EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS MEETING – 25 JULY 2014**
SUBJECT:	**COMPLIANCE FRAMEWORK QUARTERLY SUBMISSION QTR 1 2014/15**
REPORT FROM:	**DIRECTOR OF FINANCE & PERFORMANCE MANAGEMENT**
PURPOSE:	**Decision**

CONTEXT / REVIEW HISTORY

The *Risk Assessment Framework*, issued by Monitor in August 2013, sets out the approach by which they will assess the risks to the continued provision of NHS services. Monitor will use this framework to undertake an assessment of each Foundation Trust to identify:

- A risk to the financial stability of the provider of key NHS services which endangers the continuity of those services; and/or
- Poor governance at an NHS Foundation Trust.

The above will be assessed separately by Monitor and each NHS Foundation Trust will be assigned two ratings.

The Trust's annual plan was submitted on 3 June 2013 and the framework provides for quarterly monitoring. Monitor will use quarterly information to update its assessment of Foundation Trusts during the course of the year.

Continuity of services rating
The rating allocated by Monitor will be their view of the level of risk to the ongoing availability of key NHS services and the risk of a provider failing to carry on as a going concern. Main categories of in-year submissions are:

- Latest quarter financials;
- Year to date financials;
- Financial commentary;
- Forward financial events.

The rating incorporates two common measures of financial robustness: Liquidity; and capital servicing capacity. There are five rating categories:

- Rating 4: No action.
- Rating 3: Emerging or minor concern, potentially requiring scrutiny
- Rating 2*: Level of risk is material but stable
- Rating 2: Material risk
- Rating 1: Significant financial risk

Governance rating
NHS Foundation Trusts are subject to the NHS foundation trust condition 4 (the governance condition) in their licence. Monitor will use a combination of existing and new methods to assess the governance issues of NHS Foundation Trusts. Main categories of in-year submissions are:

- Performance against national standards;
- CQC information;
- Clinical quality metrics;
- Information to assess membership engagement.

There are three categories to the new governance rating applicable to all NHS Foundation Trusts:

- Green Rating: where there are no grounds for concern;
- Written description of concerns: where action is being considered but not yet taken; and
- Red: when enforcement action has begun

Exception Reporting
Monitor requires licence holders to notify them of any incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with their licence. This applies to all licence conditions, not just the conditions that are the focus of the *Risk Assessment Framework*. An exception report should describe:

- The issue that has arisen or will arise, the magnitude and when it occurred or will have an effect.
- Actions planned to address the issue.
- List of affected parties.
- How the licence holder plans to notify these parties of the issue.

The *Risk Assessment Framework* makes it clear that the role of the ratings is to indicate when there is a cause for concern at a provider. Ratings will not automatically indicate a breach of a Foundation Trust licence or trigger regulatory action. Monitor will use their ratings to consider when a more detailed investigation may be necessary to establish the scale and scope of any risk.

SUMMARY:

The report is divided into four sections outlining performance as at Quarter 1 and is summarised below:

Section 1 – Continuity of Services
It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that the Continuity of Services Risk Rating for Q1 is confirmed as:

- Rating 4: no action.
- The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

Section 2 – Governance rating
It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that not all healthcare targets and indicators have been met.

Section 3 – Exception Reports
Exception reports are included for the following areas of non-compliance:

- *C.Difficile*
- *A&E 4 hour wait performance*
- *Cancer symptomatic breast*

Section 4 – Additional Information
Additional information has been included related to the following:

- Invited Review – Royal College of Surgeons/High Risk Surgery Update
- CQC Visit Update
- Radiology Information Systems
- Outpatients Consultation Update
- Board Changes
- Governor changes

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Demonstrates the extent to which strategic objectives are being achieved.

FINANCIAL IMPLICATIONS:

No direct implications, although investment may be required where the need for corrective action is identified.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The *Risk Assessment Framework 2013/14* serves as guidance as to how Monitor will assess governance and financial risk at NHS foundation trusts as reflected by compliance with the Continuity of Services and governance conditions. NHS foundation trusts are required by their licence to have regard to this guidance.

Monitor's *Enforcement Guidance* sets out Monitor's approach to prioritising and taking regulatory action where a breach of a licence condition is likely or has occurred.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

Not applicable.

BOARD ACTION REQUIRED:

This report recommends that the Board of Directors declare that not all healthcare targets and indicators have been met during the quarter.

CONSEQUENCES OF NOT TAKING ACTION:

Monitor's *Enforcement Guidance* sets out Monitor's approach to prioritising and taking regulatory action where a breach of a licence condition is likely or has occurred.

MONITOR RISK ASSESSMENT FRAMEWORK 2014/15
QUARTER ONE (APRIL 2014 – JUNE 2014)

SECTION 1 – CONTINUITY OF SERVICES

1. At the end of Quarter 1 the consolidated position for the Trust and its subsidiary is an EBITDA of £7.2m (£0.9m below plan) and a £0.4m net surplus – £0.8m below the plan.

2. Continuity of Services Risk Rating performance is shown in the following table:

CoSRR (Cumulative)	Target	Q1 actual
Capital service cover	3.26x	2.95 x
Capital service cover rating	4	4
Liquidity metric	9.5	9.2
Liquidity rating	4	4

3. Total Operating Revenue for the first quarter is £132.4m which is £1.6m above plan. NHS Clinical income was £0.9m above plan predominantly driven by over-performance in income for High Cost Drugs and elective day cases (variance analysis by point of delivery has been provided in the templates). Private patient and non-mandatory clinical income was £0.7m above plan.

4. Operating Expenses within EBITDA amount to £125.2m which is £2.5m above plan. The main drivers include £3.1m on pay due to excess agency, bank, locum and overtime costs linked to activity pressures. £1.7m of the overspend is due to drugs overspending (largely on pass through costs). Non-Clinical Supplies were underspent by £1.7m driven by slippage on service developments and are matched by an underachievement in income.

5. The £26.8m CIP target for the year comprises £6.1m of income opportunities and £20.7m for cost reductions. Actual performance against these targets was a short fall of £0.9M for the quarter. Income Opportunities are £0.4m above plan whilst Cost Reductions £1.3m below plan due to slower than expected starts to some workforce and supplies savings.

   The trust is currently reviewing delivery plans for all CIP's and has identified an executive board member to help focus the organisation on delivery. The Trust therefore expects to deliver the required CIPs or cover any shortfall from our contingency reserve.

6. Capital expenditure for the quarter was £6.3m, £1m below plan. This is primarily due to a Theatre scheme being postponed and changes have been agreed to the programme as a result.

7. Closing cash balances were £5.5m higher than plan, largely due to settlement of old year invoices by the Specialist Commissioning Group (SCG) and some risks within the plan not having materialised.

8. The Trust continues to work with Maidstone & Tunbridge Wells Trust on the Kent Pathology Partnership project, with the aim of setting up a Joint Venture (a non-

legal entity) delivering high quality, cost effective laboratory services to our hospitals and GPs. Staffing reductions as a consequence of planned consolidation of disciplines will lead to some redundancies and other one-off project and implementation costs, possible contract penalties and impairment charges. There will be equal representation from both Trusts on the Partnership Board. East Kent hospitals will employ all the staff. No firm decision has yet been taken but it is assumed at this stage that formal arrangements would be in place by September 2014.

2. Summary and Conclusion

At the end of Quarter 1 the I&E surplus of £0.4m is £0.8m below plan. This is due to income over performance being matched by expenditure being over plan and savings targets being behind plan for the quarter. Unused general contingency was used to offset excess costs on a non-recurrent basis whilst alternative measures are developed. Divisions that are performing adverse to plan are now subject to fortnightly Executive performance review and increased focus is being given to driving through CIP schemes.

3. Recommendation

It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that the Continuity of Services Risk Rating for Q1 is confirmed as:

- Rating 4:
- The Board anticipates that the Trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

SECTION 2 – GOVERNANCE RATING

PERFORMANCE AGAINST STANDARDS AND INDICATORS

Referral to Treatment Waiting Times

This target is reportable to Monitor on a quarterly basis however the Trust is required to meet the target in every month throughout that quarter. Failure in any one month represents a failure for the quarter. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

The following table sets out the Trusts quarter 1 performance;

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q1 Performance	EKHUFT Consolidated Spencer Wing Position
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	1.0	Quarterly	90.7%	90.9%
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	1.0	Quarterly	98.1%	98.1%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	1.0	Quarterly	94.8%	95.6%

* Data will be incorporated prior to submission to Monitor.

Standard compliant.

A&E 4 Hour Achievement

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q1 Performance	EKHUFT Consolidated Spencer Wing Position
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1.0	Quarterly	94.3%	n/a

Standard non-compliant.

Cancer Waiting Times

The Cancer position stated below is as at 15th July 2014, this position is not yet signed off due to the national reporting timetable. The position is therefore subject to change until the final reporting date of 4th August 2014. April and May figures are as per signed off data on Open Exeter, June is provided using local data.

The table below shows the Trusts performance in each of the standards;

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q1 Performance	EKHUFT Consolidated Spencer Wing Position
All cancers: 62-day wait for first treatment from					
• urgent GP referral for suspected cancer	85%	1.0	Quarterly	86.37%	n/a
• NHS cancer screening service referral	90%			96.13%	n/a
All cancers: 31 day wait for second or subsequent treatment comprising:					
• Surgery	94%	1.0	Quarterly	95.74%	n/a
• Anti-cancer drug treatments	98%			99.12%	n/a
• Radiotherapy	94%			n/a	n/a
All cancers: 31-day wait from diagnosis to first treatment	96%	1.0	Quarterly	99.19%	n/a
Cancer: two-week wait from referral to date first seen comprising:					
• All urgent referrals (cancer suspected)	93%	1.0	Quarterly	93.44%	n/a
• For symptomatic breast patients (cancer not initially suspected)	93%			92.18%	n/a

Standard Non-Compliant (scores 1 point).

Clostridium Difficile

Monitor will score NHS Foundation Trusts for breaches of the *C.Difficile* objectives as follows:

- Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. The de minimis level for C.Difficile is 12.
- If a Trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied.
- If a trust exceeds both the de minimis limit and the in year trajectory for the national objective, a score will apply.
- If a Trust exceeds its national objective above the de minimis limit, Monitor will apply a red rating and consider the Trust for escalation.

Indicator	Monitor Threshold (at year end)	EKHUFT cumulative target	Monitor Weighting	Monitoring period	EKHUFT Q1 Performance		EKHUFT Consolidated Spencer Wing Position
					Qtr	YTD	
Total C Diff: (inc cases not deemed to be due to lapses in care & cases under review)		12	1.0	Quarterly	15	15	n/a
*C Diff: Due to lapses in care.	REPORTABLE FROM Q2 (SEE SUPPORTING COMMENTARY BELOW)						
C Diff: Cases under review.	-	-	-	Quarterly	2		n/a

* The policy to determine lapses of care standards have only just been agreed across K&M (18 July 2014) and it is therefore not possible to the determine lapses of care. Now this policy has been agreed, it is the intention to implement this fully and to report from Quarter 2 onwards.

Standard non-compliant (scores 1 point). Supporting commentary:

Root Cause Analysis (RCA) is undertaken for all post-72 hour cases of C. difficile infection. At RCA, avoidability / unavoidability, compliance / non-compliance are identified. "Lapses of Care" will be formally identified in conjunction with the Commissioners once there has been Kent-wide agreement as to definitions (these will include hand hygiene, cleaning, and antibiotic prescribing as per NHS England guidance (2014)). However a tentative decision as to whether there has been a lapse in care is made at the time of the RCA.

Defining whether or not a case is avoidable or unavoidable and compliant or non-compliant is judged by the multi-disciplinary RCA Team primarily on the following:

Avoidable – inappropriate antibiotic prescribing (not in accordance with Trust Antimicrobial Guidelines)

Unavoidable – appropriate antibiotic prescribing but individual patient risk factors such predispose the patient to developing C. difficile infection (i.e. chronic infections multiple / long-term courses of antibiotics in the community or in hospital, or the patient is immunocompromised following radiotherapy / chemotherapy)

Compliant – fully compliant with Trust policy in relation to the prevention and management of C. difficile infection

Non-compliant – non-compliant with one or more aspects of Trust policy (i.e. delay in obtaining stool specimen; delay in isolation)

There were 15 cases of C. difficile infection occurring post-72 hours in quarter 1; of these:

- 3 were avoidable
- 10 were unavoidable
- 2 RCAs are pending

Access to Healthcare for People with a Learning Disability.

At the Annual Plan stage, NHS Foundation Trust Boards are required to certify that their Trusts meet the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in *Healthcare for All (DH, 2008)*.
A quarterly declaration regarding continued compliance is required there after.

The Trust is compliant with the six criteria for meeting the needs of people with a learning disability, based on the recommendations set out in Healthcare for All (DH 2008). A detailed report on the issue was produced by the Practice Development Nurse (for people with learning disabilities) and considered by the Clinical Management Board (CMB) on 11 June 2014. The report highlighted the significant overall progress made in supporting access for people with learning disabilities and in particular identified areas of recognised best practice in the Carers Checklist for use with learning disability patients and their carers in hospital, the Bright Future project and the Healthcare Passport. After discussion the CMB accepted the recommendation to declare compliance with this standard.

Indicator	Monitor Threshold	Monitor Weighting	Monitoring period	EKHUFT Q1 Performance	EKHUFT Consolidated Spencer Wing Position
Certification against compliance with requirements regarding access to health care for people with a learning disability*	N/A	1.0	Quarterly	compliant	**n/a**

Recommendation

It is recommended that the Board of Directors, on assuring themselves of the evidence, declare that not all healthcare targets and indicators have been met.

SECTION 3 – EXCEPTION REPORTS

C. Difficile:

The C.difficile target for 2014/15 is 47 cases (a rate of 14.7/100,000 bed days).

For the last 3 quarters of 2013/14, rates of C.difficile returned to the previous baseline of 10 per quarter. However, for the first quarter of 2014/15, there have been 15 cases against a trajectory of 11. Although this is 4 cases above the NHS England Q1 target for the Trust this year, it represents a low rate of infection for a Trust as large as East Kent (>300,000 bed days).

There have been two periods of increased incidence (PII) in Q1 (two or more new cases of C.difficile infection occurring on a ward within a 28 day period) on Cambridge M2 at WHH and Minster Ward at the QEQMH. All isolates are routinely ribotyped in order to determine whether cross-infection is likely to have occurred. Ribotyping of the isolates on CM2 revealed no linkage between cases. A robust Action Plan has been implemented, and there have been no new cases on the ward since May. However, a Serious Untoward Incident has been declared on Minster Ward (currently located on St Augustine's Ward as part of the QEQM decant and refurbishment programme) as two different ribotypes have been identified in four patients, indicating that cross-infection is likely to have occurred. Pressures at the QEQM have been considerable, more so than at the other two sites, in relation to patient dependency and length of stay, and this has been escalated to the Commissioners. NHS Thanet and South Kent Coast CCG undertook a Quality Visit to Minster Ward on the 1st July in response to the PII/SUI, and were reassured at the processes that are in place. An Action Plan has been implemented, the ward is under "Infection Control Special Measures", and there have been no new cases of C.difficile on the ward since the 15th June.

We can confirm that the Trust *C.difficile Recovery Plan*, reported in previous Exception Reports, has been fully implemented (updated version attached).

With regard to antimicrobial prescribing, the Antimicrobial Stewardship Group and the Infection Control Doctor will be leading on a number of initiatives, including revising the *Antimicrobial Guidelines* and the *Pocket Guide*, dedicated antimicrobial prescribing sessions with the new intake of FY1 / FY2 junior medical staff during their Induction Programme in July / August, and development of antimicrobial guideline “app”.

Pending completion of a Business Case (work in progress), and following funding from the Finance Director for a six month pilot which will be fully evaluated, the IP&CT will be implementing the use of hydrogen peroxide vapour (HPV) for the high level disinfection of side rooms following discharge of C.difficile positive patients (antigen and / or toxin positive). This is due to commence within a matter of weeks and will be a managed service, provided by Hygiene Solutions (Deprox). We anticipate that this will have a positive impact and will further support our C.difficile reduction and achievement of the target.

For quarter 2 to date, there have been 2 cases of C.difficile (the trajectory is 12 cases).We anticipate that the number of cases for this quarter will return to the baseline, as it did last year, when there were 18 cases in Q1 and 10 in Q2.

A&E 4 hour wait standard:

The Trust was non-compliant with the 4 hour A&E standard in quarter one 2014/15 at 94.3%.

A&E attendances levels are up ~5% on the same period last year, particularly at the WHH (+5.5%) and KCH (+5.4%) sites. Growth has been observed across all Clinical Commissioning Groups (CCGs) and appears to be split equally across majors and minors. Variation in numbers of attendances is causing pressure in the departments, the operational impact of these surges is that the departments can become overwhelmed particularly as they occur in the evenings when there are minimal support services to facilitate timely patient flow out of ED into the main body of the hospitals. This is compounded by increasing competition for bed capacity as the majors patients convert to admissions. The effect of these surges can be felt for days as the demand continues overnight and into the following day(s).

There is considerable variation in specialty response rates at all sites, particularly prevalent at the WHH site, in some instances the average waiting time can be up to three hours. Whilst not applicable to every patient the delays caused by this inevitably impacts on other patients' journeys through the department. All breaches are analysed at the monthly A&E performance meetings with representation from all clinical divisions.

There has been a rise in long stay (14+ days) patients which has contributed to an increase in overall length of stay particularly at the QEH site; this is a pilot site for the revised social services model of care. This pilot essentially involves a relocation of the acute resources into the community with the expectation that staff will in-reach into the Trust to facilitate patient discharge. This has generated significant delays in patient discharges as referrals for social services input are processed by staff that are externally based.

This issue will be addressed by the implementation of the integrated discharge team based on the emergency floor and the main focus will be to facilitate and expedite discharge for appropriate patients with complex health & social care needs without an admission to hospital. In the meantime, the UCLTC Division are liaising with partners on a daily basis in an effort to facilitate discharges although this is becoming increasingly challenging as our social services partners' progress through their new strategy.

A copy of the A&E recovery plan is attached with these papers.

2 ww Breast Symptomatic standard:

The Breast Symptomatic referral standard is non-compliant for Q1 14/15. April 14 was non-compliant for this standard at 88% and although May and June have been compliant the level of compliance within these two months has not been high enough to counteract the number of breaches for the quarter as a whole (37).

Quarter one 2014/15 has seen a significant increase in the number of Breast symptomatic referrals (472), the highest number in recent quarters. Breach analysis shows that patient cancellations constitute the vast majority of breaches in this standard. A patient leaflet specific to symptomatic breast is being developed for GP's to give to patients being referred as a breast symptomatic. Due to the non-cancer referral element of this target there is concern that patients are not aware that they will still be require to attend within 2 weeks. This leaflet will clearly explain that although this is not a referral for cancer the patient will still be offered an appointment within 14 days. The work around capacity split between Breast 2ww and Breast symptomatic is in progress to ensure that appointments can be offered earlier within the 14 day period.

Since the period of non-compliance in April 2014 this standard has been compliant each month.

SECTION 4 – ADDITIONAL BRIEFINGS

Invited Review – Royal College of Surgeons
High Risk and General Emergency Surgery

The surgical division and particularly the colorectal surgeons continue to work with one of the RCS reviewers to ensure that the surgical action plan is on track. The new surgical leads have implemented a programme of work to meet the required actions and one site lead (at QEQMH) has taken the lead in developing a unified Trust colorectal service.

The Trust has successfully recruited 4 colorectal surgeons, 3 of which will be based on the William Harvey site and 1 at the QEQM site. The new consultants will commence their posts from August, September and October 2014. The Trust is also advertising for 2 Upper Gastrointestinal consultants and expects if the recruitment is successful that these posts will be filled by September 2014 with consultants commencing in December 2014/January 2015.
The Trust is also expecting to recruit a further 2 wte gastrointestinal surgeons for QEQm site this year and this will result in the Trust having 2 x 1:8 rotas delivered by gastro intestinal consultants. The timescale will be dependent on the quality of the applications.

CQC Visit

The Trust was inspected under the new CQC inspection regime week commencing 3 March 2014 as reported as part of the Quarter 3 submission. The inspection team (consisting of 55 inspectors) were on site for a period of 4 days. An additional team from the Patients Association was on site looking at the Trust's complaints processes.

A draft report was received by the Trust on 10 June 2014. The Trust responded to factual inaccuracies within the required timeframe of 10 working days.

A Quality Summit will be organised by the CQC to involve key stakeholder organisations to discuss the key findings from the report prior to publication. Formal confirmation of the Quality Summit and the invited attendees is awaited.

Radiological Information Systems

A facilitated meeting has been arranged for 24 July 2014 between GE Technical and the Consortium with a view to agreeing the project plan and compensation and ongoing payments that will fall from the delivery plan.

Outpatients Consultation Update

The Board of Directors received the conclusion of the out-patients consultation a meeting held on 27 June 2014. The Board of Directors supported the:

a) implementation of new ways of working in an outpatient setting i.e. to introduce and increase appropriate levels of the one stop approach to clinics and patient management to extend the working week from 0730 to 1900 Monday to Friday – introduce Saturday morning sessions and expand the use of assistive technology to support access in GP surgeries, other community settings and in peoples own homes;

b) investment of £455,000 into the extension of public transport links;

c) reduction of specialist acute outpatient clinics from 15 sites down to 6 sites to enable more local access for east Kent patients (an increase from 70.1% to 83.5% of patients) across the patch. This move will also allow access to a much wider number of specialties on these 6 sites;

d) choice of Estuary View Medical Centre as the centralised site for specialist acute outpatient services on the north Kent coast; and the

e) intent of NHS C&C CCG to develop community hubs/networks that will enable the appropriate transfer of GP/community led outpatient services into other settings beyond the 6 site model being adopted by EKHUFT.

In making this decision, the Board of Directors considered the following:

a) An option appraisal process identifying Estuary View Medical Centre as the preferred site for the North Kent Coast. The Investment Benefit Scoring model was used for this work and the final scores were available to the Board of Directors.

b) The University of Kent was employed to independently analyse the consultation responses and the results of this analysis was available to the Board of Directors.

c) The Kent HOSC endorsed the public consultation as an appropriate process.

d) Canterbury and Coastal CCG were partners in the consultation and supported the process.

Canterbury and Coastal CCG governing body also received and considered the conclusion of the out-patient consultation in a meeting on 2nd July 2014. The meeting concluded with an agreement to endorse the Trust in:

a) implementation of new ways of working in an outpatient setting

b) reduction of specialist acute outpatient clinics from 15 sites down to 6 sites

c) the choice of Estuary View Medical Centre as the centralised site for specialist acute outpatient services on the north Kent coast

Board of Director Changes

There have been no changes to the Board of Directors during Quarter 1.
Stuart Bain, CEO announced he intended to retire on 31 December 2014.

Council of Governor Changes

Ken Rogers, Public Governor (Swale), resigned on 30 June 2014 from immediate effect.

Ken also undertook the role of Lead Governor. In line with our Constitution, if a Governor resigns more than six months before the next scheduled elections, the Trust is able to invite the next highest polling candidate at the last elections for this constituency to join the Council for the remaining term of the departing Governor. The Trust can confirm that Matt Williams will represent the Swale constituency until 28 February 2015.

The Council of Governors undertook an annual review of the Lead Governor position at a meeting on 7 July 2014 and Brian Glew, Public Governor (Canterbury) was confirmed Lead Governor.

Prepared on behalf of:

Jeff Buggle Director of Finance & Performance Management	Julie Pearce Chief Nurse and Director of Quality & Operations

July 2014