East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Case for Change for Kent and Medway Pathology Network (KMPN) Joint Venture (JV)**

Meeting date: **5 June 2025**

Board sponsor: **Chief Strategy and Partnerships Officer (CSPO)**

Paper Author: **Managing Director, KMPN**

Appendices:

Appendix 1: **Case for Change slide pack**
Appendix 2: **Equality Impact Assessment**

Executive summary:

Action required:	**Approval**
Purpose of the Report:	The attached slides give an overview of the development of the KMPN, including successes and challenges. They outline the next steps to implement a formal joint venture to consolidate the clinical and managerial leadership into a single team. This will deliver the benefits we believe are achievable, as outlined in the slides, and also ensure we achieve a 'mature' network status as is expected by NHS England (NHSE).
Summary of key issues:	Kent and Medway pathology services face the same challenges and a joint approach is more likely to mitigate them: • Serious mismatch in demand and capacity for cellular pathology **services.** • Workforce **fragility in microbiology and cellular pathology services**, particularly lack of substantive consultants. • Many **estates risks**, including lack of air handling meeting current standards, poor quality estate and lab layout. • Significant risk of loss of patient data and pathology results due to **antiquated and out of support IT systems**. We can drive necessary improvement with the benefit of scale, reducing duplication of effort. Evidence shows that formal mature pathology networks are more cost-effective and productive. Pathology teams are beginning to work in a collaborative manner to deliver on digital transformation projects. However, the current dual governance and oversight structures are maintaining inequity of access for patients, making change difficult, and our current ways of working are slowing down the delivery of patient and clinical benefits, causing cost increases and preventing us from making larger transformational improvements.

East Kent Hospitals University NHS Foundation Trust

Key recommendations:	The Board of Directors is asked to **APPROVE** the following: To set up, in 2025/26, a single governance and oversight structure for pathology services that replaces existing separate Trust oversight processes (Phase 1). This will include creating a new joint committee for pathology services which would become a formal sub-committee of the four Trust Boards with an executive and non-executive representative from each organisation (Phase 1). To support a revised KMPN management structure (from October 2025) to ensure delivery of the current projects; including a new Head of Quality, Risk and Governance, and for current pathology managers to report directly into the joint oversight arrangements with line management from the KMPN managing director (Phase 2). To commit to working towards a fully consolidated joint venture following the delivery of the single Laboratory Information Management System (LIMS) programme (after April 2027) with a host employer for pathology staff and a full integrated management structure with specialty leadership for Kent and Medway (Phase 3).

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	N/A
Resource:	N - No investment required for 2025/26.
Legal and regulatory:	Y legal **-** To strengthen their collaboration and facilitate the performance of the JV Agreement, the Trusts have agreed to jointly exercise their relevant functions and to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 in order to deliver KMPN's priorities and programmes. The committee will be known as the "KMPN Joint Committee" comprising executive and non-executive members of partner Acute Trusts.
Subsidiary:	N

Assurance route:

Previously considered by: Executive Management Team 5.3.25
Quality and Safety Committee 20.5.25
Finance and Performance Committee 27.5.25

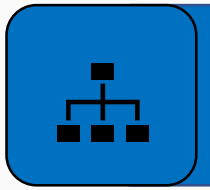
KMPN Case for Change: Summary Slides

A single pathology service across Kent and Medway that delivers excellent care for our patients and our people

Overview

The story so far

The case for joint oversight and governance for pathology services



Our proposal

Key messages and asks

The story so far: decisions since 2019

Strategic Outline Case (SOC) written in response to national requirements and approved by all Boards

Investment in initial programme team (£750k p.a)

Outline Business Cases (OBC) written for LIMS, MES and service change options. All approved by MTW and EKHUFT but service change case not approved by DGT and MFT

LIMS - £10m investment
MES - £22m savings identified

Development of **a 'third way' proposal,** delivering LIMS and MES without combined governance or management (but with agreement to review)

Service Change Savings of £6m identified but business case not approved

LIMS Full Business Case (FBC) approved by Trust Boards and contract signed with Clinisys. MES programme continues.

KMPN Collaboration Agreement developed agreed with each Trust to move to single management of pathology services. Current approach not sustainable.

Digital Pathology - £7.5m investment (NHSE capital)

New management team develop proposal for moving to single oversight and governance as per collaboration agreement with all partner Trusts.

The story so far: securing investment and planning transformation

Over **£15.5m inwardly invested** since 2022/23

£7.5 million
Digital Pathology

£4.5 million
LIMS implementation

£3 million
Community Order Comms

£260k
Acute Order Comm

£186k
Fluorescence in situ Hybridisation

Intention to deliver **£28m** savings by 2030

£22 million
MES savings

£6 million
Service Change savings

The case for joint oversight and governance for pathology

Each of our pathology services have the same challenges, which can only be addressed together

!

Slide 6

We can drive necessary improvement with the benefit of scale, reducing duplication of effort

Slide 7 - 11

Evidence shows that formal mature pathology networks are more cost-effective and productive

Slide 12 - 13

KMPN
Kent and Medway Pathology Network

Kent and Medway pathology services face the same challenges and a joint approach is more likely to mitigate them

NHS

Challenges	Mitigations and Solutions
Serious mismatch in demand and capacity for cellular pathology **services**	• Implementation of digital pathology followed by introduction of assisted reporting • Combined outsourcing contracts resulting in cheaper outsourcing capacity • Opportunity to cross-cover leave in subspecialties across sites
Workforce **fragility in microbiology and cellular pathology services**, particularly lack of substantive consultants	• Increased attractiveness in recruitment for microbiology • Opportunity to review clinical model, standardising microbiology advice OOH • Opportunity to review transport and logistics at county level improving TaTs
Many **estates risks**, including lack of air handling meeting current standards, poor quality estate and lab layout	• Opportunity to share and transfer tests easily between sites following LIMS and MES • Long term KMPN strategy to review pathology estate and write business case for new laboratory spaces at network level
Significant risk of loss of patient data and pathology results due to **antiquated and out of support IT systems**.	• Single Path IT support model meaning better resilience and more support

A joint approach will drive improvement and reduce duplication

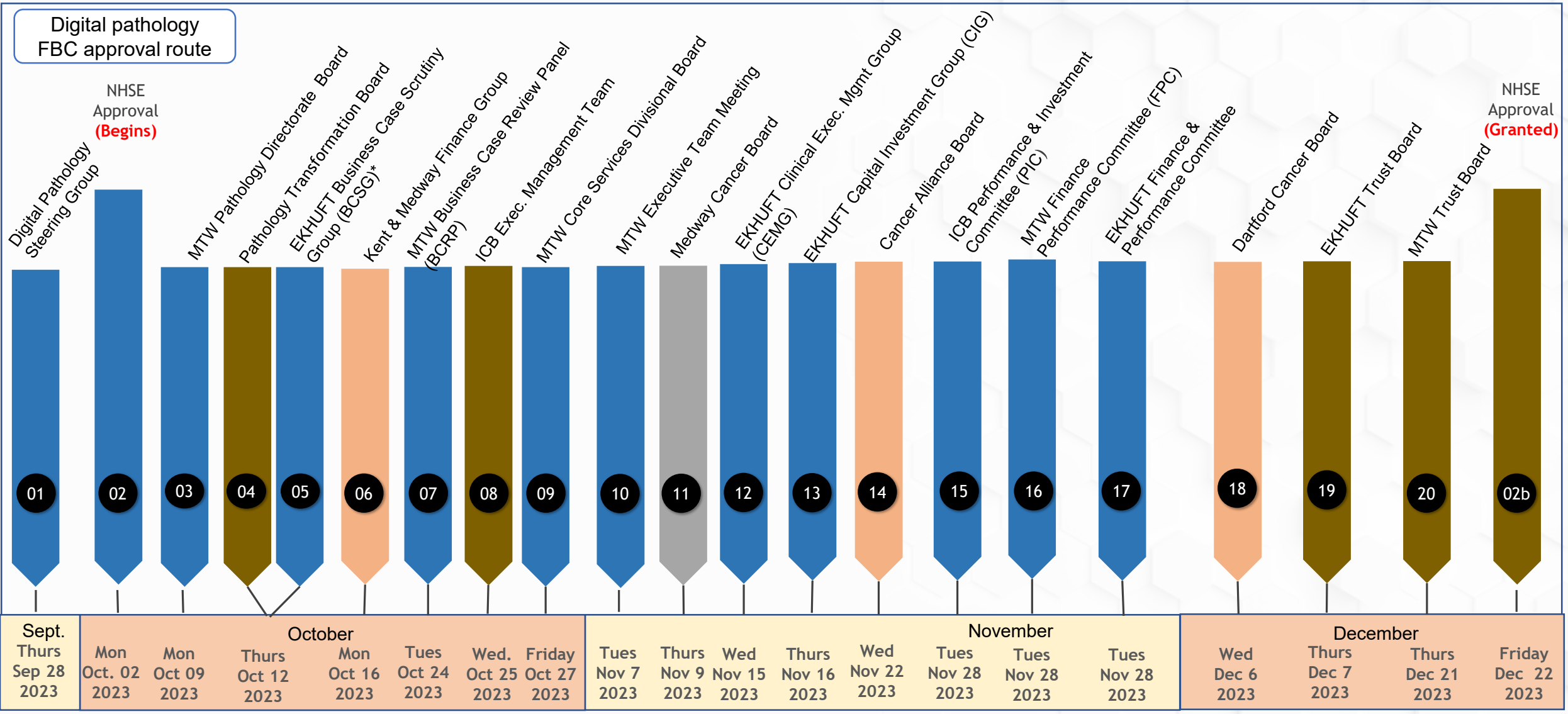
- Pathology teams are beginning to work in a collaborative manner to deliver on digital transformation projects, however
- The current dual governance and oversight structures are maintaining inequity of access for patients, making change difficult, and
- Our current ways of working are slowing down the delivery of patient and clinical benefits, causing cost increases and preventing us from making larger transformational improvements

Pathology teams are working collaboratively as requested but need their organisations to do the same

KMPN delivery meeting structure

	Mon	Tues	Wed	Thurs	Fri
Week 1	KMPN Senior Managers	Cell Path Steering Group LIMS Weekly WG OCS Weekly WG	Biochemistry and Immunology Steering Group DigiPath Weekly WG KMPN Senior Team	PNCOC	
Week 2	KMPN Senior Managers	LIMS Weekly WG OCS Weekly WG	DigiPath Weekly WG KMPN Senior Team KMPN Legal and Governance Steering Group	K&M Pathology Network Board Diagnostics Delivery Board	
Week 3	KMPN Senior Managers	Microbiology Steering Group LIMS Weekly WG OCS Weekly WG	Order Comms Project Steering Group DigiPath Weekly WG KMPN Risk and Governance	DigiPath Project Steering Group KMPN Workforce Steering Group	MES Steering Group
Week 4	KMPN Senior Managers PMO Whole Team meeting	LIMS Weekly WG OCS Weekly WG	Haem & BT Steering Group DigiPath Weekly WG KMPN Senior Team	Digital Transformation Oversight Board (incl. LIMS SG)	LIMS Project Group

Current oversight structures make change difficult



Current ways of working are slowing delivery of identified patient benefits and savings

Joint decision making:

Equity of access to testing for patients and clinicians

Shared clinical models for fragile services

Implementation of LIMS:

Complete access for clinicians across all care settings to all pathology results

Reduction in unnecessary or duplicative testing

Better clinical decision making

Implementation of same equipment:

Optimise demand for tests through digital triage tools

Single data set with the same reporting ranges for all pathology tests

Improved turnaround times for results through optimisation of reporting and analytical capacity

Current ways of working are slowing delivery of patient benefits and savings

KMPN programme ten year forecast

	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000	2029/30 £000	2030/31 £000	2031/32 £000	2032/33 £000
BROKERAGE	1,844								
SURPLUS							724	2,961	2,961
DEFICIT		(241)*	(1,531)	(633)	(547)	(0)			

In the previous few years KMPN has improved the system financial position through brokering unspent funding; but this is a symptom of slow delivery of transformation

Without action, KMPN will create a net programme deficit over the next four to five years due to the delays in delivery of our key projects

In the baseline position, KMPN will still deliver savings from current programmes by 2030 but these are later than planned

*Subject to receipt of NHSE funding

Other formal pathology networks have shown that delivering more ambitious transformational savings is possible over time

Figure 2.1: Cost per Pathology Test from Networks at different levels of maturity, from NHS England presentation October 2024

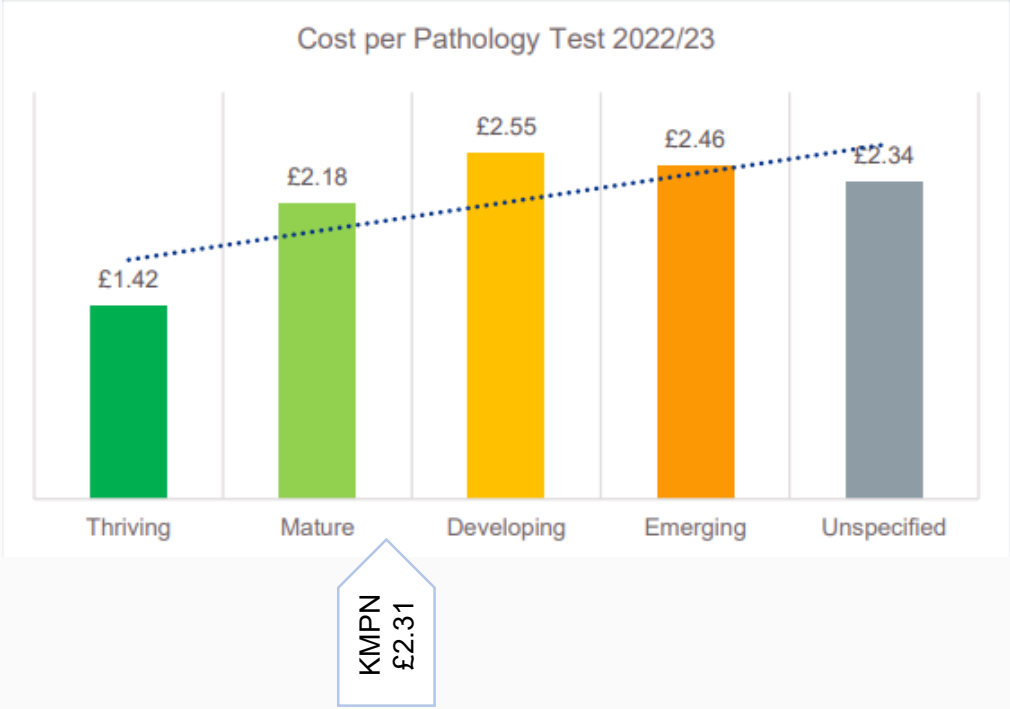
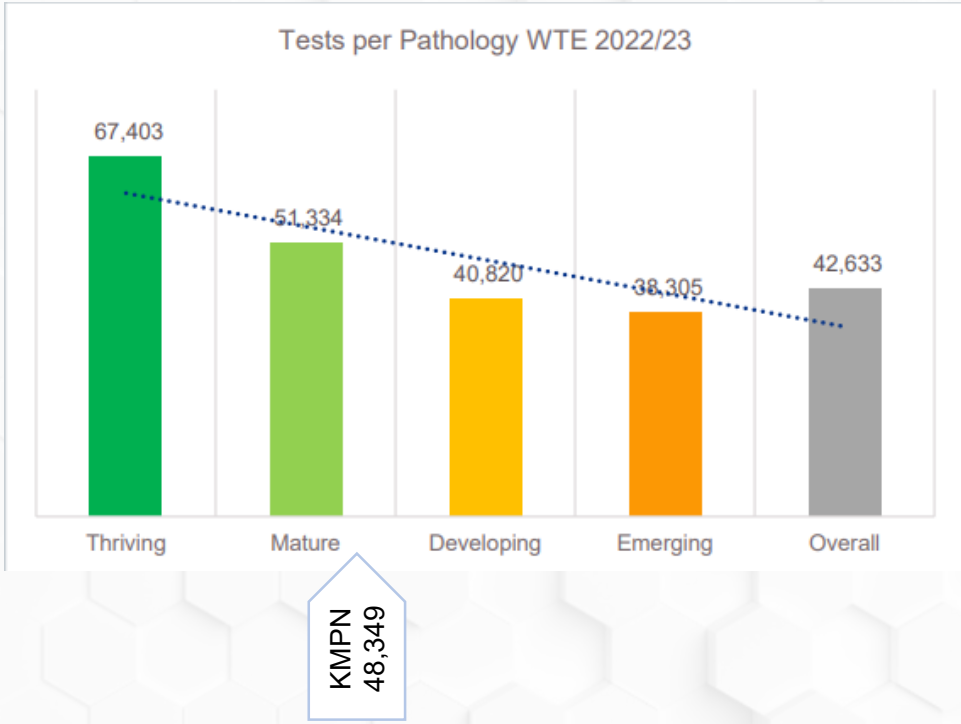


Figure 2.2: tests per Pathology Whole Time Equivalent from Networks at different levels of maturity, from NHS England presentation October 2024



Recurrent productivity opportunity for Kent and Medway if KMPN operates at average for this type of network:

KMPN combined operating budgets (£000)	Saving at mature average (£2.18) (£000)	Saving at thriving average (£1.42) (£000)
£95,800	£ 4,748 (5%)	£ 33,325 (35%)

A joint governance and oversight process can mitigate the financial gaps in the coming years

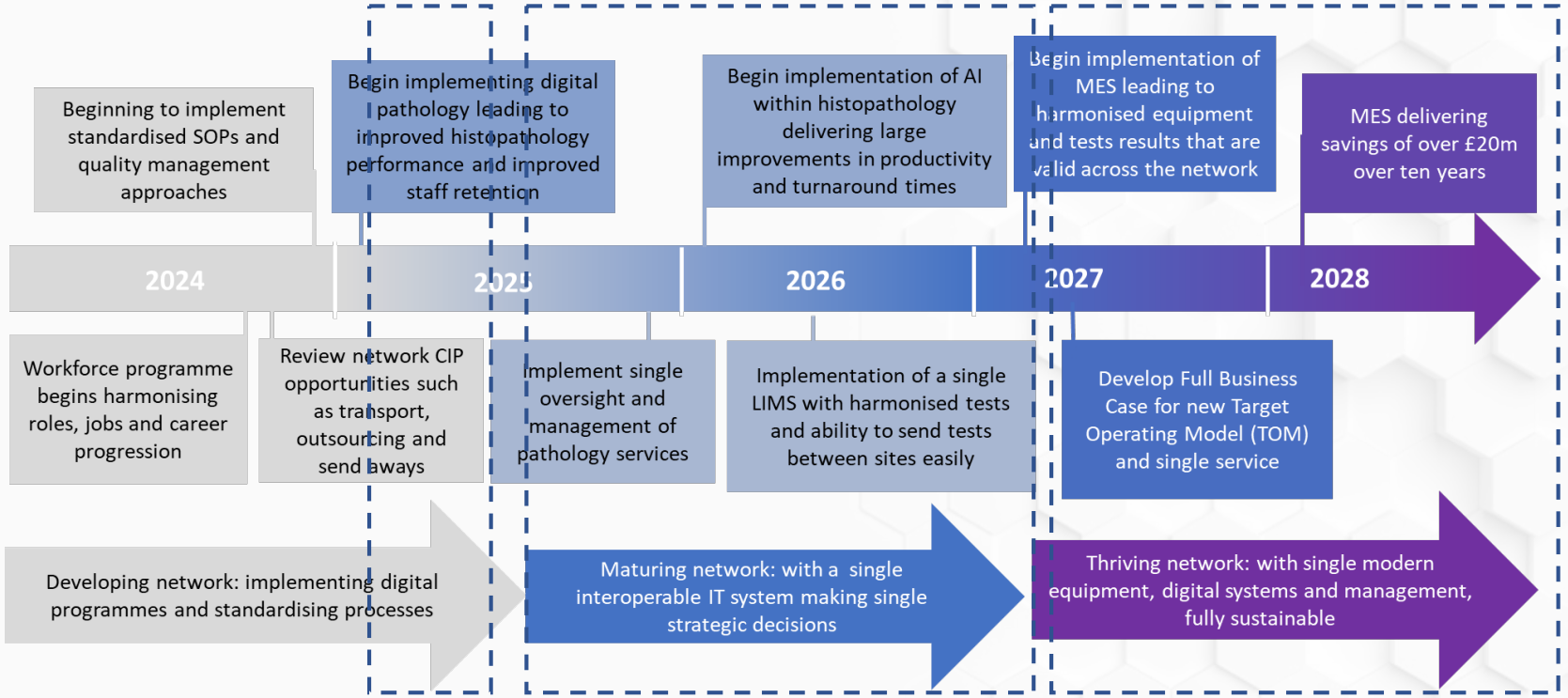
Initial review of the national benchmarking data suggests that the opportunities for KMPN are primarily in the non-pay space. The single network managed equipment service (£2.1m annual recurrent saving) remains a key objective. However, over the past year we have been identifying key other areas that a single network would be able to reduce costs:

Opportunities for joint working to deliver savings prior to major service change	Current spend and opportunity
Joint contracting approaches and consolidation: • PoCT, • transport, • test outsourcing, • quality management systems,	Current approx. spends and opportunity: • **£1.5m (opportunity £250k)** • **£1.5m (opportunity £200k)** • **£4m (opportunity £200k)**
Repatriation of work inside K&M by delivering network level activity on single analysers or with single teams alongside growth in commercial and private income	Current spend **approx. £3m** Opportunity – **Up to £100k**

	25/26 £000	26/27 £000	27/28 £000	28/29 £000	29/30 £000	30/31 £000	31/32 £000
(Surplus)/Deficit before Mitigations (£)	241	1,531	633	547	0	(724)	(2,961)
Mitigations:							
Additional MES savings - MTW	(150)	(150)	(150)				
Additional MES savings - EKHUFT		(150)	(150)				
Achievement of 25% of identified contract opportunities		(200)					
Achievement of 50% of identified contract opportunities			(400)				
Achievement of 100% of identified contract opportunities				(750)	(750)	(750)	
Total Mitigations	(150)	(500)	(700)	(750)	(750)	(750)	0
(Surplus)/Deficit after Mitigations (£)	(91)	1,031	(67)	(203)	(750)	(1,474)	(2,961)

Phasing in these savings over the next four years (which are only accessible as a network) can mitigate the majority of the cost overruns and set the foundations for fuller network consolidation.

Our proposal: joint governance in 2025 and full consolidation from 2027



Phase 1: Transition phase
April-October 2025

- Set up of new network governance structure and step down of existing Trust governance structures
- Recruitment to key new posts
- Preparation for changes in line management for senior pathology managers

Phase 2: Joint Oversight and Management, separate staff and budgets
From October 2025

- Single management structure implemented with team and individual leadership development programme
- New governance structures fully running and regularly reviewed
- Delivery of transformation projects
- Annual business plans and reports

Phase 3: Full Consolidation of Pathology Services in Joint Venture
From April 2027

- Implementation of full single management
- Transfer of staff to host organisation
- Transfer of pathology budgets to host organisation
- Delivers full benefits of transformation, harmonisation and standardisation

Phase 1: Governance transition begins in April 2025

Joint Venture Board:

Formal joint committee with unanimous voting from an executive and non-executive member of each Trust, as well as independent expert. Delegated responsibility from each Trust re: pathology services budgets. Meets quarterly.

Key reporting committees:

Includes key Trust stakeholders at Exec and divisional level to ensure network meets requirements. Includes:

- Finance and investment
- Quality and Safety
- People and Culture
- Digital
- Meets monthly/bi-monthly.

KMPN Senior Management Team:

Responsible for day to day management of budget, recruitment, contracts etc. Meets weekly.

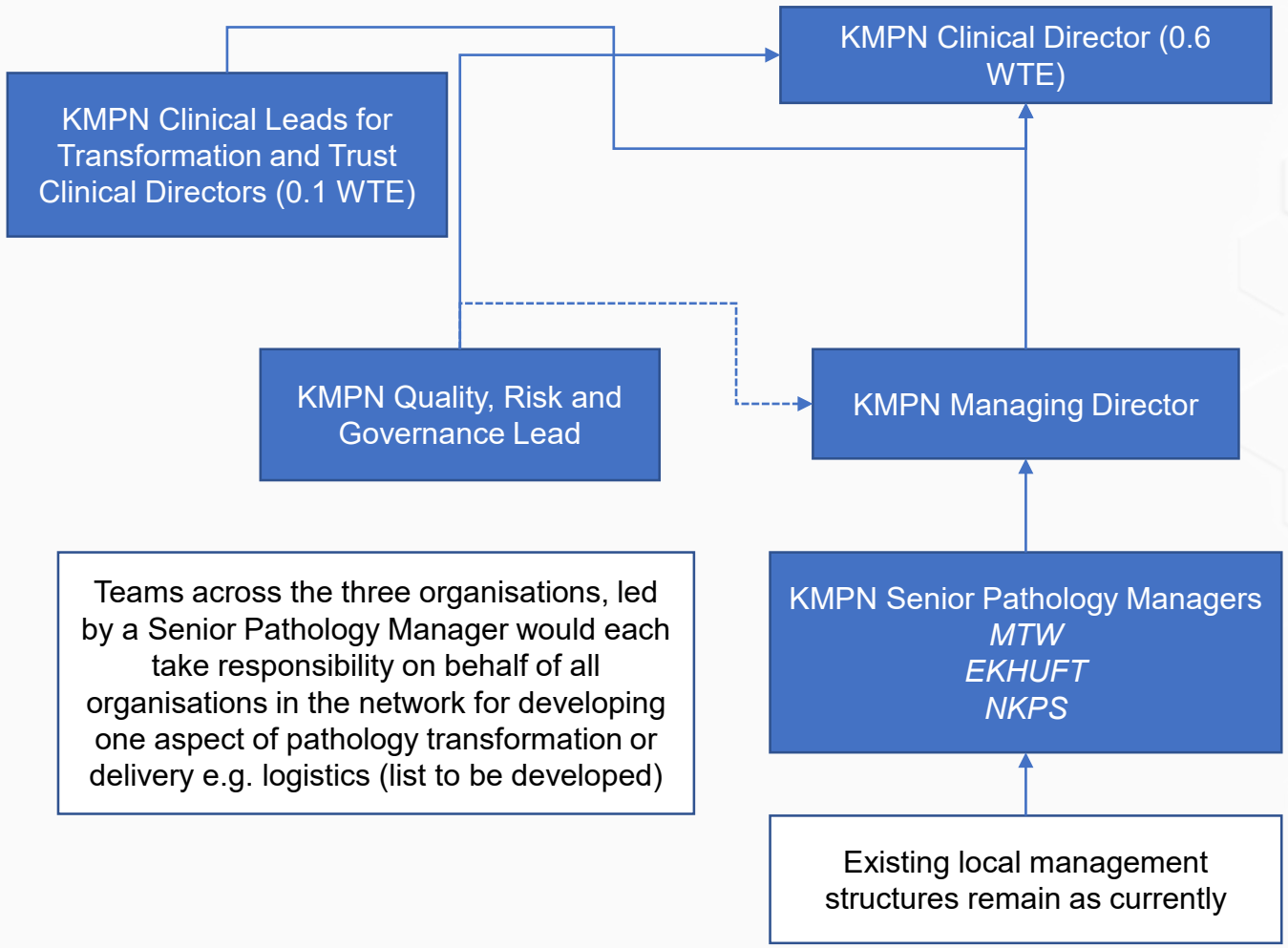
Joint committee considerations

- Could be chaired by an independent expert or by a non-executive
- Decisions would be binding on each organisation so we propose unanimous voting
- Needs to have delegated accountability for the locations of pathology testing and staff
- Will hold joint venture to account for delivery, performance and spend with agreed envelope
- Board reserved matters would include any additional spend above agreed budget
- We will work with nominated representatives to finalise draft Terms of Reference

Phase 1 – Transition – April to October 2025

- During this phase, the new network governance structure described opposite will be set up and existing Trust governance structures will be stepped down, with a period of double running to ensure a safe handover.
- Recruitment to key new posts will take place and preparations for changes in line management for senior pathology managers will be made.
- A detailed implementation plan for this has been produced including a gateway process to ensure the transition has been completed successfully.

Phase 2: Single management reporting from October 2025



Phase 2 – Implementation – from October 2025

- Subject to a robust gateway process being completed, the new interim single management structure as will have been implemented under the network Clinical and Managing Directors, and new joint governance structures will be fully running.
- During this phase, the joint venture will continue to be hosted by Maidstone and Tunbridge Wells Trust. There will then be an exercise to establish which Trust would undertake the long-term hosting arrangements that will come into effect from phase three.
- During this phase, the joint management team, under the direction of the Partner Trusts would plan and prepare for the fully consolidated joint venture.

Phase 3: Fully operational single service from April 2027 (subject to FBC process)

Under the joint governance, the network would design a Target Operating Model (TOM) that makes best use of laboratory space, staff and the latest technology:
all successful networks have consolidated their services; through creating larger hubs for some work, consolidating specialist work onto different sites and through use of automation and technology to release scarce specialist workforce

The fully operational single service would have a single organisational structure for delivery:
drawing together IT, quality, digital transformation, workforce and supply chain under one governance structure

Phase 3 – fully operational – from April 2027

- By April 2027, a FBC would be developed to describe the service changes that would accompany the development of a single service
- This phase involves full consolidation of management, workforce and budgets into a host provider and would follow LIMS implementation and the MES primary provider tender.
- The host for this phase of the joint venture is yet to be agreed. The JV would remain in Phase 2 until Phase 3 is fully signed off by the Partner Trusts.

Key messages: Ask of the Partner Trusts

- To set up, in 2025/26, a single governance and oversight structure for pathology services that replaces existing separate Trust oversight processes (Phase 1).
- This will include creating a new joint committee for pathology services which would become a formal sub-committee of the four Trust boards with an executive and non-executive representative from each organisation (Phase 1).
- To support a revised KMPN management structure (from October 2025) to ensure delivery of the current projects; including a new Head of Quality, Risk and Governance, and for current pathology managers to report directly into the joint oversight arrangements (Phase 2).
- To commit to working towards a fully consolidated joint venture following the delivery of the single LIMS programme (after April 2027) with a host employer for pathology staff and a full integrated management structure with specialty leadership for Kent and Medway (Phase 3).

Equality, Diversity and Inclusion Impact Assessment

Stage 1

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

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

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

Authors must consider what action they will take to mitigate any negative outcomes identified. Further actions may be recommended upon review of this impact assessment by Equality and Diversity Working Group members. If a negative outcome is identified, it is important to be mindful that it may also affect other protected characteristics.

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

Section 3: Equality Act 2010
This section asks CCGs equality, diversity and inclusion lead to consider compliance to the Equality Act (2010) having completed the impact assessment of each of the protected characteristics covered by the Act in section 2. Consideration should be given to whether the evidence included in the impact assessment demonstrates that the organisation has upheld its legal duty to eliminate discrimination and promote equalities and good community relations by having given due regard to equality, including all nine of the protected characteristics covered by the Act.

Section 4: Conclusions & Recommendations
Now the impact has been assessed, the reviewing panel is asked to consider whether, based on the findings, they agree with the findings and any mitigating actions.

Section 5: Planning Ahead
This section outlines the requirements for any next steps. This should be completed by the CCG's Equality, Diversity and Inclusion lead and the author of this impact assessment to ensure that requirements are reasonable and deliverable within project/programme timeframes.

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

Directorate: Kent and Medway Pathology Network
Officer responsible for assessment: Amanda Price
Date of assessment: 22.11.24

Defining what is being assessed:

What is the title of the policy, function or service this impact assessment applies to?
Kent and Medway Pathology Network **Joint Venture implementation**

Please briefly describe the purpose and objectives of this policy, function or service
The joint venture is a legal partnership of the four acute hospital Trusts in Kent and Medway, for pathology services, hosted by one of the Trusts. Phase one involves implementing a single management and new governance led by a joint committee of the four partner Trusts.

Who is intended to benefit and in what way?
Pathology users will have more reliable and quick access to test results, and an ability to share and access results across the county.
Patients will have standardized access to test results across Kent and Medway with fewer errors and delays.
The health and care system will have fewer delays in implementing transformational change
Staff working in pathology will have more streamlined ways of working and greater flexibility to work across sites.

What is the intended outcome of this policy, function or service?
Creation of a single pathology service within Kent and Medway with single governance and management structure

Who are the main stakeholders in this piece of work?
- Acute hospital Trusts
- Pathology services in Kent and Medway
- Users of pathology services in hospitals, community and primary care
- Pathology staff
- Patients and public

What factors may contribute to the outcomes of this policy, function or service?
- Approval by all four acute hospital Trusts
- Securing the funding for the joint venture implementation
- Availability of suitably qualified and skilled staff to implement the change

What factors may detract from the outcomes of this policy, function or service?

- As above

Who is responsible for implementing this change to policy, function or service?

- Kent and Medway Pathology Network Board and leadership team

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

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

1. Could there be a differential impact due to *racial/ethnic groups*?	N	

What evidence exists for this?

There is no adverse impact on provision of service for pathology users or patients of any ethnicity through this business case.
Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection.
New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.

2. Could there be a differential impact due to *disability*?	N	

What evidence exists for this?

There is no adverse impact on provision of service for pathology users or patients with disabilities through this business case.
Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection.
New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.
The network operates a hybrid and flexible working arrangements with risk assessments as applicable.

3. **Could there be a differential impact due to *gender*?**	N	

What evidence exists for this?

There is no adverse impact on provision of service for pathology users or patients of any gender through this business case.
Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection.
New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.

4. **Could there be a differential impact due to *sexual orientation*?**	N	

What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients of any sexual orientation through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.

5. Could there be a differential impact due to *religion or belief*?	N	
What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients of any religion or belief through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.		

6. Could there be a differential impact due to people's *age*?	N	
What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients of any age through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture. The network operates a hybrid and flexible working arrangements with risk assessments as applicable.		

7. Could there be a differential impact due to *marital/civil partnership status*?	N	
What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients of any marital or partnership status through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.		

8. Could there be a differential impact due to a person being *trans-gendered or transsexual*?	N	
What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients who are trans-gendered or transsexual through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture.		

9. Could there be a differential impact due to a person being *pregnant or having just had a*	N	

baby?		
What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients who are pregnant or just had a baby through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture. The network operates a hybrid and flexible working arrangements with risk assessments as applicable.		

10. Are there any *other* groups that may be impacted by this proposed policy, function or service (e.g. speakers of other languages; people with caring responsibilities or dependants; those with an offending past; or people living in rural areas, homeless or war veterans) but are not recognised as protected characteristics under the Equality Act 2010?	N	
What evidence exists for this? There is no adverse impact on provision of service for pathology users or patients through this business case. Staff consultation and recruitment to new roles will follow best practice in organizational change, recruitment and selection. New job descriptions will include network values and desired leadership qualities to enable the development of an inclusive network culture. The network operates a hybrid and flexible working arrangements with risk assessments as applicable.		

Section 3: Freda Principles

11. The FREDA principles (fairness, respect, equality, dignity and autonomy) are a way in which to understand Human Rights. What evidence exists to demonstrate that this initiative is in-keeping with these principles?

Fairness- the single service will ensure that there is the same level of service in pathology for all service users across the county.

Respect- the single management will enable a positive culture based on network values and desired leadership behaviours including respect. Implementation will be carried out transparently and in partnership with impacted staff, users and with clear and consistent communications to wider stakeholders.

Equality- the single service will ensure that there is the same level of service in pathology for all service users across the county. Recruitment to single management will follow best practice. The organizational change process will work towards having the same terms and conditions for all transferring staff.

Dignity- the single management will enable a positive culture based on network values and desired leadership behaviours including dignity. Implementation will be carried out transparently and in partnership with impacted staff, users and with clear and consistent communications to wider stakeholders.

Autonomy- the joint venture planning and implementation involves involvement of impacted staff, union and staff representatives and Trust representatives. The single management structure and job roles will be designed to enable distributed leadership at all levels with clear lines of accountability and responsibility.

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

Section 4: The Equality Act 2010

Under The Equality Act 2010, the CCG is required to meet its Public Sector Equality Duty. Does this impact assessment demonstrate that this policy, function or service meets this duty as per the questions below? A 'no' response or lack of evidence will result in the assessment not being signed off.

12. The need to eliminate discrimination, harassment and victimisation	Y	
13. Advance equality of opportunity between people who share a protected characteristic and those who do not	Y	
14. Foster good relations between people who share a protected characteristic and those who do not	Y	

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

Section 5: Action Plan

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

Potential Impact identified	Which Protected Characteristic group will be impacted upon?	Action required to mitigate against impact	Date for implementation	Who is responsible for this action (Provider/CCG- please include job title where possible)?	Update on actions (to be provided throughout project)	

Section 6 Conclusions (to be completed by the author)

Could the differential impacts identified in questions 1-15 amount to there being the potential for adverseimpact?	Y/N	n/a
Can the adverse impact be justified on the grounds of promoting equality of opportunity for one group, or another reason?	Y/N	n/a

Date of next review	April 2026
Areas to consider at next review (e.g. new census information, new legislation due)	Feedback on success of joint venture implementation
Is there *another* group (e.g. new communities) that is relevant and ought to be considered next time?	n/a
Signed (Author) Amanda Price	Date 22.11.24
Signed off by:	Date

Is there an opportunity to alter your proposal to meet the CCGs duties?	Y/N	n/a
Is there evidence of a disproportionate adverse or positive impact on any groups of protected characteristic?	N	
Are there concerns that there may be an impact that cannot be easily mitigated or alleviated through the alterations?	N	

For any 'Yes' answers, please amend your equality impact assessment and resubmit it for further review.

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS (BoD) ASSURANCE REPORT

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

Meeting dates: **8 April 2025 and 13 May 2025**

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

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

Quorate: **Yes**

Appendices:
Review of neonatal deaths at East Kent Hospitals University NHS Foundation Trust April 2023 - May 2024

Declarations of interest made:
None

Assurances received at the Committee meeting:

Papers for discussion /approval	Summary
Clinical Negligence Scheme for Trusts (CNST) Compliance	The Maternity Incentive Scheme (MIS) Year six data collection period commenced on 2 April 2024. The service completed the Board declaration process and this was approved by the Trust Board and the Integrated Care Board (ICB) Accountable Officer (AO) prior to submission to NHS Resolution (NHSR). At the April and May 2025 MNAG meetings the following papers were discussed in compliance with CNST reporting: **Perinatal Mortality Review Tool (PMRT) Quarter 4 (Q4) Report – CNST Safety Action 1** The purpose of this report is to assure the MNAG and Trust Board that all stillbirths and neonatal deaths are reviewed using the national electronic PMRT. • The report confirms that during the Q4 reporting period the service has used the tool to the required standard as set out in NHSR, CNST MIS Year 6. • During Q4, there have been a total of 12 cases reported. Of these 12 cases, three were not supported as they did not meet the national criteria. Of the nine supported cases, four were neonatal deaths and five were still births/Intrauterine deaths (IUDs). • Within the last quarter the Trust reported all cases to MBRRACE-UK: Mothers and Babies: Reducing Risk through

Audits and Confidential Enquiries across the UK within seven days of the death, with Factual Questions completed within one calendar month.

- Within the last quarter the Trust had a 100% compliance rate of commencing the review within the allocated time scales.
- There is a 100% compliance with external reviewers at PMRT meetings. The bereavement teams within the Local Maternity and Neonatal System (LMNS) meet quarterly to discuss regional themes and issues. The last meeting was on 14 April 2025.

Avoiding Term Admissions into Neonatal Units (ATAIN) Q4 report - CNST Safety Action 3

- **126** babies received transitional care in **Q4 2024/25**, with **83** babies at Queen Elizabeth the Queen Mother Hospital (QEQM) and **43** at William Harvey Hospital (WHH).
- **18** babies were between **34-35+6**-week gestation (Late pre-term) and only **one** baby at WHH from that gestation was admitted to Special Care Baby Unit (SCBU).
- Total Term Admissions at EKHUFT for Q4 2024-25: **63** babies with **33** babies at **QEQM** and **30** babies at **WHH.**
- The main reasons for admission were respiratory, infection and hypoglycaemia in line with the other units in the network.
- There is evidence to demonstrate that data and learning themes are shared amongst the team in the form of a bi-monthly poster and where appropriate, individual support for staff is provided.
- QI working party meets weekly at present. Q1 to Q4 there has been on focus on the Bobble hat initiative-NEWTT2 (Newborn Early Warning Trigger and Track) risk assessment).

There are currently nine actions on the ATAIN action plan:

- Two actions have been completed.
- Five actions are on track.
- Two at risk: **Action 5:** Review all 34-35+6 admissions at ATAIN. Explore if babies admitted to SCBU could have been cared for with Full Transitional Care (TC). Undertake Audit during ATAIN meeting collating data to be reviewed **Action 7:** Update the TC guideline within the Trust.

Saving Babies Lives Q4 report – CNST Safety Action 6

A self-assessment for Q6 against the Saving Babies Lives Care Bundle (SBLCB) was submitted on 12/03/25 and the LMNS validated result was received on 15/04/25.

- Total compliance as validated by the LMNS is currently 93%. An action plan has been created for each outstanding element and intervention to ensure compliance which is monitored internally as

	well as via the weekly LMNS meetings. The actions linked to each of the six elements of the bundle are listed below: • Element 1: 80% implementation. There are two outstanding interventions; both relating to the expansion of an in-house smoking cessation service. • Element 2: 95% compliance. There is one outstanding intervention relating to training of maternity staff. • Element 3: 100% compliance. • Element 4: 80% compliance. There is one outstanding intervention relating to the completion of the suitability for Intermittent Auscultation (IA) in labour tool. • Element 5: 96% compliance. There is one outstanding intervention relating to adherence to the full perinatal optimisation bundle in pre term labour. • Element 6: 100% compliance. Weekly meetings with the LMNS are ongoing for support to meet each outstanding intervention. **Serious Incident (SI) Q4 Report – CNST Safety Actions 9 and 10** • During Q4 one case was referred to Maternity and Newborn Safety Investigations (MNSI) for external Patient Safety Incident Investigation (PSII), there were two cases presented at the Trust Incident Review Panel (IRP) resulted in the proportionate response being requirement for internal PSII. • The service received two final reports from MNSI and one draft report sent for factual accuracy. • On receipt of MNSI final reports the findings, learning and any safety actions required are shared with the maternity service team and the LMNS. There was a total of eight MNSI accepted referrals in 2024-25 from the beginning of Q1 to the end of Q4 The maternity service continues to work collaboratively with the MNSI investigating teams. • This report confirms that during the Q4 reporting period the service has reported 100% of qualifying cases to MNSI and to NHSR's Early Notification Scheme (ENS) as set out in NHSR, CNST MIS Year 6. **For assurance and oversight in line with CNST.**
Perinatal Quality Surveillance Tool (PQST) February and March 2025	The PQST is presented to the Board in keeping with the Ockenden recommendation. It contains the minimum dataset that the Board requires oversight of for the months of February and March 2025.

	• Total Babies born in February 436 and March 488.
	• Supernumerary status compliance reported at 100% at both WHH and QEQM in both months.
	• Compliance of 1:1 in Labour was reported as 100% on both sites in both months.
	• Level 3 Adult Safeguarding compliance as of the end of February dropped to 88.9% but increased to 93% in March (90% target).
	• Child protection level 3 compliance at the end of February 90.8% and remains compliant in March at 91%.
	• Two MBRRACE stillbirths and 0 Neonatal deaths in February and two MBRACCE reportable stillbirths and three neonatal deaths in March.
	• The service also reported on three maternal deaths. All three cases were referred to MNSI and two were accepted for MNSI investigation. The third case did not meet the MNSI criteria for investigation (as death was not within 42 days of delivery) and with the support of the LMNS this case will undergo an independent external investigation.
	• 0 cases reported for MNSI in February.
	• Three moderate/severe harms reported in February and seven in March.
	
	In February the service had:
	• One open case being investigated by MNSI.
	• Two final reports returned to the Trust following completed investigation.
	• Two internal PSIIs in the process of investigation.
	
	In March the service:
	• Received one draft report from MNSI for factual accuracy.
	• Has two internal PSIIs in the process of investigation.
	
	Patient Experience
	• Friends and Family Test (FFT) received 295 responses, which is an overall 8.4% response rate.
	• 41 compliment emails sent from FFT feedback.
	• Your Voice is Heard - Response rate Key Performance Indicator (KPI) - 70%. The service achieved a response rate of 79.5% and the team spoke to 338 families.
	• Of the families that responded in March 2025:
	  • 91% were positive about Antenatal care.
	  • 94.7% were positive about Intrapartum care.
	  • 88.9% were positive about Postnatal care.
	  • 93.3% were positive about Neonatal care.
	  • 237 staff compliment emails sent in February and 241 in March.

	• Top themes include: communication, waiting times, facility and environments. **Training and Education** • Training remains on the Care Group risk register **(Risk Reference 3764)**, due to training space to enable the Maternity Training Programme to be delivered at full capacity. If training space is not secured there is a real risk that training will become unavailable for all staff groups and that Safety Action 6 and 8 of CNST will not be met. The team are currently exploring potential venues but would like to escalate that the new programme is due to start in September 2025 and this may not be achievable if training space is not secured. • PRactical Obstetric Multi-Professional Training (PROMPT) compliance is above 90% for all staff groups for February. The trajectory remains above 90% in March but anaesthetic doctors will fall below 90% in April. To ensure this group maintains ≥90% compliance additional bookings will be required for April 2025. • Training compliance for fetal monitoring is >90% for all staff groups in February and the trajectory will ≥95% for March and April 2025. • Newborn Life Support (NLS) for all staff groups is above 90% and with the exception of support workers but the trajectory will be >90% by the end of April. **For assurance and oversight in line with Ockenden and CNST Safety Action 9.**
Neonatal Death Review	The review was commissioned by EKHUFT further to the identification of an increase in the number of neonatal deaths that occurred between 31 March 23 to May 2024. Despite the local increase in the death rate the service remained below the comparator group of 1.96 per 1000 births. These cases were subjected to individual reviews, however, the aim of a collective review was to identify any themes or modifiable factors that contributed to the neonatal deaths and make recommendation for practice. 14 cases were independently reviewed and stated that: • The most frequent cause of death was complications related to extreme prematurity which accounted for 64% of cases. • There were no minor or major factors with midwifery care identified. Recommendations for maternity care were classed as ‘wider learning’. These are usually non-causal recommendations identified through the course of an investigation.

	• Within neonatal care there were no major modifiable factors identified in any of the cases. Five recommendations (across four cases) were classed as 'minor' modifiable recommendations. • Duty of Candour (DoC) has been completed. • The report has been presented at MNAG and the resultant action plan will continue to be monitored there. The report confirmed internal reviews and as such many of the suggested recommendations are already underway and included in the local improvement workstreams. **Brought for assurance.**
Hypoxic-ischaemic encephalopathy (HIE) Review	An aggregate review of the 11 cases reported in 2024 was requested by the DoM. It was noted that although the service remained below the national target range of 2.8 per 1000 (currently 1.6 per 1000) that there was an increase in the number of cases reported in 2024. In 2023 there were nine cases and in 2024 11 cases had been reported. These cases were subjected to individual reviews on independent MNSI reviews where they met the criteria. The aim of a collective review was to identify any themes or modifiable factors that contributed to the outcome of an HIE and make recommendations for practice. The review was undertaken by the Associate Medical Director. Eleven cases were initially reviewed and it was noted that in five cases the babies were born elsewhere but were transferred to the Neonatal Unit at WHH for Level 3 care. These five cases were therefore excluded from the review. Of the six cases it was concluded that: • There were no obvious Equality, Diversity and Inclusion (EDI) components which impacted on outcome. • There were no clear commonalities found. Where cases were reviewed by MNSI a review of the recommendations was also undertaken to determine any recurring recommendations. Only one recommendation was repeated over two cases: • A loss of situational awareness in relation to the passage of time was highlighted in two cases. Human Factors have since been included in Multi-Disciplinary Team (MDT) PROMPT and maternity mandatory training. All other recommendations have been actioned **Brought for discussion and approval.**
Matters to escalate to Quality & Safety	• Review of HIE cases in last 12 months. 45% of cases babies were born elsewhere.

Committee (Q&SC) and Board	• Changes to Safety Action 7 (SA7) within the MIS Year 7 criteria published in April. There is a requirement for Maternity and Neonatal Voices Partnership (MNVP) leads to attend a range of meetings. This may not be achievable on the minimal hours allocated to the roles. This risk has been flagged to the ICB as a regional risk which that can negatively impact on achievement of SA7 and thereby all of CNST. • Maternal deaths - two are outside the MNSI reviewing period but arrangements have been made for review. • Anaesthetic staffing.

Other items of business: None

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

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

Item	Purpose	Date
MNAG asks the BoD to discuss and **NOTE** this MNAG Chair Assurance Report.	Assurance	5 June 2025
The BoD is asked to discuss and **Approve** the Hypoxic-ischaemic encephalopathy (HIE) Review.	Approval	5 June 2025

East Kent Hospitals University NHS Foundation Trust

Review of neonatal deaths at East Kent Hospitals University NHS Foundation Trust April 2023 - May 2024

The Trust asked for this independent review because it had seen an increase in neonatal deaths, although the number of deaths remained below the national average.

The loss of a baby is devastating and the impact on families is significant. We have shared the findings of this review with families of the babies whose care is included in this report and we are grateful for their understanding of the Trust's decision to publish the report.

Like neonatal units across the country, our neonatal unit cares for increasing numbers of extremely premature babies, who sadly have a low chance of survival.

The Trust had carried out an internal review of the care of each individual baby to identify any learning. It asked the independent review team to look at the deaths as a group, so any common factor or themes in caring for such extremely premature and critically ill babies could be identified where looking at individual babies' care might miss something.

The review found the care in our maternity units and neonatal unit was of a good standard. However, when caring for such vulnerable, very premature babies, many factors can have an impact on how long a baby can survive outside the womb and the nature of the illnesses they need to battle. It makes neonatal care an incredibly complex and challenging branch of medicine.

The review team found no major factors which would have influenced the outcomes for these babies. We are implementing their wider recommendations in full, including those related to five minor factors which the team considered may have made a difference, to ensure our care for extremely premature babies is of the highest possible standard.

Please be aware that the review report below includes detail that may be upsetting.

Our thoughts are with the families of the babies whose care is reviewed in this report.

REVIEW OF NEONATAL DEATHS AT EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST APRIL 2023- MAY 2024

(JANUARY 2025)

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Abbreviations

ANNP – Advanced Neonatal Nurse Practitioner

BAPM – British Association of Perinatal Medicine

EKHUFT – East Kent Hospitals University NHS Foundation Trust

ETT – Endotracheal tube

IVH – Intraventricular Haemorrhage

MgSO4 – Magnesium Sulphate

NEC – Necrotising Enterocolitis

Neonatal Badger - neonatal electronic care record

NICU – Neonatal Intensive Care Unit

NNAP – National Neonatal Audit Programme

OCM – Optimal Cord Management

RDS – Respiratory Distress Syndrome

SCBU – Special Care Baby Unit

The Review Team

Dr Helen Gbinigie – Consultant Neonatologist

Sian Oldham – Advanced Neonatal Nurse Practitioner (ANNP)

Barbara Kuypers – Midwife Consultant

Introduction

This review was commissioned by East Kent Hospitals University NHS Foundation Trust (EKHUFT). This Trust is made up of 5 hospitals and community clinics. The group serves a population of approximately 700,000 people in East Kent. The hospitals serving this community are:

- Buckland Hospital, Dover
- Kent and Canterbury Hospital, Canterbury
- Queen Elizabeth, The Queen Mother Hospital, Margate
- Royal Victoria Hospital, Folkstone
- The William Harvey Hospital, Ashford.

Maternity Services are provided at William Harvey Hospital in Ashford and Queen Elizabeth, The Queen Mother Hospital in Margate. There are Birthing Centres at both William Harvey Hospital and Queen Elizabeth, The Queen Mother Hospital. There are approximately 6,500 deliveries per year at this Trust.

Neonatal services are provided at both William Harvey Hospital (7 Neonatal Intensive Care beds; 4 High Dependency beds and 14 Special Care beds) and Queen Elizabeth, The Queen Mother Hospital (2 High Dependency beds and 12 Special Care beds). These units are situated within the Kent, Surrey and Sussex Operational Delivery Network.

Background to the Review of Neonatal Deaths:

The background to this review has been provided for this report by Michelle Cudjoe, Director of Midwifery and Nursing, EKHUFT.

The Trust commissioned an external review to include neonatal deaths (of all gestations) that occurred within the time frame of 31st March 2023 to 31st March 2024. This was then extended to include the deaths of babies in May 2024. This specific timeframe was chosen given that a five-year review of all neonatal deaths identified an increase from April 2023. Although a local increase was observed, the Trust's Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) reportable neonatal death rate (deaths that occur at or over 24 weeks gestation) between April 2023 and April 2024 remained below the comparator group of 1.96 per 1000. Despite this, it was deemed necessary to undertake a thematic review to ensure learning, including all babies from the onset of the increase in the death rate from April 2023. Whilst these cases were subjected to individual reviews the aim of a collective review was to identify any common factors, themes or

care that contributed to the neonatal deaths and to make recommendations in order to improve neonatal care and reduce preventable neonatal mortality.

Prior to starting the review, all families whose care was included within the review were contacted initially by telephone, followed by written communication from the Chief Nurse, Midwifery Officer and the Chief Medical Officer informing them of the requested review. This communication included the request for an external team to look at the pathways of care of babies who died in the Trust within the defined time period set out in the Terms of Reference. The families were informed that the review would include a review of medical notes of each of the deaths, with a 'fresh eyes' approach to identify any learning for East Kent Hospitals. This was not because new information had come to light about their babies' deaths, but because the Trust wanted to ensure care was as good as it could be. Families were invited to contact Adaline Smith, Deputy Director of Midwifery, if they had any further questions.

The review team consisted of a Consultant Neonatologist, an Advanced Neonatal Nurse Practitioner (ANNP) and a Midwife Consultant. There was no obstetrician included in the review team at the decision of EKHUFT.

The role of the multidisciplinary review team was to:

- conduct a comprehensive review of all neonatal deaths (deaths within the first 28 days of life) that occurred within the defined review period
- To identify any common factors, themes or care that contributed to the neonatal deaths
- To make recommendations to improve neonatal care and reduce preventable neonatal mortality

The Trust defined review period between 1 April 2023 to 31.3.2024 within the Terms of Reference. Three additional cases from May 2024 were then added. The Terms of Reference were revised to include the deaths of babies within the review timeframe who died after 28 days if they had remained an inpatient in the neonatal unit. The review did not include stillbirths. In total, the deaths of fourteen babies who had died were identified by the Trust and their cases were reviewed by the review team. The full Terms of Reference can be found in Appendix 1.

The consultant neonatologist and consultant midwife were initially approached, with the later addition of the Advanced Neonatal Nurse Practitioner to the review team. Access to the maternal notes was given in September 2024, with Badger access for the neonatal case notes being given from mid-October 2024. Review work started when full access was given to the neonatal review team (ANNP and neonatologist) in mid-October 2024. The case reviews were completed by the end of December 2024 and the final report of findings completed by the end of January 2025.

The review team were asked to report their findings to the Deputy Director of Midwifery (Adeline Smith) and the Managing Director of Women's and Children's Care Group (Karen Costello). The timeframe given was 12 weeks.

Methodology

The case notes made available to the review team included maternity notes, maternal observation charts, ultrasonography reports, pathology reports, surgical and theatre processes such as consent forms and surgical notes and prescription charts. The review team did not have radiology access therefore neonatal X-ray images were not reviewed. Remote access was given to the neonatologist and ANNP for the neonatal clinical case notes via Neonatal Badger. The midwife consultant did not have access to Neonatal Badger during the review work. The review team did not have direct access to blood test results therefore only results entered into the maternal notes or on the electronic data record (Neonatal Badger) were reviewed.

For each case, the maternal case notes and neonatal discharge letters were reviewed independently by the three members of the review team. Key themes regarding maternal care were identified noting good practice and areas where improvements may have been made that could have impacted on the experience of the parents or outcome for the baby. This was led by the Midwife Consultant.

For each neonatal case the full neonatal case notes (accessed by Neonatal Badger) were reviewed independently by the neonatal consultant and ANNP. Key themes regarding neonatal care were identified noting good practice, aspects of good care and any modifiable factors where care could have been improved were identified. The findings and modifiable factors for each neonatal case were recorded on the standardised review tool (see Appendix 2). The standardised review tool was developed by Dr Alan Fenton and has been used with permission for this report.

A peer review discussion then followed with all members of the review team present, during a series of online meetings. Findings were agreed and modifiable factors were assessed, linking findings to local and national frameworks where applicable.

Three babies were transferred into the Neonatal Intensive Care Unit at William Harvey Hospital ex utero for ongoing intensive care. The review team found modifiable factors in some of the care received by these babies at the referring hospital during the case note assessment. One of these hospitals forms part of the East Kent Hospitals University Trust therefore this case is included in the main body of this report. Care delivered at hospitals other than EKHUFT was outside of the Terms of Reference for this review therefore modifiable factors relating to care delivered externally to EKHUFT have been removed from the main body of this report. A table summarising modifiable factors from the care delivered prior to transfer to EKHUFT can be found in Appendix 3.

Assessment Criteria

Maternity Care:

The following areas of the maternity care provided were reviewed and where applicable linked to local and national standards of care:

Table 1: Assessment of Midwifery Care

Prepregnant history
Ongoing pathways of antenatal care
Diagnosis and recognition of high-risk status

Admission and use of antenatal optimisation
Informed decision making with parents
Mode of delivery and onward care needs
Record keeping and triangulation
Discharge and advice for future pregnancies

Neonatal Care:

Using the standardised review tool (Appendix 2) the following areas of neonatal care were reviewed and where applicable, linked to local and national standards of care:

Table 2: Assessment of Neonatal Care

Supporting resuscitation and transition
Stabilisation and transfer to the neonatal unit
Admission and first few hours
Ongoing treatment
Referral (if applicable)
Clinical leadership
Education, knowledge and training
Documentation
Communication
Policies and procedures
Family

The review team identified and agreed aspects of care which could have been improved. These were classified as modifiable factors. The assessment of modifiable factors reflects the consensus professional opinion of the review team of the extent to which each modifiable factor influenced the outcome for the baby.

Each modifiable factor was assessed by the following classification:

Table 3: Definition of Modifiable Factors

None: No issues with care identified
Wider learning: Care issues identified which would have made no difference to the outcome for the baby
Minor: Care issues identified which may have made a difference to the outcome for the baby
Major: Care issues identified which were likely to have made a difference to the outcome for the baby

The terms minor and major do not detract from the final outcome for the baby but provide an assessment of the degree to which the modifiable factor may have impacted the final outcome.

Quality Assurance

Each case was reviewed independently by each member of the review team before consensus agreement was reached. The findings were agreed by all members of the review team by the peer review process detailed within the methodology process of this report.

Cohort

The deaths of 14 babies were reviewed. This involved the review of 13 maternal case notes.

Maternal Demographics:

10 of the 13 women had booked pregnancies within the hospitals of EKHUFT. 3 women had booking histories with other Trusts in the region. 1 woman was transferred in utero the EKHUFT.

The maternal demographic details are summarised in Table 4

Table 4: Maternal Demographic Details:

Maternal Age	23-42 years
Booked at EKHUFT	10
Requiring Interpreting services	1
Registered with Social Services	1
Primiparous	9
Multiparous	4

Table 5: Pregnancy Characteristics

IVF conception	2
Twin pregnancies (natural conception)	2
Previous preterm labour	2
Cervical curettage	2
Spontaneous preterm membrane rupture	8
Prolonged preterm membrane rupture	5 (33-88 hours)
Delivery mode	
Vaginal delivery	9 (4 breech presentation)
Caesarean section	4
Antenatal steroids	
Complete course	8
Incomplete course	2
No antenatal steroids	3
Magnesium Sulphate	
Administered before or during delivery	9
No MgSO4	4

3 women had a history of infertility; 2 cases reviewed were IVF conceptions. 2 cases reflected the need for a cervical suture insertion during the pregnancies due to the consequences of a preexisting medical condition impacting on the competence of the cervix. Other maternal health demographics included non-medicated anxiety conditions (2 cases); pre-existing cardiac disease (1 case) and

previous history of deep vein thrombosis (1 case). 2 women had a history of surgical procedures either as children or in late adolescence.

All of the women who were booked at EKUHFT attended Triage Services at early junctures in their pregnancies mainly due to small blood losses, a noticeable reduction in fetal activity or after trauma events. In all cases of preterm membrane rupture the women delivered within 4 days of membrane rupture and all of these women had remained in hospital for close observation and detailed monitoring via CTG and Ultra-sonography.

Table 6: Neonatal Demographic Details

Total number of babies	**14**
Admitted to NICU	13
Inborn with level 3 NICU	11
Ex-utero transfer into NICU	3
Sex	
Male	6
Female	8
Gestation at birth	21+6 – 33+0
<22 weeks	1
<23	3
$23+^{0}$-$24+^{0}$	3
$24+^{0}$-$26+^{0}$	5
>26 weeks	2
Singleton	10
Twin	4
Birth Weight	430 – 1440g
<500g	5 (430g-495g)
500g -1kg	8 (520g-860g)
>1kg	1
Delivery Mode	
Vaginal delivery	9 (4 breech presentation)
Caesarean section	5
Age at death	D1 – D56
Died in delivery room	1
Died within 24 hours of birth (in NICU)	5
Died D1 -D7	3
Died D8 – D28	4
Died > D28	1

The ethnicity of the infants shows a diverse distribution, with Indian ethnicity being the most common (28.6%), followed by White other (21.4%), British (21.4%) and Mixed other (21.4%). Smaller proportions were recorded as White & Black African (7.1%). Of note the review team identified different ethnicities were recorded for a set of twins. Twin ethnicity data was analyzed as recorded

The most frequent cause of death recorded was complications related to extreme prematurity, which accounted for 64.3% of cases. Among these, complications such as respiratory distress syndrome,

pulmonary issues, and sepsis were commonly observed. Sepsis-related deaths comprised 28.6% of cases, while one case (7.1%) was attributed to Necrotising Enterocolitis (NEC). An additional 7.1% of cases did not have a listed cause of death.

When analyzing other diseases and conditions, sepsis was present in 35.7% of cases, while intraventricular hemorrhage (IVH) occurred in 28.6%. Pulmonary complications (including pneumothorax, pulmonary hemorrhage, and hypoplasia) affected 21.4% of the infants. Respiratory Distress Syndrome (RDS) was documented in 42.9% of cases.

Key Findings

The review team agreed from the evidence made available to them that the maternity and neonatal care delivered at EKHUFT during the period reviewed was generally of a good standard. Feedback from families and staff regarding maternity and neonatal care received was outside of the Terms of Reference for this review, however it is important to recognise these both would contribute to the overall assessment of the care received.

General Comments: Maternity

Maternity care was generally considered to be timely, responsive and personalised to the women's social, cultural and clinical needs. Communication with women and their supporting partners was largely sensitive and pertinent to the issues impacting on each respective pregnancy enabling the women to come to their informed choices and decisions regard their care. All women booked at EKHUFT received information regarding accessing support and advice throughout their pregnancy, with links to other supporting services that women may need to access via their website. In all cases where women were labouring at EKUHFT, all were appropriately admitted to the Labour Ward (or Theatre) with no births occurring in on a Maternity Ward or in transit.

General Comments: Neonatal

Clinical procedures were done within an appropriate time frame, in particular procedures within the initial hours after admission. There was evidence of regular clinical assessment of babies by the senior neonatal clinical team. In most cases there was evidence of regular pain scoring and skin integrity scores and the use of a neuroprotective care bundle was documented in several cases. There were some good examples of communication with families, of note, a case which documented a series of thorough conversations and subsequent planning with a family involving the whole perinatal team prior to anticipated preterm delivery and another case which documented a clear and honest discussion between the neonatal consultant and parent regarding the risks and benefit of the use of inhaled nitric oxide in preterm babies.

Modifiable Factors

Midwifery Modifiable Factors: Themes

Common themes of modifiable factors were identified by the review team and these are presented below. All were assessed as 'wider learning' with no minor or major modifiable factors with midwifery care identified.

Diagnosis and Recognition of High-Risk Status

The review team identified 1 case of a woman who had experienced a previous loss at 20 weeks and was booked into the Pre-Term Clinic. Her initial appointment was when she was 23 weeks pregnant and her cervix was noted to be shortening and already funneling. A cervical curettage procedure was carried out the following day. Earlier insertion of the cervical curettage may have added further weeks to this pregnancy.

Admission and Use of Antenatal Optimisation:

The BAPM Antenatal Optimisation Toolkit[1] recommends:

- All women giving birth before 34 weeks of gestation, should receive a full course of antenatal steroids no longer than 7 days prior to birth, and ideally completed 24-48 hours before birth.
- All women giving birth before 30 weeks of gestation, should receive a loading dose and ideally a minimum of 4 hour infusion of antenatal magnesium sulphate within the 24 hours prior to birth.

All of the women in the cases reviewed delivered before 34 weeks and12 out of the 13 women delivered before 30 weeks of gestation. 7 women received a complete course of antenatal steroids and magnesium sulphate prior to delivery.

3 women did not receive any antenatal steroids or magnesium sulphate. These women delivered before 23 weeks and all 3 babies received initial survival focused care. 2 of these babies were subsequently admitted to the neonatal unit for ongoing intensive care. 2 women had an incomplete course of antenatal steroids; 1 woman received a full course of antenatal steroids but no magnesium sulphate. These babies all received active (survival focused) management in the delivery room with subsequent transfer to the neonatal unit for ongoing intensive care. The review team acknowledge the challenges that factors such as a short time between presentation at hospital and delivery or indication for emergency Caesarean section may have limited opportunities for full optimisation in some of the cases.

Informed Decision Making with Parents

The depth of documentation of antenatal conversations with families regarding decision making for babies born extremely prematurely was variable. In some cases the midwifery and obstetric team had documented their impression of the neonatal team counselling with the family when they themselves had not been present for these conversations. This meant accuracy and detail of these conversations were potentially lost or misrepresented. Parental wishes were not clearly recorded following antenatal counselling conversations in several cases and it was not clear in some of the cases whether comfort focused care had been discussed with families in relation to management at birth when this would have been an option available to the family. The review team identified 1 case with no antenatal counselling from the neonatal team documented, despite admission to hospital days prior to delivery and antenatal steroids had been given.

Record Keeping and Triangulation

There were several case notes where there was a lack of accurate and consistent detail between the maternal and neonatal case notes. Discrepancies in time of birth, time of death, sex of the baby, APGAR score, address of the mother, mode of delivery and presentation at delivery were noted in several cases.

Neonatal Modifiable Factors

The review of neonatal care identified 274 separate modifiable factors across the 14 cases. Good quality review should identify learning and these learning points should inform recommendations to improve or enhance future practice. It is important to recognise the majority of modifiable factors related to documentation which significantly increased the number of modifiable factors identified. Some of the modifiable factors identified were categorised in multiple assessment domains, for example lack of documented discussion between senior clinicians and family regarding parental wishes regarding active or comfort focused care at birth was categorised as a modifiable factor relating to documentation, communication and family domains.

269 (98.2%) modifiable factors presented wider learning opportunities across all 14 cases (care issues which would have made no difference to the outcome for the baby).

5 (1.8%) 'minor' modifiable factors across 4 cases (care issues which may have made a difference to the outcome for the baby).

0 major modifiable factors in any of the cases reviewed (care issues which were likely to have made a difference to the outcome for the baby).

The total number of neonatal modifiable factors are presented in Table 7.

Table 7: Neonatal Modifiable Factors of Care Delivered at EKHUFT (excludes episodes of care delivered in referring hospitals)

	Total Modifiable Factors	Wider Learning	Minor	Major
Supporting resuscitation and transition	31 (10 cases)	31 (10 cases)	0	0
Stabilisation and transfer to neonatal unit	7 (6 cases)	7 (6 cases)	0	0
Admission and 1st few hours	22 (10 cases)	20 (10 cases)	2 (2 cases)	0
Ongoing treatment	54 (13 cases)	53 (13 cases)	1 (1 case)	0
Referral	1 (1 case)	1 (1 case)	0	0
Clinical leadership	21 (12 cases)	19 (12 cases)	2 (1 case)	0
Education, knowledge and training	38 (14 cases)	38 (14 cases)	0	0
Documentation	58 (13 cases)	58 (13 cases)	0	0
Communication	13 (7 cases)	13 (7 cases)	0	0
Policies and procedures	13 (7 cases)	13 (7 cases)	0	0
Family	16/9 cases)	16/9 (cases)	0	0
Total modifiable factors	**274 (14 cases)**	**269 (14 cases)**	**5 (4 cases)**	**0**

Neonatal Modifiable Factors: Themes

Common themes of modifiable factors were identified by the review team and these are presented below.

Resuscitation and supporting transition

There was a lack of accurate and consistent documentation of perinatal events in several cases. These events included differing APGAR scores and presentation at birth recorded in the maternal and neonatal notes.

There were a number of cases where babies had multiple intubations in the delivery room due to uncertainty regarding endotracheal tube (ETT) position. The documentation in some of these case notes stated uncertainty was due to lack of positive colour change on capnography. The lack of capnography colour change may be an unreliable indicator of correct ETT position particularly in very low birth weight babies and babies in cardiac arrest[2]. The review team felt given the gestation, birth weight and severity of illness of some of these babies, there consideration of the practice of direct visualisation of the endotracheal tube prior to removal and reintubation in order to minimise the number of intubations for babies in the delivery room may be beneficial.

Stabilisation and transfer to the neonatal unit

There were several cases where the temperature of the baby in the delivery room differed significantly to the temperature on admission to the neonatal unit. The review team noted cases where babies had been hypothermic or hyperthermic in the delivery room but had reached an acceptable temperature on admission to the neonatal unit. Maintaining normothermia (36.5-37.5◦) is imperative with preterm babies as both hypothermia and hyperthermia are associated with increased morbidity and mortality[3 4 5]. Normothermia on admission to the neonatal unit is a quality performance indicator which all neonatal units report to the National Neonatal Audit Programme (NNAP)[6] however thermal control prior to admission to the neonatal unit is equally important, particularly in cases where babies have received extended resuscitation or stabilisation in the delivery room. The review team agreed measures such as the use of servo control mode on the resuscitaire or regular manual temperature checks during stabilisation in the delivery room could have guided earlier use of additional interventions such as thermal mattress use for hypothermic babies and timely reduction in overhead heater output for hyperthermic babies to optimise thermoregulation in the delivery room.

There were several cases where the mode of transfer of the baby from delivery room to the neonatal unit was not documented within the neonatal notes. Some of these babies were subsequently hypoxic or hypothermic on admission to the unit and it was unclear if this was due to issues with respiratory support or inadequate thermal care given during transfer.

Admission and first few hours

In addition to the babies who were hypothermic on admission to the neonatal unit, the review team identified cases where babies became hypothermic during or after procedures such as umbilical line insertion.

Ongoing treatment

Many of the modifiable factors with ongoing treatment related to issues with documentation.

There was a lack of documentation of x-ray findings into the relevant section of the neonatal electronic record (Neonatal Badger) in several cases. X- rays were clearly done but the reporting and assessment of line positions and clinical findings were not well captured. This was particularly pertinent in cases where suspected oesophageal perforation had later been noted.

Septic screens were not routinely entered in the relevant section on the neonatal electronic record (Neonatal Badger) in several cases. Antibiotic courses and changes were difficult to track in many of the case notes, as were rationales for antibiotic choices, changes and discontinuation of antibiotics.

Clinical leadership

The cases reviewed were babies who were born extremely preterm and/or extremely sick and the complexity of the care of these babies is acknowledged and understood by the review team. There were some cases where senior clinical oversight was not clearly recorded in the notes, in particular a lack of regular and clear documentation capturing the consultant ‘helicopter view’ evaluating the

clinical situation and ongoing decision making. This was particularly noted in a small number of cases where babies were receiving ongoing inhaled nitric oxide without apparent clinical improvement and the small number of cases of babies with severe abdominal concerns with a lack of documented evaluation of decision making regarding ongoing care planning.

Education knowledge and training

Many of the modifiable factors relating to education, knowledge and training have been discussed in other sections. Common themes were direct visualisation on the endotracheal tube when tube position was uncertain, thermal control in delivery suite, on transfer to the neonatal unit and during procedures.

There were common themes of a lack of documented clinical reasoning and evaluation of the effectiveness of treatment, particularly in cases where babies were receiving multiple inotropic medications.

Documentation

The majority of modifiable factors across the cases related to documentation. Some of the issues with documentation have already been identified in other sections.

Additional common themes were the lack of documentation of personnel attending deliveries, particularly with regards to grade of staff member and the attendance of nursing staff. The review team found a number of cases where there was a lack of attention to detail in completeness of the neonatal discharge summary for example checking of grammar, spelling, the use of abbreviations and completeness of records with regards to outstanding results after babies had died. As identified in the midwifery modifiable factors, there were several cases where the documentation of APGAR score was discrepant between maternal and neonatal notes.

The review team were unable to comment on the number of babies receiving optimal cord management (OCM) due to incomplete documentation. BAPM[8] defines Optimal Cord Management as cord clamping ≥60 seconds. The review team identified 3 cases where deferred cord clamping was done and 4 cases where the cord was clamped immediately. The reasons for immediate cord clamping were not always clearly documented and it was noted that timings of cord clamping varied between maternal notes and neonatal notes in some of the cases. 1 case was identified (not born within EKHUFT) where cord milking had occurred in an extremely preterm baby. Cord milking is not recommended practice in babies < 28 weeks[4].

Communication

Antenatal counselling was documented in the majority of cases reviewed, however parental wishes were not well documented in many cases. In these cases, it was unclear to the review team if options for comfort focussed care had been discussed with families prior to birth in cases of babies who would be considered ‘extremely high risk’ by both the local and BAPM framework for perinatal management of extreme preterm birth[7] .

Policies and procedures

Unplanned extubation occurred 8 of the cases. Unplanned extubation is recognised as an adverse clinical event[9 10] however it was not clear from the case notes whether unplanned extubation was always recognised and reported as such.

The review team identified 3 cases where babies received IV gentamicin when previously elevated gentamicin levels had been noted. The review team agreed that there was an absence of documented rationale for subsequent use of nephrotoxic drugs in these cases.

Family

The number and depth of documented conversations between the clinical and nursing team with families varied across the cases. In general, early discussion with families in the period immediately following birth around end of life decisions making were well documented, however several cases did not have regular clinical discussion and update with families documented during the period of intensive care between these initial and later conversations.

Wider learning

The majority of modifiable factors identified by the review team were classified as 'wider learning'. These are care issues which would not have made a difference to the outcome for the baby however learning points were identified. Modifiable factors for wider learning were identified in all of the cases reviewed. This is to be expected given the depth of the retrospective peer review process undertaken and is an advantage of seeking multidisciplinary external review of the care delivered. The wider learning identified has been used to inform the recommendations within this report with the intention of supporting future development of the good neonatal care already delivered at EKHUFT. The recommendations are listed in Table 9 and Table 10.

Minor modifiable factors

5 minor modifiable factors in 4 cases were identified by the review team. 'Minor' modifiable factors are care issues which may have made a difference to the outcome for the baby.

2 minor modifiable factors were identified in 1 case of an extremely preterm baby (<22 weeks) pertaining to 2 episodes of consultant led counselling regarding survival and outcomes for babies born at this gestation, after the baby was admitted to the neonatal unit. The review team identified two documented episodes of consultant led communication with the family regarding outcomes at this gestation where the information given did not align with that provided by the local guideline 'Perinatal management of extremely preterm neonates born at edge of viability 22 week – 26+6 weeks gestation' (EKHUFT, 2021)[11] or the national Framework for perinatal management of extreme preterm birth before 27 weeks of gestation (BAPM, 2019)[7]. The first of these episodes was shortly after admission to the neonatal unit and the second some hours after this. The notes document information given to the family which suggest that at 22 weeks, 7 out of 10 babies survive with one third of these babies having severe morbidity. This advice was repeated in a second consultant led documented discussion with the family where similar statistics were given to the family. The BAPM preterm birth infographic[7] designed to support families making decisions for extremely preterm

babies presents this data as 7 out of 10 babies born at 22 weeks die (51-79%) rather than survive, with 1 in 3 of these babies having severe disability (24-43%) for babies The review team agreed that the data given to the family during these two discussions was an overestimation of likelihood of survival and may have had the potential to influence decision making for the family regarding continuation of intensive care or consideration of comfort focused care.

2 cases of babies who had unrecordable temperatures on admission to the neonatal unit following birth were identified. This report has highlighted the increased mortality associated with hypothermia [3 4 5] in the 'stabilisation and transfer to neonatal unit' section. The challenges of thermoregulation in the population reviewed is recognised, however the review team identified there was potential opportunity for improved temperature management both in the delivery room and on transfer to the neonatal unit, for example, earlier recognition of hypothermia and earlier instigation of measures such as a thermal mattress.

1 minor modifiable factor was identified by the review team in a case of an extremely preterm baby who died with culture positive sepsis. This baby had 2 temperatures recorded > 38 degrees 3 days prior to the day of death with ongoing temperature instability during the following days. The baby was eventually screened and started IV antibiotics, however the review team felt there was a potential opportunity for earlier screening and the initiation of IV antibiotics which may have affected the outcome for the baby.

Major modifiable factors

The review team did not identify any major modifiable factors (care issues which would likely have made a difference to the outcome for the baby).

Concluding Comments

The review team agreed from the information made available to them, that the maternity and neonatal care provided at EKHUFT within the defined period of the Terms of Reference was generally of a good standard. The review team have identified 4 cases where there were issues with care which may have made a difference to the outcome for the baby. The rest of the modifiable factors identified areas of wider learning where care could have been improved but would not have made a difference to the outcome for the baby. The review team would like to acknowledge EKHUFT for having requested this review, demonstrating their candour and willingness to identify any modifiable factors and areas of further learning which goes beyond their own internal review processes.

Recommendations for Practice

Recommendations for practice have been based on the modifiable factors identified in this review. The review team understand that some of this work is already in progress for example work aimed at reducing unplanned extubations.

Table 8: Recommendations for Practice (Midwifery)

To audit a cohort of women who required cervical curettage and assess diagnosis, timing of insertion (and removal) and neonatal outcome. If there is learning for this to inform future policy for accessing first appointments at the Pre-Term Clinic when a history of premature labour or mid-trimester labour is known.
To review and if needed to devise a contemporaneous scorecard that collates consistent demographic information and measures features of pregnancy and birth outcomes that enables an annual synopsis report or summary of perinatal deaths occurring at EKHFT for internal use and for wider learning and future assurances.
To consider expanding the established Bereavement Team with appropriately experienced midwives with specialist knowledge of supporting women through future pregnancies to enhance personalized care for women and their families

Table 9: Recommendations for Practice (Perinatal team)

Midwifery, obstetric and neonatal staff to review process for accurate and consistent documentation of perinatal events across the maternity and neonatal notes ensuring details such as APGAR score, time of birth, presentation at birth are agreed and documented accurately
To review teaching and training needs regarding communication and documentation of discussions with parents which include parental wishes regarding treatment decisions at the edge of viability
Consideration of the use of simulation to enhance teaching and training for all staff regarding communication and enhanced decision-making regarding treatment decisions at the edge of viability
To review process for accurate documentation of all personnel attending deliveries
To review processes for recording optimal cord management at delivery to include duration of deferred cord clamping, reasons for immediate cord clamping and thermal measures or other support given to the baby during the period of optimal cord management

Table 10: Recommendations for Practice (Neonatal)

Develop teaching and training including consideration of wider use of direct visualisation of endotracheal tube position aimed at reducing the number of intubations in the delivery room
Quality Improvement work aimed at reducing the number of unplanned extubations
Reporting of unplanned extubations through the Trust adverse event reporting system
Quality Improvement work aimed at monitoring and optimising thermoregulation in the delivery room during resuscitation, stabilisation and on transfer to the neonatal unit.
Neonatal team to review processes for thermoregulation during clinical procedures such as umbilical line placement.
Neonatal team to review education and knowledge of clinical team regarding ongoing temperature instability and instigation of IV antibiotics

Neonatal team to review process of identification, chasing and documentation of results of samples sent for culture and sensitivity to include those samples pending at the time of death
Neonatal staff to ensure documentation of transfer from delivery room to neonatal unit, to include mode of transfer, ventilatory support received on transfer, any equipment or clinical issues on transfer and thermal measures used during transfer.
Neonatal clinical team to ensure the X-ray record in the relevant section on the neonatal electronic record (Neonatal Badger) is completed for each X-ray and ensure pathophysiological findings, line and tube tip positions are identified and documented.
Neonatal clinical team to ensure the sepsis screening record in the relevant section on the neonatal electronic record (Neonatal Badger) is completed for each septic screen done on every baby.
Neonatal clinical team to ensure the endotracheal intubation record in the relevant section on the neonatal electronic record (Neonatal Badger) is complete and includes all intubation attempts
Neonatal senior clinical team to enhance documentation of regular clinical oversight throughout the care episode
Neonatal clinical team to include clinical reasoning within the notes and assessment of effectiveness of intervention, particularly in babies where multiple inotropes are used in conjunction with each other therapies such as inhaled nitric oxide.
Review documentation of the decision making to use nephrotoxic drugs, particularly where drug monitoring levels have previously fallen outside of therapeutic range.
Neonatal clinical team to review processes where oesophageal perforation is suspected, including documentation of x-ray findings, consideration of surgical review, analgesia, clear management plan, consideration of reporting as adverse incident if confirmed and informing families of concerns.
Neonatal team to review indication for reporting of adverse events and ensuring when events are reported this is clearly documented in the case notes alongside relevant discussions with families

Appendix 1: Terms of Reference

Neonatal Death External Review

Terms of Reference

Purpose

To provide an expert external review of the neonatal deaths that occurred in East Kent Hospitals between 1st April 2023 to 31st March 2024

Objective

- To conduct a comprehensive review of all neonatal deaths (deaths within the first 28 days of life) that occurred within the defined review period.
- To identify any common factors, themes or care that contributed to the neonatal deaths.
- To make recommendations to improve neonatal care and reduce preventable neonatal mortality.

Scope
- The review will cover all neonatal deaths that occurred within the 1 April 2023 to 31 March 2024 at EKHUFT and 3 NNDS which occurred in May 2024
- The review will examine the medical, social, and system-level factors that may have contributed to the neonatal deaths. (Equity and Equality)
- The review will include NNDs beyond 28 days of life where they have remained as an inpatient in the NNU
- The review will not include stillbirths

Methodology
- Conduct retrospective chart reviews of the medical records of all neonatal deaths.
- Gather social and demographic data on the deceased neonates and their families.
- Analyse data to identify common factors and themes.

Outputs
- A comprehensive report detailing the findings of the review, including:
- Demographic and clinical characteristics of the neonatal deaths
- Identification of common factors and themes
- Comparison to national/international benchmarks
- Recommendations to improve neonatal care and reduce preventable mortality

Timeline
-The review is to be completed within 12 weeks from the start date or earlier if completed

Membership

- Deputy Director of Midwifery (East Kent Hospitals Link)
- Helen Gbinigie Consultant Neonatologist /Neonatal Clinicals lead K&M LMNS
- Barbara Kuypers Midwife Consultant
- Sian Oldham Advanced Neonatal Nurse Practitioner

Responsibilities

Monthly progress updates are to be provided to Adaline Smith Deputy Director of Midwifery and Karen Costelloe Managing Director Women's and Children's Care Group.
Escalation to the Trust in a timely way where any concerns are escalated
A final report to be submitted

Adaline Smith

Deputy Director of Midwifery

Women's Health Care Group

Appendix 2: Standardised Review Tool for Neonatal Cases

** please see separate document for this Excel document **

Appendix 3: Modifiable factors relating to care delivered externally to EKHUFT

Maternity care:

The review team were unable to comment on the maternity care received as these notes were not fully available to the review team.

Neonatal care:

Of the 14 cases of babies reviewed, 2 babies were born in hospitals which are not part of The East Kent Hospitals University NHS Foundation Trust. Care provided externally to EKHUFT was not included within the scope of the Terms of Reference for the review team however care issues were identified as part of the neonatal case note review. The complete maternal and neonatal cases notes were not available to the review team therefore the modifiable factors identified are derived from the available care records and do not represent a review of the entire care episode.

The standardised review tool was used to assess the neonatal care as part of each baby's complete care episode and the modifiable factors identified were assessed using the same methodology as defined within the main report.

Table 11: Neonatal Modifiable Factors of Care Provided Outside EKHUFT

	Total Modifiable Factors	**Wider Learning**	**Minor**	**Major**
Supporting resuscitation and transition	5 (2 cases)	5 (2 cases)	0	0
Stabilisation and transfer to neonatal unit	2 (2 cases)	2 (2 cases)	0	0
Admission and 1st few hours	4 (2 cases)	3 (2 cases)	1 (1 case)	0
Ongoing treatment	N/A	0	0	0
Referral	1 (1 cases)	1 (1 cases)	0	0
Clinical leadership	3 (2 cases)	3 (2 cases)	0	0
Education, knowledge and training	2 (2 cases)	2 (3 cases)	0	0
Documentation	8 (2 cases)	8 (2 cases)	0	0
Communication	2 (1 case)	2 (1 case)	0	0
Policies and procedures	1 (1 cases)	1 (1 cases)	0	0
Family	2 (1 case)	2 (1 case)	0	0
Total modifiable factors	**30 (2 cases)**	**29 (2 cases)**	**1 (1 case)**	**0**

Neonatal Modifiable Factors

29 modifiable factors were identified and assessed as wider learning. These are defined as care issues which would not have made a difference to the outcome for the baby but where wider learning for the team may improve care in future. These cases represent part of the initial neonatal care for just 2 babies therefore these have not been reported as themes. The care issues identified as modifiable factors did reflect issues similar to those identified in the main report, such as lack of documentation of means of transfer of baby from delivery room to neonatal unit, unplanned extubation and a lack of documented discussion with families.

1 minor modifiable factor was identified. This was a case of severe hypothermia on admission to the neonatal unit. As identified in the main report, hypothermia is associated with increased morbidity and mortality [3 4 5] hence has been identified as a modifiable factor which may have made a difference to the outcome for the baby.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Patient Voice and Involvement Annual Report 2024-25**

Meeting date: **5 June 2025**

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

Paper Authors: **Associate Director of Patient Experience and Lead for Patient Voice and Involvement**

Appendices:

Appendix 1: **Patient Voice and Involvement Annual Report 2024-25**

Executive summary:

Action required:	**Information**
Purpose of the Report:	The Patient Voice and Involvement annual report provides an overview of how the Trust has implemented the Patient Voice and Involvement Strategy over the previous 12 months, through the work and support of the Patient Voice and Involvement team.
Summary of key issues:	The Patient Voice and Involvement team are tasked with delivery of the Trust's Patient Voice and Involvement Strategy published in March 2022. This was a new approach for the Trust and the first time that there had been a dedicated team to support patient, family, and community involvement and to improve how the Trust learns from patient feedback and uses it to drive improvement. In the reporting period (April 2024 to March 2025), the Patient Voice and Involvement Team has gathered and/or analysed almost 40,000 pieces of patient feedback and supported colleagues to theme over 60,000 pieces of feedback: • **A third of all written Friends and Family Test (FFT) responses received by the Trust were themed by our team** (averaging 2600 a month); the total themed across the Trust in this period was 93,012, a significant increase on last year's 41,645. • We have been co-producing patient feedback surveys with several clinical and operational teams within the Trust, with an average of 32 surveys running concurrently at any given time (an increase of 20 on last year) and have had **2,621** patient/carer/family/stakeholder responses to these. • The team has responded to **116** Care Opinion posts and progressed with colleagues, averaging 10 a month (last year's

average was 17 a month). We have also received a similar amount of monthly feedback from Healthwatch Kent.

- The team has been actively reaching out to stakeholder organisations, individual patients and community groups as well as receiving contact from patients via our contact points (telephone and email). Some of this provides specific or anecdotal feedback we can use and sometimes it is more of a developmental conversation to encourage continued collaborative working; **over 2,000 individual people and stakeholder groups have been worked with across our communities**.

Our Patient Participation and Action Group (PPAG) now has 19 members, and we continue to recruit passionate people with lived experience to work with us on a more formal voluntary basis. The group still needs to grow in diversity, but the PPAG can respond to ad-hoc requests for their input on the wording of patient information, letter templates, and patient surveys, as well as more involved strategic work like the Patient Portal, Clinical Strategy and Cancer forums.

The team carries out on-going community engagement to gather feedback from a range of local communities, especially those who do not normally get their voices heard.

The majority of feedback that we hear across all channels is positive, ranging from around 60% in individual interactions to 90% in the FFT data we review. 93.9% of patients responding to the FFT survey described their experience as Good/Very Good and 88.2% of themed feedback was positive.

The key themes we have heard less positive feedback on are:

- Poor communication and information.
- Poor care given by staff.
- Quality of treatment received.
- Poor staff attitude.
- Long waiting Times: on-site at an appointment or in the Emergency Departments (EDs) and for follow-up treatment.

Responding to feedback from patients on communication and information we have:

- Provided a final summary of community and birth partner feedback for the Reading the Signals Oversight Group.
- Delivered a two-hour training session for every member of the William Harvey Hospital's (WHH's) ED over a six week period, covering our 'Seeing the Person' presentation.
- Brought IT colleagues to community groups for them to trial the Patient Portal.
- Developed co-produced changes to patient information and treatment pathways for cancer services.

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	We receive a significant amount of positive feedback in the community for both our approach and the Trust's commitment to hearing the voices of patients, their families and for working with them. On several occasions, a patient who was considering making a complaint has instead worked with us collaboratively to feel heard and see their issues resolved, feeding into our more strategic work as a team. We have looked at how we can better support carers of our patients and involve them as expert partners in care. This includes providing information for staff to raise their awareness about the importance of recognising and involving carers/families, implementing a Carers policy, and launching a carers leaflet and a carers page on our public website and Staff Zone. The team supports several workstreams related to health inequalities. This includes the implementation of Accessible Information Standard (AIS), the interpreting and translation service, reporting on the patient related outcomes in the Equality Delivery System (EDS) annual report and on Equality and Health inequalities Impact Assessments (EHIAs). This work is led by the Associate Director of Patient Experience. During 2025-26 we will be refreshing the Patient Voice and Involvement strategy. This will include incorporating the new NHS England Experience of Care Improvement Framework, which all NHS trusts are required to use to self-assess their work on patient experience by March 2026. We will also reference the new NHS England Patient safety healthcare inequalities reduction framework, and the Equality Delivery System (EDS) outcomes related to patient experience. But utilising these frameworks we will ensure our new Patient Experience Strategy is focused on supporting the Trust to improve patient and community access to healthcare, improve patient and carer / family experience and improve patient outcomes, especially for people who face significant health inequalities.
Key recommendations:	The Board of Directors is asked to **NOTE** progress in delivering the Patient Voice and Involvement Strategy and supporting the Trust to comply with NHS England (NHSE) Access Information Standard (AIS) 2016 and NHSE Involving People and Communities guidance 2022.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • Partnerships
Link to the Trust Risk Register:	**CRR 159**: Detriment to patients with a disability as we are non-compliant with the statutory Accessible Information Standard.

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Resource:	Yes. Patient Voice and Involvement team and interpreting and translation budget.
Legal and regulatory:	The Trust must comply with the Care Quality Commission Regulations. The Equality Act 2010 and the public sector equality duty under the Act require NHS organisations to demonstrate due regard to people with protected characteristics in the provision of healthcare. The Trust must comply with the NHS England Accessible Information Standard (AIS) 2016 and NHS England guidance on involving people and communities 2022.
Subsidiary:	N

Assurance route:

Patient Experience Committee 29 May 2025.

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PATIENT VOICE AND INVOLVEMENT ANNUAL REPORT 2024-25

1. Introduction

1.1 The Patient Voice and Involvement team are tasked with delivery of the Trust's Patient Voice and Involvement Strategy published in March 2022. This was a new approach for the Trust and the first time that there had been a dedicated team to support patient, family and community involvement and to improve how the Trust learns from patient feedback and uses it to drive improvement. Previously, some public engagement had been supported by the Communications team and Head of Volunteering and public services. However, the Trust had found it challenging to embed patient and public involvement without a resource to support this. Consequently, the Trust had fallen behind other trusts in Kent and Medway and nationally.

1.2 The Patient Voice and Involvement team is now well established. The team consists of the Lead for Patient Voice and Involvement, three Patient Involvement Officers, each based at one of the three main sites, a Patient Feedback Co-ordinator, and a Clinical Patient Leaflet Co-ordinator. The team is one of three teams that sit under the Associate Director of Patient Experience. The other teams are Volunteering and Public Services and Chaplaincy. All three teams are part of the Corporate Nursing Directorate. This supports closer working with nursing leaders across the Trust and is helping to make improvements in areas where we have found in hard to embed improvements, for example, the Accessible Information Standard (AIS).

2. Inputs

2.1 In the reporting period (April 2024 to March 2025), the Patient Voice and Involvement Team has gathered and/or analysed almost 40,000 pieces of patient feedback and supported colleagues to theme over 60,000 pieces of feedback:

- **A third of all written Friends and Family Test (FFT) responses received by the Trust were themed by our team** (averaging 2600 a month); the total themed across the Trust in this period was 93012, a significant increase on last year's 41645.

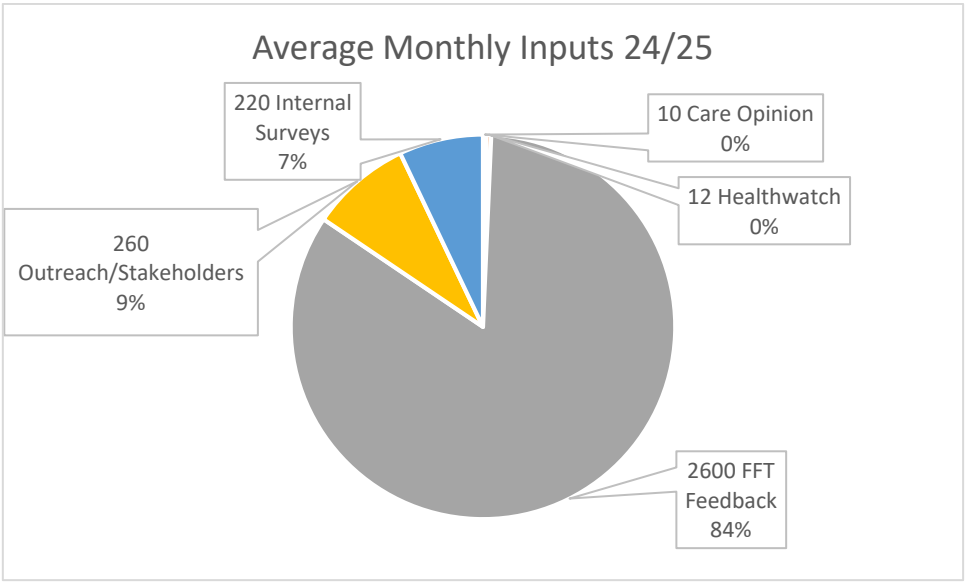
- We have been co-producing patient feedback surveys with several clinical and operational teams within the Trust, with an average of 32 surveys running concurrently at any given time (an increase of 20 on last year) and have had **2621** patient/carer/family/stakeholder responses to these. Survey feedback has increased by over 100% this year and we recently completed a 360-degree feedback exercise with our colleagues to learn how we can improve this aspect of our service. Learning from the exercise showed us that the new system we have implemented for survey requests is an improvement on the original process and there were comments about how easy the team is to work with and specific praise for our Patient Feedback Coordinator.

- The team has responded to **116** Care Opinion posts and progressed with colleagues, averaging 10 a month (last year's average was 17 a month). We have also received a similar amount of monthly feedback from Healthwatch

Kent. The lower than expected numbers of feedback are comfortably mitigated by our increase in feedback in all other areas.

- The team has been actively reaching out to stakeholder organisations, individual patients and community groups as well as receiving contact from patients via our contact points (telephone and email). Some of this provides specific or anecdotal feedback we can use and sometimes it is more of a developmental conversation to encourage continued collaborative working; **over 2000 people and stakeholder groups have been worked with across our communities**. This work is detailed in the next section.

Figure 1: Chart showing average monthly inputs (insights into patient, family, and community experience)



2.1 Most feedback – 84 per cent – comes from the Friends and Family Test (FFT) Survey comments, which are themed by the team and services. These comments are a rich source of insight. We know from our engagement with people in the community and stakeholders that the themes from the FFT comments are broadly similar. However, there are issues for some of our communities in accessing healthcare due to language barriers, their housing situation, socio-economic deprivation and due to in direct and direct discrimination.

3. Engagement

3.1 Internal Engagement:
We regularly conduct training around patient involvement ('Seeing the Person'), equality, diversity and inclusion and health inequalities with staff ranging from Health Care Support Workers to Junior Doctors. In 2024 we also started attending the New Staff Induction marketplace.

We attend team meetings and study days across the Care Groups to listen to staff's ideas and pass on feedback. This has led to a cultural shift in how EKHUFT stakeholders collaborate with what is still a new team in many colleagues' eyes. We have supported interview and stakeholder panels for many roles up to Board level, Patient-Led Assessments of the Care Environment (PLACE) inspections and support with Ward Accreditation visits on a monthly basis.

3.2 Projects that have developed from this work include:

- Cancer listening events.
- Supporting evidence and engagement for the 10 Year Trust Strategy.
- Outpatient Transformation.
- Parkinson's and Neurology patient engagement for the Neurology Governance and Business meeting.
- Drafting of wording for an Artificial Intelligence pilot with IT and an external company.
- We also continued work on projects that started in 2023-24, including gathering feedback around smoking on site, providing feedback from patients with a mental health condition for two co-located Safe Havens and a Crisis House in Medway and drafting a new Stroke Passport that will go live later in 2025.

3.3 We led the Trust's Veteran Aware Accreditation work, bringing together clinical leads and colleagues from HR, IT, Learning and Development and People and Culture to better understand and meet the needs of the Armed Forces community. This was a high profile piece of work and we underpinned the strategic work being done for the accreditation with staff engagement and outreach in the community with Voluntary, Community and Social Enterprise (VCSE) organisations like the Soldiers', Sailors' & Airmen's Families Association (SSAFA), the Royal British Legion and the Kent and Medway Armed Forces Covenant Board. We were successful in achieving the accreditation in mid-July 2024, and continue to facilitate an Armed Forces Covenant and Veteran Aware working group, a Veterans Community Leads group and a staff working group to embed the accreditation at the Trust.

3.4 Community Engagement:
We have attended meetings with community groups across East Kent, working with them to encourage service users to share feedback about East Kent Hospitals services. These include:

- Diabetes UK,
- East Kent Stoma Group's annual event,
- Mental Health Together,
- Speak Up CIC, and Take Off CIC,
- the Macular Society,
- Thanet Children's Centres and the Early Learning Collaborative,
- Adults Without Children (AWOC),
- Age UK in Thanet,
- Ethnic Minorities in Canterbury (EMIC) forum,
- Deaf Together (Ashford and Margate groups),
- the Stroke Association and
- Social Enterprise Kent Community Forums.

We completed a community survey to support colleagues from the Integrated Care Board (ICB) to understand what stakeholders and patients knew about the ICB.

We worked with colleagues from the East Kent Health and Care Partnership to support the Thanet Health Hub public consultation which included a public face to face meeting, two online meetings and a survey which received over 700 responses.

3.5 Healthwatch Kent collaborated with us to visit Outpatients and assess the new Electronic Referral Optimisation System, strengthening the communication between GP surgeries and our hospitals. We are also on the East Kent Virtual Wards working group to ensure we can report patient feedback on this new service and completed some initial patient engagement to report on the positive impact that virtual wards have been having for people who would rather be treated at home than on a ward.

3.6 We have met one-to one with over 70 patients and individual community members to hear their feedback about the Trust's services. These meetings happen in environments that people are comfortable in and often take a few hours or multiple sessions to effectively gain trust and get a clear idea of their entire experience and often involve a significant amount of restorative justice. We always offer people the choice of talking to a male or female team member and often speak to them outside of office hours to meet their needs, which has been well-received.

3.7 Our focus in all community work is to investigate the causes and impacts of health inequalities and we have been able to gather feedback about many people with protected characteristics and health inclusion groups' experiences in our care, as outlined in the Outcomes section of this report.

4. Patient Participation Action Group (PPAG)

4.1 Our PPAG now has 19 members, and we continue to recruit passionate people with lived experience to work with us on a more formal basis. The group still needs to grow in diversity, but the PPAG can respond to ad-hoc requests for their input on the wording of patient information, letter templates, and patient surveys, as well as more involved strategic work like the Patient Portal, Cancer listening events, draft policies and People and Culture programmes. We arranged for PPAG members to join the Fundamentals of Care Committee, Safeguarding Assurance Group, Safeguarding Operational Group and Medicines Safety Advisory Group and three Participation Partners have had the appropriate security (Disclosure and Barring Service (DBS)) checks to begin supporting with Ward Accreditation visits in 2025-26.

4.2 The PPAG meets every two months and is co-chaired by a Participation Partner. Six Participation Partners now sit on the Patient Experience Committee, a sub-committee of the Quality and Safety Committee.

5. A snapshot of the last quarter

5.1 The team carries out on-going community engagement to gather feedback from a range of local communities, especially those who do not normally get their voices heard. In the last quarter of 2024-25, we completed proactive community-based outreach with Speak Up CIC (mental health), Mental Health Matters and attended a Kent-wide Lived Experience event to highlight the experience of people with a mental health condition, focussing on 'High Intensity Users' who repeatedly need support in our Emergency Departments.

5.2 We completed three Cancer Listening sessions and reported the feedback to EKHUFT colleagues and to the Kent and Medway Cancer Alliance. We joined Stroke Association meetings and attended the Margate Early Learning Collaborative and Beyond the Page's 'When They Ask Questions' planning meeting to focus on the experience of migrant mothers. We delivered consultation sessions in the community to inform the trust's 10 Year Trust Strategy, including homeless people and people

living with Multiple Sclerosis (MS) and visited Ageing Without Children (AWOC) groups in Canterbury and Ashford to co-produce updated 'Seeing the Person' training for our staff.

5.2 We attended three Ward Accreditation visits, hosted a staff and patient pop-up for World Cancer Day and themed thousands of Friends and Family Test comments to better understand patient experiences and share this feedback with our colleagues. As well as the Trust Strategy work, we also held sessions with our PPAG members to support IT with their Digital Strategy development.

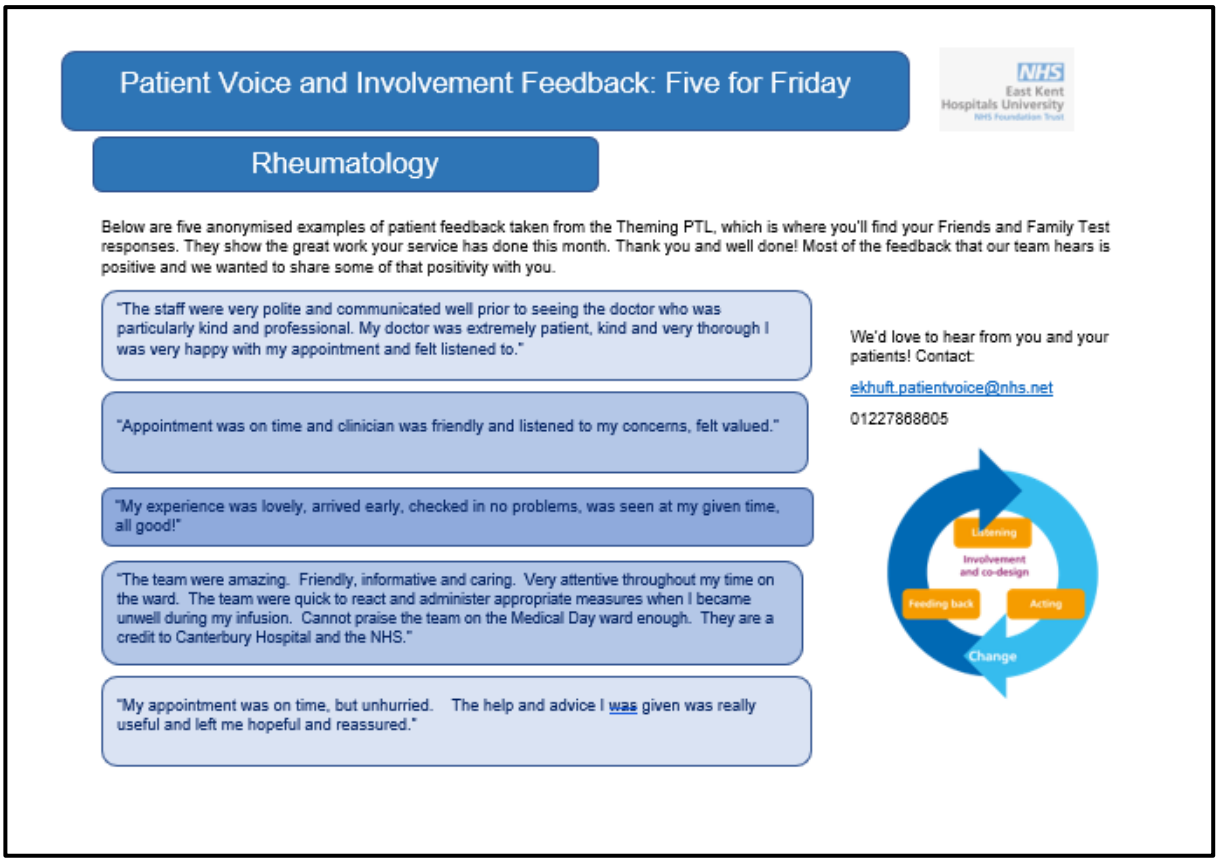
6. Key Themes Arising from Engagement with Patients, Cares, Families and Stakeholder Groups

6.1 The majority of feedback that we hear across all channels is positive, ranging from around 60 per cent of individual interactions to 90 per cent in the FFT data we review.

6.2 Over 2024-25 an average of just under 94 per cent of patients responding to the FFT survey described their experience as Good or Very Good and 88 per cent of themed feedback (comments) was positive. There was an increase in negative written feedback in September 2024 (from a year average of 12 per cent to 16 per cent) which we attributed to increased wait times during the busiest period for staff to be on holiday. It is important to emphasise that most of the feedback is positive. At every interaction with internal and external stakeholders our team is fostering a culture of celebrating success as a priority, alongside learning from more concerning feedback.

6.3 One way we have celebrated the positive feedback is launching 'Five for Friday', a weekly report that we send to three services out of the 81 in the Trust to highlight five positive pieces of feedback and to encourage colleagues to use the insight from their FFT feedback to drive improvement. These weekly reports began in October 2024 and we have had positive responses from the teams reading the reports as well as seeing an increase in FFT theming compliance.

Figure 2: Five for Friday example:



The example above is for Rheumatology and we start the report by highlighting five positive comments. We then include a summary of the themes of comments that have been reviewed and the services' compliance with theming their feedback.

6.3 The key themes we have heard less positive feedback on are:

- Poor communication and Information
- Poor or lack of care given by staff
- Poor quality of treatment
- Poor staff attitude
- Long waiting times: on-site at appointments or in the Emergency Departments (EDs) and for follow-up treatment

Other recurring themes of less positive feedback are relationships between staff at EKHUFT and with external organisations, lack of joined up approach between acute (hospital) care and primary care, lack of effective diagnostics and system flags, and support for families and carers. The above themes have not changed since last year's report, but there has been an increase in feedback on poor communication and information, with patients experiencing difficulties making contact with departments by phone and no alternative accessible contact methods being provided that can assure patients we have received their message and will respond.

7. Actions and Outcomes in 2024-25

7.1 We are seeing Patient Voice and Involvement team's reputation in the Trust and relationships with colleagues improve month on month and therefore collaboration

with services across the Trust is growing. Linking back to the key themes of feedback, we have completed the following pieces of work with Trust colleagues and services:

- Provided a final summary of community and birth partner feedback for the Reading the Signals Oversight Group. This work was guided by feedback from the two Community Family Voices sessions in local community centres that were held in 2023-24. We continued supporting the Patient Experience Midwives in community engagement opportunities (Care Given by Staff/Quality of Treatment/Staff Attitude).

- Continued co-producing the themes and processes that define the Friends and Family Test (FFT) theming Patient Tracking List (PTL), developing training sessions for staff at Care Group and operational level that are increasing the impact of FFT data on a Trust-wide level (Care Given by Staff/Quality of Treatment/Staff Attitude).

- We delivered a two-hour training session for every member of the William Harvey Hospital's (WHH) ED over a six week period, covering our Seeing the Person presentation and giving the teams space to discuss health inequalities and make suggestions for how the service could improve. These sessions were a success in terms of both staff engagement and in our opportunity to share patient feedback directly with a team who are under significant operational pressure (Care Given by Staff/Quality of Treatment/Staff Attitude/Communication & Information).

- We delivered two 'What Matters to Me' sessions, co-delivered with a patient to year 1 and year 2 doctors in September 2024.

- Brought IT colleagues to community groups for them to trial the Patient Portal: our PPAG has a working group to support the development of this critical new way for patients to access their care and was also involved in consultation around the trust's 10 year Digital Strategy (Communication & Information).

- Thanet Health Hub: We supported the public consultation for the East Kent Health and Care Partnership around a new Health Hub in Thanet that would include services from EKHUFT, Kent Community Hospital Foundation Trust and Primary Care. We ran a focussed survey for residents to have their say. We shared over 700 responses with the senior leaders involved in the project. We carried out proactive outreach in local Sixth Forms to reach under 18 year olds who were the lowest-responding age group, ran focus groups for a mental health group who could not attend the public consultation meetings and shared the survey across our network. We supported the face to face public consultation meeting and the two online public meetings. The key issues raised were around accessibility, parking and concerns that a new service may lead to closures of existing local services, but the feedback was generally very positive.

7.2 Responding to feedback from patients, we have:

- Amended the new the guidance on Staff zone for staff leaving answer machine messages for patients to improve communication.

- Written a paper on making our hospital entrances smoke-free based on feedback from patients, community groups, residents who live near our hospitals and staff.
- Joined a Falls and Frailty stakeholder event to advise colleagues on patient feedback.
- Developed multiple feedback streams and working relationships with ED colleagues.
- Provided community feedback on the need for better dementia training in non-specialist settings, supporting the dementia team to assess the training that was subsequently implemented.
- Continued directing interpreting requests to improve accessibility.
- Supported the co-production of patient-led Cancer communication, ensuring that information being shared with patients is accessible and incorporating a new diary element to enable patients to feel in control of their treatment plans. We also liaised with teams to arrange for tube feeding training for Cancer Nursing Specialists after hearing feedback about the need for more awareness in our listening sessions.

7.3 We receive a significant amount of positive feedback in the community for both our approach and the Trust's commitment to hearing the voices of patients, their families and for working with them. On several occasions, a patient who was considering making a complaint has instead worked with us collaboratively to feel heard and see their issues resolved, feeding into our more strategic work as a team.

7.4 We took three patient/carer/family stories to the Board in 2024-25. These provide an opportunity for the Board to hear directly from a patient, family member or carer. There is an opportunity for the services involved and the Trust to set out learning and actions related to the issues raised. Board members can ask questions and give an apology in person on behalf of the Trust and receive assurance of actions being taken.

7.5 In November 2024 the story related to the experience of homeless people and we presented the co-produced training that we had developed alongside Emmaus Dover, a community that supports men with an experience of homelessness. The presentation highlighted the stigma that homeless people often face in our hospitals and focussed on the need for safe discharges and an awareness of how opiate-based medication can affect a patient who is being treated for substance misuse. This training, developed across four sessions with Emmaus and incorporating interview footage, subsequently won a Healthwatch award in March 2025 for "Giving homeless people a voice recognises excellence in listening to people's views and thoughts about services".

7.6 We provided patient feedback summaries for the 41 Specialities who were part of our trust's 10 Year Strategy consultation and delivered 'We'll Come to You' listening events with the Canterbury Multiple Sclerosis Centre, Ageing Without Children, SpeakUp CIC and Emmaus. The feedback from patients and carers living with MS, older patients without a support network, mental health patients and unhoused people ensured that the two prioritisation sessions for the strategy were shaped by the voices of people who are not often heard at the early stages of strategic development.

7.7 We continued hosting a student intern from the Bright Futures programme at East Kent College who is supporting our FFT theming work and is also representing the voice of young neurodiverse people in our team.

8. Case study

8.1 Ageing Without Children

The team has been presenting at and engaging with Ageing Without Children (AWOC) sessions across East Kent for the past year. AWOC focus on the experiences of patients who do not have a next of kin or community to support them outside of hospital and have reported the following experiences to us in group sessions and in one to one conversations:

- AWOC who become patients are often of a retirement age and their transport options to and from hospital are limited, especially if they are having a procedure that makes them drowsy. We have heard examples where patients had to have painful procedures because they had to avoid receiving pain medication / sedation in order to be able to travel home independently; stories of patients who had to wait for over 12 hours in beds to access Patient Transport and two examples of patients incurring significant financial costs because they had to hire private travel pre and post-discharge.

- While hospital staff are excellent at recording a patient's next of kin, they rarely (if ever) ask a follow up question to identify where the next of kin lives and if they can support the patient, rendering the question pointless in the experience of many AWOC patients.

- The levels of isolation felt by AWOC patients when they are on our wards can often be exacerbated by both their personal situation and the behaviours and assumptions of hospital staff.

8.2 We will be co-producing some 'Seeing the Person' training sessions with AWOC members in the coming month, mirroring our successful work with homeless people in 2024 (detailed above). The above issues will be summarised using patient stories and staff will be able to learn from the feedback we have heard and think about how they can work differently. We have also shared our feedback with the Integrated Care Board to influence the procurement of the Non-Emergency Patient Transport contract.

9. Carers

9.1 The carers survey results have continued to show overwhelming negative feedback. Carers have told us that they often feel ignored, are not involved, or valued or seen as part of the support network of patients. Carers are usually the patient's partner, son, daughter, friend, or neighbour, but they could be their child or sibling. What they have in common is they know the person who is our patient far better than we do.

9.2 We continued to lead the Carers Task and Finish Group, established in July 2023 up to July 2024, when it completed its work. Their remit is to review the gaps/actions needed and create an action plan so that the Trust can support the NHS England Commitment to Carers. The Group consisted of the Associate Director of Patient Experience, Patient Involvement Officers, several nursing leaders, a Staff Wellbeing representative, the Allied Health Professionals (AHP) Workforce and Education lead, the Lead Specialist Nurse for Dementia, carers organisations, including Carers

Support East Kent (who chaired the Group), Crossroads Care Kent, Macmillan Care, Pilgrims Hospice, Age UK Thanet, Healthwatch Kent and individual carers.

9.3 The Group developed and implemented an action plan, with the Wellbeing team leading a workstream on supporting staff who are carers. The group has also written a Carers policy, launched during Carers Week in June 2024, and a leaflet for carers that has been distributed on our wards. There is now a Carers page on the Trust's public website and a carers page on Staff Zone.

10. Health inequalities

10.1 The team supports the implementation of the Accessible Information Standard (AIS). This includes organising the AIS and Reasonable Adjustments Steering Group that meets every two months. The Group is chaired by the Associate Director of Patient Experience and is attended by Care Groups and Corporate Colleagues and receives quarterly progress reports from Care Groups on their compliance with the Accessible Information Standard. We've seen improvements during 2024-25 and the Group supports sharing of good practice, learning and improvements.

10.2 The interpreting and translation service is managed by the Associate Director of Patient Experience who provides a quarterly report on the service to the AIS and Reasonable Adjustments Steering Group and an annual report to the Patient Experience Committee. Whilst the interpreting and translation provider has improved their fulfilment of bookings/requests in 2024-25, with an average fulfilment rate of 95 per cent, there remains an issue of availability of face to face interpreters for certain languages, including Nepali and Slovak – the top two languages requested in 2024-25. Interpreting data shows that the Trust had **8,843** interpreting bookings / requests in 2024-25. There were **75** different spoken languages that interpreters were needed for, plus five types of non-spoken including British Sign Language (BSL), Sign Supported English and Hands on / Deaf-Blind signing. We've seen a significant increase in the need for Arabic, Russian, Turkish, Ukrainian and Kurdish Sorani interpreters in 2024-25 compared to 2023-24.

10.3 The team support the reporting of patient-related outcomes in the Equality Delivery System (EDS) annual report. In 2024-25 we were able to work with the Business Information team to get the Friends and Family Test (FFT) data analysed by age, ethnicity, sex and deprivation. This meant that for the 2024 EDS report we were able to look at patient experience data for Cancer, Maternity and Renal by three protected characteristics under the Equality Act 2010 and by the Indices of Multiple Deprivation. This analysis highlighted that:

- Younger people aged 20-24 tended to have a poorer experience overall than those aged 40 plus, although people aged 90 plus also reported a poorer experience.
- For ethnicity, patients whose ethnicity is unknown have reported the poorest experience, followed by patients recorded as white and black Caribbean heritage. Most other patients report high levels of satisfaction, with patients whose ethnicity is recorded as Chinese or Nepalese scoring the highest levels of satisfaction.
- For sex/gender, patients whose gender identity is recorded as 'other' have a much poorer overall experience compared to female and male patients, with male patients reporting the highest satisfaction level.
- For deprivation, looking at Trust-wide data, there is a small difference in satisfaction levels between people experiencing the least and highest levels of

deprivation based on the Index of Multiple Deprivation (IMD), with all groups having an average of just over 95 per cent, except IMD group 9 who score 94.5 per cent and IMD group 1 score just over 96 per cent satisfaction.

10.4 During 2024-25 the Associate Director of Patient Experience worked with the Head of workforce Equality, Diversity and Inclusion (EDI) to update the Trust's approach to Equality and Health inequalities Impact Assessments (EHIAs), including reviewing options for an EHIA template and guidance. We developed a 90 minute workshop on EHIAs to support colleagues writing policies, managing cost improvement programmes, developing strategies or carrying out service or workforce changes. This was piloted in January 2025 and following feedback, an updated workshop has been delivered twice in in April and May 2025.

11. Conclusion

11.1 The second full year of the Patient Voice and Involvement team's work has seen the team continue to raise the profile of patient and family voices and the importance of patient, family, and community involvement. The team provides a first point of contact for voluntary, community and social enterprise (VCSE) sector organisations and have built strong working relationships with a wide range of them across East Kent.

11.2 The team has supported over two thousand colleagues across the Trust to respond to and learn from patient feedback this year. The team's priority is always to listen to patients and their families about what matters most to them, and then reflect this back to colleagues and services in the Trust. The team all live in East Kent and their families and friends use local services. This makes improvement not only important, but it also makes it personal, and their dedication and passion has inspired and motivated both colleagues and local people to get involved in our improvement journey.

11.3 During 2025-26 we will be refreshing the Patient Voice and Involvement strategy. This will include incorporating the new NHS England Experience of Care Improvement Framework, which all NHS trusts are required to use to self-assess their work on patient experience by March 2026. We will also reference the new NHS England Patient safety healthcare inequalities reduction framework, and the Equality Delivery System (EDS) outcomes related to patient experience. But utilising these frameworks we will ensure our new Patient Experience Strategy is focused on supporting the Trust to improve patient and community access to healthcare, improve patient and carer / family experience and improve patient outcomes, especially for people who face significant health inequalities.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Chief Medical Officer's (CMO's) Report**

Meeting date: **5 June 2025**

Board sponsor: **Chief Medical Officer (CMO)**

Paper Author: **CMO**

Appendices:

None

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	This report is intended to provide assurance to the Board of Directors in relation to appraisal and revalidation.
Summary of key issues:	This report provides an update on appraisal and revalidation. • Trust has 887 connected doctors, with 754 (85%) appraisals completed or within guidelines, remaining 15% of those that have missed their milestones/in progress are currently under review. • The Responsible Officer's Advisory Group (ROAG) continues to meet monthly and all revalidation recommendations are being reviewed and processed up to three months ahead of recommendation deadlines. • Since July, 223 doctors have been successfully revalidated.
Key recommendations:	The Board of Directors to requested to **NOTE** the CMO's report.

Implications:

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

Assurance route:

Previously considered by: N/A

East Kent Hospitals University NHS Foundation Trust

Chief Medical Officer's (CMO's) Report

1. Purpose of the report

1.1. This report provides an update on appraisal and revalidation.

2. Appraisal and Revalidation

2.1. The Trust has 887 connected doctors, with 754 (85%) appraisals completed or within guidelines. The remaining 15% of those that have missed their milestones/in progress are currently under review.

2.2. The Responsible Officer's Advisory Group (ROAG) continues to meet monthly and all revalidation recommendations are being reviewed and processed up to three months ahead of recommendation deadlines.

2.3. Since July, 223 doctors have been successfully revalidated.

2.4. Connection checks continue to be carried out twice per month, challenging unknown or missed connections.

2.5. The Trust reviewed the Appraisal and Revalidation Policy which was approved by the Trust Management Committee (TMC) in April 2025. The review instigated changes based on an external audit including an update on the non-engagement process.

2.6. The Trust is looking at imposing an upper and lower limit on the number of appraisals individual appraisers perform. This is to drive quality.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Cervical Screening Annual Report – 2024-2025**

Meeting date: **5 June 2025**

Board sponsor: **Chief Medical Officer (CMO)**

Paper Author: **Colposcopy and Cervical Programme Lead (CSPL)**

Appendices:

None

Executive summary:

Action required:	Information
Purpose of the Report:	The paper is presented to the BoD as an update on the performance of the cervical screening programme at the Trust. It details workforce, demand and capacity and performance against national targets.
Summary of key issues:	Colposcopy activity results mainly from direct referrals from cytology / high risk Human papillomavirus (HPV) screening In the most recent reporting period (2024–2025), cytology referrals have declined by 13.3%. While referral volumes remain historically high, this is the first significant decrease following several years of growth. A task and finish group is being established to ensure a robust and inclusive cervical screening pathway that meets the needs of all communities. Performance against national targets is met across all areas with the exception of:

CSP-S08: test: colposcopy - timely biopsy result letter sent	Target	Trust performance Q4
Women receiving biopsy (diagnostic or treatment) results within 4 weeks of the test date	≥ 90%	90%
Women receiving biopsy (diagnostic or treatment) results within 8 weeks of the test date	100%	99%

An action plan to address this is being developed which will be monitored as part of the quarterly cervical screening provider management meetings chaired by the Cervical Screening Provider Lead (CSPL).

	The aging equipment, including colposcopes and diathermy machines, across sites providing colposcopy is a growing concern, as these devices are essential to maintaining full colposcopy services. These are reviewed as part of the care group's risk register.
Key recommendations:	The Board of Directors is asked to receive this report and **NOTE** the issues detailed.

Implications:

Links to Strategic Theme:	Strategic Theme(s) this report aims to support: • Quality and Safety • Patients • People
Link to the Trust Risk Register:	2051 inadequate Colposcopy Facilities impacting on patient pathways. 3755 aging colposcope devices trust wide impacting on the delivery of cervical screening programme. 3796 Queen Elizabeth the Queen Mother Hospital (QEQM) Colposcopy inadequate Environment.
Resource:	Y – potential replacement of condemned equipment.
Legal and regulatory:	Y – regulatory – cervical screening programme standards.
Subsidiary:	N

Assurance route:

Previously considered by: None

East Kent Hospitals University NHS Foundation Trust

Colposcopy Service Report 2024/2025

1.0 Workforce

Accredited Colposcopists	
Consultant Gynaecologist, Colposcopist and Cervical Screening Provider Lead (CSPL)	1
Consultant Gynaecologist and Lead Colposcopist	1
Consultant Gynaecologist and Colposcopists	8
Consultant Gynaecological Oncologist and Colposcopists	5
Lead Nurse Colposcopist William Harvey Hospital (WHH) / Buckland Hospital Dover (BHD)	1
Lead Nurse Colposcopist QEQM / Kent & Canterbury Hospital (K&C)	1
Locum Consultant Gynaecologist and Colposcopist	1
Trainee Colposcopists	
Locum Consultant Gynaecologist and Trainee Colposcopist	1
Specialist Registrar and Trainee Colposcopist	1
Trust Doctors (Registrars) and Trainee Colposcopists	1
Nursing and Support Staff	
Registered Nurse and Colposcopy Unit Manager K&C	0.8
Registered Nurses	4.31
Health Care Assistants	4
Administrative and Operational Staff	
Operations Manager	1
Colposcopy Coordinator	1
Deputy Colposcopy Coordinator	1
Colposcopy Secretary / Administrator	2
Colposcopy Audit Admin Lead	1
Receptionists	1.27

Accredited and Trainee Colposcopists

There are currently 17 accredited colposcopists working substantively within the team and one long-term locum (more than six months). In addition, there are three trainee colposcopists actively working towards accreditation.

Nursing and Support Staff

Within Women's Health we have both nurses and health care assistants who staff the colposcopy units at K&C and QEQM.

At WHH & BHD nursing staff is provided by Outpatients for the colposcopy clinics.

Administrative and Operational Staff

The Colposcopy Admin Team is centralised and based at WHH. Currently the team structure consists of:

Band 4	Colposcopy Coordinator	1.0 Whole Time Equivalent (WTE)
Band 4	Colposcopy Audit Admin Lead	1.0 WTE
Band 3	Deputy Colposcopy Coordinator	1.0 WTE
Band 3	Colposcopy Secretaries	2.0 WTE

The team are all trained to cross-cover each other's duties when required; e.g. during periods of leave so as to meet the needs of the service.

The Band 6 Women's Health Operations Manager based at WHH oversees the Colposcopy Service Trust-wide from an Operational perspective.

In addition, there are 1.27 WTE Band 2 Receptionists who reception the colposcopy units at K&C and QEQM and are managed by the nursing team in the units. The reception of the units at WHH & BHD is managed by the Outpatients department.

2.0 Demand & Capacity

Clinic Schedule

BHD – Buckland Hospital
K&C – Kent & Canterbury Hospital
QEQM – Queen Elizabeth Queen Mother Hospital
WHH – William Harvey Hospital

Clinician	Site	Day	AM / PM	Weeks	Appts per clinic	Appt length (mins)
Agboola	WHH	Wed	PM	1,2,3,4,5	8	25
Basu	BHD	Tue	AM	1,2,3,4,5	8	25
Bugren	K&C	Mon	PM	alternate	8	25
	K&C	Tues	AM	1,3,5	8	25
Helmy	WHH	Wed	AM	1,2,3,4,5	8	25
Inetianbor	BHD	Thu	AM	alternate	8	25
Ismail	K&C	Fri	PM	2	8	25
Iyer	QEQM	Tue	AM	4	8	25
Jaworska	BHD	Wed	AM	1,2,3,4,5	7	30
	BHD	Wed	PM	1,2,3,4,5	7	30
	BHD	Mon	PM	2,3,4,5	7	30
	WHH	Tue	PM	1,3,4,5	7	30

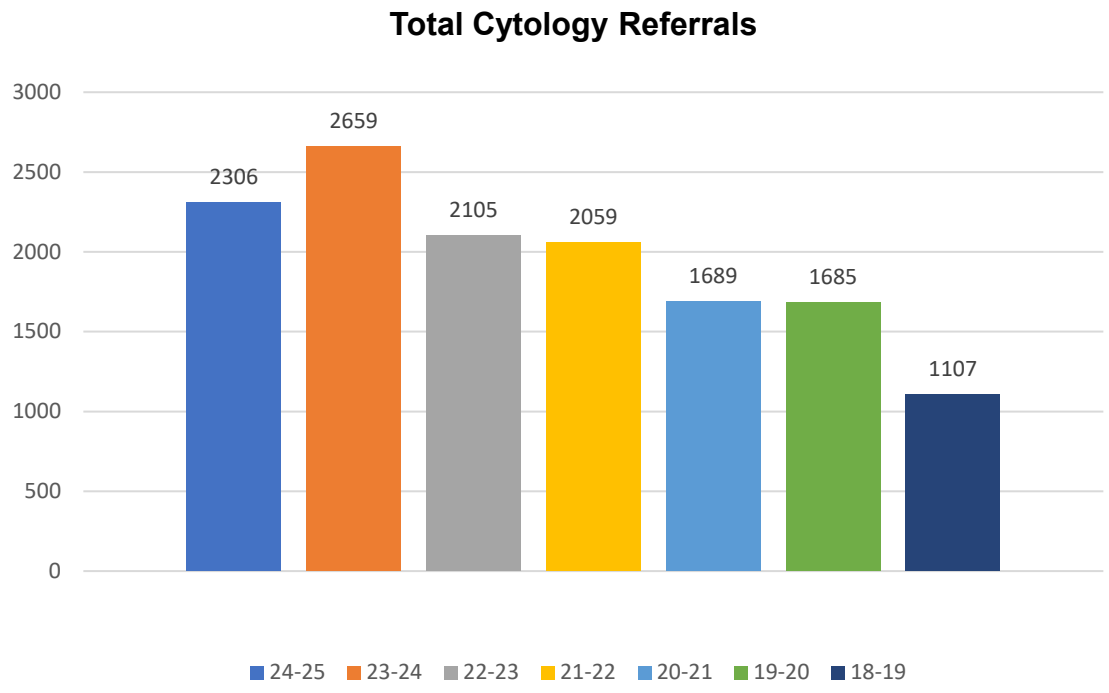
Kokka	QEQM	Thu	AM	2	8	25
Nordin	K&C	Fri	PM	4	8	25
Okorocha	K&C	Mon	AM	1,2,3,4,5	8	25
Omonua	WHH	Mon	AM	1,2,3,4,5	8	25
Seaton	BHD	Mon	PM	1,2,3,4,5	8	25
	BHD	Fri	AM	1,2,3,4,5	8	25
Shah	WHH	Tue	AM	1,2,3,4,5	8	25
Woodward	K&C	Tue	AM	4	8	25
Zhang	QEQM	Wed	AM	1,2,3,4,5	7	30
	QEQM	Mon	AM	1,2,3,4,5	7	30
	QEQM	Tue	AM	1,3	7	30
	K&C	Tue	PM	2	7	30

3.0 Workload

Colposcopy activity results mainly from direct referrals from cytology / high risk HPV screening. Additional colposcopy activity comes from referrals of symptomatic patients by their GPs, and from follow-up appointments (post first colposcopy appointment).

The service provides approximately 17 colposcopy clinics per week across the Trust.

The annual numbers of colposcopy appointments from direct referrals were as follows:



Impact of primary high-risk HPV screening on the colposcopy workload

The impact was difficult to predict. Prior to the start of primary HPV screening it had been anticipated (nationwide) that the rate of direct referrals would stay roughly the same in 2019/20, and that the direct referral rate would increase by about 30% in the following years. However, there was a significant increase in referrals in 2019/20.

The plateau in referrals in 2020/21 was likely a result of the COVID-19 pandemic.

We had a steady increase of referrals in 2021/22 - 2022/23 & 2023/24.

In the most recent reporting period (2024/25), cytology referrals have declined by 13.3%, falling from 2,659 to 2,306. While referral volumes remain historically high, this is the first significant decrease following several years of growth.

As the colposcopy and cervical programme lead (CSPL), I have convened a dedicated taskforce to investigate and address this issue. This initiative is being delivered in partnership with:

- Allied Health Professionals (AHP)
- Integrated Care Board (ICB)
- Local Community Training Hub

The taskforce will:

- Assess potential health inequalities affecting cervical screening uptake across different population groups.
- Examine systemic or operational barriers that may have impacted access to screening services.

In addition, we are launching a community engagement programme that will include:

- Local awareness meetings and outreach events
- Targeted education and myth-busting activities
- Collaboration with community leaders and trusted messengers to improve reach and impact

This multi-agency, community-focused approach aims to:

- Understand the root causes of the recent decline
- Enhance access and equity
- Increase screening uptake, especially in underserved populations

Our goal is to ensure a robust and inclusive cervical screening pathway that meets the needs of all communities.

4.0 Key Performance Indicators (KPIs) and Quality Standards

Sources for targets: Cervical Screening Programme Standards

Indicator: Colposcopy National Standards	**Target**

CSP-S08: test: colposcopy - timely biopsy result letter sent	
Women receiving biopsy (diagnostic or treatment) results within 4 weeks of the test date	**≥ 90%**
Women receiving biopsy (diagnostic or treatment) results within 8 weeks of the test date	**100%**
CSP-S09: intervention or treatment: colposcopy – 12-month follow-up after treatment	
Women who have biopsy proven Cervical Intraepithelial Neoplasia (CIN) or Cervical Glandular Intraepithelial Neoplasia (CGIN) within 12 months of the first excisional treatment.	**≤ 5%**
CSP-S10: intervention or treatment: colposcopy - inadequate referral	
Women referred after 2 consecutive samples with inadequate cytology or HPV unavailable results offered an appointment within 6 weeks	**≥ 99%**
CSP-S11: intervention or treatment: colposcopy - 6-week appointment	
Women are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline squamous changes or low-grade dyskaryosis.	**≥ 99%**
CSP-S12: intervention or treatment: colposcopy - high grade referral 2-week appointment	
Women are offered a colposcopy appointment within 2 weeks of referral due to a cytological report of high-grade dyskaryosis (moderate) or worse.	**≥ 93%**

Women who DNA first appointment	**< 10%**
Women who DNA for Treatment	**<10%**
Women who DNA follow up appointment	**< 15%**

CSP-S08: test: colposcopy - timely biopsy result letter sent	**Target**
Women receiving biopsy (diagnostic or treatment) results within 4 weeks of the test date	**≥ 90%**
Women receiving biopsy (diagnostic or treatment) results within 8 weeks of the test date	**100%**

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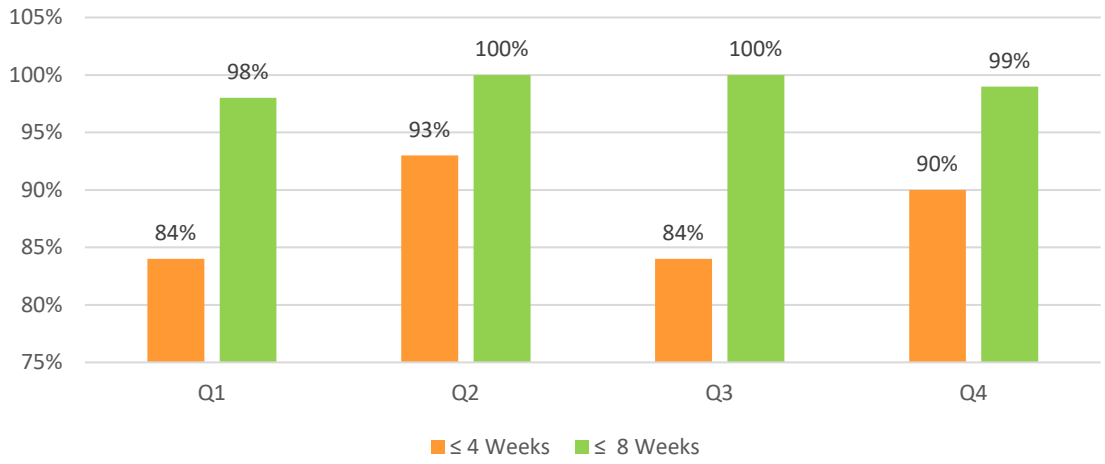
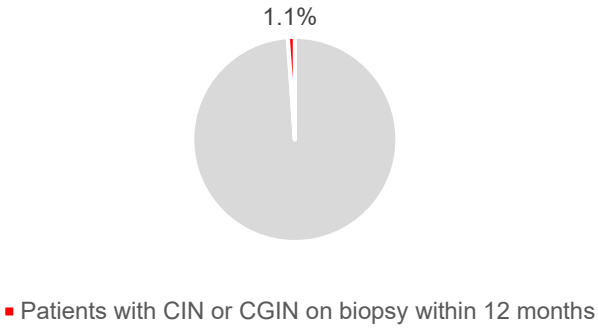
Women receiving biopsy (diagnostic or treatment) results in a timely manner

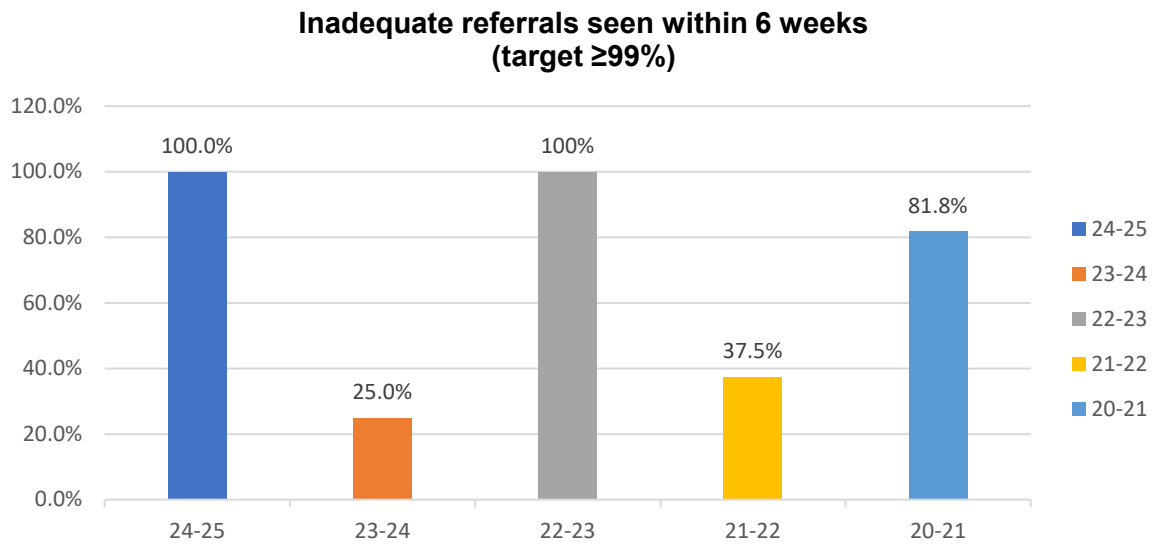


CSP-S09: intervention or treatment: colposcopy – 12-month follow-up after treatment	**Target**
Women who have biopsy proven CIN or CGIN within 12 months of the first excisional treatment.	**≤ 5%**

Women with CIN or CGIN on biopsy within 12 months of first treatment

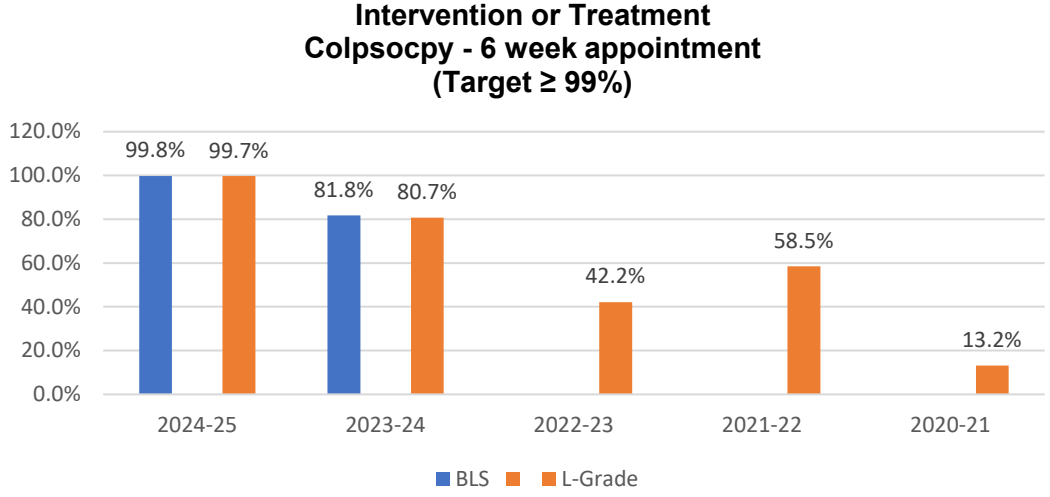


CSP-S10: intervention or treatment: colposcopy - inadequate referral	**Target**
Women referred after 2 consecutive samples with inadequate cytology or HPV unavailable results offered an appointment within 6 weeks	**≥ 99%**



Regarding the 2023-24 period, there were four cases of inadequate referrals, with only one patient being seen within the recommended 6-week timeframe.

CSP-S11: intervention or treatment: colposcopy - 6-week appointment	Target
Women are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline squamous changes or low-grade dyskaryosis.	≥ 99%



CSP-S12: intervention or treatment: colposcopy - high grade referral 2-week appointment	Target

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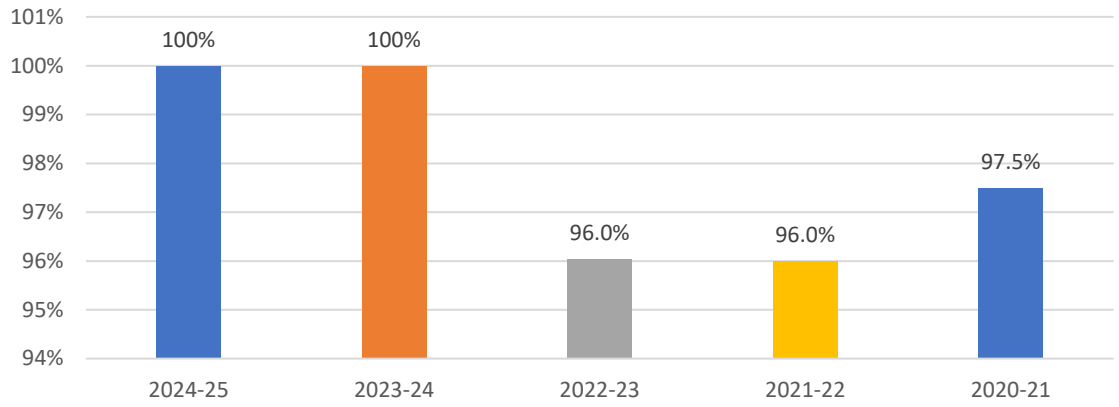
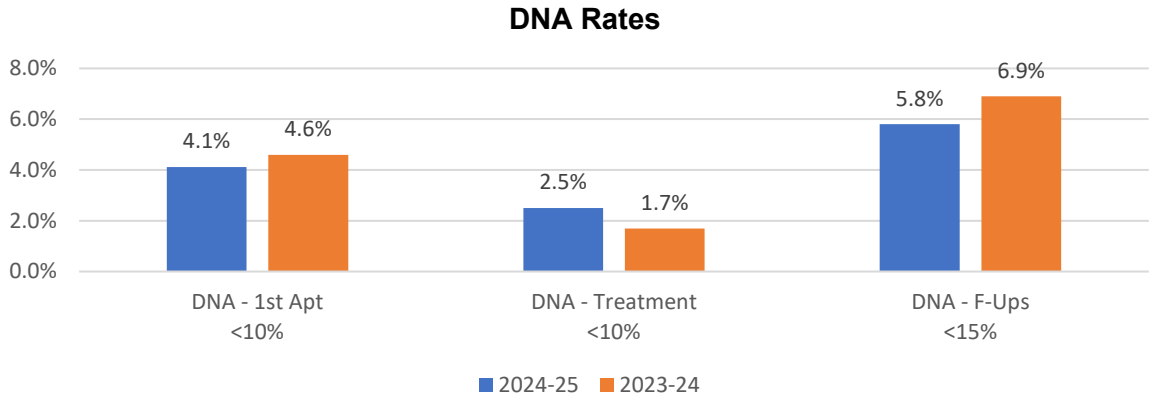
Women are offered a colposcopy appointment within 2 weeks of referral due to a cytological report of high-grade dyskaryosis (moderate) or worse.	**≥ 93%**

CSP-S12: intervention or treatment: colposcopy high Grade referral 2-week appointment (Target≥ 93%)



Did Not Attend (DNA) Rates	**Targets**
Women who DNA first appointment	**< 10%**
Women who DNA for Treatment	**<10%**
Women who DNA follow up appointment	**< 15%**

	2024-25
Women who DNA first appointment	4.12 %
Women who DNA for Treatment	2.58%
Women who DNA follow up appointment	5.83 %



5.0 Meetings

Multidisciplinary Meetings (MDM)

Cervical cancer cases are discussed as soon as possible at the weekly Gynae-Oncology MDM. All colposcopists are invite to attend either in person at QEQM or virtually via WebEx.

Non-cancerous colposcopy cases are discussed at the monthly Colposcopy MDM held at WHH. Cytologists from BSPS and Pathologists from WHH including staff based at other sites are invited to attend virtually via WebEx.

All Colposcopists are required to attend at least 50% of Colposcopy MDMs.

Colposcopy Operational Meetings

The colposcopy team holds operational meetings quarterly.

Cervical Screening Provider Management Meetings

The CSPL chairs quarterly cervical screening provider management meetings.

6.0 Medical Equipment

Charitable funding was secured for the acquisition of a second colposcope at Buckland Hospital Dover (BHD), a project led by one of the consultant gynaecologists to enhance diagnostic capacity and patient care in both cervical screening and gynae oncology.

The original colposcope at BHD was recently condemned and has been taken out of service. We are currently awaiting the release of funding to purchase a replacement.

The aging equipment, including colposcopes and diathermy machines, across the other three sites—K&C, WHH, and QEQM — is a growing concern, as these devices are essential to maintaining full colposcopy services. To mitigate the impact of the broken colposcope at BHD, we had to relocate a colposcope from QEQM although this has placed additional pressure on the service at QEQM.

7.0 Service Quality Assurance Recommendations

No.	Recommendation	Reference	Timescale	Evidence required
1	Establish quarterly cervical business meetings chaired by the Cervical Screening Provider Lead with representation from all cervical screening service leads	National Service Specification No.25 Cervical Screening	31/07/2024 (6 months)	Terms of reference
		NHS Cervical Screening Programme: the role of the cervical screening provider lead		Meeting schedule
2	Put in place resources to ensure the national invasive cancer audit data collection is up to date and complete an audit to demonstrate disclosure of invasive cervical cancer audit outcomes to individuals who have requested disclosure	National Service Specification No.25 Cervical Screening	28/02/2025 (12 Months)	Completion of invasive cervical cancer audits up to the end of 2023
		National Invasive Cervical Cancer Audit		Audit of disclosure offer and provision for 2021 to 2023
		Cervical Screening: disclosure of audit results toolkit		
3	Develop and implement a whole Trust annual audit schedule for cervical screening services	National Service Specification No.25 Cervical Screening	31/07/2024 (6 months)	Annual audit schedule covering colposcopy and histopathology
4	Ensure that all colposcopists see a minimum of 50 new NHS Cervical Screening Programme (NHSCSP) referrals a year	NHS Cervical Screening Programme and Colposcopy Management	28/02/2025 (12 Months)	Data submission showing number of new NHSCSP referrals for each colposcopist in the period 02/24-01/25
5	Implement and update Standard Operating Procedures (SOPs) to include:		31/07/2024 (6 months)	Updated ratified SOPs
	a. Cervical sample taking	NHS Cervical Screening		

	b. Colposcopy administration	Programme and Colposcopy Management		
	c. Production, validation and discussion of colposcopy internal performance monitoring data	NHS Standard Contract		
	d. Screening risk management			
	e. Screening incident management	Managing safety incidents in NHS screening programmes		
	f. Colposcopy failsafe (including non-attenders)	Cervical screening: cytology reporting failsafe (primary HPV)		
	g. Colposcopy induction for all staff			
6	Ensure colposcopy Multi-Disciplinary Team (MDT) meetings meet national requirements and all colposcopists attend a minimum of 50% of colposcopy MDT meetings	National Service Specification No.25 Cervical Screening	28/02/2025 (12 Months)	Audit of MDT case selection and outcomes for a 3 month period
		NHS Cervical Screening Programme and Colposcopy Management		MDT attendance register for a year

8.0 Conclusion

The Board of Directors are asked to receive the above report and the assurance provided that whilst there are still challenges in implementing the performance standards progress has been made and oversight and governance arrangements are in place to oversee the remaining work.

End.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: Safety, Fire and Statutory Compliance Update

Meeting date: 5 June 2025

Board sponsor: Chief Strategy and Partnerships Officer (CSPO)

Paper Author: Associate Director of Safety
Section 6 provided by 2gether Support Solutions (2gether) Estates

Appendices:

None

Executive summary:

Action required:	Assurance
Purpose of the Report:	This report provides an update to the Board on the Trust's position in relation to the status and management of safety, fire and estates statutory compliance.
Summary of key issues:	• The current year end cumulative Health and Safety Toolkit Audit (HASTA) scorecard. • Health and Safety Toolkit Audits programme continue across all Care Group and Corporate areas. Support being provided to Care Groups to enable improved outcomes for this financial and future years. • In Q3 2024/25, the Trust reported nine Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents to the Health and Safety Executive (HSE). • The overarching statutory compliance assurance level stood at c93% at the end of April, work remains ongoing to uphold and improve this position.
Key recommendations:	The Board of Directors is asked to **NOTE** and discuss the Trust's current position in relation to Health & Safety (H&S), and Statutory Compliance, especially in respect to the prevailing risks. Care Group Directors to nominate representatives and deputies for the safety related groups (Strategic H&S Committee, Health and Safety Group, Fire Safety Group and Security Management Group).

Implications:

East Kent Hospitals University NHS Foundation Trust

Links to Strategic Theme:	This report aims to support: • Quality and Safety • Patients • People • Partnerships • Sustainability
Link to the Trust Risk Register:	**SRR3354 –** Clinical environment not fit for purpose. **SRR3384** - Financial constraints for capital funding and assets replacement.
Resource:	No
Legal and regulatory:	• Health and Safety Legislation. • Estates legislative Statutory Compliance.
Subsidiary:	2gether provides the Trust's hard facilities management services.

Assurance route:

Previously considered by:

Trust Management Group (TMC) (formerly the Clinical Executive Management Group (CEMG))
Strategic Health and Safety Committee
Capital Investment Group

East Kent Hospitals University NHS Foundation Trust

Safety, Fire and Statutory Compliance Update

1. Background and Executive Summary

1.1. This report updates the Board on the Trust's position in relation to the ongoing management of Health & Safety (H&S), and the estates statutory compliance.

2. Health & Safety (H&S)

2.1 Health and Safety Toolkit Audits (HASTA's)

2.1.1 HASTA overview

HASTA Audits are scheduled throughout the year in all clinical and non-clinical wards and departments.

This year, the HASTA Care Group structure has been changed to align with the new Care Groups. For reporting purposes, the Trusts' overall score will be compared to previous years, but the new care groups will only reflect this year's scores. This has been communicated to the Care Group Safety Leads, highlighted in Safety Link Worker meetings, and raised in the strategic H&S Committee.

The Health and Safety Toolkit Audit was undertaken in line with the Health and Safety teams Safety Plan to gain assurance of the individual teams and departments compliance with the Trusts' Health and Safety policies.

The audits were undertaken by the Safety Team between June 2024 and February 2025. Scores achieved on the day of audit are reflected in the scores in Table 1.

A total of 301 audits were undertaken for the financial year 2024/25 with an overall trust score of 82.8% compliance. This is down from 88.5% from the previous year.

2.1.2 HASTA performance summary

2.1.2.1 Areas of good performance

The areas with good performance in the HASTA audit were within Staff Welfare, First Aid and Display Screen Equipment (DSE) compliance. The staff welfare section focusses on facilities available to staff and this has scored highest of all the question sections. First aid would be a section we would expect to be high due to the environment we work in and the DSE compliance is good, considering the large amount of staff we have working at desks and workstations across the Trust.

2.1.2.2 Areas of poor performance

Areas of poor performance were Ligature awareness, lone working and fire safety.

There is currently no ligature cutter training offered by the Trust, ligatures are covered briefly by the Resus' Team but this area requires focus. Lone working scoring low suggests a lack of understanding of what constitutes lone working and the mitigations that are required of them. Staff redeployment has impacted fire safety where fire wardens have moved out of departments. A recently recruited Fire Safety Adviser will enable Fire Warden Training to be re-established. Sufficient nominated fire wardens from the departments/areas will continue to be monitored via the Fire Safety Group.

2.1.3 Care Group HASTA year end performance

Critical Care, Anaesthetics and Specialist Surgery Care Group (CCASS CG)

A total of 43 Audits were undertaken for the CCASS CG scoring with an average score of 89.1%. a strong performance for the care group, performing particularly well in areas such as staff welfare, First Aid provisions and Security Management. Some areas to improve on include lone working risk assessments, lack of feedback regarding risk registers and Fire Safety. Despite an average score of 83.2% for fire safety this needs improving as departments are finding themselves without a fire warden or enough fire warden checks to score full marks for this question.

Diagnostics, Cancer and Buckland Care Group (DCB CG)

76 Audits were undertaken for DCB CG with and average score of 92.1%. The care group excelled in staff welfare, First Aid and its DSE compliance. Despite the group's strong performance its low scoring subject was manual handling with an average score of 83.4%. The low score in Manual handling is due to a particular question where high risk manual handling assessments were either not in date or not in place. The recommendation to update this is passed through to the manual handling team to support.

Kent and Canterbury and RVHF Care Group (KCVH CG)

32 Audits were completed for KCVH CG averaging 82.9% Performing well in staff welfare, first aid and DSE compliance. Lone working, Moving and Handling and Fire safety were the lowest scoring subjects for this care group though, and while all areas are important, these subjects being the lowest scoring does raise some concerns.

The lack of risk assessments in place for lone workers has been addressed in the Quarterly H&S link worker meetings offering additional training.

QEQM Care Group (QEQM CG)

32 audits were completed for QEQM CG with one department, St Augustin's, failing to produce a H&S folder despite numerous attempts by the H&S advisor to visit the department. The Care Group scored a poor 59.9% with the majority of departments scoring less than 80% putting them in the red. A few good scores from Hospital at home, Inca House, Endoscopy unit and St Margaret's ward, but the vast majority fell below expectations.

A large part of the problem is due to the loss of Link workers from departments due to staff relocation and redundancies. This has left a gap in the H&S compliance on a lot of the wards (this is also reflected in the William Harvey Hospital (WHH) care group). Despite the challenges faced by staff redeployment stress management and welfare were among the top scoring sections of their audits. Lone Working scored particularly poorly in this care group with 31.7% compliance.

A recovery plan has been devised for the QEQM to improve scores for this forthcoming audit year.

William Harvey Hospital (WH CG)

38 Audits completed for the WH CG scoring an overall of 66.8%, a disappointing result for this care group, with most of the issues coming from lack of H&S Link workers. Some poor performing departments such as ED and AMU have already attended Link worker training in light of their latest audit results. There were 5 departments that scored less than 10% which is cause for concern with just one department Cardiac Catheter suite the only one to score 100%. Welfare DSE and stress management were among the top scoring section of the audit for WH CG. Ligature awareness and Covid-19 resilience were the two lowest scoring sections with the competence assistance section scoring third lowest. This is evident ion the overall care group score as the departments either don't have link workers, do not attend the quarter link raining meetings or both.

A recovery plan has been devised with the Care Group to improve the scores for the forthcoming audit year.

Women Children and Young People Care Group (WCYPO CG)

30 Audits were completed for WCYPO CG scoring an overall of 89.5%. A strong performance from this care group with only four departments scoring less that 85% putting them in the red. The highest scoring sections were stress management, first aid and DSE compliance. Moving and handling was the lowest scoring section with only 69% of departments having department specific high-risk manual handling assessments. Lone working is also a low scoring question which is a concern due to the community work that midwives do in this care group.

Corporate Divisions.

50 Audits completed for the corporate group scoring an average of 87%. Discharge lounge and Discharge transit lounge scoring very poorly under 10% bringing the score down, but generally a strong score from most other departments with 16 departments scoring 100%. Staff welfare, DSE compliance and stress management were among the highest scoring sections in the audit. Ligature awareness and fire safety were among the lowest scoring sections. Fire wardens and checks being a low scoring question, which needs addressing by additional training and support.

Some departments and wards have struggled this year with redeployment of staff and loss of H&S link workers, this has been felt particularly through the WHH and QEQM care groups. The Safety team continues support Care Groups to try and improve this situation with additional Link Assessor training. The Health and Safety Group receives greater detail on the HASTA scorecard

and a deeper dive into the 24/25 HASTA programme will be considered at the next Strategic Health and Safety Committee.

2.1.4 EKHUFT HASTA year end scorecard

Table 1 below, shows the corporate scorecard for 24/25. Care group previous data for 22/23 and 23/24 is not shown as the care group structure was different in these audit years and are not comparable. Overall compliance has fallen year on year for the third successive year. The very poor HASTA scores for QEQM (59.9%) and poor scores for the WHH (66.8%) have contributed heavily to the overall Trust position.

The QEQM and WHH Management Boards receives monthly updates on their HASTA performance and are supported by the safety team. Suitable Site based Care Group representation at the Strategic Health and Safety Committee and its' Sub Groups would help with the oversight and scrutiny of the HASTA programme and evidence of better Care Group safety risk management at the site-based meetings should help in improving the position for 25/26.

Table 1: HASTA Score Card

HASTA Score-Card	2022/23	2023/24	2024/25
Critical Care, Anaesthetics and Specialist Surgery Care Group (CCASS CG)	N/A	N/A	**89.1%**
Diagnostics, Cancer and Buckland Care Group (DCB CG)	N/A	N/A	**92.1%**
Kent and Canterbury and RVHF Care Group (KCVH CG)	N/A	N/A	**82.9%**
QEQM Care Group (QEQM CG)	N/A	N/A	**59.9%**
William Harvey Hospital (WH CG)	N/A	N/A	**66.8%**
Women Children and Young People Care Group (WCYPO CG)	N/A	N/A	**89.5%**
Corporate Divisions.	N/A	N/A	**87.0%**
Trust Wide Totals	**90.2%**	**88.5.2%**	**82.9%**

2.2 Safety Governance

There are currently four non-clinical safety related groups in EKHUFT. The Strategic Health and Safety Committee oversees the non-clinical safety related business. There are three sub groups that feed into the Strategic H&S Committee: Fire Safety Group, Health and Safety Group and the Security Management Group. There is an identified need to ensure suitable and sustainable representation from the six Care Groups. There has been some limited attendance and engagement thus far, but it is requested that this area is improved and the safety governance within the Care Groups is improved and integrated into the EKHUFT Safety governance structure.

2.3 Safety Training: In Q3 24/25 the partnership has remained focused on delivering link worker training. Other training that has taken place during this quarter includes:

a. First Aid at Work;
b. Institution of Occupational Safety and Health (IOSH) (managing safely);
c. IOSH (working safely);
d. Control of Substances Hazardous to Health (COSHH);
e. Fire Safety;
f. Risk Assessment Awareness.

2.4 H&S Team Support: The Safety Team has been involved in a number of activities to support the Trust's activities both proactively (focused training) and reactively (incident investigations). The Ligature Risk Assessment review programme has been undertaken with clinical teams.

3. RIDDOR reports for Q3 24/25

3.1During Q2 24/25 budget period, the Trust reported nine RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) events with the HSE.

- October – Six reported (Staff member assaulted by patient, two Staff falls, three injuries of staff responding to patients (sprains and strains)).
- November – Three reported (staff slipped on spillage, two injuries to staff responding to patients, sprains and strains).
- December –zero reported.

3.2 The Safety team continue to support teams with their reporting of incidents, investigations and advice on remedial actions.

4. Fire Safety Update

4.1 **Fire Safety Governance:** The joint (2gether and EKHUFT) Fire Safety Group (FSG) meetings have been held every month. Attendance has been reduced to one Managing Director (MD) for the different sites and MD KCH attends the Fire Safety Group. 2gether Capital Projects now attend each month to provide an update on the Fire Strategy Project. This month the Authorising Engineer (AE) fire attended for the first time.

4.2 **Fire Safety Plan:** The 23/24 Joint Fire Safety Plan remains steady against most actions and is monitored by the membership of the FSG and SHSC. There was a lack of achievement with

some elements such as the introduction of a wider face to face training programme and practical training such as fire extinguishers and evacuation drills due to the lack of resource's in the Fire Team. The appointed Authorising Engineer Fire has started to collate documentation from the trust to carry out a "gap analysis "of fire safety systems and governance in the Trust.

4.3 **Longer term Fire Safety Improvement Plan:** The multiyear Fire Safety improvement plan initiated from the Fire Compartmentation report, originally produced by the Safety Team in 2023, is being delivered by the 2gether Capital Project Team, supported by the Fire Safety Manager. This is updated to senior Trust management weekly and the FSG on a monthly basis and there is a Fire Strategy Implementation Group now formed for overall governance.

The very high dependency areas prioritised initially in the report have been reviewed by Trust management as not immediately accessible due to operational pressure and time constraints, and seasonal pressures will impact on service delivery however outline agreement on clinical areas post April 2025 have been jointly agreed. Works are progressing in WHH Bartholomew and Coronary Care Unit (CCU) wards, to install thermally activated CCTV and a sprinkler system which is on target for completion by April 2025. Works are being carried out in plant rooms corridors and other non-direct facing patient areas until ward access is granted.

4.4 **Fire Risk Assessments (FRAs) and support:** The provision of FRAs has transferred with the H&S Department to the Trust. The Trust are using the previous external contractor until the posts are filled with suitably competent staff. A Purchase Order (PO) was issued on 7 August 2024 for the 24/25 annual reviews and the programme restarted in August 2024 with a backlog of approximately 170 FRAs overdue out of the total of 356. There are now 85 FRAs overdue their review, and they have been prioritised by their risk. The actions identified in FRAs are tackled on a risk basis and reported on at each FSG. There are 72 "Moderate" and 284 "Tolerable" or "Trivial" rated FRAs.

4.5 **Fire Training:** Learning and Development reported to the FSG an average of 90.4% completion of Statutory Fire e-learning training across the Trust up to January 2025 and the Trust threshold is 91%. The Trust has remained under threshold for over 12 months. The programme of Fire Warden and Fire Incident Manager training has carried on with well over 20 courses delivered this year to date. All Trust new starters are asked to attend the Virtual Fire Safety Induction training. There has been additional ward-based training in other areas working with the EPO. The planned programme of ward-based face to face training is severely restricted as is the Fire Extinguisher Training due to the two vacant Fire Safety Advisors posts.

There are notably fewer staff trained and still in post at QEQM (see RAG rated table below)

Site	Fire Warden Trained staff	Fire Incident Manager	Fire Extinguisher Training	Site TOTAL
QEQM Hospital	66	40	72	178
K&C Hospital	158	76	190	424

William Harvey Hospital	136	65	120	321
Buckland Hospital	8	4	11	23
Royal Victoria Hospital	2	0	4	6
Totals	370	185	397	

4.6 **Regulatory Interaction:** Kent Fire and Rescue Service carried out a Risk and Regulatory Fire Safety audit of the D Block (High Rise) Staff Accommodation at WHH on 28 November. A letter with a list of four deficiencies was received in January. The remedial work for these has been instructed and partially completed and should be finished by April.

4.7 **One vacant fire safety post**: There are one Fire Safety Advisors vacant post in the Safety Team. These posts are for fire training and the fire risk assessment programme.

5.0 Security

5.1 **Security contract** – The new contract has been awarded with mobilisation by July. The new contract has additional support for the two Emergency Departments (EDs) at WHH and QEQM. The security officers will also upgrade their SIA licence to enable safer interventions in accordance with EKHUFTs All Age Restraint Policy.

5.3 **Security related Training**

There have been four Right Care Right Person Training sessions with Kent police providing input regarding Missing persons and Police attendance. This will give those attendees a better understanding of the process and what to expect with a different range of incidents

5.4 **Body Worn Video Camera Trial** – QEQM ED have trialled some Body Worn Video cameras that have been deployed to nominated nursing staff in the department. The trial is now in an evaluation phase.

5.5 – **Security related Groups**
Supporting Positive Behaviours Group continues to function, chaired by Julie Yanni. This group primarily focusses on reduction of violence and aggression.

6.0 **Estates Compliancy report**
Statutory compliance results have been steadily tracking towards the target of 95%. January's results are 94%, a 2% increase on December. Improvements have been made against Air Handling Unit (AHU) verification(s), Lifting Operations and Lifting Equipment (LOLER) inspections, Pressure Systems Safety Regulations (PSSR) audits and lift servicing. This is the highest statutory inspections results on record.

East Kent Hospitals University NHS Foundation Trust

December's call volumes have decreased by approx. 16% from November's results. It was anticipated that January's call volumes would increase. As expected, January's call volumes increased by 25% on December's.

Planned maintenance has seen an overall 5% deterioration on December's results. This is due to a 25% deterioration on Servicing inspections across the sites.

Six Facet survey is 90% complete, expected completion and draft review by the end of February 2025.

Fire damper inspection works; Fire damper inspections have begun, Buckland Hospital Dover (BHD) has been completed, engineers now progressing with WHH, expected completion end of January 2025. Forecast to complete all sites by end of Financial Year (FY) is on track. Annual fixed wire testing for Kent & Canterbury Hospital (K&C) is complete, QEQM and WHH anticipated completion by end for FY 24/25.

Statutory Compliance Overview - JAN 2025									
	KCH		WHH		QEQM		Total	Actual	DEC
Compliant	138	91%	120	95%	112	92%	370	94%	92%
Non-Compliant	13	9%	6	5%	6	8%	25	6%	7%
TOTAL	151		126		118		395		

Compliant
-> Fire Damper Inspections- Buckland Hospital (BHD)
->Fixed Wire Testing- All Sites
->AHU Maintenance-Non-Crit Systems
->Annual Verifications (AHU)
-> PSSR/LOLER Inspections
-> Lift Servicing

Non-Compliant
->Fire Alarm Systems- Annual Device Testing*KCH Only
**Awaiting confirmation of inspection records/verifying asset data.*
-> Weekly FA testing non completed at QEQM/KCH/WHH
> Fire damper inspection and testing
-> Fire door inspections-significant investment required to repair/replace fire doors across the portfolio
->Annual Verifications-QEQM (x1)- scheduled for December

Progress
->Fire damper Survey & Inspection at WHH- Survey complete, remedial actions progressing.
Surveys commenced at QEQM. Project completion forecast March 24 for all sites.
->Fire Alarm Servicing tender- Open Tender- advertised
-> Lift Servicing & Maintenance tender (comprehensive cover)-advertised. Evaluated-to be awarded.

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REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Board Committee Terms of Reference (ToR)**

Meeting date: **5 June 2025**

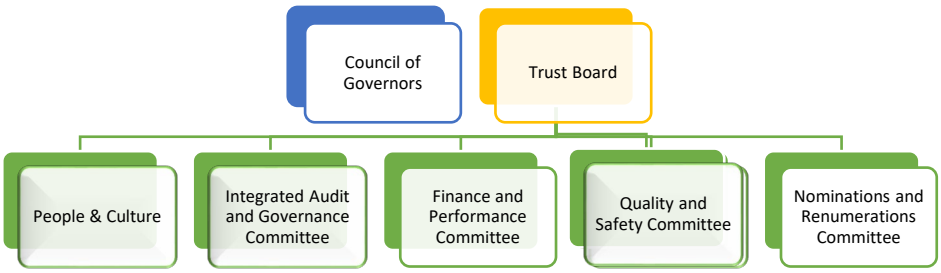
Board sponsor: **Director of Corporate Governance**

Paper Author: **Board Support Secretary**

Appendices:

Appendix 1: Nominations and Remuneration Committee (NRC) ToR
Appendix 2: Quality and Safety Committee (Q&SC) ToR
Appendix 3: Finance and Performance Committee (FPC) ToR
Appendix 4: People and Culture Committee (P&CC) ToR
Appendix 5: Integrated Audit and Governance Committee (IAGC) ToR

Executive summary:

Action required:	**Approval**
Purpose of the Report:	To present the Board Committee ToRs following review and approval at the individual Committee meetings.
Summary of key issues:	Building on the external Governance Review of December 2024 and the programme of work commissioned by the Board on governance improvement, the Board of EKHUFT instructed the Director of Corporate Governance to undertake Governance reviews of each Board sub-committee (the "**2025 Committee Reviews**") as part of EKHUFT's ongoing corporate governance improvement journey and to meet the requirements of the Committee ToR and our Constitution. **EKHUFT Committee Structure** 

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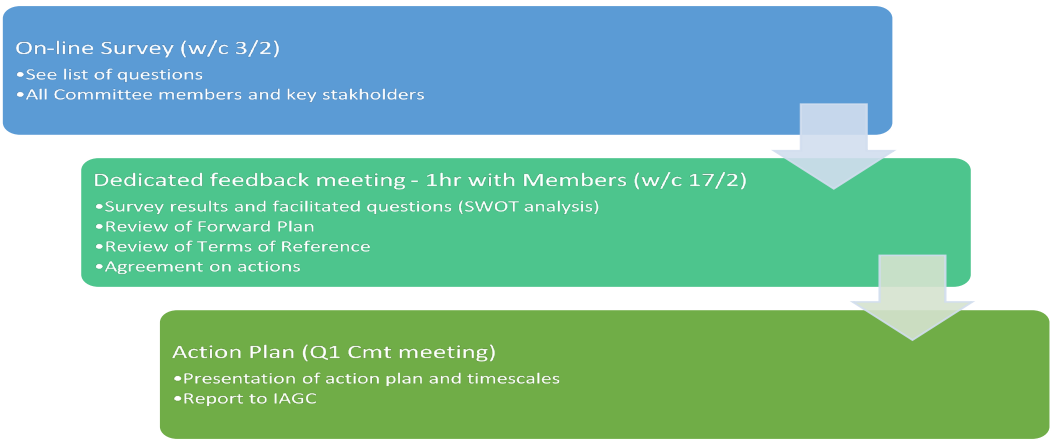
Methodology



Key recommendations:

An Action Plan was presented and agreed with each Committee and then presented to IAGC on 2 May.

EKHUFT COMMITTEE REVIEWS OVERVIEW			
Quality & Safety	**People & Culture**	**Finance & Performance**	**Nominations and Remuneration**
Follow up summary: 1. Terms of Reference reviewed and updated 2. Agreed updated work plan of committee 3. Frequency and cadence much improved 4. Consideration being given to length of meeting 5. Agreed need to enhance patient voice 6. Length of meeting pack identified as a challenge	**Follow up summary:** 1. Terms of Reference reviewed 2. Agreed updated work plan of committee 3. Agreed work of committee affected by change in CPO leadership but much improved with permanent CPO arrival in February 2025. 4. Frequency and cadence much improved 5. Work required on quality of papers 6. Also key to have People Strategy to drive assurance pathways	**Follow up summary:** 1. Terms of Reference Reviewed 2. Agreed updated work plan of committee 3. Agreed need to enhance digital and data assurance 4. Length of meetings to be kept under review and ensure time used most effectively	**Follow up summary:** 1. Terms of Reference reviewed and updated 2. Work to be done on Work Plan to meet expectations

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		7. Agreed need to enhance staff voice: additional items in workplan		**Integrated Audit and Governance** **Follow up summary:** 1. Terms of Reference reviewed and updated 2. Continue to monitor number and volume of papers 3. Continue to use external specialists for assurance.

Following the review of each Committee's ToR, updated versions are presented to the Board for approval. Outdated references to internal groups updated and changes in structure updated.

The Board of Directors is asked to **APPROVE** the following Board Committee ToR:

- NRC;
- Q&SC;
- FPC;
- P&CC;
- IAGC.

Implications:

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

Assurance route:

Previously considered by: Individual Board Committees

East Kent Hospitals University NHS Foundation Trust

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Nominations and Remuneration Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2 PURPOSE

2.1 The Nominations and Remuneration Committee is a Committee of the Board and fulfils the role of the Nominations and Remuneration Committee for executive directors described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

2.2 The Trust chairman and other non-executive directors and chief executive (except in the case of the appointment of a chief executive) are responsible for deciding the appointment of executive directors.

2.3 The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the chief executive and other executive directors including:

(i) all aspects of salary (including performance related elements/bonuses)
(ii) provisions for other benefits, including pensions and cars
(iii) arrangements for termination of employment and other contractual terms

2.4 To appoint and set the terms and conditions for subsidiary Board members and review any Key Performance Indicators/objectives/performance bonus. Receive a recommendation from the subsidiary Board and Nominations and Remuneration Committee on achievement against these.

2.5 To oversee the level of remuneration for executive directors and very senior management.

2.6 To agree and oversee, on behalf of the Board of Directors, performance management of the executive directors, including the chief executive.

2.7 Any proposed changes to the terms of reference will be approved by the Board.

2.8 The appointment of a chief executive requires the approval of the Council of Governors.

3. OBJECTIVES

The Nominations and Remuneration Committee is responsible for:

3.1 Establishing a process to identify suitable candidates to fill executive director vacancies as they arise and making recommendations to the chairman, the other non-executive directors and chief executive. Recommendations in relation to the chief executive position will be to non-executive directors only.

3.2 Considering nominations for executive directors and chief executive positions.

3.3 To set the remuneration and terms of service for the chief executive and executive directors with the support of independent advice as appropriate.

3.4 To ensure that individual executive directors have performance objectives and personal development plans, that are reviewed twice yearly. The review will also consider the capability of the executives as a team as well as at the level of individuals identifying any team development needs.

3.5 To include in its decisions all aspects of salary (including any performance related elements) and provisions for other benefits (including pensions and cars).

3.6 To decide on the appropriate contractual arrangements for executive directors, including a proper calculation and scrutiny of termination payments, taking account of legislation and such national guidance as is appropriate.

3.7 To ensure the Trust achieves proper control of the total remuneration paid to the executive directors by developing appropriate pay and reward policies for these posts. The Committee will ensure it has a clear statement of the responsibilities of the individual posts and their accountabilities for meeting the objectives of the organisation, a person specification for each post, a means of assessing the comparative job “weight”, with comparative salary information from the NHS and other areas and criteria and mechanisms for assessing performance.

3.8 To ensure the publication, in annual reports, of the total remuneration from NHS sources of the chief executive and executive directors.

3.9 To recommend and monitor the level and structure of remuneration for very senior managers. The definition of senior managers for this purpose will be determined by the Board and described in the Pay Policy for Very Senior Managers.

3.10 To receive an annual report on the application of the Pay Policy for Very Senior Managers from the chief executive.

3.11 Approve any non-contractual termination payments to staff in-line with the Trust’s Special Severance Pay Policy.

3.12 Annually reviewing the structure, size and composition of the board of directors and to make recommendations for change, where appropriate.

3.13 Evaluating the balance of skills, knowledge and experience of the board of directors and, in the light of this evaluation, preparing a description of the role and capabilities required for the appointment of executive directors and the chief executive.

3.14 Ensuring that appointments to the board of directors are based on merit and objective criteria as well as meeting the "fit and proper" persons test described in the Provider Licence.

3.15 Appointing a shortlisting and appointments panel for the appointment of executive directors and the chief executive.

3.16 Succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required on the Board to meet them.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The committee will be comprised of the non-executive directors, chairman and chief executive (except in the case of appointment of a chief executive). **Interview panel membership** will be determined by the Nominations and Remuneration Committee who will appoint from its members a selection panel, with the addition of the chief executive, where executive director appointments are being made. It may invite others as suitably qualified advisors as it sees fit.

Chair

4.2 The Chair of the committee will be the Trust chairman or non-executive director as determined by the Nominations and Remuneration Committee of the Board.

Attendees

4.3 The Chief People Officer (or representative) will attend in an advisory capacity.

4.4 The Chief Executive will attend (except when their own post is under discussion) and should attend when executive directors remuneration is discussed.

Quorum

4.5 Business will only be conducted if the meeting is quorate. The Committee will be quorate with four non-executive directors present. If the Chair is in attendance, this will count towards the quorum.

4.6 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved virtually by members and ratified at the subsequent meeting of the Committee.

Attendance

4.7 The Chair, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings.

Attendance by Officers

4.8 The Committee will be open to the Group Company Secretary to attend.

4.9 Other staff, or external advisors, may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote. Advisors to appointment panels do not have a vote.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the Committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work programme that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: Committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9. RELATIONSHIPS WITH OTHER COMMITTEES

9.1 Council of Governors' Nominations and Remuneration Committee.

9.2 The Committee will receive Chair reports from the Board Committees as required. To review and consider findings of significant assurance functions and the implications for the governance of the organisation.

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

10.4 The Committee will report on an annual basis to the Board of Directors on the work it has undertaken in the year and describe its work in the Annual Report.

Date Approved by Board:

East Kent Hospitals University NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors has established a committee of the Board known as the Quality and Safety Committee (the Committee). It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2. PURPOSE

2.1. The Committee is responsible for seeking and obtaining assurance on all aspects of quality and safety of care across the Trust (including the statutory and mandatory requirements relating to quality and safety of care). If not assured, the Committee will oversee the appropriate actions for improvement or escalation of relevant issues to the Board for consideration.

2.2. The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

3. OBJECTIVES

Quality Strategy and Performance

3.1. Oversee the development, implementation and communication of a Quality and Clinical Strategy with a clear focus on improvement, which draws on and benchmarks against ideas and best practice from external organisations.

3.2. Ensure that the Trust's Quality Strategy and performance are consistent with mandatory requirements and national guidance.

3.3. Oversee and seek assurance of an effective system for delivering a high-quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvement.

3.4. Oversee the effectiveness of the clinical systems to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards of quality and safety.

3.5. Ensure effective systems and processes are in place in order to be assured that there is systematic oversight of regulatory compliance with external bodies e.g. including but not limited to, the Human Tissue Authority (HTA), Royal Colleges and the Medicines & Healthcare products Regulatory Agency (MHRA).

3.6. Review Reports from Committees and Subject Matter Experts (SMEs) as per the Committee workplan

3.7. Review nursing and midwifery staff establishments and provide assurance to the Board that ward nursing and midwifery staff establishments provide an appropriate and safe staff level and skill mix to support the delivery of safe and effective patient care to patients.

3.8. Review the quality impact assessments for financial improvement, staff safety and wider health and safety requirements.

3.9. Receive reports on 'deep dives' from Care Groups on a rotating basis as appropriate.

Oversee an effective system for safety within the Trust, aligning with the National Patient Safety Strategy reporting principles of:

- Openness and transparency
- Just culture
- Learning and continuous improvement

Clinical Effectiveness, Outcomes and Improvement

3.8 Oversee an effective system for monitoring clinical outcomes and clinical effectiveness with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.

3.9 Obtain assurance from individual Care Groups that the Trust is compliant with guidance from NICE and other related bodies.

3.10 Obtaining assurance that the Trust is learning from deaths.

3.11 Receive the outcomes of participation in and learning from the national clinical audit programme and provide assurance to the Board that clinical audit supports the Care Groups to provide safe and clinically effective patient care.

3.12 To receive the draft annual Quality Report and Account and recommend the final version to the Trust Board.

Governance

3.13 Monitor the progress against actions to mitigate the quality and clinical risks on the significant risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

3.14 Review the controls and assurance against relevant quality and clinical risks on the Board Assurance Framework, provide assurance to the Board that risks to the annual objectives are being managed and facilitate the completion of the Annual Governance Statement at year end.

3.15 Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHS England, the Care Quality Commission, the Health and Safety Executive and other external assessors.

4. MEMBERSHIP AND ATTENDANCE

4.1 The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Chief Nursing and Midwifery Officer (Joint Executive Lead)
- Chief Medical Officer (Joint Executive Lead)
- Chief Operating Officer

4.2 Required Attendees:

- Director of Quality Governance

4.3 Attendees:

- A representative from the Kent and Medway Integrated Care Board
- A Patient Partner
- A Governor

Quorum

4.4 The committee will be quorate with four members, including at least two Non-Executive Directors, and one Executive Director. If the Trust Chair is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items

requiring approval may be approved virtually by members and ratified at the subsequent meeting of the Committee.

Attendance

4.6 The Chair and Lead Executives, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Others Invited to Attend

4.7 The Committee will be open to the Trust Chair, Chief Executive and Company Secretary to attend.

4.8 Other staff may be invited to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.9 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held bimonthly, ensuring quality assurance and quality improvement. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee has decision making powers with regard to the approval of clinical procedural documents.

6.4 The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the Committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair at least five days in advance of the meeting.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work programme that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair in collaboration with the Chief Nursing and Midwifery Officer and the Chief Medical Director.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: Committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive exception reports for scrutiny from the following meetings (minutes to be available to Committee members):

- Patient Safety Committee
- Fundamentals of Care
- Clinical Audit and Effectiveness Committee
- Infection Prevention and Control Committee
- Mortality Surveillance Steering Group

- Clinical Ethics Committee

9.2 The Committee shall refer (and have referred to it) from the other Board Assurance Committees (the Integrated Audit and Governance Committee, the People and Culture Committee and the Finance and Performance Committee) matters considered by the Committee deemed relevant to their attention. The Committee, in turn, will consider matters referred to it by those three Assurance Committees.

9.3 The annual work programme of the Committee may be reviewed by the Integrated Audit and Governance Committee at any given time.

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report to the Board outlining the activities it has undertaken throughout the year to be included in the Annual Report.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

APPROVED BY BOARD OF DIRECTORS:

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

1 CONSTITUTION

1.1 The Board of Directors has established a Committee of the Board known as the Finance and Performance Committee. It is a Non-Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2 PURPOSE

2.1 The purpose of the Committee is to maintain an overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. As well as maintaining an overview of the Trust's operational performance and activity. This will include: -

- Overseeing the development and maintenance of the Trust's financial and performance plans and medium- and long-term financial strategy;
- Overseeing the development of specific financial plans as may from time to time be required by system and regulatory partners including financial recovery plans, and other financial undertakings;
- To consider the requirements of Integrated Care System requirements on the Trust;
- reviewing and monitoring financial plans and their link to operational performance;
- ensuring that there is good triangulation between financial, performance, quality and safety and workforce plans;
- overseeing financial risk evaluation, measurement and management;
- scrutiny and approval of business cases and oversight of the capital programme;
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise;
- maintaining oversight of the Trust's performance against the contract activity plan;
- oversight and assurance of the Trust's delivery of its Digital, Data and Technology strategy; and
- maintaining oversight of the Trust's performance against the national standard and recovery trajectories.

3 OBJECTIVES

3.1 Financial Strategy

3.1.1 To consider the Financial Strategy, ensuring that the financial objectives are

consistent with the strategic direction and quality priorities.

3.1.2 To review long term financial models and strategies including the impact of the Integrated Care System.

3.1.3 To review annual operational plans including efficiency targets and savings projects.

3.1.4 To review key medium-term planning assumptions.

3.2 Monitoring Performance

3.2.1 Monitor the achievement of the financial strategy, and financial targets (including agency spend), associated activity targets and how these relate to the performance of the Trust in non-financial domains such as patient safety and effectiveness.

3.2.2 Monitor the trajectories for activity performance and financial performance.

3.2.3 Monitor productivity, cost improvement and savings targets.

3.2.4 Scrutinise financial and non-financial performance, trends, projections and underlyingdata on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.

To oversee the development of financial and non-financial performance reporting, to include:

3.2.5 Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.

3.2.6 Structuring monitoring reports around the key performance statements.

3.2.7 Developing high level metrics to focus the Committee on areas where corrective action may need to be developed.

3.2.8 Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions.

3.2.9 Monitoring agreed actions.

3.2.10 To consider the annual reference costs and review profitability analyses.

3.2.11 To review the annual accounts prior to IAGC and Board approval.

3.3 Financial Risk Management

To review financial risk and advise the IAGC and Board accordingly:

3.3.1 Review and evaluate key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity.

3.3.2 Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Executive Risk Review Group).

3.4 Business Case consideration and Capital Programme management

3.4.1 To perform a preliminary review of proposed major investments.

3.4.2 To establish the overall controls which govern business case investments, using best practice guidance required and/or recommended by regulators and commissioners on, inter alia, Capital regime, investment and property business case approvalguidance for NHS Trusts and Foundation Trusts, and to approve the Trust's Business Case Procedure. In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases.

3.4.3 To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.

3.4.4 To ensure testing of all relevant options for larger business cases prior to detailed workup.

3.4.5 To focus on financial metrics within cases e.g. payback periods, rate of return etc.

3.4.6 Review the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

3.5 Commercial Income

3.5.1 Ensure new income generating opportunities from non-clinical activities are identified, appropriately vetted and safely implemented.

3.5.2 Ensure mechanisms are in place to provide assurance that all income generating projects are implemented timely and safely.

3.5.3 Review current income streams from all non-clinically related activities.

3.5.4 Ensure a database of all contracts and service agreements are in place and updated regularly.

3.5.5 Benchmark the Trust's commercial income against other NHS providers.

3.5.6 Receives assurance that commercial opportunities are being identified and acted upon.

3.5.7 Ensure that robust processes are followed, to evaluate, scrutinise and monitor implementation of income generating opportunities so that benefits realisation can be confirmed.

3.5.8 Commission internally supported market opportunity reviews.

3.6 Other Matters

3.6.1 To provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge.

3.6.2 To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.).

3.6.3 To develop the Trust's Treasury and cash management policies in line with best practice guidance required and/or recommended by regulators and commissioners on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.

3.6.4 To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust and/or developments in thewider statutory/regulatory framework.

3.6.5 To oversee arrangements for outsourced financial functions and shared financial services.

3.6.6 To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The membership of the Committee shall consist of at least three Non-Executive Directors, together with the Chief Operating Officer, Chief Finance Officer and Chief Strategy and Partnership Officer. The Committee meetings shall be open to all the members of the Board of Directors.

Quorum

4.4 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chairman is in attendance, this will count towards the quorum.

4.5 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved virtually by members and ratified at the subsequent meeting of the Committee.

Attendance by Members

4.6 The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.7 The Committee will be open to the Trust Chairman, Chief Executive and Group Company Secretary toattend.

4.8 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4.9 The Chief Finance Officer will act as lead Executive Director for the Committee.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the Committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work programme that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: Committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

10 MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

Approved by the Board of Directors:

East Kent Hospitals University NHS Foundation Trust

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors has established a subcommittee of the Board known as the People and Culture Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2. PURPOSE

2.1 To provide strategic overview and board assurance in relation to all workforce, education, organisation and cultural development matters and identify any risks to delivery of the strategic objectives.

3. OBJECTIVES

3.1 Oversee the development and implementation of the Trust's People Strategy to include workforce, training & education, organisational and cultural development strategies, ensuring the Trust has robust plans in place to support the delivery by staff of high-quality patient care and experience in a safe, appropriate and inclusive environment aligned to the Trust's strategic objectives.

3.2 Monitor delivery against the annual strategic objectives through the agreed set of key performance indicators and provide assurance to the Board.

3.3 Ensure the Trust has robust plans and forecasts to maintain safe staffing levels in all areas and is planning for workforce changes in the long-term (10 year horizon).

3.4 Seek assurance that the Trust is supporting colleagues to ensure educational needs, professional development, training, wellbeing and formal appraisals are meeting and exceeding required standards.

3.5 Oversee the development of a Trust-wide cultural change programme that underpins a safe environment for colleagues and patients, delivers exceptional outcomes for patients and engages staff to enable the Trust to become an employer of choice.

3.6 Seek assurances that the Trust is creating a workplace that supports and rewards positive behaviours and does not tolerate negative behaviours including bullying and harassment. Ensure staff feel they have the freedom to speak up and that the Trust deals with grievances, disciplinary matters and sickness absence in a timely and professional manner.

3.7 Seek assurances that the Trust is responding to national and local reports, recommendations and best practice guidelines, to optimise our workforce provision.

3.8 Ensure the Trust has mechanisms in place which provides assurance of its workforce models to which encompass emerging new roles and new ways of working to support delivery of the Trust's strategic objectives.

3.9 To ensure that the Trust has appropriate pay, reward and recognition schemes that are linked to the delivery of the Trust's strategic objectives, outcomes and desired behaviours.

3.10 Regularly review workforce-related strategic risks and seek assurance that effective controls are in place to mitigate such risk. Ensure the Trust Risk Register and Board Assurance Framework is updated regularly.

3.11 Provide assurance to the Board that the Trust it is fulfilling its commitment to address inequal experiences of staff and improve representation across all groups in the Trust; including ensuring the Trust is compliant with its legal duties under the Equality Act 2010 and the Public Sector Equality Duty (PSED). This entails adhering to and effectively demonstrating mandatory reporting on equality, diversity, and inclusion (EDI), as well as implementing actions to enhance the experiences of our workforce. Specific areas of focus include, but are not limited to, the EDI High Impact Actions, Workforce Race Equality Standards, Workforce Disability Equality Standards, Equality Delivery System, and Gender Pay Gap initiatives.

3.12 Seek assurance regarding the appointment of staff and implementation of systems and services that support the delivery of the Kent and Medway Medical School.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The Committee shall be appointed by the Board of Directors and shall comprise:

- Non – Executive Director (Chair)
- Non – Executive Director (Deputy Chair)
- Non – Executive Director
- Chief People Officer
- Deputy Chief People Officer
- Chief Nursing and Midwifery Officer
- Chief Medical Officer

Attendance by Officers

4.2 The Committee will be open to the Trust Chair, Chief Executive, Chief Finance Officer, Executive Director of Communications and Engagement, Associate Director of Medical Education and Director of Corporate Governance to attend.

4.3 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4.4 The Chief People Officer will act as lead Executive Director for the Committee.

Attendees

Quorum

4.5 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chairman is in attendance, this will count towards the quorum.

4.6 If the meeting is not quorate the meeting can progress if those present determine. However, no business shall be transacted and items requiring approval may be approved virtually by members and ratified at the subsequent meeting of the Committee.

Attendance

4.7 The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Voting

4.8 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The Committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the Committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work programme that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: Committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be available to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee can request minutes and reports for scrutiny from any relevant Trust committee to inform and assist its ability to fulfil these Terms of Reference.

9.2 The Committee will receive escalations from the Quality and Safety Committee and Finance and Performance Committee as risks and issues relating to workforce may be identified at these meetings in respect of quality, safety and finances.

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 A review will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

Approved by the Board of Directors:
Review Date: February 2025

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **6 May 2025**

Chair: **Dr Annette Doherty, Trust Chair**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

No new interests declared

Assurances received at the Committee meeting:

Agenda item	Summary
NRC Chair	• The Committee going forward will revert to being chaired by the Trust Chair – now appointed and in place - noting thanks to the Non-Executive Director (NED), Dr Andrew Catto, for his support and willingness to take on the chair role in the intervening period.
Matters Arising	• Following appointment of two NEDs to the Board, the Committee will continue to consider any skills, background and experience gaps on the Board as well as developmental opportunities in the form of non-voting Associate NED roles. • The Director of Corporate Governance (DCG) will draft a role description for review by the NRC.
Very Senior Manager (VSM) Salary Review	• The Committee received **Assurance** from the VSM salary review report presenting 2024/25 salaries for Executive Directors and VSMs. • A more detailed report will be presented at the next Committee meeting following completion of an internal benchmarking review against local and national salaries. It was noted the outcome of the national benchmarking review was awaited. • The Committee discussed reviewing the NRC's Terms of Reference (ToR) confirming the Committee's role in considering and approving recruitment to VSM posts, salaries, pay uplifts, back pay, and establishment of new posts. • The NRC Terms of Reference (ToR) will be updated to reflect the need for VSM approval in the future by the DCG.
Succession Planning	• The Committee received **Partial Assurance** from the succession planning report, noting further detailed assessment to be

	undertaken reviewing internal succession pipelines, and identification of any gaps. • The Committee highlighted the opportunities around future talent, developing internal staff, talented staff in the local Kent & Medway system, as well as external recruitment to ensure robust succession planning. • The Committee will receive further updates on progress.
Annual NHS Fit and Proper Person Test (FPPT) Submission	• The Committee received **Assurance** from the annual FPPT submission report, and recommended the submission by the Trust Chair for 2024/25 by the 30 June 2025 submission. • The Trust Chair in liaison with the Trust's outgoing Acting Chairman will ensure completion and agreement with the individual NEDs of the 2024/25 appraisal paperwork.
NHS England (NHSE) New Board Member Appraisal	• The Committee received **Assurance** from NHSE's new Board member appraisal requirements and agreed the adoption of this approach for 2025/26 from 1 April 2025. • The Committee noted a review of the 360 feedback process will be undertaken for 2025/26 to ensure this was effective for all Board members.
NRC Chair's Action: 2gether Support Solutions (2gether) – Acting Chair Appointment	• The Committee received **Assurance** and noted the NRC Chair's action report of the appointment of Jackie Churchward-Cardiff (2gether NED) as interim 2gether Acting Chair.

Other items of business

- The Committee noted the 2025/26 Annual NRC Work Programme, and going forward quarterly meetings will be held.
- The Committee noted the Board Register of Interests.

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

Item	Purpose	Date
The NRC asks the BoD to receive and **NOTE** this assurance report.	Assurance	To Board on 5 June 2025

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting dates: **25 March 2025**

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

Paper Author: **Executive Assistant and Q&SC Chair, Dr Andrew Catto**

Quorate: **Yes**

Appendices:

None

Declarations of interest made:

None

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients • People
Link to the Trust Risk Register:	Quality risks on the Corporate Risk register were considered by this meeting.
Resource:	N
Legal and regulatory:	N
Subsidiary:	Y - Reference made to Spencer Private Hospitals (SPH) Care Quality Commission (CQC) inspection.

Assurance route:

Previously considered by: Q&SC 25/03/25 and minutes of that meeting approved at Q&SC 20/05/25

East Kent Hospitals University NHS Foundation Trust

Assurances received at the Committee meeting - focus on quality governance:

Agenda item	Summary
QUALITY GOVERNANCE REPORT (PATIENT EXPERIENCE, INQUESTS, CLAIMS, INCIDENTS AND CENTRAL ALERTING SYSTEM (CAS)	The Committee received the report and **NOTED** the following key updates: • 100% compliance with Duty of Candour (DoD) across all three components had been maintained for the second consecutive month. • The number of overdue incidents had increased to 988, with daily governance team support to handlers. A new Standard Operating Procedure (SOP) for Incident management was being drafted to be discussed with Care Group Triumvirates, to agree on the process and escalation timescales to prevent overdue incidents. • Overdue action completion was improving, women and children had the largest number of overdue actions, however, a new compliance midwife had recently been appointed. • Complaint response compliance continued to improve. • 103 (75%) National Institute for Health and Care Excellence (NICE) guidelines had been implemented, which was an improvement from the previous month of 63% (92) and exceeded the trajectory of 65%. • It was noted that a working group had been established to review the none Referral to Treatment (RTT) Patient Tracking List (PTL), as some patients were currently experiencing long waits for an appointment. • There was no SPH Data included within the report, however, work was continuing with SPH colleagues to meet the recommendations of the governance review.
ENDOSCOPY UPDATE	The Committee received and **NOTED** the report. • It was confirmed that Queen Elizabeth the Queen Mother Hospital (QEQM) care group would have single oversight of Endoscopy going forward.
PROGRESS AGAINST RECOMMENDATIONS FROM ASSOCIATION FOR PERIOPERATIVE PRACTICE (AfPP) REPORT - CRITICAL CARE, ANAESTHETICS AND SPECIALITY SURGERY CARE GROUP	The Committee received the report and **NOTED** the following key updates: • The AfPP returned in January and February 2025 to review practice with a view to request full AfPP accreditation of theatre standards on all three sites. To achieve accreditation all elements of the audit need to be assessed as green. • Kent & Canterbury Hospital (K&C) theatres were awarded accreditation, and an action plan was in place to achieve accreditation for both QEQM and William Harvey Hospital (WHH) and a further review was planned for May 2025.
MONTHLY SIGNIFICANT RISK REGISTER REPORT	The Committee received and **NOTED** the report. • A significant amount of work had taken place to work through the risk action plans.

	• It confirmed that Pharmacy risks were being discussed at a strategic level.
CARE QUALITY COMMISSION (CQC) UPDATE REPORT	The Committee received the report and **NOTED** the following key updates: • The Trust was due to receive the CQC Maternity Inspection results. It was confirmed that the maternity Section 31 notice would not automatically be lifted following the release of the results and a response was in preparation. • The Trust were also awaiting the SPH CQC report. • The Care Group check and challenge session were continuing, and the Care Groups were continuing to make improvements.
ASSURANCE REPORT ON COMPLIANCE AND DEMONSTRATING IMPROVEMENT LEARNING FROM DEATHS PROCESS	The Committee received the report and **NOTED** the following key updates: • Crude mortality was significantly lower than the last two years. • There had been small improvements in the number of Structured Judgment Reviews (SJR) being completed.
LEAD MEDICAL EXAMINER REPORT	The Committee received the report and **NOTED** the following key updates: • There was a reoccurring theme related to delays in biliary tract and gallbladder endoscopies, as we were unable to move patients around sites to access the service in a timely way. • There continued to be a theme related to corridor care and the Chief Analytical Officer was looking at the impact of length of stay in our Emergency Departments (EDs) on mortality. • The lead medical examiner was concerned that some patients were being made palliative too early on their journey and was investigating further. • Death from heart attacks and viral infections was being reviewed in detail and an update would be provided to Trust Board. • Numerically, the highest number of deaths were from respiratory causes, and the Trust was did not code highly for frailty.
REGULATORY COMPLIANCE GROUP CHAIR'S REPORT	The Committee received the report and **NOTED** the following key updates: • The purpose of the Regulatory Compliance Group was to bring all regulatory activity into once place, so they could be monitored effectively and as the process matured and triangulated. • It was noted that statutory and mandatory training compliance was a requirement of CQC well led inspection.
Q&SC EFFECTIVENESS REVIEW DISCUSSION	The key **outcomes** of the Committee Effectiveness review were as follows: • The length of the agenda, although it was noted the length of the meeting had reduced considerably over the last few years. • The Committee needed to identify and agree on improvement actions. • The Committee needed to agree on the balance between items coming to the Committee, the scope of the Committee and the length and regularity of the meeting.

	• The further meeting was arranged to work through the updates to the Terms of Reference (ToR) and work plan.
INFECTION PREVENTION AND CONTROL (IPC) REPORT	The Committee received and **NOTED** the IPC report. • There had been a notable improvement in *C-diff* infection rates. • The Trust was three quarters the way through the trial use ferrioxamine, and this was felt to have impacted *C-diff* infections. • *E-coli* infections were below the threshold. Environmental factors continued to be the focus of the team, and there had been marked improvements following the mattress audits and cleaning improvements. • There had been a 75% reduction in MRSA rates over the last year. • The had been several Norovirus outbreaks, the most notable at QEQM. • Hand hygiene and infection control training compliance remained high. There had been a drive in recruiting hand hygiene champions within the clinical teams and the monthly hand hygiene audits were showing good results. • Surgical Site Infection (SSI) surveillance for fracture neck of femur rates had reduced. SSI surveillance was also taking place with maternity in coordination with the national team. • Further work was required to reduce antibiotic prescribing. Work was underway with the Doctor's Voice Group to recruit anti-microbial champions, with there being a specific focus on Emergency Medicine.
MATERNITY & NEONATAL ASSURANCE GROUP (MNAG) AND NEONATAL DEATHS REPORT	The Committee received and **NOTED** the report. • The last Reading the Signals Group took place April 2025, after which the new Maternity and Neonatal Board would be established which would also incorporate MNAG. • The neonatal death review was a very detailed review carried out by an independent neonatologist, senior midwife and senior neonatal nurse. A detailed review took place for each case and prior to the review all the families were written to and now the review had been completed, the care group leads would meet in person with each of the families prior to the report going to Trust Board. • It was noted that there continued to be issues with culture within the neonatal team in relation to how doctors and nurses worked together, and this needed to factor into any communications.
SAFE STAFFING/ ESTABLISHMENT REVIEW – DEEP DIVE	The Committee received and **NOTED** the report. • It was recommended that the safe staffing establishment review is sent to Trust Board for review. • The review used the latest national guidance in combination with professional judgement.
INTEGRATED PERFORMANCE REVIEW (IPR)	The Committee received and **NOTED** the IPR.

East Kent Hospitals University NHS Foundation Trust

PATIENT EXPERIENCE COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Patient Experience report.
MORTALITY SURVEILLANCE & STEERING GROUP (MSSG) CHAIR'S REPORT	The Committee received and **NOTED** the MSSG report.
CLINICAL AUDIT AND EFFECTIVENESS CROUP (CAEG) CHAIR'S REPORT	The Committee received and **NOTED** the CAEG report.
PATIENT SAFETY COMMITTEE (PSC) CHAIR'S REPORT	The Committee received and **NOTED** the PSC report.
SAFEGUARDING COMMITTEE ASSURANCE REPORT	The Committee received and **NOTED** the Safeguarding Committee report.

Referrals from other Board Committees:

None.

The Committee asks the BoD to discuss and **NOTE** this Q&SC Chair Assurance Report.	Assurance	5 June 2025

Dr Andrew Catto
Chair Q&SC

Version sent to BoD 27/05/25

East Kent Hospitals University NHS Foundation Trust

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

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

Meeting date: **29 April 2025**

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

Quorate: **Yes**

Appendices: **None**

Declarations of interest made:

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

Assurances received at the Committee meeting:

Agenda item	Summary
Committee Review	The Committee received and discussed the findings of the Committee Review Survey. The survey demonstrated that the members considered the Committee to be a key assurance and oversight Committee of the Trust Board in view of the current financial challenges and the expectations going forward. The discussion confirmed the view that the frequency of the Committee meetings should be maintained at once a month but there was a need to work on the agenda and papers to ensure meetings were effective. The Committee **APPROVED** the proposed changes to Terms of Reference (ToR) and **AGREED** to submit the updated ToR to the Board for approval (see separate Board agenda item).
Significant Risk Register (SRR)	The Committee received and **NOTED** the April SRR relevant to its remit. The Committee Chair sought assurance that the internal audit finding that staff felt they had not received enough training in relation to risk management was being addressed. The Chief Nursing & Midwifery Officer (CNMO) assured the Committee that risk management training has been delivered and more work is being done to educate and upskill more staff.
Review of FPC Board Assurance Framework (BAF) Risks	The Committee **NOTED** its BAF risks and ongoing work around correlating strategic objectives, strategy and risks. The Committee heard that review of organisation's risk appetite would be undertaken in the near future.
We Care Integrated Performance Report (IPR) (M12): National Constitutional Standards for Emergency Access, Referral to Treatment (RTT),	The Committee received the IPR operational metrics and in particular **NOTED** the following points: – In the year 2025/26 the reporting of 12 hours total time in Emergency Department (ED) will change in that only main ED activity (Type 1 activity) will be reported and the compliance target will be around 19.4% as opposed to 10.3% compliance currently.

Cancer and Diagnostics	– The focus of the Urgent and Emergency Care (UEC) Improvement programme is to ascertain what needs to be true to reduce the number of patients staying in ED for longer than 12 hours from 19.4% to <10% in 2025/26. – The Trust faces significant challenge in reducing the number of long-waiting patients focusing on 52-weeks goal, which is for the year 2025/26 is 1% of the total waiting list. – There has been an increasing demand issue around urological cancers which may affect the overall cancer performance. The Committee heard that the Trust was in discussion with system partners with regards to taking a number of new planned care referrals from East Kent to other planned care facilities where mutually agreed. The Chief Finance Officer (CFO) informed the Committee that there were discussions in the Integrated Care Board (ICB) around system-wide reallocation of resources to help with timely discharges.
Planned Care Recovery Update	The Committee received and **NOTED** the Planned Care Recovery report.
Month 12 Finance Report	The Committee received the Month 11 Finance Report and **NOTED** its content. The Committee commended the efforts to ensure that at Month 12, the Group had met the planned deficit of £85.5m (excluding Deficit Support Funding).
Annual Finance Plan and Cost Improvement Programme (CIP) Oversight and Assurance **Capital Update**	The Committee received the update on the Business Plan submission with the following points highlighted: – On the 27 March 2025 the Group submitted a net plan deficit of £12.2m deficit, after Deficit Support Funding of £52m. – The plan includes a CIP target of £80m. Included within this CIP target is an expected £29.1m share of an Integrated Care System (ICS) savings total of £118.5m. – The ICB will be providing an additional, non-recurrent support funding available from the region. This funding is approximately £15m and will be allocated to three Kent Trusts (EKHUFT, Medway and Dartford) in proportion to the net deficit they hold. It is an expectation that EKHUFT will receive around £5.6m of this additional funding. The Committee **AGREED** for the CFO to start implementing the Annual Finance Plan as it stands currently, recognising the necessity to manage CIPs delivery risks. The Committee received and **NOTED** the update on the additional capital bids submitted associated with the improvement of constitutional standards and critical infrastructure risk.
2024/25 CIP Delivery – Lessons Learned	The Committee received the report providing assurance on the lessons learned during the financial improvement journey over the period November 2023 to April 2025, and **NOTED** recommendations as to what EKHUFT would need to do to become a financially sustainable organisation that is able to best serve the population needs.

Spencer Private Hospitals (SPH): update on proposals for Board	The Committee received a verbal update on ongoing work being done together with SPH on productivity, opportunities and quality and **AGREED** to receive a detailed paper on SPH at a future Committee.
2gether Support Solutions (2gether) Update	The Committee received an overview of EKHUFT's contracting processes and procedures related to contracts for services and goods, which are in the main managed by 2gether on behalf of the Trust. The Committee heard details of the processes and safeguards and received assurance on this. The CFO is undertaking the procurement process review and will present the outcome to the Committee in June 2025.
Business cases: over £1.75m Requiring Investment £2.5m for Self-Funding. Capital Business Cases Over £1m	The Committee noted there were no business cases to discuss.
Capital Investment Group (CIG) Assurance Report	The Committee received and **NOTED** the CIG Assurance report.
Annual Accounts Overview	The Committed **NOTED** that the Draft Accounts had been submitted by the deadline and there were no significant issues identified.
Review of Trust's Standing Financial Instruction (SFIs)	The Committee discussed the proposed changes to the Trust's SFIs and **AGREED** for the changes to the SFIs to be presented to IAGC on the 2 May 2025.
Feedback to Board of Directors	The Board is asked to **APPROVE** the Committee's ToR (see separate Board agenda item).
Referrals to Other Board Committees	The Committee noted no referrals to other Board Committees.

Item	**Purpose**	**Date**
FPC asks the BoD to discuss and **NOTE** this FPC Chair Assurance Report.	Assurance	5 June 2025

East Kent Hospitals University NHS Foundation Trust

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

Committee: People & Culture Committee (P&CC)

Meeting date: 13 May 2025

Chair: Claudia Sykes, Non-Executive Director

Paper Author: Claudia Sykes

Quorate: Yes

Appendices: None

Declarations of interest made: None

Assurances received at the Committee meeting: See below

Agenda item	Summary
Board Assurance Framework (BAF) risk: recruitment and retention **Recruitment**	The Committee received a report on staff recruitment with some encouraging data. Progress was being made on many hard to fill consultancy posts, such as in the Emergency Department (ED), which had seen a number of consultants join recently. The Trust was still awaiting new midwifery recruits, expected to join in July and this would fill most of the vacant positions. There remained challenges around Health Care of Older People (HCOOP) staffing. The Committee noted the excellent work done on Time to Hire. The Trust's time to hire was 7.82 weeks in March 2025, better than the NHS England target of 8 weeks, and the best within Kent and Medway. Overall agency usage in 24/25 was down 48% compared to the previous year. This, along with bank staffing, remains a priority area for significant further reductions as part of the 25/26 financial plan. The Committee was **ASSURED** of the work being done on recruitment.
BAF risk: recruitment and retention **Staff retention**	The Trust vacancy rate was 7.8%, the lowest it has been in two years. Both nursing and Healthcare support worker leaver rates had dropped, although it was also noted that some of this might be due to the national climate within the NHS. The Chief People Officer (CPO) explained the work being done as part of the response to the staff survey, working closely with Care Groups to target areas for improvement and embed accountability. Appraisal completion remained above the target of 80% for the fifth consecutive month. A deep dive on the quality of appraisals will come to the Committee in November.

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BAF risk: culture and values **Freedom to Speak up (FTSU)**	The new Guardian service started on 17 March. The Committee met with the new FTSU team, discussed their activities to promote the service, and reviewed the template report. A full report for the first quarter would come to the July Committee.
BAF risk: culture and values **Equality, Diversity and Inclusion (EDI)**	The CPO updated the Committee on work being done against the Trust's EDI objectives. The Committee reviewed specific data on recruitment for the first quarter of 2025. This showed that there was a clear adverse disparency between the numbers of white and Black and Minority Ethnic (BME) applicants proceeding at all stages of the recruitment process. BME applicants made up the majority of applicants in all three months, but had only a 63% chance of being longlisted onto interview compared with 94% of white applicants, with similar discrepancies from interview outcomes, and taking up roles. This meant that 16.5% of white applicants take up roles, and only 3% of BME applicants end up being successful and taking up positions. The Committee discussed these findings in detail. It was noted that training and support for managers to de-bias the recruitment process was vital, but also that this could only go so far. The Trust's staff survey for the last five years showed that this was an embedded issue. The CPO agreed that in some cases stronger action to address pervasive departmental management bias and discrimination would be needed.
BAF risk: organisational development and resilience	The new Director for Cultural Inclusion and Organisational Development presented her initial review of the Trust's Culture and Leadership Programme (CLP) to the Committee. The programme had established the new Staff Congress and Change Ambassadors. However, other areas had not been implemented as planned so far, and she was working on rejuvenating the programme. This included a focus on management training and development. The People Strategy would come to the Committee in July. The Committee asked that this include information on workforce demographics to allow for better succession planning and promote EDI, as well as a focus on skills needed for the future such as digital.

Other items of business: None

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

Items to come back to the Committee outside its routine business cycle: None

Items referred to the BoD or another Committee for approval, decision or action: None

Item	Purpose	Date
P&CC asks the BoD to discuss and **NOTE** this P&CC Chair Assurance Report.	Assurance	5 June 2025

East Kent Hospitals University NHS Foundation Trust

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

Committee: **Integrated Audit and Governance Committee (IAGC)**

Meeting dates: **2 May 2025**

Chair: **Dr Olu Olasode, Non-Executive Director (NED)/SID**

Paper Author: **Board Support Secretary**

Quorate: **Yes**

Appendices:

Appendix 1: Proposed Changes to Scheme of Delegation (SoD)

Declarations of interest made:

No additional declarations of interest were made

The Purpose of the Committee Terms of Reference (ToR) extracts:

The IAGC is the high-level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against CQC regulations.

Assurances received at the Committee meeting:

Assurances received through the Internal Audit function in accordance with the Public Sector Internal Audit Standards, 2013

Internal Audit –
• **May 2025 Progress Report**
• **Draft Head of Internal Audit Opinion 2024/25**
• **Internal Audit Strategy (Plan) 2025/26**
	• The Committee received ***Assurance*** and noted the **Internal Audit progress report**:
	• Six final audit reports issued since last IAGC including the following:
	  • **Financial Controls and Management – Grip and Control** – ***Partial Assurance***:
	  Lack of evidence supporting completion of the recommended management actions and these being implemented.
	  • **Payroll –**
	  Reasonable Assurance: robust system in place, with opportunity to further enhance and suggested developing an overarching Payroll Policy.
	  • **Virtual Wards –**
	  Partial Assurance:
	  Identified significant gaps in monitoring and governance arrangements, insufficient information to effectively monitor performance, and more work required to improve this.

	• **Establishment Control –** ***Partial Assurance:*** Good governance in place, areas identified for improvement, some ward areas over establishment, and inconsistencies with the approvals process. • **Business Continuity –** ***Partial Assurance:*** Identified significant gaps in management of this at Care Group and Service levels, and absence of finalised plans. Risk of failure with the removal of the Deputy role (no support to the Head of Emergency Planning and Resilience). • **Risk Management –** ***Reasonable Assurance:*** Reasonable progress implementing actions, significant progress ensuring monitoring of action deadlines, and generally improved awareness and understanding of risk management. • ***Good progress*** on follow-up of **management actions**, supported by Executive Leads in pushing actions forward. • The Committee reviewed and noted the **2024/25 Draft Head of Internal Audit Opinion:** Generally positive, in line with that issued the previous year, Trust moving in right direction, good progress being made (focusing on grip and control and outcomes). • The Committee considered and approved the **2025/26 Internal Audit Strategy (Plan)**, noted feedback received from Executive Directors and the IAGC Chair. • The Committee raised ***concern*** about the lack of assurance of the ***grip and control and establishment control arrangements*** in place. ***It referred the item to the Finance and Performance Committee (FPC) and also the People and Culture Committee (P&CC)*** to receive regular update reports on the grip and control and establishment control processes in place. This will provide assurance of review and monitoring of the effectiveness of these processes.

Assurances relating to the adequacy of Counter Fraud arrangement in line with the NHS Counter Fraud Authority's standards and requirements.

Local Counter Fraud Specialist (LCFS) RSM Risk Assurance Services LLP • **LCFS Annual Report: year ended 31 March 2025**	• The Committee received ***Assurance*** and noted the **LCFS Annual Report (year ended 31 March 2025)**. • The Committee received ***Assurance*** from the draft **Counter Fraud Functional Standard Return (CFFSR)** overall rating of green and approved this for submission.

• **LCFS Work Plan 2025/26**	• The Committee received ***Limited Assurance*** on progress to improve **compliance of staff required to make an annual declaration of interest.** Raised concern about the reliance on a manual process, noting ongoing work on actions to improve compliance and looking at other methods to support this. An update will be provided at the next meeting, as well as referral to P&CC to monitor progress of compliance as annual submissions requirement of staff terms of contract of employment. • The Committee received ***Assurance*** and approved the **LCFS Work Plan 2025/26.**

Assurances relating to the work and findings of the External Auditor and the implications and management's responses to their work.

External Audit Grant Thornton (GT): • **External Audit Progress Report and Sector Update** • **External Audit 2024/25 Audit Plan**	• The Committee received ***Assurance*** from the External Audit **Progress Report** and **Sector Update** and noted the **External Audit 2024/25 Audit Plan.** • ***Good position*** progressing work on Trust's annual audit, with financial statements provided, and sample testing already commenced. • ***On track*** to complete audit within the required timeframe.

Assurances relating to the integrity of the financial statements of the Trust, the Trust's financial performance, and significant financial reporting judgements contained in them, including the Annual Report and Accounts, and the systems for financial reporting to the Board

2025/26 Annual Plan	• The Committee received ***Assurance*** and approved the ***2025/26 Annual Plan***. • The Committee noted further additional **deficit funding support** allocated of £5.611m, resulting in reducing Trust's deficit from £12.2m to £6.5m, and gross deficit remained at £64.2m. • **Cost Improvement Programme (CIP)** target remained at £80m, current internal opportunity pipeline of £70.5m, schemes to be supported by Executive Directors. Risks remained in delivering the CIP, robust governance and architecture in place to support and monitor progress. • Plan to be further discussed at the Board of Directors (BoD) Strategy Session on 8 May. Plan reviewed and approved by FPC, who requested presentation of regular monthly update reports to include month by month CIP savings profile and progress against achieving the year-end target, along with cash flow forecasts.
2025/26 Priorities and Operational Planning Guidance – Board Assurance and Plan Overview	• The Committee received ***Reassurance*** from the Plan noting the significant progress made since the initial submission on 20 March, in moving from no assurance to partial assurance and working towards full assurance.

	• Plan discussed at the April 2025 FPC meeting, with further discussion at the 8 May 2025 BoD Strategy Session, following this the document will be updated and submitted centrally. The updated document will be presented at the next IAGC meeting.
Going Concern Review 2025/26	• The Committee received ***Assurance*** from the evidence the Group is a 'going concern' and agreed there were no material uncertainties that may cast significant doubt about its ability to continue over the next 12 months at the statement of financial position date.
Annual Accounts Process and Timetable 2024/25	• The Committee received ***Assurance*** and noted the 2024/25 Annual Accounts Process and Timetable by the required 30 June 2025 submission date.
Review of Accounting Policies 2024/25	• The Committee received ***Assurance*** and approved the 2024/25 draft accounting policies 2024/25.
Proposed Changes to Scheme of Delegation (SoD)	• The Committee received ***Assurance*** and approved the recommended proposed changes to the SoD and recommended these to the BoD for approval (appendix 1). • The Committee received A***ssurance*** ensuring a tighter approach around financial controls, the continued non-pay panel signing off expenditure above £500, noting these changes had been reviewed and approved by the FPC. • The Committee noted an ongoing broader review of Trust's Standing Financial Instructions (SFIs), and on completion the revised version will be presented to IAGC for approval.

Assurances received on the effectiveness of the Trust's integrated governance, risk management, and internal control (clinical and non-clinical) across the whole of the organisation's activities that support the achievement of the Trust's objectives.

Annual Report 2024/25 Draft (including Compliance against Foundation Trust (FT) Code of Governance) Annual Governance Statement (AGS)	• The Committee received ***Assurance*** and approved the first draft **2024/25 Annual Report and Annual Governance Statement** subject to any changes received by members of the Board and as a result of the ongoing audit. • The Committee noted excellent progress in completing the first draft that was close to completion of a finalised version. • Committee members will provide feedback on the draft version in advance of the final document being presented for approval.
Provider Licence 2024/25 – Annual Self-Declaration	• The Committee received ***Assurance*** and approved the **annual statutory declaration certificates** to the BoD and further submission to NHSE where required. • The Committee noted clarification was being sought that formal self-attestation submission was still required.

Quality Account 2024/25 – Progress Update	• The Committee received ***Assurance*** and noted the **draft Quality Account**, the arrangements for finalising and approving the final version. • The Committee noted the early draft, good progress being made to complete the contents, and on track for presentation through the Trust's required governance structure. • The Committee agreed following discussion of the updated version through the required governance structure, this will be circulated to IAGC outside the Committee prior to final presentation at the sign off meeting on 25 June 2025. • The Committee emphasised it was important to scrutinise and proof read iterative versions ahead of presentation of the final version for approval.
Escalations from 2gether Support Solutions (2gether)	• The Committee received ***Reassurance*** noting the **risks escalated** in respect of staff turnover and gaps in **2gether's** senior leadership team and Board, and gap in oversight. • The Committee noted ongoing progress to recruit a substantive Chair, identify a Trust NED as 2gether's NED in-common, and the upcoming gaps later in the year with the current two 2gether NEDs coming to their end of term of office. • The Committee noted the governance arrangements implemented providing the necessary oversight and continued progress to build open and honest working collaborative relationship. A report will be presented to the next IAGC meeting on the Trust and 2gether's governance structure.
IAGC Committee Review Results and Committee Review Actions	• The Committee received ***Assurance*** from the report on the responses to the **IAGC and Board Committee 2025 effectiveness surveys**. Agreed no changes required to IAGC's ToR, approving these for presentation to the BoD for approval (along with other Board Committee ToR) to be presented to June 2025 BoD. • The Committee noted the benefits of attendance from Executive Directors for discussion of specific items and advised consideration of this for future meetings. • The Committee noted positive feedback and assurance Board Committees working well, meeting their remit, with significant progress made and improved effectiveness of the FPC, Quality and Safety Committee (Q&SC) and People and Culture Committee (P&CC). • Positive feedback from Good Governance Institute (GGI) on the improved governance journey following their review refresh.

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Board Development Actions	• The Committee received **Assurance** from the **Board Development programme**, actions and timeframes for ongoing Board Development and review. • The Director of Corporate Governance will have a discussion with the substantive Chair on the approach to this programme, opportunities of Associate NEDs to address gaps in diversity representation and participation on the Board. • A review at the Board Strategy Session to be undertaken of Trust's Maturity Matrix. • The Committee highlighted stakeholder mapping and approach was a key area that needed earlier consideration than was currently identified for Q3. • The Committee emphasised the need for actions to be Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) to support robust monitoring of progress.
Revision to the Trust Constitution	• The Committee received **Assurance** and noted the revised Trust Constitution, approved by the BoD and Council of Governors (CoG), to be ratified by Members at the September 2025 Annual meeting.

Assurances relating to the adequacy of the Trust's internal controls (clinical and financial) and risk management systems, Board Assurance Framework, Corporate Risk Register risk and control related disclosure, the Annual Governance Statement, reports on the activities of the Executive Risk Assurance Group, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Board.

Significant Risk Register (SRR) Report	• The Committee received **Assurance** and noted the **SRR report and visibility of the key risks facing the organisation**. • The Committee noted 33 risks currently on the SRR (of which six with an extreme residual risk score of 20 and one new risk). • The Committee noted the annual Internal audit of risk management, rated ***'reasonable assurance'***, identifying sustained improvement, and progress against recommendations will be monitored by the Risk Review Group along with the action plan. • Escalation of overdue actions (associated with 16 of the risks) to the lead Executive Director to support provision of timely updates. • Team working closely with the Chief Strategy and Partnerships Officer (CSPO) to identify any 2gether risks being added to SRR.
Care Quality Commission (CQC) Update Report	• The Committee received **Assurance** from the **CQC Update Report**.

	• The Committee noted 5% of Must Do and Should Do actions remaining open from the 2023 inspections. Actions relating to Pharmacy staffing (business case produced being progressed through the Trust's governance structure), and Allied Health Professions (AHP) staffing (AHP workforce review being undertaken, outcome of report to be presented through Trust's governance structure). • Trust awaiting receipt of the final report following the unannounced inspection of Maternity Services in December 2024, delayed due to CQC operational issues. • The Committee highlighted a gap in receiving assurance of progress updates on Well Led inspection actions around learning, report to be presented at next meeting ensuring Board members appropriately briefed and prepared for any future Well Led inspections.

Assurances received on the adequacy of internal control arrangements, and all underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; including assurances on the adequacy of all policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting, self-certifications, and training requirements.

Board Assurance Framework (BAF)	• The Committee received ***Assurance*** and noted the **status of the Principal Risks in the BAF**, to continue to be reviewed and refined. • The Committee noted the agreement of FPC of the inclusion of a digital/cyber risk. • BAF Risk Ref: BAFSQC003 (experience of women and their families following the *Independent Investigation into East Kent Maternity Services (IIEKMS)*) updated expanding this beyond IIEKMS, risk to continue to improve experience of women and their families following the IIEKMS actions and other reviews. • The Committee Chair acknowledged the continued good work to improve the BAF.

Other assurance received in line with the committee's functions and regulatory compliance; including the findings of other significant assurance functions, both internal and external to the Trust, and considers the implications for the governance of the organisation. These includes, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, NHS England/NHS Improvement etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

Assurances received on the arrangements by which staff within the Trust may raise confidential concerns over financial control and reporting, clinical quality and patient safety and other matters.

Data Security and Protection Toolkit (DSPT) Submission 2024/25 - Progress Report	• The Committee received ***Reassurance*** and noted the DSPT Submission 2024/25 Progress Report. • Completed external audit in April 2025 highlighted five areas for improvement. • The Committee noted actions to address the Information Commissioner's Office (ICO) audit identifying area to address data retention and disposal. To ensure an effective process in place for timely appraisal and disposal of paper and digital records around adherence to the required periods for retention of personal data beyond required periods. • 22 open actions, two urgent, six high and 14 medium (seven items due for closure by end of May 2025, and 15 items on track for closure between June and December 2025). • Mandatory Information Governance (IG) training compliance target of 90%, current compliance at 89%, actions included targeted pop up messages to remind non-compliant staff to complete this training and improve compliance. • Continued work on toolkit for completion by final submission date of 30 June 2025, reviewing Trust's evidence and progress expected to achieve overall good rating of 'Standards Met'.
2025/26 Annual Programme for Clinical Audit	• The Committee received **Assurance** and approved the 2025/26 Clinical Audit Programme, noting ongoing monitoring of progress against this with regular updates presented to Q&SC and Clinical Audit & Effectiveness Group (CAEG). • The Committee noted alignment of the programme with the trainee doctors rotational period to support completion of audits prior to trainees moving on. • The Committee noted the programme included a total of 175 local audits, additional 88 National audits (52 mandatory, an increase from 40 the previous year).

Relationships With Other Committees

The Committee receive minutes for scrutiny from the following meetings:
- *Executive Risk Assurance Group*
- *Regulatory Compliance Committee*

The Committee will receive Chair reports from the Quality and Safety Committee, Finance and Performance Committee and People and Culture Committee, as required, to review and consider findings of significant assurance functions and the implications for the governance of the organisation.

Other items of business

The Committee noted the 2025/26 IAGC Annual Work Programme.

East Kent Hospitals University NHS Foundation Trust

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

Item	Purpose	Date
The Committee asks the BoD to discuss and **NOTE** this assurance report from IAGC.	Assurance	To Board on 5 June 2025.
The Committee asks the BoD to approve the recommended proposed Changes to the SoD.	Approval	To Board on 5 June 2025.

Scheme of delegation: proposal for tightening approval thresholds: requisitions and invoices and for payment

East Kent Hospitals University NHS Foundation Trust

The proposed changes seek to tighten the thresholds for approval to ensure there is strong financial control, while also streamlining the approach to senior sign off involved, also making reference to job roles as opposed to bands for greater clarity of responsibility.

Area	Current	Proposed
Approval of requisitions and invoices for payment		
Up to £500	Agenda for Change (AfC) 4	
Up to £1k	AfC 5	
Up to £5k	AfC 6/7	AfC Band 7/8a/8b – General Managers, Matrons, Service Managers
Up to £25k	AfC 8a/8b	Managing Director/Very Senior Manager (VSM) Deputy
Up to £50k	AfC 8c/8d	
Up to £100k		
Up to £250k	AfC 9/VSM	Executive Director
Up to £500k	AfC 9, VSM and Executive Director	
Up to £1m	AfC 9/VSM, Executive Director, Finance Director	Chief Executive Officer (CEO) and Chief Finance Officer (CFO)
Over £1m	Trust Board	Trust Board (no change)
Budget virement	As above - thresholds as above for approval of requisitions and invoices	As above - thresholds as above for approval of requisitions and invoices
Items below £5k not funded within Care Group budgets	Managing Director	Managing Director (no change)
Non-pay expenditure over £5k for which no specific budget set up and which is not subject to funding under delegated powers of virement	Managing Director and Director of Finance	Managing Director and Director of Finance, with thresholds for values set as above (e.g. if £100k, Exeutivec Director sign off required)
Approving payment of invoices in excess of tender/order price: 5% of order value up to maximum £50 per order	Payments Manager	Payments Manager (no change)

Proposal for tightening approval thresholds: signing orders and contracts

East Kent Hospitals University NHS Foundation Trust

Area	Current	Proposed
Signing orders and contracts		
Up to £2.5k	Assistant Buyer	No changes proposed at this time, pending CFO review of end to end Trust procurement process with 2gether Support Solutions (2gether) in May 2025.
Over £2.5k up to £5k	Buyer	
Over £5k up to £25k	Senior Buyer	
25 to 100	Category Manager	
100 to 250	Senior Category Manager, Head of Procurement	
Over 250k	Associate Director of Procurement and Managed Equipment Services, 2gether, 2gether Nominated Officer	

Points to note:

1) Further to review/agreement by Finance and Performance Committee (FPC) and Integrated Audit and Governance Committee (IAGC) of the proposed changes to the scheme of delegation within this document, CFO will carry out work to further improve the Standing Financial Instructions (SFIs) documentation, improving plain English usage and communication with the Trust to ensure the requirements are embedded successfully in the business.

2) In May work on the procurement to payment processes will be carried out between the Trust and 2gether team to review improvements to the current end to end process, with proposals for changes brought back to FPC and IAGC.

3) Work is also currently underway to simplify the mechanics of the Business case Scrutiny Group and policy communication, which will be shared with FPC when completed.

We care