UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS PUBLIC MEETING TUESDAY 24 2016 THE GLO CENTRE, GILGAL CAFÉ, UNIT 2, WESTWOOD BUSINESS PARK, STRASBOURG STREET, MARGATE, CT9 4JJ

Present:

Nikki Cole	Chair	NC
Alan Holmes	Elected Governor – Canterbury	AH
Chris Warricker	Elected Governor – Canterbury	CW
David Bogard	Elected Governor – Staff	DB
Eunice Lyons-Backhouse	Elected Governor – Rest of England & Wales	ELB
Jane Burnett	Elected Governor – Ashford	JB
John Rampton	Elected Staff Governor	JR
John Sewell	Elected Governor – Shepway	JS
Junetta Whorwell	Elected Governor – Ashford	JW
Mandy Carlliel	Elected Staff Governor	MCa
Marcella Warburton	Elected Governor – Thanet	MWh
Margo Laing	Elected Governor - Dover	MLa
Matt Williams	Elected Governor - Swale	MW
Michèle Low	Elected Governor – Shepway	MLo
Paul Bartlett	Elected Governor – Ashford	PBa
Paul Durkin	Elected Governor – Swale	PD
Philip Wells	Elected Governor – Canterbury	PW
Reynagh Jarrett	Elected Governor – Thanet	RJ
Robert Goddard	Elected Staff Governor	RG
Sarah Andrews	Elected Governor – Dover	SA

IN ATTENDANCE:

Alison Fox	Trust Secretary	AF
Barry Wilding	Non-Executive Director	BW
Colin Tomson	Non-Executive Director	CT
Matthew Kershaw	Chief Executive	MK
Nick Gerrard	Director of Finance & Performance Management	NG
Paul Stevens	Medical Director	PS
Richard Earland	Non-Executive Director	RE
Ron Hoile	Non-Executive Director	RH
Sally Smith	Chief Nurse & Director of Quality	SS
Sandra le Blanc	Director of HR	SlB
Satish Mathur	Non-Executive Director	SM
Amanda Bedford	Governor & Membership Lead	AB
Stephen Dobson	Foundation Trust Membership Engagement Co-Ordinator	SD

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

Minute No:		
CoG	**CHAIR'S INTRODUCTIONS** NC welcomed AH to his first Full Council meeting and welcomed CW back to the Council; both had been elected to represent the Canterbury Constituency. NC recognised the good contribution to the work of the Council made by Pauline	

	Hobson in her short period as a Governor.	
CoG 16/16	**APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** **Apologies for absence** Apologies were noted from: Carole George, Governor Roy Dexter, Governor Philip Bull, Governor Debra Teasdale, Partnership Governor Michael Lyons, Partnership Governor Jane Martin, Partnership Governor Geraint Davies, Partnership Governor Sunny Adeusi, NED **Declarations of Interest** There were no declarations of interest made.	
CoG 17/16	**MINUTES FROM THE LAST PUBLIC MEETING HELD ON 18 JANUARY 2016 AND MATTERS ARISING FROM** The minutes of the meeting held on 18 January 2016 were agreed as an accurate record with the following amendments: The following items to be included in the action points table and updates provided: • 54/15 Integrated Audit and Governance Committee – interface between ESR and the Active Directory (AD) update on progress to be reported. • 4/16 Chair/Non-Executive director reports from Board and Board Committees update on the inclusion of a tracking module as part of the new risk system. 8/16 CoG Committees – reports from Committee Chairs, Constitution Committee MLo asked that the use of the term 'supportive' in paragraphs 2 and 4 on page 10 did not correctly reflect her view. She considered that aligning Board and Council Committees blurred boundaries and had the potential to encourage Governors to seek to become involved inappropriately in Board and Operational matters. She was not supportive of the proposal but would abide by the majority decision of the Council to test out the arrangement and review after a period. 13/16 Any other urgent or important items – Radiology Services PD noted that the radiology services referred to were in the Minor Injuries Unit. New equipment was up and running and he hoped that this type of co-operation between the Trust and GPs would continue. Matters arising and Action points: 4/16 Chair/Non-Executive director reports from Board and Board Committees – Strategic Workforce	**AF**

	RJ said that he had seen little evidence that the Trust was actively promoting the East Kent area as a good place to live as part of recruitment programmes. NC said that this would be addressed later in the agenda. <u>40/15 Cultural Change Programme</u> NC noted that this had been presented to the CoG Patient and Staff Experience Committee, to which all Governors had been invited. The action was closed. <u>62/15 AOB – Kent Council Consultation on Residential Care</u> PB said that, in his view, KCC had become a commissioner of residential care rather than a provider and expressed concern about the impact of the changes on the Trust. He sought assurance that the Trust and KCC were working in partnership. RJ and JW spoke briefly about the funding of nursing home provision in Thanet and Ashford respectively.	
CoG 18/16	**CEO AND PERFORMANCE UPDATE** MK noted that had now been with the Trust for four months and had spent a lot of time visiting each of the sites and understanding from staff how they felt about the organisation and how it needed to move forward. MK said that, from a performance perspective, there were both positives and challenges and he highlighted the following. • There were clear trajectories for cancer targets and the organisation was in a comparable position nationally, there was room for improvement. • The area of greatest challenge was emergency care with many factors which impacted on the service being outside of the Trust's control. The last month had seen very high attendance, 600+, with a high proportion of major care issues. • The Trust was focussed on internal improvements but was also in conversation with partners about a number of issues: - managing arrivals; - managing admissions; and - essential nature of working with partners to manage discharges effectively/ • Contract negotiations: the Trust had moved to a payment by results model but the Sustainability and Transformation Plan (STP) had yet to be agreed centrally. • The Board had set the objectives and priorities for the year: - Patients - People: staff - Provision: to be focussed on our activity - Partnership: fundamental to success • The CQC re-inspection was likely to be in the early Autumn and the Trust would receive some three months' notice. Moving the Trust out of special measures was the top priority – to give patients and regulators confidence that the Trust was being managed properly and well. It was an issue of morale and MK said that there would be dividends gained by moving out of special measures. • The Clinical Strategy was another significant strand of the recovery process – it was essential to be clear with both the public and staff what the plans were and how these would be achieved. MK said that the draft strategy would be shared with Governors. The strategy had to form part of the STP submission to NHS Improvements at the end of June and he	

	expected public consultation to take place by the end of the year. Questions from Governors PD concurred that working with partners was essential and made reference to the KCC consultation on nursing home provision. MK said that the KCC had a vital role to play and said that he had found them to be active in the conversations taking place with partners. He suggested that it might be helpful for Governors to receive a more detailed presentation on the work with the KCC. JB commented that, having attended meetings as a member of her local primary care provider since becoming a Governor, she had been surprised at the lack of flow of information up to the CCGs. MK said that he and NC were working closely with the CCGs using a number of existing forums and introducing Board to Board and Executive to Executive meetings to improve information flow. He felt that this was now more positive but the challenge of transforming conversations to positive action remained. MLo suggested that the Governors could receive a presentation in the future on partnership engagement, which MK agreed would be a good idea. CT suggested that this could be done in the context of the five year plan. In response to a question from CW, MK said that the Integrated Performance Report provided to the Board and its Committees was connected financial, quality and workforce issues and provided data to allow NEDs to test performance and gain assurance. JS noted that there had been partnership working with the CCGs in relation to the redesign of the Emergency Care Centre at Canterbury. MK agreed and said that it was expected that the new service would be in place in August.	**Agenda** **Agenda**
CoG 19/16	**NON EXECUTIVE DIRECTOR REPORTS FROM BOARD COMMITTEES** **Board of Directors** NC noted that the report covered the February and April Board meetings, where the focus had been on setting the Trust's strategic direction and objectives. She advised the meeting that the concerns raised about a lack of focus on Health and Safety issues related to non-clinical matters. SA commented that she had attended the April Board and had been impressed with the team of ward managers who had given the presentation; they had been vibrant and enthusiastic. **Integrated Audit and Governance Committee** BW noted that since the paper had been circulated there had been a joint meeting of the Audit, Finance and Quality Committees to approve the year end accounts. He noted that there was nothing significant to report with respect to the Annual accounts, although, as the Trust was in special measures, these would be 'Qualified'. BW reported that there would be three indicators in the Quality Accounts assessed as limited assurance leading to a qualified opinion. MK commented that it was important to understand that this related to the data collection and was not a reflection on the quality of the service provided. The Auditors had not been able to complete their work in some areas as data had not been available; work was being done to resolve the problem. Questions from Governors	

	RJ expressed concern about the low level of compliance with mandatory training and noted that clinical staff were required to be up to date in order to be re-validated. He commented that staff were no longer able to access the training from their home systems and that this had impacted on performance. RG observed that the amount of training deemed to be mandatory was increasing and it was hard for staff to find time to complete the work. DB said that the situation was very frustrating for staff and managers; it was essential for this to be addressed for the work on cultural change to succeed. SlB assured Governors that the issues were recognised and Liz Shutler's team were planning to introduce an app which would make access much easier. The e-learning system was a national package and this presented the Trust with some challenges when trying to make adjustments to improve local accessibility and relevance. MLo questioned why performance had fallen in relation to the internal audit programme, especially has this had been discussed since June 2015. PS noted that the internal audit department had been increased in size and devolved into the divisional structure. As a result some of the co-ordination had been lost. As all trainees were required to undertake audits, improvements in central co-ordination were essential and changes were being made to the way in which the Audit Committee worked to ensure that this took place. BW noted that the Committee had seen some improvement, although this had not been sustained and more work was being done understand the cause. MLa sought, and received, assurance that the Active Directory had been implemented and would be followed up. MLa noted point 2b in the report that the Trust was in breach of its Provider Licence and asked when this would be resolved. MK said that the financial deficit and the Emergency Care provision across Kent were the two key issues. It was unlikely that these would be fully resolved by the time of the next inspection although a lot of work was being done to address the problems. He explained that on a practical basis many Trusts in the country were operating while being deemed to be in breach of their licence; it was important to be able to demonstrate that appropriate and robust action was being taken. In response to an enquiry from JW, BW confirmed that the Anti-Fraud, Bribery and Corruption Policy dealt with all aspects of fraud within the health service. MK confirmed that he was addressing concerns raised by a small number of staff relating to the impact of inland revenue rules capping mileage claims. SA noted the significant improvements in emergency preparedness and asked whether the Board were now confident that there was no significant risk remaining. CT said that the partnership with Maidstone and Tunbridge Wells had been very successful and the Trust was almost at a fully green status. AF noted that she would be presenting the modules to be added to the risk system to MK that week; progress on this work had not been as swift as she would have wished. **Finance and Investment Committee (FIC)** SM noted that there had been significant changes made to the planning process for 2016/17 which had meant slower progress than in previous years. The Committee had now had presentations from two divisions on their plans and two more would come to the next meeting.	

Questions from Governors

CW noted that he had raised a number of questions via email with respect to the variation in the figures reported for the value of the Cost Improvement Programme (CIP) and summarised these.

RJ requested, through the Chair, that CW apologise for the personalised manner in which he had presented his concern. CW offered his apologies immediately.

SM responded saying that he could categorically assure the meeting that the FIC, Board and the Trust was fully committed to delivering real change. The commentary within the Annual Accounts was very clear about the non-recurring nature of a proportion of the CIP savings and the figures for the year were laid out and audited. The FIC fully understood the issues and the challenges the Trust faced in the coming year as a result of the non-recurring nature of savings made in 2015/16. The Committee were robust in their expectation that there would be proper plans for each CIP work stream and that these must be meaningful.

MLa asked what assurances could be provided that agency spend, which was a critical financial pressure on the Trust, could be reduced in a sustained way. SM said that this was a complex issue and one which the Committee was fully focussed on. Staff recruitment and retention, continued delivery of quality services and managing productivity/efficiency were all key issues. Promoting Kent as an attractive area to work in was another important factor. There was a balance which had to be achieved between reducing financial pressures while maintaining the quality of services. He agreed with the comment made by MLa that it may be necessary to re-forecast agency spending; planning assumptions were subject to change. NC commented that she was seeing progress. In response to a question from SA, SM confirmed that there were monthly PRN meetings with Monitor and the Board were fully aware of their concerns. JW noted that in her view there would always be some agency spend in order to manage sudden absences.

RE supported the assurances given by SM about the robust approach taken by the FIC; information provided was challenged and tested. Having been a Non-Executive Director in the Trust for five years, he was of the view that there was now a far better understanding of the dynamics involved and more effective challenge. To illustrate this: two years ago the CIP consisted of in excess of 600 projects – it had now been reduced by at least three quarters and managed within work streams.

PB suggested that there was potential for the Trust to exploit partnership working to a greater extent and he also wondered whether there was any potential for using zero hours contracts.

SM noted that there were already a number of partnership projects underway including pathology project with the Maidstone and Tunbridge Wells. RG confirmed that the Trust's pathology department were involved in, and supportive of, this project.

SlB noted that the Trust had an internal bank for staff who wished to work on an hourly basis, run by NHSP. In response to a question from RJ she confirmed that the bank supported professionals who wished to return to work and did all they could to recruit locally.

Remuneration Committee and Nomination Committee
RE noted that the two main items considered by the Remuneration Committee were the appraisal process for the Chief Executive and receipt of performance objectives for the Executive Directors and a report on their performance from the Chief Executive. He commented that the quality of the debate on these items had been well supported by the thoroughness of the Chief Executive's approach to the process. The Committee had also looked at benchmarking data in relation to Executive remuneration.

Governor Questions:
RE provided the assurance requested by JB that there was a link between the Trust Chair's objectives and those of the Executive team. He confirmed that if the Chair's objectives' were change the Committee would expect to see appropriate carry through into other objectives.

JW sought clarification of the management level that the Committee reported on. RE explained that the Committee considered posts at a very senior level, which basically translated to roles immediately below the Chief Executive, ensuring that remuneration was justifiable, appropriate and reasonable.

RE said that he was also presenting the report on the Nominations Committee on behalf of Sunny Adeusi. There were three main issues discussed: the external review of the Board's performance; succession planning; and the appointment of Deputy Medical Directors.

Governor Questions:
RE said that the draft report of the external review may be ready to be brought to the next meeting of the Council in July. In response to a query from MLa, he confirmed that the Committee were also involved in the process for appointing a deputy CEO. MK noted that this was not a new post; the appointment would be made from the existing executive team.

Quality Committee
RH said that he would welcome comments on the structure and content of the revised reporting structure.

Governor Questions:
SA said that had found the inclusion of the dashboard data to be very helpful. She drew attention to the alert that there had been a rise in harm severity reported in March and asked whether the NEDs were confident that the investigations into incidents were thorough and action plans and learning transferred across the Trust. RE said that it was recognised that there were significant challenges to ensuring that lessons learned were shared and actions embedded in an organisation of over 7000 staff spread across three major and two smaller sites. He was assured that investigations were thorough and there was a clear understanding of the root cause, more work was needed to ensure lessons were learned on an organisational basis.

MW asked whether the targets set for quality improvements at paragraph 4d were realistic. RH said that these were inspirational targets, with the bar set high; SS and PS had been involved in the process.

MLa referred to section 2, highlighting concerns and noted that she would concur with the assessment. With respect to 2e, increases in delayed transfers

	of care, she noted that elsewhere in the papers some work had been predicated on there being an increase of 60 in bed capacity due to anticipated improvements in the speed of transfers. PS said that the situation was a complex one; some transfers were outside of the Trust's control, which was the basis for the concern expressed, however the Safer Bundle of Care approach, a Trust initiative, was expected to deliver bed savings. MLa noted that performance against VTE screening targets remained a concern; the issue had been discussed at the last Annual Members Meeting, could assurance be given that progress was being made. PS said that the Trust was committed to strict adherence to VTE assessments and he had seen the systems consultants had put into place to ensure this was done. One challenge was the reporting tool used; this was separate to the main system so required more staff time to comply with reporting requirements. That said, the Trust was very rigorous in its reporting and was clear about the performance. JW asked whether the Trust had been able to recruit to acceptable levels for midwifery staff. RH said that there were currently 3 vacancies; the establishment set did meet safety guidelines set out by the Royal College of Midwives. RG noted that the Trust had recently lost two very experienced infection control staff and asked for assurance that standards could be maintained. SS said that these had been planned changes and support staff were in place while long term recruitment was completed. The infection control processes had been well embedded within the Trust and she believed that standards would be maintained. **Strategic Workforce** CT highlighted key elements of the report: • appraisal rates had fallen slightly however assurance had been provided that the new system which had been introduced, the Committee would continue to look at the data on a divisional level; • the cultural change programme was being delivered across the organisation with objectives being aligned, the programme was being branded 'Great Place to Work'; • the presentations from the first two divisions on their action plans to deliver change had been encouraging, significant improvement should be visible by the latter part of the year. <u>Governor Questions:</u> In response to a question from JB about the failure to meet the 90% target for appraisals, CT said that the Board Committee had received assurances that there were trajectories in place in each division to reach target. JB noted that the assessments given at 3a and b relating to the cultural change programme did not seem to be supported by the results of the staff survey and reported issues relating to leadership. CT said that this had also been discussed at the Board meeting and the assessment was downgraded. NC commented that cultural change would take time, however she considered that there had been significant change already as a result of introducing the respect objective the previous summer; the culture was now much more open.	

PB noted that the target for mandatory training compliance was challenging at 90%. CT agreed and said that there had been a lot of discussion about how this could be achieved and improving staff access to the system.

PB asked whether there were targets in place for the turnover rate. CT said that the aim was to achieve a rate of 10% by March 2017. MK noted that the turnover of junior doctors was not included in this target as they had different contract arrangements and moved as part of their training. He was not aware that there had been any underlying changes in junior doctor turnaround. RG commented that this was a challenging target to achieve; CT advised that the current rate was 11.5%.

RJ noted the deterioration in the Friends and Family test and wondered whether this was because more people were now being approached to take part or an actual downturn in the outcome. CT noted that the results had been moving in a positive direction last year and the most recent result had shown a tail off from the downward curve. CT noted that there was now a divisional heat map for HR issues and this was identifying specific areas of concern. A range of tools were available to support managers to tackle problems. CT agreed with RJ's observation that the results were indicative of a serious underlying problem, noting that this was now more visible as staff were more willing to be open.

MLa drew attention to item 4e, continuing to reduce agency costs to £23M and asked what assurance had been provided that this was achievable. CT said that the Board Committee were clear that the Trust and Board were fully committed to achieving the target, however, it was accepted that the national vacancy situation and the impact of the junior doctors' strike had made it even more challenging to achieve.

JW commented that while recruitment remained a problem, agency spend would have to continue. This would have an impact on permanent staff and affect morale and feed though to the staff survey. CT said that the visibility that there now was meant that staff engagement could be seen and problem areas addressed. SlB outlined the actions being taken to control agency spend: effective e-rostering; executive sign-off on agency spend; detailed workforce plan which recognised and addressed national areas of staff shortages; engaging with staff to stress that reducing agency spend was about maintaining quality as well as for financial reasons; and developing a Trust staff bank where pay rates could be managed.

DB commented that the staff vacancy situation was driving the use of agency and the impact on finances; from his point of view he felt that the organisation now had a five – ten year plan for strategic development which was clear about the Workforce plans required and how these could be delivered. CT concurred: there was a strategy and a plan, the Board Committee's role was to gain the assurance that this was being delivered.

Charitable Funds Committee
GG noted that this report covered two meetings of the Committee. The Charitable Funds team were a small and well run group with an obvious focus on fundraising. A new fundraiser was soon to be appointed and GG said she had challenged the team to demonstrate the added value for money that the post delivered.

	Governor Questions: AH noted the cost of £2700 for a KMPG audit of the accounts and commented that an audit was not required. GG confirmed that the Committee were reviewing the situation having noted the same.	
CoG 21/16	**COMMUNICATIONS AND ENGAGEMENT STRATEGY** MK presented the paper explaining that it was a scene setting document and anticipated the arrival at the end of May of the new Director of Communications and Engagement, Natalie Yost (NY). NY had worked on the draft strategy prior to starting in post and the document laid out the principles which would be applied to internal and external communications and engagement, and the priorities. MK said that he could not overemphasise the importance of the strategy in the work the Trust had to do over the coming months. MW said that the Governors Communications and Membership group had taken a similar approach; NY had provided them with an idea of her approach and the Committee was awaiting her arrival to go into the detail of what the Committee needed to do by way of membership engagement and communication to support the Trust's aims and objectives. MK commented that work was being done while awaiting NY's arrival, however he thought it was important that she was directly involved in the work to finalise and implement the strategy.	
CoG 22/16	**2015 STAFF SURVEY RESULTS** SIB provided context to the paper noting that the survey had been undertaken in September/October the previous year some six to nine months into the Cultural Change Programme (CCP). The results had been published in April this year and had shown that the Trust's performance continued to be poor when benchmarked against other organisations. In response the Board had agreed areas to focus on and had re-launched the respect each other programme and the leadership development work had recently gone out to tender. The Picker Institute, who supported the Staff Survey for the Trust, had said that the Trust's results were indicating that there was improvement, however they estimated that it would take three years to return to the 2012 levels. Each division now had their own Friends and Family testing programme and actions plans to deliver on the GPTW programme. Questions from Governors JB asked whether the new appraisal process would identify the Trust's leaders .SIB said that her personal experience in using the new system showed her that this was the case. The aim was to have a developmental plan across the organisation to address the gaps and link to succession planning and talent management via tracking individuals. SLB noted that this had evolved from the one day people manager course programme which had been delivered at low cost. PW asked whether there was assurance that the bullying and harassment culture issues identified by the CQC were being successfully addressed. SIB said that she could assure the Governors that there was a lot of work being done to address the problems and anecdotally, the Executive Team were being told	

	by staff that change was happening. As noted previously cultural change could take three years to embed, so she could not guarantee the end result at this stage. SIB said that next year's survey should show improvement and she believed that the work was on track. JS suggested that the Trust being in special measures must be impacting on staff morale. SIB agreed and said that this was why the Board were focussing on moving out of special measures. RJ suggested that operational staff, such as nurses, may see being in special measures as someone else's problem. SIB said that it was clear that being in special measure had a reputational element which impacted on the Trust's ability to recruit top level staff. JW asked about staff exit interviews. SIB said that they were carried out but not as extensively as she would wish as the information helped to inform the plans for reducing turnover rates.	
CoG 23/16	**COUNCIL OF GOVERNOR COMMITTEES:** **Audit and Governance Committee (AGC)** CW reported that the meeting on 16 May had been well attended and had considered two key items: external audit and the restructuring of the Governors' committees. He noted that the recommendations to Council with respect to the committee restructuring from the AGC were laid out at items a – h on page 1 of the report. RE proposed that, for recommendation c, the Nominations and Remuneration Committee be attended by either the BoD chair of the Remuneration Committee or the BoD chair of the Nominations Committee. This was agreed. PW suggested that the chairs could nominate another NED from the Committee to attend as their deputy if needed, as long as they were fully briefed. This was agreed. The Committee agreed the recommendations made at items a – h on page 1. **Nominations and Remuneration** PW reported that the Committee had considered three items as follows. • The need to proceed with arrangements to appoint a NED to take over from RE when his term ends in December. • Making a recommendation to Council for the membership of the revised Committees. The Committee had tried to take into account the outcome of the skills audit and the preferences expressed by governors. He suggested that there should now be a third iteration with a chance for governors to request changes to the proposed membership. Once that was taken into account, he suggested that arrangements were made for the Committees to commence their work on the understanding that there would be a review in six months time. This was agreed. • There had been a good discussion with NC about the NED and Chair appraisals. NC advised the meeting that the Board review should be completed by June. She had discussed performance and personal development plans as part of the appraisal process with each Non-Executive. NC invited contributions to the NED	

	appraisal process from Governors directly to her outside of the meeting. JB supported the suggestion that one of the Governors to provide feedback into the NED appraisal process should be the chair of the CoG committee aligned to the BoD Committee that that NED chaired. **Strategic Committee** JS noted that the Committee had considered three key items: the draft operational plan and emerging Sustainability and Transformation Plan; the developments involving the Emergency Care Centre at Canterbury; and the reported underutilisation of resources at Buckland Hospital. MLo commented that she had not found the responses provided to Governors' questions about the use of Buckland Hospital to be comprehensive. NC said that NEDs had raised similar questions and that there were plans under development which would address these, including some creative thinking around establishing a dementia village on the site. MLo noted that an update should be provided within the Governor Committee structure in October or November. MK advised Governors that there could be some media coverage the following day relating to the sale of the old Buckland Hospital site. There was some concern locally that this had not been developed as expected. The Trust no longer owned the land being sold. MK said that he had discussed the situation with the local MP, Charlie Elphicke. **Patient and Staff Experience Committee** ELB said that the main item for the PSE Committee to report had been the drafting of the Governors' Commentary on the Trust's Quality Report; this would be reported fully in the closed session as the document was still in draft. **Communications and Membership Committee** SA reported that the focus of the last meeting had been to refresh the role and function of the committee. NC thanked the chairs of the Governors' Committees for their work over the last year in meeting the challenges presented. She looked forward to working with the new Chairs within the revised structure.	
CoG 24/16	**FEEDBACK FROM GOVERNORS WHO ATTEND WIDER TRUST GROUPS/COMMITTEES** The following was provided: • MLa noted that the last meeting of the End of Life Board had almost not been quorate and she asked that clinicians be encouraged to attend. • PD noted that he had recently re-connected with the Sepsis Group. • SA confirmed that she still attended two groups: Falls and the Improvement Programme Development Board JB commented that with the change in the Governor Committee structure this might be a good point to consider whether it was appropriate for Governors to sit on these committees. SA agreed that this should be considered.	**CoG Committee agenda**
CoG	**ANNUAL MEMBERS MEETING**	

25/16	AF explained that this item had been included on the agenda to give Governors a chance to consider how best to involve the FT membership to provide ideas about the content of the Annual Members Meeting. For the previous year members had been canvassed to choose an item for presentation from a short list provided. It was agreed that this could be considered again and that the CMC could take this forward. MK commented that the timing may be right for a presentation to be given on the Clinical Strategy. JB raised the issue of 'Meet the Governor' sessions and wondered whether these were working. MW said suggested that this was an issue that the CMC could also take forward for discussion.	**CoG Committee agenda**
CoG 26/16	**LEAD GOVERNOR: ROLE DESCRIPTION AND ANNUAL REVIEW-PROCESS AND TIMETABLE** Due to time constraints, this item was not fully discussed. It was suggested that SA be asked to continue as Lead Governor with the current remit, until such time as the job description for the role was reviewed and a decision taken. It was agreed that the AGC would be asked to undertake the review and report back to the Full Council.	**CoG Committee agenda**
CoG 27/16	**TRUST STRATEGIC AND ANNUAL OBJECTIVES** Item not covered due to time constraints.	
CoG 28/16	**CQC ACTION PLAN** Item not covered due to time constraints.	
CoG 29/16	**FEEDBACK FROM GOVERNORS WHO ATTENDED EXTERNAL/TRAINING EVENTS** Item not covered due to time constraints.	
CoG 30/16	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no members of the public present.	
CoG 31/16	**ANY OTHER BUSINESS** No other items were raised.	
CoG 32/16	**DATES OF NEXT MEETING** Thursday July 21 2016 10.00-15.00 The Guildhall Sandwich	

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING (PUBLIC) – 21 JULY 2016

ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING (PUBLIC) HELD ON 24 MAY 2016

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
There were no outstanding items from previous meetings.					
ACTIONS FROM THE LAST MEETING HELD					
17/16	May 2016	Matters arising: To include two items on the action table for update: 54/16 Integrated Audit and Governance Committee – interface between ESR and the Active Directory (AD). 4/16 Chair/Non-Executive director reports from Board and Board Committees : update on the inclusion of a tracking module as part of the new risk system.	AF	July meeting	Verbal update.
18/16	May 2016	CEO and Performance update: Presentations on partnership working with KCC and future of partnership working to be considered for a future agenda.	AB	Immediate	Added to agenda planning. **Completed.**
24/16	May 2016	Feedback from Governors who attend wider Trust groups/committees. CoG Committee to consider whether this practice should continue.	AB to add to appropriate CoG Committee Agenda	July meeting	Considered by the CoG Quality Group on 7 July and proposal put to Council in their report: CoG 42a/16. **Completed**

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
25/16	May 2016	Annual Members Meeting Governors to contribute to the content of AMM.	AB to add to appropriate CoG Committee agenda	July meeting	Considered by the CoG MECC on 23 June and proposal put to Council in their report: CoG 38/16. **Completed**
26/16	May 2016	Lead Governor: Role description and annual review process and timetable. To be taken forward by the CoG Audit and Governance Committee.	AB to add to AGC agenda	July meeting	To be considered by the CoG AGC on 19 July and proposal put to Council in their report: CoG 45/16. **Completed**

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**21 JULY 2016**
SUBJECT:	**REPORT FROM THE CoG MEMBERSHIP, ENGAGEMENT AND COMMUNICATIONS COMMITTEE**
REPORT FROM:	**MATT WILLIAMS COMMITTEE, CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The CoG Membership, Engagement and Communications (MEC) Committee met on 23 June 2016.

This report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council

The key issues discussed were:

- Annual Members meeting
- Workplan
- Terms of reference

LINKS TO STRATEGIC OBJECTIVES:	Patients: Help all patients take control of their own health. People: Identify, recruit, educate and develop talented staff. Partnership: Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to:

- note the ratification of the Committee Chair;
- note the update on the arrangements for the Annual Member Meeting;
- approve the terms of reference, including the proposed name change for the Committee to: Membership Engagement and Communication Committee; and
- contribute ideas to be included as the Committee develops the draft Membership Engagement Strategy.

Committee Chair's Overview

This meeting was not only my first as Chair but the first such meeting since the new Director of Communications and Engagement, Natalie Yost, joined the Trust, so the majority of the meeting was focused on discussing the Committee's aims and objectives for its role and work, into the future.

It was recognised that the work of the Committee will be critical as the Trust moves forward with its plans for wide consultation regarding the future clinical strategy and its provision and its work with other sections of the East Kent health economy.

Sadly, Gill Gibb had to give her apologies at short notice - for personal reasons - but we look forward to her attending future meetings.

The Committee reviewed the revised plans for the Annual Members Meeting, made several suggestions regarding its content & structure and suggested an increased role for governors.

Natalie Yost attended the meeting and introduced herself, outlined her plans for the structure and work of her department as well as confirmed that there will be a new multi channel communications and engagement strategy, together with operational plan, in place by the end of the summer. She looked forward to receiving the Governors' Membership Strategy from the Council to link into the Trust's strategy. Natalie also informed the meeting of an early action to increase the conversation with the people of east Kent via the launch of the new Trust Magazine. The magazine will have extensive distribution across East Kent.

The remainder – and majority – of the meeting was given over to wide ranging discussions on the purpose of the Committee and its importance given the consultation in our near future

We had some time to discus the Committee's name. Those attending wanted to ensure the name reflected the work, and ambition, of the committee. The discussion led to the agreement of Membership Engagement and Communication Committee (MECC)

Items discussed

Matt Williams was confirmed as Chair.

<u>Annual Members Meeting</u>
The Committee discussed the format of the Annual Members Meeting, noting that the event was now likely to take place in early October at a venue in central Canterbury with good access and sound systems, including a hearing loop. The current basic draft for the meeting was a 5.30pm opening, 30 minutes for refreshments and then a 90-minute session comprising an hour for presentations and 30 minutes for a Q&A session.

There are some items which have to be included by statute: presentation of the Annual Report, Annual Accounts and any report on these by the auditor, and the Committee had been invited to suggest further content. The Committee agreed that the meeting should focus on positive developments and showcase excellence within the Trust. The following suggestions were made during the discussions and agreed for recommendation to the Full Council.

- A short film being developed by the Communications Team to highlight innovative work would be an excellent addition to the evening.
- 'Market place' stalls should be interactive, especially when staff were giving of their time to attend – information boards could be included around the main hall area.
- There should be a presentation from the Lead Governor, possibly on the re-structuring of the Council's Committee Structure.
- A governor should be included on the Q&A panel.

- Timing for the meeting should be adjusted to take into account public transport timetables as in previous years attendees had had to leave early to catch trains.
- The agenda may need to focus on the proposed Clinical Strategy depending on how the timeframe develops.

Work plan

It was agreed that to fully develop a comprehensive membership engagement strategy some work needed to be undertaken before the committee could confirm its final purpose, objectives and work plan. But with this in mind there was agreement on several issues and/or the need for further information.

- What would be the 'right' size of membership to deliver best practice – The Committee support and Chair are to carry some benchmarking

- It was noted that what ever was decided as the 'best' size of membership it needs to be representative – how to achieve this would be proposed in the Membership Engagement Strategy (MES).

- It was agreed that The Trust needs to understand the current and future rational for having a membership, together with the rational as to why someone currently chooses to be a member together with managing their expectations. The appropriate tools and marketing and communications channels can be identified and highlighted in a the MES.

- Membership feedback should be a regular item on the committees agenda, however individual cases should not be discussed but passed to appropriate trust team. A process for this has been proposed in the report from the CoG Audit and Governance Committee.

- Engagement – though this will be fully addressed in the draft MES to be presented at the next MECC meeting, the members did touch on several 'active' engagement practices, such what place 'Ask the Governors' plays.

- The meeting was informed about the new 'Trust Newsletter', though this is not a standalone membership publication. It is to be produced with the first one going out in August. It was suggested and agreed that there would be a 'governors' column in future editions, perhaps produced by the Lead Governor

Terms of reference

The Committee considered and agreed the Draft terms of reference, at Annex A, requesting that the name of the Committee be changed to the Membership Engagement and Communications Committee.

Outcome and Recommendations

The members established that the priority business for the Committee was to move forward with completing a draft Membership and Engagement Strategy for the Council to approve ask quickly as possible. The Full Council meeting on 21 July is seen as an opportunity for all Governors to contribute ideas to this draft. The Council will also be asked to agree the name change for the Committee and the draft terms of reference.

Next steps

The next meeting of the Committee will be held on 15 August 2016. The main item of business will be consideration of a draft of the Council of Governors' Membership Engagement Strategy and this will be presented for discussion and approval at the next meeting of the Full Council on 5 September. The strategy will complement and dovetail with the Trust's Engagement Strategy.

Annex A

COUNCIL OF GOVERNORS
MEMBERSHIP ENGAGMENT AND COMMUNICATIONS COMMITTEE
TERMS OF REFERENCE

Constitution
The Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:
The Membership Engagement and Communications Committee will undertake the following.

- Develop the Membership Engagement Strategy for approval by the Council of Governors, in consultation with the Director of Communications and Engagement, and review annually.

  The Membership Engagement Strategy will include plans and objectives for:

  - Membership recruitment
  - Communication with Members
  - Membership engagement
  - Promoting the role of FT Governors;

- Hold to account the Non-Executive Director aligned to the Committee in relation to:

  - the work of the Charitable Funds Committee; and
  - Board performance in relation to communication issues and public engagement.

- Provide a report on the business of the Committee to Council of Governor meetings.

Frequency of Meetings:
Meetings of the Committee will be held on a bi-monthly basis.

Membership and attendance:
There will be eight Governor members on the Committee. One member will be elected as Chair of the Committee and will hold office for the period of one year from April. Members are asked to attend a minimum of four out of six meetings per year. All Governors are welcome to attend meetings of the Committee. Prior to the start of the meeting, the Chair of the Committee has the discretion to open the meeting to all Governors, including the right to vote.

<u>Current Membership:</u>

Matt Williams	Chair	Marcella Warburton
Carole George		Paul Durkin
Eunice Lyons-Backhouse		Philip Bull
Junetta Whorwell		Robert Goddard

Attendees:

Non-Executive Director:	Gill Gibb
Director of Communications and Engagement:	Natalie Yost or her nominated representative
Charitable Funds Committee representative	Rupert Williamson

Quorum:
The Committee shall be quorate when at least four members of the Committee are present.

Support:
The Committee will be supported administratively by the Corporate Secretariat. It shall receive advice from the Trust Secretary, or their representative, and the Director of Communications and Engagement, or their representative.

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MAY 2016

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
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Chief Executive's Summary

We continue to work on delivering our vision of “great healthcare from great people” by focussing on our 4 strategic priorities around patients, people, provision and partnerships. This integrated performance report is a crucial part of this as it demonstrates how we are working to coordinate all aspects of what we do into an integrated single approach.

With regard to this month 2 report, it is clear that there are some areas of improvement in each of the domains ranging from positive feedback from the friends and family test and inpatient survey, strong performance on diagnostic waiting times and progress with 62 day cancer against our improvement trajectory to positive results with regard to mortality rates and other key safety metrics. Similarly there has been some progress on staffing levels and this and other work has also translated into a continued improving position on income and expenditure. All of these issues are connected – if we address staffing that can and does impact on finance but also our ability to deliver the best care to our patients which is reflected in feedback from patients and outcomes in terms of safety metrics. This is how we are now working as a team and as a Trust.

It is also important to identify the areas where we face challenges and the report demonstrates again that there are issues across the domains which reflect the issues we are working hard to address within each area but also as part of our integrated approach. Therefore the issue of mixed sex accommodation which is linked to the levels of patient activity as well as how we manage the flow of patients within our wards and departments and VTE where the biggest challenge is in how we work to make recording VTE assessment a part of our day to day work right across the Trust are examples of issues which require input from across the executive team and the wider Trust to address. This is how we are working and it will continue to be the approach to the work on the 4 hour, RTT, cancer 2 week wait standards and financial position where we have real challenges. However, through our Chief Operating Officer, Chief Nurse and Medical Director working together, their teams will focus on how we can improve the management of our systems and processes as well as the input of our partner organisations to address what are crucial but also connected issues - four hour performance for example is as much to do with work on the wards and our partners as it is on a focus within the Emergency Departments and this is how we are working.

We are also focussing on how we work together and this month the Executive Team and I have been running a number of open forums for staff focussing on our vision, mission and values but also our key strategic priorities and this will be working with, listening, engaging and involving are staff will help us to continue the improvement journey we are on.

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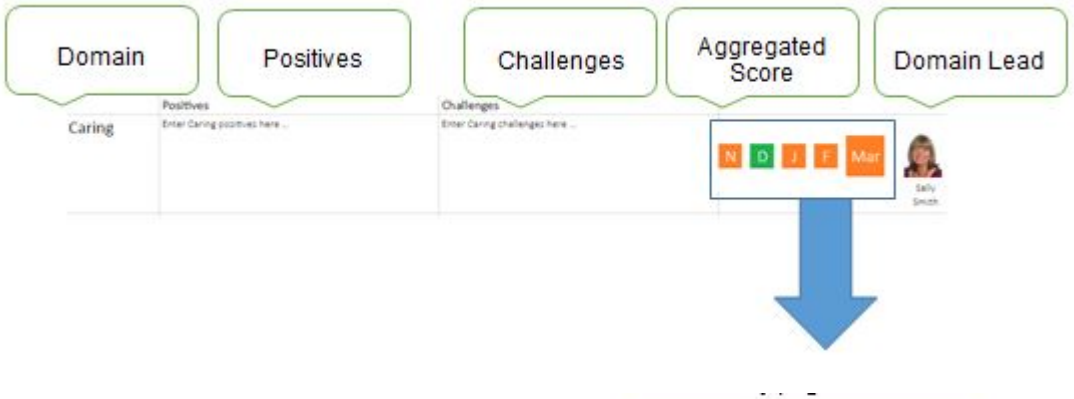
Understanding the IPR

1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.



2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.

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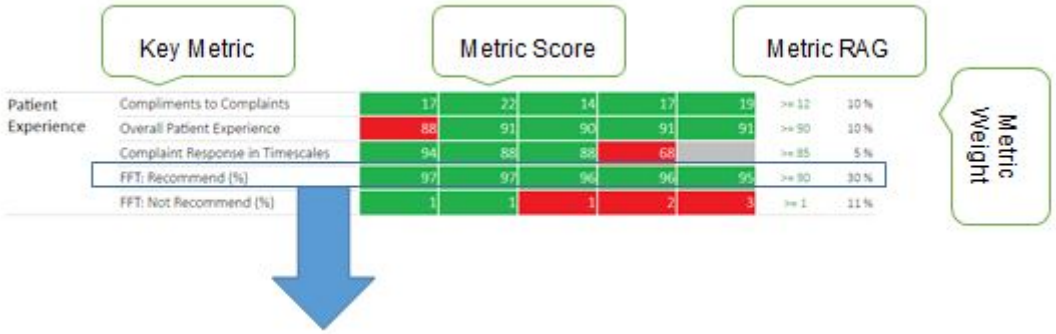
Understanding the IPR

3 **Key Metrics:** This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 **Strategic Themes**: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

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Strategic Priorities

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Contents

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Headlines

	Positives	Challenges	
Caring	• Sustained Inpatient Survey scores at above 90% • Reduction in Mixed Sex Breaches, although there may be some data that were not recorded • Improved FFT recommendation score this month	• Although much improved, complaint response times continue to be a challenge • Mixed sex breaches are still occurring • FFT recommendation scores for the Emergency Departments continue to be monitored closely	J F M A May  Sally Smith
Effective	• Bed occupancy is slightly improved yet still above ideal (NB – our STP trajectory would refer to a 92% bed occupancy not the 90% as in the IPR) • Clinical audit programme maintaining consistent performance • LOS for both elective an non-elective slightly improved • Equipment compliance maintained at 85%	• No improvement for patients to be discharged earlier in the day • Slight deterioration in the "did not attend" rate for new and follow up out patients which will be investigated	J F M A May  Jane Ely
Responsive	• Cancer 62 day standard has improved this month and is showing progress against the trajectory • 6 week diagnostic wait standard consistently met	• Trust 4 hour standard not meeting the improvement trajectory impacted by the significant increase in self-presenting attendances in May • Cancer two week wait standard not met due to increase in referrals seen in gynaecology and dermatology • 18 weeks incomplete pathways standard is behind the trajectory – primary care referrals are significantly higher than expected in Gynaecology, Orthopaedics, Dermatology and Paediatrics	J F M A May  Jane Ely
Safe	• Improving SHMI position • Continued good falls performance • Sustained position in avoidable deep pressure ulcers	• VTE assessment recording remains a concern • Infection control although on trajectory has slipped from the high performance of last year	J F M A May  Paul Stevens
Well Led	• Improvement in nursing shift fill rates, both day and night • I&E Improved for fourth month in a row • Theatre productivity improvements (cases per session) coming through • Executive Team 'visibility' plan published	• Financial control total not yet agreed. • Continued high use of agency and locum staff. £2.2m in month. Ceiling of £23m • Staff turnover, vacancies and sickness all increased in month • Appraisal rate declined from 79% to 70% • £1.9m deficit in month • Increase in uncoded spells (0 to 3%)	J F M A May  Nick Gerrard

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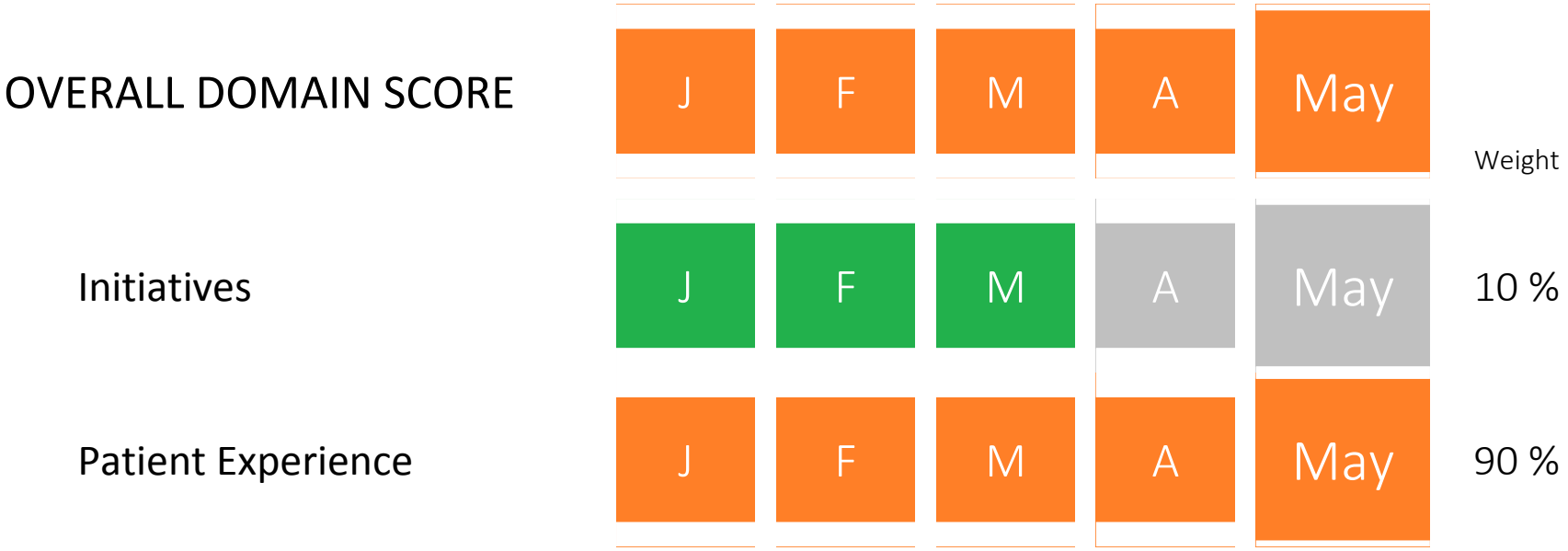
Caring



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Caring

		Jan	Feb	Mar	Apr	May	Green	Weight
Initiatives	Dementia Diagnosed CQUIN Delivered	100	100	100			>= 100	17 %
	Heart Failure CQUIN Delivered %	100	100	100			>= 100	17 %
	COPD CQUIN Delivered %	100	100	100			>= 100	17 %
	Diabetes CQUIN Delivered %	100	100	100			>= 100	17 %
	75+ Frailty Pathway CQUIN Delivered	100	100	100			>= 100	17 %
Patient Experience	Compliments to Complaints (#/1)	15	17	16	16	13	>= 12	10 %
	Mixed Sex Breaches	28	7	89	26	0	1	10 %
	Overall Patient Experience %	90	91	91	91	91	>= 90	10 %
	Complaint Response in Timescales %	88	68	82	54	84	>= 85	5 %
	FFT: Recommend (%)	96	96	95	96	97	>= 90	30 %
	FFT: Not Recommend (%)	1.4	1.8	2.5	1.6	1.5	>= 1	10 %

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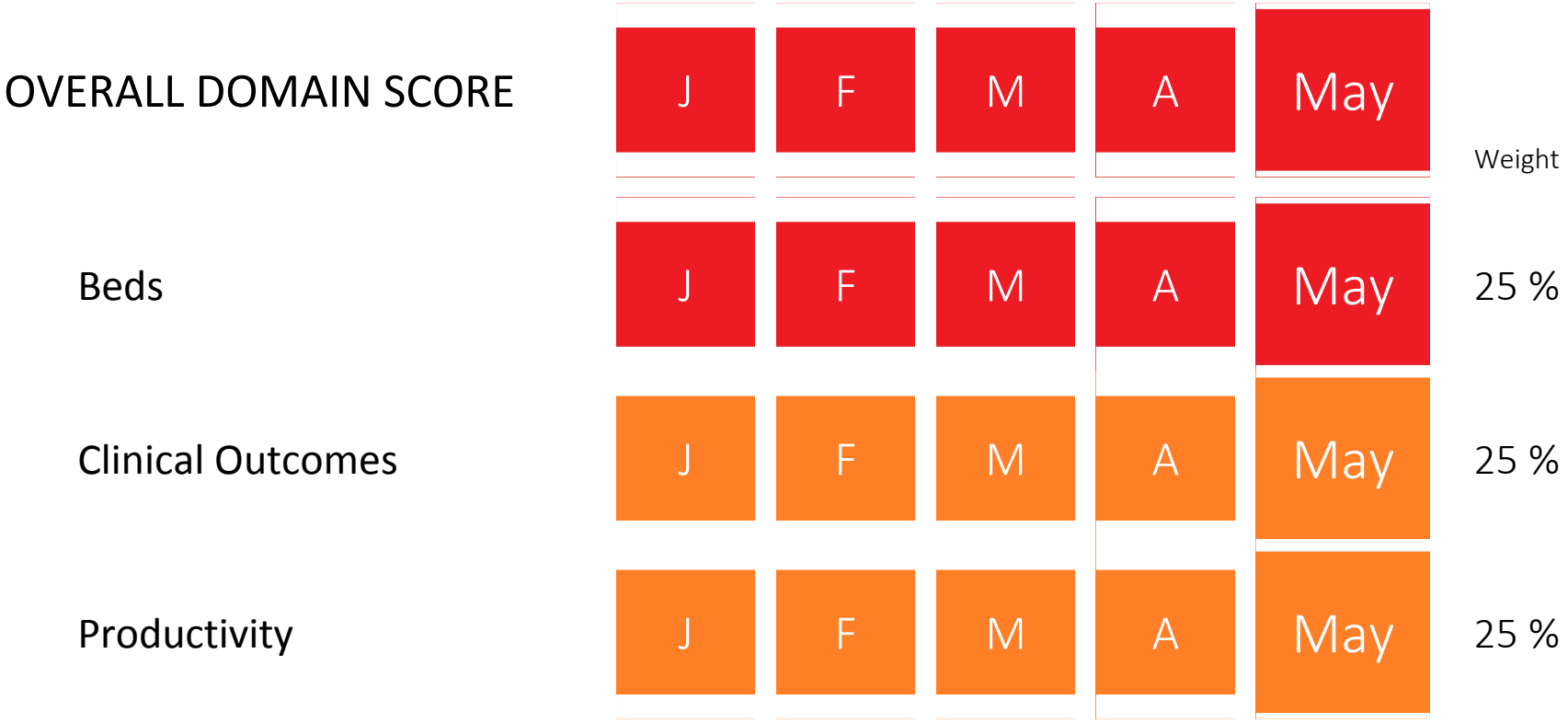
Effective



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Effective

		Jan	Feb	Mar	Apr	May	Green	Weight
Beds	Bed Occupancy (%)	109	112	107	103	101	<= 90	60 %
	IP - Discharges Before Midday (%)	19	19	18	18	17	>= 35	10 %
	DToCs (Average per Day)	65	62	71	78	62	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3	3	3	3	3	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	16	17	17	17	17	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	99	100	99	100	99	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	7.9	6.7	7.9	7.7	8.1	< 7	0 %
	DNA Rate: Fup %	8.1	6.6	7.9	8.1	9.1	< 7	0 %
	New:FUp Ratio (1:#)	0.8	0.8	0.8	0.7	0.7		0 %
Productivity	LoS: Elective (Days)	2.9	3.1	3.5	3.3	3.1		0 %
	LoS: Non-Elective (Days)	5.8	6.1	6.1	6.0	5.7		0 %
	Theatres: Session Utilisation (%)	82	81	82	82	83	>= 85	25 %
	Theatres: On Time Start (% 30min)	75	75	78	81	78	>= 90	10 %
	Non-Clinical Cancellations (%)	0.5	0.3	0.3	0.1	0.0	< 0.8	20 %
	EME PPE Compliance %	78	81	83	85	85	>= 90	20 %

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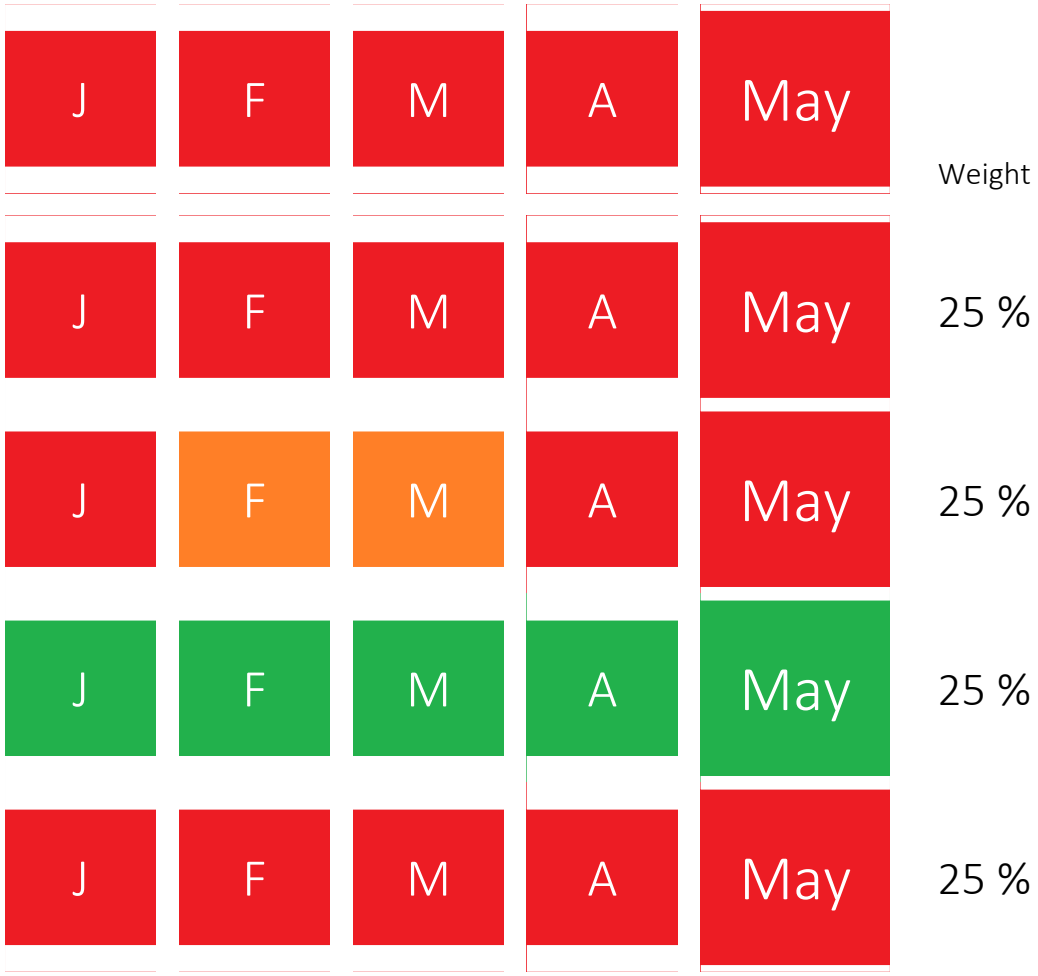
Responsive



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Responsive

		Jan	Feb	Mar	Apr	May	Green	Weight
A&E	ED - 4hr Compliance (%)	84.91	80.01	79.26	84.03	82.68	>= 95	100 %
Cancer	Cancer: 2ww (All) %	93.28	94.10	93.58	89.25	88.00	>= 93	10 %
	Cancer: 2ww (Breast) %	94.06	88.03	92.98	85.00	82.53	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	94.82	97.07	98.10	96.11	96.25	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	94.59	97.50	96.72	91.49	82.35	>= 94	5 %
	Cancer: 31d (Drug) %	86.17	100.00	100.00	98.25	98.94	>= 98	5 %
	Cancer: 62d (GP Ref) %	71.68	79.86	73.57	71.04	78.39	>= 85	50 %
	Cancer: 62d (Screening Ref) %	93.75	95.65	92.31	92.86	93.10	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	50.00	86.67	70.37	100.00	68.42	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.81	99.65	99.65	99.78	99.87	>= 99	100 %
	Audio: Complete Path. 18wks (%)	99.13	100.00	100.00	99.65	100.00	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	0 %
RTT	RTT: Incompletes (%)	90.10	89.17	89.27	88.56	87.89	>= 92	100 %
	RTT: 52 Week Waits (Number)	3	5	5	6	9	< 1	0 %

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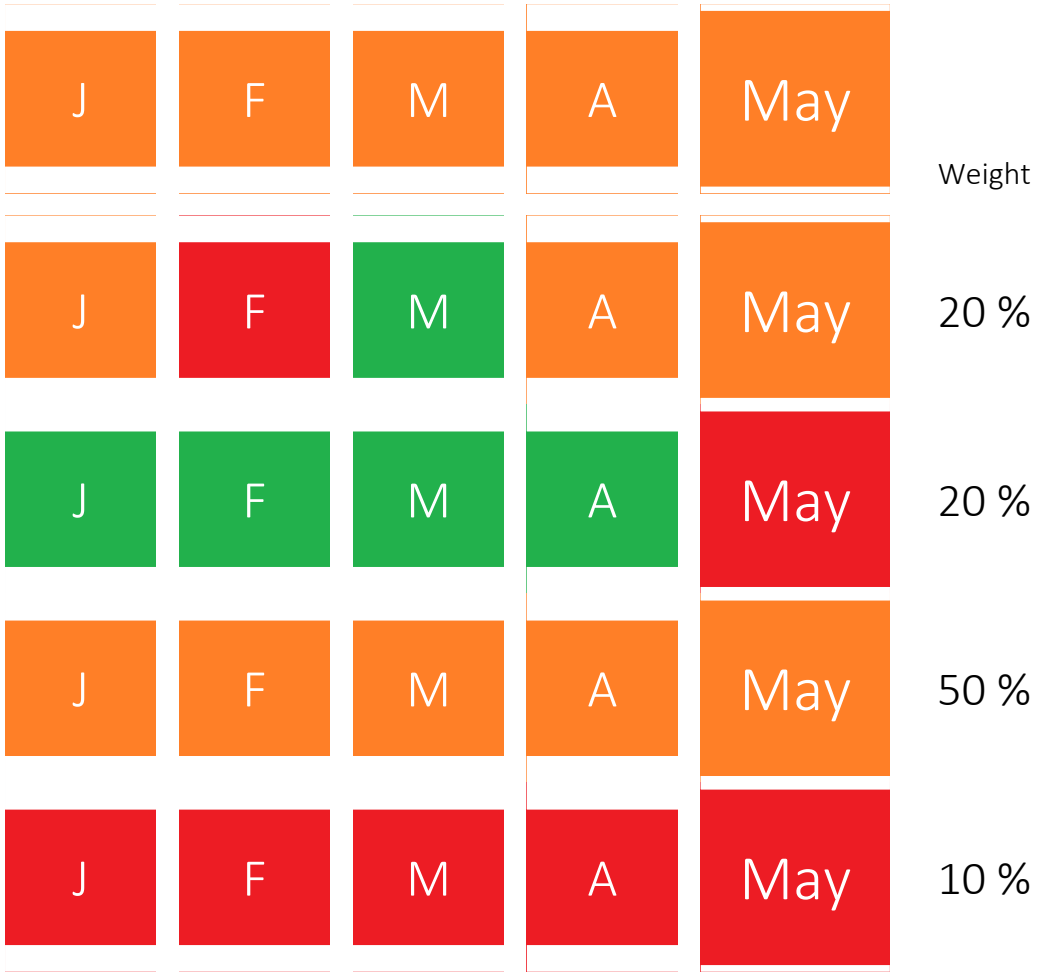
Safe



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Safe

		Jan	Feb	Mar	Apr	May	Green	Weight
Incidents	Serious Incidents (STEIS)	9	7	4	4	7		0 %
	Harm Free Care: New Harms (%)	98.1	97.9	98.2	97.8	97.7	>= 98	20 %
	Falls (per 1,000 bed days)	5.01	5.88	4.79	5.36	4.94	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.27	0.37	0.29	0.32	0.34	<= 0.15	10 %
	Clinical Incidents: Total (#)	1270	1268	1346	1216	1293		0 %
Infection	Cases of MRSA (per month)	0	0	0	0	1	< 1	40 %
	Cases of C. Diff (Cumulative)	27	28	28	4	8	<= Traj	40 %
Mortality	HSMR (Index)	84					< 90	35 %
	Crude Mortality EL (per 1,000)	0.1	0.2	0.5	0.8	0.8	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	32	36	33	29	25	< 27.1	10 %
	RAMI (Index)	90	88				< 87.45	30 %
Observations	Cannula: Daily Check (%)	29.2					>= 50	10 %
	Catheter: Daily Check (%)	27.7					>= 50	10 %
	Central Line: Daily Check (%)	28.7					>= 50	10 %
	VTE: Risk Assessment %	84	83	82	79	82	>= 95	20 %
	Obs. On Time - 9pm-8am (%)	40	35	37			>= 90	25 %
	Obs. On Time - 8am-9pm (%)	43	40	41			>= 90	25 %

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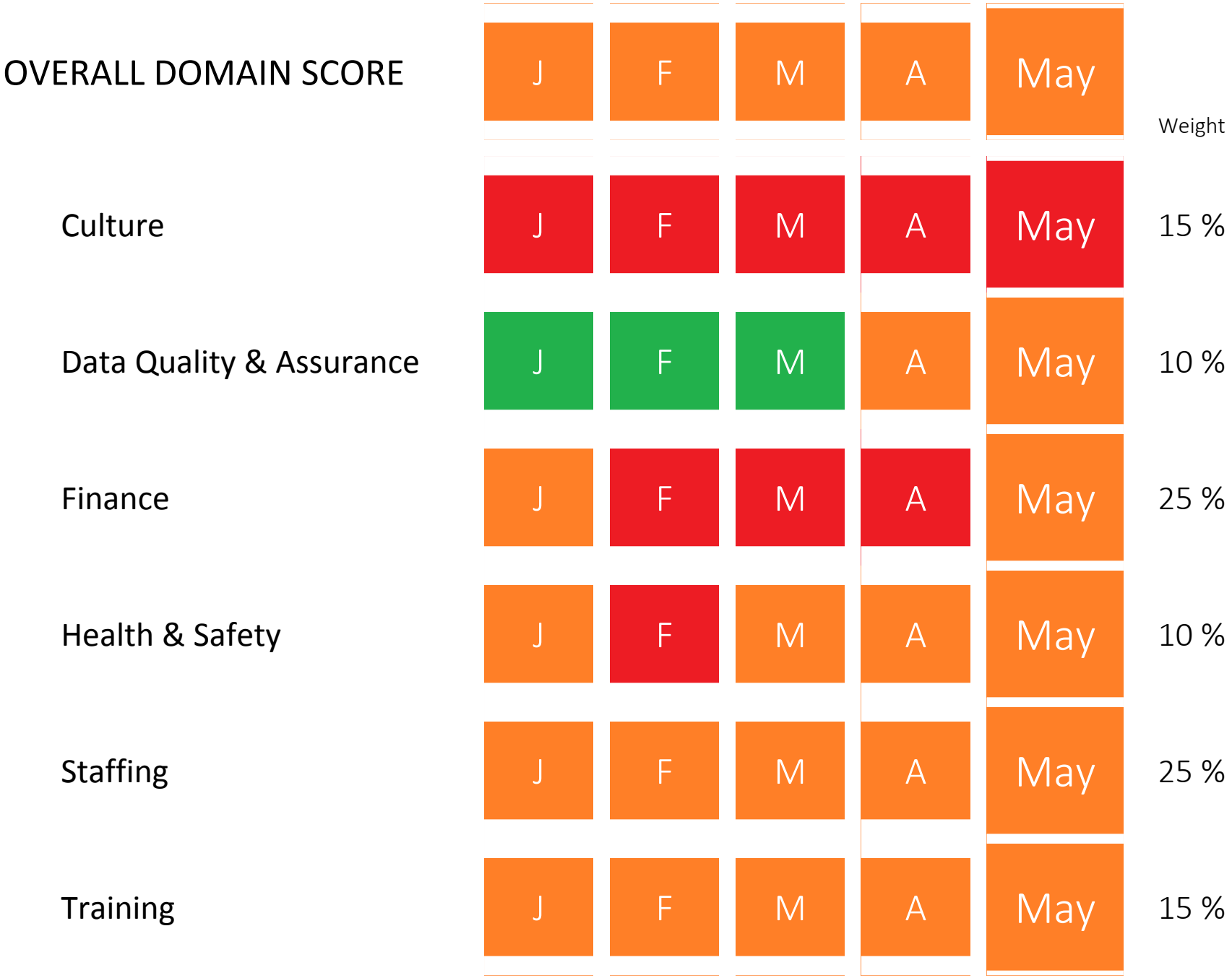
Well Led



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Well Led

		Jan	Feb	Mar	Apr	May	Green	Weight
Culture	Staff FFT - Work (%)	49	49	49	49	49	>= 67.2	50 %
	Staff FFT - Treatment (%)	76	76	76	76	76	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	1	2	2	2	2	< 4	25 %
	Valid NHS Number %	100	100	100	99	99	>= 99.5	40 %
	Uncoded Spells %	0	0	0	0	0	< 0.25	25 %
Finance	I&E £m	1.2	-4.4	-3.6	-2.8	-1.9	>= Plan	30 %
	Cash Balance £m	4.3	8.2	3.9	7.9	8.5	>= Plan	20 %
	Total Cost £m	-46.7	-47.1	-50.1	-47.9	-48.0	>= Plan	20 %
	Forecast I&E £m	-36.4	-36.4	-35.4	0.0	-11.0	>= Plan	20 %
	Normalised Forecast £m	-46.0	-46.0	-46.0	-16.6	-27.6	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	3	4	0	0	0	<= 3	20 %
	Formal Notices	0	0	0	0	1	1	15 %
Staffing	Sickness (%)	3.7	3.8	3.8	3.9	4.0	< 3.3	10 %
	Staff Turnover (%)	11.4	11.3	11.2	11.2	11.3	< 7.4	15 %
	Vacancy (%)	8.4	8.2	8.0	8.8	9.2	< 10	15 %
	Shifts Filled - Day (%)	93	90	88	97	101	>= 97	15 %
	Shifts Filled - Night (%)	101	101	97	102	105	>= 97	15 %
	Agency %	15.7	16.9	18.8	16.3	18.3	<= 10	0 %
	NHSP Use % of Agency	66.1	68.6	57.1	100.0	100.0	> 90	0 %
Training	Appraisal Rate (%)	85.5	84.2	82.2	79.2	70.0	>= 90	50 %
	Mandatory Training (%)	85	86	87	88	87	>= 85	50 %

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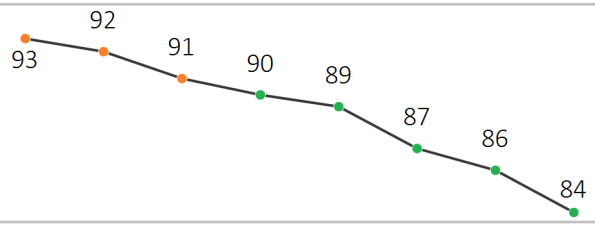
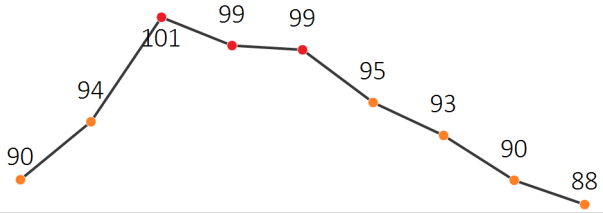
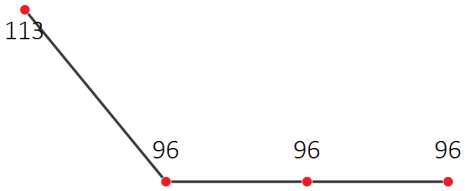
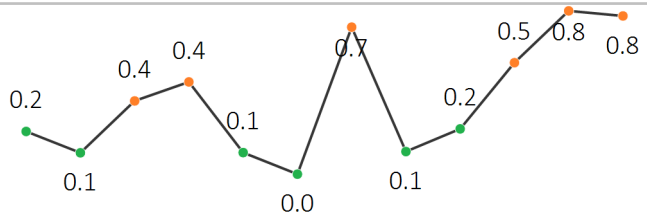
Strategic Theme: Patient Safety

Mortality

May	HSMR (Index)	89 (7.8%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data together with variance against previous
May	RAMI (Index)	94 (4.4%)		Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
May	SHMI	100 (-1.1%)		Summary Hospital Mortality Indicator (SHMI) as reported via CHKS includes in hospital and out of hospital deaths within 30 days of discharge. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Crude Mortality EL (per 1,000)	0.4 (-16.3%)		The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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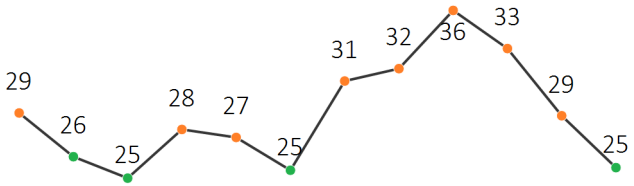
Strategic Theme: Patient Safety

May

Crude Mortality NEL (per 1,000)

29 (-4.7%)



The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: Overall mortality indices remain good. The average HSMR over the last 12 months is higher than the previous year but the run chart suggests continued improvement in year. Similar results are displayed for RAMI. It should be noted that the SHMI results displayed are from CHKS, a similar improving trend is seen on the national data. The latest SHMI being 100.
The national data is broken down into 140 diagnostic groups. Diagnostic groups of concern are acute cerebrovascular disease disease (observed 266 v. expected 246), acute myocardial infarction (162 v. 124), chronic obstructive pulmonary disease (137 v. 123 although over 50% of deaths were out of hospital) and sepsis (360 v. 299).
Biliary tract disease, carcinoma of the lung and carcinoma of the colon are also areas performing less well than the previous year. Conversely fracture neck of femur has seen a sustained improvement.

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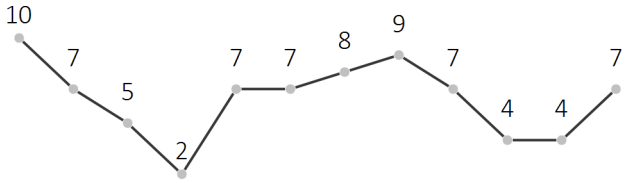
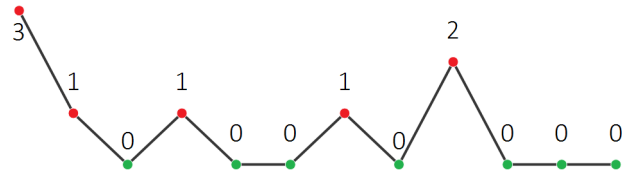
Strategic Theme: Patient Safety

Serious Incidents

May	Serious Incidents (STEIS)	77 (-7.2%)		Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
May	Never Events (STEIS)	8		Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

Thankfully there have been no never events for 3 months. An area of concern in STEIS reported serious incidents remains potential harm related to ophthalmology follow up and this is reflected in the risk register.
Work continues to take place within divisions, including assisting at RCA meetings, to improve the quality of the investigations and Duty of Candour actions to enable RCA completion within the 60 day deadline. The CCG recognises the numbers of breaches have reduced. The numbers of breached cases have dropped from 14 to 12 and work continues to ensure that the oldest cases will be closed first. No cases have now been opened for longer than a year.

There were seven new SIs relating to:
- Unexpected VTE death (two cases);
- A breast cancer treatment delay;
- Incident demonstrating existing risk relating to the ERCP pathway (near miss);
- Unexpected death of a baby;
- Unexpected death of a child and
- Allegation of abuse (amended to harm caused by surgical/invasive procedure meeting SI criteria).

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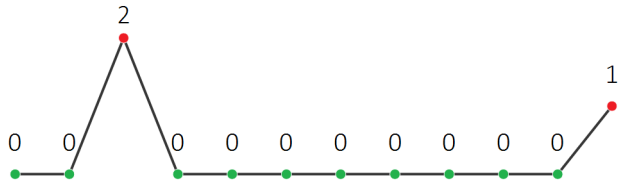
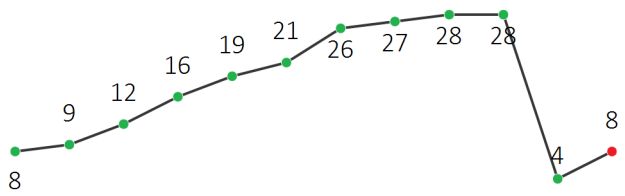
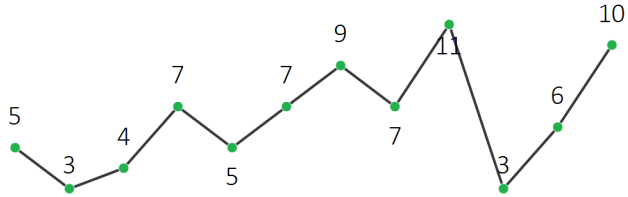
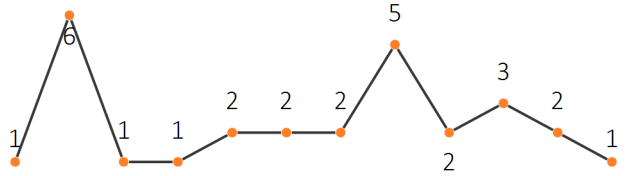
Strategic Theme: Patient Safety

Infection Control

May	Cases of MRSA (per month)	3 (200.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
May	Cases of C. Diff (Cumulative)	8 (100.0%)		Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Position in arrow shows YTD cumulative position and variance against previous month.
May	E. Coli	77 (14.9%)		The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	MSSA	28 (47.4%)		The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

Concerns that our previous excellent performance in infection control may lead to complacency and sustained performance can only be achieved by continued vigilance and best practice in infection control amongst all staff.
One case of MRSA bacteraemia was attributed to EKHUFT in May , the first case for FY2016-17. This is one lower than the cumulative total for April-May 2015-16
A Post Infection Review determined that this cases was not clinically significant and resulted from blood culture contamination.

There were 4 cases of post 72-hr C difficile in May bringing the cumulative total of cases to 8 for the April to May period. This is identical to our performance in the previous year but higher than the monthly average of 2.33 cases achieved in 2015-16 and slightly above the average monthly rate (3.9) required to achieve the DH target of fewer than 47 cases during 2016-17. Root Cause Analysis of cases does not show evidence of linkage between these cases suggesting that antimicrobial usage rather than cross infection is behind the small increase.

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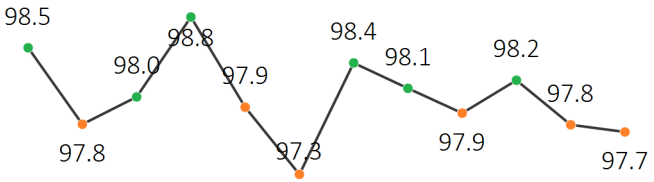
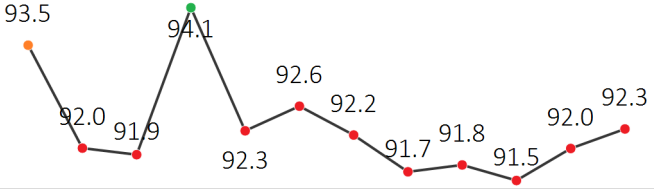
Strategic Theme: Patient Safety

Harm Free Care

May	Harm Free Care: New Harms (%)	98.0 (-0.4%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12
May	Harm Free Care: All Harms (%)	92.3 (-1.2%)		Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.

Comments: Overall Harm Free Care relates to the Harms patients are admitted with as well as those they acquire in our care and remains below national average. However, Harm Free Care experienced in our care is higher than national average which means that our patients are receiving care that causes less harm than is reported nationally. There was a slight improvement in
May (98.2%) compared to April (97.8%). All sites reported improvement, WHH from 97.8% to 98.2%, K&C from 98.1% to 98.6% and QEQM from 97.4% to 97.9%.

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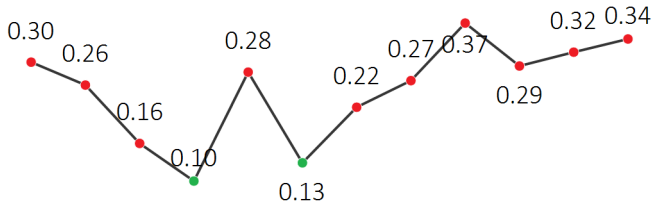
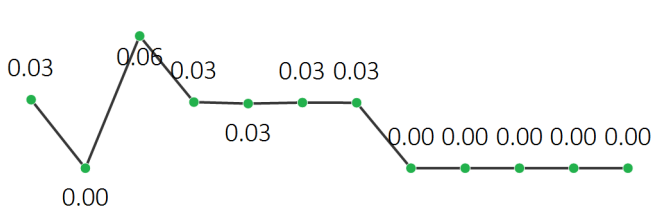
Strategic Theme: Patient Safety

Pressure Damage

May	Pressure Ulcers Cat 2 (per 1,000)	0.25 (-75.3%)		Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Pressure Ulcers Cat 3/4 (per 1,000)	0.02 (-90.6%)		Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

CATEGORY 2's

In May 16, a total of 32 acquired Category 2 pressure ulcers were reported and 11 were defined as avoidable due to learning in respect of aspects of the SKINS bundle. This is a decrease of two ulcers but equal numbers of avoidable ulcers from last month. Three of these avoidable ulcers occurred at the ears and resulted from medical devices i.e. nasal cannula. Recent trials of soft nasal cannula have identified potential product improvements which are being considered. Six of the eleven avoidable ulcers were located at the sacrum (1 at K & C, 2 at QEQM and 3 at WHH) which also occurred last month. In keeping with the 'Bottoms Up' campaign, the TVN will contact the responsible ward managers and link nurses to highlight these ulcers and request urgent actions are taken.

CATEGORY 3/4's

There was no confirmed category three of four acquired pressure ulcers in May 16. However, there were 11 unstagea-ble/deep tissue injury incidents reported of which one has been assessed as avoidable. This occurred due to a patient spend-ing too long on a bedpan and investigations are taking place to determine how this occurred. Two other incidents are yet to be assessed due to the patients being transferred to other hospitals. Their medical notes are required to enable the decision making. The remaining unavoidable ulcers occurred even though the patients were risk assessed and received appropriate interventions throughout. Sufficient evidence was available to support this decision.

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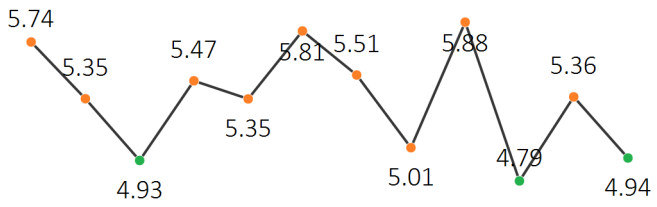
Strategic Theme: Patient Safety

Falls

May	Falls (per 1,000 bed days)	5.34 (-83.4%)		Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: There were 175 falls in May, with 39 at K@CH, 53 at QEQMH and 83 at WHH. Of these 2 falls resulted in hip fractures (1 on Harbledown at K&CH and the other on Rotary at WHH). However, 1 of these was deemed unavoidable on investigation and 1 was as a result of a medical collapse and therefore not a fall. 1 fall on CCU at WHH resulted in a wrist fracture but again, this was deemed unavoidable on investigation. Wards with the most falls were CDU at WHH (14), Richard Stevens at WHH (11) and Kingston at K&CH (10). The Falls Prevention nursing team remains very depleted with only 2 nurses in post Aand the impending departure of the consultant clinical lead in August. A new band 6 nurse will be in post from the 20.06.20116 and further recruitment is pending. The team are planning to implement the Fallstop! Quality improvement programme at WHH in September with support from therapy staff. Whilst this programme will be implemented eventually on the 2 other sites, our priority is to improve compliance with the Falls Risk Assessment and Care Plan by 30% and Post Fall Protocols within UCLTC at WHH, from the baseline reported in the National Inpatient Falls Audit for 2015.

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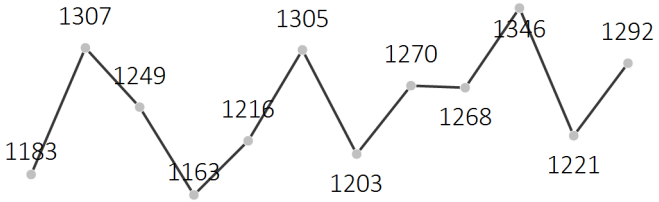
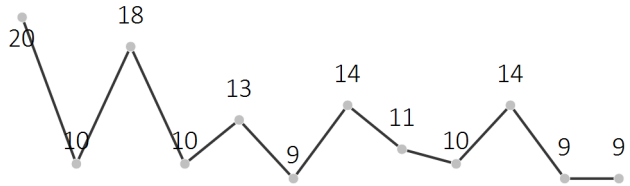
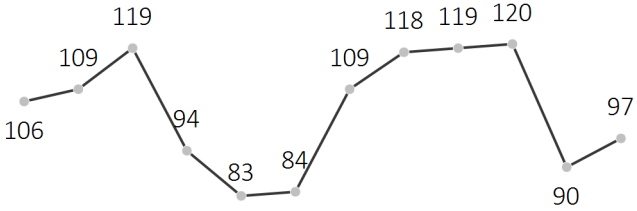
Incidents

May	Clinical Incidents: Total (#)	15023 (10.7%)		Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
May	Blood Transfusion Errors	147 (-13.0%)		The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
May	Medicines Mgmt. Incidents	1248 (2.3%)		The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

In May-16, five incidents have been graded as death and one as severe harm. In addition, 25 incidents have been escalated as a serious near miss, of which 18 are still under investigation. The number of moderate harm incidents reported during May-16 is higher than in previous months [May-16: 82 compared with Apr-16: 67 and May-15: 27]. Seven serious incidents were required to be reported on STEIS in May. Six cases have been closed; there remains 61 serious incidents open at the end of May. Over the last 12 months incident reporting has increased at QEH and WHH, but remains static at K&CH.

In May, there were seven blood transfusion errors reported (8 in Apr-16 and 16 in May-15). There was only one theme in May: two incidents of wastage of blood/blood products. Five incidents were graded no harm and two as low harm. Reporting by site: three at WHH and four at QEH.

Of the Medicine Management incidents reported, 75 were graded as no harm including four serious near misses and 17 as low harm. There were five incident graded moderate harm: Midazolam given by wrong route which had to be counteracted by administering Flumazenil, patient at risk of overdosing discharged with too large a quantity of Oxycontin and was readmitted having overdosed on this drug, patient's longterm prescription of Benzodiazepines incorrectly stopped without reduced dosing or alternative treatment prescribed, patient had been sent and had taken bowel preparation which is a contraindication to her condition (cardiomyopathy), renal transplant patient missed three days immunosuppressant medication as it was incorrectly assumed that the patient's relative would be bringing their medication in and was omitted from the drug chart. These incidents are all under investigation and may be downgraded. Top reporting areas were: Cheerful Sparrows male ward (QEH) with 12 incidents; Pharmacy (K&CH), Clarke ward (K&CH), Kingsgate ward (QEH), A&E (WHH), CDU (WHH), Cambridge M1 (WHH), Pharmacy (WHH), Rotary ward (WHH) with three incidents each; other areas reported 2 incidents or fewer. Twenty-four incidents occurred at K&CH, 32 at QEH, 39 at WHH, one at BHD and one in the community.

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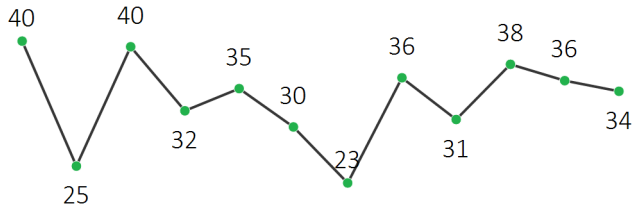
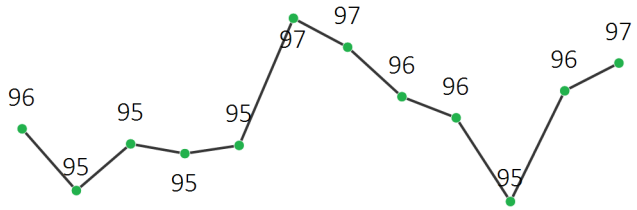
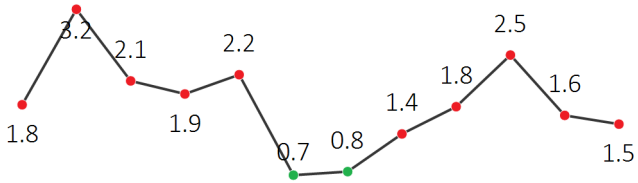
Strategic Theme: Patient Safety

Friends & Family Test

May	FFT: Response Rate (%)	33 (-20.7%)		The percentage of patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	FFT: Recommend (%)	96 (1.2%)		Of those patients who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	FFT: Not Recommend (%)	1.8 (-26.2%)		Of those patients who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During May we received 8,088 responses in total. Overall 31% of eligible patients responded and 90% of them would recommend us to their friends and family and 6% would not. The total number of inpatients, including paediatrics who would recommend our services was 96% (95% in Apr-16). For A&E it was 79% (same as Apr-16), maternity 93% (95% in Apr-16), outpatients 91% (same as Apr-16) and day cases 94% (same as Apr-16). The Trust star rating in May is 4.53 (4.52 in Apr-16).
The response rate for inpatients was 34% (36% in Apr-16), A&E 12%, (24% in Apr-16), maternity 19% (33% in Apr-16). (Please note as per DH guidelines only the Birth experience is given a response rate, FFT questions at other stages in the patient's pathway are not calculated or required nationally). The response rate for day cases was 19% (31% in Apr-16) but for outpatients was not available due to a national reporting error. All areas receive their individual reports to display each month, containing the feedback left by our patients which will assist staff in
identifying areas for further improvement. This is monitored and actioned by the Divisional Governance Teams. Further work during July-16 will focus on improving response rates.

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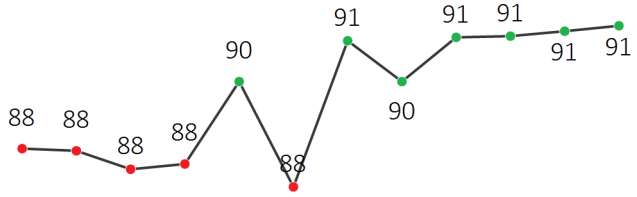
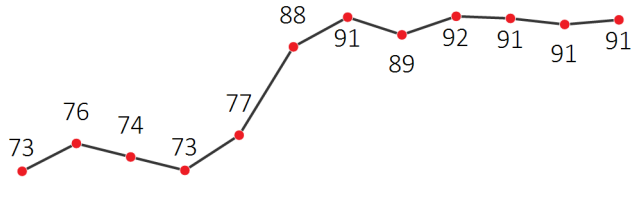
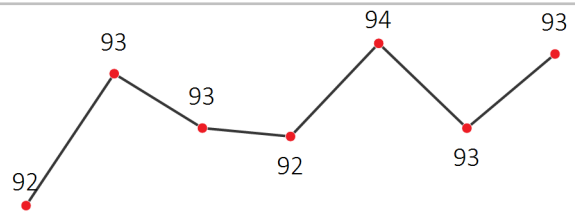
Strategic Theme: Patient Safety

Patient Experience 1

May	Overall Patient Experience %	90 (2.5%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.
May	Care Explained? %	86 (15.7%)		Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
May	Care that matters to you? %	93		Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).

Comments: Each ward reviews their real-time monitoring data regularly. This data is available via the ward dashboard and is updated frequently to ensure a valuable real time tool to capture patient experience and satisfaction feedback, to assist to identify any areas of concern and any areas of praise instantly and action can be demonstrated as needed. In Dec-15 the questions within the survey were updated to reflect the issues highlighted in the national inpatient survey to enable closer monitoring of improvement.
Questions related to involvement in care decisions, staff availability to discuss concerns and privacy in discussing treatment have been substituted for questions on explanation of care / treatment and pain control as they are areas where we perform less well. This information is also shared as "heat maps" with other teams. From this actions are taken to address the themes which are considered with the Friends and Family Test feedback, and compliments and complaint information. This is monitored and actioned by the divisional governance teams.

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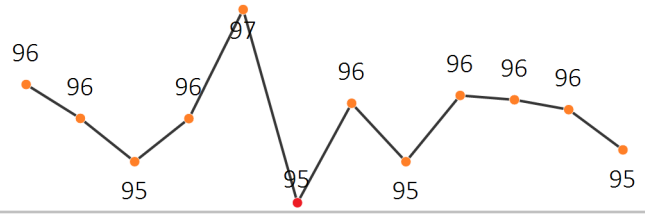
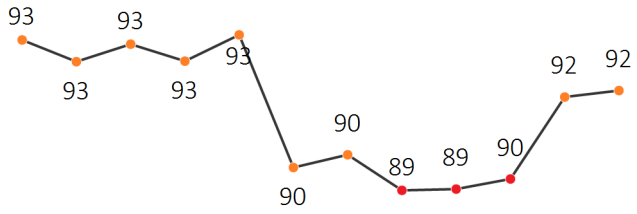
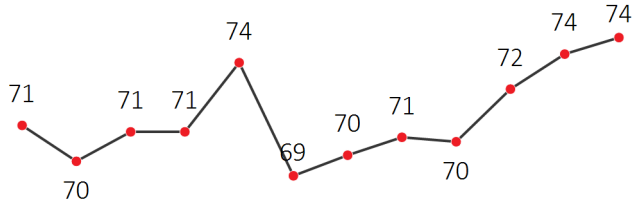
Strategic Theme: Patient Safety

Patient Experience 2

May	Respect & Dignity? %	95 (-0.2%)		Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nasing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
May	Cleanliness? %	92 (-0.6%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Hospital Food? %	71 (1.0%)		Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: Cleanliness scored fractionally down this month but remains higher than the preceding 5 months. Cleaning audit scores remain high at 98% overall.
Hospital food improved marginally from last month but remains RED if benchmarked against the PLACE scores. The Trust continues to work with SERCO to improve food standards and we have jointly won the Hospital Food Caterer of the Year Award. The Soft FM partnership board along with SERCO are going to look at potential alternative national metrics for food as it was felt 80% at Green was high compared to other sectors/providers.

East Kent Hospitals University NHS
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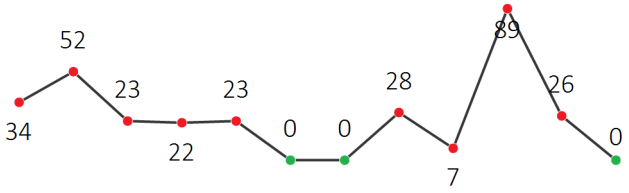
Strategic Theme: Patient Safety

Mixed Sex

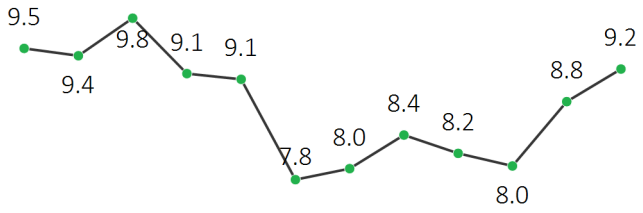
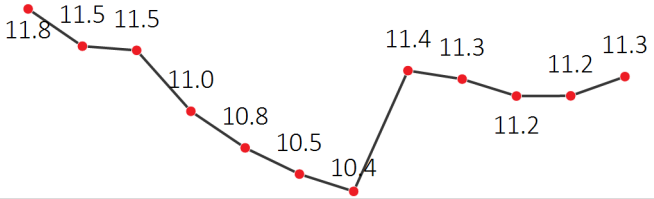
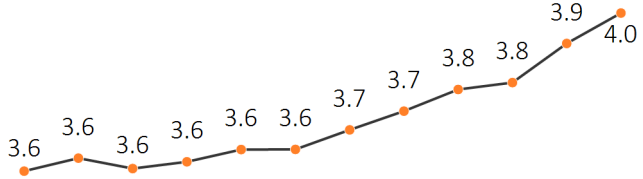
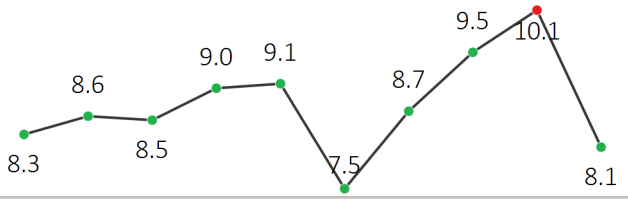
May	Mixed Sex Breaches	304 (61.7%)		Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: During May-16, no non-justifiable incidents of mixed sex accommodation breaches occurred. This information has been reported to NHS England via the Unify2 system. There were 12 mixed sex accommodation occurrences in total, affecting 51 patients. This shows a reduction from last month when there were a total of 14 occurrences
affecting 68 patients. The incidents occurred at K&C on the Kingston stroke unit (6) and at QEQM on the Fordwich stroke unit (6) which are justifiable mixes based on clinical need. Work to improve reporting of mixed sex occurrences on all sites and particularly at the WHH is being prioritised. The Divisional Head of Nursing has addressed the high number of breaches in the
Observation Bay in CDU by designating two separate bays that separate men and women to care for both the short stay and observation bay patients together.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

May	Vacancy (%)	8.8 (3.9%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Staff Turnover (%)	11.2 (-18.7%)		% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Sickness (%)	3.7 (-1.9%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Calculated cumulatively/YTD. % of FTEs lost through absence (as a % of total FTEs). Arrow indicates average of last 12 months data (as shown in
May	Overtime %	8.8		% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments: The key findings of a detailed analysis of Rostering will be presented to the Strategic Workforce Committee (SWC) in June. It has identified that the rostering system is not currently being used to its full potential and efficiencies. The deep dive data was produced using 38 ward areas and identified that most wards failed to meet their 42 day target for their approval of the roster (nb. since the data was produced Surgical wards have made a significant improvement and will be shown in next reports). Alongside this there is also under utilisation of the auto-roster function with 11 of the 38 wards producing their roster manually.

Most significantly more than half of the wards exceeded 22% headroom. This figure is the amount included in ward budgets to allow for leave, sickness etc. of staff. If wards are consistently running above this figure it will mean they will not have the planned number of nursing hours provided by permanent staff and this could affect the safety of the service.

East Kent Hospitals University NHS
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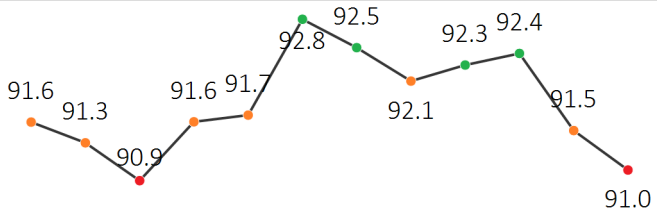
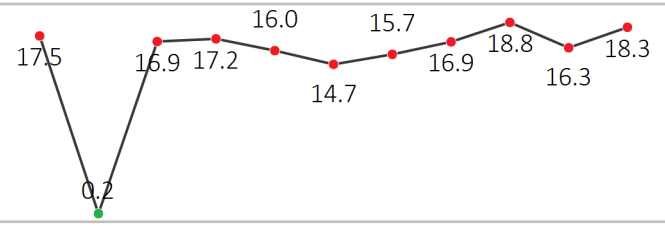
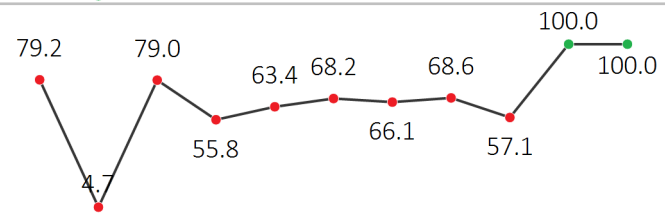
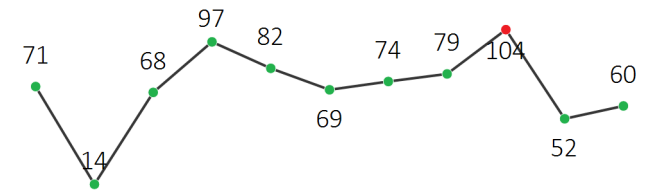
Strategic Theme: Human Resources

Temporary Staff

May	Employed vs Temporary Staff (%)	91.8 (-0.3%)		Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Agency %	15.3		% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).
May	NHSP Use % of Agency	69.9		% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).
May	Agency Orders Placed	70		Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).

Comments: Reduction in agency spend is a key component of our cost improvement programme (£4.1m). There is an agency programme programme, led by the Head of Human Resources supported by the Service Improvement Team. The Trust monitors and reports on a weekly basis, all agency shifts that breach the agency framework and NHSI pay caps by occupational group and division.
Work continues in reducing the time taken to recruit.

East Kent Hospitals University NHS
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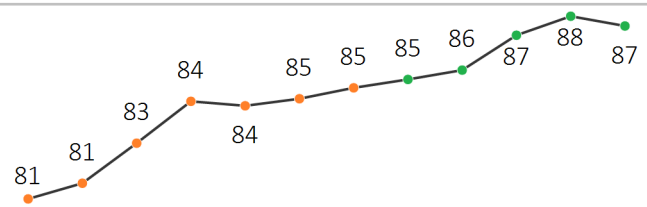
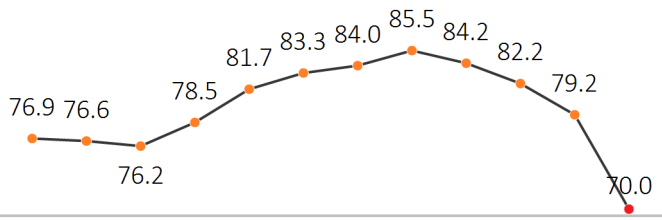
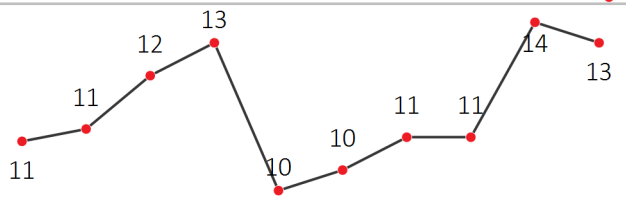
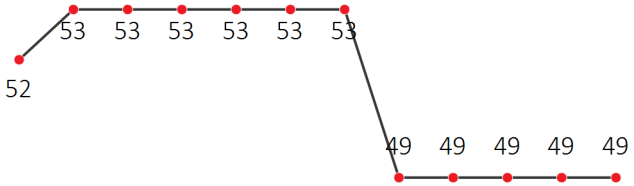
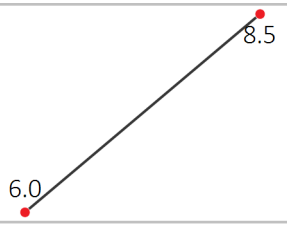
Strategic Theme: Human Resources

Workforce & Culture

May	Mandatory Training (%)	85 (7.2%)		The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Appraisal Rate (%)	79.9 (5.5%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Time to Recruit	12 (6.8%)		Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Staff FFT - Work (%)	52 (8.8%)		Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Local Induction Compliance %	7.3		Local Induction Compliance rates (%) for new starters to the Trust. Number indicates average of last 12 months data (as shown in graph).

Comments:

Statutory training was at 87% for May which remains above the target of 85%,. There remains a significant risk in regard to statutory training compliance. In April 2016 (last reported data), 753 staff were identified as not completing one or more of the statutory training courses required, this is a reduction of 16% from February's Data.

The Trust staff appraisal rate has continued to decline in May it reported at 70%, which is a further decrease from April and remains below the 90% target. The main reason is due to the majority of staff having their appraisals in April and May. I would anticipate this returning to compliant levels in June (reported in July).

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Activity

Activity vs. Internal Business Plan

Key Performance Indicators

Ap

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Green
Referral Primary Care	13,262	12,439											12,439	<=0%
Referral Non-Primary Care	8,671	8,604											8,604	<=0%
OP New	15,410	15,914											15,914	>=0%
OP Follow Up	31,606	30,976											30,976	>=0%
Elective Daycase	6,728	7,000											7,000	>=0%
Elective Inpatient	1,209	1,287											1,287	>=0%
Non-Elective Inpatient	7,160	7,230											7,230	>=0 & <5%
A&E	16,511	18,643											18,643	>=0 & <5%

The 2016/17 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2015/16 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals, activity required to achieve sustainable elective services is included and further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2016/17. It should be noted that this does not reflect demand levels agreed within the 2016/17 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

The capacity levels within the plans should be considered achievable although in many instances will stretch our services beyond their internal substantive capacity, efficiency programmes, workforce recruitments plans and it is anticipated therefore that substantial elements of the plan will continue to be delivered though additional waiting list payments. Within Orthopaedics and Dermatology projected demand exceeded our ability to deliver the operative demand and as such agreements have been made with our local CCGs for services to be directly commissioned with alternative providers.

May 2016

The Primary Care demand over performance that was observed in April has slowed significantly in May, although an over performance of 4% was still observed. The Trusts Internal Business Plan stretches most services to maximum capacity and as such we have not been able to flex our capacity further to deal with the demand received in April. As a result of this activity intended to reduce our waiting list sizes is now only serving to deal with current demand placing our recovery trajectories at significant risk. The Trust does not have the operative capacity to deal with the current demand, a key element of our business plan requires Orthopaedic referrals to be directed to the independent sector at point of referral, unfortunately there is no evidence to support the redirection of patient flow and referrals continue to arrive at a rate which far exceeds our ability to treat patients within 18 weeks.

There has been no further industrial action in May 2016 which has enabled the Trust to achieve or over-perform against planned activity levels across the majority of specialties, although a number of isolated exceptions have been observed.

Endoscopy activity is driving the biggest underperformances across the Trust. The service has been unable to recruit enough locum consultants to cover existing vacancies and high sickness levels; as such the service has been unable to deliver the business plan in the year to date. Capacity is being used to target patients on cancer and incomplete RTT pathways although this hides the follow up deficit that continues to grow. It is highly unlikely the service will be able to re-provide the lost activity in the financial year, given the continued difficulties securing locum staff to support delivery against the plan the service cannot commit to being able to deliver the shortfall in quarter one and the planned activity in quarter two. From Quarter three onwards, a full time substantive consultant will commence in post which will increase the substantive capacity but this is still not sufficient to deliver the full effect of the plan for outpatients.

Through our collaboration with the Clinical Productivity Consulting & Service Redesign Company Four Eyes Insight, we have successfully increased the number of theatre cases being delivered per session; however a converse reduction in the number of sessions provided has meant that we are only delivering similar levels of activity to previous years. As the focus now switches to reducing the number of theatre sessions that remain unused this step change in number of cases per list should enable the Trust to realise our full efficiency targets over the coming months.

The General Surgery & Colorectal specialties are carrying out significantly less activity than in previous years, a comprehensive review to investigate the issue has identified a significant loss of capacity due to middle grade vacancies affecting high productivity outpatient clinics, and furthermore unexpected consultant sickness and unplanned leave have further reduced the services ability to deliver current demand. A 10 week recovery plan has been developed to re-establish the required capacity levels using flexible consultant patient activity sessions. This is expected to be fully operational by the end of quarter 1, and the service is intending to plug the remaining gaps using additional consultant sessions.

Gynaecology continue to switch follow up slots to new outpatient appointments to maintain their Cancer & RTT positions following significant growth in Rapid Access and Primary Care referrals. This approach will generate a follow up backlog if left unchecked, monitoring against referral growth suggests the trend has now been sustained and as such the service should prepare to offer an additional 30 rapid access cases per week, and re-establish the follow up capacity accordingly. From December 2015 the service

lost a weekly theatre session, this is a contributing factor to the underperformance in elective theatre capacity. An agreement is now in place to re-provide the theatre list, and the service and the Anaesthetic General Manager have adjusted the time tables accordingly.

The Orthopaedic team have been unable to provide the Independent Sector Capacity stated in the contract in the year to date, this is in part due to delays with the tender exercises and also due to the inability to obtain enough capacity within the Spencer Wing. To mitigate against this risk the service is working with commissioners to agree alternative providers for patients waiting for elective and daycase procedures, at this stage no patients have been removed from our admitted waiting lists, and as such despite achieving our planned internal activity levels our waiting lists continue to grow.

The Neurology Service continues to over perform the business plan; the service is front loading outpatient capacity to mitigate against an expected future capacity deficit that is expected due to occur when two consultants leave in July 2016. The over performance is having a positive effect on the services RTT performance with the service 4.4% ahead of their recovery Trajectory with performance now at 95.4%.

Volumes of Accident and Emergency attendances were markedly higher than the previous month, with an average of 601 attendances per day. This increase equates to approximately 50 additional attendances per day higher than expected and those seen in April 16. The largest growth has been observed in the minor injury department with demand in May similar in volume to that seen in March 2016, and there is a growing body of evidence to suggest this unexplained Trend has now been sustained. An Emergency Department nurse staffing review has been undertaken which is awaiting review by the Executive Team, examining the profile of attendances and available staffing capacity to see these patients. The development of ambulatory care models aims to increase the number of patients who are able to be treated and discharged without being admitted overnight, mitigating some of the impact of the activity upon bed occupancy rates.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	1,433	1,585	-10%	-152
107 - Vascular Surgery	480	395	22%	85
410 - Rheumatology	608	514	18%	94
140 - Maxillo Facial	1,346	1,220	10%	126
101 - Urology	1,342	1,215	10%	127
120 - Ear, Nose & Throat	2,075	1,928	8%	147
420 - Paediatrics	896	733	22%	163
330 - Dermatology	2,448	2,178	12%	270
110 - Trauma & Orthopaedics	1,900	1,602	19%	298
502 - Gynaecology	1,841	1,459	26%	382
Total	**25,809**	**23,788**	**8%**	**2,021**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
800 - Clinical Oncology	1,643	2,069	-21%	-426
110 - Trauma & Orthopaedics	3,456	3,690	-6%	-234
560 - Midwifery	0	181	-100%	-181
120 - Ear, Nose & Throat	502	628	-20%	-126
140 - Maxillo Facial	304	398	-24%	-94
502 - Gynaecology	1,246	1,300	-4%	-54
901 - ESP	337	292	15%	45
101 - Urology	1,120	1,037	8%	83
100 - General Surgery	589	490	20%	99
130 - Ophthalmology	1,833	1,593	15%	240
Total	**17,396**	**18,155**	**-4%**	**-759**

OP New

Specialty	Activity	Plan	Var (%)	Significance
100 - General Surgery	846	1,127	-25%	-281
301 - Gastroenterology	1,100	1,370	-20%	-270
104 - Colorectal Surgery	1,057	1,150	-8%	-93
300 - General Medicine	389	201	93%	188
502 - Gynaecology	2,512	2,324	8%	188
420 - Paediatrics	1,452	1,253	16%	199
330 - Dermatology	2,174	1,952	11%	222
400 - Neurology	1,057	779	36%	278
130 - Ophthalmology	3,989	3,686	8%	303
110 - Trauma & Orthopaedics	3,877	3,392	14%	485
Total	**31,341**	**30,342**	**3%**	**999**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	1,809	2,983	-39%	-1174
502 - Gynaecology	2,324	2,668	-13%	-344
100 - General Surgery	490	833	-41%	-343
430 - HCOOP	685	955	-28%	-270
191 - Pain Management	839	1,102	-24%	-263
143 - Orthodontics	979	1,228	-20%	-249
340 - Respiratory Medicine	1,217	1,463	-17%	-246
101 - Urology	3,335	3,039	10%	296
110 - Trauma & Orthopaedics	6,384	5,599	14%	785
130 - Ophthalmology	10,267	9,056	13%	1211
Total	**62,656**	**63,111**	**-1%**	**-455**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	2,845	3,835	-26%	-990
100 - General Surgery	299	416	-28%	-117
191 - Pain Management	379	476	-20%	-97
330 - Dermatology	762	843	-10%	-81
502 - Gynaecology	322	387	-17%	-65
410 - Rheumatology	270	321	-16%	-51
320 - Cardiology	470	387	22%	83
130 - Ophthalmology	2,614	2,505	4%	109
303 - Clinical Haematology	607	477	27%	130
101 - Urology	1,347	1,217	11%	130
Total	**13,719**	**14,746**	**-7%**	**-1,027**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	638	739	-14%	-101
502 - Gynaecology	227	311	-27%	-84
100 - General Surgery	195	254	-23%	-59
320 - Cardiology	105	141	-25%	-36
430 - HCOOP	10	25	-60%	-15
140 - Maxillo Facial	55	68	-19%	-13
420 - Paediatrics	61	42	46%	19
503 - Gynaecology Oncology	26	2	1092%	24
400 - Neurology	72	39	83%	33
101 - Urology	489	430	14%	59
Total	**2,489**	**2,682**	**-7%**	**-193**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
100 - General Surgery	976	1,116	-13%	-140
501 - Obstetrics	745	852	-13%	-107
502 - Gynaecology	429	510	-16%	-81
320 - Cardiology	326	405	-19%	-79
110 - Trauma & Orthopaedics	659	734	-10%	-75
340 - Respiratory Medicine	40	100	-60%	-60
430 - HCOOP	2,144	2,068	4%	76
101 - Urology	703	615	14%	88
180 - Accident & Emergency	1,255	1,048	20%	207
300 - General Medicine	4,488	3,819	18%	669
Total	**14,391**	**13,917**	**3%**	**474**

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

82.66 %

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Green
4 Hour Compliance	87.99%	86.50%	88.46%	87.54%	87.00%	89.37%	87.79%	84.91%	80.01%	79.26%	84.02%	82.66%	95%
12 Hour Trolley Waits	0	1	2	0	0	0	0	1	0	1	1	0	0
Left without being seen	3.80%	3.88%	3.39%	2.79%	2.87%	3.06%	3.19%	2.87%	3.78%	4.20%	3.46%	4.10%	<5%
Unplanned Reattenders	9.13%	9.48%	9.39%	8.98%	8.80%	8.93%	8.71%	8.88%	8.97%	9.31%	9.10%	9.39%	<5%
Time to initial assessment (15 mins)	95.1%	94.9%	93.5%	94.9%	91.1%	89.5%	91.7%	93.3%	92.6%	91.1%	86.0%	86.0%	90%
% Time to Treatment (60 Mins)	47.6%	47.9%	53.3%	49.4%	51.0%	49.9%	50.3%	49.5%	43.5%	40.8%	46.3%	43.5%	50%

Sustainability & Transformational Funding Trajectory (Submission 18th April 2016)

-7.36 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%	
Performance	84.02%	82.66%											

Summary Performance

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated, and then admitted or discharged in under 4 hours. This target was last revised by the Department of Health in 2010. When a decision to admit a patient from the emergency department is made, there is zero tolerance for waits of over 12 hours for admission to a ward.

Due to the Trust being unable to achieve compliance against the 4 Hour Standard, it has developed an urgent care recovery plan aimed at improving performance across the Trust. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

May performance against the 4 hour target was 82.66%, against a trajectory of 90.02% and a compliance target of 95%. May's performance shows a decline compared to the April position, with a lower proportion of patients seen within 4 hours. Analysis of the breach reasons shows an increase in the proportion of breaches due to delays to be seen by a first clinician, (47% of all breach reasons, compared to 32% in April, 43% in March). The increased breaches within this area corresponded with a drop in the proportion of patients seen within 60 minutes, a sign of increased overall waiting times for patients compared to the previous month. Volumes of attendances were markedly higher than the previous month, with an average of 601 attendances per day. This is ~50 attends per day higher Trust wide than that seen in April, and similar in volume to that seen in March 2016.

Improvements in Emergency Department performance are being pursued through the urgent care recovery plan, which has gone through a detailed review to identify areas which will improve performance the most. The 4 key areas and actions are as follows;

Priority 1- Improvements in ED

Team Based Working

- Pilot has been developed by the senior clinical team at QEQMH. Senior medical, nursing and support staff are allocated into teams who are responsible for specific areas of the Emergency Department with clinical responsibility for managing patients in those areas through their pathways.
- Implemented in April 2016. The pilot is being run between the hours of 12.00 – 18.00. There was an immediate positive impact with an improvement on the 60 minute standard from 31% to 48%, which resulted in more patients being seen by a clinician within 60 minutes of arrival in the department. 4hr compliance overall saw a compliance increase for non-admitted patients during pilot hours moving from 78.9% to 85.3% in May.
- The service continues to be run during core hours, however the high 8% increase in referrals and ongoing issues with medical locums during May have resulted in the model being reviewed and adapted to allow for a more efficient use of medical resources in the 'majors' area of the department.

Consultant Recruitment

- The Emergency Department is funded for 10 Emergency Medicine Consultants on each site. There are 3 substantive consultants in post at QEQMH and 5 substantive consultants in post at WHH. Two new additional consultants have been recruited who will join the Trust in Septemner 2016.
- One of the applicants has dual training as a Paediatrician and will lead in developing emergency paediatric services. This is an excellent appointment for the Trust and will complement the greatly increased paediatric nursing establishment.

Senior Nursing pilots:

- Early Senior Review (ESI) - The senior nursing team at WHH are exploring opportunities to implement the ESI assessment using existing staff in order to try and embed ESI into the department whilst reviewing the roles and responsibilities of the senior nurses within the department.
- The Emergency Nurse Practitioners at WHH are reviewing their rosters to explore opportunities for extending their hours of cover and ensuring that the rosters reflect peaks of activity.
- The triage assessment nurses at QEQMH are piloting a member of the nursing team being based in the ED waiting room to complete baseline assessments on patients after booking in to ensure that any very unwell patients are escalated to the triage nurse as quickly as possible. This service reduces clinical risk at times of high activity.
- The triage nurse at QEQMH are piloting a an 'advice and guidance' service whereby patients who have presented with a problem which could have been managed by their GP, the triage nurse is assessing the patient and offering to make the patient an appointment with the patients GP practice. The ED staff have by pass numbers which the receptionists can use to ensure that the appointment can be made very quickly.

Priority 2 - Acute Medical Model at QEQM and relaunch at WHH.

- The QEQMH Acute Medical Model is being evaluated on a weekly basis and managed through a project structure to ensure that the learning is captured and will be shared. The model continues to evidence that senior clinical decision makers who are experienced in managing acute medical conditions have increased the number of patients who can be managed safely and effectively within an ambulatory environment.
- The high number of medical admissions in May has put increasing pressure on to the hospitals bed base and this has had a negative impact on the model in that additional medical beds have been used in the emergency assessment bay. The clinical team have continued to provide the service within the ambulatory footprint and are focussing on improving internal standards around turnaround times for patients to be transferred from the Acute Medical Unit to the wards to ensure optimal use of clinical space.
- The QEQMH team are actively planning to launch a Fraility area within the ambulatory floor, which will enhance the assessment and management of frail elderly patients and with the aim of managing frail patients on an ambulatory pathway where clinically possible.
- A range of ambulatory clinical pathways have been developed by the Acute Physicians in partnership with the speciality Clinical Leads and these are being standardised across the Trust.

- The WHH project group has been established in May and is actively planning to implement Phase 1 of their model by the end of June 2016.

- The Short Stay ward will be transferred to the Cambridge floor which will release a clinical area for the 'hot' Ambulatory Unit to be relocated. 'Hot' ambulatory care relates to patients who have presented to ED or via a direct referral from the GP with an urgent medical problem which can be managed without requiring a full medical admission. 'Cold' ambulatory care relates to patients who are being managed on a planned ambulatory pathway.

  Aims of the Acute Medical Unit:

  - Strong MDT approach to managing patients pathway
  - Direct referrals to specialist teams within MDT board round
  - Reduced LOS both short stay & specialist patients as indicated earlier in pathway
  - Improved flow across emergency floor
  - Improved patient experience
  - Increasing use of emergency ambulatory care / improved management for primary care referrals
  - Inclusion of a Frailty area within the emergency floor

  Further developments/consideration

  - 7 day working
  - Careflow electronic referrals
  - Inclusion of a geriatrician led frailty team with the AMU

NHS England Acute Medical Model (AMM) in Small Hospitals – National Programme

The Trust has been selected to be part of the AMM national programme, which provides a supportive networking approach across a wide range of hospital. Benefits include:

- Clinicians and mangers are able to use the Yammer website (managed by NHS England) to share ideas, discussions and documents.
- Dedicated time with Dr Derek Bell from Imperial College to evaluate our Acute Medical Model and develop robust outcome measures.
- Support networking visits to other Trusts to share best practice.

Priority 3 - Implementation of SAFER

- Training on the principles of SAFER has been provided to staff at WHH and QEQMH. Attendance to board rounds has been highlighted as an issue in some areas and further work is being completed to understand the blockages to full attendance. Overall the board rounds are becoming embedded on the pilot wards.
- A discharge website is being developed to include information and policies relating to simple and complex discharges, SAFER tools and patient leaflets.
- Drop in training sessions for MDT staff around discharge, SAFER principles and patient flow have been provided.

- The SAFER dashboard to monitor progress and improvements has been launched and provided excellent information for each ward to monitor its progress against a range of metrics, including the time of discharge. The report is being sent to all consultant physicians, senior nursing staff and will be shared in ward areas weekly.
- A consultant champion will be identified for each ward area during June with a focus on improving senior clinical engagement

Priority 4 - Site Management Arrangements

Operational Control Centres (OCC's)

- Plans have been confirmed to enable the QEQMH OCC to be extended into an adjacent room. This will in effect double the size of the current room and ensure that the QEQMH has an established OCC which is fit for purpose and function.
- The OCC's continue to become established as the central point for for consultants, senior nurses and managers to provide and receive information regarding the hospital status.
- The established meeting structure and information system at QEQMH is being rolled out to WHH over May and June.

Trajectory Confidence

May performance against the 4 hour target was 82.66%, against a trajectory of 90.02%. The improvements seen in April were not able to be maintained and improved upon due to the increased levels of activity experience in May. The numbers of patients attending QEQMH and WHH overwhelmed the departments in the evenings and overnight. There was a significant increase in the numbers of children attending in the evenings, with regular reports of 20 children waiting to be assessed at 9 or 10pm. Each child will require approximately 30 minutes to complete an assessment and treatment plan and the numbers of children attending during this period of time created pressure in the departments and also resulted in a poor patient experience for some children and their families due to the amount of time they had to wait to be seen. Mitigations were implemented with the paediatric medical teams supporting the ED's and ensuring that the sickest children were transferred to the paediatric wards as quickly as possible.

There were also high ambulance attendances with a greater number of majors patients, particularly in the evenings and weekends. This has caused some handover delays in the department. The ED's and management teams have excellent working relationships with SECAMB and through joint working with the ED staff, managers on call and SECAMB there has been a continued effort by the teams to ensure patients have been safely handed over as quickly as possible.

The new Emergency Care Centre (ECC) ambulance protocol which ensures that patients who are heavily intoxicated, suffering from mental health issues or a possible surgical problem are not taken to the ECC was implemented by the Trust on the 2 May. This protocol has had an impact on the QEQMH and WHH attendances and early implementation issues are being managed through communication with SECAMB and the ECC staff to confirm the criteria of patient who should continue to attend the ECC.

The on-going risk to delivery of the trajectory is:

- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of community capacity at weekend across all geographic areas, particularly at weekends and this results in increased breaches due to bed delay and increased medical outliers onto surgical ward areas.
- A high % of breaches of the 4 hour emergency access standard relate to patient flow and bed availability.
- High numbers of patients attending ED in the evenings who could be managed by primary care, in particular paediatric attendances.
- Mental health patients who are awaiting assessment overnight by the Crisis Team
- Mental health patients who require a mental health bed often having to wait several days for a bed, both in ED assessment beds and also in the wider ward bed base.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

77.98 %

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Green
62 day Treatments	72.43%	64.84%	68.83%	69.76%	70.45%	70.89%	79.11%	71.68%	79.86%	74.53%	71.43%	77.98%	>=85%
100 day breaches	116	85	86	130	87	75	57	64	65	61	42	56	<0
Demand: 2ww Refs	3,020	3,195	2,535	2,835	2,748	2,785	2,550	2,725	2,839	2,908	3,085	2,951	2695 - 2978
2ww Compliance	92.11%	90.32%	89.96%	95.05%	95.62%	94.52%	93.87%	93.28%	94.10%	93.59%	89.27%	87.97%	>=93%
Symptomatic Breast	87.50%	85.45%	80.52%	93.46%	94.12%	93.55%	92.22%	94.06%	88.03%	93.02%	85.00%	82.42%	>=93%
31 Day First Treatment	96.09%	90.64%	94.02%	93.17%	96.43%	97.48%	98.00%	94.82%	97.07%	98.14%	96.17%	96.62%	>=96%
31 Day Subsequent Surgery	92.31%	91.89%	92.86%	92.11%	94.44%	96.97%	94.44%	94.59%	97.50%	96.72%	89.80%	78.13%	>=94%
31 Day Subsequent Drug	100.00%	100.00%	100.00%	100.00%	100.00%	98.53%	98.44%	86.17%	100.00%	100.00%	98.31%	98.82%	>=98%
62 Day Screening	100.00%	96.15%	88.24%	86.27%	84.21%	86.36%	85.00%	93.75%	95.65%	92.59%	92.86%	92.86%	>=90%
62 Day Upgrades	100.00%	25.00%	33.33%	91.67%	66.67%	77.78%	70.00%	50.00%	86.67%	70.37%	95.00%	76.47%	>=85%

Sustainability & Transformational Funding Trajectory

1.58 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	74.20%	76.40%	77.60%	77.40%	82.70%	85.40%	85.00%	85.50%	85.20%	85.10%	85.40%	85.20%	Sept
Performance	71.43%	77.98%											Sept

Summary Performance

The Trust's main priority within cancer services is to ensure our patients receive treatment within the appropriate timeframe. The national target which has been consistently difficult for the Trust to maintain is the 62-day referral to treatment, which is made up of three key components: following an urgent referral from their GP, patients should be seen by a clinician within 14 days. If the diagnosis is cancer, a decision to treat should be made as soon as possible, and treatment should begin within 31 days of agreeing this treatment. Over the patient's total pathway, treatment should be initiated within 62 days of the GP making the original urgent referral. There is a zero tolerance of

patient waiting greater than 100 days for treatment, and Lead Clinicians now review each of these cases to identify causes and any risk of harm to the patient. Where potential harm is identified, a full root cause analysis will be conducted and shared with our Clinical Commissioning Groups and internal governance boards.

The Trust has been non-compliant with the 62-day standard over the past year and an improvement trajectory has been agreed as part of the Sustainability and Transformation Fund. The Trust has developed an internal plan to return to compliance, including revising capacity in outpatient clinics, re-launching multi-disciplinary team meetings and agreeing timed pathways and operation procedures. The Trust expects to deliver a compliant 62-day pathway by September 2016.

Currently, May performance against this standard is 77.98%, against its improvement trajectory of 76.40%, with 56 patients waiting 100+ days for their first treatment. The Trust delivered a total of 168 treatments, and 37 of those patients breached the 62 day timeframe. The Trust aggregate position is 1.58% above the submitted recovery trajectory. The breaches are generally caused by either capacity shortfalls or delays in agreed pathways e.g. diagnostics.

An extraordinary cancer Board has been scheduled for the 15th June to discuss key issues and actions for each Tumour site.

Priority 1 – Provide a named Executive Director responsible for delivering the national cancer waiting time standards.

The Trusts named Executive is Jane Ely (Chief Operating Officer).

Priority 2 – Deliver 62 day cancer wait performance reports for each individual cancer tumour pathway to the Trust Board.

The Trust Board receives a cancer briefing report submitted as part of the Chief Operating Officer's report on the Key Performance Standards. This report refers to monthly and quarterly performance for all the cancer standards (2WW, 31days and 62days) for each tumour site. As required the detail includes actions being taken to improve performance and on-going work with CCGs etc. In addition, the cancer tumour performance is discussed in detail at the bi-monthly Cancer Board attended by Executive members, Cancer Lead Clinicians, managers and the wider cancer MDT.

Priority 3 – Provide and adhere to a cancer operational policy which is approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.

The Operational Policy for Cancer is in its first version and has not yet been circulated to Cancer Board Members for ratification at the June Cancer Board. This document is a lengthy policy that includes information around the Access Policy, roles and responsibilities of key members of the Cancer and Leadership team along with the escalation policy. Detailed information around data quality, targets and Cancer standards are addressed. Written guidance on internal processes for MDT working is available within the document (including guidance around achieving the effective MDT). Cancer reporting mechanisms including the Cancer Dashboard is also evident within the document. Following a review of MDT Coordinators a new management structure has been agreed. The role of MDT co-ordination and Waiting list (PTL) trackers has been separated giving time for greater focus on validation and patient tracking.

Priority 4 – Maintain and publish a timed pathway, which is agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.

East Kent Hospitals University NHS Trust hosts the Kent and Medway Cancer Collaborative - which was previously the Kent and Medway Cancer Network. The collaborative continues to ensure that there are Kent and Medway wide (includes the Cancer Centre) Tumour site specific groups (TSSGs). The TSSGs review the cancer pathways on an annual basis and review the referral proforma, diagnostic tests and other milestones. These pathways are agreed with the SCN (and thus the CCGs). The Trust now has a live cancer dashboard to enable clinical and operational staff to view the cancer PTL as well as understand issues around tumour specific pathways. A list of key events to ensure teams can predict future delays and overcome these before they become an issue is developed within the Cancer Dashboard. As well as the PTL the dashboard will aim to have COSD data added so this is open and transparent.
A detailed discussion with all tumour sites and in particular Head and Neck and Lower GI is scheduled for the June Cancer Board.

Priority 5 – Maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.

Weekly PTL meetings have always taken place. We have revised the timetables with a new agreed escalation policy. The purpose of the meeting will be to ensure that the operational managers, clinical nurse specialist, Cancer data manager and MDM coordinator meet to discuss each tumour site and review the PTL. Breaches and other issues will be discussed in the weekly operational cancer performance meeting. These meetings have been superseded by the new Key Performance Indicator meetings, chaired by the Chief Operating Officer and Divisional Directors with the purpose of identifying and resolving pathway bottlenecks and key issues preventing achieving performance.

Priority 6 – Carry out root cause breach analysis for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching). These should be reviewed in the weekly PTL meetings.

Work has been undertaken with the Patient Safety Board and Governance leads. Each Monday a breach report with a summarised RCA section is sent to the MDT lead for their review. A Clinical Incident reporting form (DATIX) is also completed on the electronic reporting system. This is then reviewed within the Governance team for the Division concerned. The MDT Lead completes the RCA summary and finalises the electronic DATIX form deciding if a full Route Cause Analysis is required. This is then processed through the Trusts Governance procedures, led by the Governance team. Themes from the DATIX forms and Breach Reports are presented to the Patient Safety Board on a monthly basis and the Cancer Board Bi-monthly.
Two RCA's have been undertaken since January with an outcome of no harm.

Priority 7 – Carry out capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality). There should also be an assessment of sustainable list size at this point.

It has been agreed for all tumour sites that the pathway timelines and key milestones are to be ratified within the specialty and at the cancer board - in line with revised NICE guidance. Following this we are to use the IST capacity and demand tool to calculate the capacity need to deliver the standard. We will ask to complete this in collaboration with the CCGs as the increase in cancer referrals is significant. Diagnostic capacity and first appointment capacity planning is already commenced.

Priority 8 – Set out an Improvement Plan for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.

The Trust has met with the CCGs and agreed to work collaboratively to ensure improvement against the 62 day standard. A recovery trajectory and action plan has been submitted and is reviewed monthly with the CCGs. Urology's trajectory has improved significantly and is no longer the Trusts main concern for delivery of the 62 day standard. The Urology department have made significant improvements to their pathway and a focus has been to ensure this improvement plan is shared with other specialties facing bottlenecks around their pathways. Sharing good practice has been encouraged. Colorectal remains a high risk for the Trust, mainly due to delays in Endoscopy booking which has been recognised at National level. Each tumour site has produced an action plan that will be reviewed weekly at KPI meetings. The Cancer Dashboard will highlight capacity, demand modelling and predictions for future issues therefore making a significant improvement in performance.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.87 %

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Green
Performance	99.81%	99.92%	99.93%	99.73%	99.84%	99.86%	99.90%	99.81%	99.65%	99.65%	99.78%	99.87%	>=99%
Waiting list Size	14,431	14,271	13,990	14,137	13,962	12,799	13,593	12,496	12,993	13,358	13,449	14,812	<14,000
Waiting > 6 Week Breaches	27	12	10	38	23	18	13	24	45	47	29	19	<60
Average Wait													<4

Sustainability & Transformational Funding Trajectory

0.78 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	99.08%	99.09%	99.15%	99.15%	99.13%	99.14%	99.13%	99.05%	99.10%	99.02%	99.03%	99.13%	Apr
Performance	99.78%	99.87%											Apr

Summary Performance

The DM01 is a national monthly report of performance against the 6 week standard for 15 key diagnostic tests. These include Radiology (MRI, CT and Ultrasound), Audiology, Echocardiography, Neurophysiology and Cystoscopy. Around 13/14 thousand tests per month are measured against the 6 week standard. The Division support the pathways for all patients on an 18 week and Cancer pathway.

19 patients waited over the 6 weeks standards in May 16 – breakdown below

Computed Tomography - 2
Non-obstetric ultrasound - 9
Dexa - 1
Colonoscopy - 3
Gastroscopy – 4

Risks and Issues to sustainable performance

- Aging equipment and downtime, rebooking enabling patient choice is a risk mitigated by daily conference call across the Trust with full overview and management of slot availability and use of alternative sites. Working on case for MRI interim arrangement as mobile at KCH is limited in what clinical activity is safe to use for.
- Increasing demand in modalities of CT MRI and Ultrasound- continue to vet requests.
- Recruitment to key Consultant, Radiographer, Ultra sonographer and Nursing posts, with locums vacancies of Consultants in Radiology, Endoscopy and Neurophysiology
- Reduction to current workforce and outsourcing availability would dramatically reduce the ability to deliver and sustain the DMO1 position –it would further compromise the RTT and cancer standards
- National public drives in screening can drive capacity and demand issues particularly in Endoscopy. The volume of cancer related to endoscopy referrals this month is at unprecedented levels for the Trust and we are reporting serious incident in relation to the demand and impact this could have on waiting times.
- Management HR issues and MHPS issues may impact on performance

What actions are we taking to mitigate and improve performance?

- Management and servicing of equipment managed closely. Serviced regularly to maximise use and work flow.
- Daily overview and mapping of demand to capacity – bi-weekly overview by senior team to ensure on track and mitigate any issues in month
- Additional lists being undertaken to include both extended days during the week and Saturday lists.
- Consultant workforce recruiting to 4 vacancies and reviewing the speciality Interest of posts including Breast. Interview May 16 and July 16 - NHS Locums in place to mitigate in interim.
- Developing Business case to convert locums to substantive whilst ensuring full productivity and maximise DPA time of all consultants
- Neurophysiology- Consultant vacancy - The Consultant is employed by EKHUFT on a sessional basis to carry out the diagnostic reporting until the post is recruited to. This allows us to continue to achieve compliance. The vacancy is being actively recruited to.
- Additional outsourcing of reporting and using I.S. for MRI and Ultrasound (as required) to support delivery.
- Full Review of demand by speciality and by Division and Direct Access flows – this is actively being shared with Divisions and CCGs
- Working with Cardiology to review their pathways and booking processes and enable Nurse led booking of requests and reduce bulk ordering of tests.
- Endoscopy – we will continue to manage with daily overview of all available capacity. We continue to offer Direct access and straight to diagnostic approaches.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

18 Week Referral to Treatment Standard

Key Performance Indicators

87.87 %

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Green
Performance	86.76%	88.10%	88.14%	90.13%	92.06%	91.51%	88.82%	90.10%	89.17%	89.27%	88.56%	87.87%	>=92%
52w+	7	8	8	15	12	3	5	3	5	5	6	9	0
Waiting list Size	45,029	44,706	42,508	42,577	40,125	39,842	41,178	42,239	42,791	43,000	44,620	45,634	<38,938
Backlog Size	5,962	5,321	5,042	4,201	3,186	3,384	4,604	4,181	4,634	4,614	5,105	5,536	<2,178
Demand: PC Referrals	16,465	17,105	14,454	15,950	16,435	15,692	14,296	14,979	15,882	16,190	16,141	15,381	<15,484
Demand: Additions to IP WL	3,560	3,412	2,849	3,220	3,474	3,578	3,118	3,358	3,565	3,582	3,437	3,529	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-1.99 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%	Sept
Performance	88.56%	87.87%											Sept

Summary Performance

The NHS Constitution gives all patients the legal right to start their non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral; unless they choose to wait longer or it is clinically appropriate that they wait longer. To measure compliance against this constitutional right EKHUFT is monitored against the Percentage of Patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral, the Threshold for national compliance has been set at 92%. There is a zero tolerance for any patient waiting over 52 weeks for treatment to commence. All breaches undergo a full root cause analysis, the results are shared with our Clinical Commissioning Groups and themes and lessons learnt are cascaded through our divisional governance structure.

Throughout the last year the Trust has been unable to deliver performance against the national standard as the number of patients waiting for treatment significantly exceeded our capability to see and treat within 18 weeks of referral. The Trust has developed internal activity plans which address the imbalance, and delivery of these activity levels alongside primary care commitments to reduce demand will enable the Trust to successfully deliver the Trajectory over the course of the financial year, this has formed the basis of our Sustainability and Transformation Fund Improvement Trajectory. The Trust intends to deliver compliance against the national standard by September 2016.

In May performance against the standard was 87.87% and nine patients were waiting for treatment for more than 52 weeks as at the end of the month. Despite evidenced increases in theatre productivity, significant localised medical sickness and vacancies have meant we have been unable to fully deliver the business plan in month two. The Trust continues to receive primary care demand at an unmanageable rate which if left unchecked will render the trajectory unachievable. The increase in the number of 52 week waiters is predominantly within the ENT specialty as the Trust has a capacity deficit within the Otology sub specialty.

The Trust has developed four key priorities which address all of the issues detailed above and we will continue to work with our local commissioners to achieve the sustainability and transformational trajectories and comply with our NHS constitutional duty.

Priority 1 - Improve Pathway Management

Development of New Interactive Patient Tracking List – We have developed a new Interactive Patient Tracking System which will enable our Operational Teams to access to live data, ensuring all patients waiting for Treatment are being actively monitored and managed, it is anticipated that this will significantly reduce the risk of patients waiting in excess of 52 weeks for Treatment.

- The software is now in beta testing phase with four specialties and it is expected to be in operational use before the end of June 2016.

Documented Timed Referral to Treatment Patient Pathways – Each specialty to map 18 week compliant pathways to enable us to unblock delays, monitor and hold ourselves to account to achievement of the RTT standard.

- Maxillo Facial and Colorectal and are due to be completed and presented by the end of May 2016 – this has been delayed until the end of June.
- Full Implementation plan for the mapping of all specialities will be completed by end of June 2016.

Reinstate Patient Tracking List (PTL) meetings - Each divisional team has reintroduced a PTL meeting used to provide robust monitoring at patient level on weekly basis, this will greatly reduce the risk to patients waiting over 35 weeks for treatment to commence.

- All PTL meetings have been established

Priority 2 - Achieve the Outpatient Milestones

Demand Management – The health system acknowledges the Trust does not have the operational capacity to deal with the current demand, as such our local Clinical Commissioning Groups (CCGs) have committed to reducing referrals to East Kent in 2016/17.

- The CCGs have confirmed they have identified alternative providers to deliver Orthopaedic pathways in 2016/17, and the Trust is working with Primary Care colleagues to ensure this commences before the end of quarter one as planned.
- Referrals into the Trust over performed the plan by 12.5% in April; this level of demand will render the recovery plan unachievable and has been escalated to the Chief Executive and will be tabled for discussion at the next CCG Performance Meeting.

The Trust has identified an alternative provider who will accept tertiary referrals for complex adult ear procedures. The CCG have now confirmed funding, patients have been identified and agreed to transfer their care and we are now awaiting surgery dates for treatment

Secure Additional Required Sessions – In 2016/17 the Trust will need to provide significant additional outpatient and theatre sessions to meet demand and achieve the required improvement against the RTT standard.

- All operational teams have been asked to secure additional capacity for the first two quarters of the year.
- Risk around continued support from nursing staff to accommodate additional capacity

Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste will be reported shortly.

Bring forward the Decision to Treat Date – Identifying patients who have passed the optimal point in patient pathway and securing decision or treatment capacity

- Weekly validation, monitored at the weekly Patient treatment tracker meeting
- Decision making tree to be developed to support patient management
- Endoscopy delays are extending the colorectal pathway, to mitigate this joint clinical colorectal and gastroenterology meetings established in May 2016. Agreed actions are logged and taken forward with the respective operational teams.

Priority 3 - Deliver the Efficiency Programme

Deliver Theatre Booking Magic Numbers – In collaboration with Medical Productivity & Clinical Service Redesign Specialists, Four Eyes Insight, the Trust has identified an efficiency opportunity of 5,000 operative procedures per annum.

- The Trust has developed key monitoring documentation and enhanced the booking procedures required to achieve the required Theatre efficiency target.

- The first results of these have indicated an increase in the average number of cases per list to 3.5; as such the Trust is delivering the same level of historic activity within less theatre sessions.

6-4-2 Programme – The Trust has established a programme of work to reduce the number of Theatre sessions that are cancelled and not re-established.

- The Trust has developed future focused reports and established meetings to review underutilised and empty theatre sessions.
- Early indications show the Trust continues to Drop significant sessions compared to 2015/16, improved full utilisation these will be vital to enable the Trust to realise the full efficiency opportunity. Profile of unused theatre lists has been raised and addressed at weekly theatre site meetings and weekly trust theatre efficiency meetings.

Priority 4 – Deliver recurrent demand substantively

Live view of current demand – Monitoring referrals on a weekly basis to identify outpatient and admitted capacity required to respond

Real time response – Developing a process to empower staff to address changes in demand, this will reduce delays in responding to unplanned or unexpected changes to patient flow.

- Agree a waiting list initiative authorisation process, to include weekly demand monitoring and risk management within in the established PTL meetings.

Substantive planning – identifying demand within core capacity to deliver within financial constraints

- Job planning clinical teams to deliver flexible sessions to achieve cross covering of clinical commitment during leave in outpatient and theatres.
- Explore moving cataracts from QEQM and WHH to Dover procedure theatre to release theatre capacity – June 2016
- Identified Ophthalmology sessions to transfer to extended days to release theatre capacity and provide cross cover – July 2016
- CCG have committed to providing Independent Sector capacity to transfer patients from the trust admitted waiting list, no timescales have been received from the CCG at present and as such the Trust should consider the continued use of the Independent Sector outsourcing to avoid whole system failure of the RTT Trajectory.

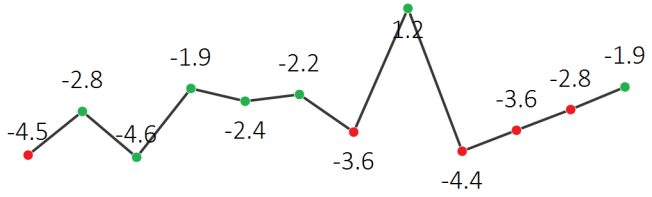
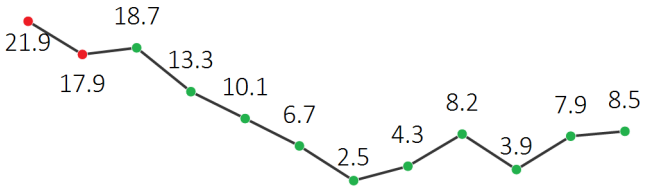
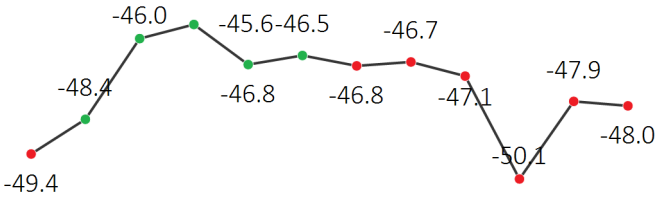
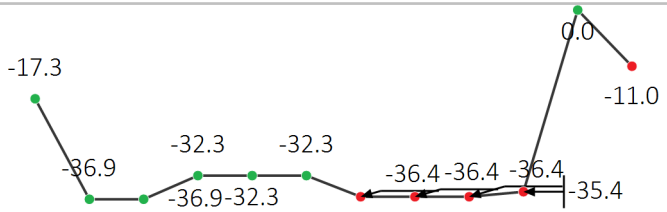
Closing the loop on business planning and accountability – Developing operational procedures and monitoring tools to ensure delivery of the Business Plan

- Develop, train and embed consultant session tracker models to ensure we achieve our substantive internal activity.
- Deliver business planning action plans at speciality level to be monitored weekly at the RTT meeting.
- Clear objective setting, monitoring and accountability at monthly 1-2-1 meetings.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Finance

May	I&E £m	-4.6 (-32.0%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest monthly figure together with % variance against the last month reported. The year to date plan = £5.2m deficit adjusted for "extra" CIPS
May	Cash Balance £m	8.5 (7.5%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Total Cost £m	-48.0 (0.3%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Forecast I&E £m	-11.0 94874.0%		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.

East Kent Hospitals University NHS
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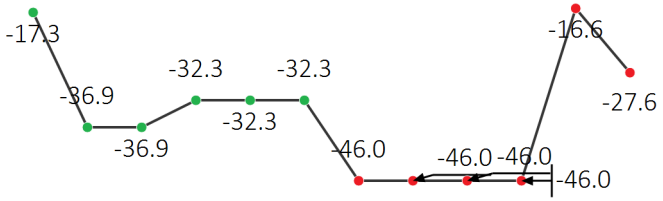
Strategic Theme: Finance

May

Normalised Forecast £m

-27.6 (66.0%)



This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

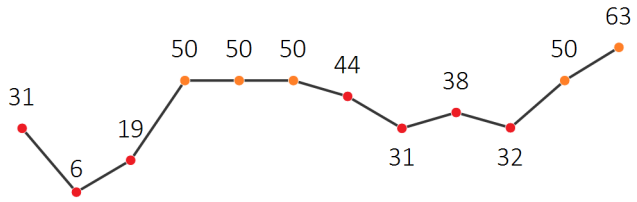
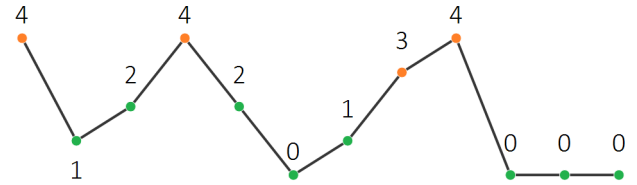
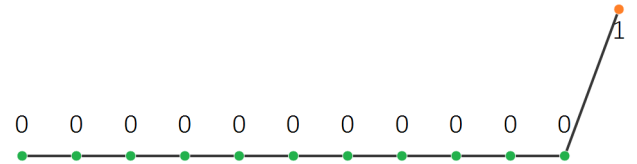
Comments:

- The Trust's monthly I&E deficit has reduced for the fourth consecutive month to £1.9m driven by higher income (average per month Apr/May £45.6m as against average per month in 2015/16 of £43.8), and 'flat' non pay and financing costs.
- The Trust does not yet have an agreed control total for 2015/16 but has included £16.1m of STF funds in the forecast together with an assumption of £20m of CIPS and limited fines and penalties.
- The forecast year end position is a £10m to £12m deficit.
- Temporary staff costs, driven by operational pressures and critical staff shortages, continue to run at £2.2m per month, higher than required to deliver the £23m ceiling set by NHSI.
- Demand for services continues to run at unprecedented levels, testing the Trust's capacity to deliver the required levels of activity and its target trajectories.
- Of the CIPS target of £20m, £17.5m has been identified with £12m risk adjusted. Work is continuing to identify further opportunities and the Turnaround Director has been asked to prepare a report for the CEO and FD on progress and forward view.
- Contracts have been signed with local CCG commissioners and NHSE.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

May	Representation at H&S	463 (-8.6%)		% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	RIDDOR Reports (Number)	21 (31.3%)		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Formal Notices	1		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).

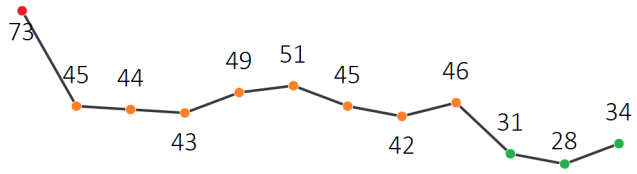
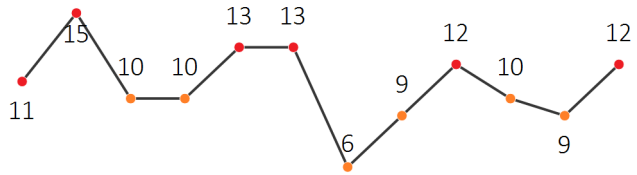
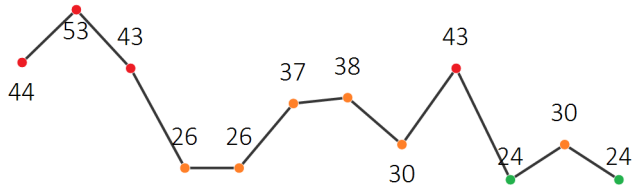
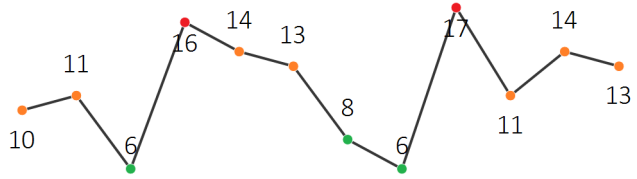
Comments:

- H&S Divisional representation has increased positively this month improving to 63% compliance. This follows the greater engagement and agreement of Divisional and named leads.
- The Trust has no RIDDORs to report this month for the third month running
- Formal notices, consist of 1 letter from Environmental Health about the Serco operated main kitchen at WHH. From a series of 34 random samples taken - 1 unsatisfactory test result related to a chopping board. 2 results where borderline and 1 positive swap for listeria in a drainage area. Serco as the licenced operator will need to improve food preparation controls. Tis was updated verbally at last months Board.
- Additional metrics as agreed by Board continue to be developed. Lost Time Accidents (LTA) data field has been entered onto Datix. Communication to staff is planned this month. Between June and September we will monitor how this fields is being embedded. Risk Registers, this is being developed as part of the new risk governance systems being led by Helen Goodwin and due for roll out in Q2.
- A new metric for numbers of staff attending H&S training (excluding elearning) has been introduced, with 56 staff attending face to face training this month.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

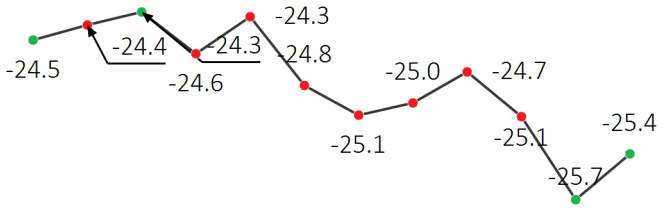
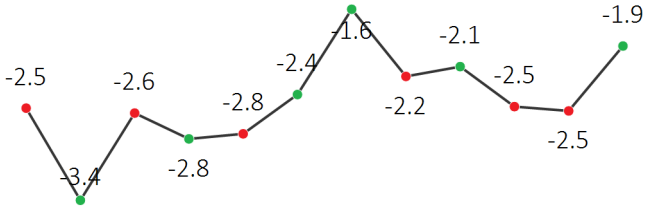
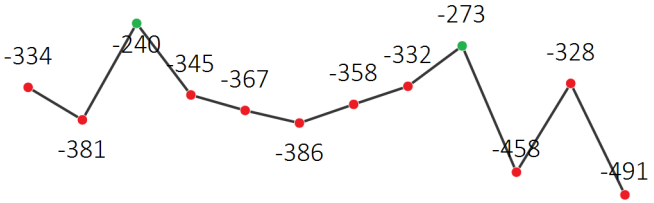
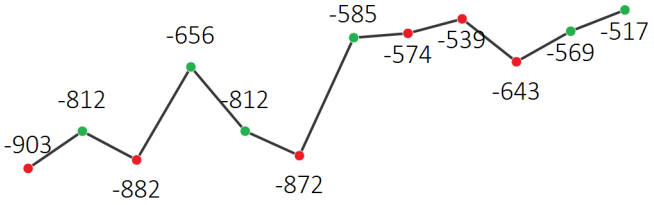
May	Accidents	531 (-2.2%)		Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Fire Incidents	130 (-1.5%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Violence & Aggression	418 (-0.7%)		Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Sharps	139 (479.2%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: Fire - Number of false alarms increased this month which reflects the age of the fire management systems. c£500,000 worth of capital is being invested into the fire management systems in 17/18.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

May	Payroll Pay £m	-25.4 (-1.4%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Agency Spend £m	-1.9 (-24.9%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Additional sessions £k	-491 (49.7%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Independent Sector £k	-517 (-9.1%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments:

- Total pay spend (permanent, overtime, WLI, bank, locum and agency) in May was £27.8m as against £28.6m in April. This reduction was largely driven by a £0.6m decrease in temporary staff costs and £0.2m of bank holiday costs from April dropping out. All pay awards for 2016/17 have now been actioned.
- Agency, Stafflow and locum spend was £1.9m in May as against £2.5m in April, the lower figure reflecting £0.3m of validation adjustments against the April figure. An average spend of £2.2m is consistent with the monthly spend in Q4 2015/16. The Trust has been set a ceiling on these costs of £23m for 2016/17. If the trend seen in the first two months of the years is continued, the ceiling would be exceeded by £3.4m, although this would represent an 11% reduction against the total 2015/16 spend of £29.3m
- Of the £3.8m spent on agency staff year to date (excluding NHS locums), 59% is in UCLTC (29% of the total in emergency medicine) and 26% in surgical services.
- Additional sessions payments in month were £0.5m compared to a monthly average of £0.35m in Q4 2015/16, and the highest level recorded in the last 13 months. The clinical productivity work with Four Eyes must start to see a reduction in this spend.
- Use of the Independent Sector in May was £0.5m, marginally down on April and the monthly Q4 2015/16 average of £0.6m. The Four Eyes work is focused on reducing this spend.

East Kent Hospitals University NHS
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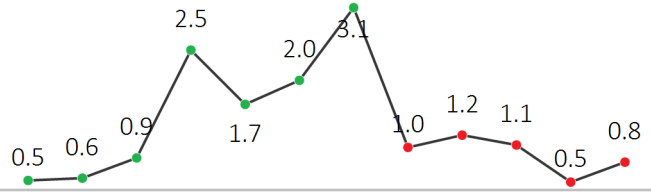
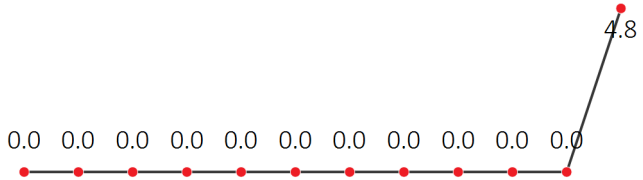
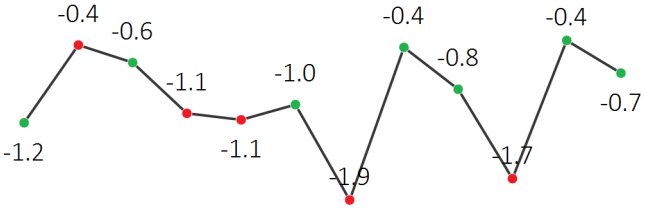
Strategic Theme: Use of Resources

Balance Sheet

May	CIPS £m	1.3 (56.7%)		Cost Improvement Programmes (CIPs) graph: ytd v plan plus forecast. Metric shows variance difference to plan %.
May	Cash borrowings £m	4.8 (Infinity)		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
May	Capital position £m	-1.0 (89.6%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Comments:

- The CIP target for 2015/16 is £20m. In May the Trust is reporting delivery of £1.3m for the year to date against a target of £1.5m.
- Current CIPs plans total £17.5m (gross) or £12m (risk adjusted) against the £20m target. Urgent mitigation is required and has been escalated to Turnaround Board.
- Divisions are developing additional plans to close the gap in Workforce, Medicines Management and Procurement.
- Cash borrowings were £4.8m in May as planned. The Trust has an approved Interim Revolving Credit Facility of £14.6m agreed. Discussions are continuing with NHSI in the profile over the rest of the year.
- Capital expenditure is on target against its annual plan. There have been no amendments to the programme

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Productivity

May	Clinical Productivity: Theatres	0.0	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Clinical Productivity graph: theatre sessions v plan.
May	Clinical Productivity: Outpatient	0.0	0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	Clinical Productivity graph: outpatient sessions v plan

Comments: The Trust is delivering improved efficiencies in theatres through being more productive within the operating sessions which is a key target metric for the joint Four Eyes/Trust programme. Early indications show that the same level of activity has been delivered, but through less sessions and that the average cases per session has increased, showing the in-session efficiency gains. Data is still being validated

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Improvement Journey

		Jan	Feb	Mar	Apr	May
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	84.91	80.01	79.26	84.03	82.68
MD03 - Maternity Capacity	Midwife:Birth Ratio (%)	28	29	31	29	28
MD06 - Pathway Flow	IP - Discharges Before Midday (%)	19	19	18	18	17
	DToCs (Average per Day)	65	62	71	78	62
MD07 - Medicines Management	Pharm: Fridges Locked (%)	88	83	90	92	94
	Pharm: Fridge Temps (%)	80	86	87	88	85
	Pharm: Drug Trolleys Locked (%)	100	99	100	98	100
	Pharm: Resus. Trolley Check (%)	92	94	91	85	88
	Pharm: Drug Cupboards Locked (%)	71	85	87	87	89
MD08 - Staffing Levels	Vacancy (%)	8.4	8.2	8.0	8.8	9.2
	Shifts Filled - Day (%)	93	90	88	97	101
	Shifts Filled - Night (%)	101	101	97	102	105
MD09 - Workforce Culture	Sickness (%)	3.7	3.8	3.8	3.9	4.0
	Appraisal Rate (%)	85.5	84.2	82.2	79.2	70.0
	Staff Turnover (%)	11.4	11.3	11.2	11.2	11.3
	Corporate Induction (%)	100	100	100	100	100
	Staff FFT - Work (%)	49	49	49	49	49
	Staff FFT - Treatment (%)	76	76	76	76	76
MD11 - Clinical Audit	Clinical Audit Prog. Audit	3	3	3	3	3
	Clinical Audit Review	3	3	3	3	3

MD12 - Environment	Cleanliness Audits (%)	99	98	98	98	98
MD13 - Equipment	EME Planned Maintenance (%)	78	81	83		
MD17 - Incident Reporting	Clinical Incidents: Total (#)	1270	1268	1346	1216	1293
MD18 - Policies & Procedures	Policies in Date (%)	73	77			
MD19 - Major Incident Planning	Major Incident Training (%)	31	29	27	28	
MD22 - Agency Staffing	Unplanned Agency Expense	111	115	111	95	68
	Clinical Time Worked (%)	70	69	67	74	73
	Temp Staff (WTE)	230	218	216	196	205
	Employed vs Temporary Staff (%)	92.1	92.3	92.4	91.5	91.0
	Local Induction Compliance %				6.0	8.5
MD26 - Complaints Process	Complaint Response in Timescales %	88	68	82	54	84
MD30 - Medicines Management	Medicines Mgmt. Incidents	118	119	120	90	97

East Kent Hospitals University NHS
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Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	<= 90	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 28	30 %
	Extra Beds	Number of extra 'unfunded' beds available		0 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Outliers	Number of Bed Outliers in the Trust, where the intended use of the bed is used for another service		0 %
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %
	Clinical Audit Review	Review of the Clinical Audit Programme	>= 3	5 %

Clinical Outcomes	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>=95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	PROMs EQ-5D Index: Groin Hernia	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Hip Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	PROMs EQ-5D Index: Knee Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		0 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 67.2	50 %

Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	< 4	25 %
	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	< 0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	0 %
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	0 %
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		0 %
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	0 %
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	0 %
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest monthly figure together with % variance against the last month reported. The year to date plan = £5.2m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %

Health & Safety	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	1	15 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %
	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 25	15 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.		0 %
	Blood Transfusion Errors	The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie free from old and new harm - Old and new pressure ulcers (categories 2 to 4); Injurious falls; Old and new Urinary Tract Infection (UTI); New Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) or Other VTE) Data source - Safety Thermometer. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 94	10 %

Incidents	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie free from: New pressure ulcers (categories 2 to 4); Injurious falls; New Urinary Tract Infection (UTI); New Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) or Other VTE) Data source - Safety Thermometer. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 98	20 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls		0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 0.15	10 %
	Pressure Ulcers Cat 3/4 (per 1,000)	Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		0 %
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	Blood Culture Training	Blood Culture Training compliance	>= 85	0 %
	C Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	0 %
	Cases of C. Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Position in arrow shows YTD cumulative position and variance against previous month.	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	E Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	0 %

Infection	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	0 %
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	0 %
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	0 %
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	0 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	0 %
Initiatives	75+ Frailty Pathway CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	17 %
	COPD CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and improve referral rates to the Stop Smoking Service and to the Community Respiratory Team	>= 100	17 %
	Dementia Diagnosed CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to monitor the diagnosis for Dementia. Green = on target for case finding, assessment and referral to reach 90% for each indicator for 3 consecutive months, AND staff training on target for improvement, AND on target to provide support to carers	>= 100	17 %
	Diabetes CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway	>= 100	17 %
	Heart Failure CQUIN Delivered %	Metric for the measurement of achievement against delivering CQUIN plan by month. CQUIN to develop integrated care pathway and sustain EQ HF measures	>= 100	17 %
Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratios (HSMRs), via CHKS, compares the number of expected deaths with the number of actual deaths, in Hospital. The data is adjusted for factors statistically associated with hospital death rates and scores the number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 90	35 %

Mortality	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, ICD10 diagnoses, OPCS procedures and discharge method is constructed. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 87.45	30 %
	SHMI	Summary Hospital Mortality Indicator (SHMI) as reported via CHKS includes in hospital and out of hospital deaths within 30 days of discharge. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.95	15 %
Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-9pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 9pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	Care Explained? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 98	4 %
	Care that matters to you? %	Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey. Arrow indicates average of last 12 months data (as shown in graph).	>= 98	4 %
	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? This measures the percentage of inpatients who answered 'very clean' or 'fairly clean' in response to the inpatient survey. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response in Timescales %	Audit due to commence in January - Percentage of controlled drugs signed off by two nurses	>= 85	5 %

Patient Experience	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	FFT: Not Recommend (%)	Of those patients who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 1	10 %
	FFT: Recommend (%)	Of those patients who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	30 %
	FFT: Response Rate (%)	The percentage of patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? This measures the percentage of inpatients who answered 'very good' or 'good' in response to the inpatient survey. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	1	10 %
	Number of Complaints	The number of complaints recorded per ward. Data source - Datix.		0 %
	Number of Compliments	The number of compliments recorded per ward. Data source - Patient Experience Team (Kayleigh McIntyre).		0 %
	Overall Patient Experience %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience percentage by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	10 %
	Respect & Dignity? %	Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? This measures the percentage of inpatients who answered 'yes always' or 'yes sometimes' in response to the inpatient survey. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 98	2 %
	Returning Complaints	Number of complaints returned		4 %
Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 90	20 %

Productivity	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		0 %
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		0 %
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total non-clinical cancellations.	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	< 5	10 %
	Pharmacy TTAs Dispensed (%)	The percentage of Discharge Prescriptions (known as TTAs, TTOs or EDNS) dispensed by Pharmacy before the time required on the ward	>= 80	0 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 1	0 %
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency %	% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %
	Agency & Locum Spend	Total agency spend including NHSP spend		0 %
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	0 %
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for new starters to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	0 %
	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	< 28	2 %
	NHSP Use % of Agency	% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).	> 90	0 %
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	0 %

Staffing	Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
	Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 97	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 97	15 %
	Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Calculated cumulatively/YTD. % of FTEs lost through absence (as a % of total FTEs). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.3	10 %
	Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		0 %
	Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		0 %
	Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 7.4	15 %
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Temp Staff (WTE)	Count of Temporary Staff in post	< 182	1 %
	Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 11	0 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Total Staff In Post (SiP)	Count of total staff in post		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %
	Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 10	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	0 %

Training	EME Planned Maintenance (%)	Planned maintenance of EME managed medical equipment	>= 95	0 %
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	0 %
	Mandatory Training (%)	The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	0	0 %
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	0	0 %
	CIPS £m	Cost Improvement Programmes (CIPs) graph: ytd v plan plus forecast. Metric shows variance difference to plan %.	0	0 %
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		0 %
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		0 %
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	0 %

Data Assurance Stars


Not captured on an electronic system, no assurance process, data is not robust


Data is either not captured on an electronic system or via a manual feeder sheet, does not follow an assured process, or not validated/reconciled


Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled

East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)
ACC - KCH A&E DEPARTMENT			2			5								
BIR - BIRCHINGTON WARD	94.4						131				49	99	0.0	90.8
BIS - BISHOPSTONE WARD	100.0	1	3			1	1	93	71	70	30	83	0.0	91.9
CAL - CENTRAL ADMISSIONS LOUNGE						1								
CATD - CATHEDRAL DAY UNIT						5								
CCU - CCU	100.0		3	1			21				91	100	0.0	86.2
CJ2 - CAMBRIDGE J2	93.9	4	5			1	2	97	94	97	30	95	5.3	83.3
CK - CAMBRIDGE K	92.6	3	3				85	95	87	96	89	95	3.8	98.0
CL - CAMBRIDGE L REHABILITATION	100.0	3	5			1	1	75	33	63	24	80	20.0	97.7
CLKE - CLARKE WARD	100.0	1	2			1	2				33	98	0.0	95.1
CM1 - CAMBRIDGE M1 SHORT STAY		1	5			1					55	97	0.0	
CM2 - CAMBRIDGE M2	100.0	1	4			1	75	100	96	99	43	93	0.0	97.6
CSF - CHEERFUL SPARROWS FEMALE	100.0		1				0	94	92	96	63	95	4.0	64.1
CSM - CHEERFUL SPARROWS MALE	96.0	1	1				1	90	93	93	53	93	1.4	75.9
DEAL - DEAL WARD	100.0	1	6			3	1	100	96	100	0			84.3
DL - DISCHARGE LOUNGE QEH			1											
DSC - DAY SURGERY CENTRE						3								
DSSC - DAY SURGERY						1								
DSU - DAY SURGERY UNIT QEH						2								
EYE - EYE UNIT						2								
FF - FOLKESTONE	100.0						92							
FRD - FORDWICH WARD STROKE UNIT	90.9		6			1	0	100	100	100	59	100	0.0	85.8
HARB - HARBLEDOWN WARD	95.7	5	6	2		2	0	100	99	93	43	89	0.0	77.9
HARV - HARVEY WARD	100.0						0				33	100	0.0	
INV - INVICTA WARD	95.7	1	3				30	98	78	86	31	100	0.0	94.6
ITU - WHH ITU	100.0	5					11							92.1
KA2 - KINGS A2	95.0	1	2	1		1	88	93	94	99	77	99	1.4	98.8
KB - KINGS B	100.0		2	1		1	167	95	93	96	45	100	0.0	98.4
KBRA - BRABOURNE (KCH)	100.0	1	1				15				54	100	0.0	
KC - KINGS C1	100.0		5				0	98	88	84	29	100	0.0	93.8

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	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)
KC2 - KINGS C2	100.0		5			2	1				51	98	1.1	87.6
KCDU - EMERGENCY CARE CENTRE	100.0					1	5	0	17	50	13	91	5.4	120.7
KDF - KINGS D FEMALE	88.9	3	3			1	17	94	91	98	44	95	0.0	95.2
KDH - AMBULATORY CARE UNIT			1											
KDM - KINGS D MALE	100.0		3				0	89	88	98	48	95	0.0	
KEN - KENNINGTON WARD	100.0		1			1	1				36	97	0.0	91.0
KENT - KENT WARD	100.0	6					0	98	98	98	48	100	0.0	102.0
KHOM - KCH HOME WARD							0							0.0
KIN - KINGSGATE WARD	100.0					1	66							97.3
KING - KINGSTON WARD	95.2	2	7			1	0				58	97	2.6	101.1
KITU - KCH ITU	100.0	1					0							89.5
KNRU - EAST KENT NEURO REHAB UNIT			1					100	100	100				94.7
MARL - MARLOWE WARD	100.0	1	4	1			57				26	100	0.0	92.3
MFU - MAXILLO FACIAL						1								
MTMC - MOUNT/MCMASTER WARD	100.0		1			1	2	73	74	86	29	100	0.0	91.9
MW - MINSTER WARD	95.7	4	4			2	91				47	93	7.4	84.0
OXF - OXFORD	100.0		2	1		2	0				54	95	4.5	
PAD - PADUA	100.0		1			2	0				32	97	0.8	
QAE - QEH A&E DEPARTMENT		15	1			11								
QCCU - QEH CCU	100.0		1				1	100	100	100	82	100	0.0	94.1
QCDU - QEH CDU	100.0	12	4			1	81				15	96	3.6	87.2
QEND - ENDOSCOPY (QEQM)						1								
QHOM - QEH HOME WARD	100.0						0							0.0
QITU - QEH ITU	0.0		1				59							101.0
QSCB - QEH SPECIAL CARE BABY UNIT	100.0						0							98.1
QX - QUEX WARD	100.0			1			97	100	92	94	84	98	1.1	92.4
RAI - RAINBOW WARD	100.0						0				28	100	0.0	94.6
RST1 - RICHARD STEVENS 1 STROKE UNIT	95.7	4	9			2	0				11	100	0.0	92.3
RW - ROTARY WARD	100.0		1			1	93	90	96	97	48	100	0.0	94.6
SAL - SURGICAL ADMISSIONS LOUNGE						1								
SAN - SANDWICH BAY WARD	95.2	1	4	1	1	2	84	87	92	97	34	100	0.0	82.3
SAU - ST AUGUSTINES, THE REHAB. WARD	100.0		6			1	0	93	89	100	33	100	0.0	59.0

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)
SB - SEA BATHING WARD	100.0			1			0	83	82	92	52	97	0.0	95.3
SBU - SEABATHING UNIT		2	2			2								
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0					1	2							
SEAU - SURGICAL EMERGENCY ASSESS WHH											0			
STM - ST MARGARETS WARD	95.7		7			3	0				3	100	0.0	95.0
SURA - SURGICAL ADMISSIONS						1								
TAY - TAYLOR WARD	100.0						0	89	92	96	42	100	0.0	81.5
TREB - TREBLE WARD	100.0	1	6				0	94	86	94	27	100	0.0	93.4
WAE - WHH A&E DEPARTMENT		23	2			8								
WCDM - WHH CDU MIXED		11	14			4		93	91	97	15	86	3.6	
WCDU - ***** DO NOT USE *****	100.0						1							
WHOM - WHH HOME WARD	100.0						0							239.0
WXRY - X-RAY (WHH)			1											

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term	Kent Pathology Partnership
Agency %	5.3	1.8	5.5	3.0	9.4	1.7	23.1	38.7	
Appraisal Rate (%)	80.9	87.7	71.0	34.5	73.3	57.3	62.3	67.9	
Employed vs Temporary Staff (%)	89.1	89.4	90.0	93.2	94.0	91.9	92.6	88.7	
Mandatory Training (%)	91	93	89	78	84	90	85	88	
NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
Sickness (%)	3.8	3.0	2.6	5.1	4.8	3.2	4.1	3.9	
Stability Index (excl JDs) %	86	86	89	86	90	90	89	88	50
Stability Index (incl JDs) %	85	85	88	87	85	90	83	84	50
Staff Turnover (%)	13.1	12.6	16.2	15.5	9.1	9.5	10.1	11.8	200.0
Vacancy (%)	10.9	10.6	11.6	8.1	7.4	8.1	7.6	10.5	

Apdx.

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**21 JULY 2016**
SUBJECT:	**REPORT FROM THE BOARD OF DIRECTORS**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**To Note**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Council of Governors with an overview of items discussed at the Board of Directors meetings held in public since the last report.

Board of Directors Meeting held in public – 10 June 2016

The following decisions were made at the Board of Directors meeting held in public:

- The Board of Directors approved the Charity Annual Report and Accounts.
- The Board of Directors approved the Charity Strategy.
- The Board of Directors ratified a recommendation from the Charitable Funds Committee to award a grant for the 2016 Trust Awards.

The following agenda items were received and discussed:

Staff Story
A report describing poor patient experience related to a complaint received about the care of a person living with dementia. The Board of Directors were assured that following this event, changes and improvements had been made which were now embedded. This had involved making difficult decisions around the leadership of the ward and cultural change.

Dementia Village
A presentation was received on the work being undertaken to explore options for building a Dementia Village facility in East Kent. Building the Dementia Village in Dover would have huge benefits for the local economy, providing new community facilities and jobs.

Chief Executive Report
The monthly report from the Chief Executive provided the Board of Directors with key issues related to: Improvement Journey; Financial recovery; Leadership Events and Staff Engagement; Emergency Department (ED) Recovery Plan; Clinical Strategy Update; Update on Junior Doctor Contract Negotiations; Integrated Performance Report; 2016/17 Contract; Good News Stories; and Chief Executive Activity February 2016 to March 2016

2016/17 Annual Objectives / Board Assurance Framework
The updated Board Assurance Framework was received. Work was ongoing with Executives to examine the level of controls and assurance in place. As part of this work, the Board of Directors requested the focus on the emergency department be appropriately reflected.

Board Committee Feedback
Reports were received from each of the Board Committee Chairs. Reports would be taken to the next Council of Governors meeting.

Integrated Performance Report
The latest performance was discussed. Updates will be provided to the Council of Governors as part of the Board Committee Reports. The latest Integrated Performance Report is published on the Trust's website:
http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/our-performance/

Trust Improvement Plans
The Board received the latest CQC Improvement Plan and Emergency Recovery.

Communications and Engagement Strategy
The Board of Directors received an update on progress made to date. The Council of Governors have received the same update at a previous meeting.

Emergency Planning Update Audit Report
The Trust's duties are underpinned by the Civil Contingencies Act (CCA) 2004. NHS England has set out the Emergency Preparedness Resilience and Response (EPRR) core standards which complement our statutory duties under the CCA 2004, the Trust is audited annually against these core standards by the South East Commissioning Support Unit (SECSU) on behalf of the CCGs. The Audit undertaken March 2016 reported **significant compliance**.

Medical Revalidation
The Board of Directors noted an improved compliance position.

The following information reports were received

- Cultural Change Programme Update
- Sustainability and Transformation Plan Update

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	NA
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	N/A
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

PRIVACY IMPACT ASSESSMENT: *YES / NO**	**EQUALITY IMPACT ASSESSMENT:** *YES / NO**

RECOMMENDATIONS AND ACTION REQUIRED:

To discuss and note the report.

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **21 JULY 2016**

REPORT FROM: **SATISH MATHUR, CHAIR BoD FIC**

PURPOSE: **Information**

SUMMARY OF KEY AGENDA ITEMS AND BUSINESS:

The meeting reviewed the following matters

- **Finance at Month 2**
  - The Trust still does not have a control total for STF and are one of 19 other Trusts in the country in a similar position.
  - NHS I has announced that Providers are forecasting a £500M deficit in 2016/17
  - All STP groups have been asked to come up with a plan for back office and pathology consolidation/savings
  - STPs have also asked to flag if any services in an area are unrecoverable financially and could be passed to another provider
  - Financial performance is currently in line with the board approved plan
  - FPC discussed risk and agreed that risks related to each paper should be reflected on during discussions.
  - The level of CIPs was discussed as the risk adjusted CIPs are at £12.5m which is below plan.
  - FRR was discussed as it is very sensitive to meeting plan.
  - Risks are flagged in the paper but are not yet built into the forecast. Currently the forecast only includes delivery of £20M not £30M of CIPs. The FPC asked for a plan for how the CIP gap to £20m was to be delivered.
  - The achievement of STF was discussed. There are significant uncertainties as NHS I have not yet defined the control totals or rules on STF qualification.
  - Risks of contracting were discussed. The challenges from the CCGs and the response from the Trust was discussed. Challenges were £1.6m for Month. The majority of the challenges have been refused or corrected. There was a TIA Day case challenge (circa £1.3m estimate for the year) which was reasonable and we are likely to lose this money. Also we will not be able to charge for some best practice tariffs. CQUIN is also unlikely to be fully paid due to know issues. Other penalties are likely to cost the Trust £500K. The challenge the Trust faces is to deliver the elective work in order we can still achieve planned income levels. As a result of the conversation it was felt there was a need to discuss the relationship between the Trust and CCGs at the forthcoming Trust/CCG Board to Board.
  - A review of risk and high level forecast was requested for the FPC in August along with an impact assessment.

- **Performance Report**
  - The IPR and activity reports were discussed.

- There were 700 attendances in A&E on 4th July which was more than the Trust had ever seen in a single day. This was 12% above plan
- In addition referrals were running above plan. (4% in month and 7% YTD). The CCGs are trying to cross correlate this increase with lower consultant to consultant referrals.
- Cancer services are doing better on delivery and were moving toward trajectory.
- DM01 – diagnostics are on plan but at a cost
- The 18 week RTT is behind plan due to high referrals and the need for CGG's to take work from the backlog as agreed in the contract. In addition the CCG triage service is directing more than expected work to the Trust.
- The emergency pressure is creating bed challenges which could have an impact on elective surgery. This is also meaning that agency reductions can't be delivered as the emergency patient numbers are still high. It was agreed this would be raised at the Trust/CCG Board to Board.
- Mental health patients were also discussed as although they are small in number the nurse support requirements have a big impact on ED.
- There was a discussion on the fact all theatre sessions had not been delivered and despite an increase in patients per session the Trust is struggling to increase productivity.
- There was a discussion around what CCGs could do to help demand management
- There was also a discussion that some of the new medical models could not be expanded, even if working, as there was a lack of staff to deliver them.

- **Clinical Strategy (CS) Update** – There had been a prior discussion on the CS at the board. This board approved review was revised and submitted as part of the K&M STP plan. The slides show the updated position. These options leave a deficit of £23M in the Trust once CIPS and bed closures are factored in. The assumptions are very challenging and require £90M of savings over 5 years. Once even these are factored into the Kent & Medway plans these still leave a £200M gap across the region. Assumptions on the reconfiguration are high level currently and therefore hold a risk. Further review of these cases is required. There was a feeling the current plan was as good as possible at this stage and the figures and risks were noted but the plan was considered as the most appropriate way forward. There was a challenge that the large bed reduction was not delivering a significant new way of working which would deliver a bigger impact.

- **Soft FM Update** – Vince Monaghan gave an update on the SERCO request for additional money to support the national living wage. The Trust has flagged it is not responsible for the living wage increase per our contract. The value put forward by SERCO seems to be circa £2M over 5 years and more detail has been promised on the numbers. There is a positive dialogue and a benchmarking exercise is underway against other providers. Carter back office work will also inform this discussion. It is felt the threat to stop the service has now been removed but there is likely to be a cost impact.

- **Finance Risk Register Review** – The finance risk register was discussed and main risks reviewed. Risk control was discussed. It was agreed that more attention needed to be focused on risk mitigation in future FPC meetings. It

was recognised there is a need to define an approach to improving medical notes and therefor depth of HRG coding. It was flagged the Board needs to consider where it requires risks to sit whether with the risk owner or Finance area with non-financial owners.

- **Developing the Finance Team** – The Finance team and Finance Governance was discussed. Much movement has been made on the Finance Governance issues flagged by GT. The wider trust Leadership Development Programme will be used to formalise development goals for Finance staff. An SLR development paper will be coming to the FPC in August. The FPC thought this should be considered a positive development.

- **PAS/Maternity Replacement Update**– The maternity system has now been implemented and is the first of any SACP sponsored projects to go live. PAS changes were discussed and the risk planning for go live was considered. The main risks were flagged. FPC noted that by implementing the 18 week reporting module ahead of the new PAS cutover the risk profile of the project had been improved.. A review of all clinics and activity was being undertaken to see what activity could be reduced stopped around go live. The system data will be downloaded 7 times before go live as test runs. MTW will go live first and this will help flag any issues before the Trust goes live. There may be further work on communications required and the need for a revised communications plan was discussed. The potential for lost income from the change was flagged.

- **Timing of Divisional Feedback-** this was discussed and agreed this should occur for only half an hour, one Division per month on a rolling basis from September. There should be clear guidelines on what needs to be presented.

- KEY ISSUES TO FLAG

    - Performance risks – e.g. A&E trajectories with unprecedented demand. Current status of clinical performance as per the IPR.
    - CIP narrowing of gap
    - Contract risks discussion
    - Clinical Strategy
    - Soft FM update
    - PAS implementation – risk on operational delivery
    - Cash risk was flagged

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**21 JULY 2016**
SUBJECT:	**REPORT FROM THE CoG NOMINATIONS AND REMUNERATION COMMITTEE**
REPORT FROM:	**PHILIP WELLS** **COMMITTEE, CHAIR**
PURPOSE:	**Discussion and Agreement**

SUMMARY

A meeting of the Nominations and Remuneration Committee (NRC) took place on 15 July 2016 to consider:

- the process for recruiting a Non-Executive Director (NED) to the vacancy created when Richard Earland's current term of office ends in December 2016; and.
- the appraisal process for the Trust Chair and NEDs
- committee terms of reference

This paper summarises the outcome of the meeting.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors are invited to:

1. approve the draft terms of reference for the Committee after reaching agreement on the principle of NED attendance as relating to quorum, detailed below;
2. agree the proposed procedure for NED recruitment; and
3. agree the proposals for Trust Chair and NED appraisal for 2016/17.

Opening remarks and Ratification of Meeting Chair

Members approved Philip Wells as the Committee Chair. Members expressed concern about NED attendance at meetings of the Committee, although it was later noted that attendance via electronic means was appropriate, especially given the demands on the NEDs' time.

NED Recruitment Process

The outline and timeframe for the process proposed by Sandra le Blanc, Director of HR, was accepted and is provided at Annex A for reference. The Committee discussed the proposal and agreed or noted the following:

- It was agreed to follow the process used for the last recruitment exercise as this had worked well.
- It was agreed that an external recruitment partner be sought to provide support to the process.
- A new tendering process was required due to the time gap since the last recruitment.
- Due to the short timeframe required, prepatory work on the tender had commenced with invitations to tender going to those companies on the national framework proposing fees of £15 – 18K. .
- The shortlisting for the recruitment partner to take place by 29 July with the selection completed by 2 August.
- It was agreed that three NRC members from a group of four volunteers would be on the selection panel, joining the Senior Independent Director (SID), Barry WIlding: Philip Wells, Reynagh Jarrett, Michael Lyons and Margo Laing. Choice of governors would depend on availability.
- In the past both Odgers and Henry Nash had been contracted to supply this support and the Committee requested that some feedback on performance be provided.
- The contract would be offered on a three year term.
- The interview pack would be shared with the NRC members for comment.
- Ideally, if diaries allowed, the Lead Governor would attend the open evening for candidates.
- There would be no reference in the advertisement about whether or not previous applicants were welcome. This decision was taken after an extensive discussion and made on balance of the views expressed.
- The Interview panel would consist of the NRC Chair, Philip Wells, the Trust Chair, Nikki Cole, one other NED and two Governors from the NRC – again depending on availability.
- The interview candidate packs to be couriered to the panel members.

The one area that the Committee was unable to resolve at the meeting was the ideal skill set for the new NED. Nikki Cole had been unable to attend the meeting as a result of an administration error when setting the date. The outcome of considerations by the Board on the key skills for the new NED, to ensure any gaps on the Board were filled, could not be provided at the meeting. It was therefore decided that the NRC Chair would have further discussions with the Trust Chair and a proposal taken to the Full Council meeting following virtual discussion between NRC members before 21 July.

Trust Chair and NED Appraisal

The meeting considered a paper from the Trust Secretary, on behalf of the Trust Chair, for the process of Chair and NED appraisal in 2016/17. The paper is reproduced at Annex B for information.

The meeting had a wide ranging discussion about what evidence would be available to them to support their feedback on NED performance. This included concerns about the time available to NEDs to attend CoG meetings, which was seen as an important opportunity to observe NED performance. The view was also put forward that many other opportunities existed for Governors including review of the many meeting papers available to them, attendance at Board meetings and information available from external sources, such as the NHS Choices website.

It was noted that the move to appraising NEDs on the anniversary of their appointment, rather than at the end of the NHS year, would mean that the Committee would need to meet on a more regular basis and this would be factored into the meetings schedule for the Board and Council for 2017 currently being developed by the Corporate support team.

The Committee agreed the proposals for the appraisal process for 2016/17 as laid out in the paper. Members were pleased to note that the process would not involve discussion about individual performance in open session when the individual was present and stated that this should not be allowed to occur in the future.

Terms of reference

The Committee agreed the draft terms of reference, at Annex C, with the following amendments:

- Meetings would be open to all Governors however voting rights would remain solely with the Committee members. This decision was taken on the basis of ensuring equity – non member Governors would need to know in advance if voting rights were to be given to them and the question of timing of that decision made the matter very complex to manage.
- Virtual attendance at the meeting via mechanisms such as conference calls was deemed to be acceptable.
- The Trust Chair was a member of the Committee.

The meeting did not come to an agreed decision on quoracy. It was agreed that four Governor Committee Members were required for the meeting to be quorate. The question of whether the presence of a NED should also be deemed to be necessary.

It was agreed that this should be the case but there was a difference of opinion about whether the presence of the Chair and the NED Chairs of the BoD Nominations and Remuneration Committees had to be present in order for the Governors to be able to meet their duty of holding the NED to account. There was some concern that the quorum needed to be set in a way in which the business of the Committee would not be delayed as a consequence of NED attendance.

The decision was taken to refer this matter to the Full Council for further debate; it was considered that the outcome of the discussion may have implications for the terms of reference of other Committees.

CoG 41 Annex A

NED Recruitment Campaign Timeline 2016

Activity	Responsibility	Proposed Timeline
Procurement to submit bidding requirements to 5 external framework recruitment Partners	Carly Millgate	8th July 2016
Agreement of Recruitment Plan & timeline by Council of Governors (COG) Nominations Committee	COG Nominations Committee	15th July 2016
Confirming who will be responsible/involved in: • **Shortlisting external recruitment partners down to 3 from 5** • **Meet the 3 external recruitment providers and make the final selection** • **Finalising job description/candidate pack** • **Being a part of the candidate shortlisting panel** • **Being a part of the candidate interviewing panel**	COG Nominations Committee	15th July 2016
Tenders to be submitted to procurement	Carly Millgate	15th July 2016
Shortlisting of external recruitment partner down to 3	Selected members of the COG Nomination Committee & Carly Millgate	Date tbc between 18th and 29th July 2016
Selection of Recruitment Partner	COG Nominations Committee	Date tbc, before 2nd August 2016
Finalisation of candidate recruitment packs and advert in conjunction with selected Recruitment Partner	Communications Team, Twyla Mart & Selected members of the COG Nomination Committee	W/C 1st August 2016
Advertisements made live	Recruitment Partner and Twyla Mart	8th August 2016

Open Evenings		17th August 2016 (tbc) 31st August 2016 (tbc)
Closing date for applications	Recruitment Partner	5th September 2016
Shortlisting Meeting	Remuneration and COG Nomination Committee	W/C 12th September 2016
Interviews	Interviewing Panel	W/C 26th September 2016

CoG 41 Annex B

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**CoG NOMINATIONS AND REMUNERATION COMMITTEE**
DATE:	**15 JULY 2016**
SUBJECT	**CHAIR AND NED APPRAISAL**
REPORT FROM:	Alison Fox, Trust Secretary
PURPOSE:	**TO NOTE**

CONTEXT/REVIEW HISTORY/STAKEHOLDER ENGAGEMENT

The Trust has an annual cycle of assessing performance of its Board members and Board level Committees. Appraisal of the Trust Chair and Non-Executive Directors (NEDs) is part of that process.

SUMMARY:

This paper sets out the process for Chair and NEDs appraisal with specific reference to the role of the Council of Governors, records the process followed for 2015/16 and proposes the timetable for 2016/17.

MEETING OBJECTIVE:

For members to review the proposed process and timetable for recommendation to the Full Council meeting.

LINK TO TRUST OBJECTIVES: Patients / People / Provision / Partnership

Relevant to all objectives as the performance of the Chair and NEDs is essential to delivering high quality of services within the resources available to the Trust.

RECOMMENDATIONS:

Process and timetable for 2016/17 to be recommended for approval to the Council. NRC members are also asked to consider agreeing to regular quarterly meetings.

NEXT STEPS:

Recommendation to be included in the Committee's report to the Full Council meeting on 21 July 2016.

Process followed for 2015/16

Chair process

The Senior Independent Director (SID), Barry Wilding, held a meeting with Governors on 1 April 2016, prior to the Strategic Committee meeting which had been opened for all Governors to attend. Subsequent to the meeting, an invitation was circulated to all Governors to provide feedback on the Chair's performance directly to the SID if they wished.

The outcome of the SID lead appraisal was reported in private session to the Full Council on 24 May 2016.

NED Appraisal

This was discussed at the meeting of the NRC held on 18 February and included in the Committee's report to the Full Council meeting on 25 May. All Governors were invited to provide any further feedback to the Chair outside of the meeting.

Objectives for 2016/17 were set for each NED as part of this appraisal process, in accordance with section 2.2 of the policy.

Process and timetable for 2016/17

The policies for NED and Chair appraisal are attached at Annexes A and B respectively.

The timetable for the Chair's appraisal is set out at Appendix 3 of this report (final page). To facilitate the discussion between the SID and Council members in March it is proposed to run a survey of all Governors in February covering the areas for assessment listed on page 9.

In accordance with the policy, NED appraisals will be undertaken annually against the individual's start date. Governors will be canvassed for their comments via an electronic survey. The outcome of each appraisal: under performing / performing / over performing, will be discussed at a meeting of the NRC and reported to the next meeting of the Full Council, in private session.

Richard Earland will complete his current term of office at the end of December 2016 and a new NED will be appointed. Objectives for the new appointee will be set within three to six months of the start date, in accordance with section 2.2 of the policy.

It is therefore proposed that the NRC set quarterly meeting dates to receive these reports.

In 2016/17 the NED appraisals will be due as follows:

RonHoile	1 January
New appointee	between March and June – first objectives set
Barry Wilding	11 May
Colin Tomson	11 May
Satish Mathur	1 October
Sunny Adeusi	1 November
Gill Gibb	1 December

Annex A to CoG 41 Annex B

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
NON EXECUTIVE PERFORMANCE EVALUATION PROCESS

1 Introduction

NHS Improvement's Foundation Trust Code of Governance states that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and of its committees and individual directors.

This document sets out the process for the evaluation of NED performance. It reflects EKHUNHS FT Guidance on the Statutory Duties of Governors.

2 The process

2.1 The Chairman will lead the process for evaluation of Non-Executive Director performance, facilitating input from the Chief Executive, Board of Directors and members of the Council of Governors.

2.2 The Chairman will meet with each non-executive director to set their objectives within 3-6 months of their start date. Thereafter the non-executive director will be appraised annually on the anniversary of their appointment against the objectives. The objectives for all non-executive directors will fall into three areas:

- The Trust annual objectives (set March / April each year)
- A specific improvement that they will lead in their chairing role; and
- An objective linked to the use of their expertise in a specific piece of work for the Trust.

2.3 The evaluation will consist of:

- 360 review with the NED nominating reviewers from:
    - the Council of Governors;
    - the Chief Executive,
    - Executive Directors and
    - other relevant senior staff;
- A discussion between the Chair and Non Executive Director relating to performance against their specific objectives, professional and personal development;
- Contributions to consultant recruitment panels; patient safety visits; attendance at Council of Governor meetings and Committees; completion of mandatory training.
- Agreement of objectives for the coming year.

2.3 The questions that will form the 360 degree element and thereafter provide the discussion between the Chair and non-executive director are:

- What has the non-executive director done well during the year; why was this good and can this be applied elsewhere?
- Identify an area for improvement; what would you have liked the non-executive director to do differently and how would this have improved the outcome?
- On a scale (1 to 7) how has the non-executive performed during the year?
- On a scale (1 to 7) is this non-executive director a team player?

A freeform box for additional comments will allow the appraiser to add anything they think relevant but that is not covered in the questions.

2.4 The outcome of each appraisal will be discussed at the Council of Governor's Nomination and Remuneration Committee and reported to the next private Council of Governor meeting. These outcomes will form the basis of any decision to re-appoint the non-executive director.

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Annex B to CoG 41 Annex B

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR APPRAISAL OF THE CHAIRMAN

APPROVED BY COUNCIL OF GOVERNORS: February 2014

REVIEW DATE: February 2016

POLICY STATEMENT

1. Good governance of Foundation Trusts requires that Board Chairs, like all other senior staff, should be subject to a formal scheme of annual performance appraisal. This ensures that Chairs are themselves appraised, and receive regular feedback on their performance, and on their responsiveness to external constituencies. It can provide evidence to NHS Improvement of accountability if needed, and can also support decisions by the Council of Governors on what actions to take when a Chairman's term of office comes to an end (including whether or not to reappoint without a further open competition).

2. This Policy statement sets out the appraisal process for the Chairman of the Trust only. It [has been agreed] by the Council of Governors and reflects EKHUNHS FT Guidance on the Statutory Duties of Governors.

3. Annual appraisal enables:
   a) Review of the performance of the Chairman of the Board
   b) Update of the job specification and personal objectives for the chairman
   c) Identification of personal development needs of the Chairman set out in a personal development plan where necessary

4. A new Chairman on appointment will have an initial appraisal meeting with the Senior Independent Non-Executive Director (SID) within 4 to 8 weeks of appointment. The primary purpose of this meeting will be to:
   a) Confirm that the job description is clear
   b) Agree objectives
   c) Agree a Personal Development Plan

The key components of the Chairman's appraisal are attached at Appendix 1.

5. An incoming Chairman will have a formal mid-year review, to appraise progress, in October/November. The end of year appraisal will take place in April/May, together with objective setting for the year ahead.

6. In subsequent years, the annual appraisal should take place within 2 months of the financial year end, and should:
   - Review performance and achievement over the preceding year;
   - Review the job description to ensure it remains up to date;
   - Identify changes to the chairman's objectives for the forthcoming year;
   - Agree any requirements for personal development, to be set out in a PDP if necessary.

7. Mid year reviews should take place for established chairs at the request of either the chair or the SID as appraiser.

8. The appraisal process should be conducted by the SID, drawing on the views of and perspectives of other directors, governors, and other stakeholders. The areas covered by the assessment are attached at Appendix 2. The timetable for the appraisal process is attached at Appendix 3.

9. The SID should present the outcome of the appraisal process (including the Chairman's written self-evaluation) each year to the Council of Governors, with a view to reaching agreed conclusions.

10.. The SID and anyone else involved in the appraisal process should attend an internal Staff Appraisal Course (1 day).

APPENDIX 1

WHAT IS APPRAISAL?

Appraisal is a participative two-way process between the appraisee and his/her line manager. When appraisal is being used effectively, it is a positive, supportive and developmental process.

It provides the opportunity for the Chairman of the Board of Directors to reflect on his/her performance as an individual and as part of a team, suggest improvements, as well as providing a vehicle for expressing perceptions and feelings.

KEY COMPONENTS OF THE APPRAISAL SYSTEM FOR THE CHAIRMAN

- The Trust considers that the following are some of the key characteristics of a successful appraisal system:

- There is top level support, from all the Trust Board and CoG.

- Training for those undertaking this appraisal will be made available.

- There must be effective mechanisms in place for delivery of the appraisal. These should include allocation of time to undertake appraisals, time for on-going discussion of individual and organisational needs and clear but simple paperwork.

- Objective setting in advance is essential

- The formal appraisal will consist of a discussion between the SID, who will have sought input from other directors, the governors, other relevant external stakeholders and the Chair who will have completed a self-evaluation of his/her progress against the objectives for the year.

    - The SID will solicit feedback from those concerned by seeking oral assessments against the chairman's personal objectives for the year in question, supplemented if necessary by written assessments;
    - The SID will solicit specific feedback from governors on those aspects of the chairman's objectives that are visible to the CoG, normally using a simple questionnaire/rating scale agreed in advance with governors.

- All those taking part in an appraisal should be aware of what happens to their documentation and ensure that issues of confidentiality are addressed.

- Summaries of job descriptions, personal objectives, and appraisals should be held by appraisers and copies retained by the appraisee.

APPENDIX 2 – AREAS COVERED BY ASSESSMENT

The Chairman's appraisal will be led by the Senior Independent Director, facilitating input from the Chief Executive, Board of Directors and members of the Council of Governors.

The appraisal will cover the following assessment:

- Performance against individual objectives;
- Effective chairmanship of the Board of Directors and Council of Governors;
- Effective leadership of both the Board of Directors and Council of Governors;
- Effective challenge at Board and committee meetings;
- Attendance at Board, committee meetings and Council of Governor meetings;
- Corporate understanding and strategic awareness;
- Commitment;
- Holding to account;
- Personal style;
- Independence and objectivity;
- Self-development and attendance at required training (including mandatory training) and development sessions and events.

CoG 41 Annex C

East Kent Hospitals University NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS'

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

Constitution

The Nominations and Remuneration Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:

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

- Considering and making recommendations to the Council of Governors on the appointment of the Chairman and Non Executive Directors. The Committee is to satisfy itself that its recommendations fulfil Trust needs in terms of skills and experience.
- Agree the process for recruitment of the Chairman and Non Executive Directors taking into account the views of the Board of Directors on the process in general and the qualifications, skills and experience required for the position.
- For NED appointments, the Chairman of the Trust will be asked to Chair the appointments panel. For appointments to the Trust Chair position, the panel will be chaired by the SID or next senior NED.
- The Committee will ensure appointments are based on merit and objective criteria as well as meeting the 'fit and proper' persons test described in the Provider Licence.
- To make recommendations to the Council of Governors on the re-appointment of the Chair and/or Non Executive Directors where it is sought and is constitutionally permissible. The Committee will look at the existing candidate against the required role description.
- To consider and make recommendations to the Council of Governors on the remuneration and terms of appointments of the Chairman and Non Executive Directors.
- To contribute to an annual review of the structure, size and composition of the Board of Directors and to make recommendations for changes to the NED element of the Board of Directors to the Council of Governors where appropriate. When undertaking this review, the Committee will consider the balance of skills, knowledge and experience of the Non Executive Directors.

Frequency of Meetings:

Meetings of the Committee will be held as and when necessary.

Membership and attendance:

There will be eight Governor members on the Committee. One member will be elected as Chair of the Committee and will hold office for the period of one year from April. All Governors are welcome to attend meetings of the Committee. Prior to the start of the

meeting, the Chair of the Committee has the discretion to open the meeting to all Governors, including the right to vote.

Current Membership:

Philip Wells (Chair)
Carole George
Geraint Davies
Jane Burnett
Margo Laing
Matt Williams
Michael Lyons
Reynagh Jarrett

Attendees:

Non-Executive Director Chairs of the BoD Nominations and Remuneration Committees:

Sunny Adeusi and Richard Earland

Trust staff: Director of HR

Quorum:

The Committee shall be quorate when at least four members are present.

- **APPENDIX 3**
-
- The timetable for the Chairman's appraisal:
-

ACTIVITY	BY WHEN
Senior Independent Director meeting with the Council of Governors to facilitate assessment of the Chairman	MARCH (Private meeting of the Council of Governors)
Self assessment against objectives completed	APRIL
Senior Independent Director to facilitate peer assessment (Executive Directors, Non Executive Directors)	APRIL
Senior Independent Director to discuss peer assessment with the Chairman	APRIL
Senior Independent Director to report outcome to the Council of Governors	MAY (Private meeting of the Council of Governors)

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REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**21 JULY 2016**
SUBJECT:	**REPORT FROM THE CoG QUALITY COMMITTEE**
REPORT FROM:	**SARAH ANDREWS COMMITTEE, CHAIR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The CoG Quality Committee met on 7 July 2016.

This report provides the Council of Governors with an update on the issues covered and makes recommendation for consideration by the Council

The key issues discussed were:

- Closing the PSE Committee
- Committee Purpose Objective and Work plan
- Terms of Reference
- Attendance at wider Committees

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The CoG Quality Committee is recommending the following for consideration/agreement by the Full Council:

- Approval of the Committee Chair
- Approval of the Terms of reference
- A decision about a Governor PET card to give to Members seeking individual assistance
- A decision about attendance by Governors at wider Trust Committees.

Committee Chair's Overview

This was the inaugural meeting of the Committee with the agenda devised to address housekeeping and procedural issues, in preparation for the meeting on 3 August, which would be the first to follow on from the Board of Directors' Quality Committee.

The meeting unanimously confirmed appointment of the Committee Chair. Good progress was made with terms of reference being agreed (see Annex) and the role of the Committee thoroughly debated and discussed. A clear theme emerged with respect to the importance of adhering carefully at all times to the Duty of the Governor – to hold the NEDs to account – and the challenge of holding this line. There was much debate about how to best enact the second Duty, to represent the interests of Trust Members and in particular to take into account feedback from Members gathered by Governors, while avoiding the risk of veering into operational areas.

It was considered this issue is likely to test all the CoG Committees and is one which may be resolved in an evolving fashion as the committee structure matures. It was noted at their forthcoming meeting the CoG Audit and Governance Committee would be considering a paper proposing a process for managing Governor questions and Membership feedback. Having such a structure to work within will be of value.

Items discussed

Closing the Patient Staff and Experience (PSE) Committee

The Committee received the minutes from the final meeting of the PSE Committee held on 9 May 2016; these were agreed by those who had been present.

There were some open actions; some related to workforce issues and would be for the CoG Workforce Committee to take forward.

The Committee noted that an issue relating to the Outpatients Service needed to be carried forward and agreed that the first step would be to review the minutes to be clear what the concerns were. Members would then decide on the action to be taken within their role of holding NEDs to account.

It was suggested that Governors would find it helpful to have information available to signpost Members in the correct direction when individual concerns were raised with them directly. It was suggested that a card with information about the PET team could be developed for Governors' use.

Committee purpose, objectives and work plan

The Committee received a presentation from the Trust Secretary on how best to use the quarterly Board Assurance Framework (BAF) and discussed the other information it would use to inform its work on holding the NEDs to account. This needed to include reports from the BoD Quality Committee; relevant sections of the Integrated Performance and the Improvement Plan .

Furthermore, looking at trends within the information provided from members but being careful to avoid looking at individual cases. The Committee was aware that the CoG Membership, Engagement and Communication Committee were looking at the issue of Membership Engagement.

The Committee recognised that the nature of its work meant that the issues covered would be of particular relevance to the CQC re-inspection visit in September and that it was essential that the agenda for the August meeting reflected this.

Terms of reference

The Committee considered the draft terms of reference and agreed that these provided a flexible framework which encapsulated their remit without being too proscriptive. The Committee noted that the terms of reference would be reviewed annually so there would be opportunity to adjust them at a later date as the Committee matured.

The Committee made some changes to the draft which other CoG Committees may wish to consider adopting:

- Attendance – virtual presence at a meeting, such as via a phone link, would count as attendance
- While meetings would be open to all Governors to attend, voting rights would not be given. To give voting rights on an ad hoc basis could be difficult to apply on a practical basis while ensuring that no Governor was disadvantaged by the timing of the decision.
- Quorum needed to refer to 'Committee Members' not 'Governors'.

The Committee's terms of reference are appended at Annex A for approval by the Council of Governors.

Attendance at Wider Trust Meetings

The Committee noted that a number of Governors were members of wider Trust Boards and Groups, such as 'End of Life Care' and that this had been appropriate at the time that the practice had been instigated. A number of Committee members are aware that in other FTs Members are asked to sit on such Committees and Groups. This is one way to widen Membership engagement. The Committee is therefore asking Council for their views on this matter. Governors could continue to sit on such Committees and Groups in their role as Members. Feedback from the Members attending could then be presented at the appropriate CoG Committee meeting and be used as triangulation data for holding NEDs to account.

Outcome and Recommendations

The CoG Quality Committee is recommending the following for consideration/agreement by the Full Council:

- Approval of the Committee Chair
- Approval of the Terms of reference
- A decision about a Governor PET card to give to Members seeking individual assistance
- A decision about attendance by Governors at wider Trust Committees.

Next steps

The Committee next meets on 3 August following the BoD Quality Committee meeting, and will be looking for assurance with respect to the preparations for the CQC re-inspection.

Annex A

East Kent Hospitals University NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS'
QUALITY COMMITTEE
TERMS OF REFERENCE

Constitution
The Quality Committee is a committee of the Council of Governors. It has no delegated power to make decisions on behalf of the Council.

Purpose:
The Committee is responsible for providing the Council with assurance on all aspects of the quality of patient care, by:

1. Seeking assurance from the Non-Executive Chair of the Board of Directors' Quality Committee that the Board of Directors is delivering the Quality Improvement Strategy and Annual Quality Objectives, and managing any associated risks identified in the Board Assurance Framework.

2. Ensuring that the NED members are effectively supporting the delivery of the key elements of that Committee's purpose and in a way which also manages Trust financial and staff resources to deliver best value

3. Ensuring that the interests of patients, members and the public are represented and taken into account by the Board of Directors.

4. Providing a report on the business of the Committee to the Council of Governor meetings.

Frequency of Meetings:
Meetings of the Committee will be held on a quarterly basis.

Membership and attendance:
There will be eight Governor members on the Committee. One member will be elected as Chair of the Committee and will hold office for the period of one year from April. Members are asked to attend a minimum of three out of four meetings per year; virtual attendance is acceptable. All Governors are welcome to attend meetings of the Committee. Prior to the start of the meeting, the Chair of the Committee has the discretion to open the meeting to all Governors to attend, without voting rights.

<u>Current Membership:</u>

Sarah Andrews, Chair
Alan Holmes
Eunice Lyon-Backhouse
John Rampton
Junetta Whorwell
Mandy Carliell
Marcella Warburton
Philip Bull

Attendees:
Non-Executive Director Chair of the BoD Quality Committee: Ron Hoile,
Trust staff: Jane Christmas, Deputy Director of Nursing

Quorum:
The Committee shall be quorate when at least four Committee Members are present.

Support:
The Committee will be supported administratively by the Corporate Secretariat. It shall receive advice from the Trust Secretary and the Director of Nursing, or their representatives.

REPORT TO:	Council of Governors
DATE:	21 July 2016
SUBJECT:	BoD Quality Committee
REPORT FROM:	Ron Hoile CHAIR OF THE QUALITY COMMITTEE
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

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.

The following provides feedback from both the July Quality Committee meetings. The report seeks to answer the following questions in relation to the quality and safety performance:

1. What went well over the period reported?
2. What concerns were highlighted?
3. What action has the Committee taken?

MEETING HELD ON 6 JULY 2016

The following went well over the reporting period:
- HSMR remains below the national average (albeit a historic position);
- SHMI is improving;
- Incident reporting has risen showing a culture of openness and willingness to report and raise issues;
- Non-elective crude mortality continues to fall (registering green, falling below the 27.1 threshold);
- There was a drop in MRSA bacteraemia;
- Hospital acquired harm free care remains high (good);
- Decrease in the falls rate;
- No avoidable deep ulcers reported;
- Safe staffing is further improved this month;
- A further slight improvement in the Friends and Family test star rating;
- While complaints response times require continued focus, an accrued backlog is being positively and actively managed. It is of note that 145 complaints were closed during May 2016 compared with 69 in April 2016. This improvement is being driven by a comprehensive review of the complaints process with development of new ways of working and greater support and outreach to the Divisions.
- Improved position for mixed sex accommodation (with no breaches in May).

Concerns highlighted over the reporting period:
- An increase in the number of serious incidents reported;
- We remain on limit for the monthly C-Diff trajectory;
- Old and new harm free care remains below where we would like;
- We are above trajectory for category 2 avoidable ulcers;
- Mixed sex breaches, although reduced this month are still occurring. There is a potential for breaches to occur in future.
- Recognising that there has been a step increase in the number of episodes of care, the complaint / episode of care ratio shows a deteriorating position in May 2016. The number of Complaints continues to rise, albeit at a less severe rate than for previous month

(April). Focused action is underway to recover this position, see above reported relative improvement since April 2016.

Other topics discussed where concerns or actions were taken:
The IPR was considered by the committee with a focus on quality metrics (domains of caring, safety and effectiveness. There was also consideration of the performance od the Emergency Department.

- Recording of VTE assessments reported an improved position. Governance around this has been strengthened at both a corporate and divisional level.
- Legibility of doctors signatures. Discussion took place around the use of stamps (with name & GMC number) versus a drive to insist doctors sign, write name & number legibly. The current situation is unsatisfactory & the Medical Director was requested to bring further details to the committee. There was uncertainty as to whether there would be an improved performance to justify the cost of stamps.
- A new maternity risk dashboard is up and running. There is also the need for a co-ordinated Uro-Gynaecology activity log. However, there was a concern around resources to collect data. The Chief Nurse and Director of Quality will be taking this forward in order to produce an estimate of ongoing costs .
- Increased serious incidents in maternity compared to the previous year associated with CTG monitoring. Key driver unknown but could be a result of increased scrutiny. As an interim measure, all twin CTGs will be reviewed by a registrar or consultant.
- Eligible consultant signatures within medical records was discussed. The Committee has asked for a report on options to resolve this at its August meeting.
- The Committee welcomed the new format Integrated Performance Report and agreed further work was required to refine thresholds and explanations of data presented in order for the Committee to draw attention to outliers in performance and form its own judgements.
- Data for Cambridge L and CDU reported some patient experience metrics lower than expected. The Committee recognised that case mix could be an element. More detail would be provided to the August Committee.
- The significant increase of the number of ED attendances was noted. This is a nationwide problem for the NHS. The Committee was concerned around the delivery of the Emergency Recovery Plan having missed the ED trajectory. RTT performance was also a concern. The impact on access to the Sustainability and Transformation Fund was unknown. This issue was discussed in more detail at the Finance and Performance Committee.
- Pressure ulcers reported a downward trend compared to the previous year.
- The outcome of the learning Disabilities Mortality Review was noted. Actions put in place:
    - Develop training for staff and raising awareness sessions. Events are planned and some have already taken place as part of Learning Disabilities week;
    - A spot check audit on documentation is planned;
    - A Learning Disabilities lead is to be identified;
    - The formation of a multi disciplinary group was proposed. The group would review the report so far, consider all the learning, actions already taken, confirm a comprehensive and SMART action plan which included targeted and trust wide action, and thereby provide assurance that learning was being taken forward.
- There is greater focus on assisted mealtimes, especially for patients with dementia, led by the Nutrition Steering Group. Assurance was provided to the Committee around risk assessments for patients and the use of the red tray and red mat systems, particularly for patients with dementia.
- Assurance was provided to the Committee that significant progress had been made on the appropriateness and completion of clinical audits. The Committee is due to receive a formal update against the plan at its September meeting.
- Aging equipment in pathology and radiology was noted. The former was linked to the Kent Pathology Partnership transformation plan. An action plan was in place for the latter and the committee noted possible cost implications.
- Increase in MRIs and CT scans was noted. The backlog for the former has reduced. The

Trust was outsourcing CT scan reporting.
- The Aseptics write off position (monitored by the Integrated Audit and Governance Committee) has significantly improved.
- Public Health England had confirmed they were content with actions put in place to address obstetric scanning issues reported through STEIS.
- Assurance was provided to the Committee that Corporate Teams and Divisions were sighted on compliance with locked drug cupboards.
- Emerging risk regarding Interventional Radiology Cover. A Kent wide solution was being explored.
- An audit was taking place to ensure all end of life care forms were properly documented.
- There had been significant progress in the development of the corporate and strategic risk register. This would enable the Committee to focus on mitigation more closely.
- Relaunch & implementation of the Global Trigger Tool required more debate at Management Board around resource (in terms of time, funding & commitment). There was a split in the opinions of the Exec Officers present. A recommendation would be brought to a future Committee.
- An update report on nasogastric tube incidents concluded NHS England was content with the action taken by the Trust following a visit week commencing 27 June 2016. Internal work will be undertaken to check no further incidents had been reported and to ensure consistent reporting as part of the national reporting learning system.
- Divisions were asked to confirm whether staff would recognise the issues recorded at their Governance Board meetings. Overall, Medical Directors present felt this to be the case but recognised that there were pockets where further work was required (top to bottom).

As a general point, the Committee felt overall performance (in terms of the quality agenda), when contextualised within the significant challenges and pressures the Trust was faced with, was a positive story. The Committee was confident the Management Team and Board were aware of the challenging areas, what mitigating actions were being put in place and that there had been more traction on issues such as VTE.

RECOMMENDATIONS AND ACTION REQUIRED:

Discuss and note the report.

REPORT TO:	**COUNCIL OF GOVERNORS' MEETING**
DATE:	**21 JULY 2016**
SUBJECT:	**REPORT FROM THE CoG WORKFORCE COMMITTEE**
REPORT FROM:	**ALAN HOLMES** **COMMITTEE, CHAIR**
PURPOSE:	**Information**

REPORT

The first meeting of the new CoG Workforce Committee was scheduled for 7 July 2016 with the aim of agreeing its terms of reference and discussing its role, objectives and work plan in preparation for the meeting on 19 August, which would be the first to follow on from the Board of Directors' Strategic Workforce Committee

A number of apologies were received for the meeting and it was therefore cancelled as the key item of business was the discussion about the objectives and work plan, an important debate which as many members as possible should be involved in.

The agenda for the meeting on the 19 August will be extended to include the items from the planned inaugural meeting, including ratification of the Chair. The Committee's Terms of Reference will therefore be presented for approval at the meeting of the Full Council on 5 September.

As the current Committee Chair of the meeting I have had a meeting with Colin Tomson, Chair of the BoD Strategic Workforce. We discussed the practicalities of the alignment of the two Committees and how this can be developed in a way which makes best use of the time of both Governors and NEDs. These discussion will be fed into the first meeting of the Committee when we discuss how best to meet the role of the Governors to hold NEDs to account.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.

RECOMMENDATIONS AND ACTION REQUIRED:

The report is presented for information.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **21 JULY 2016**

REPORT FROM: **COLIN TOMSON, STRATEGIC WORKFORCE COMMITTEE CHAIR**

PURPOSE: **DISCUSSION**

PURPOSE OF THE COMMITTEE:

The Committee is responsible for providing the Board with assurance on all aspects relating to the workforce, including strategy, delivery, governance, risk management.

This report presented reflects Committee activity for the June 2016 meetings.

EXECUTIVE SUMMARY

The report seeks to answer the following questions in relation to workforce:

- What went well over the period reported?
- What concerns were highlighted?

The following trends were reviewed:

- The Trust appraisal rate has declined again in April 2016 and is now 79%, which is below the target rate of 90%. Divisions report this as a seasonal dip
- The Trust's sickness absence rate for April 2016 is 3.9% compared to 4.0% in April 2015. However the increasing trend in sickness absence has continued through May.
- The Statutory Training Compliance Rate has remained at 87% - exceeding the Trust target of 85%.
- The turnover rate (Excluding Doctors in Training) for April 2016 has remained at 11.4%.
- We continue to monitor the risk associated with completion of statutory training. In April 2016 753 staff were identified as not completing one or more of the statutory training courses required. This shows a reduction of 16% from the 897 staff in February 2016.

The following concerns were highlighted at the June Committee Meeting:

- Most wards failed to meet the 42 day target for approval of their 4th April 2016 roster, although recently Surgical Division have made significant improvements and have achieved excellent results for future rosters.
- More than half of the wards exceeded 22% headroom. The headroom figure is the amount included in ward budgets to allow for leave, sickness etc of staff. Consistently running above this figure will mean that the ward will not have the planned number of nursing hours provided by permanent staff that it should have and this could affect the safety of the service.
- There is a significant under-utilisation of the Autoroster functionality in Healthroster, with 11 of the 38 Wards opting to produce their whole roster manually. The Executive will relaunch the Rostering programme.

The Committee received the following reports and assurances:

- The Urgent Care and Long Term Care Division and Specialist Services Division presented their

Great Place to Work Plans including their response to the staff survey results. The Committee would be programming updates from Divisions and had asked for future presentations to provide links to the Trust's turnaround programme and make progress against trajectory visible. Risks and challenges should also be spelt out

- The Trust had made investment in the Leadership Programme and a tender process was underway.
- The Committee received a report outlining the Trust's emerging recruitment and retention plan. A further presentation would be received at the July Meeting from the Project Co-Ordinator.
- The Committee received assurances around the timeline for the production of the Trust's People Strategy. A further report would be received in July 2016.
- The Executive Team were asked to review the approach taken when dealing with incremental progression to ensure Trust policy was embedded in relation to completion of mandatory training.
- The Committee approved a proposal to enable selected Associate Specialists to practice autonomously. The approach was supported by the LNC and BMA.
- A report was received from the Trust's Healthy Workplace Group updating on the positive work in place to provide lifestyle support to staff.
- The Committee supported the approach to explore further how apprenticeships can become an integral part of the Trust's workforce plans including the nursing associate role.

ACTION:

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