Board of Directors Meeting - Open (Thursday 4 May 2023)

Thu 04 May 2023, 12:45 - 16:10

Cornwallis Room, The Spitfire Ground, Old Dover Road, Canterbury CT1 3NZ/WebEx

NHS
East Kent Hospitals University
NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

12:45 - 12:55
10 min

23/16
Welcome and Apologies for Absence

To Note   *Chairman*
Verbal

12:55 - 12:55
0 min

23/17
Confirmation of Quoracy

To Note   *Chairman*
Verbal

12:55 - 12:55
0 min

23/18
Declaration of Interests

To Note   *Chairman*
📄 23-18 - REGISTER 2023-24 V62 - from April 2023.pdf (4 pages)

12:55 - 12:55
0 min

23/19
Minutes of Previous Meeting held on 6 April 2023

Approval   *Chairman*
📄 23-19 - Unconfirmed BoD 06.04.23 Open Minutes.pdf (14 pages)

12:55 - 12:55
0 min

23/20
Matters Arising from the Minutes on 6 April 2023

Information   *Chairman*
📄 23-20 - Front Sheet Public BoD Action Log.pdf (3 pages)

12:55 - 13:25
30 min

23/21
Staff Experience Story

Discussion   Chief People Officer

📄 23-21.1 - Front Sheet Staff Story for Board May 23.pdf (1 pages)
📄 23-21.2 - Appendix 1 EKHUFT Staff Experience Story 04.23.pdf (2 pages)

13:25 - 13:30
5 min

TEA/COFFEE BREAK - 13:25 - 13:30

13:30 - 13:35
5 min

23/22
Chairman's Report

Information   Chairman

📄 23-22.1 - Chairman BoD Report May 2023 ND FINAL 26.04.23.pdf (3 pages)
📄 23-22.2 - App 1 Chairman Report NEDs commitments.pdf (1 pages)

13:35 - 13:45
10 min

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

Discussion   Chief Executive

📄 23-23 - CEO Report to Board - May 2023.pdf (5 pages)

13:45 - 14:05
20 min

23/24
Board Committee - Chair Assurance Reports

Assurance   Board Committee Chairs

23/24.1
People and Culture Committee (P&CC) - Chair Assurance Report

Assurance   Chair P&CC - Stewart Baird
Paper to follow

23/24.2
Quality and Safety Committee (Q&SC) - Chair Assurance Report

Assurance   Chair Q&SC - Andrew Catto

📄 23-24.2 - QSC Chair Assurance Report 25.04.23 Final.pdf (8 pages)

23/24.3
Finance and Performance Committee (FPC) - Chair Assurance Report

Assurance   Chair FPC - Richard Oirschot

📄 23-24.3 - FPC Chair Committee Assurance Report Final.pdf (4 pages)

23/24.4
Integrated Audit & Governance Committee (IAGC) - Chair Assurance Report

Approval   Chair CFC - Olu Olasode

📄 23-24.4.1 - IAGC Chair Board Assurance Report April 2023 FINAL.pdf (5 pages)
📄 23-24.4.2 - App 1 Standing Financial Instructions.pdf (85 pages)

OUR PATIENTS OUR QUALITY AND SAFETY

14:05 - 14:20
15 min

23/25

Transforming our Trust: Our Response to 'Reading the Signals': Maternity and Neonatal Services in East Kent - Update Report

Discussion   *Chief Executive / Executive Maternity Services Strategic Programme Director*

📄 23-25 - Board report Reading the Signals - 4 May 2023.pdf (4 pages)

14:20 - 14:40
20 min

23/26

Maternity Governance:

Interim CNMO / Interim Director of Midwifery (DoM) / Deputy Director of Midwifery (DoM)

23/26.1

Maternity and Neonatal Assurance Group (MNAG) Chair's Assurance Report

Assurance   *Interim CNMO / Interim DoM / Deputy DoM*

📄 23-26.1 - MNAG chair report April report 23.pdf (2 pages)

23/26.2

Perinatal Quality Surveillance Tool (PQST) Report

Approval   *Interim CNMO / Interim DoM / Deputy DoM*

📄 23-26.2 - PQST May Board 23.pdf (11 pages)

23/26.3

Bi-Annual Midwifery Workforce Oversight Report covering staffing/safety issues

Discussion   *Interim CNMO / Interim DoM / Deputy DoM*

📄 23-26.3 - Midwifery Workforce Biannual CNST SA5 BoD Report April 2023 FINAL.pdf (9 pages)

14:40 - 14:50
10 min

TEA/COFFEE BREAK 14:40-14:50

CORPORATE REPORTING (COVERING ALL 'WE CARE' STRATEGIC OBJECTIVES)

14:50 - 15:20
30 min

23/27

Integrated Performance Report (IPR)

Discussion   *Chief Executive / Executive Team*

📄 23-27.1 - Front Sheet March 23 IPR Trust Board.pdf (4 pages)
📄 23-27.2 - Appendix 1 IPR_v4.3_Mar23_FINAL.pdf (36 pages)

23/27.1

Integrated Improvement Plan (IIP) Report

Discussion   *Interim Executive Director of Strategic Development and Partnerships*

- 23-27.1.1 - Front Sheet Integrated Improvement Plan Report 28.04.23.pdf (3 pages)
- 23-27.1.2 - Appendix 1 EKHUFT IIP Final Draft to Board 28.04.23.pdf (24 pages)
- 23-27.1.3 - Appendix 2 EKHUFT IIP Board Report - Final Draft28.04.23.pdf (16 pages)

23/27.2
Finance Reports

Interim Chief Finance Officer

- **Month 12 Finance Report   -   Information**
- **2023/24 Planning update   -   Approval**

- 23-27.1.1 - Front Sheet M12 Finance Report Board.pdf (3 pages)
- 23-27.1.2 - Appendix 1 Month 12 Short Finance Report.pdf (8 pages)
- 23-27.2.3 - Business Planning front sheet (Final).pdf (1 pages)
- 23-27.2.4 - Appendix 1 Business Planning Update Board Approval.pdf (4 pages)

15:20 - 15:30
10 min

23/28
Board Assurance Framework (BAF) Risk Register

Approval   *Chief Executive*

- 23-28.1 - BAF Risk Register BoD 28.04.2023.pdf (7 pages)
- 23-28.2 - Appendix 1 - BAF 2022-23 13.04.2023.pdf (10 pages)

15:30 - 15:40
10 min

23/29
Safeguarding Adults and Children Quarter 4 Report

Assurance   *Interim CNMO*

- 23-29 - Board Safeguarding Adults and Children April 2023 (2).pdf (6 pages)

15:40 - 15:50
10 min

23/30
Freedom to Speak Up (FTSU)

Discussion   *Chief People Officer (CPO) / FTSU Guardians*

- 23-30.1 - FTSU report to Board May 23.pdf (8 pages)
- 23-30.2 - Appendix 1 Freedom to speak up policy.pdf (9 pages)
- 23-30.3 - Appendix 2 Routes for speaking up.pdf (1 pages)

CLOSING MATTERS

15:50 - 15:55
5 min

23/31
Any Other Business

Discussion   *All*

Verbal

23/32

Questions from the Public

Discussion   *All*

Verbal

Date of Next Meeting: Thursday 1 June 2023

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM APRIL 2023

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

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM APRIL 2023

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
FLETCHER, TRACEY	Chief Executive	None	Appointed 4 April 2022
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)** Director of Dudley & Kent Commercial Services Ltd. (started 11 May 2022) **(1)**	1 April 2021 (First term)
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019 (Second term)
JONES, DYLAN	Chief Operating Officer	None	Appointed 12 April 2023
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OIRSCHOT, RICHARD	Non-Executive Director	Non-Executive Director, Puma Alpha VCT plc (July 2019) **(1)** Director, R Oirschot Limited (August 2010) **(3)** Trustee, Camber Memorial Hall (June 2016) **(4)**	1 March 2023 (First term)

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
OLASODE, OLU	Senior Independent Director (SID)/Non-Executive Director	Chief Executive Officer, TL First Consulting Group (started 9 May 2000) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, Audit and Governance Committee, London Borough of Croydon (started 1 October 2021) **(1)** Independent Non-Executive Director (Adult Care), Priory Group (Adult Social Care and Mental Health Division) (started 1 June 2022) **(1)**	1 April 2021 (First term)
PELLEY, CATHERINE	Interim Chief Nursing and Midwifery Officer	To be confirmed	17 April 2023
STEVENS, BEN	Interim Executive Director of Strategic Development and Partnerships	None	20 March 2023
STEVENS, MICHELLE	Interim Chief Finance Officer	None	1 April 2023
SYKES, CLAUDIA	Non-Executive Director	Director, Cloudier Skies Ltd **(1)** (started 21 December 2022)	1 March 2023 (First term)
WIGGLESWORTH, NEIL	Executive Director of Infection Prevention and Control	Chair and Director of the International Federation of Infection Control (started 1 January 2018) **(1)** Trustee of the International Federation of Infection Control (started 1 January 2018) **(4)**	15 March 2021
YOST, NATALIE	Executive Director of Communications and Engagement	None	31 May 2016

REGISTER OF DIRECTOR INTERESTS – 2023/24 FROM APRIL 2023

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

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

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

Spencer Private Hospitals:
Stewart Baird – Non-Executive Director in common

Categories:

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

**UNCONFIRMED MINUTES OF THE ONE HUNDRED & TWENTY EIGHTH MEETING OF THE
BOARD OF DIRECTORS (BoD)
THURSDAY 6 APRIL 2023 AT 10.00 AM
IN THE CONNINGBROOK HOTEL, CANTERBURY ROAD, KENNINGTON,
ASHFORD TN24 9QR AND AS A WEBEX TELECONFERENCE**

PRESENT:

Mr N Dickson	Chairman	ND
Mr R Anakwe	Non-Executive Director (NED) (WebEx)	RA
Ms A Ashman	Chief People Officer (CPO), People and Culture	AA
Mr S Baird	Non-Executive Director (NED)/People and Culture Committee (P&CC) Chair/Nominations and Remuneration Committee (NRC) Chair	SB
Mr S Corben	NED	SC
Ms T Fletcher	Chief Executive (CE)	TF
Ms L Fulci	NED (WebEx)	LF
Dr R Martin	Chief Medical Officer (CMO)	RM
Mr R Oirschot	NED/Finance and Performance Committee (FPC) Chair	RO
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair (WebEx)	OO
Mrs S Shingler	Chief Nursing and Midwifery Officer (CNMO)/Executive Board Maternity Safety Champion/Deputy Chief Executive Officer	SSh
Mr B Stevens	Interim Executive Director of Strategic Development and Partnerships (EDSDP)	BS
Ms M Stevens	Interim Chief Finance Officer	MS
Ms C Sykes	NED/Charitable Funds Committee (CFC) Chair	CS

ATTENDEES:

Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Ms M Durbridge	Improvement Director, NHS England (NHSE)	MD
Ms K Edmunds	Head of Patient Voice and Involvement (for Minute Number 23/006)	KE
Ms A Johnson	Specialist Financial Consultant (SPC)	AJ
Ms C Sheehan	Director of Nursing (DoN) for Urgent and Emergency Care (UEC) (for Minute Number 23/006)	CS
Dr N Wigglesworth	Executive Director of Infection Prevention & Control (EDIPC)	NW
Ms F Wise	Executive Maternity Services Strategic Programme Director (EMSSPD)	FW
Mrs A Rowe	Patient/Family Experience Story (for Minute Number 23/006)	AR
Mrs N Yost	Executive Director of Communications and Engagement (EDoC&E)	NY

IN ATTENDANCE:

Miss L Coglan	Council of Governors (CoG) Support Secretary	LC
Mrs H Pope	Executive PA	HP
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms M Bonney	Governor (WebEx)
Mr R Brittain	Governor (WebEx)
Mr T Cook	Member of the Public
Mr D Dalton	Recovery Support Programme Director
Mr J Disney-Goodwin	Member of staff (WebEx)
Mr J Fletcher	Governor (WebEx)
Ms N Lappage	Improvement Director, NHSE (WebEx)
Ms S Mahmood	Governor (WebEx)
Mrs B Mayall	Lead Governor (WebEx)
Mr T Morris	Governor (WebEx)
Mr M Norman	Health Correspondent, BBC South East News
Mr D Richford	Member of the Public (WebEx)
Mr P Schofield	Governor
Mr M Tee	Executive Director of Communications & Engagement, NHS K&M ICB (WebEx)
Mrs M Warburton	Member of the Public (WebEx)

MINUTE NO.		ACTION
23/001	**WELCOME AND APOLOGIES FOR ABSENCE**	

The Chairman welcomed those in attendance, and noted apologies received from Dr A Catto (AC), NED/Chair Quality and Safety Committee; Professor C Holland (CH), Associate NED/Dean, Kent & Medway Medical School (KMMS) (non-voting Board member); and Mr M Powls (MP), Interim Chief Operating Officer (COO).

The Chairman welcomed Ms M Stevens, Interim Chief Finance Officer (CFO); and Mr B Stevens, Interim Executive Director of Strategic Development and Partnerships (EDSDP); to their first BoD meeting. He thanked Mr Powls, Interim COO, for his support who would be leaving the Trust that month, and the Trust would be welcoming the new COO, Mr D Jones, on 12 April 2023.

The Chairman reported a Closed BoD meeting had been held that morning, the issues discussed included the Integrated Improvement Plan (IIP), financial position, and developing the Trust's long term clinical and capital strategy.

23/002 **CONFIRMATION OF QUORACY**

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

23/003 **DECLARATION OF INTERESTS**

There were no new interests declared.

23/004 **MINUTES OF THE PREVIOUS MEETINGS HELD ON 21 OCTOBER 2022 AND 9 MARCH 2023**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meetings held on 21 October 2022 and 9 March 2023 as an accurate record.

23/005 **MATTERS ARISING FROM THE MINUTES ON 9 MARCH 2023**

DECISION: The Board of Directors **NOTED** the updates on the actions from the previous meeting, those for future meetings and **APPROVED** the two actions recommended for closure.

23/006 **PATIENT/FAMILY EXPERIENCE STORY**

The daughter of the patient presented this patient/family story highlighting key points:

- Mother an 83-year-old was admitted to Queen Elizabeth the Queen Mother Hospital (QEQM) Emergency Department (ED) in Christmas 2021, had previously had sepsis, pneumonia and perforated gallbladder, so she was aware of the patient pathway that should have been followed;
- Had been diagnosed with sepsis by doctor and paramedics prior to being admitted to QEQM ED, was a vulnerable, confused patient with anxiety. She followed the ambulance and on arrival in ED was told she was not allowed to stay with her mother due to Covid restrictions, explained that her anxiety and confusion would worsen if she did not have a familiar face present with her. She contacted the Trust to make a verbal complaint about not being allowed to stay with her mother and was unable to speak to anyone to raise this;
- Poor experience contacting the Trust with delays getting through the switchboard and getting hold of someone (took 40 minutes to get through) to

be able to obtain an update on the care and treatment of her mother, and how she was. She had contacted the Trust within an hour of her mother being admitted, was concerned about the length of time and the importance of addressing and treating sepsis promptly, and was asked to ring back in another hour, which she did and was presented with unhelpful staff member who informed her that her mother had not been assessed, she continued to make contact every hour to get an update on her mother's assessment, condition and treatment;

- Her mother had not been assessed within 5 hours after arrival, doctor had prescribed antibiotics and these were not given until around 4.30 am (approximately 9 hours after her admission to ED). She had been given diazepam to address her anxiety, tried to get to the toilet unaided and had fallen, that resulted in her needing to have a CT scan, was significantly concerned that diazepam had been given and not antibiotics, and took the decision to go to the hospital and arrived around 3.30 am at ED;
- Delay in administering fluids;
- Her mother had missed her evening medication;
- Her mother was taken to Resus following a junior Sister noticing her mother had been left laying down and was gurgling, and sat her up. Two doctors in Resus seemed flustered but the junior Sister remained calm, it wasn't until a registrar who arrived and asked her what her mother was normally like, which was the first time someone had asked this;
- She was asked to sign a do not attempt resuscitation (DNAR) for her mother, which she stated was her father's decision as next of kin, at this point staff were saying that her mother was at end of life, moved to a side room and family told to come and see her;
- Her mother was a fighter and knew with the right treatment she had a good chance of pulling though, by 9.00 pm that night her mother had stabilised and improving, and was told if her mother continued to improve, she'd be moved to the Acute Medical Unit (AMU);
- On the AMU the designated nurse showed compassion and looked after both her mother and father, and when she phoned the next day the staff member she spoke to was empathetic, caring and checked her mother's notes to give her a full update;
- She made a formal complaint, had put together her own timeline of events the complaint response was "the most patronising bunch of lies" and took six months to receive this, submitted a Subject Access Request (SAR) to get her mother's notes that indicated her mother had not been triaged correctly;
- Requested a local resolution meeting and met with the CNMO, from this felt that her complaint, issues and poor experience and poor care was being taken seriously, and that staff would learn lessons;
- Emphasised the importance of staff communicating well with patients and families, as well as listening to them.

The Chairman acknowledged the failures in poor care, compassion and communication and the numerous learning from this case, thanking Mrs Rowe for sharing her, her mother's and families experience. He enquired how Mrs Rowe's mother was. Mrs Rowe stated her and her family were thankful that her mother was still with them, her short-term memory was significantly impaired, she wasn't the person she was, and physically she had returned to how she was previously.

The CNMO apologised for the poor care and experience of Mrs Rowe's mother, she identified this case was a Serious Incident (SI) due to the omissions of care and an investigation was being undertaken. Trust was liaising with the KMMS in respect of the funding provided by the Integrated Care Board (ICB) around recognising deteriorating patients and patients with sepsis. This case study would be used as a simulation case for staff on lessons learnt for how patients and

families should be communicated with, providing a real case for staff to learn from. She noted there had been improvements in how staff communicated with patients and families.

The NEDs raised concern about patient voice and patients who did not have family members to be able to voice and raise concerns on their behalf, that the Board needed to continue to reflect on this. It was noted this would be addressed with the work around recognising deteriorating patients. The CNMO commented on the improvement programme and work in respect of Fundamentals of Care and care and compassion with staff, with improvements seen in these areas. The Patient Voice and Involvement team as well as the team Champions talked to patients and families on the wards, assisting with completion of patient surveys to ensure collation of feedback. Mrs Rowe had been invited to be part of the Trust's improvement programme work to support and assist the Trust in its improvement journey.

The Board of Directors:

- **LISTENED** and **NOTED** the daughter's experience and how this made her and her mother and father feel;
- **ACKNOWLEDGED** the failures of the care provided; and
- **ENSURED** learning was used from this family's experience to ensure that patients who were presenting with suspected sepsis were triaged and treated in line with National Institute for Health and Care Excellence (NICE) guidance. Also need to reinforce the importance of a patient's family being listened to, and their concerns addressed with kindness and compassion at the time they were raised.

23/007   **CHAIRMAN'S REPORT**

The Chairman noted the IIP presented at this meeting for approval that would drive improvement, alongside acting upon the lessons from the *Reading the Signals* Report that was central and critical to this improvement work. Noting the challenges ahead, ensuring continued messages to all staff around awareness and ownership from everyone of this report, the key actions from it and the importance of continued progress to make improvements.

The Chairman noted the continued significant demand and pressures on the Trust, thanking all staff for their support and the importance of supporting each other during high pressure periods.

The CE commented on the need to create an environment empowering and supporting staff around acceptance and ownership to identify and implement solutions in response to issues raised by patients and families and confidence of staff to raise any concerns.

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

23/008   **CHIEF EXECUTIVE'S (CE'S) REPORT**

The CE highlighted key elements:

- Specific funding secured of £300,000 for the introduction of a programme focussed on frontline coaching addressing the identification and

management of deteriorating patients;

- Recruitment of more than 400 International Educated Nurses (IENs) in 2022, foster wards and staff had been instrumental in welcoming and supporting these nurses and retaining these staff in the Trust;
- Thanks to Mr Powls, Interim COO, for supporting the Trust particularly during the very busy winter period,
- Care Groups undertaking a lot of work to mitigate as much as possible the impact of the Junior Doctors strike and ensure provision of safe services during the longer strike period. Thanks to the CMO, Care Groups and all staff for their hard work and support.

The NEDs suggested consideration and review of projects by other trusts implemented on deteriorating patients that enabled patients and families to escalate and raise issues of concern to an outreach team about the care received. The CMO commented the Trust was looking at undertaking a pilot at William Harvey Hospital (WHH) and utilising Trust patient stories to support simulation of patient cases and identification of these patients.

The NEDs raised the significant number of Not Fit to Reside (NFTR) patients, 437, and enquired how discussions were progressing with the Integrated Care Board (ICB) in respect of support around patient flow and reducing this number. It was also enquired about an update on Entonox. The CE reported additional community beds funding provision from the ICB and Health and Care Partnership (HCP), with support from the Community and Social Care to open beds in the community to support patients fit to be discharged. She highlighted the importance of managing patient pathways better, using best practice approaches and doing things differently in managing patients. The Trust was exploring option of a couple of companies working together in respect of the Entonox works.

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

23/009   **BOARD COMMITTEE – CHAIR ASSURANCE REPORTS:**

23/009.1   **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The P&CC Chair provided a verbal report, noting the 28 March 2023 Committee was not a full meeting, it focussed on the outcome and results of the National Staff Survey (NSS) and the necessary work and actions across the teams to address the issues raised by staff.

The Board of Directors **NOTED** the verbal report from the 28 March 2023 P&CC Chair Assurance Report.

23/009.2   **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair highlighted key points:

- Monitoring changes in the Executive Team, appointments of interims and progress on the recruitment of substantive staff;
- Update on the development of performance objectives for Executive Directors, covering substantive and interim staff;
- Executive Director interview panels included NEDs as well as system

representatives in addition to the CE and Chairman;
- The NRC Chair had agreed to take on the role of Governor relations lead NED supporting the Chairman, and the NED, AC, had agreed to take on the Clinical Ethics Committee member role.

The Board of Directors **NOTED** the 14 March 2023 NRC Chair Assurance Report.

23/009.3 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The NED, LF, Q&SC member on behalf of the Q&SC Chair highlighted key points:

- Limited assurance and concern on the number of NFTR patients, that was the highest reported levels, and the impact of this on incidents of harm. Noted engagement and work with system partners, which was not yet resulting in improving the position and the need for this to support to reduce the numbers and improve patient flow;
- Outbreak of Respiratory Syncytial Virus (RSV) on the Special Care Baby Unit, did not result in harm to babies, was dealt with promptly, and a full debrief to be undertaken;
- Concern raised around not learning from SIs and assurance that there was ongoing learning from these incidents, discussions taking place and continuing to improve the SI review process.

The CNMO reported the Trust continued on its SI improvement journey, noting the SI escalation process had been strengthened with prompt escalation, with support to staff on the SI process, progress updates would be reported to the Q&SC at future meetings.

The Board of Directors **NOTED** the 30 March 2023 Q&SC Chair Assurance Report.

23/009.4 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted key elements:

- 2023/24 Business Plan currently showed a deficit of £72m (a reduction from £93m), significant financial challenges ahead to ensure achievement of this plan. Key area was NFTR patients and the actions required to address and reduce the number of these patients.

The Chairman questioned how confident the Trust was about achieving the efficiencies £40m target, that to date only £5m had been identified, and the identification of future schemes to bridge this gap. The NEDs commented on the key roles of Care Groups in achieving the CIP target and consideration of Board members being allocated to support Care Groups in the efficiency work. The CFO reported the need for a step chance in the Trust's approach around focussing on the efficiencies needed, transformation projects to improve patient care and quality, as well as support from the Financial Improvement Oversight Group (FIOG) in identifying savings schemes. The CE reported the responsibility and support of all staff in achieving the target and engaging with the transformation work, noting there would be Executive oversight of this work, and the proposed organisational restructure that would help to provide the future structure needed in taking forward this work.

The NEDs emphasised the importance of support and engagement from staff being involved with the CIP, taking ownership of cost pressures and reviewing costs to identify where potential savings could be made. The CFO reported pre-Covid budget controls were being re-instated, staff communications and training for budget holders and raising awareness of costs to remain within budget.

DECISION: The Board of Directors:

- **NOTED** the 28 March 2023 FPC Chair Assurance Report;
- **APPROVED** the 2023/24 Business Plan.

23/009.5 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair highlighted:

- Discussion of the Charity funds and utilising these to help achieve the Trust's transformation strategy, to produce an expenditure plan for presentation at the next meeting.

The Board of Directors **NOTED** the 29 March 2023 CFC Chair Assurance Report.

23/010 **TRANSFORMING OUR TRUST: OUR RESPONSE TO *READING THE SIGNALS* – UPDATE**

The CE reported:

- NHSE's National Delivery Plan for Maternity and Neonatal services expected to be published in the Spring;
- Investment needed for the Trust;
- Recognition that there remained a lot of improvement work still to be done, noting the Pillars of Change would be supported by the IIP, as well as delivery of the constitutional standards.

The EMSSPD reported positive meetings of the *Reading the Signals* Oversight Group held that included family representation, as well as an initial meeting with three family representatives. It had been recognised that this group could not be the sole source for collating feedback from families and to look at how to ensure a wider range of feedback providing more informal opportunities to engage with the Trust and raise any issues of poor experience and care. It was noted families were engaged and further work was need on the Terms of Reference (ToR) before these were presented to the Board. It was important to the families that they were assured the Trust was on a continued improvement journey. It was noted this formal Group was daunting for families and the need for flexibility around the number of family representatives on the Group The NED Group Chair, CS, thanked families for their engagement and being part of this group and supporting the improvement.

The NEDs commented a key element of the Group was to provide assurance, evidence and testing of improvements. The EMSSPD assured this was what the families wanted to see.

The Board of Directors discussed and **NOTED** progress to date and key next steps.

23/011   **MATERNITY GOVERNANCE:**

23/011.1   **MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG) REPORT: CHAIR'S ASSURANCE REPORT**

The CNMO reported:

- All maternity specific training compliant for midwives and obstetricians for February. However, non-compliant for maternity support workers for Newborn Life Support (NLS) due to sickness in the resuscitation team resulting in cancellation on two occasions, and these were being rebooked;
- PRactical Obstetric Multi-Professional Training (PROMPT) training was now face to face with staff on each site training together through in-situ simulation;
- Ongoing challenges for anaesthetic colleagues continuing to impact on their ability to complete PROMPT training, and work, supported by the CNMO and CMO commenced to review the workforce structure for anaesthetics to support improving training completion;
- Maternity Dashboard presented and update on SIs, 4 reported during February, 1 related to community services, 1 related QEQM, 1 related to the WHH and 1 group cluster incident relating to screening services;
- Staff listening event held on 22 February 2023 that also included Royal College of Midwives (RCM), attended by 135 staff members, who raised their concerns over the ongoing staffing challenges, especially at WHH. Trust was looking at the provision of a flexible team that could move across sites where there were operational pressures, along with increased senior leadership to ensure safety;
- Students; out of the 32 students at QEQM and WHH placement offers made, currently 25 (of which 11 would be at WHH) had accepted and would take up their substantive roles in September, awaiting responses from those remaining;
- No referrals to Healthcare Safety Investigation Branch (HSIB).

The NEDs raised the issue of completion of the PROMPT training and when this would be addressed by, looking at doing things differently to support the necessary improvements. The CNMO reiterated the challenges with capacity and staff resources as there was not a separate anaesthetic maternity team, provided assurance of the Trust's continued plan to recruit staff highlighting the risk of insufficient staff to be able to recruit. It was noted programme leads identified for completion of the workstreams within the Maternity Transformation Programme, which included a workforce workstream.

The Board of Directors **NOTED** the content of the MNAG Chair's Assurance report.

23/011.2   **SECTION 31 REPORTING: MATERNITY AND MIDWIFERY SERVICES WHH AND QEQM**

The Interim DoM reported:

- Formal joint weekly infection prevention and control (IPC) rounds implemented, supported by a Standard Operating Procedure (SOP);
- Two weekly open forums established for staff to discuss ongoing plans and

support, which were well attended;

- Challenge with age of environment/estate to address issues raised, teams working closely with 2gether Support Solutions (2gether) to address general cleaning issues as well as oversight of daily monitoring, remedial works and action taken with items needed ordered but on occasions delays in these being delivered;
- Fire visit on 9 March that did not identify any serious issues;
- Daily quality round checklist audits with areas improved and meeting compliance targets;
- There was not a national target for fresh eyes, an improvement trajectory had been set with provision of technology to support alerting staff when these were due, to improve compliance;
- Ongoing work to ensure reduced level of red non-compliance to improve to amber and green;
- Triangulation of complaints received.

The NEDs raised the submissions to the CQC providing details of the actions to address concerns raised and that these provided the necessary assurance. The CNMO stated feedback had been received and the Trust had strengthened its subsequent submissions.

The Board of Directors **NOTED** the content of the Section 31 report and the CQC S31 submission reports for both WHH & QEQM with the evidence data.

23/011.3   **PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT**

The Interim DoM reported:

- Feedback from service users and development of a register of women who wished to be involved in co-production.

DECISION: The Board of Directors:

- **NOTED** the contents of the PQST report;
- **NOTED** the key risks**:** non-compliance with PROMPT training for Anaesthetists;
- Received **ASSURANCE** and **NOTED** that a monthly perinatal quality assurance report had been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements;
- **APPROVED** for the contents of this report to be shared through the Perinatal Quality Surveillance Model Framework with the Local Midwifery and Neonatal System (LMNS), Region and Integrated Care Systems.

23/012   **INTEGRATED PERFORMANCE REPORT (IPR)**

Mortality (Hospital Standardised Mortality Ratio (HSMR))

The CMO reported on the aim to reduce mortality and be in the top 20% of all trusts for the lowest mortality rates in 5 to 10 years, against the threshold set for rolling 12 month HSMR to be below 90 by January 2027.

- Mortality discussed in-depth at Q&SC, with continued focus on monitoring mortality data:

- As at November 2022 the 12 month rolling position remained lower than expected for the Trust as a whole;
- Risk of patients staying longer in EDs.

Reduce Incidents with Harm

The CNMO reported an update on the target to achieve zero patient safety incidents of moderate and above avoidable harm within five years:

- 46 incidents in February, continued to be above threshold but a decrease from the previous month, highest contributors to harm were operations/procedures, delay/failure, care/treatment and clinical assessments with 5 incidents (one reported as severe that related to failure to escalate a deteriorating patient which was an SI and potentially an avoidable death);
- Deep dive into 7 deaths and 3 SIs in January, outcome identified one incident that might had led to an omission of care that was still being investigated, although there were no themes or specific site based issues;
- Continued pressure and overcrowding in the EDs with support from ward staff redirected to EDs to care for patients in escalation areas and corridors;
- Issues around increased harm and failure recognising deteriorating patients was correlation to increased operational pressures and demand.

Patient Experience: Inpatient Survey

The CNMO reported on progress of the Trust's ambition to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023:

- Target of 2,050 patient experience surveys again exceeded with 2,299 completed;
- Overall score of 9.3 (93%) maintained against the 7.7 (77%) threshold.

Trust Access Standards: 18 week Referral to Treatment (RTT), >12h total time in department, and Cancer 62 day
Theatre Session Opportunity
Same Day Emergency Care (SDEC)
Not fit to reside (NFTR)

The CE reported:

- Increased volume of patients waiting longer than 78 weeks for surgery (majority were ENT complex otology patients);
- Theatre session opportunity – improvement of 4.3% in actual utilisation, booking utilisation showing at 89.4% and actual at 80.2% with Elective Orthopaedic Centre (EOC) utilisation improving from 79.8% to 92% booked with an increase from 75.9% to 84.7% for actual;
- ED 12 hour total time in department – challenging position impacted by continued demand;
- Patients activity impacted as a result of the junior doctors strike the following week had been redated.

The Chairman enquired about the timeframe to reduce the number of 78 week waiters to zero. The CE confirmed a plan in place to address this by early June, which included a range of alternative work in collaboration with partners.

The NEDs commented on the Phase 3 ED works at WHH around the management of patient flow, rapid assessment areas with reduced bed numbers and evaluating the success of the changes in ED, the impact of the building works, ED patient pathway and flow. The CE agreed it would be beneficial for the Board to receive a report at the June meeting on the transformation work, covering the ED phased building works, patient pathway and flow and managing demand.

ACTION: Present report at the June meeting on the transformation work, covering the ED phased building works, evaluating the success of the changes in ED, the impact of the building works, management of patient flow, rapid assessment areas with reduced bed numbers, patient pathway (alternative pathways) and managing demand.

COO

Staff Engagement: Staff Involvement Score

The CPO highlighted key points within the people domain and to improve the staff engagement score to 6.8 by March 2023:

* Staff engagement remained stable, improving subtly from 6.33 to 6.35.

Financial Position (Income and Expenditure Margin) and Month 10 Finance Report

The Interim CFO highlighted key points:

* February position showed deficit of £23.6m against a plan of £1m deficit, key drivers were £8.8m behind plan on CIPs, £9.4m on escalation areas (additional 80 beds), £6.3m on mental health staffing, and £4.8m other staffing pressures due to demand;
* Reforecast position to a £19.3m deficit in year;
* Capital plan expected to be achieved at year-end.

The NEDs enquired whether discussions were taking place system wide about funding needs across the system. The Interim CFO commented the FPC would be kept up to date about system discussions at future FPC meetings.

Carbon Footprint (CO2e)
Recruitment to Clinical Trials

The Interim EDSDP highlighted key points:

* CO2e position reporting below the monthly trajectory of 8.27 at 7.3kgCO2e per m2, the Trust had increased its m2 during 2022/23;
* Clinical trials – February position of 121 participants, below the monthly threshold of 123, cumulative position was 1,752 patients recruited to trials and 29% above the year to date trajectory of 1,353;
* New OCEANIC study in Stroke services, the Trust was the first trust in the UK to enrol a patient and had been commended on its approach to this trial.

The Board of Directors discussed and **NOTED** the:

- True North and Breakthrough Objectives of the Trust;
- Month 11 financial report, financial performance and actions being taken to address issues of concern;
- reforecasting of the financial position to a £19.3 deficit.

23/013   **RECOVERY SUPPORT PROGRAMME:**

23/013.1   **RECOVERY SUPPORT PROGRAMME (RSP) INTEGRATED IMPROVEMENT PLAN (IIP)**

The Chairman commented the plan needed to be ambitious and also realistic, noting period to stabilise the Executive Team, the plan would be amended going forward and refined as a result of discussions with the ICB and NHSE.

The CE reported the plan outlined the approach for sustainable improvement and the work needed focussing on specific areas of performance to improve patient care, safety and experience. As well as exiting National Oversight Framework (NOF) segment 4 and moving to NOF3. Trust's aim to be an outstanding provider of care, recognising there was significant more work to be done to achieve this. Thanks to NHSE's Improvement Director and all staff involved in developing this plan.

NHSE's Improvement Director provided assurance of support, passion and energy within the Trust to deliver the plan, which was critical to move from NOF4 to NOF3, noting monthly progress reports would be presented to the Board (requirement from the ICB and Region).

The NEDs commented it would be beneficial to test the milestones quarterly to provide assurance of progress, also highlight where there were challenges and risks to delivery, and monitoring progress to ensure achievement of the plan as well as the We Care programme. It was noted the EDSDP would monitor and oversee the plan along with the We Care improvement programme work.

DECISION: The Board of Directors discussed and **APPROVED** the proposed Integrated Improvement Plan.

23/014   **NHS NATIONAL STAFF SURVEY (NSS) 2022 REPORT**

The CPO reported Teams were being asked to identify and 'change three things' and this approach was being rolled out across the organisation, giving empowerment to staff, encouraging local ownership of improvement and action. All staff webinars had been held, page on Trust intranet StaffZone showing the focus areas needed and where there had been local positive interventions. Introduction of the Trust's culture leadership programme (CLP).

The NEDs raised concern in respect of less than half of colleagues would recommend the organisation as a place to work, that needed to be addressed, and that there needed to be much improved scores in the next year's survey. The CPO commented on the impact of the Independent Investigation into East Kent Maternity

Services in respect of attracting people to come and work at the Trust, with continued focus on recruitment.

The Board of Directors **NOTED**:

- The NSS results highlighted how the Trust was performing against key markers of staff experience. The reports highlighted the most pressing challenges, along with progress being made following dedicated focus;
- Recommendation the survey and the attached reports be used as an opportunity to identify areas the Trust needed to attend to most closely throughout 2023/24 in order to deliver the improvements needed.

23/015   **ANY OTHER BUSINESS**

There were no other items of business raised.

23/016   **QUESTIONS FROM THE PUBLIC**

Mrs Warburton raised the Patient/Family experience story and that the daughter had good reason to stay with her mother, and enquired what processes were in place for people to be able to raise concerns in real time when they needed to. The CNMO reported during out of hours (OOH) periods to speak to the nurse in charge, and communication had been disseminated to staff reminding them about visiting as well as considering individual circumstances and OOH visiting.

Mrs Warburton commented on the importance of the Trust and its staff learning from complaints, concerns and where things had gone wrong, to enable it to move forward and improve.

Mr Brittain raised the Patient/Family experience story and staff accountability in respect of poor patient and family experience, duty of candour in acknowledging when things had gone wrong, the investigation, its outcome and that any actions needed would be put in place. The CNMO reported an investigation was being undertaken, it had been acknowledged that a robust compliant investigation had not been carried out, there had been significant omissions of care, any professional concerns as a result of the completion and outcome of the investigation would be addressed as appropriate in alignment with Trust's procedures.

The Chairman reported a written question had been received from a member of staff, Mr J Harman, and that the question and response would be included in the minutes, as noted below.
Follow up question in respect of previous question concerning the reintroduction of the higher parking charges for staff. "This comes at a time when many NHS workers are already struggling to make ends meet, with the cost of living crisis hitting them particularly hard. Furthermore, have seen Union members take the decision to engage in the biggest period of industrial action in the history of the NHS, with many nurses and other healthcare workers taking part in strikes and other forms of protest in the hopes of achieving better pay and working conditions. While the current pay deal proposed to staff will give some support the re-introduction of the higher rate of parking charges will potentially leave some staff worse off than when the deal was suggested. It is particularly troubling that we are seeing a return to the higher parking charges that were previously in place. It is

estimated that one in five nurses is currently using food banks, an unacceptable situation, and is clear the re-introduction of higher parking charges will only add to the financial pressures that many NHS workers are facing. It is important to remember that these workers are at the frontline of our healthcare system and deserve our support and recognition for the vital work they do every day. By re-introducing higher parking charges, sends a message that we do not value their contribution to our society, and risks undermining the morale and motivation of these essential workers. While the car share scheme that will be implemented by the Trust will go a way to offset the cost of parking for those able to take advantage of it, not everyone will be able to benefit due to factors like shift patterns and changes to commute routes. I ask to revaluate the rate of parking fee bringing it more in line with that of other NHS trusts with employee welfare in mind."

Response to follow up question - East Kent Hospitals provided free parking throughout the pandemic which continued until the 31 December, this arrangement went beyond the time when the central reimbursement to trusts stopped. It was agreed that a flat fee of £10 be introduced for the period 1 January 2023 to the 31 March 2023 after which time there would be a return to the pre-pandemic pricing structure. The Trust's Executive team considered whether it was possible to continue to provide free parking or whether a new more flexible permit scheme should be introduced. They considered factors such as: equity with staff who pay to use public transport to come to work; the fact there is not enough car parking or land owned by the Trust to expand car parking for all and the environmental impact of encouraging greater car use. On reviewing these factors it was agreed that there would be a reinstatement of parking charges at the pre-pandemic levels, a decision that was endorsed at the Trust staff committee. The pre-pandemic pricing structure is being used as the baseline for the reintroduction of the charges. The maximum pricing levels not been increased since their introduction in 2014, however following the review the new permit scheme includes the introduction of a wide range of cheaper and more flexible permits, and staff pay on a sliding scale depending on their pay grade. Students, blue badge holders and staff parking overnight do not pay for parking.   Parking is managed in-house with the proceeds of the parking charges being reinvested in Trust services which includes the maintenance and security of the Trust parking facilities.

The Chairman closed the meeting at 1.15 pm.

Date of next meeting in public: Thursday 4 May 2023.

Signature   _____

Date   _____

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	MATTERS ARISING FROM THE MINUTES ON 6 APRIL 2023
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	CHAIRMAN
PAPER AUTHOR:	BOARD SUPPORT SECRETARY
APPENDICES:	NONE

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.				
Summary of Key Issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to note the updates on the action log.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** the action log from the actions from the previous meeting and **NOTE** the actions for future Board meeting.				

Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people		Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	None				
Link to the Corporate Risk Register (CRR):	None				
Resource:	Y/N	N			
Legal and regulatory:	Y/N	N			
Subsidiary:	Y/N	N			
Assurance Route:					
Previously Considered by:	N/A				

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MATTERS ARISING FROM THE MINUTES ON 6 APRIL 2023

1.   Purpose of the report

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

2.   Background

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

2.2.   The Board is asked to note the updates on the action log.

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/14/22	Undertake a repeat analysis in March 2023 of the impact of We Care on staff engagement levels on the data provided by the National Staff Survey 2022 and National Quarterly Pulse Survey (NQPS) Quarter 4.	~~Apr-23~~/ Jun-23	Chief People Officer (CPO)	Open	The repeat analysis of the impact of We Care on staff engagement levels cannot yet be provided, as awaiting this data expected mid-April, that would then be reviewed and reported to Board.
B/26/22	Look into the delays in being assessed within the ED or being admitted to a ward, the outcome of the deep dive review, and provide details and data on the impact of these delays in the next report to be presented to the Board.	Jun-23	Chief Medical Officer (CMO)	Open	Item for future Board meeting.
B/01/23	Present report at the June meeting on the transformation work, covering	Jun-23	Chief Operating Officer (COO)	Open	Item for future Board meeting.

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	the ED phased building works, evaluating the success of the changes in ED, the impact of the building works, management of patient flow, rapid assessment areas with reduced bed numbers, patient pathway (alternative pathways) and managing demand.				3

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REPORT TO:	BOARD OF DIRECTORS MEETING (BoD)				
REPORT TITLE:	STAFF EXPERIENCE STORY				
MEETING DATE:	4 MAY 2023				
BOARD SPONSOR:	CHIEF PEOPLE OFFICER (CPO)				
PAPER AUTHOR:	HEAD OF EQUALITY, DIVERSITY & INCLUSION (EDI)				
APPENDICES:	APPENDIX 1: STAFF STORY FORM/CHECKLIST				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	Staff member Oliver Marley (he prefers to be called Ollie), who works in IT wishes to share his story of working for the EKHUFT during a very challenging time in his life. This includes discussion of multiple life stressors; previous domestic abusive relationship, his son being born disabilities (on a Trust site), looking after children with complex needs and the impact on his mental health.				
Summary of Key Issues:	Ollie feels he was well supported by his line managers and colleagues and that this has helped him to manage his mental health, increase his confidence and continue to work. He wants to use his experiences to help others and encourage supportive leadership. Ollie's son was born in an EKHUFT hospital and has disabilities and complex needs. Ollie says he does not hold any malice or blame towards the maternity services and has contacted them to express this.				
Key Recommendation(s):	The Board of Directors is asked to **NOTE** the report, and Ollie feels he was well supported by his line managers and colleagues and that this has helped him to manage his mental health, increase his confidence and continue to work. He wants to use his experiences to help others and encourage supportive leadership.				
Implications:					
Links to 'We Care' Strategic Objectives:					

Our patients	Our people	Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	N/A			
Link to the Corporate Risk Register (CRR):	N/A			
Resource:	Y/N	N/A		
Legal and regulatory:	Y/N	N/A		
Subsidiary:	Y/N	N/A		
Assurance Route:				
Previously Considered by:	None			

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Staff Story Checklist for Board Meeting

<table>
<tr>
<td colspan="3" style="background-color:yellow">Section A
To be completed by the story sponsor and supplied to the relevant team along with any additional contextual information.</td>
</tr>
<tr>
<td colspan="3">Name of person sharing the story: Oliver Marley (prefers to be called Ollie)

(contact details to be shared via email to the team: ekhuft.edi@nhs.net)
Service the story relates to: experience of staff member who has used Trust services. Includes experience of domestic abuse, having children with disabilities and support received from his line managers.

Senior sponsor name and email: Parveen Kumi; Head of Equality, Diversity & Inclusion

parveen.kumi@nhs.net

Board Sponsor name: Andrea Ashman; Chief People Officer, People & Culture.</td>
</tr>
<tr>
<th>Preparation</th>
<th>Prompt</th>
<th>Comments</th>
</tr>
<tr>
<td>Why are we hearing this story?</td>
<td>What sort of story is it?</td>
<td>Ollie wishes to share his story of working for the EKHUFT during a very challenging time in his life. This includes discussion of multiple life stressors; previous domestic abusive relationship, his son being born disabilities (on a Trust site), looking after children with complex needs and the impact on his mental health.</td>
</tr>
<tr>
<td></td>
<td>Will the story show the organisation or staff negatively?</td>
<td>No, Ollie feels he was well supported by his line managers and colleagues and that this has helped him to manage his mental health, increase his confidence and continue to work. He wants to use his experiences to help others and encourage supportive leadership.

Ollie's son was born in an EKHUFT hospital and has disabilities and complex needs. Ollie says he does not hold any malice or blame towards the maternity services and has contacted them to express this.</td>
</tr>
</table>

	What actions has the service taken to address the issues raised?	Ollie feels strongly that staff in maternity services need encouragement and positive feedback from families using the services. He has spoken to maternity services about this and is keen to promote this message.
How is this item going to be managed?	Who from the service is going to lead this item and attend the Board meeting? What preparation or information will Board members need to ensure their questioning is appropriate?	Parveen Kumi, Head of Equality, Diversity & Inclusion, will be introducing Ollie to the Board. Ollie is a very confident speaker and so will be telling his story in his own words, he may choose to use prompts or a PowerPoint. Ollie is open to the Board asking him questions and welcomes this.
What does this story add to our understanding of the quality of our services?	How does this story relate to information in our quality and/or performance reports? What additional information does the Board require to help put the story in context?	This story adds to our understanding of quality of our services by gaining an understanding of the lived experience of a staff member and how demonstrating the importance of supporting and understanding managers and colleagues. N/A

Please return completed form to the EDI Team:
ekhuft.edi@nhs.net

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CHAIRMAN'S REPORT**
MEETING DATE:	**4 MAY 2023**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**CHAIRMAN**
APPENDICES:	**APPENDIX 1: NON-EXECUTIVE DIRECTORS' COMMITMENTS**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.				
Summary of Key Issues:	Update the Board on: • Current Updates/Introduction; • East Kent Health and Care Partnership (HCP) Board; • Activity of the CoG; • Visits/Meetings.				
Key Recommendation(s):	The Board of Directors is requested to **NOTE** the contents of this Chairman's report.				

Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people		Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	N/A				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	Y̶/N	N			
Legal and regulatory:	Y̶/N	N			
Subsidiary:	Y̶/N	N			
Assurance Route:					
Previously Considered by:	N/A				

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CHAIRMAN'S REPORT

1. Purpose of the report

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

2. Introduction

As we continue to build the executive team, Tracey has led a review into the next level of our management structure – at site and care group level - to make sure they are effective and fit for purpose. This month we launched a consultation for the proposed new structure which places more emphasis on following patient pathways and raises the importance of what happens on each of our principal sites. Change of this kind can be difficult for individuals but I believe there is support for this reform and I am confident it will enable us to manage our services more effectively.

Alongside our care group structures, we must also make sure the Board has the right processes and information in place to allow it operate effectively and be confident in the levels of assurance it reaches about our services. We are committed to a fundamental review of our governance arrangements which have clearly not worked effectively in the recent past and we will continue to work with colleagues on reducing the volume of papers which the Board receives, while increasing their clarity of purpose. I hope we will be able to see the results of this work over the next few months.

We are awaiting the final report from the Care Quality Commission (CQC) following its inspection of our maternity services which we know will be highly critical of the services. This is difficult – we believe we have made progress in a number of areas over the last 18 months and we have evidence to show that but it is also clear that the inspection has identified a significant number of areas where we must act. We are so pleased that next month we will be joined by a new Director of Midwifery and her Deputy and indeed, as a Board and as leaders throughout the Trust, we must support the new midwifery team, our obstetricians and indeed all our frontline staff in maternity to make sure we turn this around. Some of the issues will be hard to remedy in short order, not least the facilities in which staff operate, but others can and must be fixed at pace. Working with these front line staff will be the only way to achieve this.

At our meeting this month, we will also focus on our current financial position. As we announced at our last meeting, we incurred a deficit of £19 million last year albeit one we had predicted. For 2023/24 we are facing a deficit which is likely to be in the region of £72 million. We cannot hope to eliminate that in the year ahead but we are determined and will be expected to bear down on our cost base and identify and drive efficiencies so that over a longer period we move to financial balance. And we must do this without damaging services to patients. The Board will today receive the 2023/24 Business Plan for approval, which aims to set out how we intend to manage this deficit moving forward. Critically we cannot allow any drift – every day that passes without bearing down on excess costs will make it harder to achieve our end year objective.

Last month the Board heard from Dame Eileen Sills and Professor Michael West both of whom challenged us on how we are going to bring about the changes in attitudes and behaviours that will create a new compassionate learning culture throughout the Trust. We cannot say this often enough – we need to learn from the *Reading the Signals* report as we embark on an East Kent conversation involving every member of our staff. This will be a major and ongoing exercise but it must be a priority and we should be able to measure its impact as it is rolled out.

This month we wished farewell to Sarah Shingler, our former Chief Nursing and Midwifery Officer (CNMO) and applaud her dedication and commitment to improving care for our patients, as well as her support for our nursing and midwifery staff and her engagement with the families who have suffered from poor care. Sarah is joining her local Trust in Worcestershire, and we wish her all the best in her future role. Catherine Pelley is currently standing in as we seek to recruit a substantive appointment.

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3. East Kent Health and Care Partnership Board (HCP)

At its last meeting in March the East Kent Health and Care Partnership Board reached the final part of its development phase as moved on to a statutory footing as a sub-committee of the Integrated Care Board (ICB) with devolved responsibilities and funding. The inaugural meeting of the 'new' partnership will take place in May. Our ambition must be to continue to build on the encouraging level of collaboration achieved thus far between partners. Both Tracey and I believe that the Partnership offers a great opportunity to build an integrated future for all the services in East Kent and in many ways, it will be crucial to the success of this Trust as it develops acute services for our communities which will begin to look rather different over the next decade.

4. Council of Governors

The Governors and Non-Executive Directors have agreed joint site visits for 2023/24 with the first of these planned for William Harvey Hospital. These will have more structure this year and will be reported on a regular basis to both the Council and the Board. I am delighted that Stewart Baird, my deputy, has agreed to support my liaison with Governors. He held his first meeting earlier this month and I understand it was well received. In addition to my programme of meeting with Governors, Stewart will hold a session three times a year to provide further ways of raising concerns and sharing intelligence.

The elections for the public Governor vacancies in Canterbury and Folkestone/Hythe are under way with the result due on 3 May 2023. Sadly, newly elected Mike Trevethick (Public Governor for Thanet) and Tom Morris (Public Governor for Canterbury) have chosen to stand down which means we now have vacancies in Thanet, Canterbury and Rest of England.

5. Chairman's Visits/Meetings/Talks since last Board

In addition to routine internal and external meetings:
- Addressed Trust welcome day for new starters in Canterbury
- Visited clinical staff and toured facilities in:
  - Clarke Ward at Kent and Canterbury Hospital
  - Kent Ward at Kent and Canterbury Hospital
- Addressed doctors in training taking part in the Medilead programme
- Meetings with individual NEDs
- Meeting with all NEDs
- Appraisals with all NEDs
- Meetings with Executive Directors
- Meetings with the Chief Executive
- Meeting with East Kent MPs
- Chaired Interviews for Chief Finance Officer (CFO)
- Chaired Interviews for Chief Nursing and Midwifery Officer (CNMO)
- Chaired Interviews for Director of Strategic Implementation and Partnerships
- Council of Governors meeting
- Development Session for the Board of Directors
- Meeting with 2gether Support Solutions (2gether) Chair
- Meeting with Spencer Private Hospitals (SPH) Chair
- Meeting with East Kent Integrated Care Board (ICB) Chair
- Attended the formal opening of the Verena Holmes Building at Kent and Medway Medical School (Canterbury Christ Church University)
- Chaired panel at University of Kent's annual lecture for the Centre for Health Services Studies (CHSS)

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Non-Executive Directors' (NEDs) Commitments

NEDs April 2023 commitments have included:

Non-Executive Directors	Meetings with Chairman Appraisals with Chairman Finance and Performance Committee (FPC) meeting Quality and Safety Committee (Q&SC) meeting People and Culture Committee (P&CC) meeting Integrated Audit and Governance Committee (IAGC) meeting Council of Governors meeting Meeting with Governors Meetings with People and Culture Department Heads Informal meetings with Chief Nursing and Midwifery Officer (CNMO) and Chief Finance Officer (CFO) candidates Interview panel for CNMO and CFO

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REPORT TO:	BOARD OF DIRECTORS (BoD)				
REPORT TITLE:	CHIEF EXECUTIVE'S REPORT				
MEETING DATE:	4 MAY 2023				
BOARD SPONSOR:	CHIEF EXECUTIVE (CE)				
PAPER AUTHOR:	CHIEF EXECUTIVE				
APPENDICES:	NONE				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS England (NHSE), Department of Health and other key stakeholders.				
Summary of Key Issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.				
Key Recommendation(s):	The Board of Directors is requested to **DISCUSS** and **NOTE** the Chief Executive's report.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	Our people		Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.				
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	N/A				

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CHIEF EXECUTIVE'S REPORT

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1. **Purpose of the Report**

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

2. **Background**

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

3. **Clinical Executive Management Group (CEMG)**

   The CEMG approved go-live of the electronic Prescribing and Medicines Administration (ePMA) within Sunrise Clinical Manager™ on 22 April 2023 at Kent and Canterbury Hospital, with roll outs at Queen Elizabeth the Queen Mother Hospital (QEQM) and William Harvey Hospital (WHH) to follow in May.

4. **Operations update**

   4.1 **Elective year end position**

   The Trust has been working to deliver against set targets, as per the national guidance, to reduce our elective backlog and to ensure that no patient is waiting longer than 18 months (78 week wait) for treatment.

   At year end, the Trust recorded 87 breaches of the zero position for those waiting 78 weeks. 16 of these breaches are classified as 'acceptable exclusions' due to patient choice, be that Covid-19 or complexity. 71 of these breaches remain in the Trust's Otology specialty and have been driven by unplanned sickness of one of the Trust's medical team. All local, regional and national options have been explored to treat these patients, but this was not viable before the end of March 2023. Detailed plans for treating these long waiting patients will roll over into Q1 2023/24 with patient by patient planning in progress to ensure these patients receive the treatment they require.

   The Trust has been successful in continuing to reduce the backlog of patients waiting 52 weeks and performed ahead of the trajectory at year end, 2997 against a Trust target of 3276.

   As we move into the next fiscal year, there is significant work in progress to review the patients that remain on the Trust's elective wait list to ensure they still require surgery, understand if circumstances have changed or indeed deteriorated to determine that the Trust has a true understanding of the demand on its elective services.

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Detailed activity plans have been submitted to NHSE outlining the planned volumes of activity the Trust will complete in 2023/24. This planned activity has been developed with two key criteria at their core:

- To maintaining the size of the Trust's elective waiting list;
- To meet the target of zero patients waiting 65 weeks for their treatment by year end 2023/24.

The planned activity targets are ambitious but achievable, with Care Groups across the Trust focussed on developing and implementing schemes of work to support delivery and seek to optimise operational efficiencies to make these targets a reality and further reduce the elective backlog.

4.2   Urgent and Emergency Care (UEC) Improvement Plan

East Kent Hospitals UEC Improvement Programme was established in Autumn 2022. The programme outlines the intentions to deliver improved UEC pathways across East Kent Hospitals led by senior clinicians and aligns to the national targets and directives. The programme of work is focussed on four key workstreams: Patient flow, Front door, Simple discharge, Same Day Emergency Care (SDEC)/Direct access and is monitored through the Trust's Emergency Care Delivery Board.

Key successes to date include:

- Emergency Department (ED) builds through winter delivered against significant changes required to UEC pathways to support the build progression;
- Extension of the SDEC service - extended hours and therefore an increased volume of patients being able to access the service;
- Implementation of clinical models within ED to support streaming to Urgent Treatment Centres (UTCs), SDECs, and Direct Access pathways to assessment units;
- Pilot of medical assessment unit commenced (William Harvey Hospital (WHH)) – 'right place first time' for patients;
- Established virtual clinics within SDEC promoting patients to be managed remotely;
- Patient Tracking List (PTL) improvements to support the improved accuracy of discharge planning;
- Cohort of P1 and P3 patients to enhance medical and therapy cover;
- Palliative care – patient cohort to provide specialist family support;
- Frailty front door services established;
- Development of access for GPs to refer to medical on-call directly, improving patient pathways to 'Right Place, First Time';
- Roll out of internal Patient Choice policy at the beginning of the patients journey, improving discharge planning.

Whilst the programme of work has some recognised successes and brings benefits to the Trust's patients, there remains challenges to flow across Trust. Capacity across the wards remains limited with high numbers of patients remaining under the

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care of the acute Trust as they await packages of care to support their on-going care needs.

5. **Finance Update**

    5.1 **Financial performance 2022/23**

    At the end of the 2022/23 financial year in March, the Trust delivered the revised year end deficit approved by the Integrated Care Board (ICB) and NHSE of £19.3m, which was supplemented by two non-recurrent allocations totalling £10.7m from the ICB & Kent & Medway NHS and Social Care Partnership Trust (KMPT) and against a breakeven plan.

    As reported throughout the year, the Trust's deficit for the 2022/23 financial year was driven by the need to open escalation areas across the Trust (80 beds) as a result of patient demand, flow and the increasing number of not fit to reside patients (£10.7m), a £5.9m overspend on drugs, a £7m overspend related to 1:1/ specialty mental health care and £6.3m in premium pay and additional staffing as a result of clinical pressures.

    The Trust's Improvement Programme delivered £19.6m of efficiency savings against its £30m target of which £10.6m was non-recurrent. The Trust delivered a small underspend of £132k for capital against a total spend of £35.6m.

    5.2 **Financial Planning 2023/24**

    As reported previously, the Trust continues to work closely with Kent and Medway system partners to develop the plan for 2023/24 with a third submission, a deficit of £72.5m, which includes a challenging £40m efficiency programme in addition to activity productivity targets to remove patients waiting over 65 weeks, reduce the number of no longer fit to reside (NLFTR) patients (to 174) and remove 12-hour Accident & Emergency (A&E) breaches, to be made to the system on 4 May 2023.

6. **Care Group Organisational Restructure Consultation**

    The Trust faces significant operational and performance challenges and remains part of the Recovery Support Programme (RSP) as a consequence of being in level 4 of the National Outcome Framework assessment (NOF4) and has considered options as to how best to structure and support operational teams to enable the Trust to exit NOF4, to address our own significant challenges, to enhance our response to Reading the Signals and to provide increased consistency in how our structures operate.

    A Consultation process to implement a new Care Group Structure was launched on 17 April 2023 with operational, nursing and medical teams. It is proposed that six new Care Groups (two site and place-based Care Groups, one site-based Care Group and three Trust-wide Care Groups) which are roughly equitable in size, will replace the existing structure which comprises of eight Care Groups and three Hospital triumvirate teams.

    These Care Groups will be organised with an emphasis on pathway management predominately at either place-based care or care that operates across the Trust and for some services, the Kent & Medway sector. Each Care Group will be led by an

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accountable Managing Director, supported by a senior leadership team and an appropriate leadership structure, including a Medical Director and Director of Nursing, or equivalent.

The process for appointment to the new structure is outlined in the detailed consultation paper, as is support for staff directly affected by the changes and details of how to provide feedback and submit counterproposals.

7.   Culture and Leadership Programme (CLP)

A development session for Executive, Care Group and Corporate Leadership Teams led by colleagues from the Transformation, People Directorate at NHSE was held on Wednesday 26 April 2023 to introduce the CLP which will be rolled out Trust wide.

A resourcing plan will be developed to support the rollout of this programme, which will require c.120 Change Leaders to assist the initial diagnostic phase.

8.   Chief Nursing and Midwifery Officer (CNMO) and Deputy Chief Executive

Sarah Shingler, Chief Nursing and Midwifery Officer (CNMO) and Deputy Chief Executive, joins her local Trust, Worcestershire Acute Hospitals, as Chief Nursing and Midwifery Officer on Monday 1 May 2023.

Catherine Pelley who has been supporting a review of the Trust's governance and risk management will act into the role of CNMO until Jane Dickson joins on 15 May 2023 as Interim CNMO. Both Catherine and Jane are experienced Chief Nurses and will cover the role until a substantive CNMO is appointed and joins the Trust.

I would like to take this opportunity to thank Sarah for her commitment and dedication to the Trust and to thank her personally for the support afforded to me since I arrived in April 2022.

9.   Conclusion

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

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety Committee (Q&SC)	25 April 2023	Dr Andrew Catto, Non-Executive Director (NED)	Committee Chair	**No**	
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
In attendance: Moira Durbridge, NHS England (NHSE) Improvement Director.					
Assurances received at the Committee meeting:					
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	*Partial assurance* was received by the Committee of the True North metrics and Breakthrough Objectives for March 2023. The Committee had a robust discussion and noted the following key highlights/assurances: − **Mortality (Hospital Standardised Mortality Ratio (HSMR)** at the time of the reporting was "lower than expected" for the Trust as a whole and the Kent & Canterbury Hospital (K&C) and Queen Elizabeth the Queen Mother Hospital (QEQM) sites with William Harvey Hospital (WHH) "as expected". The Chief Medical Officer (CMO) will undertake the analysis of the differentials between the sites. − Current 12 month rolling HSMR for fractured neck of femur patients is 100.1 (to December 2022) and remains "as expected". − **Incidents with harm:** there were 48 incidents in March 2023, which continues to be above threshold. The highest contributor to harm in March 2023 was care/treatment with 12 incidents, which is an increase from February 2023, operations/procedures was the second highest contributor with nine incidents, a decrease from February 2023. This was followed by delay/failure with eight incidents, which is a decrease from February 2023. − The Committee were made aware of five incidents regarding intravenous infusion of lipid for neonates which did not contain vitamins, and these were reported as serious incidents (SIs). The Committee noted that the supplier of the Total Parenteral Nutrition (TPN) had been changed and both lipids and vitamins are now included. Given the cluster of cases, *the Chair requested to receive a report on this incident at the next Committee meeting.* − The Committee expressed concern that the incidents with harm continued to be below the target and questioned if more radical measures should be put into place to reduce the trend. − The Committee once again highlighted the high number of overdue incidents and queried if there was enough resource to deal with the backlog. − The new Chief Operating Officer (COO) shared with the Committee his first observations, which are significant Emergency Department (ED) pathway challenges and long waiting times for elective procedures. The COO is keen to determine what these mean for the quality of care and patient experience. As this was the first Q&SC meeting for the COO, it was agreed he needed time to understand the issues and bring back further reflections to the next meeting.				

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Infection Prevention and Control (IPC) Report	The Committee received *partial assurance* of the current performance about nationally reportable infections noting the following: – Full reporting year data for 2022/23 show that the Trust has remained under the external thresholds for *Pseudomonas aeruginosa* and *Klebsiella* bacteraemia but has exceeded the thresholds for C-difficile and E. coli. – National changes to Covid-19 testing have been implemented and numbers of cases of Covid-19 are currently at their lowest level since November 2022. Going forward, the Covid-19 figures will be reported by exception as Covid-19 is now part of business as usual activities. – The Committee were assured that the procedures put in place during the Covid-19 pandemic would be reactivated rapidly should the need arise.
Care Quality Commission (CQC) Update Report	The Committee received *limited assurance* of the following: – The Care Groups have made considerable progress since January 2022 in closing must-do and should-do actions but this has slowed since November 2022. – The second Section 31 submission was sent to the CQC on the 21 March 2023 and the next submission is due on the 28 April 2023. – The Integrated Care Board (ICB) have undertaken a planned quality and safety visit to the QEQM and WHH Maternity Services in April 2023, the feedback is yet to be received. – The Committee expressed *significant* concerns about the number of open CQC actions, some of which date back to 2018, and the lack of clarity as to how to complete these actions.
Corporate Principal Mitigated Quality Risks	The Committee sought assurance that progress had been made on the revision of the Corporate Risk Register (CRR) and highlighted that the risk score had not changed for the last 12 months. The Chair informed the Committee that the Chairman requested to discuss a revised approach to risk management within the Trust, which will include Non-Executive Directors (NEDs). This would be based on best practice from other organisations and expert opinion. This work would be led by the interim Chief Nursing and Midwifery Officer (CNMO) and interim Director of Quality Governance.
Fundamentals of Care (FoC) Chair's Report	The Committee noted the assurance report on the activities of the FoC on the 16 March 2023. The Committee concluded that *only limited assurance* was provided in the report. The following key points were highlighted: – Positive patient feedback had been recorded by the Patient Voice Team around staff care and compassion. However, there were some negative comments with regards to meeting communication needs and poor discharge arrangements. – In February 2023 there were 121 falls, compared to 192 in January 2023. – Safe nutritional care and oral hydration for patients within the overcrowded EDs and escalation areas remains a continued concern.

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	– The Chair expressed serious concern that there were two patients with mental health issues who stayed in the ED for 146 and 163 hours and questioned if mental health patients staying in ED for prolonged periods of time receive daily mental health interventions. – The Committee sought urgent clarity from the COO as to how Kent and Medway NHS and Social Care Partnership Trust (KMPT) supported EKHUFT in caring for mental health patients in ED whilst awaiting placement in an appropriate mental health facility.
Clinical Audit and Effectiveness Chair's Report	The Committee commended the work undertaken by the Clinical Audit and Effectiveness Committee but noted that the number of audits undertaken by the Trust was too large and as a result, some audits were not completed and not embedded within the organisation. Discussion took place between the Chair and the clinical NEDs on getting the correct balance between time spent on junior doctor audits (essential for their development), which might not always complete the audit cycle and the need to deploy audit resource to the national audits which provide the opportunity to improve quality at scale.
Mortality Steering & Surveillance Group (MSSG) Chair's Report	The Committee noted the assurance report on the activities of the MSSG on the 22 March 2023 and noted the following: – Perinatal mortality reviews were completed and the data presented covered the period October 2021 - December 2022. Eleven cases were reported during the reporting period nine of which were still births and two were neonatal deaths. MSSG have requested an update on the continued feedback of the outcome of neonatal deaths to the coding team (code P45) and impact on mortality outlier status. The Chair sought clarity on how EKUHFT nationally benchmarked in terms of perinatal mortality. The CMO commented that EKUHFT was not an outlier, although national perinatal reports tend to be out of date by the time they are published. – 43 Structured Judgement Reviews (SJRs) were completed during February 2023 and the Trust's SJR completion rate was good in comparison with other trusts. – A need to improve the use of Local Safety Standard for Invasive Procedures (LocSSIPs) at ward level is being addressed through our review of our approach to LocSSIPs following the publication of National Safety Standards for Invasive Procedures (NatSSIPs2). This will be reported and monitored through Patient Safety Committee (PSC) and progress reported through Q&SC. – There were no new alerts identified within the February 2023 report. A number of conditions in statistical 'pre-alert' continued to be tracked and there was ongoing investigation being led by Cardiology into the myocardial infarction alert.

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Maternity and Neonatal Assurance Group (MNAG) Chair's Report	The Committee was made aware that the MNAG meeting on the 18 April 2023 had been stood down due to lack of quoracy. The Committee was assured that the Practical Obstetric Multi-Professional Training (PROMPT) training compliance was improving; however, it had not yet reached the required 90% mark. The Chair sought additional evidence on the uptake of PROMPT training for the next Q&SC.
Safeguarding Committee Assurance Report	The Committee noted the assurance report on the activities of the Safeguarding Assurance Committee on the 17 April 2023. The Chair commended the work undertaken by the Safeguarding team and felt that significant assurance had been provided. The Committee sought clarity on the leadership arrangements within the Safeguarding team given the current interim arrangements.
Lead Medical Examiner's (ME's) Report	The Committee received the Lead Medical Examiner's report. The following key points were highlighted: – The Medical Examiner's Service's unique position of having access to all care records across the system and thus being able to identify and theme problems in care both within organisations and across the interfaces of the whole system. – The Service provides a monthly report on "Learning from Deaths" to the Mortality Steering and Surveillance Group. – Information provided by the Service is triangulated with other patient safety data (complaints, audits, Datix) to identify clinical areas/teams requiring more support. – The Chair commended the insightful report and highlighted the engagement with General Practitioners as an example of good practice. – The Committee requested to receive six monthly updates from the Lead Medical Examiner and specifically to understand how the rich data arising from ME reviews could be triangulated with other sources of clinical information.
Ward Quality Concerns and Oversight Arrangement	The Committee received following assurances: – There are oversight arrangements and processes in place overseen by Site Directors of Nursing to guide and direct the senior nursing team in addressing wards and departments where patient care may not be meeting the required standard and to provide those areas with the necessary intensive support to improve patient care. – To gain assurance of the care provided to patients and the culture, knowledge and processes of ward teams an IT platform called Tendable is utilised to undertake Ward Accreditation, FoC audit, Inpatient Survey, IPC audits and Medication Management audits.
Thematic Reviews into Never Events and Thromboprophylaxis SIs Action Plan	The Committee were made aware that the Integrated Care Board (ICB) had completed two thematic reviews, undertaken across trusts in Kent and Medway (K&M), regarding SIs involving issues related to thromboprophylaxis for the period October 2020 – January 2023 and Never Events from April 2021 – June 2022.

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	The purpose of the report presented to the Committee is to provide assurance that the Trust has systems in place to manage the issues identified. The Committee received *limited* assurance noting the following: – There is a reasonable assurance regarding the management of issues and risks related to thromboprophylaxis within the Trust. – There are appropriate management controls in place in the form of policies and procedures and training provision. Compliance with venous thromboembolism (VTE) risk assessment is monitored on a regular basis and reported via Care Group Performance Review meetings and the Patient Safety Committee. – There is limited assurance regarding the oversight of the processes in place to reduce the likelihood of Never Events occurring. – There are policies for LocSSIPs available in theatres and outside of theatres, and some LocSSIPs are available on the Policy Centre. There is no organisational governance oversight of compliance with LocSSIPs.
Management of the deteriorating patient	The Committee noted the content of the Deteriorating Patient Pathway report. The following key issues were highlighted: – Consistent contributors to moderate and above harm to patients are care/treatment and delay/failure. The underlying themes of reviewing diagnostics, recognition and escalation of the deteriorating patient and placing the patient on the correct clinical pathway are the main reasons. – It is not currently possible to obtain real time data for the sepsis/deteriorating patient form compliance via Sunrise for inpatients wards. This means that it is not possible to provide assurance to regulators and external partners. Furthermore, sepsis screen on Sunrise is called Deteriorating Patient Form and can be searched for using either sepsis or deteriorating patient. This lack of clarity may be a contributing factor for poor compliance. – Patients conditions are not always escalated correctly based upon their National Early Warning Score 2 (NEWS2) trigger or observations are not repeated in accordance with Trust policy.
Serious incident reporting process	The Committee received the Serious Incident (SI) Reporting Process report and the following assurances were received: – Arrangements were now in place for identifying SIs in a timely way with a greater clinical engagement. – The quality of 72-hour reports has improved. – The process for identification of actions and learning is more robust. – The feedback from ICB is that the new serious incident reporting process is more responsive.
Safe Staffing Review Update	The Committee noted the partial assurance in the Safe Staffing Review. The Q&SC noted following key points: – The escalation areas and additional unfunded beds on most wards continues to put pressure on the current nursing establishment as well as the significant corridor care in the EDs has resulted in substantive nursing staff being moved to support.

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	− The need for 1:1 support continues to result in additional shifts being created for temporary staff. − The overseas Nursing candidate pool is rapidly reducing and there may be difficulties to fulfil the agreed numbers. In view of this NHSE would offer the Trust an opportunity to reduce the target for Internationally Educated Nurses (IEN) recruitment. − As of April 2023, NHSE have changed the English language testing requirements to become a Nurse for overseas UK residents who were registered Nurses within their home country. − There are challenges with resuscitation training largely due to the small size of the team. The resuscitation training risk has been put on the Corporate Risk Register and a business case is being written. The Q&SC will be updated on this risk in May 2023.
Shift Authorisation Standard Operating Procedure (SOP)	The Committee received the proposal to put in place an authorisation process for nursing temporary staffing. The authorisation process will allow a senior nurse to review the shifts and ensure that no shifts are being put out unnecessarily. The Committee commended the Shift Authorisation Process and agreed that it was an example of good practice.
Any other business	There was no other business to discuss.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

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:		
Item	**Purpose**	**Date**
Neonatal TPN Serious Incident	This is a cluster of 5 cases resulting from neonatal TPN. The vitamin deficiency was observed by a tertiary care provider. A preliminary report on immediate actions taken was received at Q&SC and a full report sought for the May 2023 Committee.	May 2023 Board to note. Review May 2023 Q&SC.
Inability to close CQC improvement actions at pace	The Q&SC noted considerable efforts had been made by the care groups to close MD and SD actions. The Board have previously discussed how to support the care groups to close their actions, although it was apparent from today's discussion that the focus must also be on cross cutting actions that are trust wide and require a more general approach supported by an improvement infrastructure and culture. The Q&SC noted that this	Board to note and cross reference with previous Board discussion on closing CQC actions.

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	issue was being discussed by the executive team.	
Care of patients with mental health issues in ED	The long duration of stay for a small number of mental health patients in ED was a cause for serious concern. Unfortunately, this issue is replicated in other EDs and tends to arise when a MH patient requires a specialist bed. The COO was looking into this to ensure the necessary mitigations were in place with partner organisations.	This will be reviewed at Q&SC in May 23.
Work on the BAF/CRR	The Chair explored this in some detail with the Director of Quality Governance (KW). KW had met with DD to obtain his reflections on actions taken at other large, challenged trusts. Points of note are the Board being clear on the controls, mitigations and having a clear description of the risk. Ensuring the risk arrangements are robust are a key element of the CQC well-led assessment.	*This was referred to and discussed by the April 23 IAGC, where the interim CNMO, Catherine Pelley, presented a paper entitled Risk Management and Governance (Reference 23/06)*
There is limited assurance regarding the oversight of the processes in place to reduce the likelihood of Never Events occurring.	A thematic review from K&M ICB was received regarding VTE management and never events. In the case of VTE, there is 'reasonable' assurance, although less so in the case of never event prevention. The committee noted a list of improvement actions (pages 122-124 of the Q&SC April 2023 meeting bundle).	The Board should also triangulate with comments received at the April 2023 Council of Governors (CoG) meeting on this topic. This will be kept under review by Q&SC.
Management of the deteriorating patient.	There was considerable discussion amongst the clinician NEDs present. It was noted that the Trust has the data, insight and understanding of the issues, but it appeared that 'on the ground' this does not always translate into the most effective outcomes. The debate centred on changing the configuration of the IT systems (developing a dashboard based on Sunrise that	The Board should note this was an area of concern from K&M ICB and this paper demonstrates progress is being made on safer systems of care.

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	colleagues in Dudley had developed) and a business case (currently in development) comprising the Critical Care Outreach Team (CCOT) plus resuscitation officers (the latter providing a much needed education function on escalation and the management if the deteriorating patient).	
SI reporting	At the request of the Q&SC Chair a paper detailing the response to ICB concerns was brought to this meeting. It was clear that several improvement actions were already underway including: - Process clarity - 72-hour template made clearer - 4 'questions to be answered' by the treating clinical team and patient safety team - Greater clarity on remedial actions - 1 standardised procedure trust wide - A more consistent approach to learning - EKUHFT Director of QG direct meetings with ICB opposite number	The Board should note this was an area of concern from K&M ICB and this paper demonstrates considerable progress is being made on developing more effective governance reporting systems. A key theme remains that learning needs to be embedded trust wide (a point made at the April 2023 by the staff governors).

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC				
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**
Finance & Performance Committee (FPC)	25 April 2023	Richard Oirschot Non-Executive Director	Sarah Farrell, EA/Chief Finance Officer	**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:					
Month 12 Finance Report Forecast Cash Position	The group achieved a £4.2m surplus in March, which brought the year end position to a £19.3m deficit which is £19.3m adverse to the plan. The surplus in month is due to the two additional non-recurrent allocations that the Trust received in month from the Integrated Care Board (ICB) & Kent & Medway NHS and Social Care Partnership Trust (KMPT) and non-recurrent items supporting the year end position. Cash will remain an issue for the Trust until the business plan has been approved due to the financial requirements to breakeven in year. Work is underway with the Regional and National team to support us with the required cash levels. Efficiencies for 2022/23 year end position of £19.6m, of which £10.9m were non recurrent and not all efficiencies for 2022/23 had a cash impact. Capital for the 2022/23 year end position was £132k surplus against a total spend of £35.6m				
Lessons learnt for 2022/23 Efficiency delivery	The Committee discussed and noted the Lessons Learnt for 2022/23 Efficiency Delivery. • Historical Cost Improvement Programme (CIP) and efficiency context; • 2022/23 context of the efficiency/CIP development and delivery approach; • Learnings in the CIP approach taken into 2023/24; • Proposed next steps in 2023/24 and beyond to meet the £40m 2023/24 target (developing cross cutting themes with Executive Director sponsorship).				
Patients No Longer Fitting the Criteria to Reside	In March the Trust reported 408 patients as no longer fit to reside (NLFTR), down from a record high of 437 reported in February 2023. The NLFTR trend has been on an upward trajectory since July 2021, at which time the Trust regularly reported NLFTR numbers in low 200s with P1, P2 and P3 making up just below 50% of these patients. Of the 408 recorded in March 2023, over 70% are P1, P2 or P3; the largest growth of being within the P3 cohort up from 29 patients in July 2021 to near 90 at year end 2022/23.				

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	There are a number of internal schemes in progress managed through the Emergency Care Delivery Group under four key workstreams: Patient flow, Front door, Simple, Discharge and Same Day Emergency Care (SDEC)/ Direct access. All workstreams aimed at driving discharges within the Trust's gift, divert patients to same day emergency care where possible and focus on admission avoidance. Under the 'Simple Discharge' workstream are schemes of work in train to support: • Improve flow to discharge lounge (time and volume); • Evaluation of pathway 0; • Accuracy of discharge Patient Tracking Lists (PTLs); • Review metric/board round completion; • Weekday/weekend discharge process; • Choice policy; • Implement and evaluated medically optimised wards. Externally, across the Health and Care Partnership (HCP), there are a series of schemes in development to support external capacity, some seeking support for funding and those in train being monitored through the EK Urgent Care Delivery Board. Discussed in the meeting: • Analysis completed by Business Information suggests that to maintain flow through the hospital the number of patients requiring P1, P2, and P3 should to be in the region of 178 (currently 287). The risk of failure to deliver this target number needs to be reflected in the Trust's risk register. • Close monitoring of the development and implementation of schemes in the community to support additional packages of care is paramount. This will be monitored through the EK Urgent Care Delivery Board. • The Trust is in the process of completing a review of those patients flagged as no longer fit to reside vs those that feature on the current Recovery, Treatment Support (RTS) case load for discharge. This work is in train. The outcome of this analysis hopes to highlight any disparity in the application of the no longer fit to reside status flag and those patients truly ready to be discharged and being supported by RTS. • The Trust needs to review the process and application of the pathway status to ensure this is being accurately assessed and patient onward care criteria is clear and appropriate. This work will be monitored through the Emergency Care Delivery Group and also via monthly updates to FPC.
2023/24 Business Planning Update and Approval (Submission 3)	The Committee members discussed and recommended to the Board to approve the 2023/24 Business Planning Update (Submission 3).
Integrated Performance Report (IPR)	The Committee members discussed and noted the Integrated Performance Report (IPR) with partial assurance received of the performance against key metrics for 2022/23 including the Breakthrough objectives: Improving theatre capacity, Actual utilisation, Elective Orthopaedic Centre (EOC) utilisation,

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	Same Day Emergency Care admissions, Emergency Care Delivery Programme, Direct Access Pathways, Phase 3 William Harvey Hospital (WHH) Emergency Department (ED) build, Use of Hot Slots, Hot Clinics, Staff involvement, National Staff Survey, Team Engagement and Development (TED) pilot, We Care Rollout and Premium Pay Costs.
Board Assurance Framework (BAF) and Principal Mitigated Risks	The Committee members discussed and approved the Board Assurance Framework and Principal Mitigated Financial and Performance Risks. **Headlines:** There are 3 BAF risks and 8 risks on the Corporate Risk Register (CRR) relating to 'Our Future' and 'Our Sustainability'. • **New risks:** There are no new 'Our Future' and 'Our Sustainability' risks added to the BAF and CRR during this reporting period. • **Other key changes:** There has been no movement on the BAF and CRR risk registers during this reporting period. The Committee has requested that two additional risks be reviewed for submission to the risk register: 1. Failure to secure sufficient capital; 2. Failure to deliver the reduction of not fit to reside patients to 178.
Horizon Scanning	The Committee discussed and noted the Horizon Scanning report. Items of particular note include: • Energy prices and unwarranted variation; • NHS England spending processes; • NHS Pay review process and Community & Social Care pay; • Backlog and waiting times with 7-day working & infrastructure issues; • EKHUFT maternity independent investigation; • Innovation in using technology to lower costs by reducing admin load on clinicians; • Healthcare worker burnout and support; • The future of pharmacy – the all-party pharmacy group. The Committee asked that the relevance of this report be reviewed for further submission.
Provider Licence	The Committee discussed and approved the Provider Licence for onward submission to the Integrated Audit and Governance Committee (IAGC), however, with possible caveats including failure to achieve targets and receiving Public Dividend Capital (PDC). The Trust has given a number of undertakings to NHS England and as part of the process NHS England has outlined the licence conditions that the Trust has breached. By accepting the undertakings the Trust accepts these conditions have been breached. Appendix 1 contains all the Licence Conditions and it is highlighted within as to which conditions have been breached.
Strategic Investment Group (SIG) Assurance Report	The Committee received an assurance report on the activities of SIG on 16 February 2023.

Financial Improvement Oversight Group (FIOG)	The Committee received an assurance report on the activities of the FIOG on 28 March 2023.
Other items of business	None.
Referrals from other Board Committees	There were no referrals from other Board Committees at this meeting.

Items to come back to the Committee outside its routine business cycle:		
N/A		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Board of Directors is asked to **NOTE** this assurance report.	Assurance	4 May 2023

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Integrated Audit and Governance Committee (IAGC)	28 April 2023	Olu Olasode Non-Executive Director (NED and SID)	Board Support Secretary	**Yes**	~~No~~
Appendices:	Appendix 1: Standing Financial Instructions (SFIs)				

Declarations of Interest made:
No additional declarations of interest were made.

Assurances received at the Committee meeting:	

Risk Management and Governance	• The Committee discussed and noted an update report providing assurances on the work progressed to date about risk management and governance presented by the Chief Executive and Interim Chief Nursing and Midwifery Officer (CNMO).
	
	• The Committee received assurance and noted the key elements of the work undertaken;
	  • Review of risk management and governance arrangements throughout the Trust, escalation through Committee and Group meetings, improving the systems, processes and governance to ensure these were streamlined, work included looking at the relationship with the Trust subsidiaries;
	  • Further update report will be presented to next Committee meeting in July 2023. This will include a proposal with recommendations on the governance framework structure for Care Groups, with line of sight in respect of 'place of care to board' as not all patients received care in wards. Tools supporting staff in the management of risks, their accountability and responsibilities, and how improvements will be embedded;
	  • Advice sought from governance expert in NHS England (NHSE);
	  • Currently risk management was more around backward looking at risks, and the need for much more forward looking and achieving improvements;
	  • Good discussions with Care Groups and staff, who recognised the importance of good governance and risk management, open and honest discussions, acceptance of the need for improvement, concerns raised about the complexity and suggestions on how this could be better managed, recognition that shared learning was vital;
	  • Care Group and corporate processes needed to aligned, outcome would be around co-production and that the processes and system worked for everyone in the Trust.

Internal Audit RSM Risk Assurance Services LLP – Progress Report	The Committee discussed and noted assurance from the Internal Audit Progress Report, noting good progress made to reduce the number of long outstanding overdue management actions, and implementation of actions. • The Committee noted the Draft Head of Internal Audit Opinion 2022/23, consistent opinion with that issued the previous year. Overall management had a better understanding of what the challenges were and controls had been put in place. Adequate

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	and effective risk management systems in place linked to Board Assurance Framework (BAF). The Committee noted the outcomes of internal audit reports since the last IAGC: • Budgetary Financial Control (Care Groups) – Partial Assurance; • Consultant Job Planning – Partial Assurance; • Green Plan – Reasonable Assurance; • Emergency Department (ED) – Medical Staff Self-Rostering – Reasonable Assurance; • Single Tender Waivers – Partial Assurance; • Procurement – Partial Assurance; • Data Security Protection Toolkit – Substantial Assurance; • These reports provided reassurance around the processes in place as well as suggestions for further improvement work.
Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP – Progress Report Work Plan 2023/24 Annual Report 2022/23	The Committee received and noted assurance from the LCFS progress report on the LCFS activity, and the 2022/23 annual report. The Committee received and approved the 2023/24 work plan. The Committee noted key highlights: • Updates about on-going investigations, three cases had been closed since the report had been published and these were with the Interim CFO for confirmation of approval to close; • 71% increase in referrals from last year, this was positive and recognised that LCFS were more integrated in the Trust, had provided staff training and awareness of fraud, as well as how to raise and report potential cases of fraud; • Proactive work within the work plan including to review processes and procedures, example testing, as well as reviewing counter fraud policies; • More work would be done with the Trust in respect of staff required to make a declaration of interest, ensuring these staff made their annual declarations, and embedding this annual practice. The Trust was currently rated red, the previous year was amber. The Executive Director of Communications and Engagement (EDoC&E) welcomed working with counter fraud to explore options to address and improve the Trust's position potentially using the new Electronic Staff Record (ESR)/Staff intranet.
External Audit Grant Thornton: External Audit Progress Report and Sector Update	The Committee received and noted assurance from the External Audit progress report and sector update, noting: • Annual external audit commencing 2 May, received report on the draft annual accounts, audit timeline agreed as well as detailed milestone delivery plan. Clear identification of the responsibilities of the Trust and external audit to meet the deadline for submission of 30 June 2023; • Weekly meetings would be held to ensure audit was on track and the dissemination of required information.
External Audit Plan 2022/23	• The Committee received, and noted assurance of the 2022/23 External Audit Plan.

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Provider Licence – Annual Statutory Declaration	• The Committee received, discussed and approved the annual statutory declaration of non-compliance and recommended this to the Board for approval, noting this will be considered by the Board at an additional Closed meeting at the end of June 2023 along with all the annual governance reports. It was noted non-compliance position as in previous years, reflecting the Trust's breaches, performance and NOF4 position.
Quality Account Report 2022/23	• The Committee received and noted the current version of the 2022/23 Quality Account Report, which was incomplete and further information was awaited to be included. A revised version will be presented to the Quality & Safety Committee (Q&SC) at its meeting in May 2023, following this the revised version will be circulated to the IAGC for consideration for virtual approval and recommendation to the Board for approval. Noting the deadline for laying before Parliament on 30 June 2023.
2023/24 Annual Programme for Clinical Audit	• The Committee received and approved the 2023/24 Clinical Audit Programme for 2023/24, noting ongoing monitoring via the Clinical Audit & Effectiveness Committee (CAEC) and Q&SC. • The Committee received assurance and noted there had been a review of the processes and systems, and the need for achievement of audits. • 2023/24 annual programme, would include 110 audits, of which 72 national audits and 38 local audits, each Care Group would formally agree an audit plan and any requests to undertake additional audits would need to be submitted for consideration by the central clinical audit team for review and assessment and will need to align with the Trust's quality priorities.
Draft Annual Accounts 2022/23	• The Committee noted the draft SOFI and SOFP for 2022/23, and agreed an additional IAGC meeting to be scheduled ahead of the additional Board meeting for 28 June to review the final annual accounts for approval prior to Board on 28 June 2023 for submission on 30 June 2023.
Informing the Audit Risk Assessment 2022/23	• The Committee received and noted the Informing the audit risk assessment 2022/23 document.
Annual Report 2022/23 - **Compliance Against FT Code of Governance** - **Annual Governance Statement (AGS)**	• The Committee received, discussed and noted the draft 2022/23 Annual Report, including the Compliance Against FT Code of Governance, and AGS. • The Interim Group Company Secretary (GCS), who has recently started with the Trust, will review these documents to ensure they included everything they needed to. • The final version will be shared with the Executive Team prior to presentation to IAGC and the Board. • The Committee will receive the final version for consideration and approval prior to this being presented to the Board for approval for submission.
Executive Risk Assurance Group (ERAG) Chair Reports	• The Committee noted assurance from the ERAG Chair reports from the meetings held on 24 March, 24 February and 27 January 2023, and approved the revised ERAG Terms of Reference (ToR).
Board Assurance Framework (BAF)	• The Committee received and noted assurance from the BAF. • Changes to the BAF and CRR.

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	• Quarterly performance data in the BAF aligned to the IPR that has been reported for a full financial year, identifying the need to review and refresh the Trust's risk appetite. • The Risk Manager and Interim Director of Quality Governance (DoQG) will be reviewing the Corporate Risk Register (CRR) to support assurance going forward to the Board Committees, and that risks were being appropriately mitigated.
Risk Management Workplan	• The Committee received assurance from the workplan, and noted the recommendation that the Board undertake a session to set its risk appetite at the Board Development Day in August 2023 with the Risk Management Strategy and Policy revised as a result of this. Risk Maturity Assessment will be undertaken in December 2023, reporting to IAGC in January 2024 to assess the impact of the work undertaken as identified in the Integrated Improvement Plan (IIP), the internal audit and risk management and governance review. • The Committee noted the change in how the BAF had been presented that was helpful.
Efficiencies Governance	• The Committee received assurance and noted an efficiencies governance report around previous efficiency schemes. • The Committee noted a revised governance process report will be presented to a future IAGC detailing how efficiencies will be managed by the Chief Finance Officer (CFO) and Interim Executive Director of Strategic Development and Partnerships going forward. • The Committee noted the importance of recording the impact and measuring this, what the achievements needed to be and how these will be achieved.
Review of Standing Financial Instructions (SFIs)	• The Committee noted the annual review of SFIs, approved the revised version, and recommended this to the Board for approval. • The Committee noted the only change was updating Clinical Commissioning Groups (CCGs) to Integrated Care Boards (ICBs).
Anti-Fraud, Bribery and Corruption Policy	• The Committee received and approved the amended Anti-Fraud and Corruption Policy. • The Committee noted assurance of the Policy review to ensure it remained sufficiently robust from a counter fraud perspective, and that it was legislatively accurate and compliant with the NHS Counter Fraud Authority (NHSCFA) requirements.
Data Security and Protection Toolkit (DSPT) submission 2022/23 – Progress report	• The Committee received assurance from the DSPT process and noted the progress report on the DSPT 2022/23 submission. • The Committee noted the Trust's Cyber Essentials accreditation and working towards achieving Cyber Essentials Plus (CE+) accreditation. • The Committee noted continued ongoing work to improve and sustain uptake of Information Governance (IG) annual mandatory training target to achieve the required 95%.
Losses and Special Payments Report to 31 March 2023	• The Committee received assurance from the report, noting the losses and special payments report for 1 April 2022 to 31 March 2023. • The Committee noted the Trust was not an outlier, and for the year to 31 March 2023, 395 cases totalling £317k, compared with 366 cases and £338k the previous year (presenting a decrease of £21k in year).

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Single Tender Waiver (STW) Report	• The Committee received assurance from the STW report and noted:
	  • 103 STWs approved during FY 2022/23 a total value of £4.69m;
	  • 48 STWs approved during Quarters 3-4 2022/23 with a total value of £1.76m;
	  • 26 STWs with a combined value of £1.65m were rejected during FY 2022/23;
	  • No Declarations of Interest;
	  • 5 Retrospective Approvals of STWs.

Spencer Private Hospitals (SPH) off payroll workers review	• The Committee received and noted a report and recommendations following assurance of the review of contracts of off payroll workers.
Annual Committee Effectiveness Review	• The Committee received and noted a verbal report about the upcoming annual Committee effectiveness reviews, these will be led by the Interim GCS, following completion of these the IAGC will receive a report on the outcome of the Board Committees annual effectiveness reviews at a future IAGC meeting.
Closed meeting with IAGC members	• The Committee members (NEDs) held a Closed IAGC meeting to receive an update from the Chief People Officer (CPO) on behalf of the Chief Executive about Executive Team changes. This included an update on progress to recruit substantively and the interim cover in place.
Other items of business	There were no other items of business raised for discussion.

Actions taken by the Committee within its Terms of Reference:
None

Items to come back to the Committee outside its routine business cycle:
There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
The Committee asks the BoD to discuss and **NOTE** this assurance report from the IAGC, and **APPROVE** the revised SFIs.	Approval	To Board on 4 May 2023

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EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
(SFI's)

Incorporating

Reservation of Powers to the Board of Directors

and

Detailed Scheme of Delegation

Approved by: Integrated Audit and Governance Committee, <mark>28 April 2023</mark>
Issued By: Chief Finance Officer

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

23/24.4 – APPENDIX 1

1 Forward

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

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

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

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

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

2. Terminology

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

"2006 Act" refers to the National Health Service Act 2006.

"2012 Act" refers to the Health and Social Care Act 2012.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Chief Finance Officer" means the Chief Finance Officer who is the Director of Finance of the Trust.

"Funds held on trust" shall mean those funds which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Pt. 11, Chap 2 of the NHS Act 2006. Such funds may or may not be charitable.

"Governor" shall mean a member of the Council of Governors whether elected or appointed to the Council of Governors in accordance with the Constitution.

"Legal advisor" means the properly qualified person engaged by the Trust to provide legal advice.

"Mandatory services" are those services which the Regulator has deemed it compulsory that the Trust provides, as listed in the Authorisation Agreement.

"NHS Improvement" is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety (including the National Reporting and Learning System), Advancing Change Team and Intensive Support Teams and is responsible for overseeing Foundation Trusts and NHS Trusts as well as independent providers that provide NHS funded care

"Nominated employee" means an employee charged with the responsibility for discharging specific tasks within SO's and SFI's.

"Non-Executive Director" means a person appointed as a Non-Executive Director of the Trust under paragraphs 15 to 19 (inclusive) of Schedule 7 of the NHS Act 2006 and in accordance with paragraphs 21/22 of the Constitution.

"Provider Licence" means the Licence of the Trust issued by Monitor (now NHSI) with any amendments for the time being in force.

"SFI's" means Standing Financial Instructions.

"SO's" mean Standing Orders as constituted under the Trust's Licence Conditions.

"Trust" means the East Kent Hospitals University NHS Foundation Trust.

"Trust Secretary" means a person appointed to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors, the Chairman and the Council of Governors and to monitor the Trust's compliance with the law, SO's, the Constitution, Licence conditions, statutory provisions and guidance and direction given by NHS Improvement.

2.2   Wherever the title Chief Executive, Chief Finance Officer or other nominated employee is used in these instructions it shall be deemed to include such other director or employee that has been duly authorised to represent them.

2.3   Wherever the term "employee" is used and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.4   The Trust has established a wholly owned subsidiary, 2gether Support Solutions Ltd, (2gether) as a Property Facilities Management Company that will provide an Operated Healthcare Facility (OHF) to the Trust. Under the supporting agreements the Trust has made available the supply of assets to 2gether from which 2gether provides a fully functioning building or facility within which medical and nursing professionals can treat and care for their patients. Under the OHF, 2gether makes available to the Trust the properties from which the Trust will deliver its NHS clinical services. As a wholly owned subsidiary 2gether has developed a simplified version of the Trust's SFI's incorporating a scheme of delegation with delegated authority to officers of equivalent seniority as specified by the Trust.

2.5   "Procurement Services" are currently provided to the Trust under contract by 2gether.

2.6   The approved SFI's for 2gether Support Solutions is included as an appendix to this document. Where the Foundation Trust SFI's refer to "2gether Nominated Officer" this can then be referenced in that Appendix.

3. Introduction

3.1   Save as otherwise permitted by law, at any meeting the Chairman of the Board of Directors shall be the final authority on the interpretation of SO's (on which they should be advised by the Chief Executive or Secretary to the Board).

3.2   These SFI's detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy and the sector regulator's policies, in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

3.3   The Single Oversight Framework details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in The NAO's Code of Audit Practice, and the Department of Health & Social Care Group Accounting Manual (DHSC GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

3.4   These SFI's identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These SFI's should therefore be read in conjunction with the Trust's detailed corporate policy documents, financial procedures and any departmental procedure notes. All financial procedures must be reviewed by the Chief Finance Officer before being approved in line with the Policy for the Development and Management of Organisation Wide Policies and Other Procedural Documents.

3.5   Should any difficulties arise regarding the interpretation or application of any of the SFI's then the advice of the Chief Finance Officer must be sought before acting. The user of these SFI's should also be familiar with and comply with the provisions of the Trust's SO's.

3.6   Failure to comply with the Scheme of Delegation, SFI's and SO's can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

3.7   Overriding SFI's – If for any reason these SFI's are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Integrated Audit and Governance Committee for referring action or ratification. All directors and employees have a duty to disclose any non-compliance with these SFI's to the Chief Finance Officer as soon as possible.

3.8   Employees of the Trust should note that the Scheme of Delegation, SFI's and SO's do not contain every legal obligation applicable to the Trust. The Trust and each employee of the Trust must comply with all requirements of legislation (which shall mean any statute, subordinate or secondary legislation, any enforceable community right within the meaning of section 2(1) European Community Act 1972 and any applicable judgment of a relevant court of law which is a binding precedent in England) and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to the Scheme of Delegation, SFI's and SO's. All

such legislation and binding guidance and directions shall take precedence over the Scheme of Delegation, SFI's and SO's which shall be interpreted accordingly.

4. Responsibilities and Delegation

4.1 The Board of Directors

4.1.1   The Board exercises financial supervision and control by:
   (a)   Formulating the financial strategy;
   (b)   Requiring the submission and approval of budgets and annual financial plans;
   (c)   Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
   (d)   Defining specific responsibilities placed on directors and employees as directed in the Scheme of Delegation document.

4.1.2   The Board has resolved that certain powers and decisions may only be exercised by the Board itself in formal session. These are set out in the "Reservation of Powers to the Board" document.

4.1.3   All other powers have been delegated to such other committees as the Trust has established, or directly to an executive director. Full details of Reserved matters and Delegated powers are set out in the Trust's Scheme of Delegation.

4.1.4   The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

4.2 The Chief Executive and Chief Finance Officer

4.2.1   The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

4.2.2   Within the SFI's, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accounting Officer, to NHS Improvement, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

4.2.3   It is a duty of the Chief Executive to ensure that directors and employees and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

4.3 The Chief Finance Officer

4.3.1   The Chief Finance Officer is responsible for:

(a)   implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b)   maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c)   ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

(d)   ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors:

(e)   referring all cases of fraud to the Local Counter Fraud Specialist;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(f)   the provision of financial advice to the Board of Directors, employees and the Council of Governors;

(g)   the design, implementation and supervision of systems of internal financial control; and

(h)   the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for   the purpose of carrying out its statutory duties.

4.4 Board of Directors and Employees

4.4.1   All directors and employees, individually and collectively, are responsible for:

(a)   the security of the property of the Trust;

(b)   avoiding loss;

(c)   exercising economy and efficiency in the use of resources;

(d)   conforming with the requirements of SO's, SFI's, Financial Procedures and the Scheme of Delegation; and

(e)   reporting suspected theft, fraud or bribery to the Chief Finance Officer.

4.5 Contractors and their employees

4.5.1   Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

4.5.2   For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

4.5.3   Where services are outsourced by the Trust, the Chief Finance Officer should be assured that the outsourced agent has suitable systems and control mechanisms in place

5. Audit

5.1 Integrated Audit and Governance Committee

5.1.1   In accordance with Schedule 7 (paragraph 23) of the 2006 Act and both the Trust's Constitution and SO's, the Board of Directors shall formally establish the Integrated Audit and Governance Committee of Non-Executive directors, with clearly defined terms of reference and will follow guidance from the NHS Audit Committee Handbook, the NHS Integrated Governance Handbook, National Audit Office Code of Audit Practice, the Code of Governance and Compliance Framework. The Committee will perform such monitoring, review and other functions as are appropriate. In particular the Audit Committee will scrutinise and review the Trust's systems of governance, risk management and internal control by:

(a)   monitoring and reviewing the effectiveness of the Trust's Internal Audit function and counter-fraud / bribery arrangements, including approval and review of annual audit plans;

(b)   monitoring the integrity of the financial statements and formal announcements relating to financial performance, and reviewing significant financial reporting judgments;

(c)   reviewing the Trust's internal controls (clinical and financial) and risk management systems;

(d)   reviewing and monitoring the external auditor's independence and objectivity and the effectiveness of the audit process

(e)   Approving the annual audit plan and arrangements for the auditor to supply non-audit services; and

(f)   reviewing arrangements by which Trust staff may raise concerns.

5.1.2   Where the Integrated Audit and Governance Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may be brought to the attention of the Regulator (to the Chief Finance Officer in the first instance) and the Council of Governors.

5.1.3   It is the responsibility of the Chief Finance Officer to ensure that an adequate Internal Audit service is provided and the Integrated Audit and Governance Committee shall be involved in the selection process when an Internal Audit service provider is changed.

5.1.4   The Integrated Audit and Governance Committee has a responsibility for assessing the external (financial) auditors on an annual basis, both in terms of the quality of their work and the reasonableness of their fees. The Committee is then responsible for making a recommendation to the Council of Governors with regard to their reappointment or otherwise.

5.2.1 The Chief Finance Officer is responsible for:

    (a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

    (b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards as defined within NAO Code of Audit Practice and Public Sector Internal Audit Standards

    (c) in conjunction with NHS Counter Fraud Authority, deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption (as defined in the Trust's Anti-Fraud Policy);

    (e) ensuring that an annual Internal Audit report is prepared for the consideration of the Integrated Audit and Governance Committee and the Board of Directors. The report must cover:

        (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance;
        (ii) major internal financial control weaknesses discovered;
        (iii) progress on the implementation of internal audit recommendations;
        (iv) progress against plan over the previous year;

    (f) ensuring that a 3-year strategic internal audit plan is prepared for the consideration of the Integrated Audit and Governance Committee and the Board; and

    (g) ensuring that an annual Internal Audit Plan is produced for consideration by the Integrated Audit and Governance Committee and the Board, which sets out the proposed activities for the coming year.

    (h) Only the Chief Finance Officer may commission the procurement of internal audit services (including services akin to internal audit services), having sought the approval of the Audit & Risk Assurance Committee.

5.2.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

    (a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

    (b) access at all reasonable times to any Trust land, premises or to directors and employees of the Trust;

    (c) the production of any cash, stores or other property of the Trust under the control of a director or an employee; and

    (d) explanations concerning any matter under investigation.

5.2.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

5.3 Internal Audit

5.3.1 In accordance with the requirements of the Accounting Officer Memorandum issued by the Regulator, the Trust is required to establish an independent and objective Internal Audit function. It is the responsibility of the Chief Finance Officer to ensure that this function is in place and operates efficiently and effectively, and accords with the objectives, standards and practices set out in the NAO Code of Audit practice and Public Sector Internal Audit Standards.

5.3.2 Internal Audit primarily provides an independent and objective opinion to the Accounting Officer, the Board of Directors, and the Integrated Audit and Governance Committee on risk management, control, and governance (by measuring and evaluating their effectiveness in achieving the organisation's agreed objectives) and to the External Auditor on financial systems and records used to prepare the annual accounts.

5.3.3 To fulfil these functions, Internal Audit will undertake a systematic review in accordance with the agreed annual internal audit plan. This will include a review of the overall arrangements the Board itself has in place for securing adequate assurances, and will provide an opinion on those arrangements to support the Annual Governance Statement. This will entail reviewing the way the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.

5.3.4 In addition, Internal Audit will provide specific assurances on the areas covered in the Internal Audit Plan as approved by the Integrated Audit and Governance Committee, and will work alongside other professionals wherever possible to advise on systems of control and assurance arrangements. This is a distinct role, quite different to reviewing and commenting on the reliance of the assurances themselves, which is the responsibility of the Board

5.3.5 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
(b) the adequacy and application of financial and other related management controls;
(c) the suitability of financial and other related management data;
(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration; and
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from NHS Improvement.
(f) Internal Audit shall review the Board Assurance Framework

5.3.6 The Head of Internal Audit or Internal Audit provider will normally attend Integrated Audit and Governance Committee meetings and has a right of access to all Committee members, the Chairman and Chief Executive of the Trust.

5.3.7 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Integrated Audit and Governance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

5.4 External Audit

5.4.1 The Trust is required to have an external auditor and is to provide such information and facilities as are necessary for the auditor to fulfil their responsibilities under Chapter 5 of the 2006 Act. The external auditor is appointed by the Council of Governors on the recommendation of the Integrated Audit and Governance Committee

5.4.2   Under Schedule 7 (paragraph 23) of the 2006 Act, and the Trust's Constitution, it is the responsibility of the Council of Governors at a General Meeting to appoint or remove the external auditor on behalf of the Trust. As part of the appointment process, the Trust must ensure that the auditors meet the selection criteria set out in NAO Code of Audit practice

5.4.3   Subject to annual assessment by the Integrated Audit and Governance Committee, the Council of Governors may re-appoint the external auditor for the following year without the need for a formal selection process. However in accordance with the NAO Code of Audit Practice and Department of Health & Social Care "Guidance on the local procurement of External Auditors for NHS Trusts and ICBs, a market testing exercise will be undertaken as a minimum every five years.

5.4.4   Under the NAO Code of Audit Practice, an External Auditor may, with the approval of the Council of Governors, provide the Trust with services outside the scope of the audit (see 5.4.5 below). Before engaging the auditor for additional services this will be reported to the Integrated Audit and Governance Committee for approval, or if timing precludes this, then it will be agreed jointly by the Chair of the Integrated Audit and Governance Committee and the Chief Finance Officer, and reported to the next meeting of the Committee.

5.4.5   The NAO have issued a guidance note (AGN01) in December 2016 (updated December 2017) outlining new requirements in relation to procuring non audit services provided by the External Auditor. The detail is included in the trust "policy for procuring non-core audit services" but in essence the new requirements place a cap on the value of non-audit services that can be provided to the Trust that these cannot exceed 70% of the total fee for all audit work carried out under the code in any one year.

5.4.6   The Integrated Audit and Governance Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

5.5 Fraud, Bribery and Corruption

5.5.1   In line with their responsibilities as set out in HSG(96)12 and the Trust Anti-Fraud, Bribery and Corruption Policy, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with directions issued by NHS Protect "Standards for Providers, Fraud, Bribery and Corruption" and NHS England's "Managing conflicts of Interest in the NHS – Guidance for Staff and Organisations".

5.5.2   The Trust shall nominate a suitably qualified person or provider to carry out the duties of the Local Counter Fraud Specialist as specified in the NHS Protect standards.

5.5.3   The Bribery Act 2010 outlines corporate and individual offences as defined within these SFI's (24.1.4). All staff and contractors should be made aware of the Act to ensure compliance. Any breach of the Act may result in criminal proceedings.

5.5.4   The Local Counter Fraud Specialist shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority in accordance with NHS Protects Standards.

5.5.5   The Chief Finance Officer should also prepare a "Counter Fraud Policy and Response Plan" that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

5.5.6   The Local Counter Fraud Specialist will attend the Integrated Audit and Governance Committee meetings when necessary and has a right of access to all Committee members, the Chair and Chief Executive of the Foundation Trust.

5.5.7   The Local Counter Fraud Specialist will provide a written report to the Integrated Audit and Governance Committee, at least annually, on counter fraud work within the Trust.

5.6 Security Management

5.6.1   In line with his responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

5.6.2   The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

5.6.3   The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Strategic Development and Capital Planning and the appointed Local Security Management Specialist (LSMS).

5.7 NAO Code of Audit Practice

5.7.1   The Trust has a responsibility, under its Licence conditions, to comply with the NAO Code of Audit Practice Trusts as approved by the Regulator. The Chief Executive has overall responsibility for ensuring compliance with the Code.

6. Financial Targets

6.1   The Trust is required to meet such financial targets as are specified by the Regulator, either under the terms of the initial Authorisation agreement or subsequently. These specifically include the requirement to ensure that income from the supply of NHS funded goods and services are greater than income from other sources.

6.2   Whilst there is no specific target regulating overall revenue performance in Foundation Trusts (e.g. a requirement to break-even year on year), the Regulator has the power to intervene in the Trust's affairs and potentially to place the Trust in Special Administration where financial viability is seriously compromised.

6.3   The Chief Executive has overall executive responsibility for the Trust's activities and in this capacity is responsible for ensuring that the Trust maintains its financial viability and meets any specific financial targets set by the Regulator. In this capacity the Chief Executive is responsible for setting appropriate internal targets in order to ensure financial viability

6.4 The Chief Finance Officer is responsible for:

(a) advising the Board and Chief Executive on progress in meeting these targets, recommending corrective action as appropriate;
(b) ensuring that adequate systems exist internally to monitor financial performance;
(c) managing the cash flow and external borrowings of the Trust in order to remain within HM Treasury "Managing Public Money" guidelines; and
(d) providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.

7. Business Planning, Budgets, Budgetary Control and Monitoring

7.1 Preparation and Approval of Plans and Budgets

7.1.1 Under the terms of Schedule 7 (paragraph 26) of the 2006 Act and its Constitution, the Trust is required to provide the Secretary of State with information concerning its forward plans for each financial year. In this respect, the Council of Governors is responsible for providing the Board with its views on those forward plans when they are being prepared and the Board correspondingly has a duty to consult them. The Chief Executive will therefore compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;
(b) details of major changes in workload, delivery of services or resources required to achieve the plan;
(c) all requirements defined within the Single Oversight Framework for NHS Providers and Annual Plan advice as issued; and
(d) information about activities other than the provision of goods and services for the purpose of the Health Service in England, and the income to be generated therefrom, and the percentage such income bears to total planned income; the Trust has a legal duty to ensure that such income in total is lower than income from the supply of NHS-funded goods and services.

7.1.2 With regard to clause 7.1.1 (d) and prior to submission of the Plan, the Council of Governors must determine whether it is satisfied that the carrying on of these activities will not to any significant extent interfere with the fulfilment by the Trust of its principle purpose or the performance of its other functions. A proposed increase of 5% or more in such income in any financial year (compared to total planned income) shall be put to the vote and may be implemented only if more than 50% of the Governors that voted to approve.

7.1.3 Once approved, the Chief Executive will be responsible for submitting the Business Plan to the Secretary of State via NHS Improvement. The Chief Executive is also responsible for ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.

7.1.4   Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a)   be in accordance with the aims and objectives set out in the Annual Plan;
(b)   accord with workload and manpower plans;
(c)   be produced following discussion with appropriate budget holders;
(d)   be prepared within the limits of forecast income and cash;
(e)   identify all sources of those funds; and
(f)   identify potential risks.

7.1.5   The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

7.1.6   All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled. All budget holders will sign up to their allocated budgets at the commencement of each financial year. Care Group Directors will be required to prepare and sign off Care Group business plans

7.1.7   The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

7.2 Budgetary Delegation

7.2.1   The Chief Finance Officer (on behalf of the Chief Executive) may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a)   the amount of the budget and the staffing levels associated with the budget;
(b)   the purpose(s) of each budget heading;
(c)   individual and group responsibilities;
(d)   authority to exercise virement;
(e)   achievement of planned levels of service; and
(f)   the provision of regular reports.

The Detailed Scheme of Delegation is contained within Appendix 2 of this document.

7.2.2   **Budget Holders do not have authority to exceed their budgets**. Expenditure is authorised by the Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. It is the responsibility of budget holders to maintain income and expenditure within budgetary limits. If it becomes apparent that this may not be possible, budget holders must notify their line manager and the relevant Care Group Finance Lead. If the Care Group Finance Lead is also of the opinion that there may be an income shortfall or expenditure overspend, the budget holder must then advise the Chief Finance Officer of the risk and proposed corrective action.

7.2.3   Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

7.2.4   Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Finance Officer (on behalf of the Chief Executive).

7.3 Budgetary Control and Reporting

7.3.1   The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board and/or designated Board Committee e.g. Finance and Performance Committee (FPC) in a form approved by the Board containing:
   a. income and expenditure to date showing trends and forecast year-end position;
   b. movements in working capital;
   c. movements in cash and capital;
   d. capital project spend and projected outturn against plan;
   e. explanations of any material variances from plan; and
   f. details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.
(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, workload and manpower budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers.

7.3.2   Each Budget Holder is responsible for ensuring that:

(a) they remain within their budget allocation;
(b) any likely overspending on expenditure or reduction of income which cannot be met by virement within Care Groups is not incurred without the prior consent of the Board;
(c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
(d) no permanent or fixed-term contract employees are appointed without the approval of the Chief Executive or formally-constituted Trust-wide recruitment panel taking account of available resources and the manpower establishment as approved by the Board;
(e) that any proposal to increase revenue or capital spending has an appropriate funding stream, follows the formal process set out in the Trust's Business Case Policy for any proposed service development, and has been agreed by the Chief Executive and signed off by the Chief Finance Officer or any Trust Committee to whom this role has been delegated e.g. Strategic Investment Group (SIG) This applies to all revenue or capital developments whether part of Annual Business Plan discussions or separate business case initiatives, however funded; and
(f) they identify and implement cost improvements income generation initiatives in accordance with the requirements of the approved budget.

7.3.3   The Chief Executive is responsible for identifying and implementing cost improvements, income generation initiatives and other efficiency/ productivity improvements in accordance with the requirements of the Annual Plan and a balanced budget.

7.3.4   The Chief Finance Officer is responsible for advising the Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and will also advise on the financial implications of future plans and developments proposed by the Trust.

Further guidance on the responsibilities of budget holders is contained in the Financial Management and Control of Resources Policy

7.4 Capital Expenditure

7.4.1   The general rules applying to delegation and reporting contained in section 5 of the SFI's "Detailed Scheme of Delegation" shall also apply to capital expenditure. The Trust has delegated the responsibility for delivery of the approved capital programme to its wholly owned subsidiary, 2gether, given the majority of the Trust's assets are maintained as part of the OHF. The exceptions are IT and directly managed schemes. The Trust Scheme of Delegation plus 2gethers implied SFI's, take account of these arrangements.

7.5 External Performance Information and Monitoring Returns

7.5.1   The Chief Executive, on behalf of the Trust, is responsible for providing the Regulator with such information as is necessary to monitor compliance with the terms of the Authorisation agreement.

7.5.2   The Chief Executive, on behalf of the Trust, is also responsible for ensuring that the Trust contributes to standard national NHS data flows which are required for NHS policy development/ funding.

7.6 The Trust's Operational Framework and Performance Management Framework

7.6.1   The Trust's Performance Management Framework and the Operational Framework describes how the Care Groups are performance managed. The Framework enables Care Groups to earn autonomy giving greater freedom and authority to develop services. Care Groups are managed according to the level of performance achieved in each of seven domains, aligned to the Trust's Strategic and Annual Objectives, covering Quality (Patient Safety; Effectiveness; Patient Experience), Valuing People, Innovation, Access & Productivity and Finance. Each domain has a named Executive Director.

8. Annual Accounts and Reports

8.1   In accordance with Schedule 7 (paragraph 25) of the 2006 Act and the Trust's Constitution, the Trust must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of the Secretary of State, direct. The Chief Finance Officer, on behalf of the Trust, will:

    (a)   prepare annual accounts in accordance with the Regulator's Group Accounting Manual (GAM) and any other NHSI guidance, the Trust's accounting policies, and International Financial Reporting Standards;

    (b)   prepare and submit annual accounts to the Board and an audited summary of the main Financial Statements to an annual members meeting convened by the Council of Governors, certified in accordance with current guidelines; and

    (c)   ensure that a copy of the annual accounts, and any report of the external (financial) auditor thereon, is laid before Parliament and sent to the Regulator.

8.2   The annual accounts should, in accordance with the requirements set out in the Accounts Direction, include an Annual Governance Statement within the financial statements.

8.3   The Trust's annual accounts must be audited by an external (financial) auditor appointed by the Council of Governors and be presented at the annual members' meeting.

8.4   In accordance with Schedule 7 (paragraph 26) of the 2006 Act, the Trust will also prepare an annual report which, after approval by the External Auditor and the Board of Directors, will be presented to the Council of Governors. It will then be submitted to parliament and the Regulator, published and made available to the public. The annual report will comply with the ARM for NHS Foundation Trusts issued each year by NHSI.

8.5   The Trust is to comply with any decision that the Regulator may make as to the form of the annual report, the timing of its submission and the period to which it relates.

8.6   The Chief Nurse and Director of Quality/ Medical Director/ Chief Operating Officer, on behalf of the Trust, will prepare an annual Quality Report (including the Quality Account) in such form and engaging in such external consultations as the Regulator may direct.

9 Bank Accounts and Treasury Management

9.1 General

9.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued by the Regulator. The Trust will operate in line with its Treasury Policy.

9.1.2 The Board shall approve the banking arrangements and the level of Working Capital Facility (if any). Approval and execution of Facility Agreements is delegated to the Chief Finance Officer or Chief Executive Officer following the Trust Board approval.

9.2 Bank and Paymaster Accounts

9.2.1 The Chief Finance Officer is responsible for:

(a) commercial and Government bank accounts;
(b) establishing separate bank accounts for the Trust's charitable funds
(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and
(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

9.2.2 No employee other than the Chief Finance Officer will open any bank account in the name of the Trust (or relating to any activities of the Trust).

9.3 Banking Procedures

9.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank and Paymaster accounts which must include:

(a) the conditions under which each bank account is to be operated; and
(e) those authorised to sign cheques or other orders drawn on the Trust's accounts.

9.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

9.4 Competitive Tender and Review of banking services

9.4.1 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

9.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for Government Banking Service accounts.

9.5 External Borrowing

9.5.1   As a Foundation Trust, the Trust generally has freedom to access working capital (i.e. borrow externally) subject to three constraints:-

    (a) availability of Secretary of State loans and/or additional Public Dividend capital;
    (b) prohibition on the use of protected assets as security for borrowing; and
    (c) any additional degree of scrutiny required by financial institutions.

9.5.2   These freedoms are reduced if the Trust is in Financial Special measures and guidance from NHS Improvement will be sought

9.5.3   External debt should be kept within designated limits, taking account of affordability in terms of capacity to generate operating revenue to service debt and the impact on the Continuity of Service Risk Rating.

9.5.4   For larger scale projects, current Department of Health & Social Care requirements and approval mechanisms under the Private Finance Initiative continue to apply. It is the responsibility of the Chief Executive, on behalf of the Trust, to ensure that these requirements are complied with.

9.5.5   If required, the Trust must ensure that a sufficient Working Capital Facility is available from the Department of Health & Social Care, via NHSI. Such Working Capital Facility should be reviewed on a periodic basis to ensure value for money. The Trust must have procedures in place for the draw down against the facility to ensure that only appropriate authorised transactions take place. All such short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

9.5.5   The Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new PDC borrowing, within the limits set by the Department of Health & Social Care. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

9.5.6   The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

9.5.7   The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

9.5.8   The Chief Finance Officer is responsible for ensuring that the Trust operates within NHSI guidance when making decisions regarding capital investment/external borrowing, specifically by providing appropriate advice to the Board on affordability/ serviceability of debt.

9.5.9   The Chief Finance Officer is responsible for ensuring that the Trust operates at all times within any borrowing limit set by the Regulator and the Board receives regular reports on the overall indebtedness of the Trust as against that limit

9.5.10 Any short-term borrowing must be with the authority of two authorised signatories, one of which must be the Chief Executive or the Chief Finance Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

9.5.11 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board

9.6 Investments

9.6.1   Under the terms of the 2006 Act and its Constitution, the Trust may invest money (other than money held by it as a Trustee) for the purposes of or in connection with its functions. This may include investment by forming or participating in forming bodies corporate or by otherwise acquiring membership of bodies corporate.

9.6.2   The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

9.6.3   The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

9.6.4   In the case of temporary cash surpluses, these may only be held in such form and with such public or private sector organisations as are approved by the Board within the Treasury Policy. In giving approval to the mechanisms for short term investment, the Board will take account of instructions or guidelines issued by the Regulator to Foundation Trusts

9.6.5   For other longer term forms of investment the approval of the Board will be obtained before proceeding.

10. Income, Fees/Charges, Security of Cash, Cheques and Negotiable Instruments

10.1 Income Systems

10.1.1   The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

10.1.2   The Chief Finance Officer is also responsible for the prompt banking of all monies received.

10.1.3   The Chief Finance Officer will ensure that appropriate systems are in place to comply with national requirements and timescales for invoicing and reconciliation of contract income receivable under the terms of contracts with NHS Commissioners

10.2 Fees and Charges

10.2.1   The Trust will price its service contracts with NHS healthcare commissioners according to national tariffs. In areas where national tariff arrangements do not apply, the Trust shall follow the Department of Health & Social Care's guidance in the "Costing Manual" in setting prices for NHS service contracts.

10.2.2   The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health & Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in NHS England's "Managing Conflicts of Interest in the NHS – Guidance for Staff and Organisations" shall be followed.

10.2.3   All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

10.3 Debt Recovery

10.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

10.3.2 Income not received should be dealt with in accordance with losses procedures.

10.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

10.4 Security of Cash, Cheques and other Negotiable Instruments

10.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

10.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

10.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

10.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

10.5 Money laundering Regulations

10.5.1 Under no circumstances will the Trust accept cash payments in excess of 15,000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempts by an individual employee to effect payment above this amount shall be notified immediately to the Chief Finance Officer.

11. Legally-Binding Contracts for Provision of Services (see SFI 24.6)

11.1 Contracts

11.1.1   The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in the Terms of Authorisation/Provider Licence and related schedules.

11.1.2   The Chief Executive, as the accounting officer, is responsible for ensuring the Trust enters into suitable legally-binding contracts with NHS commissioners for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator, and the provision of other services.

11.1.3   In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- service priorities contained within the Trust's Business Plan and agreed with healthcare commissioners;
- the national tariff and Operating framework, and other agreed local pricing mechanisms;
- the provision of reliable information on cost, volume and quality of services;
- relevant National Service Frameworks and guidelines published by the National Institute for Health and Clinical Excellence;
- agreed developments or investment plans; and
- Commissioning Rules, approved forms of NHS contract and applicable guidance from NHS Improvement.

11.1.4   The Chief Finance Officer shall produce regular reports detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income.

11.1.5   Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible employee should ensure that the Assistant Chief Finance Officer – Income is informed before an appropriate contract is present and signed by both parties before goods or services can be provided to or by the Trust. The advice of the Associate Director of Strategic Procurement and the Income and Contracting Manager shall be sought in compliance with the Policy on Service Level Agreements (SLA's).

11.1.6   All SLA's and contracts shall be legally binding, shall comply with best costing practice/best value for money and shall be so devised as to manage contractual risk, insofar as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income/minimise expenditure.

11.1.7   In carrying out these functions, due regard shall be given to the following matters:

- Costing and pricing of goods and services
- Payment terms and conditions
- Billing systems and cash flow management
- The contract negotiating process and timetable
- The provision of contract data
- Contract monitoring and performance management arrangements
- Amendments to contracts
- Applicability of Value Added tax
- Any other matter relating to contracts of a legal or non-financial nature

11.2 Involving Partners and jointly managing risk

11.2.1   The Chief Executive shall ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this.

11.3 Reports to the Board on contracts

11.3.1 The Chief Executive, as the accounting officer, will need to ensure that regular reports are provided to the Board detailing planned, actual and forecast income from contracts with NHS Commissioners. This analysis will particularly highlight the impact of differences between planned and actual numbers of patients treated across Healthcare Resource Groups (HRG's) at speciality level and outline any action required to address such variances. Periodically, at intervals to be agreed with the Board, the Finance Director (on behalf of the Chief Executive) will also provide information on the impact of differences between the actual cost to the Trust of treating patients in individual HRG's and the relevant national tariff.

12. Terms of Service, Allowances and Payment of Directors and Employees

12.1 Remuneration Committee and Nominations Committee

12.1.1 The Board shall establish a Remuneration Committee and Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its areas of responsibility, its composition, and the arrangements for reporting. The Committee/s will fulfil the role of the Remuneration Committee and Nominations Committee (for Executive Directors) described in the Trust's Constitution and the NHS Foundation Trust Code of Governance. The purpose of the Committee/s will be to:

    (a) decide on the appropriate remuneration, allowances and terms and conditions of service for the Chief Executive and other Executive Directors including:
        a. all aspects of salary (including performance-related elements/bonuses);
        b. provisions for other benefits, including pensions and cars; and
        c. arrangements for termination of employment and other contractual terms;
    (b) recommend and monitor the level and structure of remuneration for senior management
    (c) agree and oversee, on behalf of the Board of Directors, the performance management of the Executive Directors, including the Chief Executive, and a process for the identification and nomination of Executive Directors (including the Chief Executive). The nominations process will include the Chief Executive, except in the case of the appointment of a Chief Executive. The appointment of the Chief Executive will require the approval of the Council of Governors; and
    (d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

12.1.2 The Committee shall report in writing to the Board the basis for its recommendations and decisions. Minutes of the Committee should accurately record decisions made.

12.1.3 The Board will be notified of approval (or otherwise) by the Clinical Executive Management Group of the Chief Executive's recommendations regarding remuneration and conditions of service for those employees not covered by the Remuneration Committee.

12.1.4 The Trust will remunerate the Trust Chair and non-executive directors in accordance with the decisions of the Council of Governors taking into account any guidance issued by NHS Improvement and the Code of Governance.

12.2 Funded Establishment

12.2.1 The staffing plans incorporated within the annual budget will form the funded establishment.

12.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or as defined in the Scheme of Delegation.

12.3 Staff Appointments

12.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

    (a) unless authorised to do so by the Chief Executive (as a specific one-off approval, or under general delegation to an approved budget holder with regard to their line management responsibilities);

(b) and within the limit of their approved budget and funded establishment unless approved by the Directors of Finance and HR;

(c) and (where required) with the approval of any formal process in place to review Trust vacancies.

12.3.2 The Chief Executive will prepare procedures for the determination of commencing pay rates, condition of service, etc, for employees for approval by the Clinical Executive Management Group on behalf of the Board

12.4 Processing Payroll

12.4.1 The Chief Finance Officer is responsible for arranging the provision of an appropriate payroll service. Together with the service provider, the Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates; and
(d) agreeing method of payment.

12.4.2 Together with the service provider, the Chief Finance Officer will issue instructions in compliance with the standard operation of the national NHS Electronic Staff Record System regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act 1998;
(g) methods of payment available to various categories of employees;
(h) procedures for payment by cheque, bank credit, or cash to employees;
(i) procedures for the recall of cheques and bank credits;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash; and
(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

12.4.3 Managers authorised under the Scheme of Delegation have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer and the Head of Human Resources must be informed immediately; and
(d) reviewing actual establishment monthly and comparing this to budgeted establishment to identify adverse variances which should be reported to the Executive Performance Reviews.

12.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

12.5 Contracts of Employment

12.5.1 The Board shall delegate responsibility to the Director of HR for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

13. Non-Pay Expenditure (see SFI 24)

13.1 Delegation of Authority

13.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers which will comply with any requirement specified by NHSi including those under financial special measures. The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
(b) the maximum level of each requisition and the system for authorisation above that level.

13.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

13.2 Requisitioning

13.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Associate Director of Strategic Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

13.3 System of Payment and Payment Verification

13.3.1 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

13.3.2 The Chief Finance Officer will:

i. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFI's and regularly reviewed;

ii. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

iii. be responsible with the financial services provider for the prompt payment of all properly authorised accounts and claims;

iv. be responsible with the financial services provider and the Associate Director of Strategic Procurement where applicable, for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

   a. A list of employees (including specimens of their signatures) authorised to certify invoices;
   b. Certification that:
      i. goods have been duly received, examined and are in accordance with specification and the prices are correct;
      ii. work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
      iii. in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
      iv. where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
      v. the account is arithmetically correct;
      vi. the account is in order for payment.

v. A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and

vi. Instructions to employees regarding the handling and payment of accounts within the Finance Department; and

vii. be responsible for ensuring that payment for goods and services is only made once the goods and services are received.

   The only exceptions are set out in SFI 13.4.

13.4 Prepayments

13.4.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages, taking into account lost investment interest or cost of working capital financing incurred

(b) The appropriate employee must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

13.5 Official orders

13.5.1 The Trust operates a strict 'No PO no Pay' policy and invoices received from suppliers for goods or services, not included on the Purchase Order (PO) exception list, that do not quote a PO will be returned without payment.

13.5.2 Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Chief Finance Officer;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive; and
(e) be used for the purchase of all goods and services excluding those on the PO Exception List.

13.6 Duties of Managers and Employees

13.6.1 Managers and employees must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;
(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health & Social Care/NHS Improvement;
(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
  a. Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
  b. conventional hospitality, such as lunches in the course of working visits; and
  c. sponsorship appropriate to the needs of the service.

  (This provision needs to be read in conjunction with the Trust Constitution SO 6 within Annex 7 and SO's 6 and 7 within Annex 8, together with the principles outlined in the national guidance "Managing Conflicts of Interest in the NHS – guidance for staff and organisations" published by NHSE effective 1/6/2017

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;
(f) all goods, services, or works are ordered on an official order except purchases from petty cash and other specific areas agreed by the Chief Finance Officer;
(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase and Services are not trialled or piloted in circumstances that could commit the Trust to a future uncompetitive purchase;
(j) changes to the list of employees authorised to certify invoices are notified to the Chief Finance Officer;
(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer; and
(l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

13.6.2 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the Director of Strategic Development and Capital Planning using the professional estates expertise of 2gether.

13.7 Grants to Local Authorities and Voluntary Bodies

13.7.1 Grants to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 2006 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with this Act and any applicable guidance from the Regulator.

14. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

14.1 Capital Investment

14.1.1   As part of the annual planning process, the Board of Directors shall approve a programme of building, equipment and information technology schemes known as the capital programme. Where a requirement not in the approved programme arises during the year, approval shall be in accordance with the Scheme of Delegation and Business Case Procedure, and a report shall be made to the next meeting of the Board of Directors showing the impact on the capital programme.

14.1.2   The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of commissioners' support (where relevant) and consideration of the availability of resources to finance all revenue consequences, including capital charges.

14.1.3   For every capital expenditure proposal the Chief Executive shall:

(a) ensure that a business case is produced, in the format approved by the Trust, taking into account guidance contained within NHSI Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, the Trust's Business Case Procedure, and any other relevant guidance, in a level of detail appropriate to the value of the project, setting out:
   a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
   b. the involvement of appropriate Trust personnel and external agencies; and
   c. appropriate project management and control arrangements; and

(b) require the Chief Finance Officer to ensure that financial aspects of business cases receive appropriate professional scrutiny.

14.1.4   For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

14.1.5   The Chief Finance Officer shall ensure that the construction industry tax deduction scheme is operated in accordance with HM Revenue and Customs guidance.

14.1.6   The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.7   The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see SFI 24); and

(c) approval to accept a successful tender (see SFI 24).

14.1.8   The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Concode" guidance and the Trust's SO's, with the exception of smaller purchases handled via the Medical Devices Group or Information Development Group which manage proposals within an allowed capital limit.

14.1.9   The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes and procedures for the regular reporting of expenditure to date and forecast.

14.1.10 Following the national implementation of IFRS16 from 1 April 2023 the Chief Finance Officer shall issue guidance to the Group to ensure the collection and assessment of all relevant information relating to leases to cover:

(a) Procurement to notify the Financial Accounts team of all potential leases through Requisitions received
(b) Financial Accounts to assess lease agreements under the terms of IFRS16
(c) Financial Accounts team to create necessary account codes and journals for the correct accounting treatment of leases
(d) Comprehensive Lease Register, with supporting auditable information relating to the lease contract, to be maintained by the Financial Accounts team
(e) Financial Accounts to convert Subsidiary accounting for leases so the Group is accounted for under IFRS16 on a monthly basis

14.2 Private Finance (see SFI 24.25)

14.2.1 Where appropriate the Trust should test for PFI when considering capital procurement. When the Trust proposes to access PFI finance, the following procedures shall apply:

(a) The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;
(b) The Trust must seek all applicable approvals and comply with the requirements of NHSI and the Department of Health & Social Care; and
(c) The proposal must be specifically agreed by the Board of Directors.

14.3 Asset Registers

14.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

14.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Group Accounting Manual (GAM).

14.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets capitalised under IFRS16.

14.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.3.6 The value of each asset shall be indexed or otherwise re-valued in accordance with methods specified in the GAM for Foundation Trusts and relevant accounting standards.

14.3.7 The value of each asset shall be depreciated using methods and rates as specified in the GAM for Foundation Trusts and relevant accounting standards.

14.4 Security of Assets

14.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

    (a) recording managerial responsibility for each asset;

    (b) identification of additions and disposals;

    (c) identification of all repairs and maintenance expenses;

    (d) physical security of assets;

    (e) periodic verification of the existence of, condition of, and title to, assets recorded;

    (f) identification and reporting of all costs associated with the retention of an asset; and

    (g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

14.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

14.4.6 Where practical, assets should be marked as Trust property.

14.5 Protected Assets

14.5.1 A register of Protected Property is required to be maintained in accordance with requirements issued by the Regulator. In accordance with Condition CoS2 of the Provider Licence, the asset register shall list every Relevant Asset used by the Trust for the provision of Commissioner Requested Services. The term 'relevant asset' means any item of property, including buildings, interests in land, equipment (including rights, licences, and consents relating to its use) without which the Trust's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced.

14.5.2 Planned changes in Relevant Assets will be notified to NHSI through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected together with proposed disposals and acquisitions. The Trust may dispose or relinquish control over any relevant asset where NHSI has given general consent in relation to either transactions of a specified description, or relevant assets of a specified description.

15 Stores and Receipt of Goods

15.1 General position

Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of replacement cost and net realisable value; and
(d) obsolete or excess stock – valued at net realisable value

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers in individual areas. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Employee; the control of any fuel oil and coal of a designated estates manager.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Employee. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

15.2.6 The designated Manager/Pharmaceutical Employee shall be responsible for a system for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Employee shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see SFI 16). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by NHS Supply Chain

15.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods in areas not serviced by materials management staff. The authorised person (normally the budget holder) shall check receipt against the delivery note and ensure credit is received where an overcharge has occurred.

16. Disposals and Condemnations, Losses and Special Payments

16.1 Disposals and Condemnations

16.1.1 Under the terms of the Authorisation agreement, the approval of the Regulator is required prior to the disposal of any protected assets (above any "de minimis" limit where specified). There are no external restrictions on the disposal of other assets provided that the proceeds are used to further the Trust's public interest objectives.   The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will consult the Associate Director of Strategic Procurement or nominated 2gether officer as appropriate and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 Unserviceable articles with an estimated replacement cost of at least £100 shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and
(b) recorded by the Condemning Employee in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

16.1.4 The Condemning Employee shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

16.2 Losses and Special Payments

16.2.1 NHS Providers must follow the requirements of HM Treasury's "Managing Public Money" (sections 4.10 and 4.13), in full, in respect of recording and reporting losses and special payments.

16.2.2 This will include contacting NHS Improvement to seek HM Treasury approval for any proposed special severance payments or any claims of a novel or contentious nature

16.2.3 Any employee discovering or suspecting a loss of any kind which is not of a trivial nature must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, either directly or via the Risk Management Department.

16.2.4 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the Local Security Management Specialist (LSMS) and police if theft or arson is involved. The Chief Finance Officer must comply with any requirements of the Regulator and Secretary of State regarding the reporting of fraud and corruption.

16.2.5 Any employee may contact the Local Counter Fraud Specialist directly if fraud, bribery or corruption is suspected, in accordance with the Trust's Anti-Fraud, Bribery and Corruption Policy.

16.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Board,
(b) the Local Security Management Specialist (LSMS), and
(c) the External Auditor.

16.2.7 Within limits delegated to it by the Department of Health & Social Care, the Board shall approve a scheme of delegation for the writing-off of losses.

16.2.8 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.9 For any loss, the Chief Finance Officer should ensure consideration is given as to whether any insurance claim can be made.

16.2.10 The Chief Finance Officer shall ensure that a Losses and Special Payments Register is maintained in which write-off action is recorded

16.2.11 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health & Social Care or in accordance with instructions from HM Treasury "Managing Public Money" and the Regulator as specified in the GAM.

16.2.12 All losses and special payments must be reported to the Integrated Audit and Governance Committee on a regular basis at least twice per annum.

17. Information Technology and Financial Information Systems

17.1 General

17.1.1 The Trust, under the terms of its Authorisation agreement, is required to participate in national information technology developments, in accordance with any guidance issued by the Regulator. This requirement extends to the Chief Finance Officer in fulfilling his/her responsibilities for the computerised financial data of the Trust as set out below.

17.1.2 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Chief Finance Officer is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.3 The Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.2 Responsibilities and duties of other Directors and Employees in relation to computer systems of a general application

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director with responsibility for IM&T:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

17.3 Contracts for Computer Services with other health bodies or outside agencies

17.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

17.4.1 The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 Requirements for Computer Systems which have an impact on corporate financial systems

17.5.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) the financial systems are the prime repository of financial data;
(c) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(d) Finance staff have access to such data;
(e) data from subsidiary systems feeding the financial systems is fully reconciled to the financial systems;
(f) reporting from subsidiary systems of financial data agrees with the financial systems; and
(g) such computer audit reviews as are considered necessary are being carried out.

18. Patients' Property

18.1   The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2   The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance);
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions; and
- that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3   The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4   Where Secretary of State instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

18.5   In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained

18.6   Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7   Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19. Funds Held on Trust

19.1 Corporate Trustee

19.1.1 SO 2.4 of the Trust Constitution Annex 8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust. Although the management processes may overlap with those of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the need for compliance with Charities Commission regulations, guidance and best practice.

19.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for management of public monies within the main Trust, and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

19.1.3 The Chief Finance Officer shall ensure that each charitable fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

19.2 Accountability to Charity Commission and Secretary of State for Health

19.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

19.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust employees must take account of that guidance before taking action.

19.3 Applicability of Standing Financial Instructions to funds held on Trust

19.3.1 In so far as it is possible to do so, most of the sections of these SFI's will apply to the management of funds held on trust.

19.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20. Acceptance of Gifts by Staff and Link to Standards of Business Conduct

20.1 The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff as set out in the Trust's Anti-Fraud, Bribery and Corruption Policy. This policy follows the guidance contained in "Managing Conflicts of Interest in the NHS – guidance for staff and organisations" (issued by NHS England, effective 1 June 2017) see SO 7 of the Trust Constitution Annex 8 and SFI 13.6).

21. Retention of Records

21.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health & Social Care guidelines.

21.2 The records held in archives shall be capable of retrieval by authorised persons.

21.3 Chief Executive approval is required prior to any proposed action to destroy records before the end of the retention period set by Trust policies.

22. Risk Management and Insurance

22.1 Programme of Risk Management

22.1.1 Risk management, control and governance comprise the policies, procedures and operations established to ensure the achievement of objectives, the appropriate assessment of risk, the reliability of internal and external reporting and accountability processes, compliance with applicable laws and regulations, and compliance with the behavioural and ethical standards set for the organisation.

22.1.2 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health & Social Care/NHSI assurance framework requirements, which must be approved and monitored by the Board via the Board Assurance Framework.

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22.1.3 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;
(b) engendering among all levels of staff a positive attitude towards the control of risk;
(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) contingency plans to offset the impact of adverse events;
(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
(f) a clear indication of which risks shall be insured;
(g) arrangements to review the Risk Management programme;
(h) regular review of compliance with all statutory regulatory requirements; and
(i) ensuring appropriate responses to all interventions, reports and requirements from all statutory regulatory bodies.

22.1.4 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement on the effectiveness of Internal Control /Quality Governance arrangements within the Annual Report and Accounts as required by the ARM for NHS Foundation Trusts issued annually by the Regulator.

22.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

22.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

22.3 Insurance arrangements with commercial insurers

22.3.1 Trusts may enter into insurance arrangements with commercial insurers as follows:

(a) Trusts may enter into commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
(b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;
(c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the Department of Health & Social Care; and
(d) The Trust shall arrange appropriate Directors and Employees insurance to cover the risk of legal action against its directors.

22.4 Arrangements to be followed by the Board in agreeing Insurance cover

22.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

22.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer shall ensure that formal documented procedures (administered by the Legal Services Department) are drawn up for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

22.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

23. Consultation

23.1 The Trust shall take into account the legal duties of consultation that are applicable to the Trust when considering any changes to service provision at an early stage and seek advice where necessary.

23.2 Section 242 of the NHS Act 2006 sets out the Trust's duty as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, included in and consulted on:

(a) The planning of the provision of those services
(b) The development and consideration of proposals for changes in the way those services are provided; and
(c) Decisions to be made by that body affecting the operation of those services.

23.3 Regulation 4A of the Local Authority (Overview and Scrutiny Committee's Health Scrutiny functions) Regulations 2002 sets out that the Trust needs to consult with the Overview and Scrutiny Committee of a Local Authority where:

(a) The Trust proposes to make an application to the Regulator to vary the Terms of its Authorisation; and
(b) That application, if successful, would result in a substantial variation of the provision by the Trust of protected goods or services in the area of that local authority

24. Tendering, Quotation and Contracting Procedure

24.1 Duty to comply with Standing Financial Instructions

24.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SFI's. The Trust will ensure compliance with the Public Contract Regulations 2015 (as may be amended from time to time) and relevant NHS guidance on procurement (including but not limited to), the Principles Rules for Cooperation and Competition, and the Procurement Guide for Commissioners of NHS-funded Services.

24.1.2 The Associate Director of Strategic Procurement is responsible for the production and operation of detailed tendering and contracting procedures and the provision of advice and guidance to managers. All budget holders are required to comply with these procedures

24.1.3 This Section 24 should be read in conjunction with Section 5 of the Detailed Scheme of Delegation, in Appendix 2 of these SFI's.

24.1.4 All personnel involved in tendering and contracting activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not breach the Act.

24.1.5 The Bribery Act 2010 defines the two sections below:

  (a) Two general offences of bribery – 1) Offering or giving a bribe to induce someone to behave, or
  to reward someone for behaving, improperly and 2) requesting or accepting a bribe whether in
  exchange for acting improperly, or where the request or acceptance is itself improper; and
  (b) The new corporate offence of negligently failing by a company or limited liability partnership to
  prevent bribery being given or offered by an employee or agent on behalf of that organisation.

24.2 EU Directives Governing Public Procurement

24.2.1 The Trust shall comply with the Public Contracts Regulations 2015 and all relevant directives set by
the Council of the European Union promulgated by the Department of Health & Social Care
prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in
these SO'ss and SFI's.

24.2.2 In the case of management consultancy contracts the Trust shall comply with current Department of
Health & Social Care/NHSI guidance.

24.3 EU Public Sector Procurement Regulations 2015 – Procedures

24.3.1 The Trust shall have policies and procedures in place for the control of all tendering activity which
must be executed through the Trust's designated eProcurement system. The advice of the Trust's
Associate Director of Strategic Procurement should be taken in all circumstances.

24.4 Capital Investment

24.4.1 The Trust shall comply as far as is practicable with the requirements of the guidance published by
NHSI on capital investment including 'NHS Capital regime, investment and property business case
approval guidance for NHS Trust and Foundation Trusts and other relevant guidance.

Formal Competitive Tendering

24.5 General Applicability

24.5.1 Subject to the exceptions set out in 24.7.1 and 24.7.2, the Trust shall ensure that competitive
tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the tendering of services including sub contracted clinical services and all forms of management
consultancy services;
- For the design, construction and maintenance of building and engineering works (including
construction and maintenance of grounds and gardens); and
- for disposals of tangible and intangible property (including equipment and intellectual property).

24.6 Purchase of Health Care Services

24.6.1 Where relevant, the Chief Executive shall nominate employees to commission contracts with providers of healthcare in line with a commissioning plan approved by the Board.

24.6.2 Where the Trust plans to commission contracts with providers of healthcare, the Trust must invite tenders for the supply of such healthcare services. These SO's and SFI's shall apply and need to be read in conjunction with SFI 11.

24.7 Exceptions and instances where formal quotation and tendering need not be applied

24.7.1 Formal quote and tendering procedures need not be applied where:

    (a) the estimated whole life expenditure or income does not, or is not reasonably expected to, exceed £10,000 excluding VAT;
    (b) where the supply is proposed under special arrangements negotiated by the Department of Health & Social Care in which event the said special arrangements must be complied with. This includes the Procure 21 framework for the construction of healthcare facilities;
    (c) regarding Losses and Special Payments as set out in SFI 16*; and*
    (d) where the supply can be obtained under a framework agreement that has itself been procured in compliance with the duties set out in SFI 24.2 and where the Trust is entitled to access such framework agreement.

24.7.2 Subject to the duties at SFI 24.2 (and to obtaining appropriate advice and documentation from the Trust's Procurement Services Department and where it considers necessary external professional advice) **formal tendering procedures may be waived in the following circumstances but only in the event that the financial thresholds within the Public Sector Contract Regulations 2015 are not breached:**

    (a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in the formal tender waiver proforma;
    (b) where the requirement is covered by an existing contract let by the Trust or partner organisation;
    (c) where the timescale genuinely precludes competitive tendering. Failure to plan the requirement properly is not regarded as a justification for a tender waiver;
    (d) where specialist expertise is required and can be demonstrated to be available from only one source;
    (e) when the requirement is essential to complete a project or procurement, and arises as a consequence of a recently completed assignment and engaging different suppliers for the new task would be inappropriate;
    (f) there is a clear benefit to be gained from maintaining continuity with an earlier project or supply of goods/services. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and
    (g) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

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24.7.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a provider originally appointed through a competitive procedure, except where this represents an extension to a contract agreed in the original contract to tender.

24.7.4 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver (including any subsequent increase in value) and the reasons should be documented and recorded in an appropriate Trust record and reported to the Integrated Audit and Governance Committee, the form and content of such reports to be determined by that Committee

24.8 Fair and Adequate Competition

24.8.1 Where the exceptions set out in SFI 24.7 do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

24.9 Items which subsequently breach thresholds after original approval

24.9.1 Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Finance Officer and be recorded in an appropriate Trust record.

Contracting/Tendering Procedure

24.10 Invitation to tender

24.10.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

24.10.2 All invitations to tender shall state that no tender will be accepted unless:

(a) submitted electronically using the Trust's e-tendering system; or alternatively
(b) submitted electronically via a national e-tendering system.

24.10.3 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

24.10.4 Every tender for building or engineering works (except for maintenance work, when Estatecode guidance shall be followed) shall embody or be in the terms of the current edition of a Standard Form of Contract in accordance with the recommendations contained in Concode or other appropriate Standard Form as approved by the Assistant Director of Strategic Estates and as set out in the approved Estates Tendering Manual. These documents shall be modified and/or amplified to accord with Department of Health & Social Care guidance and, in minor respects, to cover special features of individual projects.

24.11 Receipt and safe custody of tenders

24.11.1 The Chief Executive will designate and agree a list of employees able to access the electronic tenders and release them once the Sealed Date and Time has passed.

24.11.2 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the electronic system.

24.11.3 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (see SFI 24.15).

24.12 Admissibility

24.12.1 If for any reason the designated employees are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

24.12.2 Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

24.13 Late tenders

24.13.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated employee decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

24.13.2 At the discretion of the Chief Finance Officer (or in his absence, the Deputy Finance Director), only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and the process of evaluation and adjudication has not started.

24.13.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential by the Chief Executive or his nominated employee.

24.14 Acceptance of formal tenders

24.14.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

24.14.2 The lowest tender, or Most Economically Advantageous Tender (MEAT) shall be accepted if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in the Ratification Report and held on the contract file, or other appropriate record.

24.14.3 It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

   a) experience and qualifications of team members;
   b) understanding of client's needs;
   c) feasibility and credibility of proposed approach; and
   d) ability to complete the project on time.

24.14.4 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

24.14.5 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or in accordance with the Detailed Scheme of Delegation.

24.14.6 The use of these procedures must demonstrate that the award of the contract was:

   (a) not in excess of the going market rate / price current at the time the contract was awarded; and
   (b) that best value for money was achieved.

24.14.6 All tenders should be treated as confidential and should be retained for inspection.

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24.15 Tender reports to the Trust Board

24.15.1 Reports to the Trust Board will be made on an exceptional circumstance basis only, including for the purpose of approving all contracts over the financial limit stated in the Reservation of Powers and Scheme of Delegation.

24.16 Firms invited to tender/quote

Pre-qualification

24.16.1 The Procurement Services function is responsible for carrying out pre-qualification technical, financial and economic checks on firms from whom tenders and quotations may be invited, if appropriate. All suppliers will be required to accept the Trust's terms and conditions of contract.

Building and Engineering Construction Works

24.16.2 Invitations to tender shall be made only to firms registered with Constructionline (pre-qualification database owned and endorsed by the Department of Trade & Industry).

24.16.3 Where it is necessary in the case of specialist engineering work to invite contractors not registered with Constructionline, approval shall be obtained from the 2gether nominated officer and the facts noted in the Tender Report.

24.16.4 Firms shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, they shall not discriminate against any person because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and will comply with the provisions of the Equality Act 2010 and any amending and/or related legislation.

24.16.5 Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

Financial Standing and Technical Competence of Contractors

24.16.6 The Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of contractors. The Director with lead responsibility for technical/clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

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Quotations: Competitive/Non-Competitive

24.17 General Position on quotations (values quoted exclude VAT)

24.17.1 Quotations are required where formal tendering procedures are not adopted and where the intended whole life expenditure or income exceeds, or is reasonably expected to exceed £20,000.

24.18 Competitive Quotations

24.18.1 Quotations will be obtained in accordance with the Trust's Procurement to Pay Policy.

24.18.2 Quotations should be obtained from at least 2 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust through the Procurement Services Department using the e tendering system.

24.18.3 Quotations should be in writing unless the Chief Executive or his nominated employee determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record

24.18.4 All quotations should be treated as confidential and should be retained for inspection.

24.18.5 The Chief Executive or his nominated employee should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

24.19 Non-Competitive Quotations

24.19.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible employee, possible or desirable to obtain competitive quotations;
(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts; and
(c) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this section apply.

24.20 Quotations to be within Financial Limits

24.20.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFI's except with the authorisation of either the Chief Executive or Chief Finance Officer.

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Authorisations

24.21 Authorisation of Tenders and Competitive Quotations

24.21.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in accordance with Section 5.4 of the Detailed Scheme of Delegation in Appendix 2 of these SFI's.

24.21.2 Note: Urgent matters may be dealt with under SO 4.2 of the Trust Constitution Annex 8 (by the Chairman and Chief Executive, reported at the next Trust Board) or under the Reservation of Powers Introduction and Principles of Delegation section within Appendix 1 of these SFI's. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Chairman after taking appropriate advice from the Chief Finance Officer. If both Chairman and Chief Executive are absent, and the matter cannot reasonably wait until their return, delegated powers may be exercised by the individual formally deputised by the Chief Executive.

24.21.3 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

24.22 Instances where formal competitive tendering or competitive quotation is not required

24.22.1 Competitive tendering or a competitive quotation is not required when

(a) the Trust shall uses the NHS Supply Chain for procurement of goods and services; or
(b) the Trust uses a National or Regional Framework Contract to which it has legitimate access

However, in all cases the route to market must demonstrably deliver best value for money. This may be required to be determined **through the use of a 'mini competition' procedure.**

24.23 Private Finance for capital procurement (see SFI 14)

24.23.1 Where appropriate, the Trust should market-test (competitively tender) for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
(b) The Trust must seek all applicable approvals and follow the requirements of NHSI guidance including "Risk Evaluation for Investment Decisions by NHS Foundation Trusts";
(c) The proposal must be specifically agreed by the Board of Directors of the Trust; and
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

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24.24 Compliance requirements for all contracts

24.24.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

The Trust's SO's and SFI's;

(a) EU Directives and other statutory provisions;
(b) any relevant directions including Concode and guidance on the Procurement and Management of Consultants;
(c) such of the NHS Standard Contract of Conditions as are applicable;
(d) the Care Quality Commission's "Essential Standards for Quality and Safety";
(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and
(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an employee who shall oversee and manage each contract on behalf of the Trust.

24.25 Personnel and Agency or Temporary Staff Contracts

24.25.1 The Chief Executive shall nominate employees with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

24.26 Disposals (See SFI 16)

24.26.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated employee;
(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the Procure to Pay Policy of the Trust;
(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;
(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and
(e) land or buildings concerning which Department of Health & Social Care guidance has been issued but subject to compliance with such guidance.

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24.27 In-house Services

24.27.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

24.27.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up to ensure a clear separation of duties between the tender and the house bid teams:

  (a) Specification group, comprising the Chief Executive or nominated employee/s and specialist;
  (b) In-house tender group, comprising a nominee of the Chief Executive and technical support; and
  (c) Evaluation team, comprising normally a specialist employee, a Procurement Services representative and a Chief Finance Officer representative. For services having a likely annual expenditure exceeding £250,000, a non-executive director should be a member of the evaluation team.

24.27.3 All groups should work independently of each other and individual employees may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

24.27.4 The evaluation team shall make recommendations to the Board.

24.27.5 The Chief Executive shall nominate an employee to oversee and manage the contract on behalf of the Trust.

24.28 Applicability of SFI's on Tendering and Contracting to funds held on trust (see SFI 19)

24.28.1 These Instructions shall not only apply to expenditure by the Trust but also to works, services and goods purchased from the Trust's charitable funds.

24.29 Joint Ventures and Trading Arms

24.29.1 When the Trust proposes to enter into an agreement between two or more parties to undertake economic activity together, this may take the form of a contractual joint venture or an incorporated joint venture. A robust commercial agreement covering entry, running and exit from the joint venture is required with a detailed project programme, including those activities that are specific to the joint venture in question.

25 NHSi Framework and Compulsory guidance for Finance and use of resources

- Approved Costing Guidance - Costing principles and guidance for NHS-funded services
- Department of Health & Social Care Group Accounting Manual (GAM) - This provides the detailed requirements for accounts for NHS trusts and NHS foundation trusts, and annual report requirements for NHS trusts.
- FT Annual Reporting Manual (ARM) – contains the formal accounts direction and requirements for annual reports for foundation trusts
- Use of Resources: assessment framework - aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and performance in English NHS acute hospitals.
- Reducing expenditure on NHS agency staff: rules and price caps - Sets out all the rules for NHS providers on agency expenditure, which are collectively known as the 'agency rules'.
- National Tariff payment system - Information about the currencies and prices to use in 2017/18 to 2018/19 national tariff.
- Supporting NHS Providers on executive HR issues - Guidance on a range of executive HR issues including appointments process, salaries, severance and moves.
- Consultancy spending approval criteria for providers - This guidance is for NHS providers looking to commission consultancy services.
- Single Oversight Framework for NHS Providers - Sets out how NHSI oversee NHS trusts and NHS foundation trusts, helping us to determine the level of support they need.
- NHS Operational planning and contracting guidance - Provides an update on the national priorities and long-term financial challenges for local systems.
- NHS Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts

Appendix 1 to Standing Financial Instructions

**Reservation of Powers
to the Board of Directors**

1. Introduction and Principles of Delegation

1.1 Section 5.1 of the Annex 8 SO's of the Trust Constitution provides that "subject to the Regulatory Framework and such guidance as may be issued by NHS Improvement (NHSI), the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 or by a director or an employee of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit". The Code of Governance also requires that there should be a formal schedule of matters specifically reserved to the Trust Board.

1.2 This document outlines which powers are reserved to the Board - generally matters for which it is held accountable to the Sector Regulator and the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 Board members share corporate responsibility for all decisions of the Board. Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to NHSI for the discharge of those responsibilities. Non-Executive Directors are appointed by the Council of Governors to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through Parliament and to the local community. All members are required to subscribe to the Code of Conduct and declare any conflicts of interest.

1.4 This Scheme should be read in conjunction with SO's (within the Trust's Constitution) and all other SFI's. Arrangements for the exercise of functions by delegation are covered in SO section 4 of the Annex 8 SO's of the Trust Constitution and in the introduction to SFI's.

23/24.4 – APPENDIX 1
2. Roles and Responsibilities

2.1 Role of the Chairman
2.1.1   The role of the Chairman is to:
- provide leadership to the Board; set its agenda which should be forward looking with a concentration on strategic matters;
- enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team;
- ensure that key and appropriate issues are discussed by the Board in a timely manner, and ensure that enough time is allowed for discussion of complex or contentious issues;
- ensure the Board has adequate support and is provided efficiently with all the necessary data, information and advice on which to base informed decisions;
- lead Non-Executive Board members through a formally-appointed Nominations Committee of the Board for the appointment of the Chief Executive and other Executive Directors;
- appoint Non-Executive Board members to Integrated Audit and Governance Committee, Finance & Investment, Nominations, Remuneration and Charitable Funds Committees of the main Board;
- act as Chair for the Council of Governors;
- ensure effective communication with the members and that the Board develops an understanding of the views of members of the public;
- take the lead in providing suitable induction for Non-Executive Directors, identifying and meeting the development needs of the Non-Executive Directors; and
- ensure that the performance of the Board as a whole, and of Non-Executive Directors individually is evaluated annually.

2.2 Senior Independent Director (SID)
2.2.1   The SID should be available to members of the Board of Directors and the Council of Governors if they have a concern that contact through the normal channels of Chairman and Chief Executive has failed to resolve or where such contact is inappropriate. The SID may also act as the point of contact with the Board of Directors for Governors when they discuss, for example, the Chair's performance appraisal and his or her remuneration and other allowances.

2.2.2   To be in a position to undertake this role, the SID should attend sufficient meetings with the Council of Governors to listen to their views.

2.2.3   The SID should:
- lead a meeting of the Council of Governors at least annually, without the Chairman present, to appraise the Chairman's performance; and
- lead a meeting of the Non-Executive Directors at least once a year, without the Chairman present, to appraise the Chairman's performance.

2.3 Council of Governors

2.3.1   The specific statutory powers and duties of the Council of Governors are to:

<u>2006 Act:</u>
- appoint and, if appropriate, remove the chair;
- appoint and, if appropriate, remove the other non-executive directors;
- decide the remuneration and allowances, and the other terms and conditions of office, of the chair and non-executive directors;
- approve the appointment of the chief executive;
- appoint and, if appropriate, remove the NHS foundation trust auditor; and
- receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report.

<u>Amendments to the 2006 Act made by the 2012 Act:</u>
- Hold the NEDs individually and collectively to account for the performance of the Board of Directors;
- Represent the interests of members of the Trust as a whole and the interests of the public;
- Approve "significant transactions" as defined in NHSI guidance;
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- Approve amendments to the Trust's constitution.

2.3.2   In addition
- in preparing the NHS foundation trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors and must consult them on any proposal to increase income not related to the provision of NHS healthcare by more than 5% of total planned income.

2.3.3   In the event that there is disagreement between the Board of Directors and Council of Governors the Board of Directors and Council of Governors dispute resolution procedure will be followed.

2.4 Role of the Chief Executive

2.4.1   All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Committee of the Board shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally, and those functions that have been delegated to other directors and employees.

2.4.2   All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer the Chief Executive is responsible and accountable to Parliament via the Regulator for the funds entrusted to the Foundation Trust.

2.4.3   The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with the Trust's Provider Licence and public service values, and for the maintenance of proper financial stewardship.

2.4.4   The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The duties of the Chief Executive as Accounting Officer are laid out in the Accounting Officer Memorandum; see section 4.1 of this scheme.

2.5 Caution over the Use of Delegated Powers

2.5.1   Powers are delegated to directors and employees on the understanding that they do not exercise delegated powers in a way which could reasonably be anticipated to cause public concern.

2.6 Directors' Ability to Delegate their own Delegated Powers

2.6.1   The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

2.7 Absence of Directors or Employee to Whom Powers have been Delegated

2.7.1   In the absence of a director or employee to whom powers have been delegated those powers shall be exercised by that director or employee's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Chairman after taking appropriate advice from the Chief Finance Officer. If both Chairman and Chief Executive are absent, and a matter cannot reasonably wait until their return, delegated powers may be exercised by the individual formally deputised by the Chief Executive.

3 Reservation of Powers to the Board of Directors

3.1 Introduction

3.1.1   The Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself and to ensure that management arrangements are in place to enable clear delegation of its other responsibilities. These reserved matters are set out in paragraphs 1.2 to 1.10:

3.2 General Enabling Provision

3.2.1   The Board of Directors may determine any matter it wishes in full session within its SO's and statutory powers. NHS Foundation Trusts must comply with legislation and guidance issued by Parliament, and by NHSI, the Sector Regulator, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. The powers of the Board of Directors are subject to the Constitution and Authorisation of the Foundation Trust.

3.3 Functions and Duties of the Board of Directors

3.3.1   The Board of Directors has seven key functions for which it is held accountable by the Sector Regulator of NHS Foundation Trusts (NHSI):

(a) to ensure effective financial stewardship through value for money, financial control and financial and strategic planning;

(b) to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

(c) to appoint, appraise and remunerate senior executives;

(d) to ratify the strategic direction of the organisation within the overall policies and priorities of Parliament and the NHS, define its annual and longer term objectives and agree plans to achieve them;

(e) to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;

(f) to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs; and

(g) to ensure that the Trust maintains robust clinical governance arrangements underpinning safe, effective and efficient services to its patients.

3.3.2   It is the Board's duty to:

(a) act within statutory financial and other constraints;

(b) be clear what decisions and information are appropriate to the Board of Directors and draw up SO's, a schedule of decision reserved to the Board of Directors and SFI's to reflect these;

(c) ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored with senior executives held to account;

(d) establish performance and quality measures that maintain the effective use of resources and provide value for money whilst ensuring patient safety is maintained;

(e) specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board of Directors can fully undertake its responsibilities; and

(f) establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board of Directors.

3.4 Regulation and Control

3.4.1   Approval, suspension, variation or amendment of SO's, a schedule of matters reserved to the Board of Directors, SFI's and the Scheme of delegation of powers from the Board of Directors to employees.

3.4.2   Approval of the Trust's Treasury Policy including authorisation of institutions with which investments may be made. Approval of banking arrangements. Approval of a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and CFO.)

3.4.3   Requiring and receiving the declaration of directors' and senior employees' interests which may conflict with those of the Trust and determining the extent to which that individual may remain involved with the matter under consideration.

3.4.4   Regular review of the capacity and capability of the Trust to provide the mandatory services referred to in the Provider Licence.

3.4.5   Disciplining directors who are in breach of statutory requirements or SO's.

3.4.6   Ensuring that policies are in place for disciplining employees of the Trust.

3.4.7   Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.

3.4.8   To receive reports from committees including those which the Trust is required by the Provider Licence or other regulation to establish and to take appropriate action thereto.

3.4.9   To confirm the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.

3.4.10   Ratification in formal session of any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 4.2 of Annex 8 within the Trust Constitution (emergency powers).

3.4.11   Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for Funds held on Trust.

3.4.12   Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

3.4.13   Ratification, or otherwise, of instances of failure to comply with SO's brought to the Chief Executive's attention in accordance with SO 4.6 of Annex 8 within the Trust Constitution.

3.4.14   Approval of procedures for declaration of hospitality and sponsorship.

3.4.15   Ensuring proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.

3.4.16   Provide evidence through use of the Board Assurance Framework that the Trust is doing its 'responsible best' to manage itself to meet its objectives and protect patients, staff, the public and other stakeholders, against risks of all kinds.

3.4.17   Regular review of compliance with all statutory requirements.

3.4.18   Ensuring appropriate responses are in place to respond to interventions, reports and requirements of statutory regulatory bodies of the Trust's services and facilities.

3.5 Appointments and Remuneration

3.5.1   The appointment and dismissal of committees (and individual members) which are directly accountable to the Board of Directors.

3.5.2   Confirming the appointment of members of any committee of the Trust as representatives on outside bodies.

3.5.3   Reviewing the recommendations and decisions of the Remuneration Committee regarding pay and terms of service of directors and senior employees.

3.5.4   Following consultation with the Council of Governors, appoint one of the non-executive directors as Senior Independent Director to act in accordance with NHSI's Code of Governance and the Trust's SO's.

3.5.5   Consideration and authorisation of a Mutually Agreed Resignation Scheme (MARS).

3.6 Strategy, Policy Determination, Plans and Budgets

3.6.1   Definition of the strategic aims and objectives of the Trust. Approval of strategy, business plans, budgets and workforce plans, and the capital programme. Approval of the Trust's Annual Business Plan prior to submission to NHSI.

3.6.2   The approval of significant management policies, including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff (where not specifically delegated to the Remuneration Committee or Executive Team).

3.6.3   Approval and monitoring of the Trust's strategy, policies, procedures and programmes for the management of risk.

3.6.4   Approval of major changes to the Trusts' corporate structure.

3.6.5   Ensuring adequate succession planning for the Board

3.6.6   Determination of in-house services to be subject to competitive tender

3.6.7   Approval to engage in tendering for the provision of healthcare related services (where not specifically delegated to the Finance and Performance Committee under the 'Commercial Tenders' Policy)

3.7 Direct Operational Decisions

3.7.1   Ratify proposals for the acquisition, disposal or change of use of land and/or buildings (subject to NHSI's approval in the case of property designated as Protected in the Trust's Authorisation). Approve Outline and Full Business Cases for capital and service investment, in accordance with any delegated limits from the Department of Health & Social Care and as set out in the Business Case procedure.

3.7.2   The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £1.5m.

3.7.3   Acceptance of formal written tender evaluation reports and approval of individual purchasing contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,500,000 over a 3 year period or the period of the contract if longer. (SFI 24.23.1).

3.7.4   Approval of transactions with a value in excess of that currently specified in the table of financial limits as delegated within the Scheme of Delegation, Appendix 2 Section 5 of these SFI's.

3.7.5   Agreement of action on litigation against or on behalf of the Trust, subject to delegated limits set out in Section 11 of the Detailed Scheme of Delegation, Appendix 2 Section 5 of these SFI's.

3.7.6   Review of use of NHSLA risk pooling schemes (LPST, CNST, and RPST). Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.

3.7.7   Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by Parliament, NHSI and the Care Quality Commission.

3.7.8   Approve PFI proposals.

3.7.9   Approve the opening or closing of any bank or investment account. Approval of loans taken out with repayment periods in excess of one year. Approval of a Working Capital Facility within NHSI's guidance on Operating Cash.

3.8 Financial and Performance Reporting Arrangements

3.8.1   Approval of the Trust's performance management framework known as the Operational Framework. Continuous appraisal of the affairs of the Trust by means of the receipt of reports as the Board of Directors may require from directors, committees, and employees of the Trust as set out in management policy statements and in respect of powers delegated to committees. All monitoring returns required by NHSI, the Care Quality Commission and the Charity Commission shall be reported, at least in summary, to the Board of Directors.

3.8.2   Approval of the Trust's Annual Report and Annual Accounts prior to submission to Parliament, NHSI and the Council of Governors.

3.8.3   Approval of the Annual Report and Accounts for funds held on trust.

3.8.4   Approval of the Annual Plan prior to submission to the Secretary of State.

3.8.5   Approval of the Trust's Quality Report and Quality Account.

3.9 Audit Arrangements

3.9.1   Ensure external audit arrangements (including arrangements for the separate audit of funds held on trust) are in place taking appropriate action.

3.9.2   The receipt of the annual management letter from the external auditor and agreement of action on the recommendation taking account of the advice, where appropriate, of the Integrated Audit and Governance Committee.

3.9.3   The receipt of the annual report from the internal auditor and the agreement of action on the recommendations where appropriate of the Integrated Audit and Governance Committee.

3.10 Corporate Governance Matters

3.10.1   Undertaking a formal review (annually) of the performance of the Board along with that of its Committees and individual Directors. Determining the independence of Non-Executive Directors;

3.10.2   Review of the Trust's compliance with the regulators Code of Governance (annually);

3.10.3   Review of this Reservation of Powers to the Board (annually);

3.10.4   Approval of amendments to the Constitution in conjunction with the Council of Governors.

4 Delegation of Powers

4.1 Delegation to Committees

4.1.1   The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be determined by the Board of Directors, taking into account where necessary the requirements of the Secretary of State and or the Charity Commission (including the need to appoint an Integrated Audit and Governance Committee, and a Remuneration Committee). Terms of reference covering decisions and duties delegated by the Board of Directors will be reviewed by each Committee annually and submitted for Board approval. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with SO 5.5 of Annex 8 of the Trust Constitution, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

4.2 Delegation derived from Accounting Officer Memorandum

4.2.1   The Accounting Officer Memorandum is reproduced in full in Section 4.1 of this scheme. The personal responsibility of the Chief Executive as Accounting Officer cannot be delegated except in the particular circumstances set out in the document, and to the extent that the Chief Finance Officer has operational responsibility for the preparation of accounts and effective financial management, information and processes as described in SFI's.

5 Scheme of Delegation to Employees

5.1   SO's and SFI's set out in some detail the financial responsibilities of the Chief Executive (CE) and Chief Finance Officer. Specific responsibilities relevant to other directors, budget holders and all staff are summarised in section 4.3 of this appendix.

5.2   The scheme of delegation covers only matters delegated by the Board of Directors to directors and certain other specific matters referred to in SFI's.

5.3   Section 5 sets out the Detailed Scheme of Delegation applicable to all Care Groups.

5.4   Directors are responsible for ensuring adherence to the provisions of Sections 4 and 5, and for maintaining an appropriate structure of authorised signatories, with procedures for approval of expenditure (including financial limits as necessary) in accordance with the Trust's Authorised Signatory procedure.

6 Scheme of Delegation Implied by:

6.1 NHS Foundation Trust Accounting Officer Memorandum

6.1.1 Introduction

1. The National Health Service Act 2006 (the Act) designates the Chief Executive of an NHS foundation trust as the Accounting Officer.
2. The principal purpose of the NHS foundation trust is the provision of goods and services for the purposes of the health service in England. The NHS foundation trust has a general duty to exercise its functions effectively, efficiently and economically.
3. The Act specifies that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. An Accounting Officer has the personal duty of signing the NHS foundation trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.
4. Associated with these duties are the further responsibilities which are the subject of this memorandum. It is incumbent on the Accounting Officer to combine these duties with their duties to the Board of Directors of the NHS foundation trust.
5. It is an important principle that, regardless of the source of the funding, Accounting Officers are responsible to Parliament for the resources under their control.

6.1.2 Responsibilities of NHSI

1. In relation to NHS foundation trusts, it is the responsibility of NHSI - Sector Regulator of NHS Foundation Trusts, to be satisfied that the NHS foundation trust is compliant with the governance and continuity of services requirements of their provider licence. .

6.1.3 The general responsibilities of an NHS Foundation Trust Accounting Officer

1. The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:
   - there is a high standard of financial management in the NHS foundation trust as a whole;
   - financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust; and
   - financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.

6.1.4   The specific responsibilities of an NHS foundation trust Accounting Officer

1. The essence of the Accounting Officer's role is a personal responsibility for:

    *   the propriety and regularity of the public finances for which he or she is answerable;
    *   the keeping of proper accounts;
    *   prudent and economical administration;
    *   the avoidance of waste and extravagance; and
    *   the efficient and effective use of all the resources in their charge.

2. As Accounting Officer you must:

    *   personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by NHSI in accordance with the Act;
    *   comply with the financial requirements of the Provider Licence;
    *   ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust);
    *   ensure that the resources for which you are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
    *   ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;
    *   ensure that any protected property (or interest in) is not disposed of without the consent of NHSI;
    *   ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the NHS foundation trust's staff, including yourself; and
    *   ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

3. An Accounting Officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels:

    *   have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
    *   are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money; and
    *   have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

4. Accounting Officers must make sure that their arrangements for delegation, promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the Government Internal Audit Standards.

6.1.5   Advice to the board

1. An Accounting Officer has particular responsibility to see that appropriate advice is tendered to the Board of Directors and the Board of Governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Accounting Officers will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to

their own duty as Accounting Officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.

2. The Board of Directors and the Council of Governors of an NHS foundation trust should act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman is contemplating a course of action involving a transaction which you as Accounting Officer consider would infringe these requirements, however, you should set out in writing your objection to the proposal and the reasons for this objection. If the Board of Directors, Council of Governors or Chairman decides to proceed, you should seek a written instruction to take the action in question. You should also inform NHSI of the position, if possible before the decision is taken or in any event before the decision is implemented, so that NHSI, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that you are overruled, the instruction must be complied with, but your objection and the instruction itself should be communicated without undue delay to the NHS foundation trust's external auditors and to NHSI. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction.

3. If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to your wider responsibilities for economy, efficiency and effectiveness, it is your duty to draw the relevant factors to the attention of the Board of Directors and the Council of Governors and to advise them in whatever way you deem appropriate. If your advice is overruled, and the proposal is one which as Accounting Officer you would not feel able to defend to the PAC as representing value for money, you should seek a written instruction before proceeding. NHSI should be informed of such an instruction, if possible before the decision is implemented. It will then be for NHSI to consider the matter, and decide whether or not to intervene.

4. If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 13 and 14 before the decision is taken, you must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.

6.1.6   Appearance before the Committee of Public Accounts (PAC)

1. The Comptroller and Auditor General (C&AG) may, under the National Audit Act 1983, carry out examinations into the economy, efficiency and effectiveness with which the NHS foundation trust has used its resources in discharging its functions. An Accounting Officer may expect to be called upon to appear before the PAC from time to time to give evidence on the reports arising from these examinations or reports following the annual certification audit, and to answer the PAC's questions concerning expenditure and receipts for which he or she is Accounting Officer. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence.

2. An Accounting Officer will be expected to furnish the PAC with explanations of any indications of weakness in the matters covered by paragraphs 8 - 15 above, to which their attention has been drawn by the C&AG or about which they may wish to question the Accounting Officer.

3. In practice, an Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his or her accountability. Nor, by convention, does the incumbent Accounting Officer decline to answer questions where the events took place before taking up appointment: the PAC may be expected not to press the incumbent's personal responsibility in such circumstances.

4. The PAC has emphasised the importance it attaches to accuracy of evidence, and the responsibility of witnesses to ensure this, in order to ensure that relevant lines of enquiry may be pursued at its hearings. The Accounting Officer should ensure that he or she is adequately and accurately briefed on matters which are likely to arise at the hearing. The Accounting Officer may, however, ask the PAC for leave to supply information not within his or her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the PAC has contained errors; these should be made known to the PAC at the earliest possible moment.

5. In general, the rules and conventions governing appearances of officials before parliamentary committees apply to the PAC, including the general convention that officials do not disclose the advice given to the board. Nevertheless, in a case where the procedure described in paragraph 13 was used concerning a matter of propriety or regularity, the Accounting Officer's advice, and it's overruling by the board, would be disclosed to the PAC. In a case covered by paragraph 14, where the advice of an Accounting Officer has been overruled in a matter not of propriety or regularity but of prudent and economical administration, efficiency or effectiveness, the C&AG will have made clear in the report to the PAC that the Accounting Officer was overruled. The Accounting Officer should seek to avoid disclosing the advice given to the board, though subject to their agreement the Accounting Officer should be ready to explain the reasons for their decision.

6.1.7   Absence of an Accounting Officer

1. An Accounting Officer should ensure that he or she is generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior employee in the NHS foundation trust who can act on his or her behalf if required.

2. If it becomes clear to the Board of Directors that an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Chief Finance Officer, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted.

3. The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.

Sources

This document is based on the guidance outlined in *Managing Public Money*, updated in September 2018, available on the following website link:
https://www.gov.uk/government/publications/managing-public-money

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6.2 Scheme of Delegation from Standing Orders

SO REF*	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	Chairman	Final authority in interpretation of Standing Orders (SO's).
3.2	Chairman	Call meetings.
3.9	Chairman or Deputy Chairman	Chair all Board meetings and associated responsibilities.
3.15	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings.
3.16	Chairman	Having a second or casting vote
3.30	Integrated Audit and Governance Committee	Integrated Audit and Governance Committee to review every decision to suspend SO's (power to suspend SO's is reserved to the Board of Directors)
4.2	Chairman & Chief Executive	The powers which the Board of Directors has retained to itself within these SO's may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
4.5	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion.
4.6	All	Disclosure of non-compliance with SO's to the Chief Executive or Chair of the Audit Committee as soon as possible.
6.8	Trust Secretary	Maintain Register(s) of Interests.
7.1	All staff	Comply with the Trust's Anti-Fraud, Bribery and Corruption Policy and Code of Conduct, and with national guidance contained in "Managing conflicts of Interest in the NHS – guidance for staff and organisations"
7.8	All	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board of Directors.)
8.1&8.3	Trust Secretary	Keep seal in safe place and maintain a register of sealing.
9.1	Executive Director, Risk & Legal Services Manager, Claims Manager	Approve and sign all documents which will be necessary in legal proceedings.

* SO Annex 8 within the Trust Constitution

6.3 Scheme of Delegation from Standing Financial Instructions

Nominated employees and the areas for which they are responsible are incorporated into the Trust's Detailed Scheme of Delegation document, SFI's set out detailed responsibilities of the Chief Finance Officer, Financial and other responsibilities of the Chief Executive are covered in SFI's and the Accounting Officer Memorandum.

SFI clauses applicable to other directors, to budget holders (all levels) and line managers, and in some cases to all employees and contractors, are summarised in the following table.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.3 & 4.5.2	Chief Finance Officer	Reviews all financial procedures ahead of approval in line with the Policy for the Development and Management of Organisation Wide Policies and Other Procedural Documents, and the form in which financial records are kept
3.3-3.7	All employees and contractors	Duty to comply with SFI's and report any breaches
4.2.3	Chief Executive	To ensure that all directors and employees are made aware of their responsibilities under SFI's
4.4.1	All	Responsible for security of Trust property, economy and efficiency in use of resources; avoid loss and report suspected fraud.
5.2.2	All	Internal audit are entitled to access all records and premises, and have access to all directors and employees.
5.2.3	All	Notify Chief Finance Officer of any suspected irregularity relating to cash, stores, property or other financial matter
5.6.3	Director of Strategic Development and Capital Planning	Key tasks relating to security management (with the Local Security Management Specialist)
7.1.6	Budget holders	Provide information for compiling annual budgets. Sign off budgets and prepare and sign off business plans at the commencement of the financial year.
7.2.2-7.2.4, 7.3.1 to 7.3.4	Budget holders	Budgetary control arrangements to meet agreed budgets
7.6.1	Care Group Directors	Achieve performance targets. Report on performance to the Board, Finance and Performance Committee and Executive Team.
7.6.3	Domain leads	Nominated Executive Directors agree changes to scoring/weighting/RAG rating thresholds
7.6.4	Chief Finance Officer	Ensure Performance Management framework is in place. Maintain Operational Framework.
9.5.6 & 9.5.10, 9.6.4	Finance managers	Employees authorised to make short term borrowings and invest cash surpluses (within the Treasury policy)
10.2.2 – 10.2.3	All	Ensure Chief Finance Officer approves all fees and charges where not covered by statute or determined by DHSC. For sponsorship income ensure the Trust's Ethical guidance and NHS England's "Managing Conflicts of Interest in the NHS – Guidance for staff and Organisations" is followed. Notify Chief Finance Officer of monies due from contracts, leases, tenancy agreements, private patients and other transactions
10.4.2- 10.4.4	All	All cash, cheques and payable orders received must be banked intact with no disbursements or encashment of private cheques or IOUs. Unofficial funds deposited for safekeeping in Trust safes are subject to strict procedures and obtaining written indemnities.
10.5.1	All	Money laundering regulations - cash payments in excess of 15,000 Euros will not be accepted.
11.1.5 to 11.1.7	All	Formal signed SLA's/contracts are required before goods or services can be provided to or by the Trust
12.3.1	All	Limits on employing permanent and temporary staff which must fit within approved budget levels
12.4.3	Line managers	Delegated responsibility for completion and submission of time records, termination and other payroll-related notifications which must be made in a timely manner
12.5.1	Director of HR	Ensuring Contracts of employment comply with legislation. Dealing with variations and terminations.
13.2.1	Approved requisitioners	Obtain best value for money in requisitioning goods and services (on Procurement Services advice)
13.4	Budget holders	Must submit formal request (to Chief Finance Officer) for payment in advance of goods/service being received.
13.6	All	Duties of managers and employees in relation to procuring goods and services, raising requisitions, goods on loan, verbal orders and petty cash.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.6.2	Director of Strategic Development and Capital Planning	Audit of contracts to ensure compliance with Concode and Estatecode
14.1	Director of Strategic Development and Capital Planning	Planning and reporting on the capital programme
14.1.7	Capital project managers	Expenditure on individual schemes under the approved capital programme requires specific authority to proceed.
14.4.3-5	All	Report discrepancies in the asset register (annual verification exercise for budget holders). Report damage and loss of property and equipment. Assets should be marked as Trust property.
15.2	Relevant managers and departmental employees	Stock control arrangements.
15.3.1	Budget holders and ward/departmental nominees	For goods obtained through the NHS Supply Chain ('stock' requisitions) check deliveries against the delivery note and follow up to ensure credit is received.
16.1.2	Budget holders	Condemning and disposal procedures
16.2.2	All	Notifying losses, actual and suspected.
16.2.3	All	Notifying suspected fraud (see Anti-Fraud Policy)
17.2.1	All	Notify Director of Strategic Development and Capital Planning of any proposed new IT systems/applications.
18.2	Chief Nurse/Director of Quality	Patient's property: ensuring systems and procedures are in place covering written and oral advice to patients and relatives. Ensuring Relative Support Officer function is provided.
18.6 & 18.7	Relevant ward/departmental managers	Staff to be informed, on appointment, of their responsibilities for patients' property.
19.3.1	All	These SFI's apply also to charitable funds
20	All	Staff to be aware of Trust policy on accepting gifts (see Anti-Fraud policy) plus NHS England's "Managing Conflicts of Interest in the NHS – Guidance for staff and Organisations"
21	All	Archiving and destroying records
22.1.2	Trust Secretary	Preparation and maintenance of the Board Assurance Framework.
22.1.2	Chief Nurse/Director of Quality	Preparation and maintenance of the Quality Governance Statement.
22.1.4	Trust Secretary	Annual Governance Statement
22.1.2	Chief Nurse/Director of Quality	Responsible for Trust-wide risk management strategy, processes and Board-level reporting.
22.1.3	Deputy Director of Risk, Governance & Patient Safety	Preparation and maintenance of the Corporate Risk Register.
22.1.3	Care Group and Executive Directors	Ensuring formalised Care Group/corporate governance structures in accordance with the Trust's Risk Management Strategy.
22.3.1c	Budget holders	Income generating activities may require commercial insurance
24	All	Tendering procedures

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
(SFI's)

Detailed Scheme of Delegation

Last Approved by: Board of Directors 18 May 2022

Issued By: Chief Finance Officer

Next review: April 2024 2020

Appendix 2 to Standing Financial Instructions

Detailed Scheme of Delegation

The delegation shown in the following Detailed Scheme of Delegation is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Employees as appropriate.

The use of commas in the table below is a substitute for "or". Where the authority of more than one employee is required this is clearly indicated by the use of 'and'.

23/24.4 – APPENDIX 1
Schedule A: Requisitioning and payment of invoices – revenue (Budget Holders)
A1. Requisitioning and payment of invoices within delegated budget in conjunction with Agresso e-requisitioning and workflow structures:

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post (Budget Holder)	Reference SFI13 and 24 (to comply with any specific requirements laid down under NHSi's financial special measures)
Up to £500	AfC 4	
Up to £1k	AfC 5	
Up to £5k (1)	AfC 6/7	
Up to £25k	AfC 8a/8b	
Up to £50k	AfC 8c/8d	
Up to £250k (2)(3)	AfC 9/VSM	
Up to £500k	AfC 9/VSM and Executive Director	
Up to £1.0m	AfC 9/VSM and Chief Exec and Finance Director	
Over £1.0m	Trust Board	
Budget virement	As above (4)	See Budget Virement Policy
Items below £5k not funded within Care Group budgets	Care Group Director or Assistant Finance Director	
Non pay expenditure over £5k for which no specific budget has been set up and which is not subject to funding under delegated powers of virement.	Deputy Finance Director	
Approving payment of invoices in excess of tender/order price: 5% of order value(up to maximum £50 per order)	Payments Manager	Above this limit is referred to the Procurement Services Department to investigate to request a credit note if appropriate or, if the higher price is correct, to obtain budget holder approval at the correct authorisation level and amend the purchase order accordingly.

(1) Includes Clinical Leads
(2) Includes Care Group Clinical Directors
(3) Delegated limits includes 2gether contract variations with the group based on the <u>annual full year effect</u> changes to the unitiary payment but excludes framework or other annual contract where the commitment has already been made by the budget holder e.g. NHS Professionals and NHS Supply Chain which are authorised by agreed Agency approval process
(4) The Assistant Director of Finance (Financial Management) has delegated authority from the Chief Finance Officer to allocate funds from central resources and reserves as operationally required
(5) The business case approval process is shown under section E.

Additional controls operated by the Procurement Services Department and the Finance Department may be applicable from time to time.

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A2. Expenditure from Charitable Funds – per request:

Delegated Matter	Authority Delegated to Grade/Post (1)	Reference SFI 19
Up to £2k	Delegated signatory (known as fund managers)	
Up to £30k	Delegated signatory and Executive Team member or Assistant Finance Director	
Up to £100k	Delegated signatory and CFO (or Deputy in absence of CFO)	
Over £100k	Board of Directors on recommendation of Charitable Funds Committee (CFC)	

(1) A separate authorised signatory list is maintained for charitable funds. The Business Case procedure is applicable to purchases over £5k from charitable funds. The Trust's SO's, SFI's, quotation/tendering requirements and Scheme of Delegation are all applicable to charitable funds.

Schedule B: Signing orders and contracts
(including subsequent variations) for goods and services – revenue (Procurement Services)
B1.Within delegated budget in conjunction with Agresso e-requisitioning and workflow structures:

Delegated *Matter (contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post (Procurement Services)	Reference
Up to £2.5k	Assistant Buyer	
Over £2.5k and up to £5k	Buyer	
Over £5k and up to £25k	Senior Buyer	
Over £25k and up to £100k	Category Manager (1)	
Over £100k and up to £250k	Senior Category Manager	
Over £250k	Associate Director of Strategic Procurement, 2gether nominated officer	

(1) All contracts are signed by category manager or above

B2. Authority to exceed specific ordering limits by up to 5% once a tender has been formally accepted, where the contract value is exceeded by:

Delegated Matter *(including non-reclaimable VAT)*	Authority Delegated to:	Reference
Up to £20k	Category manager	
Over £20k and up to £100k	Associate Director of Strategic Procurement	
Above £100k or 5% above contract value	Further authorisation to be sought from original approving body	

(1) Excludes 2gether contract variations within the wholly owned subsidiary (see A1).

(2) Additional controls operated by Procurement Services and the Finance Department may be applicable from time to time.

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Schedule C: Capital
C1: Requisitioning capital expenditure within agreed capital programme (see capital approval process under section E):

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference SFI 14 and 24
Up to £100k	Head of IT (for IT items only)	
Up to £250k	2gether nominated officer and Strategic Investment Group sub Group Leads, Head of IT (for IT projects only) and nominated Project Managers, Senior Financial Accountant or nominated deputy	
Up to £1.5m	As above plus Executive Director	
Above £1.5m	As above plus Chief Executive	

C2: Approval of capital schemes where tender or cost is over budget:

Delegated Matter *(including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference
Up to £10k	Senior Financial Accountant or nominated deputy	Reported to Strategic Investment Group
Up to £100k	Chief Executive, DDoF	Reviewed by Strategic Investment Group
Over £100k	Chief Executive's Group, Board Committee or Board of Directors	Referred back to the original authorising body

C3: Approval of capital schemes miscellaneous:

Delegated Matter	Authority Delegated to Grade/Post	Reference
C3a. Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Two of 2gether nominated officers	
C3b. Financial monitoring and reporting on all capital scheme expenditure	DDoF	Reported to Trust Board, Finance and Performance Committee and Prioritisation Committee
C3c. Taking on or termination of leases with annual rental of up to £150k	2gether nominated officer and DDoF	Refer to Assistant Director of Financial Accounting to advise if this would be a finance or operating lease
C3d. Taking on or termination of leases with annual rental of over £150k	CFO	As above
C3f Impacting on protected services and/or protected assets	NHSI	

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Schedule D: Quotation, Tendering and Contract Procedures
D1: Competition requirements:

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference SFI 24
Ensuring value for money is obtained for goods and services purchased under £10k	Budget signatories (within delegated limits)	
Obtaining a minimum of 2 formal written quotations on a competitive basis for goods and services between £10k and £20k, on a whole-life basis for expenditure or income.	Budget signatory (within delegated limit) and Procurement Services Department in accordance with Trust Procurement to Pay Policy.	
Obtaining formal written competitive tenders for goods or services above £20k.	Budget Director (or AFD in their absence) and Associate Director of Strategic Procurement and one other 2gether nominated officer: following Estates Tendering Procedure Manual	

D2: Waiving competition requirements: Authorisation for a single tender action and waiver of tendering requirements:

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference SFI 24
Up to £150k	Assistant Finance Director	
Up to 500k	DDoF	
Up to £1.5m	CFO or Chief Executive	
Over £1.5m	Board of Directors	

D3: Opening tenders and quotes:

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference SFI 24, and Estates Tendering Procedure Manual
Up to £20k	Any two Procurement Employees, Senior Category Manager – Procurement Services	
For electronic tenders above £20k and up to £250K	Procurement tenders: Senior Category Manager, Associate Director of Strategic Procurement. Strategic Estates tenders: received and opened by two 2gether nominated officers	SFI 24.13.2
For electronic tenders above £250k	Procurement tenders: Senior Category Manager, Associate Director of Strategic Procurement. Strategic Estates tenders: received and opened by Two 2gether nominated officers Planning	

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D4: Acceptance of tenders and quotes:

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post (after due process including approval of the relevant budget holder/service Director as applicable)	Reference SFI 24.16 and Scheme of Reservation 1.7.3
Up to £10k	2gether nominated officer (within delegated limits)	
Up to £20k	Associate Director of Strategic Procurement, Senior Category Manager - Procurement Services	
Up to £100k	Associate Director of Strategic Procurement and 2gether nominated officer	
Up to £250k	Assistant Finance Director	
Up to £500k	Chief Executive and DDoF, and 2gether nominated officer.	
Up to £1.5m	Any two of: Chief Executive, CFO or 2gether nominated officer	
Over £1.5m	Board of Directors	Or, if urgent, Chairman and Chief Executive, reported at the next Board meeting (SO 4.2)

D5: Authority to issue a letter of intent:

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference
Up to £20k	Associate Director of Strategic Procurement, Senior Category Manager, Procurement Services Department	
Up to £100k	Associate Director of Strategic Procurement, 2gether nominated officer	
Up to £500k	Chief Executive, CFO	
Over £500k	Chief Executive, CFO with Board approval	

D6: Commercial Tenders (new markets and competition for provision of services)

Delegated Matter *(contract value including non-reclaimable VAT)*	Authority Delegated to Grade/Post	Reference Strategic Development Policy agreed at Finance and Performance Committee
Services currently provided by the Trust): - Up to £499k per annum - £500k to £999k per annum - above £I.0m per annum	Executive Management Team Finance and Performance Committee Board	
New business: - Up to £249k per annum - £250k to £499k per annum - above £500k per annum	Executive Management Team Finance and Performance Committee Board	

DELEGATED INVESTMENT APPROVAL LIMITS

APPROVAL GROUP	SCOPE		
	OVERALL/ SELF-FUNDING	**REVENUE FUNDING REQUIRED**	**CAPITAL FUNDING REQUIRED**
Care Group Boards	Approve investment proposals within Care Group "redistributable resource" (approved budget baseline). **EXCEPT** New Service Business cases/impact on other Care Groups or Business cases with a contract activity Impact	-	-
	Then to (if applicable):		
Strategic Investment Group (SIG)	Approve self-funding business cases up to £1.25m cost impact over five years (<= £250k p/a average cost)	Approve non self-funding business cases up to £750k cost impact over 5 years (<= £150k ap/a average cost)	Approve up to £500k Capital Investment (only) - no revenue cost impact
	Then to (if applicable):		
Clinical Executive Management Group (CEMG)	Approve self-funding Business cases from >£1.25m to < £2.5m cost impact over five years (<= £500k p/a average cost base change)	Approve Non self-funding Business Cases up to £1.75m cost impact over five years (<= £350k p/a average cost)	Approve >£500k to <£1m Capital Investment
	Then to (if applicable):		
Finance & Performance Committee (FPC)	Approve self-funding Business cases from >£2.5m to < £5m cost impact over five years (<= £1m p/a average cost base change)	Approve Non self-funding Business cases up to £2.5m cost impact over five years (<= £500k p/a average cost)	Approve >£1m to <£2.5m Capital Investment
	Then to (if applicable):		
Trust Board of Directors (BoD)	Approve self-funding Business cases over £5m cost impact over five years (> £1m p/a average cost base change)	Approve Non self-funding Business cases over £2.5m over five years (> £500k p/a average cost)	Approve over £2.5m Capital Investment

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Delegated matter	Authority delegated to (lowest level)	Reference documents
1. Management of budgets **1.1 Responsibility for keeping within budgets**		SFI 7, 12, 13 and Performance Management Framework
Clinical Care Group	Care Group Director	
Corporate directorates	Executive Director	
Corporate budgets	Assistant Finance Director	
Individual budget	Delegated budget signatory	
2. Bank accounts	CFO. Day to day authorisations in accordance with bank mandates approved by the Board	SFI 9
Approve working capital facility and Trust's main commercial bankers	Board of Directors	
Approve external Investment Management contracts	Finance and Performance Committee	
Investment of surplus cash in accordance with Policy	Assistant Finance Director	Treasury Policy
3. Setting of fees and charges		SFI 10
Private Patients, Overseas Visitors, other patient services Income Generation	Assistant Finance Director Income	
NHS Service Level Agreements – local tariffs	Assistant Finance Director Income	
Approving credit notes to be raised by the Trust	In line with authority for raising invoices. Credit notes over £1k are subject to review by the Financial Accountant.	
4.1 Engagement of Temporary Staff	Note: This section is subject to the operation of any additional vacancy control processes authorised from time to time by the CEO. Note also that Care Groups may impose additional counter-signatory requirements.	SFI 12.3.1 and 24.27 Refer to the Trust's agency staff approval process
a. Non-Medical Consultancy Staff - all appointments	Care Group Director <u>and</u> Executive Director. Any appointment costing more than £50k will require pre-approval from NHSI.	DHSC guidance on procurement of management consultants
b. Individual temporary staff where the aggregate commitment in any one year is more than £25,000	Care Group manager and Care Group Finance Lead	This section should be read in conjunction with the NHSI Guidance on agency staff usage and the bank procedure. Where proposed expenditure is not covered within the delegated budget, additional approval must be obtained from the Chief Finance Officer and Director of HR
c. Booking of bank staff	Budget Signatory (within delegated budget)	
d. Booking of framework agency staff	Budget Signatory (within delegated budget)	
e. Booking off-framework agency staff	Care Group Director	
f. Renewal of Fixed Term Contract	Deputy budget manager (subject to relevant vacancy controls for clinical and non-clinical staff) with change forms signed off by Care Group Finance Lead/HR Business Partner	
Approval of temporary, bank or fixed term contract staff outside budget limits	CFO and HR Director	

4.2 Trust's Solicitors		
a. Engagement	Chief Executive	
b. Referral of a case etc to appointed Solicitors	Legal Services Managers	Trust's Policy on obtaining Legal Advice
5. Agreements and licences		
Preparation and signature of tenancy agreements and licences for staff	2gether nominated officer and DDoF	Subject to Trust Staff Accommodation Policy
Extensions to existing leases	2gether nominated officer and DDoF	
Letting of premises to outside organisations (in accordance with Estate Code)	2gether nominated officer	
Approval of rent based on professional assessment	DDoF	

Charitable funds properties:
  Letting premises to outside organisations
 	
  Approval of rent based on professional assessment
 	
  Appointment of agents to manage external letting
	Charitable Funds Committee
	
	Charitable Funds Committee
	
	CFO	

6. Condemning and Disposal		SFI 16
Items obsolete, obsolescent, redundant, irreparable or not cost-effective to repair:	Note: liaison with Procurement Services is required for all disposals to ensure Health and Safety issues are addressed	Sale of protected assets (land and buildings) requires Board and NHSI approval
Estimated replacement cost up to £5k	Budget Manager and Senior Category Manager: Procurement Services	
Estimated replacement cost over £5k	In line with delegated budgetary approval	
Mechanical and engineering plant	2gether nominated officer and DDoF	Note: capital receipts may not always be available for reinvestment in the area which generated the sale.
Sale of property (land/buildings)	Finance and Performance Committee to approve sale at market valuation +/- parameters for ED approval of subsequent offer	
Other	Budget Manager and Senior Category Manager: Procurement Services (after reporting to DDoF and Senior Financial Accountant)	
Disposal of X-ray film – estimated sale value up to £5k	Deputy Budget Manager	
Disposal of X-ray film – estimated value over £5k.	Budget Manager and Senior Category Manager: Procurement Services	
Sale of Charitable funds properties	Charitable Funds Committee to recommend sale at market valuation +/- parameters for Board approval. CFO or CE approval of subsequent offer	
7. Losses and Special Payments Note. The Trust has delegated authority to write off losses without limit, except that: Any novel, contentious or repercussive cases have to be referred for DH approval. Proposed staff severance payments that exceed legal or contractual obligations require prior approval from Treasury.	Note: a summary of all losses and special payments is reported to the Integrated Audit & Governance Committee. Cases over £250k are reported separately in the annual accounts. All individual cases of £250k and above require Board approval. All cases above £50k require approval from the CE and CFO and will be reported to the Finance and Performance Committee. All cases above £1k require two signatures	SFI 16 and DHSC Group Accounting Manual (GAM)
a. Loss of cash: theft, fraud, overpayment or other reason	Assistant Director of Financial Accounting and DDoF	Subject to Debtors Policy for writing off bad debts and recovery of losses due to fraud

b. Fruitless Payments (incl. Abandoned capital schemes):		
Up to £50,000	Executive Director	
Over £50,000	Trust Board	
c. Claims abandoned. Private patients, overseas visitors and other including NHS and non NHS debtors	DDoF	Subject to Debtors Policy for writing off bad debts.
d. Damage to buildings, fittings, furniture and equipment, loss of equipment including IT and property in stores and in use, due to culpable causes (e.g. fraud, theft, arson, administrative failure)	Two of 2gethers nominated officers or DDoF and Legal Services Managers or Local Counter Fraud Specialist and /or Local Security Management Specialist	
e. Compensation payments made under legal obligation resulting from a Court Order or legally binding arbitration award.	Deputy Director of Risk, Governance & Patient Safety or Corporate HR Manager PLUS Executive Director or DDoF	
f. Extra contractual payments to contractors	2gether nominated officer and DDoF	
g. Ex-gratia payments to patients and staff for loss of personal effects:		
i)Less than £1,000	Legal Services Managers	
ii) Between £1,000 and £5,000	Legal Services Managers and Deputy Director of Risk, Governance & Patient Safety (DDRGPS)	
iii)Over £5,000	DDRGPS PLUS an Executive Director	
h. Clinical negligence negotiated settlements (with legal advice)	DDRGPS PLUS an Executive Director	Note: the NHSLA has financial responsibility for all cases covered by the scheme. However, it may allow the Trust to settle low-level cases directly
i. personal injury claims involving negligence where legal advice has been obtained and guidance applied	DDRGPS PLUS an Executive Director	NHSLA guidance

j. Other ex gratia payments relating to clinical negligence and personal injury claims not subject to legal advice • Under £1,000 • Between £1,001 and £5,000 • Between £5,000 and £50,000 (in practice legal advice would be sought for a claim at this level, or for clinical negligence would be processed through the NHSLA)	 Legal Services Managers Legal Services Managers and DDRGPS DDRGPS and an Executive Director or DDoF	Note: Redress policy being developed; payments to be approved by Care Group Directors
k. Other ex gratia including maladministration up to £50,000 Bands as section j above	As section j above	Note: where complainant has suffered no financial loss, compensation can only be justified in very exceptional circumstances
l. Other – settlements on termination of employment:		
i) contractual	Head of Employee Relations and Assistant Finance Director	
ii) Under legal obligation	As section e above	
iii) other	Treasury approval	HR Policy derived from Treasury guidance in DHSC Group Accounting Manual (GAM)
m. Payment of Court Disclosure Orders	Legal Services Managers	On instruction from Trust solicitors
8. Reporting of incidents to the Local Counter Fraud Specialist or Trust's Local Security Management Specialist and the Police		SFI 5
a. Where a criminal offence is suspected:-		
i) Criminal offence of a violent nature, theft or criminal damage	Responsible Manager And Security Manager	All security related incidents of theft or criminal damage must be notified to the Chief Executive, NHS Protect and the Police by the LSMS.
ii) Other security breach or knowledge of unreported security incident	Responsible Manager and Security Manager	
b. where a fraud is involved	Employee to notify CFO or Local Counter Fraud Specialist	In accordance with the Trust's Anti-Fraud Policy
9. Petty Cash		SFI 13
a) Disbursement from local imprest/cashiers office	Imprest holder	
b) Request for reimbursement cash/general office funds:-		
• Up to £100 per item	Budget Signatory	
• Up to £200 per item	Deputy Budget Manager	
• Over £200 per item	Budget Manager or Senior Financial Accountant	
c) Reimbursement of Patients monies	Cash/general office staff, Relative Support Officer	
10. Receiving Hospitality		
In excess of £25 per item received (or offered and refused) - Applies to both individual and collective hospitality receipts, in accordance with Trust guidelines and SO's	Declaration required in Trust's Hospitality register (held by Trust Secretary	Trust guidance on sponsorship and "Managing Conflicts of Interest in the NHS – A guide for staff and organisations"

11. Implementation of internal and external audit recommendations	Lead director and designated manager	SFI 5
12. Maintenance and update of Trust Standing Financial Instructions	Assistant Finance Director	
13. Investment of Charitable Funds	CFO as Trustee (if absent: DDoF)	In accordance with policies agreed by the CFC and ratified by TB
14. Personnel and Pay	Note: this section is subject to the operation of any additional vacancy control processes authorised from time to time by the CEO	Vacancy control panel currently in force
14.1 Authority to fill funded post on the establishment with permanent staff.	Budget signatory and all Requests to Recruit are signed off by Care Group Finance lead and relevant Care Group Director or Deputy to Executive Director	Recruitment and financial management procedures
14.2 Authority in exceptional circumstances to appoint permanent staff to post not on the formal establishment.	AFD to obtain formal approval from Director of HR and CFO	Resourcing Dept Procedures and Case of need
14.3 Additional Increments The granting of additional increments to staff within national terms and conditions and the Trust's starting salaries policy	Employee Relations Manager following application from Care Group (Director or approved nominee)	AFC Management Guidance on Starting Salaries
14.4 Grading of Posts All requests shall be dealt with in accordance with Trust Procedure	Head of Employee Relations and Care Group Finance Lead	HR Policies
14.5 Establishments		
Responsibility for creating and maintaining a Trust-wide approved staffing establishment	CFO and Director of HR with appropriate sign off by the Chief Nurse and Director of Quality and Medical Director	
Additional posts to the agreed establishment with specifically allocated finance agreed by Finance Director and HR Director.	Relevant budget holder and Finance Manager and Care Group Lead and HR Business partner (clinical posts also signed off by the Head of Nursing or Clinical Lead as appropriate)	Resourcing Dept Procedures and Change to Authorised Establishment procedures
14.6 Pay	Note: This section is subject to the operation of any additional pay control processes authorised from time to time by the CEO. Note also that Care Groups may impose additional counter-signatory requirements.	
Authorisation of standing data forms affecting pay, new starters (within establishment), leavers and variations (except increments, re-grading and ad-hoc payments dealt with separately in this Scheme)	Budget signatory	
Authorisation of time and attendance on rostering system	Line manager (minimum level is budget signatory)	
Authorisation of overtime within budget	Budget signatory	
Authorisation of non-Agenda for Change or payment outside of national terms and conditions for medical staff	Head of HR and DDoF	
Authorisation of travel, subsistence and expenses claims	Budget signatory for Cost Centre charged	
14.7 Approval of additional payments to staff:		
Performance Related Pay Assessment	Remuneration Committee	
Other payments	DDoF and Head of HR	

14.8 Leave		See also Medical & Dental Terms & Conditions, and AfC T&C of Service. Refer also to Trust HR Policies.
Maintaining adequate leave records	Line manager	
Approval of annual leave	Line manager	
Medical Staff Leave of Absence - paid and unpaid	Care Group Medical Director	
14.9 Special leave arrangements		Special Leave Policy, Flexible Working Policy, Annual Leave Policy, Parents Toolkit
Compassionate leave up to 3 days	Line manager	
Paternity leave	Line manager	
Carers leave, up to 3 days	Line manager	
Special leave	Line manager	
Leave without pay	Line manager	
Time off in lieu	Line manager	
Maternity Leave - paid and unpaid	Line manager	
Flexitime – setting maximum level of accrued flexitime	Line manager	
Buying and selling annual leave	Line manager	
Flexible retirement	Line manager	
14.10 Sick Leave		Trust Sick leave policy
Extension of sick leave on half pay up to three months (in exceptional circumstances)	DDoF and Head of HR	Sickness Absence Policy, and terms and Conditions for Agenda for change staff and Medical staff
Extension of sick leave on full pay (in exceptional circumstances)	Head of HR and an Executive Director	
Return to work part-time on full pay to assist recovery	Line manager, in consideration of Occupational Health advice	
14.11 Study Leave		
Senior Medical staff study leave	Clinical Lead and Director of Med Education	Trust guidelines
Junior medical staff study leave	Relevant Consultant Educational Supervisor, Care Group Support Assistant and Clinical Tutor	KSS Deanery guidelines
All other study leave	Deputy budget manager and line manager	Trust study leave policy

14.12 Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by employees taking up new appointments (providing consideration was promised at interview)	HR Director/ Head of HR	Removal expenses guideline
14.13 Authorised Car & Mobile Phone Users		
Requests for posts to be authorised as car users	Budget manager (in line with Trust policy)	
Requests for posts to be authorised as mobile telephone users	Budget manager (and in line with Trust policy)	
14.14 Mutually Agreed Resignation Scheme (MARS)	Board	Subject to NHSI guidelines. Refer to the Trust MARS policy
14.15 Redundancy	CFO and Director of HR	
14.16 ill Health Retirement		
Decision to pursue retirement on the grounds of ill-health (final decision rests with the Pensions Agency)	Line manager	
14.17 Dismissal	Dismissing Manager (and in line with HR policy)	Trust disciplinary policies. Delivering Performance Policy, Sickness Absence Policy
15. Authorisation of new drugs where no specific source of funding or income has been identified	CFO on the recommendation of the Drugs & Therapeutics Committee	D&TC Terms of reference
16. Authorisation of Sponsorship Deals	Chief Executive, Medical Director and Director of Research and Innovation	Trust Policy: Ethical Guidelines on the Relationship between Trust Employees and the Biomedical Industry
17. Authorisation of funded Research Projects	Director of Research and Innovation	In line with Trust Policy for Management of R&D
18. Authorisation of Clinical Trials	Chief Executive, Medical Director and Director of Research and Innovation	
19. Insurance Policies and Risk Management		
a. management of the RM programme	Chief Nurse & Director of Quality	
b. Insurance arrangements	CFO and Legal Services Managers	
c. Payment of third party claims, pending recovery from the NHSLA (above the excess), and the Commissioner, based on request from NHSLA and Trust's solicitors	Legal Services Managers (over £50,000 also requires approval from the Assistant Finance Director - Financial Accounting)	NB excess may be recoverable under historic agreement with host commissioner
20. Patients and relatives complaints		Trust complaints procedure
a. overall responsibility for ensuring that all complaints are dealt with effectively	CE, Deputy Chief Nurse and Director of Quality	
b. responsibility for ensuring that complaints relating to a Care Group are investigated thoroughly	Care Group Top Team	
c. Coordination/facilitation of complaints	Head of Patient Experience Team	
d. coordinating the management of medico-legal complaints	Medical Director or CNDQ and Legal Services Managers	

21. Relationships with Press		
a. Non-emergency general enquiries	Trust Comms lead	Using Comms protocol on out of hours enquiries
b. Emergency, out of hours	On-call Exec Director via the switchboard operator	
22. Infectious Diseases & Notifiable outbreaks	CNDQ and Director of Infection Prevention and Control	Trust Infection Control policy
23. Patient Services		
a. Variation of operating and clinic sessions within existing numbers	Care Group Director	
b. All proposed changes in bed allocation and use		Notified to ICBs etc.
Temporary	Chief Operating Officer	
Permanent	CFO	
c. Activity monitoring and reporting	CFO	
24. Review of Fire precautions	Fire Safety Officer	
25. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	2gether nominated officer	
26. Review of Medicines Inspectorate Regulations	Associate Medical Director, Director of Pharmacy	
27. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Head of Strategic Intelligence	
28. Information Governance including Data Protection, Data Security and Caldicott Guardian arrangements		
a. Overall responsibility: SIRO	CFO	
b. Information (activity and contract minimum data)	Head of Information Services	
c. IT security and controls	Head of IT	
d. Overall Information Governance controls	Information Governance Manager	
e. Care Group controls	Care Group nominated leads	
f. Freedom of Information requests	Deputy Director Risk Governance and Patient Safety	
g. Publication scheme	Deputy Director Risk Governance and Patient Safety	
h. Data Protection Act requests and compliance	Information Governance Manager	
i. Review of Trust's compliance with the Access to Records Act	Information Governance Manager	
j. Review of the Trust's compliance with the code of practice for handling confidential information	Information Governance Manager	

29. Retention of Records: a. maintaining archives and compliance with Trust Policy b. Control of access to central clinical records c. Policy lead	Heads of Department Patient Access Service Manager Board Secretary	SFI 21
30. Monitor proposals for contractual arrangements between the Trust and outside bodies	Care Group Directors, DDoF, Head of Supplies & Procurement, Associate Director of Procurement (as appropriate)	
31.The keeping of a Declaration of Interests Register	Trust Secretary	SO's Section 6*
32. Attestation of Sealings in accordance with Standing Orders	Chairman, Executive Directors	SO's Section 8*
33. The keeping of a register of Sealings	Trust Secretary	SO's Section 8*
34. The keeping of the Gifts and Hospitality Register	Trust Secretary	
35. Clinical Audit: ensuring programme of risk management includes clinical audit	Medical Director and CNDQ with Chair of Clinical Audit and Effectiveness Group	SFI 22
36. Control of Stores		SFI 15
a. Central stores and materials management stock (managed by 2gether as part of the OHF)	Materials Manager Procurement Services	
b. Formal stocks (full stock take monthly or annually as agreed. Stocks included as part of the OHF are managed by 2gether)	Managers of Pharmacy, Theatres, Day Surgery, Estates, Cardiology, Haemophilia, Blood transfusion, Radiology, CSSD, Audiology, AND Assistant Director of Financial Accounting	Trust Stocktaking procedure
c. Other stock holding	Budget signatories	

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	TRANSFORMING OUR TRUST: OUR RESPONSE TO "*READING THE SIGNALS*: MATERNITY AND NEONATAL SERVICES IN EAST KENT" – UPDATE REPORT
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	CHIEF EXECUTIVE
PAPER AUTHOR:	STRATEGIC PROGRAMME DIRECTOR
APPENDICES:	APPENDIX 1: INTEGRATED IMPROVEMENT PLAN (IIP) PROGRESS REPORT UPDATE

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To update the Board on progress on Transforming our Trust - the Trust's Interim response to *Reading the Signals*, the independent report into maternity and neonatal services in East Kent.				
Summary of Key Issues:	This Report provides an update on the approach to responding to the Reading the Signals Report to provide safer care and improved staff engagement.				
Key Recommendation(s):	The Board of Directors are asked to **NOTE** and discuss progress to date and key next steps.				

Implications:	
Links to 'We Care' Strategic Objectives:	

Our patients	Our people	Our future	Our sustainability	Our quality and safety

Link to the Board Assurance Framework (BAF):	**BAF 39:** There is a risk that women and their families will not have confidence in East Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS). **BAF 32:** There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.
Link to the Corporate Risk Register (CRR):	**CRR 118:** There is a risk of failure to address poor organisational culture.
Resource:	N
Legal and regulatory:	N
Subsidiary:	N
Assurance Route:	
Previously Considered by:	N/A

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TRANSFORMING OUR TRUST: OUR RESPONSE TO "*READING THE SIGNALS*: MATERNITY AND NEONATAL SERVICES IN EAST KENT – UPDATE REPORT

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1.   Background

On 19 October 2022, the Independent Investigation published its report into our maternity and new-born services, *Reading the signals*. The Trust Board has accepted the report in full and apologised unreservedly for the Trust's unacceptable failings which led to the harm and suffering experienced by women, babies and their families, in our care. This report provides an update on the key elements of the Trust's response.

2.   The Pillars of Change and Assurance Framework

2.1.   The Pillars of Change cover the key areas for action included in the *Reading the signals*   Deliverables are both specifically focused on Maternity and Neonatal services but some are applicable to the whole Trust. They cover the practical steps the Trust has already begun to put into place and include the further work to be delivered over the next three years. The Pillars link to the areas in the Independent Investigation Report and to the Trust values that people should feel cared for, safe and respected.

2.2.   The work programme set out in the Pillars of Change details the Trust's transformation ambition over the next three years and for year one will predominantly be managed through a Trust-wide Integrated Improvement Plan (IIP).

2.3.   The IIP was agreed at the Board meeting on 6 April 2023 and monthly progress reports and quarterly reports on Key Outcome measures will be presented at future Board meetings. An extract of the relevant sections from the IIP progress report is included in Appendix 1.

2.4.   The report in June will provide a progress update on the Pillars of Change actions that are not included in the IIP.

3.   Culture and Leadership Programme

3.1.   In 2021 we started to pilot NHS England's (NHSE's) Culture and Leadership Programme (CLP), which was developed by Professor Michael West and colleagues, as part of the National Maternity Improvement Programme, in our Women's Health and Children's Health Care Groups. It is planned to roll out this programme throughout the organisation and an implementation plan will be included in the IIP.

   a.   A Board Development Session was held with Professor Michael West on 6 April 2023.

   b.   An introductory workshop to the CLP for the Clinical Executive Management Group (CEMG) led by the Chief Executive and supported by colleagues from the Culture Transformation, People Directorate at NHSE was held on 26 April 2023.

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c. A resourcing plan is being developed to support trust-wide rollout including establishing a Steering Group as a key workstream within the Strategic Transformation Programme Board.

d. Identification of Change leaders (c 120) to support the diagnostic work across the trust and attend NHSE sponsored development sessions.

4. The Reading the Signals Oversight Group

4.1. The *Reading the signals* Oversight Group will meet in public and is responsible and directly accountable to the Board of Directors. It provides oversight of the programme, making sure there is engagement with those who use our services and that steps are taken to address the issues identified in the Reading the Signals report.

4.2. The group includes representatives from patients and families as well as our Council of Governors.

4.3. The first meeting of the Group was held on 3 April 2023 and second meeting planned for 9 May 2023. There will be a further discussion about the Terms of Reference and membership. At present there are five family representatives who have indicated they wish to be involved in the work of the Group. It is intended the revised Terms of Reference will be presented to the Board of Directors in due course.

4.4. At this meeting it is also intended to discuss proposals for a series of community focused family meetings, to provide additional feedback opportunities further to family and community representation on the Oversight Group.

5. The Independent Case Review Process

5.1. We have established an Independent Case Review process. Families who have concerns about the maternity or neonatal care they received from the Trust will be offered the opportunity to meet with or speak to experts independent of the Trust, regardless of whether their care had previously been reviewed or investigated by the Trust.

5.2. The Independent Panel members have been identified. Initially 27 families approached the Trust following the publication of the Report for either Reviews or further information, but in discussion and with agreement with the families concerned there are now 21 potential Case Reviews to be undertaken. The Key Lines of Enquiry (KLOES) have at the time of writing this report been agreed with six families and two reviews are underway, one of which is nearly complete.

6. NHS England Response

6.1. NHSE published a National Delivery Plan for Maternity and Neonatal services in March 2023, which consolidates the improvement actions committed to in Better Births, the NHS Long term Plan and the Independent Investigations into Shrewsbury and Telford NHS Trust and this Trust.

6.2. The Trust has now produced its own three-year Transformation Plan which will be discussed at today's Board meeting.

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	Priority area of focus in IIP	Summary update
Leadership & Governance	Leadership Development	Adoption of the leadership Programme for the Care Group and service group triumvirates following the organisation restructure to ensure our key leaders have the skills and approach to meet our Trust aims, in a manner which reflects our values.
	Governance Framework	Implement a clear framework for governance oversight within and throughout care groups, ensuring clear responsibilities for management of and learning from risks, incidents and complaints
Maternity	Maternity Transformation	Develop Maternity Improvement Programme with robust programme management and oversight arrangements.
People & Culture	Culture & Leadership	Adoption and roll out of the Culture and Leadership Programme across the Trust and in response to issues identified within Reading the Signals.

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	MATERNITY AND NEONATAL ASSURANCE GROUP (MNAG): CHAIR'S ASSURANCE REPORT
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	INTERIM CHIEF NURSING AND MIDWIFERY OFFICER (CNMO)
PAPER AUTHOR:	INTERIM DIRECTOR OF MIDWIFERY
APPENDICES:	NONE

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The purpose of this paper is to provide the Board with an update on the work undertaken by MNAG.				
Summary of Key Issues:	MNAG has been established to oversee the improvement of maternity services as well as the adherence to national regulatory requirements. The MNAG meeting on the 18 April 2023, was stood down due to lack of quoracy. The following summarises the key points that were due to be discussed and for which papers were circulated: • All maternity specific training is compliant for midwives and obstetricians for February when maternity leave and long-term sick staff are excluded. • PRactical Obstetric Multi-Professional Training (PROMPT) is now face to face, with staff on each site training together through in-situ simulation. There remains a challenge at the William Harvey Hospital (WHH) with the consistent availability of the Midwifery Led Unit (MLU) on Mondays, due to this also being an escalation area for the adult services. • Ongoing challenges for anaesthetic colleagues continue to impact on their ability to complete PROMPT training. Work, supported by the CNMO and Chief Medical Officer (CMO) has commenced to review the workforce structure for anaesthetics. However, there is reported improvement with compliance. • Maternity Dashboard has been changed to incorporate the use of statistical process control as a more informative way of reporting performance and tracking improvement; it was previously agreed that the dashboard would be shared with the Quality and Safety Committee, however, as this MNAG was stood down there has not been an opportunity to discuss and approve the new format. • There were 4 reported serious incidents during March all at WHH. • During March 6 complaints were received. Of these 5 related to WHH and 1 community.				

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	• The response to Your Voice is heard was 70.2%. The feedback continues to represent the demography of the local community served by maternity services. • The weekly quality rounds continue to be reported through the dashboard and further improvements have been made to ensure greater rigour around assurances. . • The Perinatal Quality Surveillance Tool presented; recognised this is a summary of the maternity dashboard. Staffing remains challenged, but 5 internationally educated midwives commenced in March and 23 out of 25 3rd students have indicated they intend to take up positions as newly qualified midwives across East Kent. • Week commencing 20 March, daily staff forums held to discuss the maternity improvement programme. Good engagement from teams and input to develop detail of individual workstream plans. • The monthly Maternity Safety Support Programme (MSSP) report was circulated. • The Care Quality Commission (CQC) actions plan in response to the Section 31 notices, was shared with progress noted. • The Maternity Transformation Programme was shared with members and feedback requested before final submission to the Board. This is planned for June 2023.
Key Recommendation(s):	The Board is asked to **NOTE** the content of the MNAG Chair's Assurance report.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.			
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 122**: There is a risk that midwifery staffing levels are inadequate.			
Resource:	Y/N	No		
Legal and regulatory:	Y/N	Aligned to external assurance process.		
Subsidiary:	Y/N	No		
Assurance Route:				
Previously Considered by:	Quality and Safety Committee 26/4/23			

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	PERINATAL QUALITY SURVEILLANCE TOOL (PQST) REPORT
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	INTERIM CHIEF NURSING AND MIDWIFERY OFFICER
PAPER AUTHOR:	INTERIM DIRECTOR OF MIDWIFERY
APPENDICES:	NONE

Executive Summary:

Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion

Purpose of the Report:	The purpose of this report is: • To update the Board on East Kent Maternity's services aligned to the key elements included within the perinatal and assurance framework as defined by NHS England (NHSE). • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 9, which aims to continue to support the safer maternity and Ockenden report recommendations. Provide assurance that the service is using the tool and reporting to the required standard set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Repot December 2020, NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 4 - Safety Action nine and Ockenden 1 Report Immediate and Essential Actions.
Summary of Key Issues:	The report confirms that the service is using the tool to the required standard, as set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020. The report includes the following key messages for the group's attention: • CNST reporting has now begun a new period. **Currently the area of concern remains standard 8 in relation to PRactical Obstetric Multi-Professional Training (PROMPT) due to anaesthetic workforce challenges. The exact criteria for year 5 have not been released, and therefore the year 4 criteria are being used as reference.** • There have been **no Healthcare Safety Investigation Branch (HSIB) referrals for the 7th Consecutive Month but one case has now been reported in the April reporting month**. • Supernumerary status and 1:1 care compliance was not reported at 100%, however, the figures have been validated and records will be updated to confirm 100% 1:1 achieved on both units for March. • There were 4 reported serious incidents (SIs) during March, all at William Harvey Hospital (WHH). • The Your Voice Is Heard team recorded a response rate of 71.2% in March (increase from February which was 70.1%). Friends and Family Test (FFT) had 128 responses which is a 11.3% response rate a decrease from last month which was 12.8% response rate with 92.2% extremely likely or likely to recommend which is a stable response rate as 91.9% the previous month. • Training compliance was met across all maternity staff groups for fetal monitoring PROMPT and Newborn Life Support (NLS). • **Anaesthetic training compliance for PROMPT remains below the national standard of 90%, but is improving. However, concerns are emerging regarding the obstetric capacity to support ongoing training.**
Key Recommendation(s):	The Board of Directors is invited to: 1. **DISCUSS** the contents of this report; 2. **NOTE** the key risks: non-compliance with PROMPT training for Anaesthetists; 3. Receive **ASSURANCE** and **NOTE** that a monthly perinatal quality assurance report has been received, demonstrating full compliance in line with CNST standard and Ockenden 1 report, Immediate and Essential Action requirements; 4. **APPROVAL** for the contents of this report to be shared through the Perinatal Quality Surveillance Model Framework with the Local Maternity and Neonatal System (LMNS), Region and Integrated Care Systems.

Implications:

Links to 'We Care' Strategic Objectives:

Our patients (women and Families)	Our people	Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.			
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 122**: There is a risk that midwifery staffing levels are inadequate.			
Resource:	N			

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Legal and regulatory:	Y	Clinical Negligence Scheme for Trusts (CNST). NHS Long Term Plan-standard contract.
Subsidiary:	N	
Assurance Route:		
Previously Considered by:		Papers distributed for Maternity and Neonatal Assurance Group meeting on 18 April 2023. However, meeting stood down due non quoracy.

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East Kent Hospitals Perinatal Quality Surveillance April 2023

Month: March 2023	East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting					

Care Quality Commission (CQC) Maternity Ratings	Overall	Safe	Effective	Caring	Well-led	Responsive
	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

Maternity Safety Support Programme	Yes	Support Lead: Mai Buckley

Findings of review of cases eligible for referral to HSIB	1 referral on 03/04/2023 for neonatal death that occurred on 30/03/2023.

The number of incidents logged graded as moderate or above and what actions are being taken.

There were 9 reported moderate harm incidents and 1 death during March. 4 serious incidents declared. Below summarises the Moderate Harms and above:

Site	Location	Category	Subcategory
WHH	Labour ward / delivery suite (WHH)	Women's Health - obstetric complication	3rd or 4th degree perineal trauma
WHH	Labour ward / delivery suite (WHH)	Women's Health - obstetric complication	3rd or 4th degree perineal trauma
Queen Elizabeth the Queen Mother Hospital (QEQM)	Outpatient department	Delay / failure	Delay – Outpatient Department (OPD) clinic - late arrival of doctor / consultant or other delay
QEQM	Kingsgate ward (maternity)	Care / treatment	Delay in providing treatment
WHH	Labour ward / delivery suite (WHH)	Delay / failure	Failure / delay in diagnosis - other
WHH	Patient's home	Women's Health - unexpected problem/outcome for baby	Neonatal death
WHH	Labour ward / delivery suite (WHH)	Communication / behaviour	Staff to patient communication
QEQM	Accident and emergency (QEQM)	Operations / procedures	Unplanned return to theatre
WHH	Operating theatre (WHH)	Operations / procedures	Unplanned return to theatre
WHH	Obstetric operating theatre (WHH)	Operations / procedures	Unplanned return to theatre

The table below summarises the serious incidents:

Site	Location	Category	Subcategory
WHH	Folkestone ward (maternity)	Blood transfusion	Inappropriate transfusion given (expired blood / blood products)
WHH	Labour ward / delivery suite (WHH)	Women's Health - management of labour	Unanticipated maternal admission to Intensive Therapy Unit (ITU) / High Dependency Unit (HDU)

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WHH	Labour ward / delivery suite (WHH)	Never events	Retained foreign object post-procedure
WHH	Folkestone ward (maternity)	Women's Health - obstetric complication	Urinary retention

A summary of key actions taken forward with the Practice Development Team rolling out immediate learning and updates for staff in clinical areas are:

- Hourly fresh care
- Plotting of estimated fetal weight (EFW) on growth charts
- Completion of sepsis screening tool
- Accurate fluid balance monitoring
- Fetal monitoring requirements for women receiving a blood transfusion – review of anaemia guideline
- Holistic reviews of mother and baby
- Professional curiosity of understanding of risks associated with declining aspects of care
- Multiagency working and 'Think Family' approach

Themes from reviews of perinatal deaths	**Themes**	**Actions**
	- Pain relief during labour - Swabs for baby and placenta	- There is an established working group for pain relief in labour, also links with revised bereavement pathway - Bereavement pathway revised and launched 20/3/23 - New bereavement team now in post to improve care 7 days a week and support staff learning

100% of perinatal mortality reviews include an external reviewer	Yes	

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.

Fetal Monitoring All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	214	230	93.0%
Midwife - Community	101	108	93.5%
Other Obstetric Doctor	40	40	100.0%
Obstetric Consultant	30	31	96.8%
Unknown	4	4	100.0%
Maternity Support Worker	0	0	NaN
Total	**389**	**413**	**94.2%**

Fetal Monitoring Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	206	212	97.2%
Midwife - Community	95	97	97.9%
Other Obstetric Doctor	39	39	100.0%
Obstetric Consultant	30	30	100.0%
Unknown	4	4	100.0%
Maternity Support Worker	0	0	NaN
Total	**374**	**382**	**97.9%**

Challenges:
- Prompt room availability at the WHH is variable due to wider bed issues across the Trust and the use of the MLU as an escalation area. Discussions planned with WHH site leadership team
- Anaesthetic attendance remains an issue due to their workforce challenges.

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Prompt All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	208	230	90.4%
Midwife - Community	102	108	94.4%
Maternity Support Worker	76	81	93.8%
Other Obstetric Doctor	36	36	100.0%
Obstetric Consultant	29	31	93.5%
Unknown	4	4	100.0%
Total	**455**	**490**	**92.9%**

PROMPT Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	201	212	94.8%
Midwife - Community	96	97	99.0%
Maternity Support Worker	73	75	97.3%
Other Obstetric Doctor	35	35	100.0%
Obstetric Consultant	29	30	96.7%
Unknown	4	4	100.0%
Total	**438**	**453**	**96.7%**

Anaesthetics covering maternity	Number requiring training	Number of staff trained	Percentage Compliance by staff group
Anaesthetic consultants	42	30	71%
All other anaesthetic Doctors	35	21	62%

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	208	230	90.4%
Midwife - Community	104	110	94.5%
Maternity Support Worker	73	82	89.0%
Other Obstetric Doctor	35	36	97.2%
Obstetric Consultant	30	32	93.8%
Unknown	4	4	100.0%
Total	**454**	**494**	**91.9%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	199	212	93.9%
Midwife - Community	97	99	98.0%
Maternity Support Worker	70	76	92.1%
Other Obstetric Doctor	34	35	97.1%
Obstetric Consultant	29	31	93.5%
Unknown	4	4	100.0%
Total	**433**	**457**	**94.7%**

Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively

Supernumerary Status Maintained		
Month	**QEQM**	**WHH**
October	100%	96.5%
November	100%	97.5%
December	100%	99%
January	100%	97.9%
February	99.31%	97.4%
March	100%	97.9%
Total	**99.9%**	**97.5%**
1 to 1 care in Labour		

The medical work force during February remains the same as the picture below-

Obstetrics-
QEQM
No incidents of nonattendance escalated.
Consultant Rota
- 2 substantive consultants not undertaking Full on call rota duties due to Occupational Health (OH) recommendations.
- 2 substantive consultants not delivering full on call due to job plan changes (leadership and post retirement)
- 1 Full Time Equivalent (FTE) vacancies in recruitment. Two posts going back out as locum

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Month	QEQM	WHH
October	100%	100%
November	100%	100%
December	99.2%	100%
January	100%	100%
February	100%	99.2%
March	97.9%	100%
Total	**99.0%**	**99.7%**

1:1 care in labour:
Compliance of 1:1 in Labour was reported at 99.1%, this related to 3 patients reported as not having received 1:1 care in labour at QEQM. Validation has been completed for the 3 cases, and 1:1 care was provided. The E3 records require updating to reflect.

Supernumerary Status
Supernumerary Status: there was one reported incidence of where compliance was not met at QEQM and 3 at the WHH (two reported cases on one day) all of these are being validated currently.

Midwifery
The Midwifery workforce numbers remain primarily unchanged in terms of vacancy, sickness and maternity leave.

5 Internationally educated Midwives commenced at WHH during March.

All 3rd year student midwives were contacted and so far 25 out of 32 have   replied with 23 indicating they wish to take up roles as newly qualified Midwives in September at East Kent (11 WHH and 12 QEQM).

posts until Royal College of Obstetricians and Gynaecologists (RCOG) approve them as substantive.
- 2 locum agency consultants providing cover.

Registrar rota
- One registrar going on maternity leave at the end of April.

WHH
No incidents reported of non-attendance escalated.

Consultant rota
- 1 substantive consultant not doing full on call duties due to OH requirements.

Registrar rota
- 1 Senior House Officer (SHO) GP Specialty Training (GPST) gap

FFT Feedback		

FFT Main Themes March 2023 (collated on 3/4/23)	**Actions**
128 responses which is a 11.3% response rate a decrease from last month which was 12.8% response rate with 92.2% extremely likely or likely to recommend which is a stable response rate as 91.9% the previous month. 61 comments in total, 48 positive comments= 78.7% increased from 68.7% last month Positive experiences and Named staff in comments- 19 members of staff named Good comments for Hearing screening -Hearing screening manager looks at these on a monthly Basis	Reported back to staff via personalised email and new posters on the wards, Hearing screening manager is aware of the results
Delayed discharge- reoccurring theme	Working task finish group to look at the discharge process has been commenced – end to end process mapping has identified a number of steps where improvement and more efficient working required. Links to case for increase in number of discharge coordinator hours
Short staffed on the wards	This is known to be bigger issue at WHH where the vacancy rate is higher. Plan has been submitted to Executive for consideration
Snacks and breakfast options not suitable for diabetics	Catering have been contacted: specific menu available need to ensure staff know that these are available
Noise on the wards from other patients- specifically at night	Report back to ward managers discuss what other trust are doing in the LMNS. To design a leaflet to give to partners or wards about what is expected on the ward- in idea stages at present. PEM to go on wards to get more feedback around this issue when time allows
Inadequate pain relied on the Labour ward	Currently looking at pain relief management in working task finish group – anecdotally this is a reducing theme. TENs machines being reintroduced to support women in early labour
Felt pressure about breastfeeding from specialist	Feedback to breastfeeding leads
Delayed Induction of labour	Wards managers aware of issues due to high acuity levels. New process introduced led by band 7s to manage delays more effectively with clearer prioritisation and improved communication

Service user feedback		

Service User Feedback Themes		**Actions**
Your Voice is Heard (YVIH) – March Data		Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
• The YVIH service achieved a response rate of 71.2% which is an increase from February (70.1%). With a set Key Performance Indicators (KPIs) of a 70% response rate Some additional work has been carried out looking at women from an ethnic minority background and index of multiple deprivation (IMD) representation in the responses received. • Of the 363 conversations had 262 were positive- 72.2% 64 were neutral – 17.6% 37 were negative – 10.2%		There has been approval for a band 4 post and the jobs will go out for recruitment in the next month. When the Band 4s have been hired to run this service, the PEM will be able to go to ward areas that have the lowest response rates to gather feedback from those areas that YVIH has been unable to reach. This will also enable the team to work directly with ward managers to improve and implement actions identified.

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Ethnic Background	Total families called	Response Rate (number of families answered)
White British	430	69.1% (297)
Asian or Asian British	24	91.6% (22)
Black African, Caribbean and Black British' women,	20	95% (19)
Not Known/Stated	18	72.22 % (13)
Any other Ethnic Group	10	70 % (7)
Mixed or Multiple Ethnicity	7	62.5% (5)

- Of the families that responded, 82.7% said that they would return to East Kent for their maternity care. This is a decrease from 89.1% in February. 6.7% (23 people) were unsure if they would return to EKHUFT, 10.2% (35 people) said no they wouldn't return to EKHUFT for their care
- 226 compliment emails sent to staff members.

Decrease of themes around first day visits at home. There has been a noticeable decrease in this comment. This is reassuring as the first day home visits were introduced in community mid-December.	
Similar themes as the previous months (ongoing theme): • More comfortable chairs for partners more at QEQM than WHH, some positive comments about the chairs at WHH • Food and drinks for partners Lack of pillows and blankets for partners	PEM are still in discussion with procurement scoping out the size of the available space at QEQM and which chairs would be suitable for the space and then to organise an event for families to try them and be involved in choosing the chairs. Emails have been sent to Heads of Midwifery (HoMs) and Matrons of each site to ask how many snack boxes they think would need for the ward and we will get costing for this and report back to HoMs.
Lack of Analgesia, catheter care, bedding being changed and water offered on PN wards	Essential rounding is still occurring but is not consistent. Drug rounds have now been commenced on the ward and an extra drugs trolleys order has been submitted to procurement. We are hoping this will make the drug rounds easier for the staff. Listening event in January to discuss with patients and staff around a leaflets which explains the process and discharge on the PN ward
Lack of Analgesia in Induction of Labour (IOL) and labour	This is being discussed and followed up with the pain management group on a monthly basis on how we can assess our birthing parents pain score. This was a higher in January at WHH labour wards due to the Entonox issues at WHH in the previous 6 weeks. TENS machines are now at both sites and a Standard Operating Procedure (SOP) is in production, with adhoc training being requested so that these can commence to be offered and used on the labour wards
Delay in the Discharge Process on the Postnatal wards	There has been a discharge group set up to look at the processes and what could be improved Listening event in January to discuss with patients and staff around a leaflets which explains the process and discharge on the PN ward
Limited Birth plan appointments/Antenatal education in the community	PEM and community matron in discussion about a co-production event but in the mean time to start virtual antenatal education. Staff are emailing their expressions of interest to Director of Midwifery (DoM) concerning this.

Maternity Voices Partnership (MVP) Feedback	**NIL in month**

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Number of Complaints	6 Complaints were received during March of these 5 related to care at the WHH, and 1 at Buckland Hospital Dover (BHD).

Site	Location	Category	Subcategory
WHH	WLAB - WHH LABOUR WARD	Nursing care	Lack of response to call button
WHH	WLAB - WHH LABOUR WARD	Communication	Misleading or contradictory information given
WHH	OTH - OTHER	Attitude	Problems with doctor's attitude
WHH	OTH - OTHER	Attitude	Problems with doctor's attitude
BHD	Nursing care	Nursing care	Problems with Nursing Care
WHH	FF - WHH FOLKESTONE WARD	Surgical management	Unexpected outcome / post op complications

Listening to women engagement activities and evidence of co-production	There were no events held however feedback was continually gathered through YVIH and FFT.
Staff feedback from frontline safety champions and walk-abouts	The week commencing 20 March, daily staff forums were held to share the workstreams underpinning the Maternity Improvement Programme. Attendance by Multi-disciplinary Team (MDT) from both sites. All staff in agreement with key areas for improvement. Main areas of focus through discussion were: • Ongoing staffing challenges – further input to flexi staffing model taken onboard to inform final proposal • Inability to provide the MLU as an option for women at WHH • Duplication of processes around documentation • Ongoing challenges with maintaining environment within old estate • Provision of HDU for maternity care • Further progression of transitional care • Centralisation of telephone triage • How to improve communication of improvement plans, through existing methods plus more posters, pod costs
HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	The CQC notified the Trust of a section 31 during February. Quality rounds have now been implemented and formalised. The findings reported through the MNAG. Key metrics relate to: • Environmental and infection prevention and control (IPC) weekly rounds. These are now in place and supported by the matron or HoM on each site. These also include hand hygiene and personal protective equipment (PPE) audits. • Fresh Eyes compliance – daily audits are in place to review compliance on both sites • Equipment safety checks, including resuscitaire checks. Daily monitoring in place, 100% now being reported.
Coroner Reg 28 made directly to the Trust	N/A

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Progress in achievement of CNST 10 Safety Standards	Safety Action	Rational for Red/Green status	BRAG status (not due to deliver until 30 June 2022)
	1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Fully compliant against standards. PMRT lead midwife vacancy recruited to. Improved governance oversight on compliance with PMRT reporting. Access to an external reviewer frequently causes concern and is an ongoing risk. Ockenden and CNST require 100% compliance. To date the team have been able to ensure this. LMNS are setting up a bureau to access external reviewers. Action plan development and completion needs to be completed in a timely way to reduce risk of breeching standard requirements. This is overseen by governance and supported by a strengthened bereavement team	
	2. Submitting data to the Maternity Services Data Set to the required standard	Risk around Maternity Information System Provider-Euroking, developing system capability to meet data input quality and submission requirements. Data being submitted more accurately bypassing Euroking. Working as a region to find solutions	
	3. Demonstrating transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme	Transitional Care (TC) will be included on the audit programme from April which will improve data capture and reporting that is currently completed manually. Areas of risk are around capture of Avoiding Term Admissions into Neonatal Units (ATAIN) actions within a central repository to better understand repeat themes. Template to be developed to allow this to be captured within the weekly ATAIN meetings. Need to have an explicit staffing model in place for TC. This is in place for Midwifery team but not Neonatal. Not built into workforce Business case.	
	4. Demonstrating an effective system of clinical* workforce planning to the required standard	This standard is in relation to; obstetrics, anaesthetics as well as neonatal medical and nursing. Obstetric attendance, aligned to RCOG guidance is monitored and reported via the PQST each month through to Board Risks around progression of Neonatal Nursing actions from year 3 against British Association of Perinatal Medicine (BAPM) standards, which require significant investment to increase the workforce, based on year 4 requirements. Will need to be reviewed against year 5 requirements once known.	
	5. Demonstrating an effective system of midwifery workforce planning to the required standard?	Confident standard can be met. Biannual Midwifery Workforce Paper submitted for May to October reporting period. Supernumerary status and 1:1 care in labour remain under 100%-action plan for year 3 has been incorporated into the workforce workstream.	
	6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBV2)		

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		
5 Elements of SBLCBV2	**RAG**	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks - 83.6% compliance level
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 91.7% for women attending with reduced fetal movements. Requirement 80%. Fetal Movements having Computerised Cardiotocograph (CTGs). 99.3% of women have Fetal Growth Restriction (FGR) risks recorded at booking (requirement 80%)
ELEMENT 4: Effective fetal monitoring during labour		Compliant for all staff groups
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. National challenge- will not fail if isn't achieved. Action plan and Mat Neo Quality Improvement work in progress to support

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	7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services	Work continues with the MVP to coproduce plans to address concerns raised by women
	8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of Maternity #Incentive Scheme (MIS) year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4	The main area of concern remains in relation to the ability to comply and then maintain compliance for all disciplines for PROMPT training. During year 4 the main area of concern was in relation to anaesthetic workforce. The anaesthetic workforce are fully engaged with the faculty for the delivery of the PROMPT training and attendance as participants has been steadily improving. However, there is an evolving challenge around the capacity of the obstetric team to support both faculty/training as well as attendance, as they are not provided with scheduled time to do this.
	9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	MatNeoSip Quality Improvement work aligned to the National Driver continue around Perinatal Optimisation bundle of care. Safety Champion Walkabouts and feedback sessions continue monthly on each site. Actioning of concerns are captured in a repository and themes are included in PQST report. Midwifery Continuity of Carer remains on hold as previously reported.
	10. Reporting 100% of qualifying 2019/20 incidents under NHS Resolution Early Notification scheme	No cases for this reporting year
Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Outstanding Ockenden recommendations	Ongoing work around - Training needs analysis (TNA) - update to reflect requirements for 2023/24 - LMS reports showing regular review of training data and minutes. Criteria and greed pathways for referrals to Maternal Medicines Centre (MMC) - Personal Care and Support plans – pilot has commenced - Improving the practice & raising the profile of fetal wellbeing monitoring - Submission from MVP chair rating trust information in terms of: accessibility and quality of info available to service users - An audit of 5% of notes, on women who have specifically requested a care pathway, and also a selection of women who request a caesarean section during labour or induction. - Consider evidence of workforce planning at LMS/Integrated Care System (ICS) level given this is the direction of travel of the people plan - Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. - Risk assessments required for policies not in date – fetal monitoring is completed	

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Glossary

CCG: Care Quality Commission

CNST: Clinical Negligence Scheme for Trusts. An insurance scheme whereby NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims

CNST: Maternity Incentive Scheme. Aims to support the delivery of safer maternity care through an incentive element to trusts CNST insurance contributions. The maternity pricing is inflated by 10% which trusts are incentivised to recover through the delivery of 10 safety actions.

DATIX: The trusts incident reporting system

ENS: Early Notification Scheme. FFT-Friends and Family Test. A quick anonymous survey for service users to give views after receiving care or treatment and for staff to feedback on whether they would recommend as a place to work or receive treatment.

HSIB: Healthcare Safety Investigation Branch. Independent investigation body tasked with carrying out investigations and reporting using a standardised approach without attributing blame or liability

IEA: Immediate and Essential Actions (in relation to the Ockenden Report Recommendations December 2020)

Kleihhauer test: A test performed to understand if there is any fetal blood in the maternal circulation on Rh-negative mothers. The test should be done and any subsequent Anti D immunoglobulin administered within 72 hours of delivery, sensitising event (i.e. abdominal trauma) or invasive procedure.

MIS: Maternity Information System. At East Kent we use Euroking as our MIS provider

MNAG: Maternity and Neonatal Assurance Group. Governance reporting forum.

MSDS: Maternity Services Data Sets. A patient level data set that captures information about activity carried out by Maternity Services relating to mother and baby(s), from the point of the first booking appointment until discharge from maternity services

MVP: Maternity Voices Partnership. A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

NLS: Neonatal Life Support Training

NHSR: NHR Resolution

Partogram: A tool used to monitor labour and prevent prolonged and obstructed labour focusing on observations related to maternal, fetal condition and labour progress.

PMRT: Perinatal Mortality Review Tool. Aims to support a standardised process of perinatal mortality reviews, learning reporting and actions to improve care across NHS maternity and neonatal units.

PROMPT: Practical Obstetric Multi-Professional Training. Covers the management of a range of obstetric emergency situations

SBLCBv2: Saving Babies Lives Care Bundle Version 2. A care bundle for reducing perinatal mortality

Uterine artery Doppler screening: An ultrasound scan that uses waveform analysis in the second trimester of pregnancy as a predictive marker for the later development of preeclampsia and fetal growth restriction.

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REPORT TO:	BOARD OF DIRECTORS (BoD)				
REPORT TITLE:	BI-ANNUAL MIDWIFERY WORKFORCE OVERSIGHT REPORT COVERING STAFFING/SAFETY ISSUES				
MEETING DATE:	4 MAY 2023				
BOARD SPONSOR:	INTERIM CHIEF NURSING AND MIDWIFERY OFFICER				
PAPER AUTHOR:	HEADS OF MIDWIFERY AND GYNAECOLOGY QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL (QEQM) AND WILLIAM HARVEY HOSPITAL (WHH) INTERIM DIRECTOR OF MIDWIFERY				
APPENDICES:	NONE				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The purpose of this report is to meet the Clinical Negligence Scheme for Trusts (CNST) requirement for a systematic review of the midwifery establishment being submitted to the Board bi-annually. The Trust's Safe Staffing position is reported to the Board monthly as part of the Perinatal Quality Surveillance Tool, with a more in-depth report presented bi-annually. This meets both the CNST standards and National Quality Board guidance and Developing Workforce Safeguards guidance from NHS England. As this paper focusses on midwifery staffing the report is presented in compliance with NHS Resolution (NHSR) Maternity Incentive Scheme; CNST Safety Action 5 in relation to Maternity Incentive Scheme Standards for Safe Staffing in Maternity Settings. This report covers the five-month reporting period of October 2022 to March 2023. **Compliance is reported against CNST Safety Action 5 Standards a-e;** a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.				
Summary of Key Issues:	• The report evidences compliance against the CNST Safety Action 5 Standard including information regarding the supernumerary status of midwifery coordinators and the provision of 1:1 care in labour, both of which are outcome measures linked to safer maternity staffing.				

	- The last full BirthRate+ review was completed 2020/21. The Local Maternity and Neonatal System (LMNS) have funded a further BirthRate+ review which is currently underway lead by the Heads of Midwifery. - A recruitment pipeline and the new maternity dashboard data is included in this paper.
Key Recommendation(s):	The Board of Directors is asked to: 1. **DISCUSS** the contents of this report; 2. **NOTE** the key risks**:** regarding staffing levels at WHH; and 3. Receive **ASSURANCE** and **NOTE** that a bi-annual workforce update has been received, demonstrating full compliance in line with CNST standards.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.			
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 122**: There is a risk that midwifery staffing levels are inadequate.			
Resource:	Y	Additional resource will be required to implement the Final Ockenden Report Immediate and Essential Actions.		
Legal and regulatory:	Y	NHSR, CNST, Ockenden 1, Ockenden 2 Final and National Quality Board (NQB).		
Subsidiary:	N			
Assurance Route:				
Previously Considered by:	NA			

BI-ANNUAL MIDWIFERY WORKFORCE OVERSIGHT REPORT COVERING STAFFING/SAFETY ISSUES

1.   Purpose of the report

1.1   This briefing provides the Trust Board with an overview of the midwifery workforce between October 2022 and March 2023 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016.

1.2   This paper is presented in compliance with NHS Resolution Maternity Incentive Scheme; CNST Safety Action 5 in relation to Maternity Incentive Scheme Standards for Safe Staffing in Maternity Settings.

1.3   The requirement is that a systematic review of the midwifery establishment is submitted to the Board biannually.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
a.	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b.	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
c.	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
d.	All women in active labour receive one-to-one midwifery care.
e.	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period (from 8 August 2021 until 30 June 2022).

2.   **Standard a) A systematic, evidence-based process to calculate midwifery staffing establishment**

2.1   A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.

2.1.1.   Findings from the BirthRate+ (BR+) review carried out November 2020 and a further full midwifery line by line staffing review conducted in August 2021 have previously been shared with the Maternity and Neonatal Assurance Group (MNAG) and Board of Directors. The workforce review was supported by the Regional workforce lead and the approach was validated by the LMNS and has since been replicated across the other Trusts within the Kent and Medway Network.

2.1.2.   The LMNS has funded a refreshed BirthRate+ review of all maternity staffing across Kent and Medway, which will take place over the course of 2023. The Heads of Midwifery (HoM) are working with the BR+ team to establish the baseline datasets and to plan acuity data capture. The HoM's have spent time with the BR+ team to share the improvement journey East Kent have been on since the previous review, this is vital to ensure the staffing projections, service improvements are included therefore, "future proofing" the staffing projections.

2.2 **Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.**

2.2.1 Plans continue to recruit to all midwifery vacancies – there are rolling adverts online.

2.2.2 22 newly qualified midwives joined us last year and 23 are projected to start in post this September.

2.2.3 International recruitment of midwives has been successful with 5 internationally educated midwives staring in March 2023 and a further 5 joining the WHH team by June 2023.

2.2.4 Use of on-call midwives to cover staffing shortfalls is monitored daily by the Heads of Midwifery and captured monthly on the maternity dashboard. A proposal for the development of a flexible team to address sudden shortfalls in staffing and/or increased acuity has been submitted for Executive consideration.

2.2.5 Progress on recruitment against the workforce enhancement Business case is monitored monthly and reported through Maternity and Trust Governance structures.

2.2.6 The use of support roles has been further advanced to release midwifery time from non-clinical duties.

2.3 **Planned versus actual midwifery staffing levels**

2.3.1 The Unify Report on Health Roster provides access to information on planned versus actual midwifery levels which are reviewed as part of ongoing monthly monitoring, led by the Heads of Midwifery. Reports can be separated per unit but going forward reporting will move to using Electronic Staff Record (ESR) data which will provide more accurate reporting and can be split into area as well as site.

2.3.2 Staff Planned versus actual staffing levels are also monitored through the dashboard capture of sickness, vacancy and turnover levels.

2.4 **Midwifery Vacancy and Recruitment**

2.4.1 Following the full workforce review detailed in the previous staffing paper presented to the Trust Board in October 2022 a staffing pipeline has been developed.

2.4.2 The WHH has significant staffing gaps as shown within the pipeline table below. In contrast both the QEQM and community midwifery teams are fully established.

2.4.3 The Director of Midwifery has written to and offered all 32 third year midwifery students at Canterbury Christ Church University (CCCU) a job on qualification. To date 25 have replied with 23 confirmed acceptances.

2.4.4 The recruitment pipeline has recently been impacted by the pause in the pre-registration programme. 2022 saw no new students for the midwifery programme, which will impact on midwifery pipeline of newly qualified midwives in 2025.

2.4.5 The senior midwifery team have been working in partnership with the university, Health Education England (HEE) as well as other midwifery leads from across Kent and Medway to support the delivery of actions required to move forward with the next intake of pre-registration students for midwifery.

East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital Recruitment Pipeline:

	Current vacancy April	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Band 7 Midwives	-2.67	0.96	1																					
Band 6 midwives	-16.6		1		1	0		1				1			1			1			1			
Band 5 Nurses/Midwives	-3.7			1.2																				
Total new starters with PINS		0.96	2	0	1.2	0	0	1	0	0	1	0	0	1	1	0	0	1	0	0	1	0	0	0
Internationally Educated Nurses (Planned arrivals)	8 per year		5	3	2									2	2	2								
OSCE Exam Passed	19 yearly						5	3	2										3	3	2			
NQMs from CCU	19 yearly								11												10			
Return to Practice	0 yearly																							
Total PIN ready per month		0.96	2	0	1.2	1	5	3	14	0	0	1	0	0	1	0	0	4	3	2	11	0	0	0
Estimated trained leavers	19 monthly Average	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1	1.5	1
Rolling Total	-22.97	-22.93	-22.43	-23.43	-23.73	-23.73	-20.23	-18.23	-5.73	-6.73	-8.23	-8.23	-9.73	-10.73	-11.23	-12.23	-13.73	-10.73	-9.23	-8.23	9.5	8.5	7	6

Key

-22.97	Current Band 5 RN, Band 6 MW and Band 7 MW Vacancy as of 01/03/ 2023 - taken into account in this pipeline.
	Expected Trust Intake
	The planned/actual number of IENS to arrive in country - at this point they go into a band 5 vacancy
	Increase caviated on the following:
	Number of IENs we predict will receive their PIN - 4 months from arrival based on NMC current turnaround.
	University Intake on training programme
	Total of Band 5 Registered nursing commencing working in the Trust that month
	Rolling total of additional RN/RMs recruited - starting in minus figure as starting from current vacancy

Queen Elizabeth the Queen Mother Hospital Pipeline:

	Current vacan	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Band 7 Midwives	1		1																					
Band 6 midwives	0.6			0.6																				
Band 5 Midwives	0																							
Total new starters with PINS																								
Internationally Educated Nurses (Planned arrivals)	0																							
OSCE Exam Passed	0																							
NQMs from CCU	5								12												5			
Return to Practice	0 yearly																							
Total PiN ready per month		0	1	0.6	0	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0
Estimated trained leavers																								
Rolling Total	1.6	1.6	2.6	3.2	3.2	3.2	3.2	3.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	20.2	20.2	20.2	20.2

QEQM 2023/2024

Key

1.6	Current Band 5 RN, Band 6 MW and Band 7 MW Vacancy as of 01/03/ 2023 - taken into account in this pipeline.
	Expected Trust Intake
	The planned/actual number of IENS to arrive in country - at this point they go into a band 5 vacancy
	Increase caviated on the following:
	Number of IENs we predict will receive their PIN - 4 months from arrival based on NMC current turnaround.
12	University intake on training programme
	Total of Band 5 Registered nursing commencing working in the Trust that month
	Rolling total of additional RN/RMs recruited - starting in minus figure as starting from current vacancy

2.5   The midwife to birth ratio

2.5.1   The birth to midwife ratio is tracked and reported through the maternity dashboard, along with several other workforce performance metrics. The Trust applies a standard of 1:24 recognising that although there is no national standard agreed, it is generally considered that reporting 1:24 is acceptable.

2.5.2   The only way to get a reliable calculation on the number of staff actually on the 'shop floor' is to use ESR data rather than the currently used financial data. The senior midwifery team continue to work with the HR business partner to ensure the ESR data is accurate for all areas to aid this calculation.

2.5.3   The following table shows the Workforce Performance Metrics displayed on the Maternity Dashboard.

Domain	KPI	Thres.	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Workforce	1 to 1 in Labour	100.0%	100%	99.7%	99.8%	99.8%	99.7%	100%	99.8%	99.7%	99.4%	99.4%	99.1%	99.1%
	Worked WTE: Birth Ratio	24.00	19.65	22.51	23.03	21.71	21.51	23.31	23.88	20.72	20.34	21.36	19.26	19.27
	Midwifery/MSW Turnover Rate	11.5%	4.9%	4.8%	4.7%	5.4%	5.4%	5.9%	6.9%	7.0%	7.5%	8.9%	9.5%	10.2%
	Midwifery/MSW Vacancy Rate	10.0%	11.9%	9.3%	10.0%	10.4%	13.3%	8.7%	9.7%	9.9%	11.1%	12.3%	12.4%	10.3%
	Midwifery/MSW Appraisal Rate	85.0%	79.9%	74.5%	75.2%	74.2%	71.7%	74.2%	73.4%	74.2%	71.2%	68.0%	65.2%	63.2%
	Sickness Rate	5.0%	9.1%	7.3%	6.6%	9.1%	7.6%	8.4%	7.2%	8.1%	9.5%	7.7%	7.1%	7.8%
	Total On-Call Hours	Sigma	433.8	558.8	822.7	807.5	535.1	404.8	794.4	485.2	573.6	466.0	762.0	489.7
	Occurance On-Call In	Sigma	91	101	129	133	80	65	119	96	99	106	130	101
	Birthrate+ Meets Acuity	Sigma	52.2%	60.3%	44.6%	40.9%	54.6%	55.7%	44.9%	58.9%	55.2%	49.9%	47.9%	53.4%
	Supernumerary Status	100.0%	98.5%	99.0%	96.2%	96.2%	98.2%	97.8%	98.6%	98.9%	98.9%	99.0%	98.5%	99.0%

3.

> **Standard b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.**

3.1   Supernumerary Labour Ward Co-ordinator Status

3.1.1   Supernumerary Labour Ward Status is pulled from the intrapartum acuity tool data and recorded on the maternity dashboard. The stratified data shows overall compliance at 99%, however, this is below the national and CNST defined standard of 100%.   The Trust have now reviewed and updated their maternity dashboard inline with national dashboard data, which enables the senior midwifery team to monitor performance more closely.

3.1.2   The run chart below shows the Supernumerary Labour Ward Coordinator Status. The high levels of short-term sickness and maternity leave, especially at the WHH have impacted on the ability to reach 100%, however, there is ongoing improvement as shown by the chart below.

Supernumerary Status

Metric Definition		Num	Denom	Threshold	Value	Previous V...	Variance:
Supernumerary status acheived Based on documentation from Birthrate+ Of all time periods captured, how many of those did not record 'Coordinator not able to maintain supernumerary/supervisory status'	Variation indicates consistently falling short of the target Common cause (no significant change) XMR Run Chart	3	301	100%	99.0%	98.5%	0.5%

Not Met stratified by Ward - Mar 23

Stratified By	Num	Den	Value	Thresh.	Pareto Value	Pareto
WLAB	3	141	97.9%	100%	3	100.0%
QLAB	0	160	100%	100%	0	100.0%

Metric M_01244_Supernumerary

Last Updated 4/19/2023 10:02:00...

3.2 Workforce Red Flags incidents

3.2.1 Red flag events may indicate that there may not be enough midwives available. National Institute for Health and Care Excellence (NICE) Recommend that during the day or night shift, the midwife in charge should look out for 'red flag events'.

3.2.2 Data is collected around Red Flag events on the Birthrate Plus Intrapartum Acuity Tool which supports easier data entry and reporting on acuity and red flags including Supernumerary status for the Midwife coordinating Labour Ward.

3.2.3 Staff aim to input data into the acuity tool every 4-hour period. This was achieved on average at QEQM 82.4% and at WHH 62.4% of the time. Depleted workforce availability has been the key contributor to this data not being recorded.

3.2.4 The most commonly reported red flag is the delay to inductions of labour, which is impacted by staffing levels and/or activity levels.

4.

Standard c) All women in active labour receive one-to-one midwifery care

4.1 1:1 care in labour is recorded on the maternity dashboard and review of each case of non-compliance takes place by the Maternity Matrons to draw out any learning themes. The 6-month compliance average is 98.7%. The national and CNST defined standard is 100% 1:1 care for all women in established labour. The Midwifery Workforce Action Plan shows mitigations to improve.

4.2 The run chart below shows compliance over the last five-month period One-to-One Care in Labour. There is a need to ensure the care of the women identified as not receiving 1:1 is reviewed promptly, as initial analysis has identified that the care episodes are not always recorded completely thus impacting this result. Ongoing reporting will be taken monthly through the Maternity and Neonatal Assurance Group

4.3 Each month cases identified as not receiving 1:1 care are reviewed and validated by the matron or Head of Midwifery for the respective unit. In the majority of these cases 1:1 care has been provided, but records have not been completed to accurately reflect this. The revised position is incorporated as part of the Perinatal Quality Surveillance tool, following validation and reported each month to the Board

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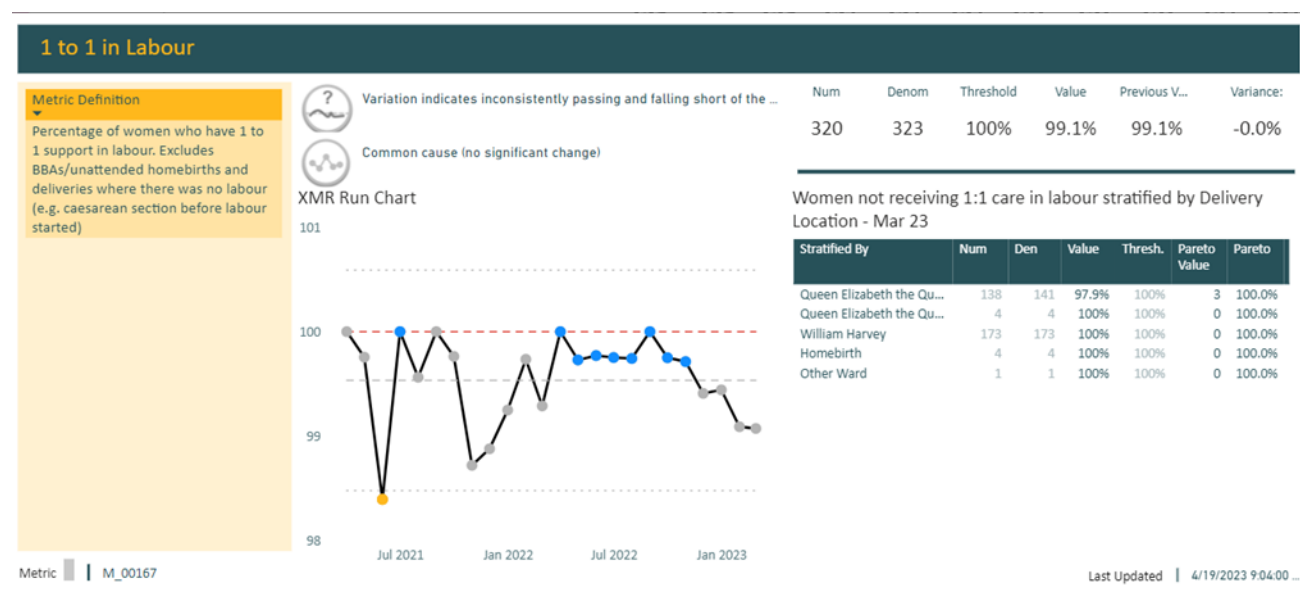
5.

> Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period

5.1 Bi annual midwifery staffing oversight reports, covering staffing and staffing safety issues, as defined by the CNST Safety Action 5 standards, have been presented to Trust Board.

5.2 The last Midwifery Workforce report was received by this board in October 2022 and covered April 2022 to September 2022.

5.3 This report covers the five-month reporting period of September 2022 to March 2023.

6. Additional key areas of Work

6.1 Staff communication and engagement sessions

6.1.1 A regular communication update is provided to all staff within maternity services through the Director of Midwifery's weekly wrap up. Additionally, bi-monthly Multi-Disciplinary Team (MDT) staff forums have been established to share information on the maternity improvement programme, staffing and recruitment.

6.1.2 A bi-monthly staffing task and finish group has been established. This meeting is open to all maternity staff and is also attended by the Royal College of Midwives (RCM) regional representative. The purpose of this group is to listen to all staff and their ideas to improve staffing morale, recruitment and retention.

6.1.3 To support communication flow and provide opportunities for Q&A sessions and escalation of concerns, several additional staff forums have been set up. These are in addition to the formal Site and Trust wide and Governance meetings. These include; Women's Health Care Group Feedback session, Virtual Student Forums, Band 6 and Band 7 Forums, Community Midwife forums and Senior Midwife Forums.

6.1.4 The Perinatal Quality Surveillance Tool Report is shared with leads to cascade to their teams and provides a high-level summary of safety themes including Serious Incidents, HSIB and Perinatal Mortality Review Tool (PMRT) cases, Feedback from staff and service users, training compliance, workforce updates and issues and progress against Saving Babies Lives Care Bundle, Ockenden and CNST actions.

7.   Next Steps

7.1   Progress mitigation/escalation plans to cover shortfalls identified in workforce action plan including recruiting to business case posts.

7.2   Scope additional workforce and Specialist roles, with the new Director and Deputy Director of Midwifery to further mitigate against exposed safety and quality gaps.

7.3   Work has started to implement the Maternity Support Worker (MSW) Competency, Education and Career Development Framework to ensure that MSWs can achieve standardised levels of competency required to carry out this vital role. The role of the MSW will then become more defined and consistent across England, ensuring that women receive good quality care provision in line with Health Education England (HEE) requirements.

7.4   A model to introduce a team of obstetric nurses is being taken forward to release midwifery time.

7.5   Next Workforce paper will be presented to the Board in September 2023.

7.6   The ongoing actions to address the challenges across the midwifery workforce will be coordinated and monitored as part of the Maternity Transformation Programme.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**INTEGRATED PERFORMANCE REVIEW (IPR)**
MEETING DATE:	**4 MAY 2023**
BOARD SPONSOR:	**CHIEF FINANCE OFFICER**
PAPER AUTHOR:	**CHIEF FINANCE OFFICER**
APPENDICES:	**APPENDIX 1: MARCH 2023 IPR**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The Trust has been engaged with a quality improvement programme called "We Care". The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep). This report is updated for the key metrics that the Trust will focus on in 2022/23.				
Summary of Key Issues:	The attached IPR is now ordered into the following: **True Norths-** These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years the targets are not met immediately and it is important to look at longer term trajectories. The areas are: • our **quality and safety.** The two metrics the Trust has chosen to measure against incidents with harm and mortality rate. • our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) 12-hour in department standard, the Referral to Treatment (RTT) 18-week standard and the Inpatient Survey score. • our **people.** The one metric chosen is for staff engagement. • our **sustainability.** The two metrics chosen to improve are the Trust's financial position and carbon footprint. • our **future.** The two metrics chosen are the percentage of patients no longer fit to reside in hospital and Recruitment to Clinical Trials. **Breakthrough objectives-** These are objectives that we are driving over the next year and are looking for rapid improvement. The four key areas are: • **Improving theatre capacity.** By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In March the potential opportunity increased to 46 lists, from 43 in the previous month. • In March there was a deterioration from February with booked occupancy reducing by 0.5% to 88.9% and actual occupancy reducing by 1.2% to 79%. This was further impacted due to the industrial action which took place over				

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three days from the 13th March. Elective Orthopaedic Centre (EOC) had a booked utilisation of 90.4% and saw an increase in actual utilisation by 0.4% to 85.1% which is the highest since November 2022.

- The number of cases per list in the most recent week has been maintained at 2.3 from an average of 1.9 across the last 20 weeks.
- Late starts saw a reduction in March reducing from 11% to 8% of which general surgery has improved by 1% from February. General Surgery continue to reduce delays due to Intensive Therapy Unit (ITU) bed through putting a small case first on the list this has provided a solution for ITU capacity enabling additional time to source capacity.
- The theatre optimisation group continues to meet monthly led by the Surgery & Anaesthetic leadership team. This group continues to focus on the development of Standard Operating Procedures regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. The group are to review turnaround times, Theatre starts times and speciality theatre utilisation with an aim to improve and maintain actual utilisation to 85% by April 2023.
- We continued to successfully appoint theatre staffing across the sites and increase skill mix.

Same Day Emergency Care (SDEC) Admissions. The chart shows the SDEC total activity across all services remains static. Queen Elizabeth the Queen Mother Hospital (QEQM) have seen a month on month decrease in the volumes going through the Gynaecology and Children's Assessment Unit with Surgical Units maintaining an upward trend of numbers seen through the service, following the downward trend 3 months ago.

- As part of the workstreams within the Emergency Care Delivery Programme, clinical pathways have been developed in collaboration with the surgical, acute medical and orthopaedic leads to increase the cohort of patients accessing the SDEC services.
- The plan to start delivering pathways for the specialty conditions commences April following training for staff to stream specific presentations directly to the Surgical Emergency Assessment Unit (SEAU) and Medical SDEC These pathways reduce the demand within the Emergency Department (ED), supporting the right place, first time approach but require a period of training for staff which is planned to roll out across the sites end April.
- Medical SDEC (William Harvey Hospital (WHH)) has introduced Virtual clinics (March) to reduce the number of on site patient follow-ups, through consultant telephone consultations. This will in turn release capacity to maximise the opportunity for patients with same day conditions.
- Meeting are set up in April to increase the awareness of the service with primary care, enhancing the direct access pathways for GPs to the service.

2

	• The use of 'Hot Slots' for referral into SDEC the next day has proven successful reducing some patients waiting overnight to access the service. The offer of 'Hot Slots' has gradually increased over time, particularly at the WHH, with an approximately 20-25 slots offered per week preventing these patients from staying overnight in ED awaiting treatment. • Work has commenced with specialty medical services to provide 'hot clinics 'within SDEC to enable patients to be seen by a specialist through a rapid booking process. The plan is to roll this out with gastro/respiratory. • Frailty services for SDEC are being developed within the General and Specialist Medicine (GSM) group, with planning to re-introduce a front door frailty unit at the WHH. **Staff Involvement.** Staff Involvement has declined following two consecutive quarters of improvement, from 6.43 in September '22 to 6.18 in January '23. Overall, there has been a 25-point decline quarter-on-quarter (from 6.43 to 6.18). Staff involvement had improved by 8 points against last years' National Staff Survey (NSS), from 6.35 to (2021) to 6.43 (2022) and so this will continue to be closely monitored. These scores remain below the national average, and there is a risk the gap widens without significant work to repair the extent to which staff would recommend the organisation, to work or be treated. • The approach to the NSS is for each Specialty to 'change 3 things' – involving staff across every area in the identification of key objectives and action. • A NSS toolkit has been completed and an 'Involvement Toolkit' is being finalised to provide support at team leader, speciality and Care Group level. • 58 managers or team leaders have now been trained as part of the Team Engagement and Development (TED) pilot. • The We Care rollout has been extended into Waves 5 & 6, with a further 16 areas becoming accredited. **Premium Pay costs.** The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits. This is caused by the Trust ensuring all costs in that financial year are captured and include unpaid claims due in year. This information is the baseline for which we will measure improvement over 2022/23. In March premium pay increased by £369k in relation to escalation areas. Key Interventions include: • Detailed focus by Care Groups on drivers of premium pay. • Review of bank, agency and overtime rates across all staff groups. • Ensure improved sign off processes and governance across the Trust.

3

	• Recruitment to key clinical posts to reduce the need for temporary staffing. • Ensuring exit plans in place for high cost medical agency locums. **Watch Metrics -** these are metrics we are keeping an eye on to ensure they don't deteriorate.
Key Recommendation(s):	To **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

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

4

Integrated Performance Report

March 2023

Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our focus centres on five "True North" themes. These are the Trust-wide key strategic objectives which it aims to significantly improve over the next 5 years:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

True North metrics, once achieved, indicate a high performing organisation.

What is the Integrated Performance Report (IPR)?

To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing Patient Safety Incidents resulting in harm
- Reducing time spent in our ED Departments
- Improving theatre capacity
- Improving our Staff Involvement Score
- Reducing Premium Pay Spend

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.

Integrated Performance Report

IPR

Performance Review Meetings

PRM

Board   Ward
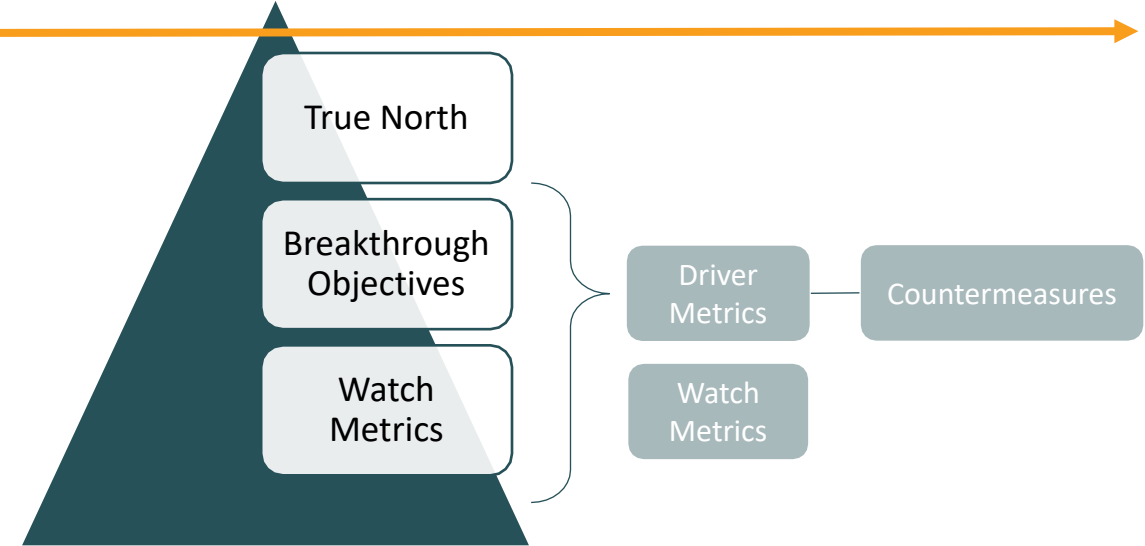
The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2022/23. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

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.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules 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.

NHS Improvement SPC icons

Where to find them

What are the Business Rules?

Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Mortality (HSMR)

Rebecca Martin

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
85.8	86.6	87.5	88.8	88.5	87.4	89.0	89.6	91.2			

P

Variation indicates consistently passing the target

L

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

Flag Description

Below Mean Run Group

XMR Run Chart
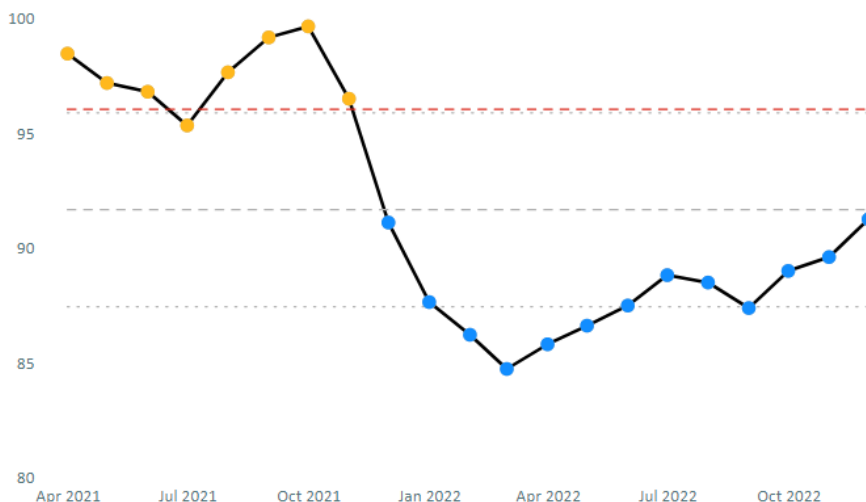
What the chart tells us

The Trust HSMR is above the lower control limit, overall showing 'special cause variation of improving nature'. The metric demonstrates a 12 month rolling position to December 2022 which is the last data release. At time of reporting this remains 'lower then expected' for the Trust as a whole and the K&CH site (69.5) and QEQM (88.8) with WHH (100.2) 'as expected'. This represents an increase in the relative risk of dying with the admission diagnosis, alongside an increase in the number of expected deaths, to last months position. Our Palliative care rate 2.96% is above the national average and peer rates.

The Trust now lies 29th out of the 121 acute non-specialist Trusts on the Telstra Health platform.

Intervention and Planned Impact

- The fracture Neck of Femur pathway is our focus for 2022/23 to improve outcomes for this group of patients and time to theatre had been a driver metric for Surgery and Anaesthetic Care group. Current 12 month rolling HSMR for fractured neck of femur patients is 100.1 (to December 2022) and remains 'as expected'.
- Mortality metrics continue to be reported and discussed at monthly Mortality Surveillance Group (MSSG) and intelligence used to drive deep dives into pathways where indicated. There were no new alerts in April 2023 Mortality report.
- Inclusion as quality metric driver to be reviewed for 2023/24 with monitoring and response to mortality metrics to continue through MSSG

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk with the national baseline not stabilised. The impact on health due to the consequences of the pandemic are still not fully understood and it is likely will impact on national and local mortality metrics.

Our quality and safety

Incidents with Harm

The True North target is to achieve zero patient safety incidents of moderate and above avoidable harm within 5 years. We want to reduce harm caused to patients, to improve their experience and outcomes. **Our target for the next 12 months is to reduce avoidable harm incidents of moderate harm and above to no more than 26 incidents per month by March 2023 (5% reduction).**

The breakthrough objective will be to reduce all patient safety harm incidents with a harm severity score of moderate and above, this will be achieved through the Fundamentals of Care and Patient Voice and Involvement workstreams.
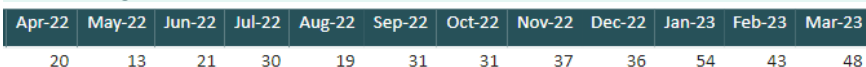
Sarah Shingler

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
20	13	21	30	19	31	31	37	36	54	43	48

Variation indicates inconsistently passing and falling short of the target

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

Flag Description

Above Mean Run Group
Two Out Of Three Beyond
Two Sigma Group

XMR Run Chart
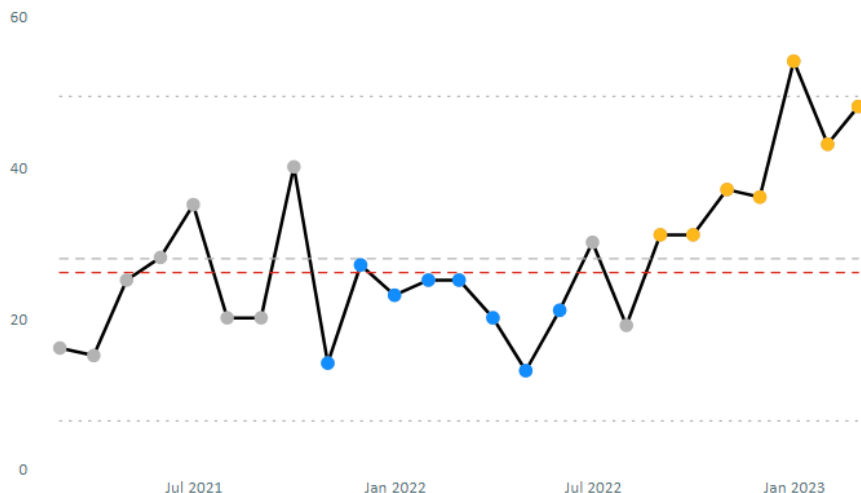
What the chart tells us

The chart details all patient safety incidents with a harm severity score of moderate and above. There were 48 incidents in March, which continues to be above threshold. The highest contributors to harm this month were care/treatment with 12, which is an increase from the previous month, operations/procedures was the second highest with 9 incidents, a decrease from the previous month. Of these 9 moderate incidents 8 were associated with unplanned return to theatre and 1 was a recognised complication. This was followed by delay/failure with 8 incidents which was a decrease from the previous month. In fourth place was medications with 7 incidents, 5 of these incidents were related to neonatology regarding intravenous infusion of lipid which do not contain vitamins, reported as a serious incident.

Intervention and Planned Impact

A monthly Trust wide meeting with site medical and nursing directors has commenced to ensure that there is a system based approach to addressing themes identified in the site based deteriorating patient focus groups to prevent silo working and share learning. A pilot of a deteriorating patient educational programme is planned to take place in June/July 2023, focussing on newly qualified Band5's and IENS. It will utilise a blended learning approach, incorporating real life examples of serious incidents so reinforcing the learning from incidents. It will be evaluated with aspiration being to develop a 1-2 day programme that can be incorporated into the preceptorship programme. The development of a deteriorating patient dashboard remains challenging due to the complexity of data retrieval required. The updated sepsis form template is being quality checked by the Sunrise team. Once approved the next phase will be to develop a deteriorating patient dashboard, which after talks with another Trust that uses Sunrise is achievable and will prove pivotal in monitoring improvement s in the management of the deteriorating patient.

There was no increase in falls for March despite the current inpatient capacity constraints which means that patients are remaining in our emergency departments (EDs) for longer than is necessary. Escalation areas which are not included within the ED staffing establishment continue to be utilised due to high numbers of patients being cared for in corridors and other non-clinical areas. In both EDs there is direct correlation between audit compliance staffing and overcrowding.

Risks/Mitigations

Temporary staffing strategies are in place to support all areas where staffing is significantly compromised and where high risk patients are cared for. The risk register for the deteriorating patient is being updated. An essential NEWS2 e-learning module is now live , with a quarterly monitoring report to ensure the uptake of training by our staff. An assurance paper on the deteriorating patent pathway including an improvement plan will be presented at the next Quality & safety committee meeting.

Alerting watch metrics

Supporting metrics that have either;
- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Harm Events	W4		IPC: CDiff Infections		6	12	7	9	13
			Medication Errors; Severity C+		1	4	6	1	7
			Pressure Ulcers: Unstageable		Sigma	12	10	13	9
			IPC: Audits Composite		85.0%	85.5%	86.1%	84.4%	84.6%
	W4		VTE Assessment Compliance		95.0%	93.0%	92.8%	91.8%	90.9%
	W4		Overdue Incidents		Traj.	6,637	6,635	5,716	4,755

IPC: C diff Infections
This position reflects that, in common with most acute trusts we have exceeded out external threshold for Cdiff cases in 2022/2023. All existing processes, as previously described, remain and the 2023/2024 plan will describe additional approaches to antimicrobial stewardship and the processes for investigation of, and learning from cases.

IPC: Audits Composite
The IPC audit processes and the mechanism by which these results are measured are currently being reviewed and discussed at the Infection Prevention and Control Committee.

Medication Errors; Severity C+
The Medication Safety Advisory Group has been recently restructured to focus on understanding themes from medication safety incidents. The work around allergies is being refreshed and the Care groups are risk assessing allergy safety within their areas.

VTE Assessment Compliance
There are ongoing issues with the reporting of VTE Assessments. This has been raised with the system provider and is being investigated.

Overdue Incidents
The Trust has experienced a backlog in closing incidents in a timely manner. The responsibility for closing these incidents sits within the Care Groups however with extreme clinical pressures these have built up to a significant backlog. The numbers have been steadily reducing, this is owing to one member of staff within the patient safety team, working one extra day per week focusing on the backlog. We are currently managing to close approx.. 500 incidents per month. There a plan in place to start working with the Care Groups to increase that number so that we can clear the backlog within the next three months.

Our patients

Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our patients

Dylan Jones

Trust Access Standards: 18wk Referral to Treatment

The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the population health work with the Health Care Partnership early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
58.4%	60.2%	59.7%	59.5%	59.7%	58.4%	58.3%	59.0%	58.1%	56.7%	56.9%	57.7%

(F) Variation indicates consistently falling short of the target

(L) Special cause of concerning nature or higher pressure due to lower values

Flag Description

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

XMR Run Chart
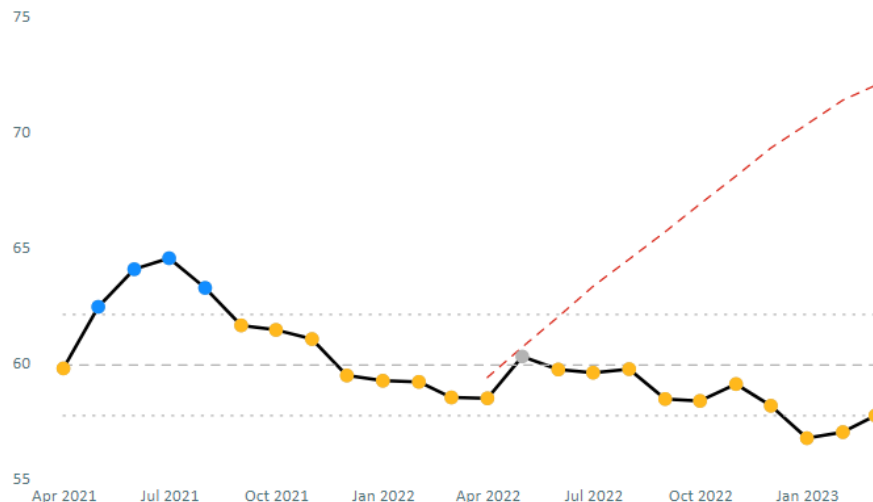
What the chart tells us

March performance continues to be impacted by the critical mass of patients waiting longer than 18 weeks for their first out patient appointment. A small improvement in performance is noted in month; with an increased volume of patients treated over 52 weeks and 50% reduction in 78 weeks breaches. The Trust declared 71 capacity breaches due to unexpected absence in the ENT service with a small volume of patients choosing to wait longer for surgery or clinically complex, which are acceptable.

Intervention and Planned Impact

- Patients waiting longer than 104 weeks for treatment have been eliminated except where they choose to wait longer for first definitive treatment.
- With limited local, regional and national options to secure ENT complex otology capacity the service is seeking to treat the patients waiting longer than 78 weeks within the Trust over the coming months.
- Validation of our patient pathways continued in month and this has enabled patients to proceed with treatment where they are fit, ready and able to proceed.
- Maximising theatre capacity to treat our longest waiting patients continues to be a key feature in the Trust improvement and recovery journey.
- Focus on improving access to first outpatient appointments and reducing the waiting time is a priority for all specialities where waiting times are longer than we would prefer for our patients.

Risks/Mitigations

- Despite all complex otology capacity/staffing options being explored the service, pending an established ENT Consultant joining the service in the summer are planning to treat patients in clinical and chronological order to reduce the number of patients waiting longer than 78 weeks for surgery.
- Theatre staffing recruitment and sickness levels remain an issue in our elective recovery journey. Oversight of staffing levels and scheduled activity continue to be monitored closely and solutions to address areas of risk continue to be mitigated where possible through the weekly theatre scheduling meetings.
- Outpatient waiting times continue to be elongated and will continue to impact RTT 18 week performance until out patient waiting times are significantly reduced. Specialities are identifying options to improve out patient services through transformation and identify options to increase capacity to improve the pathways for patients in the new financial year.

22/23 breakthrough objective

Theatre Session Opportunity

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.

It is imperative that elective surgery deferred during the global pandemic is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
36	31	29	33	43	45	42	37	42	40	43	46

?
Variation indicates inconsistently passing and falling short of the target

⌇
Common cause (no significant change)

Flag Description
No Special Cause Flags

XMR Run Chart
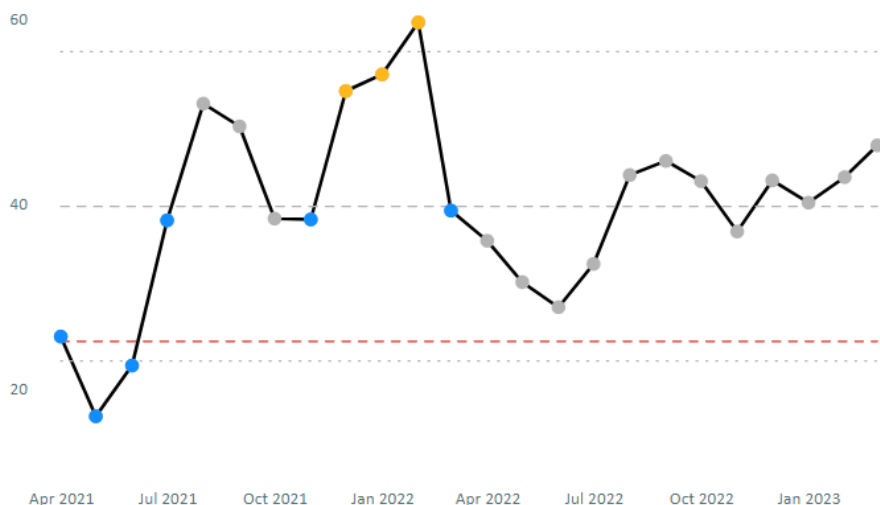
What the chart tells us

By counting every minute of theatre time not utilised we describe an opportunity for more effective utilisation. In March the potential opportunity increased to 46 lists, from 43 in the previous month.

Intervention and Planned Impact

- In March there was a deterioration from February with booked occupancy reducing by 0.5% to 88.9% and actual occupancy reducing by 1.2% to 79%. This was further impacted due to the industrial action which took place over three days from the 13th March. EOC had a booked utilisation of 90.4% and saw an increase in actual utilisation by 0.4% to 85.1% which is the highest since November 2022.

- The number of cases per list in the most recent week has been maintained at 2.3 from an average of 1.9 across the last 20 weeks

- Late starts saw a reduction in March reducing from 11% to 8% of which general surgery has improved by 1% from February. General Surgery continue to reduce delays due to ITU bed through putting a small case first on the list this has provided a solution for ITU capacity enabling additional time to source capacity.

- The theatre optimisation group continues to meet monthly led by the Surgery & Anaesthetic leadership team. This group continues to focus on the development of Standard Operating Procedures regarding theatre utilisation and the analysis of the data regarding early finishes/late starts and cancellations with actions to improve performance. The group are to review turnaround times, Theatre starts times and speciality theatre utilisation with an aim to improve and maintain actual utilisation to 85% by April 2023

- We continued to successfully appoint theatre staffing across the sites and increase skill mix

Risks/Mitigations

- Theatre staffing recruitment is ongoing with a trajectory to fully recruit by July 24 subject to business case approval.

- Daily reviews of staffing across all sites are maintained to mitigate reduction of lists.

- Theatre Business case (pending CEMG approval) would provide increased substantive staffing levels across all sites & staff the current unfunded theatre sessions.

Our patients

ED 12h Total Time in Department

There is a nationally proposed new set of Emergency Department Access Standards which will focus on 12 hour Total Time in Department. This measures from arrival to either discharge, transfer or admission.

ED performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Dylan Jones

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
10.4%	8.7%	9.5%	11.2%	12.1%	11.4%	10.5%	9.9%	12.2%	11.8%	11.5%	12.4%

F

Variation indicates consistently falling short of the target

H

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

Flag Description

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

XMR Run Chart
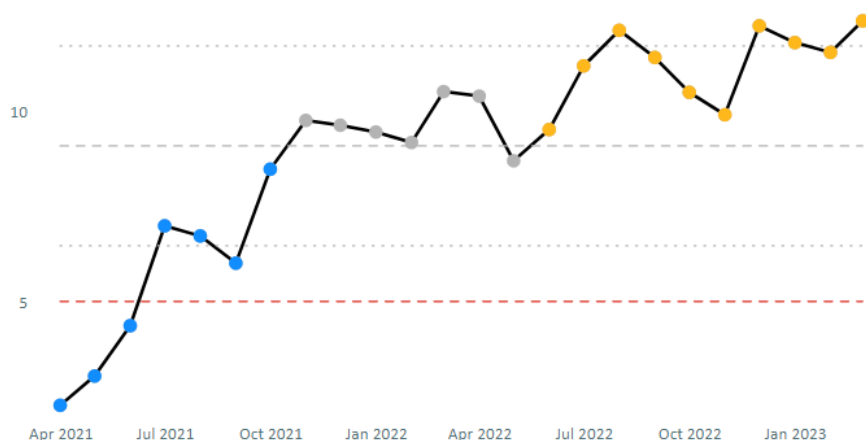
What the chart tells us

The chart details the challenging position of patients remaining in the ED departments over 12 hours with March reporting the highest % of total times in the last 12 months (12.4%) A review of the analysis in further detail shows the increase in the patients waiting over 12 hours, 'not admitted'. This is being driven by the changes in the specialty in-reach model and Acute Physicians x 2 daily review of patients with a decision to admit being discharged from the front door. The average numbers of patients waiting in ED for an inpatient bed at 08:00hrs across the EDs was 110.8 and shows a month on month increase since October 22. the Trust declared Business Continuity on 1 -3 rd. March at the WHH, due to the high numbers of patients in ED waiting for beds at 08.00 hours (90 plus) with ITU under significant pressure to create capacity. This was stood down to OPEL 4 on 03/03/23

Intervention and Planned Impact

The focussed work through the Emergency Care Delivery Group (ECDG) workstreams to implement clinical models for the UEC pathways to reduce the demand on the front door, supporting patients going to the right place first time for their care

As part of the ED build, Phase 3 commenced end March , this will result in the loss of 7 major cubicles and the loss of the escalation area –Corridor A – which was caring for up to 7 patients will also be taken down as part of the build . This has required a detailed clinical and operational plan for the ED to continue to manage the demand within a smaller footprint . The clinical plans sees the introduction of a pilot Medical Assessment Unit together with a dedicated short stay acute medical unit and the Dr Initial Assessment model at the front door . This enables medical patients to be seen in the right place , first time for assessment , plans and onward care . It also ensures the utilisation of alternative pathways to SDEC, UTC . It aims to work with GPs and SECAMB to accept medical expected patients directly to the unit to reduce waits in ED

QEQM, Phase 3 build commences in June 23, with the teams planning the clinal and operational plans to deliver safe services during this phase of the work .

The speciality in reach to the front door supports early decision making and plans for patients requiring speciality intervention with plans to include HCOOP specialty from April

Risks/Mitigations.

- The adaptation of a Medical Assessment Unit and Short stay ward is in place from the end March and is part of the wider UEC improvement programme overseen through the ECDG
- Surgical and Orthopaedic clinical leads working in collaboration with the UEC have agreed direct access pathways mitigating the need to go through the ED's; to be launched end of April
- Medical SDEC Direct Access Pathways in place with training for staff continuing through April to advance the number of patients streamed directly to the unit

22/23 breakthrough objective

NHS
East Kent
Hospitals University
NHS Foundation Trust

Same Day Emergency Care (SDEC)

Ensuring patients are seen and treated in the right setting, at the right time and in the right way are key aspects of efficient and effective patient care. A number of patients currently accessing our Emergency Departments can be safely assessed, treated and discharged via a Same Day Emergency Care pathway, such as Emergency Ambulatory Care, Gynaecology, Surgery or Frailty). Access to an SDEC service may be following a direct referral by a GP or via the Emergency Department.

It is anticipated that an average of 2,600 patients each month can be safely seen and treated via a Same Day Emergency Care pathway, this is the ambition for 2022/23.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
2,101	2,258	2,137	2,196	1,970	2,041	1,989	2,182	2,264	2,263	2,218	2,266

Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart
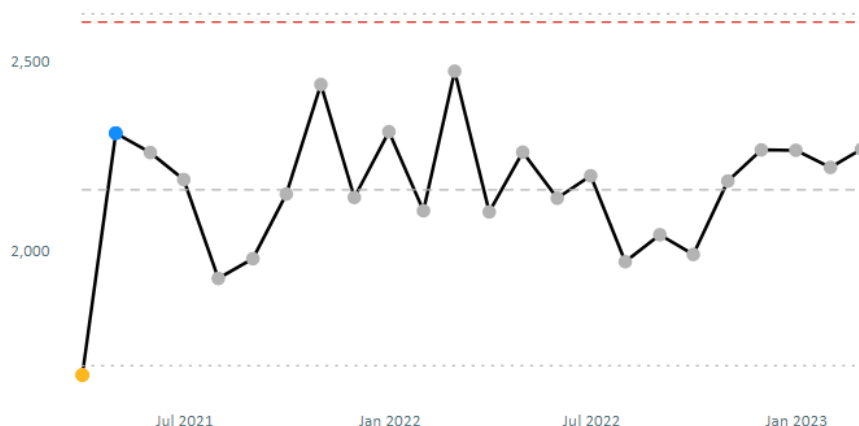
What the chart tells us

The chart shows the SDEC total activity across all services remains static. QEQM have seen a month on month decrease in the volumes going through the Gynaecology and Children's Assessment Unit with Surgical Units maintaining an upward trend of numbers seen through the service, following the downward trend 3 months ago There was a decrease in the number of patients accessing the frailty front door service reported in February and March , partly as previously documented, due to the change in the front door model at the WHH (dedicated unit to a roving model as a result of the build programme).

Intervention and Planned Impact

- As part of the workstreams within the Emergency Care Delivery Programme, clinical pathways have been developed in collaboration with the surgical, acute medical and orthopaedic leads to increase the cohort of patients accessing the SDEC services.
- The plan to start delivering pathways for the specialty conditions commences April following training for staff to stream specific presentations directly to the SEAU (Surgical Emergency Assessment Unit) and Medical SDEC These pathways reduce the demand within the ED, supporting the right place , first time approach but require a period of training for staff which is planned to roll out across the sites end April .
- Medical SDEC(WHH) has introduced Virtual clinics (March) to reduce the number of on site patient follow-ups , through consultant telephone consultations . This will in turn release capacity to maximise the opportunity for patients with same day conditions .
- Meeting are set up in April to increase the awareness of the service with primary care, enhancing the direct access pathways for GPs to the service
- The use of 'Hot Slots' for referral into SDEC the next day has proven successful reducing some patients waiting overnight to access the service. The offer of 'Hot Slots' has gradually increased over time, particularly at the WHH, with an approx. 20-25 slots offered per week preventing these patients from staying over night in ED awaiting treatment.
- Work has commenced with specialty medical services to provide 'hot clinics ' within SDEC to enable patients to be seen by a specialist through a rapid booking process . The plan is to roll this out with gastro/respiratory
- Frailty services for SDEC are being developed within the GSM group, with planning to re-introduce a front door frailty unit at the WHH.

Risks/Mitigations

- A planned review of the SDEC opportunity using the AEC (Ambulatory Emergency Conditions) will be completed with the clinical leads to continue to evolve the services provided for patients (April onwards)
- Exploring the pathways to Gynaecology Assessment Units and Children's Assessment Unit across both sites is planned for review to work towards a direct access for patients requiring the specialty
- Work with the UTC network to enhance the service provision provided to reduce the number of patients directed back to ED/SDEC (April onwards)

Our patients

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patients are seen, diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Dylan Jones

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
66.1%	61.7%	73.2%	78.0%	71.7%	65.8%	65.3%	71.5%	73.3%	63.0%	65.0%	74.1%

Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart
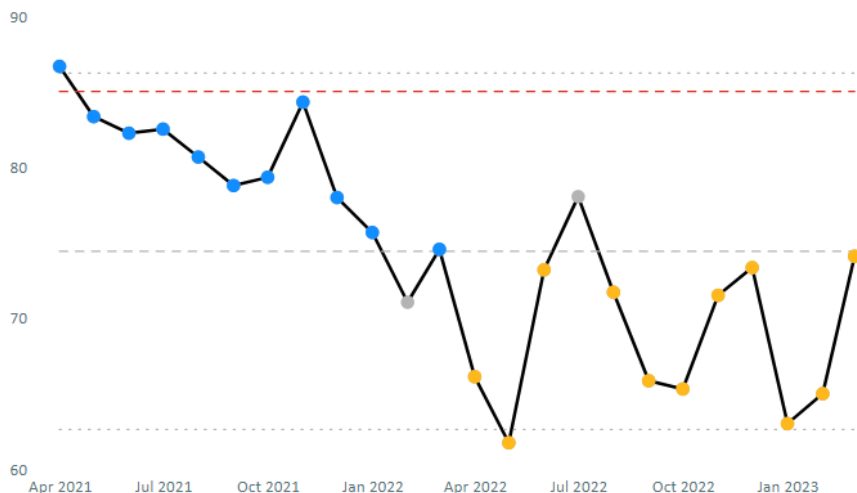
What the chart tells us

Performance has improved significantly for March. The Trust remains in the top 3 performers nationally for 2-week wait access and is still making the biggest contribution to a Cancer Alliance that has the 3rd smallest backlogs for 62 day breaches. The straight to test service is an exciting and sustainable approach to improvement.

Intervention and Planned Impact

- Enhanced escalation process put in place for Consultant reviews, Tertiary referrals, surgical dates and diagnostics. New three times weekly multi-professional PTL's piloted for Lower Gi and Urology to further support.
- CCHH and Clinical Support Services working closely to optimise the radiology diagnostic capacity in the CDC to support faster and early diagnosis. Need to move closer to referral to report within 10days compliance is to be achieved and sustained.
- Achieving the 28-day FDS standard will support the continued reduction of patients waiting over 62 days.
- PGD now in place, minimising delays and repeat colonoscopies.
- Proactive management of long waiting patients continues to fully understand how we can best manage these groups through to treatment. .
- All roles within CCHH Compliance team being reviewed to support improved learning. Standardising practice for all teams, to help improve morale, support co-design and share best practice.
- Community Qfit being utilised for 66% of patients referred, new SOP and pathway to improve consistency being finalised for sign off at Network TSSG Meeting.
- The STT pathways coming on line is the most exciting thing with direction of travel.
- From the CQUINS calculation for LGI for the patients who have gone through the STT pathway so far 75% have hit their timed pathway target.

Risks/Mitigations

- Delays to diagnostics vetting, booking and reporting remains a significant risk but pathway mapping and changes being investigated to agree sustainable solutions.
- Histopathological reporting remains a significant contributor to the teams ability to achieving sustainable compliance, again work in progress with CSS to support improved turnaround times, understanding the significant reality of a national shortage of Histopathologists.
- Theatre capacity for Specialities within Urology, Head & Neck, Breast and Lower continues to be a risk.
- Tertiary capacity for OPA's, diagnostics and treatments remains challenging, working with the Alliance to support improvements.
- MDM radiology cover consistency continues to be a significant risk, need to confirm plans for future cover.

Our patients

Patient Experience: Inpatient Survey

The National In Patient Survey published in October 21 (surveyed patients discharged in November 2020), completed responses for the trust were received from 515 patients (1,250 invited) with a response rate of 43%. The survey consists of 45 questions and the trust scored below the national trust average on all questions, and in 23 out of the 45 responses the trust scored in the bottom five trusts in the region, and in the bottom five Nationally.

The Trust has chosen ten questions from the National In-Patient survey, and our average for our focused 10 questions is 7.13 compared to 7.65 as a national average.

41 adult in-patient wards will complete 50 surveys per month (2,050) using the tendable app using the 10 questions.

Our ambition is to improve performance against the focussed ten questions to achieve the national average score of 7.65 as a minimum by March 2023.

Sarah Shingler

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
			8.9	8.8	8.9	8.9	9.0	9.0	9.4	9.2	9.3

P Variation indicates consistently passing the target

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

Flag Description

Two Out Of Three Beyond Two Sigma Group

XMR Run Chart

What the chart tells us
In March, 2274 Patient Experience Surveys were completed via Tendable across 52 wards. The target of 2050 surveys has again been exceeded.
The Trust continued to maintain the overall score of 9.3 (93%), the Trust threshold is 7.7 (77%).
The exception continues to be patients reporting that they had difficulty sleeping at night due to noise. The 'No' response for this specific question is a positive, therefore the February score is that 34% of patients responded that they were disturbed by noise at night.

Intervention and Planned Impact
Night time reviews continue to confirm that the noise disturbance is not just from other patients but from staff voices, lights, equipment, bin lids and dripping taps.

A standard operating procedure has been disseminated to all wards. Measures to counteract the noise disturbances at night continue to be raised with the frontline teams, including the provision of earplugs and eye masks for patients and sharing of guidelines for night duty staff across all wards and our escalation areas. The Procurement Team are leading on ways to safely reduce the noise from equipment. There has been a delay in providing patients with the newly developed information booklet, which includes information on night time processes and the night time packs available for patients. This has been forwarded to the Communications team. A printing date is to be confirmed.

The HoNs and DoNs continue to support the wards to complete their surveys and develop actions to address poor responses, reporting monthly to the Nursing, Midwifery and AHP Board. The data is also presented and reviewed at the monthly Fundamentals of Care Committee (FoC).

The Patient Involvement Team continues to review the feedback provided via targeted Friends and Family responses, via Care Opinion and via community engagement events. This has led to specific workstreams related to implementation of the Accessible Information Standard and provision of translation and interpreting services. Fieldwork continues for the 2022 national survey, through external advertising on the Trust social media channels and the Trust website.

Risks/Mitigations
If culture and behaviours do not change and the patients voice continues not to be heard, there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;
- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Cancer 62d	W4		Cancer 28d Performance		75.0%	67.8%	52.9%	66.3%	65.2%
	W4		Radiology Diags vs Plan		Traj.	17.1K	18.6K	17.1K	19.0K
	W4		Endoscopy vs Plan		Traj.	1,088	1,247	1,280	1,464
RTT - 18 Weeks	W4		RTT 78w Breaches		Traj.	357	314	197	86
	W4		RTT 52w Breaches		Traj.	3,299	3,317	3,187	2,997
	W4		DM01 Compliance		75.0%	60.6%	57.6%	62.0%	60.3%
	W4		RTT OP Booking Breaches		14,000	28.7K	27.6K	28.4K	
	W4		Elective Admissions vs Plan		Traj.	8,036	8,565	8,559	9,551
ED Compliance	W4		ED Compliance		90.0%	64.7%	68.4%	67.3%	67.1%
	W4		Unplanned Re-attendance ED		10.0%	12.6%	13.2%	13.8%	13.5%
	W4		Super Stranded >21D		107	287	310	307	296
	W4		NEL Admissions vs Plan		Traj.	6,708	6,672	6,251	6,731

Cancer
The 28d faster diagnosis metric has recovered from the dip in performance in January back to 65.2%. This pattern is reflective of the reduced activity in December and January for cancer diagnostics due to winter pressures.

RTT 18 Weeks
Continued improvement across 78 and 52 week breaches since December. 78 week breaches have been reported due to capacity impacted due to sickness absence with no local, regional or national solution to recovery the position before the end of March. Out patient booked breaches remain significantly increased above the threshold, opportunities to improve this position through the annual business planning cycle are being scoped and modelled.

Improvement work across Radiology, Endoscopy and Cardiology continues, with focus on reducing the request to reporting times for patients on our urgent and cancer pathways, ensuring diagnostic requests can be scheduled at point of referral without delay and benchmarking our services against best practice pathways and booking processes.

ED Compliance
Compliance with the 4h standard deteriorated in March (67.1% v 67.3% in February)with Type 1 performance for both sites reported at 38.9% . QEQM and WHH saw a deterioration on type 1 performance with both sites reporting an overall increase in type 1 activity (6,826 in March 23 v 6,010 Feb 23)

Overall the 4 hour compliance for admitted patients deteriorated in March (15.9% v 17.05 in February) with the same deterioration in non –admitted 4 hour compliance in March (47.9% v 46,2 % in February)
The mean time for ED waits for admitted patients was 30.1 with 4 consecutive months at reporting a mean of > 30 hours. There is a correlation with the numbers of complex pathway patients reported ; 3 consecutive months of > 400 pts (Jan 430, Feb 450, March 426) compared to Dec 22 of 364

Alerting watch metrics

Supporting metrics that have either;
- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
FFT	W4		FFT Maternity Response Rate		18.0%	15.5%	15.6%	13.4%	11.7%
	W4		Complaint Response		90.0%	43.5%	59.6%	45.9%	71.9%

Duty of Candour

Good progress has been made in March with the Verbal Compliance at 98% and 100% for both the follow up letter to the conversations and the sharing of the findings. The Care Groups are engaged and eager to achieve full compliance. There is further work needed in terms of training within the Care Groups on specific types of cases. The DDQG continues to meet with the Care Group twice weekly to ensure that compliance is sustained. We are proposing a change to the way in which DoC elements are measured as the scorecard is misleading.

Complaints

March 2023 continues to see a high number of contacts to the PALS and complaints teams - 674. Of these 88 were taken forward as a formal complaint - 13% of contacts were formal complaints. 97% of new complaints were acknowledged within three working days, the team have met target for all of quarter 4. The complaint response within timescales is a slowly improving position with 72% within timescales.

The complaints and PALS teams are now fully resourced and the new team members are being trained and supported in their new roles. There is an interim Complaint Manager working with the Complaints team until 28.04.23 focussing on reviewing the majority of the compliant response drafts from the Care Groups. This has enabled the team leader to embed the four inexperienced team members.

Our people

Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our people

Staff Engagement (score)

Staff Engagement levels have remained below the national average throughout the last five years. The Staff Engagement Index itself has been on a downward trend for three years and, as an organisation, we are one of the most challenged in the country, sitting in the bottom 20% nationally. Given the negative implications of reduced staff engagement, it is imperative that levels are significantly and consistently improved.

The National NHS Staff Survey (NSS) is used to give an indication of staff engagement, providing an overall Staff Engagement Index to the Trust. In order to monitor this more regularly, we are also measuring this at quarterly intervals through the National Quarterly Pulse Survey (NQPS). Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Andrea Ashman

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
6.26	6.26	6.26	6.33	6.33	6.33	6.35	6.35	6.35	6.17	6.17	6.17

Variation indicates consistently falling short of the target

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

Flag Description

Astronomical Point
Two Out Of Three Beyond
Two Sigma Group

XMR Run Chart
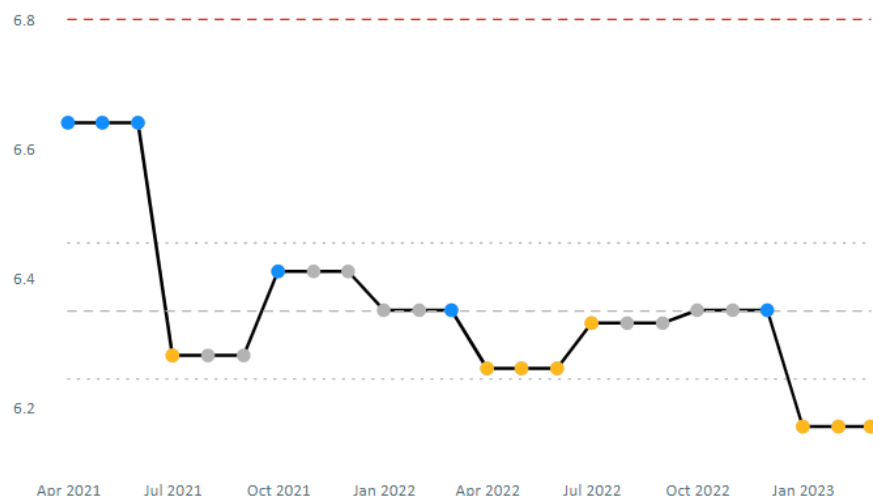
What the chart tells us

Staff Engagement levels had improved for each of the successive three quarters, albeit subtly and to 6.35. However in Q4 there has been a notable reduction in staff engagement. This was measured by the National Quarterly Pulse Survey (NQPS), taken in January 2023 and follows the national trend which is currently seeing levels of motivation and advocacy, in particular, decline.

Whilst typically a small reduction is typically seen in January as the National Staff Survey results are still under embargo and cannot be socialised with the organisation, it is important to monitor this very closely. Improvement is required in Q1 and the NQPS is currently taking place throughout April.

Interventions and Planned Impact

The National Staff Survey results have now been socialised across the organisation and action agreed at three levels; organisational, hotspots (targeted interventions) and locally (Specialty).

All staff now have access to earlier and improved workforce insights and intelligence through the enhanced dashboard. Work is currently taking place at a Specialty level to identify key challenges and to 'change three things'. This ethos has been encouraged, with a template to record activity – translating data into action. Business Partners are working closely with Specialties to support the identification of these priorities and to identify respective action. These will be captured and monitored through a project management system and reported monthly to PCC to provide assurance around action.

Risks/Mitigations

Staff Engagement levels are declining nationally, most notably with reductions in motivation levels and advocacy – two key components of staff engagement. There is a risk that national strike action perpetuates this reduction in overall motivation levels and advocacy. Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores. The Kirkup Report appears to have had an impact on staff advocacy and affected the way colleagues respond overall to engagement questions in the National Staff Survey.

22/23 breakthrough objective

NHS
East Kent
Hospitals University
NHS Foundation Trust

Staff Involvement Score

EKHUFT's staff involvement score is lower than the national average for acute trusts (6.7). Staff involvement is one of the 3 components that contributes to staff engagement – the We Care People True North. Of the three components, staff involvement is more heavily weighted, it can be tangibly impacted and also influences the other two components - staff motivation and advocacy. Our aim is to improve staff involvement, as a core aspect of improving the overall staff engagement score.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
6.13	6.13	6.13	6.28	6.28	6.28	6.43	6.43	6.43	6.18	6.18	6.18

Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart
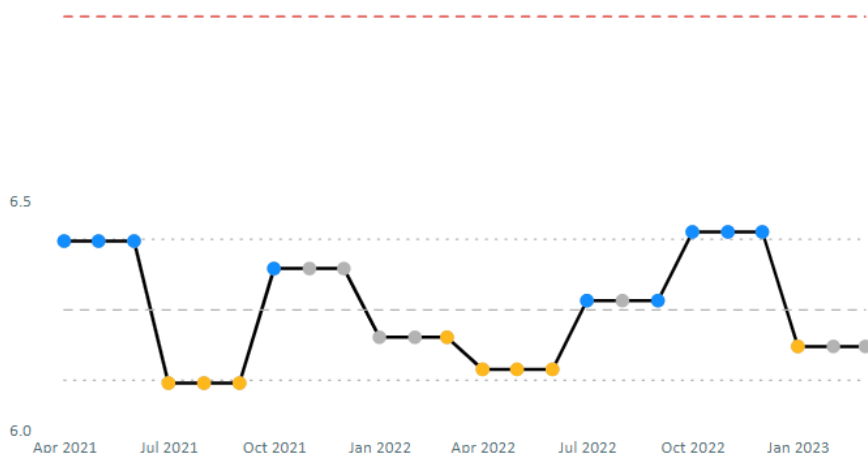
What the chart tells us

Staff Involvement has declined following two consecutive quarters of improvement, from 6.43 in September '22 to 6.18 in January '23.

Overall, there has been a 25 point decline quarter-on-quarter (from 6.43 to 6.18). Staff involvement had improved by 8 points against last years' NSS, from 6.35 to (2021) to 6.43 (2022) and so this will continue to be closely monitored.

These scores remain below the national average, and there is a risk the gap widens without significant work to repair the extent to which staff would recommend the organisation, to work or be treated.

Intervention and Planned Impact
- The approach to the National Staff Survey is for each Specialty to 'change 3 things' – involving staff across every area in the identification of key objectives and action
- A National Staff Survey toolkit has been completed and an 'Involvement Toolkit' is being finalised to provide support at team leader, speciality and Care Group level
- 58 managers or team leaders have now been trained as part of the Team Engagement and Development (TED) pilot
- The We Care rollout has been extended into Waves 5 & 6, with a further 16 areas becoming accredited

Risks/Mitigations
- Nationally, levels of staff involvement in the NHS have been on a downward trend for the last 3-4 years and there has been a pronounced fall in recent quarters
- The Kirkup Report appears to have had a significant impact on staff morale and affected the way colleagues respond overall to engagement questions in the National Staff Survey
- Rising pressures surrounding the cost of living can raise stress and anxiety levels and lead to reduced overall engagement scores

Alerting watch metrics

Supporting metrics that have either;
- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Staff Engagement	W4		Appraisals Compliance		80.0%	68.9%	69.9%	70.5%	70.5%
	W4		Safeguarding Adults Training		90.0%	83.9%	84.1%	83.1%	82.9%
	W4		Safeguarding Children Training		90.0%	84.6%	85.5%	84.8%	
	W4		Premature Turnover Rate		25.0%	25.1%	25.8%	26.1%	26.1%
	W4		Medical Job Planning Rate		90.0%	29.1%	50.1%	31.2%	38.3%

Appraisal Compliance
Overall appraisal compliance had been on an upward trend from June 22 to February 23. Compliance remained 70.5% in March, and is above 70% for the first time since May 2022. The metric remains below the reviewed alerting threshold of 80%. Compliance by Care Group ranges from 84% for Surgery HNBD, to 66% for Women's Health. Corporate areas are the lowest of the groups at 55%.

Safeguarding Training (Adult & Children)
Safeguarding Children Training rates remain stable at 85% but below the 90% threshold. Safeguarding Adults Training remains around 83% and is also below the required threshold. A new TNA is currently going through the approval process of the SMET Steering Group, recognising training availability challenges and enabling greater levels of occupancy at Level 3.

Premature Turnover Rate
Premature turnover stands at **26.07%.** This is above the target threshold (25%) and has been for the last five months. Some of this is a consequence of improved overall turnover, with actual premature turnover remaining stable and comparing favourably to 2022. The 'New Starter Experience Survey' is beginning to give intelligence across the first of five time-points. Over 190 staff have already responded, and early insights indicate that East Kent is performing significantly better than the Kent and Medway regional average against all of the respective new starter experience measures. For example, the net engagement score for EKHUFT colleagues with <1years' service is 20% higher than the K&M average (57%).

Medical Job Planning
Medical job planning rates have improved by 7% and stand at 38%. Job planning policy has been subject to negotiation but is now signed off and is receiving renewed focus from Clinical Directors with support from the DCMO. This is being reviewed at each PRM.

Our sustainability

Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our sustainability

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the years up to 2019/20, in the last two financial years a breakeven position or better was delivered. This metric will measure us against our long term aim to maintain a breakeven position.

For 2021/22 the impact of Covid-19 paused the NHS business planning process nationally and had limited the ability of the Trust to hit its cost efficiency targets. In 2022/23 there is a return to a more traditional planning process and an efficiency target of £30m, in additional to Covid spending reductions of £9m and elective recovery fund (ERF) income of £18m. The current plan is for breakeven which improves from the figures quoted last month because of £6m additional inflation funding and £16m non-recurrent ICS funding.

Michelle Stevens

Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
0.076	-3.700	-6.624	-6.604	-7.7...	-11.4...	-13.0...	-15.3...	-19.3...	-24.5...	-28....	-23.5...

F

Variation indicates consistently falling short of the target

L

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

Flag Description

Below Mean Run Group Astronomical Point Two Out Of Three Beyond Tw..

XMR Run Chart
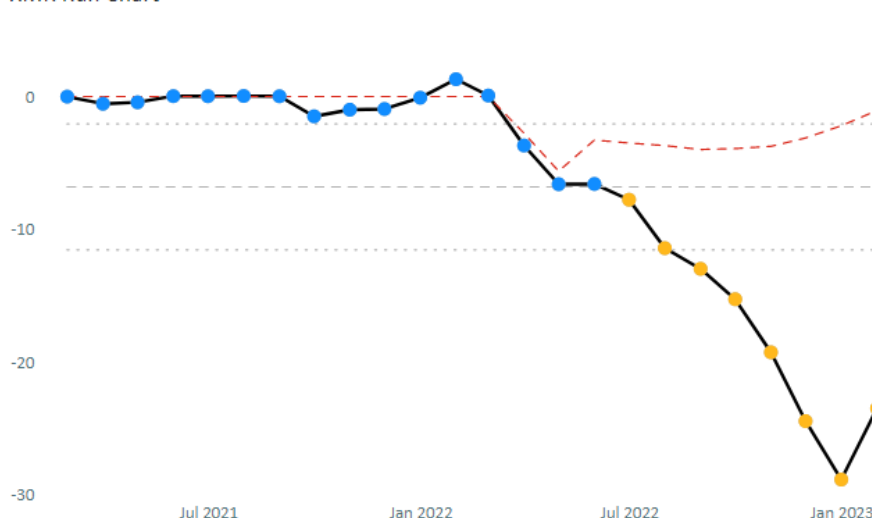
What the chart tells us

The first two years of the graph show the monthly financial performance of the organisation which has resulted in both years being breakeven. The final graph point shows position in March which is a £19.3m deficit against a breakeven plan. The key drivers behind the deficit are: £8.8m behind plan on CIPs, £10.7m on escalation areas (additional 80 beds), £7.0m on metal health staffing, £6.3m other staffing pressures due to demand, overspends on work permits £1.4m, drugs overspend £5.9m and not charging for parking £2.3m. Additional allocation of £10.7m and non recurrent benefits of £14m supported the position to offset these cost drivers.

Interventions and Planned Impact

The largest interventions for the plan were:

- Delivery of the £30m CIP programme, the largest pillar of this is the reduction of premium pay which is a breakthrough objective. Fortnightly meetings being held with clinical and corporate areas, use of national benchmarking data, plus detailed budget reviews underway.
- CEO/CFO finance deep dive held in December.
- Increased controls on pay/ non-pay introduced.
- System working to minimise overspends on escalation areas.
- Full analysis of activity, workforce and expenditure for the period of 2019/20 to 2022/23 has been completed for each care group.

Risks/Mitigations

For 2022/23 the key risk and mitigations are:

- Increased usage of escalation areas, Trust working with system partners and increased national investment to reduce usage.
- Efficiency target of £30m, PMO team working with care groups and executive directors
- Covid-19 spend reductions £9m, DIPC working with finance to release costs
- Non-pay inflation. Procurement is working closely with NHS England procurement and supply chain to minimise impact.

22/23 breakthrough objective

Premium Pay Spend

Premium pay spend consists of agency (circa £36m per annum), bank (circa £32m per annum) and overtime/ locums (circa £19m per annum) across the Trust. The total value is around £87m per annum (18% of total pay bill). These costs are amongst the most influenceable by the management of the organisation and therefore a good area for a breakthrough objective that will positively impact the finances of the Trust.

The objective is to reduce the spend by 10% or £8.7m in 2022/23 but may be refined once the full project plan is developed.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
7,890	7,497	8,894	8,702	8,809	9,618	9,178	8,577	8,413	9,034	8,689	9,058

? Variation indicates inconsistently passing and falling short of the target

H Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group

XMR Run Chart
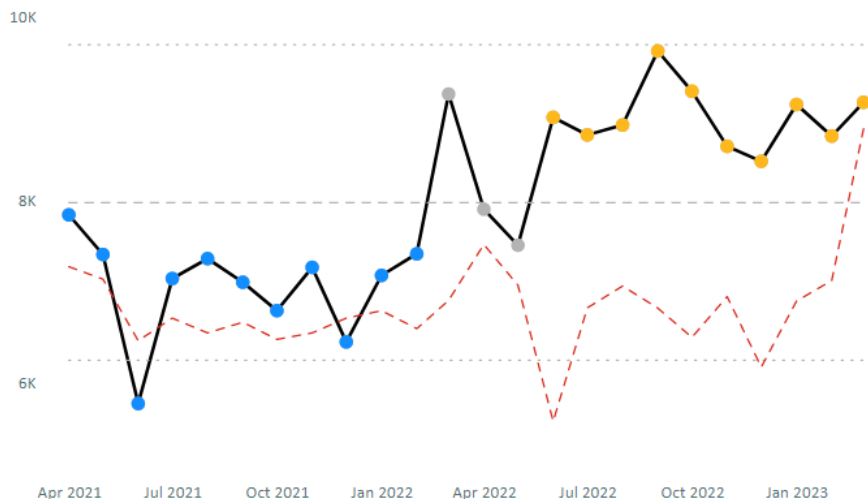
What the chart tells us

The chart tracks premium pay spend in £'000 across the last two years. There are two points in March 2021 and March 2022 where a spike is seen above the usual control limits. This is caused by the Trust ensuring all costs in that financial year are captured and include unpaid claims due in year.

This information is the baseline for which we will measure improvement over 2022/23. In March premium pay increased by £369k in relation to decreased escalation areas opened.

Intervention and Planned Impact

The breakthrough objective although having a finance executive lead will be run by senior HR colleagues and will need support of all care groups to help deliver.
Key Interventions include:
- Detailed focus by care groups on drivers of premium pay.
- Review of bank, agency and overtime rates across all staff groups.
- Ensure improved sign off processes and governance across the Trust.
- Recruitment to key clinical posts to reduce the need for temporary staffing.
- Ensuring exit plans in place for high cost medical agency locums

Risks/Mitigations
- Most Care Groups have identified premium pay as a driver and will need support to align and focus on the biggest opportunities for reduction
- A significant proportion of premium pay is caused by vacancies and will need targeted recruitment support to fill
- The remainder of spend is caused by sickness and operational demand. The former should reduce but work is required to control and reduce the latter.
- The increase in escalation beds and the increased need for specialing patients has increased the need for temporary staff

Our sustainability

Ben Stevens

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North. The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water, steam, anaesthetics and inhaler usage. It is these areas we will be focussing on improving over the coming five to ten years. We also plan to add in other measures such medicines waste, NHS fleet and leased vehicles and staff travel, as we develop these metrics in the future. Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
6.84	7.00	2.95	5.29	5.12	4.75	6.31	6.29	8.66	8.15	7.40	

? Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart
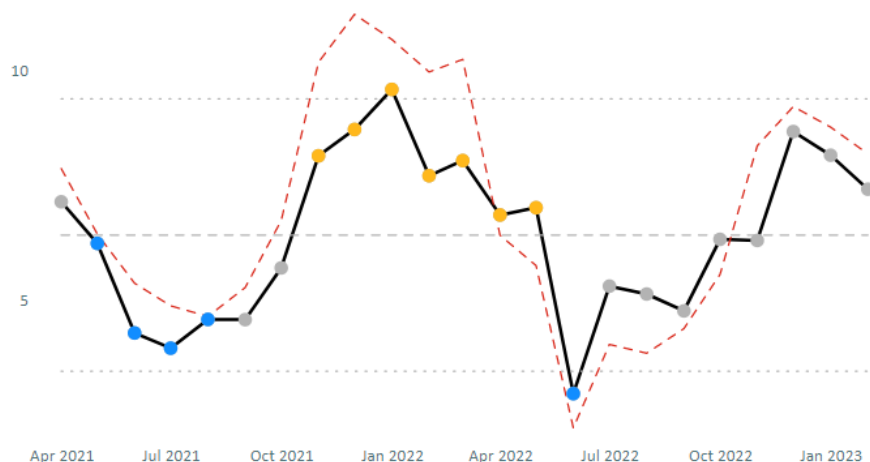
What the chart tells us

There is a clear seasonal effect to the Trust's carbon footprint as demonstrated in the chart. The position is reporting below the monthly trajectory of 9.21 at 8.66C02e per m2 but is slightly higher than the same period last year (which reported at 7.7). The Trust has increased its m2 during 2022/3 (ie, new Emergency Department expansions at both Queen Elizabeth The Queen Mother Hospital and William Harvey (WHH), and the ITU build at the WHH) and this, plus the installation of combined heating and power (CHP), will have an impact on the Trust's energy usage. CHP in particular will have an impact on the amount of gas used. The annual 10% reduction is a fixed value and the reduction is phased across the year and is based on seasonal phasing and on historic assumptions. While this allows greater tolerance in the winter months, it also increases the potential for missing the trajectory in month, because seasonal predictions can be difficult. We are, however, currently reporting that we will be within the annual 10% reduction for the end of the year. The trajectory now compares performance against historical data to a trajectory of systematic carbon reduction in line with NHSE/I's 'Delivering a Net Zero NHS'. This allows the measurement of carbon used to be proportionate to the size of the Trust's estate. An increase in our site footprint will, as a consequence, increase the use of carbon and therefore the new metric allows for appropriate contextualisation.

Interventions and Planned Impact

Breathe Energy has been working with the Trust and 2gether to identify carbon reduction schemes that could be commissioned in the new financial year. The Trust, with 2gether, produced a business case which identifies the installation of heat pumps on the three acute sites funded via the PSDS 4 Grant. The Trust submitted its bid on 15 October 2022 and, although this successfully passed through to the second stage, we have been notified that we have been unsuccessful for this particular funding round, due to the total value of applications received. Subsequent public sector grants have recently been announced and the Trust is working with 2gether to prepare for a new submission. A technical review and feedback of our original project has been requested against PSDS criteria to ensure we are in a good position to successfully secure funding.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions. Our Green Plan is in the process of being finalised and objectives relate to:

Sustainable Estate (Using energy, water, waste, travel, procurement and buildings efficiently while adapting to climate change); and Sustainable Healthcare (Delivering healthcare that reflects wider corporate, social and environmental issues, including prevention of poor health and developing more environmentally sustainable models of care). The Joint Carbon Reduction Steering Group will drive the strategic improvements required to reduce the carbon footprint, in line with our agreed trajectory.

Risks/Mitigations
- Appropriate funding to trigger significant change is not available.
- Lack of behaviour change & culture in the organisation negates the opportunity to promote carbon reduction.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Alerting watch metrics

Supporting metrics that have either;
- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Financial Position	W4		Total Pay		0.0%	-7.4%	-7.8%	-8.2%	-11.3%
	W4		Non Pay		0.0%	-2.4%	-2.6%	-3.6%	-10.5%
	W4		Efficiencies YTD Variance (£M)		0.0	-4.6	-6.4	-8.8	-10.4
	W4		Efficiencies FOT Variance (£M)		0.0	-7.7	-8.0	-9.1	-10.4
	W4		Efficiencies Green Schemes		90.0%	66.0%	65.7%	65.4%	48.3%
	W4		I&E YTD Variance (£)		0	-21M	-26M	-22M	-19M
	W4		I&E FOT Variance (£)		0	-30M	-19M	-19M	-19M

Total Pay

This metric is mainly driven by the expected reduction in premium pay not being achieved. Premium pay reductions are still a focus of care groups as a break through or driver metric. Other key drivers are the opening of escalation beds and a shortfall in CIP.

Efficiencies YTD Variance/ Efficiencies Green Schemes

The Trust has been slower than expected in developing its CIP programme due to operational pressures in Q4 of 21/22. The total CIP plan for the year was £30m for which £23m was identified, however on £19.6m was delivered.

I&E Monthly Variance Trust/ I&E YTD Variance

The key drivers behind the deficit are: £8.8m behind plan on CIPs, £10.7m on escalation areas (additional 80 beds), £7.0m on metal health staffing, £6.3m other staffing pressures due to demand, overspends on work permits £1.4m, drugs overspend £5.9m and not charging for parking £2.3m. Additional allocation of £10.7m and non recurrent benefits of £14m supported the position to offset these cost drivers.

Our future

Our future

Dylan Jones

Not fit to reside (patients/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. This allows us to easily identify the ongoing support and care patients need to leave hospital.

Patients are delayed in hospital awaiting a supported discharge which may be a care package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works in partnership with the local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
351.1	352.9	354.9	402.6	385.9	358.3	362.2	350.4	354.1	392.3	437.1	407.5

Variation indicates inconsistently passing and falling short of the target

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

Flag Description

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

XMR Run Chart
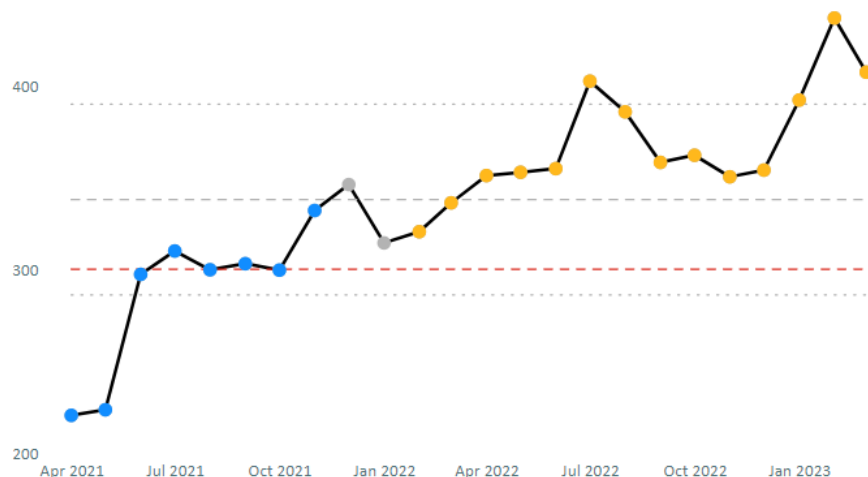
What the chart tells us

This month the Trust reports 408 patients as 'No longer fit to reside', down from a record high of 437 report in February 2023. Of the 408 'No Longer Fit to Reside' patients approx. 70% require an on-going package of care to enable these patients to safely be discharged from acute care. The March breakdown across the different discharge pathways is Pathway 0: 120, Pathway 1: 129, Pathway 1: 66, Pathway 3: 92.

With a high number of patients residing on the back wards of the Trust that no longer need to be in an acute care setting, patient flow through the hospital is impacted. In March 2023, the average number of patients in our Emergency Department with a decision to admit and awaiting transfer to a ward was 111. As the ED department becomes more congested and resources are taken up with the care of an increased number of patients, the turnaround time for non-admitted patients is elongated.

Intervention and Planned Impact

Conversations are on-going with partners and colleagues across the ICB and East Kent HCP seeking alternative placements for our patients.

Two of the additional facilities supported by 'winter funding' will cease in late March. This will result in the closure of enablement beds, however, 15 of these beds will be transferred over for Stroke provision.

Since January 2023 funding from the Adult Hospital Discharge Fund has supported additional external placement provision of highly complex, long stay patients with 92 patients discharged to date with 32 patients currently remaining in additional care home placements. The 92 patients discharged from the Trust equates to a total length of stay of 6,655 days.

The Trust identified 30 additional beds with provider, OPUS Care (20 Ashford and 10 Folkestone). Conversations progressed but funding to support the scheme was no available.

Regular Pathway 0 meetings held across the acute sites to ensure the Trust is discharging patients who do not require a package of care, in a safe and timely manner.

Regional Improvement Therapy Hub with external and internal therapy support provided by the ICB is reviewing P1 to P3 patients and their on-going care needs

Emergency Care Delivery Group focus workstreams: Patient Flow, Front door, Simple discharge, SDEC and Direct access are all aimed at driving discharges within the Trust's gift, divert patients to same day emergency care where possible and focus on admission avoidance

Risks/Mitigations

- The volume of Pathway 0 patients residing within the Trust's back wards is declining. The overall number of average discharges per day for P0 has also declined. This is an outcome of the impacted flow where more patients are being turned around or treated in ED prior to admission. The number P0 patients on the back wards has reduced as volumes of complex patients increase.
- The largest growth within the NLFTR cohort has been the number of patients requiring P3 support. In July 2021 19 patients required P3, this number is now frequently above 80, near to 90.

Our future

Recruitment to Clinical Trials

In order to deliver outstanding care for patients, we need to provide and promote access to clinical trials and innovative practice for all our local population. Research, education and innovation are not yet embedded in our organisation at the heart of everything we do. We need to encourage and enable more multi-professional staff, across all clinical specialities, to engage with research and innovation to deliver excellence. The preferred measurement of success is the number of staff participating actively in research and innovation. However, at present the total number of staff involved in research and innovation is unclear and work is being undertaken to enable this metric to be measured and used going forward. Data does, however, enable us identify the number of patients recruited to trials within the Trust and this metric will be used initially.

Ben
Stevens

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
129	162	430	82	161	190	120	124	116	127	128	99

Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart
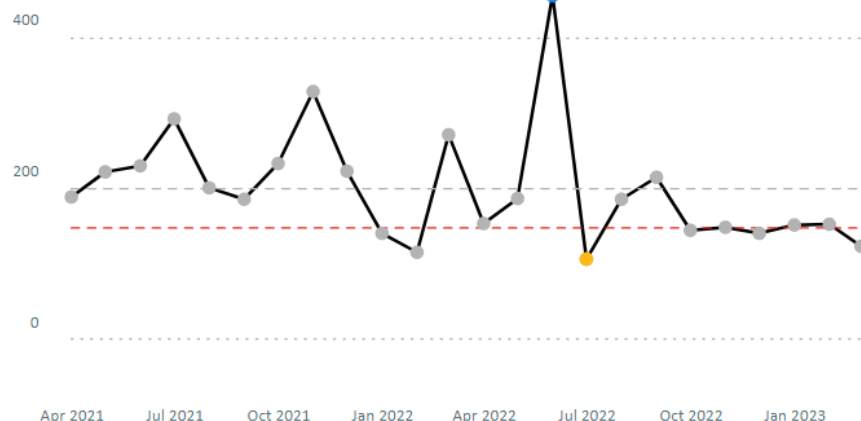
What the chart tells us

The March position of 99 participants is below the monthly threshold of 123 (negative). Validation of the final position indicates that the March position is likely to increase slightly from 99 to 110.

The March position reflects the transition to more interventional and commercial studies, which tend to be more complex to set up and run, have a slower recruitment pace and lower targets to match.

However, the 2022/23 full year position shows that the annual target has exceeded with 1,879 participants recruited - 27% above the full year plan (positive).

Intervention and Planned Impact

- A refreshed target for 2023/24 is in place to reflect the switch in focus to more interventional studies.
- 5 key areas for Clinical Fellows have been identified and supported by CEMG: Anaesthesia and Perioperative Medicine (already appointed); Cardiovascular disease; Neurological disease; Surgery; and Trauma and Emergency care.
- The Trust continues to design its first real-world data project using the Trinetx platform (a collaborative international platform which connects Trusts with sponsors and provides real world data to investigators) with access to 114 million patient records globally.

Risks/Mitigations

- The IT delays to the Trinetx integration project are now impacting on the revenue opportunities into the Trust. In 2022, the team received 30% fewer collaboration requests than other similar secondary acute care Trusts that are fully integrated. This has been escalated to the Director of IT for support.
- Urgent care pressures within the Trust have impacted on clinician time in the acute settings, making it hard for the delivery teams to coordinate study activity.
- Space at K&C has been identified as a constraint to the Trust's ability to continue to provide a number of cancer trials. The Oncology/Haem-Oncology research delivery teams are merging to mitigate the risk of having to close cancer studies to recruitment and work is underway to facilitate the space to enable the merged team to co-locate.

Appendix 1
Non-Alerting Watch Metrics

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Harm Events	W		Falls		Sigma	177	192	122	137
	W		IPC: EColi Infections		10	12	13	6	8
	W		IPC: Klebsiella Infections		6	3	1	4	7
	W		IPC: Pseudomonas Infections		3	2	5	2	1
	W		52w Severe Harm Review		0	0	0	0	0
	W		Reported Medication Errors		Sigma	207	205	224	205
	W		Nutrition Incidents		Sigma	52	34	44	60
	W		Pressure Ulcers: Cat 2		Sigma	35	40	34	40
	W		Pressure Ulcers: Cat 3 & 4		Sigma	1	3	0	1
	W		Pressure Ulcers: DTI		Sigma	5	6	7	7
	W		Safeguarding Incidents		Sigma	28	32	17	22
	W		Clinical Incidents		Sigma	2,196	2,436	1,962	2,262
	W		IP Spells with 3+ Ward Moves		Sigma	378	344	386	427
	W		Serious Incidents		Sigma	13	16	16	36
	W		Serious Incidents Breached		0	16	0	2	6
	W		Never Events		0	0	1	0	1
	W		Maternity Serious Incidents		2	0	4	4	5
Mortality	W		Extended Perinatal Mortality		5.93	4.64	4.33	4.53	4.44

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Cancer 62d	W		Cancer 31d Performance		96.0%	98.5%	96.2%	97.9%	98.4%
	W		Cancer 2ww Performance		93.0%	95.8%	96.9%	96.4%	94.7%
RTT - 18 Weeks	W		RTT 60w Waiters (w/o TCIs)		Sigma	1,580	1,443	1,239	1,104
	W		OPA vs Plan		Traj.	66.4K	78.6K	73.1K	79.7K
ED Compliance	W		Clinician First Seen within 1h		50.0%	44.4%	53.4%	50.8%	51.3%
	W		A&E Atts vs Plan		Traj.	25.4K	22.6K	21.7K	24.5K
	W		Discharges by Midday		15.0%	15.1%	14.5%	13.8%	15.2%
	W		Pathway 0 Patients >7 Days		Sigma	125	128	152	146
	W		NEL Readmissions		15.0%	10.1%	8.7%	9.8%	8.6%
	W		Stroke Ward within 4 Hours		50.0%		74.4%	69.3%	79.1%
FFT	W		FFT IP Response Rate		15.0%	18.2%	18.8%	20.2%	19.6%
	W		FFT DC Response Rate		27.0%	28.3%	30.6%	30.0%	31.4%
	W		FFT ED Response Rate		12.0%	14.0%	14.8%	14.0%	14.8%
	W		FFT OP Response Rate		17.0%	18.5%	19.6%	19.3%	19.5%
	W		Complaints Number		Sigma	62	96	80	86
	W		Mixed Sex Breaches		Sigma	101	71	113	46
	W		Duty of Candour - Verbal		100.0%	77.8%	100%	97.8%	98.0%
	W		Duty of Candour - Written 15wd		100.0%	76.9%	80.0%	97.4%	100%
	W		Duty of Candour - Findings		100.0%	100%	62.5%	100%	100%

True North Domain	BR	Flag	KPI	SPC	Thres.	Dec-22	Jan-23	Feb-23	Mar-23
Staff Engagement	W		Sickness		5.0%	5.9%	5.1%	4.9%	4.8%
	W		Statutory Training		91.0%	90.4%	90.2%	90.5%	92.2%
	W		Staff Turnover Rate		11.5%	10.2%	10.0%	9.9%	10.0%
	W		Vacancy Rate		10.0%	9.8%	9.1%	8.7%	8.4%
	W		Staff Turnover: HCA		13.5%	13.6%	13.5%	13.1%	13.0%
	W		Staff Turnover: Nursing		10.0%	9.6%	9.2%	9.0%	8.8%
Financial Position	W		I&E Monthly Variance Trust (£)		0	-5.8M	-5.4M	4.2M	3.3M

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Appendix 2
Trust Priority Improvement Projects

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Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Sarah Shingler	To have a central repository of for all clinical guidelines	Jan 2022 1st phase complete 2nd phase April 23	• CGAG meeting arranged for the end of April. • Revision of clinical guidelines governance continues with several being transferred to the new approved template. • Removal of outdated guidance from MicroGuide has commenced.	• Continue to review and revise current MicroGuide content to ensure current, fit for purpose and accessible. • Arrange meeting with acute medicine to assess their needs for transfer to MicroGuide. • Consider requirements of clinical support services (Pharmacy, Pathology, etc.) who frequently have to update guidance to ensure alignment with national guides.
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	April 23	**Process / System Workstream** • The beds on Sandwich Bay are up and running work continues for WHH • ReSPECT – led by Judith Banks. Updates to Sunrise / KMCR functionality prevent full electronic go live. Plan for phased approach with paper ReSPECT first. **Education workstream** • PEoLC education framework live on StaffZone. • Focusing on film development and launch. **Culture workstream** • Focusing on film development and launch.	**Process / System Workstream** • Further discussion required to agree medical solution for Sandwich Bay. • Recruitment to palliative care medical staff required to progress WHH beds – option being explored. • Hold care group triumvirate workshop to engage and agree improvement plan refresh with care group held improvement plans **Culture workstream** • Aim to launch Mandatory Training Film 'Caring with Compassion' during Dying Matters week, alongside other engagement activities and workshop event,
Fractured Neck of Femur	Rebecca Martin	To agree, develop and implement a Trust wide Fractured Neck of Femur pathway that will address and improve the eight Key Performance Indicators on the National Hip Fracture database	April 23	• Continued good figures, over 90% compliance at WHH to get patients to theatre in timely manner • Prompt mobilisation training starting this month with trauma cos and ward staff • QEQM ward staff and therapists are submitting requests for rehab beds directly to rehab facilities rather than through discharge to see if more timely access	• Training is progressing at the QE • Theatre sister developing Draft SOP when identifying the golden patient. • Interviews taking place for new Hip fracture practitioner. • All confused patients to be seen by the dementia team on admission to improve their care.

Appendix 2
Completed Trust Priority Improvement Projects

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Nicky Bentley	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Nicky Bentley	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Nicky Bentley	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Safeguarding	Sarah Shingler	Timely assessment of patients with mental health &/or cognitive impairment risks, to determine the level of support required carried out for 100% of patients. Provision of individualised treatment plan to optimise support and care to maintain safety.	Mar 2022 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	Moved to BAU Oct 22
Trust wide Job Planning	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	Moved to BAU Oct 22
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	Moved to BAU Oct 22
Safe & Effective Discharge	Rebecca Martin	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	Project to become more targeted within the Trust Emergency Care Delivery Group Nov 22
Maternity Ultrasound Booking	Rebecca Martin	All patients will have an Ultrasonography appointment that is linked to their pathway and consultant. To ensure the capacity and staffing is available to meet the demand of the service.	Moved to BAU Nov 22

33/36

198/301

Appendix 3: Glossary of Terms

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 3: Glossary of Terms

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is red against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

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REPORT TO:	BOARD OF DIRECTORS (BoD)				
REPORT TITLE:	INTEGRATED IMPROVEMENT PLAN (IIP) REPORT				
MEETING DATE:	4 MAY 2023				
BOARD SPONSOR:	CHIEF EXECUTIVE				
PAPER AUTHOR:	IMPROVEMENT DIRECTOR AND DEPUTY IMPROVEMENT DIRECTORS				
APPENDICES:	APPENDIX 1: SLIDE DECK PROVIDING PROGRESS UPDATE ON DELIVERY OF THE IIP SINCE LAST MONTH APPENDIX 2: UPDATED SLIDE DECK DETAILING THE IIP				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	To update the Board on progress of delivery of the Integrated Improvement Plan and provide oversight of key risks to delivery.				
Summary of Key Issues:	We are in the early stages of delivery of the Integrated Improvement Plan and whilst there has been progress over the last month, the size of challenge remains. Some programmes have made more progress than others which is demonstrated in the impact against certain trajectories. We are more confident that the programme milestones and measures of success are right; and have a clearer understanding of the resources required to deliver the plan. We continue to align the plan and delivery approach with the Pillars of Change work and 'We Care Quality Improvement Programme'.				
Key recommendation(s)	Trust Board members are invited to discuss the report and progress of delivery of the Integrated Improvement Plan to date.				
Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**		**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	BAF 32 – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered. BAF 34 – There is a risk that our constitutional standards are not met. BAF 38 – Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE).				
Link to the Corporate Risk Register (CRR):	N/A				
Resource:	Y/N	Y - discussions with National team regarding the use of available resources.			
Legal and regulatory:	Y/N	Y – regulatory impact.			
Subsidiary:	Y/N	Y – in the overall provision of services within the resources available to the Trust.			
Assurance Route:					
Previously Considered by:	From June onwards, this report will be considered by the Strategic Improvement Committee ahead of the Trust Board. The Strategic Improvement Committee is being established to oversee delivery of the Integrated Improvement Plan.				

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Recovery Support Programme (RSP) Integrated Improvement Plan (IIP) Report

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1. **Purpose of the report**

    1.1   The purpose of this report is to update the Board on progress of delivery of the Integrated Improvement Plan. It is also intended to give the Board oversight of key risks to delivery.

    1.2   From June, the report will update on key evidence that has been added to the evidence repository to support exit from the RSP.

    1.3   On a quarterly basis the report will also demonstrate in detail the impact that delivery of the plan is having against the overall programme objectives.

2. **Background**

    2.1   The Integrated Improvement Plan sets out the Trust objectives over the next 12-18 months to deliver sufficient sustained improvement to support an exit from the National RSP in March 2024.The final version of the Integrated Improvement Plan (IIP) is set out in Appendix 2.

    2.2   The report set out in Appendix 1 provides an update on delivery of the Integrated Improvement Plan to date. Progress against the 'priority areas of focus in the first six months' are set out in a high-level summary, followed by a progress update for each of the 6 key programme areas within the plan. A progress update on the Communications and Engagement Plan which supports delivery of the IIP, is also included in the report.

    2.3   The Strategic Improvement Committee is being set up to oversee delivery of the Integrated Improvement Plan and will be chaired by the Chief Executive, Tracey Fletcher. Once established the Strategic Improvement Committee will be asked to sign-off of the monthly Integrated Improvement Plan report ahead of each Trust Board meeting.

3. **What progress has been made over the last month?**

    3.1   There has been progress across all six programme areas evidenced through the milestones that have been delivered to date, although this has not yet, in many instances, demonstrated impact in terms of agreed trajectories starting to be delivered.

    3.2   Detailed updates and delivery of milestones in each programme area are provided in the attached report.

    3.3   A meeting was held with Trust Executives in April to discuss funding requirements for the programme. Programme Senior Responsible Officers (SROs) have been asked to present bids for funding related to the exit criteria and bids are to be formally considered by the National team in May.

    3.4   Ben Stevens, Interim Director of Strategic Implementation & Partnerships, has been appointed as the Programme SRO. Ben has been working with Trust Executives and the Programme SROs to align the Integrated

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Improvement Plan with the Pillars of Change work and 'We Care Quality Improvement Plan'.

3.5 A Communications and Engagement Plan has been developed and is being implemented.

4. What are the risks to delivery of the plan and how are they being considered?

4.1 Through the process of developing the Integrated Improvement Plan a number of key risks have been highlighted. Initial risks highlighted have included: Deficits in planned workforce; Estates and equipment; Strike action; Resource to deliver the programme and Capacity of Business Intelligence to support all the programmes on a timely basis.

4.2 One of the first jobs of the Strategic Improvement Committee is to review the overall risks of the programme, consider whether there are any further risks and what the appropriate mitigations should be.

5. How is progress going to be tracked and monitored effectively?

5.1 Progress will be tracked via the Strategic Improvement Committee. Programme SROs will be asked to submit a monthly highlight report to this Committee which will include key progress updates, risks and issues for escalation, and Key Performance Indicators (KPIs)/metrics and trajectories to measure improvements being made.

5.2 Wider supportive programme management arrangements are also in development.

6. How is the impact of delivery of the plan going to be demonstrated?

6.1 The Programme SRO and Improvement Director will give further consideration to KPIs and evidence that will be provided to the Board, in order to give assurance that delivery of the plan is having the expected impact.

7. Conclusion

7.1 Board members are invited to note the progress and the risks in delivery of the Integrated Improvement Plan and recommend any further actions.

28 April 2023

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East Kent Hospitals University Foundation Trust Integrated Improvement Plan

Journey to Exit NOF4
4 May 2023

Revised Final Draft

Creating the Conditions for Success

- Stabilising the new executive team

- Implementing the agreed organisational restructure

- Aligning the infrastructure to support delivery

- Establishing a robust clinical and corporate governance and accountability oversight framework

- Targeted Recovery Support Programme expertise with significant financial support

Taking a phased approach to delivery...

Stabilising (1)

Steadying the ship...

Control and stability is in place. Improvement Plan is defined and mobilised.

- Executive Team in place
- Improvement Plan defined & resourced
- Delivery is managed

Performing (2)

...Getting into the pack

Integrated Improvement Plan delivered to allow exit from NOF4 and set the foundations to embed safe, well led care.

- IP projects delivering to plan
- Minimum of average across Kent and Medway for all areas of IP

Transforming (3)

...Leading the field

Designing and delivering the long term vision for EKHUFT.

- Outstanding provider of care
- Place of choice to train and thrive
- Upper quartile performance nationally

Consistent and robust internal and external communications

What the Integrated Improvement Plan is aiming to deliver?

Programme

Journey to sustained improvement

Consistent and robust internal and external communications

Compliance with regulatory standards

1. Leadership & Governance
Stable executive with effective leadership development plan. Trust Board are sighted on the transformation programme including communication & engagement, risks and actions taken via the appropriate escalation routes.

2. Maternity
Sustained improvement in governance with maternity services meeting regulatory standards and showing evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff to support safe, effective and women centred care.

3. Operational Performance
Improved grip, attainment and sustained delivery of the agreed benchmarked improvement trajectories across urgent and emergency care whole system pathways, cancer and elective care.

Improving basics / Step change in quality and safety

4. Quality & Safety
Improved management of Serious Incidents with a particular focus on prevention through early identification and appropriate management of Deteriorating Patients, alongside a robust safeguarding plan with a continuous improvement cycle and implementation of best practice.

5. People & Culture
Delivery of agreed international recruitment trajectories alongside improved staff and user involvement and engagement supporting the levels of sickness and vacancies levels to be reduced and not to be outliers.

Transformation and Sustainable Improvement

6. Financially Sustainable
Development and evidence of delivery in the first year of an agreed Three Year Plan to improve the financial position of the Trust and support an improvement trajectory to fulfil the Trust's statutory financial duties.

Integrated Improvement Plan Portfolio

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Portfolio:

EKHUFT Integrated Improvement Plan — SRO: CEO

SRO: CEO	SRO: CN&MO	SRO: COO	SRO:CN&MO/ CMO	SRO: CPO	SRO: CFO
Programme:					
1. Leadership & Governance Programme	2. Maternity Programme	3. Operational Performance Programme	4. Quality & Safety Programme	5. People & Culture Programme	6. Financially Sustainable Programme
Project:					
1.1 Executive Leadership Team	2.1 Team Working	3.1 UEC Whole Pathway Flow	4.1 Quality Governance	5.1 Workforce	6.1 Financial Governance
1.2 Governance	2.2 Clinical Escalation & Handover	3.2 Elective Recovery	4.2 Safeguarding	5.2 Culture & Leadership	6.2 Financial Improvement
1.3 Communications & Engagement	2.3 Clinical Assessment & Care Pathways	3.3 Cancer	4.3 Fundamentals of Care	5.3 Medical workforce	6.3 Financial Consciousness
1.4 Transformation Programme	2.4 Governance & Patient Safety		4.4 The Deteriorating Patient		
	2.5 Engagement Listening & Leadership				

Compliance with regulatory standards	Improving basics / Step change in quality and safety	Transformation and Sustainable Improvement

Consistent and robust internal and external communications

Priority areas of focus in the first six months

Programme	Priorities	How
Leadership & Governance	Leadership Development	Adoption of the leadership Programme for the Care Group and service group triumvirates following the organisation restructure to ensure our key leaders have the skills and approach to meet our Trust aims, in a manner which reflects our values.
	Governance Framework	Implement a clear framework for governance oversight within and throughout care groups, ensuring clear responsibilities for management of and learning from risks, incidents and complaints
Maternity	Maternity Transformation	Develop Maternity Improvement Programme with robust programme management and oversight arrangements.
Operational Performance	UEC Patient Pathways	Continue the work through the established emergency care delivery workstreams including Patient Flow, Front Door, Simple Discharge and Direct Access Pathways which emphasises a reduction in harm to patients as a consequence of long waits. Work with community, primary care and social care colleagues to establish improvements across the system to reduce hospital admission and attendance and to facilitate earlier discharge
Quality & Safety	The Deteriorating Patient	Adopt a front line coaching approach with clinical teams to establish earlier identification and management of deteriorating patients
	Ward Accreditation	Review and implement evidence based revision of the ward accreditation programme to strengthen the confidence in the quality assurance provided by the programme, in addition evidence collated around ward cultures will support the Cultural Leadership programme
People & Culture	Culture & Leadership	Adoption and roll out of the Culture and Leadership Programme across the Trust and in response to issues identified within Reading the Signals
Financially Sustainable	Workforce Plan	Establish a targeted plan to tackle those service areas with high vacancy rates coupled with high premium payments. Understand and deliver the benefits of better patient pathway management for urgent & emergency care

Updated Exit Criteria as at 30 March 2023

1	Leadership & Governance	• Executive leadership team posts filled. • Executive leadership development plan in place. • Trust Board sighted on key risks and actions taken via appropriate escalation routes, which is demonstrated by an aligned BAF and board risk register. • Evidence of effective communication, which is aligned across the Board and executive, with clear engagement channels between the frontline and the Board and outwards to ICB/NHSE/system partners, inclusive of routes of escalation for risks and concerns. • In response to the 2022 Independent Investigation into Maternity Services, evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology to address culture, psychological safety and teamworking within the maternity service, which delivers an improvement in the performance of the metrics for maternity services. • The Trust is making a full contribution to the HCP for East Kent, the provider collaboratives and the ICS.
2	Operational Performance	• Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024, aiming to move the performance to the 76% floor for all types of the national plan. • Sustained improvement in cancer 62-day performance by March 2024. • Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024 with elimination of 78 week waits.
3	Quality and Safety	• Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process. • Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity, with continuous cycle of review, assessment and implementation of best practice and learning.
4	Maternity	• Evidence of improved and sustained maternity governance process in place. • Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024. • Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff.
5	People & Culture	• Evidence of staff and user involvement in improvements and changes made through methods of capturing feedback e.g. use of template proformas asking staff how they have been involved in specific improvements. • Staff survey demonstrating an improvement in staff engagement and Trust leadership in line with national/peer/ICS. • Staff sickness and vacancy trajectories tracked and reduced to agreed trajectories in line with regional and national position with no evidence of being a significant outlier when compared with the rest of the ICS. • Improvement in the retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in the hard to recruit specialties. • International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024.
6	Finance	• Agreed financial recovery plan in place supported by a clear evidence base, approved of by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system. • Evidence of improved delivery against agreed financial plans, trajectories, and envelopes. • The Trust fulfils its statutory duties with regard to financial management. • Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures. • That the Trust benchmarks well against the Model Hospital financial efficiencies, or where this is not the case has a trajectory which brings alignment as soon as possible. • The Trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place. • Control of the costs of overseas recruitment against plan.

Communication and Engagement framework

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AIM: To develop and implement a clear and consistent approach to internal and external communications and engagement with all our stakeholders to support the delivery of our vision, values, aims and strategic objectives

PROGRAMME OBJECTIVE: Structured, systematic and meaningful communication and engagement both internally and externally

NOF4 EXIT CRITERIA: Evidence of effective communication & engagement channels between the frontline & the Board & external partners

Our Trust-wide communication and engagement objectives

Keep **patients** informed throughout their health journey with us, be open, listen, involve them in decisions and use their feedback to improve their experience	Our **staff** are listened to, informed and engaged, and feel valued and able to make a difference	Our **stakeholders** are informed about the Trust's performance and feel involved so they can support their communities and hold us to account

Integrated Improvement Plan Communications and Engagement objectives

To raise awareness of our challenges and priority areas for the year ahead, "how" we will bring about improvements for our patients and staff and the difference it will make.	To listen to and engage our wide range of stakeholders: clinical and non clinical staff, patients, the public, our stakeholders and partners so there is a shared understanding.	To proactively connect with the middle of the organisation to gain wide-spread support and involvement in our improvement journey at every level.	To work with all our staff so that they understand their individual contribution to improving the way we care for patients in their day to day work and the tools available to help.	To create a desire to be involved and create change, which is owned and delivered by us and improves the experience of patients and staff.	To build hope and pride in what is achieved on the steps in our journey by providing positive feedback on things that are working and the difference they are making to patients.

Timeline

By May 2023: Publish a clear narrative explaining our improvement plan	**By May 2023**: Develop a monthly rolling programme of key messages to support staff engagement and the steps in our journey for stakeholders	**By May 2023:** • Maintain weekly roll out of key messages, feedback, quick wins and success stories. • Include and be honest about the areas that need further work. • Provide regular updates on progress and share stories of achievement to maintain momentum.	**By June 2023:** Build our improvement journey into all communications and opportunities to connect and engage.	**By July 2023:** Complete roll out of detailed communications and engagement plan, tailored to the needs of our clinical and non clinical staff, patients, the public, stakeholders and partners

1. Programme Overview: Leadership and Governance

Programme Objectives (A)

- Stable and substantive executive leadership team in place including an effective executive leadership development plan
- Effective and transparent corporate governance model supported by an improved accountability framework to strengthen risk management, governance and assurance
- Structured, systematic and meaningful communication and engagement both internally and externally underpinning the transformation programme.
- Effective Board oversight and leadership of transformation programme approach with clear Quality Improvement methodology to address culture, safety and teamworking .
- The Trust makes a full contribution to the East Kent HCP, provider collaboratives & ICS.

Projects (B)

1.1 Executive Leadership Team	Recruitment programme in place to recruit a substantive executive leadership team Develop and implement a comprehensive executive leadership development plan to support both individual and team development
1.2 Governance	Review and refresh the governance model to be aligned with the organisation restructure and in particular to embed ward to board assurance to support appropriate and timely escalation and embed a culture of on-going learning
1.3 Communications & Engagement	To develop and implement a clear and consistent approach to internal and external communications and engagement with all our stakeholders to support the delivery of our vision, values aims and strategic objectives.
1.4 Transformation Programme	Develop a structured transformation approach, initially focused on maternity services, with built in Quality Improvement methodology to build a sustainable long-term approach to continuous improvement.

Success Measures (C)

- Substantive executive leadership posts filled by March 2024 (>90%)
- Successful external Well Led Assessment
- Identification of risks and effective controls and learning as evidenced in BAF, Risk Management, SI process and triangulation at all levels.
- Positive executive leadership is reflected in ongoing staff and partner's feedback.
- Positive feedback on both internal and external communications and engagement.

Project Leads (D)

- Andrea Ashman, CPO – Recruitment, induction and leadership development plan
- Caroline Pelly, CNO – Governance Model
- Natalie Yost, DC&E – Communications and engagement
- Ben Stevens, DSD&P – Transformation Programme

NOF 4 Exit Criteria contribution (E)

1
- Executive leadership team posts filled.
- Executive and Board leadership development plan in place.
- Trust Board sighted on key risks and actions taken via appropriate escalation.
- Evidence of effective communication and engagement channels between the frontline and the Board and external partners including escalation of risks.
- Evidence of Board oversight and leadership of a structured transformation programme approach with a clear Quality Improvement methodology within maternity to address culture, psychological safety and teamworking.
- Full contribution made to the HCP for East Kent, provider collaboratives & ICS.

1. Leadership and Governance Programme – Product Milestones

1. Executive Leadership Team

1.101: Substantive COO in post	Apr-23
1.102: Executive Director induction plans in place and on-going	Apr-23
1.103: Review and refresh Executive Leadership Development Plan	Jun-23
1.104: Current vacant Executive Director posts successfully recruited to	Jun-23
1.105: Critical mass of substantive Executive Directors in post (>50%)	Dec-23
1.106: Executive Team Leadership Development Programme commenced with critical mass in post	Dec -23
1.107: External Well Led Governance Review commissioned with plan to report to Board	Mar 24
1.108 Substantive executive leadership posts filled by March 2024 (>90%).	Mar-24

1.2 Governance

1.201: Review and refresh Governance Model to ensure it is aligned with the organisation restructure	Jul-23
1.202: Undertake external diagnostic on Board effectiveness	Oct-23
1.203: Embed Integrated Improvement Plan Governance and Reporting	Dec-23
1.204: QI Oversight/Governance	Jan-24
1.205: Risk Management Training	Jan-24
1.206: EKHUFT New Governance Model Live	Mar-24
1.207: External Well Led Review Completed	Apr-24

1.3 Communications and Engagement

1.301: Outline Communications and Engagement Plan published	May-23
1.302: Monthly programme of activity including key messages, feedback, quick wins and success stories	May-23
1.303 Detailed Communications and Engagement Plan developed, based on feedback received, and rolled out across Trust	July-23

1.4 Transformation Programme

1.401: Revise Trust organisational structure and launch consultation	Apr-23
1.402: Refocus We Care Programme	Apr-23
1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23
1.404: Develop the Leadership Behavioural Framework	Jun-23
1.405: Develop and adopt the Behavioural Code in Maternity	Jun-23
1.406: Pilot "Civility Saves Lives" in Maternity	Jun-23
1.407: Introduce a simple tool to assist staff to challenge poor behaviours	Jun-23
1408: Start the leadership programme for team leader, first line, middle manager	Jul-23
1.409: Undertake recruitment to new organisational structure	Aug-23
1.410: Undertake an external diagnostic of board effectiveness	Autumn-23

2. Programme Overview: Maternity

Programme Objectives (A)

- Deliver high quality, safe, effective and personalised maternity and neonatal services in partnership with service users.
- Identify opportunities to learn to continually ensure that women receive the best care for themselves and their babies, that meets their wishes and needs.
- Embed an inclusive culture where staff feel valued, listened to and supported to deliver patient centred
- Deliver a safe maternity service that is underpinned by a first-class clinical governance process, to drive and improve the delivery of high-quality person-centred care

Projects (B)

2.1 Team Working	Review to Assess: consultant arrangements; roles and responsibilities of senior staff; triage oversight and shift handovers including safety huddles. Review and strengthen existing plans to support safe challenge around behaviours and to build teams that value, support and trust each other
2.2 Clinical Escalation and Handover	Development of systems and processes to allow staff to recognise deteriorating patients including sepsis management assessment and CTG tools. This will include a review and audit of emergency pathways to ensure these are appropriate and informed by woman's experience.
2.3 Clinical Assessment and Care Pathways	Development of care pathways: High Dependency Units, Triage, centralised telephone triage, ANNBS/Sonography, Discharge, and VTE. Focus on SBAR Handover process and escalation processes. Undertake staff surveys to identify barriers and levels of staff confidence to escalate concerns
2.4 Governance & Patient Safety	Agree quality and safety framework aligned to Trust and national ambitions Ensure there are no backlogs in Patient Safety activities. Learning to be identified and communicated through regular incident learning events and monthly sharing of learning from incidents
2.5 Engagement Listening & Leadership	Coproduced communication plan to ensure staff feel listened to, and staff receive relevant and timely information. Maternity User Engagement framework aligning to Trust Patient Involvement Strategy. Service will work with partners to develop high quality supported training experiences.

Success Measures (C)

- Positive experiences of care reported through Your Voice is Heard
- Compliance with MDT attendance at handovers/rounds
- Appropriate senior obstetric oversight for triage
- Clinical MDT development of action plans
- Regulatory action plans closed within agreed timeframes
- Quarterly staff survey reporting that staff feel safe to escalate and report harm
- Reduction in formal complaints
- Reduction in the number of repeat incidents with the same causal factors e.g. consultant oversight or failure to escalate

Project Leads (D)

- Team Working – Zoe Woodward, CD, and Director of Midwifery
- Clinical Escalation &Handover – Zoe Woodward, CD, and Director of Midwifery
- Clinical Assessment & Care Pathways – Deputy Director of Midwifery (1st May)
- Governance & Patient Safety– Michelle Burrows, Head of Governance
- Engagement, Listening & Leadership – CD, and Director of Midwifery

NOF 4 Exit Criteria Contribution (E)

4
- Evidence of improved and sustained maternity governance process in place.
- Evidence of improvements in service with clear process for providing evidence of compliance and completed regulatory actions by March 2024.
- Evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff.

2. Maternity Programme – Product Milestones

2.1. Team Working

2.101: Agree sustainable senior obstetric workforce model in place for triage — Jul-23

2.102: Site based MDT structures embedded and working to implement the quality and safety framework — Aug-23

2.2 Clinical Escalation and Handover

2.201: Demonstrable improvement with fetal heart monitoring guideline compliance — Sep-23

2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE — ongoing

2.3 Clinical Assessment & Care Pathways

2.301: Centralisation of telephone triage — May-23

2.302: Agree model and implementation plan for improved discharge pathway — May-23

2.303: Agree model and implementation plan for HDU — Jun-23

2.304: Implementation of discharge pathway — Jul-23

2.305: Implementation of revised bereavement pathway — Aug-23

2.306: Agree model and implementation plan for ANNBS/USS/FMU — Sep-23

2.307: Implementation of HDU model — Feb-24

2.308: Embedded quarterly audits supporting appropriate clinical assessment – showing improvement SBAR, MEOWS, sepsis and VTE — Ongoing

2.4 Governance and Patient Safety

2.401: No backlogs for SIs. HSIB investigations — May-23

2.402: Agree maternity Quality and Safety framework — Sep-23

2.5 Engagement, Listening & Leadership

2.501: Coproduced plan developed and agreed by staff — May-23

2.502: Coproduced (staff and a service users) revised Maternity strategy agreed and communicated — Jun-23

2.503: Coproduced maternity user engagement framework agreed and approved through MVP — Jul-23

2.504: Demonstrable improvement that staff feel listened to (quarterly survey) — Ongoing

3. Programme Overview: Operational Performance

SRO: COO

Programme Objectives (A)

- Trust urgent and emergency care (UEC) performance, and Trust's contribution to the whole system UEC pathway performance, improved and delivery sustained in line with the refreshed improvement trajectories
- Elective Recovery Plan implemented and recovery sustained against the agreed improvement trajectory to deliver the national elective recovery standards
- Cancer Performance Plan delivered against the agreed trajectories

Projects (B)

3.1 UEC & Whole System Interface Flow	Emergency Care Delivery Group driving internal improvements and ensuring appropriate linkage with whole system interfaces. Scope includes: pre-hospital; Emergency Department; Acute Medicine including SDEC; wards and specialties; ED capital builds; job planning aligned to UEC capacity and demand and engaging with out of hospital/system key interfaces.
3.2 Elective Recovery (including Diagnostics)	Elective Care Delivery Group driving internal improvements including diagnostics, with a focus on the continued reduction of 52ww and P2 patients. Scope to include clinical harm reviews undertaken for all long waiters and job planning aligned to elective capacity and demand.
3.3 Cancer	Cancer Care Group to drive internal improvements to address the backlog and meet the national cancer standards with a focus on the continued reduction of 62 day+ and 104-day patients on the cancer PTL. Scope to include clinical harm reviews undertaken for all long waiters.

Success Measures (C)

Trust UEC performance, and the Trust's contribution to the whole system UEC pathway performance, against refreshed local trajectories in line with regional and national standards including:

- Ambulance handover delays
- Emergency Department Type 1 (50%) and All Types 4-hour performance (76%)
- Emergency Department Type 1 12-hour performance and impact of crowding qualitative measures
- 21-day Long length of stay

Elective Recovery performance against agreed local trajectories and national standards including:

- Eliminate patients waiting longer than 65 weeks
- Reduce 52 week waits in line with agreed improvement trajectory
- Deliver OP transformation targets (PIFU 5%/ Virtual appointments 25%/ Reduce follow up activity 25%)
- Deliver diagnostic stretch target in line with the agreed trajectory

Cancer Recovery performance against agreed local trajectories and national standards including:

- Compliant with Faster Diagnosis Standard (FDS) and 62-day performance
- Eliminate patients waiting longer than 104 days on the PTL
- Increased delivery of diagnostic tests within the Buckland Clinical Diagnostic Centre by 25%
- Implement Straight to Test Services to meet the 28 day Faster Diagnostic Standard

Project Leads (D)

- Sandra Cotter, UEC Lead - UEC & Whole System Interface Flow
- Lisa Neal, Elective Care Lead - Elective Recovery including Diagnostics
- Sarah Collins, Cancer Lead - Cancer Recovery

NOF4 Exit Criteria Contribution (E)

2
- Evidence of an improved grip and realistic refreshed improvement trajectory in UEC whole pathway performance and out of hospital flow, benchmarked both nationally and regionally, by March 2024 aiming to move to 76% floor for all types.
- Elective recovery plan implemented with evidence of delivery against trajectory and continued reduction in 52ww and P2 patients by March 2024 with elimination of 78 week waits.
- Sustained improvement in cancer 62-day performance by March 2024.

3. Operational Performance Programme – Product Milestones

NHS
East Kent
Hospitals University
NHS Foundation Trust

3.1 Urgent and Emergency Care (UEC) and Whole System Interface Flow

3.101: WHH Emergency Department Build Phase 3 started	Mar-23
3.102: WHH implementation of the front door clinical model established	Mar-23
3.103: QEQM End of Life Model implemented	Mar-23
3.104: Co-horting wards pathway 1 across WHH/QEQM implemented supported with daily pathway zero reviews, development of board rounds and PTL	Apr-23
3.105: Updated Patient Choice Process rolled out Trust wide (Discharge)	Apr-23
3.106: Direct Access Pathways launched in Acute Medicine, General Surgery & Orthopaedics with training programme for nurse streaming roll out	Apr-23
3.107: QEQM Emergency Department Build Phase 2 started	Apr-23
3.108: UTC new inclusion and exclusion criteria implemented	Apr-23
3.109: MAU Pilot at WHH with access to Short stay Ward, SDEC virtual clinics for acute medicine	Apr-23
3.110: Direct Access Pathways launched in Respiratory, Gastroenterology and Cardiology with hot clinics established in SDEC	May-23
3.111: Established pathways to the MDU at KCH (nurse led)	May-23
3.112: QEQM Emergency Department Build Phase 3 started	Jun-23
3.113: WHH End of Life Model implemented	Jun-23
3.114: Patient Flow SAFER principles in place across Trust with metrics focussed on discharges by 10.00, golden patients, reduction in 12-hour ED waits	Aug-23
3.115: WHH Emergency Department Build Phase 3 completed	Sep-23
3.116: Critical UEC medical and nurse staffing rotas and job planning in line with the DAP and Dedicated assessment units- business plans	Oct-23
3.117: Bed reconfiguration plan to support establishment of medical and surgical assessment models approved	Oct-23
3.118: QEQM Emergency Department Build Phase 3 completed	Dec-23
3.119: A&E four-hour 76% performance delivered	Mar-24

3.2 Elective Recovery (including diagnostics)

3.201: P2 monitoring report amended to highlight compliance/non-compliance with weekly oversight across each speciality	Apr-23
3.202: Business planning assumptions agreed by executive management team and detailed speciality stretch targets articulated	May-23
3.203: Trust Access Policy revised to incorporate clinical review policy and the new Kent and Medway Access Policy	May-23
3.204: Outpatient transformation plan re-launched with key milestones and stretch targets for transformation including activity increases (1st OP) and decreases (follow-up)	Jun-23
3.205: Validation plan agreed and implemented for all diagnostic modalities utilising digital transformation available within the Trust	Jul-23
3.206: Actions agreed and implementation started to deliver diagnostics stretch target (tbc)	Sep-23
3.207: Volume of 65-week breaches reduced before December 2023 (in line with winter planning and risk of elective cancellations)	Nov-23
3.208: Eliminate all 65-week patients as per trajectory and ensure 52 week planned forecast delivered	Mar-24

3.3 Cancer

3.301: Clinical harm reviews fully embedded with shared learning and improvement cycle	Mar-23
3.302: Internal improvements in place to meet 62-day compliance	Aug-23
3.303: Internal improvements in place to meet 28-day compliance	Sept-23
3.304: Buckland Clinical Diagnostic Centre increased delivery of diagnostic tests to cancer patients by 25%	Dec-23
3.305: Mobile Cancer Unit increased from 3 to 5 days per week raising awareness whilst providing services to facilitate earlier diagnosis	Dec-23
3.306: Internal improvements in place to deliver the 75% early diagnosis ambition	Mar-24
3.307: No cancer patients waiting over 104 days on the PTL	Mar-24

4. Programme Overview: Quality & Safety

SRO: CNO&MO/ CMO

Programme Objectives (A)

- Learning framework embedded to support improved early identification and appropriate management of Serious Incidents (SIs)
- Robust safeguarding sustainability plan in place with continuous improvement programme with the key aim to address gaps in systems and process at care group level through a revised training programme and a new safeguarding competency framework for staff.
- Refreshed Fundamentals of Care framework focused on key service priorities, aligned to Quality Strategy
- Improved focus, identification and proactive management of deteriorating patients

Projects (B)

3.1 Quality Governance
- Review SI process ensuring alignment to Patient Safety Incident Review Framework to improve early & appropriate escalation with clear accountability
- Implement the revised SI Declaration Process and enhance clinical engagement
- Learning to be identified and communicated within and outside the Trust through regular learning events and monthly sharing of learning from incidents

3.2 Safeguarding
- Delivery of safeguarding sustainability plan with improvement audit cycle
- Implement training and safeguarding competency framework enabling staff to demonstrate increased understanding and practical application.
- Implement Safeguarding recommendations from Internal Audit
- Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements

3.3 Fundamentals of Care
- Develop the Fundamentals of Care Framework to guide priorities and provide assurance that they are integrated into care at all levels of the organisation, enabling the patient voice to be at the centre of services
- Implement evidence-based revision of ward accreditation programme
- Implement Patient Voice and Involvement Strategy

3.4 The Deteriorating Patient
- Design and deliver a continuous improvement programme using a safety improvement coaching approach to improve the timely recognition, escalation and response to identify the deterioration patient
- NEWS 2 e-learning module, deteriorating patient education programme, deteriorating patient dashboard, CQUIN –NEWS2

Success Measures (C)

- Reduction in cases of moderate harm and above for the top 5 recurring incidents, with a month-on-month improvement trajectory for each, and look to switch the KPI aligned to PSIRF later in the year
- Reduction in the number of repeat incidents with the same causal factors
- Reduction in Hospital Falls with Harm
- Reduction in Hospital acquired pressure damage
- Improvement in KPIs that are within the Fundamentals of Care Framework.
- Increase in NEWS compliance (escalation process)
- Reduction in inpatient admissions to ITU related to the deteriorating patient
- Increase in compliance of safeguarding concerns (KASCFs) being submitted by the care groups within 24hrs of the request from the safeguarding team (KPI on safeguarding dashboard)
- Reduction in delays in the completion of section 42 investigations – increasing & compliance of investigations completed within 30 days (KPI on safeguarding dashboard)

Project Leads (D)

- Samantha Gradwell – Incident Reporting and Learning Framework Lead
- Ian Setchfield – Deteriorating Patient Lead
- Wendy Ling - Fundamentals of Care Framework/Ward Accreditation Lead
- Karen Edmunds – Patient Voice and Involvement Lead
- Pat Hobson – Safeguarding Lead

NOF4 Exit Criteria Contribution (E)

3
- Evidence of an improved process based on best practice and in accordance with framework standards for the management of serious incidents with evidence of delivery, leadership and learning from incidents, reflecting a single approach which aligns to the Trust governance process.
- Evidence of sustained improvement in safeguarding compliance with the NHS Safeguarding Accountability and Assurance Framework 2022 overseen by the Trust Board, including oversight of any sub-contracted activity with continuous cycle of review, assessment and implementation of best practice and learning.

15/24

219/301

4. Quality & Safety Programme – Product Milestones

4.1 Quality Governance

4.101: Define roles and responsibilities to promote senior clinical engagement and leadership — Apr-23

4.102: Develop new cross Trust Patient Safety Incident Response systems and processes (replacing current SI process), including beginning to share the learning from SIs — May-23

4.103: EKHUFT SI Learning Framework Designed — Jun-23

4.104: Commence transitioning across to the new PSIRF — Aug-23

4.105: Board BAF & Risk Management Session — Oct-23

4.106: EKHUFT SI Learning Framework Implemented — Nov-23

4.107: Patient Safety Incident Response Plan Implementation — Feb-24

4.2 Quality

4.201: Review and refresh current sustainability safeguarding plan — April-23

4.202: Finalise sustainability safeguarding team business case and take through Trust business planning process — April- May 23

4.203: Revised training and competency framework approved by safeguarding committee — April-23

4.204: Set up task and finish group with oversight through safeguarding operational group — April-23

4.205: Implement revised level 2 training for international nurses — May-23

4.206: Implement new safeguarding competencies for international nurses — May-23

4.207: Commence roll out of competencies for all staff — June-23

4.208: Audit of effectiveness of training and competency-based framework — June -23

4.209: Review sub-contracted safeguarding arrangements as part of quality schedule and oversight arrangements — June -23

4.3 Fundamentals of Care

4.301: Review current FOC workstreams and develop FOC framework — May-23

4.302: Review and refresh Pressure Ulcer/Falls/Nutrition delivery plans — June-23

4.303: Develop dementia strategy delivery plan & associated KPIs — June-23

4.304: FOC confirmation of metrics — July-23

4.305: Learning Session 1 Nutrition — Sept-23

4.306: Learning Session 1 Falls — Oct-23

4.307: Learning Session 1 Pressure Ulcers — Nov-23

4.308: Learning Session 2 Falls — Jan-24

4.309: Learning Session 2 Pressure Ulcers — Jan-24

4.310 Learning Session 2 Pressure Ulcers — Feb-24

4.311: FoC Metrics Deep-dive Review and Refresh — Mar-24

4.4 The Deteriorating Patient

4.401: Agree with ICB the required funding for Patient safety specialist role and Improvement Project — Mar-23

4.402: Confirm The Deteriorating Patient Safety Improvement Project building on current Trust improvement capacity — June-23

4.403: Launch NEWs-2 e-learning module — May-23

4.404: Commence roll out of deteriorating patient education programme — Jul-23

4.405: Deteriorating Patient Dashboard developed and shared with care groups — Jul-23

5. Programme Overview: - People and Culture

Programme Objectives (A)

- Design & Embed NHS's Culture & Leadership Programme within EKHUFT to make EKHUFT a Great Place to Work & Learn.
- Deliver tactical task and finish work to drive improvements to key metrics, e.g. appraisal, rostering compliance and visibility of job-planned hours
- Develop an attraction and retention strategy to deliver a sustainable workforce
- Improving attendance toolkit to be used to assess and generate outcomes for an improved sickness rate
- Collation and monitoring of recruitment and training trajectories for IENs and HCSWs, inclusive of training date for OSCE and ready to care to ensure that colleagues are ward ready and trained.

Projects (B)

Project	Description
5.1 Attract and Retain	Strategy developed alongside workforce plans by speciality in correlation to the clinical adjacencies programme. Attendance and collaboration as a Kent and Medway partnership. Dashboards built to support People and Culture KPIs.
5.2 Culture and Leadership	Strategic, group wide transformation project to engage the workforce in designing embedding a new culture within EKHUFT, through initiatives such as Culture Leadership programme, behaviour framework, Pulse Survey Reviews, Embedding Culture Dashboard, EDI Strategy & Plan and embedding a Culture Change Team within trust
5.3 Medical workforce	Tactical task and finish work to develop dashboards demonstrating improvement in key medical workforce metrics, e.g. appraisal, training compliance, rostering compliance, visibility of job-planned hours etc. Medical attraction and recruitment programme plan and working group in place.

Success Measures (C)

- Improved 'National Staff survey (YOY trend) / Pulse data (1/4ly trend): increased response rate, engagement and staff recommending EKHUFT as a place to work
- Improved National Staff survey (Manager questions YOY trend)
- Improved Culture dashboard monthly data trends
- Improved WRES / WDES / F2SU data
- Improved 'Appraisal Conversation' completion rates
- Leadership development (Development plan + 360 feedback – Board to HLT)
- Improved 'Well Led' domain CQC rating (date tbc)
- Improved People Metrics / KPI's (recruitment, vacancy rate, retention, job planning, /pipelines, disciplinary's and sickness rates)
- Listening Sessions/Anecdotes / staff live feedback
- Pastoral Care award
- Development of and improved performance against medical workforce dashboard
- Job planning and PA review completed by May 2023
- Specialist registration (CESR) programme to be expended and rolled out.

Project Leads (D)

- Andrea Ashman, Chief People Officer
- Rita Lawrence – Programme Director, Culture & Leadership Programme
- Rebecca Martin – Chief Medical Officer

NOF 4 Exit Criteria Contribution (E)

5
- Evidence of staff and user involvement in and feedback on specific improvements .
- Improved staff engagement and Trust leadership in line with national/peer/ICS.
- Staff sickness and vacancies tracked and reduced so Trust not an outlier across ICS.
- Improved retention and turnover rates for all staff groups and sustained improvement in vacancy rate trajectory in hard to recruit specialties.
- International nursing and Clinical Support Worker recruitment trajectories agreed and evidence of delivery against these by March 2024.

5. People & Culture Programme – Product Milestones

5.1 Attract and Retain

5.101: Recruitment trajectories produced and progress monitored for IENs and HCSWs	May-23
5.102: Workforce specialty developed plans linked to clinical adjacencies	Jun-23
5.103: Workforce strategy inclusive of recruitment strategy developed and communicated	Jun-23
5.104: Absence audit completed with analysis of outcomes	Jun-23
5.105: Pastoral Care award	Jun-23
5.106: Nursing pipeline plan developed 3-5 years	Jul-23
5.107: NHSE absence tool	Jul-23
5.108: Appraisal quality reviews	Jul-23

5.2 Culture & Leadership Development

5.201: Launch of New Starter Experience survey	Jan-23
5.202: Development of enhanced NSS dashboard	Jan-23
5.203: Launch of new Benefits platform & EAP	Feb-23
5.204: Publication of enhanced NSS dashboard	Mar-23
5.205: Promote & communicate	Mar-23
5.206: Thematic analysis of NSS free-text comments	Apr-23
5.207: Review of We Care progress through NSS data	Apr-23
5.208: Behavioural framework created	Jun-23
5.209: Culture & Leadership Development rolled out Trust wide	Jul-23
5.210: Define EDI Strategy & Plan	Jul-23
5.211: Effective succession planning and cycle established	Jul-Dec-23

5.3 Medical Workforce

5.301: Medical attraction programme plan developed for fragile clinical services	Jun-23
5.302: Digital and social media targeted recruitment	Jun-23
5.303: Dashboard for medical attraction and trends built	Jun-23
5.304: Rostering trial	Sep-23
5.305: Medical Job Planning assessment of levels of attainment and trajectory developed to reach level 4	Sep-23
5.306: Specialist Registration (CESR) programme development	Sep-23
5.307: Pastoral Care for all international recruits	Sep-23
5.308: Development of a medical workforce dashboard	Sep-23
5.3.09: Development of GMC survey dashboard	Sep-23
5.3.10: Review of clinical digital induction	Sep-23

6. Programme Overview: Financially Sustainable

Programme Objectives (A)

- Achieve financial sustainability within the ICS financial envelope through the design and delivery of a Three-Year Financial Plan
- Enable and embed sound financial `governance and practice from ward to board.
- Create a multi-year productivity and efficiency programme across care group and pathways.
- Improve financial consciousness across the organisation through the development and roll out of a financial and efficiency communications strategy.
- Drive financial sustainability alongside planned trajectory to reduce carbon footprint.

Projects (B)

6.1 Financial Governance	Project to embed strong financial governance, productivity and efficiency delivery governance across the organisation. Reinstate and embed financial training
6.2 Financial Improvement	Develop a Three-Year Plan to move EKHUFT to a sustainable financial position. Establish a Financial Improvement and PMO infrastructure to increase the amount of recurring CIP delivered. Articulate the ask and potential EKHUFT opportunity from the East Kent £.
6.3 Financial Consciousness	Project to engage staff on the financial challenge the Trust faces and the productivity and efficiency opportunity available to the Trust through making the most of our money for patients.

Success Measures (C)

- Review of the whole financial governance aligned to organisational restructure including appropriate agreed oversight, assurance and performance management to support budget holders to deliver
- Financial Improvement Oversight Group (FIOG) well attended and discussing and progressing full range of productivity and efficiency improvements.
- Regular review of key financial oversight mechanisms to ensure efficacy.
- Three-year FRP developed reflecting engagement with key stakeholders and agreed as credible.
- Two consecutive quarters of Year 1 3YP run-rate delivered
- Improvement over the year in underlying financial run rate.
- Programme of regular communications and engagement underway with Trust staff relating to finance, productivity, and efficiency.

Project Leads (D)

- Michelle Stevens – Interim Chief Financial Officer
- Ann Johnson – Financial Improvement Director

NOF4 Exit Criteria Contribution (E)

6
- Agreed Financial Recovery Plan in place supported by clear evidence base, approved by the board and compliant with agreed trajectories
- Evidence of improved delivery against plans, trajectories and envelopes
- The Trust fulfils its statutory duties with regard to financial management
- Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures
- Benchmarks well against model hospital efficiencies or has agreed trajectory.
- The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place
- Control the costs of overseas recruitment against plan

6. Finance Programme – Product Milestones

6.1 Financial Governance

6.101: Implement Financial Improvement Oversight Group	Mar-23
6.102: Effective Care Group oversight approach in place	Jun-23
6.103: Embed monthly finance reviews with Care Groups	Jun-23
6.104: SFIs definition & refresh	Jul-23
6.105: Meeting structure and review of TOR	Jul-23
6.106: Review, relaunch and embed Strategic Investment Group (SIG)	Aug-23
6.107: Budget Holder training restarted and embedded	Sep-23
6.108: Rebasing to revised hospital structure	Sep-23
6.109: Joint Trust and ICB action plan re. Financial Recovery Plan (FRP) Development	Ongoing

6.2 Financial Improvement

6.201: Develop and agree FRP core base year (FY24)	Mar 23
6.202: Update deficit drivers analysis	May-23
6.203: Model years one and two of FRP	Jun-23
6.204: Update FRP document	Jun-23
6.205: Fully develop FY24 efficiencies	Jul- 23
6.206: Identify and prioritize development of "harder to achieve" improvements	Jul-23
6.207: Develop multi-year productivity and efficiencies approach covering pathway improvement and GIRFT	Jul-23
6.208: Review and sign off including FRP base year Q1, Q2 and Q3 reviews	Jan-24
6.209: Review and sign-off FRP including: Trust and ICB sign off and FRP progress quarterly reviews	Jan-24
6.210: Input to Kent and Medway System Finance Work	Ongoing

6.3 Financial Consciousness

6.301: Implement Clinical Leaders Efficiency Group (CLEG) to engage clinicians in productivity and efficiency, followed by a review of the approach	Mar-23
6.302: Update financial and efficiency communications strategy	Mar-23
6.303: Regular communications on finance and efficiency	Ongoing
6.304: Regular updates to and oversight by FPC & FIOG	Ongoing

Integrated Improvement Plan (IIP) Governance & Reporting

Assurance updates to System Oversight Group, Trust Board & RSP Review Meetings

SRO: CEO

A

Format:
1. Chaired by Chief Executive
2. Attended by SROs or nominated deputy in absence
3. 1 Hour Fortnightly within existing EKHUFT EMT Time
4. Updates & risks and issue management by exception and invite
5. Standard fortnightly highlight report
6. Monthly sign-off of IP Reporting Pack for Trust Board and SIB

Portfolio:

B

Format:
1. Chaired by Chief Executive
2. Attended by NHSE Improvement Director, IP Programme Director, Deputy IDs
3. Focussed Huddle (30 mins)
4. Delivery Highlights
5. Risks & Issues by Exception
6. Benefits Identification
7. Time & Materials to date

NHSE Intensive Support Director: Moira Durbridge

EKHUFT Strategic Improvement Committee

Programme:

C

Format:
1. Chaired by SRO
2. Attended by Project Leads & other stakeholders as required
3. Monthly Highlight report for Programme Board
4. Product & Action Tracker for Weekly Huddles

SRO: CEO	SRO: CN&MO	SRO: COO	SRO: CN&MO/CMO	SRO: CPO	SRO: CFO
1. Well Led Programme	**2. Maternity Programme**	**3. Operational Performance Programme**	**4. Quality & Safety Programme**	**5. People & Culture Programme**	**6. Financially Sustainable Programme**
Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle

Project:

D

1.1 Executive Leadership	2.1 Team Working	3.1 Whole UEC Pathway Flow	3.1 Quality Governance	5.1 Attract and retain	5.1 Financial Governance
1.2 Governance	2.2 Clinical Escalation & Handover	3.2 Elective Recovery	3.2 Safeguarding	5.2 Culture & Leadership	5.2 Financial Improvement
1.3 Comms & Engagement	2.3 Clinical Assessment & Care Pathways	3.3 Cancer Improvement	3.3 Fundamentals of Care	5.3 Medical Workforce	5.3 Financial Consciousness
			3.4 The Deteriorating Patient		

Format:
1. Project Leads to choose most appropriate format to drive delivery, e.g. Daily Huddles, Delivery Group, Project Board, Task & Finish Group etc
2. Mandatory for all Projects to update Fortnightly Highlight Report in standard format
3. Project milestones to explicitly link in with gateway criteria to access additional resources

What will be different this time?

- Stable substantive new executive team

- Working as a unitary board

- Improved local partnership working

- Organised for success

  - An organisational structure that allows improved site focus and delivery: early positive feedback that this is both necessary and welcomed by staff

  - Right people in the right posts: to maximise synergy & increase pace and buy-in

- Increased understanding of the fundamental challenges

- Targeted Recovery Support Programme expertise and financial support

Closing Comments

- Exit criteria updated and trajectories agreed for a number of workstreams with others being progressed to inform the development of SMART success measures

- Monthly oversight reports to the Board with quarterly Key Performance Indicator (KPI) report – through the Strategic Improvement Oversight Board (chaired by Chief Executive Officer (CEO))

- Risks will be identified as part of each of the programmes of work and there will be a cross reference to the Board Assurance Framework (BAF)

- Review and refresh of the Recovery Support Programme (RSP) exit evidence repository

- This is the start of the Trusts journey from NOF 4 to NOF 3 and on to outstanding and is aligned with other plans. Our Long Term Plan will need to be aligned to this

Resources

- Targeted Recovery Support Programme expertise with significant financial support

- Process in place to invite bids which will need to be prioritised

- Focused on achieving the exit criteria

- Money will be linked to key milestones

East Kent Hospitals University Foundation Trust Report on Integrated Improvement Plan

Journey to Exit NOF4
4 May 2023

Final Draft

Purpose of Report

This report has been established to update the Board on progress of delivery of the Integrated Improvement Plan. It is also intended to give the Board oversight of key risks to delivery; and to update on key evidence that has been added to the evidence repository to support exit from the Recovery Support Programme (RSP).

Delivery of the Integrated Improvement Plan will be overseen by the EKHUFT Strategic Improvement Committee which will be chaired by the Chief Executive, Tracey Fletcher.

The Board will receive an update on the IIP on a monthly basis focusing on successes, challenges and actions to mitigate any key risks to delivery. We will also provide a quarterly deep dive to demonstrate impact and progress against the overall programme objectives.

What the Integrated Improvement Plan is aiming to deliver

1. Leadership & Governance → Stable executive with effective leadership development plan. Trust Board are sighted on the transformation programme including communication & engagement, risks and actions taken via the appropriate escalation routes.

2. Maternity → Sustained improvement in governance with maternity services meeting regulatory standards and showing evidence of improved culture, behaviours, relationships and communications between all relevant teams and frontline staff to support safe, effective and women centred care.

3. Operational Performance → Improved grip, attainment and sustained delivery of the agreed benchmarked improvement trajectories across urgent and emergency care whole system pathways, cancer and elective care.

4. Quality & Safety → Improved management of Serious Incidents with a particular focus on prevention through early identification and appropriate management of Deteriorating Patients, alongside a robust safeguarding plan with a continuous improvement cycle and implementation of best practice.

5. People & Culture → Delivery of agreed international recruitment trajectories alongside improved staff and user involvement and engagement supporting the levels of sickness and vacancies levels to be reduced and not to be outliers.

6. Financially Sustainable → Development and evidence of delivery in the first year of an agreed Three Year Plan to improve the financial position of the Trust and support an improvement trajectory to fulfil the Trust's statutory financial duties.

High level summary on programme delivery to date

Progress over last month:

- Programme plans and milestones for all six programme areas have been finalised.
- Progress across all six programme areas evidenced against milestones delivered to date although this has not yet, in many instances, demonstrated impact against agreed trajectories.
- Individual programme updates are provided in the main body of the report.
- The Strategic Improvement Committee which oversees the delivery of the Integrated Improvement Plan (IIP) will meet for the first time in May. This is integral to the successful delivery of the IIP.
- Ben Stevens, Interim Director of Strategy & Partnerships, has been appointed as the Programme Senior Responsible Officer (SRO).
- The attached updated version of the Integrated Improvement Plan includes the updated exit criteria with amended programme workstream details where relevant.
- The approved IIP is being taken to the Integrated Care Board (ICB) on the 2 May.
- The final RSP exit criteria are due to go to the National Quality and Performance Committee (QPC) for approval on the 16 May.

Key risks:

- Through the process of developing the Integrated Improvement Plan a number of key risks have been highlighted. Some of these risks are already recognised within a number of the programmes.
- One of the first jobs of the Strategic Improvement Committee is to review the overall risks of the programme, consider whether there are any further risks and what the appropriate mitigations should be.
- Initial risks highlighted have included:
    1. Deficits in planned critical workforce
    2. Estates and equipment constraints
    3. Impact of National Strike action
    4. Resource to deliver the IIP
    5. Capacity of Business Intelligence to support all the programme on a timely basis

Funding to support delivery of programme

- A planning meeting was held with Trust Executives in April.
- Programme SROs have been asked to present bids for funding related to the exit criteria.
- Bids are to be formally considered by the National team in May 2023.

High-level summary on programme delivery to date

	Priority area of focus in IIP	Summary update
Leadership & Governance	Leadership Development	Good progress made against including appointment to key substantive executive posts e.g. the Chief Operating Officer (COO). The organisational restructure consultation will conclude by end of May 2023 with plans in place to rapidly recruit to all key posts. The Leadership Programme for the Care Groups and Service Group triumvirates is planned to commence soon after to support key leaders across the Trust to develop and utilise relevant skills and approaches to deliver our aims in a manner that reflects our values.
	Governance Framework	Some progress made with a new clinical lead appointed to implement and embed the clear framework for governance oversight within and throughout the Care Groups, ensuring that all staff are clear on their responsibilities for the management and learning from risks, incidents and complaints.
Maternity	Maternity Transformation	Some progress has been made in particular with the substantive appointments of Head of Midwifery (HOM) and Deputy HOM. Work is ongoing to develop and confirm the updated Maternity Transformation Plan which has now been agreed to be finalised by July 2023. Pace of delivery continues to be an issue with some planned improvement activities cancelled due to clinical availability and the junior doctors strikes.
Operational Performance	Urgent and Emergency Care (UEC) Patient Pathways	Good progress made against planned UEC milestones and, despite Emergency Department (ED) phased handovers at both William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) and acute on chronic ED workforce issues at QEQM, UEC type 1 performance has exceeded expectations and the planned Type 1 trajectory on occasions. Further work is required to sustain this initial improvement. A system UEC working plan has been developed & was presented to the Urgent Care Delivery Board in April with weekly meetings now in place to drive UEC system pace and delivery.
Quality & Safety	The Deteriorating Patient	Some progress made against planned milestones with the ICB having supported the bid for new monies to appoint a specific clinical lead and to fund a front-line coaching approach with clinical teams to achieve earlier identification and improved management of the deteriorating patient. Initial partner discussions were not productive and the Trust is currently developing an alternative solution with a new partner with details still to be confirmed.
	Ward Accreditation	Some progress made with plans on track to review the Fundamentals of Care work streams /Ward Accreditation programme and develop a new framework by end of May 2023.
People & Culture	Culture & Leadership	Good progress has been made with Culture & Leadership Development with multiple programme milestones realised as set out in the detailed programme slide. The NHS Staff Survey Report 2022 has received and been discussed in multiple Trust forums including the performance review meetings to increase awareness of the survey results and agree next steps.
Finance	Workforce Plan	Good progress made re. improved understanding of service areas with high vacancy rates coupled with high premium payments supported by an increased focus in the individual performance review meetings with specific plans to be developed. New system UEC plan and weekly meetings are starting to support the Trust and System to understand individual provider and cross system provision and to deliver the benefits of better patient pathway management across urgent & emergency care

Improvement Framework

Progress update

- A review has been undertaken of the IIP, Pillars of Change and the We Care programme.

- The improvement objectives and actions were reviewed to identify the commonality and golden threads across the programmes.

- A proposed single framework has been drafted that will encompass the IIP, Pillars of Change and We Care.

Review of Improvement Programmes
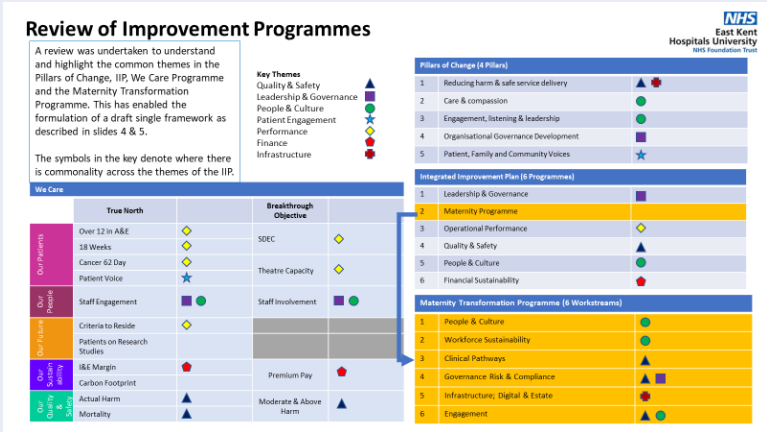
Next steps

- Agree and finalise the single framework

- Present the framework to Clinical Executive Management Group (CEMG)

- Finalise and agree the reporting structure

Programme Summaries

Leadership & Governance Programme

SRO: CEO

Progress over last month:

- Dylan Jones commenced as the substantive Chief Operating Officer
- Michelle Stevens, Interim Chief Financial Officer and Ann Johnson, Financial Director of Improvement have taken up post
- Ben Stevens, Interim Director of Strategy & Partnerships in post; and confirmed SRO for the Transformation Programme
- Board workshop on Leadership and Development held in April
- Culture and Leadership Programme Director appointment and programme commencing in April
- Discussions regarding the Executive Leadership Plan and what it should look like have commenced. Plan is on track to be in place by June 2023
- Organisational structure of the Trust has been revised and out to consultation
- Triangulation exercise completed of the IIP, Pillars of Change and the We Care programme, including proposed governance and oversight using the We Care framework.

Key risks and issues:

- Substantive executive posts not yet filled
- Organisational restructure process still to be concluded
- Multiple changes in executive/SRO leads
- Business Intelligence capacity to support

Plan for next month:

- Complete review and refresh of Governance Model
- Publish Communication and Engagement Plan; and commence roll out of key messages, feedback, quick wins and success stories

Leadership & Governance Programme - - Product Milestones to end May	Due	RAG
1. Executive Leadership Team		
1.101: Substantive COO in post	Apr-23	Blue
1.102: Executive Director induction plans in place and on-going	Apr-23	Green
1.3 Communications and Engagement		
1.301: Outline Communications and Engagement Plan published	May-23	Green
1.302: Weekly roll out of key messages, feedback, quick wins and success stories	May-23	Green
1.4 Transformation Programme		
1.401: Revise the organisational structure of the trust and launch consultation	Apr-23	Green
1.402: Refocus We Care Programme	Apr-23	Green
1.403: Continue the Cultural and Leadership Programme focus in maternity and review effectiveness	May-23	Green

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Maternity Programme

SRO: Chief Nurse and Midwifery Officer

NHS
East Kent
Hospitals University
NHS Foundation Trust

Progress over last month:

- Catherine Pelley, Interim Chief Nursing and Midwifery Officer, appointed
- New Programme Director for Maternity identified and commenced
- Second round of Quarterly audits supporting appropriate clinical escalation now underway. Results are being reported in the maternity dashboard
- Improved Discharge pathway model agreed and implemented.
- Site Safety Visits undertaken on both sites by ICB – initial feedback in relation to consistency of documentation and equipment check. Formal report awaited.
- Quarterly survey currently out to staff (aiming to demonstrate improvement that staff feel listened to
- Maternity SI now integrated into the Trust SI Process
- Triage process improved at QEQM
- Resuscitation process has improved on both sites
- Planned process mapping of Fetal Medicine Unit (FMU) pathway was cancelled due to clinical availability due to be rescheduled
- The revised Maternity Improvement Plan (MIP) and the Maternity Transformation Proposal was presented to NHS Kent and Medway ICB. Further work was requested.
- NHSE Clinical Productivity Team met with the team to feedback on Obstetric Workforce planning – work is ongoing

Key risks and issues:

- Significant midwifery staffing deficit particularly at WHH
- Effective management of clinical escalation and Serious Incidents (SIs)
- Ongoing reputational damage impacting staff recruitment and patient choice

Plan for next month:

- Director of Midwifery (DoM) and Deputy DoM due to start in May 23
- Continued work on Maternity Transformation Programme Plan
- Deliver Coproduced plan on engagement, listening and leadership

Maternity Programme - - Product Milestones to end May	Due	RAG
2.2 Clinical Escalation and Handover		
2.202: Embedded quarterly audits supporting appropriate clinical escalation showing improvement; SBAR, MEOWS, sepsis and VTE	ongoing	
2.3 Clinical Assessment & Care Pathways		
2.301: Centralisation of telephone triage	May-23	
2.302: Agree model and implementation plan for improved discharge pathway	May-23	
2.308: Embedded quarterly audits supporting appropriate clinical assessment – showing improvement SBAR, MEOWS, sepsis and VTE	Ongoing	
2.4 Governance and Patient Safety		
2.401: No backlogs for SIs. HSIB investigations	May-23	
2.5 Engagement, Listening & Leadership		
2.501: Coproduced plan developed and agreed by staff	May-23	
2.504: Demonstrable improvement that staff feel listened to (quarterly survey)	Ongoing	

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Operational Performance Programme

SRO: COO

Progress over last month

Urgent and Emergency Care (UEC)

- Good progress against milestones with early improvement in Type 1 performance
- WHH Implementation of the Front Door Model including Medical Assessment Unit (MAU) pilot and short stay area has delivered improvements in the timeliness of early clinical assessment and supported improved patient flow
- End of Life model implemented at QEQM (5 beds) with good effect and a plan to broaden the associated criteria. WHH model planning to increase capacity in May
- Launch of Direct Access Pathways in three specialties is a significant step forward
- Urgent Treatment Centre (UTC) new inclusion and exclusion criteria have been implemented, as planned however the full programme of work may take 3-6 months to complete

Elective Recovery

- Good progress against milestones but National Strike has had significant impact
- Continued focus on monitoring agreed plans to recover the end of year position

Cancer

- Good progress against planned cancer milestone, however access to timely diagnostics has continued to impact on delivery

Plan for next month:

- Build on the learning from the ICB UEC walkthroughs at WHH & QEQM
- Launch of Direct Access Pathways in Respiratory, Gastroenterology and Cardiology and establish pathways to the MDU at Kent & Canterbury Hospital (K&CH) (nurse led)
- Ongoing work to recover elective end of year position

Key risks and issues:

- Impact of ongoing National Strikes
- Organisational Restructure Consultation with potential multiple change of leads
- Estate and Kit constraints - weekly breakdowns requiring workarounds and rework

Operational Performance Programme - - Product Milestones to end May	Due	RAG
3.1 Urgent and Emergency Care (UEC) and Whole System Interface Flow		
3.101: WHH Emergency Department Build Phase 3 started	Mar-23	
3.102: WHH implementation of the front door clinical model established	Mar-23	
3.103: QEQM End of Life Model implemented	Mar-23	
3.104: Cohorting wards pathway 1 across WHH/QEQM implemented supported with daily pathway zero reviews, development of board rounds and PTL	Apr-23	
3.105: Updated Patient Choice Process rolled out Trust wide (Discharge)	Apr-23	
3.106: Direct Access Pathways launched in Acute Medicine, General Surgery & Orthopaedics with training programme for nurse streaming roll out	Apr-23	
3.107: QEQM Emergency Department Build Phase 2 started	Apr-23	
3.108: UTC new inclusion and exclusion criteria implemented	Apr-23	
3.109: MAU Pilot at WHH with access to Short stay Ward, SDEC virtual clinics for acute medicine	Apr-23	
3.110: Direct Access Pathways launched in Respiratory, Gastroenterology and Cardiology with hot clinics established in SDEC	May-23	
3.111: Established pathways to the MDU at KCH (nurse led)	May-23	
3.2 Elective Recovery (including diagnostics)		
3.201: P2 monitoring report amended to highlight compliance/non-compliance with weekly oversight across each speciality	Apr-23	
3.202: Business planning assumptions agreed by EMT and detailed speciality stretch targets articulated	May-23	
3.203: Trust Access Policy revised to incorporate clinical review policy and the new Kent and Medway Access Policy	May-23	
3.3 Cancer		
3.301: Clinical harm reviews fully embedded with shared learning and improvement cycle	Mar-23	

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Quality & Safety Programme

SRO: Chief Nursing and Midwifery Officer / Chief Medical Officer

Progress over last month:

- Good progress against milestones for April, with May milestones on track to be delivered
- Senior clinical engagement and leadership has been promoted through CEMG and Serious Incident Declaration Panel (SIDP)
- Interim Director of Governance has led on the development of a new cross Trust Incident response system and processes replacing the current SI process
- Revised Sustainability Safeguarding Plan, Training and competency framework, and Terms of Reference for new Task & Finish group in place
- Trust has joined the Regional Strategic Safeguarding Oversight Group
- ICB secured £300k of new monies which has been agreed to support both a Trust Patient Safety Specialist role and a frontline coaching improvement project focused on improving the management of the Deteriorating Patient. Initial discussions with a potential partner did not meet the key aims of the project. The Trust has therefore identified and is pursuing an alternative offer with a local well regarded potential educational partner.

Plan for next month:

- Implement revised level two training and new safeguarding competencies for international nurses.
- Finalise review of current Fundamentals of Care workstreams and Fundamentals of Care framework
- Launch NEWs-2 e-learning module

Key risks and issues:

- Increased number of SIs reported in March compared to previous months - analysis required to understand underlying drivers
- Business Intelligence capacity to support the Quality & Safety Programme

Quality & Safety Programme -- Product Milestones to end May	Due	RAG
4.1 Quality Governance		
4.101: Define roles and responsibilities to promote senior clinical engagement and leadership (through revised Terms of Reference (ToR) for SIDP)	Apr-23	
4.102: Develop new cross Trust Patient Safety Incident Response systems and processes (replacing current SI process), including beginning to share the learning from SIs	May-23	
4.2 Quality		
4.201: Review and refresh current sustainability safeguarding plan	April-23	
4.202: Finalise sustainability safeguarding team business case and take through Trust business planning process	April- May 23	
4.203: Revised training and competency framework approved by safeguarding committee	April-23	
4.204: Set up task and finish group with oversight through safeguarding operational group	April-23	
4.205: Implement revised level 2 training for international nurses	May-23	
4.206: Implement new safeguarding competencies for international nurses	May-23	
4.3 Fundamentals of Care		
4.301: Review current FOC workstreams and develop FOC framework	May-23	
4.4 The Deteriorating Patient		
4.401: Agree with ICB the required funding for Patient safety specialist role and Improvement Project	Mar-23	
4.402:Confirm The Deteriorating Patient Safety Improvement Project building on current Trust improvement capacity	Jun-23	
4.403: Launch NEWs-2 e-learning module	May-23	

Key: Delivery against plan

Action is complete
Action is on track
Action mainly on track with minor issues
Action not on track with major issues
Action not started

11

People & Culture Programme

SRO: CPO

Progress over last month:

- Good progress made against planned milestones to date with May milestones on track to be delivered
- Staff survey showed a marginal improvement in staff engagement from 6.33 in 2021 to 6.5 in 2022 with 4,000 staff providing feedback. The results have been shared through a new NHS Staff survey results dashboard which allows teams to understand their local staff survey results. Next steps have been focused on three levels: organisational (closing the gap on national standards); hotspot related with targeted interventions and locality based with specialties and teams being asked to review the results and "change three things" building on a successful locality led pilot last year.

Key risks and issues:

- Significant staffing deficits across the organisation in crucial areas
- Impact of ongoing National Strikes
- Organisational restructure consultation

Plan for next month:

- "Change three things" will be project managed by the BPs and will allow for involvement across all levels of the organisation
- Recruitment strategy developed
- Recruitment trajectories produced

People & Culture Programme -- Product Milestones to end May	Due	RAG
5.1 Attract and Retain		
5.101: Recruitment trajectories produced and progress monitored for IENs and HCSWs	May-23	🟩
5.2 Culture & Leadership Development		
5.201: Launch of New Starter Experience survey	Jan-23	🟦
5.202: Development of enhanced NSS dashboard	Jan-23	🟦
5.203: Launch of new Benefits platform & EAP	Feb-23	🟦
5.204: Publication of enhanced NSS dashboard	Mar-23	🟦
5.205: Promote & communicate	Mar-23	🟦
5.206: Thematic analysis of NSS free-text comments	Apr-23	🟦
5.207: Review of We Care progress through NSS data	Apr-23	🟦

Key: Delivery against plan

- Action is complete
- Action is on track
- Action mainly on track with minor issues
- Action not on track with major issues
- Action not started

Finance Programme

SRO: CFO

Progress over last month:

- Good progress has been made against planned milestones
- Joint Trust and ICB actions are in place to support the Financial Recovery Plan development
- Appropriate financial foundations are being put in with some examples of improvements in Performance Review Meetings
- Improvement foundations have been put in place: financial governance through establishment of Financial Improvement Oversight Group; financial Improvement developed both internally through Performance Review Meetings (PRMs) and externally with input into Kent and Medway system Finance work; and financial consciousness through the implementation of the Clinical Leaders Efficiency Group and the updating of the financial and efficiency communications strategy.

Key risks and issues:

- Lack of embedded financial controls across the Trust
- Organisational Restructure Consultation – potential loss of focus on finance
- Impact of ongoing National Strikes
- Estate and Kit constraints – access to necessary capital

Plan for next month:

- Ongoing work to re-establish financial controls across the Trust
- Setting the financial position of the Care Groups, clinical and non-clinical, agreeing the baseline budgets across the Trust including efficiency targets to be delivered

Finance Programme -- Product Milestones to end May	Due	RAG
6.1 Financial Governance		
6.101: Implement Financial Improvement Oversight Group	Mar-23	
6.109: Joint Trust and ICB action plan re. Financial Recovery Plan (FRP) Development	Ongoing	
6.2 Financial Improvement		
6.201: Develop and agree FRP core base year (FY24)	Mar-23	
6.202: Update deficit drivers analysis	May-23	
6.210: Input to Kent and Medway System Finance Work	Ongoing	
6.3 Financial Consciousness		
6.301: Implement Clinical Leaders Efficiency Group (CLEG) to engage clinicians in productivity and efficiency, followed by a review of the approach	Mar-23	
6.302: Update financial and efficiency communications strategy	Mar-23	
6.303: Regular communications on finance and efficiency	Ongoing	
6.304: Regular updates to and oversight by FPC & FIOG	Ongoing	

Key: Delivery against plan

	Action is complete
	Action is on track
	Action mainly on track with minor issues
	Action not on track with major issues
	Action not started

Communication and Engagement

NHS
East Kent
Hospitals University
NHS Foundation Trust

AIM: To develop and implement a clear and consistent approach to internal and external communications and engagement with all our stakeholders to support the delivery of our vision, values, aims and strategic objectives

PROGRAMME OBJECTIVE: Structured, systematic and meaningful communication and engagement both internally and externally

NOF4 EXIT CRITERIA: Evidence of effective communication & engagement channels between the frontline & the Board & external partners

Our Trust-wide communication and engagement objectives

Keep **patients** informed throughout their health journey with us, be open, listen, involve them in decisions and use their feedback to improve their experience	Our **staff** are listened to, informed and engaged, and feel valued and able to make a difference	Our **stakeholders** are informed about the Trust's performance and feel involved so they can support their communities and hold us to account

Integrated Improvement Plan Communications and Engagement objectives

To raise <u>awareness</u> of our challenges and priority areas for the year ahead, "how" we will bring about improvements for our patients and staff and the difference it will make.	To <u>listen to</u> and <u>engage</u> our wide range of stakeholders: clinical and non clinical staff, patients, the public, our stakeholders and partners so there is a shared understanding.	To proactively <u>connect</u> with the middle of the organisation to gain wide-spread support and involvement in our improvement journey at every level.	To work with all our staff so that they <u>understand</u> their individual contribution to improving the way we care for patients in their day to day work and the tools available to help.	To create a <u>desire</u> to be involved and create change, which is owned and delivered by us and improves the experience of patients and staff.	To build hope and <u>pride</u> in what is achieved on the steps in our journey by providing positive feedback on things that are working and the difference they are making to patients.

Timeline

By May 2023: Publish a clear narrative explaining our improvement plan	**By May 2023**: Develop a monthly rolling programme of key messages to support staff engagement and the steps in our journey for stakeholders	**By May 2023:** • Maintain weekly roll out of key messages, feedback, quick wins and success stories. • Include and be honest about the areas that need further work. • Provide regular updates on progress and share stories of achievement to maintain momentum.	**By June 2023:** Build our improvement journey into all communications and opportunities to connect and engage.	**By July 2023:** Complete roll out of detailed communications and engagement plan, tailored to the needs of our clinical and non clinical staff, patients, the public, stakeholders and partners

Communication and Engagement

Our communications and engagement plan will continue to develop based on feedback from staff, patients and stakeholders and will be informed by the culture change programme. Our current priorities:

Develop strategic narrative:
❖ Turn the plan on a page into a single high-level narrative, accessible to all audiences by May 2023.
❖ Engage on a monthly rolling programme of engagement opportunities and strategic communications "The East Kent Conversation"
❖ Maintain a weekly and monthly rhythm of Trust-wide communications
❖ Hold bi-annual staff conferences

Connect ward to Board:
❖ Engage and support Trust leaders to cascade messages, e.g. team brief
❖ Develop care group skills to improve communication/engagement with front-line staff and patients
❖ Use patient and staff stories/campaigns to engage front-line staff/make improvement plan relatable
❖ Develop maturity of quality improvement approach in wards using We Care and roll out to other areas, as a key driver of staff engagement.
❖ Engage staff through Culture Leadership Programme and recruit >120 change champions

Develop relationships and patient and community voice:
❖ Develop and maintain relationship with NHS Kent and Medway and through East Kent Healthcare Partnership
❖ Maintain regular contact and relationships with stakeholders, e.g. MPs, Health Overview and Scrutiny Committee (HOSC)
❖ Continue to build patient and community voice and involvement through patient voice and involvement team and strategy

❖ Celebrate and share success stories and milestones, internally and externally

IIP AIM: Develop and implement a clear and consistent approach to internal and external communications and engagement with all our stakeholders to support the delivery of our vision, values, aims and strategic objectives.
IIP PROGRAMME OBJECTIVE: Structured, systematic and meaningful communication and engagement both internally and externally.
NOF4 EXIT CRITERIA: Evidence of effective communication and engagement channels between the frontline/Board/external partners.

Best practice communications and engagement

- Build and maintain a rhythm
- Be open and honest
- Use clear, concise, accessible language
- Tailor content to the audience
- Don't overload with messages
- Repeat, repeat, repeat and use different methods, e.g. digital, print, social, face to face
- Provide feedback route
- Complete the feedback loop, report back on what you did with the feedback

Communication and Engagement

Progress update April 2023

Improvement plan

- Socialised with Clinical Executive Management Team

- Improvement plan included in monthly team brief with focus on sustainable finances as theme for April (100 Trust leaders in attendance, written brief sent to 270 Trust leaders to use in team meetings)

- All staff forum in April focussed on monthly theme of sustainable finances (180 staff attended)

- April stakeholder newsletter introduced improvement plan

- Featured in east Kent MP's briefing 25 April

- Half day away day with Trust Leaders on IIP and CLP

Pillars of change

- Printed letters sent out to managers to hand deliver to every staff member from CEO and Chair asking them to read and discuss Reading the signals and the Pillars of Change and watch CEO and Chair video (digital comms resulted in 1000+ views of video by teams and individuals)

- Printed letter follows on from Open Letter in local media, digital and social communications to public, staff and stakeholders

- Your Hospitals magazine distributed across east Kent publicising open letter and pillars of change

- 1st Our Journey printed newsletter sent to teams includes Pillars of Change and sources of support

Next steps (May)

- Publish summary of IIP and narrative to describe how IIP, Pillars and We Care fits together

- Develop rhythm of regular, clear and consistent communications for staff, public and stakeholders

- Maintain monthly rolling programme of key messages and opportunities for engagement and feedback "The East Kent Conversation".

- Launch Culture Change champion recruitment campaign and develop engagement plan in line with culture change programme

- Review and support development of ways care groups share Trust-wide messages and communicate and engage locally

- Link patient and staff stories to improvement plan and develop campaign approach to engage all staff in individual projects

- Develop dashboard to report on reach and evidence of outcomes from engagement

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	MONTH 12 FINANCE REPORT
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	INTERIM CHIEF FINANCE OFFICER (CFO)
PAPER AUTHOR:	INTERIM CHIEF FINANCE OFFICER
APPENDICES:	APPENDIX 1: M12 FINANCE REPORT

Executive Summary:

Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The report is to update the Trust Board on the current financial performance and actions being taken to address issues of concern.				
Summary of Key Issues:	The group achieved a £4.2m surplus in March, which brought the year-end position to a £19.3m deficit which is £19.3m adverse to the plan. The surplus in month is due to the two additional non-recurrent allocations that the Trust received in month from the Integrated Care Board (ICB) and Kent & Medway NHS and Social Care Partnership Trust (KMPT) and non-recurrent items supporting the year end position. The Trust worked with Kent & Medway (K&M) NHS system partners to resubmit a financial plan for 2022/23 at the end of June following a national announcement confirming additional funding to mitigate inflationary pressures. In the resubmitted plan the Trust receives £22m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing our overall plan to a breakeven position. Delivery of this breakeven 2022/23 financial plan looks extremely challenging as it requires that the Trust: 1) Delivers £30m of efficiency savings. 2) Receives £18m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold. 3) Reduces the average spend on incremental Covid-19 costs by £9m as compared to the previous financial year. 4) Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.				

Group Position

£'000	This Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
EKHUFT Income	70,701	96,595	25,894	846,994	898,886	51,892
EKHUFT Employee Expenses	(42,737)	(61,912)	(19,174)	(511,898)	(569,740)	(57,841)
EKHUFT Non-Employee Expenses	(27,103)	(50,067)	(22,964)	(337,043)	(369,379)	(32,336)
EKHUFT Financial Position	**861**	**(15,383)**	**(16,244)**	**(1,947)**	**(40,232)**	**(38,285)**
Spencer Performance After Tax	36	(41)	(77)	209	153	(56)
2gether Performance After Tax	100	513	413	1,196	1,908	712
Rephasing/Sub IFRS16 Adjustment	50	(783)	(833)	467	(981)	(1,448)
Consolidated I&E Position (pre Technical adjs)	**1,046**	**(15,695)**	**(16,741)**	**(75)**	**(39,152)**	**(39,077)**
Technical Adjustments	6	19,933	19,927	75	19,835	19,760
Consolidated I&E Position (incl adjs)	**1,052**	**4,238**	**3,186**	**0**	**(19,317)**	**(19,317)**

1

The key drivers to the Year to Date (YTD) deficit are:
- Escalation Areas opened of around 80 plus beds across the Trust due to patient demand and flow £10.7m (This relates to the nursing costs and does not include the non-pay or increased levels of medical staffing which is estimated that the total cost to be c£20m).
- Cost Improvement Programme (CIP) Slippage £10.4m. In addition, over half of the achieved in year is on a non-recurrent basis. (Total achieved £19.6m of which £10.9m are non-recurrent)
- Drugs £5.9m.
- Premium pay and additional staffing £6.3m.
- 1.1 speciality for mental health patients £7m.
- Work permits £1.4m.
- Parking income £2.3m.
- Offsetting these cost drivers is the increased non recurrent allocation from the ICB and KMPT of £10.7m and net non-recurrent benefits of c£14m to support the position.

All NHS systems have access to funding in 2022/23 through the Elective Recovery Fund (ERF), subject to meeting the required threshold of 104% of 2019/20 activity levels. We have assumed to receive full ERF funding in April to March as it is expected that activity shortfalls for the full year are underwritten by national funding which has recently been announced.

The Group cash balance (including subsidiaries) at the end of March was £37.5m.

Total capital expenditure at the end of March was £35.7m which was a small underspend of £0.1m against the various total capital allocations in year.

The Trust achieved efficiency savings of £2.4m in March which was £1.6m below plan. The total CIP achievement for 2022/23 was £19.6m against a plan of £30m. £10.9m of the in year CIP achievement was non recurrent.

The Trust has investigated the Non-Elective underperformance against plan compared to the increased pressure the services are under. The Trust is experiencing difficulties with the flow of Non-Elective patients, caused by significant delays to the discharging of medically fit patients. The combination of this and an evolution in the use of observation bays appears to have resulted in a greater proportion of patients seen and treated in Accident & Emergency (A&E) with stays >48hrs, resulting in the number of Non-Elective admission being lower. The underlying reason is a lack of capacity of Non-Elective beds, due to the numbers of delayed discharges.

Day case and Elective inpatient activity has underperformed by 9.7% against plan YTD. The financial element of Elective Inpatients and Day cases is under plan by £10.5m Financial Year-End (FYE). Activity is behind plan by 10.4%.

Employee expenses performance is adverse to plan in March by £19.2m and by £57.8m YTD (11.3%) of which £0.6m and £8.9m respectively relates to the above plan pay award. In line with national guidance, estimated costs of £17.2m for additional Agenda for Change (AfC) pay awards, pending agreement, were accrued in March offset by accrued

2

	income included as patient care income. Substantive staffing increased by 23 Whole Time Equivalent (WTE).			
Key Recommendation(s):	The Board of Directors is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.			
Implications:				
Links to 'We Care' Strategic Objectives: **Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further				
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 38**: Failure to deliver the financial breakeven position of the Trust as requested by NHS England (NHSE).			
Link to the Corporate Risk Register (CRR):	**CRR 137**: There is a risk that the Trust will not be able to meet its 2022/23 efficiencies target equating to £30m. **CRR 136**: Failure to secure planned income due to underperformance against the Elective Recovery Fund baseline.			
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:	None			

Finance Performance Report 2022/23
March 2023

Interim Chief Finance Officer
Michelle Stevens

Contents	Page	**Appendices**	Page

Executive Summary

The group achieved a £4.2m surplus in January, which brought the year-to-date (YTD) position to a £19.3m deficit which is £19.3m adverse to the plan.

The Trust worked with Kent & Medway NHS system partners to resubmit a financial plan for 2022/23 at the end of June following a national announcement confirming additional funding to mitigate inflationary pressures. In the resubmitted plan the Trust receives £22m of additional funding, consisting of £6m inflationary funding and £16m of non-recurrent income, bringing the overall plan to a breakeven position. Since then additional £10.7m non recurrent funding has been received by the Trust.

Delivery of this breakeven 2022/23 financial plan was extremely challenging as it requires that the Trust:
Delivers £30m of efficiency savings.
Receives £18m of additional Elective Recovery Funding for treating planned patient activity above a nationally-set threshold.
Reduces the average spend on incremental Covid-19 costs by £9m as compared to the previous financial year.
Supports delivery of a further £16m of K&M system financial efficiency which does not yet have identified plans.

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Income and Expenditure   R

The key drivers to the YTD deficit are:
- Escalation Areas opened of around 80 beds across the Trust due to patient demand and flow £10.7m. This is the direct nursing cost only and does not include increases in non pay, overheads, therapy & medical staff. Full cost of the additional capacity is c£20m FOT.
- CIP Slippage £10.4m
- Drugs £5.9m
- Premium pay for incresed levels of taffing to meet clinical c£6.3m
- 1.1 speciality/mental health £7.0m
- Work permits £1.4m
- Parking income £2.3m
- Additional allocation of £10.7m & non recurrent benefits of £14m offset the costs listed above
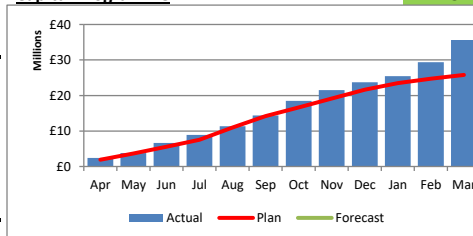
Cash   G
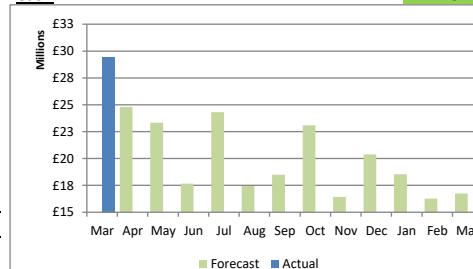
The Group cash balance (including subsidiaries) at the end of March was £29.4m.

Trust cash balances were in line with the planned balance in March.
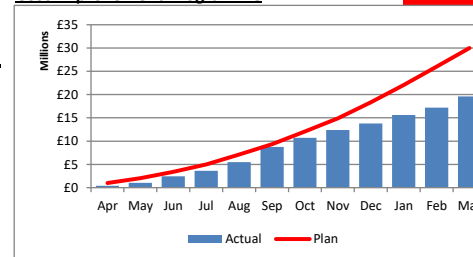
Capital Programme   G

Total capital expenditure at the end of March was £35.6m against an £35.7m plan which included external capital allocations.

Cost Improvement Programme   R

The Trust achieved efficiency savings of £2.4m in March which is £1.6m below plan bringing the year end position to £19.6m. £10.4m below the plan of £30m. £10.9m of the acheived CIP's in year are non recurrent.

Unconsolidated

£000	This Month Plan	Actual	Var.	Year to Date Plan	Actual	Var.
Income						
Electives	9,902	9,612	(289)	108,860	99,156	(9,705)
Non-Electives	20,002	18,641	(1,361)	238,198	212,435	(25,763)
Accident and Emergency	3,534	4,030	496	44,972	46,173	1,201
Outpatients	10,290	10,846	556	115,522	107,843	(7,680)
High Cost Drugs	3,869	3,672	(197)	46,424	51,807	5,383
Private Patients	23	45	22	279	228	(52)
Other NHS Clinical Income	17,977	42,122	24,145	232,905	320,716	87,812
Other Clinical Income	115	211	97	1,375	1,638	263
Total Income from Patient Care Activities	**65,711**	**89,180**	**23,469**	**788,536**	**839,994**	**51,459**
Other Operating Income	4,990	7,415	2,425	58,458	58,891	433
Total Income	**70,701**	**96,595**	**25,894**	**846,994**	**898,886**	**51,892**
Expenditure						
Substantive Staff	(39,327)	(54,462)	(15,136)	(455,299)	(486,499)	(31,200)
Bank	(1,933)	(3,691)	(1,757)	(28,215)	(40,241)	(12,026)
Agency	(1,477)	(3,758)	(2,281)	(28,384)	(43,000)	(14,616)
Total Employee Expenses	**(42,737)**	**(61,912)**	**(19,174)**	**(511,898)**	**(569,740)**	**(57,841)**
Other Operating Expenses	(26,163)	(49,779)	(23,616)	(326,549)	(360,882)	(34,333)
Total Operating Expenditure	**(68,900)**	**(111,690)**	**(42,790)**	**(838,447)**	**(930,621)**	**(92,174)**
Non Operating Expenses	(940)	(288)	652	(10,493)	(8,497)	1,997
Income and Expenditure Surplus/(Deficit)	**861**	**(15,383)**	**(16,244)**	**(1,947)**	**(40,232)**	**(38,285)**

Consolidated

£000	This Month Plan	Actual	Var.	Year to Date Plan	Actual	Var.
Income						
Income from Patient Care Activities	67,170	110,053	42,883	805,623	874,499	68,876
Other Operating Income	4,557	6,420	1,863	52,783	56,192	3,409
Total Income	**71,727**	**116,473**	**44,746**	**858,406**	**930,691**	**72,285**
Expenditure						
Employee Expenses	(45,983)	(85,015)	(39,032)	(550,772)	(634,258)	(83,486)
Other Operating Expenses	(23,728)	(46,862)	(23,134)	(296,843)	(326,724)	(29,881)
Total Expenditure	**(69,711)**	**(131,877)**	**(62,166)**	**(847,615)**	**(960,982)**	**(113,367)**
Non-Operating Expenses	(970)	(291)	679	(10,866)	(8,861)	2,005
Income and Expenditure Surplus/(Deficit) (pre Technical adjs)	**1,046**	**(15,695)**	**(16,741)**	**(75)**	**(39,152)**	**(39,077)**
Technical Adjustments	6	19,933	19,927	75	19,835	19,760
Consolidated I&E Position (incl adjs)	**1,052**	**4,238**	**3,186**		**(19,317)**	**(19,317)**

Income from Patient Care Activities

In month the Trust saw an overperformance against plan of £23.5m (£51.5m YTD).

Other NHS Clinical Income over performed in month by £24.1m (£87.8m YTD). This is made up of:

- £17.2m 2022/23 Pending Pay award
- £1.0m of additional funding to cover the cost of earlier pay award (£12.0m YTD).
- £0.2m under performance due to unfunded service developments inherent in our plan (£2.1m YTD)
- £0.2m additional funding from October for UTC telephone service (£1.35m YTD)
- £0.5m additional funding released for 1:1 specialist mental health (£5.5m YTD)
- £0.4m additional non recurrent funding support from NHSE (£5.2m YTD)
- £0.1m growth and ERF funding (£0.9m YTD)
- £2.5m income for Virtual Wards, Thrombectomy and Cardiac MRI, plus provision release (£2.7m YTD)
- £1.0m of contract income in excess of the activity performance (£34.7m YTD).

Out of Area patients are now directly funded and set nationally, paid in block amounts from ICBs which are direct payments. The majority of the annual amount of this income has been collected. Overseas patients invoicing is higher than planned, generating an overperformance of £0.2m YTD.

As per national guidance, the current income position assumes no clawback for underperformance against the 104% Elective Recovery year-end target.

Other Operating Income and Expenditure

Other operating income is favourable to plan in March by £2.4m and by £0.4m YTD. The main drivers for the variance in month are DHSC income for donated Covid-19 consumables of £1.7m and above plan education and training income of £0.5m.YTD, income relating to parking charges, property rental, including staff accommodation, research and innovation and Covid-19 are below plan by a total of £4.1m. These adverse variances are offset by donated income including Harmonia Village and Covid-19 inventory of £2.5m and above plan income for education and training £1.8m.

Total operating expenditure is adverse to plan in March by £42.8m and by £91.2m YTD.

Employee expenses performance is adverse to plan in March by £19.2m and by £57.8m YTD of which £0.6m and £8.9m respectively relates to the above plan pay award. In line with national guidance, estimated costs of £17.2m for additional AfC pay awards were accrued in March, offset by accrued income from patient care. Indicative direct costs for escalation beds continue to be at least £1.25 in month and £10.7m YTD, and 1:1 specialing costs are at least £0.7m and £7.0m YTD.

Total expenditure on pay in March was £61.9m, an increase of £14.1m when compared to February, mainly relating to permanent staff which increased by £13.6m. The £17.2m accrual for pending pay awards is offset by the planned release of annual leave accruals of £3.7m. Expenditure on bank and agency staff increased by £0.3m.

Other operating expenditure is adverse to plan by £23.6m in March and by £34.3m YTD, with the main driver being a technical adjustment of £20.0m for impairments. Overspends on drugs, clinical and non clinical supplies and premises totalling £7.7m (including £1.7m of Covid-19 consumables) are offset by favourable variances on purchase of healthcare and other expenditure totalling £5.0m.

Other operating expenditure was £49.8m in March, an increase of £19.8m when compared to February. The main driver for the increased spend in month is the adjustment for impairments of £20.0m. Reduced expenditure on court and legal fees, purchase of healthcare and injury benefits totalling £4.4m is offset by increases in computer hardware and software, donated Covid-19 consumables and the operated healthcare facility totalling £4.8m.

13 Month rolling cash flow
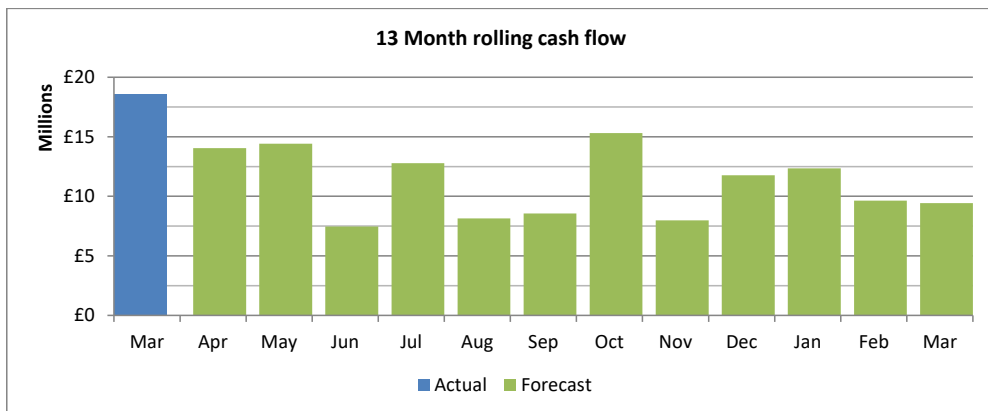
Unconsolidated Cash balance was £18.6m at the end of March 23, £14.6m above plan.

Cash receipts in month totalled £105.4m (£31.1m above plan)
K&M CCG paid £65.3m in March. £11.4m above plan.
NHS England receipts were over plan by £3.2m.
Other NHS receipts were £7.5m above plan, largely due to £4.4m received from HEE and £2.6m from Kent & Medway Partnership Trust.
Capital PDC receipts totalled £10.2m. (£7.6m above plan)
Other non NHS receipts totalled £6.7m (£1.4m above plan due to receipts in from Spencer Private Hospitals)

Cash payments in month totalled £108.2m (£24.1m above plan)
Creditor payment runs including Capital payments were £61.7m (£19.8m above plan)
Of this, £15.6m was paid to one key supplier to clear all outstanding invoices.
Payroll was £4.5m above plan

YTD cash receipts total £981.0m (£88.3m above plan - largely driven by block receipts from K&M ICB and additional receipts from NHS England, receipts from 2gether Support Solutions and revenue funding).

YTD cash payments total £989.9m (£73.07m above the plan - mainly driven by creditor payments (£44.3m) and Payroll (£30.9m))

2022/23 Plan

The revised group plan submitted to NHSE/I in June 2022 shows a breakeven position at the end of 2022/23. A breakeven position eliminated the option of borrowing cash and so all borrowing was removed from the forecast. (The Trust had expected to require additional funds from September 2022)

Closing group cash balance for 2022/23 was £37.5m. (£4.5m below group plan)

Forecast

2023/24 receipts and payments are based on the plan submitted in late February.

A monthly borrowing amount has been forecast in 2023/24, in line with the planned Trust deficit, to ensure the Trust can continue to pay creditors in a timely manner.

Creditor Management

The Trust closed the year at 30-day creditor terms to all suppliers.

The Trusts requested to draw £7m in April 2023 but following discussions with the ICB this request was withdrawn, creditor payments remain closely monitored.

The Trust has submitted a request to draw revenue support of £4.8m in May 2023.

At the end of March 2023, the Trust was recording 46 creditor days (Calculated as invoiced creditors at 31st March/ Forecast non-pay expenditure x 365).

Delivery Summary

Programme Themes £000	This Month Plan	Actual	Variance	Year to Date Plan	Actual	Variance	Forecast Outturn	Variance
Agency	726	346	(380)	5,561	4,083	(1,478)	4,083	(1,478)
Bank	(0)	26	26	(0)	113	113	113	113
Workforce	96	150	54	598	1,824	1,227	1,824	1,227
Outpatients	-	-	-	-	-	-	-	-
Procurement	278	72	(206)	1,800	349	(1,451)	349	(1,451)
Medicines Value	168	62	(106)	1,200	869	(331)	869	(331)
Theatres	396	23	(373)	3,000	301	(2,699)	301	(2,699)
Care Group Schemes *	1,988	706	(1,282)	15,183	8,772	(6,411)	8,772	(6,411)
Sub-total	**3,651**	**1,385**	**(2,266)**	**27,341**	**16,310**	**(11,031)**	**16,310**	**(11,031)**
Central	359	1,034	675	2,659	3,303	644	3,303	644
Grand Total	**4,010**	**2,419**	**(1,591)**	**30,000**	**19,614**	**(10,386)**	**19,614**	**(10,386)**

* Smaller divisional schemes not allocated to a work stream

Delivered £000

Month	Target	Actual
April	999	391
May	1,023	662
June	1,399	1,375
July	1,562	1,205
August	2,129	1,863
September	2,212	3,270
October	2,733	1,957
November	2,848	1,650
December	3,446	1,422
January	3,694	1,835
February	3,945	1,565
March	4,010	2,419
	30,000	**19,614**

Efficiencies

The submitted Efficiencies plan for 2022/23 is £30m. The Trust achieved savings of £2.4m in March, which is below the planned figure for the month. The in-month performance relates to shortfalls in Care Groups, Agency, Procurement & Theatres, offset by overperformance in Central, Workforce and Bank. YTD underperformance is primarily due to timing of schemes in Theatres, Procurement and Care Groups currently being developed. Recurrent savings in March amounted to £0.9m, with £1.5m being on a non-recurrent basis. savings YTD amount to £8.7m with £10.9m (56%) on a non-recurrent basis. Fortnightly Care Group meetings continue with an increased focus on determining values for 2023/24 ideas, and seeking further opportunities to develop savings plans.

Savings: Plan v Actual

Capital Programme	Year to Date	
£000	Plan	Actual
ED Expansion WHH & QEQM	11,654	14,955
24 Bed ITU Kennington Carpark WHH	350	399
Electronic Medical Records	910	2,916
PEIC - Backlog maintenance/ Patient environment improvement	3,750	3,900
MDG - Medical equipment replacement (<£250k per item)	1,136	3,173
IDG - IT hardware/ systems replacement	2,400	1,453
New Interventional Radiology (IR) suite - K&C	160	247
Endovascular theatre (EVT) kit installation - K&C	937	949
Maternity Training		145
Clinical Trials Unit	1,000	484
Community Diagnostic Hub - BHD	250	286
Maternity Estates Review	376	103
Refurbishment of SCBU QEQM and meeting IPC requirements	341	75
Theatre 4&5 - AHU Replacement - KCH	1,200	1,475
Restore and Recovery	250	214
East Kent Transformation Programme	178	
Donated Assets	900	846
2gether Support Solutions		179
Spencer Private Hospitals		38
Other IFRS16 Assets		1,084
All Other		(205)
Other IT		1,075
Mechanical Thrombectomy		1,315
Imaging Diagnostic Equipment		538
Maternity - Entonox		
	25,792	**35,644**
Funded By:		
Operational Cash		23,308
System Set Underutilisation		(822)
Grants and Donations		1,762
Disposals		120
Front Line Digitisation PDC		1,820
Other PDC		8,397
Right of Use Asset Liabilities		1,191
		35,776
Under/(Over) Commitment		**132**

2022/23 Capital Programme - Year-end performance against the available funding envelope and the System Control Total target set by the K&M ICB

Background

The Trust submitted the final 5-year Capital Plan to NHSE/I on 28th April 2022, the programme totalling £25.8m in 2022/23. This included a target System Control Total of £23.5m (made up of the available internally generated funding and the System Capital Support PDC allocated) and £2.3m of other national funding streams.

Throughout the year, the Trust received £9.8m of additional capital funding, increasing the 2022/23 Capital Programme from the £25.8m plan to £35.6m available capital funding.

Capital Spend Position - as at M12 (March 2023)

The group's gross capital year-to-date spend to the end of Month 12 was £35.6m, representing a break-even position against the available capital funding.

Against the System Control Total target set by the K&M ICB, the Trust reported an immaterial under-utilisation of the available internally generated funding of £0.08m.

Capital PDC

The Trust drew a total of £10.2m of Capital PDC but underspent £132k on the Discharge Lounge project. This will be notified to NHSi as this generates a validation error in the year-end reporting process. The Trust maybe required to repay the cash relating to this underspend.

£000	Opening	To Date	Movement	
Non-Current Assets	**418,987**	**402,107**	**(16,880)**	▼
Current Assets				
Inventories	5,527	6,749	1,222	▲
Trade Receivables	17,933	11,677	(6,256)	▼
Accrued Income and Other Receivables	16,715	29,981	13,266	▲
Assets Held For Sale				-
Cash and Cash Equivalents	27,372	18,618	(8,754)	▼
Total Current Assets	**67,547**	**67,025**	**(523)**	▼
Current Liabilities				
Payables	(33,309)	(41,537)	(8,228)	▲
Accruals and Deferred Income	(54,360)	(46,653)	7,707	▼
Provisions	(5,761)	(2,887)	2,874	▼
Borrowing	(5,738)	(4,838)	900	▼
Net Current Assets	**(31,621)**	**(28,892)**	**2,730**	▲
Non Current Liabilities				
Provisions	(4,417)	(3,405)	1,012	▼
Long Term Debt	(83,503)	(77,371)	6,132	▼
Total Assets Employed	**299,446**	**292,439**	**(7,007)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	425,777	454,994	29,217	▲
Retained Earnings	(181,901)	(217,590)	(35,689)	▼
Revaluation Reserve	55,569	55,035	(534)	▼
Total Taxpayers' Equity	**299,446**	**292,439**	**(7,007)**	▼

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions. A "full" revaluation of the Groups estate was completed as at 31 March 2023, generating net movements in the value of non-current assets, revaluation reserve and impairments.

Trust closing cash balance was £18.6m (£21.4m in February) £14.6m above plan. See cash report for further details. Cash was supported in year by £19m of PDC working capital and £12m cash (£4m dividend and £8m early repayment of loan) from 2gether.

Trade and other receivables have reduced from the 2021/22 opening position by £6.3m (£1.0m reduction in February). Key drivers are detailed on the Cash report

Payables have increased by £8.2m (£21.2m increase in February) See Working Capital sheet for more detail on debtors and creditors.

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

PDC increased in year by Capital receipts (£10.2m) and Working Capital (£19m). The movement in Retained earnings reflects the year-to-date unadjusted deficit and 2gether dividend receipt. Revaluation reserve movement is the result of the net movements following the revaluation.

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	2023/24 PLANNING UPDATE
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	INTERIM CHIEF FINANCE OFFICER
PAPER AUTHOR:	INTERIM CHIEF FINANCE OFFICER
APPENDICES:	APPENDIX 1: 2023/24 PLANNING UPDATE PRESENTATION

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	To update the Board of Directors on the proposed 2023/24 plan and gain approval for proposed plan.				
Summary of Key Issues:	The paper gives an update on the Trust's proposed business plan for 2023/24.				
Key Recommendation(s):	The Board of Directors is asked to **review and discuss** the proposed 2023/24 plan including the key risks and issues, and **APPROVE** the outline plan and next steps.				

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	Our people	**Our future**	Our sustainability	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	N/A			
Link to the Corporate Risk Register (CRR):	N/A			
Resource:	Y	All resource.		
Legal and regulatory:	Y	The Trust is bound by the accounting rules and guiding principles set out in the Annual Report Manual (ARM) and those applicable under the NHS Capital Regime.		
Subsidiary:	Y	The 2023/24 plan is a Group programme incorporating the planned expenditure of subsidiaries.		

Assurance Route:	
Previously Considered by:	Finance and Performance Committee 25 April 2023

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2023/24 Planning Update

Third Submission

Board Approval
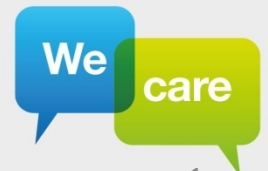
Our latest plans are appropriately ambitious for patients

		2019/20	2020/21	2121/22	2022/23	2023/24	Var to 19/20	Var to 22/23
Activity	Elective activity	104,792	71,053	98,413	104,597	105,212	0%	1%
	First outpatients	298,337	218,449	292,422	306,609	322,885	8%	5%
	Follow up outpatients	484,683	412,477	493,478	488,244	499,341	3%	2%
	Follow up with procedures	98,405	64,331	88,738	85,149	83,226	-15%	-2%
	Diagnostic tests	234,063	171,288	214,178	238,997	247,210	6%	3%
	Non Elective Admissions	96,425	80,723	94,352	82,907	102,721	7%	24%
	A&E attendances - Type 1	184,809	140,782	150,163	142,819	160,332	-13%	12%
	A&E attendances - Type 3	42,486	52,397	111,339	134,054	143,864	239%	7%
	Patients in ED for >12hours	5.71%	3.93%	7.31%	11.27%	N/A	N/A	N/A
	12hour trolley waits in A&E	43	234	1,395	11,036	N/A	N/A	N/A
Resources	Number of adult G&A beds	981	948	1,027	1,019	1,033	38	14
	Number of escalation beds	41	28	27	58	58	17	0
	No longer fit to reside		206	336	437	174	N/A	-263
	Theatre average cases per list	2.79	1.98	2.33	2.34	N/A	N/A	N/A
	Theatre cancellations per day	6.97	2.18	4.83	5.67	N/A	N/A	N/A
Standards (March)	A&E four hour wait	74.05%	81.67%	67.52%	67.28%	76.00%	2%	9%
	Cancer 62d wait	77.80%	81.54%	74.53%	66.59%	85.00%	7%	18%
	Patients on the rtt waiting list	47,331	52,230	65,958	72,354	72,243	25,023	-111
	Patients waiting over 18w	9,010	21,506	27,407	31,151	30,914	22,141	-237
	Patients waiting over a year	2	5,250	3,816	3,187	2,223	3,185	-964
	Patients waiting over 65weeks	0	2,101	1,776	901	0	901	-901
	Patients waiting over 78 weeks	0	585	716	197	0	197	-197
	Patients waiting over 2 years	0	4	54	2	0	2	-2

Planned care – elective and outpatients
- Largely returning to pre Covid levels or better
- Delivering this level of activity is key to keeping the total patient waiting list flat (72k in March '23 and '24) and ensuring no patient waits more than 65 weeks for treatment by March 2024

Urgent and emergency care
- Non elective admissions are expected to rise as a consequence of growing A&E demand (modelled based on system forecasts) and eliminating long waits in our Accident & Emergency (A&Es)
- To meet this demand will require us to more than halve the number of patients waiting to be discharged ('no longer fit to reside), from 437 beds occupied to 174 beds occupied.

We care

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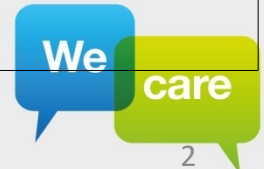
EKHUFT Workforce Plan Submission 23/24

Categories	Staff in post outturn 31-Mar-23	Establishment 31-Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Staff in post outturn 31-Mar-24	Establishment 31-Mar-24
	Total WTE	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*	*Total WTE*
TOTAL WORKFORCE	9963.00	9954.43	9979.86	10001.15	9988.21	9958.85	9929.08	9902.30	9915.98	9891.10	9881.98	9866.10	9854.98	9792.62	10070.46
Total Substantive	8969.44	9954.43	9011.25	9079.15	9116.21	9131.85	9164.08	9171.30	9222.98	9222.98	9243.98	9256.10	9273.98	9276.62	10070.46
Total Bank	536.50	0.00	521.19	495.00	462.00	443.00	417.00	403.00	386.00	386.00	342.00	321.00	307.00	263.00	0.00
Total Agency	457.06	0.00	447.42	427.00	410.00	384.00	348.00	328.00	307.00	307.00	296.00	289.00	274.00	253.00	0.00

Substantive Staff in post at 31 March 2023: 8969.44 Whole Time Equivalent (WTE)
Vacancy: 984.99 WTE
Vacancy Rate: 9.89%

Planned Substantive Staff in post at 31 March 2024: 9276.62 WTE
Vacancy: 793.84 WTE
Vacancy Rate: 7.88%

Bank and Agency WTE at 31 March 2023: 993.56 WTE
Bank and Agency Rate (% of Total Workforce): 9.97%

Planned Bank and Agency WTE at 31 March 2024: 516.00 WTE
Bank and Agency Rate (% of Total Workforce): 5.27%
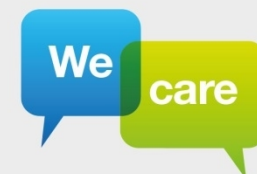
Bridge of forecast outturn to third plan submission

	Clinical Income	Other Op Income	Pay	Non-pay	I&E	Non-opex	Sum of Surplus/Deficit	Main drivers
2022-23 M10 Submitted FOT	**£849,122**	**£52,782**	**(£607,285)**	**(£314,423)**	**(£19,804)**	**£504**	**(£19,300)**	
Covid funding impact	(£11,021)	£0	£2,804	£2,076	**(£6,141)**	£0	**(£6,141)**	
FYE 22-23 changes	£4,408	£0	(£2,302)	(£7,888)	**(£5,782)**	£0	**(£5,782)**	Increase in CNST from 22/23
Non recurrent 22-23 Efficiencies	£0	£0	(£5,421)	(£2,380)	**(£7,801)**	£0	**(£7,801)**	
Non recurrent funding	(£32,319)	£0	£2,311	£0	**(£30,008)**	£0	**(£30,008)**	ICB allocation £21m, 121 care £6m, Drugs £4m
Reverse Balance sheet flexibilities	£46	(£849)	(£3,693)	(£4,204)	**(£8,700)**	£0	**(£8,700)**	Annual leave accrual, Legal provision
Reverse NR Income	(£5,252)	£0	£0	£0	**(£5,252)**	£0	**(£5,252)**	Income defered from 21/22 released
2022-23 Underlying position	**£804,985**	**£51,933**	**(£613,587)**	**(£326,819)**	**(£83,488)**	**£504**	**(£82,984)**	
Efficiencies	£129	£0	£21,297	£18,574	**£40,000**	£0	**£40,000**	4.10%
Funding for growth	£686	£0	£0	£0	**£686**	£0	**£686**	
Impact of inflation	£21,989	£0	(£12,846)	(£10,250)	**(£1,107)**	£0	**(£1,107)**	
23/24 Cost Pressures	£0	£0	(£10,692)	(£3,705)	**(£14,397)**	£0	**(£14,397)**	FYE of 22/23 cost pressures
Tariff efficiency	(£8,864)	£0	£0	£0	**(£8,864)**	£0	**(£8,864)**	
Other operating Income 23/24	£0	(£1,687)	£1,260	£420	**(£6)**	£0	**(£6)**	
Finance/Cap Charges	£0	£0	£0	£3,677	**£3,677**	(£1,448)	**£2,230**	
Revise Asset Disposal Expectation	£0	£0	£0	£0	**£0**	£50	**£50**	
Corporation Tax	£0	£0	£0	£0	**£0**	(£318)	**(£318)**	
Other	£52	(£1,014)	£0	(£1,523)	**(£2,485)**	£0	**(£2,485)**	Reduction in cash donations
Subsidiary impact	£1,816	£0	(£3,129)	(£2,317)	**(£3,629)**	(£20)	**(£3,649)**	Increase in pay costs not included in allocation
Income risk	(£3,719)	£0	£0	£0	**(£3,719)**	£0	**(£3,719)**	CDC & ICB offer
Move to 23/24 Contract Offers	£4,141	£0	£0	£0	**£4,141**	£0	**£4,141**	
Service Developments 23/24	£9,334	(£1,200)	(£4,576)	(£2,672)	**£886**	£0	**£886**	
Remove Ers Additional Pension Contribution	(£19,000)	£0	£19,000	£0	**£0**	£0	**£0**	
Technical Adjustments 23/24	£0	£0	£0	£0	**£0**	(£2,948)	**(£2,948)**	
Grand Total	**£811,547**	**£48,032**	**(£603,273)**	**(£324,614)**	**(£68,307)**	**(£4,179)**	**(£72,486)**	

	22/23 FOT £m	N/R £m	23/24 Plan £m
Income	898.9	- 43.3	859.6
Expenditure	- 569.7	- 6.8	- 603.3
Non-Pay	- 359.3	- 11.8	- 324.6
Non-Operating Expenditure	- 8.4	-	- 11.4
I&E	*- 38.5*	*- 62.0*	*- 79.7*
Technical Adjs	19.2	-	7.2
Reportable Position	*- 19.3*	*- 62.0*	*- 72.5*

The main drivers of the deficit is the non recurrent income allocations in 2022/23 c£43m, Balance sheet releases c£14m & non recurrent Cost Improvement Programme (CIPs) of £8m.

The Trust is planning a £40m CRES CIP target which equates to 4.1%. This target is above the productivity target of the increase in activity to deliver the reduction in the waiting lists detailed on the first slide.

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	BOARD ASSURANCE FRAMEWORK RISK REGISTER
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	CHIEF NURSING AND MIDWIFERY OFFICER
PAPER AUTHOR:	RISK MANAGER
APPENDICES:	APPENDIX 1: BOARD ASSURANCE FRAMEWORK 18.04.2023

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	This report provides the BoD with updates on and changes to risks on the Board Assurance Framework (BAF) as at 18 April 2023. It also includes an update on Board Committee risk activity during this reporting period.				
Summary of Key Issues:	• **Headline**: There are currently **10 risks on the BAF**. • **New risks:** There have been no new risks added to the BAF in this reporting period. • **Other changes:** Other changes to the risk records are included in the BAF risk register at Appendix 1. • **Quarter Four Performance:** The full quarter four performance data (i.e. January to March) and related commentary is shown on Page 4. • **Tracker report:** A BAF tracker report has been included on page 5 of this report. • **Board Committees:** Risk activity summaries for meetings held in quarter four are included on pages 6-7. This includes the IAGC meeting held on 28 April 2023.				
Key Recommendation(s):	The BoD is asked to **APPROVE** the latest update of the BAF; and discuss whether: • the correct risks are identified on the BAF; • any reports or assurances received in the work of the Board and its Committees impact on the assurance levels in the BAF; • controls, assurance, gaps and actions are appropriate; • any further controls may be required to mitigate the risks identified; • the projected target current risk scores for 2022/23 are appropriate given the actions planned to mitigate the risks; and • it is **assured** that risks on the BAF are being appropriately mitigated. **Reassurance** **Assurance** ⬅──────────────────────────➡				

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	It is okay because management say it is: • Strong management personalities may dominate • Track record of success • Professional background or expertise • No contradictory evidence	It is okay because how management have responded to questions from the Board has given me confidence: • Clear and logical explanations from board members • What has happened; why it has happened and what is the response • Management explanations are consistent	It is okay because I have reviewed various reliable sources of information: • Independence of information source • Evidence of historic progress, outcomes • Triangulation with other information

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	This paper provides an update on the BAF.			
Link to the Corporate Risk Register (CRR):	This paper provides an update on the CRR.			
Resource:	N	Resource implications are considered as part of the risks.		
Legal and regulatory:	N	Legal and Regulatory implications are considered as part of the risks.		
Subsidiary:	N	The Trust has a Subsidiary Shared Risk Register that is monitored at the Contract Performance Meeting.		
Assurance Route:				
Previously Considered by:	Corporate Risk Register (CRR) - Clinical Executive Management Group (CEMG) BAF and CRR - Board Committees – People & Culture Committee (P&CC), Finance & Performance Committee (FPC), Quality & Safety Committee (Q&SC); and Integrated Audit & Governance Committee (IAGC).			

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BOARD ASSURANCE FRAMEWORK RISK REGISTER

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1.   Purpose of the report

1.1.   This report provides the BoD with an update on and changes to risks on the Board Assurance Framework (BAF) as at 28 April 2023.

1.1   The BAF contains the principal risks for the Board corporately to assure itself after successful delivery of the organisation's strategic objectives.

1.2   **Key changes – New risk for escalation 'Our Sustainability'**. There was one new risk escalated to the BAF approved by the FPC. Other changes to the risk record during this reporting period have been highlighted in red font in the summary page or noted in the key changes' column.

1.2.1   **Executive Risk Owner: Chief Finance Officer**
Failure to deliver the financial plan of the Trust as requested by NHS England (NHSE) for 2023/24. This risk has been approved for addition due to the extremely challenging financial landscape for 2023/24, with an underlaying deficit for the Trust of c.£45-50m included as part of the business planning process. Planning guidance issued for the new financial year has a focus on the recovery of core services and productivity with a return to payment by results for most elective care. Detailed plans are being developed with each Care Group for activity for the financial year, however, with current controls in place the risk remains extreme (25) with a severity of extreme (5) and a likelihood of almost certain (5).

1.3   **Key changes** – **Increase in risk rating 'Our Quality and Safety'**. There was one risk approved for an increase in risk rating on the BAF by the Q&SC.

1.3.1   **Executive Risk Owner: Chief Medical Officer**
BAF 32 – There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.
This risk has been approved for increase in risk rating from a high (16) to an extreme (20) as the level of activity across the Trust is increasing the likelihood of the risk occurring. This is due to overcrowding resulting in patients being cared for in areas not designed for clinical care. Actions to mitigate this are described in CRR 78 – There is a risk of overcrowding in Emergency Department (ED) due to a lack of capacity in the system and increased local demand.

1.4   **Key change – Risk for closure 'Our Sustainability'**. There was one risk approved for closure on the BAF by the FPC.

1.4.1   **Executive Risk Owner: Chief Finance Officer**
Failure to deliver the financial plan of the Trust as requested by NHSE. This risk has been approved for closure by the FPC as the risk has now crystallised. The Trust forecast a deficit of £30m for the 2022/23 financial year, which is being formally agreed with the Integrated Care Board (ICB) and NHSE, whilst internal financial controls continue to be heightened.

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1.5 **Quarterly Performance**: The Trust's risk management framework links risks to the Trust's strategic objectives. The BAF will be reported to the Board and its Committees alongside the Integrated Performance Report (IPR) on a quarterly basis.

1.5.1 The IPR forms the summary view of organisational performance against the strategic objectives and looking at the BAF risks in parallel will support the Board in determining whether the risks are appropriately managed, whether the risk appetite is set at the right level and whether further resources are required to control the risk.

1.5.2 The table below provides an aggregated overview of the performance against the True Norths as at quarter 4.

True Norths		Q4 Performance	Related BAF Risk and Risk Movement	Risk Appetite and Risk Appetite status in bracket	Overall Assurance
Our Patients	Over 12 Hour Wait	Red	BAF 34 (High) =	High (within appetite)	Limited
	18 Weeks	Red			
	Cancer 62 day	Red			
Our People	Staff Engagement	Red	BAF 35 (High) =	Significant (within appetite)	Limited
Our Future	No related True Norths	N/A	BAF 36 (Extreme) =	Significant (within appetite)	Limited
Our Sustainability	I&E Margin	Red	None BAF 38 closed during the quarter as risk crystallised		
Our Quality and Safety	Actual Harm	Red	BAF 32 (High) =	High (within appetite)	Limited
	Mortality	Green	No related BAF risk.		

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BAF Risks Movement Tracker:

Strategic Goal	BAF ref.	Risk Title	Movement of the current risk rating within the year												Target risk rating
			A	M	J	J	A	S	O	N	D	J	F	M	
Our Patients	33	There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	10 =	5
	34	There is a risk that our constitutional standards are not met	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	16 =	8
Our People	35	There is a risk of failure to recruit and retain high calibre staff	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	10
	40	There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals.					12 'N'	12 =	12 =	12 =	12 =	12 =	12 =	12 =	8
Our Quality and Safety	32	There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5
	31	Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	15 =	5
	39	There is a risk that women and their families will not have confidence in east Kent maternity services if the Trust does not respond effectively to the recommended themes of the 'Reading the Signals' report						20 'N'	20 =	20 =	20 =	20 =	20 =	20 =	5
Our Future	36	Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	20 =	5
	30	Failure to deliver the full benefits of the We Care Improvement system	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	12 =	4
Our Sustainability	41	Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24												25 'N'	15

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2.   Board Committee Risk Activity

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

2.1.1   At the meeting on 26 January 2023, the Chair questioned the effectiveness of the BAF and CRR as most risks scored around 15-20 and there had been little movement on the risks for 12 months.

2.1.2   Q&SC members expressed a range of views including:
   2.1.2.1   The CRR appeared to be a list of issues but how we manage risk is important.
   2.1.2.2   There is a need to articulate the risks more clearly and have clarity on the mitigating actions.
   2.1.2.3   The mechanism for this work is the Executive Risk Assurance Group (ERAG).
   2.1.2.4   What is the alignment with the organisational strategy?

2.1.3   At this stage, the Q&SC had partial assurance on the process and sought assurance that the risks are being managed and the BAF is reviewed and aligned to the strategy.

2.1.4   At the meeting on 2 March 2023, the Committee received limited assurance that the 5 BAF risks and the 13 CRR risks relating to 'Our Patients' and 'Our Quality and Safety' are being appropriately mitigated.

2.1.5   The Committee sought assurance that the Executive team had oversight of the risks and discussed them regularly.

2.1.6   The Committee again questioned the effectiveness of the BAF and CRR and felt that the BAF needed to be re-set against the strategy.

2.1.7   The Chair escalated to the Board of Directors that the target risk level drop seems ambitious and challenged if the required actions will deliver the required change. The NHSE Improvement Director commented that the BAF should be replaced in line with the impending Integrated Improvement Plan (IIP). The Q&SC noted the intended direction of travel and felt it should also include reference to a refreshed Trust strategy. The Q&SC also noted that responsibility for the BAF would sit in the Director of Quality Governance portfolio.

2.1.8   At the meeting on 30 March 2023, the Q&SC noted that the CRR had moved into the Chief Nursing and Midwifery Officer (CNMO) portfolio and the CRR review was currently underway.

2.1.9   The Committee re-iterated their commitment to manage the risks within the Trust. The Chair made it clear the Q&SC and Board remained committed to understanding and effectively managing risk but that requires the CRR and BAF to be revised, as proposed by the Executive Team.

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

2.2.1   At the meeting on 31 January 2023, the FPC received partial assurance that the 11 risks relating to 'Our Future' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

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2.2.2 Further information and rigor was requested by the committee in relation to the Cost Improvement Programme (CIP), changes in leadership, CRR 34 (Failure to sustain and improve health and safety standards across the Trust) and CRR 126 (There is a risk of failure to provide adequate accommodation (residential, training and office).

2.2.3 At the meeting on 28 February 2023, the FPC received partial assurance that the 11 risks relating to 'Our Future' and 'Our Sustainability' are being appropriately mitigated with one new risk added to the BAF and one risk added to the CRR. There was also one risk in the CRR which has been approved for a reduction in risk rating.

2.2.4 At the meeting on 28 March 2023, the FPC received partial assurance that the 11 risks relating to 'Our Future' and 'Our Sustainability' were being appropriately mitigated with two new risks added to the CRR, two risks closed from the CRR and one risk approved for de-escalation.

2.3 People and Culture Committee (P&CC)

2.3.1 At the meeting on 31 January 2023, the P&CC received assurance that the risks relating to 'Our People' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

2.3.2 At the meeting on 28 February 2023, the P&CC received assurance that the risks relating to 'Our People' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

2.3.3 The Committee will undertake a detailed review of the BAF and CRR later in the year.

2.3.4 At the meeting on 28 March 2023, the P&CC received assurance that the risks relating to 'Our People' and 'Our Sustainability' are being appropriately mitigated with no new risks added to the BAF or CRR in the reporting period.

2.3.5 The Committee noted the de-escalation of CRR 126 – There is a risk of failure to provide adequate accommodation (residential, training and office) and requested that this risk remain on the Corporate Risk Register for monitoring.

2.4 Integrated Audit and Governance Committee (IAGC)

2.4.1 At the meeting on 28 April 2023, the IAGC noted the ERAG assurance reports for January, February and March 2023. The Committee approved the ERAG revised terms of reference.

2.4.2 The IAGC received and noted the BAF and CRR report including the quarter 4 performance data aligning the IPR and BAF and the Board sub-Committee risk activity for quarter 4 from Finance and Performance Committee, Quality and Safety Committee and People and Culture Committee.

2.4.3 The IAGC noted the risk management workplan to align with the Integrated Improvement Plan and recommend to the Board of Directors that the risk appetite is set at the Board Development Day in August 2023.

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BOARD ASSURANCE FRAMEWORK

QUARTER 4 – 2022/2023

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: The True North target is to achieve zero patient safety incidents of moderate and avoidable harm within 5 years. Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years.

Executive Owner: Chief Medical Officer (CMO)	Date last reviewed: March 2023
Responsible Committee: Quality and Safety Committee	Next review scheduled: April 2023
	Date risk identified: May 2021

Principal Risk – BAF 32	Risk Appetite	Initial Risk Rating: L4 x S5 = 20
There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered.

Effect: Poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers, financial impact | The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite | Current Risk Rating: L4 x S5 = 20 |

Movement of the current risk rating within the year / Projected for 23/24

A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	20				
=	=	=	=	=	=	=	=	=	=	=	↑				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)

Aligned BAF Risks
39 - There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS)
Aligned Corporate Risks
117 – Patients may be harmed through poor medicines management due to poor culture towards medicines prescription and administration at ward and department level that may result in patient harm, poor patient experience and increased length of stay (16)
77 – Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services (15)
110 – Children may receive sub-optimal quality of care and poor patient experience within our children's services (15)
36 – Patient outcome, experience and safety may be compromised as a consequence of failure to 1. Identify patients with additional vulnerabilities (adult and children) 2. Assess their needs 3. Plan appropriate care, including relevant safeguarding legislation and local safeguarding policies 4. Mitigate any risks 5. Work in line with relevant legislation (including Children Act, Care Act, Mental Capacity Act, Equalities Act, Mental Health Act) (12)
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 (20)
122 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate midwifery staffing levels and skill mix to meet patient's needs (20)
123 - 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 (15)
78 – There is a risk of overcrowding in ED due to a lack of capacity in the system and increased local demand
139 – Trust fails to adequately investigate clinical incidents in a timely manner and identify themes in order to action change and avoid future repetition

Emergent Risks/Issues
- Change in focus of We Care objectives
- Use of escalation areas across the Trust
- We Care objectives need to be redefined in view of current priorities
- Identification and response to the deteriorating adult and child
- Capacity of staff to deliver focused improvements
- Timely access and response to diagnostics
- Learning from serious incidents, complaints, mortality, incidents and claims

Future Opportunities
- Realisation of Safer Staffing Business Case
- We Care Improvement Programme – In Year Breakthrough Objectives
- RSP exit

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as almost certain (5), the severity is more likely to occur than not with the current controls in place.

Latest Commentary
Risk scoring agreed for increase at February Q&SC. The roll out of MicroGuide continues to expand across wider areas of care. An update on project progress is to be presented at CEMG on 22/02/23 which includes CGAG membership. Support materials are in development to assist specialties with the transition. Each GSM specialty have an M&M meeting where cases are discussed identified through the SJR process, complaints and incidents or areas of best practice. The specialties report to the Care Group governance meeting presenting a case on rotation to share learning across the Care Group. UEC Care Group have monthly M&M meetings. Learning is shared via a journal with the multi-disciplinary team. Surgery – HNBD have M&M meetings for ENT, Breast and Max Fac with feedback presented at their monthly audit meetings. Ophthalmology and Dermatology review complications and discuss at their audit meetings. There is a space for each specialty to update the Care Group regards M&M on their monthly performance and governance reports that are submitted to monthly Care Group meetings. Revised Patient Safety Committee terms of reference approved at February Quality and Safety Committee, action closed. Integrated Improvement Plan to be presented to Trust Board in April 23.

Action required and date
1) Outcome of governance review to define and agree governance and reporting by subsidiaries **Chief Executive Jun 23**
2) Roll-out of MicroGuide across specialties **Director of Quality Governance Mar 25**
3) Appoint a Trust-wide mortality lead **CMO May 23**
4) Work to address deteriorating patient incorporated in Integrated Improvement Plan **CMO Dec 23**
5) Agree Quality Improvement workstreams through We Care **Head of Transformation Jun 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) The Quality Strategy (2022-2026), approved at Board of Directors (BoD), Sep 22	**Internal**
1) Approval and monitoring of the Trust Quality Strategy through SLT, Q&SC and BoD.
2) Approval and monitoring of the Trust Quality Strategy, We Care objectives and Trust priority improvement projects through SLT, Q&SC and BoD

External
1) CQC reports monitored by the BoD and action plans developed and monitored by CQC and NHSE | 1) Improve oversight of health and safety governance that impacts on patient safety |
2) Reduction in harm and reduction in mortality are True North objectives agreed by the Executive team and progress monitored monthly at Executive management Team meetings and reported in the Board Integrated Performance Report (IPR)		
3) NHSE led Governance review supported restructure and revised terms of reference for the Q&SC		
4) Breakthrough Objectives aligned to True North are monitored at monthly Executive management Team meetings and reported in the Board IPR		
5) Monthly performance Review Meetings established to ensure Care Group accountability against the delivery of quality and safety priorities, and to escalate new concerns to driver metric status through Catchball when identified		2) Improve clinical outcomes through internal review, effective use of data and implementation of recommendations from national clinical audits and outcomes, NICE recommendations and Getting it Right First Time (GIRFT)

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CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver safe care	3) Embedding of morbidity and mortality and outcome reviews
6) Systematic processes in place to review mortality	

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: The True North target is to achieve zero patient safety incidents of moderate and avoidable harm within 5 years. Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years.

Executive Owner: Executive Director of Infection Prevention and Control (DIPC)
Responsible Committee: Quality and Safety Committee
Date last reviewed: April 2023
Next review scheduled: May 2023
Date risk identified: May 2021

Principal Risk – BAF 31
Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements

Effect: Leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	15				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025 (to align with the Journey to Outstanding Care Programme)

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks	**Rationale for Current risk score** The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Risk reviewed with Executive Director of Infection Prevention and Control. Risk revised for expected 2023/24 contract to be presented to the Infection Prevention and Control Committee in April 2023 for discussion. Closure of IPC workplan for 2022/23 will be reported to the IPC Committee on 20 April. Awaiting formal publication of revised Infection Prevention and Control Board Assurance Framework; this will then be presented to the Board formally and reported bi-annually after this. Meeting with antimicrobial stewardship pharmacist to develop antimicrobial stewardship strategy.	**Action required and date** 1) Delivery of annual IPC workplan **EDIPC Mar 23** 2) Delivery of antimicrobial stewardship strategy **Antimicrobial Pharmacist Mar 24** 3) Launch revised IPC Committee Structure **EDIPC Apr 23** 4) Assessment against revised Infection Prevention and Control Board Assurance Framework **EDIPC Mar 23** 5) Annual IPC workplan to be developed following the publication of revised code of practice **EDIPC Apr 23**
Emergent Risks/Issues • Ongoing Covid-19 pandemic • Fragility of infrastructure **Future Opportunities** • Plan to increase surveillance through annual plan			

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS) 2) Compliance with requirements of the "hygiene code" with a plan to address any gaps 3) Collaboration and agreement with 2gether Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning 4) We Care Breakthrough Objective focussed on externally reportable HCAI organisms	**Internal** 1) Formally reportable data are signed off by the CEO are reported monthly to the Quality and Safety Committee and annually, publicly via DIPC Annual Report 2) Infrastructure issues reported via Director of Strategic Development and Capital Planning (reference to strategic goal 4 and statutory compliance) 3) "Hygiene Code" gap analysis report to Quality and Safety Committee **External** 1) Data are shared with ICB and are available to NHSE and CQC (automatically)	1) "Hygiene Code" gap analysis identified gaps in compliance and assurance

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STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics.

Executive Owners: Group Company Secretary (CoSec)
Responsible Committee: Quality and Safety Committee
Date last reviewed: February 2023
Next review scheduled: March 2023
Date risk identified: May 2021

Principal Risk – BAF 33
There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.

Effect: Poor delivery and quality and safety of services; failure to meet statutory and regulatory requirements resulting in damage to reputation, regulatory action, harm patients, legal challenge.

Risk Appetite
The Trust has a **HIGH** appetite for risks to improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L2 x S5 = 10
Current Risk Rating: L2 x S5 = 10

Movement of the current risk rating with the year												Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
10	10	10	10	10	10	10	10	10	10	10	10				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 December 2022

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			Assurance Level: None/**Limited/**Adequate/Substantial
Risks & Opportunities	**Risk and Scoring Commentary**		**Actions (Planned)**
Aligned BAF Risks **39 -** There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS) **Aligned Corporate Risks** None **Emergent Risks/ Issues** • Strategies/policies not consistently followed and are not embedded • Staffing structures may not be adequate to deliver the governance agenda. • Knowledge and skills gaps identified **Future Opportunities** • CQC Well led review recognising improvements in governance. • Trust evidencing improvements in the Leadership and Governance domain as part of the exit criteria of the Recovery Support Programme.	**Rationale for current risk score** The current risk score is rated as a moderate (10) risk. The severity of the risk is scored as extreme (5), due to the potential for patient experience to be unsatisfactory; breaches of statutory duty and subsequent prosecution; adverse publicity undermining public confidence in organisation; inquest/ombudsman inquiry. The likelihood of the risk is scored as unlikely (2), due to the expectation that the risk is not expected to crystallise due to the controls in place however it is possible it may do so.	**Latest Commentary** Revising RSP criteria, awaiting further updates from NHS Improvement and Oversight Directors.	**Action required and date** 1) Communicate/train and embed strategies/policies in relation to the governance framework **CoSec/EDQG Jul 22** 2) Ensure the knowledge, qualification and skills in the Care Group governance job descriptions are fit for purpose **COO Jul 22** 3) Recovery Support Programme Action plan to be delivered **Chief Finance Officer (CFO)** ~~**Dec 22**~~ **Mar 23** 4) Develop specific risk management training and roll out across the Trust **Corporate Governance and Risk Consultant** ~~**Jul**~~ ~~**Dec 22**~~ **Mar 23** 5) Develop integrated governance document to support understanding **CoSec** ~~**Jul**~~ **Oct 22**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Suite of governance policies in place	**Internal**		1) Strategies/policies not consistently followed and are not embedded
2) Additional Executive post created, and portfolios split to provide more capacity and expertise. Director of Quality Governance appointed and joined the Trust May 21	1) Policies are presented to PAG and BoD (if required) for ratification. Robust sign off process for policies including via groups and PAG		2) Possible gaps in understanding of the breadth of both the clinical and corporate governance agenda
3) Organisational structure in place below Executive Level to support the governance agenda	2) Challenge of BAF and CRR at Board and Board Committees		
4) Governance Review Action plan in place and agreed with NHSE	3) We Care meetings to provide evidence against progress for each metric		
5) Terms of reference for various committees and groups approved	4) Calibration and challenge of risks on Care Group, Corporate and Board Assurance Framework (BAF) risk registers at ERAG		3) Deliver and embed the actions from the Governance Review action plan and agree how outcomes will be measured
6) Risk registers in place, BAF, CRR and Care Group level			4) Gaps in knowledge due to a lack of specific training in risk and governance, for all levels and roles
7) Incident Management, Complaints Management and Clinical Audit process in place	**External** 1) RSM independent audit program (Risk management planned)		5) A lack of integrated governance document for the Trust to support understanding
8) Statutory training in place that includes elements of risk management	2) Regional oversight committees		
9) Other training including incident investigation	3) Well-led governance review (NHSE)		

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The new national standard is for no more than 2% of patients to spend longer than a total of 12 hours in the emergency department, from arrival until being admitted, transferred or discharged. The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient.

Executive Owners: Chief Operating Officer
Responsible Committee: Quality and Safety Committee

Date last reviewed: December 2022
Next review scheduled: January 2023
Date risk identified: May 2021

Principal Risk – BAF 34 There is a risk that our constitutional standards are not met The fluctuating nature of the Covid-19 pandemic necessitates a localised approach to escalation. When the number of positive patients admitted as emergencies exceeds trigger points for safe, effective cohorting there is a risk that elective care capacity is then compromised. **Effect:** Access for patients who are Covid and non-Covid is governed by the current IPC guidance. Patients who present in the emergency department are subject to point of care testing and the results of this test determine the IPC support required for admission. If ITU capacity is required there is a further risk to patient's elective procedures being cancelled. Patients who are requiring discharge from hospital on complex pathways for example if a nursing or residential placement is required will be delayed awaiting a suitable bed for a patient with a Covid positive status. Patient experience is impacted by cancellation of surgery or procedures by self-isolation prior to procedure. The prioritisation of only cancer or urgent elective care will increase the length of time for patients with routine but important surgery during the Covid surge. Patient experience in the ED is impacted as ED becomes more congested. This is driven by the restricted availability of an inpatient bed or assessment area. There is a financial impact of failing to deliver an elective recovery programme to the level of 19/20 pre-Covid activity. The Trust may remain in RSP if	**Risk Appetite** The Trust has a **HIGH** appetite for risks to improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards. **Risk Appetite Status**: Within appetite	**Initial Risk Rating: L4 x S4 = 16** **Current Risk Rating: L4 x S4 = 16**

Movement of the current risk rating within the year / **Projected for 23/24**

A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
16	16	16	16	16	16	16	16	16	16	16	16				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L2 x S4 = 8
Projected Target Date: ~~31 December 2022~~ **31 March 2023**

Assurance Level: None/**Limited/**Adequate/Substantial

agreed thresholds for improvement aren't reached these include the reduction of very long waiting patients and deliver 110% activity

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks CRR 78 – Risk of overcrowding in ED compromising patient safety and patient experience due to a lack of capacity in the system and increased local demand **Emergent Risks/ Issues** • Failure to manage the balance of demand and capacity and risk across the health and social care system • With patients delayed in the hospital setting and the priority to off-load ambulances, care and treatment of patients is taking place outside an established inpatient and treatment area (escalation areas) • Continued pressure on emergency department for both admitted and non0admitted patients • The risk of a combined presence of covid-19 and influenza impacts on both restricted capacity and staff absence • Cost of living crisis impacts on the health and well-being of vulnerable groups • Possible industrial action in key health and care support services will have a cumulative impact • Winter may impact on elective capacity and staff as emergency pressures build • Capacity of the centralised booking team **Future Opportunities** • Structure services on cold and hot site scenario – allow us to have a clearer access pathway for patients • Independent sector and insourcing – extend resources and capacity to mitigate any delays • Continued focus on length of stay and new models of care i.e. virtual wards • Manage demand more effectively across the health and social care system to balance risk – cognisant and focused on quality issues around waiting list	**Rationale for current risk score** The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the number of patients affected by the risk; potential for increased length of hospital stay; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.	**Latest Commentary** Review of outpatient models of care and clinic space including the increase in advice, guidance and patient initiated follow up to release outpatient space. The DNA rate has reduced as part of work of this group from 11 to 7.8%, reviewed weekly through touchpoint meeting, action closed. The number of vacancies in the booking team has reduced from twenty to six. Pipeline in place for new starters and still out to advert. Move from recovery phase to business as usual undertaken, action closed. Formal collaboration with the HCP system partners to support winter planning and health and social care. This is reviewed through the Urgent Care Delivery Board and through winter plan and IPR at Trust Board. All patient escalation areas are assessed using a checklist and support of DoN for relevant hospital site. This includes review of clinical appropriateness of area and appropriate levels of staffing. Trust continues to work with Kent and Medway ICS to Kent wide approach to manage risk which includes mutual aid and escalation processes. Trust has a multi-professional group working with staff side to ensure risks of industrial action are understood and patients are supported. Trust Winter Plan contains specific triggers for elective on our winter services monitored by the Trust Board. Weekly winter planning meeting in place led by Programme Director and Hospital Leadership.	**Action required and date** 1) Establish a workforce focus group to address the recruitment into the booking team **Programme Manager, Sep 22** 2) Systemwide programme implemented for elective recovery to reduce to zero 52-week breaches **Interim Director for Elective Care, Mar 23** **3)** Delivery of Trust Winter Plan **Interim Director for Elective Care, Mar 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Kent and Medway System Elective Care Programme Board and A&E Delivery Board provides system wide strategic direction attended by the COO. The A&E Delivery Board is chaired by the Trust CEO.	**Internal** 1) We Care Breakthrough Objective 'Improving theatre capacity' monitored monthly through the Integrated Performance Report presented to the BoD **External** 1) Kent and Medway System Elective Care Programme Board reports to the ICS Partnership Board	1) Delivery of 25% of all patient appointments and 60% of all follow ups to be conducted virtually
2) The Kent and Medway ICS have engaged a Winter Director who will report to the Trust CEO and attend the A&E Delivery Board.		2) Optimisation of additional capacity via ICB
3) The Trust has established an elective care board that meets monthly and covers a range of workstreams including validation; theatre utilisation; diagnostic support cancer services and clinical harm reviews		3) Number of same day cancellations reducing theatre utilisation
4) Weekly monitoring at the PTL meeting is chaired by the COO. The Trust has weekly monitoring by a touch point meeting covering all RTT waiting list cohorts. It also monitors cancer and diagnostic performance. This meeting is support by ICS and NHSE improvement directors. It is led by the Trust Elective Director and the COO.		4) Waiting list patients exceeding 104 weeks
5) Use of the independent sector and community providers is managed by the ~~Deputy COO~~ Trust Elective Delivery Director for planned care. Capacity is maximised.		
6) Trigger tool developed to move elective capacity to K&CH and ICS		
7) Clinical validation of patients needing procedures to reduce cancellation of the day target high risk groups		
8) Weekly meeting with Care Group Directors, COO and Recovery MD for individual case management of very long waiting patients		

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STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics.

Executive Owners: Chief Nursing and Midwifery Officer (CNMO) Responsible Committee: Quality and Safety Committee	Date last reviewed: February 2023 Next review scheduled: March 2023 Date risk identified: August 2022

Principal Risk – BAF 39

There is a risk that women and their families will not have confidence in east Kent maternity services if the Trust does not respond effectively to the recommended themes of 'Reading the Signals' report

Effect:

Risk Appetite

The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20

Movement of the current risk rating within the year												Projected for 23/24			
A	M	J	J	A	S	J	J	A	S	O	N	Q1	Q2	Q3	Q4
					20	20	20	20	20	20	20				
					'N'	=	=	=	=	=	=				

Target Risk Rating: L3 x S5 = 15
Projected Target Date:

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)

Aligned BAF Risks
32 - There is a risk of harm to patients if high standards of care and improvement workstreams are not delivered
Aligned Corporate Risks

Emergent Risks/ Issues
•

Future Opportunities
•

Rationale for current risk score
The current risk score is rated as an extreme (20) risk. The severity of the risk is scored as significant (4), due to the Trust facing major difficulties which are likely to undermine its ability to deliver quality services. The likelihood of the risk is scored as almost certain (5), the severity is more likely to occur than not with the current controls in place.

Latest Commentary
Families case review process in place, action closed. The internal audit of effectiveness of MNAG is scheduled as part of the internal audit programme. Pillars of Change presented to the Board of Directors February 2023.

Action required and date
1) Deliver staff webinars to enable staff to ask questions **CEO Nov 22**
2) Implement robust action plan to ensure staff at all levels are supported and communication channels established including help line
3) Ensure coordinated response to recommendations from the report with external regulators and commissioners
4) Focused listening events taking place to explore staff feelings, reaction to report, readiness to accept findings of report and to make improvements
5) Families meeting with CNMO and CEO
6) Declaring retrospective serious incidents which are externally investigated with family involvement
7) Listening events for the whole Trust
8) Finalise Pillars of Change delivery plan **Dec 22**
9) Internal audit of effectiveness of MNAG **Feb 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Regular open forums for staff with the Care Group and Executive Leadership 2) Regular walk arounds by the Maternity Safety Champions 3) Your Voice Is Heard – 6 week follow up calls after birth 4) Continued representation and reporting from Director of Midwifery and Clinical Director to Trust Board	**Internal** 1) Maternity Improvement Plan monitored by Maternity and Neonatal Assurance Group and reported to the Board of Directors 2) Maternity Dashboard in place 3) Your Voice Is Heard reported to MNAG **External** 1) Maternity and Neonatal Assurance Group has external Maternity Voices Partnership representation, NHSE Improvement Director, Local Maternity and Neonatal System representation	

STRATEGIC GOAL: 3) Our People:
Strategic Objective: Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Executive Owner: Chief People Officer (CPO) Responsible Committee: People and Culture Committee	Date last reviewed: March 2023 Next review scheduled: April 2023 Date risk identified: February 2016

Principal Risk – BAF 35

There is a risk of failure to recruit and retain high calibre staff

Effect: Negative patient outcomes, reputational damage, ability to deliver services, financial, patient harm, regulatory impact, staff wellbeing

Risk Appetite

The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

Movement of the current risk rating within the year												Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
15	15	15	15	15	15	15	15	15	15	15	15				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L2 x S5 = 10
Projected Target Date: 30 April 2023

Assurance Level: None/**Limited**/Adequate/Substantial

NHS
East Kent
Hospitals University

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risks **39 -** There is a risk that women and their families will not have confidence in east Kent maternity services if sufficient improvements cannot be evidenced following the outcome of the Independent Investigation into East Kent Maternity Services (IIEKMS) **Aligned Corporate Risks** CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace CRR 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 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs	**Rationale for current risk score** The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the potential for non-delivery of key services due to lack of staff or ongoing unsafe staffing levels The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Working through the interface between NHS Professionals and Locum's Nest to achieve a collaborative medical bank approach. International and domestic nurse and midwifery recruitment pipeline achieved for 2022/23, action closed. Meeting held in January to determine baseline for 2023/24. East Kent HCP working group continues to meet, EKHUFT hosting a secondment from the ICB to develop further with schools and higher education colleges. Recruitment strategy being presented to PCC in April following strategic workforce planning.	**Action required and date** 1a) Development of collaborative medical bank approach across the system **Deputy Chief People Officer Apr 23** 1b) International and domestic nurse and midwifery recruitment pipeline utilisation with cohorts planned throughout 2023 to achieve 150 additional nurses by Mar 2024 **Deputy Chief People Officer Mar 24** 2a) Links with HCP and newly formed Kent and Medway Medical School (KMMS) to develop rotational and joint posts to support medical staff recruitment **Chief Medical Officer Mar 23** 2b) Active involvement in east Kent HCP recruitment and retention strategy **Deputy Chief People Officer ongoing, 30 Apr 2023** 3) Delivery of actions in Rural and Remote Strategy **Associate Medical Director Mar 24** 4) Revamping recruitment strategy focusing on organisational brand and targeted recruitment campaigns **Deputy Chief People Officer Feb Apr 23**
Emergent Risks/ Issues • Do not have the right establishment • Accommodation • Agenda for change pay scales for lower banded staff • Delay in TNP digital solution affecting domestic recruitment numbers in pipeline			
Future Opportunities •			

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) A five-year People Strategy – People at the Heart 2020-2025 has been approved by Trust Board and is monitored via the People and Culture Committee (PCC).	**Internal** 1) Approval and monitoring of the agreed HR KPIs (inc vacancy rate and engagement scores) are monitored via We Care and PRMs and reported at PCC. 2) The People Dashboard has been developed with the aim of demonstrating progress against the key objectives identified in the People Strategy. The Dashboard brings together information in an accessible and co-ordinated format that is reviewed as part of our regular People team processes each month and reported through the People and Culture Committee. 3) Workstreams and project work is monitored via the HR Senior Leads meeting, We Care and reported through PCC to BoD. **External** 1) Review of EKHUFT's People Strategy via NHSE. Benchmarking and links with national People Team. 2) Director of HR and OD part of Future of NHS and OD national programme 3) Trust involvement in Kent and Medway Health and Wellbeing Board and Kent and Medway Recruitment and Retention Board	1) Lack of supply of professional qualified staff including AHPs is a national issue
2) Engagement of staff scores are True North measures which are reported and monitored monthly via We Care and Staff Committee		2) Hard to recruit areas such as Nursing and Consultants have been identified
3) A Recruitment and Retention Strategy with associated plans has been signed off and is monitored via the PCC		
4) A Rural and Coastal Strategy led by the Associate Medical Director has been developed and agreed at Trust Board and is monitored via the PCC		
5) The Director of HR and OD attends ICP workforce groups to align plans and develop other system side opportunities and agendas		
6) A Diversity and Inclusion action plan has been developed and published as part of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and is monitored via the Equality, Diversity and Inclusion (EDI) Steering Group, Staff Committee and reported to PCC		
7) Medical recruitment toolkit launched on 24 September 2021		
8) Developing a positive culture strategic initiative		
9) Refreshed EDI strategy		
10) Launch of cultural programme		
11) Revised People Strategy		
12) Ready to Care Programme in place		
13) Centralised booking team in place		

STRATEGIC GOAL: 3) Our People:
Strategic Objective: Our aim is to improve our Staff Engagement Index score to 6.8 by March 2023, as demonstrated in the annual staff survey.

Executive Owner: Chief People Officer (CPO)
Responsible Committee: People and Culture Committee

Date last reviewed: March 2023
Next review scheduled: April 2023
Date risk identified: August 2022

Principal Risk – BAF 40	Risk Appetite	Initial Risk Rating: L4 x S4 = 16
There is a risk of failure to address inequality, lack of diversity and injustice for staff working at East Kent Hospitals. **Effect:** Staff feel disengaged, discriminated against and excluded in the workplace resulting in a lack of opportunity to progress and meet their full potential; ultimately impacting negatively on patient care	The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation. **Risk Appetite Status:** Within appetite	**Current Risk Rating: L3 x S4 = 12**

Current Risk Rating: L3 x S4 = 12

Movement of the current risk rating within the year													Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M		Q1	Q2	Q3	Q4
				12	12	12	12	12	12	12	12					
				'N'	=	=	=	=	=	=	=					

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 31 March 2023

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks CRR 118 – Failure to address poor organisational culture CRR 88 – Failure to support staff health & wellbeing **Emergent Risks/ Issues** • Lack of appreciation and understanding of the experiences of BAME, other under-represented groups and those with a protected characteristic • Lack of opportunity to fulfil potential • Lack of equality of opportunity through selection processes • The Trust's management does not represent the diversity of the workforce **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the number of staff affected by the risk. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Three different levels of leadership programmes being developed for three different types of leaders. EDI is a golden thread through these programmes. Action to remain open whilst feedback of attendees is collated. Reciprocal mentoring is due to start as planned in summer 23. Care Group triumvirates creating tailored plans since the publishing of staff survey results. Reasonable Adjustments policy review is being updated. Diverse recruitment panels are in place, action to remain open whilst seeking assurance that this is embedded. Recruitment strategy being presented to PCC in April following strategic workforce planning.	**Action required and date** 1a) Programme for aspiring new leaders **Assistant Director of Organisational Development Mar 23** 1b) Introduce reciprocal mentoring for Exec team **Chief People Officer ~~Dec 22~~ ~~Mar 23~~ Aug 23** 2a) Use staff survey results to create tailored plans for specialities **Mar 23** 2b) Review and update Reasonable Adjustments policy **Head of Occupational Health ~~Dec 22~~ Jun 23** 3a) As a result of pilot in recruitment for diverse panels seeking assurance EDI is embedded in the recruitment process and within recruitment related training to improve staff experience and reduce potential bias in recruitment processes **Head of EDI Mar 23** 3b) Update Recruitment Strategy – ensuring EDI focus **Deputy Chief People Officer Mar 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) New senior Head of EDI leading a small EDI team within P&C function working on project work	**Internal** 1) WRES and WDES reviewed and monitored via the EDI Steering Group, Staff Committee and reported to People and Culture Committee	1) Lack of EDI awareness in leadership/management population
2) Equality, Diversity and Inclusion Policy, Strategy & action plan in place		2) Staff Survey (2021) – staff with Long Term conditions report lack of adjustments in the workplace
3) Equality, Diversity and Inclusion mandatory training renewed three yearly	**External** 1)	3) WRES and WDES data analysis shows BAME and disabled staff less likely to be appointed via a recruitment process
4) Staff networks in place for BAME, LGBTQ+, Disabilities and Women		4) Lack of EDI involvement in decision-making in the Trust
5) Culture and Leadership programme – focus on Equity & Inclusion		
6) External review in 2021 by Jagtar Singh Associates – informed approved EDI strategy		
7) Part of regional programme to de-bias recruitment		
8) Established P&C policy group to renew all staff policies to make them accessible for all, with thorough Equality Impact Assessments		
9) Exec and NED sponsors for all staff network groups		
10) Leadership programme has a focus and 'golden thread' of equality, diversity and inclusion		
11) Inclusion and Respect Charter		

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: Develop a clinical strategy for the Trust that addresses key risks faced in terms of **service delivery, workforce and estate condition (backlog and statutory compliance).**

Executive Owner: Interim Executive Director of Strategic Development and Partnerships
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2023
Next review scheduled: April 2023
Date risk identified: April 2021

Principal Risk – BAF 36
Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)

Effect: Result in lapses in core clinical standards and patient safety issues, and may affect adherence to estate statutory compliance, increased estate backlog risks this could result in further emergency service moves/restrictions and impact on the Trust's reputation

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20

Movement of the current risk rating within the year												Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
20	20	20	20	20	20	20	20	20	20	20	20				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 Mar 2032

Assurance Level: None/**Limited**/Adequate/Substantial

NHS
East Kent
Hospitals University

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks CRR 127 – Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace CRR 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 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs **Emergent Risks/ Issues** • Reliance on locums • Risks are increasing due to retirement and covid **Future Opportunities** • Recruitment strategy (BAF 35) • New hospital programme • Emergency capital • Robotic strategy • Development of medical school	**Rationale for current risk score** The current risk score is rated as a high (15) risk. The severity of the risk is scored as catastrophic (5), due to the potential for permanent loss of core services, disruption to facility leading to significant 'knock-on' effect across local health economy and extended service closure. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** No notification received as yet by the Trust regarding the new hospital improvement programme. It has been agreed that oversight of east Kent transformation will be the east Kent HCP with sign off by the ICB. 91% statutory compliance will be achieved by year end.	**Action required and date** 1a) Trust has put in an expression of interest to join the new hospital improvement programme. Due to be finalised by Autumn 22. **EDSDP Sep Oct Dec 22 Jan 23 Mar 23** 1b) Continue to lobby key stakeholders to maximise success of EOI **EDSDP Sep Oct Dec 22 Jan 23 Mar 23** 1c) Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the east Kent HCP/ICB Partnership Board Strategic Priorities **CEO Sep 22 Mar 23** 1d) Continue lobbying NHSE if expression of interest for new hospital improvement programme is not successful **EDSDP Mar 23** 2a) Implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory for 22/23 **EDSDP Mar 23** 2b) Prioritise through SIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken by NHSE on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD **EDSDP Mar 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) The Chairman and CEO confirm that the Sustainability and Transformation Partnership (STP)/ICS Partnership Board prioritises and signs off the East Kent Transformation for agreement with NHSE.	**Internal** 1) Approval and monitoring of the Trust framework proposals and workstreams through Strategic Investment Group (SIG), CEMG, JDB, SCP&PC, Q&SC, FPC and BoD (Controls 2 and 3) 2) Minutes of JDB, CEMG, FPC, SIG, SCP&PC Q&SC and BoD (Controls 4,5 and 6)	1) Final sign off and approval of capital investment is outstanding from NHSE
2) The Director of Strategic Development and Capital Planning ensure that the PCBC is signed off by the Trust's FPC and BoD.		2) Gaps and risks relating to backlog and statutory compliance have been identified
3) The Director of Strategic Development and Capital Planning ensures that the implementation of the clinical strategy receives oversight from the Joint Development Board, SCP&PC and FPC	**External** 1) Sign off by HCP, ICB and NHSE (Control 1) 2) Stage 2 assurance process passed awaiting allocation of capital (Control 1)	3) Unable to consult
4) The Trust's position in terms of statutory compliance is published, reported and reviewed six-monthly by CEMG and the BoD		4) Risk appetite reduced by regulators. Derogation required from regulators to maintain services
5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD		5) Interim capital required to meet the compliance of estate and equipment risks
6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD		
7) Rural and Coastal Recruitment Strategy		

STRATEGIC GOAL: 4) Our Future: Strategic Objective: There is no specific strategic objective, this risk is an enabler. A risk that has an impact on the achievement of our strategy but does not have a primary link to the metrics

Executive Owner: Chief Executive Officer Responsible Committee: Finance and Performance Committee	Date last reviewed: March 2023 Next review scheduled: April 2023 Date risk identified: May 2020

Principal Risk – BAF 30
Failure to deliver the full benefits of the We Care Improvement system

Effect: Improvement plan will fail to deliver, sub-optimal implementation, financial impact, HR impact, reputational risk

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S4 = 12

Movement of the current risk rating within the year												Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M	Q1	Q2	Q3	Q4
12	12	12	12	12	12	12	12	12	12	12	12				
=	=	=	=	=	=	=	=	=	=	=	=				

Target Risk Rating: L1 x S4 = 4
Projected Target Date: 31 March 2026 (due to the four-year delivery plan of the change system)

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned Corporate Risks None	**Rationale for current risk score** The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due	**Latest Commentary**	**Action required and date** 1) Business case to be developed to extend team to meet demand **Head of Transformation Jun Sep 22 Jun 23**

Emergent Risks/ Issues	to the potential for the Trust to face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long-term strategy. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	Risk reviewed with Site Director, QEQM. Business case for expansion of team is on hold due to changes in organisational structure. Additional action added.	2) Review of We Care following delivery of winter plan and how this will change with new care organisations **Head of Transformation Jun 23**
• Change of executive directors			
Future Opportunities			
•			

Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) We Care Improvement Strategy approved by BoDs and implemented across the Trust.	**Internal**		1) The system may not be sustained due to the size of the organisation and capacity of the transformation team to support
2) SLT leads monthly cycle of the OMS and reports and update progress on implementation	1) Coaching and mentoring in place for Executive Team; Care Groups; and Frontline Teams.		
3) Executive led workstreams in place (strategic deployment; OMS Frontline / Management; Leadership behaviours; Transformation and Step Change; Centre of Excellence; and Communications) reporting into SLT.	2) Skills matrix agreed for internal Improvement Team, which links to personal objectives		
	External		
4) IPR linked into We Care and reports monthly to sub Board Committees and BoDs	1) System has been implemented and proven to work in international healthcare systems (USA, Canada, Iceland) and in similarly complex NHS organisations.		
5) Monthly PRMs with Care Groups wired in to We Care	2) VFM review undertaken by NHSE with positive findings reported.		
6) Intensive Support process agreed for implementation as and when required.	3) Endorsement for the change model from the National Director for Lean Transformation		

STRATEGIC GOAL: 5) Our Sustainability:
Strategic Objective: Our long term aim is to maintain a breakeven position

Executive Owner: Chief Finance Officer (CFO)	**Date last reviewed: February 2023**
Responsible Committee: Finance and Performance Committee	**Next review scheduled: March 2023**
	Date risk identified: February 2023

Principal Risk – BAF 41

Failure to deliver the financial plan of the Trust as requested by NHSE for 2023/24

Effect: not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S5 = 25
Current Risk Rating: L5 x S5 = 25

Movement of the current risk rating within the year													Projected for 23/24			
A	M	J	J	A	S	O	N	D	J	F	M		Q1	Q2	Q3	Q4
											25					
											'N'					

Target Risk Rating: L3 x S5 = 15
Projected Target Date: 31 Mar 2024

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities	**Risk and Scoring Commentary**		**Actions (Planned)**
Aligned Corporate Risks	**Rationale for current risk score**	**Latest Commentary**	**Action required and date**
• Efficiencies delivery	The current risk score is rated as an extreme (25) risk. The severity of the risk is scored as catastrophic (5), due to the financial impact being at least £5million non-recurrent or at least £10million over 3 years. The likelihood of the risk is scored as almost certain (5), the severity is likely to occur with a probably of more than 80%.	New risk approved at Finance and Performance Committee on 28 February 2023.	1) Financial plan for 2023/24 to be submitted to NHSE **CFO Mar 23**
• Elective recovery fund delivery			2) Shared target to be approved across the Kent and Medway system **CFO Mar 23**
Emergent Risks/ Issues			3) Developed medium-term and long-term financial plans in conjunction with NHSE and Kent and Medway ICS **CFO Jun 23**
• Efficiencies delivery			4) Summary of impact of inflation to be presented to Finance and Performance Committee **CFO Apr 23**
• Elective recovery fund delivery			
• Inflation			
• Corporate memory/changing leadership			
Future Opportunities			
•			

Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) The Chief Finance Officer is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance and Investment Oversight Group, Performance Meetings with Care Groups and Directors	**Internal**		1) The Trust is likely to remain in Recovery Support Programme until a balanced longer-term plan is developed
	1) Monthly performance meetings are held with Care Groups		
2) Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis	2) The financial plan and monthly performance are monitored and minuted at the Finance and Performance Committee and the Trust Board monthly		
	External		
3) Other controls in place; annual business planning process, annual cost improvement programme developed, fortnightly financial control meeting in place.	1) The financial performance of the Trust is monitored by NHSE through a monthly return. This is approved by the Chief Finance Officer.		
4) Financial turnaround specialist in place for six months	2) The Trust has a monthly oversight meeting with the regional NHSE team to discuss financial performance (amongst other agenda items).		

NHS
**East Kent
Hospitals University
NHS Foundation Trust**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**SAFEGUARDING ADULTS AND CHILDREN QUARTER 4 REPORT**
MEETING DATE:	**4 MAY 2023**
BOARD SPONSOR:	**INTERIM CHIEF NURSING AND MIDWIFERY OFFICER**
PAPER AUTHOR:	**HEAD OF SAFEGUARDING CHILDREN**
APPENDICES:	**NONE**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The purpose of this report is to provide an update and assurance to the Board on the progress and challenges of the safeguarding adults and children activities for Q4. The report will also outline the progress of the All Age Safeguarding sustainability plan which the Trust had been implementing over the last few months. The current systems and process in place as a result of this plan will be highlighted, as well as evidence of how the safeguarding children activities have continued to provide core statutory duties required to remain compliant.				
Summary of Key Issues:	Although the Trust has the evidence to demonstrate that it now has systems and processes in place to undertake its safeguarding activities, there remains risks associated with this delivery of this, as the Trust continues to address the issues around safeguarding adults' workforce and competencies and skills issues at Care Group level. The plan has been to develop and implement sustainability plans for safeguarding activities through strengthening interim leadership to maintain the core activities whilst arrangements for workforce are being considered and recruited into substantively. In response to levels of training compliance being below the expected 85% additional training sessions have been provided over the year alongside confirming with staff the level of training they require. The Trust has agreed with the Integrated Care Board (ICB) and region a programme of intensive support to ensure we focus activities on improving our overall safeguarding performance.				
Key Recommendation(s):	The Board is invited to: 1. **NOTE** the report and **DISCUSS** the key issues highlighted. 2. **ASSURANCE** on the Q4 activities and the progress of the sustainability plan for safeguarding adults and children.				
Implications:					
Links to 'We Care' Strategic Objectives:					

1

Our patients	Our people		Our future	Our sustainability	Our quality and safety
Link to the Board Assurance Framework (BAF):	BAF 32: Patient outcomes may be compromised as a consequence of a failure to identify patients at risk of abuse, neglect and harm for both adults and children in line with relevant legislation (Children's Act, Care Act, Mental Capacity Act, Equalities Act, Human Rights Act and Mental Health Act).				
Link to the Corporate Risk Register (CRR):	CRR Ref 36: Lack of evidence of sustaining and embedding revised systems and processes to enable the Trust to meet its statutory duties relating to the Care Act, Children's Act, MCA/DoLS/LPS, Domestic Abuse/Violence, Prevent and identification of risks associated with this.				
Resource:	Y	Safeguarding adults and children's teams to effectively deliver safeguarding activities.			
Legal and regulatory:	Y	Statutory safeguarding duties as defined in the Care Act and Children's Act legislation and statutory guidance.			
Subsidiary:	Y/N	None			
Assurance Route:					
Previously Considered by:	None				

2

SAFEGUARDING ADULTS AND CHILDREN QUARTER 4 REPORT

1. Purpose of the report

1.1 The purpose of this report is to update the Board on the core safeguarding activities for Q4 with a key focus on the sustainability deliverables that had been implemented over the last few months. These addressed the recommendations from the Independent Safeguarding Review and the plans to support the Trust in terms of maintaining its statutory duties.

2. Background

2.1 In Q4 January-March 2023 safeguarding activity undertaken throughout the Trust to enable it to meet its statutory responsibilities was discussed at the Quality and Safety and Safeguarding Assurance Committees for assurance along with actual or potential challenges and the mitigations in place to address these.

2.2 Responsibilities included:

1. Children, young people and adults and their families, who use the Trust services and demonstrating how they were safeguarded by our staff, policies and processes.
2. Staff being suitably skilled and supported and the challenges in workforce issues.
3. Commitment at all levels of the organisation for safeguarding including, leadership, full engagement and support of local accountability and assurance structures.
4. Encouraging a culture where safeguarding is everybody's business
5. Poor practice being identified and addressed.

2.3 In order to achieve this, the following activities were undertaken by the Safeguarding Children and Adult teams.

1. Maintaining business as unusual activities between Monday - Friday, 9-5 with provisions to support staff out of hours.
2. Highlighting of children and adults at risk on Allscripts, use of Child Protection-Information System and Female Genital Mutilation-Information System.
3. Multi-agency partnership working and to meet the statutory reporting for Female Genital Mutilation and PREVENT reporting.
4. Providing assurance to the ICB and Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and Kent and Medway Safeguarding Adult Board (KMSAB), through schedule 4 reporting.
5. Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) Implementation Plan by strengthening the current systems and processes in place and working in conjunction with the ICB and NHS England (NHSE).
6. Domestic abuse and domestic homicide statutory duties in conjunction with our key partners.
7. The core activities were provided to the Safeguarding Assurance Committee in April and will be shared with the Quality and Safety Committee in May.

3. Completion of the AASD actions and Progress on the Sustainability Action Plan Deliverables.

3

3.1 Over the year, the Trust had been implementing the AASD action plan deliverables, which built upon the existing safeguarding systems and processes in place for the 6 key areas of the Trust's safeguarding arrangements. This was to ensure that the Trust met its statutory duties under the Care Act for safeguarding adults. These have been previously shared with the Board.

3.2 This quarter has focused on the Organisational self-audit within adults to establish the progress of the AASD action plan and outputs. In addition further work including a restraint thematic review and work to ensure we manage allegations of abuse by people in positions of trust in line with Kent policies and procedures.

3.3 Although the Trust has the evidence to demonstrate that it now has systems and processes in place to undertake its safeguarding activities, there remains risks associated with this delivery of this, as the Trust continues to address the issues around safeguarding adults training and development needs.

4   **Summary of Safeguarding Activity during Q4**

4.1 The Trust continues to report cases of Female Genital Mutilation in line with our statutory responsibilities.

4.2 The Safeguarding Teams did not make any PREVENT referrals but has provided information to the Channel panel for 6 PREVENT cases for under 18's and 11 for over 18s during this reporting period. The team trained 602 staff in PREVENT during this timeframe.

4.3 During this reporting period, the Safeguarding Children team undertook no rapid reviews or Child Safeguarding Practice Reviews. The Safeguarding Adult team undertook 1 Domestic Homicide Review (DHR) and 5 rapid reviews.

4.4 Safeguarding Children Supervision has continued virtually across all specialities, with some teams returning to face to face sessions. 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 4 sessions being offered to those staff, as per the policy, the expectation is that they will attend 3 of those sessions meaning we would achieve attendance at 75% by the end of the year.

4.5 Safeguarding staff have meet with the GPLs in Community Midwifery, sessions for Community Midwives (CMWs) have moved to a different timeslot and being undertaken face to face. A podcast has been filmed and is being made publication ready and a revamped leaflet about supervision for practitioners being designed.

4.6 Supervision on the children's wards has commenced, a meeting has been undertaken between safeguarding and the ward manager for Rainbow ward and the first session was undertaken in December, this was well received and sessions are planned. This will then be taken forward across both main sites.

4.7 The Interim Joint Head of Safeguarding attends the Fundamentals of Care Committee where themes emerging for individual care groups from S42 investigations are highlighted and discussed. In addition, the Operational Safeguarding meeting is being developed and this forum is where assurance will be gathered and then shared with the Safeguarding Assurance Committee

4.8 The number of referrals for Deprivation of Liberty Safeguards **(**DoLS) remains proportionate to the size of the Trust since mitigation was put in place in July 2020 for

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low levels of referrals. The outcome of DoLS applications by EKHUFT has been notified to the CQC, since January 23.

5.   Changes to Safeguarding Training Strategy and Training Needs Analysis

5.1   Training has been delivered as joint training for new starters and refresher training. Training rooms have been able to accommodate a greater number of candidates from May 2022 due to a change in infection control guidelines and the course availability has been extended to reflect this moving forward.

5.2   The Training Strategy has been reviewed to incorporate both children and adult requirements as per the intercollegiate documents (Royal College of Paediatrics and Child Health (RCPCH) 2019 and Royal College of Nursing (RCN) 2018). This has resulted in changes to the training needs analysis particularly for staff on adult wards. This has been sent to the care groups for comment and was presented to the safeguarding assurance committee in December 2022, then the 'Statutory, Mandatory & Essential Training Steering Group' in February 2023 and then the 'Integrated Education, Training and Leadership Development Group'.

5.3   The most significant change has been as a result of the Health and Care Act (2022) which now requires all staff to have training in learning disabilities and Autism. This has been added to the strategy and staff will be able to achieve this via Oliver McGowan e- learning on Electronic Staff Record (ESR).

6   Partnership working activity

6.1   The Trust continues 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 engagement with the Trust at the point of the missing episodes. The adult team are also contacted on a daily basis for vulnerable missing adults.

7   Domestic Abuse and MARAC

7.1   The Domestic Abuse Hospital Independent Violence Advocates (HIDVA) project continues 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. All HIDVAs are now in post and cover all sites.

7.2   To strengthen the Trust's position on domestic abuse, a stand-alone domestic abuse policy for patients and staff is currently going through the ratification process to reflect the Domestic Abuse Act 2021 and National Institute for Health and Care Excellence (NICE) guidance.

8   Homelessness Nurse

8.1   The Homeless Nurse continues to work across all sites and has been able to support the wards with challenging discharges. The ICB have secured funding for the pilot project for homelessness to continue.

9.   Key Recommendations/Next Steps

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9.1 To maintain the interim measures to support the gaps in safeguarding workforce and operational leadership, whilst the options are being considered. To continue to recruit to and develop individuals within the safeguarding team, to strengthen safeguarding leadership and support with complex patients.

9.2 Continue to deliver the safeguarding sustainability plan based on the deliverables from the AASD, including commencing addressing the findings from the thematic reviews

9.3 To complete the final stages of the ratification process for safeguarding policies and procedures that are currently under review which are aligned to strengthening safeguarding activities. These include the Managing Allegations Against Staff, MCA Policy, Safeguarding Adult Policy, Prevent Policy and   Restraint Policy.

9.4 To focus on managing the transition between the safeguarding children and adults teams and strengthen the existing structures through scoping skills across the team to address some of the challenges relating to joint safeguarding activities. These include Think Family, transitional safeguarding and domestic abuse.

9.5 To manage activities relating to section 42s for safeguarding adults' activities to ensure that these are updated whilst working closely with the local authority.

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	FREEDOM TO SPEAK UP (FTSU)
MEETING DATE:	4 MAY 2023
BOARD SPONSOR:	CHIEF PEOPLE OFFICER
PAPER AUTHOR:	LEAD FREEDOM TO SPEAK UP GUARDIAN
APPENDICES:	APPENDIX 1: FTSU POLICY APPENDIX 2: FTSU POSTER

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report gives a six-monthly update on the activity, issues raised with and actions taken by the Freedom to Speak Up Team.				
Summary of Key Issues:	• The FTSU Team continue to see a steady rise in the number of concerns they handle. There is a 269% increase in number of concerns raised between 2021/22 and 2022/23 financial years. • Concerns about behaviours and leadership continue to be the prominent theme. • Two new Deputy FTSU Guardians are in post to support with the demands of the Team. • A new FTSU policy has been published and the FTSU e-learning modules have been made mandatory. • Strong working relationships have been forged to offer ongoing support to vulnerable workers. • The focus for 2023 is on how we collaborate with others to triangulate data and take a more strategic approach to learning and improvement.				
Key Recommendation(s):	• Focus on rebuilding trust to create a psychologically safe environment to speak up. • Complete the three mandatory FTSU e-learning modules. • Improve openness and transparency by acknowledging where mistakes are made and share the learning that comes from those instances Trust-wide.				

Implications:					
Links to 'We Care' Strategic Objectives:					
Our patients	**Our people**		**Our future**	Our sustainability	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	**CRR Risk Ref 71, 77, 110 and 36:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **CRR Risk Ref 76:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.				
Link to the Corporate Risk Register (CRR):	**SRR 2 and 8:** Failure to maintain standards of high quality care and to recruit and retain high calibre staff.				
Resource:	N				
Legal and regulatory:	N				
Subsidiary:	N				
Assurance Route:					
Previously Considered by:	None				

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FREEDOM TO SPEAK UP (FTSU)

1. Purpose of the report

1.1 This report gives a six-monthly update on the activity, issues raised with and actions taken by the Freedom to Speak Up (FTSU) Team.

1.2 This report covers activity from October 2022 – March 2023.

2. Background

2.1 The FTSU Team is made up of a Lead FTSU Guardian, a Maternity FTSU Guardian and two Deputy Guardians. The FTSU Team has been established since January 2022.

2.2 The FTSU Team help the Trust to:
- Protect patient safety and the quality of care.
- Improve the experience of workers.
- Promote learning and improvement.

They do this by ensuring that:
- Workers are supported in speaking up.
- Barriers to speaking up are addressed.
- The organisation encourages a positive culture of speaking.
- Matters raised are used as opportunities for learning and improvement.

2.3 It is widely recognised that the health of an organisation's speaking up culture directly correlates with the standard and quality of care delivered to its patients. A healthy speaking up culture enables workers to speak up without fear of detriment and confident that they will be heard.
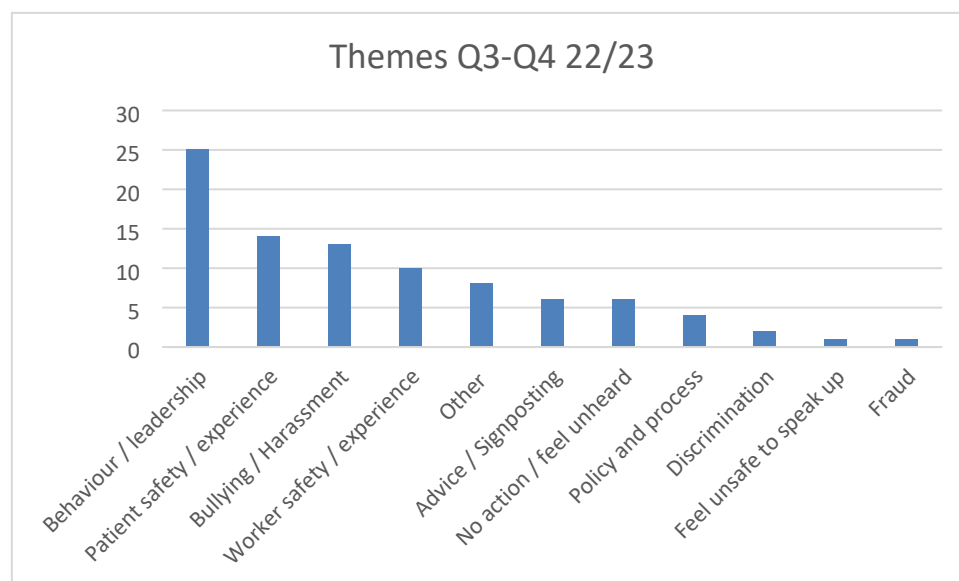
2.4 The FTSU Team last reported to the Board of Directors in September 2022.

3. Activity

3.1 The work of the FTSU Team can be broadly categorised as Proactive and Reactive.

4. Reactive work

4.1 The Freedom to Speak Up Team were contacted a total of 155 times in the 2022/2023 financial year. 90 of those were between Q3 and Q4 2022/2023.

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Graph 1:

Yearly total of contacts with the FTSU Team

Graph 2:

Contacts made per quarter
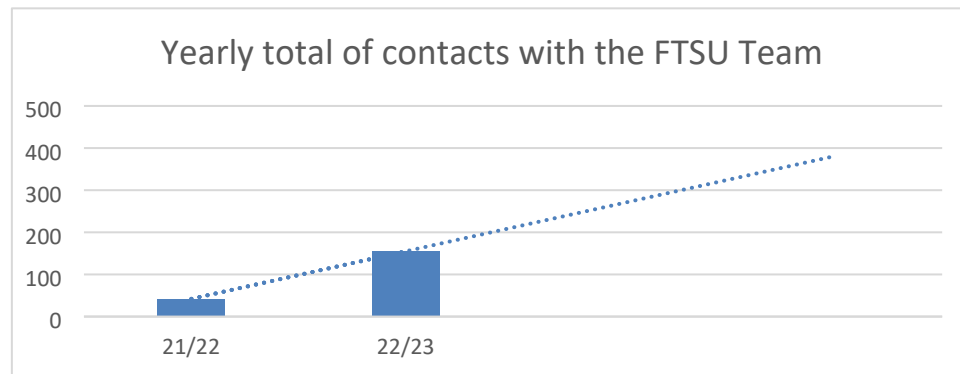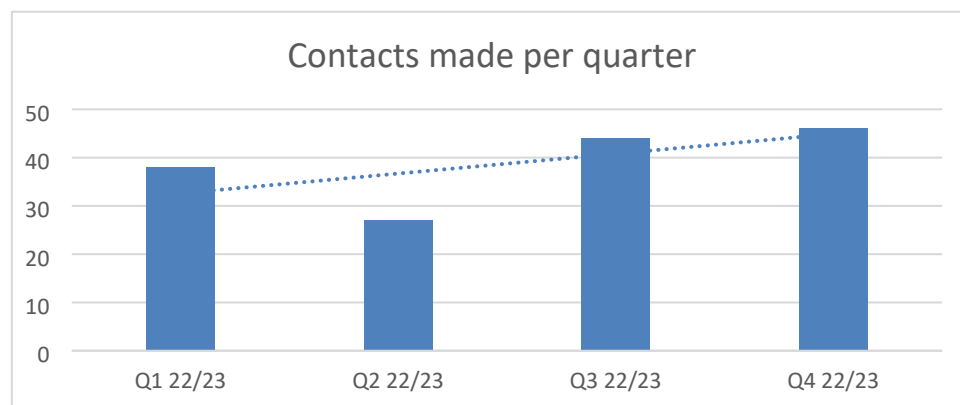
Graph 3:

Themes Q3-Q4 22/23

Graph 1 shows that the FTSU Team have seen a 269% increase in the number of contacts between the 2021/22 and 2022/23 financial years.

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Graph 2 demonstrates the steady average increase in matters handled by the FTSU Team. With the addition of two new Deputy FTSU Guardians in January 2023, it is anticipated to rise even further.

Graph 3 highlights that concerns about 'Behaviours / Leadership' continue to be the main theme for Q3 - Q4 (2022/23). These concerns raised include examples of incivility, uncompassionate leadership and lack of trust.

It was anticipated that the team would see an influx of contact following the publication of the Kirkup report, but this did not happen. A number of alternative routes for raising concerns were offered to workers and this may account for this.

4.2   Listening events

On occasion, the FTSU Team are approached for support where it is felt that an alternative route to speaking up is necessary. This tends to be after concerns have been raised and leaders from the team are curious to understand more about the scope, experience and impact on the team in an effort to address the concerns. The FTSU Team works collaboratively with these teams to ensure that all workers have the opportunity to be and feel heard. Some examples of where this approach has been used are in Theatres and Medical Education.

Proactive work:

Expansion of the FTSU Team

4.3   The FTSU Team expanded in January 2023 following a successful recruitment process. There are now part-time site-based Deputy FTSU Guardians in post at the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. The ambition for these new roles is to increase engagement and improve visibility across the two largest sites.

Adoption of the National FTSU policy

4.4   NHS England and the National Guardians Office co-produced a national policy for FTSU with the expectation that this be adopted by all trusts by January 2024. We adopted the policy, in full, in December 2023 [Appendix 1].

Mandating the FTSU e-learning modules

4.4   Three nationally available e-learning modules on FTSU, developed by the National Guardians Office and Health Education England, have been made mandatory by the Trust. An engagement plan is being developed with a view to support the launch of these modules in May 2023.

Connectors

4.5   Connectors are a new support and signposting role, co-designed by People and Culture teams to remove barriers to speaking up and provide access to support quickly. The role consolidates and replaces a number of similar support roles, including FTSU Champions, and streamlines the support available for all workers.

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4.6 A six-month plan to close down the FTSU Champion network will be delivered in June 2023. This has provided all current FTSU Champions with the time to transition in to the new Connector role.

4.7 The FTSU Team has committed to personally delivering the training input around speaking up to all Connectors as well as play an active role in their continuous support, learning and development.

4.8 Connectors will provide invaluable soft 'intelligence' which will be used to influence and drive change and improvement across the organisation.

Profile raising

4.9 The importance of speaking up is championed across the Trust in the following ways:
- Input from the FTSU Team at all Trust Welcome Days, during the induction period for all Internationally Educated Nurses and Midwives and during development sessions for Healthcare Assistants.
- Delivery of talks to Newly Qualified Midwives and students.
- Attendance at the Junior Doctors Forum and future reoccurring listening events for Junior doctors.
- Engagement with Staff Networks, the Equality, Diversity and Inclusion (EDI) steering group and Staff Committee meetings.
- Specific mention in the 'reading the signals' video from the Trust's Chief Executive Officer (CEO) and Chairman.
- Encouragement by the Chief Medical Officer (CMO) to all workers to raise concerns about Serious Incident investigations with the FTSU Team.
- Distribution of posters [Appendix 2], screensaver messages, Trust news articles and social media posts.

5 **National Staff Survey**

5.3 The results of the National Staff Survey (NSS) which was completed in November 2022 have now been published.

5.4 There are four questions that are categorised under the NHS People Promise 'We each have a voice that counts' and they provide us with a sense the health of our speaking up culture.

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Legend: ■ 2022 ■ 2021
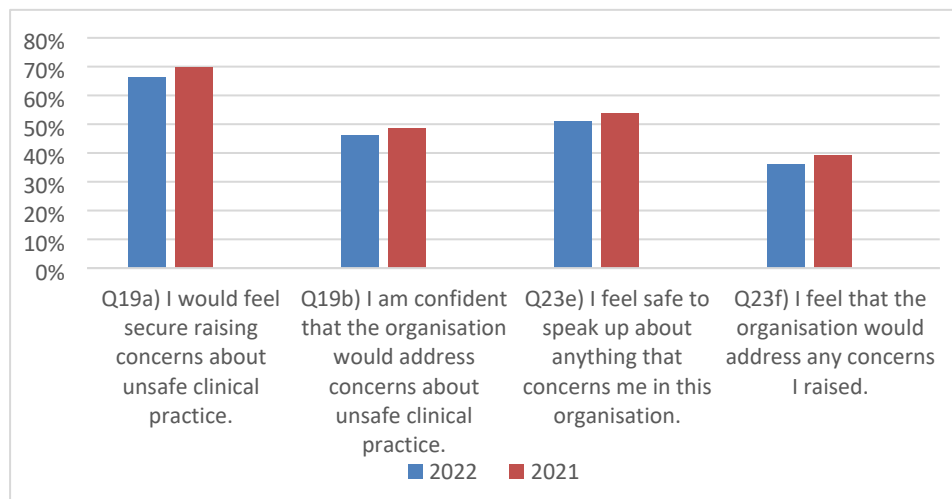
5.5 In the 2022 NSS there were some new questions added, which have some relevance to speaking up.
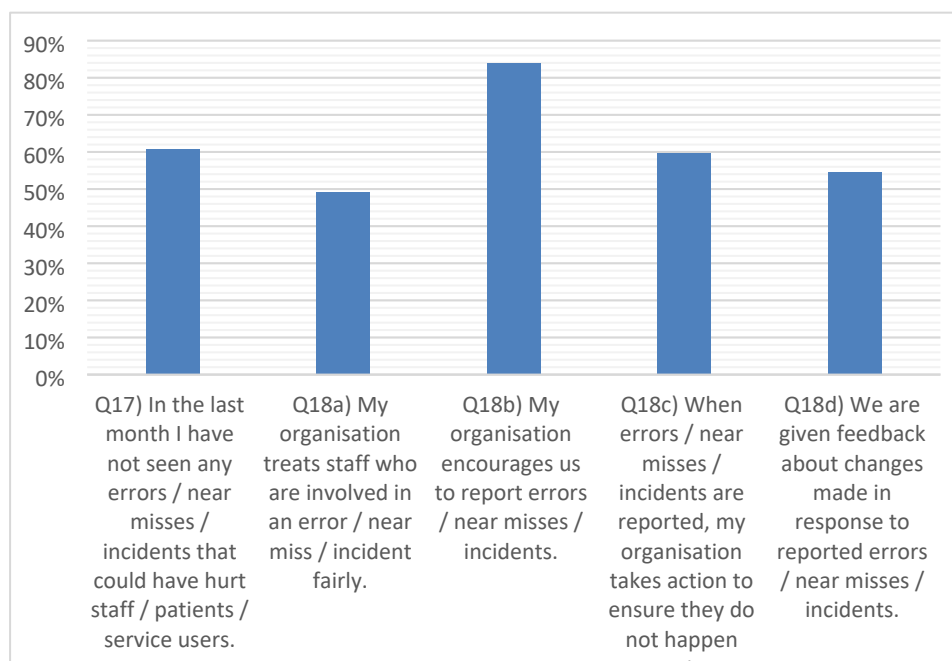
5.6 Nationally, the NSS results reflect a decrease in workers' confidence to speak up.

5.7 Our NSS data indicates that 83.9% of respondents feel that they are encouraged to report errors, near misses and incidents. It shows that respondents feel less confident than the previous year to actually speak up. Furthermore, they feel even less confident that concerns that were raised would be addressed compared to the previous year.

5.8 We continue to see that workers feel much more able to report clinical concerns as opposed to anything that concerns them. This could be understood by the fact that the expectation to raise clinical concerns is set in professional codes. It could also be understood that raising clinical concerns about patients is felt easier to do than raising personal concerns at work.

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5.9 We are now understand that just over half of respondents feel that those involved in an error, near miss or incident are not treated fairly. Just over half of respondents felt that action was taken by the organisation to ensure that errors, incidents and near misses do not happen again and that feedback is given about those changes.

5.10 The NSS results conclude that, nationally, speaking up in healthcare has worsened and continues to be a challenge.

6 **Challenges**

6.1 Three of the greatest challenges faced by the FTSU Team are:

- Apathy for speaking up.
- Fear of speaking up.
- Competing organisational demands, with priority given to direct patient care.

6.2 Leaders, at all levels across the organisation have a lot of work to do to build up the trust of the workers to enable them to speak up and raise concerns.

6.3 Whilst improvements have been made to transform the organisation from a blame culture to one that is just and learning, we continue to hear examples of leadership which undermines this work.

6.4 Patient care will and should always be the priority of workers. Demands to deliver safe care creates pressure on leaders meet the demands as well as nurture the changing organisational culture by recognising those speaking up and responding in a timely manner.

7. **Future activity by the FTSU Team**

7.1 It is clear that significant improvements are needed to create an organisational culture which feels psychologically safe enough to speak up, learn and improve in. Speaking up is everyone's business and the FTSU Team will continue to work with and support teams and individuals and influence them to make these critical changes.

7.2 In 2023 the FTSU will look to support workers to complete the mandatory e-learning training which will lay the foundations on which to develop each persons' understanding of FTSU and consider their input to the Trust's organisational culture.

7.3 The Team's work on the FTSU Guidance and reflection tool has highlighted some areas of focus for improvement. These are:
- Learning from speaking up.
- Continually improving speaking up culture.

7.4 To address these points, the FTSU Team has been involved with the newly implemented Quality Intelligence Forum (QIF) and People & Culture Multi-Disciplinary Team (MDT) data meetings. The purpose of both groups is to triangulate data sources to identify areas of risk as well as those areas which perform well. It has been recognised that organisational culture and workforce issues impact on patient safety, experience and outcomes and therefore these two groups will need to continue to work more closely and share information. Doing so will also reduce

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siloed working and improve working relationships and collaboration between corporate and clinical teams.

7.5 Given that a majority of workers do not feel that those involved in an error, near miss or incident are treated fairly and that only 36% of respondents feel that the organisation would address concerns raised, it is important to frequently review the success of the newly implemented Just and Learning Culture and local resolution work.

7.6 The completed FTSU Guidance and reflection tool will inform the FTSU strategy. The strategy will outline how we will continue to make improvements in our workers ability to speak up, their confidence that action will be taken and that it will lead to change and improvements.

8   Conclusion

8.3 The FTSU Team continue to be contacted by high numbers of workers wishing to raise concerns. The demand stretched the capacity of the FTSU Team and the addition of two new Deputy FTSU Guardians will support with this.

8.4 Our NSS results indicate that workers feel less able to speak up. We can confidently say that the majority feel they are encouraged to speak up by the organisation. Of those who feel able to speak up, they feel more confident raising concerns about clinical matters. Our workers are marginally more confident that the organisation will address clinical issues.

8.5 The health of our speaking up culture is everyone's business. Speaking up via the FTSU Team is only one of many routes to speak up. The FTSU Team will continue to collaborate with key stakeholders across the organisation to share information and inform changes and improvements.

8.6 In 2023 the FTSU Team will develop the FTSU strategy. Areas of focus include working collaboratively with People and Culture and Patient Safety teams so that a more strategic approach to change and improvement can be taken. This will enhance the assurances we can give as well as support workers to see the value of speaking up.
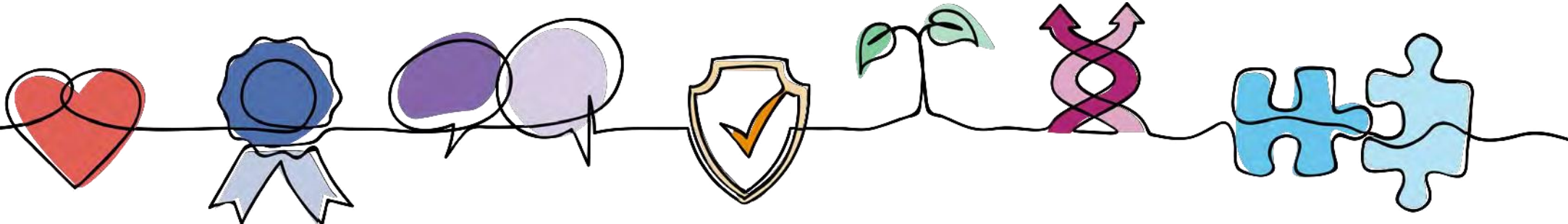
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Freedom to Speak Up policy

Version 1, December 2022

Note: This policy has been adapted for use locally from the NHS England 'Freedom to Speak Up policy for the NHS' Version 2

This policy is available in other formats, for example, in large print, Audio and Easy Read on request.
Please contact ekhuft.edi@nhs.net

Contents

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

• Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

• Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Speak up – we will listen

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our workers.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.

This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos

This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality the HR helpdesk (contact details above) can advise further on which applies to your situation but you may find these policies useful:
Resolution Policy (Grievances and Respect at Work); Duty of Candour Policy; Equality, Diversity and Inclusion Policy

As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise
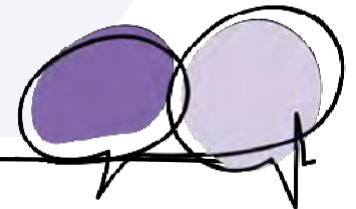
We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

Who can I speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you:

• Senior manager, partner or director with responsibility for the subject matter you are speaking up about.

• The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality:

-Serious Incidents **ekhuft.serious-incidents@nhs.net**

4 **Freedom to Speak Up policy for the NHS**

-General/Non-urgent **ekh-tr.CorporatePatientSafety@nhs.net**
-Safety alerts **ekh-tr.safety-alertskent@nhs.net**

• Local counter fraud team:
Natalie Nelson 020 3201 8358 natalie.nelson@rsmuk.com

• Our Freedom to Speak Up Guardians can be contacted at **ekhuft.freedomtospeakupguardian@nhs.net**

Or directly:
For all care groups/departments: **Celina Todd (Lead FTSU Guardian) 07866 183236 celina.todd@nhs.net**

For Maternity/NICU/SCBU: **Katie Clark (Maternity FTSU Guardian) - 07875 193328 or k.clark10@nhs.net**

They can support you to speak up if you feel unable to do so by other routes. The guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.

• You can contact your Care Group People & Culture (P&C) Business Partner or call the P&C Service Desk on **01227 866450** (open Monday to Friday from 8am-5pm) or the Employee Relations team.

• Our senior lead responsible for Freedom to Speak Up, **Andrea Ashman (Chief People Officer)** - provides senior support for our speaking-up guardians and are responsible for reviewing the effectiveness of our FTSU arrangements.

• Our non-executive director responsible for Freedom to Speak Up **Stewart Baird** – **Stewart.Baird@nhs.net** – provides more independent support for the guardian; provides a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed.
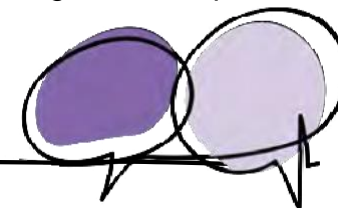
Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

• Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.

• NHS England for concerns about:
- GP surgeries
- dental practices
- optometrists
- pharmacies
- how NHS trusts and foundation trusts are being run
(this includes ambulance trusts and community and mental health trusts)
- NHS procurement and patient choice
- the national tariff.

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

• NHS Counter Fraud Agency for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a 'protected disclosure'.
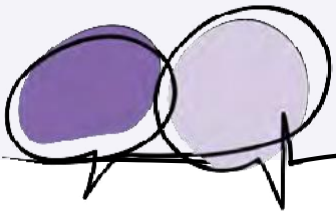
How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

• **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.

• **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.

• **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Advice and support

You can find out about the local support available to you at [either link to organisation intranet or reference other locations where this information can be found]. Your local staff networks [include link to local networks] can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

• Support available for our NHS people.

• Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to

for support. You can also contact the following organisations:

• Speak Up Direct provides free, independent, confidential advice on the speaking up process.

• The charity Protect provides confidential and legal advice on speaking up.

• The Trades Union Congress provides information on how to join a trade union.

• The Law Society may be able to point you to other sources of advice and support.

• The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.
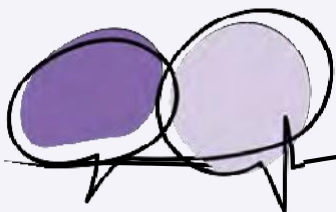
What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix A.

Resolution and investigation
We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you
We will treat you with respect at all times and will thank you for

speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you
(while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome
with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

Appendix A:
What will happen when I speak up?

We will:

Thank you for speaking up

- Help you identify the options for resolution

- Signpost you to health and wellbeing support

- Confirm what information you have provided consent to share

- Support you with any further next steps and keep in touch with you

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

- Referral to HR process

- Referral to patient safety process

- Other type of appropriate investigation, mediation, etc

Outcomes:

The outcomes will be shared with you wherever possible, along with learning and improvement identified

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS trust)

- Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England

Appendix B:
Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the Protect or a legal representative.

9 **Freedom to Speak Up policy for the NHS**
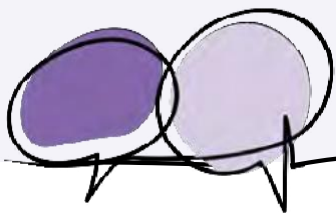
How will you speak up today?

NHS
**East Kent
Hospitals University**
NHS Foundation Trust

Speaking up can feel like a really difficult thing to do. The Freedom to Speak Up
Guardians and Connectors are here to support you to speak up.

Ways we speak up

- Kent and Medway Integrated Care System
- NHSP/agencies
- Freedom to Speak Up team
- Professional leads
- Exception report
- Board members
- SOS platform
- Staff survey
- IT helpdesk
- Managers
- Safeguarding
- Patient Advice and Liaison Service
- NHSE/I
- Police
- DATIX
- Connectors
- Guardian for Safer Working Hours
- CQC
- Professional bodies
- Exit interviews
- Wellbeing teams
- Occupational Health
- Preceptor
- National Guardian's Office
- People and Culture Business Partners
- Employee relations
- Unions / staff side
- Counter Fraud
- Staff networks
- Infection Prevention and Control
- Whistleblowers hotline (08000 724 725)
- Professional (Nurse/Midwife) Advocate
- Information Governance
- Mental health first aiders
- Health and Safety

We care