East Kent Hospitals University NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING IN PUBLIC
MONDAY 18 JANUARY 2016
10:00 – 12:30

Please find attached the agenda for the next Council of Governors Public Meeting to take place at **Smith's Court Hotel, 21-27 Eastern Esplanade, Cliftonville, Margate, CT9 2HL**
(map attached)

AGENDA

*Refreshments available from 9.00*am

CLOSED SESSION: 9:15 – 9:45				
1	Pre-meeting of the Council of Governors	**Discussion**		All
MEETING HELD IN PUBLIC: 10.00 – 12.30 (Timing of whole meeting duration)				
2	Chair's Introductions		10 mins	Nikki Cole
3	Apologies for Absence and Declarations of Interest			
4	Minutes from the last Public Meeting held on 10 November 2015 and matters arising			
TRUST PERFORMANCE AND ACCOUNTABILITY: 10.10 – 11.40 (section timing)				
5	Chair/Non Executive Director Reports from Board and Board Committees:	**Discussion**	40 mins	Board Committee Chairs:
	• Board of Directors	**CoG 01/16**		Nikki Cole
	• Finance and Investment Committee	**CoG 02/16**		Satish Mathur
	• Remuneration Committee	**CoG 03/16**		Richard Earland
	• Nominations Committee	**CoG 04/16**		Sunny Adeusi
	• Quality Committee	**CoG 05/16**		Richard Earland
	• Charitable Funds Committee	**CoG 06/16**		Satish Mathur
	• Strategic Workforce Committee	**CoG 07/16**		Colin Tomson
	• Integrated Audit and Governance Committee	**CoG 08/16**		Barry Wilding
6	Performance:	**Information/ Discussion**	20 mins	
	• Performance Update	**CoG 09/16**		Nick Gerrard, Director of Finance & Performance Management
	• Clinical Quality and Patient Safety (CQPS) report	**CoG 09.1/16**		Sally Smith, Chief Nurse & Director of Quality
	• CQPS Scorecard	**CoG 09.2/16**		

	• Corporate Performance Report (CPR) Scorecard	**CoG 09.3/16**		
	• CQC High Level Improvement Plan	**CoG 09.4/16** **CoG 09.5/15**		Emma Kelly Quality Improvement And Cquins Programme Manager
7	Annual Quality Report – Overview of guidance from Monitor including arrangements for any local Indicator	**Presentation** **CoG 10/16**	20 mins	Helen Goodwin, Deputy Director Of Risk, Governance & Patient Safety

COUNCIL OF GOVERNOR GOVERNANCE: 11.40 – 12.25 (section timing)

8	To note appointment of Chief Executive Officer	**Verbal**	2 min	Nikki Cole, Chair
9	Council of Governor Committees – Reports from Committee Chairs:	**Discussion**		CoG Committee Chairs
	• Nominations and Remuneration Committee	**CoG 11/16**	5 mins	Philip Wells
	• Strategic Committee	**CoG 12/16**	5 mins	Dr John Sewell
	• Patient and Staff Experience Committee	**CoG 13/16**	5 mins	E. Lyons-Backhouse
	• Communications and Membership Committee	**CoG 14/16**	5 mins	Dr Philip Bull
	• Constitution Committee	**CoG 15/16**	15 mins	Alison Fox
10	Feedback from Governors who attend wider Trust Groups/Committees:	**Information**	6 mins	Governor Representatives:
	• End of Life Care Board	**CoG 16/16**		Margo Laing
	• Falls Steering Group	**CoG 17/16**		Sarah Andrews
	• Clinical Handover of Care	**CoG 18/16**		John Sewell

Note: The Cultural Change Steering Group, We Care Steering Group and Clinical Excellence Awards Committee have not met since the last meeting of the CoG. There is no CoG representation on the Nutrition Steering Group and Patient Safety Board. There is no report from the Sepsis Collaborative.

11	Feedback from Governors who attended training events:	**Information**		
	• Core skills	**CoG 19/16**	2 min	Jane Burnett/Robert Goddard

BUSINESS: 12.25 – 12.30 (section timing)

12	**QUESTIONS FROM MEMBERS OF THE PUBLIC**		5 mins	Please notify Committee Secretary of matters to be raised – deadline 48 hours before meeting
13	**ANY OTHER URGENT OR IMPORTANT ITEMS**			
14	**DATES OF FUTURE MEETINGS**	Attached		

RESOLUTION TO MOVE INTO PRIVATE SESSION
That pursuant to the Trust's Constitution the Council of Governors is moving into closed session. All members' of the public, including press, are to be excluded due to the confidential nature of the business to be discussed concerning contracts, negotiations and staff.

UNCONFIRMED MINUTES OF THE THIRTY SECOND MEETING OF THE IN PUBLIC COUNCIL OF GOVERNORS TUESDAY 10 NOVEMBER 2015 THE JULIE ROSE STADIUM, WILLESBOROUGH ROAD, ASHFORD, TN24 9QX

PRESENT:

Nikki Cole	Chair	NC
Carole George	Elected Governor – Dover	CG
David Boggard	Elected Governor – Staff	DBo
Debra Teasdale	Nominated Governor – Partnership	DT
Eunice Lyons-Backhouse	Elected Governor – Rest of England & Wales	ELB
Jane Burnett	Elected Governor – Ashford	JB
Jane Martin	Nominated Governor – Partnership	JM
John Sewell	Elected Governor – Shepway	JS
Junetta Whorwell	Elected Governor – Ashford	JW
Mandy Carlliel	Elected Staff Governor	MCa
Marcella Warburton	Elected Governor – Thanet	MWa
Margo Laing	Elected Governor – Dover	MLa
Matt Williams	Elected Governor – Swale	MW
Michael Lyons	Nominated Governor – Partnership	ML
Paul Bartlett	Elected Governor – Ashford	PBa
Paul Durkin	Elected Governor – Swale	PD
Philip Bull	Elected Governor – Shepway	PB
Philip Wells	Elected Governor – Canterbury	PW
Reynagh Jarrett	Elected Governor – Thanet	RJ
Sarah Andrews	Elected Governor – Dover	SA
Susan Seymour	Elected Governor – Shepway	SS

IN ATTENDANCE:

Alison Fox	Trust Secretary	AF
Christopher Corrigan	Non Executive Director	CC
David Baines	Deputy Finance Director	DB
Mark Angus	Deputy Chief Operating Officer	MA
Richard Earland	Non Executive Director	RE
Sally Smith	Chief Nurse & Director of Quality	SS
Satish Mathur	Non Executive Director	SM
Selena Moore	Ward Manager	SMo
Stephen Dobson	Foundation Trust Membership Engagement Co-Ordinator	SD
Valerie Owen	Non Executive Director	VO
Jane Cooper-Neville	Committee Secretary (minutes)	JCN

PUBLIC ATTENDEES:
There were no members of the public present.

Minute No:

CoG 50/15 **CHAIR'S INTRODUCTIONS**

NC welcomed Paul Bartlett to the Council of Governors.

CoG 51/15 **APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Apologies for absence

Apologies were noted from:

- Barry Wilding, Non Executive Director
- Geraint Davies, Nominated Governor - Partnership
- Chris Bown, Interim Chief Executive
- Colin Tomson, Non Executive Director
- David Hargroves, Consultant Physician
- Jane Ely, Chief Operating Officer
- Liz Shutler, Director of Strategic Development & Capital Planning
- Nick Gerrard, Director of Finance & Performance Management
- Paul Stevens, Medical Director
- Robert Goddard, Elected Staff Governor
- Sandra LeBlanc, Director of HR
- Sunny Adeusi, Non Executive Director
- Pauline Hobson, Elected Governor - Canterbury

Declarations of Interest

NC declared that she had been elected to the Board of East Kent Medical Services (EKMS).

CoG 52/15 **MINUTES OF THE LAST PUBLIC MEETING HELD ON 9 JULY 2015**

Minutes for accuracy

The minutes of 9 July 2015 were agreed as an accurate record.

Matters arising

<u>40/15 New Buckland Hospital Dover</u>
MLa asked for an update on when staff would be moving back to Deal.

NC said that this matter would not be addressed until the end of the year.

It was agreed to seek confirmation of the date of circulation of the recruitment and retention strategy. JCN

<u>40/15 Cultural Change Programme</u>
It was noted that the presentation by the Cultural Change Manager had been deferred.

<u>40/15 Monitor</u>
SA reported that in their closed session Governors had agreed that the Lead Governor would feed back to the Council on any contact with Monitor.

41/15 Finance and Investment Committee
The issue of the information requirements of governors will be addressed under item 8 (Establishing and Audit & Governance Committee). AF

43/15 Cultural Change Steering Group
PB reported that a decision had been made at the Cultural Change Steering Group that the issue of Mindfulness should be taken forward via Occupational Health (OH). PB would be meeting with OH on 16 November and requested that Mindfulness be included on the next Council of Governors (CoG) agenda at which point he will report back on progress. PB/ Secretariat

42/15 Communication and Membership Committee
PW expressed disappointment that at the latest road show 'Meet the Governors' had been the only exhibitor.

MCa clarified that it had been decided that to have other exhibitors would have distracted from the key focus of the meeting which was to discuss the Case for Change.

CoG 53/15 **PERFORMANCE UPDATE**

A&E Indicators

MA gave a brief update on the key A&E indicators.

The trust wide performance against the emergency 4 hour access standard for the first two quarters of the financial year was around 87% - 88%, with significant variations across sites. The aim is to get above 90% and then towards 95%; a strategy which has the support of Monitor.

The immediate focus will be to strengthen the trust's capability to move towards a clinically led site management and escalation model, working with system partners to achieve integrated discharge.

Council of Governors discussion:

JB asked why there was a variation in performance across sites.

MA highlighted the different challenges within the sites. For example, the challenges for WHH are to improve site management, escalation, performance of the emergency department and to become proactive rather than reactive. For QEQM it is about flow and the number of older people presenting and therefore the challenge is to support better integrated discharge. K&C is not so challenged.

JB asked what is being done at the 'front line' to address these issues.

MA said that the engagement of clinical staff with the weekly action plan meetings was in place and plans had been developed by the clinical teams.

PD pointed out that the planned closures of residential homes by Kent County Council (KCC) will impact on the trust's ability to achieve integrated discharge.

MA said that this emphasised the need for a systemic approach so that all of the partners across the local economy have a better understanding of the impact that the actions of individual stakeholders have on others.

PB highlighted the on-going use of prefab structures that house the CDU (Clinical Decision Unit) at WHH, these were intended to be temporary but have not been included in the list of priorities.

MA said that he was not aware of any specific plans linked to the CDU, he is looking at plans to develop the whole service.

PB said that the trust needed to make the 'front door' attractive to both staff and patients and governors need clarity about how this is going to happen. Estates

RJ questioned whether A&E staff are being given sufficient support to drive targets.

SS said that the trust has initiated a number of leadership initiatives at WHH and QEQM as part of the internal leadership programme. There has been a successful recruitment of staff to A&E at the WHH (making the staffing establishment stable), turnover at QEQM is higher and subsequently there remains a need to focus on leaderships support at this site.

JS highlighted the establishment of a number of 'whole systems' groups across Kent and requested information in relation to their governance and lines of accountability.

NC said that this matter would be addressed during the presentation to the CoG in January by the CCGs (Clinical Commissioning Groups).

PB asked whether the trust had responded to the Kent County Council (KCC) consultation on the future of residential care across the county and if it had could the submission be shared with the CoG.

NC said that the trust would be responding and that she would find out if the response could be shared with governors (see minutes 62/15).

CG asked how the issue of 'bed blocking' at the weekend is being addressed.

MA said that this relates to need for a whole systems approach to 7 day working; without 7 day integrated care systems the 'flow' of patients during the weekend will be restricted. He followed on to report that:

- At the end of October the trust had achieved a 92% compliance in 18 week referral to treatment waiting time; this he felt was a significant achievement
- Cancer performance remains a challenge (this is reflected nationally and a cancer task force has been set up to support improvement), the trust is meeting its 2 week target but this is placing additional demands on radiology and endoscopy.

CG sought assurance that the technological infrastructure is aligned so that it supports the efficient flow of patients through their respective pathways.

MA said that in relation to cancer, each team was in the process of mapping the patient pathway and this will enable them to monitor the patient journey against the respective standards.

JM questioned the compatibility of existing IT systems and suggested that the CoG PSE (Patient and Staff Experience) Committee look deeper into this matter.

High Level Improvement Plan – CQC Update

There were no questions in relation to the previously circulated presentation.

Financial Update

DB tabled a presentation providing a high level overview of the trust's financial situation.

A revised plan was submitted to Monitor on 13th October with a new projected deficit of £32.2M. Improvement would be very difficult but was based on:

- Improved clinical productivity/reduction in outsourcing (£1.5M),
- Additional winter funding (£2M),
- Further Agency/vacancy reductions (£1M)

In July the head lines were as follows:

- YTD the EBITDA position is now £5.2M deficit which is £0.1M behind the new plan
- Contract benefit is £3.3M YTD. Main drivers are penalty avoidance, lower than planned Surgery, Oncology and A&E activity
- The bottom line position YTD is a deficit of £20.1M (£0.1M behind plan)
- The new Consolidated Financial Stability Risk Rating FSRR is 2 (on plan) but capital service capacity rating and I&E margin ratings are only achieving a 1 rating
- Cash decreased by £5.3M to £13.3M. This was above the planned level due to slow invoicing from SERCO and higher than expected VAT reclaims

The main drivers of the deficit are:

- Agency/Staff flow spend YTD £14.6M:
    - Medical £7.3M
    - Nursing £3.8M
    - Spend in ULTC £6.8M and Surgery £3.8M
- Outsourcing Costs £5.1M YTD
- Additional Sessions payments £3.5M YTD
- CIP delivery needs to increase rapidly to deliver year end position:
    - £5.8M delivered in 1st 6 months
    - £10.4M required in 2nd 6 months

The following actions have been undertaken:

- PMO in place
- Review Balance Sheet
- Full Stock take
- Weekly cash flow
- Capital Spend Reductions £5m
- Asset sales £5m
- Ernst & Young report clinical productivity
- Financial Governance Report
- 15/16 plan reviewed and Agreed by Monitor
- 16/17 planning strategy
- Appointment of a Turnaround Director

In addition the following recovery actions will be implemented as part of the turnaround programme:

Short term:

- Budget scrape
- 10% management reduction review
- Band 8A recruitment "freeze"

Longer Term:

- Staff Recruitment/Agency Reduction
- EY benchmarking Review
    - Clinical efficiency (e.g. T&O, Vascular etc)
    - Targeted Reductions
        - Strategic Development
        - Hospital Meals
        - Modern Matron Review

Council of Governors discussion:

ML questioned the ability of the trust to make further reductions to the hospital meals service and asked how this would be achieved. He also asked for further information about the modern matron review. DB

DB assured members that all the actions listed within the CIP will be subject to a robust risk assessment and authorisation by the Medical Director and Chief Nurse.

PB was of the opinion that no other hospital is comparable in its structure to East Kent. He also suggested a re-fresh of initiatives to encourage staff to save electricity. This was agreed. Comms

JB referred the meeting to the written report provided by the Strategic Workforce Committee and requested that the CoG be provided be an update on the sickness absence project which could provide significant savings.

DB said that it was difficult to drill down to the precise cost of sickness absence to the trust, his gut feeling was that there would be scope for some savings but perhaps not as much as in other areas.

PW asked who will continue the work of the Turnaround Director when his contract is complete.

SM agreed to address this point in the Finance and Investment Committee (FIC) report.

PBa sought assurance that the trust's auditors were in agreement with the strategies being used to reduce the deficit and he also asked why the CCGs are withholding payment.

DB confirmed that the auditors were being consulted on the intended provisions.

He confirmed that a meeting would be held with the CCGs later in November discuss each outstanding area of payment.

DBo expressed concerns about the impact on well being and performance of a reduced cohort of managerial staff at a time when workload is increasing. He also questioned the whether the definition of the modern matron as contained within the Ernst & Young review was compatible with the role as carried out by modern matrons in EKHUFT.

DB as agreed that the trust needed to understand why EKHUFT has more modern matrons than its counterparts.

CoG 54/15 **CHAIR AND NON EXECUTIVE DIRECTOR REPORTS FROM BOARD AND BOARD COMMITTEES**

NC requested that NEDs assume that their reports had been read and to only provide a verbal update on additions to their report.

Board of Directors – Nikki Cole

NC reported that every second board meeting is now a development workshop rather than a business meeting. To date the workshops have been used to:

- Refresh the trust's vision and mission
- Participate in a risk management workshop and develop a risk appetite statement
- Participated in the 1st of a 2 day workshop looking at the role of directors
- Review the strategic objectives which will be undertaken on day 2 of the above workshop

All the work carried out will be presented to the board for agreement as necessary.

Council of Governors discussion:

JB asked if there is an available budget for bespoke training for governors.

AF said that she in discussion with NHS Providers to develop some 'in house' training for governors which will be delivered towards the end of March, once the full complement of governors is established.

Finance and Investment Committee – Satish Mathur

SM reported that the role of the FIC is to ensure that the trust has strategies in place to deliver the turnaround programme and associated delivery plans. The first stage in the turnaround challenge is to stabilise the trust's finances, with the cash position as the immediate priority. Each CIP will need a detailed action plan.

CG expressed what to her feels like an inherent contradiction between what the trust needs to achieve financially and its aspiration to provide high quality care, within a environment where the trust has little control over external factors, such as reduced funding and a shortage of skilled candidates for vacant posts. She suggested that the trust needed to get its situation in perspective and share the extenuating factors with the public.

Remuneration Committee and Nominations Committee – Richard Earland

RE highlighted the committee's decision not award a pay increase for executive directors in 2015/16 and that remuneration for new executive appointments would be based on the recent benchmarking exercise.

Going forwards the committee will need to align with the CoG Nominations and Remuneration Committee and report on the board self assessment of its effectiveness to Monitor by the end of January.

Quality Committee – Christopher Corrigan

CC summarised the topics that had been discussed the Quality Committee meetings in September and October as outlined in the previously circulated written report.

Council of Governors discussion:

DBo raised the issue of monitoring and enforcement of VTE compliance.

It was agreed that DBo and CC would discuss the development of the compliance action plan outside of the meeting.

Charitable Funds Committee – Valerie Owen

VO highlighted the fall in charitable donations by 31% and the discussion by the Committee about how it could further support the trust in managing its financial challenges. She asked the CoG to note that the CFC had agreed to the continued support for the Staff Long Service Awards but not the Christmas Ball. It was also noted that a review of the Committee's terms of reference will be discussed at its meeting on 13 November.

Strategic Workforce Committee – Richard Earland

RE reported that he had chaired the last meeting in the absence of Colin Tomson. He commended the work of the committee and the contributions of the Director of HR and staff in the finance department in supporting the work of this committee.

PW pointed out that on the bottom of p3 of the report there is a draft note that should have been removed.

Integrated Audit and Governance Committee – Valerie Owen

In the absence of Barry Wilding, VO asked the CoG to note the report.

Council of Governors discussion:

ML asked for some further detail of the potential stock write off of £900k within the Pharmacy department.

RE said that this related to medicines with a short shelf life and that the NEDs were still bearing down on this issue.

ML asked for an update on the outstanding IT network security access issue

identified in the report at the bottom of p2. AF

AF clarified that this matter had been closed and that she would provide the CoG with further detail of the action taken.

CoG 55/15 **ELECTION OF LEAD GOVERNOR**

AF referred the CoG to her previously circulated written report on the process and the outcome of the Lead Governor election.

She requested that the CoG endorse the appointment of Sarah Andrews as lead Governor and up to July 2016.

Council of Governors decision/agreed actions:

The CoG endorsed the appointment of Sarah Andrews as Lead Governor until July 2016. Agreed

It was agreed that the role of the Lead Governor be explored by the Audit and Governance Committee (pending agreement to establish such committee – see minute 56/15).

CoG 56/15 **ESTABLISHING AN AUDIT AND GOVERNANCE COMMITTEE**

AF summarised her previously circulated paper which provided the rationale for establishing a CoG Audit and Governance Committee.

Council of Governors discussion:

NC pointed out that the alignment of CoG committees with the board committees had been suggested by the late Brian Glew and that this proposal supported that strategy by integrating three existing committees.

ELB suggested that at some point the Patient and Staff Experience Committee could become a Quality Committee.

DT proposed that the existing Constitution Committee be convened to develop draft terms of reference for discussion by the CoG in the new year.

SA suggested that, if established, the Audit and Governance Committee should carry out the work of aligning the board and council committees.

JS pointed out that with the death of Brain Glew there would need to be a refresh of the members of the Constitution Committee.

Council of Governors decision/agreed actions:

The CoG agreed to convene the Constitution Committee to develop a proposed terms of reference for the Audit and Governance Committee for discussion by the CoG in January. Agreed

CoG 57/15 **COUNCIL OF GOVERNOR COMMITTEES – REPORTS FROM COMMITTEE CHAIRS**

Nominations and Remunerations Committee

PW requested that the CoG:

- Formally note the outcome of the electronic voting process appointing Gill Gibb, Sunny Adeusi and Ron Hoile as Non Executive Directors
- Endorse the proposal that Barry Wilding be appointed as Interim Senior Independent Director, pending further discussion by the Board's Nomination Committee on 18 November
- Note that governor alignment to hospital sites will be discussed in more detail by the CoG Audit and Governance Committee (if established)
- Endorse the recommendation that new NED remuneration levels be put in place from 1 November 2015 (back dated).

Council of Governors decision/agreed actions:

The CoG noted/endorsed the above as requested. Noted/ Endorsed

Strategic Committee

JS reported that a 3 further submissions sent to Monitor at the end of October had been circulated to governors and would also form part of the papers for the next Strategic Committee meeting to be held on 15 December. The main item for discussion at this meeting will the draft long term clinical strategy and the meeting will be open to all members of the Council.

In response to a request from JS, AF said that she would endeavour to provide a draft of the long term clinical strategy for circulation with the papers for 15 December. AF

JS said that he would welcome comments from governors on the draft strategy by 20 December

Council of Governors discussion:

NC pointed out that the document submitted to Monitor at the end of December will not contain a single options but rather four options for consultation. She also highlighted that the trust is having to develop a draft strategy ahead of those to be developed by the CCGs and as such she will need to take advice about what can be put in the public domain.

In response to a question from PB, NC reiterated that opportunity for governors to contribute to the draft strategy at their meeting on 15 December. She also pointed out that the Medical Director is contributing to the development of the draft.

Patient and Staff Experience Committee

ELB gave a resume of her previously circulated written report.

RJ reported that he had asked about the feasibility of remunerating part time staff that work overtime at an enhanced rate because he if of the belief that this would result in additional work being carried out by part time staff and

subsequently reduce the need for agency staff. He reported that the Deputy Chief Nurse is also exploring opportunities for part time staff to work more overtime.

CoG 58/15 **FEEDBACK FROM GOVERNORS WHO ATTEND WIDER TRUST GROUP COMMITTEES**

End of Life Board

SA reported that MLa will be taking her place as the governor representative on this board.

She commended the work of the board as an excellent example of all partners within the health economy working collaboratively.

Falls Steering Group

SA pointed out that the December board papers will contain an update on the latest falls data.

Cultural Change Steering Group

JB had nothing to add to the previously circulated written report.

PB drew members attention to the staff guidance on email etiquette and suggested that this be adopted by governors.

Council of Governors decision/agreed actions:

It was agreed that the reporting arrangements for this group to the CoG be considered by the Audit and Governance Committee (if established). Agreed

CoG 59/15 **FEEDBACK FROM GOVERNORS WHO ATTEND TRAINING EVENTS**

Governwell – Core skills

The report was noted.

CoG 60/15 **SCHWARTZ CENTRE ROUNDS**

SMo spoke to her previously circulated presentation and extended an invitation to governors to participate in future sessions.

Council of Governors discussion:

JM asked to what degree low attendance at the Schwartz sessions was a result of work pressures or resistance within some staff groups.

SMo replied that some professional groupings were more resistant to engagement than others and that leadership was the key to securing a more positive engagement.

CG commended the Scwartz rounds and asked how staff are supported to managed incidents that might have an emotional impact on a day to day basis.

SMo said that staff are regularly reminded of the services provided by Occupational Health and the helpline.

DT also commended the initiative and she took the opportunity to remind the CoG that within medical education there is a focus on building emotional resilience. She is of the opinion that effective clinical supervision provides the foundation for building resilience within staff.
JW said she was delighted to hear the extent of inclusivity and support for overseas staff to align their cultural experiences with that of the trust.

PB supported the Schwartz rounds as one tool, amongst others, that can support staff to deal with stress at work.

DBo suggested that a topic for a future round be for administrative staff.

CoG 61/15 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

There were no questions from members of the public.

CoG 62/15 **AOB**

Kent County Council Consultation on residential care

In response to questions from PD and CG, AF clarified that governors are welcome to participate in the ongoing consultation either collectively or as individual members of the public.

PBa request that governors be sent a copy of the trust's response to the consultation as soon as possible to allow the governors to consider a collective response in support of the trust or to respond as individuals. AF

CoG 63/15 **DATES OF FUTURE MEETINGS**

The previously circulated dates of CoG meetings in 2016 were noted.

Date of next meeting: Monday 18th January, Smith's Court Hotel, Margate

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING (PUBLIC) – 18 JANUARY 2016

ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING (PUBLIC) HELD ON 10 NOVEMBER 2015

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
40/15	9.7.15	**CEO AND PERFORMANCE UPDATE** **Cultural Change Programme** Presentation and full discussion on the work of the Cultural Change Committee. **New Buckland Hospital Dover** Seek conformation of the date of circulation of the recruitment and retention strategy.	Jane Waters JCN	10.11.15	Deferred – to be agreed. Closed – Strategy circulated 3.12.15.
ACTIONS FROM THE LAST MEETING HELD					
43/15	10.11.15	**MINUTES OF LAST PUBLIC MEETING HELD ON 9 JULY 2015** **Matters arising** <u>43/15 Cultural Change Steering Group</u> Receive update on Philip Bull's meeting with Occupational Health on the Mindfulness initiative.	PB	18.1.16	Ongoing - To be agreed.
53/15	10.11.15	**PERFORMANCE UPDATE** **A&E Indicators** Provide clarification to governors on strategies for making the 'front door' attractive to patients and staff.	Estates	18.1.16	Closed – see below examples of strategies: 1. Replaced the barrier matting in main and A&E entrances

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
					2. The above entrances are inspected at least twice per day for general cleanliness 3. Purchased new wheelchairs that sit in the entrances 4. Artwork/posters are monitored for appropriateness 5. All glass cleaned at least twice per year and then by exception 6. Seating has been re-enamelled 7. Serco installing new and up to date vending facilities. 8. The WHHS shop has been re-fitted.
		Financial Update Provide governors information about the modern matron review.	DB	18.1.16	Closed - Currently no action has been taken to review Modern Matrons. Instead a more general action has been put in place to control, the recruitment of all staff. All staff posts now have to be approved by a Vacancy Review Committee which reviews the justification to recruit any new or replacement post. Only if approved by the group can the post be appointed to. Replacements of Modern Matrons and all clinical and non-clinical staff all have to be approved by this group.
		Explore possibility of a re-fresh of initiatives to encourage staff to save electricity.	Comms	18.1.16	Closed – Top 5 energy/money saving tips included in Trust News during 2015 – Comms to review what has been and can be done.
54/15	10.11.15	**CHAIR AND NON EXECUTIVES DIRECTOR REPORTS FROM BOARD AND BOARD COMMITTEES** **Integrated Audit and Governance Committee** Provide CoG with detail of action taken to IT network security access issues.	AF	18.1.16	Ongoing - Progress had been made. The IAGC is due to meet on 19.1.16 and would receive an update on the actions taken.

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
57/15	10.11.15	**COUNCIL OF GOVERNOR COMMITTEES – REPORTS FROM COMMITTEE CHAIRS** **Strategic Committee** Provide a draft of the long term clinical strategy for circulation with the papers for the next Strategic Committee meeting – 15 December.	AF	18.1.16	Closed - Presentation given to open meeting of Strategic Committee on 15 December.
62/15	10.11.15	**AOB** **Kent County Council consultation on residential care** Share the Trust response to KCC consultation on the future of residential care across Kent.	AF	18.1.16	Ongoing – Awaiting update

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT FROM THE BOARD OF DIRECTORS**

REPORT FROM: **CHAIR**

PURPOSE: **Information**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This report provides the Council of Governors with the following information:

- An overview of items discussed at the Board of Directors meetings held in public since the last report.
- Proposal for reporting Trust performance to future Council meetings.

SUMMARY:

OVERVIEW OF ITEMS DISCUSSED AT BOARD MEETINGS HELD IN PUBLIC – DECEMBER 2015

Agendas and papers for Board of Director meetings held in public have been shared with the Council of Governors.

The following items were taken at the December Board of Directors and include a brief summary of the purpose. Full reports can be found on the Trust's website.

A copy of the minutes will be made available once approved by the Board.

Patient Story
The report described a poor patient experience, learning identified and actions taken. The report will be taken through the next available Council of Governors Patient and Staff Experience Committee.

Chief Executives Report
The report included and update on: Improvement Journey/CQC; Financial Recovery; Emergency Department Recovery Plan; Clinical Strategy Update; Performance Updates; Black History Month; We Care Trust Awards; Industrial Action; NSL Patient Transport Update; Chief Executive Activity (October and November 2015); and Trust Seal Activity.

CQC Report
The Board formally received the latest report from the CQC.

CQC Draft Improvement Plan
The updated plan is included on the main Council of Governors agenda.

EKHUFT Performance Reports
The latest performance is included in a report on the main Council of Governors agenda.

Risk Appetite Statement
The Board of Directors endorsed the Trust's risk appetite statements which had been developed at a recent Board Development Workshop. An example of a statement agreed is below, relating to "Reputational Risk Appetite":

> The trust has a **MODERATE** tolerance for risks to its reputation for financial management or quality of care. Risk taking should limited to those events where there is little chance of any significant repercussions for the organisation should there be failure. Mitigation should also be in place for any undue external interest.
>
> However, the trust has a **HIGH** tolerance for risks to its reputation arising from the implementation of a new clinical strategy, where the potential benefits outweigh those risks. The trust will prospectively manage its reputation in order to mitigate risks arising from decisions that have the potential to expose the organisation to additional scrutiny or interest.

Strategic Risks
The Board of Directors endorsed the Trust's strategic risks.

Medical Revalidation
A progress report was received.

Medical Director's Report
The report included an update on: HEKSS Deanery visit; Venous Thromboembolism (VTE) assessment; and Nasogastric (NG) tube never events.

Board Committee Feedback
Reports received at the December Board are included on the main Council of Governor agenda.

Board Committee Terms of Reference
The format of all Board Committee Terms of Reference has been standardised.

Paperless Board Update
The Board of Directors received an update on the procurement process to implement a system

PROPOSAL: PERFORMANCE REPORTING TO COUNCIL OF GOVERNORS

Given that the Board of Directors is now taking responsibility for specific aspects of performance updates via appropriate Board Committees, it is proposed that in future there would not be a separate performance update to Council of Governors except in exceptional circumstances.

The proposal, for Governors to consider, is for Board Committees to report the latest performance through their Chair reports to Council meetings and for the Chair to provide an overall performance update within her Chair Report.

Governors will continue to have access to the Trust's latest performance reports through the Trust website in the usual way.

The process will be kept under review.

RECOMMENDATIONS:

To note the report.

To agree the proposal to include performance updates within Board Committee Chair Reports rather than a separate agenda item.

NEXT STEPS:

Reports will be received at Council meetings.
Closed minutes will continue to be shared with Governors.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Board reporting links to all Strategic objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

Board reporting links to delivery of all annual objectives.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

N/A

FINANCIAL AND RESOURCE IMPLICATIONS:

N/A

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

N/A

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

ACTION REQUIRED:

To note and discuss the report**.**

CONSEQUENCES OF NOT TAKING ACTION:

N/A

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

REPORT FROM: **REPORT FROM THE FINANCE & INVESTMENT COMMITTEE CHAIR TO THE DECEMBER BOARD OF DIRECTORS (Meetings held on 3 November 2015 and 8 December 2015)**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE

The purpose of the Committee is to maintain a detailed 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. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan, delivery of any financial undertakings to Monitor in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance 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.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 3 NOVEMBER 2015

The meeting reviewed the following matters:

- Finance Performance for period ended September:
  - Plan re-submitted to Monitor 30 September indicates a deficit of £36.7M
  - YTD the loss is £1.2m adverse to plan at £18.2M.
  - The main driver for overspend remains heavy agency/locum spend
  - Cash is £18.7M, £0.8M above plan due to early VAT re-imbursement
  - Cash Forecast is still on plan for zero balance at year end.
  - Trusts FSRR (new Monitor measure of sustainability) calculation is 2 which is on plan. However Debt Service Cover and I&E Margin are only scoring 1
  - CIPs on plan in month but behind plan £0.3M YTD. CIPs delivered YTD £3.3M.
  - Capital largely on plan.

- There was a discussion of the approval of Monitor returns and accounts due to BOD meetings being re-scheduled. It was agreed the Trust Chair, FIC chair, FD and CEO would approve these returns via email on behalf of the board. The process for Final Accounts was to be covered once Monitor had issued a timetable.
- The FIC were updated via minutes on the conversations at the August Financial Recovery Group and Management Board.
- The Director of Finance and Performance gave a verbal update of the Financial

Governance action plan. There are 188 actions in the plan and external resource is needed to move the plan forward.
- The Corporate Planning and Performance Lead gave a presentation on the high level timescales for the 2016/17 business plan. The need for strong Divisional engagement and ownership was discussed.
- A proposal for the future strategy for Service Line Reporting (SLR) was discussed. The need for more use of SLR was agreed to aid the planning process and potential involvement in performance management.
- Progress on CIP delivery was discussed and there was a discussion about the focus on delivery required now the new Turnaround Director is in post. The Turnaround Director will now report monthly to the FIC and progress on CIPs is expected to improve.

MEETING HELD ON 8 DECEMBER 2015

The meeting reviewed the following matters:

- Performance for period ended October 31st:-
  Performance
  - Trust met 92% RTT target
  - Cancer targets are improving but 62 day waits are not yet achieved
  - Diagnostics are within waiting time limits
  - A&E performance is improving to just below 90%
  - Referrals are above plan
  - October activity in most areas is at or above plan

  Finance
  - To the end of October (month 7) the deficit is £22.6M
  - YTD EBITDA is a £5.5M deficit
  - The main driver for overspend remains heavy Agency/locum spend
  - Cash is £10.1M, £3.3M above plan.
  - The current cash forecast is still for a zero balance at year end
  - Trusts FSRR (new Monitor measure of sustainability) calculation is 2 which is above plan. However Capital Service Cover, Liquidity and I&E Margin are only scoring 1
  - Capital is a little behind plan but is a phasing issue.

- There was a discussion about how the risk associated with Medical equipment replacement were being assessed and addressed.
- The group also considered the potential impact on beds and services over winter.
- The cash position of the Trust was discussed. The Trust will need to make an application to the Independent Trust Financing Facility for cash support in 2016/17.
- Going concern was discussed. Boards should review their future plans and disclose any issues which may impact the Trusts as a going concern. It was felt the board needed to review the position formally.

- There was a discussion led by the Turnaround Director. Areas discussed were:-
  - Rapid cost reduction focus is in 2 areas a) Agency reductions b) Budget scrape.

- The process of sign off of accounts was discussed and agreed
- 2016/17 planning process was discussed. 20 specialty planning meetings were being held. A timetable for discussion of the plan with COG has been agreed and the Trust was a pilot site for the new planning templates with Monitor.

- Backlog Maintenance was discussed. Risks were highlighted and the process of prioritisation of the maintenance outlined.
- Trust Demand and Capacity Planning was presented. The methodology was presented and the process of closing the gap between demand and capacity was flagged. The committee welcomed the new approach.
- The Information assurance board was discussed. The board is new and came about as a result of Governance reviews post CQC. It covers data quality and data related projects such as PAS changes.
- A verbal update on the Financial Governance action Plan was delivered identifying the process on reviews of SFIs, SOPs and Reporting. Restructuring of the Finance Department is under discussion. The plan progress will be reported back in February.
- The pro-forma Finance reports were discussed and the need for consistency was flagged.
- The FIC effectiveness survey was discussed. But it was felt that as the committee had changed so much this survey needed to be run again in 6 months.

TREASURY POLICY

The policy was reviewed by the Finance Committee in October with no changes. The policy was reviewed by the Integrated Audit and Governance Committee for control purposes at a meeting held on 19 October 2015.

In line with the Trust's Standing Financial Instructions, the Policy was recommended to the December Board for approval on recommendation from the Finance Committee.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Finance Committee.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

REPORT FROM: **REPORT TO THE DECEMBER BOARD FROM THE REMUNERATION COMMITTEE CHAIR: MEETING HOLD ON 16.11.15**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

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

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

To recommend the level of remuneration for Executive Directors and monitor the level and structure of remuneration for very senior management.

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

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 16 NOVEMBER 2015

Guidelines for Relocation and Associated Expenses

The Committee approved amended guidelines which had been revised to ensure equitability and to ensure the Trust's position was in line with its peers.

Mid Year Review of Executive Director Performance

The Committee received a report from the Interim Chief Executive on individual and collective performance of the Executive Team, in the context of the current climate and challenges faced by the Trust. The Committee had asked the Interim CEO to provide formal feedback to individuals.

The Committee would be looking to strengthen the performance review process in discussion with the new CEO when appointed.

Succession Planning

The Committee received a report providing details of the revised approach the Trust intends to take for executive directors and senior managers, by taking the following actions:

1. Reviewing key leadership and business critical posts;

2. Establishing employment basis of post holders;
3. Undertaking an assessment of retention risk taking into account impact on service delivery;
4. Identifying key talent / potential successors, taking into account diversity analysis (WRES);
5. Identifying and implementing primary development needs focussed on requirements to progress to next level (priority high risk retention and high impact on service delivery roles);
6. Development activities monitoring and review.

It is intended that the development activities will be incorporated into individual performance plans from January 2016 onwards.

Local Clinical Excellence Awards

Following the Trust's decision not to run local awards this year, a communication had been sent to Consultants.

Pay Terms and Conditions

The Committee noted a Pay Optimisers report was being developed by the Trust under the new Workforce cost improvement programme. A report would be received by the Remuneration Committee in March 2016.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Remuneration Committee**.**

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

REPORT FROM: **REPORT TO THE DECEMBER BOARD FROM THE NOMINATIONS COMMITTEE CHAIR: MEETING HELD ON 18.11.15**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

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

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.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 18 NOVEMBER 2015

Chief Executive appointment – proposal for induction

The Committee noted a comprehensive induction programme would be firmed up once a commencement date for the new Chief Executive had been confirmed. In addition, the Trust Chair would be looking to introduce a handover period.

Review of the balance, size, skills and composition of the Board

The Nominations Committee agreed for two reviews to be conducted.

Internal Self-Assessment

- An internal assessment would be conducted by the end of December 2015, externally facilitated.
- Non-Executive Directors were asked to review the criteria set out in the paper and send comments back to the Director of HR within seven days (26 November 2015).
- The outcome of the self-assessment would be shared with the CoG Nominations Committee in terms of any skills gaps around the Non-Executive Director component of the Board.

External Review

- An external review would be conducted on the same basis as the review undertaken by Deloittes in 2013.
- The Committee was keen for alternative providers to be explored.
- NC agreed to discuss the timescales with Monitor, taking into consideration new Non-Executive Director appointments, to ensure the full Board was fully operational prior to the review being conducted.

Outcomes of the reviews related to Board would be monitored by the Nominations Committee. Further consideration would be given to the role of the Strategic Workforce Committee in taking forward the outcomes of a review into Board effectiveness.

Non-Executive Director Commitments

The Committee agreed the Non-Executive Director composition of Board Committees, together with chairing responsibilities. The Committee also agreed Non-Executive Director alignment to Governor Committees. This is attached at appendix 1 for information. The membership would commence from 1 January 2015, once the new Non-Executive Director composition was fully in place. However, it would not preclude Non-Executive Directors attending their new Committees during the transition period.

As the Clinical Strategy develops, the Board of Directors would need to consider, through its committees (IAGC/Quality Committee) the quality governance was appropriate.

The Council of Governors would be reviewing its Committee structure which may result in a further review of Non-Executive Director alignment.

The Committee put forward recommendations to the Council of Governors for:

- Barry Wilding to be appointed as Senior Independent Director.
- Richard Earland to be appointed as Deputy Chair.

These recommendations were ratified.

The Committee also agreed Non-Executive Director alignment to hospital sites in line with the recommendation from the Trust's Improvement Board:

- Colin Tomson – Royal Victoria Hospital
- Satish Mathur – Kent and Canterbury Hospital
- Barry Wilding – William Harvey Hospital
- Richard Earland – Queen Elizabeth The Queen Mother Hospital
- Gill Gibb / Colin Tomson – Buckland Hospital
- Ron Hoile (Non-Executive Director commencing in January 2016) would liaise with the Medical Director and report back on specialty type issues.

The alignment would not preclude cross patch working and it was agreed to review effectiveness in four months' time. The Committee agreed further clarity was required about the role of the aligNon-Executive Director Non-Executive Director.

It was agreed that the Committee would review at a future meetings national guidance for specific Non-Executive Director responsibilities on Boards and to discuss alignment of the most appropriate Non-Executive Director (in accordance with skills and experience).

As a general point of principle, the Committee agreed to more flexibility around physical attendance at meetings and to make use of Skype and telephone conferencing facilities. The Committee agreed this should be the decision of the Committee Chair in accordance to the items to be discussed on the agenda.

Non-Executive Director Commitments would be shared with the Council of Governors.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Nominations Committee**.**

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **18 JANUARY 2016**

REPORT FROM: **REPORT TO THE DECEMBER BOARD FROM THE QUALITY COMMITTEE CHAIR: MEETINGS HELD ON: 04/11/15 & 09/12/15**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, , clinical audit; and the regulatory standards relevant to quality and safety.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 4 NOVEMBER 2015

National pre-existing diabetes in pregnancy audit

The Committee had recognised at a previous meeting the Trust had not participated in this audit and asked the Division to attend the meeting share the barriers.

The Committee heard that national audit requires clinicians to counsel and obtain written consent prospectively from pregnant women attending antenatal / joint antenatal diabetes clinics for care. It was suggested that this will add an additional 20-30 minutes to the consultation time.

The next NICE Implementation Committee meeting was devoted entirely to diabetes, including Diabetes in pregnancy. A plan has been put in place (led by a Senior Midwife) for systems to be in place to fully participate in this national audit from January 2016.

Additional audit resource has been provided by the Clinical Audit Manager to facilitate this.

An update report would be received by the Committee in three months' time.

Update on patient safety

There continued to be issues around misplaced NG tubes and a meeting with the Cortrak practitioners and the Nutrition Committee was planned to discuss the way forward. NHS England had recommended that EKHUFT carry out a review of Cortrak to demonstrate that its benefits were in the best interest of the patient. EKHUFT was also part of a group of trusts that were evaluating systems but in the meantime a standard operating procedure was in place.

VTE performance had significantly increased following a recent improvement drive across the Trust, further improvement is still required.

The challenges around provision of a 24/7 GI/bleed rota would be discussed at the next Patient Safety Board meeting.

Sepsis screening had been audited monthly for the last three months. As performance appeared to have plateaued focus had been placed back on this area.

Clinical Quality and Patient Safety Report
The Committee received the latest performance report. The report had been published on the Trust's website.

Update on Clinical Effectiveness: NICE Effectiveness Committee

This is a new committee formed in response to concerns raised by the 2014 CQC report concerning compliance with NICE guidance within the Trust. The Committee is chaired by the Medical Director and has met 5 times since April 2015.

Relevant NICE guidance is divided into specialty specific and cross-specialty guidance and a nominated clinical lead is sought / appointed. The lead is then requested to assess compliance against the guidance and advise of any exceptions.

Future reports to the Quality committee will detail areas of exception requiring action.

Quarter 1: Integrated patient experience and claims report

The Committee discussed the claims profile of the Trust and heard that this was not out of line with other organisations of this size.

It was noted that the number of claims had reduced but the reasons were not yet known. There were plans to produce a profile for each Division.

The Committee would continue to monitor on a quarterly basis.

Quarter 2: Performance against the Quality Strategy

The following highlights were reported to the meeting:
- Further work was required on the Friends & Family Test with A&E waiting times being a particular challenge.
- Green Rating was achieved re complaints and concerns standards.
- The Never Events standard for quality improvement was failing and would remain Red for the duration of the Strategy.
- The Green rating for 'A Great Place to Work' was welcomed; it now needed to be maintained and improved.

The Committee noted performance against access targets had deteriorated. Difficulties largely related to capacity in Urology and the 62 Day standard. Work was planned with the CCGs to understand differences between the areas.

GMC Report – Progress on actions

The Committee received the outcome following the GMC's visit to the Trust to assess training provided.

Reports from Governance Boards

The Committee received minutes from each Governance Board and each Divisional was asked to report areas of important business:

Clinical Support Services Division:
- A group had been convened to drive forward improvements relating to the transportation of the deceased to the mortuary.
- The Facilities team was addressing an issue to ensure timely transportation of samples to avoid expiry.

- Progress had been made on the move to the SaLT services being provided in the community.
- Chemotherapy e-prescribing was due to start in mid November for brain and breast cancer. Further work was required to integrate the Pathology system with e-prescribing although it would not impact on progress.
- The appraisal rate for Pharmacy appeared low but and had risen since the minutes were published. Bands 2 and 3 had achieved 100% compliance.

Surgical Services Division
The minutes were noted. However, no representative was present at the committee.

Specialist Services Division
- A maternal death had been investigated and the RCA was due to be signed off. This was a complicated case and the results of the post mortem were awaited.
- A trajectory was in place for competency of CTG monitoring. A continuous improvement had been evident.
- It was the intention to include audit as an agenda item at divisional level.
- Discussion of risks needed to be strengthened.
- Reporting upwards of health and safety incidents needed to be strengthened through reports scheduled routinely at Management Board, IAGC and Board.

Urgent Care and Long Term Conditions
- *C.difficile* continued to report below the threshold.
- There was a limited mental health service provided to the Trust which had impacted on the Division.
- Pressure ulcers had reduced since the last previous month.
- F&F data from discharged patients was low. Senior Matrons had been asked to identify a 'discharge nurse for the day' who would approach patients for data.
- Compliance for complaints was at 93% and rated Green..
- A rise in mortality in Cardiology would be investigated and a deep dive was planned.
- There was concern about capacity in Neurology and Gastroenterology, following a significant increase in activity.

MEETING HELD ON 9 DECEMBER 2015

Patient Safety

The key issues that were reported to the Committee were as follows:

Never Events re NG Tubes:
Following a decision to retain the Cortrak© system, an external Consultant had been engaged to assess the system's safety, terms of reference for this review have been agreed with the CCG Chief Quality nurse. All of the other actions from the NG tube assurance have either been addressed or are in process of being addressed, the CAS alert policy external review is awaiting receipt of nominations for Monitor approval from NHS England.
Consultant cover at K&C:
- HEKSS' original requirement for a Consultant to be present in the Emergency Care Centre 24/7 whenever Doctors in Training were admitting patients was not feasible and HEKSS have downgraded this request, subject to ongoing monitoring, to cover for Doctors in Training available for 12 hours a day.

Mandatory Resuscitation Training:
- Training for a number of people at a time was an effective use of time but was not recorded anywhere. There remained other issues of non recording. A review of workforce information via the HR systems was underway.

The Committee also received the last minutes from the Patient Safety Board together with a draft agenda for the next meeting for information.

Clinical Quality and Patient Safety

The Committee received the latest performance report. The report had been published on the Trust's website.

The following issues were highlighted:

- A category 4 pressure ulcer had been reported and the root cause analysis was underway. The deep ulcer panel was still in place and was robust and challenging.
- The national falls audit results had demonstrated that the Trust was slightly better than the national average. William Harvey Hospital continued to plateau and specific remedial actions had been identified.
- There had been a reduction in incident reporting, mainly driven by successful recruitment and the resultant reduction in use of agency staff.
- Although the Trust had achieved the national standard, the stretched target of 30 days remained but was proving challenging, with the average length of time being 42 days.

The Committee felt it would be beneficial for a dashboard with the key quality indicators to be added to the summary sheet in future. A review was planned to remove data that was no longer needed from reports.

Update on Patient Experience

The Committee received a report from the first Patient Experience Group meeting held on 19 November 2015. Agenda items included:

- Quarter two quality Improvement Strategy;
- Trust wide action plan from the Falls Prevention and Injury Steering Group;
- Report from the Pressure Ulcer Steering Group and Trust wide action plan.
- Concerns about the ordering and receipt of equipment at patients' homes were being addressed.

Update on Clinical Effectiveness

The Medical Director reported on two guidelines regarding myocardial infarction and prostate cancer. Discussion ensued regarding the role and deployment of the Cancer Nurse Specialists.

Endoscopy JAG Accreditation

Accreditation was withdrawn in August 2015 as a result of waiting time standards not achieving level A standard. Level A status requires 100% for all waiting time standards, with a zero tolerance approach.

A report was received by the Committee outlining current challenges and actions taken to identify solutions.

Concerns related purely to waiting times, largely due to an increase in demand and lack of available workforce which was a national problem and would be included in contract discussions. A business case was due for presentation to the Trust's Strategic Investment Group and the Management Board. The need for Surgery and Medicine to work together was stressed.

EKHUFT Clinical Divisions Clinical Audit Programme 2015/16 – Progress Report

A report was received on progress against the clinical audit programme for 2015/16. The report concluded it was unlikely the original list of topics set out in the plan will be completed. The current position is that the around half of the programme will not be completed.

The Emergency Departments were a particular hot spot but the Divisional Medical Director for Urgent Care and Long Term Conditions Division reported on improved engagement. An audit lead had been appointed for six months and audit now featured on every Divisional agenda. Discussions were underway with each of the specialties regarding their programmes. Consideration was being given to a 3 year rolling programme tied to quality metrics and CHKS had agreed to assist with the design of a programme, focusing on the challenged areas.

It was agreed that the number of audits needed to be reduced, following dialogue with Clinicians and Divisions.

The Committee welcomed a better understanding of the outcomes as a result of audits.

CQC Report – Quality and Safety Issues

The Quality Committee received a summary of the key findings from the latest CQC Reports. An agenda item is scheduled for the December Board meeting.

VTE Compliance

Compliance remained challenging with no enforcing mechanism, but it was believed that an improvement would evident when linked to e-prescribing. There was disparity between data reported via Qlikview and from VitalPac and electronic discharge notice. A monthly report was being provided to the Patient Safety Board. The improving trajectory has been covered in the Medical Director's report.

Lessons Identified from RCA Investigations

The Committee sought assurance that lessons learnt were being embedded; this was by use of the Divisional Change Registers and randomly selected deep dives by the corporate team. There is a monthly RCA panel at which completed RCAs, their actions and the necessary learning are reviewed.

Quality Impact Assessments

A report was received updating the Committee on assessments signed off by the Medical Director and Chief Nurse and placed on the Trust's cost improvement programme.
All were in the process of being signed off.

Surgical Claims Review 2014/15

The Trust's claims profile is reviewed quarterly by the Committee and was last reviewed in November 2015. At this meeting, it was agreed to bring a response to the surgical division's claims profile to the December meeting. It was intended to roll this work out to the other Divisions. National benchmarking data had demonstrated that EKHUFT's number of open claims was markedly lower than other smaller acute trusts and the Committee was assured that the Trust's level was appropriate.

Corporate Risk Register

The emerging risks were reported. Future reports would give a high level view of the mitigations or to reassure the Committee of control. There was concern that the new risk system to be procured only included the risk register and policy management and the ability to consistently track the progress of other action plans was an additional module.

External Visits – Update on Position of Outstanding Actions and Overview of Recent Visits

The Committee received a high level summary of progress against actions required following the issue of reports of external inspections/reviews.
The report also included external visits from April 2015 to November 2015.

Annual R&D Report 2014/15

The Annual report was received and the committee concluded 2014/15 was another highly successful year for R&D in EKHUFT. Highlights included:

- 2364 patients were recruited into National Institute for Health Research (NIHR) portfolio studies - a 41% increase on 2013-14.
- 79 studies given NHS R&D approval by the Trust. 50 were in the NIHR Portfolio,15 were clinical trials of investigation medicinal products (CTIMPs) and 14 were industry-funded/-sponsored studies.
- Staff achieved national recognition for their work including Dr Chris Pocock, Consultant Haematologist, Dr Emilia Duarte-Williamson and Dr David Stephensen
- A number of events co-ordinated by the R&D Department took place during the year. These included: a major awareness raising campaign & patient-public survey about attitudes to research, our annual symposium, and jointly hosted mini-symposium with KentHealth.
- Total income received on behalf of R&D during the year was £2.56m. Industry-derived income increased 18% to £823k.
- During 2014-15 financial year the Trust received £1.62m from NIHR/DH (via Research Networks and directly). This included £148,559 from DH Research Capability Funding.
- R&D oversaw distribution of funds totalling £54,581 to Trust staff via the Internal Projects Grant Scheme and funding for consultant and AHP sessions (1x 2 years x 1 PA; 1x 8 months x 1 PA; 1x 2 years x 0.2 WTE) via the Research Session Scheme.
- Our staff published 78 articles in peer-reviewed journals – equalling 2013-4.
- NHS R&D approval was granted within 30 days (from receipt of valid application) for 90% of NIHR Portfolio studies, meaning that the Trust achieved the target set down by the NIHR/DH. The median time to obtain NHS permission was 3 days.
- The Trust is the lead for a number of multicentre studies nationally and is the highest recruiter in one study and the third highest recruiter in another.

The Non Executive Directors welcomed conversations with R&D about any opportunities that required their support.

Reports from Governance Boards:

The Committee received minutes from each Governance Board and each Divisional was asked to report areas of important business:

The Committee received the following minutes from Divisional Governance Boards:

- Clinical Support Services Division - Risk & Governance Committee mtg – 13.10.15
- Specialist Services Division - Quality & Governance Board mtg – 19.10.15
- Surgical Services Division - Clinical Governance Board mtg -13.10.15

Urgent Care and Long Term Conditions
There was no October meeting held by this Division since the last Quality Committee meeting.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Quality Committee**.**

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT TO THE DECEMBER BOARD FROM THE CHARITABLE FUNDS COMMITTEE CHAIR – Meeting held on the 13 November 2015**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE

The purpose of the Committee is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy, specifically:-

- Develop the strategy and objectives for the charity for consideration by the Board of Directors
- Oversee the implementation of an infrastructure appropriate to the efficient and effective running of the charity
- Oversee the development and delivery of the fundraising strategy
- Oversee the charity's expenditure
- Oversee the charity's investment plans
- Monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements

Chairman's Summary of Meeting

1. Update by Cazenove on Investment Performance

1.1 An update on the strategy and performance of the current portfolio was presented by Portfolio Director Jeremy Barker, supported by the Portfolio Manager, Emily Monk.

1.2 Whilst Cazenove provided assurance that the Charity's investment performance was in line with other Charities, the Committee questioned the longer term underperformance of elements of holdings.

1.3 Cazenove agreed that some elements – mainly in oil, had underperformed they explained that this was a long term strategy which they ultimately believed would benefit the portfolio. They conceded that the current underachievement had gone on longer than anticipated, but did feel that they were right to continue to hold.

1.4 Other underperforming shares had been sold which should provide a better return against the benchmark towards the end of the financial year.

1.5 The managers referred to the diversity of the portfolio which was providing a yield of 3.2% at a medium level of risk.

1.6 The Committee questioned the fee structure and requested that future reports included all costs including third party costs which were not always reported since they were deducted at point of trade.

1.7 The Committee were advised that these costs were identified fully in the Charity Accounts.

Fundraising Update

2.1 The Committee were updated on the success of the Annual Great Kent Bike Ride and the decision to run this again in 2016.

2.2 Innovations for fundraising had been introduced including:-

- Challenge 500 – all wards and departments challenged to raise £500 by Christmas for the Dementia Appeal which would support their own area.
- Pennies from Heaven – scheme whereby staff were asked to donate the 'pence' from their pay directly to the Dementia Appeal. Further marketing to raise awareness and increase take up was planned as only recently launched.
- Additional places in Prudential Bike Ride – all of which had been allocated.
- Concert in aid of Dementia by P&O Choir was planned for May 2016 to coincide with Dementia Awareness Week.
- Opportunities to use Just Giving to purchase tickets for events was being investigated.

2.3 The Committee were advised that the Fundraising Strategy would be integral to the Charity Strategy a draft of which would be presented at the next meeting.

2.4 An Award to recognise charitable endeavours by members of staff was requested by the Committee to be included in the Trust Awards.

Finance and Expenditure Report

3.1 A summary of the assets of the Charity was noted as £4.5m as at 30 September and the Committee were advised of how the funds were held as either Divisional or Individual ward funds with some General Purpose Funds for each of the five sites within the Trust.

3.2 The Committee noted that there was a small endowment fund and some restricted funds with larger number but lower value, held in designated or 'earmarked' funds. There was only one totally unrestricted fund (Umbrella) which held the Reserves.

3.3 The reports identified 'committed' monies, but the Committee requested that this be shown in a more detailed breakdown of grants approved and those awaiting approval as well as specific funds held from legacies that were totally restricted.

3.4 The Committee recognised the significant increase in applications and discussed the pressures on the Charity to support the Trust whilst having a more defined approach to prioritisation of applications.

3.5 An update was provided on the sale of the three properties, one of which was completed with money in the bank. One property is under contract awaiting completion and the final property has been sold subject to contract. *(The Committee was subsequently made aware of a break in at this property which required immediate repair to secure the sale and prevent further damage.)*

4 Applications for Consideration of Support

4.1 In recognition of the request by the Committee at the last meeting, applicants seeking support for high value (£50k+) were asked to attend the meeting to present their case. This was the first time this Committee had taken such action and there was significant discussion around how this was to be taken forward.

4.2 There were three presentations made to the Committee and each application had its merits and defaults. Discussion centred around the process prior to applications being submitted to the Committee and members agreed to review this process with the Charitable Funds Manager for further discussion.

4.3 The three requests made to the Committee were agreed with provisions.

- Sonosite Ultrasound and Probe was approved at £38.6k from K&C General Purpose Funds

- The Cardiac Monitors with Atrial Fibrillation function were partially supported from specific funds from a Legacy for the Stroke Unit at WHH held in General Purpose Fund and from the funds held in their own Unit Fund. Application was for 10 monitors and the agreed total support of £37.6k from specific funds would purchase 4 monitors.

- A project to provide a separate suite at the QEQM for mothers who have to endure a stillbirth, was supported in full. The Committee agreed to immediately provide a grant of £70k, and noted that the staff had embarked on fundraising which had already raised nearly £10k and they were prepared to raise the additional £28k required to complete the project.

4.4 The Committee praised the staff for this undertaking and requested that the Fundraising Team provide support and sought Community and Grants from local businesses and Foundations to achieve the target in support of the staff.

4.5 Further information was to be sought from Stroke Consultants to determine the need and improvement to treatments and outcome for patients for consideration of further support for more Cardiac Monitors for the Stroke Unit at WHH.

5 Policies and Terms of Reference

The Committee noted that the Policies and Terms of Reference were due for review and updating. It was agreed that due to the change of Committee membership at the end of November and the introduction of a new Strategy for 2016-19, to recommend to the Trustees to extend the current Policies for a further six months to provide time to debate the changes required supporting a revised strategy.

COUNCIL OF GOVERNORS ACTIONS REQUIRED:

To discuss and note the report.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

REPORT FROM: **REPORT TO THE DECEMBER BOARD FROM THE STRATEGIC WORKFORCE COMMITTEE CHAIR: MEETINGS HELD ON: 23/10/15 AND 20/11/15**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

The purpose of the committee is to provide advice , and make recommendations to the Board of Directors on all aspects of workforce and organisational development, and raise concern (if appropriate) on any workforce risks that are significant for escalating.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 23 OCTOBER 2015

Draft Workforce Plan 2015/18

An outline of the workforce plan was received by the Strategic Workforce Committee in September 2015 and an update was presented to the October meeting. The workforce plan will support the Long Term Recovery Plan which will be developed and submitted to Monitor by 31st December 2015.

The Committee is reviewing the plan on behalf of the Board of Directors prior to submission to Monitor. Further iterations of the plan will be received. In reviewing the plan, the Committee will take into consideration:

- Assurances from the Executive Directors, in the absence of any guidance from Monitor.
- Recognition the plan will be developed in line with the long term recovery plan and long term clinical strategy.
- Comparisons to Trust peers.

In reviewing the plan as at October 2015, key observations included:

- Various programmes of work had commenced in the Trust looking at reduction in workforce, vacancy rates and job planning.
- The Trust was exploring different workforce models and evidence of workforce models applied in other organisations.
- The Committee requested further details as to the rate at which change can be implemented, progress against work programmes already in place and separation of what is being done and what is yet to commence.
- A request for more narrative around the workforce reduction, linked to the Trust's clinical strategy.
- The Senior Management Capability and Capacity to Deliver Programmes of Change Report was received. It was noted this would be submitted to Monitor with the Trust's workforce plan submission.

Heat Map for HR

A heat map was presented which would provide the Strategic Workforce Committee with an overview of workforce data to enable improved management and visibility. The Committee agreed the Chair of the SWC would work with staff and executives to support the further development of the heat map.

Cultural Change Programme Update: Draft Organisational Development Strategy

The Committee received a first draft organisational development (OD) strategy for EKHUFT. It uses an organisation development and performance model to analyse the external and internal environments of the Trust, and also to provide a framework for a three year OD strategy. At the date of the committee, the strategy was to be shared with the Executive Team for further development.

The Committee's feedback included the need to develop SMART objectives, implementation plan and costings.

The Committee requested an updated plan to the January 2016 meeting.

GMC Report

The Committee received the GMC Report following their visit as part of their regional review. Areas for exploration included: Patient safety, supervision, workload, rota design, handover, induction, support for doctors in training, quality management processes, equality and diversity, transfer of information, bullying and undermining, teaching and training, training and support for trainers, risk and issue management, relationship with the LETB and medical school, sharing of good practice.

MEETING HELD ON 20 NOVEMBER 2015

Staff from overseas

A written report was received by the Committee covering the following areas:

- How the Trust is supporting existing staff to manage the integration and impact of new staff from overseas.
- An outline of the cultural differences and how these will be managed
- How the Trust will support staff from overseas to understand the cultural norms in this country and within EKHUFT
- Gather feedback from agencies about how other Trusts support cultural awareness and help overseas staff to integrate

The Committee discussed the risks around retention of staff and to be clear about what else could be done and to gain assurance that the work was having an impact. The Committee requested a further update at its January 2016 meeting.

Workforce Plan 2015/16

The Trust's workforce plan had been submitted to Monitor on 30 November 2015. No feedback had yet been received. Each specialty had been tasked with producing a business plan. The Committee had agreed to invite those involved in the Emergency Department's plan to present it to the next (or subsequent) meeting, including their progress and timeline. The Division's HR Business Partner would also be invited to present best practice elsewhere.

GMC Report

The Committee received a copy of the Trust's action plan in response to the GMC review. The

GMC's review was of HEKSS and not solely EKHUFT but a major concern for the Trust was the capacity for Consultants to provide clinical supervision.

The Committee would be inviting the Trust's Director of Medical Education to its next meeting to discuss the challenges faced by the Trust and to identify any support required.

The Committee also discussed the benefit of a workshop on the impact of external reviews. This would be particularly useful for new Board members.

Demand and Capacity Modelling

As part of the Monitor undertakings, the trust has developed a comprehensive demand and capacity model.

The Committee received a report which demonstrated, at speciality level, areas where demand varies from substantive capacity. The specialty areas with capacity constraints are, in most circumstances, those already identified as having workforce force issues (including hard to recruit, team dynamics) and wider implications for contract negotiations.

Phase 2, covering how to close the gap and the workforce implications, would be presented to the January 2016 Strategic Workforce Committee meeting.

Cultural Change Programme Update

The Committee received a report providing a schedule of measures for the Cultural Change Programme and when the outcomes would be reported to future meetings.

The first report on outcome of the measures would be discussed at the April 2016 Committee meeting.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Strategic Workforce Committee**.**

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT TO THE DECEMBER BOARD FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE CHAIR: MEETING OF 19 OCTOBER 2015**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

The Integrated Audit and Governance Committee (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.

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

MEETING HELD ON 19 OCTOBER 2015

Risk Management Training for Senior Managers

This document provided the Integrated Audit and Governance Committee (IAGC) with an update of risk management training compliance for senior managers within the Trust.

Compliance with training for senior Managers improved last year following the initial report to the committee in June 2013. Compliance this year has fallen; however, there have been significant changes Executive Team and to the divisional director roles and current performance for this group may reflect the interim nature of some posts.

The Committee noted that mandatory training would form part of the induction process for non-executive directors going forward.

Information Governance Toolkit

The Committee noted the situation and the current position with the proviso this is a report at the six-month period. Compliance reported was now over 60%. Assurance was received by internal audit that this was an acceptable level at this point in time. Assurances were also provided mitigating actions were in place for areas currently reporting as red.

Corporate Risk Register

The Risk Register as at 30 September 2015 was received by the Committee. The following updates were noted as at this date:

New – added formally	Two	• Provision of general surgical cover to the Kent and Canterbury Hospital • Potential patient safety risks associated with a

		backlog in patient follow up in Ophthalmology – on divisional risk register
Reduced	None	
Increased	None	
Substantially changed	None	
Removed	None	
New – not yet added	Four	• Repatriation of non-European nurses earning <£35,000 annually – proposed for HR risk register • Compliance with VTE recorded risk assessments • Loss of JAG accreditation in endoscopy • Patient safety risks associated with a reduction in liaison psychiatry services.

The Board had agreed at an Away Day in September a complete revision of the risk register. Systems were being explored by the Trust. The 'Controls in Place' and 'Additional Actions' needed to be kept up to date and when the new system was running, a culture of using it daily as a live system would need to be engendered.

The BAF would not be progressed until the risks had been appropriately defined, and would map the assurances for each Annual Objective for the Board to review.

2014/15 Clinical Coding and Costing Audit Update

The Trust was randomly selected for a 2014/15 coding and costing audit against the Payment & Tariff Assurance Framework. The audit was conducted by Capita CHKS on behalf of Monitor. Monitor's functions include developing, publishing and enforcing the national tariff, a necessary part of which is auditing the coding and costing information recorded by Trusts, which is used to develop the national tariff.

It was reported to the Committee that there were no surprises in the general findings of the clinical coding audit. Training and a dedicated coding validator had been put in place to help raise the standards and work was underway with the Urgent Care and Long Term Conditions Division on the quality of clinical documentation.

Clinical Coding:

The auditors concluded there was good engagement from the Stroke clinicians but was variable for other specialties. Problems identified related to:

- Difficult navigation of the case notes.
- The need to strengthen quality of case notes.
- Lack of documentation and depth of information associated with some HRGs.
- Inconsistent recording of diagnoses on the EDN

Reference Costs:

The overall Reference costs submission was deemed to be 'accurate' and the arrangements for completion were good in most areas of the Trust. The maintenance of records of the formal sign-off of the submission, however, was deemed to be poor. The processes for costing were generally found to be good, with no errors found in the detailed review. However, admitted patient care costing was noted as poor due to the level of errors found in the coding audit.

Losses and Special Payments Report to August 2015

The Committee received the latest report and the following was highlighted specifically:

The Aseptic Suite write-off figures included what would be termed as appropriate losses which would be expected due to the nature of the stocks, as well as other unexpected

stock write-offs. In future, for transparency, it may be wise to separate natural wastage and what could be considered culpable.

There were many redress payments shown and this may need to be monitored.

Single Tender Waiver Report 2014/15 Quarter 3 and 4

Based on Q3 and Q4, with comparison to the previous year, the report demonstrated a continuing increase in the number of STWs generated. Six months subsequent data was available and would be included in the next report to the Committee. Benchmarking data had also been requested for comparison.

The majority of the STW expenditure was in an area that was difficult to tackle commercially, with little scope to negotiate, but the Trust's Procurement Department and the Divisions had worked closely on them.

The Procurement Department continued to monitor and challenge STWs wherever possible.

Treasury Policy Review

The Policy was reviewed by the Committee from an 'internal control' perspective. The Policy would be formally reviewed by FIC and recommended to the Board for approval.

Pharmacy Aseptics Unit Briefing

The unit was on track to produce 275 aseptic products this month which was an increase. An inspection was due at the end of October. The report presented provided the following assurances:

- The aseptic unit is now preparing products in an safe and effective manner.
- The waste from the unit is now managed and controlled.
- The waste caused by clinical issues is recharged to NHS England.
- Active Weekly and Monthly monitoring is in place to give assurance
- Ongoing work includes increasing activity and responding to recommendations.
- The unit will be re-inspected at end of October when it is expected we will continue to meet quality standards
- Replacement of Isolator equipment in the unit needs to begin in 2016

Audit Reports

External Audit:

KPMG (External Auditors) presented a progress report and highlighted the following updates since the last IAGC meeting:

- The results of the Auditors work in 2014/15 has been presented to the Council of Governors Audit Working Group, including the financial statements and quality report audits.
- Work over the coming quarter will include continuing discussions with officers to inform the preparation of our 2015/16 audit plan.

Internal Audit:

Baker Tilley (Internal Audit) presented their progress report and brought the following to the attention of IAGC:

- The importance placed on the review around temporary staffing. Some work was planned on sickness absence and pre-employment checks, with follow-up work on temporary staffing scheduled for February/March 2016.
- Follow-up activity against audits was generally good, with the exception of the audit

around IT network access security. (This had been previously reported to IAGC). However, there was now movement and progress should have been made by the end of November.

Baker Tilley have issued a red rated report around temporary staffing, highlighting concerns with the use of unapproved agencies and the arrangements for rostering. It was noted that agency trajectories were discussed at each Executive Performance Reviews with Divisional Teams. Utilisation of e-rostering was a specific area of focus for the Trust.

Local Counter Fraud Progress Report

TIAA delivered their Counter Fraud progress report, which was noted. The Committee was encouraged by the number of reports being made which reflected the increasing open culture. A comparison of the level of reporting compared to the previous year would be available to the Committee next year.

There was concern about the high percentage of staff who stated in the Staff Awareness Survey that they had received no information about fraud. A slot for TIAA to attend staff induction meetings would be in place by the end of this financial year.

Committee Effectiveness

An annual review of effectiveness was undertaken and would feed into the overall work programme for the Committee. It was noted that there were a number of new members on the Committee. The same survey would be undertaken next year and comparisons would be made.

IAGC Work Programme

This was noted and comments sought from Committee members. It was agreed to formally review the work planner once the new committee structure has been embedded.

Any Other Business raised

Going Concern

The Committee has a role in reviewing the Trust's going concern position as part of the annual reporting cycle. A report has been requested to the January 2016 meeting in light of the Trust's current financial position to allow for early discussions around any appropriate disclosures that need to be reported.

Future Plans:

- The Committee will be discussing an internal audit against the Trust's whistle blowing policy.
- The Committee will be discussing appropriate reporting and monitoring of executive expenses for transparency.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the IAGC.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**18 JANUARY 2016**
SUBJECT:	**PERFORMANCE UPDATE**
REPORT FROM:	**DIRECTOR OF FINANCE AND DEPUTY CHIEF OPERATING OFFICER**
PURPOSE:	**Information / Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Performance metrics relevant to the Trust's licence and Monitor's Risk Assessment Framework (principally governance and finance) are distributed monthly to the Council of Governors at the same time as they are received by the Board of Directors. (Reports are also published on the Trust's website.)

SUMMARY:

Governors will therefore already have received the latest performance reports which were issued in December 2015.

The attached summaries are taken from the: Clinical Quality and Patient Safety Report; Key National Targets Report; and Corporate Performance Reports.

The full reports have been made available to the Board and Governors and can be found on the Trust website via the link below:
http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/our-performance/

RECOMMENDATIONS:

The Council of Governors are invited to note and discuss the report.

NEXT STEPS:

None. The metrics within this report will be continually monitored.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Clinical quality, the patient safety programme and patient experience underpin many of the Trust's strategic and annual objectives. Continuous improvements in quality and patient safety will strengthen the confidence of commissioners, patients and the public.

Governance AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This report links to AO1 of the BAF: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified clinical quality and patient safety risks are summarised in the attached report.

Standards are being closely monitored and mitigating actions are being taken where appropriate (in collaboration with the whole health economy).

FINANCIAL AND RESOURCE IMPLICATIONS:

Continuous improvement in quality and patient safety will make a contribution to the effective and efficient use of resources.

There is a financial penalty for not achieving targets.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Reduction in clinical quality and patient safety will impact on NHSLA activity and litigation costs.

Most of the patient outcomes are assessed against the nine protected characteristics in the Equality & Diversity report that is prepared for the Board of Directors annually. The CQC embed Equality & Diversity as part of their standards when compiling the Quality Risk Profile.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:
To discuss and note the report.

SUMMARY OF PERFORMANCE

KEY NATIONAL INDICATORS

A&E Indicators

Monitor Indicator and threshold:

	Threshold	Monitoring Period
Maximum of four hours from arrival to admission/ transfer/ discharge	95%	Quarterly

EKHUFT Performance 2015/16:

	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mch
Compliance	89.3 %	88.3 %	88.0 %	86.5 %	88.5 %	87.5 %		89.3 %				

Activity levels and performance against the emergency 4 hour access standard for November is broken down by site in the table below:

	Trust wide	QEH	WHH	K&C	BHD
Total Numbers attending A&E	16,386	5,600	5,965	3,658	1,163
Change from Previous Year	-2.03%	-4.53%	-0.43%	-6.06%	19.28%
Breaches (Numbers Not Seen within 4 Hrs.)	1,746	961	696	89	0
% met	89.34%	82.84%	88.33%	97.57%	100.00%
Numbers of 20-30 year olds	2,518 (15.37%)	821 (14.66%)	860 (14.42%)	654 (17.88%)	183 (15.74%)
Numbers of 75+	2,723 (16.62%)	950 (16.96%)	999 (16.75%)	704 (19.25%)	70 (6.02%)
Nursing Vacancies	23.72	B7 x 1 B5 x 4 B4 x 1.13	B6 x 1.54 B5 x 2.75 B4 x 2.80 B3 x 8.5	B5 x1	B6 x 0.5 B2 x 0.5
ED Middle Grades vacancies	12	7	5	N/A	N/A
ED Consultants vacancies	11.5	7	4.5	N/A	N/A

Referral to Treatment Waiting Time Performance

Monitor Indicator and threshold:

	Threshold	Monitoring Period
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted.	90%	Quarterly
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted.	95%	Quarterly
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	Quarterly

EKHUFT Performance:

Pathway	< 18 Weeks	> 18 Weeks	Total	% Compliance	52 Week Waiters
Non Admitted Pathway	7,726	776	8,502	90.9%	
Admitted Pathway	1,993	816	2,809	71.0%	
Incomplete Pathways	36,458	3,384	39,842	91.5%	3

Table 3.1 – RTT Position Compliance by Pathway (November 2015)

Cancer Performance

Monitor Indicator and threshold:

	Threshold	Monitoring Period
All cancers: 62 day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS cancer screening service referral	85% 90%	Quarterly
All cancers: 31 day wait for second or subsequent treatment comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	94% 98% 94%	Quarterly
All cancers: 31 day wait from diagnostics to first treatment	96%	Quarterly
Cancer: two week wait from referral to date first seen comprising: • All urgent referrals (cancer suspected) • For symptomatic breast patients (cancer not initially suspected)	93% 93%	Quarterly

EKHUFT Performance: Cancer targets – November 2015

	2ww 93%	Breast Symptomatic 93%	31 day 96%	31 day Sub Surg 94%	31 day Sub Drug 98%	62 day GP 85%	62 day Screening 90%
Q4 14/15	93.88%	95.29%	97.52%	96.62%	99%	75.18%	86.72%
Q1 14/15	93.37%	91.04%	94.41%	89.57%	100%	74.27%	96.83%
Q2 14 / 15	*91.62%*	*88.09%*	*91.27%*	*88.79%*	*100%*	*67.28%*	*92.11%*
Sep-15	94.62%	93.63%	92.54%	88.90%	100%	69.76%	83%
Oct-15	95.05%	93.46%	93.17%	92.11%	100%	70.45%	86.27%
Nov-15	*94.39%*	*93.55%*	*96.57%*	*96.77%*	*98.51%*	*71.04%*	*90.00%*

Quality Performance

A copy of the performance summary is attached.

Financial Performance

A copy of the latest scorecard is attached.

January 2016

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**18 JANUARY 2016**
SUBJECT:	**CLINICAL QUALITY & PATIENT SAFETY – NOVEMBER DATA**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY** **MEDICAL DIRECTOR**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The clinical metrics programme and annual and strategic objectives were reviewed as part of the business planning cycle in January 2015. Alignment with the corporate and divisional balanced scorecards has been reviewed.
- Performance is monitored via the Quality Committee and the Integrated Audit and Governance Committee.
- This report covers
    - Patient Safety
        - Harm Free Care
        - Nurse Sensitive Indicators
        - Infection Control
        - Mortality Rates
        - Risk Management
    - Clinical Effectiveness
        - Bed Occupancy
        - Readmission Rates
        - CQUINS
    - Patient Experience
        - Mixed Sex Accommodation
        - Compliments and Complaints
        - Friends and Family Test
- This report also appends data relating to nurse staffing, which is a requirement to report planned staffing versus actual staffing levels to the Board of Directors. Appendix 2 is a detailed complaint activity report and a heatmap of wards and departments in relation to quality indicators is included.

SUMMARY:
A summary of key trends and actions of the Trust's performance against clinical quality and patient safety indicators in 2015/16 is provided in the dashboard and supporting narrative.

The summary front sheet shows comparison in performance compared to one year ago. Of the 24 indicators, 13 report a worsening picture to last year, although one of the indicators (adult inpatient experience) is achieving the target satisfaction rate.

Key areas to note of this summary are:

- Mortality rates are improved;
- Readmission rates and the bed usage metrics show a poorer picture than this time last year. This reflects the operational pressure the Trust is under this year, and in particular the difficulty the Trust is having in ensuring adequate emergency flow through the hospitals;
- Falls, pressure ulcers and the Safety Thermometer are discussed below, but the Trust is reporting half the number of avoidable deep ulcers than this time last year. Unstageable ulcers are now reported and if they deem attributable to the Trust, they will be assigned a category once known;
- The number of serious incidents that remain open is slightly less than November 2014, and the Divisions are working towards a trajectory to complete and close all breach cases. This is performance managed at the Divisional Executive Performance Reviews. The Surgical Division has made particular progress in this area. Learning is always shared as it emerges and while investigations are underway.

The remaining metrics are discussed below and weave in the ward specific data depicted on the heatmap.

PATIENT SAFETY

- Harm Free Care – The Trust's 'Harm Free Care' performance remains lower than the national benchmark (92.6% vs 94.3% nationally), although slightly improved on October's figure. Harms relating to VTE and catheter related urinary tract infections were improved (reduced) this month. Key areas of improvement work are around falls and pressure ulcer care that directly influence this metric. Focused work is in place to address pressure ulcer and falls rates, both working to a Trust Wide Action Plan and Steering Groups in place to drive forward the improvement work. Where on the heatmap wards are reporting less than 100% harm free care, it can be seen whether falls and pressure ulcer prevalence contributed to this. Analysis of the wards reporting harms shows that they are medical and surgical wards that admit patients as emergencies. The relevance of this is that their workload can be very intense, and they also care for patients who are acutely unwell.

  The Tissue Viability Team is leading on a campaign entitled 'Bottoms-Up' following an increase in sacral sores. This commenced at the start of November and this month we have reported zero avoidable deep ulcers. We are currently achieving against the trajectory of 25% reduction in deep ulcers. However, the Trust remains above the trajectory to achieve a 25% reduction for category 2 pressure ulcers. The pressure ulcer panel remains in place in order to hold wards and departments to account and to enable the sharing of learning. Referring to the heatmap, it can be seen that the wards reporting avoidable pressure ulcers are the stroke wards and the renal ward, which also had a higher than normal number of falls. These ward care for very dependant patients whose mobility is reduced due to their clinical condition.

  The number of falls that our patients are experiencing is not reducing. During November we reported 3 serious incidents on StEIS relating to falls. The Falls Team is launching a 'Fall Stop' campaign in January 16 in order to make improvements in this area. The National Falls Audit showed that the Trust's Falls rates are in line with national – 6.3/1000 bed days compared with 6.6/1000 bed days (national rates). In addition the NHSE lead for falls held the Trust up as an exemplar. K&C and QEQM are meeting the quality standards for falls, with no red flags. WHH site has several indicators that

they are not meeting currently and is where the team are focusing their improvement work.

Some of the wards that are reporting the highest number of falls are also reporting this month staff fill rates below 80%. These wards are those who care for the elderly and frail, including stroke patients.

- HCAIs – There was one case of MRSA bacteraemia in Nov-15 that is waiting for assignment. Two cases have occurred this year against the NHS England objective for 2015/16 of zero avoidable cases. C-Difficile rates remain below national rates and the Trust is currently below the DH limit for 2015/16. MSSA bacteraemia rates are also below the national average. Trust wide mandatory Infection Prevention and Control training compliance continues to exceed the 85% standard.

- Mortality Rates – There has been no update on the Trust's HSMR and SHMI performance, but both crude non-elective and crude elective mortality rates have decreased this month. Indeed the Trust reported zero deaths for elective crude mortality.

- Staffing – There continues to be a reduction in incidents recorded due to staffing levels in November compared to October 15. The revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff. This is expressed by day and by night, and also by individual hospital site.

  An overall reduction in % shift hours filled has been seen since Nov-14 which reflects the national trend, linked to shortages of registered nurses. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in Nov-15 are almost 99% at K&C and over 96% for QEQM and WHH sites which shows improvement from Oct-15. The lower fill rates during the day reflect the priority to ensure night shifts are properly covered. During the day Matrons and other RNs are able to assist on the wards to ensure safe staffing. This isn't always reflected on the E-Rostering system.

  The fill rates this month reflect the vacancy position, sickness and maternity leave in some areas and annual leave at the higher end of permitted levels. Recruitment and retention initiatives are in progress and around 100 Registered Nurse posts have been filled between September and November including 38 newly qualified nurses. The remainder were EU nurses.

  Analysis of the heatmap indicates that several of the wards flagging less than optimal staffing levels reported falls, and a lower level of patient satisfaction, or even no inpatient survey results this month. These wards include Kingston, Richard Stevens Unit, both stroke wards with highly dependent and acutely unwell patients; St Augustines and Cheerful Sparrows Ward, both contain escalation beds; and Clarke ward. This is a similar picture to last month. Please see the attached appendix for greater detail on nursing staffing and the 'heatmap' for correlation of patient safety and quality of care against the fill rates.

- Risk Management – Incident reporting continues to be high in the Trust reflecting a culture of risk awareness and a proactive approach to managing risk. Last month saw the severe harm cases reach the upper confidence limit. These data have been re-run and show this month an improved picture. All cases are thoroughly investigated with processes in place to share learning across the organisation.

CLINICAL EFFECTIVENESS

- CQUINs – The 2015/16 CQUINs include national quality improvements for Sepsis, Acute Kidney Injury and dementia. Development of the integrated Heart Failure, COPD, Diabetes and Over 75s pathways continue into 2015/16 as local CQUINs. Implementation of all quality initiatives are underway and all required milestones negotiated for Q1 & Q2 have been met. Progress towards Q3 milestones are underway with particular challenges identified in the Sepsis and Acute Kidney Injury pathways.

PATIENT EXPERIENCE

- Mixed Sex Accommodation – The Trust continues to report mixed sex breaches in the Clinical Decision Units across the Trust. This month 2 sites reported breaches although less than last month. The reasons for this are usually due to poor patient flow from the Emergency Departments (ED) through to the wards. Patients are offered a bed to enable them to be discharged from the ED.

- Compliments & Complaints – Appendix 2 contains the compliment, complaint and concerns analysis for the month of November. The Trust continues to exceed the 85% standard with 94% of the responses sent out within the date agreed with the client. However, the clinical Divisions are not achieving the Trust's stretch target of 85% of the responses being sent out within 30 working days. This month we have seen an improvement (reduction) in the number of returning complainants.

  The highest recurring themes raised within complaints for November 2015 are:
  - Clinical Management
  - Communication
  - Diagnosis
  - Delays
  - Discharge.

  In comparison to October 15, clinical management remains the top reason for complaint. Concerns about surgical management and problem with attitude have been replaced by problems with diagnosis and problems with discharge. Problems with communication and delays remain in the top five. The heatmap shows that the clinical wards and departments received no more than 3 complaints, apart from the two EDs where 7 in total were recorded. This correlates with the lower satisfaction scores received via the friends and family test which is always less in the EDs.

- Friends and Family Test – During Nov-15 we received 10600 responses from our patients. This includes inpatients, A&E, maternity, outpatients, day cases and paediatrics. The satisfaction scores are depicted in the table below:

  Table 1 - Percentage Recommended – Nov-15

Department	Percentage recommended	
Inpatients*	97%	↑
A&E	80%	-
Maternity	98%	-
Day Cases	96%	↑
Outpatients	91%	↑

  * Now includes paediatrics.

  No ward received less than 89% satisfaction rate, with most achieving 100% recommendation. This can be seen on the heatmap.

  Our real time inpatient feedback showed a decrease in the percentage of patients able to find someone to talk through their worries and fears compared to last month, but improved satisfaction in pain management and feeling involved in decisions made about them with them. However, it is clear from the heatmap that we have more improvement work to undertake in order to improve this metric to the standard we would like. This will be shared with the ward managers at the January 16 Chief Nurse Forum. The other metrics remained similar to previous months.

RECOMMENDATIONS:

The Council of Governors are invited to note the report and the actions in place to continue patient safety and quality improvement.

NEXT STEPS:

None. The metrics within this report will be continually monitored.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Clinical quality, the patient safety programme and patient experience underpin many of the Trust's strategic and annual objectives. Continuous improvements in quality and patient safety will strengthen the confidence of commissioners, patients and the public.

LINKS TO BOARD ASSURANCE FRAMEWORK:

This report links to AO1 of the BAF: AO1: Deliver the improvements identified in the Quality and Improvement Strategy in relation to patient safety, patient experience and clinical effectiveness.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified risks include:

1. Ability to maintain continuous improvement in the reduction of HCAIs in particular MRSA bacteraemias and C.difficile although we are currently meeting the C.difficile limit set by NHS England. An action plan is in place which is being monitored via the Infection Prevention and Control Committee;
2. The achievement of the stretch pressure ulcer reduction programme. The team are providing focussed improvements with the wards and the pressure ulcer panel interrogates avoidable ulcer RCAs for sharing and embedding learning and being aware of specific areas of work that need to be carried out;
3. The delivery of same sex accommodation in all clinical areas in the Trust given the change in reporting due to CCG concerns of the previously agreed justifiable criteria based on clinical need. Work is in progress within the Divisions to ensure we meet these standards;
4. The consistent achievement of the response rate standard for formal complaints. Although we have achieved this for many months, the length of time complaints are open now needs focus to maintain our improvement journey. The Complaints Management Steering Group oversees the delivery of the Improvement Plan;
5. The maintenance of the improvement in patient satisfaction as depicted by the FFT and the internal inpatient survey. Divisions are addressing specifically the feedback and developing plans to address patients' concerns;
6. The maintenance of safe staffing levels given the vacancy factors and occasions where extra beds are opened due to operational pressures. A robust recruitment and retention action plan is in place including an overseas recruitment drive to ensure our ward staffing remains safe;
7. Successful delivery of the updated Improvement Plan following the outcome of the July-15 visit.

FINANCIAL AND RESOURCE IMPLICATIONS:

Continuous improvement in quality and patient safety will make a contribution to the effective and efficient use of resources.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Reduction in clinical quality and patient safety will impact on NHSLA activity and litigation costs.

Most of the patient outcomes are assessed against the nine protected characteristics in the Equality & Diversity report that is prepared for the Board of Directors annually.

The CQC embed Equality & Diversity as part of their standards when compiling the Quality Risk Profile.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED:

(a) Discussion

(b) Information

CONSEQUENCES OF NOT TAKING ACTION:

Pace of change and improvement around the patient safety programme and patient experience will be slower. Inability to deliver a safe, high quality service has the potential to affect detrimentally the Trust's reputation with its patients and within the wider health economy.

CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE SUMMARY

Introduction

A summary of key trends and actions of the Trust's performance against the clinical quality and patient safety indicators is provided together with supporting narrative. The report is structured around the key themes of the annually published Quality Report/Account; Patient Safety, Patient Experience and Clinical Effectiveness.

	Measure	Improvement Metric		Target 15/16	Mar-15	Mar-14	vs Mar-14	YTD
Patient Safety	Mortality Rates	HSMR		-	80.6	81.4	↓	
					Q1 14/15	Q1 13/14	vs Q1 13/14	YTD
		SHMI (%)		-	95.30%	95.51%	↓	-
					Nov-15	Nov-14	vs Nov-14	YTD
		Crude Mortality: All Ages (Per 1000)	Non-Elective	-	25.559	28.628	↓	27.666
			Elective	-	0.000	0.890	↓	0.207
	Risk Management	Serious Incidents (STEIS)	New Incidents	-	7	3	↑	-
			Open Incidents	-	60	62	↓	YTD
	HCAI	MRSA	Attributable	0	2	1	↑	YTD
		C. difficile	Post 72h	45	21	40	↓	YTD
	Infection Prevention				Nov-15	Nov-14	vs Nov-14	YTD
		Mandatory Training Compliance (%)		85.0%	86.8%	84.6%	↑	84.4%
	Harm Free Care (HFC)				Nov-15	Nov-14	vs Nov-14	YTD
		Safety Thermometer HFC (%) - Old & New Harm	EKHUFT	93.0%	92.6%	93.1%	↓	92.9%
			National	-	94.2%	93.9%	↓	-
	Nurse Sensitive Indicators	Pressure Ulcers: Category 2,3 and 4	Acquired	-	23	20	↑	194
			Avoidable	79	5	10	↓	52
		Pressure Ulcers	Unstageable	-	5			31
		Falls		-	178	152	↑	1321
	Clinical Incidents	Total Clinical Incidents		-	1262	1141	↑	9601
Patient Experience	Experience	Friends and Family Test (Star Rating)		5.0	4.5	4.4	↑	-
		Adult Inpatient Experience (%)		80.00%	86.88%	88.14%	↓	-
		Mixed Sex Accommodation Occurrences		-	6	5	↑	102
Clinical Effectiveness	Readmission				Oct-15	Oct-14	vs Oct-14	YTD
		7 Day (%)		2.00%	3.99%	3.94%	↑	4.05%
		30 Day (%)		8.32%	7.39%	8.36%	↓	8.20%
	Bed Usage				Nov-15	Nov-14	vs Nov-14	YTD
		Bed Occupancy (%)		-	87.13%	87.10%	↑	-
		Extra Beds (%)		-	6.84%	5.52%	↑	5.85%
		Outliers		-	32	25	↑	32.00
		Delayed Transfers of Care (Average)		-	46.75	34.75	↑	37.20

NB: RAMI - Data sharing agreements with CHKS have now been resolved. An up to date RAMI position will be published in the near future.

EKBI Business Intelligence | Beautiful Information®

< November 15 >

RESET

SCORES

VALUES

As at 14th December 2015, Primary Care Referrals maintained their positive variance in November, over plan by 8%. Elective and Non Elective Inpatient PODs also achieved a higher level of activity than plan for the second successive month, however Day Case activity dropped below plan marginally. New Outpatient appointments also exceeded plan in November at +1.5%, whereas Follow Up's remained under. Year to Date, Primary Care Referrals and Ward Attenders remain the only PODs above plan. Elective Day Cases and Non-Elective admissions however remain very close to their YTD planned position.

Outpatient attendances, overall, have moved closer to their planned position in month. Noticeably the Surgical and UC&LTC divisions have over achieved against plan (as a total) in month, whereas the Specialist and Clinical Support have performed below planned levels. Specialist, in particular, is due to the decreased levels of Oncology activity. However, Anti-Coagulation services are also -21% below planned levels.

High levels again in Specialist and Surgical activity have ensured the overall Day Case position is stable. A surge identified in the Specialist Division has been caused by Dermatology as part of the RTT recovery plan. UC&LTC activity is below plan due to General Medicine.

The planned level of Elective Inpatient activity in November continues to be driven by the Surgical Division, particularly Orthopaedic activity.

Non Elective admissions performance of 2.7% above plan is reflective of two of the three bed holding divisions. UC&LTC activity is driving this increase through General Medicine (due to an overall shift towards the recording of patients when under the care of acute physicians) together with Paediatrics (through the Paediatric Assessment Unit) in Specialist. The Surgical division however is under plan noticeably in General Surgery and Trauma & Orthopaedics.

A&E activity during November 2015 was at a similar level to the previous year (-2%). However, as with previous months there has been a reduction in the proportion of Minors (Trust wide compared to Nov-14) and a year on year increase in the majors stream.

Key National Targets

Monitor

Domain	Metric Name	MTD	QTD	YTD
Patient Safety	Cases of C.Diff (Cumulative)	5	5	5
Effectiveness	A&E: Time in A&E (%)	1	1	1
	Cancer: 2ww (All)	5	5	5
	Cancer: 2ww (Breast)	5	5	1
	Cancer: 31d (Diag - Treat)	5	5	1
	Cancer: 31d (2nd Treat - Surg)	5	5	1
	Cancer: 31d (Drug)	5	5	5
Access & Productivity	Cancer: 62d (GP Ref)	1	1	1
	Cancer: 62d (Screening Ref)	5	1	5
	RTT: Admitted (%)		1	1
	RTT: Non-Admitted (%)		1	1
	RTT: Incompletes (%)		5	1
	DM01: Diagnostic Waits	5	5	5

Internally Monitored Indicators

Quality

Domain	Metric Name	MTD	QTD	YTD
Patient Safety	HSMR			
	Crude Mortality EL (per 1,000)	5	5	5
	Crude Mortality NEL (per 1,000)	5	5	4
Effectiveness	Readmissions: EL dis. 30d (12M%)		4	4
	Readmissions: NEL dis. 30d (12M%)		2	2

Activity (% Variance to Plan)

Domain	Metric Name	MTD	QTD	YTD
Activity	Referrals - Primary Care			
	Referrals - Total			
	A&E: Attendances			
	Outpatient Appointments			
	Elective Admissions			
	Non-Elective Admissions			
Access & Productivity	DNA Rate: New	4	4	4
	DNA Rate: F1Up	4	3	4

Efficiency

Domain	Metric Name	MTD	QTD	YTD
Valuing People	Clinical Time Worked (%)	1	1	1
	Unplanned Agency Expense	1	1	1
	Appraisal Quality			5
	Training Plans (Quarterly)			5
	Sickness (%)	5	4	4
Access & Productivity	BADS	3	4	5
	Theatres: Session Utilisation (%)	4	4	4
	Non-Clinical Cancellations (%)	5	5	5
	Non-Clinical Canx Breaches (%)	5	5	5

East Kent Hospitals University NHS
NHS Foundation Trust

FINANCIAL COMMENTARY - NOVEMBER 2015

Overview of Trust Financial Performance

Trust Key Performance Indicators (£m)	Annual target	Year to Date Plan	Year to Date Actual
Total operating income	528.9	351.0	**350.8**
CIP savings	16.2	8.5	**9.5**
EBITDA	(1.2)	(5.9)	**(5.2)**
I&E net surplus	(32.2)	(25.8)	**(24.7)**
Cash balance	0.08	5.8	**6.7**

Monitor Financial Stability Risk Rating	Annual target	Year to date Plan	Year to Date Actual
Financial Stability Risk Rating	**1**	**1**	**2**

The financial statements and summaries in this report are prepared for internal performance monitoring purposes and have not been audited. The Trust accepts no liability for any decisions made by persons external to the Trust based on this information.

Note: Detailed financial tables are on page 3

Statement of Comprehensive Income (Income and Expenditure)
The Income and Expenditure YTD position is £1m favourable against a plan of £(25.7)m.
- The subsidiary company (Healthex Limited which runs the Spencer Wing at QEQMH) is reporting a YTD surplus of £0.1m, which is not included in the above position.

Improvement Programme
CIPs are showing a £0.3m favourable variance in Month 8 and £1m favourable variance YTD.

Statement of Financial Position (Balance Sheet)
The Trust Statement of Financial Position and Cash summary are set out on page 3.
Unconsolidated Cash decreased by £3.3m to £6.7m in November 2015. The revised planned balance was £5.8m, therefore, the balance was £0.9m above plan.

Capital Expenditure Programme
The table on page 3 summarises £7.5m of expenditure on capital projects in the year so far.

Financial Performance Indicators
The Trust is achieving the rating of 2 under Monitor's Financial Stability Service Risk Rating.

Identified Financial Risks
The risk of ongoing adverse performance in the delivery of the CIP target.
Final agreement and managing within the Winter Funding envelope for 2015/16.
Cash Management.

How financial risks are being addressed
The following actions are in place:
- The establishment of a Financial Recovery Group to develop and drive a robust Financial Recovery Plan chaired by the CEO.
- Continued HR drive to recruit to vacant posts in an effort to reduce Agency Staffing costs.

Draft High Level CQC Improvement Plan

Ref Number	Domain	Work stream	Applicable Site	CQC Finding or Improvement	Source	Divisional Lead	Accountable Lead	Outcome/Getting to Good	Action	Measure/Indicator (and Target where applicable)	Was it on previous plan?	Due Date	Governance Arrangements	RAG Rating
MD of KF No	CQC Domain	Thematic Work stream (governance to be specified)	EKHUFT site(s)	Description of CQC finding or area hospital is looking to improve	Where was improvement identified (CQC or other)	Person responsible for delivering the action	Person accountable for delivery of the action	Description of what the end state will look like including quality targets	What will be done to deliver the change	Specific target or KPI that will used to determine whether target has been achieved	Was it on previous plan?	Due Date as determined by Board	Workstream Governance	Current RAG (to be populated from Jan 16)
MD01	ALL Domains	End of Life Pathway	ALL	End of Life Pathway	CQC Report	Divisional Head of Nursing Specialist Services	Chief Nurse and Medical Director	A suitable End of Life Pathway will be in place and staff will be competent in its consistent application. Contribution to local and national audits to evidence compliance.	1. Engage wider local health care partners producing a 'wrap around' policy / agreement / implementation with joint ownership and delivery, (March 2016). 2.Implementation of the Interagency Policy Tier 3 Acute KPIs (March 2016). 3. Ensure full engagement of key medical staff through a process of co-design and co-creation of any plans in development, (on-going). 4. Palliative care team will support the implementation of the documentation (by 14th December 15). 5. The end of life care plan will go live in Jan 16. 6. Set up mandatory eLearning for EoL care and design and set up systems for ensuring compliance is captured (June 2016). 7. The link nurse programme is further developed and embedded (March 2016). 8. Associated communications policy - cultural change programme will be rolled out Trust wide (on-going building on current work). 9. A review of the pay resources required within EoL team (including admin) will take place (during 2016). 10. Undertake the EOL national audits during 2016.	1. Implementation of the EoL interagency policy (March 2016). 2. Voices survey pre implementation plan (100 bereaved relatives). 3. National Audits undertaken. 4. Quarterly audits of uptake of documentation. 5. % of staff accessing electronic EOLC training. 6. Staff satisfaction survey on EoLC resources and support.	Yes	March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	End of Life Programme Board	
MD02	ALL Domains	Urgent & Emergency Care	ALL	Urgent & Emergency Care	CQC Report	Divisional Director UCLTC	Chief Operating Officer	The Trust has an effective and safe emergency and urgent care pathway. Care is delivered in the most appropriate environment, working alongside local partners, with multi-agency leadership.	1. Delivery of the Emergency Care Recovery Plan in place that is being implemented and overseen by the Emergency Care Programme Board and WHE Surge Resilience Group. This includes key work streams that are evidenced-based and meet ECIST and ECIP standards and recommendations (dates as per Recovery Plan). 2. Work with external partners and East Kent IT Strategy Development to build the 'digital health care record road map' with health care partners to ensure 24/7 access to patient PMH/ meds etc (Timescales as per NHS England digital road map plan). 3. Consideration to be given to primary care commitment to face to face assessment prior to (bar immediate life threatening illness) referral to EKHUFT, (February 2016). 4. Explore the feasibility of an accelerated CCG business case decision to provide equitable access to community senior specialist decision making (admission avoidance) service (as in West Kent model), (February 2016). 5. Maintain staff ownership using 'Vision' workshops (on-going through 2016). 6. Implementation of intentional rounding and a review of the nursing processes across all of the EDs, ECC and MIUs (March	As detailed in Emergency Care Recovery Plan. To include compliance with 4 hour target (95%), vacancy rates and turnover, incident reporting, patient and staff satisfaction (FFT) and metrics relating to timely specialist response. Delivery of the Emergency Pathway Recovery Plan. An increased FFT score (to be determined). The 'Caring Domain' rated as 'Good' at the next inspection.	Yes	On-going (key milestones set out in column K and detailed in Emergency Care Recovery Plan).	Emergency Care Programme Board	
MD03	ALL Domains	Maternity	ALL	Maternity	CQC Report	Divisional Director Specialist Services	Chief Operating Officer	The hospital has sufficient capacity to cope with the number of women in labour and new born babies on a day to day basis.	1. Review the demand and capacity of the maternity units across the Trust, (February 2016). 2. Develop live tools to understand capacity required based on bookings (June 2016). 3. Maintain detailed records in relation to escalation to understand and report diverts and closures (January 2016). 4. Implement Maternity Improvement Plan (Timescales as per plan).	Continued reduction in diverts to achieve target of zero.	No	April 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Womens Health Clinical Governance Forum	
MD04	ALL Domains	Maternity	ALL	Maternity	CQC Report	Divisional Director Specialist Services	Chief Nurse/Director of Quality	The Trust offers safe, effective, caring, responsive and well-led maternity services.	1. Develop a Maternity services Strategy that includes: a) governance (incident reporting and recording and maintenance of equipment and replacement programme) b) culture (creating stable leadership team and impacting on clinician behaviour) c) mother and partner experience (facilities for partners) d) bereavement suite and improved mother contact time in antenatal clinic) and e) capacity (relates to MD03) (Timescale will be determied following receipt of the external review report). 2. Finalise and embed Maternity Dashboard (Feb 16). 3. Implement the recommendations of the RCOG and RCM review (Timescale will be determined following receipt of the report). 4. Implement findings of Birthrate Plus (March 2016). 5. Implement Maternity Improvement Plan (Timescales as per plan).	Run rate of incident reporting by disciplines, live database for recruitment, maternity dashboard created and embedded, record of diverts and closures and learning from near misses (and low and no harm incidents). Workforce indicators as per MD08, MD09 and MD22). Delivery of recommendations by the external reviewers.	No	April 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Womens Health Clinical Governance Forum	
MD05	Effective	Mental Health	ALL	Mental Health	CQC Report	All Divisional Heads of Nursing	Chief Nurse/Director of Quality	Patients receive timely mental health assessment and have appropriate facilities whilst waiting.	1. Action plan to be agreed between KMPT and the Commissioners for the model of psychiatric Liason service in order to provide access to mental health assessment in all emergency areas of EKHUFT to meet their requirements to be agreed as part of KMPT and EKHUFT CQC improvement plans, (January 2016). 2. Design solutions with Stakeholders (clarity over provision of service and how to reduce delays in transferring patient following assessment) (January 2016). 3. Evaluate current plan for ED investment 16/17 to include new roles across all three sites (Timescales as per Emergency Recovery Plan). 4. Undertake a workforce review that evaluates the establishment, skill mix and development of new roles as part of the Trust workforce strategy. (e.g. Associate Practitioner role to undertake assessments and provide expert care) (Timescales as per Emergency Recovery Plan). 5. Review the environment where mental health clients are cared for in ED and CDU and implement findings where feasible (February 2016 for review, implementation timescales will be based on the review findings).	2 hour referral to being seen by specialist MH nurses. Fill rate of shifts for 'specials' (RMN or security) for delayed transfers. Level of MH training amongst general staff. Number of inpatients waiting for assesssment and also transfer to MH reduced (% target to be defined based on baseline).	No	April 2016 (agreed with partnership stakeholders on 04/12/15).	Emergency Care Programme Board	

MD06	Caring & Responsive	Access & Operations	ALL	Access & Operations	CQC Report	All Divisional Directors	Chief Operating Officer	Effective processes are in place on each site (and between sites) to manage flow - senior on site leadership supported by accountable leads. Information supports escalation and decision making. Patients are cared for in the most appropriate place and care is coordinated.	1. Strengthen the site management by designing and implementing systems and processes that improve emergency flow through the Trustery (Timescales as per Emergency Recovery Plan). 2. Review of patient pathways, divisional and specialty accountability for the emergency pathway action plan (Timescales as per Plan). 3. Review the total bed base and specialty provision across the Trust (March 2016). 4. Involve 3rd sector in provision of alternative services for inpatient stay (June 2016). 5. Deliver agreed whole system (SRG) A&E action plan. (Time scales already embedded in this work) 6. Up to date mapping of current provision of social care (NH or RH) in each CCG area with note of relevant changes to provision (KCC by January 2016). 7. Joint KCC and EKHUFT review of social care delays to discharge with memorandum of understanding that no patient should wait in hospital for assessment (February 2016). 8. Agree joint approach to communication with regard to joint patient / pubic / provider engagement events regarding delayed discharges, (March 2016). 9. Ensure that contracting and commissioning is based on actual capacity (Timescale as per contract negotiations timelines)	Access target compliance, metrics around patient transfers for non clinical reasons (to ascertain appropriateness of bed placement). Readmission figures. Patient experience. Control room metrics - consistent attendance, adherence to action card prompts, supportive IT solutions (interactive boards). Define and agree baseline interventions for referrals from ED to specialties.	Yes	On-going (key milestones set out in column K and detailed in interrelated Emergency Care Recovery Plan).	Emergency Care Programme Board	
MD07	Safe	Patient Safety	ALL	Patient Safety	CQC Report	Divisional Director CSSD	Director of Pharmacy	There are robust systems to monitor the safe management of medicines and IV fluids according to national guidelines.	1. Staff will be made aware of their responsibilities with weekly auditing of compliance in place - with leadership from lead nurse/clinical leads and pharmacy for each area (January 2016). 2. Undertake a review of current facilities for safe storage working alongside estates and facilities team as required to develop a case for investment (February 2016). 3. Plan the roll out of patient near side dispensing (During 2016).	1. Secure storage of IV fluids to be added to local auditing arrangements. 2. Medicines Management NICE/NHS Protect Standards adhered too.	No	March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Patient Safety Board	
MD08	Safe	Recruitment and Training	ALL	Recruitment and Training	CQC Report	All Divisional Directors	Director of Human Resources	There are sufficient numbers of suitably qualified, skilled and experienced staff available to deliver patient care in a timely manner.	1. Explore alternative solutions for recruitment and retention of consultants and middle grades, including radiology, paediatrics, surgery and A&E and hard to recruit areas. Partnership approach with Deanery and appropriate supervision and support. (March 2016). 2. Initiate work to understand and improve retention including comprehensive 'on boarding'/induction processes for all staff especially hard to recruit areas. (February 2016) 3. Focus on hard to fill posts to develop recruitment strategies. (March 2016). 4. Work with local health economy to implement 'Passport' system for mandatory training, (August 2016) . 5. Issue Smart Cards at induction build in time in local induction for mandatory training to be completed. (April 2016). 6. Nursing rotas should reflect acuity of patients and changing demand during the 24/7 period. (interim solutions but mid/long term goal re procurement of IT solution) (during 2016). 7. Retention strategy to include development and education and staff facilities (March 2016).	1. Vacancy rate % target split by professional group (target max 5% for RNs, HCAs and junior doctors. 2% for consultants. 2. % turnover in targeted groups where above expected average. Data on Agency/Overtime/NHSP usage. 3. Overall improvement in % of shifts filled during the night and the day. Target is a 95% score for planned shifts filled by day and night. 4. Agreement on OOH medical cover and duties. 5. Specific reports as per points 1 to 3 above for those areas highlighted in MD section (emergency care, medical care and maternity). Target as per Balanced Scorecard. 6. Re-establish site based pool of NHSP nursing to cover short-term staff sickness difficulties.	Yes	On-going (key milestones set out in column K and detailed in Strategic Resourcing Plan).	Strategic Workforce Committee	
MD09	Well-Led	Workforce and Culture	ALL	Workforce and Culture	CQC Report	All Divisional Directors	Director of Human Resources	There is a positive workforce culture demonstrated by content staff who are supported and empowered to lead improvement, are aware of the Trust vision and their role within it and provide excellent patient care. Leaders at all levels have the skills to support and embed cultural change.	1. Continue to take forward the Cultural Change Programme (milestones to be confirmed within Trust OD Strategy - by January 2016). 2. Communications strategy to be developed based on local champions and QII Hubs (February 2016). 3. Develop a staff engagement and communication plan (interdependencies with other key corporate communications plans - eg Strategy) (During 2016). 4. Continue to ensure that Leaders are adequately trained against relevant training needs analysis (On-going through 2016).	Staff FFT results and Staff Survey results. Patient feedback - informal and formal. Outcomes from incident, Datix and SIs - correlating different indicators of workforce culture - and ensuring cultural indicators are part of action plans. Leadership training coverage and compliance.	Yes	On-going (key milestones set out in column K and detailed in Cultural Programme Plan).	Strategic Workforce Committee	
MD10	Well-Led	Clinical Strategy	ALL	Clinical Strategy	CQC Report	ALL Divisional Heads of Nursing and Medical Directors	Director of Strategic Development and Capital Planning	The clinical strategy plan is delivered to timescale and communicated and implemented successfully led by clinical champions.	1. Delivery of the East Kent Strategy Programme Board Programme (As per timescales determined by the East Kent Strategy Board). 2. Processes are in place to ensure that there is effective clinical engagement and a communications strategy for the total workforce (Timescales as per Strategy Board). 3. Public/external communications strategy to be signed off by Programme Board (Timescales as determined by the Strategy Board)	Programme Plan delivered to time. Metrics are established to assess effectiveness of clinical engagement. Processes are in place to support public consultation working with stakeholders.	Yes	TBC - milestones within programme plan overseen by programme board.	Clinical Strategy Board	
MD11	Effective	Clinical Audit & Effectiveness	ALL	Clinical Audit & Effectiveness	CQC Report	All Divisional Directors	Chief Nurse and Medical Director	There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes. Clear action plans developed and managed through the Trust governance framework.	1. Ensure that plans are in place to ensure that the Trust participates in all national clinical audit programmes and all areas identified as priority in the divisional and specialty audit plans for 2016/17. 2. Ensure that the audit cycle is completed - and that findings from audits are implemented (On-going through 2016). 3. Undertake review of cost of clinical audit function (including job planned PAs) and accountability of named leads (June 2016). 4. Involve audit leads in the site QII Hubs with re-defined responsibilities (January 2016).	1. Trust wide and divisional audit programmes delivered to time and relevant to the areas of risk identified. 2. Workforce/Job planning review for all clinical audits undertaken and results to inform improvements. 3. Development of communications strategy regarding audit and quality improvement cycle based on results.	No	Jan-16	Clinical Audit and Effectiveness Committee	
MD12	Effective	Environment & Equipment	ALL	Environment & Equipment	CQC Report	All Divisional Directors	Director of Strategic Development and Capital Planning	The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet current best practice standards.	1. QII voice for approval of annual refurbishment schedule (As required through 2016). 2. Pilot enviornment/ward checklist at hand over (January 2016). 3. Complete/re-launch 'Planet' roll out and communucations plan (June 2016).	1. Formulate a Patient Environment Investment Committee plan. 2. Audit of checklist effectiveness and customer response/feedback.	No	On-going but with key milestones achieved and evidenced by April 2016.	Patient Environment and Investment Committee	

MD13	Effective	Environment & Equipment	ALL	Environment & Equipment	CQC Report	Divisional Director CSSD	Chief Operating Officer	There is sufficient equipment in place to enable the safe delivery of care and treatment, equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.	1. Undertake an assessment of all equipment needed across the Trust (June 2016). 2. Develop and implement a system for monitoring and undertaking timely maintenance of all equipment (January 2016). 3. Review the systems that provide assurance that staff are trained on using equipment (March 2016). 4. Ensure that all staff are aware of their responsibilities regarding equipment (February 2016).	1. 95% equipment compliance level (PPM) following approval of resources. 2. Maintenance breakdown levels and response times.	Yes	February 2016.	Medical Devices Group	
MD14	ALL Domains	Children & Young People	ALL	Children & Young People	CQC Report	Divisional Director Specialist Services	Chief Nurse/Director of Quality	There are sufficient numbers of paediatric trained staff within Emergency and Urgent Care Pathway to ensure that children and young people receive effective care and treatment to meet their needs.	1. Undertake a full review of staffing once new models of care within the emergency care setting have been fully implemented to ensure that the recent investment into the nursing establishment for Paediatric services is sufficient (As per 6-monthly staffing reviews programme during 2016).	1. Review completed. 2. Rotas evidenced of appropriate and safe paediatric cover.	Yes	January 2016.	Childrens Assurance Board	
MD15	ALL Domains	Children & Young People	ALL	Children & Young People	CQC Report	Divisional Director Specialist Services	Chief Nurse/Director of Quality	Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.	1. Undertake 6 monthly establishment reviews, as per Safer Staffing requirements (NHSE) to ensure adequate provision and plan for investment as appropriate (As per the review timetable).	1. Recruit to all Child RN vacancies. Target <5% vacancies. 2. National Standards achieved in A&E, Out-Patients, Day Surgery, Operating Theatres.	Yes	March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Childrens Assurance Board	
MD16	Well-Led	Governance & Leadership	ALL	Governance & Leadership	Other External Review	All Divisional Directors	Chief Nurse/Director of Quality	The governance and assurance arrangements for the Trust are robust and transparent. Governance arrangements are understood by staff at all levels of the organisation.	1. Full implementation of the action plans associated with the PWC and Deloittes external reviews (March 2016). 2. Undertake an evaluation of the new Governance arrangements (January 2016). 3. Include in the evaluation the level of understanding and use by staff at all levels of the organisation, particularly speciality level (January 2016).	All actions completed according to timeframe set in action plan. Metrics to be established regarding understanding of Trust governance at all levels of the organisation.	Yes	March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Management Board	
MD17	Well-Led	Patient Safety	ALL	Risk Management	CQC Report	Deputy Director of Risk, Governance & Patient Safety	Chief Nurse and Medical Director	The Trust incident reporting process is robustly followed by all departments - with focus on ED departments at WHH, QEQM and Maternity services. Ensure that incidents are acted on in a timely manner and that staff receive feedback and Lessons are learned and communicated widely to support improvement in other areas as well as services that are directly affected. Opportunities to learn from external safety events are also identified. Improvements to safety are made and the resulting changes are monitored.	1. Continue to roll out the Datix improvement plan (Timescale as per Improvement Plan). 2. Develop a standard template for handover, including safety issues, with responsibilities for reporting defined (April 2016). 3. Formulate and deliver a structure for all M&M meetings (April 2016). 4. Review practice of splitting HCR to make all risk assessments more visible (June 2016). 5.Use of whole team - including admin - to assist in Datix reporting and change JDs to reflect duties for incident reporting (June 2016). - Communicate incident reports and lessons learned (shared learning) (On-going through 2016) - Involve all grades of staff connected with and reporting incidents in any investigations / RCAs undertaken in relation to any such incidents (On-going through 2016).	1. National bench-marking for incident reporting. Divisional KPIs linked to the NRLS. 2. Actual number of incidents reported by month increases from Nov 15. 3. Increasing % as a proportion of the average reporting levels for large acute Trusts via 6-monthly NRLS. 4. Number of staff reporting that they receive feedback on lessons learned from RCA investigations increases via interim staff surveys, baselined on Jan 15 figures. 5. Increase the number of incidents reported by low-reporting professions in the annual staff survey from 2014 results	Yes	Sep-16	Patient Safety Board	
MD18	Well-Led	Governance & Leadership	ALL	Governance & Leadership	CQC Report	All Divisional Directors	Chief Nurse/Director of Quality	Trust wide policies are procedures are up to date and in line with best practice. Policies and procedures are clearly written and easily accessible by staff.	1. Ensure the electronic system in place to monitor and update policies in line with their due dates is fit for purpose (June 2016). 2. Carry out a needs analysis to identify the best document management system to enable the systemisation of updating policies (and design the implementation) (June 2016).	1. System review in place and clear project plan with milestones for completion. 2. Communications Plan to ensure that staff are aware of where to access key documents - covered within Trust wide and divisional induction programmes. 3. 98% of policies in date (to allow for review time slippage and alignment to approval committees). 4. 95% of policies in date monthly by division reported on Balanced Scorecard 5. Document management system in place that staff can access and know how to use (measure through question on interim staff surveys)	Yes	June 16 (but trajectory for improvement set based on programme plan)	Patient Safety Board	
MD19	Safe	Governance & Leadership	ALL	Access & Operations	CQC Report	All Divisional Directors	Chief Operating Officer	The MAJAX policy is up to date and staff are aware of their roles and responsibilities. Staff are confident in its application having received sufficient training and 'drills' in appropriate areas.	1. Update the Trust Major Incident Policy (March 2016) 2. Design a process that evaluates and ensures the policy is accessible and understood by all staff, (March 2016). 3. Ensure business continuity plans are in place for all areas, (January 2016). 4. Implement a training plan for staff, (March 2016) 5. Implement 'drills' as per best practice standards, (September 2016) 6. Ensure the Trust meets its national standard requirements, (September 2016).	1. Training trajectory delivered. 2. Table top major incident response scenario/drill delivered in identified areas (TBC). 3. % of staff trained in A&E, % of staff trained in assessment units, % of staff trained across the Trust against the TNA. Target is at any one time 85% of staff in A&E and Assessment Units to be trained within the last year. 4. All staff when asked are aware of how to access the policy	No	Sep-16	Patient Safety Board	
MD20	Safe	Safeguarding	ALL	Safeguarding	CQC Report	All Divisional Heads of Nursing	Chief Nurse and Medical Director	Staff training is focused on the principles of the MCA (2005) and how to assess capacity. Trust policies relating to adult safeguarding are updated regularly and are easily accessible. There is evidence that staff consider mental capacity in the planning and delivering care. Capacity assessments are considered carefully and are proportionate to patients' needs. Best interests decisions are timely and issue specific.	1. Review of compliance with Adult Safeguarding training, specifically around MCA and DoLS (January 2016). 2. Ensure that training data is readily available from HR systems, (June 2016). 3. Review the TNA and role specific guidance on the frequency of training, (February 2016). 4. Develop a consistent training programme include adult safeguarding, DoLS, MCA etc. so staff receive updates in line with TNA (April 2016). 5. Review the possibility of a SG link worker role in order to cascade training (February 2016). 6. HR systems to improve capturing training data (June 2016). 7. Improve governance around induction of temporary staff (April 2016). 8. Use Claims, Concerns and Issues tool for individual teams re SG/LD reporting themes through the QII Hubs (On-going through 2016). 9. Improve visibility, participation of Learning Disability PDN (January 2016). 10. Align current EKHUFT MCA/DoLS training with social and mental health trusts (April 2016).	1. Existing safeguarding training compliance to meet that required within the standard contract for all clinical staff. 2. Local measures for compliance with temporary staff induction, compliance with 'This is Me' and 'My Healthcare Passport'. 3. No of KASAFs raised by/against the Trust reported in the 6-monthly reports of activity. 4. Ask 5 questions audit of staff knowledge of MCA and DoLS	No	Jun-16	Multi-Agency Safeguarding Board	
MD21	ALL Domains	Safeguarding	ALL	Safeguarding	CQC Report	Divisional Director Specialist Services	Chief Nurse/Director of Quality	There is a Trust specific Children's Safeguarding Policy (which is consistent with the Kent & Medway Multiagency policy).	1. Review Kent multiagency child safeguarding policy to develop Trust specific version to include FGM (March 2016).	Development and approval of policy. Escalation of policy and metrics around staff knowledge of application.	No	Mar-16	Multi-Agency Safeguarding Board & Childrens Assurance Board	
MD22	Safe	Recruitment and Training	ALL	Recruitment and Training	CQC Report	All Divisional Directors	Director of Human Resources	All temporary/agency staff (all disciplines) should have the appropriate competencies for the clinical environment they are placed within and receive appropriate induction.	1. Implement roster interface with NHSP so that name of individual is on system with personal information for verification (pending funding) (During 2016). 2.Enforce verification procedures when the temporary worker starts shift (e.g. competency checklist) - (IT solution dependent) (March 2016). 3. Review of local induction handbooks to ensure are consistent and clinically appropriate, (April 2016). 4. Design a process where assurance is gained that temporary staff have received local induction at the start of their shift(s) in the Trust. (March 2016). (IT solution dependent).	1. Induction checklists complete (%). 2. Review of local induction handbooks undertaken. 3. Verification procedure in place. 4. Audit of compliance and implementation of recommendations.	No	On-going but with key milestones achieved and evidenced by April 2016.	Strategic Workforce Committee	

MD23	Safe	Patient Safety	ALL	Patient Safety	CQC Report	Divisional Director CSSD	Chief Operating Officer	The pharmacy department is appropriately staffed and skilled to support the timely and safe discharge of patients.	1. Review of pharmacy workforce requirements with relevant benchmarking, to include skill mix and career development. 2. Continue to recruit to current vacancies detailed in pharmacy service development business case (June 16). 3. Develop a Pharmacy Strategy and ensure aligned with implementation of Trust Clinical Strategy (Throughout 2016 in line with the Clinical Strategy timeline).	1. Review undertaken and approved. 2. Action plan developed including workforce development plan. 3. Workforce metrics to include % vacancy rate, % turnover, % training compliance and staff satisfaction. 4. EDN KPIs (TTAs available upon discharge). 5. % compliance with drug chart availability on ward.	No	Mar-16	Patient Safety Board	
MD24	Caring & Responsive	Patient Experience	All	Patient Experience	CQC Report	All Divisional Directors	Chief Nurse and Medical Director	Patients' pain scores should be regularly and clearly documented and there should be interventions - pharmaceutical and alternative therapies. There are clear tools for use with patients with dementia and learning disability.	1. Audit of pain management scores across Trust and patient's experience of pain and associated action plan (August 2016). 2. Review of pain interventions available and access to specialist advice as required (April 2016). 3. Ensure pain assessment documentation is universal (August 2016). 4. Develop and implement effective pain assessment tools for patients with dementia and Learning Disabilities (June 2016).	Audit results of regular pain management audits and use of approved documentation.	No	March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Patient Experience Board	
MD25	Caring & Responsive	Access & Operations	ALL	Access & Operations	CQC Report	Divisional Director CSSD	Chief Operating Officer	Inpatient areas are supported by 7 day services (radiology, therapies and pharmacy) to enable effective use of capacity and enable flow.	1. Scope demand/benefits for seven day working of support services, including service offer already in existence (Timeline as per Clinical Strategy work). 2. Prioritisation of key staff based on patient acuity and demand (April 2016).	Implementation of action plan following review. Where services are not 7 days, assessment of availability of on call staff to prevent delays to patient care.	No	On-going but with key milestones achieved and evidenced by April 2016.	Emergency Care Programme Board	
MD26	Caring & Responsive	Patient Experience	ALL	Patient Experience	CQC Report	All Divisional Directors	Chief Nurse/Director of Quality	Patients' complaints are responded to as per national standards. Ensure there is a clear process for learning across the Trust.	1. Review local procedures for complaint handling and ensuring accountability is clear (April 2016). 2. Review training requirements in dealing with complex complaints (February 2016). 3. Review local processes for capturing and sharing learning with teams (February 2016). 4. Deliver the Complaints Improvement Plan (Timeline as per Complaints Improvement Plan).	1. 85% complaint response compliance against Trust policy. 2. Evidence of processes in place for sharing learning from complaints and associated improvements.	Yes	On-going but with key milestones achieved and evidenced by April 2016.	Patient Experience Board	
MD27	Effective	Surgery & Critical Care	ALL	Environment and Equipment	CQC Report	Divisional Director Surgical Services	Director of Strategic Development and Capital Planning	Operating Theatres on all sites comply with HTM 05-01, particularly in relation to risk assessment, the environment and staff training.	The autoclave has been decommissioned. Review of theatres against HTM 05-01 standard (June 2016).	Review of theatres complete and evidence of compliance produced.	Yes	March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Patient Safety Board	
MD28	Safe	Patient Safety	ALL	Patient Safety	CQC Report	ALL Divisional Heads of Nursing and Medical Dire	Chief Nurse and Medical Director	Fine bore naso-gastric tubes are inserted and checked in accordance with NHS England's patient safety alerts; the Trust NG Policy is in line with this guidance.	1. Review the current NG Policy and ensure it meets national standards and NPSA guidance (December 2015) 2. Implement the policy Trust wide (December 2015) 3. Monitor compliance (Throughout 2016). 4. Ensure any additional actions noted in the NHSE external review are reflected, (Timeline as determined by the NHSE review report).	100% compliance to national safety and best practice standards.	No	Dec-15	Patient Safety Board	
MD29	Effective	Urgent & Emergency Care	All	Environment & Equipment	CQC Report	Divisional Director UCLTC	Director of Strategic Development and Capital Planning and Chief Operating Officer	All escalation wards/clinical areas are appropriately staffed and equipped to safely care for the cohort of patients intended.	1. Review the environment of St Augustine's ward from safety standards perspective and develop plans to address the findings (February 2016) 2. Review all escalation ward areas to ensure they are fit for purpose and take corrective action (March 2016) 3. Review the staffing establishments of all escalation areas in the Trust and make recommendations to improve and implement (As per the review timetable) 4. Ensure all escalation bed areas are fully equipped, (January 2016). 5. Undertake formal risk assessment before opening of any escalation beds/area and evaluate the risk of opening v other options (January 2016).	Safety and Patient Experience standards are achieved.	No	Mar-16	Patient Safety Board	
MD30	Safe	Patient Safety	All	Patient Safety	CQC Report	Divisional Director CSSD	Medical Director	The Medicines Management Policy is adhered with - and there are systems in place to ensure that prescribing practices across site for critical drugs are uniform.	1. Ensure prescribing practice is standardised for critical drugs - e.g noradrenaline infusions/inotropes used in critical care (March 2016). 2. Audit compliance with Policy for other 'critical drugs' (identified via Datix/SIs/specialist pharmacist) (June 2016).	Evidence of compliance with Policy.	No	Feb-16	Patient Safety Board	

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE**:**	**18 JANUARY 2016**
SUBJECT:	**CQC DRAFT IMPROVEMENT PLAN**
REPORT FROM:	**CHIEF NURSE & DIRECTOR OF QUALITY** **IMPROVEMENT PLAN DELIVERY BOARD CHAIR**
PURPOSE:	**Discussion**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The Trust was put into special measures in August 2014 following a CQC inspection in March 2014 which rated the Trust overall as inadequate.
- In response the Trust developed a detailed action plan based on the 21 Key Findings and 26 Must Do areas that were identified in the CQC report.
- The Trust underwent a re-inspection w/c July 13th 2015.
- The Trust has now received the reports from this inspection and has been rated overall as 'Requires Improvement.'
- We expect to be re-inspected in 6 months' time.

SUMMARY

Following the re-inspection of each of the Trust five sites in July 2015, the Trust has received the finalised reports. These were formally presented to the Board of Directors and external partners by the CQC at the Quality Summit on November 16th.

During the period of time between the July visit and receipt of the draft reports at the beginning of November, staff have been reflecting on the feedback received at the time of the visit. Using the Quality Improvement and Innovation Hubs (QIIHs), reporting into the fortnightly CQC Improvement Steering Group and monthly Improvement Plan Delivery Board, the teams have continued on the improvement journey. The improvements we have made since July have been reported to the CQC and were also presented to them at the Quality Summit on the 16th November 2015. Key themes were identified from the draft reports and these were explored with the staff at a series of workshops. The staff engagement piece is has formed the basis for the new plan and is being led by the staff who will be delivering the improvements in their wards and departments. This is a key principle of the new plan development.

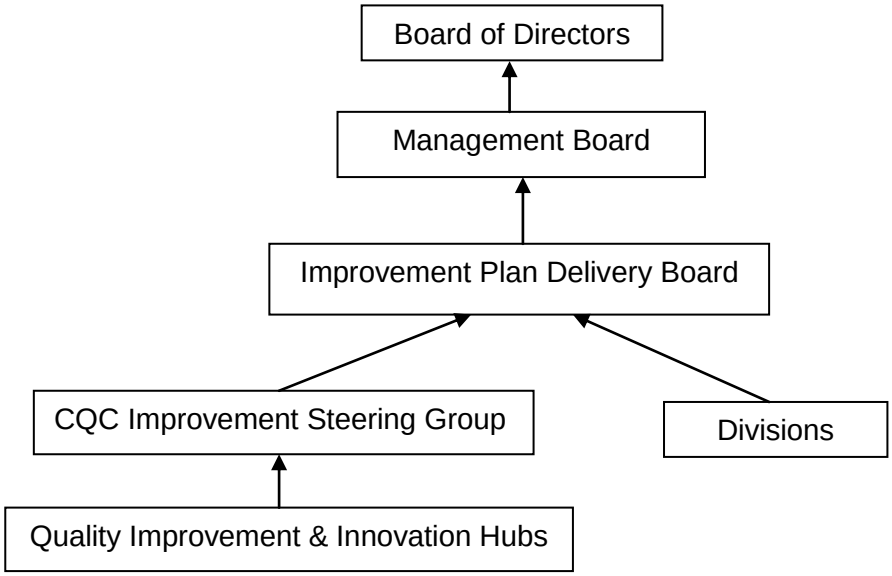
Following receipt of the final reports on the 16th November at the Quality Summit the following actions are in place to develop the new Improvement Plan in readiness for the next inspection:

1. Outstanding actions from the previous Improvement Plan have been discussed with Monitor and have been agreed to take forward in the new plan. These included staffing, culture, emergency pathway, equipment, and medicines management;
2. Monitor have acknowledged that some aspects of the Deloittes review and Price Waterhouse Coopers review require embedding in the organisation and will also feature in the new plan;

3. The outputs of the staff workshops have been analysed;
4. All of the 'Must Do' and 'Should do' findings have been captured on a new detailed plan as actions. There are 463 of these actions cited in the six reports;
5. Divisions have been working independently on the reports relating to their services;
6. A high level plan has been drafted that is themed across a number of areas in order to contain and marshal the rich data the CQC have given to us;
7. A workshop with key staff who will be delivering the new plan has taken place on Friday 27th November where each theme of the plan has been discussed and actions with milestones and delivery dates have been drafted;
8. On the 4th December a workshop with our external partners is due to take place (at the time of writing the report, 28th November 2015, this meeting had not taken place);
9. The final draft Plan will be submitted to Monitor on the 9th December 2015 and will, going forward, be monitored at our performance meetings with Monitor and more locally by the CCGs;
10. The final Plan will be received by the CQC on or before the 14th December 2015;
11. In turn, the QIIHs will continue to deliver the actions and work with staff to prepare us for another re-inspection in 6 months' time. The findings and ratings of the next inspection will determine whether the trust comes out of Special Measures.

Programme Management and Monitoring Arrangements

Similar to last year, we have put programme management arrangements in place to ensure the Improvement Plan is monitored and delivered to the agreed deadlines. The Programme Management Office comprises of Dr David Hargroves as Chair of the Improvement Plan Delivery Board, the Programme Manager, a Quality Improvement Facilitator (recruitment in progress), and A&C support. The Chief Nurse & Director of Quality is the Executive lead. The Trust monitoring and reporting arrangements are depicted below:



The Quality Improvement & Innovation Hubs meet weekly. The CQC Improvement Steering Group meets fortnightly, but this will increase to weekly as the improvement work increases. The remaining Boards will receive progress reports monthly.

Attached is the draft high level Improvement Plan for discussion by the Board of Directors.

RECOMMENDATIONS:

The Council of Governors is asked to note the attached revised High Level Improvement Plan which was updated following input from the Board of Directors at their meeting on 11 December 2015.

NEXT STEPS:

Monitoring will continue by the Board of Directors.
Preparation for the next inspection has begun.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

SO1: Deliver excellence in the quality of care and experience of every person, every time they access our services

SO2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare

SO3: Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects and rapidly implementing best practice from across the world

SO4: Identify and exploit opportunities to optimise capacity and, where appropriate, extend the scope and range of service provision

SO5: Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust

LINKS TO BOARD ASSURANCE FRAMEWORK:

This paper links to AOs 1, 2 & 6 of the BAF:

AO1: Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness

AO2:Embedding the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected

AO6: Delivering the cultural change programme to increase staff engagement and satisfaction

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

Identified risks include:

1. Successful delivery of the CQC Improvement Plan;
2. Failure to be removed from Special Measures status after the next inspection.

Management Actions are:

1. The CQC Improvement Steering Group continues to meet fortnightly to engage staff and work alongside the Quality Improvement and Innovation Hubs;
2. The Improvement Pan Delivery Board will continue to meet monthly to ensure delivery of the regulatory requirements cited by the CQC and to ensure all of the recommendations in the reports are delivered;
3. Preparation for the next inspection has begun.

FINANCIAL AND RESOURCE IMPLICATIONS:

Improvement initiatives that are successfully delivered and embedded into daily operations support the more effective and efficient use of resources.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust is currently in breach of its Licence with Monitor by virtue of being placed in Special Measures.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:

None.

ACTION REQUIRED:

(a) Information
(b) Discussion

CONSEQUENCES OF NOT TAKING ACTION:

The Trust may remain in Special Measures and in breach of its Licence.

East Kent Hospitals University NHS
NHS Foundation Trust

Quality Report/Account 2015/16

Council of Governors

18 January 2016

We care

Background

- 2015/16 is the seventh year the Trust will be required to publish a Quality Report and Account
- The report is subject to formal assurance from the Trust's external auditor KPMG to assess if this follows Monitor's mandated requirements
- As in previous years, the auditor will be required to opine on a series of indicators, some of which are mandated

Background

- Mandated indicators in 2014/15 were two of the following areas
  - Maximum time of 18 weeks from point of referral to treatment – patients on incomplete pathway' – target 92%
  - 62 day Cancer Waits, or
  - Emergency Readmissions within 28 days – not used
- Last year, governors were able to select a local indicator in addition to the mandated indicators
  - Compliance with VTE recorded risk assessments

Current position

- The consultation document for the Quality Report for 2015/16 has not yet been issued by Monitor – this is expected within the next 4 weeks
- In order for KPMG to perform a complete audit, data must align with a unique patient
- Any decision on a local indicator must take this into consideration

Indicator testing

- Usual external audit opinion on the accuracy of the indicators included in the Quality Report for 2015/16
- Test of the effectiveness of the systems and processes generating data and the accuracy of the underlying indicator
- This will result in a limited assurance opinion for the mandated indicators and a report to the Council of Governors and the Board of Directors for the “local indicator”
- There is a cost associated with the external audit

Suggestions for local indicator 2015/16

- Re-assess the response times to formal complaints
  - This was the local indicator for 2013/14
- Cardiac Arrest Data
  - Review patient outcomes following cardiac arrests within our service. This would capture end of life decision making and whether arrest audit data is being accurately completed
- VTE risk assessment documentation
  - Review of the completion of a fully documented VTE risk assessment and the compliance with NICE guidance

…or

- Consider not requesting a governor indicator this year to reduce some of the external audit costs

Next steps

- Seek your views today and identify the selected indicator or whether to identify an additional indicator this year
- Agree time frame with KPMG for the assessment and audit opinion

Questions?

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**18 JANUARY 2016**
REPORT FROM**:**	**CoG NOMINATION AND REMUNERATION COMMITTEE CHAIR**
PURPOSE:	**INFORMATION**

SUMMARY OF COMMITTEE ACTIVITY

At time of writing the CoG Nomination and Remuneration committee is scheduled to meet on 15th February but has not met since the last CoG.

The committee are grateful to the CoG for endorsing the appointment of Mr. Ron Hoile as a NED and we look forward to his contribution to the work of our Trust.

SUMMARY OF COMMITTEE'S FORWARD PLANS:

On 15th February we will consider:-

- Board's Internal Assessment: *Skills / Balance of NEDs + skills gaps*
- Review of NED term end
- Council of Governors Committee membership
- NED Alignment to Council of Governor Committees (For information)
- NED Commitments
- Permanent appointment of SID.

COUNCIL OF GOVERNORS ACTION REQUIRED:

- To note the report.

Philip Wells
7th January 2016

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**18 JANUARY 2016**
SUBJECT:	**REPORT FROM THE CHAIR OF THE STRATEGIC COMMITTEE**
PURPOSE:	I**nformation**

SUMMARY

The meeting of the Strategic Committee on 15 December was open to all Governors, as agreed, to address the second tranche of Monitor Submissions (circulated electronically to all Governors on 5th November) and to receive a presentation on "The Case for Change" (tabled and subsequently circulated to Governors) as the basis for the Trust's emerging Clinical Strategy.

The Director of Finance and Performance Management presented the Addendum to the Short Term Recovery Plan including the outcomes of the work commissioned by the Trust from Ernst and Young. Compared to the Trust's peer group this showed adverse variances (low productivity) in T&O, O&G, Neurology and Vascular Surgery and 'Opportunities" (for Savings : £20.9 m) including Back Office services, Theatres, Beds, Medical and Nursing Workforces and Premium pay spending. A Business Case for implementation of the preferred option has been submitted to Monitor.

The Chief Operating Officer presented the Demand and Capacity briefing paper previously circulated based on an analysis of 78% of the Trust's templated capacity. This had showed there is little room to flex substantive capacity in Outpatients to meet any unexpected and seasonal surges in demand and that for Admitted Care only 65% of activity is delivered through substantive templated capacity (with substantial Deficits in Ophthalmology , T&O and Urology, identifying these as Key Risks). Governors were impressed by the methodology of this analysis and noted that this would also be the basis for the 2016/17 Business Planning Round and for the longer term Clinical Strategy.

The Director of Finance and Performance Management presented the Workforce Plan 2015-18 (in the absence of the Director of Human Resources). Governors noted that this was a "Plan" and not a Strategy as the wider clinical strategy had not yet been agreed and that a Programme would be prepare when this had been, The Trust's Workforce Cost Improvement for 2014/15 through to 2015/16 is included and the need for further work to be carried out on the Risks, Sensitivity and Mitigations of the assumptions made in the Workforce Plan.

Governors have been informed that, in agreement with the CCGs. the timing of the proposed public consultation on Clinical Strategy has been extended to "before November 2016" and that the development of this would be iterative and include consideration of the CCG's Joint Clinical Strategy from March, Monitor's Responses and the views of the Stakeholders represented on the East Kent Strategy Board, including KCC, the Clinical Senate, The Whitfield and Canterbury Vanguard Project Healthwatch, HEKSS and the Regional Team. Governors are also aware that any proposed configuration of hospital providers will need to conform with NHS England's developing Urgent and Emergency Care Facilities Specifications, including those for "Emergency Hospitals" and "Emergency Centres with Specialist Services " (August 2015) and the

Five Year Forward View.

The Director of Strategic Development and Capital Planning presented a summary of the EKHUFT Case for Change presented to Staff, Stakeholders and the Public (through Healthwatch) highlighting the analysis carried out together with Ernst and Young on the Services "under most pressures" - with key sustainability risks. (Governors are urged to study this summary). She then explained to Governors, in reply to their concerns, that Consultant Physicians at the Kent and Canterbury had agreed a rota there to provide the "cover" requested by the Dean for junior medical staff from December 1st. and that this issue would be kept under review of its sustainability.

SUMMARY OF COMMITTEE'S FORWARD PLANS:

The Committee will be following the responses from Monitor to the 6 submissions made by the Trust in the past 3 months including that to the Clinical Strategy and also the plans of the CCGs and other partners and stakeholder in relation to this.

The Trust's Annual Operational Plan Draft will be considered at the February open meeting and, as in previous years, members will be involved in preparing a draft for approval by CoG for the Monitor required Commentary on this.

COUNCIL OF GOVERNORS ACTION REQUIRED:

To note the report.

John Sewell
Chair CoG Strategic Committee

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT FROM THE PSE COMMITTEE CHAIR**

PURPOSE: I**nformation**

SUMMARY

This Committee has met only once prior to our CoG Report. It was decided to cancel the meeting scheduled for 10th. December 2015, owing to difficulty for staff, to provide updates upon the Colorectal Pathway and Kent Maternity Services. Maternity Services has been deferred until January 2016 and we will also request an overview of the Trust Midwifery Plan/update on plans following publication of the CQC Report in November. We will liaise with the Deputy Divisional Director for Surgical Services to arrange a suitable date in the New Year for a Colorectal Pathway update. The Breast Nurse Consultant, intended to carry out a verbal presentation, updating the Committee upon current provision of Lymphedema Clinics, but she was due to attend a Cancer Meeting later in December and felt it would be far more meaningful to update us after this. Accordingly, this will also be rescheduled.

The January 2016 P&SE will be our quarterly meeting at which we review Clinical Quality and Patient Safety.

Meeting 13th. November 2015

Our Cultural Change Manager outlined vision and the work which has taken place since the end of 2014. Development of leadership/management skills. A programme, developed in partnership with Hay Consulting, for senior executive/medical/corporate leaders is to be cascaded out from February 2016. A one day programme for middle managers has been attended by 500 staff. Staff information points have been established/monthly newsletter highlighting the Trust as a great place to work. Bullying and harassment is being addressed via a confidential helpline, workplace contacts, a staff charter, with an internal mediation service. The members of the Committee reiterated their interest in pursuing Emotional Touchpoints as a tool to assist with a Staff Engagement Programme. It was agreed that once the CoG Constitution Committee has commenced its review of the CoG Committee structure and, as part of this review, considered substantive changes, Jane Waters be invited back to progress the issue.

The Head of Outpatients provided an overview of the outpatient improvement programme. The outpatients department manages 1.1 million appointments per year and improvements have been prioritised, following the CQC visit in July 2014. Included, is a new post-operative optional appointment system; this to be agreed, when appropriate, by the consultant. Exploration of DNA and reminder systems. Escalation of appointments for patients waiting longer than they should. Obtaining diagnostic cardiac results prior to making a consultant outpatient appointment. A weekly audit of 20 patients to monitor the quality of staff welcome. Indeed, these improvements have been commended by the CQC at its last visit. She has duly

provided PSE with a report outlining comparison of services offered by the Trust at Buckland Hospital and the Royal Victoria Hospital, Folkestone, as Committee members expressed some concern regarding local perception that closure of the RVHF was probable.

We said farewell to Valerie Owen who has been our aligned Non-Executive Director for some time now. The Committee expressed its thanks for her valuable assistance and wished her well for the future.

SUMMARY OF COMMITTEE'S FORWARD PLANS:

Committee members welcome future enhanced opportunities to monitor clinical and safety quality issues, along with feedback from the revised programme for Trust EPSV's. We will continue to progress the Outpatient Patient Engagement Project, in conjunction with Drop-in Meet the Governor Sessions.

COUNCIL OF GOVERNORS ACTION REQUIRED:

To note the report.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

REPORT FROM**:** **THE COMMUNICATIONS AND MEMBERSHIP COMMITTEE CHAIR**

PURPOSE: **INFORMATION**

SUMMARY OF COMMITTEE ACTIVITY

The committee last met on 4 December 2015 and the following matters were discussed.

Committee Chair
Philip Bull agreed to chair the committee up to the completion of CoG committee structure.

Update on trust IT Developmental Work
The Director of IT presented many positive updates including;

- VitalPAC
- Access to GP records
- Portal to view all clinical data, an enabler for paperless working
- Electronic cas cards
- Open eye system for ophthalmology
- New maternity system
- Chemo E prescribing
- Pas replacement
- Health informatics now in-house
- Patient Wi-Fi and entertainment system (Hospedia) to be piloted on Taylor ward.

Other items discussed

- The new Communication team arrangements outlined by the Corporate Events, Trust Membership And Volunteer Services Manager
- The membership newsletter is under review
- Sarah Andrews to join the committee
- Thanks to Richard Earland for his input as aligned NED, this was Richard's last meeting.
- Special thanks to the late Brian Glew for his Chairmanship and support over the last few years.

COUNCIL OF GOVERNORS ACTION REQUIRED:

To note the report.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**18 JANUARY 2016**
SUBJECT:	**CONSTITUTION COMMITTEE**
PURPOSE:	**APPROVAL**

CONTEXT

At the November Council of Governors (CoG) meeting it was agreed the CoG Constitution Committee should meet as soon as practicable to discuss the establishment of an Audit and Governance Committee. In order to seek the views of as many Governors as possible the meeting was opened up to all to attend.

The suggestion was to take three of the Council of Governor Committees concerned with governance to see if they could be brought together. These Committees are:

- Audit Working Group, the
- The Committee Leads (Chair's) meeting and
- the Constitution Committee.

The above committees are the bodies through which governors are able to discharge delegated activities, in other words committees which may act in an advisory capacity to assist the Council of Governors in carrying out its functions (*5.1 Annex 7 – Standing Orders for the Practice and Procedure of the Council of Governors – EKHUFT Constitution*) in relation to:

- Proposed changes to the EKHUFT Constitution
- Establishing the criteria for the appointment, re-appointment or removal of the Trust's external auditors
- Reviewing the external auditor's plan, work timetable for the year, performance and year end audit recommendations
- Considering the structure, terms of reference, frequency and membership of CoG committees
- The effectiveness of CoG committee structures.

This would streamline and ensure all aspects of governance are considered when making recommendations to the full Council. It is therefore proposed to merge the above committees into a new CoG Audit and Governance Committee (AGC). Draft Terms of Reference are provided for approval at Appendix 1.

A number of other aspects were highlighted that could be discussed at this meeting:

- Alignment of all Council of Governor Committees with the Board Committees
- Governor training
- Other meetings Governors attend / clarity on the reasons for attending
- Feedback from public and patients
- Structure of the CoG meetings.

SUMMARY OF MEETING

An open meeting of the Constitution Committee was held on 14 December 2015.

There was a general consensus that the role of CoG committees should be to support governors in meeting their statutory duties either in full Council, or through recommendations to the CoG Committees. Appendix 2 provides an overview of the statutory duties and identified the CoG Committee that could undertake the detailed work prior to reporting to the full CoG.

It was felt that there were two distinct roles for governors; firstly to hold NEDs to account and secondly to represent the views of trust members. Training to support governors to fulfil these roles will be made available in 2016 through the in house Governwell core skills training (11 April) and a developmental training session on how to represent the views of trust members. There are being organised by the Trust Secretary.

It was agreed that the governors are well placed to feedback issues to the Board of Directors (BoD) from staff and members of the public whilst bearing in mind the existing structures to deal with individual complaints. It was felt that the committee structures were a useful conduit for identifying and presenting 'themes' to the CoG and BoD. It was agreed that the development of a database for governors to record issues would be a useful tool for identifying 'themes' that could then be investigated in the relevant CoG Committee for presentation at CoG.

It was felt that the position of Governors on wider trust committees needed to be reviewed as there is a lack of transparency in relation to the role that Governors are fulfilling when they attend such committees. Guidance on the involvement of Governors in other operational initiatives is also needed. For example, the possible involvement of Governors at staff exit interviews was discussed and it was felt that this was not an appropriate role.

It was suggested that Governor committees should mirror the BoD committees which would mean changing the current CoG Committee structure. It was also suggested that the NED Chair should be the link NED on the "mirrored" CoG Committee. The first step was to agree the new terms of reference for the Audit and Governance Committee as they would be tasked with looking at the detail behind these proposals. At first glance the BoD and CoG Committees would be as follows:

BoD Committee	Existing CoG Committee	Proposed CoG Committee
Nominations Sunny Adeusi	Nominations & Remuneration	Nominations & Remuneration
Remuneration Richard Earland	Nominations & Remuneration	Nominations & Remuneration
Quality Ron Hoile	Patient & Staff Experience	Quality
Integrated Audit & Governance Barry Wilding	Audit Working Group Constitution Committee Committee Chairs (Leads)	Audit & Governance
Finance & Investment Satish Mathur	Strategic	Finance & Investment
Strategic Workforce Colin Tomson	Strategic	Workforce
Charitable Funds Gill Gibb	Communication & Membership	Communication & Membership

It was suggested that the CoG Nominations and Remuneration Committee should carry out a Governor core skills audit to recommend CoG Committee membership based on skills and experience. This is the same methodology used for appointment to Board committees.

Communication in general was discussed and the following points made:

- More time is needed to be given at GoC meetings for governors to discuss agenda items in depth. This could be facilitated by a change in the structure and flow of committee reporting to quarterly CoG meetings. It was agreed that a proposal for timing and frequency of the CoG and its Committees should be proposed by the Trust Secretary. Appendix 3
- The annual joint CoG/NED meeting be used as a development opportunity
- Development of the CoG webpages to provide easy access to CoG Committee minutes and other relevant information
- Development of a rota for Governor attendance at BoD meetings and a pro forma for governors to share the key messages from the meeting.

It was suggested that the alignment of Governors to individual hospital sites and wards could be explored more fully at the joint CoG/NED meeting on 22 February 2016. Pro's and con's were identified and it was important to agree the rationale for the alignment and understand the benefits and output required.

The above summary and recommendations (below) were circulated to the CoG for comment on 24 December 2015.

RECOMMENDATIONS:

The CoG is asked to consider the following recommendations:

1. To establish a CoG Audit and Governance Committee (AGC) to replace the existing Audit Working Group, Committee Chairs (Leads) meetings and Constitution Committee and **APPROVE** the draft terms of reference at Appendix 1
2. **APPROVE** the revised CoG meeting schedule shown as Appendix 3: resulting in 4 (quarterly) CoG meetings each year; an annual CoG/NED meeting for use as a development opportunity and replace the joint BoD/CoG/Annual Members meeting with the required Annual Members meeting;
3. Discuss the alignment of governors to hospital sites at the joint CoG/NED meeting on 22 February 2016;
4. Ask the CoG Nominations and Remuneration Committee to take the lead on development of a core skills audit of the CoG and to use this to make recommendation on CoG Committee membership; and
5. Authorise the AGC to develop the detail of a CoG Committee structure which will mirror the BoD committee structure and will provide for:
    a. CoG committees to have a directly aligned NED as the main point of contact who will be the Chair from the "mirrored" BoD Committee i.e. Chair of BoD Quality Committee to be the link NED on the CoG Quality Committee;
    b. All CoG Committees to be chaired by a Governor (recommended through CoG Nomination and Remuneration Committee;
    c. The Chairs of the BoD and CoG committees to work together to develop the agendas for both meetings;
    d. Exploring the feasibility of joint reporting by aligned BoD and CoG

committees to CoG meetings;
e. Reviewing the frequency of the CoG Committees;
f. Reviewing the agendas of the CoG and CoG Committees to ensure that all statutory duties are reflected and given sufficient air time (see Appendix 2);
g. Reviewing the involvement of governors on trust wide committees and link these into the relevant CoG Committee where applicable

NEXT STEPS:

Once approved to schedule in the actions to the relevant CoG Committee meetings and ensure Governor and Membership Lead takes forward the development of a database and work on the website.

COUNCIL OF GOVERNORS ACTION REQUIRED:

1. To agree recommendations 1 - 4
2. To consider recommendation 5 for agreement

Appendix 1

AUDIT AND GOVERNANACE COMMITTEE

TERMS OF REFERENCE

Purpose:
The committee is responsible to the Council of Governors for the following:

1. Working with the Board of Directors' Integrated Audit and Governance Committee (IAGC) to establish the criteria for the appointment, re-appointment or removal of the Trust's external auditors, including the method for monitoring the quality of the external audit as set out in HEFMA NHS Audit Committee Handbook;
2. Presenting to the Council of Governors the procurement process that it has followed for the appointment of the external auditors, the results of the procurement processes and recommendations
3. Receiving the external auditor's plan and work timetable for the year, to review the external auditor's performance and review any year end audit recommendations
4. Receiving the internal auditors plan, work timetable and annual report, for information only
5. Seek assurance from the Chair of the IAGC that internal control processes are in place and working effectively
6. Enhancing and improving the effectiveness of the Council of Governors and to support closer working relationships between the Council of Governors and Non-Executive Directors
7. Working with the Trust Secretary to ensure the Trust's Constitution complies with latest legislation and Monitor guidance
8. Considering any locally proposed amendments to the EKHUFT Constitution
9. Reviewing the effectiveness of NED engagement with Council Committees and Working Groups and report conclusions to the Council
10. Reviewing the effectiveness of Council of Governor meetings and committee structures; including terms of reference, frequency of meetings and membership (in conjunction with the Nomination and Remuneration Committee);
11. Reviewing Committee activity, identifying common themes and key issues arising and report these to the Council
12. Identify any emerging priorities for Council debate and engagement and make recommendations to the Council for its future agendas
13. Monitoring all elements of the working of Council of Governor meetings and make any recommendations to the full Council.

Membership:
To be agreed

Quorum:
To be agreed

Structure and Frequency of Meetings:
To be agreed

The committee will be supported administratively by the Corporate Secretariat and receive professional advice from the Trust Secretary.

APPENDIX 2 - LIST OF COUNCIL OF GOVERNOR STATUTORY DUTIES / RESPONSIBILITIES

It is accepted that only the full Council of Governors can make decisions and the CoG's committees / working groups make recommendations after having the opportunity to scrutinise the available information in detail in their committee. In relation to holding the non-executive directors' to account, the opportunity for this is currently at the Council of Governors. Going forward the plan will be to take the performance aspects to the relevant CoG committee with the Chair of the NED committee attending the CoG Committee to present and to allow the members' of the CoG Committee to hold them to account. The performance elements will then be dealt with under the Chair reports to CoG with the NED link presenting and the CoG Committee Chair outlining the challenges discuss at the CoG Committee.

DUTY	**BoD Committee**	**CoG Committee Recommendation (Current)**	**CoG Committee Recommendation (Future)**
Appoint and, if appropriate, remove the chair	n/a	Nominations / Remuneration (N&R)	Nominations / Remuneration (N&R)
Appoint and, if appropriate, remove the other Non-executive directors	n/a	N&R	N&R
Decide the remuneration and allowances and other terms and conditions of office of the chair and the other non-executive directors	n/a	N&R	N&R
Approve (or not) any new appointment of a chief executive	Nominations	N&R	N&R
Appoint and, if appropriate, remove the NHS foundation trust's auditor	n/a	Audit Working Group	Audit & Governance Committee (AGC)
Receive the NHS foundation trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the council of governors.	Scrutiny at IAGC & Quality Committee	Audit Working Group	Scrutiny at AGC & Quality before AMM
Hold the non-executive directors, individually and collectively, to account for the performance of the board of directors	n/a	CoG	Finance & Investment Committee (FIC) Quality Committee (QC) Strategic Workforce (SWC)
Represent the interests of the members of the trust as a whole and the interests of the public		Comms & Membership	Comms & Membership

Approve “significant transactions”	FIC / BoD	Strategic Com / CoG	FIC
Approve an application by the trust to enter into a merger, acquisition, separation or dissolution	FIC / BoD	Strategic Com / CoG	FIC
Decide whether the trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions	FIC / BoD	Strategic Com	FIC
Approve amendments to the trust’s constitution or ways of working	BoD	Constitution	AGC

OTHER RESPONSIBILITIES	**BoD Committee**	**CoG Committee Recommendation (Current)**	**CoG Committee Recommendation (Future)**
To receive and consider updates on the Trust’s strategic direction and act as a critical friend in providing feedback to the Board of Directors on the development of the Trust’s Forward Plan	FIC / BoD	Strategic Committee	FIC / CoG
To approve the removal from office of a Governor	n/a	Constitution Committee to advise on process / CoG	AGC to advise on process / CoG
To approve the expulsion of a member of the Trust	n/a	Constitution Committee to advise on process / CoG	AGC to advise on process / CoG
to approve and routinely review the procedure for the resolution of disputes between the Board of Directors and the Council of Governors	BoD	Constitution Com /	AGC
Approve the membership strategy	BoD	Comms & Membership Com	Comms & Membership Com
To approve the allocation of members to committees or working groups of the Council of Governors	Nominations (for BoD committees)		Nomination / Remuneration Com
Agree Lead Governor role	n/a	CoG	CoG

APPENDIX 3: PROPOSED TIMETABLE

	JAN	FEB	MCH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
COUNCIL OF GOVERNORS[1]												
JOINT NED/COUNCIL OF GOVERNORS MEETING												
ANNUAL MEMBERS' MEETING												

Council of Governor meeting rationale:

1 Proposal to hold quarterly meetings to fall soon after quarter end submission to Monitor.
2 Audit and Governance Committee to review the supporting structure of the Council of Governor committees and frequency.
3 Propose to delegate responsibility to Governor Committee for scrutiny of trust strategies and annual plans. Ensure full understanding of whole Council via Chair reports or formal papers/presentations.

Joint NED/Council of Governors Meeting

1 Development day.
2 Previously this meeting was held as an opportunity to challenge NEDs around the Trust's annual plan submission.

Annual Members' Meeting

1 Monitor guidance states meeting should be held soon as practicably possible after the Annual Report and Accounts have been laid before Parliament.
2 Annual Report and Accounts will be published on the Trust website in July (after submission to Parliament and laid reports to Monitor).

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT FROM GOVERNOR MEMBER**

PURPOSE: I**nformation**

SUMMARY

The report provides a summary of the End of Life Board (the Board) meeting in December 2015.

Terms of Reference (TOR)
Amendments were reviewed and accepted. It was agreed to add representatives from Woman & Children's health, the bereavement office, A + E and Diabetes to the membership.

CCG End of Life Pathway Redesign Group Feedback
EKHUFT is focusing on Tier 3 (acute care) pathway design for hospital patients. Feedback was given from the Tier 3 group meeting that concentrated on pathway redesign and the KPIs. The amendments have been submitted to the main group for discussion and approval. Training was also discussed and it was agreed that any training had to integrate and support any requirements that have come out of the CQC Report on our End of Life care. It is hoped that the whole East Kent Healthcare Economy will be signed up to the integrated Care Policy for End of Life by the end of March 2016.

IM&T (Information Management & Technology) task and finish group for the CCG End of Life pathway redesign is chaired by our Medical Director. At the last meeting of this group, a presentation was given of the CareFlow system used by us. The benefits and possibility of using this system throughout East Kent will be discussed at the next main Pathway Redesign Group meeting. Over 95% of East Kent GPs have signed up to and are using the MIG (Medical interoperability Gateway) that allows our clinicians to see GP records. This means that all those involved in a patient's care will be able to view medical history, medication details, anticipatory and advance care plans and DNACPRs. This will assist smooth transition between GP, hospital, care home and hospice care.

EOL Documentation Implementation
An update was given on the progress of the new documentation. It was agreed to go live with the documents and then follow-up with any training that is required as soon as possible.

CQC End of Life Report
End of life care was red in the latest CQC report. Within a couple of weeks of the CQC Report being published, the Improvement Board had identified the areas that need improving. As of the EOL Board meeting, twenty points were identified and ten were still outstanding. The High level Improvement Plan which includes the points identified for EOL was presented to the Trust Board for approval on 11/12/2015 and

then sent to Monitor on 14/12/2015.

Other Items Discussed
Funding has been approved to employ a CNS (Clinical Nurse Specialist) for End of life Care by the Trust. The Board was pleased to hear that there has been a great deal of interest in this newly created role.

After discussion it was agreed to add End of Life to the Heat Map to monitor how it is working. From the beginning of January 2016, Voices documents are going to be sent out to respective families on a three monthly basis for feedback on their End of Life experience. We should expect about 200 responses. They are also going to be sent to staff.

SUMMARY OF COMMITTEE'S FORWARD PLANS:

- Continue with the work to complete the CCG End of Life Pathway Redesign
- Implement the new documents and EOL Care Improvement plan
- The next meeting of the Board is on 11th February 2016.

COUNCIL OF GOVERNORS ACTION REQUIRED:

To note the report.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT FROM GOVERNOR MEMBER**

PURPOSE: **Information**

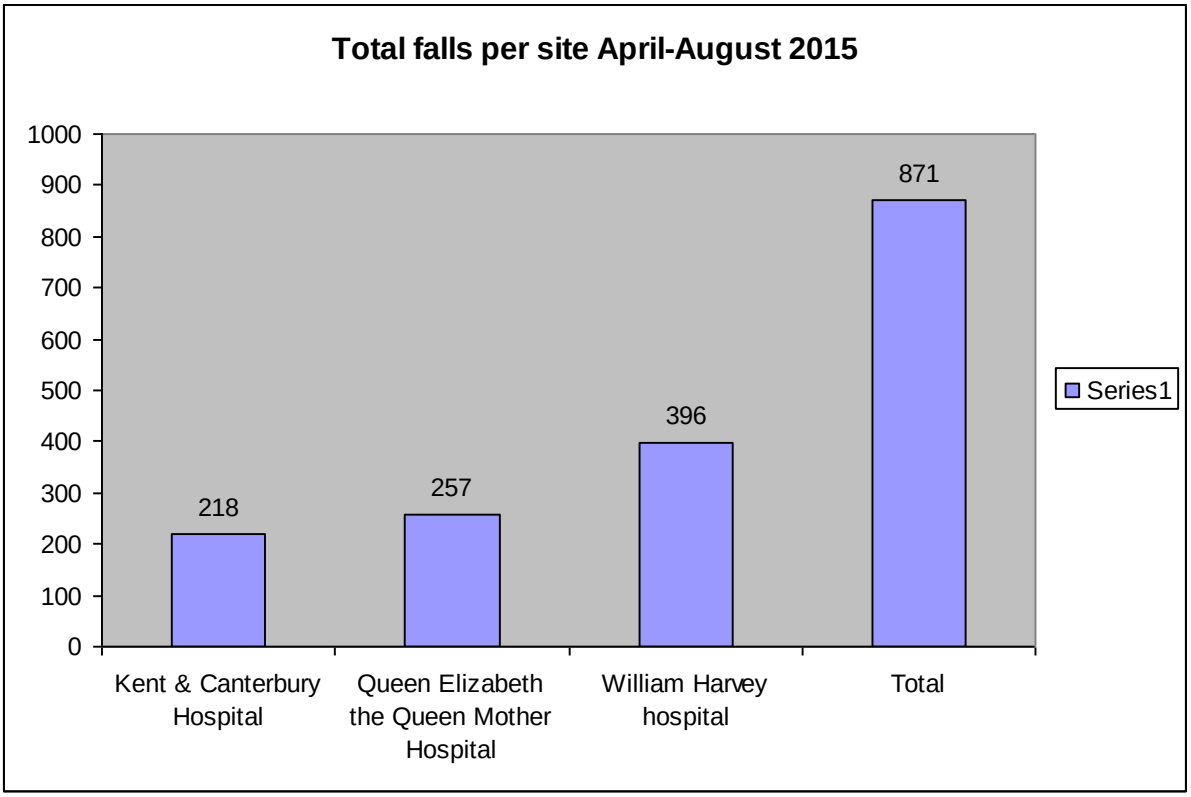
SUMMARY:

The report provides a summary of the fourth meeting of the Prevention of Falls and Injuries Steering Group (the Group) meeting on 23rd September 2015.

On this occasion the meeting was chaired by a member of the Group, a Consultant in the Health Care of Older People and the Falls Clinical Lead for Royal College of Physicians. *National Audit of Inpatient Falls: audit report 2015.*

The audit was created to measure against the National Institute for Health and Care Excellence's (NICE's) guidance on falls assessment and prevention (NICE clinical guidance 161 (CG161)) and other patient safety guidance on preventing falls in hospital. The audit was open to all acute hospitals in England and Wales and EKHUFT participated fully.

The Chair led the meeting through this recently published report that reinforces the fact that patient falls during a stay in hospital are the most frequently reported patient safety incident nationally. The figure below indicates the number by site for EKHUFT between April and August 2015.



The Chair pointed out that the National Audit indicated that EKHUFT (all sites) fell within the middle range of falls reported when compared with other Trusts in England. She highlighted the key recommendations from the National Audit that are already being incorporated into the Trust's action plan for the Prevention of Falls, which are:

- **Falls steering group** – trusts have a board-level falls steering group that has representation from and reports to the Board. This group should regularly review their data on falls and moderate harm, severe harm and deaths per 1,000 OBDs and assess the success of their practice against trends in these figures.
- **Falls multidisciplinary working group** –trusts have a falls multidisciplinary working group that meets regularly, monitors interventions to improve prevention of falls in hospital and use proven methods to embed these changes.
- **Do not use a fall risk prediction tool** –trusts review their falls pathway to see whether they are still using a fall risk prediction tool. If they are, they should stop using it with immediate effect, regard the following groups of inpatients as being at risk of falling in hospital and manage their care accordingly as per NICE CG161:
  - all patients aged 65 years or older
  - patients aged 50–64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.*
- **Audit bed rail use** –trusts regularly audit the use of bed rails against their policy and embed changes to ensure appropriate use.
- **Review multifactorial falls risk assessments (MFRAs)** –trusts review their MFRA and associated interventions to include all the domains in this audit. This will then need to be linked to quality improvement projects to ensure that what is included in the policy actually translates into what happens on the ward.

The full audit report may be accessed via:
https://www.rcplondon.ac.uk/projects/outputs/naif-audit-report-2015

NEXT STEPS:

- Finalise and implement the Trust's "Falls Stop" programme that will be the means by which intensive support will be provided on a ward by ward basis on each EKHUFT site to:
  - Reduce the incidence of falls
  - Reduce harm from falls
  - Embed falls prevention into everyday practice
  - Engage clinical staff to identify patients at risk and enable appropriate implementation of harm prevention strategies.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **18 JANUARY 2016**

SUBJECT: **REPORT FROM GOVERNOR MEMBER**

PURPOSE: I**nformation**

BACKGROUND

The CHOC Group was formed in 2014 to review and set core Standards for Handover and Transfers of Care and to ensure that speciality handover documentation is in line with these. Also to develop an assurance framework for these by monitoring adherence to policies through audit, examining incidents and trends and reviewing RCAs of all serious incidents relating to handover. It has a wide and representative membership and currently meets every 2 months under the chairmanship of the Associate Director of Patient Safety. Marcella Warburton and John Sewell have been alternating as governor representatives to provide a service user perspective.

SUMMARY OF RECENT ACTIVITY

Its most recent meetings were on 23rd November and 28th September. These included examination of a revised maternal/neonatal Transfers Policy, update on implementation of "Careflow" communication (an application to replace paper documentation) across the 3 main sites, revision of Handover of Care Policy and examination of an audit of 50 reported transfer incidents and 32 handover incidents carried out between April and August 2015.

The main concerns arising from the last were failures to use the required and agreed SBAR forms (Situation, Background ,Assessment and Recommendation documentation) and in communication of dietary needs, drug dosage, DNAR status, forward plans and behaviour issues.

It was clear at the November meeting that despite the best efforts of the Group, there were still a few "islands" of non-compliance at the 3 main sites (despite a thorough distribution of guidance posters) and some communication problems with ambulance staff involved in transfers ,These were being addressed and mandatory requirements agreed with the Divisions and with SECAMB were to be implemented throughout January 2016 - which it is hoped will resolve these issues - these will be reviewed by the Group in January.

COUNCIL OF GOVERNORS ACTION REQUIRED:

To note the report.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**18 JANUARY 2016**
SUBJECT:	**REPORT FROM GOVERNORS ATTENDING GOVERNWELL CORE SKILLS TRAINING EVENT (NOVEMBER 2015)**
PURPOSE:	I**nformation**

The training was exemplary.

Underpinning the whole day was that in all we do as governors we should be holding NEDs to account.

The day included the following

- To understand the framework within which NHS trusts operate
- To understand governors statutory and non-statutory roles
- To understand the concept and methods of holding the board to account
- To provide a forum for governors to meet and learn from each other

We considered the current NHS facts and figures compared to the past. The 5 Year Way Forward and new models of care were discussed in detail and how Foundation Trusts fit into the health system in England.

There was an excellent introduction to finance including income flows and expenditure. The role of governors in financial monitoring was developed in some depth, particularly the relationship with NEDs. In particular we found the explanation about CCGs and NHS England very helpful as well as the detail about staffing costs and planning patterns.

The most insightful aspect of the day was that we were told at several points that governors should be :

Understanding the process
Getting the right information
Testing the information
Forming a judgment
Feedback to the board

Assurance = Sufficient evidence + confidence

The final part of the day was to consider how strategy impacts upon the work of the Trust.

As governors we should ask ourselves

- Is the Trust sustainable?
- How does the board know this?

- What are the risks?
- What actions do we know are happening to produce results?
- How do we spot problems early enough?
- How do we know we are effective?

Three areas that we found particularly interesting and helpful :

1. Governance and the role of the governor - overarching statutory duties of representing the interests of members and the public and holding the NEDS to account for the performance of the board. Understanding how boards achieve good assurance and manage the risks. We learnt that holding to account is a process and why it is important.

2. Effective Questioning and Challenge – how to prepare your questions, the way to ask them, are they reasonable, have you the right to ask them and would others agree. There was a group exercise which was lively and entertaining at the same time very helpful.

3. How funding flows through NHS organisations to reach Foundation Trusts.

Robert Goddard
Jane Burnett
January 2016

COUNCIL OF GOVERNORS ACTION REQUIRED:

To note the report.