East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS PUBLIC MEETING
24 MAY 2019, 10.40am
BOARDROOM, KENT & CANTERBURY HOSPITAL

This meeting follows on from a closed session of the Council of Governors, which will commence at 09.30am. The meeting will be conducted in line with the Trust Values below:

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**

AGENDA

Reference 19/ **Paper CoG 19/**

	HOUSEKEEPING			
01.	**Chair's introductions**	To note	10.40 (05)	*Jane Ollis Deputy Trust Chair*
02.	**Apologies for Absence and Declarations of Interest**	To note		*Jane Ollis Deputy Trust Chair*
03.	**Minutes from the last Council of Governors' Public meeting held on 14 February 2019**	To agree /03		*Jane Ollis Deputy Trust Chair*
04.	**Matters arising**	To agree /04		*Jane Ollis Deputy Trust Chair*
	BUSINESS			
05.	Chair's report	To discuss /05	10.45 (20)	*Jane Ollis Deputy Trust Chair*
06.	CEO's report	To discuss Verbal	11.05 (10)	*Susan Acott Chief Executive Officer*
07.	Governance: a. Lead Governor election outcome b. Fit and Proper persons declaration c. Register of interests d. Travel & Expenses Policy	To note /07 a /07 b /07 c To agree /07 d	11.15 (05)	*Alison Fox Group Company Secretary*

We care

08.	Report from the CoG Audit and Governance Committee	To discuss /08	11.20 (10)	*John East Committee Chair*
09.	Report from Board of Directors Integrated Audit and Governance Committee	To discuss /09	11.30 (15)	*Barry Wilding NED Committee Chair*
BREAK 11.45 12.00				
10.	Staff Survey	To discuss /10	12.00 (15)	*Andrea Ashman Acting Director of Human Resources*
11.	Report from Board of Directors Quality Committee	To discuss /11	12.15 (15)	*Barry Wilding NED Committee Chair*
12.	Report from CoG Membership Communication and Engagement Committee **cover members evening meetings in item**	To discuss /12	12.30 (10)	*Nick Wells Committee Chair*
13.	Members and Membership Engagement strategy 2019/22	To agree /13	12.40 (10)	*Nick Wells MECC Committee Chair*
14.	Effectiveness Review	To discuss /14	12.50 (10)	*Alison Fox Group Company Secretary*
CLOSE				
15.	**ANY OTHER BUSINESS** Please notify Committee Secretary of matters to be raised deadline 48 hours before the meeting.		13.00 (10)	*Jane Ollis Deputy Trust Chair*
16.	**QUESTIONS FROM THE PUBLIC**		13.10 (10)	*Jane Ollis Deputy Trust Chair*
17.	**DATE OF NEXT PUBLIC MEETING** See below		End: 13.20	*Stephen Smith Trust Chair*

Dates of remaining 2019/20 meetings:

DATE	DAY	TIME	TYPE	VENUE
2019				
5 August	Monday	09.30	Closed & Public	WHH Boardroom
3 September	Monday	17.30	Annual Members Meeting	Spitfire Cricket Ground Canterbury
12 November	Tuesday	09.30	Closed & Public	QEQM Boardroom
2020				
21 January	Tuesday	09.30	Strategy meeting	WHH Boardroom
27 February	Thursday	All day	Closed & Public - morning Joint with NEDs - afternoon	TBC

UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS PUBLIC MEETING
14 February 2019, 09.45
The Glo Centre, Unit 2, Westwood Business Park, Margate, CT9 4JJ

PRESENT:

Stephen Smith	Trust Chair (Chair)	StS
Sarah Andrews	Elected Governor Dover	SAn
Philip Bull	Elected Governor Shepway	PBu
Mandy Carliell	Elected Governor Staff	MCa
Jenny Chittenden	Elected Governor Swale	JCh
Roy Dexter	Elected Governor Thanet	RDe
John East	Elected Governor Dover	JEa
Sharon Hatfield-Tugwell	Elected Governor Staff	SHT
Alex Lister	Elected Governor Canterbury	ALi
Ken Rogers	Elected Governor Swale (Up to item 63/18)	KRo
John Sewell	Elected Governor Shepway	JSe
Marcela Warburton	Elected Governor Thanet	MWa
Nick Wells	Partnership Governor Volunteers	NWe
Philip Wells	Elected Governor Canterbury	PWe
Junetta Whorwell	Elected Governor Ashford	JWh

IN ATTENDANCE:

Sunny Adeusi	NED	SAd
Jane Ollis	NED	JOl
Susan Acott	Chief Executive (Item 63/18)	SA
Alison Fox	Trust Secretary	AF
Amanda Bedford	Committee Secretary (minutes)	AB

MIN.NO		ACTION
61/18	**CHAIR'S INTRODUCTION** The Chair opened the meeting.	
62/18	**APOLOGIES FOR ABSENCE AND DECLARATION OF INTEREST** Apologies for absence were received from: David Bogard, John Bridle, Julie Barker, Chris Wells and Debra Towes. PBu declared that he had accepted a post with the Trust as a clinical teacher and would therefore have to stand down as a public governor.	
62/18	**MINUTES OF PREVIOUS MEETING** The minutes of the meeting held on 6 November 2018 were agreed as an accurate record, with the following amendments: <u>Item 53/18 - Page 3 paragraph 2</u> JSe advised that 'in response to the unacceptably cost which would be incurred' should read 'in response to the unacceptable cost which would be incurred.'	

	Item 54/18 - Page 3 final paragraph JSe advised that JSe queried how the frailty of patients was being taken into account should read JSe queried how frailty was defined in the Trust. SHT indicated a new geriatrician in the Trust had set up a method for automatically electronically scoring frailty. This was readily accessible to staff. The Chair highlighted that discussions for setting up a department to deal with frailty, including consultants in and outside of the hospital, were ongoing.	
63/18	**MATTERS ARISING** 55/18 (a) Board of Directors Quality Committee report ***Ongoing*** 55/18 (b) Board of Directors Quality Committee report The review of the Trust complaints process was still ongoing; d significant changes had already been made to the process. ***Ongoing.*** 55/18 Outpatients updates PBu noted that an update from Lee Martin (LM) had been planned but had not yet happened. JCh s personal issue had been resolved, but general issues remained. ***Closed.*** 60/18 AF to prepare written response to ALi on public perception and reusable plastics. A position on reusable plastics was included within the sustainability policy that was in place. An email had been sent to the Governors in response to this question and would be recirculated. ***Closed.*** The updates on the remaining actions were noted and the items closed.	
64/18	**TRUST CHAIR REPORT** The Chair introduced the report and noted that the Joint Site visits programme was ongoing. MWa commented that reports resulting from visits she had attended had been brief, not reflecting all issues noted. NWe commented that the visits were valuable and those who had signed up for them should be strongly encouraged to attend. There was a marked degree of variation in the visit reports produced. **ACTION:** To review the reporting on Joint Site Visits. The Council **NOTED** the report.	AB
65/18	**VERBAL REPORT FROM THE TRUST CEO** SAc joined the meeting to provide a verbal report. She noted that	

	the new resuscitation area had been opened at William Harvey, adding six bays to the current four. The observation ward at Margate had opened. The observation ward at William Harvey was due to open at the beginning of the next week. Excess funding from the observation ward would be used to install air conditioning in A&E and a canopy for ambulance unloading. A meeting with the clinical directors had been very positive, with a good quality discussions. The pilot orthopaedic work at Canterbury was going well, with good feedback from patients, nursing staff and surgeons. Discussions with NHSI around making this a permanent arrangement were ongoing. Children from the Trust's Nursery had been meeting with elderly in-patients, some with dementia, and this was proving positive from both groups . A large research grant had been awarded to the Haemophilia team. SAc said that she was pleased to report that Cancer waiting times had continued to fall. The CQC paediatric report had been disappointing. Actions had been taken since the October visit, such as recruiting more paediatric staff in A&E. It was hoped the CQC would lift restrictions by the end of the week. The Governors would be informed of this once it was confirmed. The visit by the CCGs to children's services had been positive and their visit report had been sent to the CQC to provide external assurance. A meeting had been held with Health Education England, relating to improving the experience of junior doctors. PBu commented positively on the new Care Group structure. PBu highlighted that the infrastructure of monthly business meetings and education meetings was no longer present in many areas and suggested that these should be re-instated. SAc commented that the geography of the multisite structure was a challenge; there was value in facilitating clinicians coming together whenever possible. SAc said that a new frailty director for East Kent had been appointed. It was hoped this would give a strategic direction to the joining together of services across the hospitals and the community. PBu commented that increased psychiatric liaison within A&E departments had been shown to be very beneficial for patients.	

	SAc noted that investment in acute trusts could assist with mental health issues in the community, for example, the funding received for a drug and alcohol nurse at Margate. This could t be regarded as a legitimate use for community funding. The Council **NOTED** the report SAc and KRo left the meeting.	
66/18	**BOARD OF DIRECTORS COMMITTEE REPORT: FINANCE AND PERFORMANCE (FPC)** SAd commented that the Trust's first priority was the year outturn. Any issues here would affect the following year. The FPC had reviewed a list of schemes and initiatives aiming to ensuring a successful outcome. Income was off plan by around £6.5 million. An outturn of around £42.2 million was forecast, as opposed to the initial estimate of £30 million. This disparity related to reduced elective work income, necessary investment and agency spend. JOl indicated that there were controls in place around agency spend in the new clinical care group structure. SAd reported that FPC had been working with the Director of Finance and other colleagues on the executive team on business planning for FY20. NWe asked for assurance that current controls on agency spend would deliver the required result. SAd replied that Andrea Ashman (AA), acting Director of HR, would be attending the next FPC to provide evidence on these controls. Fewer people were now authorised to sign off on agency spend. JOl added that there had been a £0.6 million reduction in in-month agency spend for December. However, this needed to be sustained. The Chair commented that clinical directors in care groups had been specifically tasked with controlling agency spend. Assurance was being provided to the Board more promptly than in the past. NWe asked if there was any risk around reducing outpatient activity and increasing elective activity. SAd replied that outpatient activity should not be sacrificed for increased elective activity, especially as there was a degree of conversion from outpatients to elective. ALi queried what actions the Trust had taken around planning for the EU exit. The Chair replied that the Trust was engaged with the issues. SAc was part of an East Kent working group considering the consequences of the EU exit. The Chair said that he had spoken with the chair of the ambulance trust. The EU exit	

	would be discussed at the public Board in March. No extra financial provisions had been made. He noted that the Trust was required to align with central NHS communications when commenting publicly. ALi requested the Governors be privately made aware of any issues the Trust was facing around the EU exit. AF noted that the Director of Operations would be providing a full briefing to the private section of the Board. This could be shared with Governors. A budget code had been set up so any spend could be accounted for. JCh noted differences in spend on agency staff and substantive employed staff, particularly relating to staff pay and pension and national insurance contributions. The Chair explained that agency staff typically had a net cost of 20-30% more than substantive staff. SAd commented that reducing lead time for employing substantive staff could reduce agency spend; processes needed to be streamlined. JOl and the Chair confirmed that recruitment time was reducing. MWa asked if existing staff were being encouraged to work longer hours as bank staff and queried what was in place to monitor these staff to ensure they were safe to work. **ACTION:** JOl to investigate procedures in place to ensure staff working extra bank hours were safe to do so. SHT noted that nurse rotas flagged up if too many hours had been worked, but this would not include hours worked outside the Trust. The Chair confirmed that in future financial controls would be Health Economy Systems based rather than having a specific Trust control total. Questions remained around sharing of responsibility within the system. JCh reported that midwives had recently been told they could only work overtime through NHS Professionals. This meant that pay was lower and it was uncertain if pensions and other contributions were covered. MWa commented that this situation might be counter to employment legislation and requested further clarification. **ACTION:** Further clarification to be sought regarding midwives and overtime procedures. The Council **NOTED** the report	JOl AB
67/18	**BOARD OF DIRECTORS COMMITTEE REPORT: STRATEGIC WORKFORCE (SWC)** JOl commented that the workforce was still hugely under pressure	

	and this was reflected in staff turnover. Recruitment for the first three quarters of the year was higher than for the whole of the previous year. The Trust had voluntarily joined an NHSI programme focused on staff retention. Two recruitment matrons had been appointed to the HR team to support recruitment in challenged areas. Nursing turnover had fallen to 18% from 25% in the previous year. The national average was 15%. Care Groups were being encouraged to take a strategic approach to workforce planning. There was external support STP-wide from Ernst & Young. There had been innovation around new models of working and competency based approaches to roles. SAn asked for further details around allowing staff to work at the upper end of their licence and encouraging their development. JOl replied that a key aspect of staff retention was empowerment. Managers sometimes struggled with this as it was a coaching skill and took time. MWa noted that HCAs in the ENT department were being trained to take on some nursing responsibilities. JOl answered that the HCAs should be supported to deliver those functions; she could not comment on the specific situation. JWh noted the concerns of older people around acute and community services. The EU exit could lead to further issues if EU nationals currently working as social carers left the country. JOl explained that the STP was considering workforce capability Kent and Medway-wide, not just in the acute sector. The appointment of a director for frailty was part of an integrated approach. The clinical lead for support services within the Trust came from a community background so understood the need for collaboration. JCh suggested a meeting between the Trust and Community Care to discuss care of the elderly and frail, particularly in their own homes would be helpful. The Chair noted that the partnership board was currently developing plans to facilitate cooperative meetings, for example between Boards and Governors of different trusts. The Council **NOTED** the report	
68/18	**MEMBERSHIP ENGAGEMENT STRATEGY REPORT FROM WORKING GROUP** NWe indicated that the overarching objective of the strategy was to grow an engaged membership that was representative of the East Kent population. There were three elements underpinning the strategy: • Identifying the value of members to the Trust. Members were a valuable source of insight and a route to providing	

	the public with information. • Identifying the value of being a member to members. Members contributed to the Trust and were informed about Trust issues. and being informed about Trust issues. • Identifying the Governors responsibilities are around members. These responsibilities could include hosting site visits for members and ensuring the governors newsletter was structured, informative and published regularly. Membership strategies from other trusts had been reviewed to inform the strategy. Instead of a tick box exercise, the Trust should aim for an active and involved Council of Governors that added value. Time and commitment would be required from Governors to carry out the necessary roles and activities. The Trust would need to support Governors in this. Council meetings should be more focused on general principles. Actions delivered should be reported back to the membership. ALi commented that defining the function of a member would add value to membership. The structure of meetings could be changed so that any member could propose a motion, which would then be discussed and voted on. There was a general lack of knowledge around the membership system and the role of Governors, so more publicity was needed. This could be achieved by piggybacking on district council magazines. The Chair thanked Governors for their contribution to the discussions on the draft strategy and confirmed that these issues would be discussed in more depth in the afternoon session.	
69/18	**COUNCIL OF GOVERNORS MEMBERSHIP ENGAGEMENT AND COMMUNICATION COMMITTEE REPORT** PBu drew the meeting s attention to the paper on Trust communications and public perception. The Trust could do more to promote its successes. The Chair agreed that the Trust should endeavour to present a balanced position, including the good news. This would be discussed further in the afternoon session. The Council **NOTED** the report	
70/18	**COMMITTEE MEMBERSHIP AND CHANGES TO THE TERMS OF REFERENCE FOR THE AUDIT COMMITTEE** AF drew the Council s attention to the committee membership proforma which would be circulated for completion for the annual review. AF explained that under the current terms of reference the Audit Committee would generally meet every three years. It was proposed that the terms of reference were extended to include the	

	statutory role around providing a commentary to the Trust's annual quality report. If the change was approved, it would be implemented quickly. AF suggested that the Audit and Governance Committee could be used as a forum to discuss changes to policies, although decisions would still be made at Council. SAn welcomed the proposed changes. Care would be needed with the TOR, particularly if quality was added, to ensure the commitment for Governors was manageable and oversight was present. AF commented that the board assurance framework report could be used to triangulate feedback received. JSe supported the proposal and noted that the change in TOR might mean current members of the Audit Committee wanted to resign and others wanted to join. ALi noted that committees had previously been oversubscribed and suggested that existing members of committees who wanted to remain should not be removed. The Council **AGREED** the proposed changes to the terms of reference of the Audit Committee, including the change of name to the Audit and Governance Committee.	
71/18	**LEAD GOVERNOR ELECTIONS** AF presented the report and noted the change proposed to the term of office so that it would run from the date of the email confirming the election result. Results 0f the 2019 election would be announced by email and formally included in the minutes on 24 May 2019. AF reminded Council that one of the roles of the Lead Governor was liaison with NHS England. This was particularly important currently, with the Trust remaining in financial special measures and needing to build trust with the regulators. The Council **AGREED** the proposed timeline for the elections and the change to the date that the term of office would run from.	
72/18	**POLICIES** **Chair and NED appraisal process** AF indicated that the document included the Governors' role in providing feedback on the chair and NEDs' performance. The senior independent director was the lead for replacing the chair and the chair was the lead for replacing the NEDs. Objective setting was covered elsewhere but could be included in this document if required. The guidance was **APPROVED**, with the proviso that it would be brought back to a future meeting if more detail was added around objective setting.	

	Fit and proper persons test There was still a requirement for Governors to meet the fit and proper persons test, but it was a slightly lower test, overseen by NHSI and not the CQC. References to executive directors and NEDs had been removed as the policy had been split. The policy was **APPROVED**. **Media** There had been a minor change to the policy to recognise social media, but no significant changes. The policy was **APPROVED**.	
73/18	**ANY OTHER BUSINESS** There was no other business.	
74/18	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no members of the public present. The meeting was closed.	
75/18	**DATES OF NEXT PUBLIC MEETING** The next meeting would be held on Friday 24 May.	

Future meetings

DATE	DAY	TYPE	TIME	LOCATION
2019				
24 May	Friday	Closed and Public Council	0930 1300	KCH
10 July	Wednesday	Training session	0930 - 1300	WHH
5 August	Monday	Closed and Public Council	0930 1300	WHH
September	TBC	Annual Members Meeting	TBC	TBC
12 November	Tuesday	Closed and Public Council	0930 1300	QEQM
2020				
24 January	Thursday	Strategy development	0930 1230	WHH
27 February	Thursday	Closed and Public Council Joint meeting with NEDs	0930 1600	TBC

COG 24/18

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING (PUBLIC) PRESENTED ON 24 MAY 2019

ACTION POINTS FROM THE COUNCIL OF GOVERNORS MEETING (PUBLIC) HELD ON 14 FEBRUARY 2019

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
55/18 (a)	06.11.18	**Board of Directors Quality Committee report** Provide an update to Council on the outcome of the Quality Review undertaken on 2 October and confirm the frequency of the reviews moving forward.	AB	When available	**14.02.19 Update: ongoing**
55/18 (b)	06.11.18	**Board of Directors Quality Committee report** Update the Council on the progress with the review of the Trust's Complaints process.	AB	Next meeting	**14.02.19 Update:** update to the meeting
ACTIONS FROM THE LAST MEETING HELD ON 14 FEBRUARY 2019					
64/18	14.02.19	**Trust Chair Report** Review the reporting on the Joint Site Visits	AB	Next meeting	**14.02.19 Update:** Amanda Bedford is now attending all visits and will write the reports. Template has been changed and the first report was received favourably by the visit team. Moving forward, the reports will be shared with all governors via the MECC meeting papers. **Propose close action**
66/18 a	14.02.19	**Finance and Performance Report** Confirm that there are procedures in place to ensure staff working extra bank hours were safe to do so	AB	Next meeting	**14.02.19 Update:** Trust staff are required to inform their managers if they intend to take up an additional post or posts and request agreement. Their manager has a responsibility to ensure that this will not adversely affect their ability to undertake their primary job with the Trust. **Propose close action**

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
66/18 b	14.02.19	**Finance and Performance Report** Further clarification to be sought regarding midwives and overtime procedures	AB	Next meeting	**14.02.19 Update:** update to the meeting

CoG 19/05

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**TRUST CHAIR'S REPORT**
PAPER AUTHOR:	**ACTING TRUST CHAIR** **JANE OLLIS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**Annex A:** Note to Governors from Stephen on Council Vacancy **Annex B:** Pathology Group Terms of Reference

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report provides an update to the Council on key issues.

Background

I am looking forward to chairing my first Council of Governors meeting as Acting Trust Chair during Stephen's absence. We have a very full agenda with some interesting items to consider and I look forward to everyone's contribution.

Vacancies on Council

In January this year Philip Bull resigned as a public Governor for Folkestone and Hythe, as he had accepted a teaching post in the Trust. Neither of the other two candidates who stood at the last election were able to step into the vacancy, so the post needs to be filled via an election.

The Council were asked to agree to waive the Trust Constitution to allow this election to take place at the same time as the next scheduled elections; the proposal circulated is at Annex A as a reminder. The outcome of the request to ratify the proposal was inconclusive so on 25 March Stephen wrote to you as follows:

> Dear Governors, I have followed with interest your virtual discussions on the proposal to hold the vacancy for the Folkestone and Hythe Governor open for two months longer than is allowed for in the constitution. The vote closed last Friday and, unfortunately, only 12 governors voted. This is less than the minimum number required 14, so the vote is void.
>
> The points raised, both in support of and against the proposal, are valid and persuasive. Constitutional questions were also raised which it would be helpful to address in full session. I am therefore going to take the proposal as an item at the next Council meeting in closed session. This will allow for a full discussion with a real time exchange of views and therefore a more robust debate.
>
> As the proposal, if agreed, waives an element of the Constitution, it would have to be endorsed by the Trust Board if it were to be passed by Council. I will take the opportunity at the Board meeting on 4 April to canvass the views of Board members as to whether they are likely to agree to such a proposal in principle, sharing with them the views you have expressed.
>
> I thank you for engaging honestly and thoughtfully with this situation and look forward to an interesting debate.

Since then, John Bridle has also resigned from Council, leaving a vacancy in Ashford. There were three other candidates for the constituency vacancy; two have declined the offer to take up the post and we are currently awaiting a response from the final candidate.

I will invite the Council to discuss this situation at the meeting and would like to propose an alternative approach for consideration. There are eight public governors and two staff governors coming to the end of their terms of office on 28 February 2020. We could run these elections early, together with the two current vacancies. If the notice of elections was published in July, there would be time to do some work on advertising the vacancies and the Members Evening Meetings scheduled for July could include an item on being a Governor.

The results of the elections would come through around September. The successful candidates for the two current vacancies could start immediately with a start date of 1 March for the others.

This would have the advantage of saving money by avoiding two elections processes and allow for a group induction process, meaning that those starting in March 2020 would have an opportunity to prepare for the role in advance. There is a risk that the circumstances of successful candidates may change before the commencement date. I look forward to an interesting debate.

On the subject of Council membership; the Local Authority elections took place on 2 May and, as a consequence, the appointment of the Local Authorities Partner Governor is being re-considered. The Local Authority Leaders are currently considering appointments within their Councils and will be looking at the appointment of the Partner Governor as part of that process. We expect to hear from them in early June.

<u>Governors on other Groups or Committees</u>

This is an issue which has been discussed on a several occasions by Council over a number of years. Requests are often received by the Corporate support team for a Governor to sit on a Committee or Group; these can be both internal to the Trust and from external organisations. The current position is that governors should not sit on other groups or Committees.

However, a request has since been received Kent and Medway Sustainability and Transformation Partnership for a governor to join the Patient, Public and Stakeholder Group, Kent and Medway Pathology Programme. The terms of reference for the Group is attached at Annex A, for information. Stephen is of the view that it is important that the Trust is represented on this group and feels that the invitation should be accepted. It is also likely that similar requests will be made in the future by the Kent & Medway STP.

I would therefore like to ask the Council to think again about this issue and whether the approach to such requests should be altered from an automatic decline to one of asking the requester to explain why there needs to be a Governor representative, as opposed to a patient or public representative. Each case could then be considered by Council on its own merits, perhaps on the basis of whether it fits with the statutory duties of the Governors. For example, will it be a significant transaction, a major change to services or increase private patient income

If this is agreed, I would further request that Council consider the invitation twhether there should be Governor representation on the Pathology Patient, Public and Stakeholder Group.

I am also aware that Junetta Whorwell asked for clarification about her removal as a Governor representative on the Trust□s Equality and Diversity Steering Group, and that she

may wish this to be re-considered.

Patient/Staff experience presentations to Council

The Governors who attend the public Board meetings will be aware that these traditionally begin with a short presentation from a patient or member of staff about their personal experience. At the May Board the presentation was from staff talking about the Listening into Action projects, which was very well received. Stephen has asked you to consider whether you would like similar presentations to be arranged for the start of Full Council meetings.

Members meetings

A reminder that the Annual Members meeting is taking place at the Spitfire Cricket Ground on 3 September 2019, starting at 5.30. The plan is to follow the format used last year as this was considered to be successful. An update on the planning will be provided to the Membership Engagement and Communication Committee on 1 July 2019.

The next round of Members Evening Meetings will be taking place in July:

- 9 July KCH
- 22 July QEQM
- 29 July WHH

The plan is to follow the same format used for the March meetings: hosted by the Trust Chair with time at the start for Governors to talk with members while refreshments are served. Each meeting will focus on the work of one clinical team and I will update Council at the meeting on the potential speakers. I would welcome the views of Council on this plan.

Joint site visits

Stephen has included the following information on Joint Site Visits in his reports to the Board since the last Council meeting:

March meeting

There have been two joint site visits since my last report to the Board. Visits are made to all departments across the Trust including those managed by the League of Friends and 2gether Support Solutions (e.g. EME and the Restaurant). Both teams were impressed by the staff they met and felt that there was some strong leadership apparent. The reports from the visits are shared with the relevant member of the Executive Management Team for action to be taken as appropriate.

The first was at the William Harvey Hospital on 13 February and took place in the evening. The team visited the Electrical and Mechanical Engineers Department (EME), the League of Friends shop, the Pathology Department and the Clinical Decision Unit (CDU). The EME team were pleased to receive the visit as this is a department with a very low public profile, yet one which delivers an absolutely essential service maintaining clinical equipment across the Trust. The staff spoke about the negative impact of changes in the induction process relating to procedures for dealing with equipment faults which need to be reviewed.

The second visit was on 19 February at the QEQM Hospital and covered Day Surgery, the Diabetes Centre and the Restaurant. One theme from this visit was poor décor in various areas; this needed to be addressed. In the restaurant area, the staff expressed their willingness to undertake the work themselves. In both the clinical areas, the staff talked about their ideas for making best use of the resources in their areas.

April meeting

One joint site visit took place in March at Kent and Canterbury Hospital. The team

visited the Audiology Department, Electrical and Mechanical Engineers, Clinical Haematology, Pathology and the Vascular Unit. At the time of writing this report, the visit report was awaited. To improve the speed at which actions can be taken following the visits, moving forward the Governor and Membership Lead will join the team and take responsibility for producing the visit report.

May meeting
One joint site visit took place in April at the QEQMH. The team visited the dermatology secretaries, Pain Services, Rainbow Ward (Children's) and Sandwich Bay (respiratory). The team were impressed with the staff they spoke with and their commitment to providing quality care and their energetic approach to developing and improving those services. In both ward areas the staff were seeking ways to make the best use of the space available. Staff vacancies and sickness was recognised as an issue in all the areas visited; the team felt that strong leadership was evident in all areas. The opportunity was taken to look at the record books for resuscitation trolleys and fridge temperature checks on the wards and all was found to be in order.

The team felt that the Pain Services team would be an ideal candidate for presenting at a Members Evening; they are the one department in the South of England, outside of London, able to undertake a procedure for inserting spinal cord stimulators.

The meeting scheduled for May had to be postponed at short notice as the Executive, Phil Cave, was called to an urgent meeting. The visit is being re-scheduled. As noted in Stephen's report to the April Board meeting, Amanda is now joining all the visits and will produce the visit reports. The process is bedding down well, although there is still some work to be done to make sure that actions are followed through in a timely fashion.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to:

a) discuss the timing of elections to the current governor vacancies and those scheduled for 2020;
b) consider a process for responding to requests for governors to sit on groups or committees;
c) consider the inclusion of staff, public or patient stories onto the Council agenda; and
d) respond to the proposed plan for Members Evenings.

CoG 19/05

East Kent Hospitals University NHS Foundation Trust

5

CoG 19/05 Annex A

Governor vacancy in Folkestone and Hythe Constituency

Dear Governors you know Philip Bull resigned on 13 January 2019, with effect from 28 February. His term of office was scheduled to end on 28 February 2021.

The Trust's Constitution states the following with respect to a governor resigning mid-term:

> Section 14.4
>
> **14.4** Subject to paragraph 14.5 below, if an elected member of the Council of Governors shall die or resign before the expiry of his term of office, then the Council of Governors shall invite the next highest polling candidate for that seat at the most recent election, who is willing to hold office, to fill the seat for any unexpired period of the term of office. Candidates will be approached in the order of the percentage of votes received. If there is no such candidate, then a by-election shall be conducted.
>
> **14.5** If an elected member of the Council of Governors shall die or resign in the 6 months prior to the trust holding elections for the Council of Governors, the Council may elect that the position will remain vacant until such time as an election has been held and an individual has been appointed to fill such position on the Council of Governors.

The last elections in Philip's constituency took place in January/February 2018. Three candidates stood and the results were:

1. Philip Bull 173 votes
2. Garry Harrison 24 votes
3. Terry Mullard 19 votes

Garry Harrison was offered the vacancy and would have liked to take the position but has moved outside of the area since the elections so is no longer eligble. Terry Mullard originally agreed to take the post but later withdrew as he felt his personal circumstances would not give him enough time to undertake the role properly. Both these candidates have stood in the elections in the constituency before.

Under the constitution, a by-election should now be held in the constituency. The Trust is contracted to UK Engage as our election provider and they will need three weeks' notice to prepare; the process takes a little over two months to complete from the publication of the notice of elections. The election would therefore start in April and be completed by June/July.

The constitution allows for a governor vacancy to be held open if an election is scheduled within 6 months. For this to apply, the next elections need to be scheduled to start in September this year.

The next scheduled Governor Elections are for appointments to be made to vacancies arising from Governors' with terms of office ending on 29 February 2020. The election timetable is laid down in the constitution, and needs to be completed before the end of February. The election starts with the publication of the Notice of Elections, which is planned for November 2019.

Recent experience, at this Trust and the other three Foundation Trusts in Kent and Medway, has shown that it is getting increasingly difficult to attract candidates to stand for election. The corporate team are planning a longer lead-in time to the 2020 elections to allow for a long term publicity exercise.

The cost of elections is in the region of £3000 per constituency. In 2020 there will be 6 constituencies with governor vacancies, including Folkestone and Hythe as John Sewell comes to the end of his term of office.

It is therefore proposed that the Council be asked to agree to hold the vacancy in the Folkestone and Hythe constituency until the 2020 elections. This holds the position open for two months longer than allowed for in the constitution elections starting in November rather than September (the 6 month point).

The benefits of taking this action are:

- Taking advantage of the planned programme scheduled for the latter part of 2019 to improve the numbers of candidates standing for elections.
- Avoiding two elections in the constituency in the same year.
- Financial saving of £3000.
- Staff resource saving - Governor & Membership Lead s time.
- Better induction for the new governor as there will be a cohort induction programme after the scheduled election.
- Council stability the Trust s election cycle of one no election year every three years provides an opportunity for the Council to focus on its aims and goals without having to manage change in the membership.

It is recognised that the constituency would be represented by only one governor for an extended period. John Sewell has confirmed that he is willing to manage this situation.

CoG 19/05 Annex B

Transforming health and social care in Kent and Medway

NHS

Kent County Council kent.gov.uk

Medway Council Serving You

PATIENT AND PUBLIC STAKEHOLDER GROUP
TERMS OF REFERENCE
KENT & MEDWAY PATHOLOGY PROGRAMME

DRAFT FOR DISCUSSION

1. PURPOSE

The role of this group at Outline Business Case (OBC) stage should be as follows :-

- the engagement of key public and patient stakeholders in understanding the goal, methods and outcome of the OBC
- the use of the group as sounding board for input into the project
- awareness of the progress of the project
- internal communication to their organisations
- equality impact assessment of options on groups and individuals

2. BACKGROUND AND SCOPE

The Kent and Medway Pathology Programme is at OBC stage which involves detailed evaluation of options for service configuration and commercial delivery; plus separate business cases for a single Laboratory Information Management System (LIMS) and single Managed Equipment Services (MES). Several sub-groups of the project team have been set up in order to feed in to the OBC. The public and patient stakeholder sub-group is one of those and will ensure that considerations relating to patient users of pathology services and organisations representing patients are taken into account in option evaluation.

3. MEMBERSHIP

This comprises of :-

- Programme Manager/Workforce and Organisational Development Lead - chair
- Clinical director MTW
- Healthwatch Kent representative
- HOSC representative no keep them informed instead
- public members of trust boards/Trust governors
- representatives from patient groups with significant interaction with pathology e.g. Diabetes UK, Renal Patients Association, Kent Cancer Trust, Haemaphilia Society
- Point of Care Coordinators
- Communications lead

CoG 19/05 Annex B

-

4. ROLES AND RESPONSIBILITIES

XXX

5. GOVERNANCE

The sub-group will report in to the project team which in turn reports to the Programme Board.

6. REVIEW AND APPROVAL

The terms of reference will be further developed at the first meeting and reviewed at the end of the OBC stage.

CoG 19/08

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**AUDIT AND GOVERNANCE COMMITTEE (AGC) CHAIR'S REPORT**
PAPER AUTHOR:	**AGC CHAIR JOHN EAST**
PURPOSE:	**DISCUSSION**
APPENDICES:	**None**

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report provides a summary of the key items discussed at the AGC meetings held on 26 March and 10 April 2019.

Background

The inaugural meeting of the Committee, under the expanded terms of reference agreed at the February Council meeting, took place on 26 March. On a practical basis it was a challenging meeting involving both Skyping and conference calling, however, it was necessary in order to organise the work needed to draft the Governors' commentary on the Trust Quality Report.

The work on the commentary took up much of the time at both meetings of the Committee and it has been summarised in the report taken to the closed session of Council today – item 5 on that agenda.

The other main item on the March agenda was looking at, and agreeing, a draft for the Committee's annual schedule so that it can meet its terms of reference. The meeting looked particularly at the requirement to:

- At each meeting, consider:
    - issues of Quality raised by Governors or their constituents to identify trends and themes;
    - the Board assurance framework; and
    - quarterly performance against the annual quality objectives and identified risk.

  Use this information to inform the development of a draft of the Council commentary on the Trust's Quality report to take to Council for agreement.

The Committee agreed that it would time its meetings so that it can receive the same reports as the Board of Directors' Quality Committee on the Board Assurance Framework and the Quarterly performance report against the annual quality objectives. The intention is to have Quality Performance as an item at every meeting and to use these reports, together with feedback from the members and the public, to test Board performance on quality issues. The Committee's views will then be brought to Council to enable NEDs to be challenged. If needed, the Committee intends to request further information from the Trust.

The Committee believes that this approach will mean that it will be in a better position at year end to draft the Governors' Commentary on the 2019/20 Quality report and comment on

whether the contents of the report is "not inconsistent with internal and external sources of information".

At the April meeting the Committee also received the terms of reference for the Board of Directors Integrated Audit and Governance Committee. At the next AGC meeting these will be considered in greater detail in order to provide comments to the IAGC prior to their annual review of their terms of reference.

The Committee will be meeting on a quarterly basis and dates will be set for the remainder of 2019/20 once the Board of Director Quality Committee meeting dates are confirmed. These are currently being reviewed in order to match better to the Trusts cycle for gathering and reporting on monthly data.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to note and discuss the content of this report.

CoG 19/09

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**Report from the Chair of the Board of Directors' Integrated Audit and Governance Committee**
PAPER AUTHOR:	**Chair, Board of Directors' Integrated Audit and Governance Committee** **Barry Wilding**
PURPOSE:	**DISCUSSION**
APPENDICES:	**Annex A:** IAGC report to Board from 17 January 2019 meeting **Annex B:** IAGC report to Board from 7 April 2019 meeting **Annex C:** Board Assurance Framework **Annex D:** Report on Annual Priorities

BACKGROUND AND EXECUTIVE SUMMARY

Summary

This report provides Council with an outline of the key issues that the Integrated Audit and Governance Committee (IAGC) has been focussed on, highlighting to Governors how the Non-Executive Directors are seeking assurance about the performance of the Board.

Background

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

The Board of Directors' IAGC meets on a quarterly basis and there have been two meetings since the last time a report was presented to the Council of Governors. The Chair's reports to Board relating to the IAGC meetings held on 17 January and 7 April 2019 are attached at Annex A and B respectively.

The most recent Board Assurance Framework considered by the Committee is attached at Annex C, the report on the Annual Priorities 2018/19 at Annex D.

CHAIR'S REPORT TO COUNCIL

One of the key papers that the IAGC receives at every meeting is a report on the principal corporate and strategic risks. As Non-executive Directors we will be looking for evidence that the risks that we have identified, based on our own knowledge and experience, appear on the risk register and that suitable action is being taken. We will also look for reasonable progress in those actions.

In period the Committee agreed to the closure of two risks:

- CRR 39 – delays in radiological reporting
- CRR 31 – exposure to Cyber Security

In January the Committee received an update report on CRR 34 – inadequate H&S Systems embedded within Care Groups.

In April the Committee expressed disappointment with the untimely progress updates on the risk register and will expect to see an improvement in the report presented to the next meeting.

At every meeting the Committee also considers the Board Assurance Framework and a paper on the delivery against the annual priorities (see Annexes C and D).

In January the Committee noted that the Partnership Strategic Objective was currently outside the Board's agreed risk appetite tolerance and this strategic risk was aggregated as extreme (significant). Work with partner organisations continues to develop an East Kent Accountable Care Partnership/Integrated Care System. The Committee also noted that the overall performance for Provision was currently Red, which is a deterioration from Amber in Q1 and that this reflected the challenges in the Emergency Departments (EDs).

The Committee considered reports on the items below and my reports to the Board covers the key outcomes of the discussions.

In summary,

- Reports on Deep Dives into:
  - Theatre Improvement Plans
  - Agency Direct Engagement Model Scheme.
- The Annual review of the Trust's Standing Financial Instructions (SFIs), with some housekeeping changes made in response to the introduction of the Care Groups and the setting up of 2gether Support Solutions Ltd. There was a significant change in relation to the introduction of a £1m contract value limit over which Board approval is required for requisitioning goods and services.
- The revised Risk Management Strategy and Policy, again to take into account the introduction of Care Groups, which was then recommended to the Board for approval.
- The methodology and results of the annual review of the Trust's Risk management maturity based around the risk management policy. The response to the self-assessment survey was poor and consideration was being given to repeating the exercise. A key area for improvement is delivering training to embed risk management across the new Care Group structures.
- A report regarding the system wide management of Strategic and Partnership Risks.
- A quarterly report, at both meetings, from the Freedom to Speak UP Guardian which included details on publicising the Guardian's role.
- The draft Internal Audit report on the Single Tender Waiver (STW) arrangements was presented to the January meeting. The Committee requested to see an action plan at their next meeting, in April, and were pleased to note then the improvement in relation to the number of retrospective STWs.
- A report on the results of the annual IAGC effectiveness review; the feedback was positive and some minor changes were made to the Committee's terms of reference in response.
- A report on Losses and Special payments.
- The Committee was pleased to note that the Trust has reported 100% compliance against the national Data Security and Protection Toolkit.
- Progress reports were received from the Internal and External Auditors and the Counter Fraud team at both meetings.

The Committee requested the Board to take the following actions at their February meeting, with none at the May Board meeting.

a) Approve the revised SFIs;
b) Approve the revised Risk Management Strategy and Policy;
c) Approve the IAGC ToR.

CoG 19/09

East Kent Hospitals University NHS Foundation Trust

I look forward to attending the Council of Governors meeting when I will be able to report on the outcome of the Joint meeting of the Board of Director Committees, which takes place on 22 May, to approve the Trust s Annual governance documents.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care.

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to discuss this report and take the opportunity to share with the Non-Executive Directors present intelligence arising from Governors engagement with FT members and the public relevant to the work of the Committee as reported to the Trust Board.

CoG 19/09 Annex A

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX A: RISK MANAGEMENT STRATEGY AND POLICY** **APPENDIX B: BOARD ASSURANCE FRAMEWORK** **APPENDIX C ANNUAL PRIORITIES 2018/19** **APPENDIX D: IAGC TERMS OF REFERNCE (TOR)**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

- What positive assurances were received?
- What concerns in relation to assurance were identified?
- Were any risks identified?
- What other reports were discussed?

MEETING HELD ON 17 JANUARY 2019

Positive assurance was received in relation to:

1. The Committee received and discussed a report on the Full Strategic and Corporate Risk Registers, noted the changes that had been made to the risk register. The Committee took assurance from the progress updates provided in relation to the management of the risks, but emphasised that there remained 17 extreme and high risks on the register. It was highlighted that statistically it was likely that some of these risks would crystallise during the year and that there needed to be in place appropriate action plans to mitigate these risks. The Committee noted the following:

   1.1 The heat map showed 32 live (open) strategic and corporate risks;
   1.2 The change to the residual risk score regarding SRR 8 Inability to attract, recruit and retain high calibre staff (substantive) to the Trust. This has been reduced due to the improved recruitment processes and subsequent increase in the number of new starters. There had also been a change to one target score for SRR 16 Failure to maximise/sustain benefits realised and evidence improvements to

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REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

services from transformational programmes, which has decreased from 8 (moderate) to 6 (low);

1.3 There were two risks proposed for closure and these were agreed; CRR 39 - Delays in radiological reporting, as the major fluctuations had been reduced and the current backlog is in a good position and monitored closely; CRR 31 - Exposure to Cyber Security, as sufficient controls are now in place to mitigate the risk to a tolerable level;

1.4 There were no risks that had been requested for escalation;

1.5 An emerging Health & Safety (H&S) risk in relation to window restrictors at Kent and Canterbury Hospital (K&CH) in terms of compliance with H&S Executive (HSE) guidance as to the depth of the window restrictors.

2. The Committee received and discussed a verbal Cost Improvement Programme (CIP) deep dive update regarding the theatre improvement plans. The Committee received assurance that a realistic and achievable improvement plan is in place and will be taken forward, albeit that this plan had been deferred to the next financial year 2019/20.

3. The Committee received and considered a report on the annual review of the Standing Financial Instructions (SFIs). The SFIs have been revised and the final version will be presented to the Board in March for approval. The Committee noted:

3.1 The revised SFIs take account of the new management structure around the Care Groups and the setting up of the Trust's wholly owned subsidiary, 2gether Support Solutions Limited;

3.2 The significant change in relation to the introduction of a £1m contract value limit over which Board approval is required for requisitioning goods and services;

3.3 That the numbering and alignment will be adjusted when the final version is approved.

4. The Committee received and considered the revised Risk Management Strategy and Policy, and recommended this for approval by the Board (Appendix B). This has been revised to reflect the new Care Group structure and has also been moved to the new policy template.

5. The Committee received and approved the 2018/19 Annual Accounts Process and Accounting Policy. The Committee noted the key deadlines and the high level actions to ensure the Trust remains on track for completing the accounts process. The draft (unaudited) accounts and Provider Finance Return forms (PFR) are required to be submitted by noon on 24 April 2019, and the audited accounts and PFRs by noon on 29 May.

The following reports were also discussed:

6. The Committee received and discussed the Quarter 2 report on the Board Assurance Framework (BAF) (Appendix C) and Annual Priorities 2018/19 (Appendix D): Delivery against priorities Quarter 2. These reports are attached for the Board to note.

6.1 The Committee noted that the Partnership Strategic Objective was currently outside the Board's agreed risk appetite tolerance and this strategic risk was aggregated as extreme (significant). This is as a result of the delays that continue around the delivery of the Sustainability and Transformation Partnership (STP). The Committee highlighted the importance of taking forward the necessary actions to progress the delivery of the STP and requested that there is focussed work to ensure this is progressed and that the residual risk score is reduced;

6.2 A communication will be issued to all risk owners for individual risks that are

CoG 19/09 Annex A

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

extreme in terms of taking the required actions to reduce the residual risk score;

6.3 Work with partner organisations continues to develop an East Kent Accountable Care Partnership/Integrated Care System. This included work around delivering a frailty pathway, developing an Estates Strategy, Kent Care Record, and the programme around the pathology partnership;

6.4 The Committee noted the amber rated performance and adequate assurance achievements regarding the other strategic objectives for Patients, People and Provision;

6.5 The Committee noted that the overall performance for Provision was currently Red, which is a deterioration from Amber in Q1 and that this reflected the challenges in the Emergency Departments (EDs).

7. The Committee received and discussed a report on the methodology and results of the annual review of the Trust's risk management maturity based around the Risk Management Policy. The Committee noted:

7.1 The disappointing poor response to the self-assessment questionnaires as only 12 out of the 44 questionnaires sent were completed and returned, which could have been due to the timing that this was undertaken during the Christmas and New Year period. The review process will be considered to be undertaken again following the Board risk appetite session;

7.2 Following this annual assessment the Trust's risk maturity remains at the start of Level 3 with an overall score of 67/110, this describes the Trust's risk as 'Risk management applied consistently and thoroughly across the organisation', which is the same score as the 2017/18 assessment;

7.3 A key area for improvement is delivering training to embed risk management across the new Care Group structures;

7.4 An internal audit exercise on risk management will be undertaken towards the end of this financial year, the recommendations from this will be consolidated with the results of the annual review to support the development of a comprehensive work plan for 2019/20 to strengthen the risk management of the Trust.

8. The Committee received and discussed a report regarding the system wide management of Strategic and Partnership Risks. Systems are in place across the individual organisations and the Committee noted the challenges around when these risks are shared with partners across the NHS. It was acknowledged the advantages of adopting a standard approach for partnership risks and that risk management is a key element to the successful delivery of the NHS long term plan.

9. The Committee received and discussed a quarterly Freedom to Speak Up Guardian (FTSUG) report providing an update on the activity of the FTSUGs in Q3, which was beginning to get traction. The following was noted:

9.1 Ten cases have been reported to the FTSUGs;

9.2 The common themes were around local leadership development, lack of opportunity for staff to voice concerns and to discuss resolution at a team level, the need for active listening and environments that support open and honest communication;

9.3 Learning as a result around strengthening leadership development at middle management level, improving opportunity for listening events, staff forums and local team meetings. This will give staff a voice and also enable issues to be addressed locally;

9.4 The activity of the FTSUGs during Q3, which included collaborating with HR around the events held on all of the Trust's five sites in October promoting speaking up. A Schwartz Round was also held on this topic at the William Harvey Hospital (WWH). A review of relevant policies has been undertaken with the HR Team, and

CoG 19/09 Annex A

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

amendments have been agreed to comply with the NHS Improvement (NHSI) guidance. There has been preliminary work to triangulate data to identify hot spots within the organisation. The Trust's website has been updated to include the FTSU Champions and also the FTSUGs mobile numbers providing an alternative means of contact for people to raise any issues;

9.5 A third FTSUG has been appointed, who is a Urology Consultant;

9.6 The successful recruitment of FTSU Champions across the three main hospital sites;

9.7 A 'Speak Up' icon is being developed on all Trust devices to give staff an alternative way to raise concerns and also to enable anonymous reporting, it is anticipated that this will be launched at the end of February/beginning of March 2019;

9.8 The Trust acknowledges the importance of allocating ring fenced time for the appointed FTSUGs to carry out their roles, and continues to work on having in place a formalised process.

10. The Committee received and discussed the draft Internal Audit Report on the Single Tender Waiver (STW) arrangements. The Committee noted:

10.1 The Internal Audit Report, which was not positive but that the internal process had been improved and was much more robust;

10.2 The recommendations around learning and closing gaps in internal control;

10.3 This remained an area of concern. An action plan will be produced, which will be presented to the next IAGC meeting;

10.3 That the Trust had commissioned a wider review of the procurement and tendering process.

11. The Committee received and discussed an update report on CRR 34 – Inadequate H&S Systems Embedded within Care Groups. The Committee noted:

11.1 Performance had deteriorated;

11.2 There has been a lack of engagement from Care Groups with the Internal Auditors, who are currently undertaking an audit focussing on H&S performance;

11.3 The exposure as a result of the lack of improvements achieved and the importance of embedding the required level of H&S management within the organisation;

11.4 The 5 Control of Substances Hazardous to Health (COSHH) related Care Quality Commission (CQC) required improvement actions;

11.5 The H&S Team will be working closely with the Care Group leads to formalise H&S responsibilities and also create clear H&S management structures. The Team will be supporting Care Groups by attending the monthly quality and safety meetings, are also looking at offering more in-house courses as well as bidding for extra funding for CQC improvement areas including COSHH management.

12. The Committee received and discussed a report on the results of the annual IAGC effectiveness survey in relation to the views of members and regular attendees regarding its effectiveness in line with its ToR and the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook. The Committee noted the feedback and the positive results of the survey, a few amendments were recommended to the ToR that were approved along with a couple of recommendations. The Committee approved the amended ToR and recommend these for approval by the Board (Appendix E).

13. The Committee received and discussed an update report regarding raising concerns, noting that five concerns were received, and that the Policy had been revised. Regular meetings will be held with the Employee Relations Team and the FTSUGs to discuss any trends and offer feedback.

CoG 19/09 Annex A

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

14. The Committee received and discussed a progress update from External Audit regarding the work undertaken during the quarter reported, and approved the Audit Plan 2018/19.

15. The Committee received and discussed the Internal Audit progress report. Three internal audit reports had been completed and were reported to the Committee, these were regarding Workforce and Rostering, Monitor Licence and T3 Project Management. Two of these audit reports were issued with substantial assurance and one Workforce and Rostering was issued with partial assurance in relation to financial management. The Committee noted that steady progress has been made on the follow up of management actions.

16. The Committee received and discussed the Counter Fraud progress report and noted the following:

    16.1 The Fraud Check exercise regarding gambling had been completed;
    16.2 Face to face training had been provided to over 60 staff along with all of the Finance Divisions via the on-line learning package;
    16.3 Various policies had been reviewed in relation to fraud proofing these.

17. The Committee received a report regarding the appointment of the Trust's External Auditors. As the current contract for the provision of external audit services expires on the completion of the 2018/19 audit. The report explained the appointment process and for the IAGC to consider the recommendation made by the Council of Governors' Audit Committee. The IAGC approved the recommendation for the appointment of the Trust's External Auditors for a three year period commencing with the 2019/20 audit, which will be proposed to the Council of Governors (CoG) at the Full CoG meeting on 14 February for approval and ratification.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to:

a) Discuss the report;
b) Approve the revised SFIs;
c) Approve the revised Risk Management Strategy and Policy;
d) Approve the IAGC ToR.

CoG 19/09 Annex B

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**9 MAY 2019**
REPORT TITLE:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

- What positive assurances were received?
- What concerns in relation to assurance were identified?
- Were any risks identified?
- What other reports were discussed?

MEETING HELD ON 11 APRIL 2019

Positive assurance was received in relation to:

1. The Committee received and discussed a Cost Improvement Programme (CIP) deep dive report regarding the Agency Direct Engagement Model scheme. The Committee received assurance from the processes in place and reviewed evidence direct on the internal monitoring system 'Aspyre'. The Committee recognised the work and procedures of the Programme Management Office (PMO) and its team were working really well.

Negative assurance was received in relation to:

2. The Committee received and discussed a report on the Full Strategic and Corporate Risk Registers. The Committee was disappointed with untimely progress updates on the risk register, resulting in not receiving the required assurance. The process around the risk register being updated was not currently working as it should, as updates to outstanding actions were not timely. A review of the risk management process is currently underway to address this issue.

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NHS
East Kent
Hospitals University
NHS Foundation Trust

The following reports were also discussed:

3. The Committee received and discussed a report regarding the Data Security and Protection Toolkit noting the Trust's positive 100% compliance. The Committee will receive a report following the 31 October 2019 baseline submission.

4. The Committee received, discussed and provided suggested amendments regarding the year-end statements, reports and accounts, in relation to the:
   - 4.1 Annual Governance Statement;
   - 4.2 Annual Accounts – verbal update received;
   - 4.3 First Draft Annual Report;
   - 4.4 Draft Quality Report – suggested amendments were provided along with incorporating the comments received from Governors;
   - 4.5 Compliance with NHS FT Code of Governance – recommended for Board approval mid May;
   - 4.6 Statutory Compliance with Provider Licence - recommended for Board approval mid May

5. The Committee received and noted a report on Losses and Special Payments.

6. The Committee received and discussed a report regarding Single Tender Waivers (STWs) noting the improvement in relation to reducing the number of retrospective STWs.

7. The Committee received and noted a quarterly Freedom to Speak Up Guardians (FTSUGs) report.

8. The Committee received and discussed a progress update from External Audit noting the early indications in relation to the audit findings in respect of indicator testing:
   - 8.1 In relation to the 62 day cancer waits there was positive improvement;
   - 8.3 A&E 4 hour waits is still to be tested and likely to be unqualified;
   - 8.3 The Governor's indicator - Delayed Transfers of Care (DTOC) has been chosen and is currently being audited, early indication that there has been no improvement and possibly further deterioration.

9. The Committee received and discussed the Internal Audit progress report noting the:
   - 9.1 Follow-up of completion of audit recommendations has improved;
   - 9.2 The partial assurance received for Getting it Right First Time (GIRFT) and Health & Safety (H&S), and the draft Head of Internal Audit Opinion (HoIAO) and the positive feedback on the Annual Governance Statement.

10. The Committee received and discussed the Counter Fraud progress report and approved the 2019/20 Annual Work Plan.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services**.

CoG 19/09 Annex B

East Kent Hospitals University NHS Foundation Trust

	• **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: NO	**EQUALITY IMPACT ASSESSMENT:** NO

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss, note and accept the report for approval from the IAGC.

Board Assurance Framework

Report Date	31 Dec 2018
Risk Status	Open
Risk Register	1. Strategic Risk Register
Control Status	Existing
Action Status	Outstanding

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 11 Dec 2018 **Latest Review Date:** 03 Dec 2018 **Latest Review By:** Alison Fox **Latest Review Comments:** The risk may require revision to ensure it adequately reflects the current position in relation to regulatory requirements. This will be carried out during December 2018.	**Cause** *The Trust came out of Quality Special Measures early 2017 and needs to ensure the momentum for the improvement journey is sustained. * The withdrawal of the junior doctors in medicine from the K&C site and the level of uncertainty about where services will be delivered has added operational pressure across the Trust, in particular the WHH & QEQM sites. * A particularly difficult and challenging Winter compounded an already pressurised system. * The most recent CQC inspection gave a rating of RI demonstrating a stable position. **Effect** - Loss of autonomy; - Impact on staff morale; - Increased operational pressure on the two acute sites; - Staff health and well being issues; - Staff retention issues; - Reputational damage; - Decline in pace and development of services; and - Regulatory concerns	I = 5 L = 5 Extreme (25)	Agreed Improvement Plan in place with supporting Care Group plans. **Control Owner:** Sally Smith	Quality Improvement Programme Manager 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)	NHSIProgress Review meetings - provides challenge over progress of Trust in meeting deadlines CQC Inspection 07/15 - improved rating Internal Audit on CQC readiness completed - adequate assurance given. CCG assurance provided monthly	Adequate		I = 5 L = 4 Extreme (20)	Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Nov 2018	**09 Oct 2018** **Sally Smith** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December.	I = 4 L = 2 Moderate (8)	Quality Committee
				External Consultancy and NHSI/E support in delivering the improvement programme. **Control Owner:** Lee Martin	*Carnal Farrar providing a PMO service to manage the delivery of the A&E Improvement Plan *Weekly monitoring *Report to the COO	Report to the Board of Directors	Carnal Farrar commissioned by NHSE/I	Adequate			Delivery of the emergency pathway improvement work. Actions as per CRR 28 & 61 **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**05 Dec 2018** **Rhiannon Adey** Winter plan commenced. Ward opened at WHH. Observation units on track to be mobilised by mid January on both sites.		
				External help from Community Trust, social care, CCGs to deliver improvements in the emergency pathway. **Control Owner:** Lee Martin	Twice daily site meetings; Twice daily site 'huddles'; Board Rounds; Length of stay meetings; Weekly monitoring of the improvement initiatives; Escalation policies and procedures.	Patient Safety Board Clinical Executive Management Group Quality Committee Board of Directors	Fortnightly whole system calls Weekly MADE (Multi Agency Discharge Event) calls (CEO level) CCG contract meetings NHSI performance meetings	Limited	Delivery is not evident at present.		Implementation of the system wide NHSI/NHSE/CQC - Safety Plan **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	**09 Oct 2018** **Sally Smith** Assurance received at the oversight meeting in September. Plan being delivered except 4 hour performance and Duty of Candour which are requiring closer monitoring and focus. The next meeting's focus will be Infection Control for October's meeting.		
				Local improvement plan is in place meeting weekly to deliver an improvement plan. **Control Owner:** Lee Martin	Operational Programme Management Office in place	Steering Committees for referral to treatment times, emergency department access and cancer waiting times in place to assist with clinically led improvement. Highlight reports presented to Finance and Performance Committee.		Adequate						
				NHSI Improvement Director is working with the Trust. **Control Owner:** Sally Smith				Limited			Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 30 Apr 2019	**03 Dec 2018** **Rhiannon Adey** Review of current strategy with the improvement director has taken place and the strategy will be aligned to the actions required in the various CQC reports.		
				Quality Strategy is in place. **Control Owner:** Sally Smith	Published on the Trust website	Approved by QC and monitored quarterly by the QC (objectives are monitored)		Limited			Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 01 Sep 2020	**03 Dec 2018** **Rhiannon Adey** Board workshop took place in November to discuss wider improvement plan.		

Board Assurance Framework

AO1: Patients. Help patients take control of their own health														
Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 4	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Elizabeth Shutler **Last Updated:** 18 Dec 2018 **Latest Review Date:** 14 Nov 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Clinical Commissioning Group timeline now identifies the Pre-Consultation Business Case (PCBC) to be drafted by December 2018.	**Cause** - Backlog of work (£74million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	I = 4 L = 5 Extreme (20)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Elizabeth 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	FPC receive reports about Backlog maintenance showing the risks.		Adequate		I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Mar 2019	**18 Dec 2018** **Elizabeth Shutler** PCBC now due for circulation to NHSI and NHSE March 2019.	I = 4 L = 2 Moderate (8)	Quality Committee
				Interim Estates Strategy in place **Control Owner:** Elizabeth Shutler	*Approved by Clinical Executive Management Group	- Strategy approved by the Trust Board - New NED in place to provide challenge		Adequate			The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	**18 Dec 2018** **Elizabeth Shutler** Business Case being prepared and will be completed in January 2019 for sign off at Trust Board in March 2019.		
				Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Clinical Executive Management Group 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	FPC and Trust Board receives quarterly reports on capital spend.		Adequate						
				Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2017/18 **Control Owner:** Elizabeth Shutler	PEIC Action Plan available to view - The Patient Environment Investment Committee (PEIC) manages the annual investment, replacement and repair programme	*Plan approved by SIG in May 2017 *Strategic Investment Group (SIG) monthly reviews progress of action plan		Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Risk assessed condition survey carried out every 5 years (rolling interim plan every 18months) **Control Owner:** Elizabeth Shutler	Reviewed by Estates Managers Meeting (Chaired by Head of Engineering and Compliance)	Expenditure against plan reported to SIG	*Stock Condition Survey by External Company - During 2015/2016, the Trust invested in a number of estates surveys, in line with the requirements set out within the Health Technical Memorandum (HTM's) / Health Building Notes (HBN's). These included: 1) Fire Compartmentation (HTM 05); 2) Domestic Hot Water Services (HTM 04); 3) Medical Gases (HTM 02); and 4) Critical Ventilation (HTM 03). *Independent District Valuer reviews	Adequate						
				Statutory Compliance dashboard in place **Control Owner:** Elizabeth Shutler	Reviewed by Executives monthly	6 monthly review by IAGC	Independent Authorised Engineer	Adequate						

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 8	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 18 Dec 2018 **Latest Review Date:** 16 Nov 2018 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Action updated - new processes taken to CEMG and are in place	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff * Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas **Effect** * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of newly qualified nursing staff locally. **Control Owner:** Sally Smith	*Dedicated Practice Development Nurse lead for supporting students on placement. *Progress monitoring and clinical support of all students. *Mentor support and training	*Regular meetings with Canterbury ChristChurch University - Contract monitoring meetings, faculty learning placement committee, curriculum group attended regularly. *100% students who apply to work with us are offered a post. *Monitoring of numbers of newly qualified nurses recruited and reported within N+M workforce plan. This demonstrates an improvement from 50% to 70% since 2014.		Adequate		I = 5 L = 3 High (15)	Develop and agree set of KPIs to measure the effectiveness of the People Strategy which will be reported regularly to the SWC **Person Responsible:** Sandra Le Blanc **To be implemented by:** 28 Feb 2019	**23 Nov 2018** **Rhiannon Adey** Working with the Chair of the Strategic Workforce Committee to develop the KPIs	I = 5 L = 3 High (15)	Strategic Workforce Committee
				Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	- Plans available for all to access on Staff zone - Reviewed at the Care Group Business Boards	Progress of Plan reviewed quarterly at Clinical Executive Management Group and annually at the Strategic Workforce Committee		Adequate	Action Plan requires updating following receipt of the Annual NHS Staff Survey Results		Revise and implement Care Group Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	**13 Nov 2018** **Jane Waters** Listening into Action feedback analysed and themed. Ten projects launched and underway		
				Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	*Updated fortnightly by the Resourcing team *Sent to the HRBPs on a monthly basis	*Signed off at the end of July 2017 *Reported monthly as part of the high level CQC improvement plan		Adequate	Plan may not be progressing		To produce and implement a People Strategy that focusses on attracting, developing, engaging and retaining staff. **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	**09 Oct 2018** **Sally Smith** As per previous action - update received today at October's SWC. Some additional actions agreed to ensure we retain our staff and recruit the people we need as we expand for Winter.		
				Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Discussed at the Workforce CIP meeting	Regularly reviewed at SWC (deep dives on Turnover and Exit information)		Adequate			Develop and implement a plan to recruit nurses from the UK and Europe **Person Responsible:** Louise Goldup **To be implemented by:** 30 Apr 2019	**09 Oct 2018** **Sally Smith** The plan is in place. The Board has approved the attract and retention initiatives. This is monitored monthly through the IPR.		
				Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Highlight Occupational Health reports Director and Deputy Director of HR Exit Interviews and Picker Survey reports highlight areas of concerns	Occupational Health Reports to SWC quarterly		Adequate						
				Recruitment process in place **Control Owner:** Andrea Ashman	Length of time to recruit is monitored monthly and provided as part of the IPR	Workforce KPI reviewed by the SWC at every meeting		Adequate	Programme of work being looked at to reduce time to hire (target to reduce this to 8 weeks). Updated Recruitment Improvement Plan produced which will support delivery of this timescale.					

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Revised recruitment process has been implemented **Control Owner:** Andrea Ashman				Adequate						
				Staff Performance Appraisals in place **Control Owner:** Jane Waters	*HR BPs carry out audit on the quality of the process and monitor the numbers of appraisals that take place	- Regular monitoring through a number of routes - Care Group Governance Boards, EPR meetings and Strategic Workforce Committee and Board	Annual staff survey results and the Picker Exit survey	Substantial	Achieved target set by the Board and now moving towards monitoring of the quality of appraisals					
				Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	- Each Division agrees their training plan - HR BPs review the plans on an annual basis	- Annual review by the Divisions - Annual reports to the Integrated Education Board		Adequate	*Funding gap - more bids than can be supported *Understanding of process and outcomes					

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 12	Insufficient capacity and capability of the leadership team (Executive and Care Group Clinical Directors) to develop and deliver key strategies and recovery plans **Risk Owner:** Susan Acott **Delegated Risk Owner:** Sandra Le Blanc **Last Updated:** 23 Oct 2018 **Latest Review Date:** 23 Nov 2018 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** The Leadership Framework was presented to Senior Leads in September at a Leadership Away Day. First cohort of Care Group Leadership teams commenced development programme Friday 16 November.	**Cause** *The Trust is not meeting its constitutional standards *Large number of complex priorities that need to be delivered including the sustainability and transformation plan, A&E recovery plan, Financial Special Measures turnaround plan, Cost Improvement Plans as well as business as usual *The Trust is under the Financial Special Measures regime *Those tasked with delivery have focus diverted due to other urgent external matters *The move of acute medicine, acute geriatric medicine and Stroke from the K&C site *Governance structure fails to support the delivery of CIPs *Increased Patient activity in A&E during the winter period **Effect** * Inability to achieve strategic priorities * Failure to come out of Financial special measures * Further Regulation action/concerns * Reputational damage * Financial loss * Negative impact on patient safety / care / experience * Reduced staff morale * Failure to meet operational performance standards (RTT/A&E/Cancer) * Failure to meet regulatory requirements (CQC / NHSI, GMC and HEKSS)	I = 4 L = 5 Extreme (20)	Chief Executive in place (experienced CEO in the NHS) **Control Owner:** Elizabeth Shutler	Objectives agreed with the Chairman	Reports to the Board	Liaised with NHS Improvement	Adequate		I = 3 L = 3 Moderate (9)	Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Dec 2018	**23 Nov 2018** **Rhiannon Adey** The Leadership Framework was presented to Senior Leads in September at a Leadership Away Day. First cohort of Care Group Leadership teams commenced development programme Friday 16 November.	I = 3 L = 2 Low (6)	Strategic Workforce Committee
				Business Partnering roles in place (Finance, HR & Information) together with support from central governance team. They are an integral part of the Care Group Leadership Team (Capacity) **Control Owner:** Lee Martin	- BPs exist with clear job descriptions and provide support to each Care Group to ensure delivery of Strategic Objectives - Line Management appraisals in place	Support within Care Group Report to Performance reviews		Adequate						
				Car Group Clinical Director responsible for the national Performance Standards e.g. Cancer, ED, 18weeks (Capacity) **Control Owner:** Lee Martin	*Reviewed at 121s with COO at least monthly and appraisals (discussion around resources required for their teams) *ED and Flow: Site management in place as part of the recovery plan	Reviewed at EPR monthly - capacity discussed	*Regular contract performance meetings with the CCGs *NHSI single oversight/performance review meetings monthly	Limited	Reviewing related team capability (e.g.validation)		To finalise the Trust–wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 31 Dec 2018	**13 Nov 2018** **Jane Waters** Draft framework developed and feedback gained at Leadership Forum. Work is currently being done to provide the feedback in electronic format supported by relevant resources.		
				Deputy Chief Operating Officers appointed with both site and portfolio responsibilities. **Control Owner:** Lee Martin	Reporting to the COO with clearly defined objectives, linked to Board priorities for 2018/19			Limited			Develop operational leadership and tactical competencies at Clinical Director, Head of Nursing and Director of Operations level, General Manager and Matron level provided by external facilitator and NHS Elect. **Person Responsible:** Lee Martin **To be implemented by:** 29 Mar 2019			
				Director of Finance in place with continuity in delivery of the FSM **Control Owner:** Susan Acott	*Reports to the CEO	*Supported and Continuity by the FID *Reports produced and the FPC provides oversight of the FRP	Delivery of FRP and monthly reporting to the NHSI	Adequate						
				Experienced COO appointed **Control Owner:** Sandra Le Blanc	Clear objectives set by the Chief Executive to mirror those agreed by the Board of Directors.	Regular reporting to Quality Committee and Finance and Performance Committee.		Adequate			Review of key action plans in line with capacity and capability (A&E Improvement Plan and Cancer) **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**05 Dec 2018** **Rhiannon Adey** Action plans underway		
				External Consultancy Support (2020, Carnal Farrar, A&E Improvement Director, Financial Improvement Director) supporting Care Groups and the Corporate Team to deliver transformation programmes (Capacity) **Control Owner:** Lee Martin	*Regular reports through the Executive Team meetings and Management Board *Financial Improvement Director reports to CEO *2020 - 2 site based teams for 12 weeks with targeted support	*Reviewing monthly at Board Sub-Committees and Executive (Quality, FPC and SWC) and weekly telephone calls with NEDs *Performance Reviews (IPR)	*Peer review and Benchmarking (Reports by Consultants include this) *Weekly single oversight meetings (twice a week meetings with NHSI and NHSE)	Adequate	Sustainability of the 2020 improvements following their exit		Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	**09 Oct 2018** **Sally Smith** Plum are working with the Trust to develop the new Care group leadership and management development.		

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Leadership Development Plans and targeted development plans for individuals in place (Capability) **Control Owner:** Sandra Le Blanc	- Senior Leadership has 6 monthly objectives and appraisals - Executive review succession plans and talent pipeline for Senior Leadership and key posts quarterly	- Nominations Committee review the Appraisals, objectives and Talent pipeline six monthly - Latest update of the talent pipeline went to the Nominations Committee in April 2017 - The CE has 6 monthly objectives and appraisals - done by Chair of the Board SWC - regular updates and reports on Leadership development		Adequate						
				Leadership development programme in place for Clinical staff all professions (Capability) **Control Owner:** Sally Smith	The programmereflects the shared purpose framework and Trust values, and the Quality Strategy.	The Senior Leadership & Quality Forum meet every 6 weeks with the Chief Nurse to review progress.		Adequate	Work in progress to refresh the fortnightly band 7 catch up forums.					
				New clinician development programme (now into the 6th cohort) (Capability) **Control Owner:** Paul Stevens	5 programmes have already been completed and from these cohorts several doctors have gone on to take on leadership roles in the organisation			Adequate	*Routine monitoring of Clinician Development Programme by SWC					
				Outline Programme Plan in place for the Leadership Development Programme (Capability) **Control Owner:** Sandra Le Blanc	Reports to Clinical Executive Management Group monthly	Reports to SWC and Board monthly	NHSI review - Initial feedback was received from NHSI on 9 August 2017. A conference is planned to respond to this and re-submit the business case.	Limited	Re-submission of the business case to NHSI following MB approval					
				Performance Reviews in place where delivery is challenged to support senior leadership team in prioritising and highlighting competing pressures (Capacity) **Control Owner:** Susan Acott	Meetings taking place monthly with minutes and actions	Exceptional reports to Clinical Executive Management Group to highlight issues with wider organisational impact		Adequate						

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Recent appointment to two key posts in the Trust below Executive Director level (Capability) **Control Owner:** Sandra Le Blanc	*The two posts are the Head of Transformation reporting to the CEO and Director of Strategy and Business Development reporting to the Director of Strategy and Capital Planning and Deputy Chief Executive. *Induction programme in place			Adequate						
				Substantive staff in place for Executive and Care Group Clinical Director positions (Capacity) **Control Owner:** Sandra Le Blanc	* Currently no vacancies exist for Executives and Divisional Directors *Succession plans in place *Substantive Chief Executive has been appointed	The Nominations Committee reviews Succession plans; Appraisals and Performance Development Plans for Executives and Divisional Directors six-monthly		Adequate						
				Succession Plan in place for Executive Directors, Care Group Clinical Directors, Care Group Directors and key posts to the organisation **Control Owner:** Sandra Le Blanc				Limited						
				Targeted resources into key CIP schemes in place e.g. patient flow, Cardiology (Capacity) **Control Owner:** Philip Cave	Head of PMO and Financial Improvement Director posts in place	Regular updates to the Executive Team from the Head of PMO to identify gaps		Limited	Recruit into identified gaps					
				Transformation Programme in place (designed and resourced) (Capacity) **Control Owner:** Simon Hayward	*Governance structure in place which links to Financial Special Measures	*Approved by the Trust Board on 10 April *Time limited implementation team in place (Purpose agreed by EMT in June 2017) *Reports to EMT and the Transformation Board		Limited						

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 5	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime **Risk Owner:** Philip Cave **Delegated Risk Owner:** David Baines **Last Updated:** 09 Oct 2018 **Latest Review Date:** 03 Dec 2018 **Latest Review By:** Philip Cave **Latest Review Comments:** At the end of M7 the Trust is £2.5m behind plan with a forecast risk position of up to £22m off plan by year end but a likely position of £7m worse. New actions have been added this month to try to ensure the plan is achieved and the risk fully mitigated.	**Cause** Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery (See Risk Ref. 1037) * Inability to collect income due * Poor cash management * Operational pressures relating to Emergency Care, High Agency usage *Failure to deliver RTT, A&E and cancer targets (See CRR 28) * Political climate (Brexit) and price inflation *Inability to deliver the planned levels of activity and collect the planned levels of income *Workforce pressures including inability to recruit (See SRR 9) *Lack of capacity of Finance and PSO staff *Lack of capacity and capability to deliver operational and financial performance (See SRR 12) *Inability to secure external support for key projects *Demand from CCGs higher or lower than annual plan *Failure to secure all the contractual income due from commissioners (See Risk Ref. 101) *Failure to deliver the CQUIN programme (See CRR 53) *Financial Special Measures governance not embedded *Additional costs of reconfiguring services across sites due to temporary move of acute medicine, acute geriatric medicine and Stroke from the K&C site(See CRR 51) *Negative impact of the new PAS and EMR implementation (See CRR 37) *Inability to resource the Trust's A&E improvement plan (estimated at £9.5 million) **Effect**	I = 5 L = 5 Extreme (25)	Cash Committee in place **Control Owner:** Philip Cave	*Led by the Director of Finance *Report on Daily and weekly cash balances	*Monthly review by FIOG; and FPC	*Submission of cash profile/capital plan to NHSI and Department of Health (on a 13 week rolling basis)	Substantial		I = 5 L = 4 Extreme (20)	Develop the Cost Improvement Plan for 2019/20 **Person Responsible:** Philip Cave **To be implemented by:** 31 Dec 2018	**28 Nov 2018** **Rhiannon Adey** As at 22 November 2018 £16.4 million of ideas has been identified. See attached for details.	I = 5 L = 3 High (15)	Finance & Performance Committee
				Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	*Clinical engagement forums led by CEO and Medical Director *Review by the Confirm & Challenge meetings with Divisions	*Review by FIC; and feeds into the FPC and Board	Annual survey of Medical Engagement scale (last done in September 2016 with two of three scales rated low)	Limited	Poor clinical engagement					
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	*Monthly Executive Performance Review and Key Metric Reviews *Fortnightly confirm and challenge meetings with the Financial Improvement Director (FID)	* Executive review weekly * Turnaround report to FPC * Exception reports to BoD	- NHSI challenge at Performance Review meetings (monthly) - NHSI carrying out deep dive review around sustainability for 2017/18, 2018/19 (including Governance) - Appointment of Financial Improvement Director	Adequate			Mobilise care groups to deliver the £30 million CIP ideas for 2019/20 programme **Person Responsible:** Lee Martin **To be implemented by:** 31 Dec 2018	**05 Dec 2018** **Rhiannon Adey** Financial controls reviewed and further communication and actions taken to deliver 2018/19 financial plan		
				Financial Improvement Director in place to provide support **Control Owner:** Susan Acott	Reports to CEO	- Report to Executive Team and Board - Report to FPC	Appointed by NHSI and reports to NHSI	Substantial			Design and implement finance function training for clinicians **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**05 Dec 2018** **Rhiannon Adey** Commenced in November, General Manager and Matron development commencing in January.		
				Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	*Chaired by the Finance Director	*Monthly reports to FIC	NHSI and FID attend FIOG meetings	Adequate			Ensure accountability for budgetary management by developing a standard objective for all budget holders **Person Responsible:** Philip Cave **To be implemented by:** 01 Apr 2019			
				Financial Recovery Plan in place **Control Owner:** Philip Cave	- Care Groups, PSO and FID developed plans	*Board received plan on 10/04/17 *Reviewed at FPC monthly	* Approved by NHSI in April 2017 with monthly Financial Special Measures (FSM) meetings to review progress	Substantial			Develop Trust wide financial culture training for budget holders **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019			
				Fortnightly confirm and challenge meetings with the Care Groups (including Corporate) **Control Owner:** Philip Cave	*Chaired by the Financial Improvement Director	*Monthly review by FIC		Adequate			Develop strong relationships with commissioners **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019			
				Local Vacancy Control Panel in place **Control Owner:** Philip Cave	Chaired by the Deputy Chief Executive	*Escalation to weekly EMT meetings *Review at Confirm and Challenge sessions with the FID		Adequate						
				Monthly Financial Special Measures (FSM) review meetings with NHSI. This has now been combined with the local IAM meeting with NHS I. **Control Owner:** Philip Cave	DoF and DDoF produce slides with FSM position for review with the Executives	*Internal pre-meet review prior to meeting with NHSI. *Following FSM meeting, update at MB and FPC	Feedback from NHSI positive year to date	Substantial						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
		Resulting in * Potential breaches to the Trust's Monitor licence * Adverse impact on the Trust's ability to deliver all of its services * Impact on ability to deliver the longer term clinical strategy * Poor reputation * Impact on organisational form		New approach to developing CIPs in place **Control Owner:** Philip Cave	Led by Financial Improvement Director	Review of progress of CIP monthly by the FPC	*Part of review process at monthly FSM meetings *Internal audit on CIPs with substantial assurance	Substantial						
				New Care Group (clinically led structure)implemented with action plans to deliver national standards and agreed trajectories. **Control Owner:** Lee Martin	Care Group management of the standards through Governance and Business Boards	*Compliance reports to Performance Reviews, Clinical Executive Management Group, Finance and Performance Committee Board of Directors and Council of Governors *Review at A& E Governance (meeting three times a week)	External review from: * CCG's through monthly performance reviews; * NHSI through 6 weekly progress review meetings; *Single Oversight meetings with NHSI, NHSE, KCC etc.)	Limited	Key operational performance targets (A&E, RTT, Cancer) not being met.					
				Payment by results infrastructure (coding and data quality) **Control Owner:** Philip Cave	*Data validation done monthly by team *Monthly Contracts, Finance and Internal Contracting meeting to review activity and income level *Monthly confirm and challenge meetings with the Financial Improvement Director	*Review by the FOIG; and monthly report to the Finance & Performance Committee	External Audit: *External validation of clinical coding data *Positive External Audit results on costing as part of National Audit "Costing Assurance Review"	Adequate	Clinical activity not consistently captured, coded and costed.					
				Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	*Escalated through the FD to the CEO	*Escalate concerns to NHSI *Finance & Technical Group meetings with NHSI	*New MoU signed with the Commissioners	Adequate	Trust is seeking assurance from NHSE/I about next steps - Commissioners challenge					
				Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	*Information and Income Teams monitor and report on plan *Information Team produce monthly update of Productivity plans (with forward looking indicators)	Review by the FIOG; and FIC if escalation is required		Adequate						
				Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	*Weekly CIP tracking *Direct line management by Director of Finance	*Monthly reports to CEMG, EPR and FPC	Regular contact with NHSI	Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Regular reporting on the Trust's Financial position to the Trust Board and senior management team (including ensuring the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood). **Control Owner:** Philip Cave	*Review by Executive Management Team *Care Groups attend FPC on a four monthly rolling basis	*Regular updates to FPC, Board, Clinical Executive Management Group and Transformation Improvement Group *Review at the A&E Governance Board (currently meeting three times a week)	Monthly FSM meetings with NHSI and FID.	Adequate						
				Signed MoU in place with commissioners that provides greater clarity on specific areas of agreement which were previously disputed **Control Owner:** Philip Cave	*Contract management meetings with CCGs *2018/19 planning discussions with CCGs	Review at EMT, FPC and FIC	MoU signed with the CCGs	Adequate						
				Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Chaired by Director of HR	Monthly review by FIC		Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 16	Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes **Risk Owner:** Susan Acott **Delegated Risk Owner:** Simon Hayward **Last Updated:** 21 Dec 2018 **Latest Review Date:** 21 Dec 2018 **Latest Review By:** Simon Hayward **Latest Review Comments:** Agree a Transformation programme of work with clear owners and milestones that links to the Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019	**Cause** * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed improvements * Mechanism / governance structures for Transformation is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	I = 4 L = 5 Extreme (20)	Financial Improvement Director appointed by NHS Improvement following financial special measures. The FID brings vast experience in "turnaround" and has implemented a new methodology for identification and development of improvement programmes. Working alongside the Executive and Programme Support Office. **Control Owner:** Susan Acott	Direct line reporting to the Chief Executive as well as NHS Improvement	Chairs Confirm and Challenge sessions with the Divisional Teams and Executives to ensure delivery moves at pace and any blocks addressed. Involved in development of the financial special measures governance process and has attended the Finance and Performance Committee who oversee the delivery of the financial position of the Trust on behalf of the Board.	Financial Improvement Director liaises with NHS Improvement to discuss the Trust's engagement and performance.	Substantial		I = 4 L = 4 High (16)	Approval for 2nd Phase of the Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Dec 2018	**09 Oct 2018** **Sally Smith** LiA is in place and progressing although the NHSI leadership development business case has not yet been approved by NHSI.	I = 3 L = 2 Low (6)	Board of Directors
				Non-executive directors experience in finance and transformation provides additional input into plans / governance. Linked to individual work-streams to provide advice / challenge **Control Owner:** Susan Acott	Working relationships between linked NED and Lead Executive	Non-executive input at Board of Directors and Committees in relation to development and delivery of the transformation and financial recovery plans.		Adequate			Agree a Transformation programme of work with clear owners and milestones that links to the Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019 **Person Responsible:** Simon Hayward **To be implemented by:** 22 Feb 2019	**13 Nov 2018** **Simon Hayward** New TIG agenda and standard documentation agreed and now being taken to all Care Group leads for first submission by meeting on 14th December		
				Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Sandra Le Blanc	Implementation plan in place and completed for Phase . Alignment review completed and shared with NHSI	EMT workshops held between February and April 2017 to agree transformation work-streams linked to financial recovery CIPs and annual priorities.		Adequate						
				Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS and European / International hospitals **Control Owner:** Elizabeth Shutler	*Programme Manager does monthly horizon scanning *Periodic trips to other European Health Services *Periodic visits to other NHS Trust with similar issues to identify good practice.	*Reports on Horizon Scanning are presented for information to EMT and Management Board. * Presentations to committees and Board on an ad hoc basis.	Clinical Senate reviews held periodically - reviews models of care and adherence to best practice	Adequate	Links to transformation / service improvement from learnings not explicit.					

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Time limited implementation team in place for the Transformation Programme **Control Owner:** Simon Hayward	*Implementation Team in place to deliver 8 point agenda *Skills audit complete *Head of Transformation in post and Chairing Group *Focus on training and development and Trust wide methodology	*Purpose agreed by EMT in June 2017 *Reports to EMT and the Transformation Improvement Group *Programme, project and improvement methodology for the Transformation journey was submitted the Transformation Improvement Group in October 2017 - to be agreed with programme refresh in 2018 *Improvement proposal going to Trust board March 2018		Adequate					
				Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	*Principles for the transformation governance agreed through alignment review, workshops and follow-up work with EY / Plum *Financial recovery governance included input from Financial Improvement Director and linked to Transformation governance.	* EMT review of governance structures via email * Board reviewed the draft proposal (10/4/17)	Discussed at a Financial Oversight meeting with NHSI	Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 09 Oct 2018 **Latest Review Date:** 18 Dec 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Reviewed	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation - Lack of CCG leadership **Effect** - Delay to EKHUFT clinical strategy - Poor patient care - Emergency transfer of services will become necessary - Enforcement actions - Trust's provider licence (finance)	I = 5 L = 4 Extreme (20)	Clinical standards reviewed **Control Owner:** Elizabeth Shutler	Reviewed at the Clinical Strategy Group	Minutes received by MB	Final response received from Clinical Senate	Substantial	Needs feeding back into the PCBC	I = 5 L = 4 Extreme (20)	Presentation of the capital requirements to the NHSE Investment Committee as part of the Pre-consultation Business Case **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Mar 2019	**18 Dec 2018** **Elizabeth Shutler** PCBC now due for circulation to NHSI and NHSE March 2019.	I = 5 L = 2 Moderate (10)	Finance & Performance Committee
				East Kent Programme Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Susan Acott	- Trust Executive membership of the Board to influence the discussion. - Trust Secretary holds all copies of agendas/minutes	- Reported monthly to Clinical Strategy Board and Management Board	In attendance are all Health economy partners	Limited						
				Internal Clinical Strategy Group in place **Control Owner:** Elizabeth Shutler	Chaired by CEO			Adequate			Produce Financial Plan linked to delivery of the STP **Person Responsible:** Philip Cave **To be implemented by:** 01 Aug 2019	**03 Dec 2018** **Philip Cave** The action date has been moved back to August in line with the latest guidance from NHS I which sets out that STPs should create a 5 year plan by Summer 2019. A new 10 year NHS plan is due out in December 2018 along with more detailed planning guidance.		
				Kent and Medway STP Programme Board in place **Control Owner:** Elizabeth Shutler	*Trust CEO and Chair of East Kent Delivery Board attends to influence the programme. *Trust CEO is on the Management Board and Chairing the Hospital work stream which Deputy CE is the Lead for *PMO established	- Various Senior Managers involved in STP work streams - Trust Board sighted on presentations to Programme Board	PMO reviewed by NHSE and found to be adequate	Adequate						
											Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Sep 2019	**18 Dec 2018** **Elizabeth Shutler** Consultation now planned for September 2019.		

		Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
PATIENTS: Providing high quality care to patients with great outcomes for their health and lives - getting the basics right every time and building healthcare that is best in class																									
We will improve FFT satisfaction for ED	Achieve national average	85%	80.60%	85%	83.20%	85%	85.50%	85%	80.00%	85%	83.70%	85%	80.10%												
We will improve patient experience	Monthly survey against national benchmark	90	91.1	90	91.4	90	91.1	90%	91.90%	90%	89.80%	90%	90.10%												
	Annual inpatient survey against national benchmark	Annual reporting -						National benchmark 82.3%	80%																
Promote effective care to patients with mental health needs and Learning Disabilities	Implement best practice guidelines/NCEPOD report on mental health in general hospitals	Quaterly reporting - baseline against NCEPOD awaited - progress to be reported to the August Patient Expereience Group and Quality committee								Behind schedule. Meeting with key stakeholders November. Executive lead updated - monthly reporting to be established to support required pace.															
	Improved mortality rates	An audit was carried out in 2015 in relation to mortality rates and a repeat audit is scheduled for February 2019.																							
	Improved length of stay																								
	Improved readmission rates																								
Ensure that EKHUFT work in partnership with our service users to define, monitor and deliver great care	Scope current patient involvement within EKHUFT	Quaterly reporting - progress measured against action plan; Preliminary scoping to be completed and detailed plan in progress by end of quarter 2. On track with plan - presentation of plan and outcome of initial scoping to be presented to next (September) complaints steering group - quaterly reporting against plan thereafter.						Patient involvement scoped - current activity described and future plans presented to the October PEG. On track.																	
	Identify and implement best practice models	On track with plan - quaterly reporting						On track. Supportive strategy in development action plan in place - next report to the PEG December 2018. . Harder to reach groups included within current activity with establishment of a youth forum (which had its first meeting in October).																
Embed a patient safety culture	Measured through improvement against Texas safety culture tool	Quarter one baseline. Testing results from previous staff survey results. Culture tool developed electronically						Results from 3 years' worth of staff surverys segmented and reviewed. Survey design reviewed and plan in place to fit with latest IT Portal/web-based platform. Slight hiatus due to PAS implementation. Survery renamed to Safety Climate Survey. All other actions in line with plan.																
Deliver on our CQC Improvement journey	improvement plan completion	Improvement plan cleansing underway						Work is in place to integrate CQC improvement milestones into the Trust Quality Strategy																	
	subsequent CQC inspections	Outcome of May and June 2018 visit(s) awaited								Remains "Requires Imrovement"															
Strengthen engagement with our academic partners	Scope out potential for Clinical Research Facility on at least one EKHUFT site	Q1 saw the finalisation of these priorities in discussion with key members of the research and innovation department, Jane Ollis and Paul Stevens. These will be reported on in terms of agreed timelines for delivery as most are longer term.						Currently undertaking work with Strategic Development to define (high level) estate requirements to inform approximate costings																	
	Relaunch the Trust's Research Session Scheme (RSS) with goal to realise at least two external grant applications (of which one successfully funded) within 24 months of RSS funding start							RSS relaunched. 1st round of applications were considered in July and 2 form 3 applications were approved (1x 0.2 WTE, 1x 1 PA). A further call has gone out, for consideration in Nov 2018. Too early to expect conversion from RSS awards to external grant funding awards.																
	Refresh the Trust's IP policy and establish a clear process that supports EKHUFT staff to develop innovations, including early stage funding via the R&I Catalyst and a new late-stage innovation fund, and the establishment of an innovation committee							Updated IP policy remains in draft. Will now be presented to R&I committee in Feb 2019 (intention had been Oct 2018). Innovation Committee ToR to be included as an appendix to redrafted policy and membership of IC have been approach. Funds set aside (£20k per annum, carried over if unutilized) for Innovation Fund.																

		Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
PEOPLE: Attracting the best people to our team, who are passionate, motivated and feel able to make a difference and investing in them																									
Staff engagement:Deliver a programme of work including Listening into Action methodology to deliver an improved staff engagement	Staff FFT / National Staff Survey (baseline)	Not available in Q1 - annual report						Not available in Q2 - annual report																	
	Treatment (54%)	70%	70%	70%	70%	FFT not run in June 2018 due to Listening in to Action survey		FFT not run in Q2 due to Listening in to Action survey																	
	Work (43%)	50%	48%	50%	48%																				
Staff retention: Retain skilled and experienced staff to provide continuity of person centred care	Turnover Baseline All Staff: 13.5% (Jan 2018) 12.77% (YTD)	13.50	12.59	13.50	12.33	13.50	12.17	13.50	12.80	13.50	12.09	13.50	12.29												
	Turnover Baseline Nursing Staff: 10% (January 2018) (204 YTD)	10.00	19.14	10.00	15.43	10.00	25.02	10.00	14.75	10.00	20.76	10.00	17.89												
Leadership development: Implement the Trust wide leadership and management development programme	Deliver to 200 staff by the end of 2018/19	The Board will be aware that NHS Improvement did not support the Trust in the consultancy spend for this piece of work. Therefore this objective will need to be delivered in=-house and will not commence until Spring 2019																							

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
PARTNERSHIP: Work in partnerships to design health and social care which transcends the boundaries of organisations and geography													
Work with partner organisations to develop an east Kent Accountable Care Partnership / Integrated Care System by	establishing an agreed programme of work that focuses on setting up clear patient pathways for the frail elderly population of east Kent and creating a joint east Kent Department of Geriatrics with KCHFT	MOU has proposed pathways for joint work included within it - frail elderly is a priority			There are on-going discussions around joint working and frailty initiatives. There is a proposal being developed and this is at an early stage.								
	working with KCHFT, KCC and KMPT to expand and finalise the MOU by June 2018	Work underway. Draft MOU written and discuused at EMT. Comments incorporated and due to go back this month then sign off at August board			Under review								
Subject to the production of the pre-consultation business case (PCBC), finalise a 5 year Estates Strategy that looks at public and private sector partnerships to deliver high quality health and social care from campus style sites	Deliery of an estates strategy	When a preferred option has been decided the estates strategy will be drafted and approved by the Board of Directors			In the meantime the Trust is working with NHSI to address that the backlog estates issues and bid for £27.7m to invest over the next 3 years, In addition priority investments have been the subject of business case to NHSI and the Trust has seen investment on observations bays, wards and A&E estate and IT.								
Deliver the EKHUFT elements and work with the Sustainability and Transformation Programme for Kent and Medway	Finalise consultation on the Trust Clinical Strategy in line with the CCG timeline	EY has been engaged by CCG to undertake a state of readiness for PCBC and consultation.In adition changes to national assurance governance have become more stringent. The EY report identifies a number of gaps which need to be completed before PCBC can be completed. The gaps are around governance , lack of a robust local care plan and perceived lack of clarity for option 2. Action plan and work to rectify this well underway			Completed the hurdle criteria on the long list of options to generate a medium list of options. This list will now be taken to the next step of the process (evaluation of the medium list of options) to generate the shortlist and inform the Pre Consultation Business Case (PCBC) The PCBC is being drafted with a deadline for early 2019. Public Consultation is scheduled to commence in late Spring / early Summer of 2019.								
	Contribute to a system wide PCBC (Pre Consultation Business Case) for the east Kent reconfiguration work stream in line with the deadline for capital bidding process in 2018	PCBC as above. Wave 4 capital bids completed and submitted in line with STP time-line.			EKHUFT secured central funding to expand capacity in the two A&E Departments at the William Harvey and the Queen Elizabeth The Queen Mother Hospital. These projects are on track to deliver the adddional capacity by the end of December 2018. Programme on the production of the PCBC as above.								
	Continue to work with partners on a joint pathology project in line with the STP revised timeframe	Project Director appointed (Mark Hackett) investment in IT solutions identified by all partners and programme now moving at pace			Business case being prepared for single Pathology system (EKHUFT & MTW).								
	Develop an approach to look at more effective models of providing back office functions such as facilities management, estates and procurement, learning from other NHS successes	2gether support solutions limited established, transfer of first phase staff 1 August 2018			Second phase completed on 1 October 2018 when Equipment and Estates management transferred to the new wholly owned company (total 1,150 employees). Engaged an NHS subsidiary to deliver and support the project.								
	Progress the Kent Care Record project with partners with a view to delivering: Phase 1 - readiness for market by July 2018. Phase 2 - procurement by May 2019 Phase 3 – mobilisation by May 2020	Ready to go to market in July 2018. Estabishing that the required resources are available through the STP			We are currently in the procurement phase and is expected to complete by July 2019								

		Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
PROVISION: The provision of high quality care through the use of technology, research, education, innovation and intelligence																									
Improve people's experience of and our performance in emergency care: ED RECOVERY PLAN: - Implement and deliver sustainable improvement in the ED to be measured against the agreed improvement trajectory / standard (linked to STF trajectory	Compliance with 4 hour access standard (trajectory) (performance)	78.60%	76.93%	77.50%	80.80%	78.50%	82.55%	83.89%	79.18%	85.37%	80.04%	85.39%	77.15%												
	Number of patients seen by a clinician in the first hour (performance)	55%	46.20%	55%	49.50%	55%	51.70%	55%	52%	55%	43%	55%	48%												
	Bed occupancy (performance)	95%	100%	95%	101%	95%	95.80%	95%	94.11%	95%	94.75%	95%	95.94%												
	Friends and Family test (ED) (quality)	85%	80.60%	85%	83.20%	85%	85.50%	85%	80.90%	85%	83.75%	85%	80.13%												
	Emergency re-admission rate (quality)		9.61%		9.08%		9.29%		9.8%		9.8%		8.6%												
Deliver value for money for the taxpayer: FINANCIAL PLAN: Deliver the financial plan for the Trust, measures against the final plan submitted to NHSI on 30 April 2018	Income: achievement against plan	£45.7m	£45m	£48.6m	£49.9m	£50.0m	£51.4m	£48.9m	£52.6m	£47.4m	£49.7m	£48.9m	£52.6m												
	Expenditure: achievement against plan	£48.9m	£47.9m	£49.5m	£51m	£49.5m	£50.9m	£48m	£51.8m	£49.2m	£51.9m	£48m	£51.8m												
	Cost Improvement Programme: achievement against plan	£1.5m	1.2m	1.5m	£1.8m	£1.6m	£1.6m	£3.4m	£4m	£2.2m	£1.8m	£1.3m	£1.6m												
CONTRIBUTION: Increase the contribution of particular services	Neurology	Finance and Performance Committee recommendation to the Board that the areas listed are those to be focused on in 2018/19. Chief Operating Officer to review the list and confirm that these fit with the overall business plan for 2018/19						The Divisions CIP programmes are in place with actions to improve the contribution and are monitored monthly through performance reviews. The schemes will be reviewed by the new Care Group leadership teams over Q3/4																	
	Gastro / endoscopy																								
	Trauma and orthopaedics																								
	Vascular																								
	ENT																								
	Obstetrics and Paediatrics																								

CoG 19/10

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**ANNUAL STAFF SURVEY**
PAPER AUTHOR:	**ACTING DIRECTOR OF HR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report is in response from a request from Council, and provides a summary of the results of the Trust's 2018 Annual Staff Survey and the actions being taken to improve the organisation's culture.

Background

A total of 7477 staff were invited to complete the survey and 3529 of those returned a completed survey. This is our second-highest response rate ever (47%) which should give the results a great deal of legitimacy and credence. The Trust compares favourably with our national counterparts, 3% above the national average (44%).

Headlines from our 2018 National NHS Staff Survey are as follows:

- 47% (3529) staff completed the survey
- We performed the *same* as last year on **71%** of our questions
- We performed significantly *worse* than last year on **24%** of our questions
- We performed significantly *better* that last year on **5%** of our questions
- We are ranked 41st out of 43 Acute Trusts nationally for our overall score
- We are ranked 33rd out of 43 Acute Trusts nationally for our overall score change
- Our overall score change is approximately -0.6%
- Staff engagement has remained stable (2017: 6.5 vs. 2018: 6.5)
- 45% would recommend the Trust as a place to work
- 54% would recommend the Trust as a place to be treated
- 65% of staff feel care is the organisations' top priority

Our top 5 scores and greatest improvements can be themed under the following categories:

- Training, learning & development
- Satisfaction with level of pay
- Physical violence & discrimination

Of those who responded to the survey request, 824 provided information in a free text area. These comments have been thematically analysed, which identified the following top 5 challenges/themes:

- Staffing levels (perception strongly negative)
- Bullying Culture (prevalent in almost 10% of all comments)
- Senior management (perception both positive & negative)
- Feeling valued (strong negative sense)
- Allscripts PAS (Patient Administration System) (frustrations around the launch/ functionality)

Developing Trust Culture

It is evident from the survey responses that we need to invest our resources to develop and promote a more positive environment where members of staff are keen to come to work and participate freely in developing our patient services without concern about any potential personal impact.

To this end the results have been considered by the Clinical Executive Management Group (CEMG) to agree areas of particular focus and alignment to key responsibilities within each care group. Our objectives for 2019 / 20 are to ensure that:

- Our people feel cared for, valued by and connected to the organisation
- Patient/ service-user feedback is used proactively to learn and improve
- Our people feel trusted, empowered and involved at all levels

The timing of survey was such that it cut across a period of significant change for the organisation with: the transition from divisions to care groups; and an almost complete change in the leadership of the organisation as we moved from a managerially led to a clinically led/managerially enabled organisation. This was not without challenge and it was expected that some of this would be reflected in the survey results. Rather than wait for the publication of the survey results, the organisation has been on the front foot implementing programmes that are designed to support delivery of the objectives.

In particular, the programme branded Listening into Action (LIA) was launched in the Autumn with a very clear remit to listen to the views of staff, receive feedback and respond with a series of actions to be led and driven by staff, for staff and patients. This method has been successful in engaging staff in developing and promoting their ideas and services.

The programme comprising 10 specific projects and a series of quick wins has had visible sponsorship from the Chief Executive and her Executive Director colleagues, which culminated in a series of pass it on events during May. These have been well received and drawn in a wide cross section of staff members who are learning from each other, developing as teams and finding a voice.

This programme is developing into a wider initiative as the year progresses, with a campaign identified as We said, we did! encouraging a bottom up as well as the more matrix approach to improvement for staff and patients, by staff. This is with the express intention of developing a: greater connection to the organisation; sense of, and belief in, their own empowerment; and ability to be our own agents for change.

We have also relaunched a respect and resilience programme which is being rolled out across the trust. This happened in March with a series of events planned across all sites to support staff with regard to their health and wellbeing. In part this is to encourage individuals to speak up when they are unhappy in their own situation, but it is also aimed at enabling individuals to manage their own circumstances and access suitable services without fear or anxiety. For this reason we have also enabled access to mindfulness programmes which is a facility that we plan to extend in due course.

The Trust is also developing a plan to introduce a new quality improvement programme which will run trust wide and is expected to be quite transformational. Whilst different methodologies have been considered, we expect to implement a programme that will drive not only service improvement but also significant cultural change and will get to the heart of some underlying behaviours that have caused concern and to which we are responding.

We have undertaken extensive research as to the most appropriate programme and have taken a proposal to the Board of Directors which has been agreed in principle. We will

require final approval from NHSI to undertake the level of investment required, but understand that the main thrust of our plans is understood and welcomed.

This specific activity rests against continuing work within care groups to develop and promote new ways of working, establish and build new teams and support structures with assistance from HR Business Partners and the Trust Transformation Team. Each Care Group has received an anonymised breakdown of results for the own areas of responsibility (albeit based on the previous division due to the timing of the survey) and are targeting specific issues with local improvement action plans and direct interventions where appropriate.

The trust is seeking to address the underlying cause of the issues we face. It is evident that these are multi -faceted and requires the systematic approach that we are seeking to implement.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to note and discuss the contents of this report.

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NHS
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REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**Report from the Chair of the Board of Directors Quality Committee**
PAPER AUTHOR:	**Chair, Board of Directors Quality Committee** **Barry Wilding**
PURPOSE:	**DISCUSSION**
APPENDICES:	**Annex A** Report from Chair of Quality Committee to 9 May Board meeting **Annex B** 2019/20 Strategic Objectives Getting to Good

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report provides Council with an outline of the key issues that the Quality Committee has been focussed on, highlighting to Governors how the Non-Executive Directors are seeking assurance about the performance of the Board.

The report to the Trust Board meeting on the last Quality Committee meeting, held on 30 April, is attached for information - at Annex A.

Background

The Committee receives a report on Quality, Risk and Governance from each of the Care Groups at every meeting. The reports received at our last meeting, in April, are demonstrating an improvement in quality, safety and experience across the Trust. That the reports highlight areas of concern in each Care Group, together with details on how these are being mitigated, provides reassurance that governance processes are working.

One area of feedback shared by all Care Groups was the need to recognise the level of compliments received in a robust fashion. While it is important to investigate and learn from complaints received, there is valuable information to be gained from the compliments given, as well as the importance of such recognition for staff morale. A system is to be introduced to improve the capture of compliments.

The Committee also receives a monthly report on Principal Mitigated Quality Risks and this, together with the Care Group reports, provides the evidence the Committee requires to gain assurance that risks are being identified and addressed in a comprehensive and timely manner. There have been occasions when the Committee has not gained assurance from the updates provided and this is always a matter of great concern. In such circumstances we will expect to be provided with evidence of significant improvement at the next meeting.

At the April meeting of the Committee we began to receive the early data on year end performance against quality targets. The report on compliance against the annual priorities set by the Trust for 2018/19 under Patients was most disappointing, with only one of the seven standards met Strengthen engagement with our academic. The Committee noted that other standards were partially met and was of the view that the quality and experience delivered for patients had improved markedly by comparing incidents between 2018 and 2019.

The Committee received and discussed a draft of the Trusts Quality Account. These discussions were informed by the comments provided from the Councils Audit and Governance Committee. The Committee was very disappointed to see that most of the targets had not been achieved, albeit some were close to meeting the criteria

set. Governors will be aware that there have been major changes within the Executive team. Whilst it is too early for this to have translated into improved performance, the Committee have been pleased to see coherent plans in place which the Executive team are developing and signs of improvement are becoming evident, albeit there is still a long way to go.

Looking forward, the Committee also looked at the proposed Annual Strategic Objectives for 'Getting to Good'. Some changes were agreed to ensure that the measures were clear and confirmed with the services leads. These are presented at Annex B.

As part of the Trust's Governance process, several Committees report into the Quality Committee: NICE/Clinical Audit & Effectiveness Committee; Patient Safety Committee; and Patient Safety Committee. As a Committee we look to the reports from these Committees, together with the Clinical Quality & Patient Safety report, to provide assurance around quality and safety issues in the Trust. The Committee looks particularly for assurance that action plans result in real and sustainable change. At the April meeting, for example, we requested that evidence be brought to the next meeting relating to the actions taken following an incident involving a fall from a restricted window.

I am aware that the extension of the terms of reference for the Council's Audit and Governance Committee tasks them with looking at the Trust's performance against quality measures through the year. This is a positive step which I feel will support the Council in its duty to hold NEDs to account, and also add value to the process of developing your commentary on the Trust's Quality Report. I look forward to discussing this report with the Council.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to discuss this report and take the opportunity to share with the Non-Executive Directors present intelligence arising from Governors' engagement with FT members and the public relevant to the work of the Committee as reported to the Trust Board.

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NHS
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REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**9 MAY 2019**
RECIPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: DRAFT ANNUAL REPORT AND ACCOUNTS ANNUAL PRIORITIES 2018/19 NARRATIVE** [Note: not appended to this report for Council meeting] **APPENDIX 2: MONITORING 2019/20 STRATEGIC OBJECTIVES** [Note: appended to the report to Council as Annex B to CoG 19/11]

BACKGROUND AND EXECUTIVE SUMMARY

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

The following provides feedback from the April 2019 Quality Committee meeting. The report seeks to answer the following questions in relation to the quality and safety performance:

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

MEETING HELD ON 30 April 2019

1. Quality, Risk and Governance Care Group:

The Committee was pleased to see improvement in quality, safety and experience across the Care Groups. The Care Groups presented their key points and the Committee asks the Board to note the following:

Cancer

1.1 Learning events will be set up to support the sharing of learning across the trust in relation to cancer, clinical haematology and haemophilia. The Care Group had identified how it would influence quality and reduce risk and the Committee requested an update on 1 or 2 of these as to how they would be measured / delivered;

1.2 Concern was raised in relation to compliance with sepsis compliance at Queen Elizabeth Queen Mother Hospital, this was being progressed by the Care Group.

Women's & Children's

1.3 A health and safety risk had been highlighted following a change of practice put in place following advice after the pseudomonas outbreak. This related to a particular chemical being used without sufficient ventilation. The Committee requested a review of the COSHH Policy to ensure it had been followed when the changeover of substance occured.

Surgery & Anaesthetics

1.4 Patient experience had improved and re-assurance was provide that the CQC actions outstanding in relation to implementing and embedding learning from incidents. The Care Group are reviewing the historic incidents to identify themes and trends.

1.5 A deep dive on risk 1095 in terms of hip fracture mortality rates and mitigations /

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investment required.

Surgery: Head & Nick, Breast and Dermatology
1.6 Good progress around investigating and closing incidents;
1.7 VTE compliance was of concern for ENT and this was on the risk register and being actively managed.

General and Specialist Medicine
1.8 The Care Group will be focussing on developing their risk register to the required standard. One highlighted risk was around staffing in relation to stroke services with the progression on the hyper acute stroke initiative.

Urgent and Emergency Care
1.9 Significant improvements made in nursing and will be reviewing the risk in the next two weeks to reassess;
1.10 There is a focus in the Care Group on improving consistency regarding hand hygiene.

Clinical Support Services Care
1.11 Friends and Family test was reported for musculoskeletal services and outpatients and were 94% and 96% respectively;
1.12 Pharmacy ward storage audit was positive, driven by the daily audits during the audits a number of additional storage areas were identified and the Committee has requested a briefing to understand how this has occurred and how it can be stopped or controlled going forward.

Committee general feedback:
1.13 Concern was raised by many of the Care Groups regarding the capture of compliments and it was confirmed that a new process / system was being developed to make this more robust.
1.14 The QI learning section in the Care Group presentations is developing well but more focus on demonstrating what the impact is would be the next step.

2. Highlight report on Constitutional Standards:

The Committee received and discussed the report, and asks the Board to note:
2.1 ED 4 hour compliance 81.5% (including MIUs) which is an improvement on February from 77.5%. There is an increase in 7 day and 21 day patients and high bed occupancy. Overall there has been an increase in attendances of 6.4% the equivalent of 13,362 patient in the year;
2.2 Referral to treatment time is at 80% up from 77.8% in February 2019 with 8 patients waiting longer than 52 weeks, all have plans.
2.3 Cancer 2 week wait has been achieved for the last 4 months with 31-62 day wait also improving and the 7 patients waiting over 104 days are being managed daily;
2.4 The diagnostic wait target has been met for the 6th consecutive month;
2.5 It was noted that the quality and experience for patients had improved markedly by comparing the incidents between 2018 and 2019.

3. Annual Priorities 2018/19: Board Assurance Framework:

The Committee received the Board Assurance Framework and Achievement against the 2018/19 Annual Priorities.
3.1 The Committee discussed the draft achievement against the annual priorities and subject to a review of the Embed a patient safety culture and some narrative to put the achievement or non-achievement in to context the Committee recommend Appendix 1 to the Board

4. Risk Briefing Update Fall from a restricted window:

4.1 The Committee received the recommendations from the investigation in to a recent incident relating to window restrictors. A report relating to the health and safety

elements would be presented to the Integrated Audit and Governance Committee to confirm the work has concluded;

4.2 In terms of the patient safety elements the Committee requested assurance that the recommendations were sustainable and this would be brought back to a future meeting.

5. Clinical Quality and Patient Safety Report:

The Committee would like to highlight the following points to the Board:

5.1 There is a risk around staffing fill rates at Kent and Canterbury with the focus on filling shifts at the acute sites

5.2 There were a number of key metrics within trajectory the Committee was assured that the aim was to make continual improvements, especially in relation to falls and pressure ulcers;

5.3 Harm free care remains good at 99.6% and the prevalence of new harms is positively below the national average for acute hospitals;

5.4 Complaint management continues to improve.

6. Annual Strategic Objectives Getting to Good:

6.1 The Committee reviewed the proposed strategic objectives for Getting to Good and subject to a couple of changes to ensure the measures were clear and agreed with the service leads it recommends this to the Board for approval and is provided as Appendix 2.

7. NICE / Clinical Audit and Effectiveness Committee:

7.1 The Committee noted the issue of the meeting not being quorate and this was being reviewed by the Medical Director; and

7.2 There was a risk in terms of vacancies within the Clinical Audit team and the roles were being actively recruited to.

The Committee also received and discussed the following reports.

- The Principal Mitigated Quality Risk Report
- Care Quality Committee Update
- Patient Safety Committee Report
- Patient Experience Committee Report
- Medical Directors Mortality Report
- Draft Quality Account 2018/19
- Quality Impact Assessment

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to **APPROVE** the:

- Monitoring for the Strategic Objectives; and
- Achievement against the 2018/19 Annual Priorities.

CoG 19/11 Annex B

Getting to good 2019-20

East Kent Hospitals University NHS Foundation Trust

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
Quality and safety standards embedded at all levels in the organisation; e.g. pressure ulcers, falls rates, MUST scores	Pressure ulcers >= 0 & <0.15 % Falls >= 0 & <5 % MUST TBC VTE >= 95 % MRSA / MSSA C. Dificile MUST assessment within 24 hours 95%	Trust Organisational Strategy 2019/ 22 Quality Strategy Mealtime Matters Plan Exemplar Ward Project Electronic Daily Audits	Quality Committee Infection Control Committee Quality and Risk Committee Serious Incident Panel Care Group Governance Quality and Risk Performance Meeting	Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role
Improved identification, treatment and support of patients at high risk of deterioration	Achieve 98%% of patients having their vital signs recorded accurately to ensure early detection of deterioration and 100% were Early Warning Score (NEWS)	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Quality and Risk Committee Serious Incident Panel Infection Control Committee Care Group Governance - Quality and Risk Performance Meeting	Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role
Deliver the Falls Stop programme and reduction in falls	Programme delivered Falls >= 0 & <5 %	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Serious Incident Panel Care Group Governance - Quality and Risk Performance Meeting	Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information, education and tools to carry out their role

Getting to good 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
Improved medicines safety	Completion of essential checks Ward storage audits Environmental monitoring Controlled drugs audits Achieve the required national standards for medicines reconciliation Complete and report on Staffs view of medication safety via the Trust Medication Safety Self-assessment tool Medication Safety thermometer Reduction in omitted doses of medicines to below national benchmarks Medication incidents Reduction in harm caused by medication incidents by 50% over the next 3 years	Trust Organisational Strategy 2019/ 22 Quality Strategy Trust Medication Safety Plan Exemplar Ward Project Electronic Daily Audits Drugs and Therapeutics Committee Hospital Pharmacy Transformation Plan	Quality and Risk Committee Serious Incident Panel Patient Safety Committee Drugs and Therapeutics Committee Care Group Governance - Quality and Risk Performance Meeting	Improved Medicines Value i.e. positive health outcomes from effective use of medicines Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role
All ward-based audits complete	All wards peer reviewed and consistently exceeding minimum % rating for good / compliance Monthly audits green , zero tolerance of nil returns Mock CQC surveys in all care groups rating Good	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Infection Control Committee Care Group Governance -Quality and Risk Performance Meeting	Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role

Getting to good

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East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**MEMBERSHIP ENGAGEMENT AND COMMUNICATION COMMITTEE (MECC) CHAIR'S REPORT**
PAPER AUTHOR:	**MECC CHAIR NICK WELLS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**None**

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report provides a summary of the key items discussed at the MECC meeting held on 8 April 2019.

Background

This is my first report as the MECC Chair; my fellow committee members are Junetta Whorwell, Alex Lister, Roy Dexter, Marcella Warburton, Julie Barker and David Bogard. The eighth member of the Committee was John Bridle, who resigned in April this year.

Committee wishes to bring the following information to the attention of Council.

Council Membership and Members' Engagement Strategy (MMES)

Much of the meeting was dedicated to discussing the latest draft of the MMES in preparation for completing a final draft to present to the Council at this meeting: this is at item 13. As a committee we commend this draft to you and stress the importance of Governor commitment to the chosen objectives if it is to deliver successfully.

Governor newsletter (GNL)

The plans to issue a GNL shortly after the January meeting were not successful and the Committee received a revised draft to consider at this meeting. The content was agreed and the GNL was issued shortly afterwards. In future a draft will be brought to each MECC meeting so that the newsletters are issued on a regular basis.

One of the principle aims of the newsletter is to increase the public profile of governors and the Council. As such, the Committee is suggesting that the agenda for all meetings of the Council and its committees should include a final item inviting members to consider whether there were any discussions or decisions taken at the meeting which could be included in the newsletter.

Membership Feedback Summary

The Committee received the report on membership numbers and feedback covering the previous three months. It was agreed that a priority for recruitment of new members would be to address gaps in the demographic profile.

The next MECC meeting is scheduled for 1 July 2019.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality**

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East Kent Hospitals University NHS Foundation Trust

	and experience of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to note this report and agree to the proposal that the agenda for all meetings of the Council and its committees should include a final item inviting members to consider whether there were any discussions or decisions taken at the meeting which could be included in the newsletter.

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REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**MEMBERS AND MEMBERSHIP ENGAGEMENT STRATEGY 2019/22**
PAPER AUTHOR:	**GOVERNOR AND MEMBERSHIP LEAD** **For Task and Finish Group**
PURPOSE:	**DISCUSSION**
APPENDICES:	**ANNEX A:** Members and Membership Engagement Strategy 2019/22 Draft

BACKGROUND AND EXECUTIVE SUMMARY

The Council of Governors tasked the MECC to draft the next Members and Membership Engagement Strategy, which will start in September this year and run for three years. In turn, the MECC formed a task and finish group of three of their members to work on the drafting.

The Council has been updated on progress, and given the opportunity to contribute, on two occasions: at the Joint meeting of Governors and NEDs in February and at the last Council meeting. The draft has gone through a number of iterations and is presented here for discussion. The final draft, taking into account these discussions, will be brought to the Council meeting in August for ratification.

The aim of the Task and Finish Group has been to draft the Strategy as simply as possible and to ensure that it is realistic in the objectives which are set. To this end, the Action Plan (Section 4), is intended as a 'menu' of a range of possible engagement and communication activities. The Council is asked to consider these carefully and discuss which should be included in the final strategy document giving due consideration to the resources available by way of governor time, funding and Trust staff time.

The purpose of the Strategy is to provide a practical framework for governors to engage with their members and the public, thereby meeting one of their two key statutory responsibilities. The Task and Finish Group had lengthy discussions about how the outcomes of this engagement should feed into Council meetings and be used to meet the other key responsibility to hold the Non-Executive Directors to account. While this is referenced in the draft, the Task and Finish Group consider that it is integral to the success of the Strategy and feel that it should be an important element of the Council discussions on the draft.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for**

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East Kent Hospitals University NHS Foundation Trust

	patients. • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to consider the draft of the Members and Membership Strategy 2019/22 giving particular consideration to the:

a) engagement and communication activities suggested; and
b) the mechanism for how feedback from engagement activities will be used by Council.

Draft: V5 Council meeting May 2019

East Kent Hospitals University NHS Foundation Trust

Council of Governors
Membership and Members Engagement Strategy

September 2019 August 2022

CONTENTS

1. INTRODUCTION

The role of the Council of Governors is to work alongside the Board of Directors holding Non-Executive Directors to account for the performance of the Board. The Council also has a statutory duty to represent the interests of the FT members who elected them and the public as a whole.

- To be able to meet its statutory responsibilities there must be effective engagment between the Council and those it represents the members and the public. This has to be two-way process. The engaement has to be a two - way process:

  a) from governors to public members, staff and the general public in order to raise awareness of the role of Governors , provide updates on the work being done and the outcomes achieved and to encourage membership growth and involvement.

  b) to governors from staff and public members, and the general public in order to provide intelligence which will then be used to facilitate governor challenge of NEDs , to inform the Board and provide insights to inform service development opportunities.

This Strategy document lays out how the Council plans to use its resources over the coming three years to meet these responsibilities.

2. AIMS OF THE STRATEGY

The overarching aim of the strategy is:

To grow an engaged and informed membership that is representative of all parts of East Kent.

The purpose of the Strategy is to provide a framework for the Council to deliver this aim making best use of the resources available, recognising that these are finite and must be focussed to achive maximum effect.

The framework has been built around addressing the following key questions:

1. Why is it important to have a membership and a Council?
2. What are the benefits of being a member of the Trust?
3. What does the Council want to achieve?

Why is it important to have a membership and a CoG?

It is a Statutory requirement of FT status to have a membership, but beyond this there is the potential for paving the way for service improvements based on the insights from service users. They have knowledge, experience, skills and views which can be of immense value to the Trust. Opportunities to make best use of this resource should be maxised.

Furthermore, Governors represent their constituents on Council and can utilise members and the publics views to challenge NEDs about the Boards, and ultimately the Trusts, performance.

What are the benefits of FT membership to members?

To have an engaged and representative membership, people must be able to see how they will benefit from being a member.

The following are seen as member benefits.

- A regular newsletter and other ad hoc communication from the Council to keep members updated on the work the Governors are doing and how their feedback has supported this work.
- Regular communications from the Trust to keep members updated on service developments and hot issues.
- Opportunities to raise their concerns with Governors and learn what has happened as a result.
- Members meetings with presentations on interesting issues and the opportunity to engage with Governors and senior Trust managers.
- Access to the NHS discount scheme.

What does the Council want to achieve?

By increasing the understanding of the role of Governors and the purpose of the CoG, delivering the benfits of membership and ensuring effective means of engagement, the objective is to grow an engaged and informed membership that is representative of all parts of East Kent.

This in turn will enable the Council of Governors to carry out its key roles:

- represent the interests of members and the public.
- hold the Non-Executive Directors to account for the performance of the Board.

In order to realise the benefits of delivering the strategy , Governors will need to:

- Be clear about how the information gained from engagement is most effectively used to hold NEDs to account,can be utilised as evidence for Council to raise concerns or questions and to inform the agendas for Council meetings.
- Commit to ensuring there are a variety of opportunities to engage with members and to participate in these.
- Be active in promoting membership across the whole community.
- Be able to signpost members appropriately if the issues they raise are outside of the remit of the Council ie direct those with patient complaints to the PET.

3. SPECIFIC OBJECTIVES TO DELIVER THE STRATEGY

It is important that the strategy identifies clear and measurable objectives to justify the:

- time given by governors to engage with members;
- staff time and funding invested by the trust to support membership; and
- the time given by members and the trust placed in the governors that they will act on the information provided.

The objectives underpinning this strategy are:

1. Raise staff and public awareness of the role of Governors.
2. Public Membership to be developed to fully reflect the population that the trust serves.
3. Increase Member engagement.
4. Develop pro-active approaches to seeking the views of members and the public on service development which will inform Council and Board discussions on the issues.
5. Update members on the work that they do and the outcomes achieved.
6. Increase the proportion of public members who can be contacted electronically.

7. Ensure there is a clear process for managing the information gathered via engagement and that is used to faciltate the Council's responsibilities.
8. Develop means of obtaining insights into the Trust's services, and how they might be improved, from the members and the public

The Action Plan below sets out in detail the way that Council intends to deliver the Strategy objectives during 2019 – 2022, the timelines for each action and the measures of successful delivery. The document will be amended, as may be necessary over time. It should be emphasised that the resources available to the Council are finite; govenors are volunteers who give of their own time and the Council is supported by a full time administrator within the Trust Secretary's office. It is therefore essential to prioritise the work of the Council to ensure that the best use is made of these resources, in delivering the objectives.

4. ACTION PLAN

This section is presented as an early draft for discussion by Council. It provides a menu of engagement events which Council could become involved in. It is not exhaustive, so governors may have other suggestions to make.

For the final version of the Strategy a decision needs to be taken on the choice of events which Council believes will best deliver the strategy objectives and governors are able to realistically support and sustain. The measures of success and time frame have only been completed for the first event as an indicator.

Ref No	Action	Objective/s met	Measure of success	Time frame
1	Piggyback Governor Communications on existing external systems, such as Council newsletters.	1 – 6 & 8	Identify X external sources and evidence Y number of contacts with the public	End of year 1. Review and decide on whether to continue in years 2 & 3.
2	Governor newsletter	1 – 6 & 8		
3	Ad hoc communication to members	1 – 6 & 8		
4	Members Evening meetings – general interest	1 – 5 & 8		
5	Members Evening meetings – strategic developments	1 – 5 & 8		
6	Meet the governor sessions – on site	1 – 5 & 8		
7	Meet the governor sessions – off site	1 – 5 & 8		
8	Joint site visits	4 & 8		
9	Involvement in Trust reviews ie PLACE	4 & 8		
10	Attending community events	1 – 5 & 8		
11	Attending events with NHS partner organisations	1 – 5 & 8		
12	Giving talks to groups ie local branches of an association	1 – 5 & 8		
13	Linking to schools/colleges	1 – 5 & 8		

5. CHALLENGES TO THE DELIVERY OF THE PLAN

The details of the action plan will need to be carefully balanced so that it can be delivered using the resources available. Governor agreement with, and commitment to, the plan will be esential to that delivery.

There will be Governor elections in February 2020 and 2021; understanding the Strategy will need to be included in the induction plan to ensure that momentum is not lost as the Council manages the changes in dynamics resulting from a change in membership. Simlarly, any changes to Trust staff involved in delivery of the plan will need to be managed to ensure continuity.

National changes to the role of Council and Governors may impact on the plan.

6. MONITORING THE PLAN

Progress against the plan will be reported at each of the quarterly meetings of the Council's Membership Engagement and Communication Committee. The MECC Chair will provide a report to Council after each meeting updating on progress against the plan and inviting discussion to ensure that the Council is in agreement with the plan as it develops.

The Strategy will be formally evaluated once a year, against the specified measures of succes, with a report provided to the Full Council meeting in August.

CoG 19/14

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**24 MAY 2019**
REPORT TITLE:	**COUNCIL AND COUNCIL EFFECTIVENESS SURVEY**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**DISCUSS**
APPENDICES:	**Annex A: survey results**

BACKGROUND AND EXECUTIVE SUMMARY

The Council undertakes an effectiveness survey annually to assess how well it is performing and where improvements can be made. The 2019 survey has been completed; there were 11 responders from a Council of 17.

The 2018 survey was issued to Governors in May. It was decided not present the results formally at Council as this was a significant period of change for the Trust with both the Chair and CEO having changed and a large proportion of the Council having been newly elected in February. A number of the new governors commented that they had been unable to answer questions relating to performance as they had not been in post long enough. The 2016 survey used the same questions and is presented here for comparison.

It was decided that the survey results would be used as a baseline comparison for the next survey undertaken. The corporate office did take note of the comments made.

Annex A provides the comparative data on the three surveys for discussion at this meeting.

LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to discuss the contents of the paper.

COUNCIL AND COUNCIL COMMITTEE EFFECTIVENESS SURVEY							
Section 1: Roles & Responsibilities							
No.	Statement 2019 - 11 responders from 17 2018 - 13 responders from 19 2017 - 17 responders from 26	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments from 2019 survey
1	I have a clear understanding of the roles of the Governor, including those within the Health and Social Care Act 2012	4 2 4	3 8 10	1 2 3	1 1 0	1 0 0	8 years as governor & many training events
2	I have a clear understanding of what it means to hold the Trust's Board of Directors to account.	4 5 8	2 3 6	2 5 1	1 0 2	1 0 0	
3	The Council of Governors adopt a rigorous process for the appointment of new Non-Executive Directors.	2 5 9	3 6 6	5 2 2	0 0 0	0 0 0	Chair of Nom & Rem
4	The Council of Governors adopt a rigorous process for the appraisal of the Chair and Non-Executive Directors.	2 2 4	5 8 6	3 3 2	0 0 3	0 0 1	In transition to new system. It may be helpful to consider discussion in person as part of a closed Council session. This might be combined with the current e mail correspondence.
5	Overall, the Governors, via the Council or Committee meetings alongside other activities, make a valuable contribution to the Trust.	1 1 1	4 6 6	4 5 7	0 1 1	1 0 2	The revised Committee structure and reintroduction of visits and Members events alongside strengthened public Board meetings facilitate contributions made.
Section 2: Full Council of Governor Meetings							
No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments:
6	Agendas and supporting documents are circulated in sufficient time for each meeting.	2 1 5	7 9 5	0 3 1	2 0 5	0 0 1	Well supported by the admin team. With rare exceptin this is the case.
7	The agendas contain an appropriate mix of items.	0 1 4	8 8 8	1 4 3	1 0 1	0 0 1	
8	Governors have sufficient opportunity to identify 'topics of interest' to add to the Council of Governors programme/meeting planner.	0 1 2	4 7 9	5 5 2	1 0 4	0 0 0	
9	Meeting papers contain sufficient information to allow me to participate in discussions.	1 2 5	7 7 10	1 4 1	0 0 1	1 0 0	
10	Everyone has an opportunity to contribute to the discussion.	3 3 2	6 9 9	0 0 1	1 1 3	0 0 1	
11	Action points are followed up in a timely fashion	1 1 1	6 6 9	2 6 5	0 0 1	1 0 1	

12	The time allocated to Council of Governor meetings is adequate.	0 0 1	7 7 8	3 5 3	0 1 4	0 0 1	Hard to balance length of meetings with amount of material. However govetnors have access to a range of other sources of information. Public meetings yes. Closed sessions might benefit from more time for discussion.
13	The Council of Governors meet at the most appropriate time.	1 0 0	5 6 12	3 6 3	0 0 1	1 1 0	Since I was elected, the Council of Governors meetings have always been in the daytime. 9 am. Mindful that the time of day meeetings are arranged may not suit everyone.
14	The Council of Governors meet sufficiently regularly to discharge its duties.	0 0 0	5 5 6	7 4 4	0 1 4	0 0 1	The agenda of Council of Governors meetings is planned in time and the topics and agenda items together with with effective charing, the meetings are productive Based on the understanding that an extraordinary meeting can always be added if necessary.
15	Overall, Council of Governor meetings are productive.	0 0 1	6 7 9	2 5 1	2 1 4	0 0 2	Inevitably some meetings are more productive than others.
Section 3: Council of Governor Committees							
No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments:
16	Council of Governor Committees make an effective contribution to the work of the Governors.	0 0 4	6 7 8	3 6 5	1 0 0	0 0 0	With reenergised Membership Committee and reintroduced Quality element to Audit and Governance I believe this is so.
17	I have the opportunity to be involved in the Committees that interest me.	3 3 7	6 8 9	1 2 0	0 0 0	0 0 0	I think that as Governors we should at least be asked which committee we would like to be on and not just changed at the end of the year. Memberdhip Engagement Commincations Committee is of intrest because it deals with matters to Trust members. There are some committees which are operantional and so Governors are not allowed to be involed
18	The Committees receive appropriate support from the Trust.	2 1 3	7 5 13	1 6 0	0 1 1	0 0 0	
19	The current number and structure of Council Committees are appropriate to carry out the Council's statutory duties.	0 1 1	6 3 12	4 7 3	0 2 1	0 0 0	We are at the moment two Governors down so are we able to carry out our Statutory duties?
20	The Committees effectively engage with the Council of Governors as a whole in undertaking their work.	1 1 1	6 5 13	3 6 1	0 1 2	0 0 0	
Section 4: Effectiveness of the Council of Governors							
No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments:

21	As a Governor I am able to effectively communicate with members.	1 0 1	4 6 5	3 6 7	2 1 4	0 0 0	Thus is a very difficult thing to do and I'm not aware of any Trust that has satisfactorily solved this problem To some degree I agree. For example, meet the GOV sessions on Hospital sites enable me to personally meet and engage with the public and members
22	Governors effectively engage with and represent the views of the Trust membership.	1 0 0	3 0 4	4 12 5	2 1 7	0 0 0	I engage with people from all backgrounds and listen to their veiws and their feedback of the services and how satisfied they were with the care they received. Communication is probably partial as not all members choose to engage .
23	Governors are effective in communicating with the membership about the activities they undertake on its behalf.	1 0 1	3 5 3	4 7 9	2 1 3	0 0 1	I engage with people from all backgrounds and listen to their veiws and their feedback of the services and how satisfied they were with the care they received. This is so through the AMM and Governor Newsletter
24	The Council of Governors effectively discharges its role of holding the Board of Directors to account for the performance of the Trust.	1 2 1	4 3 9	4 6 5	0 2 1	1 0 1	As already mentioned we are Two governors down so are we effectively discharging our role?
25	The Council of Governors is able to influence the direction of the Trust's future strategy.	0 0 0	3 2 3	5 9 7	2 2 3	0 0 3	I am not sure how much of our opinions are taken forward In the present climate future strategy is significantly bound up with partners.
26	The Council of Governors is the appropriate size to effectively carry out its statutory duties.	2 0 2	4 9 9	4 4 2	0 0 3	0 0 1	Again we are two Governors down
27	I believe the role of the Lead Governor enhances the effectiveness of the Council of governors.	0 3 1	7 4 5	1 5 5	2 1 4	0 0 1	I do not think we need to have a Lead governor I feel that we are able to make comment, by putting ideas through a third party ones comment might be given a different slant.
28	Relationships within the Council are constructive and work effectively.	1 0 1	6 6 9	1 7 3	1 0 3	0 0 0	
29	The Council of Governors plays an active role in developing the Trust's membership strategy (recruitment and engagement).	2 0 2	4 5 12	4 8 3	0 0 0	0 0 0	Governors have the opportunity to sit on MECC and one talk undertaken in 2019 is to reveiw the Membership Engagement Strategy Via the committee
Section 5: Working with the Trust							
No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments:
30	Governors can readily approach the Chair with a query or issue.	3 2 6	4 7 10	2 4 1	1 0 0	0 0 0	By liasing with the Lead Governor who meet with the Chair regularly and raise issues by the Governors
31	Governors are able to approach any Board member with a query or issue.	2 1 5	3 6 9	5 5 3	0 1 0	0 0 0	We need to have a definitive contact list of all the Board members, contact details Monthly at the Board meetings when members of the public are able to ask queastions

32	The Board of Directors is supportive of the Council of Governors.	1 2 2	4 3 2	4 6 1	1 1 1	0 0 0	
33	Governors have sufficient contact with the Trust's Executive Directors	0 1 1	2 4 7	7 7 6	1 1 2	0 0 0	Monthly at Board meetings
34	Governors have sufficient contact with the Trust's Non-Executive Directors.	1 1 1	2 3 9	5 6 6	2 1 0	0 2 1	We need to have a definitive contact list Site visits are arranged and Governors jointly undertake these visits with the Executives and the Non- Executives
35	The Trust provides Governors with sufficient information to enable them to perform their roles.	1 2 1	4 4 10	4 5 5	0 1 0	1 1 0	Our roles need to be more defined
36	The Trust provides sufficient support to the Governors to enable them to effectively discharge their role.	1 2 2	5 4 9	4 6 6	0 1 0	0 0 0	
Section 6: Skills/knowledge development for Governors							
No.	Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments:
37	I have sufficient skills, knowledge and experience to make an effective contribution as a Governor.	3 2 5	6 9 9	1 2 3	0 0 0	0 0 0	
38	Governor's specific training and development needs are identified and the appropriate training is provided.	0 1 1	7 1 9	3 5 5	0 1 2	0 1 0	More training needs to be given to new Governors The appropriate training us not always available Undecided because personally I have not had any specific training or deveoplment needs addressing. NHS Providers have provided training which all Governors were invited to
39	External development opportunities are drawn to Governors' attention and made available.	0 1 2	6 6 11	4 5 2	0 1 1	0 0 0	I am not aware of this or been involved Within financial limits
40	The induction programme for new Governors sufficiently meets their initial familiarisation needs.	0 0 0	6 6 8	2 4 5	1 2 1	0 1 2	Been a governor for many years. I understand from new govetnors that it is good.
	Comments						Comments:
41	Please enter any comments you have about this survey.						None