UNCONFIRMED MINUTES OF THE THIRTY THIRD MEETING OF THE IN PUBLIC COUNCIL OF GOVERNORS MONDAY 18 JANUARY 2016 SMITH'S COURT HOTEL, 21-27 EASTERN ESPLANADE, MARGATE CT9 2HL

PRESENT:

Nikki Cole	Chair	NC
David Boggard	Elected Governor – Staff	DBo
Debra Teasdale	Nominated Governor – Partnership	DT
Eunice Lyons-Backhouse	Elected Governor – Rest of England & Wales	ELB
Jane Martin	Nominated Governor – Partnership	JM
John Rampton	Elected Staff Governor	JR
John Sewell	Elected Governor – Shepway	JS
Junetta Whorwell	Elected Governor – Ashford	JW
Mandy Carlliel	Elected Staff Governor	MCa
Michele Low	Elected Governor – Shepway	MLo
Paul Bartlett	Elected Governor – Ashford	PBa
Paul Durkin	Elected Governor – Swale	PD
Pauline Hobson	Elected Governor – Canterbury	PH
Philip Bull	Elected Governor – Shepway	PB
Philip Wells	Elected Governor – Canterbury	PW
Robert Goddard	Elected Staff Governor	RG
Roy Dexter	Elected Governor – Thanet	RD
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
Helen Goodwin	Deputy Director of Risk, Governance & Patient Safety	HG
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
Amanda Bedford	Governor & Membership Lead	AB
Stephen Dobson	Foundation Trust Membership Engagement Co-Ordinator	SD
Jane Cooper-Neville	Committee Secretary (minutes)	JCN

PUBLIC ATTENDEES:
There were two members of the public present.

Minute No:

CoG 01/16 **CHAIR'S INTRODUCTIONS**

NC welcomed Michele Low, John Rampton, Ron Hoile, and Matthew Kershaw to their first meeting of the Council of Governors (CoG). She also welcomed two members of the public.

Thanks were given to Jane Cooper-Neville for her support to the CoG.

Amanda Bedford and the new Governor and Membership Lead was introduced to the CoG.

CoG 02/16 **APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST**

Apologies for absence

Apologies were noted from:

- Carole George, Elected Governors – Dover
- Jane Burnett, Elected Governor – Ashford
- Marcella Warburton, Elected Governor – Thanet
- Margo Laing, Elected Governor – Dover
- Matt Williams, Elected Governor – Swale
- Reynagh Jarrett, Elected Governor – Thanet
- Michael Lyons, Nominated Governor - Partnership
- Chris Bown, Interim Chief Executive
- Gill Gibb, Non-Executive Director
- Jane Ely, Chief Operating Officer
- Liz Shutler, Director of Strategic Development & Capital Planning
- Sandra LeBlanc, Director of HR
- Satish Mathur, Non-Executive Director
- Sunny Adeusi, Non-Executive Director

Declarations of Interest

There were no additional declarations of interest.

CoG 03/16 **MINUTES OF THE LAST PUBLIC MEETING HELD ON 10 NOVEMBER 2015**

Minutes for accuracy

The minutes of 10 November 2015 were agreed as an accurate record.

Matters arising

<u>54/15 Integrated Audit & Governance Committee (IAGC)</u>

AF reported on update from IAGC held on 15 December 2015 where it was agreed that there had been significant progress toward a solid solution to the IT network security access issues. A three phase approach has been agreed. The first is to map out the 'As is' process, starting with joiners. There will then be a challenge phase, the main driver here being efficiency. In parallel, HR has a piece of work under way which is establishing the organisational hierarchy within

ESR. This is the first step to implement Role Based Access. This will create groups within ESR. An interface between ESR and AD (Active Directory) has been established. These groups will be replicated within AD and this will form the basis for Access to systems. The implication for leavers is that, as soon as ESR is updated with the leaver information, they will be removed from the group and the AD interface will remove their access to systems. This is sound strategic approach to the issue which we expect to have implemented by the start of the next financial year.

62/15 KCC consultation on residential care

AF said that she was awaiting an update on whether the Trust had submitted a response to this consultation.

NC said that the Trust would ask KCC for an update on the outcome of the consultation exercise. JCN

CoG 04/16 **CHAIR/NON EXECUTIVE DIRECTOR REPORTS FROM BOARD AND BOARD COMMITTEES**

NC asked that reports be taken as read and invited questions from members of the CoG.

Board of Directors

No questions were asked in respect of this report.

Finance and Investment Committee (FIC)

In the absence of Satish Mathur, NC reported that the forward focus of this committee would be the on-going management of cashflow, monitoring of the CIPs and injecting pace into the work to reduce costs.

In light of the fact that agency/locum spend was identified as the main driver for overspend at the November and December meetings of FIC, DT asked for assurance that these costs are being managed effectively.

RE said that the main challenge for the Board of Directors (BoD) was to mitigate the cost of agency staff against the need to maintain quality. The assurance that DT was seeking is the same as that sought by the Non-Executive Directors (NEDs) and that this would be an ongoing call of judgement.

SS reported that in respect of therapies and nursing staff the Trust had well developed recruitment programme which is helping to reduce agency costs. Executives are being held to account on a weekly basis on the use of 'off framework' agency staff. There are a number of metrics and tools that are being used to support the BoD to monitor ward establishment levels and skill mix of staff against the need to provide safe, quality care.

PB pointed out that a significant proportion of understaffing was as a result of staff sickness and that the occupational health service works on the basis of referring staff in need of help rather than by proactive intervention. He asked what more could be done.

SS said that sickness rates are constantly monitored through the Strategic

Workforce Committee (SWC), managers are held to account in respect of their implementation of the Trust's absence policy and there is also a wellbeing programme for staff.

JS expressed his support to the BoD by noting the difficulty in reducing the workforce, while at the same time maintaining quality services to patients. DB asked for an assessment of the balance of risk in light of the fact that medical equipment can only be replaced every 10 years.

RE said that because of a lack of funds equipment replacement decisions are being made on the basis of prioritisation. NEDs are assured that there are appropriate processes in place to carry out an ongoing assessment of risk in relation to the need for the replacement of medical equipment.

SA asked how NEDs had maintained an overview of the use of beds and services over the winter months.

RE said that the NEDs look at performance reports presented to the BoD and monitor the situation by using the data contained in these reports.

Remuneration Committee

No questions were asked in respect of this report.

Nominations Committee

No questions were asked in respect of this report.

Quality Committee

NC pointed out to the CoG that since the report of the Quality Committee had been written another meeting had been held. She was therefore asking RH to give a brief verbal update on the most recent meeting, bearing in mind that a report of this meeting had not been considered by the BoD as yet.

RH reported that at the January meeting of the Quality Committee it was noted that the improvement plan and delivery was on track. In respect of patient safety there was some good and not so good news. On a positive note, harm free care had improved, incidence of falls and pressure ulcers continue to fall, mortality rates are down and serious incidents are slightly reduced compared to this time last year. There are areas of concern related to, the need to resolve serious incidents; improve performance around the Duty of Candour, and use morbidity and mortality meetings more effectively.

Other areas for discussion were:

- The identified risks to the Trust during the improvement period these include, staffing, patient safety culture, and emergency pathway and performance.
- The quality of clinical audit data was discussed and will be considered further at the IAGC on 19 January.
- New Data Protection Rules
- Claims against the Trust are up by 42% on Q2
- The need to review all deaths as recommended by the Mazars Report

NC asked whether the review of deaths was as a requirements resulting from

the review of deaths at Southern Health Trust.

PS said that NHS England require a mortality review of all deaths which will result in a significant increase in workload as the anticipated minimum length of time needed to review each set of case notes will be 30 minutes.
MLo asked why the quality of clinical audit data is so poor and what action is being taken to address this.

RH said that this was exactly the discussion that was being had within the Quality Committee at the moment.

PS reminded the CoG that clinical audit had been an area of concern identified in the CQC report. The existing Clinical Audit Committee is being restructured and will examine NICE guidelines and standards to ascertain the level of compliance and explore the reason for incomplete audits.

SA asked whether there was any identifiable relationship between non-compliance with NICE guidelines and negative effect.

PS said that none had been identified to date.

MLo asked for clarification in respect of the concerns highlighted at the last Quality Committee about the available modules within the risk system to be procured.

AF reported that this issue will be discussed at the Integrated Audit & Governance Committee (IAGC) on 19 January. She assured the CoG that the matter would be resolved by the next CoG at which time she was hopeful that she would be able to give an update to the effect that the tracking module was part of the risk system.

Strategic Workforce Committee

CT said that the Workforce Plan would remain in draft until there is final agreement on the clinical strategy. However, this was not preventing on-going business planning using the demand and capacity modelling tool to identify options and pressure points. He therefore felt able to provide assurance that the workforce issues are being managed in a professional manner. He was of the opinion that the Trust has the potential to be a 'talent magnet' and that in his early discussion with the new Chief Executive there was common agreement of the need to promote the Trust as 'a great place to work'.

JS acknowledged the challenges in developing a workforce strategy within the context of an 'emerging' clinical strategy over the next year.

Charitable Funds Committee

DT asked how the cost of on-going maintenance is accounted for in equipment funded through the charitable trust.

MK said that as a general approach it would be expected that these costs would be included in the business case submitted to the charitable trust.
Integrated Audit and Governance Committee

No questions were asked in respect of this report.

CoG 05/16 **PERFORMANCE**

By way of introductory comments, MK highlighted the task of the Executive officers as being to make the difficult choices necessary to maintain an appropriate 'balance' between the competing demands of quality, finance and performance. The role of NEDs is to ensure that this balance is being achieved. His initial reflections are that staff are focussed on achieving the necessary 'balance' and he looks forward to discussing the extent to which 'balance' is being attained.

NC proposed that at future CoG meetings performance data will be integrated into the board committee reports, which will in turn create opportunity for a fuller discussion of each committee report.

There were no dissenters to this proposal. Agreed

Performance Update

The previously circulated performance report was noted.

Council of Governor Discussion:

JM noted that the activity levels and performance against the emergency 4 hour access standard for November was significantly better at K&C than across the other sites and she wanted to know if there was any learning that could be shared to improve performance across all sites.

PS clarified that the Emergency Care Centre (ECC) is a different 'beast' to the A&E department at WHH and QEQM with a different complement of staff and a difference in the way activity is recorded.

PB questioned the usefulness of collecting data that does not enable a 'like for like' comparison of activity.

NG said that there are different types of activity carried out but that it is counted in the same way.

JS noted that in the national press it had recently been reported that K&C had the highest percentage of 24 hour avoidable admissions and he asked whether this was as a consequence of the way in which data is recorded.

PS said that the admissions relate to people over 75 and from the Atlas of Variation the rate of emergency admission to hospital for people aged >75 from nursing or residential care with length of stay <24 hours is high in all 4 CCGs but highest in the country in Canterbury (11,010.9/100,000), Thanet is 4th in the league (10,137.1), South Kent 8,108.1 and Ashford 6,514.0. It might be that these cases could be dealt with in the community if there services were there to support them. The rates of emergency department attendance per 1000 population was highest in Thanet (389.2, in the 2nd quintile), the other 3 CCGs are clustered in the 4th quintile ranging from 268.3 to 285.3. Conversion of emergency department attendance to admission is lowest in the country in Canterbury (10.7%), Thanet is 15.2%, South Kent 20.5% and Ashford 22%.

SA asked for an update on clinical performance over the past weeks of

December and January.

PS said that there had been 82.9% bed occupancy on Christmas Eve and 354 people had presented across the Trust on Christmas Day. This number increased between Christmas and the New Year. Of interest, during the junior doctor's strike performance against the 4 hour standard was higher than at any stage in the year to date.

NG reported that the financial deficit had increased over the winter months as the Trust was finding it difficult to move patients from the hospital into the community. He is not expecting an improvement in the financial position in January.

MK added that many of the issues facing East Kent are replicated across England and can only be addressed sustainably by a major change in approach to the way in which health and social care services are configured.

Clinical Quality & Patient Safety – November data

The reported was noted.

CQC Improvement Plan Update

NC reported that the CQC will visit the Trust for a third time, sometime in or after mid May 2016 and added that there is a determination to create the best possible outcome.

Council of Governor Discussion:

JS noted that the CQC had been critical of the signage to the ECC at K&C in their 2014 report, highlighting the confusion among ambulance staff about where to take patients. The report of the CQC re-visit in 2015 highlighted this again. He asked that action be taken to resolve this in preparation for the third CQC visit in May.

SS stated that conversation had been had with South East Coastal Ambulance Service (SECAMB) to explain the ECC model of care. One of the highway signs directing people at A&E at K&C had been removed and lobbying efforts continue to have the others removed.

MLo said that as a new governor she found the presentation of the CQC High level Improvement Plan (HLIP) difficult to understand and asked if it were possible to have a summary of progress against plan.

SS said that the HLIP had been presented to the board and sent to the CQC. The CQC Improvement Plan Delivery Board meets monthly to monitor progress against the Plan and a monthly update of progress against plan is published on NHS Choices. In addition site based Steering Groups meet every two weeks to facilitate progress.

RE added that NEDs have had the advantage of receiving a monthly presentation from the Improvement Plan Lead and so they are very familiar with the presentation of the plan. He acknowledged that it was difficult to get a sense of progress from the HLIP circulated to governors. He was of the opinion that significant progress had been made and he is confident in the ability of those

leading the improvement programme to demonstrate improvement to the CQC.

BW believes that the Trust needs to continue to develop its ability to track adherence to processes and procedures so that NEDs and governors can be confident in the assurances they are seeking.

MLo said that she was reassured to know that NEDs have a sense of progress being made and in addition, in her role as a governor, she would like to see the evidence.

SA shared her view that the presentation of the first improvement plan developed following the CQC visit in 2014 was very effective and clearly highlighted areas of risk. She was confident that the presentation of this second improvement plan which was being developed following the CQC re-visit in 2015 would be equally comprehensive once completed.

SS clarified that the purpose of the HLIP was to gain approval of the approach from the board not to provide the detail of progress against the individual actions. The first submission to NHS Choices against the new plan was made in the second week of January for December's progress.

NC asked that the NHS Choices submission be circulated to governors. JCN

CoG 06/16 **ANNUAL QULAITY REPORT – OVEVIEW OF GUIDANCE FROM MONITOR INCLUDING ARRANGEMENTS FOR ANY LOCAL INDICATOR**

HG spoke to her previously circulated presentation setting out the background, current positions and options in relation to mandated indicators in 2015/16.

Council of Governor Discussion:

PB asked if there would be any additional cost incurred if the governors were to choose a local indicator.

HG said there would be an additional charge made by the auditor, which last year was £18k. She suggested that any chosen indicator should provide added value and reminded governors that KPMG, as financial auditors will only be able to provide limited assurance on any indicator chosen.

JS said that he had been one of the governors that had been supportive of the VTE as the chosen indicator last year and was keen to avoid choosing another indicator that could not be audited.

PB said that he would like to see an audit related to staff wellbeing, including staff sickness and visits to occupational health.

HG said that she thought such an audit would be difficult because of the need to gain access to confidential staff records.

SA questioned the need for governors to choose an indicator for this year and whether such an exercise would add value.

CT drew the CoG's attention to the Carter Review which will include a series of measures, one or two of which may be linked to quality and safety. This will be backed by a national database providing the facility to compare data across

Trusts.

ML was supportive of the suggestion that governors should not choose and indicator for this year.

MK added that an audit of staff wellbeing was an interesting suggestion and that the Trust has existing mechanisms for interrogating this area, for example data from the NHS Staff Survey.

NC proposed that governors do not choose a local indicator for 2015/16.

This was agreed. Agreed

CoG 07/16 **TO NOTE THE APPOINTMENT OF THE CHIEF EXECUTIVE OFFICER**

NC asked the CoG to once again note the appointment of Matthew Kershaw as Chief Executive, having already done so electronically.

The CoG noted the appointment of Matthew Kershaw. Noted

CoG 08/16 **COUNCIL OF GOVERNOR COMMITTEES – REPORTS FROM COMMITTEE CHAIRS**

NC asked that reports be taken as read and invited questions from members of the CoG.

Nominations and Remuneration Committee

No questions were asked in respect of this report.

Strategic Committee

JS asked colleagues to note that the report was written prior to the publication of the planning guidance on 22 December therefore much of the report has been overtaken by events. The new guidance is, in his opinion the most significant change to planning within the NHS for 25 years.

PB drew colleague's attention to the open consultation on the proposed new motorway junction in Ashford which will improve access to the WHH. He asked how the Trust intended to participate in the consultation.

NC asked that this discussion be held over to the afternoon session of the CoG meeting where a fulsome discussion about the future configuration of the local health economy will be had.

Patient and Staff Experience Committee

No questions were asked in respect of this report.

Communications and Membership Committee

PB reported that the Communications and Membership Committee is eagerly awaiting the appointment of a new Director of Communications over the coming months. A focus of the work of the committee going forward will be to support way to promote positive news to Trust members and staff.

Constitution Committee

PW wanted to ensure that the work of the existing CoG Audit Committee would be included within the proposed Audit & Governance Committee (AGC). He also asked whether any group is monitoring the value for money derived from the various audits and inspections carried out across the Trust.
AF drew the CoG's attention to Appendix 2 of the previously circulated report that sets out the way in which the governors' statutory duties are discharged. The issue of value for money will come under the remit of the new AGC and link with the IAGC.

MLo expressed a number of concerns in relation to the recommendations contained within the report:

- 'Mirroring' BoD and CoG committees could compromise their mutual independence
- The role of the CoG could be undermined by having all the substantive discussions within committees which are not as a matter of course attended by all the governors

Despite these reservations she would be supportive of the recommendations if it was agreed by the CoG to review the effectiveness of the new structures after 3 months.

AF said that one of the tasks of the AGC will be to review each committee's terms of reference to ensure that they are focused on fulfilling the governors' statutory duties and not straying in operational areas. All members of the CoG will be invited to participate. She assured the CoG that the Council will remain sovereign in respect of decision making. She also suggested a 6 month review of the new structure. Agreed

MLo said that she did not want impede progress and as a new member of the CoG she would support whatever decision the CoG made in relation to the recommendations.

DT was supportive of the recommendations as the proposed structure feels like it would provide the CoG with the necessary assurance to meet its statutory obligations. She asked that the CoG have an opportunity to consider the terms of reference for all governor committees at their next meeting. She also suggested that the Trust's vision statement be included at the top of each of the terms of reference. AF

ML said she was not in support of recommendation 5d and was of the opinion that BoD and CoG committees should continue to report separately.

This was agreed. Agreed

Council of Governors decision/agreed actions:

The CoG agreed:

- To establish a CoG Audit and Governance Committee (AGC) to replace the existing Audit Working Group, Committee Chairs (Leads) meetings and Constitution Committee
- The draft terms of reference for the AGC
- The revised CoG meeting schedule: resulting in 4 (quarterly) CoG

meetings each year; an annual CoG/NED meeting for use as a development opportunity and to replace the joint BoD/CoG/Annual Members meeting with the required Annual Members meeting
- To discuss the alignment of governors to hospital sites at the joint CoG/NED meeting on 22 February 2016
- That the CoG Nominations and Remuneration Committee take the lead on the development of a core skills audit of the CoG and to use this to make recommendation on CoG Committee membership
- To authorise the AGC to develop the detail of a CoG Committee structure which will mirror the BoD committee structure and will provide for:
    - CoG committees to have a directly aligned NED as the main point of contact who will be the Chair from the "mirrored" BoD Committee i.e. Chair of BoD Quality Committee to be the link NED on the CoG Quality Committee;
    - All CoG Committees to be chaired by a Governor (recommended through CoG Nomination and Remuneration Committee;
    - The Chairs of the BoD and CoG committees to work together to develop the agendas for both meetings;
    - Reviewing the frequency of the CoG Committees;
    - Reviewing the agendas of the CoG and CoG Committees to ensure that all statutory duties are reflected and given sufficient air time;
    - Reviewing the involvement of governors on trust wide committees and link these into the relevant CoG Committee where applicable

DT requested web based facility for governors to access all relevant papers and documentation.

AF reported that the Trust is in the process of procuring a portal that will facilitate central access to papers for governors.

CoG 09/16 **FEEDBACK FROM GOVERNORS WHO ATTEND WIDER TRUST GROUPS/COMMITTEES**

End of Life Care Board

No questions were asked in respect of this report.

Falls Steering Group

No questions were asked in respect of this report.

Clinical Handover of Care

No questions were asked in respect of this report.

CoG 10/16 **FEEDBACK FROM GOVERNORS WHO ATTENDED TRAINING EVENTS**

Core Skills

RG reported a very positive experience of the Governwell Core Skills training.

CoG 11/16 **UPADTE ON MINDFULNESS**

PB said that he had engaged in a discussions with a number of colleagues

about how the Trust should progress the All Party Mindfulness Initiative and noted the enthusiasm within Education for equipping post graduate staff with Mindfulness skills.

CoG 12/16 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Member of the public 1 asked why the Trust was not promoting QEQM as the trauma unit for East Kent rather than the unit at Medway.

JS was of the understanding that the decision to allocate trauma units lay with the South East Trauma Network and that their decision making is based on the premise that the trauma units should be 'on the way' to the main trauma centre at King's College Hospital in London.

PB added that the trauma facilities at QEQM have been judged to be 'exceptional'.

JR added that the Trauma Network review the performance of trauma units on an on-going basis.

JW said that members of the public had received a presentation on the excellent work of the WHH trauma unit at the annual members meeting last October.

Member of the public 2 asked for an update on the promised public consultation cuts to be made across all hospital sites.

MK said that it was expected that the public the consultation on the long term clinical strategy would have happened at a faster pace than it has. The Trust now has guidance on setting out a 5-year plan which will need to be submitted in the summer, this means that the detailed process for developing the plan will be made clearer over the coming weeks and months.

CoG 13/16 **ANY OTHER URGENT OR IMPORTANT ITEMS**

Radiology services

PD reported on feedback from GPs as to the excellence of radiology services provided by the Trust at a recent HealthWatch meeting.

CoG 14/16 **DATES OF FUTURE MEETINGS**

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

Date of next meeting: Monday 14 March 2016, 10:00 – 15:00, The Julie Rose stadium, Willesborough Road, Ashford TN24 9XQ

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING (PUBLIC) – 24 MAY 2016

ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING (PUBLIC) HELD ON 18 JANUARY 2016

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
40/15	9.7.15	**CEO AND PERFORMANCE UPDATE** **Cultural Change Programme** Presentation and full discussion on the work of the Cultural Change Committee.	Jane Waters	10.11.15	Deferred – to be agreed.
62/15	10.11.15	**AOB** **Kent County Council consultation on residential care** Share the Trust response to KCC consultation on the future of residential care across Kent.	AF	18.1.16	Closed - This was a very specific consultation about 2 residential (not nursing) homes owned by Kent County Council (KCC) - one in Faversham and one in Sandwich. EKHUFT do not commission any beds from them and we have negligible contact as the Trust links mainly with nursing homes, not residential. The Trust did not make an individual response to the consultation as this was led by the CCGs.
ACTIONS FROM THE LAST MEETING HELD					
62/15	10.11.15	**AOB** **Kent County Council consultation on residential care** Request update from KCC on the outcome of the consultation exercise.	JCN		The consultation closed on 20th December and the final report is being taken through KCC committees.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2016**
SUBJECT:	**REPORT FROM THE BOARD OF DIRECTORS**
REPORT FROM:	**CHAIR**
PURPOSE:	**Information**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This report provides the Council of Governors with the following information:
- An overview of items discussed at the Board of Directors meetings held in public since the last report.
- Proposal for reporting Trust performance to future Council meetings.

SUMMARY:

OVERVIEW OF ITEMS DISCUSSED AT BOARD MEETINGS HELD IN PUBLIC – FEBRUARY 2016 AND APRIL 2016

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

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

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

- Trust annual objectives have been set for the year and endorsed by the Board;
- Lengthy discussions about performance, especially in Emergency Department and around the industrial action and our ability to mitigate the risks posed;
- Health and Safety is a subject the Board believes has not had sufficient attention;
- Attention was given to the Risk Register and how it is being used to help drive change across the Trust;
- The latest staff survey was a disappointment for the Board and there is a renewed energy o work on the programme of Cultural Change. Further analysis of the result is being undertaken.

FEBRUARY 2016

Patient Story
The report described a positive patient experience, learning identified and actions taken. Themes are drawn out and the actions being undertaken to address the points made by the patient were presented.

Chief Executives Report
The report included and update on: Improvement Journey; Financial Recovery;

Emergency Department Recovery Plan; Clinical Strategy Update; Performance Updates; Industrial Action; Chief Executive Activity December 2015 to January 2016.

Chair's Actions
The Chair approved the long awaited IT solution for a paperless Board. This system is now in place as at the April Board.

A copy of Quarter 3 Submission to Monitor was received.

Trust Improvement Plans
The Board received the latest CQC Improvement Plan; Turnaround Programme Report; and Emergency Recovery plan

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

Six Monthly Health and Safety and Estates Statutory Compliance Report
In summary, key areas for the Board to note were:

- No Health & Safety Executive (HSE) Notices or visits in the last 6 month.
- 10 Trust wide H&S related RIDDOR reportable incidents or issues to escalate to the Committee.
- No H&S related compliance claims have been made against the Trust in this period.

It was agreed that Health and Safety would remain an agenda item on the Board of Directors until further notice.

Emergency Planning: NHS Preparedness for Major Incident; Emergency Planning and Business Continuity Annual report
Trust's duties are underpinned by the Civil Contingencies Act (CCA) 2004.
The Trust was last audited against the NHS England Emergency Preparedness Resilience and Response (EPRR) core standards in September 2015.
The Report summarised activities of the Emergency Planning Team over the past twelve months, specific actions being taken to address areas of non-compliance following the audit, details of training programmes in place and a summary of collaborative work being undertaken with MTW.

Risk Register – New Format
The Board of Directors received a copy of the new format risk register for the first time at Board level. The report summarised new and updated risks.

Medical Director's Report
The report included an update on: Emergency Care Centre Update; Clinical chemistry analyser incident; England Revalidation-South (NHS ENGLAND) quarterly return; Update on nasogastric tube assurance visit actions; and MHPS Investigations.

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

APRIL 2016

Staff Story
In April 2015 the William Harvey Hospital (WHH) Ward Managers attended the Board of Directors and described their concerns around how the winter pressures wards

were being operationalised. The Ward Managers requested to attend the Board of Directors' meeting in April 2016 (one year later) to provide an update.

Chief Executive's Report
The report included and update on: Improvement Journey; Financial Recovery; Staff Engagement; Emergency Department Recovery Plan; Clinical Strategy Update; Performance Updates; LGBT History Month; Chief Executive Activity February 2016 to March 2016.

2016/17 Annual Objectives
The Board of Directors approved the Strategic and Annual Objectives for 2016/17.

Chair's Actions
The Board of Directors received the scope of the External Board Governance Review. The process is now underway.

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

Trust Improvement Plans
The Board received the latest CQC Improvement Plan; Turnaround Programme Report; and Emergency Recovery plan

2015 Staff Survey Results
A summary of the results was received and the Board agreed the following priority areas:

- A continuing focus on the 'Respecting Each Other' campaign including working with Health & Safety on the broader aspects of violence and aggression
- Re-launch of the health and well-being group for the organisation with a focus on providing useful interventions to support staff in feeling well, using recent NICE guidance as a road map for action
- Post implementation evaluation and promotion of Trust's new appraisal process
- A focus on capacity and capability of managers / leaders in the organisation

Health and Safety KPI Update
The Board received the current Health and Safety KPIs. It was noted health and safety would be incorporated into the Trust's integrated performance report. A further report was requested for the June Board to see the evolution of the data.

- Inclusion of near misses;
- Top three accidents: frequency and mitigation;
- Extract sharps into a separate reporting line;
- A schedule to be set behind the timescales with a range of indictors.

Corporate Risk Register
The Board of Directors received a report summarising new and updated risks.

Medical Director's Report
The report included an update on: Junior doctors contract; Emergency Care Centre Update; Update on nasogastric tube assurance visit actions; and Mortality and Mortality Governance Review.

RECOMMENDATIONS:

To note the report.

NEXT STEPS:

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

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Board reporting links to all Strategic objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:

Board reporting links to delivery of all annual objectives.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

N/A

FINANCIAL AND RESOURCE IMPLICATIONS:

N/A

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

N/A

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

ACTION REQUIRED:

To note and discuss the report**.**

CONSEQUENCES OF NOT TAKING ACTION:

N/A

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **24 MAY 2016**

REPORT FROM: **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE CHAIR REPORT**

PURPOSE: **DISCUSSION**

PURPOSE OF THE COMMITTEE:

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

This report is presented to the Council of Governors to assist them in their statutory duty "holding non-executive directors' to account for the performance of the Board". It is a standing agenda item in relation to risk, assurance and governance and reports on the April 2016 meeting.

EXECUTIVE SUMMARY

The report seeks to answer the following questions in relation to risk, governance and assurance:

1. What positive assurances were received?
2. What concerns in relation to assurance were identified?
3. Were any risks identified?
4. What other reports were discussed?

1. Positive assurance received in relation to:
    a. The Board Assurance Framework was presented for 2015/16 and it was felt that this was now providing the Board and its Committees with a clear view of the risks, mitigations and gaps against its Annual Objectives. Work was taking place to update it with the 2016/17 Annual Objectives;
    b. The Trust reported compliance with all the relevant requirements of the Information Governance Toolkit at level 2 (satisfactory) or above on 31 March 2016. The score was 75%; an increase of two percent on the previous year;
    c. Aseptic write-off: the newly appointed Director of Pharmacy provided assurance that recommendations from the Internal Audit report, external review by the Regional procurement specialists from the SE and SW of England and confirmed that improvement is being measured using the Carter metrics developed in the South West of England;
    d. Emergency Planning Audit: this was received by the Committee in the absence of a May Board of Directors meeting. The September 2015 audit showed that the Trust was non-compliant against the NHS England

Emergency Preparedness Resilience and Response (EPRR) core standards. The revised audit showed good improvement and an achievement of significant compliance.

2. The following concerns were highlighted:
    a. Clinical Audit: there was concern in relation to the number of audits being carried forward by Divisions from 2015/16 to 2016/17. However, the Committee did receive positive assurance in relation to how the 2016/17 clinical audit programme would be delivered;
    b. Statutory Declaration to NHS Improvement, Compliance with Provider Licence, whilst the process for gathering the evidence to confirm compliance with the Provider Licence was robust the Trust remains in breach of its Licence. The evidence provided did give assurance that the Trust continued to improve its position.
    c. Internal Audit of Pharmaceutical Drug Processes: this audit was requested by Management following the identification of the aseptic write-off issues, it received an Amber/Red assurance. Point 1c above confirms that the Committee felt assured that the recommendations were being implemented. The Director of Pharmacy will be returning to the Committee later in the year to provide assurance that all the recommendations have been implemented and that these are delivering the required outcome.

3. Identified Risks:
    a. Information Governance mandatory training: 74% against a standard of 85%, however, 47% of those showing as non-compliant had undertaken the training but had accessed it in the wrong manner.

4. Other reports discussed:
    a. In year review of NHS Improvement Quarterly Return – this showed that the Trust was predicting potential problems in performance accurately and advising NHSI in a timely way, in line with the Provider Licence requirements;
    b. Risk Register – this risk register had improved significantly but additional work would make it more robust;
    c. Annual Report and Accounts, Quality Account and associated documents: these were reviewed and assurance received that they met the statutory requirements;
    d. Single Tender Waiver report: For the full year there has been a decrease in the quantity (an average decrease of 9.7%) but an increase in the value (0.66%) of STW's when compared to 2014-15;
    e. An update from KPMG on their audit work, in April 2016 there was little to report due to timing;
    f. Internal Audit reports on:
        i. Capital Procurement (Amber/Green)
        ii. Chief Executive and Chairman's expenses (Amber / Green)
    g. Local Counter Fraud reports, Anti-Fraud, Bribery and Corruption Policy was approved.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Integrated Audit and Governance Committee**.**

BAF (Incorporating Corporate Risk Register)

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	17 May 2016
Risk Status	Open
Annual Objective	AO3: Provision: Provide the services need and do it well
Risk Area	1. Strategic Risk Register

AO3: Provision: Provide the services need and do it well

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 5	Failure to achieve financial stability **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Reviewed current status of controls; adding to assurances (Trust Secretary)	**Cause** due to: - poor planning - poor recurrent CIP delivery - - poor cash management and - gaps in financial governance **Effect** resulting in - potential breaches to the Trust's Monitor licence, - adverse impact on the Trust's ability to deliver all of its services and in the longer term clinical strategy, - poor reputation and - failure to be a going concern	I = 5 L = 5 Extreme (25)	Turnaround Director in post (10/15) **Control Owner:** Nick Gerrard	Direct line management by Chief Executive			Limited	Feedback from Chief Exec sought on individuals performance against objectives	I = 5 L = 4 Extreme (20)	Implementation of finacial governance action plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2016	**25 Feb 2016** **Alison Fox** FIC to receive report on progress highlighting any areas for concern / risk to delivery. (to be scheduled).	I = 5 L = 3 Extreme (15)	Finance & Investment Committee
				Clinical Workstreams in place to ensure quality of care **Control Owner:** Nick Gerrard	Reports to Executive Team from workstream (weekly)	Feeds into Finance and Investment Committee	Feeds into BoD	Adequate			CIP deep dive - Report to FIC on reasons for slippage on Theatres, Outpatients and Workforce **Person Responsible:** Nick Gerrard **To be implemented by:** 08 Mar 2016	**25 Feb 2016** **Alison Fox** On FIC agenda in March 2016 **25 Feb 2016** **Alison Fox** On FIC agenda for March 2016		
				Financial govenance in place **Control Owner:** Nick Gerrard	Director of Finance oversees the governance	Integrated Audit Committee reviewed controls through reporting from Internal and External Audit	- Grant Thornton governance review (07/15)	Adequate	Action plan development and requires full implementation					
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Nick Gerrard	Divisional Challenge meetings for Execs to challenge	- executive review weekly - Turnaround report to FIC - Exception reports to BoD	Monitor challenge at Progress Review meetings (6-8 weekly)	Adequate						
				Financial Recovery Plan **Control Owner:** Nick Gerrard	Divisions report progress into Financial Recovery Group on a monthly basis.	- Exceptions reported into Finance and Investment Committee (monthly) - Board has final oversight (bi-monthly)	Monitor reviewed draft plan and discusses the financial position at Progress Review meetings (6-8 weekly)	Adequate	Reporting shows slow improvement; Monitor still to provide feedback on 2 year plan					

BAF (Incorporating Corporate Risk Register)

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	18 May 2016
Risk Status	Open
Annual Objective	AO4: Partnership: Work with other people and other organisations to given patients the best care
Risk Area	1. Strategic Risk Register

AO4: Partnership: Work with other people and other organisations to given patients the best care

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 1	Unable to deliver a clinical strategy that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Reviewed controls and assurances 25/2/16	**Cause** - Four CCGs having differing agendas; - Lack of stakeholder agreement; - Lack of clear commissioning intentions; - Parliamentary timings may not be conjucive to timely implementation **Effect** - Patient care - Enforcement actions - Trust's Monitor licence.	I = 5 L = 4 Extreme (20)	Financial Recovery Plan **Control Owner:** Nick Gerrard	Divisional / Executive Transformation Meetings (held bi-weekly)	FIC and Board reporting from Turnaround Director	Monitor receive monthly reports on the Trusts finances as well as the quarterly returns and discussions at PRM's.	Adequate	Traction around clinical efficiencies - FIC requested an update on Theatre efficiencies / Outpatients and Workforce - scheduled for 03/2016	I = 5 L = 3 Extreme (15)	Agree for approval by EKSB a timeline for delivery of STP **Person Responsible:** Liz Shutler **To be implemented by:** 11 Mar 2016	**25 Feb 2016** **Alison Fox** Matthew Kershaw / Liz Shutler and Rachel Jones to produce this item for EKSB	I = 5 L = 2 Extreme (10)	Finance & Investment Committee
				Regular meetings with external partners / MP's and within the Trust **Control Owner:** Liz Shutler	Awaiting engagement plan						Presentations on Outpatients / Theatres and Workforce CIP schemes to FIC to facilitate understanding of slippage. **Person Responsible:** Nick Gerrard **To be implemented by:** 08 Mar 2016	**25 Feb 2016** **Alison Fox** On FIC agenda for March 2016		
				East Kent Strategy Board **Control Owner:** Liz Shutler	Trust Secretary hold all copies of agendas / minutes East Kent Strategy Board	In attendance are all Health economy partners	Monitor received first submission of Annual Plan 2016/17 02/2016	Adequate			Agreement of final consultation document by all partners **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2016			
SRR 3	Loss of clinical specilaities and services that are Kent & Medway wide **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Reviewed risk - actions due by end of March 2016. Added the delivery of a Sustainability & Transformation Plan to controls.	**Cause** due to the Networks in place / competition and decision-making across the CCGs **Effect** result in a loss to the Trust of some of the services that may adversley impact on the local population's expereince of care	I = 4 L = 3 Extreme (12)	East Kent Strategy Board (Health Economy wide) that drives the delivery of an agreed set of options for service reconfiguration to be consulted on **Control Owner:** Liz Shutler	Director of Strategy and Capital Planning has oversight of the progress made within the EKSB.	Minutes from EKBS to BoD meetings (02/16)		Adequate	Monitor / NHS England approval of transformation programme (07/16)	I = 4 L = 2 High (8)	Delivery of a Sustainability and Transformation Plan **Person Responsible:** Liz Shutler **To be implemented by:** 30 Jun 2016	**25 Feb 2016** **Alison Fox** Worth through the East Kent Strategy Board to support this. Meetings are monthly	I = 4 L = 2 High (8)	Finance & Investment Committee
											Awareness of external factors that may indicate commissioning (both local and specialist) intends to tender out services that the Trust currently provides **Person Responsible:** Matthew Kershaw **To be implemented by:** 31 Mar 2017	**25 Feb 2016** **Alison Fox** Local meeting to take place in relation to vascular services (26/2/16) Discussions on-going regarding pathology services		
											One year operational plan to set the ground work for delivery of the five year plan. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2016	**25 Feb 2016** **Alison Fox** Draft Annual Plan to be reviewed at BoD in March 2016.		

AO4: Partnership: Work with other people and other organisations to given patients the best care

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Priority	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Priority	Action Required	Progress Notes	Target Risk Priority	Reporting Committee
SRR 7	IT purchases may not be aligned to / prioritised against the clinical strategy **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Andy Barker **Last Updated:** 05 May 2016 **Latest Review Date:** 11 May 2016 **Latest Review By:** Andy Barker **Latest Review Comments:** Risk discussed with Liz and ok.	**Cause** -Procurement processes not consistently followed - lack of clinical or professional involvement in process; - no consideration to deskilling of staff; - creation of supplier lock in with closed technology through legacy acquisitions. **Effect** - negative impact on patient experience - negative impact on staff motivation - cost of additional effort and resources / not VFM	I = 3 L = 4 High (12)	All technology purchases are reported to the Strategic Investment Group and scrutinised at the Information Development Group **Control Owner:** Andy Barker	Director of IT who is aware of IT purchases to ensure that these follow the correct processes.	Minutes and actions reported through to Finance and Performance Committee			Evidence that IT purchases always follow that pathway	I = 3 L = 3 High (9)	Identify the policies and procedures that ensure purchases follow the correct route and make sure staff are aware of these. **Person Responsible:** Andy Barker **To be implemented by:** 29 Jul 2016		I = 3 L = 2 Moderate (6)	Board of Directors

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **24 MAY 2016**

REPORT FROM: **FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT**

PURPOSE: **DISCUSSION**

PURPOSE OF THE COMMITTEE:

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan, delivery of any financial undertakings to Monitor in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and oversight of the capital programme
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

This report is presented to the Council of Governors to assist them in their statutory duty "holding non-executive directors' to account for the performance of the Board". It is a standing agenda item in relation to finance reports on the May 2016 meeting. The May 2016 meeting also reviewed the year end performance and the annual objectives for 2016/17 discussed.

EXECUTIVE SUMMARY

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

1. What went well over the period reported?
2. What concerns were highlighted?
3. Were the annual objectives for 2015/16 met?
4. Looking forward, what are the annual objectives for 2016/17 and what are the risks to achieving these?

1. The following went well over the reporting period:
    a. Draft accounts for 2015/16 prepared and submitted on time.
    b. Tentative contract for clinical services agreed with local CCGs in broad terms.
    c. FPC assured that the new integrated performance report is on schedule and will be used for presenting the April 2016 information. It was noted that the report would be accompanied by commentary/explanations and any actions required so that the FPC received sound understanding of all key issues, including performance breaches.
    d. Safer Bundle has been implemented in two wards as a pilot

2. The following concerns were highlighted:
    a. Monitor continues to raise concerns around finances, quality, workforce, and ED – pace of change and achieving an appropriate balance between the conflicting aims whilst there continues to be increased demand for our services.
    b. 2015/16 CIPS reported on plan but consist of almost a quarter (as reported) are non-

recurring items. This has put further pressure on the Trust's finances and increased the need to deliver sustainable cost reductions.

c. Agency spend is still proving stubbornly high and has gone back to higher than the last 3-4 months. Total for 2015/16 was £26.2m and £29.5 including locums.

3. Progress was made against each of the objectives under review by the Finance and Performance Committee, below is the high level achievement, more details is provided in Appendix 1:
    a. Deliver Improvements in patient access performance to meet the standards expected by patients as outlined in the NHS Constitution and our Provider Licence with Monitor - Partial
    b. Improve the Trust's financial performance through delivery of the 2015/16 Cost Improvement Programme and effective cost control – Good (downgraded to partial)
    c. Develop, engage and consult on a clinically and commissioner supported strategy that achieves both clinical and financial stability - Limited

    FPC recommended and it was agreed at the Board meeting in May 2016 to downgrade to "partial" the achievement in relation to 3b to reflect that, whilst the Trust had met its financial plan, the position was not positive in relation to CIP delivery and run rate reduction.

    3c was amended from "limited" to "partial" to reflect that a lot of work had taken place over the year but the directive from NHS England to produce a sustainability and transformation plan had refocused the work and timescales.

4. The following annual objectives were discussed in relation to "Provision", following approval at Board, in terms of the risks and will form a key part of the Committees work programme for 2016/17:
    a. Implement a new Integrated Performance Report by May 2016.
    b. Submit a financially sustainable plan for 2016 /17 and the following 4 years that meets the agreed control totals, by June 2016.
    c. Agree core services and a timetable to review and refresh these services, by September 2016.
    d. Be recognised as a provider of high quality care and as a system leader by NHS, social care and other public sector partners, as measured by 360 feedback from partners, by December 2017.
    e. Achieve a net positive balance on press coverage as measured by press, Trust data and social media, by January 2017.
    f. Develop and grow a number of whole system leaders, joint appointments that cross the boundaries of the whole health care economy and are designed around the patient pathway.
    g. Delivery of £20m cash releasing, recurrent saving by March 2017.
    h. Hit a year end deficit plan of £12.5m (after adjusting for any portion of STF funding not provided by Department of health), by March 2017.
    i. Continue to progress improvements in 7 day services focussing on the implementation of priority schemes agreed following further work internally and benchmarked with other similar organisations.

    The following annual objectives were discussed in relation to "Partnership", following approval at Board, in terms of the risks and will form a key part of the Committees work programme for 2016/17:

    a. Submit an agreed Sustainability and Transformation Plan (STP) by 30 June 2016 that would define and enable delivery of:
        - an agreed financial improvement trajectory;
        - a comprehensive clinical productivity improvement programme; and
        - a sustainable clinical model for the Trust.

b. To submit by June 2016, with partners, a single Local Digital Roadmap which will outline how we will use technology to provide improved patient services.
c. Working with CCGs commence formal consultation on a sustainable clinical configuration by December 2016
d. By working with the Vanguard, increase community provision to transfer the equivalent of 60 acute beds in patient activity, by March 2017.
e. To deliver an estates strategy that supports the Trust's clinical configurations by March 2017.
f. Continue to work with MTW on a joint pathology project, delivering a signed commercial agreement with external partners by June 2017. Report will be made back to the Board and FIC at key stages of the procurement process.

Risks associated with these are presented as Appendix 2.

COUNCIL OF GOVERNORS ACTION:

To note and discuss the report from the Finance and Performance Committee**.**

Matters to be taken to the Trust Board for Action

1. To note that whilst progress is being achieved, the pace of improvement has been disappointing in 2015/16. Whilst the Trust's contracting team has driven the process to ensure contracts were signed in a timely way, there have been delays in getting final agreement to the operational plan and clinical contracts for 2016/17. This means that time has already been lost at the start of the financial year.
2. The growing pressure on the NHS to deliver more activity requires a balance between money, safety, and quality.
3. The Board should review the governance around turnaround and improvement activities to ensure they have full oversight.
4. Board to receive a comprehensive update on 2016/17 plan and contracts (likely to be Payment by Results (PBR) based) in line with NHS requirements for delivering key targets, identifying key areas of risks, and mitigation action required. This update is to address the issue of data quality for PBR contracts and actions required to ensure the Trust is fully paid for all work done.
5. The FPC recommends that the Board approve the following 2 contracts:
   - Kent wide Total Waste Management contract to SRCL for a period of 5 years (option to extend for a further 2 years).
   - Award of contract to NHS Professionals for workforce management for a period of 2 years with option to extend by a further 2 years.

Matters to Note

1. Draft accounts for 2015/16 prepared and submitted on time.
2. Tentative contract for clinical services agreed with local CCGs in broad terms.
3. FPC assured that the new integrated performance report is on schedule and will be used for presenting the April 2016 information. It was noted that the report would be accompanied by commentary/explanations and any actions required so that the FPC received sound understanding of all key issues, including performance breaches.
4. The Director of Finance has updated the non-executive directors regarding the current status of Monitor undertakings.
5. FPC and the Board will be kept sighted on the 'cause and effect' of improving financial and operational performance so that safety and quality is also kept at the forefront.
6. FPC received brief business plan presentations from two divisions; two more in June.
7. FPC to receive regular update from each operating Division relating to the delivery of performance and financial plans.
8. FPC to receive the business case for the planned patient flow workstream.
9. Satish Mathur and Richard Earland held a useful discussion with the Turnaround Director and the Director of Finance prior to the FPC concerning progress made against the Turnaround programme.
10. The 2016/17 cost of turnaround programme had been circulated to FPC.
11. FPC to receive PMO/delivery plan for 2016/17 CIPS (June). There must be clear links between workstream activities and finance, with SMART KPI's.
12. FPC to receive monthly progress reports on against Four Eyes programme.

13. FPC to receive report on the operational and financial risks of the implementation phase including managing through limiting capacity (July).
14. A clearer definition of CIPs is to be prepared by the Director of Finance.
15. FPC considered the CQC Improvement Plan Affordability and recognised the need to implement the plan and having to find the monies to make urgent changes whilst also recognising the need to prioritise and justified.
16. A list of current projects being worked on by finance was reviewed by the FPC.

Reports Against Agenda Items

DoF/COO/HRD Report

- FPC noted that 25% of emergency department breaches were due to 'waiting for first clinician review' and 26% related to 'treatment decision waits' – 50% of breaches linked to internal processes. Following an explanation from the Executive it was explained that this outcome was indicative of internal and external flow issues, it was agreed that a breach analysis would be included in future reports. Safety bundle and changes to patient flow generally are expected to relieve these breaches.
- There is pressure generally in the NHS to deliver greater activity and achieve performance targets (eg., 88.5% 1st qtr A+E target) .
- Performance continues to impact financial position with high agency usage and significant amount of clinical work being outsourced.
- Safer Bundle has been implemented in two wards as a pilot
- Productivity was the lever to delivering financial benefits and maintaining a balance between safety and quality of care was important.
- Year-end forecast c£36.4m deficit.
- Run rate is not coming down as anticipated.
- DG to circulate draft accounts for 2015/16 to the FPC.

Cash Flow

- Cash at year end £3.8m
- 2016/17 range of funding required £25m to £40m

Turnaround Report

- Monitor continues to raise concerns around financial, quality, workforce, and ED in relation to the pace of improvement.
- 2015/16 CIPS reported on plan but consist of almost a quarter (as reported) are non-recurring items. This has put further pressure on the Trust's finances and increased the need to deliver sustainable cost reductions.
- FPC has requested the FD to develop more explicit definition for 2016/17 CIPs. It is clear that CIPs must in future be sustainable planned cost reductions.
- Agency spend is still proving stubbornly high and has gone back to higher than the last 3-4 months. Total for 2015/16 was £26.2m and £29.5 including locums.
- Four Eyes commenced theatres efficiency project. Just about to start outpatients. Combined £5m saving.
- Four Eyes developing two further workstreams: patient flow (£1.5m to £2m) and clinical admin support (£1.5m). Business case required.
- Completing detailed planning of 2016/17 CIPs. Currently £17.6m over a number of schemes, £12.5m risk adjusted. Some plans had come into effect. The CIP

profile The profile currently shows £2.4m for the first quarter, rising up to £5.4m for quarter 2 and £6.2 for quarter 4.

- More work is being done to establish a better "run rate" position which is also a concern of Monitor.
- Narrative in future reports to provide assurance around the work to change the run rate and to better describe to the FPC and the Board how the Trust ensures the protection of the trinity of quality, cost and safety.

Financial Risk Register: felt to adequately reflect current issues

Capital Programme and Major Projects Update: no issues raised. Limited capital availability noted.

2016/17 Plan Update:

- Discussions still taking place and no clear outcome as yet. However, the timetable has been extended.

PAS Implementation Update

- Joint programme with MTW who had delayed implementation by 3 months .
- The Trust's implementation may also be delayed as a consequence but this is unlikely to have an operational impact.
- However, implementation of the new PAS is a considerable "switch over" risk and is recorded on the risk register. A robust programme committee is in place.
- FPC asked to see was how the Chief Operating Officer would be involved and empowered through the PAS upgrade structure to ensure operation performance risks were managed during the upgrade.

APPENDIX 1: FINANCE AND PERFORMANCE ANNUAL OBJECTIVES 2015/16

AO3: Deliver Improvements in patient access performance to meet the standards expected by patients as outlined in the NHS Constitution and our Provider Licence with Monitor

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
RTT-against national targets				
Accident and Emergency-against national targets				
Cancer targets-against national targets				
Diagnostic Wait-against national targets				

AO4: Improve the Trust's financial performance through delivery of the 2015/16 Cost Improvement Programme and effective cost control

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
Achievement of Plan Target				
Delivery of CIP			No measure	No measure

AO5: Develop, engage and consult on a clinically and commissioner supported strategy that achieves both clinical and financial stability.

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
To go to public consultation on agreed options by March 2016 (against milestones)				

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **24 MAY 2016**

REPORT FROM: **REMUNERATION COMMITTEE**

PURPOSE: **DISCUSSION**

PURPOSE OF THE COMMITTEE:

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

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

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

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

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

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

EXECUTIVE SUMMARY

The following summarises discussions held at the 17 May 2016 Committee meeting.

- The Committee agreed a proposal put forward by the Trust Chairman on how the Chief Executive's performance would be assessed by the Chairman and the Remuneration Committee. At the end of the year the Remunerations Committee will discuss the balance of performance across all objective areas leading to a final assessment which it will be able to articulate and justify publically.
- The Committee received performance objectives for each Executive Director and a report from the Chief Executive summarising his views on performance for discussion. The Committee agreed the process for determining performance objectives had been conducted in a balanced and fair way. A mid-year report will be received by the Remuneration Committee in November 2016.
- The conducted a review of executive director remuneration against benchmarking information available.

The Chief Executive's performance and Executive Director objectives are based on the four main strategic priorities agreed by the Board:

1. **Patients**. Enable all our patients (and clients who are not ill) to take control of all aspects of their healthcare by 2021. There are 6 Annual Objectives in this category.

2. **Partnerships**. As a co-creator in the East Kent health economy, help define and deliver sustainable clinical services and associated pathways, providing clarity about who does what, by 2021. There are 6 Annual Objectives in this category.
3. **People.** Identify, recruit, educate and develop a talent pipeline of clinicians, healthcare professionals and broader teams of leaders, skilled at delivering integrated care and designing and implementing innovative solutions for performance improvement. There are 6 Annual Objectives in this category.
4. **Provision**. Clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'. There are 9 Annual Objectives in this category.

COUNCIL OF GOVERNORS ACTION:

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

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **24 MAY 2016**

REPORT FROM: **NOMINATIONS COMMITTEE**

PURPOSE: **DISCUSSION**

PURPOSE OF THE COMMITTEE:

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

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

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

EXECUTIVE SUMMARY

Internal Assessment, Action Plan and Board Development Plan

A self-assessment review was undertaken by an independent HR consultant, and the report dated 30 December 2015 was shared with the Board of Directors and Monitor and the Council of Governors Nominations and Remuneration Committee.

The resulting action plan was first considered in detail by the Nominations Committee in January 2016. In February 2016, the Board of Directors agreed the following areas of focus and the plan was updated:

- Strategic Marketing;
- Estates & Assets Management;
- Diversity, equality and strategy to support workforce planning.

At its May meeting, the Committee received assurances that the Internal Board Assessment Action Plan had been updated to reflect:

- Personal Development Plans in place for Non Executive Directors;
- Grant Thornton's contract to undertake the Board Governance Review on the "Well Led Framework".

The Board Development Plan is continually reviewed and updated. The latest version received by the Committee incorporated development areas around: Board Readiness for CQC Re-inspection; Sustainability and Transformation Plan rollout; Estates and Asset Management; Statutory and Mandatory Training; and an appropriate level of media training/awareness.

Board Governance Review

Grant Thornton's External Governance Review was underway. All Interviews with the Board and Divisions were scheduled. On-site focus groups were being scheduled with

ward managers and other clinical staff.

The final report would be shared with the Council of Governors.

Succession Planning

The HR Department had undertaken work to review all Executive Director positions and business critical posts to ensure that the organisation has staff with the right skills and potential, to move into key leadership roles.

The Nominations Committee received the current position providing: Details of current post holders; collective Executive Team view on the talent pipeline and staff who can cover immediately; RAG rating on the level of risk to the organisation of not having the necessary skills in place to support business continuity and improving performance.

Matthew Kershaw's approach to determining a Deputy CEO Position was discussed. The Council of Governors will be informed of the outcome of this process.

Policy on Director's Fit and Proper Persons Test

The amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which took effect from 27th November 2014 resulted in a new *'Directors Fit and Proper Persons'* test. This applies to all NHS organisations and includes Executive and Non-Executive Directors appointed to the Board.

The Committee endorsed a policy which defined local principles.

COUNCIL OF GOVERNORS ACTION:

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

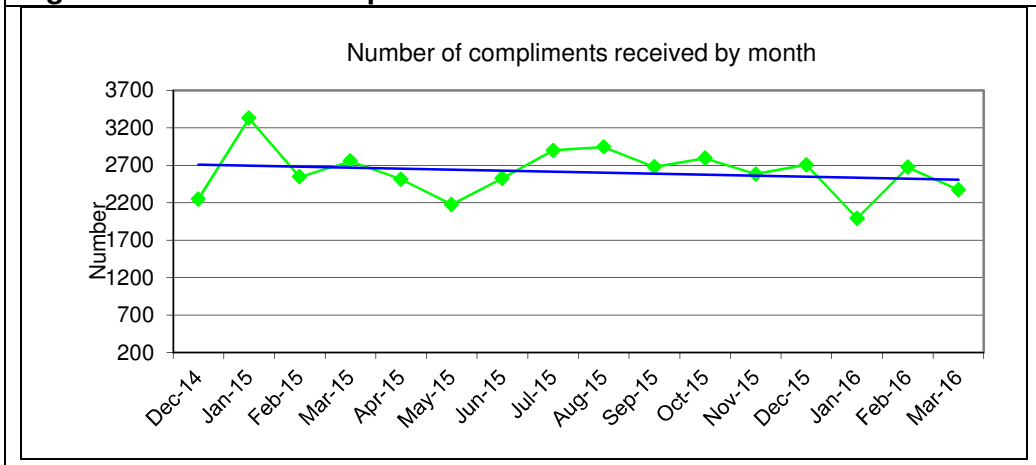
Patient Experience Report

This report provides the Board of Directors with activity and performance information about the complaints, concerns, comments and compliments during March 2016. The information reported is for cases received in March 2016.

Activity

Complaints received for March: 48
Concerns for March 62
PALS contacts for March: 153 logged
Compliments for March: 2372
There are 25 contacts received in March 2016 that are still awaiting consent from the client. Once consent is received, these will be triaged as either a complaint or concern.

The charts below show the number of complaints and compliments received on a monthly basis since December 2014. The total number of recorded episodes of care for March 2016 was 80,701 which means that one formal complaint has been received for every 1681 recorded spells of care, in comparison to February's figures where one formal complaint was received for every 1204 recorded spells of care.

Figure 1: Number of compliments received	
	The number of compliments received has decreased slightly by 1.6% compared to the previous month. The ratio of compliments to formal complaints received for the month is 49:1. There has been one compliment being received for every 34 recorded spells of care.

Examples of Compliments received in March 2016

Mr GK Reddy – Orthopaedics- WHH

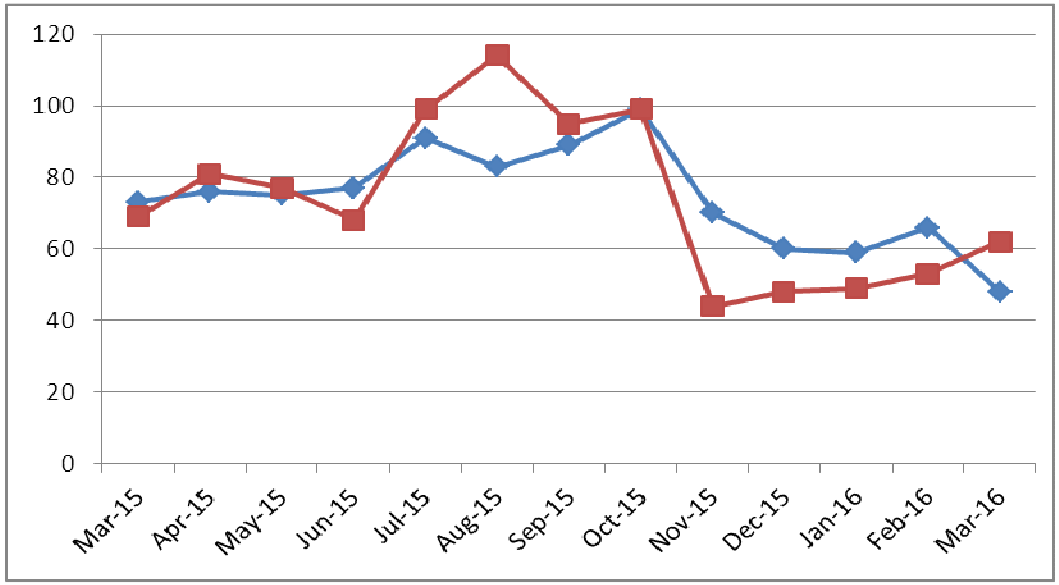
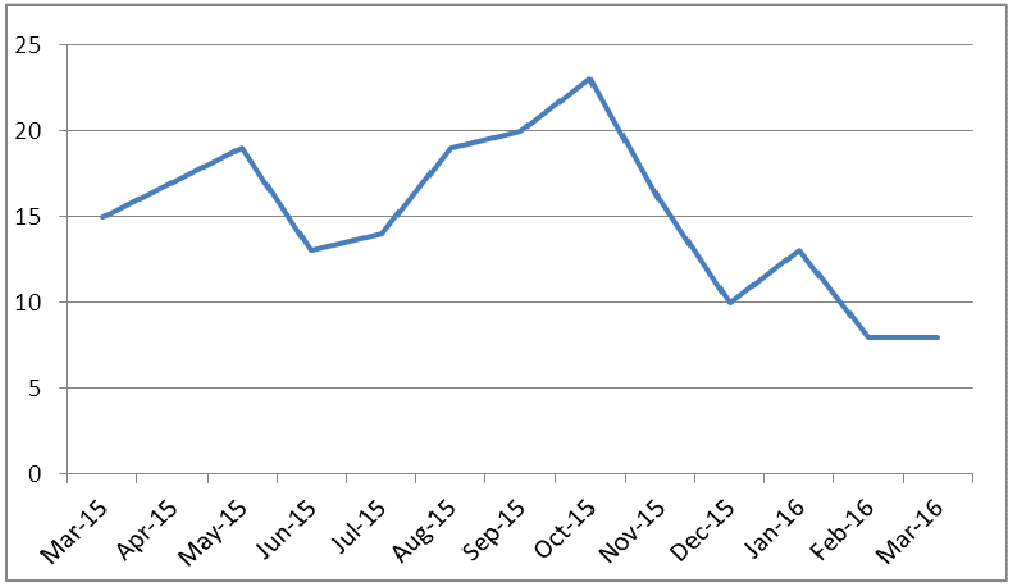
I have had two hip replacements at the William Harvey in 2014 and 2015 and I would like to say what excellent care I have received. Mr Reddy's team have been caring and courteous at all times.

Surgical Emergency Admissions Unit - WHH

Visited the SEAU department at the William Harvey hospital in Ashford on Friday and earlier today and just wanted to compliment the staff on duty. They are very efficient and very friendly. So nice to see a team that works well together and very happy with the way I was treated here.

A&E, then Stroke Clinic, then Richard Stevens Unit – WHH

My wife suffered a stroke and she was taken by ambulance to A&E. The prompt response and the fantastic treatment by Dr Hargroves and his team has resulted in a miraculous recovery. We both cannot thank you enough. We think the NHS is the greatest!

Figure 2: Number of Complaints and Concerns Received	Figure 3: Number of Returner Complaints received
	
The number of complaints (blue line) received has decreased by 27% compared to February 2016 (48 compared to 66). The number of complaints received from March 2016 compared to March 2015 has decreased by 34% (48 compared to 73). The number of concerns (brown line) has increased by 17% compared to last month (62 compared to 53). Compared with March 2015 there has been a 10% decrease (69 then; 62 now).	The number of returner complaints received has remained the same as February 2016 (9). The number of returner complaints received in March 2016 compared to March 2015 (15) has decreased by 7. We have been working hard recently to get the first response to be thorough and empathetic.

Themes and Trends in March 2016 – PALS Contacts

The top five subjects raised within PALS in March are detailed in the table opposite. Please note that issues around delays constitute a significant contact to PALS.

Table 1: Top Five Themes for PALS: March 2016

Delays	43
Problems with Appointments	27
Enquiry clarification or admin query	26
Problems with Communications	20
Attitude	9

Themes and Trends in March 2016 – Concerns

The top five subjects raised within concerns in March are detailed in the table opposite.

Table 2: Top Five Themes for Concerns : March 2016

Delays	19
Problems with communication	16
Problems with Appointments	9
Problems with Attitude	9
Diagnosis	4

Themes and Trends in March 2016 – Complaints for all of Trust

Table 3: Complaints

The breakdown of the top five issues by sub-subject are below and opposite (joint fifth position this month):

Problems with communication	**32**
Doctor communication issues	15
Misleading / contradictory information given	3
Nursing communication issues	12
Other staff communication issues	1
Unable to contact department / ward	1
Delays	**27**
Delay in allocation of outpatient appointment	4
Delay in going to theatre	1
Delay in receiving x-ray results	2
Delay in referral	4
Delay with elective admission	2
Delays in being seen in A&E	1
Delays in receiving treatment	13
Concern about Clinical Management	**16**
Unhappy with treatment	7
Referral issues	2
Lack of/inappropriate pain management	4
End of life/palliative care issues	3
Problems with Nursing Care	**11**
Delay in receiving treatment	1
Inappropriate physical handling	1
Lack of response to call button	3
Nutrition	1
Unclassified problems	5
Concern about surgical management	**10**
Consent issues	3
Difficulties during procedure	2
Unexpected outcome/post op. complications	5
Problems with diagnosis	**10**
Delay with results	1
Delay in receiving diagnosis	1
Mis-diagnosis	3
Missed fracture/other medical problem	5

The highest recurring subjects raised within complaints for March 2016 are:

Problems with Communication;
Delays;
Concern about Clinical Management;
Problems with Nursing Care;
Concern about surgical management/problems with diagnosis.

Table 4: Themes and Trends by Division.
The breakdown of the top five issues for complaint received in March by Division are opposite:

Problems with communication	UCLTC	Surgical	Specialist	Clinical
Doctor communication issues	3	9	3	1
Misleading/contradictory information given	0	0	3	0
Nursing communication issues	1	5	6	0
Other staff communication issues	1	0	0	1
Unable to contact department/ward	0	1	0	0
Delays				
Delays in allocation of outpatient appointment	1	3	0	0
Delays in going to theatre	0	1	0	0
Delays in receiving x-ray results	1	1	0	0
Delay in referral	1	1	0	0
Delay with elective admission	0	2	0	0
Delay in being seen in A&E	0	1	0	0
Delay in receiving treatment	3	5	5	0
Concern about Clinical Management				
Unhappy with treatment	0	5	1	1
Referral issues	0	2	0	0
Lack of/inappropriate pain management	0	3	1	0
End of life/palliative care issues	3	0	0	0
Problems with Nursing Care				
Delay in receiving treatment	0	0	1	0
Inappropriate physical handling	1	0	0	0
Lack of response to call button	0	2	1	0
Nutrition	0	2	0	0
Unclassified problems	1	4	0	0
Problems with surgical management				
Consent issues	0	3	0	0
Difficulties during procedure	0	0	2	0
Unexpected outcome/post op complications	0	3	2	0

Performance

Table 5: Current Open Cases by Division

Division	Complaints	Concerns	Total
Urgent Care and Long Term Conditions	72	110	182
Surgical Services	62	99	161
Specialist Services	38	12	50
Clinical Support	5	13	18
Corporate	4	2	6
TOTAL	**181**	**236**	**417**

Table 6: Divisional Performance

	Divisional activity in March 2016					Divisional performance in March 2016		
Division	**Complaints**	**Compliments**	**Concerns**	**PALS Contacts**	**Compliments: Complaints ratio**	**First response target met (within agreed timescales)**	**First response target met (30 working days)**	**No. of returning complaints**
UCLTC	16	679	27	29	42:1	20 of 31 (64%)	8 of 31 (26%)	3
Surgical Services	18	1196	19	62	66:1	27 of 30 (90%)	3 of 30 (10%)	5
Specialist Services	13	304	6	17	23:1	14 of 14 (100%)	3 of 14 (22%)	0
Clinical Support	1	30	7	24	30:1	2 of 2 (100%)	0 of 2 (0%)	0
Corporate	0	4	2	20	-	1 of 1 (100%	1 of 1 (100%)	1
Other	0	159	1	1	-		-	0
TOTAL	**48**	**2372**	**62**	**153**	**41:1**	**64 Of 78 (82%)**	**15 of 78 (19%)**	**9**

Rating	% of first responses met
	85 – 100%
	75-84%
	< 75%

Key Outcomes and Service Improvements as a Result of Complaints

Table 8: Outcome of Complaints Closed in March 2016

Upheld	Partly Upheld	Not Upheld	Withdrawn or consent not received	Meeting held and awaiting outcome	Comments sent to another organisation
28	25	24	1	0	0

Key Improvements as a result of Complaints in March 2016:

Health Care of Older Person - QEQM

Concerns over poor communication with the family leading up to the patient's death. They were given to understand that the treatment was for an infection when they had been told that patient was suffering from metastatic cancer and ischaemic heart disease. They felt that a lack of consideration and empathy was given when the patient died.

Sadly the patient was very unwell and was deteriorating fast. A detailed explanation of the clinical and nursing care provided was given with apologies for the lack of detailed explanations at the time. Actions taken included:

1. Consultant discussing with the doctor involved the impact of his communications with the family.
2. Matron sharing the episode with the ward staff and at the ward managers' meeting.

Clinical Support – Pathology - WHH

The client has raised concerns at the attitude of a phlebotomist who took blood prior to the client having a first trimester scan. The client was advised by the midwife to ensure that the phlebotomy staff took two vials of blood to ensure the correct tests took place, including for Downs Syndrome. The client reports mentioning this to the staff member only to be spoken to in an abrupt manner. At a later appointment, the client was told that the Downs Syndrome screening test had not taken place. The client then opted to have a private scan and test.

There were a number of places where we let the client down with regard to communication and with poor attitude from the staff.
Action point: to ensure that the requests for Downs Syndrome tests are handled in a better fashion

Processes in outpatient clinic

Concerns raised by patient's GP regarding the delay in administrative staff typing and sending urgent referral
The doctor concerned did not know that urgent letters had to be dictated onto a particular machine. The induction had not been adequate.
Fortunately the patient's lesion was benign.

Action point: to ensure all new doctors are properly inducted with regard to administrative processes.

Specialist Services – Obstetrics WHH

Concerns over the management of the client's monochorionic diamniotic twin pregnancy and the lack of monitoring and poor communication over twin to twin transfusion syndrome. Client believes this was a case of chronic twin to twin transfusion syndrome that was not identified. Delivery of babies was induced following their death, with concerns over the delivery and parts or placenta retained. Babies were placed in separate coffins for the funeral, when specifically asked they were together.

Action: reminder that placenta always has to accompany a dead baby to the mortuary.
Action: Twin to Twin Syndrome awareness increased and staff advised to download the leaflets when required.
Action: Midwife to be reminded about the need to feel abdomen for uterine size on discharge.
Action: Cannulation escalation protocols are to be adhered to and midwife to receive update training.
Action: Catering manager reminded that if staff feel they cannot enter a room then they are to ask a midwife.

Accident and Emergency Department QEQM

Issues raised with regards to a member of staff's comments towards the family which implied they did not care about their loved one, who had mental health issues and which the family were finding very difficult and stressful to cope with.

The attitude of the staff was not what we would have wished and we were very sorry to have added to their distress at this very difficult time.
Actions taken:

- This scenario will be used as part of our dementia education, Trust wide.
- The Dementia Specialist Team will provide education to Emergency Department staff, including Dementia Friends sessions and new education in the form of Simulation Training.
- This scenario will also be shared with all the senior team leaders, and the nurse in charge group, to ensure safety is always considered for both the patient with dementia and their families.
- Matron will be reviewing the current handover process to minimise the possibility of a similar incident reoccurring.
- Individualised teaching for staff member involved, including customer care and reflection.
- Consultant has been asked to ensure that this locum reflects on his actions and this will be shared with his agency.

Feedback Received via the Patient Opinion and NHS Choices Websites

Table 9 - Compliments and Concerns Received in March 2016

Site:	WHH	KCH	QEQM	RVHF	BHD	TOTAL
Compliments	7	3	2	2	0	14
Complaints	5	3	0	0	0	8

Examples of Compliments received on the Patient Opinion and NHS Choices Website in March 2016 :

- **RVH - Attended for blood tests and xray**
  I was treated as soon as I went to each department by very pleasant and professional staff who seemed happy and proud of the service they provide. Could not have wanted for better treatment.
  Visited in March 2016. Posted on 04 March 2016
- **WHH – attended surgical assessment unit**
  I attended your unit whilst on holiday from Cheshire. I had a very painful condition which was dealt with in a speedy manner. I am most grateful for the care, advice and medication given to me. Many thanks to all.
  Visited in March 2016. Posted on 20 March 2016
- **WHH – CDU – end of life care**
  We could not thank the staff who looked after our relative for the last four days of his life. The staff were so attentive to the individual and our family. Nothing was too much and they all respected our wishes as a family. I would like to thank the staff for all their great care and hope this message is received by them all.
  Visited in March 2016. Posted on 31 March 2016
- **KCH – Excellent care in Day Surgery**
  I attended the Day Surgery unit on 10/03.2016 for a knee operation.
  From arrival to departure all staff were most polite, professional and worked well as a team. It is good to see nurses with a sense of humour in the current climate and all working happily. This does reflect onto the patient especially if they are a little apprehensive. Very well done to all staff on the unit and thank you for your care.
  Visited in March 2016. Posted on 11 March 2016
- **QEQM – the very best care**
  Dear QEQM I just wanted to tell you about the fantastic level of care I had during my stay with you in the Quex ward, all the nursing staff worked their socks off to provide a level of care I have not had before in any hospital I have had to use, they all went the extra mile to look after me , they worked so well together as a team and I think having the Quex ward for knee and hip replacements is a great idea and shows just how well the NHS can work when you have such dedicated staff. All the nurses were fantastic I would like to give a special mention to a young nurse just about to qualify. To see how hard the nurse worked and how caring they were is a very good indicator of just how lucky we are having the Quex ward look after us after our surgery.Many thanks.
  Visited in March 2016. Posted on 21 March 2016

Examples of Complaints received on the Patient Opinion and NHS Choices Website in March 2016 :

- **WHH – Waiting time for pharmacy**
  Had to wait 3¾ hours for drugs to be delivered to ward so that patient could be discharged.
  Visited in March 2016. Posted on 29 March 2016
- **WHH – x-ray department - could not be contacted - very poor service.**
  I rang all morning on the William Harvey's 01233 616033 number given on their appointments letter, but no one ever answers. I checked the Internet using an alternate number and every time I reached the William Harvey X ray department the phone is answered, and they put the phone down on me (mainly around 12:30pm Thursday). The reason for wishing to cancel my Friday, 11 March 2016 appointment is because after a very long wait my appointment was double booked, one at the William Harvey the other at the new Whitstable Health Centre, which I have recently attended. .I wish to bring to your attention the incompetence, the rudeness and general inefficiency surrounding this early stage of my health problems
  Visited in March 2016. Posted on 10 March 2016
- **WHH** - **Biopsy results sent to wrong doctor resulting in 7 week delay**
  Despite having previously received adequate treatment at the William Harvey, an administrative error has meant a 7 week delay in starting treatment for endometrial cancer. Apparently, the consultant's mail is regularly sent to other doctors with the same surname and in my case, it was sent to a doctor with the same surname who does not even work at the hospital. This is not acceptable and has delayed treatment for my cancer by 7 weeks. As this is not the first time the same error has been made, I doubt it will be the last and action really has to be taken to find the root cause of this error to ensure it does not happen again. I trust there will be no further delays with my treatment and this delay will be taken into consideration when scheduling appointments and my operation.
  Visited in March 2016. Posted on 25 March 2016
- **KCH - Ultrasound Department/Cardiology**
  I attended an appointment at the Ultrasound department, next door to Taylor Ward for an 08.30 appointment but the staff carrying out the ultrasound did not start till 09.00.So when I went in to have the wrong ultrasound done, the department was already running late. The department is dirty and more information from the staff behind reception would be a good idea. There is a lack of seats in the waiting area and the whole place needs sorting out. It is a terrible place to visit or be treated in.
  Visited in March 2016. Posted on 14 March 2016
- **KCH – Colposcopy - did not feel involved**
  I have attended the colposcopy unit twice following an abnormal smear. First time I was given a calm and reassuring explanation by the nurse, their examination was well explained and I felt very much part of what was happening. The second time I was seen by a doctor. I was given no choice in the gender of the doctor. In the pre consultation, the doctor gave me the impression they were going to carry out a biopsy before they examined me. I had not expected this - the letter did not say this might be an option. In the procedure, which physically was carried out well, the doctor described what they were seeing but not what it meant. The doctor carried out a biopsy. I was given no choice or option. I was due to fly on an international long haul later in the day and I was not able to mention this. I felt completely powerless and 'done to'. I had to leave distressed and then call back and speak to the accompanying nurse to try to make sense of what had happened, what would happen next and what the outcomes might be. Whilst it is fine to say 'have you any questions' repeatedly, when you are a woman lying there being examined intimately it is very hard to think straight when the procedure had already been determined. Not at all happy.
  Visited in March 2016. Posted on 03 March 2016

CLINICAL QUALITY & PATIENT SAFETY PERFORMANCE HEAT MAP

Ward/Site	Patient Safety									Patient Experience						Clinical Effectiveness	
	Risk Management		HCAI		Harm Free Care	Nurse Sensitive Indicators				Experience						Nurse Staffing	
	Complaints	Compliments	MRSA	C. diff	Safety Thermometer HFC - New Harms (%)	Pressure Ulcers: Category 2, 3 and 4		Falls	Cardiac Arrests	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Did you get the care that matters to you?	Were you treated with respect and dignity while in hospital?	Was your care or treatment explained to you in a way you could understand?	Day - Staff Fill Rate (%)	Night - Staff Fill Rate (%)
						Unavoidable	Avoidable										
Cambridge J2 Ward - WHH	1	0	0	0	94.1%	0	0	3	0	44%	96%	0%	100%	100%	100%	84%	96%
Cambridge K Ward - WHH	4	0	0	0	100.0%	0	1	2	2	73%	98%	0%	100%	100%	100%	81%	95%
Cambridge M2 Ward - WHH	0	0	0	0	94.7%	1	0	2	0	80%	100%	0%	93%	100%	98%	78%	89%
Coronary Care Unit (Taylor) - KCH	0	0	0	0	100.0%	0	0	0	2	30%	100%	0%	100%	100%	100%	62%	100%
Coronary Care Unit - QEH	0	0	0	0	100.0%	0	0	3	0	63%	100%	0%	100%	100%	100%	75%	105%
Coronary Care Unit - WHH	0	0	0	0	100.0%	0	0	0	1	108%	100%	0%				93%	108%
Minster Ward - QEH	0	0	0	0	91.3%	0	1	3	0	61%	97%	0%				76%	99%
Oxford Ward - WHH	0	1	0	0	100.0%	0	0	3	1	71%	95%	0%				95%	102%
Sandwich Bay Ward - QEH	1	0	0	0	100.0%	1	1	5	1	34%	94%	6%	100%	100%	100%	100%	123%
St Margaret's Ward - QEH	2	20	0	0	100.0%	0	0	6	1	18%	100%	0%				107%	99%
Deal Ward - QEH	0	24	0	0	96.4%	0	0	5	0	26%	100%	0%	100%	100%	100%	93%	100%
Harvey Ward - KCH	0	0	0	0	94.7%	0	0	3	0	100%	100%	0%				100%	100%
Invicta Ward - KCH	0	1	0	0	100.0%	0	0	3	1	44%	100%	0%	100%	100%	91%	76%	96%
Cambridge L Ward - WHH	1	3	0	0	92.3%	1	0	5	0	45%	94%	0%				69%	113%
Treble Ward - KCH	0	3	0	0	100.0%	0	0	7	0	70%	91%	4%	100%	100%	100%	83%	103%
Mount & McMaster Ward - KCH	0	47	0	0	100.0%	0	0	2	1	24%	96%	4%				87%	102%
Fordwich Stroke Unit - QEH	1	2	0	0	100.0%	0	0	7	0	24%	100%	0%				89%	100%
Kingston Stroke Unit - KCH	0	0	0	0	100.0%	0	0	3	1	25%	100%	0%	100%	100%	100%	79%	82%
RSU Unit - WHH	0	0	0	0	100.0%	0	0	7	0	62%	92%	4%	100%	100%	100%	76%	68%
Harbledown Ward - KCH	1	0	0	0	100.0%	0	0	6	0	53%	89%	0%				91%	92%
St Augustine's Rehab Ward - QEH	1	0	0	0	100.0%	0	0	4	0	77%	74%	0%	100%	100%	100%	65%	58%
CDU - QEH	1	40	0	0	100.0%	0	0	4	0	15%	84%	12%	100%	100%	93%	81%	89%
CDU - WHH	3	2	0	0	100.0%	3	0	8	0	18%	77%	17%	100%	100%	100%	98%	99%
Emergency Care Centre - KCH (CDU only)	1	0	0	0	100.0%	0	0	1	0	19%	82%	10%				99%	90%
Rotary Suite - WHH	0	44	0	0	100.0%	0	0	0	0	61%	96%	2%	100%	100%	100%	97%	94%
Cheerful Sparrows Ward Female - QEH	1	0	0	0	96.3%	0	0	0	0	73%	98%	0%	100%	100%	100%	90%	99%
Clarke Ward - KCH	2	106	0	0	95.8%	0	1	6	1	22%	99%	0%				68%	118%
Cheerful Sparrows Ward Male - QEH	0	1	0	1	95.8%	0	0	4	0	40%	90%	2%	96%	98%	98%	83%	98%
Kent Ward - KCH	0	1	0	0	100.0%	0	2	7	0	24%	100%	0%	100%	100%	100%	129%	138%
Kings B Ward - WHH	0	87	0	0	100.0%	0	1	2	0	60%	100%	0%				91%	91%
Kings A2 Ward - WHH	0	93	0	0	100.0%	0	1	2	1	91%	97%	0%	98%	100%	100%	86%	76%
Kings C1 Ward - WHH	1	0	0	0	96.0%	0	0	4	0	15%	100%	0%	100%	100%	100%	90%	122%
Kings C2 Ward - WHH	0	0	0	0	100.0%	0	0	2	0	72%	97%	1%				75%	98%
Kings D Ward Male - WHH	2	143	0	0	100.0%	1	0	3	0	58%	100%	0%	100%	100%	94%	84%	90%
Kings D Ward Female - WHH	1	0	0	0	94.4%	0	1	2	0	52%	100%	0%	100%	100%	100%		
Quex Ward - QEH	0	90	0	0	100.0%	0	0	6	0	40%	97%	3%	100%	100%	100%	99%	122%
Bishopstone Ward - QEH	0	0	0	0	94.7%	1	0	5	1	66%	100%	0%				88%	89%
Seabathing Ward - QEH	0	0	0	0	95.2%	0	0	0	2	51%	100%	0%	100%	100%	93%		
Critical Care - WHH	0	4	0	0	100.0%	0	2	0	0							117%	113%
Critical Care - KCH	0	1	0	0	100.0%	0	0	0	0							92%	104%
Critical Care - QEH	0	23	0	0	100.0%	0	0	0	0							87%	93%
Marlowe Ward - KCH	1	85	0	0	97.0%	0	0	5	1	23%	92%	8%				90%	84%
Neonatal Intensive Care Unit - WHH	1	0	0	0	100.0%	0	0	0	0							86%	81%
Padua Ward - WHH	0	0	0	0	100.0%	0	0	0	0	18%	99%	1%				101%	102%
Rainbow Ward - QEH	1	7	0	0	100.0%	0	0	1	0	3%	88%	13%				82%	101%
Birchington Ward - QEH	0	1	0	0	100.0%	0	0	1	0	36%	96%	0%	100%	100%	100%	81%	100%
Kennington Ward - WHH	0	0	0	0	100.0%	0	0	0	0	110%	94%	4%				87%	85%
Brabourne Ward - KCH	0	43	0	0	100.0%	0	0	1	0	92%	95%	5%				72%	86%
Folkestone Maternity & Labour Ward - WHH	4	0	0	0	100.0%	0	0	0	0							102%	98%
Kingsgate Maternity & Labour Ward - QEH	0	0	0	0	100.0%	0	0	0	0							99%	56%
Hospital at Home - QEH	0	0	0	0	100.0%	0	0	0	0								
Hospital at Home - WHH	0	0	0	0	100.0%	0	0	0	0								
Special Care Baby Unit - QEH	1	0	0	0	100.0%	0	0	0	0							84%	102%
A&E Department - QEH	8	0	0	0		0	0	0	0	25%	77%	14%					
A&E Department - WHH	7	0	0	0		1	0	1	0	27%	67%	21%					

Criteria
The Heat Map uses Mar-16 data.

Data are sourced from the Ward Dashboard* and therefore only relate to Inpatient Care, not Trust-wide numbers which the Clinical Quality and Patient Safety Report will include.

* With the exception of FFT data, sourced from the FFT Dashboard, and Safe Staffing data, taken from the CQC Action Dashboard.
Where applicable, RAG ratings are assigned to the data using thresholds taken from the Ward Dashboard and the CQC Action Plan. FFT threshold for Recommended % taken from the NHS England average. Where complaints are over 1, the RAG is marked red.

For the purposes of this Heat Map, the RAG is either red or green, to help with simplified alerting and emerging patterns.

Key	
Data recorded but unavailable	-
Data not recorded for the Ward	

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**QUALITY COMMITTEE**
DATE:	**4TH MAY 2016**
SUBJECT:	**INFECTION CONTROL REPORT 2015-16 Q4**
REPORT FROM:	**INTERIM DIRECTOR INFECTION PREVENTION AND CONTROL**
PURPOSE:	**INFORMATION/DISCUSSION**

CONTEXT

Good performance against targets throughout the year

SUMMARY:

- Continued good performance with low numbers of MRSA cases
- Exceptionally low C difficile numbers representing a 40% reduction compared with the previous year
- The impact of 2 senior Infection Control staff leaving East Kent.has been risk assessed and is being addressed through recruitment and reorganisation
- Legionella contamination of patient showers is reported and remedial action has been taken

RECOMMENDATIONS:

The Board are asked to note the good performance in terms of MRSA and C difficile numbers compared with peers in England.

NEXT STEPS:

NA

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

The performance described is consistent with the following Trust objectives:

- Deliver excellence in the quality of care and experience of every person, every time they access our services
- Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects and rapidly implementing best practice from across the world

LINKS TO BOARD ASSURANCE FRAMEWORK:

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

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

AO3: Delivering Improvements in patient access performance to meet the standards expected by patients as outlined in the NHS Constitution and our Provider Licence with Monitor.

AO5: Developing, engaging and consulting on a clinically and commissioner supported strategy that achieves both medium and long terms clinical and financial stability

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

- Temporary reduced capacity in the infection prevention and control committee has been addressed through risk assessment and a recruitment and reorganisation strategy
- Delayed detection of Legionella in showers has been addressed through enhancement of the Legionella water sampling programme

FINANCIAL AND RESOURCE IMPLICATIONS:

NA

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

NA

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

NA

ACTION REQUIRED:

(a) Discussion.
(b) To note

East Kent Hospitals University Foundation Trust Infection Control Report 2015-16 Q4

Introduction

This report summarises the numbers of healthcare associated infections recorded in mandatory surveillance reported to Public Health England during 2015-16 Q4 compared with the previous year. A more detailed analysis of related infection prevention and control issues will be provided in the Infection Control Annual Report for 2015-16.

Performance in the 4th quarter continued to be good with low MRSA rates and a striking reduction in C difficile compared with the previous year

Staphylococcus aureus MRSA

Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infections are an important indicator of healthcare associated infection and increased numbers are associated with a breakdown in hospital hygiene and factors such as IV line infections.

Table 1

Meticillin Resistant (MRSA) blood stream infections East Kent by Quarter 2014-15 to 2015-16

	Apr--Jun	Jul-Sep	Oct-Dec	Jan-Mar	total
2015-16	2	0	0	[2]under review]	2*
2014-15	1				1

* The final EKHUFT total will depend on the attribution of the 2 Quarter 4 cases under review

There were 2 cases of MRSA bacteraemia in March 2016. An external HCA panel organised by the Regional Chief Nurse will determine whether these cases are attributed to a local healthcare organisation or to a third party. Case 1 is a pre-48hr bacteraemia where infection was thought to be already underway at the time of admission. The second is a particularly unusual case of a toxin producing MRSA belonging to the USA300 strain of MRSA which has been a notorious cause of community acquired MRSA infection in the United States. This patient has also been an in-patient in France shortly before admission to EKHUFT.

The EKHUFT MRSA rate/100,000 occupied bed days is 0.66 compared with 1.26 for KSS region and 0.89 for England .

Staphylococcus aureus (MSSA)

Meticllin sensitive Staphylococcus aureus (MSSA) infections largely represent community acquired infections with more than 80% of infections present at the time of admission. However a minority of infections arise from IV site infection or surgical site infection and for this reason cases are monitored.

Table 2

Meticillin sensitive (MSSA) blood stream infections East Kent by Quarter 2014-15 to 2015-16

	Apr--Jun	Jul-Sep	Oct-Dec	Jan-Mar	total
2015-16 pre-48hr	29	31	19	36	**115**
2015-16 post 48hr	2	8	6	10	**26**
2014-15 pre 48hr	19	23	27	21	**90**
2014-15 post 48hr	5	6	4	5	**20**

There has been a modest increase in both community and hospital acquired MSSA cases during 2015-16 . No ward or departmental clusters were noted. Root cause analysis (RCA) of post procedure related cases during 2015-16 indicated that IV site infections are the most significant potentially preventable group. For this reason RCA of IV site infections caused by MSSA will continue during 2016-17 and a running statistic of such infections will be compiled.

The cumulative rate per 100,000 occupied bed days is 7.7 compared with a KSS rate of 7.9 and an England rate of 8.3 . Given that the majority of cases are community acquired, a rate per 100,000 head of population is probably a more relevant statistic. Population rates are influenced by local demographics and range through 12.3 for Ashford CCG, 17.3 for Canterbury & Coastal CCG, 23.6 for South Kent Coastal CCG and 22.5 for Thanet CCG . The England population rate is 17.9 per 100,000 head of population.

Clostridium difficile

C difficile cases diagnosed within 72hours of admission are considered to be hospital acquired

Table 3 **Cdifficile cases East Kent by Quarter 2014-15 to 2015-16 Post 72hr cases are Trust apportioned (hospital acquired)**

		Apr--Jun	Jul-Sep	Oct-Dec	Jan-Mar	total
Trust apportioned	**2015-16 post-72hr**	8	8	10	2	**28**

Trust apportioned	**2015-16 pre 72hr**	39	28	27	19	**113**
	2014-15 post 72hr	15	17	10	5	**47**
	2014-15 pre 72hr	31	47	16	29	**123**

Table 3 demonstrates a striking 40% reduction in hospital acquired C difficile cases during 2015-16 with only 2 cases recorded during Q4 . There were 28 cases at the end of March 2016 against a total DH limit of 45 cases. The monthly C difficile rate/100,000 occupied bed days for the April 2015 –Feb 2016 period is 9.4 compared with the national average of 15.2 and KSS rate of 12.

Escherichia coli

Ecoli is the most frequent cause of blood stream infection diagnosed in UK hospitals and a common cause of "septic shock" . Sources of infection include urinary tract, gall bladder and the gastrointestinal tract.

Table 4

Ecoli blood stream infection East Kent by Quarter 2014-15 to 2015-16					
	Apr--Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**total**
2015-16 pre-48hr	103	128	115	107	**453**
2015-16 post 48hr	16	15	21	21	**73**
2014-15 pre 48hr	100	101	104	95	**400**
2014-15 post 48hr	18	18	19	13	**68**

Ecoli infections continue to increase nationally and locally. This is probably due to higher numbers of frail elderly patients in hospital and in the community. During 2014-15, root cause analysis of Ecoli blood stream infections occurring within 30 days of hospital procedures showed that post 48hrs infections largely represented underlying medical problems rather than complications of surgery.

Ecoli bacteramia rates are influenced by local demographic factors with the rate of Ecoli bacteraemia per 100,000 population ranging from 58.3 in Ashford CCG to, 71.6 in

Canterbury & Coastal CCG , 78.1 in South Kent Coast CCG and 92.9 in Thanet CCG. The England population rate is 64.8 per 100,000 head of population.

Legionella pneumophila

There were no cases of Legionella infection during Q4 , however a high counts of Legionella pneumophila SG1 were detected in a shower in Queen Elizabeth the Queen Mother Hospital. Poor flow in a hospital main which may have been contributory was also detected. As a precautionary measure , filters were fitted to relevant showers and remain in place. Remedial engineering work has addressed the flow problem detected. The routine Legionella sampling programme has been altered to give a higher priority to detecting Legionella colonisation of showers in the future.

A comprehensive Legionella control programme is in place throughout the trust and is compliant with the Health & Safety Executive Code of Practice for the Control of Legionella in Healthcare premises (L8)

Infection Prevention and Control Team

Two experienced senior members of the infection control team (Sue Roberts and Debbie Weston), leave the trust in April/May 2016. This will have a significant short term impact on the ability of the team to react to adverse events and develop policy. A risk assessment has been undertaken and recruitment is underway.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS MEETING**

DATE: **24 MAY 2016**

REPORT FROM: **QUALITY COMMITTEE CHAIR**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

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

This report is presented to the Council of Governors to assist them in their statutory duty "holding non-executive directors' to account for the performance of the Board". It is a standing agenda item in relation to quality and safety performance and reports on the May 2016 meeting. The April 2016 meeting was cancelled due to the junior doctors' strike. The May 2016 meeting also reviewed the year end performance and the annual objectives for 2016/17 were discussed.

EXECUTIVE SUMMARY

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. Were the annual objectives for 2015/16 met?
4. Looking forward, what are the annual objectives for 2016/17 and what are the risks to achieving these?

1. The following went well over the reporting period:
    a. Non-elective crude mortality has fallen: Non elective deaths per 1,000 non elective admissions decreased from 36.18 in Feb-16 to 33.43 in Mar-16;
    b. Less Serious incidents: 4 serious incidents were reported in March 2016 against 7 in February 2016;
    c. 40% reduction in C.difficile infections in 2015/16 with no cases in March 2016
    d. Post 48 hour E. coli bacteraemia decreased from 11 in February to 3 in March 2016, the average being 7 per month; see appended report on infection control from Dr Nash;
    e. No avoidable deep pressure ulcers and the end of year Trust performance was 8 against a maximum of 9;
    f. Lower rate of falls in March 2016 with the Trust seeing an overall improvement on the previous year of 5.47 falls per 1000 which is below the national average;
    g. Incident reporting rate has increased and in terms of the quality of the root cause analysis reports, the CCGs have complimented the Trust;
    h. Less deaths/serious harm reported, there were 5 reported in March but these may be downgraded once the investigation starts;
    i. Reduction in 7-day readmission rates improved both on a month by month basis and compared to the same period last year but they are still above the target of 2% at 3.7%;

j. Reduction in bed occupancy from 100.9% in February to 94.44% in March 2016, although it is higher than March 2015 (95.25%);
k. Reduction of extra beds (following high number during the winter); and
l. In general the number of outliers remains high although there was a reduction in March 2016 on February 2016 figures from 8.38% to 7.27%.

More detail is provided in Appendix 1

2. The following concerns were highlighted:
   a. Harm free care is reduced from 91.8% in February to 91.5% in March 2016 against a national standard of 95%. This figure represents the harms a patient is admitted with as well as those occurring while the patient is with us. New harms only (those we can influence) are better than the national average at around 98% harm free care;
   b. Elective crude mortality has risen: Elective deaths per 1,000 elective admissions saw an increase from 0.22 in February to 0.66 in March 2016. All elective deaths are reported on Datix and discussed at the Surgical Morbidity and Mortality meetings;
   c. Staffing / Recruitment continue to be an issue which saw an increase in incidents relating to staffing. This remains on the risk register;
   d. Mixed sex accommodation occurrences increased in March 2016 which was mainly as a result of 11 breaches at the William Harvey Hospital which is mainly due to an acknowledgement of better reporting. The site team are addressing this issue;
   e. Increase in delayed transfers of care: The Committee was not assured in relation to the provision of continuing health care pending assessment by Social Services and community services;
   f. Duty of Candour is poorly recorded and the Medical Director was charged with addressing this through the Serious Incident Meeting and Root Cause Analysis Panel;
   g. The Trust continues to perform badly in terms of documenting VTE assessments on VitalPac. The Committee has tasked the Medical Director with discussing the concerns at the Local Medical Committee in terms of sanctions for doctors;
   h. Whilst the Trust met the compliance rate of 85% in March 2016 concerns remained about the systems capability to record all training attempts;
   i. Consultant job planning was not completed but assurance was given that a timeline was in place to achieve this;
   j. Consultant engagement is of concern in certain divisions, especially in relation to clinical audit. However, the Clinical Audit Manager is working with the Divisional Medical Directors to ensure the 2016/17 audit plan is achievable.

More detail on the performance and relevant actions are provided in Appendix 1.

Other topics discussed where concerns or actions were taken:

- Patient Experience Team (PET): The Chief Nurse highlighted a concern about the capacity of this team due to a high level of sickness and maternity leave; this had resulted in a backlog of complaints. In addition March 2016 was the first time that the 85% standard of sending responses to clients within the agreed timescale had not been met in a year. The Committee were pleased to hear that a recent appointment was seeing an improving position;
- Intra-site transfers continued to be challenging and a new risk was being discussed at Management Board. The Committee supported the suggestion that the Trust Chief Executive should write to South East Coast Ambulance to discuss the criteria;
- Maternity Services: overall the Committee was assured about the progress being made and congratulated the Head of Midwifery and Divisional Medical Director. Evidence showed that they were under established but recruitment was underway. The aim was to have 1 midwife for every mother in labour; and

- External Visits: the Committee called for immediate escalation of one outstanding action relating the requirement for Ashford Borough Council to undertake an intrusive survey.

3. Progress was made against each of the objectives under review by the Quality Committee, below is the high level achievement, more details is provided in Appendix 2:
    a. Person-Centred Care – good progress
    b. Safe Care – partial progress
    c. Effective Care – good progress
    d. Implementation of the Improvement Plans – good progress

4. The following annual objectives were discussed, following approval at Board, in terms of the risks and will form a key part of the Committees work programme for 2016/17:
    a. Deliver the CQC and emergency care improvement plans to ensure Trust is removed from Special Measures at its next CQC re-inspection in 2016.
    b. Deliver the agreed improvement trajectories (as submitted to and agreed with NHS Improvement) for the emergency care, RTT, cancer and diagnostic wait standards, by end of March 2017.
    c. Transform care for people with learning disabilities with local providers as measured by self-assessment against metrics by December 2016.
    d. Deliver the following service quality improvements by March 2017:
        i. 20% reduction in sepsis associated mortality;
        ii. 20% reduction in harm from poor handover of care/transfer of care;
        iii. 30% reduction in preventable venous thromboembolism events;
        iv. 30% reduction in medication errors;
        v. 30% reduction in catheter associated urinary tract infection;
        vi. 30% reduction in falls with harm; and
        vii. 30% hospital acquired pressure ulcers.
    e. Agree new pathways with commissioners for patients 'medically fit' and not requiring an acute bed to reduce delays by 5% by December 2016.

    Risks associated with these are presented as Appendix 3.

COUNCIL OF GOVERNORS ACTION:

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

APPENDIX 1: PATIENT QUALITY AND SAFETY REPORT

Key Issues of Year to Year Analysis

This month of the 25 indicators 10 are reported as worse than the same time last year and 15 show an improved position. This is an improvement on last month where 15 of the 25 indicators reported a worsening position. Of those 10 indicators 9 are the same metrics as last month.

Comparison Overview between Month

A high level summary of the improvement or deterioration of key metrics is described below. The following indicators have improved since last month's report:

- Non-Elective crude mortality;
- Lower number of serious incidents reported this month;
- No C.difficle cases reported during March;
- Lower number of post 48hr Eschericha coli bacteramias reported;
- No avoidable deep ulcers occurred;
- Lower rate of falls;
- New harm free care improved;
- Incident reporting rate has increased;
- Less number of death/serious harm incidents reported;
- A reduction in 7-day readmission rate;
- Bed occupancy reduced this month;
- Number of extra beds open is less;
- The number of outliers has reduced;
- The ward and department heatmap shows an improving picture compared to the previous month.

The following indicators have deteriorated since last month's report:

- Elective crude mortality has risen;
- Cases of post 48hr Meticillin sensitive Staphylococcus bacteraemias increased by 1 case in March;
- Harm free care was marginally worse compared to February;
- Incidence of category 2 pressure ulcers exceeded the 25% reduction trajectory;
- The number of severe harm incidents was higher;
- Incidents relating to staffing difficulties rose;

- The number of reported mixed sex occurrences increased in March;
- Average delayed transfers of care increased.

The remaining metrics show a similar position to last month.

The key issues that the Board of Directors need to be aware of are discussed below.

Mortality Rates

HSMR and elective crude mortality are showing a higher position than the previous year. Indeed elective crude mortality has shown a rise this month compared to last. However it is worth noting that the Trust's HSMR is significantly lower than the national average. The SHMI is also showing a good position.

HSMR is lower than national average

<u>Actions in place</u>

- As reported last month the Medical Director is exploring the specific conditions that are alerting to gain a greater understanding of the significance of the change. This involves a serial case note review of 30 consecutive deaths following abdominal hernia repair and a serial case note review of all cardiac arrests over the past year.
- The Divisional Medical Director for Urgent Care & Long Term Conditions Division is carrying out serial case note reviews of acute myocardial infarction, lung cancer and gastrointestinal haemorrhage. The review is due by the end of May.
- We are reviewing all deaths that occur in the Trust as per the recommendations of the Mazars report.
- The findings of the reviews and actions taken will be reported to the Board of Directors once completed.

SHMI is showing good performance

Risk Management

Incident reporting continues to increase demonstrating an open culture and staff feeling able to raise concerns. This month we saw a drop in serious incidents reported. The number of breach cases is also reducing.

Incident reporting is slightly higher than the national rates

<u>Actions in place</u>

- Monthly serious incident review meetings are in place;
- The Divisions are being held to account around open cases and timely submission to the CCGs at the Executive Performance Review (EPR) meetings;
- Root cause analysis is undertaken in all serious incidents, including some that do not meet the StEIS criteria but the teams feel warrant that level of investigation;
- Recurrent themes are being addressed through task and finish groups. The sepsis safety collaborative is an example;
- Learning is shared at the serious incident review meetings, via the intranet, 'Risk Wise' and within the Divisional teams and meetings.

In March the number of severe harm incidents reported rose. Actions in place • Investigations are in progress on these specific cases to draw out the root cause and learning; • It is possible the severity of the cases will be downgraded in line with national guidance if the level of harm to the patient is not as first thought when the incident was reported. **Infection Control** The Trust finishes the financial year in a very positive position with regard to infection control. Although we failed our MRSA bacteraemia standard we still have MRSA bacteraemia rates that are lower than national. We end the year with the lowest number of C.difficile cases to date in any one financial year. In March we have seen a drop in the total number of E-coli and MSSA bacteraemias, although the rates in the community remain higher than national. Actions in place • Joint working with our community colleagues is being strengthened; • Continued high vigilance and adherence to infection prevention and control standards. **Safety Thermometer, Pressure Ulcers and Falls** The percentage of harm free care that relates to the harms patients are admitted with as well as those they acquire in our care remains below national average (91.5% in March, 91.8% in February and the national is 94.1%). The percentage of harm free care the patients experience when in our care is above the national average. This means our patients are receiving care that causes less harm than is reported nationally. This improved in March compared to February. K&C saw the greatest improvement increasing from 97.9% to 98.8% in March, WHH reported a slight improvement from 97.7% in February to 97.9% in March. QEQM remained at 98%. Actions in place • Improvement work is embedded in the specific working groups in place for infection control, falls, pressure ulcers and VTE; • The Matrons will focus their attention to the wards that did not achieve 100% harm free care. All wards bar two achieved or exceeded the national harm free care percentage (Minster and Cambridge L).	 Rise in harm severity reported in March  The Trust has exceeded the standard this year  Old & new harm free care is worse than national  Trust only harm free care is

Falls
The number of falls has decreased in March compared to February. The Trust's falls per bed days rate is less than the national average and for the year is in line with the national average. We have also seen an improved standard in the completion of falls risk assessments. K&C and QEQM benchmarked well in the National Inpatient Falls Audit.

Areas of concern remain the falls that result in harm. In March we reported 4 falls that resulted in a head injury or fracture. WHH has a higher rate of falls than QEQM and K&C and did not fare well in the National Inpatient Falls Audit. The Stroke wards and frailty wards continue to report the highest number of falls on the heatmap. The Falls team are experiencing staff shortages currently.

Actions in place

- The Falls Steering Group meets regularly to monitor the number of falls and their root causes;
- All falls are investigated and the learning shared;
- A specific focus on WHH with additional support to improve the completion of falls assessments. The site is being set targets to reduce the rate below the national average. This will be monitored;
- The Trust wide falls action plan is in place and is monitored by the Steering Group;
- Scoping of the 'Falls Stop' programme is underway;
- Additional support for the Falls Team is being discussed given their current vacancy factor;
- We are about to develop KPIs and metrics around the new Annual Objective for 16/17.

Pressure Ulcers
During March there were no avoidable deep ulcers reported. This has resulted in us achieving our 25% reduction trajectory for the year. We reported 5 unstageable ulcers and 8 avoidable category 2 ulcers. This is an improvement on last month, but regrettably we have not met our 25% trajectory for category 2 ulcers this year. Our rate per 1000 bed days is improved on February. We are in the process of exploring how we benchmark ourselves with peers to ensure we are not outlying in our pressure ulcer care.

The heatmap depicts those wards that have reported avoidable pressure ulcers. This month this is largely the surgical wards, and in particular those at WHH. Due to the recurrence of similar issues, a cluster root cause analysis meeting is planned at WHH to address the delays in assessment and promote early intervention. Ron / Sally do we want Governors to have the heatmap?

Celebration to note with regard to the end of year position relating to heel ulcers, we have reported a 69% reduction in avoidable heel ulcers and 5% reduction on total number of acquired heel ulcers from the baseline.

better than national

Falls rate is n line with national

Category 3 & 4 ulcers

Category 2

Actions in place

- The Pressure Ulcer Steering Group is in place and continues to meet;
- In addition wards present their RCAs to the Deputy Chief Nurse, Matrons and Divisional Heads of Nursing to account for their lapses in care. This forum allows sharing of learning;
- A working group is undertaking the focussed work on hotspots that arise. Currently this relates to sacral sores and we need to revisit the 'Bottoms Up' campaign to gain further traction on the improvements required to reduce the incidence of category 2 and unstageable ulcers;
- The Trust wide action plan is in place and is monitored by the Steering Group;
- Benchmarking with peers is in progress in conjunction with the Patient Safety Collaborative across Kent, Surrey and Sussex;
- A cluster root cause analysis meeting is planned at WHH to address the delays in assessment and promote early intervention;
- We are about to develop KPIs and metrics around the new Annual Objective for 16/17.

Staffing

Staffing levels and recruitment and retention continue to be an issue for the Trust in many professional groups. This report appends the actual versus planned fill rates on each ward which shows an overall improved position this month. The heatmap highlights those areas that reported staffing difficulties. There appears this month to be less correlation on the heatmap between the fill rate and incident rates. This may be because Matrons and off framework staff fill the shifts where shortages occur at short notice. These shifts are not recorded in the electronic data given their adhoc nature. Again – do we want them to have the staffing data – don't want to overwhelm them with detail.

Areas of concern at present are Cheerful Sparrows wards, the winter wards including the impact escalation has on other areas (borrowing staff), and the chemotherapy areas. During March there were less incident reports on staffing difficulties than last month and compared to last year (35 in Mar-16, 52 in Mar-15). Staffing remains a risk to the Trust and is on the Corporate Risk Register.

Actions in place

- Staffing is managed and made safe on a daily basis by using temporary staff or existing non-ward based staff;
- Recruitment continues to be led centrally by HR;
- A recruitment fair is planned during April for the Cheerful Sparrows Wards;
- More work is needed to ensure the rosters are completed in a timely way. The Divisional Heads of Nursing are leading this work and are being held to account via the EPRs;
- Overseas recruitment plans are in place and we have just returned from Romania;
- Specific work is taking place around the shortage of chemotherapy nurses;
- Recruitment and retention initiatives are being monitored via the Strategic Workforce Committee.

ulcers

69% reduction in avoidable heel ulcers in year

Trust wide issue

Patient Experience
The key areas to bring to the Board of Directors' attention are Friends and Family Test feedback, complaints and compliments and mixed sex accommodation.

Friends and Family Test
March has seen a small decline of 1-2% in recommendation this month compared to February, although overall our star rating has remained the same. The continued key area of concern remains the Emergency Departments where the themes are around waiting times. This links to the operational difficulties the Trust is facing and the improvement work is captured in the Emergency Pathway Recovery Plan. The Table below depicts the specific recommendation scores for each element of the FFT.

Department	Percentage recommended February 16	Percentage recommended March 16	
Inpatients*	95%	93%	↓
A&E	78%	75%	↓
Maternity	95%	97%	↑
Day Cases	94%	93%	↓
Outpatients	91%	91%	-

*Includes paediatrics.

There is a wealth of additional data that we are not always able to capture that staff in the wards departments and teams act upon. The inpatient real-time data is showing a positive picture across the wards on the heatmap. Each ward area receives their data and formulate their own plans to address any deficits. From the data we have received from Mar-16 all wards achieved a 90% or more satisfaction rate except Rainbow ward (88%), CDU at QEQM (88%), ECC (82%), CDU at WHH (77%) and St Augustines ward (74%) at QEQM. Harvey ward and Kings D ward who flagged last month both received 100% recommendation in March. Most wards achieved 100% recommendation.

<u>Actions in place</u>

- The Patient Experience Group receives reports on a monthly basis on patient feedback and care and takes corrective action as required. Patient feedback is monitored via this group and the Patient Feedback Group reviews all themes and actions required;
- The Emergency Pathway Recovery Group are addressing the patient flow issues, implementing improvements that will be monitored for their impact on patient feedback;
- New actions will need to be considered for the ECC and CDUs.

Mixed Sex Accommodation
In March we reported a higher number of mixed sex breaches. These occurred in the Observation bay at WHH and are due to improved reporting by the staff. Action has been taken to un-mix the bay by combining the Short Stay and Observation Bay patients in single gender bays.

Actions in place

- Continued monitoring on a monthy basis;
- The area breaching has been un-mixed;
- Ensure privacy and dignity are maintained when this does occur;
- The review of the estate (to ensure abathroom facilities are complian Trust wide) is in progress;
- A task and finish review group will be set up when the new Deputy Chief Nurse is in post (commencing in May).

Mixed sex accommodation breaches

Complaints, Concerns and Compliments
Please find attached the Complaints Concerns and Compliments report. In summary this shows a reduction in number of complaints compared to February; a very slight increase in concerns and the number of returning complaints remains the same as last month. Performance against the 30 day standard remains poor, and the 85% standard of sending responses within the timescale agreed with clients was not met this month for the first time in a year. In addition there is a backlog of complaints due to sickness and maternity leave within the Patient Experience Team.

Actions in place

- Additional Relative Support Officer posts are advertised to expand the opening times;
- Additional band 5 cover for the maternity leave commences 18 April 2016;
- A web based Datix system is being considered for purchase which would enable all Divisions and PET to manage the complaints in real time reducing the length of time a complaint is open;
- A workshop exploring different ways of working has taken place;
- A meeting between the Divisional complaint teams and PET is being planned to explore ways to improve integrated working and the complaints management;
- Monitoring of performance will be via the Complaints Steering Group;
- Training on response writing is being scoped.

Response rate standard not achieved

CQUINs

The 2015/16 CQUINs include national quality improvements for Sepsis, Acute Kidney Injury and dementia. Development of the integrated Heart Failure, COPD, Diabetes and Over 75s pathways continue into 2015/16 as local CQUINs. Implementation of all quality initiatives are underway and all required milestones negotiated for Q1 & Q2 were met although Q3 milestones have identified particular challenges in the Sepsis and Acute Kidney Injury pathways and these were not fully achieved. Work has been ongoing to ensure that improvement is sustained and improved upon for Q4 although it is likely that only partial CQUIN payment may be achieved. The 16/17 CQUINs are currently being discussed and locally will focus on patient flow and end of life care.

Bed Occupancy

Seven day readmissions has improved compared to last month and compared to last year. The 30 day readmission rates have also reduced in February, although they remain consistently higher than the same period last year.

Outliers and Delayed Transfers of Care (DTOCs) are higher than this time last year. Outliers are due to patient flow difficulties and the DTOCs are due to the capacity of external partners in providing care and facilities for patients who are ready for discharge.

Bed occupancy has reduced compared to last month. The number of extra beds open has also decreased compared to last month but remains a risk and issue for the Trust.

<u>Actions in place</u>

- Emergency Pathway Recovery Plan is in place to help with the flow issues;
- Thrice daily bed meetings are in place to manage patient flow and bed capacity throughout the day;
- Clinical Site Operational leads are in post to provide leadership at a senior level around patient flow, quality and safety;
- Further work is in progress to strengthen the site management arrangements;
- The SAFER initiative is being implemented to help facilitate timely discharge and a shorter length of stay;
- The Emergency Care Improvement Programme is in progress with support from NHSI.

Bed occupancy and flow

APPENDIX 2: QUALITY COMMITTEE ANNUAL OBJECTIVES 2015/16

Annual Objective 1: Person-centred care - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
Patients will recommend our service to family and friends: 95% inpatients 98% maternity 90% outpatients 90% day case 85% A&E 75% of patients feel involved and informed 85% of complaints responded to within timeframes set by client				

Annual Objective 1: Safe - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
Achieve a 20% reduction in mortality in sepsis 50% reduction in harm (serious incidents) from inappropriate or poor transfers between sites and hospitals 30% reduction in preventable VTE events 30% reduction in errors for those on anti-coagulation 30% improvement in prevalence of CAUTIs Never Events: - Design and implement fail-safe mechanisms for catastrophic pathways - Develop and deliver programmes on improvement methodologies including human factors Maintain HSMR below 85				

Annual Objective 1: Effective Care - Delivering the improvements identified in the Quality Strategy in relation to patient safety, patient experience and clinical effectiveness

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
Clinical outcomes achieved will be within the top quartile for benchmarked Trusts Service Improvement and Transformation will be an embedded approach to continuous quality Improvement -Improved quality with demonstrable cost reduction -Deliver patient and staff facilities and equipment which meets the needs of a high performing organisation				

Annual Objective 2: Embed the improvements in the High Level Improvement Plan to ensure the Trust provides care to its patients that exceeds the fundamental standards expected.

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
Achieve a high percentage of completed and on track actions from the NHS Choices report.				
Overall rating from CQC visit in July (No longer inadequate)			Not available	Not available
90% of staff have received their annual appraisal, including an interim review at 6 months and 50% of all staff have a well-structured appraisal				