EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS MEETING 24 MAY 2016**
SUBJECT:	**CoG PATIENT AND STAFF EXPERIENCE COMMITTEE**
REPORT FROM:	**EUNICE LYONS-BACKHOUSE, ELECTED PUBLIC GOVERNOR, CHAIR**
PURPOSE:	**INFORMATION**

CONTEXT / REVIEW HISTORY

The Committee has met on two occasions since the last meeting of the Council: 11 January and 9 May 2016.

COUNCIL OF GOVERNOR' ACTION REQUIRED:

To note the report.

SUMMARY OF COMMITTEE ACTIVITY

At the January meeting, the Committee was updated on aspects of cultural change and noted that the Chair of the Strategic Workforce Committee would be ascertaining the extent to which personal objectives relate through all levels of staff objective setting. It was also noted that update information from the Head of Outpatients had provided concise details of the service offered at Buckland and the Royal Victoria Hospitals, alleviating some of the concerns expressed by local residents.

Discussion took place upon progress on the development of a business case for NICU (WHH) and SCBU (QEQM) currently being supported by the Strategic (Workforce) Division; members were encouraged to learn of the progress being made, while taking account of current workforce risks. The Committee also sought current information upon completion of the Kent & Medway Maternity Services Review. The maternity services dashboard, previously discussed at P&SE, had been further developed, incorporating CCG metrics, and it was confirmed that the Trust is taking part in the review of Maternity Services across Kent; outcomes to be discussed with the Trust Board.

The quarterly report on Clinical Quality and Patient Safety was received and discussed. Although there had been a reduction in formal complaints, it was felt that the mechanism for making a formal complaint remains sometimes open to conjecture.

Nursing staff recruitment had improved and the Committee sought an assessment on Trust confidence in its ability to provide high quality placements for students. The Acting Deputy Chief Nurse confirmed confidence in the present package offered by the Trust, albeit whether or not the current increase in student placements will meet the future workforce demand.

Improvements to patient pathways, particularly uncoordinated outpatient appointment

scheduling, causing financial waste, additional pressure upon staff and patient dissatisfaction. Co-ordinated, integrated discharge procedures between hospitals and social services are deemed to be necessary urgent future agenda items.

The Acting Deputy Chief Nurse agreed to enquire regarding changes in steroid injection protocols following outcomes of the Patient Story (presented to Trust Board December 2015).

The P&SE Meeting which took place on the 9th May was primarily devoted to preparation of the CoG Commentary upon the Annual Quality Report 2015/16. A draft text, taking account of commentaries submitted by a number of Governors, was discussed in detail, with beneficial amendments suggested. This revised text would be circulated to all Governors for virtual agreement, as the Quality Report had to be signed off by the Trust before the Council meeting on 24 May. A paper will be brought to the meeting summarising the process.

The Deputy Director of Risk, Governance and Patient Safety attended the meeting and welcomed questions from the Committee. She also explained the decision, and the reason thereof, to proceed with Response Times to Formal Complaints as the Governors' Local Indicator for 2016/17.

The Chief Nurse/Director of Quality presented the Clinical Quality and Safety Report (March 2016). During March one formal complaint was received for every 1681 recorded spells of care, in comparison to one complaint received for every 1204 recorded spells of care in February. Returner complaints remain the same as February i.e.. nine. Compliments received for March show a slight decrease (1.6%). The top 5 themes for written complaints remain: Delays; Problems with Communication,; Problems with Appointments; Problems with Attitude; and Diagnosis.

During March the lowest C.diff. rates were recorded, falls were below the National average, incidence of heel pressure ulcers, vis-a-vis occupied bed days analysis was reduced. Mortality rates remain low. Bed occupancy outliers were high, with medical cases occupying surgical beds.

There has been an improvement in the nursing staff establishment. The Patient Experience Team has recruited additional staff, but continues to have some staff members on long term sickness/bereavement leave.

SUMMARY OF COMMITTEE'S FORWARD PLANS:

At the May meeting members considered the action Points from the previous meeting in January and the outstanding items from P&SE's schedule were reviewed and either identified for appropriate pursuance within the proposed new committee structure or closed. Once the new structure is in place, with subsequent alignment between Board and CoG Committees, these items including integrated discharge-co-ordinated patient care, update upon the colorectal pathway, and provision of lymphodema outpatient clinics, will devolve to the appropriate CoG committee.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS MEETING 24 MAY 2016**
SUBJECT:	**CoG COMMMUNICATIONS AND MEMBERSHIP COMMITTEE**
REPORT FROM:	**PHILIP BULL, ELECTED PUBLIC GOVERNOR, CHAIR Presented on his absence by Sarah Andrews**
PURPOSE:	**INFORMATION**

CONTEXT / REVIEW HISTORY

The Committee has met once the last meeting of the Council on 18 April and this paper summarises the business undertaken.

COUNCIL OF GOVERNOR' ACTION REQUIRED:

To note.

SUMMARY OF COMMITTEE ACTIVITY

The Committee has had one meeting since the last Full Council meeting in January on 18 April with the meeting scheduled for the 10 March cancelled.

There was some discussion at the April meeting about the direction and purpose of this Committee and it was acknowledged that with the sudden death of Brian Glew in November and the pending Council Committee re-structuring there had been a loss of focus. In addition the Trust had recently appointed a new Director of Communications, Natalie Yost, who was not due to commence in post until 31 May. The Committee was, therefore, not in the right position to actively move forward, however there was a useful discussion at the meeting about members' views on the purpose of the Committee which has been minuted for reference and consideration once the meeting structure is agreed.

Members received a brief update on membership numbers and the proposal to hold the Annual Membership Meeting on 5 September. They were also advised of the scoping work undertaken to create a Governors only section of the Website and agreed that this would be a useful additional resource but that it should not replace direct email communication with Governors. There was some discussion about Elected Public Governors having access to the Staff Zone; I note that Natalie Yost has commented that Governors of other trusts are given such access.

The Committee was advised that there had been one contact via the Governors' email address chasing a response to a complaint submitted to the Patient Experience Team. This had been followed up and resolved with the PET Manager. All other contacts had been spam or invitations to conferences.

SUMMARY OF COMMITTEE'S FORWARD PLANS:

The focus for the next meeting of the Committee is on clarifying its role, reviewing the terms of reference and developing a forward plan. Members look forward to the presence at that meeting of the new Director of Communications to provide an insight into the Trust's Communications and Engagement Strategy.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS – 24 MAY 2016**
SUBJECT:	**LEAD GOVERNOR ELECTION PROCESS**
REPORT FROM:	**TRUST SECRETARY**
PURPOSE:	**APPROVAL**

CONTEXT / REVIEW HISTORY

Role of the Lead Governor (based on NHS Improvement guidance):

- The Lead Governor will liaise between NHSI and the CoG where NHSI has concerns about the leadership of the Trust or in circumstances where it would be inappropriate for the Chair to contact NHSI or vice versa
- NHSI does not intend the Lead Governor to "lead" the CoG or assume greater power or responsibility than other Governors
- NHSI's only requirement is that the Lead Governor act as a point of contact between NHSI and the CoG when needed
- The presence of a Lead Governor does not, in itself, prevent any other Governor making contact with NHSI directly if they feel this is necessary.

There have been discussions previously about extending the role of the Lead Governor, this would require Council and Board approval. The Audit and Governance Committee on 16 May 2016 will be discussing this under the matters arising and will make a recommendation to the Council based on their discussion.

The Council of Governors had previously agreed to undertake an annual review of the position of Lead Governor of the Council of Governors.

Sarah Andrews has held this position since November 2015.

The paper outlines the timeline for this year's review.

SUMMARY OF KEY MESSAGES FROM THE REPORT:

Self Nominations to amanda.bedford1@nhs.net no later than 3 June 2016, to include a statement of no more than 500 words as to why you would like to be Lead Governor and what you can bring to the role.

Voting slips will be circulated to Governors on 6 June 2016, with a closing date of Friday 17 June 2016.

A review of responses will be undertaken week beginning 20 June 2016 and the candidate with the majority of votes will be contacted by telephone. In the event of a tie there will be a further vote between the tied candidates.

The result will be formally announced and endorsed at the July 2016 Council of Governors meeting.

COUNCIL OF GOVERNOR' ACTION REQUIRED:
The Council of Governors are asked to APPROVE the timeline and approach, subject to any update from Audit and Governance Committee.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **COUNCIL OF GOVERNORS**

DATE: **24 MAY 2016**

SUBJECT: **STRATEGIC AND ANNUAL OBJECTIVES**

REPORT FROM: **TRUST SECRETARY**

PURPOSE: **DISCUSSION**

EXECUTIVE SUMMARY

The Trust has recently created a new vision and mission and has reviewed our values against these and found they continue to be absolutely relevant.

Our Vision GREAT HEALTHCARE FROM GREAT PEOPLE

Our Mission TOGETHER WE CARE – IMPROVING HEALTH AND LIVES

Our Values WE CARE SO THAT:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference

How did the Board decided and agree on the strategic direction and annual objectives?

- The Trust Board held a development session in January 2016 to produce an outline long term strategic direction for the organisation in support of the vision, mission and values;
- The outputs were discussed at the private session of the Board in February resulting in some additional refinement;
- At the April 2016 public Board meeting the outputs were approved with some minor changes.

How are the annual priorities disseminated to staff?

- Following approval by the Board a number of leadership events were held across each of the main sites where the strategic directions was discussed. These were well attended and were interactive with good discussion / question and answer sessions;
- The May 2016 Team Brief included a slide pack detailing the strategic direction and outlining the annual priorities. The Team brief is available online and managers brief staff face to face;
- The Chief Executive's blog featured each one of the "P's" separately over the course of a few weeks as an additional forum for input and exchange;
- Still to come are "Open Forums" which again gives an excellent way for the strategic priorities to be discussed openly;
- In terms of operationalising the annual priorities these will form the basis of the Chief Executive's annual objectives. The Executive Directors' will also have objectives based on these and the Divisions are already incorporating the priorities into their work plans. The new appraisal paperwork includes the new strategic priorities so that they can be built into all staff objectives.

How are the annual priorities measured and reported?

- Each annual priority has specific metrics and these are agreed by the Board / NED committees;
- Each metric will have a phased trajectory and so that the achievement can be "RAG" rated tolerances are agreed to give either a Red, Amber or Green status;
- Each committee is assigned oversight of one or more of the annual priorities and they report upwards on any concerns;
- The Committees receive a quarterly report on performance against the annual priorities along with the risks to achieving them – this report is provided by the Trust Secretary.

What was the final performance against the 2015/16 annual priorities?

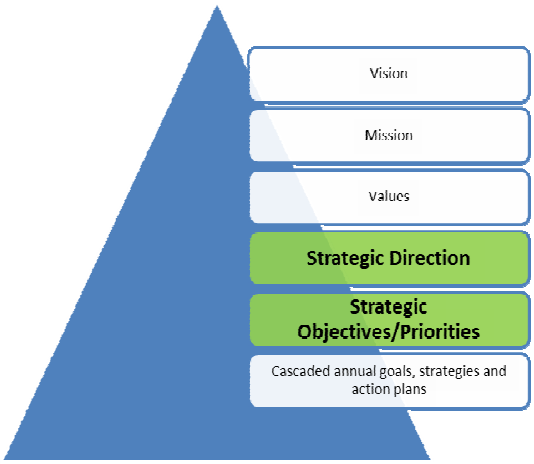
- The Board, following recommendations from the Committees, agreed the final position in relation to each of the annual priorities as follows:
    - Patient Centred Care – Good
    - Safe Care – Partial
    - Effective Care – Good
    - Workplace Culture – Good
    - Improvement Journey – Good
    - Performance and access standards – Partial
    - Financial performance – partial
    - Clinical strategy progress – partial
    - Culture Change - good

BOARD DEVELOPMENT OF STRATEGIC DIRECTION / ANNUAL PRIORITIES:

The long term strategic vision for the Trust is a crucial statement that will set the direction for the organisation over the next 5 to 10 years. Whilst the vision, mission and values that have been set give a clear ultimate position it is similarly important that the specific actions required to deliver this are established. This means identifying our strategic direction and strategic priorities and objectives, which can then be used to determine annual objectives and action plans that can be cascaded through the organisation.

The Board has a number of immediate challenges with the sustainability of clinical services today including clinical, financial and performance risks. The strategic direction sets out the work to create sustainable clinical services that sits between the immediate work and the long term five year plus vision. This work, known as the clinical strategy is crucial as we will not be able to sustain the current services as now until full achievement of the long term vision. It will also form the central part of the Sustainability and Transformation Plan the Trust and our partners need to submit by end June as part of the NHS England and NHS Improvement timetable recently published.

This more immediate work sits within the long term strategic vision and must be consistent with it. To this end this paper sets out the discussions to date which once agreed will set the context for the immediate priorities and clinical strategy work now underway. The diagram below describes this more pictorially.



Strategic Direction

At the board workshop in January 2016 we posed the question - **What do we believe will be the main characteristics of a healthcare provider and specifically EKHUFT in 10-15 years' time?**

From the discussions the main bullet points were as follows:

- Multi-skilled, flexible, values-driven workforce
- More staff 'out in the community'
- Person centred
- Increase in self- monitoring and treatment enabled by new technology e.g. wearable devices
- Increase in day surgery
- Increase in Nano surgery
- Increase in remote surgery/virtual care with core 'acute hospital' for intensive/emergency/HD/ITV
- Patients supported more at home
- People managing individual patient pathways
- Trust consultants/employees are thought leaders in the community
- Integrated single managed healthcare system
- Holistic approach focused on wellbeing
- Integrated health and social care
- 3D printing of body parts
- Chronic disease management changes e.g. genetics
- Purchase and integration of new technology
- Greater focus on prevention
- Perfect information across the whole health system

Underpinning this we expected a rise in dementia, co-morbidities and mental health issues in this timeframe and this would need to be addressed as part of our work.

Our discussions at the board workshop integrated these into a first draft Strategic Direction Statement, with a view to being able to communicate it succinctly to our staff and partners as part of our story. The statement is as follows:

"We will be an organisation that is seen to provide a leadership role in the delivery of a high quality, person centred, healthcare service.

This integrated service will be provided by skilled, motivated, values-driven and

caring staff who enjoy proactively developing and implementing innovative and effective approaches to continuously improve the patient experience.

Strategy for healthcare as a whole will be determined by a team of healthcare organisations who have deep and specialised experience and together are able to devise and deliver an integrated and holistic person-centred approach to prevention and treatment, which leads to greater wellness of the people of East Kent".

Strategic Priorities/Objectives

The main focus of the Board's discussions was around partnering and developing patient pathways, developing a talent pool that can make this happen, using technology to improve productivity and enable patient self-management and self-treatment and focusing on what we are good at and want to be known for.

We consolidated the views and identified four main strategic priorities as follows:

1. **Patients**. Enable all our patients (and clients who are not ill) to take control of all aspects of their healthcare by 2021.
    - enabling self-management and understanding the importance of health status, exercise, dietary advice and well-being. We intend to offer 25% of our population the ability to self-manage their condition by 2019.
    - working with our partners, we will pilot a single healthcare professional in each of each of four geographical localities, to act as information and advice integrators by 2018. These integrators will support and monitor self-management by patients.
    - considering integration with European health systems, to create a wider population base post 2021.

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
    - defining and agreeing with the East Kent Strategy Board specific KPIs for the priority patient pathways, by June 2016.
    - working directly with the Vanguard to increase community capacity in Canterbury, Faversham and Whitstable to enable the transfer of acute activity to a community setting, by July 2017.
    - ensuring the health economy has the right capacity and the required supporting infrastructure to deliver a sustainable model of care in East Kent, by 2021.

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
    - becoming the NHS employer of choice in Kent measured by the staff friends and family test, NHS staff survey and other metrics benchmarked to upper quartile performance against peers, by 2019;
    - agreeing an appropriate measure of staff turnover to reflect positive benefit of improving the talent pool, whilst reducing high levels of staff leaving within first year of employment, by September 2016;
    - improving the quality and quantity of applicants to the top 5 clinical and non-clinical posts, as measured by successful recruitment and delivery of objectives, by 2018; and
    - increasing clinical productivity and reducing clinical variation.

4. **Provision**. Clearly identify 'what business we are in', what we want to be known for, our core services
    - engaging with staff and key external partners to define our core services. This work will be annually refreshed to ensure our service provision remains appropriate;
    - continuing our improvement journey and ensuring the Trust is removed from Special Measures at its next CQC re-inspection in 2016;
    - ensuring all staff groups can articulate and, are positive about, our overall strategic direction, December 2016;
    - maintaining a net positive balance on press coverage as measured by press, Trust data and social media;
    - being recognised as provider of high quality care and as a system leader by NHS, social care and other public sector partners, by March 2018;
    - demonstrating our contribution to sustainability, corporate responsibility and our position as a major local employer and contributor to the local economy; and
    - being identified as a paperless organisation, by 2020.

2016/17 ANNUAL PROIRITIES

The Annual priorities are shown in Appendix 1 which is the presentation sent out to all staff on 12 May 2016. For ease of reference they are replicated below:

Patients

This year, we need to:

- Deliver the CQC and emergency care improvement plans
- Deliver the improvement trajectories for the emergency care, RTT, cancer and diagnostic wait standards, by end of March 2017
- Transform care for people with learning disabilities with local providers
- Deliver the following service quality improvements by March 2017:
    - 20% reduction in harm from poor handover of care/transfer of care
    - 30% reduction in preventable venous thromboembolism events
    - 30% reduction in medication errors
    - 30% reduction in catheter associated urinary tract infection
    - 30% reduction in falls with harm – reducing avoidable hip fractures to below 7, reducing the number of moderate and above harms to below 31 and ensure the falls rate in all our hospitals is below the national average. A 30% increase in completion of Falls Risk Assessments at the WHH.
    - 30% reduction in category 2 pressure ulcers rate compared with last year, no more than 8 category 3 and 4 pressure ulcers. A 30% increase in completed pressure ulcer assessment in the ECC, EDs and CDUs.
    - All patients diagnosed with sepsis get antibiotics within an hour of screening, aiming to reduce mortality by 20% by March 2018.
- Agree new pathways with commissioners for patients 'medically fit' and not requiring an acute bed to reduce delays by 5% by December 2016.

People

This year we need to:

- Reduce the level of staff leaving by 2%, particularly in the first year of employment, by March 2017
- Achieve a staff turnover rate of 10%, by March 2017
- Roll out the Trust wide leadership and management development programme

to another 200 staff, by September 2016
- Continue with the implementation of the cultural change programme, incorporating divisional and corporate led plans into the programme, by June 2016
- Continue to reduce agency and temporary staffing spend to £23m, as agreed with NHS Improvement, by March 2017 (plan to be confirmed)
- Improve staff engagement, as measured by the staff survey, by March 2017.

Provision
This year we need to:
- Agree core services, and a timetable to review and refresh these services, by September 2016
- Be recognised as a provider of high quality care and as a system leader by NHS, social care and other public sector partners, by December 2017, and ensure staff and service achievements are recognised in press coverage
- 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
- Submit a financially sustainable plan for 2016/17 and the following four years that meets agreed control totals, by June 2016
- Make a £20m recurrent saving by March 2017 and hit a year-end deficit plan of £12.5m by March 2017 (plan to be confirmed)
- Continue to progress improvements in 7 day services, focusing on the implementation of priority schemes agreed following further work internally and benchmarked with other similar organisations.

Partnerships
This year we need to:
- Submit an agreed Sustainability and Transformation Plan by 30 June 2016 that defines an agreed financial improvement trajectory for the Trust, a comprehensive clinical productivity improvement programme and a sustainable clinical model for the Trust
- 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
- Working with CCGs, begin commence formal consultation on a sustainable clinical configuration by December 2016
- By working with the Vanguard, increase community provision to transfer the equivalent of 60 acute beds in patient activity, by March 2017
- Deliver an estates strategy that supports the Trust's clinical configurations by March 2017
- Continue to work with Maidstone & Tunbridge Wells NHS Trust on a joint pathology project, delivering a signed commercial agreement with external partners by June 2017.

MEASUREMENT

The 2016/17 priorities / metrics will be phased (where appropriate) so that the first quarter, April to June 2016, can be reported on in late July / early August to the relevant non-executive committee. The Council of Governors will receive the reports on achievement against the annual priorities in the Committee Chair reports.

ACHVIEVEMENT AGAINST THE 2015/16 PRIORITIES

Appendix 2 shows the metrics against which the 2015/16 objectives were measured and the "RAYG" ratings through the quarters. The final quarter is usually reflective on the position recommended and agreed by the Board.

For 2015/16 there were a couple of changes made by the Board:

- AO4: Improve the Trust's financial performance through delivery of the 2015/16 Cost Improvement Programme and effective cost control. On the RAYG rating this should have been reported as "Good" because the Trust had met the financial plan and achieved 95% or more of the CIP target. In recognition of the Trust's poor financial position, the RAYG rating was amended to "Amber" resulting in "partial" achievement (**a move from "Yellow / Good" to "Amber / Partial**);
- AO5: Develop, engage and consult on a clinically and commissioner supported strategy that achieves both clinical and financial stability. The Finance and Performance Committee recommended to the Board that the achievement should be recorded as "Partial" for this objective given the progress made. The new requirement for the Trust to produce a Sustainability and Transformation Plan on a Kent and Medway wide basis has radically changed the metrics for this objective (**a move from "Red / No progress" to "Amber / Partial**); and
- Annual Objective 1: Effective Workplace Culture, the Board reviewed the metrics set for this objective at the beginning of 2015/16 and agreed that as it was process based and not outcome based rating it as "Fully achieved / Green" would not give the right indication of how the culture was being embedded and therefore agreed to change this to "Good" and "Yellow" (**a move from "Green / Full" to "Yellow / Good**).

RECOMMENDATIONS:

- Discuss the contents of the paper.

NEXT STEPS:

- Quarterly reporting to the Non-Executive Director Committees and reporting upwards to Board and Council of Governors in Chair reports.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Not applicable – paper is descriptive on the process and not being brought in relation to updating on a current strategic or annual priority.

LINKS TO BOARD ASSURANCE FRAMEWORK:

Each strategic priority has a number of risks and these are shown in Appendix 3. The discussions at Board Committee level identified a number of additional risks and these are currently being described for inclusion.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

None.

FINANCIAL AND RESOURCE IMPLICATIONS:

The resources to complete this work will be from within existing managerial and clinical leaders from within the organisation.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Nil.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

Nil.

ACTION REQUIRED:

The Council of Governors is asked to

- note the process for agreeing the strategic direction and annual priorities; and
- note how the Council will be updated on the progress against the 2016/17 annual priorities.

CONSEQUENCES OF NOT TAKING ACTION:

None.

Let's talk

East Kent Hospitals University NHS
NHS Foundation Trust

The start of something special

This month we are launching our new Trust vision and mission statements, and our strategic priorities for the year ahead.

Our vision is: *"Great healthcare from great people"*

Our vision is deliberately simple but sums up what we want to achieve for every patient every day.

Our mission is: *"Together we care: improving health and lives"*

Our mission statement explains why we exist – what East Kent Hospitals is here to do.

Our values are:

Our values describe what's important to us and what we want it to feel like to work and be treated here.

We care

Let's talk

East Kent Hospitals University NHS
NHS Foundation Trust

The year ahead: our four strategic priorities

We have four strategic priorities:

- **Patients**
- **People**
- **Provision**
- **Partnerships**

The next slides give you more information about each priority.

Our vision, mission, values and priorities build on the Shared Purpose Framework.

We care

Priority one: patients

East Kent Hospitals University NHS
NHS Foundation Trust

We want to enable all our patients (and clients who are not ill) to take control of all aspects of their healthcare by 2021.

This year, we need to:

- Deliver the CQC and emergency care improvement plans
- Deliver the improvement trajectories for the emergency care, RTT, cancer and diagnostic wait standards, by end of March 2017
- Transform care for people with learning disabilities with local providers
- Deliver the following service quality improvements by March 2017:
  - 20% reduction in harm from poor handover of care/transfer of care
  - 30% reduction in preventable venous thromboembolism events
  - 30% reduction in medication errors
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  - 30% reduction in falls with harm – reducing avoidable hip fractures to below 7, reducing the number of moderate and above harms to below 31 and ensure the falls rate in all our hospitals is below the national average. A 30% increase in completion of Falls Risk Assessments at the WHH.
  - 30% reduction in category 2 pressure ulcers rate compared with last year, no more than 8 category 3 and 4 pressure ulcers. A 30% increase in completed pressure ulcer assessment in the ECC, EDs and CDUs.
  - All patients diagnosed with sepsis get antibiotics within an hour of screening, aiming to reduce mortality by 20% by March 2018.
- Agree new pathways with commissioners for patients 'medically fit' and not requiring an acute bed to reduce delays by 5% by December 2016.

How are you doing?

You can find out how your area is doing against key quality improvements through the ward dashboard.

East Kent Hospitals University NHS
NHS Foundation Trust

Priority two: people

We want to 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.

This year we need to:

- Reduce the level of staff leaving by 2%, particularly in the first year of employment, by March 2017
- Achieve a staff turnover rate of 10%, by March 2017
- Roll out the Trust wide leadership and management development programme to another 200 staff, by September 2016
- Continue with the implementation of the cultural change programme, incorporating divisional and corporate led plans into the programme, by June 2016
- Continue to reduce agency and temporary staffing spend to £23m, as agreed with NHS Improvement, by March 2017 (plan to be confirmed)
- Improve staff engagement, as measured by the staff survey, by March 2017.

We care

East Kent Hospitals University NHS
NHS Foundation Trust

Priority three: provision

We want to clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'. We need to provide the right services and do it well.

This year we need to:

- Agree core services, and a timetable to review and refresh these services, by September 2016
- Be recognised as a provider of high quality care and as a system leader by NHS, social care and other public sector partners, by December 2017, and ensure staff and service achievements are recognised in press coverage
- 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
- Submit a financially sustainable plan for 2016/17 and the following four years that meets agreed control totals, by June 2016
- Make a £20m recurrent saving by March 2017 and hit a year-end deficit plan of £12.5m by March 2017 (plan to be confirmed)
- Continue to progress improvements in 7 day services, focusing on the implementation of priority schemes agreed following further work internally and benchmarked with other similar organisations.

East Kent Hospitals University NHS
NHS Foundation Trust

Priority four: partnerships

We want to define and deliver sustainable services and patient pathways together with our health and social care partners, by 2021.

This year we need to:

- Submit an agreed Sustainability and Transformation Plan by 30 June 2016 that defines an agreed financial improvement trajectory for the Trust, a comprehensive clinical productivity improvement programme and a sustainable clinical model for the Trust
- 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
- Working with CCGs, begin commence formal consultation on a sustainable clinical configuration by December 2016
- By working with the Vanguard, increase community provision to transfer the equivalent of 60 acute beds in patient activity, by March 2017
- Deliver an estates strategy that supports the Trust's clinical configurations by March 2017
- Continue to work with Maidstone & Tunbridge Wells NHS Trust on a joint pathology project, delivering a signed commercial agreement with external partners by June 2017.

East Kent Hospitals University NHS
NHS Foundation Trust

Let's talk

What are we asking you?

- What do the four priorities and the year's objectives mean for your team?

Any questions?

If you have any questions about our vision and priorities, please tell us through the online survey at https://www.surveymonkey.co.uk/r/EKHUFTMay

We care

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST: ANNUAL OBJECTIVES 2015/16

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				

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST: ANNUAL OBJECTIVES 2015/16

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				
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 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				

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST: ANNUAL OBJECTIVES 2015/16

FINANCE AND PERFORMANCE COMMITTEE 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: ANNUAL OBJECTIVES 2015/16

STRATEGIC WORKFORCE COMMITTEE ANNUAL OBJECTIVES 2015/16

Annual Objective 1: Effective Workplace Culture - 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				
25% of clinical leaders have undertaken leadership development				
System and process revalidation of registered nurses and midwives in place by Q4				
100% of doctors revalidated successfully (due for 15/16)				
Implement leadership development programme				
Implement behavioural framework, Staff are enabled to share examples of quality improvement				

Annual Objective 6: - Delivering the cultural change programme to increase staff engagement and satisfaction

	Quarter 4	Quarter 3	Quarter 2	Quarter 1
Measure				
Peer review process of clinical areas embedded and the ward accreditation and roll out programme in place				
90% of staff have had an appraisal and personal development plan				
Culture Change Programme - the 1st year milestones are achieved				
55% Staff would recommend the Trust as a great place to work				

BAF (Incorporating Corporate Risk Register)

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	13 May 2016
Risk Status	Open
Risk Area	1. Strategic Risk Register, 2. Corporate Risk Register

AO1: Patients. Help patients take control of their own health

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
CRR 1	K&CH Ward or ECC patients may suffer adverse harm **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 10 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** - Lack of separate medical rota to cover ECC - No formal consultant rota to support trainees over a 24 hr period - Reliant for several years on a medical rota covered only by trainees **Effect** - Poor training experience for our trainees - Possibility of losing trainees at K&CH - Dilute consultant cover from wards to cover ECC rota - Patient experience / harm - Media interests	I = 3 L = 5 Extreme (15)	Monitoring of harm through incidents and complaints and reported claims arising from ECC **Control Owner:** Helen Goodwin	Quarterly integrated report produced by Deputy Director Risk, Governance and Patient Safety	Report goes to Quality Committee quarterly and escalated to Board as appropriate	Quality Committee for the 4 CCG's receive s report every 6 months	Substantial		I = 3 L = 4 High (12)	Consult on Clinical Strategy around emergency care provision **Person Responsible:** Liz Shutler **To be implemented by:** 30 Sep 2016		I = 1 L = 1 Low (1)	Quality Committee
				New and separate physician rota to provide 12 hrs a day where they are rota'd only in EEC **Control Owner:** Paul Stevens	Rota provision overseen by Divisional Director of UC and LTC in conjunction with Divisional Senior Leadership Team	- UC Board (weekly) and Executive Performance reviews (monthly) - Executive Medical Director meets with ALL trainees monthly for feedback on their training experience and patient issues	External review by HEKSS	Substantial	Current controls only provide 12hr cover and not 24hr cover and HEKSS may not see this as acceptable					
				There is an Emergency Care Improvement Programme (ECIP) in place that reviews all actions identified by external review (Oct 15) **Control Owner:** Jane Ely	Divisional Leadership Team oversee the ECIP and progress against actions identified	Urgent Care Programme Board including Monitor's improvement Director scrutinise reports and identify further actions	Progress review meeting with Monitor monthly and ECIP	Adequate						
CRR 4	Patients with sepsis are not recognised or treated in a timely way which may affect their outcome **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The opportunities and systems in place to recognise and manage patients presenting with or developing sepsis are not taken and/or the deteriorating patient is not recognised. Patients with cancer undergoing chemotherapy are susceptible to neutropenic sepsis. Previously fit and healthy adults may compensate clinically until they are critically ill. **Effect** Treatment is not administered in a timely way due to delayed recognition and and patients may suffer adverse outcomes.	I = 5 L = 3 Extreme (15)	Clinical staff issued with aide-memoire on sepsis managment and compliance tested using CEM audit and local audit **Control Owner:** Paul Stevens	Sepsis champions from all specialties at the monthly Sepsis meeting, including ED, Paediatrics, surgery and medicine. Programme led by Associate Medical Director of Patient Safety.	Sepsis Committee reporting to PSB in line with workplan	Leading and participating in the Sepsis Collaborative across Kent, Surrey and Sussex coordinated by the AHSN. Review of mortality associated with patients with LD and patient under 59 years presented to commissioners and to Collaborative	Substantial	Nationally coding of sepsis is inconsistent making outcome comparisons difficult	I = 5 L = 2 Extreme (10)	Trust requires a solution to electronic recording of vital signs across the whole Trust to ensure the deteriorating patient can be readily identified from the point of access. **Person Responsible:** Paul Stevens **To be implemented by:** 03 Apr 2017		I = 4 L = 2 High (8)	Board of Directors
				All Point of Care testing equipment for blood gas analysis updated to include lactate measurements in EDs. **Control Owner:** Paul Stevens	POCT coordinator in post	Divisional Governance meetings held monthly in CSSD and reports submitted in line with workplan.	All equipment subject to PPM and audit of accuracy	Substantial	PPM scheduling					
				Documentation in all EDs revised to record consistently patients vital signs and blood test results **Control Owner:** Paul Stevens	Responsible lead identified in each ED.	Compliance reported to ED governance meetings in line with workplan	Deep dives undertaken by commissioners for each ED and reports submitted.	Substantial	Not currently possible to use VitalPAC in the EDs to capture this information making collation of data more challenging.					
				Staff training in place on the recognition of patients with sepsis in line with national best practice, including primary care and Ambulance service **Control Owner:** Paul Stevens	Sepsis lead and sepsis coordinator undertaking training to key clinical groups	Reports to PSB in line with workplan	Audit of compliance with CEM sepsis audit run over time in order to demonstrate and sustain changes to practice. Use of Yellow Alert in use by SECAmb and use audited.	Adequate	Results of audit showing improvement but not consistent across sites					

AO1: Patients. Help patients take control of their own health

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
CRR 5	Blood and blood product transfusion errors **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** A patient, or patients, may receive incompatible blood or blood products in error **Effect** The patient may suffer a blood transfusion reaction resulting in harm or death	I = 5 L = 3 Extreme (15)	Specific training and competency assessment for clinical and non-clinical staff on PPID, blood group compatibility and fating in line with NPSA SPN 14 **Control Owner:** Sally Smith	Blood transfusion practitioners in post on each main Trust site with Senior practitioner in post. Existing TNA in place for role-specific training	Regular reporting to PSB and Quality committee in line with workplan on monitoring the current Blood Transfusion Policy. NICE guidance (NG 24) on blood transfusion reported and monitored through NICE committee. BAT completed and reported in Feb-16	Inspection programme by MHRA in place with no significant findings or actions to be taken.	Adequate	Basic induction for clinical staff no longer includes blood transfusion	I = 5 L = 1 High (5)	Ensure A+ patient trigger alert is activated for O+ plasm on APEX system **Person Responsible:** Sally Smith **To be implemented by:** 03 Feb 2016		I = 5 L = 1 High (5)	Board of Directors
				Alert triggers in place for ABO and rhesus incompatibility **Control Owner:** Sally Smith	Current laboratory systems have in-built incompatibilities incorporated	Compliance monitored via divisional CSSD and PSB meetings in line with workplan.	Blood transfusion part of the national clinical audit programme; the scope of the mandated audits are changed annually. MHRA inspection on a rolling programme.	Substantial	Plasma trigger for A+ patients not functioning for the administration of O+ plasma					
CRR 6	Trust-wide clinical audit programme is incomplete in scope and does not prioritise the national programme **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** Lack of consistent participation in all areas of the national clinical audit programme and an existing local clinical audit programme that is incomplete **Effect** The Trust is unclear of the areas where improvements are required and the BoD is not assured that clinical priorities for audit are being led effectively by the designated audit leads.	I = 3 L = 4 High (12)	There is an annual clinical audit programme aligned to the national clinical audit programme agreed with each division **Control Owner:** Paul Stevens	Nominated clinical leads for each division and specialty in place with dedicated support from the audit team.	Local audit teams meet to progress audits and there is a CAEC that meets every 2 months. There is a report to the Quality and the Integrated Audit and Governance Committees in line with the workplan.	The CQC inspect clinical audit activity at each inspection. The Internal Audit programme for 2015/16 includes a review of clinical audit processes. External auditors provide an opinion on the Quality Account annually and this includes clinical audit. Internal audit to commence view of divisional arrangements on 29/02/2016	Adequate	Programme of audit fails to meet the national and "must do" areas and the programme is not always completed. The actions and learning from audits are not consistently actioned,	I = 3 L = 2 Moderate (6)	Commission a further internal audit on the effectiveness of clinical audit in the Trust and respond to the findings. The audit should not focus on systems and process but on the clinical responsibility for participating in clinical audit across the country. **Person Responsible:** Paul Stevens **To be implemented by:** 29 Apr 2016		I = 2 L = 2 Low (4)	Board of Directors
				There are other quality improvement programmes in place that are nationally, regionally and locally driven that support the Trust clinical audit activity. **Control Owner:** Paul Stevens	There is a dedicated lead for oversight and validation of CQUINS, the Enhanced Recovery Programme (ERP), the Enhancing Quality (EQ) programme and the Safety Thermometer.	Data validation and verification processes exist as part of the IAB and the Internal Patient Safety meeting	There is external regional benchmarking of the EQ and ER programmes and national performance is monitored as part of the Safety Thermometer data	Adequate						

AO1: Patients. Help patients take control of their own health

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
CRR 7	Potential delayed treatment of patients requiring emergency acute general surgery intervention at the Kent and Canterbury Hospital site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There is provision for specialist vascular and urology surgery on the Kent and Canterbury site only and the provision for the emergency pathway is restricted to an ECC model and not a full ED. This situation was widely shared with GP and SECAmb partners over 10 years ago. In the past general surgical intervention, when needed, was covered by vascular surgeons. With the introduction of Specialist Medical Training (Calman Report) the ability of surgeons to be deemed competent to perform procedures outside their registered speciality has decreased. **Effect** Patients requiring general surgical intervention are occasionally transferred to the K&CH site and require subsequent transfer to either the WHH or QEQMH after stabilisation. Some vascular surgeons do maintain core clinical competencies for general surgery but there is not a formal rota at the K&CH site and this can result in delays to treatment. Where the patient is considered	I = 5 L = 3 Extreme (15)	Clarity of the function of the K&CH site as not having the capability to manage general surgical emergencies communicated to external partners including SECAmb and GPs. Rapid assessment of patients and transfer out to the WHH and QEQMH or competent vascular surgical intervention at the K&CH, Fundamentally, the clinical strategy will mitigate the risk. **Control Owner:** Paul Stevens	Senior vascular input into either patient stabilisation before transfer, or use surgical input on site.	Incidents involving general surgical patient intervention reported onto Datix and reviewed as part of the quarterly report and to PSB.		Adequate	Full rota cannot be covered using an ad hoc mechanism and the skills required my not be fully up to date as the number of patients affected is small. There may be inpatients who develop a general surgical emergency after admission for a different reason.	I = 5 L = 3 Extreme (15)	Implementation of clinical strategy with a stable rota of general surgical cover across the Trust. **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2017		I = 5 L = 1 High (5)	Quality Committee

AO1: Patients. Help patients take control of their own health

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
CRR 8	Patients with mental health problems may be harmed because they do not receive timely mental health interventions **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** KMPT have reduced the llaison Psychiatry cover to the Trust to 08.00 to 16.00 hours as they are not able to recruit into their current vacancies and they have relied on agency cover to maintain their rotas. There is a national shortage of in-patient mental health beds. **Effect** Patients with recognised mental health disorders may not be treated in a timely way. There are an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. Other patients and staff are put at risk of harm from violent episodes. Patients who require in-patient mental health care are managed in acute facilities which are not fit for this purpose.	I = 4 L = 4 Extreme (16)	Planned increase in cover arrangements for a 12 hour period across all 3 sites planned from May 2016. **Control Owner:** Jane Ely		Multi-agency Surge Resilience Group meeting monthly		Limited	Actual times of cover yet to be agreed and there will be a lead time of 6 weeks while rotas are agreed with clinical staff	I = 4 L = 3 Extreme (12)	On-going work with local Commissioners and the mental Health Trust is underway, following a wider health economy improvement plan away day in December. A cogent and coherent action plan is required to ensure cover is provided in line with national timescale. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2017		I = 4 L = 2 High (8)	Patient Safety Board
				Single point of access for referrals for emergency and urgent patients from 01 April 2016 with a separate crisis team covering this area. Arrangements for other patients, including self-referrals and existing patients set up through GPs and NHS111. **Control Owner:** Jane Ely		Surge Resilience meeting monthly and Liaison Psychiatry meetings quarterly	CQC will review arrangements at the next inspection in 2016.	Limited	Capacity may be an issue					
				Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commissioning intentions up to this date. **Control Owner:** Jane Ely	The UCLTC Divisional Detailed Action Plan containing specific actions to assist with this action completed with executive sign off 15th January 2016	Regular reporting of staffing issues to shared CCG Quality and Performance Committees		Limited	May not be possible to recruit dual qualified personnel. The funding for mental health commissioning of additional staff may not be realised across the locality.					
				Employment of dual qualified RN and RMNs in Emergency Departments. **Control Owner:** Jane Ely	Advertising and re-structuring of EDs in order to provide flexibility	Workforce committee in place. Six-monthly reviews of nurse staffing to the BoD using recognised activity and workforce tools.	CQC inspections	Limited	May not be possible to recruit dual qualified personnel					
				Nominated consultant psychiatric cover for each site with Band 7 RMN and 5xBand 6 support to cover 08.00 to 16.00 hours. **Control Owner:** Jane Ely	Clinical lead for transformation in post. Crisis team in place out of these hours but this covers mental health services across Kent and Medway for all community and in-patient services.	Local meetings with KMPT and COO in place. Liaison Psychiatry meetings re-established from Feb-16. High level CQC plan identifies actions and monitoring required in collaboration with mental health providers and commissioners.	CQC inspection programme	Limited	Existing cover, despite increased funding in 2015/16, only provides 08.00 to 16.00 hours. No additional local funding identified for 2016/17 within current commissioning intentions.					

AO1: Patients. Help patients take control of their own health

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
CRR 9	Backlog of Planned Preventative Maintenance of clinical equipment **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** A new inventory system for all Trust equipment was introduced in 2013. This identified more equipment for PPM than initially assessed. The number of staff in EME was not able to service the equipment on a rolling basis and there were complex items of equipment where existing external servicing arrangements were not in place. Internal staff were not trained to complete the PPM on these high risk items. **Effect** There were a number of items of clinical equipment that were in direct patient use where the scheduled date for PPM had passed. Assurance that the items were safe to use on patients could not be given.	I = 2 L = 4 Moderate (8)	The Trust purchased a new database to identify, control and manage all equipment used in the care and management of patients **Control Owner:** Paul Stevens	EME department with engineers trained to maintain clinical equipment.	Improvement Plan Delivery Board meeting monthly	NHS Choices action plan completed monthly and shared with Improvement Director	Adequate	There remains a backlog of maintenance for medium, and low risk items.	I = 2 L = 3 Moderate (6)	**Person Responsible:** **To be implemented by:**			Divisional Governance Boards
				The medical device co-ordinators have attended all clinical areas to raise awareness of this issue, and encourage ward / clinical staff to report overdue equipment to EME. **Control Owner:** Paul Stevens	Regular ward attendence by EME staff	Compliance reported to Improvement Plan Delivery Board		Adequate						
				Each major site has access to an equipment library where items are cleaned and checked before re-use **Control Owner:** Paul Stevens	Equipment library with a formal operational plan in place. Equipment maintained by EME	Medical Devices Group reporting monthly and Improvement Plan Delivery Board reveiwing progress against HLIP.		Adequate	Current activity and workforce are unable to complete the outstanding PPM within the target timeframe.					
				High risk clinical equipment is purchased with servicing and support arrangements as part of the contractual terms and maintained throughout the asset life of the equipment. **Control Owner:** Paul Stevens	EME service to manage the day to day PPM	Procurement Committee and Medical Devices Committee overseeing capital and revenue implications of purchasing new equipment with PPM included.	CQC inspection	Adequate						

AO1: Patients. Help patients take control of their own health

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
CRR 10	New European Data Protection Rules **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** European Privacy Law will become part of UK statute in 2018 placing specific responsibilities on all organisations for the use of personal data; this will affect patients in the main, but staff records will be included within the regulations. **Effect** The Trust may not have the necessary infrastructure in place to deliver against the following key areas: 1. Obtaining individual consent for disclosure 2. Privacy Impact Assessments to enable the organisation to understand the risks to personal data and privacy. 3. The Trust will need to establish systems to ensure that protections of personal data are included in all areas of business. 4. The Trust will need to be transparent in reporting externally all breaches of security and confidentiality to regulators and the persons affected. 5. A process is required to give individuals the right to be forgotten. 6. There is a financial penalties, up to 4% of turnover is possible, equivalent to £20million,	I = 5 L = 3 Extreme (15)	The Trust is registered with the Office of the Information Commissioner and reports IG breaches locally and nationally **Control Owner:** Paul Stevens	Monitoring and investigating breaches and responding to individual concerns raised by patients and service users.	Information Governance Steering Group meeting monthly and participation in regional committees. Regular learning published in RiskWise	External audit of the Annual Governance Statement published in the Annual Report and Accounts. Internal audit of IG toolkit compliance as part of the internal audit function.	Substantial		I = 5 L = 2 Extreme (10)	Comprehensive review of the IG function and succession planning arrangements to identify core gaps internally. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017		I = 4 L = 2 High (8)	Board of Directors
				The IG Manager is actively engaging nationally with peer and national leaders in order to assess accurately the impact of the proposed changes to legislation within the Trust. **Control Owner:** Paul Stevens	Training booked for IG Manager on cyber security and data protection changes.	Regular feedback to Information Governance Steering Group	Internal audit reviews	Adequate						
				The Trust has an Information Governance function within the corporate team to support the changes required **Control Owner:** Paul Stevens	IG Manager and administrative support in place	Information Governance Steering Group meeting monthly with reports to IAGC.	Active participation in regional and national fora. Internal audit of IG Toolkit	Adequate	The scope of the new legislation is likely to exceed current internal capacity.					

AO1: Patients. Help patients take control of their own health

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
CRR 11	Errors in the latest version of the British National Formulary (BNF) may result in patient harm **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 10 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The BNF 70 hard copy publication was issued with a numbers of errors. **Effect** Prescribers using the hard copy version of BNF 70 may make errors in the dosage and frequency of administration of some drugs affected.	I = 3 L = 2 Moderate (6)	Each paper copy issued has a note to double-check dose and frequency against the Trust's e-formulary **Control Owner:** Paul Stevens				Substantial		I = 2 L = 2 Low (4)	**Person Responsible:** **To be implemented by:**			Patient Safety Board
				Electronic versions of the affected BNF 70 are unaffected and prescribers have been sign-posted to the BNF App and the electronic versions **Control Owner:** Paul Stevens	Controlled access by Pharmacy	Monitoring by the Drugs and Therapeutics Committee	BMJ Press and Pharmaceutical Society overseeing distribution	Substantial						
				The Pharmacy department has restricted access to hard copy versions of BNF 70 and these have not been issued in bulk to prescribers. **Control Owner:** Paul Stevens	Controlled access by Pharmacy	Monitoring by the Drugs and Therapeutics Committee	BMJ Press and Pharmaceutical Society overseeing distribution	Substantial						
				The next hard copy version of the BNF will be issued in March 2016 and this will be monitored for accuracy **Control Owner:** Paul Stevens				Adequate						

AO1: Patients. Help patients take control of their own health

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
CRR 12	Patient's eyesight may be adversely affected by inadequate follow up arrangements **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** Due to historic PAS systems, the true patient follow up capacity gap has never been visible. Partial booking has given transparency to the issues facing patients requiring regular follow up. Ophthalmology specialties provide services in predicted high growth areas and these are expected to further increase with an aging demographic. **Effect** There are approximately 7,000 patients waiting for a follow up appointment outside of their required timeframe to be seen. Nearly 1,500 patients are being validated as they are not indicated at speciality level. Therefore nearly 5,500 patients have been escalated as requiring an appointment that is overdue and require urgent follow-up within the specialty. There is a lack of out-patient capacity to manage the backlog and maintain the current patient cohort.	I = 4 L = 5 Extreme (20)	Proposals for Virtual clinics have been described in the business case for follow up diabetic medical retina patients, with a conservative estimate of 3,000 patients who would benefit from this approach. **Control Owner:** Paul Stevens				Limited		I = 4 L = 3 Extreme (12)	Implement the ophthalmology transformation strategy, which involves an increase in staff numbers and new equipment to support these staff. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017		I = 4 L = 2 High (8)	Divisional Governance Boards
				A pathway has been developed for the commissioners to enable the safe transfer of stable follow up glaucoma patients into the community **Control Owner:** Paul Stevens				Limited			Introduce an electronic patient record system in the form of Openeyes software, which will drive both efficiency increases and cost savings. The system can also be rolled out to, and integrated with, community services to support the flow of patients in and out of acute services. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2016			
				The service has been successful in bidding for government monies for an electronic patient record which can be shared from acute to community. This will facilitate patient flow with speed and reduce clinical risk. **Control Owner:** Paul Stevens	Dedicated ophthalmology manager. Service meetings to review backlog position	Divisional Governance Committee (Surgery) reviewing position. Position updated with Commissioners at Quality Committee		Limited	Ophthalmology is only able to implement limited solutions to address the capacity associated with the follow up waiting list and the rise in new referrals. Without a phased investment the status quo will remain and the risk to permanent sight impairment is high.					
CRR 13	High cost and high risk items of medical equipment is coming to the end of its asset life **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There has been a reduction in the capital allocation for replacement and updating of high cost essential clinical equipment over several years; this includes the diagnostic services, Pathology and Radiology, as well as equipment in critical care areas, operating theatres and renal. The overall financial position of the Trust means there is insufficient funding for a replacement programme to cover all equipment at the end of its asset life. **Effect** Items of clinical equipment has reached the end of its asset life and requires increased maintenance and support in order to ensure that safety is maintained. The limited resource must be prioritised and the equipment replacement backlog is likely to deteriorate further.	I = 3 L = 4 High (12)	The Planned Preventive Maintenance Programme identifies and manages equipment used in the care of patients **Control Owner:** Nick Gerrard	F2 database contains items of clinical equipment and the asset age	Medical Devices Group monitoring equipment replacement programme	There is a named Medical Devices Patient Safety Officer for the Trust held externally by the CAS.	Limited	Not all equipment may be on the F2 database	I = 3 L = 3 High (9)	**Person Responsible:** **To be implemented by:**			Risk Group
				The Medical Devices Group prioritises the replacement programme using a risk-based model outlined in the Medical Devices Policy. **Control Owner:** Nick Gerrard	There is a clinical lead, supported by the Trust Medical Device Safety Officer, with the responsibility for the replacement programme	Medical Devices Group monitoring equipment replacement programme	Medical Devices Safety Officer named and listed with CAS.	Adequate						
				There is an annual capital allocation, under the auspices of the Medical Devices Group that make decisions on the priorities for purchase and replacement. **Control Owner:** Nick Gerrard		FIC monitoring the financial position		Adequate	There is an gap in the funding allocation and the amount of equipment that requires replacement.					

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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
CRR 16	Delays in first response times and the quality of the Trust replies to written complaints is resulting in an increased number of returners and dissatisfaction **Risk Owner:** Sally Smith **Delegated Risk Owner:** Sally Smith **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The Trust has seen an increase in the number of written complaints following the first CQC inspection. There is an increasing complexity in the scope and nature of concerns raised. The processes in divisions and within the Patient Experience Team have resulted in delays across the whole pathway. There is a gap in communication between the PET and the divisional governance teams. **Effect** The ability of the Trust to respond to the agreed first response time frame and within the 30 days of receipt is not being met consistently. The time-frame agreed with the complainant is often being met but the quality of the Trust's response is failing to meet expectation. The divisional teams do not receive timely notification of written complaints.	I = 3 L = 4 High (12)	The Trust responds to its legal and professional duty of candour **Control Owner:** Paul Stevens	Duty of candour compliance monitored using the incident management system.	DoC compliance reported quarterly in the integrated complaints, claims and incident reports to the Quality Committee.		Adequate	The completion of Duty of Candour requirements on Datix is not undertaken consistently; there is a delay in updating the duty requirements, which may have been fulfilled but the evidence of completion is not consistently visible.	I = 3 L = 3 High (9)	Implement a web-based complaints management system to interface with the existing web-based incident system. **Person Responsible:** Helen Goodwin **To be implemented by:** 01 Oct 2016		I = 3 L = 2 Moderate (6)	Patient Experience Group
				The Datix system is used to record complaints and Trust responses. This system can monitor agreed time scales and record satisfaction with the responses. **Control Owner:** Helen Goodwin	Corporate complaints team in place with staff on each of the three Trust's main sites. The divisional governance teams coordinate the responses to written complaints.	Patient Experience Group (PEG) in place reporting to the Quality Committee. Monthly reporting to the BoD in the Clinical Quality and Patient Safety Report.	Previous external audits of the response process as part of the Quality Account Audit and separately commissioned audits.	Substantial	Lack of visibility of the Datix main application at divisional level. This results in the divisions not being alerted in a timely way of complaints relevant to them.		Explore the costs of adopting a web-based complaints system across the Trust in order to increase visibility across the divisions. **Person Responsible:** Helen Goodwin **To be implemented by:** 01 Jun 2016	**24 Apr 2016** **Helen Goodwin** Datix contacted and initial quotation received. For a decision at PEG in May 2016.		
				The PET provide support and specific training in the management of complaints to staff in all clinical and non-clinical divisions. **Control Owner:** Sally Smith	Established programme in place	Training compliance reported to PET and records of training is linked into ESR by the Human Resources systems team		Limited	The ability of the PET to provide timely training is affected by the time spent on complaint responses. There is a delay in getting accurate and up to date training information.					
CRR 17	Relevant cancer treatment is not forming part of the main, current healthcare records for cancer patients and elective and emergency admissions outside the cancer pathway may not have relevant information included as part of their assessment **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Liz Mount **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The oncology service is managed outside the Trust by a neighbouring acute Trust, which segments and manages all oncology and radiotherapy records separately. **Effect** Oncology/radiotherapy records are currently stored and managed outside the main patient healthcare record. This does not follow recognised best practice regarding a single unified health record for each patient in order to ensure clarity and transparency of management decision-making across differing specialties. The requirement for a single healthcare record is enshrined in NHS practice within the document Records Management: NHS Code of Practice 2006	I = 3 L = 4 High (12)	Full review of HCR storage in progress **Control Owner:** Liz Mount				Limited		I = 3 L = 3 High (9)	Trust to review current contractual arrangements with MTW regarding legacy hard copy records and electronically held information relevant to patient care **Person Responsible:** Liz Mount **To be implemented by:** 01 Sep 2016		I = 3 L = 2 Moderate (6)	Quality Committee
				The main Trust records contain a summary of treatment in the form of letters by the patient's oncologist to the lead clinician and the GP **Control Owner:** Jane Ely				Adequate			CEOs from both Trusts to meet to discuss and explore the risks associated with the current process **Person Responsible:** Matthew Kershaw **To be implemented by:** 01 Sep 2016			
				Access to information contained in the separate HCR available on site at K&CH **Control Owner:** Jane Ely				Limited						

AO1: Patients. Help patients take control of their own health

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
CRR 18	There is not sufficient capacity for clinicians to undertake a retrospective case note reviews on every patient who dies in the Trust in line with the recommendations of the Mazar's report **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathon Hawkins **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** Following the Mazar's Report into deaths at Southern Health NHS Foundation Trust published in December 2015, NHS England introduced the concept of a retrospective case note review on all patient deaths, expected or not, for all trusts in England. This process was due to commence on 01 April 2016. The national pro forma was due to be shared by 31 January 2016; however this has still not been consulted upon or disseminated. **Effect** The Trust has over 2,500 deaths annually, the majority are within the UC&LTC division. The time required for clinicians to undertake these reports and the Admin and Clerical resource is significant and it may not be possible, without a complete review of the morality and morbidity function and financial investment, to act on all the recommendations made in the report.	I = 3 L = 5 Extreme (15)	Clinician oversight, using data from HSCIC, of all coded mortality alerting as outliers. Programme of retrospective case note review in place at divisional and corporate levels. **Control Owner:** Paul Stevens	M&M meetings in place	Patient Safety Information Group meeting monthly with clinical, coding and information representation. PSB receiving quarterly mortality reports		Limited	Inconsistencies in format and minuting these meetings and in formalising the lessons learned. Inconsistent representation from all professional groups	I = 3 L = 4 High (12)	Design pro forma for reporting all mortality in the absence of any national tool **Person Responsible:** Helen Goodwin **To be implemented by:** 04 Jul 2016		I = 3 L = 3 High (9)	Quality Committee
				Established programme of Mortality and Morbidity meetings across all specialties **Control Owner:** Paul Stevens				Limited						
				Review of M&M meetings and a template designed for presentations and for learning **Control Owner:** Helen Goodwin	Structure of M&M meetings in place	Divisional and specialist governance meetings. Oversight by PSB		Limited						
CRR 19	Harm may be caused to patients from delays in the cancer pathway of over 100 days **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul Stevens **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** A letter was issued by NHS England, Monitor and the TDA in October 2015. This outlined a process for all trusts for any patient waiting for more than 104 days on any cancer pathway. The commissioners sought assurance at the February 2016 Performance meeting that the Trust had a process in place to assess each patient and evaluate the potential harm caused by the delay, to undertake a full RCA for each patient and report externally onto StEIS where harm was serious. **Effect** Each lead consultant has been asked to assess every patient waiting for more than 100 days and to assess specific pathway delays that may have caused harm to patients. There is variation in the responses from individual consultants and the role of the lead consultant for each cancer pathway requires clarification.	I = 3 L = 3 High (9)	Tracking system in place with an updated position disseminated weekly. **Control Owner:** Jane Ely	Cancer compliance manager in post	Oversight by Patient Safety Board and specific issues at the Cancer Board		Adequate		I = 3 L = 3 High (9)	**Person Responsible:** **To be implemented by:**			Quality Committee
				Process outlined for clinicians to complete initial screening of pathway delays **Control Owner:** Jane Ely	Cancer compliance manager reviewing all pathways and disseminating to lead clinicians	Cancer Board and quarterly reporting to PSB	Quarterly reporting to commissioner-led Quality Committee	Limited						
				Use of Datix incident reporting for all delayed cancer patients to improve visibility of patient affected. **Control Owner:** Helen Goodwin				Adequate						

AO1: Patients. Help patients take control of their own health

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
CRR 21	Patient safety may be affected by the industrial action taken by junior doctors **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jane Ely **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The BMA and the Secretary of State for Health have failed to negotiate successfully changes to a junior doctors contract over the past four years. A series of strike action has been planned and actioned over the past 6 months. The forthcoming strike action is set to affect all services, including the emergency pathway for the first time. **Effect** Elective surgery has been cancelled resulting in 18 week performance being affected. Out-patient clinics for new and follow-up patients have also been cancelled; this too have resulted in more patients waiting for treatment. Withdrawal of junior doctor cover for emergencies affects the ability of the trust to provide safe services for the EDs and maternity services.	I = 3 L = 5 Extreme (15)	Robust emergency planning in place led by the COO and medical director. Divisional emergency plans in place monitored within each specialty. **Control Owner:** Jane Ely	Utilisation of Trust's consultant body and SAS doctors not involved in the industrial action	EPRs		Adequate	Emergency activity not controlled	I = 3 L = 4 High (12)	**Person Responsible:** **To be implemented by:**			Strategic Workforce Committee
				Cancellation of all non-urgent trust activities and use of all qualified staff to assist in clinical care **Control Owner:** Jane Ely				Adequate						

AO1: Patients. Help patients take control of their own health

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 2	Adverse effects on Local services: Organisational Shape and Form **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** 25 Feb 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Controls and assurances updates with documentation	**Cause** Failure to action and deliver our regulatory requirements that may result in being taken over by another organisation **Effect** - Loss of autonomy; - Impact on staff morale; - Reputational problems; - Decline in pace and development of service.	I = 4 L = 4 Extreme (16)	Financial Recovery Plan - Monitor Undertaking (12/16) **Control Owner:** Nick Gerrard	Director of Finance and Chief Executive review of document prior to submission.	Plan circulated to Finance and Investment Committee members and thereafter all BoD members for input (12/16)		Adequate	Monitor feedback expected	I = 4 L = 3 Extreme (12)	Internal Audit to undertake a review of the CQC Improvement Plan **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2017	**21 Apr 2016** **Sally Smith** This action will be scoped in the 16/17 financial year. Dates are yet to be agreed. **25 Feb 2016** **Alison Fox** Intelligencesuggests that the CQC revist will not take place until May / June 2016. Work on implementing the plan continues. The Hubs / staff have been involved in mock inspections (to be BAU).	I = 4 L = 2 High (8)	Quality Committee
				Emergency Department Recovery Plan (agreed with partners and submitted to Monitor) 12/2015 **Control Owner:** Jane Ely	ED Plan updated by Urgent Care and Long Term Conditions	- report to Executive Team on a weekly basis for information - UCLTC update on actions at Executive Performance Reviews - discussions at both Quality and Finance Committee in relation to impacts on safety, quality and finance - monthly BoD report showing progress against plans	Health Economy ED Recovery Meeting Monitor review of ED plan Improvement Director oversight of plan	Adequate	Clear understanding of the ED pathway and how the plans start to resolve the key issues.					
				Improvement Plan in place with supporting Divisional plans in place (01/2016) **Control Owner:** Sally Smith	Emma Kelly manages the updates to the Improvement Plan on at least a monthly basis.	Improvement Board monitor progress (meets monthly) BoD receives exception and progress reports (bi-monthly)	Monitor Progress Review meetings - provides challenge over progress of Trust in meeting deadlines Improvement Director - challenge to Trust CQC Inspection 07/15 - improved rating Internal Audit on data quality (11/15)	Adequate	Internal Audit on CQC (04/16) Internal Audit on Risk Management (04/16)		CQC re-visit plan to provide timeline and actions to ensure organisation readiness for CQC insepction due around April 2016 **Person Responsible:** Sally Smith **To be implemented by:** 31 May 2016	**11 Apr 2016** **Alison Fox** Report presented to BoD, however, as the Trust has not been provided with its inspection date the timeline presented was an example and the Board will receive a further timeline once a date is confirmed. **25 Feb 2016** **Alison Fox** Intelligence suggests that the CQC visit is likely to take place in May / June 2017; work is on-going to implement the improvements required.		

AO1: Patients. Help patients take control of their own health

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
											Emergency Department Board workshop to provide a good understanding of the issues and plan to address performance. **Person Responsible:** Jane Ely **To be implemented by:** 11 Mar 2016	**12 Mar 2016** **Jane Ely** Workshop completed with Board (Exec & Non-Exec) 11th March as planned. New Ed dashboard shared and the priority actions that would make a difference noted by all. Follow up action to review ED staffing at SWC and circulate to the Board. **29 Feb 2016** **Alison Fox** Planned for March 2016 BoD development session		
											Internal Audit to undertake review of the risk management systems and controls following output of Deloitte and PWC reviews **Person Responsible:** Helen Goodwin **To be implemented by:** 27 May 2016	**25 Feb 2016** **Alison Fox** Reviewing workload to programme in this review.		
SRR 4	Estate Condition - Unable to source improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Liz Shutler **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** 26 Apr 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Scores revised following discussion with Liz Shutler	**Cause** - Backlog of work (£4-5 million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** resulting in poor patient and staff experience, potential breaches to health & safety standards and legislation, inefficiencies and difficulties in moving forward with providing services of the future.	I = 3 L = 5 Extreme (15)	Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Liz Shutler	Management Board receives reports from Director of Strategy and Capital Planning. Business cases are received on an ad-hoc basis - some of which require improvement to infrastructure	FIC receives quarterly reports on capital spend.		Adequate		I = 3 L = 3 High (9)	**Person Responsible:** **To be implemented by:**			Quality Committee
				An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Liz Shutler	Deputy Director of Estates and Director of Capital receive information from all areas of the Trust regarding maintenance and undertake a first pass at prioritisation. Capital PLanning Group - review the prioritisation exercise	FIC receive reports about Backlog maintenance showing the risks.		Adequate						

AO1: Patients. Help patients take control of their own health

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 6	Ability to upgrade IT and take advantage of new technology **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:** I have considered this risk and agree with its current status.	**Cause** - Financial constraints on capital funding and the ability to invest in IT **Effect** - poor patient experience - poor staff experience - inefficient processes	I = 3 L = 3 High (9)	Continued investment in technology has been agreed at Strategic Investment Group as a priority **Control Owner:** Andy Barker	Director of IT manages the new and replacement programme on a day to day basis	- Information Development Group manages delivery of replacement and new IT - Finance and Performance Committee receives reports on the capital programme as a whole.		Limited		I = 3 L = 2 Moderate (6)	Maintain overview of investment in IT for both new and replacement programmes **Person Responsible:** Andy Barker **To be implemented by:** 29 Jul 2016		I = 3 L = 2 Moderate (6)	Finance & Investment Committee
				Replacement programme has been agreed to the level required to maintain good performance. **Control Owner:** Andy Barker										

AO2: People: Identify, recruit and develop talented staff

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
CRR 15	Ability to attract, recruit and retain high calibre staff to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There is a national shortage of staff in some specialties. The results of the annual staff surveys and the staff FFT have placed the Trust in the lowest performing quartile for several years. The location of the Trust in relatively close proximity to London, makes the retention of staff more challenging. Publication of NICE guidelines on ward-based staffing has raised the profile of the adequacy of staffing. **Effect** This is affecting some allied health professions more than other staff groups, including Pharmacy, SaLT etc. There has been an increase in the number of agency staff usage to meet the staffing shortfalls; this has come as in creased cost pressure for the Trust.	I = 3 L = 5 Extreme (15)	Publication of scheduled versus actual staffing levels on each ward, updated each shift to ensure visibility. **Control Owner:** Sally Smith	Associate Chief Nurse responsible for receiving reports and checking staffing levels	Strategic work force committee. Reporting to the BoD formally every 6-months. Day to day dashboards in place		Substantial	Acuity tools not consistent in all areas and specialty areas such as the EDs have not currently been comprehensively assessed	I = 3 L = 4 High (12)	**Person Responsible:** **To be implemented by:**			Strategic Workforce Committee
				Programme of overseas nurse recruitment established with 109 nurses recruited from Spain, Portugal, Greece, Italy, Malta, Romania and Croatia. **Control Owner:** Sally Smith	Head of Strategic Resourcing and Acting Chief Nurse and Director of Quality leading programme with nominated leads at division level.	Strategic Workforce Group with formal strategy in place		Adequate	Sustainability of model for overseas recruitment in the medium to long-term unclear					
				Universities well engaged and the Trust recruits the majority of newly qualifies staff locally. Specific education and training programmes developed for Band 4 practitioner posts to cover EDs and operating theatre vacancies. **Control Owner:** Sally Smith		Regular meetings with Canterbury ChristChurch University		Adequate						
				Recruitment process revised and Job descriptions updated to incorporate Trust values and behaviours. **Control Owner:** Sandra Le Blanc	HR Business Partners supporting divisions and corporate areas	Strategic workforce committee		Adequate						
				Development of the Cultural Change Programme and recruitment based on the core Trust values. **Control Owner:** Sandra Le Blanc	Cultural change programme manager leading local implementation of programme with divisional leadership teams.	Quarterly progress report to the BoD and to the Improvement Plan Delivery Board reporting against key milestones and outcomes, evaluating progress and making recommendations on changes	Diagnostic phase supported by external consultancy. Staff survey published and benchmarked annually.	Adequate	Continued poor results of staff surveys and 2015 results place the Trust in the lowest quintile.					

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
CRR 2	Failure to achieve financial stability and deliver financial plans **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**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, the clinical strategy, which further impacts on - the reputation of the organisation, and - the Trust being sustainable as a going concern in future as creditors lose confidence and there are reduced resources for investment.	I = 5 L = 5 Extreme (25)	Financial recovery plan in place **Control Owner:** Nick Gerrard	Monthly reporting by Divisions on progress against plan to the Financial Recovery Group	Exception reporting to Finance and Investment Committee monthly with BoD oversight of final reports bi-monthly	Draft plan reviewed by Monitor and the financial position is reviewed at the PRMs (6-8 weekly)	Adequate	Reporting shows slow improvement. Monitor still to provide feedback on 2 year plan.	I = 5 L = 4 Extreme (20)	Implementation of financial governance action plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2016		I = 5 L = 3 Extreme (15)	Board of Directors
				Financial governance systems in place **Control Owner:** Nick Gerrard	Director of Finance responsible for overseeing governance arrangements	Finance and Investment Committee	Review of current governance arrangements undertaken in July 2015 by Grant Thornton	Adequate	Action plan developed from review findings requires full implementation and on-going monitoring to ensure sustainability					
				Clinical workstreams in place to ensure the standards of care delivered are not adversely affected **Control Owner:** Sally Smith	Reports to Executive Team (weekly) from workstream	Report from Executive Team monthly to Finance and Investment Committee (FIC) and monthly reporting to BoD	CQC quality inspection scheduled for 2016 - date to be confirmed	Limited						
				Turnaround Director in post from October 2015 **Control Owner:** Nick Gerrard	Direct line management by CEO			Adequate						
				Divisional specific Cost Improvement Plan targets in place with PMO and workstream support **Control Owner:** Nick Gerrard	Divisional challenge meetings in place for Executive Team to challenge progress against plan	- Weekly review of performance by Executive Team - Turnaround report to FIC monthly - Exception reporting to the BoD monthly	Progress Review Meetings with Monitor (6-8 weekly) to review progress	Limited						

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
CRR 3	The Trust fails to plan for changing levels of demand appropriately **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** There is a increased and un-planned local demand for emergency and elective services that the Trust is unable to meet with the resources and infrastructure available. Surge resilience plans do not meet unprecedented demand **Effect** Plans in place for activity and demand are not synchronised with actual activity performed and there is a resultant loss of income and the Trust carrying the risk in isolation. Engagement with commissioners and specialist commissioners is compromised making agreement about contracted activity difficult to manage. The Trust experiences increased costs associated with out-sourcing activity further compromising financial stability, patient safety and experience. The Trust is in breach of its licence to operate and is subject to close scrutiny by Monitor	I = 4 L = 5 Extreme (20)	The Trust is participating in the Emergency Care Improvement Programme (ECIP) **Control Owner:** Jane Ely	Urgent Care Board Improvement leads meeting weekly Head of Nursing supporting EDs directly	Workstream leads working to deliver an ED improvement plan Weekly KPI meetings	ECIP network of clinically led support with regular inspection and review Fortnightly meetings held across health economy Surge Resilience Group meetings	Adequate	Current assurances are not ensuring a consistent performance of 95% consistently across all sites	I = 4 L = 3 Extreme (12)	Review of clinical leadership in ED and effectiveness of current controls to be assessed by ECIP **Person Responsible:** Paul Stevens **To be implemented by:** 02 May 2016		I = 3 L = 3 High (9)	Board of Directors
				Demand and capacity monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely	Reports from CSSD for Diagnostic compliance (DM01) Reports from UC&LTC on ED and ECC performance Reports from Surgical Division on referral to treatment performance Reports from Specialist Services on cancer compliance - all reported to executives	Reporting of core areas within the monthly Executive Performance Reviews. Exception reports to Management Board monthly Cancer compliance reviewed by Kent Cancer Board and RCA programme established for long cancer waits	Data quality review undertaken by KPMG in 2014 to cover all areas within the operating framework. Mandated indicators audited as part of the annual Quality Account	Adequate						
				The CEO and COO are both active members of the SRG and have raised this lack of whole health economy capacity plans. **Control Owner:** Jane Ely										
CRR 14	Equipment requested for patients to support them post discharge is being delayed **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The commissioned provider of equipment required to support patients post discharge has changed. **Effect** The type and volume of equipment requested is not being fulfilled in a timely way resulting in further delays to discharge and the risk that patients may be harmed as a direct result of their increased LOS.	I = 3 L = 3 High (9)	Assessment of the number of discharge delays associated with the provision of equipment is being monitored and the results will be consolidated and shared. Meetings have taken place with the new provider, and there is an agreed escalation process. In addition our Acute Physiotherapist teams are escalating ordering for patients. Level of delays now reduced. **Control Owner:** Jane Ely	Staff trained in the use of the new ordering system	Feedback to commissioners as part of monthly Performance meetings		Limited	Initial feedback is that the provision of equipment is causing delayed discharges. The areas of specific concern are pressure relieving mattresses and specialist low beds.	I = 3 L = 2 Moderate (6)	**Person Responsible:** **To be implemented by:**			Board of Directors

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)	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		I = 5 L = 4 Extreme (20)	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	I = 5 L = 3 Extreme (15)	Finance & Investment Committee
				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					
				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			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).		
				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					
				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					

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
CRR 20	GPs may not receive timely information on their patients who are receiving specialist treatment from the Trust **Risk Owner:** Jane Ely **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 05 May 2016 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** The Trust is now reporting turnaround times for clinic letters sent to GPs against agreed stretched standards. The Trust did not measure its compliance against letter typing and delivery previously and has agreed with commissioners a stretch standard for this year – benchmark across the Country advises there are no nationally agreed metrics with exception of 2WW and Rapid access performance; however best practice suggests locally agreed metrics with tolerance levels approved by commissioners and Providers improves the quality of the letters and patient care overall. **Effect** The Trust is not currently meeting our agreed standards and tolerances for all correspondence to GPs. These are 90% of all routine letters to be received by the patients GP within 10 working days and 90% of all 2 week wait and rapid access letters within 72 hours. Our current year to date performance is 65.7% compliance.	I = 2 L = 4 Moderate (8)	Performance standards for response times agreed and monitored for standard and patients on urgent pathways. **Control Owner:** Mary Tunbridge		Monitoring of performance at commissioner -led performance meetings		Adequate		I = 2 L = 3 Moderate (6)	**Person Responsible:** **To be implemented by:**			Executive Performance Reviews
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)	Regular meetings with external partners / MP's and within the Trust **Control Owner:** Liz Shutler	Awaiting engagement plan					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
				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		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			

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 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)	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	I = 4 L = 2 High (8)	Finance & Investment Committee
											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.		
											Delivery of a Sustainbability 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		
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

Special Measures Improvement Plan Update

East Kent Hospitals University NHS Foundation Trust

Date of Report: 11th May 2016

Date of Reporting Period: April 2016

KEY
Delivered
On Track to deliver
Some issues – narrative disclosure
Not on track to deliver

East Kent Hospitals University NHS Foundation Trust
Our improvement plan & our progress

Background & Summary

- The Trust was put into special measures on the 29th August 2014 following a CQC inspection with reports that identified two of the three main sites as "inadequate" and the Trust rated overall as "inadequate". The sites rated as inadequate were the Kent and Canterbury Hospital and the William Harvey Hospital. The Trust was also rated "inadequate" in the safety and well-led domains.
- On the 16th November 2015, the CQC presented the findings of their subsequent inspection in the Trust which took place in July 2015. The reports identified improvement since the last inspection. The overall Trust rating went from "inadequate" to "requires improvement". The trust was rated "requires improvement" for the domains of safe, responsive and well-led. The domain of caring was rated as "good". The Trust was rated as "inadequate" for effective services. The three acute sites (William Harvey Hospital, Kent & Canterbury Hospital and Queen Elizabeth Queen Mother Hospital) were all rated as "requires improvement" with the Buckland Hospital and Royal Victoria Hospital, Folkestone, rated as "good".
- The Trust has been given a variety of recommendations that can be themed below:
  - Trust leadership and governance arrangements– sustaining of changes made since the last report;
  - Staff engagement and organisational culture to address the gap between frontline staff and senior managers;
  - Safe staffing to delivery timely patient care;
  - Staff training and development, specifically around mandatory training;
  - Demand and capacity pressures on patient experience, specifically within the emergency pathway and onward flow through the hospital and maternity services;
  - Following national best practice and policy consistently, specifically in relation to end of life care – ensuring there is a suitable pathway, documentation and education in place;
  - Support services are in place to ensure 7 day services can be delivered in priority areas – including pharmacy and radiology;
  - Mental health provision and timely specialist response for our patients;
  - Caring for children and young people outside dedicated paediatric areas;
  - Estate and equipment maintenance and replacement programme concerns;
  - Key national and local audits are undertaken and action plans implemented to improve care;
  - Incident reporting processes are robustly followed and learning from incidents and complaints is shared with all teams to improve services
  - Clinical Strategy - in place and communicated with all members of staff.

- The published CQC report can be found on the CQC website: : *http://www.cqc.org.uk/provider/RVV*
- The Trust agreed an implementation plan to deal with 30 must do actions within the High Level Improvement Plan. These can be grouped into 12 thematic work streams. Each clinical division also has a local plan containing actions surrounding all of the detailed key findings, with timeframes and corresponding key performance indicators. We recognised all of the recommendations and are addressing them to improve the quality of services.
- This document provides a summary of Trust progress against our published High Level Improvement Plan - which provides further detail. A decision was made that despite evidence of improvement, the Trust should remain in 'special measures' to ensure that required changes made are sustained. The new Improvement Plan builds on the previous plan to continue the Trust Improvement Journey and get to "good".
- Oversight and improvement arrangements have been put in place to support changes required. The Improvement Plan is overseen by a monthly Improvement Plan Delivery Board, chaired by Dr David Hargroves, Clinical Lead. The Delivery Board is accountable to the Board of Directors. Operationally progress is reviewed via a fortnightly Improvement Plan Steering Committee with accountable named leads for each site and division. A Quality Innovation and Improvement Hub is in place on each hospital site and is used as a vehicle to drive change and communicate progress. A Programme Office has ben established with Programme Management support and a Quality Improvement Facilitator working with front line divisional teams.
- This report outlines on a monthly basis the progress that is being made in implementing the organisational improvement plans – our Trust Improvement Journey.

Who is responsible?

- Our actions to address the recommendations have been agreed by the Trust Board and shared with our staff.
- Our Chief Executive, Matthew Kershaw, is ultimately responsible for implementing actions in this document. Other key staff are the Chief Nurse, Director of Quality and the Medical Director, who provide the executive leadership for quality, patient safety and patient experience.
- The Improvement Director assigned to East Kent Hospitals University NHS Foundation Trust is Susan Lewis, who will be acting on behalf of Monitor and in concert with the relevant Regional Team of Monitor to oversee the implementation of the action plan overleaf and ensure delivery of the improvements. Should you require any further information on this role please contact specialmeasures@monitor.gov.uk
- If you have any questions about how we're doing, contact our Trust Secretary, Alison Fox on 01227 766877 (ext 722 2518) or by email at alison.fox4@nhs.net

East Kent Hospitals University NHS Foundation Trust - Our improvement plan & our progress

How we will communicate our progress to you

- We will update this progress report every month while we are in special measures. Our High Level Improvement Plan will also be available through the Trust internet site (link to be added when live).

Chair / Chief Executive Approval (on behalf of the Board):

Chair Name: Nikki Cole	Signature:		Date: 11 May 16
Chief Executive Name: Matthew Kershaw	Signature:		Date: 11 May 16

East Kent Hospitals University NHS Foundation Trust – Summary of progress against improvement plan

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Safe *MD07 - There are robust systems to monitor the safe management of medicines and IV fluids according to national guidelines.*	December 2015 – March 2016	The monthly audit tool has been strengthened. Average monthly performance continues to be 80-90% with medicine trolley locking 98%. An environmental audit of current IV storage facilities has been undertaken. Audit has shown most areas only require minor works – aside from critical care, theatres and renal OPD. Decision to be made at Heads of Nursing meeting in May 2016. Readjustment of stock levels for IV fluids has taken place. External assurance will be required by the CCGs	Red: Slippage – on implementing findings re IV storage audit and monitoring compliance. **Status of previous reporting month (March 16) – Amber (MD07)**
MD30 – The Medicine Management Policy is adhered with – and there are systems in place to ensure that prescribing practices across site for critical drugs are uniform.	December 2015-February 2016	Noradrenaline standardised prescribing policy agreed and has been rolled out to all areas. Compliance monitoring in place. Audit on track for completion in June 16 according to plan.	Green: On track **Status of previous reporting month (March 16) Green.**
MD08 - There are sufficient numbers of suitably qualified, skilled and experienced staff available to deliver patient care in a timely manner.	December 2015 – On-going (with monthly review)	Over 138 RNs have been recruited since July 15. In March 16, Trust is carrying a 12.3% vacancy factor in nursing. Workforce and recruitment and retention plans are in place. Safe staffing reports for nursing are reported every month to the Board. Work has been initiated to look at 'retention' rates for hard to recruit staff (Recruitment Strategy 15-18) including working with agencies relating to further overseas recruitment. Further overseas recruitment in progress this month. A more in depth induction programme is being devised for overseas doctors to support retention. Some slippage regarding 'on boarding' and exit interview strategy. Exit interview process re launched in October 15. Revised vacancy trajectories to be approved at May 16 Strategic Workforce Committee and presented at Improvement Plan Delivery Board. External assurance will be required by the CCGs	Amber: Delays given recruitment and retention challenges (although plans in progress as part of Recruitment Strategy 15-18). Concerns remain around the ability to recruit sufficient Consultant staff in the Emergency Departments, Pharmacy and Therapy staff due to national supply. Ability to recruit overseas nurses a risk due to changes in ELTS (English Language qualification). **Status of previous reporting month (March 16) - Amber**
MD19 - The major incident policy is up to date and staff are aware of their roles and responsibilities. Staff are confident in its application having received sufficient training and 'drills' in appropriate areas.	December 2015 - September 2016	The Trust has enlisted the help of Maidstone & Tunbridge Wells NHS Trust Emergency Planning Team. In December 2015 a major incident test took place. On 22nd March a full table top exercise was conducted led by external partners. Training DVD has been re launched. 2139 staff trained since April 15. Emergency Planning Annual Report presented to the Trust Board. External assessment undertaken by CSU on behalf of NHSE– compliant in most areas. Further work to do on training trajectories. External assurance provided South East CSU on behalf of NHSE	Green: On Track **Status of previous reporting month (March 16) - Green**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD20 - Staff training is focused on the principles of the MCA (2005) and how to assess capacity. Trust policies relating to adult safeguarding are updated regularly and are easily accessible. There is evidence that staff consider mental capacity in the planning and delivering care. Capacity assessments are considered carefully and are proportionate to patients' needs. *Best interests decisions are timely and issue specific.*	December 2015 –June 2016	The Policy was approved in December 2015. The content of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training has been reviewed and TNA refreshed. Agreement that refresher should be every 3 years (not 2 years) in line with UK Core Skills Training Framework. Need for trajectory to be refreshed to take account of this. The Safeguarding intranet and internet has been refreshed with much clearer signposting for staff on accessing the correct information. The Trust has met with Brighton University and will be the lead organisation for the Kent, Surrey and Sussex Learning Disability Mortality Project (LeDeR). Training has been delivered in the QII Hubs on MCA and DoLS and will continue across all sites on a rolling programme. An "Ask 5 questions" audit is being rolled out to assess staff understanding of both areas. Collaboration with Learning and Development has identified the cohort of staff requiring extended training and will be used to report training compliance. 1200 clinical staff have received training this year (L1 and L2). The CCG Contract Quality Metrics require reporting of training numbers by level. To be in place by June 2016.	Amber: some slippage against milestones. Some risks around availability of training data by level but plan in place to resolve by June 16 as per plan. **Status of previous reporting month (March 2016) - Green**
MD21 - There is a Trust specific Children's Safeguarding Policy (which is consistent with the Kent & Medway Multiagency policy).	December 2015 - March 2016	The Trust specific Policy was approved at the Policy Compliance Group in March and is being disseminated to staff. Board Seminar on Safeguarding to be held. The Kent & Medway Children's Safeguarding Board require assurance and receive this via the Board's work.	Blue: Compete **Status of previous reporting month (March 2016) - Blue**
MD22 - All temporary/agency staff (all disciplines) should have the appropriate competencies for the clinical environment they are placed within and receive appropriate induction.	December 2015 – August 2016	Following review of current medical locum induction processes a template has been issued to Divisions to be developed locally and implemented from 1st April. Induction checklists for nursing have been compiled and shared with wards to use for local inductions from the end of March. A process have been agreed with NHSP and Stafflow to record the completion of local induction and report monthly, this data to be included in Divisional reporting and monitoring. The bank contract is currently out to retender and the requirement for agency checklists to be stored and available for reporting is included (from June 16). External assurance is being requested by the CCGs	Amber: Slippage in programme but plan in place. Additional target of compliance with induction process to be agreed and achieved by August 2016. **Status of previous reporting month (March 2016) - Amber**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD23 - The pharmacy department is appropriately staffed and skilled to support the timely and safe discharge of patients.	December 2015 - March 2016	Recruitment and retention plans are in place, but at present the pharmacy department is carrying a 27% vacancy factor for qualified staff and a 14% vacancy factor for unqualified (March 16). The Department have taken part in the 'Safer Start' initiative during January and have tested out prioritising those being discharged to reduce delays. The workforce development plan has been completed and submitted to CSSD Board in March, along with the pharmacy business plan which describes in detail the strategic plan for development of pharmacy in line with the recommendations of the Carter Report. To be finalised in May 2016. An initial assessment using the TDA Trust development tool for Medicines Optimisation has been completed. A proposal has been made about level of service by ward (with associated KPIs) to be discussed at Improvement Plan Delivery Board.	Red: Delays due difficulties in recruiting and retaining Pharmacy staff. National/regional shortages of Pharmacists. Workforce development plans – including retention strategies – developed to address this. Slippage against original timeframes. **Status of previous reporting month (March 2016) - Amber**
MD28 - Fine bore naso-gastric tubes are inserted and checked in accordance with NHS England's patient safety alerts; the Trust NG Policy is in line with this guidance.	December 2015	Trust NG policy implemented. Governance procedures in place to ensure compliance against standards. There is an article in Risk Wise (Trust wide Risk publication) this month to reinforce the learning. An external review of the safety of the system for NG tube insertion was independently reviewed by a Patient Safety Consultant; there were no issues identified. NHS England undertook an external review of Trust use of the Central Alert System (CAS) on Friday 19th February 16. This does not impact on completion of this action but will provide assurance regarding Trust use of the CAS.	Blue: Completed **Status of previous reporting month (March 2016) - Blue**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Effective *MD11 - There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes. Clear action plans developed and managed through the Trust governance framework.*	December 2015 - January 2016	An Internal Audit of divisional engagement and governance started on the 20 February 2016. First draft received and to be ratified in May 2016. The clinical audit forward programme for 2016 / 17 was approved by the Clinical Audit and Effectiveness Committee in March and is due to be reviewed by the Integrated Audit Governance Committee in April. Prior to submission of the forward programme, all programme were approved by the divisional medical directors. As part of the approval certain conditions aimed at improving completion rates were applied to the programme & these conditions will be communicated to the clinical specialities shortly. The forward programme is divided into "Must do", Carried over & New audit topics with priority given to the "Must do" topics. The programme will be reviewed by each division at six months to ensure the "Must do" topics are on track. The clinical audit website is to be re launched in April. The Board Audit Committee has requested a report on progress of this scheme. Internal audit assurance is at the planning stage with an anticipated start in March 2016	Red: Slippage against original timescales agreed. Review of job planned activities by June 2016. **Status of previous reporting month (March 2016) - Amber**
MD12 - The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet current best practice standards.	December 2015- On-going but with key milestones achieved and evidenced by June 2016	1617 investment programme agreed. Consultation has closed regarding availability of estates team. Team now available 7am-10pm with increased availability. This will also increase capacity for planned maintenance. Work on going to develop Estates Web Portal for reporting jobs and monitoring progress. To be complete by June 2016. Estates checklist has been piloted and revised version now rolled out. A project to establish a procurement run stock system is being developed, this will seek to ensure that jobs raised by staff can be completed in a timely manner and not delayed by the lack of parts. Plan to go live in May 16. The Trust has run two fire evacuation exercises with Kent Fire and Rescue to test the robustness of procedures and safety. Work to WHH ED is nearing completion and work has commenced in St Augustine's Ward, QEQM. HSE are working with the Trust at present to ensure compliance to essential standards.	Green: 1617 investment programme agreed. Further investment to be agreed for subsequent years based on priority areas. **Status of previous reporting month (March 2016) - Green**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD13 - There is sufficient equipment in place to enable the safe delivery of care and treatment, equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.	December 2015 Start February 2016 End	A programme of equipment maintenance is in place and will continue going forward. The equipment library is working effectively. The Medical Devices Group manages the equipment requirements across the Trust ensuring there is sufficient equipment in place for safe delivery of care and to manage the risk. Some slippage against the business case to ensure team can achieve 95% compliance level for high risk equipment. Sign off to happen in June and then mobilisation of approved option. Current performance is 83% for EME equipment and 94% for high risk equipment. New electronic system is in place where departments can review equipment and date of last service. To be communicated to all leads. No external assurance is being sought at present.	Red: Slippage against original timescales agreed. Business Case to go to SIC in June 16 and decision to be made regarding mid-long term resourcing of the team. Scheme to go Green at this stage. **Status of previous reporting month (March 2016) – Amber.**
MD27 - Operating Theatres on all sites comply with HTM 05-01, particularly in relation to risk assessment, the environment and staff training.	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Compliant. All operating theatres are compliant with HTM 05-01 and undergo an annual verification. The General manager for surgery works closely with estates to co-ordinate a cycle of closures and repairs annually External assurance is provided via the Trusts external Authorised Engineer.	Blue: complete **Status of previous reporting month (March 2016) - Green**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD29 - All escalation wards/clinical areas are appropriately staffed and equipped to safely care for the cohort of patients intended.	December 2015 -March 2016	Recruitment is in progress and each of the escalation areas has been risk assessed. Where possible the escalation beds are closed when not required according to the demand in the Trust. The Trust has approved funding for substantive staff in areas that are consistently opened. These posts are being recruited into currently. A paper presenting the care model options for St Augustine's is in progress - for agreement in May 16. Capital works have commenced on St Augustine's ward. Confirmation has been made to recruit to unfunded beds on Cheerful Sparrows Ward.	Red: Slippage against original timescales. Estates works to be completed by July 16. Model of care outstanding and to be agreed. **Status of previous reporting month (March 2016) - Amber**
Caring *MD24 - Patients' pain scores should be regularly and clearly documented and there should be interventions - pharmaceutical and alternative therapies.* *There are clear tools for use with patients with dementia and learning disability.*	December 2015-August 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Pain scores are collected via Vital Pac and there is an audit process in place. A review of pain interventions available and access to specialist advice is underway. A tool has been developed for patients with dementia and also learning disability. Consultation and communication has been undertaken with patients and staff and the tool has been made available on PAS as a clinical form. In addition to the above, an audit of pain management scores across the Trust and patient's experience of pain and an associated action plan will be in place by August 2016. Pain assessment documentation will also be made universal (August 2016). No external assurance or support being sought.	Green: on track. Extension agreed to end date of plan to August 16 to represent milestones. **Status of previous reporting month (March 2016) - Green**
MD26 - Patients' complaints are responded to as per national standards. *Ensure there is a clear process for learning across the Trust.*	December 2015 - On-going but with key milestones achieved and evidenced by April 2016.	There is still significant work to do to improve the response time within 30 days. A trajectory for improvement will be discussed and agreed by the Complaints and Patient/Carer Feedback Group. Q3 compliance of complaints responded to within 30 days is 33%. Surgical Services have a very effective 'Outcomes with Learning' newsletter for staff related to complaints. This format is being shared with the other divisions. The Terms of Reference for the Steering Group have been revised now incorporating other forms of patient feedback. Complaints training is being considered as part of the 1617 action plan for the Group. An Away Day was with the Patient Experience Team w/c 29th March and additional investment made in the RSO role. Trajectory for improvement agreed. Training to be delivered in June 16. No external assurance or support being sought.	Red: some slippage against timescales agreed. **Status of previous reporting month (March 2016) - Amber**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Responsive *MD06 - Effective processes are in place on each site (and between sites) to manage flow - senior on site leadership supported by accountable leads. Information supports escalation and decision making. Patients are cared for in the most appropriate place and care is coordinated.*	December 2015 On-going (key milestones set out in column K and detailed in interrelated Emergency Care Recovery Plan).	Clinical Site Operational Leads in place on each site and substantive model agreed for implementation. Baseline bed model agreed and to be agreed in May 16. Access target trajectories agreed with CCGs as part of 1617 contract. The Emergency Pathway Improvement Plan is being implemented. ECIP are working with the Trust to make the necessary improvements in patient flow, safety and quality across the Trust. The Site Management Standard Operating Procedure draft to be circulated for the end of February. The Safer Care Bundle has been launched across all sites. Information has been improved to support predicted admission and discharges from each site and a revised dashboard is now in place. The Clinical site Operational Leads have tested processes and the learning will be used to replicate better practice. Slippage identified in relation to mapping of social care beds (external partner led) and review of bed base across Trust. ECIP Support is in place and multi partner support via the SRG	Amber: Slippage against some milestones in ED Recovery Plan. (Programme risks include insufficient pathway 3 bed capacity out of hospital. This is being taken forward via the SRG. Safer Care Bundle to be further embedded - job planning will support maintenance). **Status of previous reporting month (March 2016) - Amber**
MD25 - Inpatient areas are supported by 7 day services (radiology, therapies and pharmacy) to enable effective use of capacity and enable flow.	December 2015 Start On-going but with key milestones achieved and evidenced by April 2016.	Clinical Divisions are assessing which services are currently 7 days and which services may benefit from 7 day working. This forms part of workforce plans. Also ensuring that teams are aware of how to access out of hours services and is clearly documented. Diagnostic audit has been undertaken and action plan to be developed. Discussion within contract negotiations with commissioners around short, medium and long term plan. No external support or assurance requested.	Amber: Some slippage. Workforce plans being scoped where there is a service need and commissioner support. **Status of previous reporting month (March 2016) - Amber**
Well led *MD09 - There is a positive workforce culture demonstrated by content staff who are supported and empowered to lead improvement, are aware of the Trust vision and their role within it and provide excellent patient care. Leaders at all levels have the skills to support and embed cultural change.*	December 2015 Start On-going (key milestones set out in column K and detailed in Cultural Programme Plan).	Following the Staff Survey results the Trust priorities have been agreed. These are to continue the 'Respecting each Other' programme around bullying and harassment, a focus on health and wellbeing of staff, quality of appraisals and leadership and management development capacity and capability. Work has commenced. Re launch of Respecting each Other' video and further workshops planned. Health and Wellbeing Group has been established. New appraisal process to be launched on 1st April with conversation around Trust Values and Behaviours. Proposal agreed for leadership development and assessment. Tender closes May 16. HR BPs working on 'Great Place to Work' action plans. There is slippage against timescales for the OD Strategy. Communications Plan work to be finalised in April. External consultancy support has been utilised for OD Strategy. Monitor are requesting further assurance around the next steps and embedding of the cultural values.	Amber: Minor slippage against milestones. **Status of previous reporting month (March 2016) - Amber**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD10 - The clinical strategy plan is delivered to timescale and communicated and implemented successfully led by clinical champions.	December 2015 - December 2016 (interim milestones within HLIP). Next milestone – development of models of care (April 16). STP due end of June 16.	The Clinical Forum meetings have continued and have focussed on developing out of hospital models. This has been supported by provider organisations who are both providing and triangulating in hospital data to better understand the type of activity that will be managed out of hospital future models of care. We continue to work closely, via the East Kent Strategy Board and aligned clinical meetings, to design of sustainable model of health and social care for east Kent. The national request for health economies to produce a 5 year Sustainability and Transformation Plan by June 2016 has also been aligned with the work on strategy. The Trust held a significant clinical engagement event on 1st to 3rd March to consider how acute care will be developed in the future and a range of meetings have taken place with staff who responded to a call for ideas for future ways of working. The output of these sessions was reviewed by the Trust Board in April and further work is being progressed for presentation back in June 16. External collaboration is central to this item and is in place.	Green: On Track **Status of previous reporting month (March 2016) - Green**
MD16 –The Trust governance arrangements are clear and transparent	December 2015 - March 2016 (with interim measurable milestones)	The outputs of the external governance reviews have been implemented. An evaluation of the new governance arrangements is outstanding as is a review of staff understanding of the arrangements. External support commissioned by Trust from Grant Thornton regarding board governance.	Red: Slippage against original timescales. **Status of previous reporting month (March 2016) - Amber**
MD17 - The Trust incident reporting process is robustly followed by all departments - with focus on ED departments at WHH, QEQM and Maternity services. Ensure that incidents are acted on in a timely manner and that staff receive feedback	December 2015 Start September 2016	Incident reporting is high across the Trust when benchmarked against peers. Forums are in place where incidents are reviewed and action plans monitored. The next national report from the NRLS is awaited in order to confirm national benchmarking for reporting. Datix V14 testing was completed in April and fully rolled out across the Trust with a few minor issues which were resolved without issue. External support is not required.	Green: On Track **Status of previous reporting month (March 2016) - Green**
MD18 - Trust wide policies are procedures are up to date and in line with best practice. Policies and procedures are clearly written and easily accessible by staff.	December 2015 Start June 16 (but trajectory for improvement set based on programme plan)	Policy group has been set up and meets regularly to ensure policies are up to date and are in line with best practice. There is a manual process for identification if any policy documentation which will be out of date within 2 months. A system has been purchased to provide assurance that staff have accessed and read policies relevant to their role. In order for this to work effectively, the system must be configured and a member of staff must be nominated to work on this project. MicroGuide app functionality to be explored for clinical guidelines. External support is not required.	Amber: Some risk regarding slippage to milestones to enable June 16 achievement. Resourcing to be agreed in month to mitigate risk. **Status of previous reporting month (March 2016) - Green**

East Kent Hospitals University NHS Foundation Trust – Summary of progress against improvement plan

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
End of Life *MD01 - A suitable End of Life Pathway will be in place and staff will be competent in its consistent application. Contribution to local and national audits to evidence compliance.*	December 2015 Start June 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The End of Life Board meets bi monthly chaired by the Divisional Head of Nursing, Specialist Services. Revised documentation which is trust specific and nationally compliant is now complete and available. Multidisciplinary staff awareness of the inclusive responsibility of end of life knowledge and expertise is progressing through specific training on end of life conversations local clinical area based Link Nurses. The Link Nurse contract has been agreed and nurses identified for most areas. The EKHUFT section of the Interagency Policy was completed for the end of March. A report following the EoL Carers Experience Questionnaire was presented to the EoL Board in April 16. The Link Nurse Contract has been agreed. The EoL Facilitator will start in June 2016. Macmillan have in addition confirmed two band 7 posts for a two year period to support the Trust's implementation programme. Draft recommendations for training were discussed on the 14th April at the EoL Board. Revised proposal to be presented at the May EoL Board. To be implemented from June. Final Multi-Agency Policy sign off delay - CCG led. Tier 4 (EKHUFT) section complete.	Green: On Track **Status of previous reporting month (March 2016) - Green** .
Urgent & Emergency Care *MD02 - The Trust has an effective and safe emergency and urgent care pathway. Care is delivered in the most appropriate environment, working alongside local partners, with multi-agency leadership.*	On-going (key milestones set out in column K and detailed in Emergency Care Recovery Plan).	The Emergency Pathway Improvement Plan is being implemented. ECIP are working with the Trust to make the necessary improvements in patient flow, safety and quality across the Trust. The ED Recovery Plan has been updated to reflected the HLIP and vice versa (February 2016). Work has commenced on defining the ECC model with a due date of June 2016. A workforce model for mid grade doctors is being written. The building work in ED Minors has been completed meaning there is more space and an appropriate paediatric waiting area. Funding has been agreed for continuation of IDT and H&S Care Village beds until July 16. The ED Escalation Policy/SOP has been approved and being rolled out. There is some slippage against programme schemes and risks. Continued risks regarding the ability to recruit to medical vacancies although 9 senior grade/consultant offers have recently been made. Revised trajectory agreed by SRG around 4 hour performance. 84.01% achieved for April. Improvement in clinician see first assessment times in under an hour in month. ECIP Support is in place	Amber: Some slippage against the ED Recovery Plan. **Status of previous reporting month (March 2016)- Amber**

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Children & Young People *MD15 - Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.*	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Recruitment and retention plans are in place to ensure appropriately trained staff are in place.	Green: On Track **Status of previous reporting month (March 2016)- Green**
MD14 - There are sufficient numbers of paediatric trained staff within Emergency and Urgent Care Pathway.	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement	Recruitment of paediatric nurses in the ED is almost complete to enable 24/7 cover. From May 16 there will be 24/7 paediatric RN cover at the QEQM and from June 16 for the WHH site.	Red: Slippage against original timescale given. Vacancies filled from May and June 16 when status will go blue. **Status of previous reporting month (March 2016 – Green)**
Maternity Services *MD04 - The Trust offers safe, effective, caring, responsive and well-led maternity services*	December 2015- September 2016	The MBRRACE-UK report has been published and shows the Trust to have a 10% lower average mortality rate for its comparator group. The RCOG final report has been received and an action plan will be signed off in May 2016. The deadline for embedding the new maternity dashboard slipped due to the new E3 electronic reporting system. The April dashboard has been completed and this will be populated monthly going forward from mid May. Work underway on bereavement suite at QEQM. Environmental constraints mean problematic to improve facilities for partners but written information to be reviewed. CTG machines received and replacement programme in place. Maternity Vision Strategy shared for comment with staff and 'Great Place to Work' workshops set up for staff involvement.	Amber: Some slippage against milestones. Agreement from Improvement Director that scheme should be split with implementation of RCOG separate RAG after plan sign off. **Status of previous reporting month (March 2016) - Amber**
MD03 – The Trust has sufficient capacity for women in labour on a day to day basis	April 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The final version of Birth Rate Plus has been received. The Trust assesses staff requirements on a shift basis and addresses any shortfalls that occur with temporary staffing. A live database is in place for recruitment. A database has also been put in place to record the number of diverts and closures to the unit and a revised policy circulated for comment for sign off by end of May 2016. The review of demand and capacity and development of live tools (based on bookings) remains outstanding - this has been impacted by the implementation of the new E3 electronic system. The demand and capacity analysis will be undertaken in May with findings presented in June. There have been 11 diverts in place since December 15.	Red: Slippage against original timescale given for demand and capacity work. To be completed by June. **Status of previous reporting month (March 2016) -Amber**

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Mental Health *MD05 - Patients receive timely mental health assessment and have appropriate facilities whilst waiting.*	December 2015-May 2016	In December 2015, a HLIP partnership engagement session took place where the accountable officers for the local CCGs agreed to support an action plan regarding the level of psychiatric liaison support required as part of the emergency pathway. An interim solution was agreed until the end of March 2016. SRG have approved an options appraisal for model of care. From end of May 16, KMPT will provide 8-8pm cover on all three sites 7 days per week. A third consultant will also be employed. Changes to the physical environment in the WHH ED will be complete by June 2016. Internal escalation policy in draft - to be agreed in May 16. Consideration to be given of additional training required by staff. KMPT (MH provider) and all CCG Accountable Officers	Amber: Some minor slippage. **Status of previous reporting month (March 2016) - Amber**

Other (e.g. concerns arising after CQC re-inspection; awaiting CQC report from re-inspection etc.)

No other concerns noted.

Other comments for reporting period (April 2016):

A regular programme of Improvement Visits has been established and the template embedded in operational process. The fourth Improvement Visit (May 2016) is about to commence. A Communications Plan has been launched – a themed fortnightly message is cascaded to staff and supported by training and a programme of speakers in the Quality Innovation and Improvement Hubs.

The pace of progress has continued since the plan was signed off and continues to progress - as part of our organisational Improvement Journey.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**COUNCIL OF GOVERNORS – 24 MAY 2016**
SUBJECT:	**GOVERNOR FOCUS 2016, NHS PROVIDER CONFERENCE**
REPORT FROM:	**SARAH ANDREWS, ELECTED GOVERNOR DOVER**
PURPOSE:	**INFORMATION**

CONTEXT / REVIEW HISTORY

Report on attendance at the Governor Focus 2016 Conference, 20 April:
The Governor Role Now and in the Future

Introduction
Attended by 200 or so Governors from across the FT sector this conference reaffirmed the role of the Governor going forward whilst alluding to a change of emphasis in the role.

This change of emphasis reflected the move of Monitor to be part of NHS Improvement (NHSI) and the backdrop of partnership working to develop local Strategic Transformation Plans (STPs).

The full set of presentation slides are appended to this brief report.
In due time a recording of the Conference will be available on YouTube

Current State of Play in the NHS – National Policy Update
Chris Hopson, CE NHS Providers gave a candid presentation about the NHS landscape at this time. (see slides).

He pointed out that the current difficulties faced by the NHS are primarily structural rather than the result of individual organizational failings. Common purpose is required to overcome this situation, together with considerable change over the next two years to recover financial balance and to achieve continuous quality improvement.

He introduced a theme that continued throughout the day – that FT member and public engagement would be essential to achieve the changes necessary, with potential for Governors to play a significant role.

He urged Governors to read/reread the Five Year Forward View. (attached).

The Governor Role Now and in the Future
Stephen Hay, Executive Director of Regulation with NHS Improvement gave a presentation in place of Jim Mackey. (see slides).

Formerly with Monitor, he described the change of emphasis in regulation, with a focus on support and improvement and acting as a critical friend in achieving earned autonomy.

In future FTs and NHS Trusts would be treated in the same way. However an internal system within NHSI was being established to maintain Monitor's regulatory function although there was an intention to reduce the regulatory burden.

Support for all Trusts is being developed including a new Faculty for Improvement.

He emphasized the continued importance of the Governor role, including in developing STPs.

Governor Role – Round Table Discussion
The round table discussions I engaged in revealed the extent of variation in approach to enacting the governor role in different FTs. Calling NEDs to account was a principle aspect of this session.

Examples of variation included:

- In some FTs Governors were positively invited to attend Board of Director meetings with a lunch session after each Public Meeting where Executives, NEDs and Governors met and shared thinking.
- In a small number of FTs Governors were invited to attend the Closed/Part 2 Meeting.
- In some FTs work was underway to establish CoG Committees for the first time, in others the pattern was to have few CoG Committees but to have Governors attend Board of Director Committees. (A straw poll directed by the Chair for the day, Dame Gill Morgan, indicated that about 50% of those present attended BoD Committees).
- In many FTs Governors reported feeling fully informed about all aspects of Trust business, in a few there was concern that this was not so.
- It was agreed there was no “right answer” , but that sharing approaches to enacting the role at events such as this conference was useful.

Governor Role and Quality
Professor Ted Baker, Deputy Inspector of Hospitals, CQC,
Led this session with a presentation that stimulated feisty discussion and challenge.

He described the essential role of Governors in CQC Inspections, emphasizing the importance of governor focus on:

- effective risk management,
- audits
- the annual Staff Survey
- the Duty of Candour
- complaints management, and
- involvement in CQC visits and resulting Improvement Plans

Prof Baker considered the staff survey to be the most important indicator, with a direct correlation between staff satisfaction and measureable quality improvement.

He outlined the changes in approach to Inspections going forward, and highlighted the new Guide for Governors and film on the CQC www site. (see slides).

Representing Interests of members and the Public
The afternoon session focused on engagement with members and the public with presentations from Sam Grayson, Senior Manager for member Engagement at the Nationwide Building Society and three Governors from the Homerton FT, Rotherham, Doncaster and South Humber FT and Salisbury FT.

Key learning from this session:

- opportunity to learn from other sectors

- variety of approaches in different FTs
- success of having a membership interactive www site
- success of an “adopt a ward scheme” (governors visiting alone by arrangement with the ward sister/charge nurse)
- importance of praise and pride in the Trust as well as critique and accountability.

Summary
A useful conference with excellent presentation materials included with this report for all EKHUFT Governors.

When the proceedings are placed on YouTube we will be notified.

COUNCIL OF GOVERNOR’ ACTION REQUIRED:

For information