across Trust following approval of January 2024 workforce establishment review. Monitoring temporary staffing usage with consideration of impact on quality of care.

Appendix 2 Bed capacity included in the establishment review

	Care Group	Beds - Funded	Escalation / unfunded beds	Total Bed included in establishment review
K&C - Wards				
BRABOURNE WARD	DCB	8		8
CLARKE WARD	KCH	36	6	42
HARBLEDOWN WARD	KCH	24		24
INVICTA T&O WARD	KCH	24		24
KENT WARD	KCH	28	3	31
KINGSTON WARD	KCH	26		26
MOUNT & MCMASTER WARD	KCH	22	4	22
HARVEY WARD	KCH	19		19
MARLOWE WARD	KCH	27	4	27
ST LAWRENCE WARD	KCH	24		24
TOTAL K&C IP WARDS		**238**	**17**	**238**

	Care Group	Beds - Funded	Escalation / unfunded beds	Total Bed included in establishment review
QEQM - Wards				
BIRCHINGTON WARD	WCYP	19	1	19
BISHOPSTONE WARD	QEQM	22	2	22
CHEERFUL SPARROWS WARD FEMALE	QEQM	32		32
CHEERFUL SPARROWS WARD MALE	QEQM	17		17
CORONARY CARE UNIT	WHH	12	1	12
DEAL WARD	QEQM	28	3	28
FORDWICH WARD	QEQM	19	4	19
QUEX MEDICAL WARD	QEQM	22		22
RAINBOW WARD	WCYP	20	3	20
SANDWICH BAY FRAILTY WARD	QEQM	6	17	23
SEABATHING WARD	QEQM	30	2	30
ST AUGUSTINE'S WARD	QEQM	28	3	28
ST MARGARET'S WARD	QEQM	24	3	24
TOTAL QEQM IP WARDS		**279**	**39**	**296**

	Care Group	Beds - Funded	Escalation / unfunded beds	Total Bed included in establishment review
WHH - Wards				
BARTHOLOMEW UNIT	WHH	22		22
CAMBRIDGE J1 WARD	WHH	20		20
CAMBRIDGE J2 WARD	WHH	19		19
CAMBRIDGE K WARD	WHH	27		27
CAMBRIDGE L WARD	WHH	26		26
CAMBRIDGE M1 WARD	WHH	18		18
CAMBRIDGE M2 WARD	WHH	19		19
CORONARY CARE UNIT	WHH	10		10
KENNINGTON WARD	WHH	15		15
KINGS A2 WARD	WHH	20		20
KINGS B WARD	WHH	23	1	23
KINGS C1 WARD	WHH	27		27
KINGS C2 MEDICAL WARD	WHH	24		24
KINGS D1 MALE	WHH	25		25
KINGS D2 FEMALE	WHH	19		19
OXFORD WARD	WHH	14		14
PADUA WARD	WCYP	28	3	28
RICHARD STEVENS WARD	WHH	24	4	24
ROTARY SUITE	CCASS	16		16
TOTAL WHH IP WARDS		**396**	**8**	**396**
TOTAL IP BEDS		**913**	**64**	**930**

Appendix 3: Summary of Current and Proposed Nursing Establishments with SNCT Recommendations and Quality Metrics (for In-Patient Wards, AMUs and EDs)

ED Recommendations

Ward Name	Care Group	Budget code	Initial assessment within 15 mins	Sepsis screen *	Falls	Medication Errors	Complaints	Complaints	Turnover	Vacancies	Sickness	Current Establishment			SNCT Recommendation (25%)			Indicative of activity	Skill Mix	Final Proposed 25%			Outcome
												RN	HCSW	Total	RN	HCSW	Total			RN	HCSW	Total	
Emergency Department	QEQM	1606	96%	90%	7	7	11	6	6.50%	10.00%	5.93%	132.56	56.27	188.83	49.8	12.4	62.2	No	70/30	132.56	56.27	188.83	Same
Paediatric Emergency Department	QEQM	1656			N/A				6.70%	6.60%	5.43%	21.78	8.05	29.83	12.2	3	15.2	No	73/27	21.78	8.05	29.83	Same
Emergency Department	WHH	1605	70%	82%	10	9	0	9	9.30%	3.20%	2.70%	147.14	60.72	207.86	57.2	14.3	71.5	No	71/29	147.14	60.72	207.86	Same
Paediatric Emergency Department	WHH	1655	68.4%		N/A				33.00%	21.10%	3.02%	18.78	8.05	26.83	17.4	4.4	21.8	No	70/30	18.78	8.05	26.83	Same

AMU Recommendations

Ward Name	Care Group	Beds	Falls	Medication Errors	Pressure ulcers	Complim ents	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Skill Mix	N:P ratio	Proposed Final 22%			Outcome
													RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
ACUTE MEDICAL UNIT A - QEQM	QEQM	30	5	1	2	0	1	10.10%	8.10%	2.80%	0	9.1	52.1	19.08	71.18	42.07	22.65	64.72	Yes	66/34	1:3.75	44.5	20.95	65.45	Decrease
ACUTE MEDICAL UNIT B - QEQM	QEQM	23	4	2	1	0	1	5.70%	6.80%	9.70%	6	9	35.13	18.33	53.46	30.99	16.69	47.67	Yes	63/37	D 1:3.3, N 1:4.6	34.65	18.33	52.98	Decrease
ACUTE MEDICAL UNIT - AMU A	WHH UEAM	17 + 8 AAU	1	1	1	0	2	6.30%	2.30%	5.10%	35	24.8	115.74	48.64	164.38	59.83	32.22	92.05	Partial	70/30	1:3.6	37.27	15.71	52.98	Decrease
ACUTE MEDICAL UNIT - AMU B	WHH UEAM	26	2	0	4															70/30	1:3.7	37.27	15.71	52.98	
ACUTE MEDICAL UNIT - SDEC	WHH UEAM		1	1	0															69/31		21.55	10.48	32.03	
TOTAL AMU WHH			4	2	5																	5		142.99	

CCASS Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medicati on Errors	Pressure ulcers	Complim ents	Complain ts	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicativ e of activity	Skill Mix	N:P ratio	Proposed Final 22%			Outcome
															RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
ROTARY SUITE	CCASS	ENT	16	Yes	3	1	0	25	0	2.60%	4.81%	10.20%	7	9.90	**25.15**	**17.73**	**42.88**	21.56	11.61	33.16	Yes	62/38	D 1:3.2, N 1:4	**25.15**	**17.73**	**42.88**	Same

K&C Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Complim ents	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Skill Mix	N:P Ratio	Proposed Final 22%			Outcome
															RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
CLARKE WARD	KCH	Surgical	36 + 6	No	2	0	3	0	0	11.20%	11.30%	5.90%	0	7	32.03	18.33	50.36	31.06	16.73	47.79	Yes	65/35	D 1:5.1 N 1:6	32.03	18.33	50.36	Same
HARBLEDOWN WARD	KCH	Stroke	24	No	6	1	3	0	0	3.80%	9.2%	1.70%	3	10.1	46.12	15.71	61.83	27.14	14.62	41.76	Yes	56/44	D 1: 4.8 N 1:6	46.12	15.71	61.83	Same - undertake service review
INVICTA T&O WARD	KCH	T&O	24	Joint school & Telephone clinic	3	3	0	53	1	5.70%	13.4%	12.14%	1	10.3	21.83	13.09	34.92	18.79	10.12	28.91	Yes	69/31	D 1:3.4 N 1:8	21.83	13.09	34.92	Same
KENT WARD	KCH	Vascular	28+3	No	10	4	1	0	0	4.60%	5.8%	3.00%	1	6.9	27.79	15.71	43.5	29.72	16	45.72	Yes	70/30	D 1:4.7 N 1:7	27.79	15.71	43.5	Same
KINGSTON WARD	KCH	Stoke	26	No	5	1	1	94	1	0.00%	8.2%	5.60%	10	8.6	32.83	18.33	51.16	28.81	20.95	49.76	Yes	58/42	D 1:3.7 N 1:6.5	32.83	18.33	51.16	Same
MOUNT & MCMASTER WARD	KCH	Medical	22+4	No	2	2	1	18	0	8%	11.8%	6.80%	0	9.1	29.41	15.71	45.12	22.26	11.99	34.25	Partial	63/37	D 1:4.40 N 1:5.2	29.41	15.71	45.12	Same
HARVEY WARD	KCH	Neuro	19	No	2	0	0	109	1	3%	5.5%	6.00%	3	8.9	24.17	13.09	37.27	23.51	12.66	36.17	Yes	64/36	D 1:3.8 N 1:4.8	24.17	13.09	37.27	Same
MARLOWE WARD	KCH	Renal	27+4	Day case & Dialysis bay	2	2	1	25	1	5.80%	7.7%	5.10%	3	6.8	34.45	17.1	51.55	25.5	13.73	39.23	Partial	66/34	D 1:4.9 N 1:6.8	35.6	18.5	54.1	Increase
ST LAWRENCE WARD	KCH	MFFD	24	No	3	2	1	0	0	5.60%	9.1%	5.10%	11	7.1	21.55	13.09	34.65	27.29	14.69	41.98	Yes	62/38	D 1:4.8 N 1:8	21.55	13.09	34.65	Same

QEQM Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Complim ents	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Skill Mix	N:P ratio	Proposed Final 22%			Outcome
															RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
BISHOPSTONE WARD	QEQM	Surgical	22+2	No	5	2	1	40	0	12.50%	7.2%	5.40%	1	7.4	23.26	13.09	36.35	28.20	15.19	43.39	Yes	69/31	D 1:4.8, N 1:6.0	23.26	13.09	36.35	Same
CHEERFUL SPARROWS WARD FEMALE	QEQM	Surgical	32	No	7	2	0	6	0	11.30%	12.1%	6.70%	12	6.7	32.03	20.95	52.98	32.08	17.27	49.35	Yes		D 1:4.6, N 1:5.3	34.65	20.95	55.60	Increase
CHEERFUL SPARROWS WARD MALE	QEQM	Medical	17	No	1	0	1	49	0						18.93	10.48	29.41	18.66	10.05	28.70	Yes	64/36	D 1:4.3, N 1:5.7	18.93	10.48	29.41	Same
DEAL WARD	QEQM	Medical	28+3	No	3	3	2	29	0	8.40%	5.6%	7.80%	6	7.1	29.41	18.33	47.74	34.29	18.47	52.76	Yes	66/34	D 1:5.2, N 1:6.2	29.41	18.33	47.74	Same
FORDWICH WARD	QEQM	Respiratory/NIV	19+4	No	3	0	1	161	1	30.80%	11.7%	8.60%	12	8.6	34.71	15.71	50.42	28.18	15.18	43.36	Yes	70/30	D 1:3.8, N 1:4.6	29.41	15.71	45.12	Decrease
QUEX MEDICAL WARD	QEQM	Frailty	22+8 chairs	Yes	8	0	2	0	2	5.50%	-26.5%	3.90%	5	8.0	22.11	16.19	38.30	27.81	14.97	42.78	No	66/34	D 1:5.5, N 1:5.5	24.17	18.33	42.5	Increase
SANDWICH BAY FRAILTY WARD	QEQM	Medical	6+17	No	2	5	0	0	1	14.70%	-92.4%	5.20%	2	7.9	24.17	15.71	39.88	28.33	15.25	43.58	Yes	61/39	D 1:4.6, N 1:5.75	24.17	15.71	39.88	Same
SEABATHING WARD	QEQM	Surgical	30+2	No	3	3	9	280	2	11.00%	8.1%	3.00%	4	6.4	32.03	18.33	50.36	40.90	22.02	62.92	Yes	64/36	D 1:5.3, N 1:6.4	32.03	18.33	50.36	Same
ST AUGUSTINE'S WARD	QEQM	Medical	28+3	No	0	1	0	0	0	17.40%	19.00%	11.40%			24.23	15.71	39.95	36.10	19.44	55.54	Yes	64/36	D 1:4.6, N 1:5.6	21.45	23.57	45.12	Increase
ST MARGARETS WARD	QEQM	Medical	24+3	No	3	1	0	0	0	5.50%	16.40%	6.30%	2	7.0	26.79	15.71	42.50	30.99	16.69	47.68	Yes	63/36	D 1:5.4, N 1:9.0	26.79	15.71	42.5	Same

WHH Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Complim ents	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Skill Mix	N:P ratio	Proposed Final 22%			Outcome
															RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
BARTHOLOMEW UNIT	WHH	Cardiology	22	No	2	0	3	4	0	7.80%	-1.30%	0.70%	2	6.80	24.17	10.48	34.65	20.02	10.78	30.80	Yes	69/31	D 1:4.4, N 1:5.5	24.17	10.48	34.65	Same
CAMBRIDGE J1 WARD	WHH	Medical	20	No	1	2	3	0	1	3.80%	0.90%	4.60%	0	8.00	26.79	13.09	39.88	24.71	13.30	38.01		60/40	D&N 1:5	24.17	15.71	39.88	Same
CAMBRIDGE J2 WARD	WHH	Respiratory/NIV	19	No	1	2	1	0	0	2.20%	4.40%	4.20%	1	10.50	29.41	18.33	47.74	24.00	12.93	36.93	Yes	62/38	D 1:3.2, N 1:3.8	32.03	15.71	47.74	Same
CAMBRIDGE K WARD	WHH	Medical	27	No	7	1	4	0	0	18.80%	31.40%	3.50%	2	7.70	26.79	15.71	42.50	29.38	15.82	45.20	Yes	65/35	D 1:4.5, N 1:5.4	29.41	15.71	45.12	Increase
CAMBRIDGE L WARD	WHH	Medical	26	No	1	0	0	0	0	8.50%	8.60%	2.10%	11	7.50	32.03	15.71	47.74	23.76	12.80	36.56	Yes	65/35	D 1:4.3, N 1:5.2	32.03	15.71	47.74	Same
CAMBRIDGE M1 WARD	WHH	Medical	18	No	7	1	1	0	0	7.20%	2.50%	7.40%	5	7.60	18.93	13.09	32.03	18.41	9.91	28.32	Yes	59/41	D 1:4.5, N 1:6	18.93	13.09	32.03	Same
CAMBRIDGE M2 WARD	WHH	Gastro	19	No	3	1	0	4	1	18.00%	4.60%	3.90%	13	7.00	18.93	11.60	30.53	16.22	8.73	24.95	Partial	60/40	D 1:4.75, N 1:6.3	18.93	13.09	32.03	Increase
CCU QEQM	WHH	Cardiology	12+1	No	0	0	0	0	1	6.80%	9.0%	9.40%	45	8.4	18.93	7.74	26.68	14.14	7.61	21.76	Yes	76/24	D 1:3.3, N 1:4.3	18.93	6.03	24.97	Decrease
CCU WHH	WHH	Cardiology	10	PPCI/Tel	2	0	0	0	0	16.30%	10.20%	2.40%	2	16.50	26.79	5.24	32.03	12.33	5.68	18.97	Partial	84/16	D 1:2, N 1:2	26.79	5.24	32.03	Same
KENNINGTON WARD	WHH	Fraility	15	No	6	3	2	6	0	6.20%	5.10%	9.60%	0	8.00	18.93	10.48	29.41	18.57	10.00	28.57	Yes	72/28	D 1:3.75, N 1:5.0	18.93	10.48	29.41	Same
KINGS A2 WARD	WHH	Surgical	20	No	2	6	2	0	0	2.70%	-8.70%	4.20%	11	6.80	21.55	13.09	34.65	19.87	10.70	30.57	Yes	68/32	D 1:4, N 1:6.6	21.55	13.09	34.65	Same
KINGS B WARD	WHH	Surgical	23+1	No	1	0	0	0	2	7.60%	4.40%	5.90%	19	6.50	24.17	13.09	37.27	24.85	13.38	38.23	Yes	63/37	D 1:4, N 1:6	26.79	10.48	37.27	Same
KINGS C1 WARD	WHH	T&O	27	No	3	0	4	0	0	16.20%	4.40%	6.90%	33	7.50	26.79	18.33	45.12	35.64	19.19	54.84	Yes	64/36	D 1:4.5, N 1:6.75	32.03	18.33	50.36	Increase
KINGS C2 MEDICAL WARD	WHH	Medical	24	No	3	0	4	0	0	4.30%	6.10%	5.70%	3	6.30	24.17	13.09	37.27	20.18	10.87	31.05	Yes	65/35	D 1:4.8, N 1:6.0	24.17	13.09	37.27	Same
KINGS D1 MALE	WHH	Surgical	25	No	2	2	1	0	1	5.40%	2.20%	3.80%	14	15.70	18.93	13.09	32.03	22.76	12.25	35.01	Yes	64/36	D 1:4.2, N 1:6.25	26.79	13.09	39.88	Same
KINGS D2 FEMALE	WHH	Surgical	19	No	6	1	1	0	0						24.17	13.09	37.27	19.97	10.75	30.73	Yes	64/36	D 1:3.8, N 1:6.3	21.55	15.71	37.27	Same
OXFORD WARD	WHH	Infection	14	No	7	0	2	0	0	11.30%	28.60%	5.60%	14	10.80	24.17	13.09	37.27	19.49	10.49	29.99	Yes	65/35	D 1:2.8, N 1:3.5	24.17	13.09	37.27	Same
RICHARD STEVENS WARD	WHH	Medical	24+4	Yes	5	0	0	0	3	4.80%	8.50%	6.50%	2	7.50	30.63	15.71	46.34	30.07	16.19	46.26	Yes	72/28	D 1:1.7, N 1:5.6	30.63	15.71	46.34	Same

DCB Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medicati on Errors	Pressure ulcers	Complim ents	Complain ts	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicativ e of activity	Skill Mix	N:P Ratio	Proposed Final 22%			Outcome
															RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
BRABOURNE WARD	DCB	Haematology	8	No	1	1	0	79	0	0%	8.90%	10.50%	1	9.5	**12.95**	**5.99**	**18.93**	7.12	3.83	10.95	Yes	62/38	D 1:3.2 N1:4	**12.95**	**7.86**	**20.81**	Increase

W&CYP Recommendations

Ward Name	Care Group	Speciality	Beds	Clinics	Falls	Medication Errors	Pressure ulcers	Complim ents	Complaints	Turnover	Vacancies	Sickness	Red flags	CHPPD	Current Establishment			SNCT Recommendation (22%)			Indicative of activity	Skill Mix	N:P ratio	Proposed Final 22%			Outcome
															RN	HCSW	Total	RN	HCSW	Total				RN	HCSW	Total	
BIRCHINGTON WARD - QEQM	WC&YP	Womens	19+1	Yes	0	3	0	0	1	5.60%	3.30%	3.80%	10	8	22.59	13.09	35.69	14.49	7.8	22.29	No	59/41	D 1:4, N 1:6.6	18.93	13.09	32.03	Decrease
RAINBOW & DOPLHIN WARD - QEQM	WC&YP	Childrens	20+3	Yes	N/A	3	N/A	25	0	8.70%	16.10%	2.70%	0	6.7	37.66	13.91	51.57	17.2	8.7	26	No	73/27	1:4	37.66	13.91	51.57	Same
PADUA WARD - WHH	WC&YP	Childrens	28+3	Yes	N/A	6	N/A	14	0	3.90%	6.40%	1.20%	0	8.3	43.5	8.66	52.16	23.4	11.9	35.4	No	79/21	1:4	43.5	8.66	52.16	Same

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Review of Never Events reported 1 October 2022 to 3 October 2024**

Meeting date: **3 April 2025**

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

Paper Author: **Head of Patient Safety and Improvement**

Appendices:

Appendix 1: Detailed list of Never Events 1 October 2022 to 3 October 2024
Appendix 2: EKHUFT Never Event History and background information including previous reviews
Appendix 3: Enduring standards and general principles from previous issues patient safety alerts
Appendix 4: Summary of Integrated Care Board (ICB) recommendations and Trust actions in place or planned, April 2023, and updated, October 2024

Executive summary:

Action required:	Information
Purpose of the Report:	1.1. This report includes Never Events reported in the previous two years. 1.2. The review draws on current national recommendations with a view to informing safety critical workstreams. 1.3. Common issues are presented, along with existing and planned mitigation and recommendations.
Summary of key issues:	2.1. The majority of Never Events occurring in the previous two years relate to surgical invasive procedures (11 of 15). 2.2. All of the Never Events fall into the subtypes currently under review nationally. There is acknowledgement that the recognised barriers are not strong enough to make an incident wholly preventable as there remains a reliance on people (individuals and interactions). 2.3. A peer review of theatres across the Trust (2023) by the Association for Perioperative Practice (AfPP) identified primarily good practice and some areas of improvement. An improvement plan continues with the aim of achieving AfPP accreditation in 2025. 2.4. The organisational oversight of National Safety Standards for Invasive Procedures Version 2 (NatSSIPs 2) requires strengthening. This includes the: • governance arrangements; • processes to embed the existing Local SSIPs (LocSSIPs) outside of theatre; and • regular audits to reduce drift from the required sequential standards. 2.5. The recording of consent and engaging patients within the consent process, requires strengthening. 2.6. In order to embed the NatSSIPs 2 organisational standards, and support staff in relation to LocSSIPs outside of theatre, the Trust

We care

	training and awareness of systems thinking and human factors must continue. The Trust has adopted the requirements on the National Patient Safety Syllabus (Level 1 e-learning) for all staff and achieved 88.5% compliance. Level 2 e-learning for clinical staff and managers of clinical staff has been agreed as essential to role training. The update to the Electronic Staff Record (ESR) to prompt completion and enable compliance monitoring is awaited. Human Factors training is available on request. 2.7. The investigations and initial review of the events related to medication (2), nasogastric tube (1) and connection to an airflow meter (1), identified that the intention was to deliver timely treatment. 2.8. The medication administration training and competence assessment was reviewed internally and confirmed to be fit for purpose. 2.9. The nasogastric tube insertion LocSSIP has been updated to clarify contraindications and the nutrition policy and procedures have been reviewed and rationalised. 2.10. Previous Root Cause Analysis investigations, adopted a linear approach and thus were unlikely to clarify the complexity of the 'work as done'. The introduction of the Patient Safety Incident Response Framework and the revised Patient Safety Incident Investigation (including the Systems Engineering Initiative in Patient Safety (SEIPS)) provides the opportunity to undertake the current investigations using a systems thinking and human factors approach. This includes consideration of the contributory factors related to the safety culture and factors external to the immediate environment.
Key recommendations:	The Board of Directors is asked to **NOTE** the following actions which will be undertaken: **NatSSIPs2 / LocSSIPs** 1.1. Identify oversight committee responsible for NatSSIPs implementation. 1.2. Appoint a clinical lead responsible for LocSSIPs outside of theatres in relation to the NatSSIPs 2 requirements. (There is an existing lead for theatres). 1.3. Review and update the LocSSIPs policies (theatres and outside of theatres). 1.4. Identify the clinical leads responsible for each current LocSSIP outside of theatres. 1.5. Review and update current LocSSIPs in accordance with NatSSIPs 2. 1.6. Identify and resource support required for LocSSIPs implementation and auditing. 1.7. Identify clinical leads for the Safety Alert audit programme, align with LocSSIPs audits and the enduring standards and general principles from previously issues patient safety alerts (NHS England (NHSE)). 1.8. Add NatSSIPs 2 / LocSSIPs to the Care Group Quality Governance Meeting agenda template. **Consent** 1.9. Appoint a clinical lead for consent.

East Kent Hospitals University NHS Foundation Trust

	1.10. Ensure the consent policy and training is strengthened in relation to patient engagement. **Patient Safety training** 1.11. Continue Level 1 and Level 2 e-learning and promote and deliver Human Factors training utilising existing accredited/trained trainers. 1.12. Propose, during the planned review of clinical induction, that multidisciplinary sessions on communication, restorative just culture, seeking support and medicines safety are included. **Investigation** 1.13. Ensure that the six (6) current Never Event investigations are systems focused and actions strengthened as far as practically possible.

Implications:

Links to Strategic Theme:	Quality and Safety
Link to the Trust Risk Register:	None identified
Resource:	Yes Appointment of Clinical Lead for NatSSIPs 2 Appointment of Clinical Lead for Consent
Legal and regulatory:	Yes
Subsidiary:	Yes Spencer Private Hospitals (SPH)

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

REVIEW OF NEVER EVENTS REPORTED 1 October 2022 TO 3 October 2024

1. Purpose of the report

1.1 This review includes Never Events reported in the last two years (1 October 2022 to 3 October 2024). See Appendix 1 for the detail of each event.

1.2 The review draws on current national recommendations with a view to informing safety critical workstreams.

1.3 Common issues are presented, along with existing and planned mitigation.

2. Background

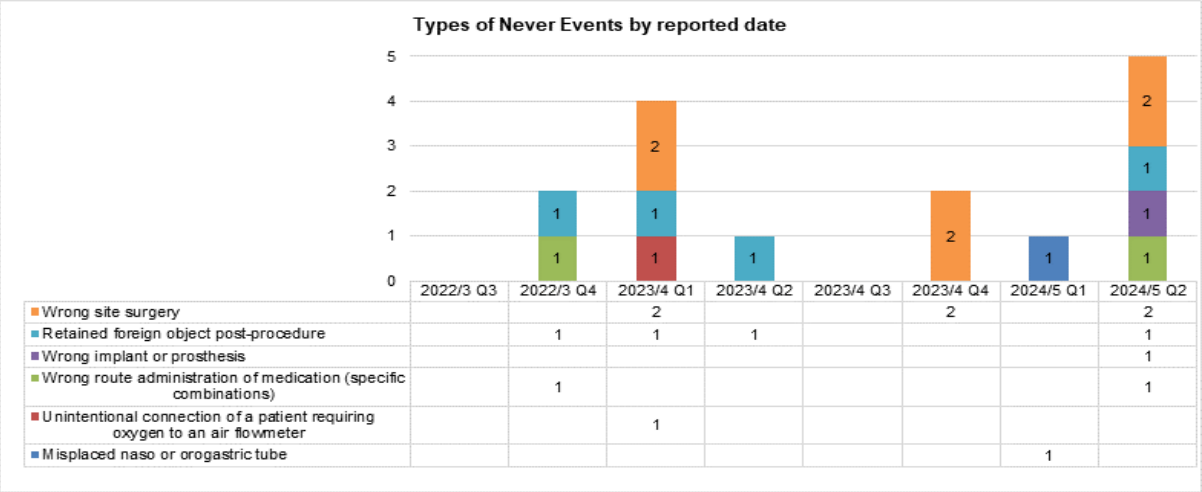
2.1 In Q2 2024/25 five (5) Never Events were reported by the Trust. This is the highest number reported in any quarter since Never Events were introduced. Subsequently, both internal and external concerns, were raised regarding the effectiveness of current controls.

2.2 This review includes information from previous internal reviews, a Kent and Medway Integrated Care Board review, national reviews undertaken by the Healthcare Safety Investigation Branch (HSIB, Never Events Analysis, 2021) and Care Quality Commission (CQC, Opening the Door to Change, 2018), and the NHS England Never Events consultation.

2.3 A summary of the history and background information is included within Appendix 2.

3. Never Events reported 1 October 2022 to 3 October 2024

3.1 Since 1 October 2022 there have been 15 incidents reported and declared as Never Events. See below for a breakdown of the type of Never Event reported within each quarter.



3.2 Nationally, the recommendation is to analyse themes within the same organisation over time and implement improvements based on local learning. However, national and one comparator Trust data has been included within this report. The contributory factors are unlikely to be comparable between different organisations due to environmental, system and process, and safety culture differences. Never Events data is published quarterly by NHSE, the provisional data for 1 April 2023 to 31 March 2024 is summarised below.

Number of Never Events reported	1	2	3	4	5	6	7	8	9	10	11
Number of Organisations	53	29	13	21	7	4	4 Inc. EKHUFT	1	0	3	1

3.3 The organisations reporting seven or more Never Events were:

3.3.1 East Kent Hospitals (7)
3.3.2 Kingston (7)
3.3.3 Cardale and Huddersfield (7)
3.3.4 Coventry and Warwickshire (7)
3.3.5 Barts (8)
3.3.6 Southampton (10)
3.3.7 St. Georges (10)
3.3.8 Newcastle-upon-Tyne (10)
3.3.9 Birmingham (11)

3.4 Comparison to Barts, as a similar organisation (size and structure), from October 2022 demonstrates 11 Never Events compared to 15 within EKHUFT over the same time period.

	EKHUFT			**Barts**			
	2023	2024	**Total**	2023	2024	**Total**	*Difference*
Wrong site surgery	2	4	**6**		2	**2**	*+4*
Retained foreign object post-procedure	3	1	**4**	3	1	**4**	=
Wrong implant or prosthesis		1	**1**	1	1	**2**	*-1*
Wrong route administration of medication (specific combinations)	1	1	**2**	1		**1**	*+1*
Misplaced naso or orogastric tube		1	**1**	1		**1**	=
Unintentional connection of a patient requiring oxygen to an air flowmeter	1		**1**			**0**	*+1*
Overdose of insulin due to abbreviations or incorrect device			**0**		1	**1**	*-1*
Total	7	8	**15**	6	5	**11**	*+4*

3.5 The majority of Barts' Never Events relate to surgical invasive procedures (8 out of 11).

3.6 Similarly, the majority of EKHUFT Never Events relate to surgical invasive procedures (11 out of 15). Two (2) Never Events relate to wrong route medication administration; one (1) to a misplaced nasogastric tube; and one (1) was an unintentional connection of a patient requiring oxygen to an airflow meter.

3.7 Of the 11 **surgical invasive procedure Never Events**:
- 3.7.1 Four (4) occurred outside of theatre, with three (3) of those occurring within 2024/5 Q2.
- 3.7.2 Seven (7) occurred within a theatre environment, with one (1) of those occurring within 2024/5 Q2.

Location (exact)	2022/3 Q3	2022/3 Q4	2023/4 Q1	2023/4 Q2	2023/4 Q3	2023/4 Q4	2024/5 Q1	2024/5 Q2	**Total**
Accident and emergency (WHH)								1	**1**
Breast screening (mammography) unit (KCH)								1	**1**
Labour ward / delivery suite (WHH)		1							**1**
Maxillo facial unit (WHH)								1	**1**
Operating theatre (KCH)				1		1			**2**
Operating theatre (QEQM)			3			1			**4**
Recovery (theatres, WHH)								1	**1**
Total	**0**	**1**	**3**	**1**	**0**	**2**	**0**	**4**	**11**

3.8 (The pattern is similar for Barts, with two (2) outside of theatre and six (6) occurring in a theatre environment.

3.9 For EKHUFT, the issues identified for Never Events occurring **within theatre** were:
- 3.9.1 Assumption of consent, rather than confirmation through written consent.
- 3.9.2 Site marking before block administration.
- 3.9.3 Post procedure check completion.
- 3.9.4 Checking completeness of equipment prior to end of procedure.
- 3.9.5 Count completed – reason for miscount unclear – improve sign out process.
- 3.9.6 Verbalisation of number of packs in situ and removed.
- 3.9.7 Culture in theatre, challenging behaviours / speaking out.
- 3.9.8 Frequency of theatre list changes.

3.10 The issues identified for Never Events occurring **outside of theatre** were:
- 3.10.1 Scheduling procedure prior to clinical vetting.
- 3.10.2 Consent – operator decision to change plan without patient knowledge.
- 3.10.3 Consent – no engagement in confirming procedure with the patient.
- 3.10.4 LocSSIP not used (new staff).
- 3.10.5 Small swabs available on labour ward.
- 3.10.6 Swab count not evidenced.
- 3.10.7 Distractions / poor environment.

3.11 Both **medication administration** events occurred in ward areas, the first in Q4 2022/3 at William Harvey Hospital (WHH), and the latest in Q2 2024/5 at Queen Elizabeth the Queen Mother Hospital (QEQM). In both events, oral medication was crushed and administered intravenously. The intention was to reduce the likelihood of harm through timely administration of medication. The first case the nurse was junior with minimal senior support; in the second case the nurse was experienced.

3.12 One **unintentional connection of patient requiring oxygen to an airflow meter** event occurred in Q1 2023/4 at QEQM. Attempted and partial connection of Bilevel positive airway pressure (BiPAP) to capped air outlet. Junior staff member.

3.13 One **misplaced nasogastric tube** event occurred in Q1 2024/5. Initial findings indicate learning in relation to appropriate pathways to access nutritional support, embedding and clarity of LocSSIP and procedures and clarity of X-ray report template.

4. Discussion

4.1 The Never Events framework consultation, commenced following the findings of the Care Quality Commission (CQC), Opening the door to change (2018) and Health Services Safety Investigations Branch (HSIB) Never Events Analysis (2021) reports.

4.2 Opening the door to change recommended organisations attend to:
- 4.2.1 Training for staff;
- 4.2.2 Empowering patients;
- 4.2.3 Exploration of barriers such as human behaviours; and
- 4.2.4 Leadership and safety culture.

4.3 The Never Event Analysis recommended that NHSE:
- 4.3.1 Review the Never Events list; and
- 4.3.2 Commission a programme to find strong systemic barriers.

4.4 The Never Events framework consultation 2024 has closed. Work is ongoing with stakeholders in relation to the subtypes of Never Events where the nationally recognised barriers are not strong enough to make an incident wholly preventable.

4.5 The Never Events occurring within EKHUFT over the last two years fall into the subtypes that are currently under review in relation to the identification of strong systemic controls as opposed to controls which are people focused.

4.6 The hierarchy of controls (national tool) categorises the types of controls available and the strength of these in relation to preventing errors occurring. Elimination, Substitution and Engineering are stronger system focused controls. Administration / Behavioural and General behaviour advice are weak people focused controls that are unlikely to prevent error.

4.7 Hierarchy of controls (1 is stronger and 5 is weakest)

System focused	**1. Elimination**	- Physically remove
	2. Substitution	- Replace with something less hazardous
	3. Engineering	- Redesign environment / equipment
People focused	**4. Administration / Behavioural**	
	• Knowledge / rules	- Restrict staff group / competency assessment - Memory aids/checklists
	• Lapses of concentration	- Reduce distraction
	• Routine violations	- Make desired action easier
	5. General behaviour advice	- Campaigns - Encouraging self-care

4.8 The investigations using a Root Cause Analysis methodology are unlikely to have had a full systems analysis as is now required under the Patient Safety Incident Response Framework. Thus, there may have been missed opportunities to develop a robust understanding of the 'work as done' and the influence of factors outside the area / speciality where the event occurred.

4.9 The improvement plans developed following investigations were, and continue to be, brought back to the Serious Incident Approval Panel for oversight of completion. Some evidence of completion has been attached to the records on the incident system.

4.10 In relation to the Never Events over the last two years, only three have system focused controls:
- 4.10.1 Removal of small swabs from labour ward;
- 4.10.2 Capping of air outlets (although this was not effective in preventing the attempted connection);
- 4.10.3 Amending radiology reporting template.

4.11 The remaining recommendations relate to people focused controls:
- 4.11.1 Training and competence assessment;
- 4.11.2 LocSSIPs amendment, development, raising awareness of/training;
- 4.11.3 Human factors awareness; and
- 4.11.4 Reminders of process.

4.12 Specifically related to surgical invasive procedures Never Events (11 of the 15), the National Safety Standards for Invasive Procedures 2 (NatSSIPs 2) was launched in 2023, replacing the original NatSSIPs requirements. The Trust used the original NatSSIPs to inform the development of procedural documents within and outside theatres. This included updating the Surgical Care Pathway (documentation booklet) and Theatre standards; and the development of Local SSIPs (LocSSIPs) for 33 procedures completed outside of theatres. These documents encompass the sequential standards required to maintain safety for each procedure and are available on Policy Centre. There are two LocSSIPs policies, one for main theatres and one for outside of theatres. The latter outlines the process for the development, implementation and auditing of LocSSIPs. This is not monitored at an organisational level.

4.13 The majority of the Trust LocSSIPs were not updated following the launch of NatSSIPs 2, thus the new sequential steps, (see table below) may not be reflected in the current Trust LocSSIPs.

1 – NEW	Consent, Procedural verification and Site Marking
2	Team Brief
3	Sign In
4	Time Out
5 – NEW	Safe and efficient use of implants (where relevant)
6 – NEW	Reconciliation of items in the prevention of retained foreign objects
7	Sign Out
8	Handover / Debrief

4.14 The organisational standards, outline the Trust board responsibilities as:
- 4.14.1 Adequately resourced, clinically-practicing senior and specialty-level leadership to enable sustained implementation of NatSSIPs 2 across every part of the organisation.

4.14.2 Sufficient time and resource for multidisciplinary team training.
4.14.3 Sufficient skilled and knowledgeable teams to deliver invasive care safely.
4.14.4 Appropriate induction for new staff and agency staff.
4.14.5 Governance processes for NatSSIPs 2 that are focussed on improvement.

4.15 The Trust regulators and commissioners require:
4.15.1 Inclusion of NatSSIPs 2 in training and assessment.
4.15.2 Use of NatSSIPs 2 as a framework for evaluation of services.
4.15.3 Use of NatSSIPs 2 in policy, reports and communications.

4.16 In relation to the board responsibilities:
4.16.1 The Trust lead for NatSSIPs stepped down in early 2023 and was not replaced.
4.16.2 Clinical leads have changed and may not be aware of their previous role in developing and maintaining specific LocSSIPs.
4.16.3 Following a reorganisation in 2022, the patient safety team were redirected to other workstreams (however have, on request, continued to support individual specialities in the development of their LocSSIPs).
4.16.4 The quality governance review in 2023/24 did not identify NatSSIPs2 per se, however Care Group Quality meeting Terms of Reference and templates include overdue documents and audits within the Effectiveness section.

4.17 In relation to the regulatory requirements:
4.17.1 Following a series of Never Events within theatres in 2023, in-house human factors training was provided for theatres, anaesthetic and surgical speciality staff. It has been reported verbally that the uptake was primarily theatre staff and anaesthetics.
4.17.2 The Association for Perioperative Practice (AfPP) undertook a peer review of theatres in 2023/24. The audit sections were:
- Five Steps to Safer Surgery (including NatSSIPs 2).
- Management / Human Resources.
- Accountable items.

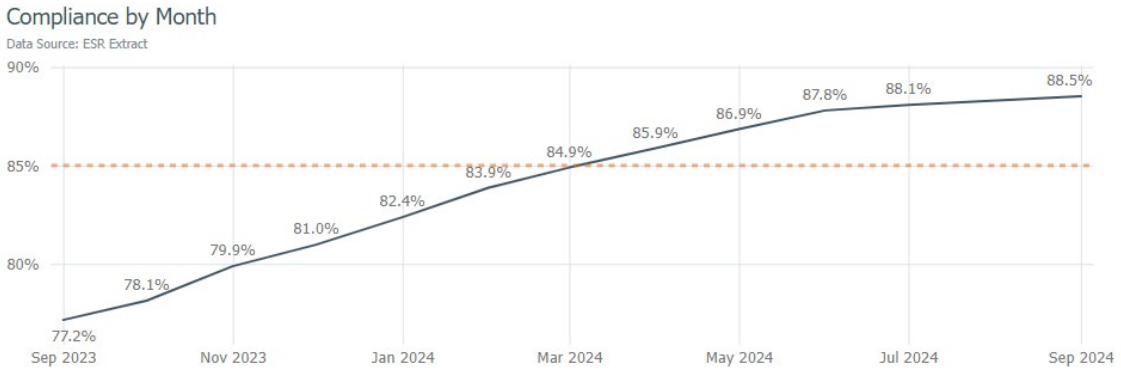
4.17.3 Overall, the findings were positive and good practice identified. An improvement plan was developed for the actions recommended and continues to be implemented with the aim of achieving AfPP Accreditation in early 2025. Forty-one (41) actions were identified, to date 25 have been completed and there are 16 remaining, all of which are in progress / on schedule.

4.18 The Clinical Audit team commenced planning a programme of audits of Safety Alerts related to Never Events in 2023, however this has not progressed at pace due to difficulties identifying appropriate clinical leads for the audits. This programme may benefit from review against the NHSE recommendations in relation to current alerts (from 2019) and the Enduring standards and general principles from previously issued alerts (see NHS England » Our National Patient Safety Alerts and Appendix 3 for further information).

4.19 In both of the wrong route medication Never Events, the intention was to reduce the likelihood of harm. One related to patient discomfort and the other to the administration of critical medications. The first investigation identified a junior staff member was working in isolation, the second investigation is ongoing. It is hoped that the systems thinking and human factors analysis will clarify how the event occurred to enable improvement actions to benefit beyond the individual staff and team.

4.20 The Trust has identified culture improvement workstreams as a priority. These support the development of a safety culture which encompasses the functional operation of the organisation to enable space to identify and address safety risks (e.g. NatSSIPs 2 organisational standards) and the non-technical skills deployed by individuals to maintain effective team working and communication (patient safety awareness and human factors).

4.21 The National Patient Safety Syllabus and curriculum (2022) aims to create a critical mass of trained practitioners who will adopt a proactive approach to identifying the risks to safe care through knowledge of systems thinking and human factors. The curriculum is spiralled through pre and post registration training; Level 1 and Level 2 are available on e-learning for all NHS staff. Level 1 is mandatory for all staff in EKHUFT and the current compliance is 88.5%, with all Care Groups being above 85%.



4.22 It has been agreed that Level 2 will be essential to role for professional clinical staff and managers of clinical staff. Updates to the Electronic Staff Record are currently awaited to prompt staff to complete and to enable compliance data to be collated. Level 2 training incorporates the principles of a restorative, just culture to support proactive patient safety and safety culture improvement.

4.23 Human Factors training (technical and non-technical skills) has been available to staff within the Trust since 2015 and is delivered by staff who have completed external human factors and train the trainer courses. Availability has not been consistent over time due to organisational changes and priorities. The Corporate Patient Safety team and a very small number of human factors trainers working clinically currently deliver sessions on request. Human factors is also incorporated into simulation training and leadership development training.

4.24 In March 2023, the Kent and Medway Integrated Care Board (ICB), shared a review of Never Events from April 2021 to June 2022. In response, an assurance report was drafted for the Director of Quality Governance (see summary within Appendix 2). At that time the ICB recommendations were mapped to EKHUFT actions in place or planned. This has been revisited and updated within Appendix 4. There has been limited progress in embedding LocSSIPs outside of theatres. A recent nasogastric tube Never Event has, prompted a review of the LocSSIP, training and competence assessment and nutrition procedures.

5. Conclusion

5.1 The majority of Never Events occurring in the previous two years relate to surgical invasive procedures (11 of 15).

5.2 All of the Never Events fall into the subtypes currently under review nationally. There is acknowledgement that the recognised barriers are not strong enough to make an incident wholly preventable as there remains a reliance on people (individuals and interactions).

5.3 A peer review of theatres across the Trust (2023) by the AfPP identified primarily good practice and some areas of improvement. An improvement plan continues with the aim of achieving AfPP accreditation in 2025.

5.4 The organisational oversight of NatSSIPs 2 requires strengthening. This includes the:
- 5.4.1 governance arrangements;
- 5.4.2 processes to embed the existing Local SSIPs (LocSSIPs) outside of theatre; and
- 5.4.3 regular audits to reduce drift from the required sequential standards.

5.5 The recording of consent and engaging patients within the consent process, requires strengthening.

5.6 In order to embed the NatSSIPs 2 organisational standards, and support staff in relation to LocSSIPs outside of theatre, the Trust training and awareness of systems thinking and human factors must continue. The Trust has adopted the requirements on the National Patient Safety Syllabus (Level 1 e-learning) for all staff and achieved 88.5% compliance. Level 2 e-learning for clinical staff and managers of clinical staff has been agreed as essential to role training and the update to ESR to prompt completion and enable compliance monitoring is awaited. Human Factors training is available on request.

5.7 The investigations and initial review of the events related to medication (2), nasogastric tube (1) and connection to an airflow meter (1), identified that the intention was to deliver timely treatment.

5.8 The medication administration training and competence assessment was reviewed internally and confirmed to be fit for purpose.

5.9 The nasogastric tube insertion LocSSIP has been updated to clarify contraindications and the nutrition policy and procedures have been reviewed and rationalised.

5.10 Previous Root Cause Analysis investigations, adopted a linear approach and thus were unlikely to clarify the complexity of the 'work as done'. The introduction of the Patient Safety Incident Response Framework and the revised Patient Safety Incident Investigation (including SEIPS) provides the opportunity to undertake the current investigations using a systems thinking and human factors approach. This includes consideration of the contributory factors related to the safety culture and factors external to the immediate environment.

Appendix 1: Detailed list of Never Events 1 October 2022 to 3 October 2024

#	Year	Current Care Group	Unit	Location type	Description	Never Event	National guidance/ information	Links	Learning	Actions update	Strength of control	System / People focus
1	2022	Critical Care, Anaes and Specialist Surgery Care (CCASS)	WHH	Ward	**Oral medication for insomnia administered via PICC**	Wrong route medication - oral via IV	Enduring standards - none applicable Previous PSA to inform local safety initiatives - Organisational responsibility re: improvement plans and training content (recognised limited safety impact).	https://www.england.nhs.uk/patient-safety/patient-safety-insight/patient-safety-alerts/enduring-standards/	Nurse working in isolation Acuity of ward Junior nurse Intention to alleviate patient symptoms	All weak actions, all local area only, all actions complete	4. Admin / Behavioural	People
2	2023	Women, Children & Young People (WCYP)	WHH	Labour ward	**Retained swab following 2nd degree tear repair**	Retained foreign object - swab	Rapid Response Report - Reducing the risk of retained swabs after vaginal birth and perineal suturing (2010) NatSSIPs2	https://webarchive.nationalarchives.gov.uk/ukgwa/20171030124650/http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=74113	Small swab available in delivery room. No evidence of swab count 2 signatures required on Euroking and one on LocSSIP	Small swabs removed from Labour ward LocSSIP updated to two signatures All actions completed.	1. Elimination 4. Admin / Behavioural	2 part - system and people
3	2023	WCYP CCASS	QEQMH	Theatre (day surgery)	**Retained swab Hysteroscopy and polypectomy**	Retained foreign object - swab	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	Count done - not clear why one swab missed out of five	Introduction of count sheet in addition to whiteboard Accountable items audit Bagging of swabs Improve focus on sign out Improve culture in theatre Update Theatre standards count process	4. Admin / Behavioural	People

25/17

#	Year	Current Care Group	Unit	Location type	Description	Never Event	National guidance/ information	Links	Learning	Actions update	Strength of control	System / People focus
4	2023	QE	QEQMH	Emergency Department	**Attempted connection of BiPAP to air outlet (capped) instead of oxygen - patient hypoxic secondary to fractured ribs (following fall at home), Normally on BiPAP at home.**	Unintentional connection of a patient requiring oxygen to an air flow meter	PSA - Reducing the risk of oxygen tubing being connected to air flowmeters (2016)	NHS England » Reducing the risk of oxygen tubing being connected to air flowmeters	Junior staff Competencies not complete	Non-Invasive Ventilation (NIV) checklist to include photos of ports Competency assessment of all trained staff NIV patients to be in Resus or RAP NIV refresher training Block air port with cover Reminders	3. Engineering 4. Admin / Behavioural	2 part - system and people
5	2023	WCYP CCASS	QEQMH	Theatre (Gynae)	**Mirena coil inserted without consent when patient attended for hysteroscopy and polyp resection**	Wrong site surgery (query should be wrong implant)	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	Coil not added to written consent following discussion (never confirmed by patient) Theatre list changes on the day are common Lack of challenge re: coil insertion	Strengthen consent process Challenge doctors Improve communication of planned changes within the team	4. Admin / Behavioural	People
6	2023	CCASS	QEQMH	Theatre (T&O)	**Regional block administered on the wrong side prior to surgical site marking**	Wrong site surgery	Stop before you block (SB4UB) NatSIPPs2	https://www.ra-uk.org/index.php?option=com_content&view=article&id=485&Itemid=919	Site not marked Culture - challenging medical staff	Consent and pre-op checks on the day Collection process and pre- op checks Human Factors training Anaesthetic assistant inc. in sign in Review consent form 4 Mental Capacity Act (MCA) assessment completion Address frequency	4. Admin / Behavioural	People

25/17

#	Year	Current Care Group	Unit	Location type	Description	Never Event	National guidance/ information	Links	Learning	Actions update	Strength of control	System / People focus
										of theatre list changes on the day Update Stop Before You Block (SB4UB) process Review audit clerk role 7 Trauma & Orthopaedic (T&O) audit of consent and site marking		
7	2023	KCVH	Kent & Canterbury Hospital (K&C)	Theatre (Urology)	**Fragment of guidewire retained within kidney (previous procedure)**	Retained foreign object	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	Checks for completeness of wire on withdrawal (possible causation - introducer, laser cut, withdrawal through scope)	Standard Operating Procedure (SOP) check follows National Institute for Health and Care Excellence (NICE) Review risk assessment process on change of equipment	4. Admin / Behavioural	People
8	2024	KCVH	K&C	Theatre (Urology)	**Retrograde pyelogram completed on wrong side**	Wrong site surgery	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	WHO checks were done. Operator 'moment of confusion'. List of same procedure mixed lateralities. Staff in theatre did not notice as busy with their jobs.	Introduce 'stop' moment before starting. Check current procedures in line with NICE. Consider lists of single laterality.	4. Admin / Behavioural	People

25/17

#	Year	Current Care Group	Unit	Location type	Description	Never Event	National guidance/ information	Links	Learning	Actions update	Strength of control	System / People focus
9	2024	QE	QEQM	Theatre (Gynae)	**Mirena coil inserted without consent when patient attended for hysteroscopy, endometrial biopsy resection of polyps and fibroids**	Wrong site surgery (query should be wrong implant)	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	Consent process incomplete. Culture - behaviour of medical staff.	Strengthening the consent process for hysteroscopy cases. Amendments / changes on day of surgery to be clearly communicated between teams. Theatre staff to be confident to challenge clinicians during surgery.	4. Admin / Behavioural	People
10	2024	WH	WHH	Emergency Department	**Feed was commenced without realising that the imaging report reviewed did state (further down) that the tube was not correctly sited. Patient diagnosis oesophageal Ca, dysphagia, weight loss.**	Misplaced naso or orogastric tube	PSA - nasogastric tube misplacement: continuing risk of death and severe harm (2016) Initial placement checks for nasogastric and orogastric tubes: a resource set (NHSI, 2016)	NHS England » Nasogastric tube misplacement: continuing risk of death and severe harm	X-ray reporting (external provider template) Embedding of LocSSIP	Introduce Nasogastric (NG) LocSSIP to Emergency Department (ED). Trust wide Safety Pin re: NG LocSSIP Update NG LocSSIP to prompt contraindications Plan to add LocSSIP to Sunrise NG LocSSIP removed from Soliton, In House reporting on SECTRA Radiology to liaise with external provider to establish if they can adopt Appendix 8 adult nutrition policy Clinical lead to reiterate reading whole radiology report.	4. Admin / Behavioural	People

25/17

#	Year	Current Care Group	Unit	Location type	Description	Never Event	National guidance/ information	Links	Learning	Actions update	Strength of control	System / People focus
11	2024	CCASS	WHH	Max Fax	**Wrong mouth lesion biopsied**	Wrong site surgery	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	*Under investigation Query deliberate plan change (not discussed with patient)*	*Initial mitigation LocSSIP updated to confirm site of lesion with patient*	4. Admin / Behavioural	People
12	2024	WH	WHH	Emergency Department	**Wrong laterality block**	Wrong site surgery	SB4UB NatSIPPs2	https://www.ra-uk.org/index.php?option=com_content&view=article&id=485&Itemid=919	*Under investigation Checklist not used New staff to Trust Distractions / poor environment No written consent*	*Initial mitigation Present Anaesthetic M&M Pre-Stop-Block training for new trainees as a matter of urgency LocSSIP sent to all anaesthetists.*	4. Admin / Behavioural	People
13	2024	QE	QEQM	Ward	**Oral seizure medication administered via IV cannula**	Wrong route medication - oral via IV	PSA - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes (2007) (not applicable in this case)	https://www.england.nhs.uk/patient-safety/patient-safety-insight/patient-safety-alerts/enduring-standards/	*Under investigation Medical and pharmacy review of critical medications (change from oral to other route) Intention to prevent harm to patient, experienced nurse and no concerns regarding competence.*	*Initial mitigation Nurse give final written warning (query appropriateness of this as initially no concerns regarding competence were identified and investigation not yet completed) Immediate review of medication safety and IV training.*	4. Admin / Behavioural	People

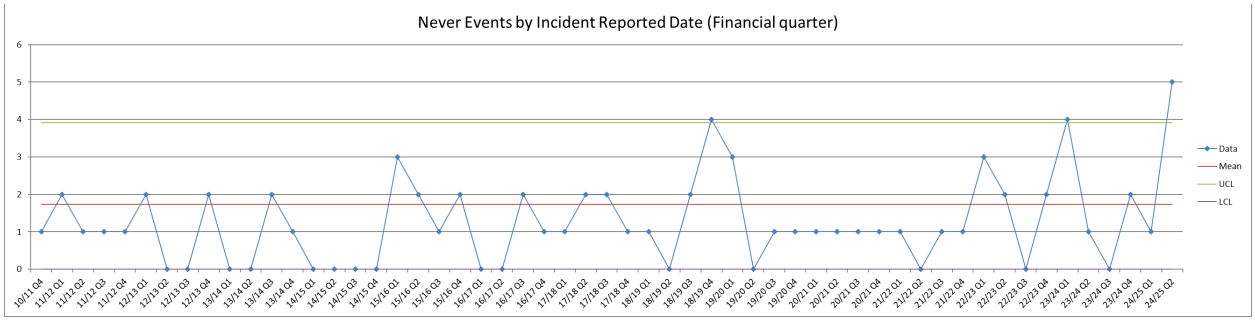
25/17

#	Year	Current Care Group	Unit	Location type	Description	Never Event	National guidance/ information	Links	Learning	Actions update	Strength of control	System / People focus
14	2024	KCVH	K&C	Mammography unit	**Localisation wire inserted rather than coil (patient did not require either procedure).**	Wrong implant or prosthesis	NatSIPPs2	https://cpoc.org.uk/guideline/guidelines-resources-guidelines/national-safety-standards-invasive-procedures-natssips	*Under investigation Patient scheduled prior to clinical vetting completion. Patient involvement and consent*	*Initial mitigation Discussion with immediate team, breast radiology huddle, scheduling leam, breast surgery team. Clinical vetting must occur prior to scheduling - monitored via Business Telecoms meeting.*	4. Admin / Behavioural	People
15	2024	WH	WHH	Theatre (ENT)	**Retained throat pack**	Retained foreign object - throat pack	Safe Practice Notice (2009) - Reducing the risk of retained throat packs after surgery NatSIPPs2	[ARCHIVED CONTENT] Throat Packs (nationalarchives.gov.uk)	*Under investigation Use of packs to be avoided Ensure verbalisation of presence of number of throat packs in situ and number removed Ensure number captured on whiteboard Behaviours of staff*	*Initial mitigation Throat packs LocSSIP developed*	4. Admin / Behavioural	People

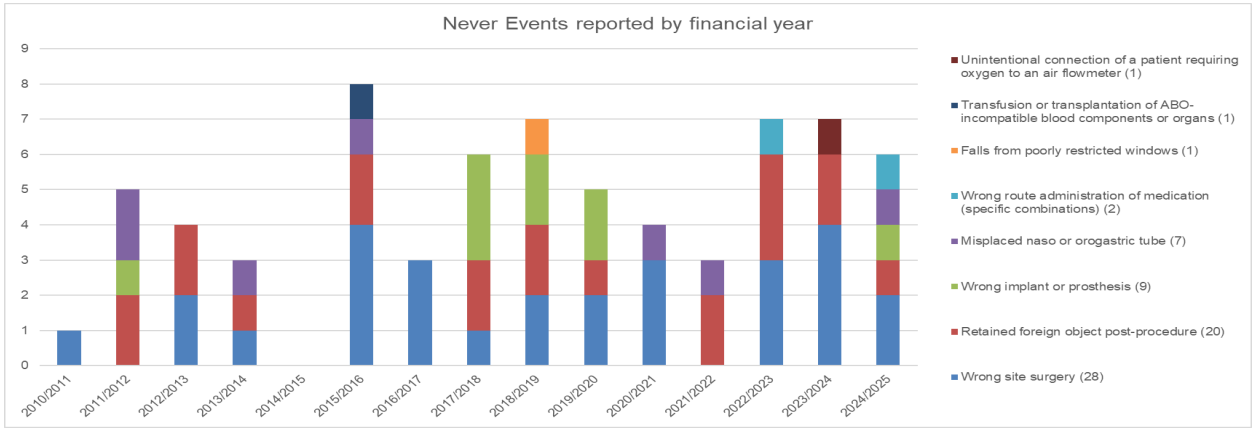
East Kent Hospitals University NHS Foundation Trust

Appendix 2: EKHUFT Never Event History and background information including previous reviews

Since January 2010 the Trust has reported 69 Never Events. The chart below indicates that there has been an increase in Never Events reported. It is acknowledged that, during this period, there has been an increase in reported incidents (excluding the reduction seen in 2020 due to the Covid pandemic). Thus, the increase in reported Never Events may reflect the improved reporting culture within the Trust. However, six months into the current financial year the Trust has reported six Never Events compared to seven reported in the previous full financial year.



The graph below shows the types of Never Events reported; the most prevalent being related to invasive procedures (wrong site, retained foreign object, wrong implant/prosthesis).



Never Events report 2021

The last formal review of Never Events occurring within the Trust was in 2021 and presented to the Patient Safety Committee. The report concluded:

- The Trust has implemented improvements which have resulted in a reduced likelihood of Never Events occurring. In particular pleural procedures; ophthalmology outpatient procedures, obstetric / gynaecology retained swabs/tampons.
- Other Never Events have proved more challenging to address. The Stop before you block process became high profile within anaesthetics and theatres due to the number of incidents occurring. The introduction of visual prompts and inclusion within the Surgical Care Pathway led to no further Never Events related to blocks for those teams after 2019. However, due to disruption to the implementation of LocSSIPs during the Covid-19

pandemic the Trust wide LocSSIPs for blocks was not shared effectively. This was identified when a block Never Event occurred outside of anaesthetics and theatres. This has now been strengthened to ensure that the implementation plans for Trust wide LocSSIPs are in place and communicated to relevant specialities.
- For nasogastric tube Never Events, the decision to feed is reliant on interpretation of imaging and even with double checks, this is prone to human error. The main recommendation continues to be to ensure staff are appropriately trained and document adherence to the four point process and pH testing.

The recommendations were to:
- Ensure the process for and assurance from the Safety Alerts process is robust.
- Ensure the process for and assurance from LocSSIPs is robust and continually monitored.
- Promote the proactive implementation of known safety improvement methods as outlined within the NHS Patient Safety Strategy and Trust We Care improvements.
- Ensure the Serious Incident Panel supports the Care Groups to strengthen Serious Incident, and thus Never Event, improvement plans.

Draft Never Events Assurance Report 2023
In response to thematic reviews completed by the Kent & Medway (K&M) ICB in March 2023, a review of Never Events against the themes identified by the ICB was drafted. This concluded:
- There is limited assurance regarding the oversight of the processes in place to reduce the likelihood of Never Events occurring.
- There are policies for Local Safety Standards for Invasive Procedures (LocSSIPs) (theatres; outside of theatres) available and some LocSSIPs are available on policy centre.
- There is no organisational governance oversight of compliance with LocSSIPs (new, auditing and updating).
- There is some evidence of embedding organisational standards to deliver safe invasive care. The evidence is more robust for main theatres than for procedures undertaken outside of theatres where there are gaps in training, human factors understanding, access to standardised documentation, governance of LocSSIPs, audit data for assurance and external oversight. As a result, assurance in relation to the sequential standards is weaker outside of theatres.

The draft recommendations were:
- The Corporate Patient Safety team to develop an improvement plan for implementation of NatSSIPs2 (including organisational requirements and communication plan) in liaison with working group membership (care group LocSSIP leads) and Patient Safety Committee membership. Oversight of progression will be via a monthly report to the Patient Safety Committee.
- The Chief Medical Officer to provide guidance on how to establish organisational oversight for the ongoing introduction, auditing and updating of LocSSIPs with the Trust governance structures (e.g. Patient Safety Committee or Clinical Audit and Effectiveness Committee).

Appendix 3: Enduring standards and general principles from previously issues patient safety alerts

NHSE Enduring standards that remain valid from previous patient safety alerts.

These are the actions from previous alerts that remain valid and should already be embedded systematically across NHS provider organisations. These relate to:

- Medication safety
- Medical device safety
- Surgical / anaesthetic / maternity safety
- Cross speciality safety (Falls, Acute Kidney Injury, Emergency calls, Identity bands).

General principles that should inform local safety initiatives.

These were described in alerts but apply more widely across an organisation. These are the underpinning principles of good safety systems and good clinical governance and will likely require a continuing improvement focus (thus aligning with the requirements of the Patient Safety Incident Response Framework). These relate to:

- Safety systems – Training/competency, audits, policies/procedures, risk assessment, access to emergency 'kits'
- Linking with national systems – improving incident reporting, nominated safety specialists
- Purchasing for safety – connectors, medications
- Empowering patients – information, hand held records, self-administration, self-care.
- Priority setting – local safety improvement for medication
- Information for healthcare professionals – access to clinical guidance / information, guidance for specific procedures, deterioration and sepsis, blood transfusion safety
- Personal responsibilities – staff personal awareness and vigilance, checks before prescribing, dispensing, administering (with the caveat that there should be clear understanding of the limited effectiveness of raising awareness and personally striving to avoid error).

Appendix 4: Summary of ICB recommendations and Trust actions in place or planned (April 2023) and updated (October 2024)

ICB recommendations and next steps	EKHUFT actions in place or planned

Accessibility of Trust level information	• LocSSIPs available on Policy Centre for procedures undertaken in Main Theatres (supporting the Adult Surgical Care Pathway) and individual LocSSIPs for procedures undertaken outside of Main Theatres. **Now have all known LocSSIPs on Policy Centre. LocSSIPs outside of theatre policy expired September 2023.**
	• Review of all LocSSIPs commencing in response to publication of the National Safety Standards for Invasive Procedures 2 (NatSSIPs 2) | Centre for Perioperative Care (cpoc.org.uk) (See summary in Appendix 5). Initial meeting with care group representatives 19/04/2023. Further meetings to be planned to increase attendance and provide support and monitoring of progress. Initial meeting identified different versions of LocSSIPs have been developed in different specialities due to lack of Trust wide governance oversight. **Not progressed**
	• Transferring LocSSIPs to Sunrise added to Long List for Sunrise (timeframe for transfer has not yet been agreed). **Not progressed**
	• Available on Policy Centre:
	  • Positive Patient Identification Policy
	  • Transfer of Care and Clinical Handover of Care Policies. Currently open action for Patient Safety Committee to review and align the content of transfer/handover related policies and processes across the Trust. Consider re-introduction of SBARR (situation-background-assessment-recommendation-read back) communication training. **Not progressed**
	• Adult Nutrition Policy (including information regarding nasogastric tube feeding). **Updated September 2024 following NG NE.**
	• Nasogastric Tube Insertion LocSSIP. **Updated September 2024 following NG NE.**
	• Trust induction and local induction procedures in place, including agency. **Currently under review, led by Learning and Development.**

LocSSIPs implementation plan	• Initial implementation plan was completed in 2021 and was overseen by the Patient Safety Committee and Chief Medical Officer. The ongoing governance in relation to the development of new LocSSIPs and auditing and updating existing LocSSIPs transferred to the Care Groups to manage. **Lack of evidence of care group oversight within governance meeting templates.**

ICB recommendations and next steps	EKHUFT actions in place or planned
	• Compliance with main theatre processes robustly monitored through routine auditing and theatre governance processes. **AfPP peer review and plan for accreditation early 2025.** • Procedures outside of main theatre (e.g. speciality procedure areas and clinical areas) not monitored robustly, audit cycle of LocSSIPs not embedded. • There is no current oversight of compliance via the Trust Governance structures. • NatSSIPs2 offers the opportunity to revisit the Organisational Standards for delivery of safe invasive care. • Patient Safety Partner to be appointed to attend the Patient Safety Committee to provide a level of independent support and challenge for patient safety improvement including LocSSIPs. **Not progressed.**
Positive patient identification (PPID)	• NatSSIPs2 clarified requirements for outpatient procedures – to be incorporated into LocSSIPs. • PPID policy and request submitted for Trust wide audit for 2023/24. Repetition of the same incident occurring in the same speciality evidences inability to embed learning from incidents, complaints and claims across the Trust.
Staffing related issues – fatigue, burnout, stress	• Trust wide recruitment plan and workstreams monitored via the People and Culture Committee. • Health and Wellbeing Team and resources and support available (accessible via the staff intranet) • Burnout sessions delivered in 2022 – resources and tools available on the staff intranet. • Stress Management Policy and Toolkit. • Lack of proactive processes in relation to the recognition of the risk of and management of fatigue (Sleep, fatigue and the workplace, NHS Employers, 2023). • **Introduction of wellbeing champions 2023.**
Site marking	• Not applicable to Trust Never Events reviewed by the ICB - Mohs procedure site identification completed by histological map. • Relevant LocSSIPs include reference to site marking. **Verbalisation of laterality and site marking action required.**
Staff changes, interruptions and distractions	• Human factors training delivered to the majority of Main Theatres staff Trust wide in 2019 (following a series of Never Events). **Further training in 2023 for primarily theatres and anaesthetic staff (following a series of Never Events).** • Human Factors training includes situational awareness, impact of fatigue, self-care (updated training, aligned to the PSIRF, due to restart in June 2023 and available to all Trust staff). **Restarted and continues to be booked on request.** • Patient Safety Level 1 e-learning mandatory for all staff (Compliance 81% February 2023 – further work required to

ICB recommendations and next steps	EKHUFT actions in place or planned
	validate data) . Patient Safety Level 2 e-learning essential to role for Band 7 clinical and managers of clinical staff and registrars and above (pending set up on ESR to enable compliance monitoring). Both metrics to be added to the Quality and Safety Dashboard. **Level 2 has not progressed – currently awaiting ESR feedback following mapping of staff groups by Patient Safety.**
Adherence to Trust policy	• Visual checks of equipment to be added to relevant LocSSIPs as part of NatSSIPs2 work. **Not progressed.** • LocSSIPs audits to be included within Care Group Clinical Audit plans. **Needs to be mapped.** • Compliance with agency induction process not currently monitored, however temporary workforce team now in place and promoting appropriate local induction procedures. **Update required.**
Prevention of NG feeding associated incidents	• Recent NG feeding tube serious incident reported in relation to feeding tube becoming dislodged (not a Never Event as not related to placement), investigation ongoing. **Updated September 2024 following NG NE.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Annual Emergency Preparedness, Resilience & Response (EPRR) Report and National Assurance Outcome (2024)**

Meeting date: **3 April 2025**

Board sponsor: **Chief Operating Officer (COO)**

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

Appendices:

Appendix 1: Outcome of EKHUFT annual assurance process - NHS England (NHSE) Core Standards for EPRR (2024)

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This paper provides the annual assurance to the Trust Board on the workstreams, risks and activities within EPRR in 2024. The purpose of this paper is to provide assurance to the Trust Board, that there are: • Robust plans, training and exercises for incident response arrangements; • Processes and governance in place to debrief and learn from incidents that have occurred; • Processes in place to assess ongoing risk as well as horizon scanning for new and emerging threats. This report also details the outcome of the annual assurance process against the NHSE Core Standards for EPPR.
Summary of key issues:	Annual Report outlines the: • Risk assessment process; • Incidents that have happened since the last report; • The Business Continuity Programme; • Training and exercises; • Ongoing partnership working. This year EKHUFT again rated as fully compliant in the annual self-assessment assurance process against the NHSE Core Standards for EPRR.

We care

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to receive and **NOTE** the Annual EPRR Report and National Assurance Outcome (2024) for information and assurance.

Implications:

Links to Strategic Theme:	Quality and Safety
Link to the Trust Risk Register:	No
Resource:	No
N	No
Subsidiary:	No

Assurance route:

Previously considered by: Clinical Executive Management Group 06.11.24
Quality & Safety Committee 26.11.24

East Kent Hospitals University NHS Foundation Trust

Annual EPRR Report and National Assurance Outcome

1. Purpose of the report

1.1 The purpose of this paper is to provide assurance to the Trust Board that there are:
1.2 robust plans, training and exercises on incident response arrangements,
1.3 governance mechanisms in place to ensure EPRR work programme is overseen by the Accountable Emergency Officer,
1.4 processes and governance in place to debrief and learn from incidents that have occurred,
1.5 processes in place to assess ongoing risk as well as horizon scanning for new and emerging threats.

2. Background

2.1 NHS England Core Standards for EPRR outline the standard functions and capabilities healthcare providers should be achieving, which the Trust annually self-assures against.
2.2 Standard 3 states:
2.3 *"The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.*
2.4 *This should include:*
2.5 *training and exercises undertaken by the organisation,*
2.6 *summary of any business continuity, critical incidents and major incidents experienced by the organisation,*
2.7 *lessons identified and learning undertaken from incidents and exercise,*
2.8 *the organisation's compliance position in relation to the latest NHS England EPRR assurance process".*

3. Risk

3.1 The EPRR team assess risk as organisational or operational, whereby the latter can be resolved within a set timescale.
3.2 The EPRR Risk Register has been reviewed inline with the revised Trust Risk Management Policy.
3.3

Risk Ref	Organisational Risk Title	Residual Risk Score
2626	The trust is required to respond to a Mass Casualty Incident	8 - Moderate
3607	Capacity surge requiring declaration of a Critical Incident (Amended)	12 - Moderate
3608	Requirement to manage a contaminated body in the decontamination area or the mortuary	12 - Moderate
3338	EKHUFT healthcare setting experiences telecommunications failure	12 - Moderate
3344	Requirement for full Hospital site search for missing vulnerable person (Amended)	9 - Moderate
3331	IT Failure	8 - Moderate
3335	EKHUFT healthcare setting experiences a local power failure	8 - Moderate

3336	Emerging Infectious Diseases (Including Pandemic)	8 - Moderate
3325	The Trust is subject to a deliberate cyber security attack	12 – Moderate
3428	Unsafe helicopter take-off and landing (Amended)	6 – Low
3429	Strategic and Local Transport Infrastructure Interruption	6 – Low
3002	National Planned Power Outages	4 – Low
3337	Unable to meet the Trusts requirement, under NHS England Core Standards for EPRR, to maintain healthcare services during severe winter weather	4 – Low
3000	Failure of the National Electricity Network (Amended)	5 – Low
3323	Suspected Improvised Explosive Device on Trust Site (Amended)	4 – Low
3332	Unable to meet CQC requirements to have in place and tested, an Infant Abduction Plan	4 – Low
3334	Inpatient hospital experience full or partial piped oxygen failure	4 – Low
3427	Hazards Rendering Trust Estate Unsafe and requiring evacuation (Amended)	4 – Low
3345	Not being able to sustain full compliance of NHS England Core Standards for EPRR annual assurance (Amended)	4 – Low
3640	Unplanned generator failure identified during monthly generator testing or other routine maintenance (no disruption to mains power)	**6 – Low**
3326	The Trust is unable to meet the requirements, under the NHS England Core Standards for EPRR, to respond to a CBRNe Incident	3 - Very Low
3342	William Harvey Hospital is designated the mass fatalities receiving mortuary for K&M by the Coroner	3 - Very Low
3328	Unable to meet the Trusts requirement, under NHS England Core Standards for EPRR, to maintain healthcare services during heatwaves and prolonged hot weather	3 – Very Low
3339	EKHUFT healthcare setting experiences water supply disruption	3 – Very Low

3.4

Risk Ref	Operational Risk Title	Residual Risk Score
3147	Inability to access CCTV in a timely manner 24/7 on all sites	9 – Moderate
2769	Inability to effectively carry out a Lockdown of the 3 main hospital sites	6 - Low
3496	Procurement of new or replacement PRPS Suits for decontamination (CBRN)	6 – Low
2179	The Trust is unable to meet the requirements, under the NHS England Core Standards for EPRR, to have 24-hour access to a trained loggist(s) to ensure support to the decision maker	6 – Low
3483	Uncoordinated Fire Response - Buckland Hospital	3 - Very Low

3.5

Risk Ref	Emerging Risk Title	Date:	Residual Risk Score
3698	Electronic Entry System (Official Sensitive)	June 2024	15 - High

4. Plans

4.1 The following plans have been revised over the past 12 months in line with the document review schedule or with learning from incidents and exercises.
4.2 Business Continuity Plan
4.3 Major Incident Plan
4.4 Mass Casualty Plan
4.5 Critical Incident Plan
4.6 Severe Winter Weather Plan
4.7 IT Failure Response Plan
4.8 Piped Oxygen Failure Response Plan
4.9 Chemical, Biological, Radiological or Nuclear (CBRN) & Hazmat Decontamination Plan
4.10 Telecommunications Failure Plan
4.11 Water failure Incident Response Plan
4.12 Fuel Supply Disruption Plan
4.13 EPRR & Business Continuity Policy.

4.14 Helicopter Operations
4.15 In April 2024, the Civil Aviation Authority published version 2 of CAP 1264 - Standards for Helicopter Landing Areas at Hospitals. This revision sets out designated roles and responsibilities for Hospital Trusts who operate helicopter landing sites.
4.16 The Helicopter Operations Policy outlines these roles and responsibilities within the Trust and has been ratified as a new Policy through the Strategic Safety Committee and Policy Approval Group (PAG) in November 2024.
4.17 Whilst all other EPRR activity reports directly to the Accountable Emergency Officer, the Chief Operating Officer, helicopter operations report to the Chief Strategy and Partnerships Officer as the Accountable Manager.
4.18 The Head of EPRR is the designated “Responsible Person” and reports to the Chief Strategy and Partnerships Officer on matters relating to helicopters.

5. Business Continuity

5.1 In August 2023, the care groups underwent a restructure which meant service level business continuity plans required updating. EPRR took this opportunity to review and revise Trust Business Continuity Management and carried out a pilot programme introducing training and improved plan templates.
5.2 This programme is now being rolled out across the Trust in 3 phases, with the Trusts critical services prioritised in phase 1.
5.3 The target for completion is end of Quarter 4 in 2024/25.

6. Incidents

6.1 All significant incidents impacting or experienced by EKHUFT are debriefed with documented lessons identified and recommendations, monitored through the Tactical and Strategic Resilience Groups.
6.2 Some of the key incidents were:
6.3 Bleep System Failure
6.4 In December 2023, The Trust experienced a bleep system which required urgent downtime to facilitate the repair in the last working days before Christmas.

6.5 Whilst the incident was unplanned, the resulting learning was invaluable and has led to improvements so bleep failure mitigations are more robust.

6.6 **Major Incident Standbys**

6.7 South East Coast Ambulance Service have placed one or more of EKHUFT sites on major incident standby twice in 2024 (to date). Both incidents were stood down without being declared Major Incidents. This has led to an ongoing review of what actions should be taken in standby to have a proportionate response, particularly out of hours. Any changes will be approved through the Strategic Resilience & Capabilities Group.

7. Training & Exercises

7.1 **Training**

7.2 The core EPRR training programme is ending for 2024 having delivered training for Incident commanders, the decontamination team and Loggists along with ad hoc sessions with the Emergency Departments (EDs) and helicopter training at Queen Elizabeth the Queen Mother Hospital (QEQM).

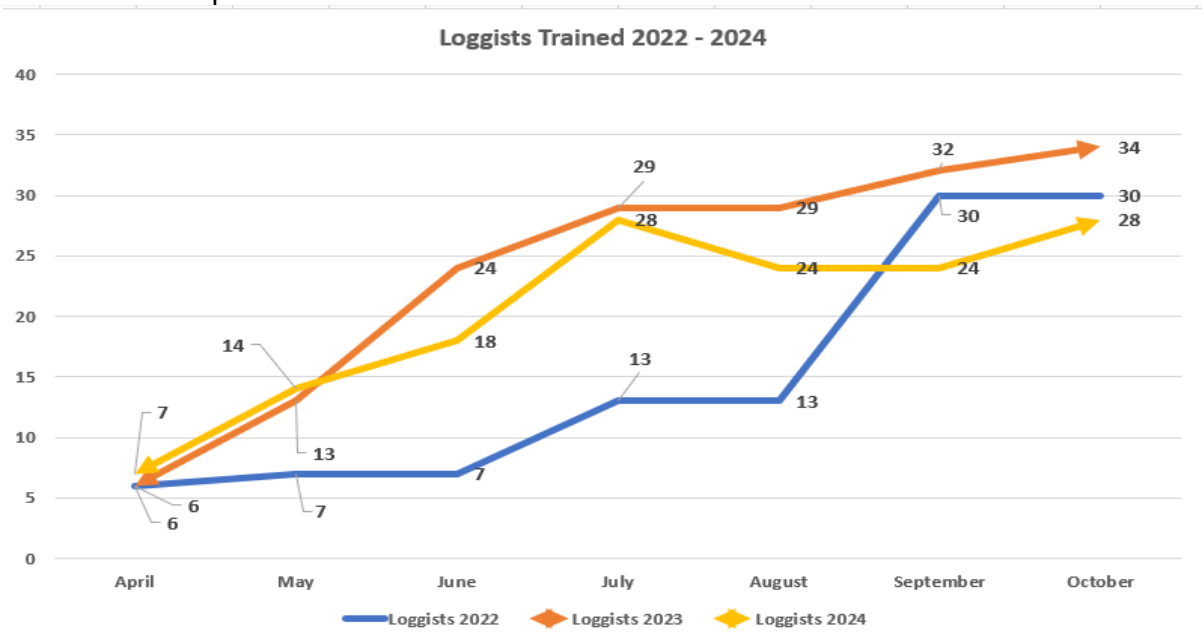
7.3 There has been good compliance with command training.

7.4 20 new staff have been trained and an additional session has been added in December to capture new joiners to the rota.

7.5 A large proportion of the training schedule is delivering decontamination training for CBRN or Hazmat (hazardous material) incidents. To date, in 2024, 235 staff have been trained as new team members or refreshers.

7.6 Loggist recruitment continues to be the greatest on-going challenge along with retaining numbers of active staff. The graph below demonstrates the decline in numbers over 2024 despite multiple campaigns through staff news, local forums and team events.

7.7 The risk is on the Trust Risk register and monitored through the Tactical and Strategic Resilience Groups.



7.8 **Exercises**

7.9 Throughout 2024, the exercise programme has been delivered to meet specific risks or as part of the emergency resilience workplan.

7.10 Hospital Evacuation

7.11 In April 2024, EKHUFT Emergency Planning led the planning group and jointly delivered **Exercise Melville**, a Kent & Medway multiagency table top exercise examining Hospital evacuation. The exercise was deemed a success and well represented by health and multiagency partners from Kent & Medway, South East London and NHS England. EKHUFT Head of EPRR gave a presentation on the exercise in October 2024 to the South East NHS England virtual conference on Hospital Evacuation.

7.12 Internally, site specific evacuation plans are being developed following face to face workshops. Unfortunately, there was not enough staff available to carry out an exercise in November 2024, so it has been postponed to Spring 2025.

7.13 **Exercise Starling** was carried out in June 2024 at QEQM, testing a live, no notice, response to an infant abduction in the maternity ward. All lessons have been identified and are being implemented under the lesson and recommendations process.

7.14 **Exercise Pipeline** was carried out at QEQM with Kent Fire & Rescue Service (KFRS), testing the live response to a steam pipe rupture in the tunnel underneath the hospital. The exercise tested the process of an incident not involving a clinical area and as such the primacy of the response was led by the estates team. The debrief and report are currently outstanding due to sickness within the fire service but will be completed as soon as possible.

7.15 **Exercise Windermere** was carried out in October 2024 with service providers from Dungeness, South East Coast Ambulance Service, KFRS, EKHUFT Radiation Protection Advisors and William Harvey Hospital (WHH) ED team. The exercise tested the live response to a critically injured casualty being transferred from Dungeness to WHH. The exercise was very well attended by EKHUFT staff who took part with enthusiasm and a great deal of learning is being processed to improve response.

7.16 Monthly communications exercises are carried out to test different elements of the communications strategy including the Everbridge mass notification system.

7.17 Throughout the year local exercises have also been led by Emergency Planning in response to specific site risks including lockdown and fire evacuation.

8. Partnership working

8.1 EKHUFT have a duty as a Category 1 responder under the Civil Contingencies Act (2024) to *co-operate with other local responders to enhance co-ordination and efficiency.*

8.2 Throughout 2024 the EPRR team have been promoting our partnerships to improve not only the Trusts resilience but also to develop and improve collectively.

8.3 We continue to chair the Kent, Surrey Sussex Forum for CBRN Providers, set up by EKHUFT. This group meets quarterly and is well attended across the 3 counties. Not only has it created a forum for good practice, support and sharing of knowledge but it has created a collective voice which is now recognised by the South East (SE) Regional CBRN Forum. The Head of EPRR also is a member of the latter forum.

8.4 The Head of EPRR has taken on the role of the Co-Chair for the Kent & Medway Resilience Forum Training & Exercising Group.

8.5 Horizon scanning and 2025 Workplan

8.6 The EU Entry and Exit System has been postponed again with no set date. It is currently on the Trusts risk register as an emerging risk and planning will recommence when the new date is announced.

8.7 Hospital Evacuation will continue to be a key workstream through 2025, both in the Trust and working with wider health partners.

8.8 Exercises and incidents in 2024 have identified gaps in CBRN/Hazmat response arrangements. These areas do not currently have national or local guidance and as such EKHUFT EPRR team will continue to work with local and regional colleagues to endeavour to resolve these gaps.

8.9 National funding has now stopped for the supply of powered respirator protective suits and Trust are required to fund the procurement of replacement suits to maintain the national standard. EKHUFT have 15 suits expiring in 2025 and have submitted a business case to purchase the required stock. These are a new model and will require additional training to roll out to staff.

8.10 An internal business continuity audit will take place in March 2025 carried out by the Trusts independent auditor.

East Kent Hospitals University NHS Foundation Trust

Appendix 1- NHS England Core Standards Emergency Preparedness, Resilience and Response Annual Self-Assessment Outcome Report 2024

1. Introduction

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

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

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

The table below outlines the RAG rating scoring system.

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

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

2. 2023 Outcomes

East Kent Hospitals University Foundation NHS Trust were rated Fully Compliant against all 62 core standards.

The deep dive on EPRR Training was also self-assessed and the Trust was rated Fully Compliant against all 10 standards.

3. 2024 Outcomes

3.1 Core Standards

East Kent Hospitals University Foundation NHS Trust have self-assessed against 62 core standards and have rated as Fully Compliant.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	62	0	0

3.2 Good Practice

The following areas have been identified as areas of good practice within the self-assessment.

	Core Standard	Example of Good Practice
Areas of Strength (1)	Standard 38 The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) demonstrating engagement and co-operation with partner responders.	EKHUFT Head of EPRR is the Co-Chair for the KMRF Training, Exercising & Development Group and chaired the planning group for Exercise Melville, a multiagency table top exercise looking at acute Hospital evacuation.

Areas of Strength (2)	Standard 6 The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	EPRR have a clear process for capturing evidence and learning from incidents and exercising, which include visibility at an Executive level via quarterly CEMG reports
Areas of Strength (3)	Standard 58 The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	The Trust has reviewed and updated the Hazmat & CBRN Decontamination Plan in line with the new IOR principles which have been embedded into training. The training programme is extensive and has been revised to improve refresher sessions and launched a new eLearning package for UTCs. EKHUFT continue to host and chair the KSS CBRN Forum which is well attended and recognised by the SE Regional CBRN Forum, which EKHUFT also attend.

3.3 Deep Dive

This year's Deep Dive topic is Cyber Security. The deep dive assessment does not impact the overall outcome of the core standards. Working with EKHUFTs IT team, the Trust rated fully compliant in 8/11 standards and partially complaint in 3/11 standards.

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	8	3	0
Total	11	8	3	0

The areas below are noted as examples of good practice

'Deep dive'	Core Standard	Example of Good Practice
Areas of Strength (1)	DD1 Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	EKHUFT IT team engage with EPRR in formal governance process but also in planning, exercising and incident response.
Areas of Strength (2)	DD2 Cyber Security & IT related incident response arrangements	The Cyber Incident Response Plan was developed in conjunction with EKHUFT IT and tested in Exercise Ultron

Areas of Strength (3)	DD5 The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	Exercise Ultron was carried out in November 2023 and tested a variety of cyber-attack modes. The exercise was Trust wide with partners from K&M ICB and Kent Police Cyber Crime Team.

The standards rated as partially complaint and the relevant action plan is tabled below.

	Core Standard	Key areas for improvement
Areas for improvement (1)	DD7 The organisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	EPRR to include IT Cyber Security element in Command training package
Areas for improvement (2)	DD9 The Cyber Security and IT teams are aware of the organisation's critical functions and the dependencies on IT core systems and infrastructure for the safe and effective delivery of these services	Create Core Systems BIA as part of the BCM review
Areas for improvement (3)	DD11 IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	1.Trustwide service level plans are under review as part of the BCM programme review. Critical services IT core systems will be included in revised plans. 2. IT to complete internal service BIA and BCP.

4. Action Plan

All actions have been designated to a responsible person and aim to be completed by the end of Q4. Tracking of the actions will be through the Strategic Resilience and Capabilities Group.

5. Final Outcome letter

NHS
East Kent
Hospitals University
NHS Foundation Trust

Kent and Medway LHRP

NHS
Kent and Medway

Private and confidential

Rob Hodgkiss
Accountable Emergency Officer
East Kent Hospitals University Foundation Trust

Sent via email

NHS Kent and Medway ICB
Gail House
Lower Stone Street
Maidstone
Kent
ME15 6NB

Monday, 27th January 2024

Dear Rob,

RE: NHS England EPRR Assurance 2024 – East Kent Hospitals University Foundation Trust

Firstly, can I thank East Kent Hospitals University Foundation Trust EPRR Lead, Hayley Lingham, for her work with Kent and Medway ICB's EPRR team during this year's assurance process.

As discussed at the LHRP Executive Group meeting on 18th November 2024, East Kent Hospitals University Foundation Trust have been assessed as **Fully compliant** against this year's NHS England EPRR core standards.

NHS England define Fully Compliant as: The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards.

As outlined at the LHRP Executive Group meeting, Kent and Medway ICB and LHRP partners are looking to continue to build on the EPRR assurance process with agreed ambitions for the coming year:

- For every LHRP member to either maintain their current level of compliance or for those requiring it – to move up at least 1 compliance level in the coming year.
- This will be delivered with support from the wider Local Health Resilience Partnership working collaboratively together

On behalf of the Kent and Medway Local Health Resilience Partnership and NHS Kent and Medway ICB, our sincere thanks for your help and assistance in completing this year's annual EPRR assurance process.

Yours sincerely

Mike Gilbert
Executive Director of Corporate Governance
NHS Kent and Medway
Co-Chair of the Kent and Medway LHRP

Prof David Whiting
Director of Public Health

Medway Council
Co-Chair of the Kent and Medway LHRP

Chair | Cedi Frederick
Chief Executive | Paul Bentley

Together, we can

www.kentandmedwayicb.nhs.uk

We care

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **28 January 2025**

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

Paper Author: **Executive Assistant / Dr Andrew Catto**

Quorate: **No**

Appendices:

None

Declarations of interest made:

The Chair advised his provider organisation, IC24, was member of the Urgent Treatment Centre (UTC) Alliance and would be asking about controlled drug utilisation in the UTCs at item 168/24.

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

Agenda item	Summary
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS)).	The Committee received the report and **NOTED** the following key updates: • In December, the Trust submitted the last and final Serious Incident (SI) report to the Integrated Care Board (ICB), following the implementation of the Patient Safety Incident Response Framework (PSIRF). • There has been a significant improvement in Duty of Candour (DoC) reporting and the Trust was currently 100% compliant in all areas. • The outstanding After Action Reviews (AAR) remained a challenge to complete and close. There were 44 open at the end of November 2024. • Work was ongoing to close overdue incidents responses and this remained a challenge. This would be kept under review • Clinical Audit was on track to deliver against the agreed trajectory with regards to National Institute for Health and Care Excellence (NICE) compliance. • There were currently four open Patient Safety Alerts: three of which were overdue for completion. All had a robust plan in place to complete the required actions. • There was no legal element of the report due to the current pressures within the team. Work was currently taking place to rebuild and restructure the Legal Team, noting the pressure resulting from the number of open inquests.

East Kent Hospitals University NHS Foundation Trust

ENDOSCOPY UPDATE	The Committee received the report and **NOTED** the following key updates: • It was confirmed that Endoscopy DMO1 was now in a more stable position. The backlog in overdue surveillance had now been cleared and there were just 24 patients beyond the Joint Advisory Group (JAG) tolerance who were being managed individually. • It was confirmed that no new patient harms related to endoscopy had been identified. • The Chair sought clarity on the status of the endoscopy business case in a challenging financial climate.
QUALITY ACCOUNT PLAN FOR COMPLETION AND SIGN OFF AND 2025/26 QUALITY ACCOUNT PRIORITIES	The Committee received the report and **NOTED** the following key updates: • The Quality Account would be themed using We Care domains and Quality Improvement themes, to ensure it was not an isolated document. • The aim was for the document to be drafted by March. • The Quality Account would be merged with the Annual Report, and this would increase the audience for the document. The Chair sought clarity on whether combining the reports was appropriate and was reassured that this was accepted practice.
MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received the report and **NOTED** the following key updates: • 18 of the 31 risks related to quality risks and nine of the 18 had overdue actions, which was an improvement since the last report. • A new risk lead recently joined the Trust, Angela Callaghan, Head of Risk Management and Assurance. • A new risk training package was being developed for relevant staff and the team were working to embed risk review as a business-as-usual process. • Risk 2123 Health Records Lack of Storage and risk 3727 Inadequate staff attendance with mandatory resus training, had been escalated to the significant risk register.
CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received the report and **NOTED** the following key updates: • A maternity inspection took place in December 2024 and the Trust was due to receive the report in circa February 2025. • Three Care Groups had now attended their second internal 'check and challenge' meeting and have demonstrated improvement in scores for across all five CQC domains. • The CQC inspected Spencer Private Hospitals (SPH) the week beginning 2 January 2025. The full report is awaited, and the central governance team continue to support to SPH.

We care

QUARTERLY INTERNAL AUDIT UPDATE	The Committee received the report and **NOTED** the following key updates: • The Trust was in a much-improved position, and 97% of the audit plan was on track for completion. • The Trust was participating in 92% of National Audits.
PROFESSIONAL STANDARDS COMPLIANCE UPDATE	The Committee received the report and **NOTED** the following key updates: • Professional standards related to the time related intervals, where we would expect certain events on a patients journey to happen, for example the target to be seen by clinical teams from arrival in the emergency department, timescales for diagnostic test and decision making regarding appropriate treatment. This important data will provide improved insights on care outcomes in relation to time taken to senior review and timely access to diagnostics. • The Chief Medical Officer (CMO) was working with the Information Team to identify and provide data on performance for meeting these targets, so manual audits of individual admissions were not required.
REGULATORY COMPLIANCE GROUP CHAIR'S REPORT	The Committee received the report and **NOTED** the following key updates: • The purpose of the Regulatory Compliance Group (RCG) was to bring all regulatory activity into once place, so they could be monitored effectively and as the process matured and triangulated. • External visits from all regulatory agencies would be monitored by the RCG and any improvement actions arising from a visit would be tracked. • The Medical Education deanery visits had now been incorporated into review process.
NEO-NATAL DEATHS REPORT	The Committee received the report and **NOTED** the following key updates: • It was advised that the Neonatal Death report had been delayed, although it should be available by the next Q&SC.
MATERNITY & NEONATAL ASSURANCE GROUP (MNAG)	The Committee received the report and **NOTED** the following key updates: • MNAG was being changed to the Maternity Board and the Board would be joined by two members of the 'Reading the Signals' Group. • The Freedom to Speak Up guardian service was in the process of being re-provided with a view to starting a new service in March 2025. • It was anticipated that after the Maternity Safety Support Programme (MSSP) review visit, the Trust would move to sustainability stage.
NEVER EVENT 2 YEAR LOOK BACK	The Committee received the report and **NOTED** the following key updates: • There had been a cluster of five Never Events in quarter 2, which required further review and therefore a 2 year look back exercise was completed. The look back exercise looked at 15 events, 11 of which related to surgical invasive procedures. • A peer review of theatres across the Trust (2023) by the Association for Perioperative Practice (AfPP) identified primarily good practice and some areas of improvement. An improvement plan continued with the aim of achieving AfPP accreditation in 2025. An update would be brought to QSC on the AfPP reviews in March 2025.

	• The organisational oversight of National Safety Standards for Invasive Procedures Version 2 (NatSSIPs 2) required strengthening. • It was confirmed that the Trust's data was comparable to acute trusts of similar size.
RIGHT CARE RIGHT PERSON STRATEGY UPDATE	The Committee received and **NOTED** the regulatory compliance chair's reports: • The Trust had seen an impact of a new Associate Director of Mental Health joining the Trust at the end of 2024. • The Trust was looking to bring in more mental health professionals and we were working closely with Kent and Medway NHS and Social Care Partnership Trust (KMPT). • A training programme for Trust Staff related to de-escalation was being developed.
CONTROLLED DRUGS– DEEP DIVE.	The Committee received the report and **NOTED** the following key updates: • As a Trust, there was an increased number of controlled drugs issued, these tend to present risks around habit forming. • Training for staff remained important in supporting the safe use of controlled drugs, particularly in palliative care where such training must be recognised as essential for staff delivering end of life care. • An annual audit of controlled drugs on discharge would be taking place • Pharmacy was working with the nursing teams on ward storage of controlled drugs.
INTEGRATED PERFORMANCE REPORT (IPR)	The Committee received and **NOTED** the IPR.
PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience report.
MORTALITY SURVEILLANCE & STEERING GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the Mortality Surveillance & Steering Group report.
CLINICAL AUDIT AND EFFECTIVENESS CROUP (CAEG) CHAIR'S REPORT	The Committee received and **NOTED** the Clinical Audit and Effectiveness Group report.

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PATIENT SAFETY COMMITTEE (PSC) CHAIR'S REPORT	The Committee received and **NOTED** the Patient Safety Committee report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.

Referrals from other Board Committees

The following referrals from Council of Governors was also considered at this meeting.

- Pharmacy delays
- Neonatal Death review
- Patient Appointment concerns

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

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: **18 March 2025**

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

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

Appendix 1: NRC Terms of Reference (ToR)

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary
Update on Chair and NEDs Recruitment	• The Committee received **Assurance** of the recruitment exercises in train.
Board Development Programme 2024/25	• The Committee received **Assurance** of the NHS Providers Board Development Programme undertaken in 2024/25 and feedback for consideration for future Development Programmes.
Annual NED Responsibilities and Skills Review	• The Committee received **Assurance** from the annual review noting the division of responsibilities across NEDs currently, the roles/positions that remained interim or unfilled. It was noted there will be a further review following the NEDs recruitment ensuring responsibilities are equally shared, and this will also address current skills gaps.

Committee Effectiveness Review	• The Committee received **Assurance** from the responses/findings of the NRC effectiveness survey for 2025, and noted the following key points:
	  • Majority of respondents 'strongly agreed' or 'agreed' to positive statements of the Committee's performance;
	  • Concerns raised included: quality of papers needed to improve, providing adequate information to permit decisions to be made with presentation of various options;
	  • Reviewed NRC ToR with no amendments required, attached (Appendix 1) for BoD approval.

East Kent Hospitals University NHS Foundation Trust

Pay Policy for Very Senior Managers (VSMs)	• The Committee received **Assurance** from the policy updates and approved the revised policy.

Other items of business

- The Committee noted the 2025/26 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 NRC asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 3 April 2025
The NRC asks the BoD to **APPROVE** the NRC ToR.	Approval	To Board on 3 April 2025

East Kent Hospitals University NHS Foundation Trust

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

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

2 PURPOSE

2.1 The Nominations and Remuneration Committee is a Committee of the Board and fulfils the role of the Nominations and Remuneration Committee for executive directors described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

2.2 The Trust chairman and other non-executive directors and chief executive (except in the case of the appointment of a chief executive) are responsible for deciding the appointment of executive directors.

2.3 The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the chief executive and other executive directors including:

(i) all aspects of salary (including performance related elements/bonuses)
(ii) provisions for other benefits, including pensions and cars
(iii) arrangements for termination of employment and other contractual terms

2.4 To appoint and set the terms and conditions for subsidiary Board members and review any Key Performance Indicators/objectives/performance bonus. Receive a recommendation from the subsidiary Board and Nominations and Remuneration Committee on achievement against these.

2.5 To recommend the level of remuneration for executive directors and monitor the level and structure of remuneration for very senior management.

2.6 To agree and oversee, on behalf of the Board of Directors, performance management of the executive directors, including the chief executive.

2.7 Any proposed changes to the terms of reference will be approved by the Board.

2.8 The appointment of a chief executive requires the approval of the Council of Governors.

3. OBJECTIVES

The Nominations and Remuneration Committee is responsible for:

3.1 Establishing a process to identify suitable candidates to fill executive director vacancies as they arise and making recommendations to the chairman, the other non-executive directors and chief executive. Recommendations in relation to the chief executive position will be to non-executive directors only.

3.2 Considering nominations for executive directors and chief executive positions.

3.3 To set the remuneration and terms of service for the chief executive and executive directors with the support of independent advice as appropriate.

3.4 To ensure that individual executive directors have performance objectives and personal development plans, that are reviewed twice yearly. The review will also consider the capability of the executives as a team as well as at the level of individuals identifying any team development needs.

3.5 To include in its decisions all aspects of salary (including any performance related elements) and provisions for other benefits (including pensions and cars).

3.6 To decide on the appropriate contractual arrangements for executive directors, including a proper calculation and scrutiny of termination payments, taking account of legislation and such national guidance as is appropriate.

3.7 To ensure the Trust achieves proper control of the total remuneration paid to the executive directors by developing appropriate pay and reward policies for these posts. The Committee will ensure it has a clear statement of the responsibilities of the individual posts and their accountabilities for meeting the objectives of the organisation, a person specification for each post, a means of assessing the comparative job “weight”, with comparative salary information from the NHS and other areas and criteria and mechanisms for assessing performance.

3.8 To ensure the publication, in annual reports, of the total remuneration from NHS sources of the chief executive and executive directors.

3.9 To recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose will be determined by the Board and described in the Pay Policy for Very Senior Managers.

3.10 To receive an annual report on the application of the Pay Policy for Very Senior Managers from the chief executive

3.11 Approve any non-contractual termination payments to staff in-line with the Trust’s Special Severance Pay Policy.

3.12 Annually reviewing the structure, size and composition of the board of directors and to make recommendations for change, where appropriate.

3.13 Evaluating the balance of skills, knowledge and experience of the board of directors and, in the light of this evaluation, preparing a description of the role and capabilities required for the appointment of executive directors and the chief executive.

3.14 Ensuring that appointments to the board of directors are based on merit and objective criteria as well as meeting the "fit and proper" persons test described in the Provider Licence.

3.15 Appointing a shortlisting and appointments panel for the appointment of executive directors and the chief executive.

3.16 Succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required on the Board to meet them.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The committee will be comprised of the non-executive directors, chairman and chief executive (except in the case of appointment of a chief executive). **Interview panel membership** will be determined by the Nominations and Remuneration Committee who will appoint from its members a selection panel, with the addition of the chief executive, where executive director appointments are being made. It may invite others as suitably qualified advisors as it sees fit.

Chair

4.2 The Chair of the committee will be the Trust chairman or non-executive director as determined by the Nominations and Remuneration Committee of the Board.

Attendees

4.3 The Chief People Officer (or representative) will attend in an advisory capacity.

4.4 The Chief Executive will attend (except when their own post is under discussion) and should attend when executive directors remuneration is discussed.

Quorum

4.5 Business will only be conducted if the meeting is quorate. The Committee will be quorate with four non-executive directors present. If the Chair is in attendance, this will count towards the quorum.

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

Attendance

4.7 The Chair, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings.

Attendance by Officers

4.8 The Committee will be open to the Group Company Secretary to attend.

4.9 Other staff, or external advisors, may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote. Advisors to appointment panels do not have a vote.

5. FREQUENCY OF MEETINGS

5.1 Meetings of the Committee shall be generally held up to four times a year, as determined by the work of the Committee. The likely timetable of meetings is as shown below:

Date	Purpose
End May	Sign off Executive Director performance appraisal for preceding financial year and performance objectives for current financial year. Identify personal and team development needs for the Executives as individuals and as team members.
July	Review salaries of Executive Directors as appropriate
Oct / Nov	Review mid-year performance of Executive Directors. Make a final decision on any appeals from Executive Directors on access to annual pay uplift Review progress against personal development plans where appropriate.
Feb / Mar	Review policies for remuneration of Executive Directors and senior managers not covered by National terms and conditions

6. AUTHORITY

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

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

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

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

7 SERVICING ARRANGEMENTS

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

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

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

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

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

9. RELATIONSHIPS WITH OTHER COMMITTEES

9.1 Council of Governors' Nominations and Remuneration Committee.

9.2 The Committee will receive Chair reports from the Board Committees as required. To review and consider findings of significant assurance functions and the implications for the governance of the organisation.

10. MONITORING EFFECTIVENESS AND REVIEW

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

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

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

10.4 The Committee will report on an annual basis to the Board of Directors on the work it has undertaken in the year and describe its work in the Annual Report.

East Kent Hospitals University NHS Foundation Trust

Date Approved by Board:

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **25 February 2025**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Associate Director of Quality Assurance presented an update, noting the details included within the report. There are 31 risks in total on the SRR, 12 of which are related to finance and performance; five risks have overdue actions associated with them. One risks has been added to the Residual Risk Register for finance *('Failure to plan effectively for 25-26 delivery of activity within available funding').* This is a Trust-wide risk with the residual score of 12 (moderate). There is a proposal to add the national review of job profiles of Band 2 and 3 Health Care Support Workers (HCSWs) and risk related to local implementation to the SRR.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee reviewed its BAF Risks as it does at each Committee, recognising the agenda had been framed with reference to the BAF. The Director of Corporate Governance (DCG) advised there was no significant change from January 2025 and noted that the Executive team had scheduled their annual review of the BAF risks and scoring to ensure they still reflect strategic risks.
Digital Risk	The Committee received the report detailing the risks associated with cyber security and also around digital transformation for the organisation. The current BAF does not have cyber security or digital risk. Therefore, it is the Committee's recommendation that two further risks be considered for the BAF: cyber risk; and separately one around digital, data and technology (DDAT) risk.

	The Committee discussed that older equipment and systems could be more vulnerable to potential cyber-attacks and sought assurance around monitoring of the risks posed by unsupported systems in terms of making financial savings. The Committee had a robust discussion around financing of projects associated with digitisation and agreed that a robust and accountable governance process would be needed in the context of the Trust's ability to finance new systems.
We Care Integrated Performance Report (IPR) (M10): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee **NOTED** the IPR operational metrics and in particular noted the following key points: – The Trust continues on the improvement trajectory in terms of operational metrics overall, which is to be commended. – However, there have been infection prevention and control challenges associated with Norovirus which elevated risks held in the Emergency Departments (EDs) both at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM). – Patient discharge remains very challenging for the Trust. Whilst the desired position would be 50-60 discharges per day across all sites, there are instances when the Trust can only achieve ten discharges per day for reasons beyond its control. – There are some concerns around the 65 – week trajectory. The Committee heard there are currently 90 patients who have been waiting for treatment for 65 weeks but the Executives are striving to reduce this to 0 by the end of March 2025. The work is ongoing to establish if long-waiting patients had come to any harm as a result of the delay. The Committee awaits information on the Trust's position with regards to the new 2025/26 standards and targets.
Patients no Longer Fitting the Criteria to Reside	The Committee received and **NOTED** the Patient No Longer Fit to Reside report. The Committee agreed that it would be useful to receive insights as to what is driving the current position and gain assurance around actions that would help to improve the situation.
Cost Improvement Programme (CIP) Oversight and Assurance	The Committee Received an update of the CIP and these are the highlights: – In Month 10 the Trust is forecasting to deliver £48.45m of savings against a plan of £49m, which is slightly below the plan. – The recurrent savings are currently at 77% and meets the expectations of the planning assumptions. – In month 10 Length of Stay (LoS) was significantly below trajectory increasing to 11.4 days in January 2025. The under delivery of LoS was

	mitigated by the over performance in the Theatres, which delivered £508k more than plan in Month 10. – Whilst overall the Trust is forecast to deliver £48.45m of savings, there are concerns around some high value schemes, which could impact delivery of the total savings target. The Committee discussed the increased Theatre performance. It was noted that whilst this generated a substantial income for the Trust, the challenge remained to use the capacity in a more efficient way within core NHS hours. The Committee acknowledged that the Trust had a good process for identifying CIPs but the ongoing challenge was to move faster and deeper to maximise CIP benefits.
Month 10 Finance Report	The Committee received an update and **NOTED** the following: – At Month 10 the Group recovered the overspend of £2.1m occurred in Month 9. – The Trust's run rate between Month 9 and Month 10 improved by £0.5m. The Trust needs to see a continued reduction in the final two months of the financial year from £6.5m to £5.1m to achieve the planned deficit position. Chief Executive Officer (CEO) and Chief Finance Officer (CFO) are working closely with the Care Groups to contain expenditure and mitigate winter related risks. – In addition to the internal measures to achieve the planned deficit position, the Trust collaborates with the Integrated Care Board (ICB) partners to evaluate all opportunities to contain spending in order to achieve the deficit target. The Chief Strategy & Partnerships Officer (CSPO) informed the Committee about the discussions held at regional levels in relation to the allocation for the Community Diagnostic Centre (CDC) in Thanet. There will be underspend against CDC for EKHUFT in this financial year but the Trust was assured that the system and region would support the Trust and there will be no detrimental impact on EKHUFT in terms of capital in the year 2025/26.
Financial Sustainability Plan (FSP) Update	The Committee received an update regarding the FSP. The Chief Finance Officer (CFO) informed the Committee that in January 2025 the NHS England (NHSE) South East team and the ICB shared their feedback with regards to the FSP approved by the Trust Board in December 2024. The consensus is that the Year 3 deficit of £43m does not meet expectations. Therefore, the CFO has commenced a piece of work in collaboration with CSPO and digital team to understand what additional interventions could be added to the plan.

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Update on Spencer	The CFO informed the Committee that given constraints on the NHS income, she is in conversations with the CEO of Spencer Hospitals to understand their strategy and business plans to identify interventions that would help growth.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee **NOTED** there were no business cases to discuss.
Workforce Quarterly Report	The Committee received the report outlining the Quarter 3 position on substantive recruitment for hard to recruit roles and premium spend. The main challenge is that agency expenditure remains significantly above the national target (5.1% against the target of 3.7%). The majority of agency spend is in the medical area. The Committee **NOTED** the Trust are currently working on a number of workforce schemes to reduce reliance on agency locums and in turn increase bank optimisation. The Committee sought assurance that Vacancy Control Panels (VCPs) were achieving their purpose. It was acknowledged that the VCPs could be more effective and the clarity around establishment would help to achieve this.

Business Case Scrutiny Group (BCSG) Assurance Report	There were no business cases to discuss. The Committee will receive assurance on the contract approval governance in the Trust at a future meeting.
Financial Improvement Programme Board (FIPB) Assurance Report	The Committee **NOTED** the report.
Feedback to Board of Directors	The Committee noted no feedback to Board Members.
Referrals to Other Board Committees	The Committee noted no referrals to Board Members.

Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	3 April 2025

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **25 March 2025**

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

Paper Author: **Executive Assistant**

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Significant Risk Register (SRR)	The Committee received and **NOTED** the March SRR relevant to its remit. The update highlighted the reduction in the number of overdue actions associated with the finance and performance related risks. The Committee recognised the work that continues to identify, mitigate and update the Trust's risks. The Committee requested the report includes timing milestones for achieving the target risk scores in the next report. The Committee also noted, in particular, the Risk relating to *Increased length of stay for mental health patients awaiting inpatient community beds and working with Kent and Medway NHS and Social Care Partnership Trust (*KMPT) and impact of Safe Haven initiative.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee **NOTED** its BAF risks and that the next Committee meeting will receive the end of year review of the existing BAF risks for the Committee and recommendations for 2025/26.
We Care Integrated Performance Report (IPR) (M11): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics	The Committee received the IPR operational metrics and in particular **NOTED** the following key points: – There are plans to re-set the Theatre Improvement Programme and Urgent Treatment Centre (UTC) Improvement Programme. – Drive to eradicate 65 weeks wait by the end of March 2025 continues but the realistic expectation is that it will be achieved by the end of April 2025. – The Committee noted that there is one breach of 78 weeks wait, which is largely due to erroneous pathway usage.

	The Committee heard specific challenges related to delays in sending out clinic letters to patients and challenges with digitisation of medical records. The Committee **NOTED** that these are areas being addressed by the Executives.
Month 11 Finance Report	The Committee received and the Month 11 Finance Report and **NOTED** its content. It was welcomed that the Trust was on track and recognised the work done to stay on track to the forecast year end position.
Business Planning and Update on capital	The Committee reviewed and **NOTED** the latest position on the capital allocation plan. The Chief Finance Officer (CFO) provided the Committee the updated and latest position on the contract discussions with Integrated Care Board (ICB) and expectations on the Trust's deficit position. The Committee **NOTED** the discussions with the ICB around the system-level saving schemes. The Committee acknowledged that providers would have to take responsibility and, therefore, risks for the system-level schemes they participate in. The Committee appreciated that the discussions were ongoing and any final position would be for the Board to approve.
Cost Improvement Programme (CIP) Oversight and Assurance	The Committee received an update on CIP. The Committee spent some time focussing on the 2025/26 CIP plan. The total unadjusted savings opportunity is valued at £32.8m which reduces to £20.6m when risk adjusted based on the planning status of schemes. Due to the ICB funding position, the Trust will be required to deliver a higher savings programme separate and in addition to any contribution from clinical income. The Committee **NOTED** the key actions including consideration of all services and opportunities including decommissioning and consolidation of service delivery. The Committee welcomed the assurance that savings delivery planning will include an engagement-based approach to ensure Care Groups and Corporate functions approve plans prior to the removal of savings from budgets to ensure upfront buy-in to the delivery of CIP. The Executives are identifying all saving opportunities and/or where the Trust could go further in terms of already proposed saving opportunities. The Committee requested that the Committee and Board are kept close to the detail as it emerges.
Financial Sustainability Plan Update (FSP)	The Committee received an update regarding the FSP. The Committee **AGREED** for the CFO to formally submit the addendum to the Financial Sustainability Plan for EKHUFT Board approval at its April 2025 meeting.

	The Committee endorsed the proposed interventions to support the closing the residual £43m gap as requested by the NHS England (NHSE).
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee **NOTED** there were no business cases to discuss.
Tax Matters	The Committee received and **APPROVED** the Trust Tax Strategy and Transfer Pricing Strategy. The Committee received an update and **NOTED** on changes to Section 41 of the UK VAT Act 1994 around refund rules. The current VAT recovery arrangements are considered complex and inefficient. Several options were proposed and a Full Refund Model (FRM) is the preferred option. This would enable VAT on all goods and services required for non-business activities to be recovered, similar to the tax benefits enjoyed by EKHUFT, in relation to its wholly owned subsidiary. The Committee **NOTED** the risks associated with the current discussions related to tax relief in this area by HM Treasury. This presents a significant financial risk to EKHUFT and other NHS Trusts with wholly owned subsidiaries, particularly if adjustments are made to the detriment of individual organisations.
2025/26 Revenue Support **Accounts Timetable**	The Committee received and **NOTED** 2025/26 Revenue Support Report and Accounts Timetable.
Financial Improvement Programme Board (FIPB) Assurance Report	The Committee **NOTED** the report.
Committee Review	This item was deferred to the FPC meeting on the 29 April 2025.
Feedback to Board of Directors	The Committee noted no feedback to Board Members.
Referrals to Other Board Committees	The Committee noted no referrals to Board Members.

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Item	Purpose	Date
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	3 April 2025

East Kent Hospitals University NHS Foundation Trust

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

Committee: People & Culture Committee

Meeting date: 26 March 2025

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

Paper Author: Claudia Sykes

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: See below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention **Staff recruitment**	The Committee discussed the action being taken on staff recruitment, including ideas for converting agency to substantive roles. Improvements should be seen in midwifery shortly due to the start of 26 newly qualified midwives. There remains a high vacancy level for Healthcare Support Workers (20%) partly due to the pause on recruitment whilst discussions on banding have been taking place.
BAF risk: recruitment and retention **Staff retention**	The Committee received a presentation on the Staff Survey results. • Staff continue to remain less likely to choose East Kent as a place to work or be treated than many other Acute Trusts. There were considerable variances, with a range from 8% to 82% across departments. • East Kent benchmarks 54th out of 58 Acute and Acute & Community Trusts. • East Kent ranks 23rd out of 58 Trusts for overall positive score change, indicating a challenging national climate (with 35 Acute Trusts deteriorating year-on-year). The results masked significant variation between departments; for example Compassionate leadership results varied from 4.72 to 9.12. The Chief People Officer (CPO) presented the plans to address the concerns raised in the Staff Survey. This included targeted support on the 21 departments with the lowest results; and a renewed focus on the Culture and

	Leadership Programme (CLP) which had stalled. This will also link in with the People Strategy being developed. The Committee noted that the appraisal completion rate had met the target of 80% for several months now. Work was being done to review the quality of appraisals and a report would come to the committee in the autumn. The Committee was **ASSURED** around appraisals. The Committee discussed the Medical Job Planning Rate which had been significantly under the target of 90% for the whole year. The Chief Medical Officer (CMO) advised that clinical leads were receiving training on this, and he was closely monitoring the work; he is aiming to be at 95% by the end of May if staff engage with the work needed.
BAF risk: culture and values **Freedom to Speak Up (FTSU)**	The new Guardian service started on 17 March. The Committee will receive the first report in May.
BAF risk: culture and values **Equality, Diversity and Inclusion (EDI)**	The CPO updated the Committee on the priorities for EDI: (1) **Embed fair and inclusive recruitment processes**. The most recent annual Workforce Race Equality Standard (WRES) metric 2 data from 2024 shows that white applicants are 3.57 times more likely to be shortlisted for interview in comparison to applicants from global majority backgrounds. This disparity ranks the Trust in the bottom 4% of NHS Trusts. The target is to reduce this disparity to 2 by the end of 2026. (2) **Career Progression & Increasing Leadership Diversity** The Trust will provide development opportunities and coaching to staff aspiring to be leaders (band 7+, senior medical grades). This will focus on staff from global majority backgrounds and those with disabilities as the WRES and Workforce Disability Equality Standard (WDES) data shows these groups are underrepresented at senior levels; February 2025 global majority at band 7+ is 14.1% of the total workforce. The goal is to achieve a leadership profile (band 7+, senior medical grades) that reflects the Trust's ethnicity and disability diversity within three years, with clear improvement milestones. For global majority this target is 28.9%.. (3) **Reducing Discrimination and Harassment:** Targets are set to reduce workplace discrimination (target 93% by 2026/27) and unwanted sexual behaviour (target 97% by 2026/27). Actions include data analysis, staff support measures, campaigns encouraging staff to speak up, and accountability measures for perpetrators. The Committee welcomed this work, and the specific targets set. The Committee discussed the need to set milestones as part of the People Strategy to ensure this work could be monitored. It was noted that achieving

	some of the targets might be affected by staff turnover rates and workforce planning as part of the Cost Improvement Programme (CIP).
BAF risk: organisational development and resilience **Workforce planning**	The CPO gave an update on the workforce planning underway as part of the Trust's CIP. The Trust is being asked to make significant cost savings, and this will require difficult decisions to be made. The Committee discussed the need to ensure that any staff changes were done with transparency and compassion, fully involving staff affected when this became known. It was important that some of the issues which had arisen during the restructuring of the Administrative and Clerical team in 2024 were addressed and mistakes not repeated. The CPO gave assurance that the People and Culture team had the necessary expertise and capacity.

Other items of business: None

Actions taken by the Committee within its Terms of Reference: None

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

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

Item	Purpose	Date
P&CC asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	3 April 2025

East Kent Hospitals University NHS Foundation Trust

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

Committee: Charitable Funds Committee

Meeting date: 18 March 2025

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

Paper Author: Claudia Sykes

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: See below

Agenda item	Summary
Charity finances	The Committee reviewed the charity's finances against plan, and noted that income was £471k against £581k in January. Reserves are £1.8m, with £0.8m committed to previous funding applications, leaving a balance of £1m. The charity team advised that donations for most health charities had fallen over the last financial period. The Committee discussed whether to revise the charity's income targets for the following years, which had been agreed by the Committee and Trust Board in July 2023 as part of a three year strategy to March 2028. The Committee noted that the charity was now fully staffed, and some activities like major campaigns, which had not started whilst recruitment was underway, should now be pursued at pace. The strategy income targets would be maintained. The Committee noted the reduced funding available for grant applications. This meant that applications would need to have very strong benefits for patients and be sustainable without future charitable funds, to be approved.
Investments	The Committee received a presentation from the charity's investment advisers, Cazenove. They were monitoring the charity's investments carefully to maintain the investment returns at the target of CPI+3%. This had been achieved over the last 12 months, but the market had become extremely volatile since the US change of government.

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Other items of business: None

Actions taken by the Committee within its Terms of Reference:

Approval of 26 patient recliner chairs for £53k for Queen Elizabeth the Queen Mother Hospital (QEQM) Emergency Department (ED)

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

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

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

Item	Purpose	Date
CFC asks the BoD to discuss and **NOTE** this CFC Chair Assurance Report.	Assurance	3 April 2025

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

Committee: **Integrated Audit and Governance Committee (IAGC)**

Meeting dates: **31 January 2025**

Chair: **Dr Olu Olasode, Non-Executive Director (NED)**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No additional declarations of interest were made

The Purpose of the Committee Terms of Reference (ToR) extracts:

The IAGC is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against CQC regulations.

Assurances received at the Committee meeting:

Internal Audit

The IAGC shall ensure that there is an effective Internal Audit function established by management that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the IAGC, Chief Executive and Board. The committee shall monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans.

Internal Audit Progress Report	• The Committee received **Assurance** and noted the Internal Audit progress report:
	  • Two final audit reports issued since the last IAGC meeting:
	  • Data Quality & Performance (Reasonable Assurance): focussed looking at DM01 diagnostic, cancer faster diagnostics standards and endoscopy backlog. Positive report about quality of data and action plans driving forward improvements with clear accountability and oversight;
	  • Business Cases Processes (Partial Assurance): good new process implemented, too early to fully assess its effectiveness, need to better manage and identify the benefits of these going forward in respect of being measured and delivery.

	• Increased number of outstanding actions, with visibility and oversight by the Executive Management Team (EMT) monitoring progress and prompt closure of actions. • Planning in progress for 2025/26 Audit Plan with meetings already held with Executives, and meetings to be scheduled with NEDs. Plan to be presented to EMT and at the next IAGC meeting for approval.

Counter Fraud

The IAGC shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas. The committee will review the adequacy of all policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority.

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 on current open and closed case investigations. • LCFS had reviewed and updated (minor amendments) of the Trust's Anti-Fraud, Bribery and Corruption Policy requiring IAGC approval. • The Committee noted a referral to FPC in monitoring progress implementing a proactive and effective contracts monitoring process (contracts were delivering what was expected and timely looking at new contracts being tendered prior to those in place ending).
Anti-Fraud, Bribery and Corruption Policy	• The Committee received **Assurance** and approved the reviewed and revised policy.

External Audit

The IAGC shall review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements. The Committee shall make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures.

The Council of Governors will take the lead in agreeing with the IAGC the criteria for appointing, reappointing and removing auditors. The IAGC will make recommendations to the Council of Governors on these matters, and approve the remuneration and terms of engagement of the External Auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the IAGC.

The IAGC shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. The Head of External Audit will have unhindered and confidential access to the Chair of the IAGC.

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. • Good position preparing for the 2024/25 audit, early interim testing undertaken, with positive engagement from Finance staff with requested information provided.

	• The Committee received reassurance of sufficient staff resources in the Finance team to ensure the Trust met the June submission deadline for the 2024/25 Annual Accounts.

Financial Reporting

The IAGC will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. In doing so, the IAGC shall additionally utilise the findings of the Finance and Performance Committee.

The Committee shall monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them.

The IAGC shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

The IAGC should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Valuation of Trust Estate for Accounting Purposes 2024/25	• The Committee received **Assurance** from the report on the change of valuers for the 2024/25 valuation, no issues expected as new valuer is experienced and reputable. • Continuing to work closely with the Trust's External Auditors during the valuation process.
2024/25 Quality Accounts – Production and Approval Process	• The Committee received **Reassurance** from a verbal report noting a planning report presented to the Quality and Safety Committee (Q&SC) setting out the process and timetable for production and approval of the 2024/25 Quality Accounts (agreed this to be circulated to IAGC for information). • It was noted the Director of Quality Governance will be working closely with the Governors to ensure their early review of the draft and final version prior to approval and submission.

Governance

The IAGC shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control (clinical and non-clinical) across the whole of the organisation activities that supports the achievement of the Trust's objectives.

Governance Improvement Programme • **Committee Review: Proposal and Timeline** • **Good Governance Institute (GGI) Refresh Report**	• The Committee received **Assurance** from the report, noting each Board Committee had reviewed and agreed the proposed approach of the Committee review plan and timetable. Survey to be published, results and action plans to be discussed at the next round of Committee meetings. An overview report of all Board Committee reviews will be presented to the next IAGC meeting. • Trust's Constitution will be reviewed and updated, to be progressed by a Governor sub-group. The revised version to be presented to Council of Governors and Board of Directors (BoD) for approval of any changes.

	• Further update report on the governance improvement programme to be presented to the next IAGC meeting that will include the GGI action plan for ongoing monitoring.
Quality Governance (QG) Update	• The Committee received **Assurance** and noted the Q&SC were testing the outcome and effectiveness of the QG work around the Care Groups Care Quality Commission (CQC) compliance, with good progress already made. • The Committee noted the baseline assessment undertaken using GGI QG Matrix, majority of Care Groups had low scores with an action plan developed to improve these, to be reassessed in 12 months. Plan in place to address variation in practice of QG across Care Groups with robust actions.
Board Assurance Framework (BAF) Review	• The Committee received **Assurance** from the BAF, noting a new risk regarding digital/cyber risks of cyber security and data loss.

Risk Management

The Committee will review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Executive Risk Assurance Group, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Board.

The Committee shall review the Trust's internal controls (clinical and financial) and risk management systems.

The IAGC will undertake periodic review of progress against the Board Assurance Framework and Corporate Risk Register, with significant changes highlighted. Where these items are of such a significant nature, 4.2 refers, the Chair of the IAGC will bring them to the immediate attention of the chair of the Board of Directors. A full copy of these key documents will be made available to the IAGC in accordance with the timetable agreed by the Board and will normally be reviewed in full prior to the production of the Annual Report and Accounts and the Annual Governance Statement and as part of the Trust's mid-year review process.

Risk Register Report	• The Committee received **Assurance** and noted the Significant Risk Register providing visibility and oversight of the key risks facing the organisation. It recognised the improvements in the risk management process, also identified by the Board Committees. • The Committee highlighted the need to look at an achievable timeframe that actions will reduce risk scores, enabling risks moving from the residual risk score to the target risk score. • All risks assigned an Executive Director and reported monthly to Clinical Executive Management Group (CEMG) ensuring robust oversight. • Overdue actions escalated for immediate attention with risk owners and discussed at Risk Review Group (RRG) (deep dives continuing with Care Groups presenting on their risks at these meetings). Ongoing improvement work to be a key focus for the new Head of Risk Management and Assurance. • Robust assurance process in place with the Trust subsidiaries providing oversight of their risks and working much more closely.

	• Update on the Legal Services team risk and position regarding staff resources support to ensure sufficient management of case load to be presented to the next IAGC meeting.

Internal Control

The Committee will review the adequacy of all underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

The Committee will review the adequacy of all policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, and consider any training requirements to ensure committee members are kept up to date with emerging requirements.

Grip and Control PricewaterhouseCoopers (PwC)	• The Committee received **Assurance** from a verbal update on the improved grip and control processes, to be further supported with additional resources in the Finance team and recruiting to the Programme Management Office (PMO). • Internal Audit review of the processes in place with recommendations and actions to be taken forward with oversight from the Chief Finance Officer (CFO). • Continued focus, monitoring and challenge with Care Groups on effectively managing their financial budgets and expenditure, as well as reducing the Trust's staff agency use and costs.

Losses and Special Payments Report	• The Committee received **Assurance** and noted the report for the year to 31 December 2024, noting:
	  • Losses and special payments totalled £228k (158 cases), compared to £215k (236 cases) in the previous financial year representing an increase of £13k in year;
	  • Overseas visitor debt written off represented 34 cases valued at £170k, compared to 55 cases valued at £144k in the same period of the previous year.

Other Assurance Functions and Regulatory Compliance

The IAGC shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, NHS England/NHS Improvement etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

The Committee will review the adequacy of all arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

The IAGC shall review arrangements by which staff within the Trust may raise confidentially concerns over financial control and reporting, clinical quality and patient safety and other matters.

Data Security and Protection Toolkit (DSPT) Submission 2024/25 Progress Report	• The Committee received **Assurance** on the preparation of the 2024/25 DSPT submission, noting focus on IG training, multi factor authentication (MFA), and records retention compliance. • The Committee noted the Cyber Assurance Framework (CAF) reflecting the increased thresholds of cyber risks, and Information Commissioner's Office (ICO) consensual audit assurance levels and associated action plan.
Freedom to Speak Up (FTSU) Service	• The Committee received **Assurance** of the new service outsourced to the Guardian Service, to go live mid-March, this will provide assurance FTSU being effectively managed. Ongoing reports to be provided to the People and Culture Committee (P&CC) and Board of Directors (BoD). The Committee will receive an update on progress as part of the Internal Audit progress report and audit review of the new service. • The Committee highlighted the importance of a robust handover of existing individual cases and taking forward actions.

Relationships With Other Committees

The Committee will receive minutes for scrutiny from the following meetings:

- *Executive Risk Assurance Group*
- *Regulatory Compliance Committee*

The Committee will receive Chair reports from the Quality and Safety Committee, Finance and Performance Committee and People and Culture Committee, as required, to review and consider findings of significant assurance functions and the implications for the governance of the organisation.

Other items of business

The Committee noted the 2025/26 IAGC Annual Work Programme.

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 3 April 2025.
The Committee referred to the Finance and Performance Committee (FPC) to monitor implementing a proactive and effective contracts monitoring process (contracts delivered what was expected and timely looking at new contracts being tendered prior to those in place ending).	Assurance	
The Committee referred to the People and Culture Committee (P&CC) ongoing monitoring of the new FTSU service.	Assurance	